How to receive CME credit for this handbook:

1. Go to www.fhcme.com
2. Click “Online CME Activities”
4. Click register and follow instructions
How To Use This Handbook

This handbook is available electronically on www.fhcme.com. The material in this handbook is updated yearly. As policies are updated throughout the year, they are updated electronically in FH Policy and Procedures on the FH Intranet. The printed version of this handbook should only be used as reference. Some policies in this handbook have been condensed. To review policies in their entirety in the most up to date format, please refer to the FH Intranet.

Policies are distributed through the FH Intranet.

❍ In the computer under Intranet (BIG E - Internet explorer)  Click on “References”  Click on “FH Policy & Procedures” or “AHS Policy & Procedures” or click on  “Department and Campuses” click  “Med Staff” and click  “Bylaws/Policies/Protocols/Forms.

❍ Printed copies of policies are for temporary use only. Always refer to the FH intranet for the current official document.
# Table of Contents

MISSION, VISION, VALUES. ................................................................. 4  
REGULATORY AGENCIES ............................................................... 7  
MEDICAL STAFF ............................................................................ 15  
HIM/DICTATION ........................................................................... 23  
PATIENT RIGHTS ........................................................................... 33  
MANAGING RISK FOR PATIENT SAFETY ...................................... 51  
EMERGENCY CODES ..................................................................... 61  
INFECTION PREVENTION. ............................................................. 65  
PATIENT SAFETY .......................................................................... 85  
IMPORTANT PHONE NUMBERS. ................................................... 116
Our Mission:
To extend the healing ministry of Christ

Florida Hospital Vision
Florida Hospital will be a global leader providing highly advanced, faith-based health care and will develop a sustainable community health system that

• Improves the experience of care
• Improves the health of our community
• And reduces the per-person cost of health care

This system will provide major, relevant contributions to the re-shaping of America’s health care model.

Our Values:
“ICS BEST”

I ntegrity
C ompassion
B alance
E xcellence
S tewardship
T eamwork
CREATION Health takes a life-transforming approach to total person wellness -- mentally, physically and spiritually -- with the eight universal principles of health. Our CREATION Health Lifestyle has a long, proven history of wellness and longevity, worldwide.

**C** Choice is the first step toward improved health. Making healthy choices is the key to lifestyle improvement.

**R** Rest is both a good night’s sleep and taking the time to relax during the day.

**E** Environment is everything around us, yet affects what takes place inside us.

**A** Activity improves the health of the mind, body and spirit.

**T** Trust in God speaks to the relationship between spirituality and healing. Our faith, beliefs and hopes all affect our health.

**I** Interpersonal relationships with family, friends and others are important to our well-being.

**O** Outlook is our view of life and affects our body and our health.

**N** Nutrition is the fuel for our body and mind. Small diet changes can improve our health.

Contact us at CREATIONHealthEmployees@flhosp.org and (407) 200-2850.
Regulatory Agencies
Regulatory Agencies

**CMS:** Centers for Medicare and Medicaid Services.
- CMS Conditions of Participation (CoPs) are federal law for hospitals

**AHCA:** The Agency for Health Care Administration.
- Enforces Florida law for hospitals
- Works on behalf of CMS
Det Norske Veritas (DNV)

- DNV’s NIAHO standards are the requirements based on the CMS CoPs.
- DNV integrates the CMS CoPs with the internationally recognized ISO 9001 quality management framework.
- DNV is an accrediting body, similar to the Joint Commission and the American Osteopathic Association.

Florida Hospital uses CMS, AHCA, DNV and ISO 9001 as a foundation for its policies, procedures and processes.
What is ISO 9001?
ISO 9001 is an international standard by which organizations manage the quality, business and compliance of the organization. ISO 9001 was developed through the International Organization for Standardization.

Simple explanation of ISO 9001
Say What You Do:
Design processes that deliver results and communicate them clearly in policy, procedure and work instructions.

Do What You Say:
Reliably performed processes are the most certain way to deliver positive clinical outcomes and patient experience.
Measuring and auditing our processes is the best way to demonstrate the value we deliver to patients over time.

**Internal Audit/Tracer Methodology:**

- Industry standard for assessing consistency of our processes, policies and procedures.
- Completed through staff interviews, inspecting buildings, reviewing records and observing processes in action.
- Florida Hospital’s Internal Audit/Tracer Team conducts audits across all departments, clinical and non-clinical, at every campus, including off site campuses.

**Your Involvement in the Internal Audit Process:**

- You will be asked to describe the work you do every day.
- You may also be asked to guide the Auditor through records, such as logs or the medical record.
Improve It:

Continuous improvement at Florida Hospital can be anything from streamlining your daily work to reducing falls on your unit.

Corrective Action: Improvement that addresses a trend on a scorecard, patient complaint, audit findings or a serious event after it has occurred.

Preventive Action: Improvement that addresses potential problems before they occur.
Medical Staff
Medical Staff General Rules and Regulations

The Medical Staff General Rules and Regulations are deemed necessary to implement more specifically the general principles found within the Bylaws. They define the proper conduct of medical staff organizational activities, as well as the level of practice that shall be required of each practitioner in the hospital.

The medical staff assists Florida Hospital in developing, reviewing, and amending Florida Hospital’s Policies and Procedures (and are bound to comply with such policies). These policies are available for review in the Medical Staff Services Office and by accessing Florida Hospital Intranet Site under Departments and Campuses (Medical Staff) page.
Physician Privileges

To view the Florida Hospital privileges for Physicians and Allied Health Professionals, go to the FH Intranet Applications, Physician/AHP Privilege Lookup.
Consultation Categories of the Medical Staff

General Rules and Regulations Article 4 Section 4.3

The Medical Staff recognizes the following four categories of consultations. Although the requesting physician is encouraged to personally discuss the request and the condition of the patient with the consultant, each category has a defined requirement for communication and response time.

Stat Consult

- Requesting physician or AHP must personally discuss with the consultant
- Must respond by telephone within 15 minutes
Routine Consult

• Requesting physician or AHP may either personally discuss with the consultant OR provide sufficient information in the order to allow consultant to understand nature of consult.

• Must provide the consultation within 24 hours

Physician to Physician Consult

• Requesting physician or AHP will personally discuss case with the consultant

• Must respond within 2 hours

Courtesy Consult

• The physician receiving the courtesy consult is not obligated to see the patient or contact the requesting physician.
Medical Staff Peer Review

The Peer Review Department facilitates ongoing evaluation of physician performance data, consistent with the Medical Staff Bylaws. The organized medical staff’s commitment to a culture of safety is facilitated by defining circumstances requiring monitoring and evaluation of a practitioner’s performance. Monitoring and evaluation is accomplished through:

- Formal Peer Review
- Focused Reviews
- Extending Excellence Performance Data
- Department Specific Quality Monitors
- External Review
These activities are part of Florida Hospital’s Patient Safety Evaluation System. Under the direction of your medical staff leaders, peer review has been designed to enhance physician satisfaction, patient safety and quality. The primary focus is reducing risk from harm or injury (safety), and striving for excellence and value (quality), in a non punitive environment for sharing and learning. No cases reviewed through the peer review process will have a “standard of care” assigned. Instead, there are “action” items intended to encourage and foster a collegial and educational approach. Informational tools are also utilized to assist in identification of system issues that may be a contributing cause for cases requiring peer review.

Peer Review Contact
Mailing address: 601 E. Rollins Street, Box 91, Orlando, FL 32803
Office address: 901 Lake Destiny Road, Suite 301D, Maitland, FL 32751
Main Office Number: 407-200-1330
HIM/Dictation
The Medical Record
Medical information is maintained on all patients in all care settings at Florida Hospital. Medical records can be accessed electronically in the Cerner Powerchart application, with portions of the medical record on paper. Policy 715.004

Documentation Requirements
ALL entries in the medical record must be legible and properly authenticated (name, FH ID #, date and time). Policy 700.719

Patient Document Review Committee
• ALL paper forms in the medical record must be approved by the Patient Document Review Committee (PDRC)
• Patient Document Review Committee Contact number: 407-303-9279
Release of Information

Medical records can be released to patients, caregivers, physicians, insurance companies and legal representatives. To release medical records, except for in the case of treatment, payment and operations, the patient or legal representative must sign a valid “Authorization for Release of Information” form. The form must be dated on the day of discharge or after. Patients may be required to pay a fee for obtaining copies of medical records. For questions, contact the Health Information Management Release of Information Department at 407-303-9175.
History and Physical Required Components

General Rules and Regs - Article 7 Section 7.4.2

- Chief complaint
- Details of present illness
- Medical and surgical history
- Relevant social and family history
- Pre-admission medication list
- Review of systems
- Physical examination
- Assessment
- Plan
**Update** (for H&P’s completed within 30 days prior to admission)

- Document “H & P was reviewed, patient was examined, no changes were found to patient’s condition since H & P was completed” or document changes if any.

- The H&P update must be completed within 24 hrs after admission but prior to surgery or procedure.
Discharge Summary Requirements
General Rules and Regs - Article 7 Section 7.4.8
Health Information Management

A discharge summary must be documented for any patient hospitalized more than two days, and must be completed within five Business Days after the discharge or disposition of the patient.

- Reason for Hospitalization
- Procedures Performed
- Summary of care, treatment, and service provided
- Outcome of hospitalization
- Prognosis/disposition of care
- Final diagnosis
- The name of the individual or facility assuming responsibility for the patient after discharge and any provisions for follow up care
- Medications the patient should take post discharge
- Comparison of condition and disposition
Complete Orders Requirements

General Rules and Regs - Article 7 Section 7.5

Health Information Management

• Date and Time

• If a medication:
  ◦ Name
  ◦ Dosage or strength
  ◦ Route of administration
  ◦ Frequency of administration
  ◦ Scheduled start time
  ◦ If the initiation is conditional (e.g., prn, on call) the condition required to trigger the initiation (e.g., prn pain, on call to operating room) must be specified

• Approved abbreviations per policy 700.703

• Physician/Allied Health Professional’s

• Orders must be legible and properly authenticated (name, FH ID #, date and time)
Dictation Instructions

Florida Hospital Physician

**Step 1**  Lift receiver and dial 407-303-5590 or tie line 831-303-5590.

**Step 2**  Enter 4-digit dictate code followed by the # sign.

**Step 3**  Select patient’s location code by entering the corresponding 2 digit number from the list below:

- Orlando 01
- Winter park 07
- Altamonte 02
- Kissimmee 08
- Apopka 03
- Celebration 09
- East Orlando 06
- Winter Garden 11

**Step 4**  Enter 2 digit work type.

- 55 Pre-Surgical H&/Consult
- 13 Consultation
- 16 Catheterization
- 20 Radiation Oncology
- 28 Pain Center
- 98 Letter
- 11 History and Physical
- 14 Discharge Summary
- 17 Neurology/Sleep Study
- 23 Echos, Dopplers, Carotids
- 38 Discharge Summary/Addendum
- 97 Correction to Report
- 12 Operative Report
- 15 Cardiac Rehab & Holters
- 19 Procedures
- 25 Inpatient Cardiology

**Step 5**  Enter patient’s 8 digit account #

**Step 6**  Begin dictation

**Controls**

Press * to go to beginning of report
Press # to go to end of report
Press 9 to disconnect or 5 to end report and Begin new report
Florida Hospital Allied Health Practitioners

Step 1 Lift receiver and dial 407-303-5590 or tie line 831-303-5590.

Step 2 Enter 4-digit dictate code followed by the # sign.

Step 3 Enter Authenticating Physician’s Dictate Code (The Authenticating Physician Is The Physician For Whom You Are Dictating.)

Step 4 Select patient’s location code by entering the corresponding 2 digit number from the list below:

- Orlando 01
- Kissimmee 08
- Altamonte 02
- Apopka 03
- Celebration 09
- East Orlando 06
- Winter Garden 11

Step 5 Enter 2 digit work type.

- 55 Pre-Surgical H&/Consult
- 13 Consultation
- 16 Catheterization
- 20 Radiation Oncology
- 28 Pain Center
- 98 Letter
- 11 History and Physical
- 14 Discharge Summary
- 17 Neurology/Sleep Study
- 23 Echos, Dopplers, Carotids
- 38 Discharge Summary/Addendum
- 12 Operative Report
- 15 Cardiac Rehab & Holters
- 19 Procedures
- 25 Inpatient Cardiology
- 97 Correction to Report

Step 6 Enter patient’s 8 digit account #

Step 7 Begin dictation

Controls
Press * to go to beginning of report
Press # to go to end of report
Press 9 to disconnect or 5 to end report and
Begin new report
PATIENT SAFETY
Their Right ✓ My Responsibility
Patient Rights
Patient Rights

Policy 010.010

Patients receive a written statement of his/her rights during the admission process. These include the right to:

- Access to Healthcare
- Participation
- Health Information
- Dignity, Privacy, Safety
- End of Life
- Communication
- Visitation
- Financial Information

Patient Rights: Access to Healthcare

The patient has the right to impartial access to medical care, treatment or accommodations that are available and medically indicated regardless of race, sex, sexual orientation, national origin, religion, handicap or source of payment.

Patient Rights: Participation

The information provided to the patient and his/her family may be written or verbal, but should be appropriate to each of the following:

- The right to be informed about and participate in decisions regarding their care
- When the patient is either incompetent, incapacitated or a minor, the patient’s rights shall be exercised by the legally authorized person
- The right to exclude any or all family members from participating in their healthcare decisions
- The right to have a family member or representative of their choice and their physician promptly notified of their admission to the hospital
• The patient or LAP on behalf of the patient has the right to be given consistent with Florida law, information concerning:
  1. Diagnosis and health status
  2. Planned course of treatment
  3. Benefits and risks
  4. Alternatives, including non-treatment
  5. Prognosis.

**Patient Rights: Health Information**
Each patient has the right to:
• Know the name, function and qualifications of each physician and healthcare worker who is providing care to that patient
• Confidentiality of information
• Review their medical record while a patient in accordance with all federal and state laws
• Access, request amendment to, and obtain information on disclosures of their information, in accordance with Law and Regulation

**Patient Rights: Dignity, Privacy, Safety**
Each patient has the right to:
• The patient has the right to care that is considerate and respectful with recognition of his/her personal individual dignity, values and beliefs.
• The patient has the right to express his/her spiritual beliefs and cultural practices as long as these do not harm other patients, staff or visitors.
• The patient has the right to request and be provided religious and other spiritual services
• The patient has certain rights to privacy, which shall be respected without regard to the patient’s economic status or payment source
• The patient has the right to receive care in a safe environment
• The patient has the right to retain and use personal clothing and/or possessions unless prohibited by law or contraindicated due to medical or safety reasons.
• The patient has the right to be free from all forms of physical or mental abuse, corporal punishment or harassment.
• The patient has a right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure immediate physical safety of the patient, staff member, or others; and must be discontinued at the earliest possible time.
• The patient has the right to access protective services (for example: Department of Children and Family Services).
• The patient has the right to know what rules and regulations apply to patient conduct.

Patient Rights: End of Life
• The patient has the right to formulate an Advance Directive (Living Will / Durable Power of Attorney for Healthcare) indicating his / her choices regarding healthcare decisions involving life prolonging procedures and/or designating someone to make healthcare decisions in the event of later incompetence or incapacity.
• The patient has the right to discuss with their physician whether to use, forego or discontinue resuscitative measures.
• The patient who is terminally ill, has an end stage condition, or is in a persistent vegetative state has the right to have life prolonging procedures withheld or withdrawn. Medication shall be administered or medical procedures performed that provide comfort care, alleviate/mange pain or promote hygiene unless otherwise directed by the patient’s Advance Directive.
• The dying patient has the right to comfort and dignity and to guide all aspects of care which include:
  1. Providing appropriate treatment for any primary and secondary symptoms, according to the wishes of the patient or the legally authorized person.
  2. Managing pain aggressively and effectively
  3. Respecting the patient’s values, religion, and philosophy
  4. Responding to the psychological, social, emotional, spiritual, and cultural concerns of the patient and family
  5. Sensitively addressing issues, such as autopsy and organ donation

Patient Rights: Communication
• The patient with limited English proficiency or non-English speaking has the right to free language assistance when receiving medical care that is readily available.
• The patient with vision, speech, hearing, or cognitive impairment has a right for communication in a manner that meets the patient’s needs.
• The patient has the right to receive information in a manner tailored to his / her age, language, and ability to understand.
• The patient has the right to access a telephone and mail service, based on the setting and patient population. Communication may be restricted for therapeutic reasons. The restrictions will be explained to the patient.
• The patient has the right to prompt and reasonable response to his/her questions.

Patient Rights: Visitation
• The patient (or support person when appropriate) has the right to be informed of his / her visitation rights including any clinical restriction or limitation of such rights, when he / she is informed of his / her visitation rights.
• The patient (or support person when appropriate) has the right, subject to his / her consent, to receive visitors whom he / she designates, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member or friend, and to withdraw or deny such consent at any time.
• Visitation privileges shall not be restricted, limited or otherwise denied on the basis of age, race, color, national origin, culture, language, religion, sex, gender identify or expression, sexual orientation, socioeconomic status, or physical or mental disability.
• The patient has the right to expect that all visitors enjoy full and equal visitation privileges consistent with his/her preferences.

Patient Rights: Financial Information
• The hospital shall, upon request, furnish the patient prior to receiving medical services, a reasonable estimate for charges for services to be provided.
• The hospital shall, upon request, disclose to the patient eligible for Medicare, in advance of treatment, whether the hospital accepts assignment under Medicare reimbursement as payment in full for medical services and treatment rendered in the hospital.
• The patient has the right to be given, upon request, information and counseling on the availability of known financial resources for the patient healthcare.
• The patient has the right to receive a copy of an itemized bill upon request. The patient has a right to be given an explanation of charges upon request.
• A patient eligible for Medicare has a right to know, upon request and in advance of treatment, whether the health care provider accepts the Medicare assignment rate.
Patient Privacy Policy 010.128

When patients come to Florida Hospital, they expect and trust that their privacy and confidentiality will be protected.

Rules that govern patient privacy and confidentiality are part of a federal law called the Health Insurance Portability and Accountability Act (HIPAA). HIPAA uses the phrase Protected Health Information (PHI), which includes all medical, financial and demographic information such as:

- Patient name
- Address
- Phone Number
- Social Security Number
- Birth Date
- Medical Record Number (MRN)
- Financial Identification Number (FIN)
- Any information which could individually identify the patient

HIPAA requires compliance by every employee with strict regulations regarding the management of medical information in the following areas:

- ALL medical records, including inpatient and outpatient records, as well as, electronic records
- ALL forms of communication regarding a patient, including oral, written and electronic communications
- ALL financial records

HIPAA’s Minimum Necessary Rule

Employees may only use or disclose information that is necessary for the purpose. When it comes to access to information, EMPLOYEES MUST NOT ACCESS:

- The employee’s own medical records
- Information on a friend, family member or co-worker
- Information out of curiosity
It is a violation of HIPAA if you access information outside of your job duties.

**Discussions regarding patient information**
While working with patients, more than likely there will be many conversations with the patient, their family members and other clinicians. If a visitor or family member is in the room, you must obtain permission from the patient before sharing information with them. If a person is calling to check on the status of a friend or relative, steps should be taken to validate the identity of the person calling and to ensure that the patient has provided consent to discuss his/her care with this individual. Make sure to document the consent received from the patient.

**Data Security**
- Do not share your password
- Log off electronic devices such as computer, laptop, toughbook, tablet or phone when done using it or if you have to leave the area.
- Do not send patient information via unsecured email or text
- Do not forward patient information to your personal email accounts
- Do not post patient information on social media sites
- Report lost or stolen electronic devices to the FH MIS Help Desk
- If traveling with PHI, be sure that it remains secure at all times

**Enforcement of HIPAA**
- The law provides for civil and criminal penalties with fines and jail time for violations of HIPAA
- Florida Hospital takes HIPAA violations seriously. If you are found in violation of HIPAA laws, disciplinary action will occur at Florida Hospital up to and including termination.

**Reporting HIPAA Issues**
Contact the Corporate Responsibility Privacy Division for any complaints or inappropriate disclosures of patient information, questions or concerns at FH.Privacy@flhosp.org or (407) 303-9659.
Social Media Policy 800.275

Our organization is committed to providing a secure environment for general and confidential information, including Protected Healthcare Information (PHI).

All Florida Hospital staff members using electronic communication to share information and knowledge regarding Florida Hospital’s mission, business or clinical activities are required to do so in a manner that protects the confidentiality, integrity and availability of all FH information and knowledge. Additionally, use may not disrupt business operations within FH or any other organization, nor violate local, state or federal regulations. Do NOT put identifiable patient information on social media sites without a HIPAA-compliant patient authorization.
In general, use of electronic communications:

- Must support the needs of the business.
- May not be used for solicitations of any kind that are unrelated to FH business.
- Must not interfere with work performance or business needs if used incidentally for personal reasons.
- Must be protected using an FH-approved method of encryption when sharing confidential information including, but not limited to, PHI.

Questions regarding appropriate use of electronic communications should be directed to a Manager, HR, Corporate Responsibility Compliance and Privacy Division and/or the Corporate Data Security Office.
Patients have a right to receive information in a manner they understand.

A full time staff of qualified medical interpreters, supplemented by agency staff interpreters and over-the-phone and video remote interpreters, is available to assist any FH employee or physician 24 hours a day, seven days a week, 365 days a year, to facilitate clear communication with Limited English Proficient or deaf patients and their family members or authorized person(s). Assistive devices for the deaf are available. Please review the Assistive Devices SOP and contact FH Interpreter Services for locations and details.

To ensure accurate interpretation/understanding of healthcare terminology, only qualified medical interpreters or qualified bilingual staff (verified through a testing process to determine qualification) must be used when engaging in medically relevant communication with an LEP/NES or deaf patient or their family member/s or their authorized person/s.

**LEP (Limited English Proficient):** A limited ability or inability to speak, read, write, or understand the English language at a level that permits the person to interact effectively with healthcare providers.

**NES (Non-English Speaking):** An inability to speak, read, write or understand the English language.
Language Assistance Toolkit

In-person Interpreters
• American Sign Language (ASL)
• Spanish Sign Language
• Tactile interpreters (for patients who are both blind and deaf)
• Non-English spoken language interpreters
• To schedule an in-person Interpreter:
  ◊ Same-day requests for Interpreters - call ext. 831-1103025
  ◊ Next-day or future appointments - e-mail in FH Outlook: FH Interpreter Services Dept

Video Remote Interpreting (VRI)
This tool provides immediate access to live, qualified American Sign Language interpreters, as well, as the most frequently encountered non-English spoken languages using our existing laptop computers with the addition of a small webcam and speaker phone. Patient care areas not equipped with VRI, may request VRI set up through FH MIS and FH Interpreter Services.

Over-the-phone Interpreters
This tool provides immediate access to live qualified medical interpreters and language identification assistance using over the phone interpreters.
• Use any Florida Hospital phone or Spectra link:
  ◊ Dial ext. 1108510 at FH Orlando campus and Medical Plaza
  ◊ Dial ext. 8510 at all other FH campuses
• Pre-programmed dual handset phones – corded or cordless telephone equipment available through FH Telecom.
Advance Directives  Policy 010.070

Patients have a right to make decisions about care, treatment and services received at the end of life.

An Advance Directive is a legal document that:

-Clarifies a person’s wishes related to his/her health care and medical treatment.
-By law, each patient is to be asked about Advance Directives. At FH, the patients are asked about Advance Directives during registration and given a copy of the Advance Directive Summary Statement. During the admission process, the nurse will obtain information regarding the existence of Advance Directives and offer assistance as needed.
-If the patient requests to complete an Advance Directive later, then Nursing, Case Management and Pastoral Care receives a task in i-Extend to follow-up within 24 hours and then at 48 hours.

Any adult employee CAN witness an adult patient signing an Advance Directive. Two witnesses are required for the Advance Directive to be valid. A notary is NOT required.
Two types of Advanced Directives are:
1. Living Will
2. Designation of a Health Care Surrogate

A Living Will identifies the patient’s wishes related to life prolonging procedures at the point when they are unable to make decisions for themselves.

A Living Will should not be confused with Do Not Resuscitate (DNR) status. See policy 010.072 for further information on DNR.

The “Designation of a Health Care Surrogate” allows for an adult person to appoint another adult to make health care decisions on his/her behalf if he/she becomes unable to make their own medical decisions.
If a patient is unable to make a health care decision, the patient’s Legally Authorized Person (LAP) would be empowered to do so according to the following order of priority:
Prioritization of LAP

1. Court appointed guardian, if authorized to consent to medical treatment
   - Guardianship paperwork required
2. Health Care Surrogate
   - Properly completed Advance Directive naming individual as Health Care Surrogate is required
3. Patient’s spouse
   - Has to be legally married
4. Adult child(ren)
5. Parent(s)
6. Adult sibling(s)
7. Adult relative
   - Maintained regular contact with patient and is familiar with patient’s beliefs
8. Close personal friend
   - Has to have notarized Close Person Friend Affidavit
9. Social Worker Proxy  \textbf{Note: Refer to Social Worker Proxy Policy # 010.146}
   - Not an employee of Florida Hospital
   - Licensed Clinical Social Worker approved by the Ethics Committee for this purpose
Informed Consent

Patients have the right to give or withhold Informed Consent.

A consent form documents the discussion that has occurred between the physician and the patient. It is the responsibility of the physician/credentialed practitioner to provide the patient with sufficient information to give informed consent.

The physician/credentialed practitioner informs the patient concerning the invasive medical procedure and the benefits, alternatives and risk associated with it.

If the patient or LAP has questions or concerns, the physician is to be notified.

When the patient is incompetent, incapacitated or a minor, the right to participate in health care decisions is exercised by the patient’s legally authorized person.

When, in the opinion of the physician/credentialed practitioner, an emergency and/or life threatening condition arises and the patient is either unable to give informed consent, or there is insufficient time to obtain informed consent from the patient or LAP, the physician/credentialed practitioner may proceed with the invasive medical procedure, and/or anesthetics or therapy.
The physician/credentialed practitioner shall document in the medical record as follows:

a. Why the emergency surgery, procedure, and/or anesthetics, or therapy has to be performed; **and**

b. That the patient is unable and the LAP is unavailable to provide informed consent; **or**

c. That there is insufficient time to obtain the consent of the patient or LAP.

The physician/credentialed practitioner who provided informed consent is to sign the Florida Hospital Consent Form. The nurse or another department authorized health care employee is responsible to ensure that the consent form has been completed prior to the surgery or procedure.

Some tests and procedures, such as blood transfusions and HIV testing, have specific policies and consent forms.
Managing Risk for Patient Safety
Risk Management

The overall goal of the Risk Management Department is to ensure a safe environment for patients, visitors, employees, and physicians. Each campus has a dedicated Risk Management Coordinator(s) assigned. The Risk Managers responsibilities cover a wide range of activity, which includes both preventative activities and management of serious events that may have occurred.
A Physician Generated Event Report (PGER) is a Clinical Event that has occurred outside of the normal routine activity of the hospital that may or may not have cause injury. The PGER is an effective method of communication for the physician to address concerns related to patient care. The unit manager or director can assist you with this reporting process and follow up.

The reports are tracked and trended on a monthly basis and noted trends may trigger a hospital plan of correction to prevent reoccurrence.

We encourage physician participation in the Clinical Event report process.
Sentinel Event
Policy 305.751

A Sentinel Event (SE) is an unexpected occurrence involving death or serious physical or psychological injury to a patient, or the serious risk thereof. Serious injury specifically includes loss of limb or function.

When a potential sentinel event is reported, the Risk Management Coordinator will conduct an investigation of the Clinical Event, and review for SE criteria with the interdisciplinary Serious Event Analysis Team (S.E.A.T.) Committee.

When a Clinical Event is identified as a SE, a Root Cause Analysis (RCA) will be initiated to identify the factors that underlie variation in performance. The focus is primarily on systems and processes, not on individual performance.
What is Sexual Misconduct?
Policy 010.051

Sexual Misconduct is inappropriate behavior of a sexual nature by an employee to a patient. Sexually demeaning or seductive behaviors, both physical and verbal, between an employee and a patient are not permitted. Any allegation of sexual misconduct regarding a patient is to be reported to Risk Management immediately.
Disclosure of Unanticipated Outcomes
Policy 010.130

Disclosure is a process Florida Hospital has put into place to provide information to a patient and or family when an unanticipated outcome occurs. An unanticipated outcome is a result that differs significantly from what was anticipated to be the result of a treatment or procedure. The purpose of disclosure is to support the patient’s right to information about the outcomes of diagnostic tests, medical treatment and surgical/procedural intervention and to meet statutory obligations as applicable..

The attending physician, or another physician involved in the treatment, surgery or procedure, is responsible for ensuring disclosure takes place when indicated. Risk Management should be contacted immediately when you become aware of a Clinical Event that may require disclosure to the patient and/or family.
Patients Complaints & Grievances

Policy 010.030

What is a Complaint?
Center for Medicare and Medicaid Services (CMS) defines a complaint as: A patient issue that can be resolved at the time of the complaint by the staff present or responsible for patient’s care. “Staff present” means any hospital staff present at the time of the complaint or who can quickly be at the patient’s location. Service related issues are considered complaints (wait time, rudeness, cleanliness, etc.). The manager of the involved unit/department would address and respond to these issues.

What is a Grievance?
A patient grievance is a formal or informal written or verbal complaint that is made to a hospital by a patient or the patient’s representative when a patient issue cannot be resolved promptly by staff present. If a complaint cannot be resolved promptly by staff present or is referred to a complaint coordinator, patient advocate or hospital management, it is considered a grievance.

What is the process for a Grievance?
Grievances are the responsibility of Risk Management, who follows up on patient care concerns, (wrong medications, misdiagnosis, patient harm, etc.) The involved staff members may be asked to assist as well. The Risk Manager is to assist with the grievance investigation, resolution and response to the patient or legally authorized person. Premature discharge issues are followed up and addressed by Care Management, and financial issues are followed up and addressed by Patient Financial Services (PFS). HIPPA issues are followed-up by the Compliance Officer.
The Patient Safety and Quality Improvement Act of 2005 is a federal law which provides for the improvement of healthcare quality and patient safety. It authorized the creation of federally certified Patient Safety Organizations (PSO).

To encourage a culture of safety, quality and a non-punitive cooperative system, Florida Hospital has joined the Quality Circle of Healthcare (AHS PSO), a federally designated Patient Safety Organization. This organization will assist us to elevate our quality care and patient safety by analyzing data and incorporating evidence based practice.
Key definitions associated with PSOрг:

- **Patient Safety Evaluation System (PSES):** PSES is achieved through safety initiatives and various patient safety activities such as event reporting, trigger tool data and Patient Safety Walk Rounds. It manages the collection and/or analysis of information that is reported to a federally designated Patient Safety Organization (PSOрг).

- **Patient Safety Work Product (PSWP):** includes any data, reports, memoranda, analysis (such as root cause analysis) or written or oral statements that are/is collected and used solely to improve patient safety and are held CONFIDENTIAL. It does not include the patient’s medical records, billing and discharge information or original patient or provider information. PSWP cannot be used punitively or for discipline. PSWP is confidential to Florida Hospital.

Oversight for activities related to the PSES and PSWP is provided by the PSOрг Executive and Advisory Committees. All FH employees should ensure PSWP is held confidential and should not be disclosed to parties outside of FH without approval by PSOрг Chairperson or his/her designee. If you are asked for information you believe may be considered Patient Safety Work Product (PSWP) or have questions regarding this, contact your Patient Safety Officer or Risk Management Coordinator.
Emergency Codes
Emergency Safety Conditions

During a large scale emergency or community disaster, Florida Hospital follows an Emergency Operations Plan that is managed from a designated space called the Hospital Command Center. Hospital executives and leaders follow this plan to manage the disaster separate from the day-to-day operations so as to minimize its impact on patient care.

The overhead paging system is used to communicate emergent situations to FH staff using color codes for some and plain language for others. Upon hearing these codes and locations announced overhead, execute your department’s standard operating procedures to respond.
• **Code Red** – Smoke/Fire

• **Code Pink** – Infant/Child/Adolescent Abduction

• **Code Yellow** – Prepare for internal building evacuation

• **Code Green** – Commence building evacuation

• **Code O2** – Loss/failure of oxygen

• **Code Blue** – Cardio-pulmonary arrest

• **Code Black** – Bomb threat

• **Code Orange** – Hazardous material incident

• **Mass Casualty** – Prepare to receive patients due to mass casualty in community

• **Active Shooter/Armed Intruder** – Avoid area announced and listen for further instruction
Infection Prevention
Hand Hygiene: Wash/Sanitize Your Hands

Your 5 Moments for Hand Hygiene

1. BEFORE TOUCHING A PATIENT
2. BEFORE CLEAN/ASEPTIC PROCEDURE
3. AFTER BODY FLUID EXPOSURE RISK
4. AFTER TOUCHING A PATIENT
5. AFTER TOUCHING PATIENT SURROUNDINGS
|   | BEFORE TOUCHING A PATIENT | WHEN? Clean your hands before touching a patient when approaching him/her.  
|   | WHY? To protect the patient against harmful germs carried on your hands.  
| 2 | BEFORE CLEAN/ASEPTIC PROCEDURE | WHEN? Clean your hands immediately before performing a clean aseptic procedure.  
|   | WHY? To protect the patient against harmful germs, including the patient’s own, from entering his/her body.  
| 3 | AFTER BODY FLUID EXPOSURE RISK | WHEN? Clean your hands immediately after an exposure risk to body fluids (and after glove removal).  
|   | WHY? To protect yourself and the health-care environment from harmful patient germs.  
| 4 | AFTER TOUCHING A PATIENT | WHEN? Clean your hands after touching a patient and his/her immediate surroundings when leaving the patient’s side.  
|   | WHY? To protect yourself and the health-care environment from harmful patient germs.  
| 5 | AFTER TOUCHING PATIENT SURROUNDINGS | WHEN? Clean your hands after touching any object or furniture in the patient’s immediate surroundings when leaving – even if the patient has not been touched.  
|   | WHY? To protect yourself and the health-care environment from harmful patient germs.  

Infection Prevention
A significant exposure requires a point of entry (non-intact skin, mucus membrane or through the skin injury) and contact with blood or an “other potentially infectious material” (spinal, amniotic fluid, etc.)
## Prevention of Exposure

<table>
<thead>
<tr>
<th>General</th>
<th>Contaminated items</th>
<th>Sharps Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always use standard precautions with all patients regardless of perceived risk.</td>
<td>Use appropriate containers for regulated medical waste.</td>
<td>Dispose of used syringes and sharps immediately after use in an approved sharps container.</td>
</tr>
<tr>
<td>In areas where exposure to blood or body fluids is possible:</td>
<td>Follow recommended practices for handling contaminated clothing and laundry, including performing hand hygiene after handling.</td>
<td>Use needle-less system/needle safety devices appropriately.</td>
</tr>
<tr>
<td>• Do not apply cosmetics, lip balm or manipulate contact lenses.</td>
<td></td>
<td>Never attempt to recap a used needle.</td>
</tr>
<tr>
<td>• Do not eat, drink or put objects (like pens) in your mouth.</td>
<td></td>
<td>Do not attempt to remove a sharps device from a sharps container.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Replace sharps containers when ¾ full.</td>
</tr>
</tbody>
</table>


Exposure Control Plan

In the event an exposure occurs, immediately:

- Flush exposed mucous membranes and eyes with clean water (remove contact lenses prior to flushing).
- For sharps injury, such as a stick with a used needle, clean the punctured area with soap and water.
  - Seek emergency assistance if unable to control bleeding or wound requires medical attention.
Post-exposure Medical Follow-up

Immediately perform necessary first aid.

Call the Exposure Hotline at
(407) 200-4702 or (888) 807-1020, option 2

Provide a phone number where you may be reached. Describe incident; have source info; know device detail if a sharps injury. The Post Exposure Nurse (PEN) will arrange follow up with you on-site. DO NOT DELAY! If post-exposure medication is appropriate, it should be started as soon as possible.
Standard Precautions
Policy 500.110 and Policy 500.100

Standard Precautions combine the major features of Universal Precautions and Body Substance Isolation and are based on the principle that all blood, body fluids, secretions, excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents.

**Standard Precautions include:**

◊ **Hand hygiene**
◊ **Personal Protective Equipment (PPE):** Gloves, gown, mask, eye protection (goggles), face shield
◊ **Work Practice Controls:**
  - Shared (used or soiled) patient care equipment: Handle in a manner that prevents transfer of microorganisms to others and to the environment; wear gloves if visibly contaminated; disinfect shared patient equipment after each use with hospital approved disinfectant (example: glucometers must be disinfected after each patient use).
  - Environmental control: Care, cleaning and disinfection of environmental surfaces and shared patient equipment.
• Textile and laundry: Handle in a manner that prevents transfer of microorganisms to others and to the environment
• Needles and other sharps: Do not re-cap, bend, break or hand-manipulate used needles; if re-capping is required, use one-hand scoop technique only; use safety features when available; place used sharps in puncture-resistant container
• Patient resuscitation: Use mouthpiece, resuscitation bag or other ventilation devices to prevent contact with mouth and oral secretions

Additions to Standard Precautions:
• Respiratory Hygiene/ Cough Etiquette: Instruct symptomatic persons to cover mouth and nose when sneezing or coughing; use tissues and dispose in no-touch receptacle; perform hand hygiene after soiling of hands with respiratory secretions; wear surgical mask if tolerated or maintain spatial separation >3 feet
• Safe injection practices: Use single-dose vials whenever possible; avoid using multiple dose vials for more than one patient; always use a new needle and syringe for each injection, even if for the same patient
• Infection control for special lumbar puncture procedures: A face mask must be worn by the practitioner performing a spinal procedure (e.g. myeologram, lumbar puncture, spinal anesthesia)
**Transmission Based Precautions**

Transmission-based precautions are used **in addition to Standard Precautions**.

<table>
<thead>
<tr>
<th>Type</th>
<th>Purpose</th>
<th>Components</th>
</tr>
</thead>
</table>
| Contact          | To prevent transmission of infectious agents, including multidrug-resistant organisms (MDRO), which are spread by direct or indirect contact with the patient or the patient’s environment | • Private room preferred  
• Isolation gown when in patient’s room  
• Gloves when in patient’s room  
• PPE should be removed and discarded before leaving patient’s room, then perform hand hygiene  
• For transport, patient wears clean gown and performs hand hygiene |
| Enteric/Contact  | Used for patients with diarrhea or Clostridium difficile (C diff) infection | • Identical to Contact (above), but hand hygiene must be performed using soap and water after patient care or contact with environment in room of patient with diarrhea or known C diff infection |
| Droplet          | To prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions; including B. pertussis (whooping cough), influenza, bacterial meningitis, group A streptococcus, etc. | • Private room preferred  
• Surgical or procedure mask when in patient’s room or within 3 feet of patient if out of room  
• During transport, patient wears mask |
<table>
<thead>
<tr>
<th>Type</th>
<th>Purpose</th>
<th>Components</th>
</tr>
</thead>
</table>
| Airborne   | To prevent transmission of infectious agents that remain infectious over long distances when suspended in air; including respiratory tuberculosis, chickenpox, measles, DISSEMINATED shingles | - Airborne infection isolation room (AIIR) with negative pressure compared to hallway Door must remain closed  
- N95 respirator when in patient’s room  
- Transport is discouraged, but if absolutely necessary, patient wears a surgical or procedure mask (NOT respirator)  
- When AIIR is not readily available, consult IP for patient placement recommendations:  
  - Confirmed or high risk for active TB: Requires AIIR even if transfer necessary to accommodate patient  
  - Rule out TB with low to medium risk: May use private room with HEPA filter.  
  - Chickenpox, measles, DISSEMINATED shingles: Requires AIIR even if transfer necessary to accommodate patient. DO NOT use HEPA filter for viral illness. |
Multidrug-resistant Organisms (MDRO)

Multidrug-resistant organisms are organisms that have developed resistance to antibiotics or antivirals that would normally be used to control them. There are varied mechanisms of resistance; organisms develop resistance with exposure to antibiotics and then these resistant organisms can be transferred to other patients, either on the hands of healthcare workers, via contaminated environmental surfaces, or by contact with contaminated shared patient care equipment.

Examples of MDRO’s include:

- **MRSA**  Methicillin-resistant *Staphylococcus aureus*
- **VRE**  Vancomycin-resistant *Enterococcus faecalis or faecium*
- **ESBL**  Positive Extended Spectrum Beta Lactamase, an enzyme that is secreted by some bacteria (usually found in the urine, bowel, or wounds) that renders them resistant to some antibiotics
- **CRE**  Carbapenem-resistant *Enterobacteriacae* and *Klebsiella pneumonia*
- **KPE**  Carbapenemase have an enzyme that is secreted by certain bacteria, typically *Klebsiella* and *Eschericia coli*. The enzyme that makes them resistant to most antibiotics, including Carbapenems.
To Prevent the Transmission of MDRO’s:

- Use antibiotics judiciously
- Place patients with MDRO colonization or infection on contact precautions
- Avoid sharing of patient care equipment between patients; if it must be shared, disinfect equipment between patients
Healthcare Associated Infections

Elements of these infection prevention bundles are outlined below:

Surgical Site Infection (SSI)
- Use of prophylactic antibiotics according to current guidelines, CHG bath or shower the night before and morning of surgery
- Hair removal only if needed, outside the OR, and clipped, not shaved
- Controlled postoperative serum glucose in cardiac surgery
- Maintain perioperative normothermia in colorectal surgery patients, MSSA/MRSA screening and decolonization for patients having surgery with implants

Central Line-Associated Bloodstream Infection (CLABSI)
- Hand hygiene
- Maximal barrier precautions and use of checklist during insertion
- Chlorhexidine skin antisepsis
- Optimal catheter site selection, avoiding femoral site in adults
- Daily review of line necessity with prompt removal of unnecessary lines
- Replace emergently placed central lines within 24 – 48 hours
- Daily CHG bathing
Catheter-Associated Urinary Tract Infection (CAUTI)
- Insert catheters only for appropriate indications
- Hand hygiene
- Assess daily for continued need with prompt removal when no clinical indication
- Ensure that only properly trained persons insert and maintain catheters
- Insert catheters using aseptic technique and sterile equipment in the acute care setting
- Following aseptic insertion, maintain a closed drainage system (do not irrigate unless indication for irrigation exists and physician order is obtained)
- Use securement device
- Maintain unobstructed urine flow, drainage bag positioned at least 12 – 18” below the level of the bladder and off the floor
- Twice daily CHG pericare for catheterized patients

Ventilator-Associated Pneumonia (VAP)
- Elevate the head of the bed to 30 – 45 degrees
- Daily “sedation vacation” and assessment of readiness to extubate
- Peptic ulcer disease (PUD) prophylaxis
- Deep venous thrombosis (DVT) prophylaxis
- Daily oral care with chlorhexidine
Clostridium difficile (C. difficile)

C. difficile is a gram positive, anaerobic, enteric (from the gastrointestinal tract), spore-forming organism.

Testing should only be performed on liquid stool. There is no need to test a patient who has a history of C. difficile and is not experiencing symptoms. No need to retest after diagnosis or treatment.
C. difficile can be transmitted in several ways. The most effective prevention and control measures are:

- **Hand Hygiene:** Use soap and water after patient care or touching objects within the environment.
- **Environmental cleaning:** Use hospital approved disinfectant that is bleach based or sporicidal, like Pericept especially focusing on “high-touch” surfaces.
- **Precautions:** Use “special” contact precautions appropriately.
- **Equipment:** Use dedicated patient care equipment when possible. Disinfect any shared equipment after each use.
Antimicrobial Stewardship (ASP)

The Infectious Disease Society of America (IDSA) defines ASP as “coordinated interventions designed to improve and measure the appropriate use of antimicrobials by promoting the selection of the optimal antimicrobial drug regimen, dose, duration of therapy, and route of administration.” ASP programs are in place in most academic centers and many larger hospitals nationwide.

The goals of ASP include:

- Achieving the best clinical outcome
- Minimizing drug toxicities
- Minimizing adverse events
- Reducing resistance to antibiotics
- Reducing overall healthcare costs
ASP at Florida Hospital takes a multidisciplinary approach.

The team consists of:

- Infectious Disease specialists
- Pharmacists with special ID training
- Infection Prevention
- Microbiology
- Information Technology

At the campus level providers may see a Pharmacist PowerNote with suggested interventions related to patients antibiotic regimen. This may include de-escalating from a broad spectrum antibiotic, adjusting dose to optimize for indication and renal function and changing or adding agents to optimize coverage. Other activities may include switching from an IV agent to and oral agent with equal bioavailability. Occasionally a physician or provider may be contacted by the campus champion regarding a more urgent recommendation. The ASP is here to ensure safe, high quality care is delivered to our patients. We appreciate your support of this important program.
Patient Safety
Survival and Readmission Outcome Measures

CMS measures outcomes for key patient populations. Both measures are adjusted for risk factors such as age and comorbidities.

- Percent of patients who survive 30 days from the date of hospital admission.
- Percent of patients who are readmitted to any hospital within 30 days from the date of discharge.

Measured populations:
- Heart Attack
- Heart Failure
- Pneumonia
- Stroke
- Cardiac Surgery
- Chronic Obstructive Pulmonary Disease
- Hip and Knee Replacement Surgery
**Value Based Purchasing**

Starting in October 2012, Medicare began rewarding hospitals that provide high-quality care for their patients through the Hospital Value Based Purchasing (VBP) Program. The quality of inpatient acute care services is currently measured according to the following domains:

- Clinical Care
- Patient Experience of Care
- Safety
- Efficiency and Cost Reduction
Venous Thromboembolism (VTE)

VTE 1  All patients 18 years of age or older are assessed for VTE Risk. Moderate or high risk patients are started on anticoagulants or mechanical prophylaxis or a reason is indicated if contraindicated.

VTE 2  All patients 18 years or older admitted to ICU level units are assessed for VTE Risk. Moderate or high risk patients are started on anticoagulants or mechanical prophylaxis or a reason is indicated if contraindicated.

VTE 3  All patients with confirmed VTE who received less than 5 days of overlap parenteral anticoagulation (IV or SQ) and warfarin therapy should be discharged on both medications or have a reason for discontinuation of parenteral anticoagulation therapy documented.

VTE 4  Platelet counts of patients on unfractionated heparin are monitored. Heparin dose is adjusted to platelet count.

VTE 5  Patients going home on warfarin/Coumadin must receive written education about the importance of taking medication, dietary considerations, follow-up monitoring with lab tests, potential for adverse drug reactions and interactions.

VTE 6  Patients with confirmed VTE during hospitalization must receive VTE prophylaxis between hospital admission and the day before the diagnostic tests for Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE) are ordered.

Effective 2016, Quality Measures VTE 5 and VTE 6 will continue to be reported to CMS. Since VTE Quality Measures 1 through 4 impact our reportable measures, our current practice and bundle remains the same.
Stroke
The 8 Stroke Quality Measures include:

- VTE Prophylaxis by the end of hospital day two
- Antithrombotic therapy (e.g. ASA, Plavix, Aggrenox, or an anticoagulant) by the end of hospital day two
- Thrombolytic therapy (tPA) administered to eligible patients
- Stroke education on 5 elements: warning signs of stroke; personal risk factors for stroke; activation of EMS; importance of follow-up medical care after discharge; and medications prescribed
- Assessed for rehabilitation services
- Patients with Atrial Fibrillation or history of A-fib prescribed anticoagulation therapy at discharge
- Discharged on antithrombotic medication
- Discharged on statin medication

Additionally, Screen for Dysphagia prior to oral intake is a quality measure reported to the national stroke registry, Get With The Guidelines.
Brain Attack

Brain Attack, or stroke, is the number one cause of adult disability and the fifth leading cause of death in the U.S. During a stroke, brain cells die when blood flow to an area of the brain is slowed or stopped due to a blocked or broken blood vessel.

**STROKE**

**KNOW THE SIGNS**

Think F.A.S.T.

- **F** = Facial Droop
  If a person’s smile droops to one side.

- **A** = Arm Drift
  If a person’s arm drifts down when they hold out both arms with eyes closed.

- **S** = Speech
  If a person’s speech sounds slurred, absent or abnormal.

- **T** = Time
  If a person fails one or more of these tests, Call 911 immediately. They may be having a stroke.

Stroke is an emergency!
Seek immediate attention (for yourself or anyone you observe possibly having a stroke) even if the symptoms go away. For patients in the hospital, report symptoms to the patient’s nurse, who can quickly alert the Rapid Response Team. If you are in the Medical Plaza or outside the hospital - Call 911!
Prevent Surgical Site Infections & Surgical Complications

Ensure these measures have been followed for your adult surgical patients. They are considered “best practices” for infection prevention. These interventions have been reviewed at all Surgery Department meetings and OR Committees and have been approved for use in the ADULT surgical population.
<table>
<thead>
<tr>
<th>Intervention/Population</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-op bathing /shower with CHG</strong></td>
<td>Pre-operative showering with CHG has been shown to reduce the number of skin flora at the incision site.</td>
</tr>
<tr>
<td>Night prior to &amp; morning of surgery, completed on inpatient unit or at home by patient prior to coming in.</td>
<td></td>
</tr>
<tr>
<td><strong>CHG skin wipes</strong></td>
<td>Patient compliance with pre-op bathing/showering cannot be validated. Using the CHG wipe in the holding area can provide one last opportunity to reduce skin flora.</td>
</tr>
<tr>
<td>Orthopedic, Podiatry, Neuro, Cardiovascular, Hysterectomy, Colorectal procedures, to be completed in the pre-op holding area.</td>
<td></td>
</tr>
<tr>
<td><strong>Antibiotic Prophylaxis</strong></td>
<td>Antibiotics should be selected according to SCIP/ASHP guidelines &amp; be weight-based. Vancomycin should be infused over a 1-2 hour period.</td>
</tr>
<tr>
<td>According to SCIP guidelines in conjunction with the American Society of Healthcare pharmacist (ASHP) guidelines.</td>
<td></td>
</tr>
<tr>
<td><strong>Antibiotic Prophylaxis</strong></td>
<td>For procedures lasting &gt;4 hours consideration should be given for re-dosing.</td>
</tr>
<tr>
<td>Pre-op dose should be given between 10-60 minutes prior to incision except for Vancomycin.</td>
<td></td>
</tr>
<tr>
<td><strong>Intra-operative Skin Prep</strong></td>
<td>Alcohol-based solutions provide better reduction of skin flora than betadine paint and scrub.</td>
</tr>
<tr>
<td>Completed with Chloraprep or Duraprep (except on mucus membranes).</td>
<td></td>
</tr>
</tbody>
</table>
Recognizing and Surviving Sepsis

Sepsis is the body’s overwhelming and life-threatening response to infection which can lead to tissue damage, organ failure, and death. Hospital deaths related to sepsis are around 30-40%. (Sepsis Alliance, 2015)

Categories:

Sepsis – demonstrates 2 or more SIRS (Systemic Inflammatory Response Syndrome) criteria, suspected or confirmed infection: most common are pneumonia, urinary source (UTI, pyelonephritis, post-nephrostomy tubes), abdominal source (CDT colitis, perforated bowel, gallbladder), skin wounds/cellulitis, central lines, post-surgical).
Severe Sepsis – evidence of 1 or more organ dysfunction (new change for patient)

Septic Shock – blood pressure remains low after fluid bolus or lactic acid >4.0

Early Detection +
Implement Bundles

Decreased Mortality
Core Measures

Core Measures are a publicly reported set of care processes developed to improve the quality of health care by implementing a national, standardized performance measurement system. The Core Measures were derived largely from a set of quality indicators defined by the Centers for Medicare and Medicaid Services (CMS). They have been shown to reduce the risk of complications, prevent recurrences and otherwise treat the majority of patients who come to a hospital for treatment of a condition or illness. Core Measures help hospitals improve the quality of patient care by focusing on the actual results of care.
Currently Reported Core Measures are:

Acute Myocardial Infarction (AMI)
Severe Sepsis/Septic Shock Early Management Bundle
Severe Sepsis / Septic Shock
Stroke (STK)
Venous Thromboembolism (VTE)
Global Immunizations
Emergency Department Throughput
Perinatal Care
Substance Abuse - Inpatient Psychiatric Facility
Tobacco Use - Inpatient Psychiatric Facility
Outpatient Measures
## Acute Myocardial Infarction

<table>
<thead>
<tr>
<th>ACUTE MI CORE MEASURE ELEMENT</th>
<th>PHYSICIAN’S RESPONSIBILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fibrinolytic Therapy Received within 30 minutes of Hospital Arrival</td>
<td>- If Fibrinolytic therapy is primary reperfusion therapy physician must document in the medical record that a delay occurred and that the reason for delay in initiating fibrinolytic therapy after hospital arrival was non-system in nature</td>
</tr>
</tbody>
</table>

## Stroke

<table>
<thead>
<tr>
<th>STROKE CORE MEASURE ELEMENT</th>
<th>PHYSICIAN’S RESPONSIBILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>STROKE CORE MEASURE ELEMENT (Use of Brain Attack PowerPlans will achieve most elements)</td>
<td>- Emergency Dept: Administer IV tPA within 180 min from Last Known Well for eligible pts arriving to ED ≤ 2 hrs of symptom onset, OR</td>
</tr>
<tr>
<td>Thrombolytic Therapy Admin (Ischemic Stroke only)</td>
<td>- Document reason for not initiating IV tPA therapy OR reason for delay in administering IV tPA, if &gt; 60 min arrival.</td>
</tr>
</tbody>
</table>

## Venous Thromboembolism

<table>
<thead>
<tr>
<th>VTE CORE MEASURE</th>
<th>PHYSICIAN’S RESPONSIBILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>VTE-5</strong> Venous Thromboembolism Warfarin Therapy Discharge Instructions</td>
<td>- Orders for discharge instructions to educate the patient on Warfarin medication and monitoring</td>
</tr>
<tr>
<td><strong>VTE-6</strong> Hospital Acquired Potentially-Preventable Venous Thromboembolism</td>
<td>- Follow VTE prevention steps (VTE 1-2)</td>
</tr>
<tr>
<td></td>
<td>- VTE prophylaxis must be ordered between hospital admission and the day before the order date of a VTE diagnostic test or document a reason for no administration of VTE Prophylaxis</td>
</tr>
</tbody>
</table>
# Severe Sepsis/Septic Shock Early Management Bundle

<table>
<thead>
<tr>
<th>Severe Sepsis/Septic Shock MEASURE ELEMENT</th>
<th>PHYSICIAN’S RESPONSIBILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis of Severe Sepsis present or source of infection</td>
<td></td>
</tr>
<tr>
<td>- Within three hours of Severe Sepsis Presentation:</td>
<td></td>
</tr>
<tr>
<td>- Initial Lactate Level</td>
<td></td>
</tr>
<tr>
<td>- Broad Spectrum Antibiotic Administration</td>
<td></td>
</tr>
<tr>
<td>- Blood Cultures drawn prior to antibiotics</td>
<td></td>
</tr>
<tr>
<td>- Within six hours of Severe Sepsis Presentation:</td>
<td></td>
</tr>
<tr>
<td>- Repeat lactate level only if initial lactate level is elevated</td>
<td></td>
</tr>
<tr>
<td>ONLY if Septic Shock Present</td>
<td></td>
</tr>
<tr>
<td>- Received within three hours of Septic Shock Presentation</td>
<td></td>
</tr>
<tr>
<td>- Resuscitation with 30ml/kg Crystalloid Fluids</td>
<td></td>
</tr>
<tr>
<td>ONLY if hypotension persists after fluid administration, received within six hours of Septic Shock Presentation</td>
<td></td>
</tr>
<tr>
<td>- Vasopressors</td>
<td></td>
</tr>
<tr>
<td>- ONLY if hypotension persists after fluid administration or initial lactate level $\geq 4$mmol/L, within six hours of Septic Shock Presentation</td>
<td></td>
</tr>
<tr>
<td>- Repeat volume status and tissue perfusion assessment consisting of either:</td>
<td></td>
</tr>
<tr>
<td>- A focused exam including:</td>
<td></td>
</tr>
<tr>
<td>- Vital signs, AND</td>
<td></td>
</tr>
<tr>
<td>- Cardiopulmonary exam, AND</td>
<td></td>
</tr>
<tr>
<td>- Capillary refill evaluation, AND</td>
<td></td>
</tr>
<tr>
<td>- Skin examination OR</td>
<td></td>
</tr>
<tr>
<td>- Any two of the following four:</td>
<td></td>
</tr>
<tr>
<td>- Central venous pressure measurement</td>
<td></td>
</tr>
<tr>
<td>- Central venous oxygen measurement</td>
<td></td>
</tr>
<tr>
<td>- Bedside cardiovascular ultrasound</td>
<td></td>
</tr>
<tr>
<td>- Passive leg raise or fluid challenge</td>
<td></td>
</tr>
</tbody>
</table>
Global Immunization

This measure states that all patients discharged from acute inpatient care must be assessed for and offered influenza immunizations as appropriate.

Influenza (Flu) Immunization

Most effective method for preventing an influenza virus infection and its potentially severe complications. Given annually between October – March.

Vaccine to:

- Everyone aged 6 months or older
High-Risk indicators for developing serious complications related to an influenza virus infection include:

- Aged 65 or older
- Aged 2 years or younger
- Cardiovascular, respiratory, or kidney disease
- Diabetes
- Immune system deficiency (of any etiology)
- Pregnancy (2nd and 3rd trimesters)
- Household contacts and caregivers of those with certain medical conditions including asthma, diabetes and chronic lung disease

The Medical Staff Leadership has endorsed this Florida Hospital policy and encourages all medical staff and Allied Health Professional members to adhere to the policy.
Patient Experience

What is HCAHPS?
The HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey is a national, standardized, publicly reported survey of patients’ perspectives of hospital care. It is government mandated and administered to patients at all hospitals across the country.

- Surveys are mailed to 50% of eligible adult inpatients about one week after discharge (100% of eligible patients from Florida Hospital Apopka).
- Exclusions include patients
  - with primary psychiatric diagnosis
  - discharged to hospice or a skilled nursing facility
  - with foreign home address
  - that are prisoners
- Surveys are sent in English or Spanish, depending on the primary language of the patient.

How are HCAHPS results reported?
HCAHPS results are reported on the U.S. Department of Health & Human Services’ Hospital Compare website (www.hospitalcompare.hhs.gov).

- Florida Hospital seven campuses are reported as a system.
- To ensure that publicly reported HCAHPS scores allow for accurate comparisons, the results are adjusted for factors that are not directly related to hospital performance but affect how patients answer HCAHPS survey items (e.g. mode of survey, patient mix).
What is included in the Survey?

The HCAHPS survey includes 21 core questions about critical aspects of patients’ hospital experiences that make up 10 publicly reported measures, one of which is Doctor Communication. The questions in that composite are:

1. During this hospital stay, how often did doctors treat you with courtesy and respect?
2. During this hospital stay, how often did doctors listen carefully to you?
3. During this hospital stay, how often did doctors explain things in a way you could understand?

Responses are on a frequency scale: never, sometimes, usually, and always. Scores are reported by top box percentage (the percent of respondents who select “always”).

How can I enhance the patient’s perception of care?

Simple actions enhance the patient’s perception of the communication between the patient and doctor. The following three evidence-based practices can improve the Doctor Communication scores:

1. Sit down at the patient’s bedside to make eye contact and actively listen at the patient’s eye level.
2. Demonstrate Physician/Nurse rounds in view of the patient using the nurse’s name to show continuity of care and partnership.
3. Summarize the plan of care and verify the patient’s understanding prior to parting.

If you have any questions about the HCAHPS survey, patient surveying of other service areas or about improving the Patient Experience at Florida Hospital, you may send them to FHPatientExperience@flhosp.org
**Patient Identification**
*Policy 100.480*

Two patient identifiers are verified to identify patients when providing care, treatment or services.

**Florida Hospital uses:**
- Patient’s full name and date of birth.

Verify the patient’s verbal information against the name and date of birth on the wristband.

Match the patient’s name and date of birth with those on the order, requisition or electronic record before administering care, treatment or service.

  a. Prior to administering medications, blood or blood components
  b. When collecting blood samples and other specimens for clinical testing
  c. When providing treatments or procedures

The patient’s room number or physical location is not used as an identifier.
PATIENT, PROCEDURE, SITE AND SIDE VERIFICATION FOR SURGICAL AND INVASIVE PROCEDURES
Policy 100.226

<table>
<thead>
<tr>
<th>ED and Bedside Procedures</th>
<th>Operating Room and Procedural Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Identification</strong> – Per policy 100.480</td>
<td><strong>Pre-Procedural Verification</strong></td>
</tr>
<tr>
<td><strong>Procedure Verification</strong></td>
<td>• In these high risk areas the nurses and / or procedure area personnel will follow detailed steps and utilize a checklist for patient, procedure, site and side verification.</td>
</tr>
<tr>
<td>• Verbal verification with the patient or Legally Authorized Person (LAP) is best practice. When not possible, the verbal verification can occur between the team members and the physician or allied health provider performing the procedure.</td>
<td><strong>Time Out</strong></td>
</tr>
<tr>
<td>• There may also be written documentation in the patient’s medical record that may be referenced for procedure, site and side verification. (consent form, H&amp;P, etc.)</td>
<td>• The OR and procedural areas will continue to perform a time out prior to the start of the procedure.</td>
</tr>
<tr>
<td><strong>Time Out</strong></td>
<td>• The time out is a brief, less than one minute pause, in the operating or procedure room immediately before the start of the procedure, at which time all members of the team verbally verify the identity of the patient, the procedure site, the procedure to be performed, and any other information pertinent to the patient or procedure.</td>
</tr>
<tr>
<td>• Although a formal time out is not required, there needs to be verification between the team members prior to performing a procedure on a patient, ideally including the patient.</td>
<td></td>
</tr>
</tbody>
</table>
Restraints  Policy 010.147

All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate and physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time. (A-0154)

A. Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm. (A-0164)

B. The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member or others from harm. (A-0165)

C. Order: The use of restraint or seclusion must be in accordance with the order of a physician responsible for the care of the patient. An order for restraints will be obtained before application, or in emergency situations, during/immediately after application (A-0168).

1. The order for restraint may be obtained via computerized physician order entry (CPOE), telephone, written or verbal and shall include the type and reason for the restraint. The order includes all devices that may be utilized during the restraint episode with the goal of utilizing the least restrictive method.

2. A protocol cannot substitute for obtaining an order.

3. Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN). (A-0169)
4. The patient’s attending physician must be consulted as soon as possible if the attending physician did not order the restraint or seclusion. (A-0170) The expected time frame for notification in this case would be within the shift the order was received or not to exceed 12 hours from the time of order.

D. Application: A Registered Nurse (RN) may initiate restraints upon physician order, or in emergency situations, prior to obtaining an order from a physician.

E. Order Renewal: Each order for restraint(s) used to ensure the physical safety of the patient may be renewed as authorized below (A-0173):

1. Non-Violent: An initial order for non-violent restraints is valid until all ordered restraints are discontinued or until an order to discontinue, whichever comes first. (A-0173)

2. Violent Restraint/Seclusion: Orders for the violent restraints or seclusion may only be renewed in accordance with the following limits for up to a total of 24 hours (A-0171):
   - Four hours for adults 18 years of age or older.
   - Two hours for children and adolescents 9-17 year of age.
   - One hour for children under 9 years of age.
   a. The time limits represent the maximum amount of time of each order for restraint or seclusion based on age. The physician has the discretion to write the order for a shorter length of time. (A-0171)
   b. Each order for violent restraints is valid until all ordered restraints are discontinued within each renewal period. The original restraint or seclusion order may only be renewed within the required time limits for up to a total of 24 hours. After the original order expires, a physician must see the patient and conduct a face-to-face re-evaluation before writing a new order. (A-0172)
Transitioning from Hospital to Home

Recommendations for transitioning diabetes care from hospital to home or SNIF/Rehab include:

- Reinstitute preadmission anti-hyperglycemic regimen that include oral agents, non-insulin injectable and insulin at discharge for patients with acceptable preadmission glycemic control and without contraindications for their continued use.
For contraindicated medical conditions or uncontrolled diabetes, intensify anti-diabetic regimen (oral agents, insulin or combination of both). For patients with limited financial resources or restricted health care coverage Lantus can be substituted for NPH or a pre-mix regimen on discharge.
### ADULT TRANSFUSION GUIDELINE POCKET CARD

#### RED BLOOD CELL TRANSFUSION

Transfusing at levels other than listed here may be indicated if symptomatic anemia present. Symptoms include: chest pain, orthostatic blood pressure changes, tachycardia (heart rate > 110-130 pulse/min or > 120-130% of baseline) unresponsive to fluid resuscitation or heart failure.

* In the absence of acute hemorrhage, RBCs should be given as single unit.

<table>
<thead>
<tr>
<th>ACTIVELY BLEEDING</th>
<th>NOT ACTIVELY BLEEDING</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Hypovolemia and reduced O2 carrying capacity due to acute blood loss.</td>
<td>• Hemodynamically stable ICU Pt. Hgb ≤ 7 g/dL.</td>
</tr>
<tr>
<td>• Rapid acute hemorrhage without immediate control.</td>
<td>• Med/Surg Pt. including (post-op) Hgb ≤ 8 g/dL.*</td>
</tr>
<tr>
<td>• Acute loss of at least 15% of EBL volume with evidence of inadequate O2 delivery following volume resuscitation.</td>
<td>• Hgb ≤ 8 in peri-op period after CABG.</td>
</tr>
<tr>
<td></td>
<td>• PreExisting Cardiovascular Disease, Hemodynamically stable Hgb ≤ 8.</td>
</tr>
<tr>
<td></td>
<td>• Exchange Transfusion.</td>
</tr>
<tr>
<td></td>
<td>• Red Cell Exchange.</td>
</tr>
</tbody>
</table>

* A lower threshold may be considered if clinically indicated.
**PLATELET TRANSFUSION: CONTRAINDICATIONS**

Do not use this component if bleeding is unrelated to decreased numbers of platelets or abnormally functioning platelets.

**INDICATIONS:**

**ADULT PROPHYLACTIC**
- PLT count less than 10,000 without risk factors for bleeding.
- PLT count less than 20,000 and risk factors for bleeding.

**INDICATIONS:**

**ADULT ACTIVELY BLEEDING**
- PLT count less than 50,000 and active bleeding.
- PLT count less than 50,000 in setting of trauma.

**INDICATIONS:**

**ADULT PERI-PROCEDURE**
- PLT count less than 50,000 and invasive procedure planned.
- Platelet dysfunction and microvascular bleeding.
- PLT count between 50 and 100,000 and risk of bleeding into a confined space.

**INDICATIONS:**

**HLA MATCHED PLATELETS**
- Refractoriness to platelets from alloimmunization.

**INDICATIONS:**

**CROSS-MATCHED PLATELETS**
- Patients with known anti-platelet antibodies.
- Refractoriness to platelets from alloimmunization.

**FRESH FROZEN PLASMA (FFP): CONTRAINDICATIONS**

Do not use when coagulopathy can be corrected more effectively with specific therapy, such as Vitamin K, cryoprecipitate, factor concentrates or medication discontinuation.

Do not use FFP as a source of blood volume. IgA-deficient patients at risk for anaphylaxis should receive IgA-deficient plasma.

**INDICATIONS:**

- Patients on Warfarin who are bleeding or need to undergo an invasive procedure before Vitamin K could reverse the Warfarin effect or who need to have anticoagulation therapy after the procedure.
- Bleeding or invasive procedure in conditions with multiple factor deficiencies and INR ≥ 2.
- Bleeding or invasive procedure in a single-factor deficiency condition for which no specific factor concentrate is available.
- Massive transfusion with coagulation abnormalities.
- Treatment of Thrombotic Thrombocytopenic Purpura-Hemolytic Uremic Syndrome.
- Treatment of inherited Factor XI deficiency.
FRESH FROZEN PLASMA (FFP): CONTRAINDICATIONS
Do not use when coagulopathy can be corrected more effectively with specific therapy, such as Vitamin K, cryoprecipitate, factor concentrates or medication discontinuation. Do not use FFP as a source of blood volume. IgA-deficient patients at risk for anaphylaxis should receive IgA-deficient plasma.

INDICATIONS:
- Patients on Warfarin who are bleeding or need to undergo an invasive procedure before Vitamin K could reverse the Warfarin effect or who need to have anticoagulation therapy after the procedure.
- Bleeding or invasive procedure in conditions with multiple factor deficiencies and INR ≥ 2.
- Bleeding or invasive procedure in a single-factor deficiency condition for which no specific factor concentrate is available.
- Massive transfusion with coagulation abnormalities.
- Treatment of Thrombotic Thrombocytopenic Purpura-Hemolytic Uremic Syndrome.
- Treatment of inherited Factor XI deficiency.
RED BLOOD CELL TRANSFUSION

Transfusing at levels other than listed here may be indicated if symptomatic anemia present. Symptoms include: chest pain, orthostatic blood pressure changes, tachycardia (heart rate > 110-130 pulse/min or > 120-130% of baseline) unresponsive to fluid resuscitation or heart failure.

* In the absence of acute hemorrhage, RBCs should be given as single unit.

ACTIVELY BLEEDING

- Hypovolemia and reduced O2 carrying capacity due to acute blood loss.
- Rapid acute hemorrhage without immediate control.
- Acute loss of at least 15% of EBL volume with evidence of inadequate O2 delivery following volume resuscitation.

NOT ACTIVELY BLEEDING

- Hemodynamically stable ICU Pt. Hgb ≤ 7 g/dL.
- Med/Surg Pt. including (post-op) Hgb ≤ 8 g/dL*.
- Hgb ≤ 8 in peri-op period after CABG.
- Pre Existing Cardiovascular Disease, Hemodynamically stable Hgb ≤ 8.
- Exchange Transfusion.
- Red Cell Exchange.

ADULT TRANSFUSION GUIDELINE POCKET CARD

INDICATIONS:

CRYOPRECIPITATE

- Hypofibrinogenemia (fibrinogen level less than 100 mg/dL) and microvascular bleeding.
- Congenital fibrinogen deficiencies.
- Correction of dysfibrinogenemia either congenital or acquired.
- Treatment of Hemophilia A as a second-line therapy.
- Treatment of Von Willebrand’s disease as a second-line therapy.
- Uremic platelet dysfunction with bleeding or planned invasive procedure when other measures to correct the dysfunction have failed.

For additional information please contact Dr. Juliana Gaitan, Medical Director of Transfusion Medicine and Patient Blood Management at Juliana.Gaitan.MD@FLHosp.org

FLORIDA HOSPITAL

The skill to heal. The spirit to care.
Radiation Safety & Diagnostic Medical Physics Office

Who we are & what we do: Collaborative team of Physicists and Technologists that provide support on a system level for all departments utilizing ionizing radiation. Some of our responsibilities include quality assurance & acceptance equipment testing, quarterly Nuclear Medicine and Radiation Oncology audits, oversight of the Radiation Exposure Monitoring Program, and maintenance of the Florida Hospital broadscope radioactive materials license.

Florida Hospital Radiation Exposure Monitoring Program

The REMP program is a DNV initiative to guide Florida Hospital in maintaining compliance to the State of Florida Administrative Code (FAC) 64E-5 and Radioactive Materials License 2897-1 that require As Low As Reasonably Achievable (ALARA) radiation exposure monitoring of individuals occupationally exposed to radiation.

Radiation exposure monitoring badges are required for:

- Individuals who actively operates radiation emitting equipment (excludes specimen imaging devices)
- Individuals within 6 feet of active x-ray equipment
- Individuals who routinely handles radioactive material for imaging or therapy
Department Directors are the point person for your badge related requests and can explain the badge process in detail including where your badge is housed, the exchange process, spare badge assignment etc.

Badge exchanges are required at regular intervals (monthly or quarterly based upon specialty) to ensure ALARA practices are being maintained. Leaving your radiation badge at the department badge board when not in use allows for a timely exchange regardless of your frequency at that particular campus/department.

**Radiation Exposure Monitoring badges are to be worn as follows:**
- If you are not wearing a lead apron, place badge at chest level.
- If you are wearing a lead apron, place badge on outside of thyroid shield or on collar.
- If you are wearing a fetal badge, place that badge underneath lead apron & personal badge on outside of thyroid shield or collar

**ALARA - As Low As Reasonably Achievable**

Radiation philosophy utilized for maintaining low radiation doses while still achieving diagnostic, therapeutic, or other desired goal

3 **Cardinal Rules of ALARA:**

1. Minimize the radiation emitting time
2. Maximize your distance from radioactive sources
3. Shield yourself and patients as applicable

For Additional information please contact the Florida Hospital Radiation Safety office at 407-834-2210, visit our Radiation Safety Page on FH Insite, or email FH.RAD.Badges@flhosp.org
Important Phone Numbers

RAPID RESPONSE TEAM
Orlando . . . . . . . . . . . . . . . . . 110-2000
East Orlando . . . . . . . . . . . . . . . . 2911
Winter Park . . . . . . . . . . . . . . . . . 2911
Altamonte . . . . . . . . . . . . . . . . . 6632
Apopka . . . . . . . . . . . . . . . . . . . 7779
Kissimmee page overhead . . . . . . . . 8970
Celebration wireless CH CAT Team or CH RRT
Children’s . . . . . . . . . . . . . . . . . 110-4836
Perinatal . . . . . . . . . . . . . . . . . 110-4938

NURSING SUPERVISORS
Orlando . . . . . . . . . . . . . . . . . 303-8981 or 303-8982
East Orlando . . . . . . . . . . . . . . . . . 7377
Winter Park . . . . . . . . . . . . . . . . . 7619
Altamonte . . . . . . . . . . . . . . . . . 8613
Apopka . . . . . . . . . . . . . . . . . . . 1975
Kissimmee . . . . . . . . . . . . . . . . . . 5741
Celebration . . . . . . . . . . . . . . . . . 4071
Winter Garden . . . . . . . . . . . . . . . . . 1301
Lake Mary . . . . . . . . . . . . . . . . . . 124-3050
Children’s NICU and Peds NM or Director

SECURITY
Orlando, East Orlando, WP, Altamonte,
Winter Garden, Lake Mary and Apopka
(Orlando dispatches all campuses except
CH and Kissimmee)
. . . . . . . . . . . . . . . . . . . . . . . Non emergency 407-303-1916
. . . . . . . . . . . . . . . . . . . . . . Emergency 407-303-1515

RISK MANAGER on Call
Contact campus operator

INTERPRETER SERVICES
All campuses except Orlando . . . . . . 8510
Orlando . . . . . . . . . . . . . . . . . . . 110-8510

EXPOSURE HOTLINE
. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . 407-200-4702
Altamonte: 407-303-2200
Apopka: 407-889-1000
Celebration: 407-764-4000
Children’s Hospital: 407-303-5600
East Orlando: 407-303-8110
Kissimmee: 407-846-4343
Orlando: 407-303-5600
Winter Park: 407-646-7000