2023 SURVEY READINESS GUIDE

TALKING WITH SURVEYORS

If you are selected to speak with a surveyor, the following points will help you respond appropriately.

DO'S

- Stay calm — take deep breaths. Be proud of the great work you do every day!
- Welcome the surveyor(s) to your area.
- Be courteous and respectful.
- Keep your communication concise and positive. Answer questions truthfully in clear, simple terms based on your everyday practice.
- Ask for clarification if you don't understand what the surveyor is asking.
- It's ok if you don't know the answer to a question. **Don't guess**. Simply say, "I don't know but this is how I would find the answer." It's important to know your resources (e.g., manager, supervisor, policy/procedure, connections guide, code of conduct etc.).
- Allow others to participate in the conversation. You collaborate with others in your work. If appropriate, include others to effectively answer questions asked.
- Be a good listener and thank the surveyor(s) for their time.

DON'TS

- Don't panic.
- Do not volunteer extra information (answer only the question that is being asked — no more, no less).
- Do not guess if you don't know the answer.
- Don't perform a running negative monologue while searching for documentation (i.e., "I don't think it's here, I don't think s/he documented that, we don't document that all the time…").
- Do not say "What I am supposed to do is ..." — this indicates that you do not follow the policy.
- Do not give answers you know are incorrect under any circumstances.
- Don't use the words "always" or "never" in the answers to questions. Instead, talk about NCHC's policie

First and foremost, you are an advocate for your patient. If your patient needs care or treatment while you are being interviewed, it is okay to tell the surveyor, politely excuse yourself, and return later. **PATIENT CARE ALWAYS COMES FIRST**.

REMEMBER YOUR RESOURCES:

Code of Conduct	Connections Guide	Communication Board
Policy & Procedure	Flash Fridays	Training & Education
(UKG/UltiPro)	Manager/Supervisor	Badge Buddies

GENERAL QUESTIONS

	QUESTION	ANSWER
1	What is the acronym for The Joint Commission?	**TJC:** for **T**he **J**oint **C**ommission. TJC changed its name from Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in 2007. Please do not refer to The Joint Commission as JCAHO — it leaves the impression we are behind the times.
2	What is NCHC's mission?	Langlade, Lincoln, and Marathon Counties partnering together to provide compassionate and high-quality care for individuals and families with mental health, recovery, and long-term care needs.
3	What is NCHC's vision?	Lives Enriched & Fulfilled.
4	What are our Core Values?	Integrity, Accountability, Partnership, Dignity, Continuous Improvement
5.	If a surveyor arrives in your department what do you do?	Follow the Do's and Don'ts. Be proud of the great work you do every day! This is your time to shine!
6.	Where can you find the polices & procedures?	Our policies & procedures are in UKG/UltiPro which can be accessed online and from the desktop icon. Please reference the job aid as well as the Flash Friday for helpful tips.

RIGHTS & RESPONSIBILITIES OF THE INDIVIDUAL

	QUESTION	ANSWER
1	How are patients and families informed of their rights and responsibilities?	Individuals receive this information at admission and annually thereafter. Posters are also mounted in patient care areas. This information is also available through the website and in the brochure titled "Patient Rights & Responsibilities."
2	Do we offer services for writing an advance directive?	Yes, they can be made available to any patient over 18 years of age requesting services. Upon admission, individuals served should be asked if they have advanced directives and this should be documented accordingly in the medical record.
3	What is an Advanced Directive?	A legal document addressing: (refer to policy) that allows for individuals served to indicate their wish for health care in case they become involved in an end-of-life situation or unable to speak for themselves. • Legal health care documentation • Durable power of attorney for finance • Living Will • Anatomical Gift Donation • Psychiatric Advanced Care Directives
4	What does it mean to ask a patient/family what their preferred language is?	The preferred language is the language that the patient/family wants to receive their medical information.
5	How do you address the care and learning needs of patients with religious, cultural or language barriers?	Involve and coordinate for interpreter services for all language barriers, or for hearing and/or sight impaired patients. A patient's learning preferences and spiritual, cultural, and personal beliefs are incorporated into the treatment/care planning processes.
6	If a patient has a complaint, what do you do?	All staff are expected and empowered to seek prompt resolution of patient issues and complaints expressed by a patient or a family. Supervisors and managers should be contacted, as needed, to assist with immediate response. If it cannot be resolved, a formal grievance resolution process is requested or the complaint is written, involves a rights or caregiver misconduct concern, the complaint becomes a grievance. Staff should inform the grievance official and enter in an occurrence report.
7	Who would you notify if you suspect abuse, neglect, misappropriation, or exploitation of a patient?	You would first **IMMEDIATELY PROTECT THE PERSON**. Secondly, you would notify your manager and submit a Safetyzone. The report would be investigated, and reporting completed as required. If a crime is suspected, law enforcement should be notified as well.

INFORMATION MANAGEMENT & RECORD OF CARE

	QUESTION	ANSWER
1.	How do you protect the confidentiality of protected health information (PHI)?	· Log off computer when not in use and at the end of shift. · Lock computer when left unattended. · Do not discuss patients in public areas. · Store written patient information in a way that prevents viewing by the public. · Dispose of confidential paper documents in appropriate locked bins.
2.	Who is NCHC's privacy officer?	Jennifer Peaslee, Compliance Officer
3.	Where do you find the Notice of Privacy Practices?	· Posted in physical locations. · Given to all patients upon admission. · Paper copies are available upon request on the norcen.org website.
4.	What are the components of an informed consent?	The goal is to establish mutual understanding and agreement between the patient and the provider who is providing the treatment. It allows for the patient to fully participate in decisions about their care and to be fully informed of the risk, benefits, and alternatives before giving consent which is obtained prior to treatment.
5.	What is the time frame in which verbal orders need to be signed by a physician?	All verbal orders need to be signed within 24 hours.

PROVISION OF CARE, TREATMENT & SERVICES

	QUESTION	ANSWER
1.	What is the plan of care for your patient?	Know your patient. Describe history, goals and discharge plans, and interventions and progress to date. Use the medical record to show documentation to support the described plan of care. The documented plan of care should reflect the status of the patient, including any changes in patient condition.
2.	How are patients and their family involved in care decisions?	Patients and their families are involved through the entire admission, stay and discharge. This is done via daily rounding, multidisciplinary rounds, care conferences and day-to-day discussions with their care providers.
3.	When are patients re- assessed?	Each shift, at minimum, and when needed. Frequency of assessment depends on patient status.
4.	When does discharge planning begin?	Goals for discharge should be set by the care team as early as possible after admission.
5.	How do staff identify patients with pain during the initial assessment?	By asking the patient/family or observing signs of pain. Any self-reports or observations of pain should be scored with the appropriate pain tool and documented.
6.	Do you have a process for nutrition screenings? What is that process? What do you do if the screening is positive?	Yes, our screen is in the EMR and is completed upon admission and then annually thereafter. If someone scores positive on the screen, we refer to primary care if a need is identified and this is documented in the EMR.
7.	What is waived/point of care testing?	Waived/point of care testing are tests performed on the unit that requires a specimen from the patient. Only certain areas conduct waived tests and staff who conduct these tests are trained to do them competently. The following are the waived tests performed at NCHC: glucose, urine drug screens, CoaguCheck, urine pregnancy, COVID antigen tests.
8.	How are patients assessed for fall risk? How frequently are they reassessed?	For individuals in our hospitals, the fall risk assessment is completed in the EMR on admission and reassessed every shift. We use the MORSE Fall Scale.
9.	What interventions are used to reduce a patient's risk for falls?	Increased vigilance and use of the falls plan of care to share interventions. Examples include: Patients wear red grippy socks if identified as fall risk. Based on fall assessment score, patient placed on falls precautions (communicated every shift) and/or PT consult is sought.

10.	Please describe your assessment of a patient's need for restraint and/or seclusion.	Restraint and seclusion are used only: • when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others • Least restrictive or alternative interventions are ineffective Restraint and seclusion are not used as a means of coercion, discipline, convenience, or staff retaliation.
11.	How are staff educated and assessed for competence in the use of restraints?	Education and assessment of competence occurs at orientation as appropriate to the employee's role and the patient population they are working with before the employee assists with or participates in the use of restraint/seclusion and annually thereafter.
12.	What criteria do you use to identify who may be a victim of trauma, abuse, neglect, or exploitation? When is an assessment performed? How is this documented?	A trauma screen is completed for every patient upon admission, annually or as circumstances change. It is also an assessment domain in Community Treatment, which is re-assessed every 6 months. The screening is documented in the patient's medical record.
13.	How does your program give and receive warm hand-offs for clients/patients?	When a client or patient is moving from the Crisis center into a program, or stepping from one program to another, a warm handoff occurs that includes a member of the referring program doing two things: sending the referral information to include client/patient information and reasons for referral, and second, holds a conversation with the accepting program to verbally discuss the client/patient to provide information and answer any questions the receiving program may have.
14.	What are some things your program does to provide individualized care?	Our programs provide individualized care by developing a treatment plan which addresses each client's/patient's specific needs and to address the client's/patient's treatment preferences as appropriate, as well as provision of regular client/patient checks and interactions to assess each client's/patient's needs ongoing.

NATIONAL PATIENT SAFETY GOALS

	QUESTION	ANSWER
1.	How do you properly identify a patient before administering medications or treatment? (identify individuals served correctly)	Always use two patient identifiers: Examples include: 1. **Name**, and 2. **Date of birth** or **medical record number**
2.	What is the purpose of medication reconciliation? (use medicines safely)	Medication reconciliation is the process of identifying the most accurate list of all medications the patient is taking including name, dosage, frequency, and route by comparing the medical record to an external list of medications obtained from a patient, hospital or other provider and is done to avoid medication errors, adverse complications leading to harm to the patient.
3.	How do you screen patients for risk of suicide? (reduce risk of suicide)	Every patient is screened for suicide risk at admission and at regular intervals thereafter including when there's a change in protective, risk and/or environmental factors. In our hospitals, patients are reassessed every shift utilizing a self-harm assessment. Prior to discharge, patients are re-screened. We use the Columbia CSSRS for screening and if a patient screens positive, we use the Columbia SAFE-T assessment. Both are in our EMR and available for viewing at the client level.
4.	What would you do if your patient was showing signs of suicide risk? (reduce risk of suicide)	Complete the screening to determine risk level and complete recommended assessments and provide correlating intervention based on assessment results, which could include crisis contact, crisis and/or safety plan. If in our hospital, staff would notify the treating provider, and potentially be placed on Line of Sight monitoring, Suicide precautions and continue 15 minute checks, Suicide blanket. 1:1, if required.
5.	What is the single most effective way to reduce infection? (infection prevention)	Handwashing. We use the hand cleaning guidelines from the Centers for Disease Control and Prevention. We conduct hand washing competencies and round for compliance including goal setting to improve hand washing.

MEDICATION MANAGEMENT

	QUESTION	ANSWER
1.	What are the 10 rights for medication safety?	1. Right Patient 2. Right History & Assessment 3. Right Drug-Drug Interaction Evaluation 4. Right Medication 5. Right Dose 6. Right Time & Frequency 7. Right Route 8. Right Drug Approach 9. Right Education & Information 10. Right Documentation
2.	What is a high alert or high-risk medication and how can it be identified?	A high alert medication is a medication that has more devastating consequences to patient when used in error. Mistakes may or may not be more common with these medications, but consequences of errors are more harmful to patients. A list of the medications considered high alert is posted in medication storage areas on patient care units.
3.	What do you do when an actual or potential adverse event or medication error occurs?	1. Notify Treating Provider and document in the medical record 2. File a SafetyZone Report-management including pharmacy will be notified for appropriate follow up and investigation
4.	What is a look alike/sound alike medication?	A medication that has a similar looking or sounding name or appearance. This may include the brand or generic names of the medication as well as the appearance of the medication in its original container. A complete list can be found in medication storage areas within patient care units. Highlighted medications are those commonly used at NCHC
5.	What is the process for patients using their own medications from home?	1. Obtain an order from a Provider 2. Home medication must be in original container or package dispensed from a pharmacy. Patient's own meds must be labeled per medication labeling standards. 3. Medication must be verified with some drug identifier source if pharmacy is not open. Once pharmacy is open medication must be brought to pharmacy to verify.

INFECTION CONTROL

	QUESTION	ANSWER
1.	What is the single most important thing you can do to prevent the spread of infection?	Hand hygiene!!
2.	When should you perform hand hygiene?	**Use soap and water:** when hands are visibly soiled, before eating, after using rest room, and when leaving an enteric precautions room. **Use alcohol-based hand rub OR soap and water:** before direct contact with patients, before donning sterile gloves, before inserting an invasive device such as urinary catheter or IV, after contact with patient's intact skin, after contact with body fluids, mucus membranes, non-intact skin, or soiled wound dressing, when moving from contaminated body site to clean body site, after contact with inanimate objects in the patient environment, after removing gloves.
3.	What is the correct hand washing procedure?	**When washing hands with an alcohol-based hand rub**: · Apply product to palm of one hand (an adequate amount is a walnut or golf ball sized portion depending on hand size) · Rub hands together, covering all skin surfaces of hands, fingers, and around nails, rub until product dries; an appropriate amount will dry in 10- 15 seconds. **When washing hands with soap and water:** · Wet hands first with water · Apply an adequate amount of soap · Rub hands together vigorously for at least 20 seconds, covering all surfaces between fingers and around nails · Rinse hands with water and dry thoroughly with a disposable towel (patting, not rubbing with towel will reduce abrasion) · Use towel to turn off faucet · Avoid using hot water because repeated exposure may increase the risk of dermatitis
4.	When should you change gloves? Why?	Gloves are changed when moving from dirty to clean on the same patient or in the same patient environment to prevent organisms found in the dirty area from spreading to clean area.

5.	Why do you need to wash hands before donning and after taking off gloves?	Gloves may have tiny holes through which infectious agents could enter and contaminate skin. It is also possible to contaminate your gloves with your hands when donning gloves, and it is possible to contaminate your hands with your dirty gloves when taking them off.
6.	How long should your nails be?	Nails are to be kept short (cannot extend past the tip of the finger) and clean to prevent tearing of gloves and to decrease the potential spread of pathogens to patients. Clear or colored nail polish, that can be removed within 5 minutes with acetone and a cotton ball, may be worn if well-manicured; chipped polish must be removed.
7.	What does MDRO mean?	**M**ultiple **D**rug **R**esistant **O**rganism.
8.	What should you do if your patient has an MDRO?	Patients with an MDRO should be in a private room in contact precautions. Gown and gloves should be donned on room entry, regardless of reason or length or time you will be in the room. As much as possible, equipment is dedicated, and remains in the patient room until discharge.
9.	Where can you locate the precautions the patient is on?	These are visible as you enter a patient room.
10.	When a patient is placed in precautions what should you do?	· Follow the indicated precautions · Provide education to the patient and family on what the assigned precautions are
11.	How should patient food be handled?	· Cover food from the cafeteria on the way to the floor. · Store food in a separate refrigerator from medications. · Label food with a date and the patient's name (do not include MRN or any other PHI).
12.	What items may be stored in patient food, medication and laboratory refrigerator/ freezers?	1. Patient food refrigerator/freezers: Only patient food 2. Medication refrigerator/freezers: Only medications and laboratory media 3. Laboratory refrigerator/freezers: Only laboratory media and lab specimens Note: Do NOT mix items between dedicated fridges/freezers!

PERFORMANCE IMPROVEMENT

	QUESTION	ANSWER
1.	What are you doing on your unit to improve performance and clinical outcomes?	Know what your area is working on! Know generally how you're doing in each area your department is working on. If you don't know of any, ask your manager or supervisor. Examples could include: · "We hold huddles at start of shift to review our patients, acuity and discuss any patient safety issues." · "Let me show you our key indicators or other measures ..." · "We are working on this process improvement project…" *Surveyor synonyms: PI, QI, Improved Patient Care, Clinical Outcomes, Quality, Continuous Improvement, Process Improvement*
2.	What are NCHC's quality improvement goals?	· Improve hand hygiene rate · Reduce medication errors · Reduce/eliminate safety events with harm=zero harm
3.	What is a sentinel event?	A sentinel event is an event that has resulted in an unanticipated death or major permanent loss of function (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in: Death or Permanent harm or Severe Temporary harm (critical, potentially life-threatening harm lasting for a limited time with no permanent residual, but requires transfer to higher level of care/monitoring for a prolonged period of time, transfer to a higher level of care for a life-threatening condition, or additional major surgery)
4.	What is the specific methodology used at NCHC for performance improvement activities?	PDSA (Plan-Do-Study-Act) is our model for improvement. • Plan: Plan the improvement • Do: Do the improvement and data collection • Study: Study the results of the implementation • Act: Act to maintain the change
5.	How are occurrences (incidents) reported at NCHC?	Occurrence reports are entered into our online system, SafetyZone within 24 hours of the event occurring. These include all near misses, adverse events, and sentinel/significant events. Management is responsible for providing follow up. Any significant or sentinel events are also reported to the administrator on call.
6.	What is a Root Cause Analysis?	A root cause analysis is a process that uses information gathered during an investigation to determine what contributed to the occurrence. The goal is to identify root causes and fix underlying system/process issues to prevent recurrence of a similar event.

MEDICAL STAFF

	QUESTION	ANSWER
1.	Who is responsible for credentialling & privileging?	Jess Putrus. She works with each licensed practitioner to collect all necessary information and documents, runs initial background checks, and then she works closely with Northcentral Credentialing Services (NCS), the Credentials Verification Organization NCHC uses to perform primary source verification. Jess continuously works with these providers and NCS to maintain complete and up-to-date credentialing and privileging files for all North Central Health Care providers that we employ or contract with.
2.	What is credentialling & privileging?	**Credentialing** is the process of obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services in or for a health care organization. Credentials are documented evidence of licensure, education, training, experience, or other qualifications. Examples of credentials are a certificate, letter, or experience that qualifies somebody to do something. **Privileging** is the process whereby the specific scope and content of patient care services (that is, clinical privileges) are authorized for a health care practitioner by a health care organization, based on an evaluation of the individual's credentials and performance. An organization must verify a person's credentials before granting privileges.
3.	How does NCHC evaluate each practitioner's performance on an ongoing basis?	Focused Professional Practice Evaluation (FPPE): initiated upon hire, reviewed every 3 months for a minimum of 1 year. Can be continued or re-initiated as defined by policy. Ongoing Professional Practice Evaluation (OPPE): start after a minimum of 1 year, reviewed ongoing – every 6 months. Peer Review: 2 types – random & event reviews. Random routine reviews are conducted annually, event reviews are conducted on an as needed basis.
4.	What types of data do you collect to inform your ongoing professional practice evaluation (OPPE)? How is this analyzed and tracked?	Qualitative and quantitative data is collected regarding the following 6 core competencies: • Medical/clinical knowledge • Technical and clinical skills • Clinical judgment • Interpersonal skills • Communication skills • Professionalism Data is analyzed and tracked via reports from the EMR.
5.	When do focused professional practice evaluations (FPPEs) occur and why?	FPPEs occur when an organization does not have documented evidence of competently performing the requested privilege at the organization. This process can also be used when a question arises regarding a currently privileged provider's ability to provide safe, high quality care. FPPEs are a time-limited, during which the organization evaluates and determines the practitioner's professional performance.
6.	What purpose does the Medical Staff Bylaws have?	Medical Staff Bylaws is a document that is approved by the Medical Staff and NCCSP Board of Directors. It specifically governs providers and establishes requirements for the members of the medical staff.

HUMAN RESOURCES

	QUESTION	ANSWER
1.	Do you function according to your job description?	Yes. All employees sign off on their job descriptions at time of hire or transfer into a new position/department. All job descriptions are available to any employee through Human Resources or by accessing UltiPro. Job descriptions are also re-acknowledged each year as part of NCHC Work Expectations and HR Policy Review and Acknowledgement module. This is usually done in January/February of each year.
2.	What education/training are you required to attend?	All employees are required to attend NCHC new hire orientation. In addition, all employees are required to complete annual organization-wide education and competency training (i.e., infection control, hazardous materials, bloodborne pathogens, MOAB, Code of Conduct training etc.,). Any job specific education applicable or any new rules or regulations may require additional training.
3.	What education/training have you attended recently?	Think about what training you've completed recently and talk about this if asked (for example, ethics, clinical supervision, specific competency training, etc.,)
4.	What processes do you have in place for competency assessment? How are these processes documented? How are they validated?	Competency and validation assessment is completed as part of orientation and at least once every three years or more frequently in accordance with regulation, policy and by program. Validation methods are documented in UltiPro by management and can include: o LMS (Learning Management System) Modules in UltiPro o Return demonstration o Written test o Verbal response o Evidence of daily work o Records audits o Skills labs or Competency Days o Refreshers: like CPI, Restraint Chair NCHC offers education and training to fulfill regulatory and competency requirements which are tracked in the LMS and through the use of checklists completed and verified by the trainer or manager.

ENVIRONMENT OF CARE & EMERGENCY MANAGEMENT

	QUESTION	ANSWER
1.	Where can you reference NCHC's emergency, safety, and security information?	This information is held in UltiPro under policies and procedures. You can also refer to your badge buddy for quick, at-a-glance information regarding our emergency codes.
2.	How do you maintain safe access within stairwells and corridors?	**Stairwells:** Please do not put anything in stairwells. No equipment is allowed in exit enclosures (exit stairwell) that could interfere with function as an area of refuge except for those that support its functionality that do not interfere with the use of the exit. (Ex. badge reader) **Corridors:** Corridors must be kept clear of clutter. Items cannot be stored in corridors designated as egress access corridors no matter the width of the corridor. The exception are crash carts, which are considered permanently in-use emergency medical equipment, and carts containing PPE for isolation when associated for a specific patient(s), which are also considered permanently in-use. Wheeled items that are in-use, such as mobile computer on wheels, linen and housekeeping carts can be in the egress access corridor, if these are moved within 30-minutes. In the event of an emergency in-use carts and equipment must be moved to provide unobstructed egress. Alcoves in corridors can be used for storage if the stored items do not project into the corridor. Dead-end corridors, any pathway longer than 20 feet with no exit, may be used for storage or sitting areas if it occupies less than 50 square feet of space and does not inhibit egress.
3.	How frequently do you have fire drills?	At a minimum, NCHC holds quarterly fire drills. We do them on all shifts and all departments are required to participate.
4.	In case of a fire, what would you do?	**RACE** **R**escue: Move anyone in immediate danger to a safe area. **A**lert: Call out " FIRE! " to other employees, pull the fire alarm pull station, call 4599 **C**onfine: Close all doors after checking rooms. Extinguish: Fight fire if it is safe to do so, or **E**vacuate: Evacuate all occupants to the adjacent smoke compartment (non-evacuation locations) or outside (evacuation locations). Do not use eleators!
5.	Explain how you would use the fire extinguisher.	**PASS** **P**ull extinguisher pin **A**im at base of fire **S**queeze extinguisher handles **S**weep side to side from front of fire toward back of fire

6.	What would you do if you learned of a fire in another part of the building?	**For non-evacuation buildings**: If the alarms sound in your area, but you are not threatened by smoke/fire: · Alert others in your area; account for all patients, visitors, and staff · Close doors and windows · Clear equipment from corridors, exit pathways and stairways · Prepare to evacuate and/or receive patients and visitors from adjacent smoke compartments · Stand by and await further instruction **For evacuation buildings:** Alert others and evacuate the building
7.	Do you know how to evacuate your unit or department?	**Non-evacuation buildings:** Occupants in non-evacuation buildings should relocate to the adjacent (horizontal) smoke compartment first, and use vertical evacuation as a last resort.
	Where is your evacuation plan located?	**Evacuation buildings:** Occupants in evacuation buildings must leave the building. Reference your department specific evacuation plan.
8.	How far away from sprinklers must items be stored?	There must be at least an 18" clearance below the sprinkler head. Shelving and the storage can extend up to the ceiling as long as an 18" perimeter is maintained around the sprinkler head.
9.	How do you know that the medical equipment you are using is safe to use?	Wisconsin Biomedical Services inspects medical equipment prior to being put into service. The equipment is then put into a preventive maintenance schedule.
10.	How do you report a malfunctioning piece of medical equipment that has caused patient/staff injury?	• Malfunctioning equipment that has resulted in patient injury or compromise should be left unaltered, tagged, and quarantined. • Notify the Quality and Safety Manager immediately. • Complete an occurrence report.
11.	What are NCHC's Emergency Codes?	• Facility Alert: Fire • Facility Alert Fire Watch • Facility Alert: Evacuation • Medical Emergency: Code Blue • Medical Emergency: Rapid Response • Medical Alert: Mass Casualty • Security Alert: Abduction/ Missing Person • Security Alert: Armed Violent Intruder/ Active Shooter/Hostage Situation • Security Alert: Building Threat • Security Alert: Dr. Green (Psychiatric or Behavioral Health Emergency) Reference Emergency Response located on your ID badge buddy.
12.	What is a safety data sheet (SDS)? Where are they located?	Safety Data Sheets are provided by the manufacturer of a product. They include important information for each chemical such as: chemical identity, characteristics, health hazards, first aid/emergency measures and procedures for clean-up and safe handling.  Safety Data Sheets are in MSDS (shortcut on computer screens)