NAVAL HOSPITAL
Jacksonville
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TJC Readiness Pocket Guide

JAN 2025

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This TJC Readiness Pocket Guide is a tool to assist in identifying and correcting commonly found Environment of Care (EOC) findings and provide general information regarding Ready Reliable Care, Patient Safety, Team*STEPPS* and Quality Improvement.

Who: All active duty, reserve military, civilians and contractor personnel assigned, detailed to or visiting NMRTC JAX and Branch Health Clinics.

What: Improved patient safety and readiness thru standards compliance.

When: Review at morning huddles, department meetings and for reference as needed.

Where: NMRTC Jacksonville & Branch Health Clinics

Why: Constant vigilance over daily processes improving patient safety and quality healthcare.

Action: Examples: Correct on the spot, educate staff, implement a process change and/or submit a work order request.

Note: *This pocket guide is intended as a quick reference and is not all inclusive. For more information regarding TJC Compliance or High Reliability as we strive for Zero Preventable Patient Harm, please contact QM Staff*

CONTENT INCLUDES:

DHA PM 6025.13

Clinical Quality Management Volume 5:

Accreditation and Compliance

"Achieving and maintaining accreditation by a recognized external accrediting organization (AO) provides benchmarks for measuring standards compliance and builds stakeholder confidence in the quality of health care delivered."

The Defense Health Agency has chosen

The Joint Commission

as our AO.

Naval Hospital Jacksonville is proudly accredited in two programs:

Hospital
Primary Care Medical Home

A Message from The Joint Commission:

Any individual who provides care, treatment and services can report concerns about safety or the quality of care to The Joint Commission without retaliatory action from the hospital.

TRAINING RECORDS

° Section 1: Position Description
Reviewed annually–updated as needed.
° Section 2: Copies of Resuscitative Certificates
As required by position description and duties.
° Section 3: Departmental Check-in
Command Orientation-within 30 days of hire/PCS
Nursing Orientation-within 90 days of hire/PCS
° Section 4: Individual and Staff Competencies
Initial and reviewed every 3 years, signed by an individual with the education, experience or knowledge related to the skills being assessed.
Nursing Competencies/Clinical skills
° Section 5: Evidence of ongoing training/education related to job specific responsibilities.
In-service, CME/CEUs, skills fair, Low-Volume/High Risk, etc.
° Section 6: FEMA Emergency Response Certificates

°Paper/digital records permitted; available upon request.

Privileged Providers

°CAF (Clinical Activity Files) maintained within the department.

°List of Approved Privileged Providers (including reserve and TAD Providers) are available on Share-Point.

INFECTION CONTROL

° Hand hygiene is the most effective way to prevent infection.

°Enzymatic spray is used on medical instruments at point-of-use with proper PPE (gloves/goggles) and placed in red bin for return to SPD.

°Equipment is cleaned and maintained per manufacturer's guidelines.

° Furniture cleaned and disinfected in waiting area (daily) and exam rooms (after every patient).

° Patient food refrigerators/freezers clean. No intermingling with medications, immunizations, specimens, etc.

° No items stored under sinks. Place a work order request if evidence of leaks or stains.

° Privacy curtains are labeled with last change-date. Curtains may be utilized one year from change date unless visibly soiled.

° Expired supplies are removed from stock.

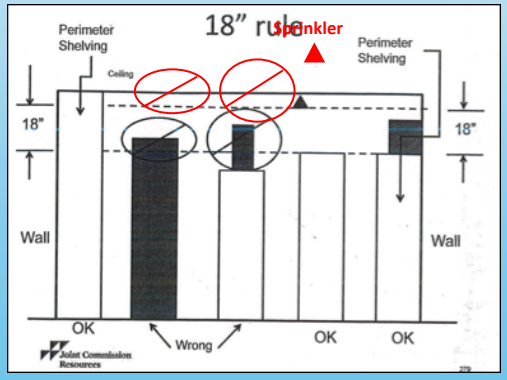
Infection Control Manual available on SharePoint.

GENERAL HOUSEKEEPING

°18 inch clearance from sprinkler head to the top of supplies (exception along wall – to not impede sprinkler flow coverage in event of fire).

° Supplies stored off the floor. Lowest wire shelves have hard waterproof barrier. Sterile items stored above non-sterile items.

° No corrugated shipping boxes in supply rooms (Breakdown and remove cardboard boxes that have labels with hospital address).



GENERAL HOUSEKEEPING

° Walls/Windows are clean and high/low dusting is completed as needed.

° Ceiling/vents are dust/mold free. Lights are functional. Sprinkler heads are clean of dust and grime.

°Floors are clean and in good condition. No soiled carpet. Cables/cords are orderly to prevent fall hazards.

° Furniture is clean and in good condition. Furniture in disrepair should be brought to the attention of leadership and removed from staff/patient use.

°No food/drink, chemicals/cleaners from home on housekeeping carts. Do not leave carts unattended.

°Janitor closets should not be propped open unless housekeeper is in general area actively cleaning.

°Facilities maintenance requests are required for stained/broken/missing tiles, dirty sprinkler heads and flooring concerns.

° Questions regarding housekeeping responsibilities? Please contact housekeeping for clarification at (904) 542-7434/9654.

SECURITY & INFOSEC

° Staff shall wear hospital identification badge annotating assigned department. Official visitors and contractors shall be identified with hospital identification badge.

° No unsecured or unattended CACs in computers.

° No unsecured PHI in exam rooms, provider offices, adrift or disposed of in regular trash cans.

° CUI: Any unclassified information that requires safe guarding or dissemination controls.

° PHI: Any health information that allows the patient to be identified.

°Prevent workplace violence by reporting actions or threats such as verbal, non verbal, written or physical aggression; threatening, intimidating harassing or humiliating words/actions; bullying, sabotage; sexual harassment; physical assault or other behaviors of concern involving staff, licensed practitioners, patients or visitors.

° If you see something, say something!

REGULATED MEDICAL WASTE

° Also known as infectious waste, biohazardous waste and biomedical waste. Any solid or liquid waste which may present a threat of infection to humans.

° Disposal:
1. Identify Regulated Medical Waste (RMW).
2. Segregate waste at the point of generation.
—Place Trace chemo waste in yellow biohazard bags.
—Place all sharps being disposed of (contaminated or not) in a sharps container. Sharp containers secured and emptied when 3/4 full.
—Place RMW in red biohazard bags.
3. Seal bags through gooseneck method.
4. Label bags with hospital name and address.
5. Transport bags to bin in the designated dirty utility room.
6. Call housekeeping when red bin is full.

° Spills: Notify housekeeping immediately and secure area to decrease staff exposure.

STAFF SAFETY

° ESAMS is utilized for safety information, training, medical surveillance, respirator fit test, and unsafe/ unhealthful conditions reports.

° Ensure there are no slip, trip, or fall hazards; correct or report issues to leadership or safety staff.

° Ensure Personal Protective Equipment (PPE) is readily available and in good condition.

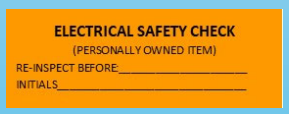
° Eyewash stations are to be unobstructed and tested weekly, logged with initials, MM/DD, and pass/fail (note: flush for 3 minutes until water is clear, report deficiencies for repair).

° Electrical Safety:

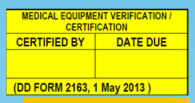
-Space heaters and extension are cords prohibited! The only approved items with heating elements are coffee pots, kettles, and toasters.

-Surge protectors are only for office equipment (i.e., TV, Phone, etc.).

-Personally owned items must be inspected by a Unit Safety Representative.



MEDICAL EQUIPMENT



° Verify preventative sticker is present and not overdue before use.

° Clean and maintain your equipment per manufacturer's guidelines.

° Notify department equipment or supply PO about medical device failures

° Any medical device and attached consumables identified in a patient safety event must immediately be removed from service and quarantined for patient safety investigation. Submit incident in JPSR system.

° Biomed Service requests for repairs are located on SharePoint.
-DFA-MMD-Biomed-Biomed Repair Request Icon.

° Transportable medical devices are to be delivered to 4th floor Biomedical shop for repairs.
-Services are available M-F, 0730-1600; Call 542-7451 or contact CDO for after hours emergencies.

THIS UNIT CONTAINS PHI DATA
PATIENT HEALTH INFORMATION MUST BE REMOVED
PRIOR TO BEING SENT OUT OF FOR REPAIR OR CALIBRATION

HAZARDOUS MATERIAL & WASTE

° Waste with properties that make it dangerous or capable of having a harmful effect on human health or the environment. Examples: hand sanitizer, aerosols, batteries, amalgam, and solvents.

° All HAZMAT annotated with AUL unique identifier number to link to SDS tab

° Disposal: Designated waste containers are available at Satellite Accumulation Points. Ensure lids are closed, labels facing outward, and batteries are individually taped with clear tape to securely cover terminal points. Special waste pickups can be coordinated with the Environmental Program Manager, (904) 542-7786.

° Spills: Stop the leak (if able), clear the area and report to supervisor immediately. Remain in area at safe distance until a spill response personnel arrive or until relieved by supervisor. 911 in case of fire, injury or if situation appears dangerous.

ENVIRONMENTAL

3 Waste Streams
Medical Waste
Pharmaceutical Waste
Hazardous Waste

MEDICAL GAS

° Wall shutoff valve location is known and readily accessible. Does staff know who authorizes shutoff? (per dept. policy, i.e., charge nurse/clinic manager).

° Identified empty and full cylinders are secured and in separate segregated stands from each other.

° Oxygen cylinders have green tags identifying FULL/ IN USE/EMPTY.

MEDICATION MANAGEMENT

° Six Rights of Medication Administration: 1. right patient 2. right medication 3. right dose 4. right time 5. right route 6. right to refuse.

° Medications are secure and not expired.

° Opened irrigation solution bottles dated and discarded after 24 hours (i.e., Sterile NS, H2O, etc.).

° HAM/SALAD and Do not use abbreviations posters are up to date and available at nursing stations, within pharmacy, and medication storage areas.

° Hazardous drugs & pharmaceutical waste are labeled, stored, transported and disposed of according to federal, state, and local regulations.

FIRE SAFETY

°**RACE** (Rescue, Alarm, Contain, Evacuate)

°Fire alarms are located by all exit doors.

°Fire Extinguishers: **PASS** (Pull the pin, Aim nozzle at base of fire, Squeeze the handle and Sweep nozzle from side to side).

° Contact Quarter deck via emergency phone number 542-7878 inside the hospital. (Call 911 in all BHCs and outlying buildings).

° Egress Safety: Evacuate patients horizontally beyond nearest smoke doors. Only evacuate vertically if directed by the fire department.

° All Corridors, Stairwells, Exits are to be unobstructed. Temporary items are not to be left in corridors.

° Utility panels and fire extinguishers are not to be blocked and shall be easily accessible.

° Doors shall fully open and close (without sticking) and nothing prevent closure during an evacuation.

EMERGENCY MANAGEMENT

°Emergency Operations Plan (EOP): The hospital's comprehensive written plan for emergency and disaster response. The EOP is derived from the Hazard Vulnerability Analysis (HVA) which identifies hazards and risks to the hospital and BHCs impacting the ability to provide safe care.

°The Mass Warning Notification System (MWNS), also known as the electronic Incident Command System (e-ICS), provides alerts specific to emergency and disaster events and describes procedures to follow when an emergency or disaster event occurs.

Staff responsibilities:
- Know your dept. emergency response plan
- Know what to do: evacuation, shelter-in-place, lockdown, and surge procedures
- Participate in after action report (AAR) discussions with a focus on lessons learned

° Phases of **Emergency Management**:
- Prevention: stop hazards from occurring
- Mitigation: efforts to reduce impact
- Preparedness: actions to ↑ability to respond
- Response: intervention during/after emergency
- Recovery: supporting

° More information and resources are available on the **Emergency Management** intranet portal.

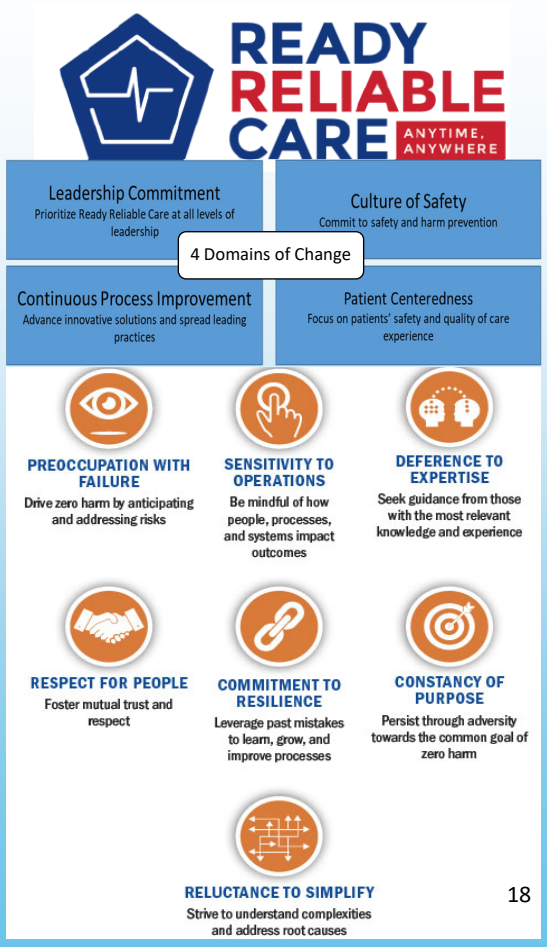
PAIN ASSESSMENT

° Is based almost entirely on information obtained from the patient, whether subjective or objective. When present, further assessment includes pain intensity and quality (character, frequency, location, and duration), associated symptoms, functional limitations, and psychosocial impact. Patient's goal for pain relief will be assessed in determining care team's goal. This may be functionally or numerically.

° Assessment Method: Defense and Veterans Pain Rating Scale (DVPRS), for age 12 years and older. For children who are communicative but less than 12 years of age, the Wong-Baker Faces scale can be used, which is included in DVPRS. Other situation-specific pain scales can be used at provider discretion, though the scale used should be noted in the assessment.

° Assessment Time: Pain reassessment shall be completed within a maximum of one (1) hour of any pharmacological intervention but prior to discharge or end of visit.

° Outpatient Assessment: Pain level should be assessed at every clinic visit with exception of purely admin visits. If a pain problem is identified, unrelated to visit, pain should be noted. This may prompt scheduling a future visit. All outpatient procedures will include pre and post procedural pain


READY
RELIABLE
CARE
ANYTIME, ANYWHERE
Leadership Commitment
Prioritize Ready Reliable Care at all levels of leadership
Culture of Safety
Commit to safety and harm prevention
4 Domains of Change
Continuous Process Improvement
Advance innovative solutions and spread leading practices
Patient Centeredness
Focus on patients' safety and quality of care experience
PREOCCUPATION WITH FAILURE
Drive zero harm by anticipating and addressing risks
SENSITIVITY TO OPERATIONS
Be mindful of how people, processes, and systems impact outcomes
DEFERENCE TO EXPERTISE
Seek guidance from those with the most relevant knowledge and experience
RESPECT FOR PEOPLE
Foster mutual trust and respect
COMMITMENT TO RESILIENCE
Leverage past mistakes to learn, grow, and improve processes
CONSTANCY OF PURPOSE
Persist through adversity towards the common goal of zero harm
RELUCTANCE TO SIMPLIFY
Strive to understand complexities and address root causes

TeamSTEPPS

Two-Challenge Rule

° When an initial assertion is ignored:
-It is your responsibility to assertively voice concern at least ***two times*** to ensure it has been heard.

° The member being challenged must acknowledge.

° If the outcome is still not acceptable:
-Take a stronger course of action;
-Utilize supervisor or chain of command.

CUS

I am **C** ONCERNED!
I am **U** NCOMFORTABLE!
This is a **S** AFETY ISSUE!

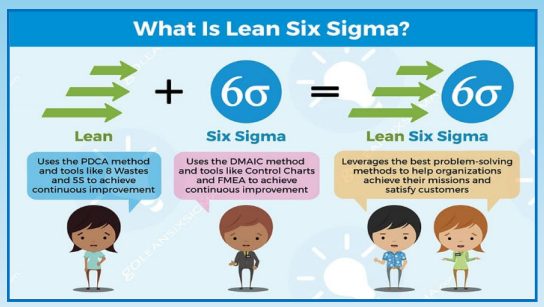
SAFETY-COMMUNICATION: UNIT BASED HUDDLE

A routine checklist/planning meeting which establishes and maintains a shared mental model of the plan for the day, shift, or event of patient care to identify and reduce the stress known to underlie staff member burn out.

Staff:
° Who is on the team
° What is staff availability throughout the shift?
°How is workload shared among team members?
Plan:
° What is the plan of patient care? Which patients are high risk?
° Do all team members understand their roles and responsibilities?
Resources:
° What resources are available?
Needs
° What are the safety risks or risks to the plan?
° Do all members understand and agree on goals?
Well-being
° What matters to you today?
° Is there a workplace stressor that impacts your ability to do your work?

QUALITY IMPROVEMENT

Quality Improvement (QI) embraces the entire staff and prospectively examines key processes, rather than focusing on individuals, in an effort to continuously identify opportunities for improvement.



PDC(S)A CYCLE

° Systematic process for gaining valuable learning and knowledge for continual improvement.

Plan - identifying a goal or purpose, formulating a theory and defining success metrics.

Do - components of the plan are implemented.

Check (Study) - outcomes are monitored to test the validity of the plan for signs of progress and success, or problems and areas for improvement.

Act - closes the cycle, integrating the learning generated by the entire process, which can be used to adjust the goal, change methods, reformulate a theory altogether, or broaden the learning.

PATIENT SAFETY

° The Joint Patient Safety Reporting (JPSR) program is utilized to identify, correct, and track systemic process errors to initiate patient safety improvements. The JPSR link is on every PC Desktop.

Types of Reportable Patient Safety Events (PSE)

Adverse Event: PSE that resulted in harm to a patient

No-harm Event: PSE that reaches the patient but does not cause harm

Close call (or "good catch"): PSE that did not reach the patient

-Good Catch Award nomination form available on SharePoint.

Hazardous (or "unsafe") condition: Circumstance (other than the patient's own disease process or condition) that increases the probability of an adverse event

Sentinel event: PSE that reaches a patient and results in any of the following: Death, permanent harm, severe temporary harm and invention required to sustain life.

National Patient Safety Goals

at Naval Hospital Jacksonville

NPSG #1: Identify patients correctly.

- °Two Patient Identifiers: Full name and date of birth.
- ° Label containers used for blood and other specimens in the presence of the patient.
- ° Use distinct methods of identification for newborns:
  -Double bands for infant, matching band to mother and support person. Include mother's full name, infant's DOB, delivering HCP, and billing number.

NPSG #2: **Improve staff communication** (Critical Results)

Laboratory: STAT– max 1 hour turnaround time. ASAP– 2 hour turnaround time.

Reporting sequence: OutPT: Ordering Provider, MOOD. InPT: Charge RN, Ordering HCP, MOOD.

Radiology: STAT– available w/in 1 hour of completion. ASAP– w/in 1 hour of completion during normal working hours. The interpreting radiologist will make a voice report to the first available provider in the medical chain of command.

- ° **NPSG #3 Use medicines safety**
  - ° Label medicines that are not labeled (i.e. medicines in syringes– do this in the area where medicines and supplies are set up).
  - ° Take extra care with patients on blood thinners.
  - ° Record and pass along correct information about a patient's medications.
- ° **NPSG #6 Use alarms safely**— by answering alarms quickly.
- ° **NPSG #7 Prevent infection**—Hand washing– per CDC guidelines.
- ° **NPSG #15 Identify patient safety risks**— reduce the risk for suicide.
- °**NPSG #16 Improve health care equity–** Identify and address health related social needs of food/housing insecurity for pregnant beneficiaries.
- ° **Universal Protocol**– Prevent mistakes in surgery.
  - ° Verify correct surgery, on correct patients, at the correct place on the patient's body.
  - ° Mark the correct place on patient's body for surgery.
  - ° Pause before surgery to make sure a mistake is not being made.

EMERGENCY CODES

Call the Quarterdeck: 542-7878

Code	
BLACK	BOMB THREAT
BLUE	CARDIAC ARREST
BROWN	SEVERE WEATHER
GRAY	DISASTER.MASS CASUALTY
GREEN	COMBATIVE PERSON.SECURITY
ORANGE	HAZMAT RELEASE OR LOCKDOWN
PINK	INFANT OR CHILD ABDUCTION
PURPLE	OB EMERGENCY
RED	FIRE
SILVER	LOST ADULT
WHITE	ARMED INTRUDER
YELLOW	UTILITY FAILURE

° Be sure you are familiar with the Emergency Operations Plan (EOP) and Continuity of Operations Plan (COOP) within your workspace.

MISSION:

Train, deploy and deliver superior, patient centered, quality healthcare to our warfighters and their families

VISION:

We are the choice for healthcare and the premier readiness and training command

GUIDING PRINCIPLES:

Set the Standard...Be the Standard…
Lead the Standard