

University of Rochester Medical Center

Strong Memorial Hospital

2009

Department Resource Guide

Mandatory In-Service Education Program



MEDICINE of THE HIGHEST ORDER

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CODE PINK CHILD/INFANT ABDUCTION (SMH Specific)

Subject Matter Expert: Lorraine McTarnaghan (275-2500)

For more information, go to:

<http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/documents/2-8.pdf>

<http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/3-3.pdf>

Protection of Minor Patients

All admitted infants and children while receiving care at University of Rochester Medical Center-SMH shall be checked minimally every 2 hours and this check shall be documented in some fashion in their medical chart. Admitted infants and children shall be assessed to include risk of abduction.

Assessment

Staff identifying a potential security risk for abduction of a patient should confer with area/unit leadership and other departments as applicable (for example, Social work). If a security risk is identified for a patient, the Patient Protection Plan (SMH Form 1375) should be completed by unit/area staff. The Patient Protection Plan includes a check-off of descriptive information for the patient as well as possible perpetrator. Staff should fax a copy of the Patient Protection Plan to UR Security Services (273-1053) and keep a copy of the form on the unit/area for reference. Staff will need to notify Security when the patient is discharged and the plan is no longer in effect.

In the Event of a Suspected Infant or Child Abduction

1. If you are in the area where the abduction occurred:

The staff member learning of the possible abduction should **immediately contact Security Services, extension 13, and request a Code Pink:**

- Give the location, age, of infant/child, description of infant or child and of the abductor, if known.
- Remain on the phone with Security Services until all necessary information is communicated.
- "Code Pink (age and location)" will be announced via the page system.

Other staff in the immediate area should:

- Not allow anyone to enter or leave the area where the abduction took place.
- Search the area.
- Identify all witnesses (separate them if possible).
- Follow any department-specific policies. For example, maternity units have additional policies.

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CODE PINK CHILD/INFANT ABDUCTION – SMH (continued)

2. Staff in an area other than the site of the abduction should:
 - Report suspicious activity or persons to Security at extension 13.
 - Monitor the nearest perimeter door in your area. Direct all persons attempting to exit with a child, package, or appearing to be pregnant, to one of the following exits where UR Security Services will be screening pedestrian traffic:
 - Main Lobby, First Floor Medical Center Parking Garage Link
 - Ground Floor, Medical Center Parking Garage Link
 - Patient Discharge
 - Clinical Research Center (former UHS entrance)
 - Staff monitoring exits should remain at their location to redirect pedestrian traffic until relieved by Security Services, another staff member, or until the "Code Pink, All Clear" overhead page is announced.
 - Follow any department-specific policies. For example, some departments are assigned specific doors to monitor.
3. Staff Safety and Responsibility
You should not place yourself in danger by attempting to detain a suspicious person. If you encounter a suspicious person, observe the following and immediately **call Security at extension 13**:
 - Gender, race
 - Age, height, body build
 - Facial features, hair color and type, eye color
 - Characteristics (clothing, glasses, limp, tattoo, etc.)
 - Vehicle description, including license plate number
 - Direction of travel
4. Communication of information
No information should be given to the press regarding the incident. All inquiries shall be directed to the Public Relations Department or the Administrator-On-Call.

COMPLIANCE: EVERYONE'S RESPONSIBILITY

Subject Matter Expert SMH and HH: Fred Holderle (275-1609)

It is University of Rochester Medical Center (URMC) policy that all employees and affiliated professional staff comply fully with state and federal laws and conduct themselves in accordance with the highest ethical standards. The Compliance Office supports employees, providers and management in providing effective, quality care while performing their responsibilities ethically and within the bounds of the law.

Reporting Noncompliant Behavior: You have the responsibility to report suspected illegal or noncompliant activities. You can report any concerns **without fear of retribution** by:

- Contacting your supervisor/manager.
- Contacting the Compliance Office at 275-1609 or in writing at Box 520.
- Calling the **Integrity Hotline** at **756-8888**; callers may remain anonymous.

Government Investigations/Searches

On occasion a government official or agency conducting an investigation may ask to talk with you or request documentation. Although such contacts and investigations are rare, employees should know:

Talking to agents is voluntary. You may wait for an attorney before answering questions.

DO:

1. Call the Office of Counsel through the page office at 275-2222 and contact your supervisor/manager.
2. If you speak to an agent, stay in control, inspect the search warrant (what is alleged), take notes.
3. Observe the search process; record documents that are reviewed. Object **politely** if the search goes beyond warrant authorization.
4. Inventory seized materials; copy documents and protest the seizure of computers.

DON'T:

1. Panic
2. Destroy materials
3. Volunteer information or materials
4. Make small talk with the agents

Reporting External Audit Requests

Requests from payors/investigators to audit, copy or review medical records come from many sources and can be addressed to a variety of individuals. It is critical that all requests be reviewed by the leadership of the affected department or area and that appropriate action be taken in a timely fashion. The URMC Compliance Office tracks audit/record requests and oversee the response to all Medicare and Medicaid audit requests.

Any area within URMC that receives a written audit request should **contact the Compliance Office immediately at 275-1609.**

Need More Information?

Specifics about the URMC Compliance Program can be obtained at our website, <http://www.urmc.rochester.edu/urmc/compliance/>, or by contacting Fred Holderle.

CONFLICT OF CARE

Subject Matter Experts: **SMH:** Peg Lee (275-2537), **HH:** Kathleen Gallucci (341-0118)

The need to provide care or treatment of a patient may be in conflict with an employee’s ethical, cultural or religious beliefs. If so, please contact the appropriate person.

	SMH	Highland
Contact Person/ Department/ Phone No.	Department Manager	Department Manager and Human Resources x1-6332
Written Resource (Policy Manual to reference)	<i>SMH Policy Manual, Policy 13.6: Employee and Medical Staff Right to Non- Participation in Specific Health Care or Research Activities</i>	<i>Human Resources Personnel Policy Manual, 341, Conflict of Care</i>
Procedures Specific to Site		<i>HR Personnel Policy 341 outlines the procedures and provides a sample of the “Request to be Excused From Providing Patient Treatment/Care” form.</i>

ELECTRICAL SAFETY

Subject Matter Experts: **SMH:** Mike Rink (275-4810), **HH:** Paul Bloser (341-0120)

Plugs and Receptacles

- Plug caps should fit securely in receptacle outlets.
- Grasp the plug cap and pull it out of the outlet. Never pull the cord.
- Do not reset a ground fault indicator outlet with an item plugged in.
- In the event of a major power outage, an independent power source will be activated. The table below describes the location of receptacles on emergency and nonemergency power.

Receptacle Identification

	SMH	Highland
Receptacles on emergency power (generators) ONLY PATIENT CARE RELATED EQUIPMENT SHOULD BE PLUGGED INTO THESE RECEPTACLES	Red (Critical Life Support Equipment) Located in ICU, ORs, Emergency depts., other patient care areas.	Red
	White (General Patient Care Equipment–Beds, Call Systems, etc.) Located in all patient care areas	Ivory
	Orange (Individual Patient Care Equipment) Life support equipment located in ICUs, ORs, Cath Scan/MRI, X-ray areas.	Orange Dedicated/ isolated outlet
Receptacles NOT on emergency power (normal house power)	Brown (General Use Such As Vacuum Cleaners, Floor Polishers, Desk Lamps, etc.) Located throughout the hospital.	Brown

Cords/Grounds

- Report any loose plug caps in wall receptacles.
- Never use a cord that is frayed, has exposed wires, or loose prongs. Keep cords out of water, oil, or any material that could cause deterioration.
- Do not position cords in traffic areas. This could lead to someone tripping and/or damaging a cord.
- Use properly grounded electrical devices.
- Never roll a bed, cart, etc. over an electrical cord; keep all objects off electrical cords.

Shock Avoidance

- Do not touch any electrical device with wet hands.
- Do not stand in water when touching any electrical device.

Highland-Specific Electrical Safety

- Adapters must be approved by Clinical Engineering.

EMERGENCY PAGE CODES—SMH

Subject Matter Experts: Lorraine McTarnaghan (275-2500), Pam Papatelli (275-6004)

For full information on codes, go to: <http://intranet.urmc.rochester.edu/Policy/SMHPolicies/>

Emergency	Phone #	Page Code
Investigation of a fire/smoke alarm	x-13	Condition 3-0 (location)
Confirmed incident: fire, flood, etc.	x 13	Condition 1-3 (location)
Patient and/or visitor is posing a safety threat	x-13	Condition Gray (location)
Incident involving hostages and/or weapons	x-13	Condition Yellow (location)
Cardiac or respiratory arrest	x5-STAT x5-7828	Blue 100 (location)
Pediatric cardiac or respiratory arrest	x5-STAT x5-7828	Pediatric Team (location)
Medical assistance	x-13	MERT (location)
Abduction	x-13	Code Pink (age and location)
Utility Failure	x-13	Condition Utility (location & type of utility affected)
External/Internal Disaster	x-13 Disaster Emerg Ops Ctr x5-0500	HIMS Response

END OF LIFE CARE

Subject Matter Experts:

SMH: Rev. Robin Franklin (275-2187), **HH:** Rev. Angel Sullivan (341-6890)

For more information, go to: <http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/index.asp>
or <http://intranet.highlandhospital.org/Policy/>.

It is recognized that there are many medical situations in which cure or recovery is not possible. A challenging part of medicine is caring for patients at the end of their lives. Priorities for end of life care are to develop a plan of care which educates patients as to options for care and to provide methods for a dignified, pain and symptom controlled death.

The Ethics Committee (HH), the Palliative Care Consultation Service (SMH), the Ethics Consultation Service (SMH), and Chaplaincy Services (SMH/HH) are available to patients, families and providers to aid in the discussion or resolution of issues that may arise in the course of care.

For additional information:

SMH Policies	HH Policies
3.8 <i>Hospice Patients</i>	3.11 <i>Patient's Bill of Rights</i>
9.3 <i>Advance Directives</i>	3.15 <i>Management of Ethical Issues</i>
9.3.1 <i>Health Care Proxy</i>	4.14 <i>Health Care Proxy</i>
9.3.2 <i>Do Not Resuscitate Orders</i>	4.2 <i>Advance Directives</i>
9.3.3 <i>Withdrawing/Withholding Unwanted Life Sustaining Medical Care</i>	4.4 <i>Do Not Resuscitate Orders</i>
9.3.4 <i>Ethical Issues</i>	4.5 <i>Withdrawing/Withholding Unwanted Life Sustaining Medical Care</i>

FALSE CLAIMS PREVENTION (FALSE CLAIMS ACT)

Subject Matter Expert SMH and HH: Fred Holderle (275-1609)

Policy 114, Compliance Education, in the University of Rochester Personnel Policy Procedure Manual at www.rochester.edu/working/hr/policies/pdfpolicies/114.pdf and Policy 133, Compliance, in the Highland Hospital Human Resources Policy Manual at <http://intranet.highlandhospital.org/Policy/HRpolicy/documents/HR133-Compliance.pdf> furnish specific compliance education. These policies cover employees' responsibilities and rights in assisting their employer in complying with all legal and regulatory requirements.

What is the Federal False Claims Act?

The Federal False Claims Act is a federal statute that establishes liability for knowingly presenting a false or fraudulent claim for payment to the United States government or to a government contractor. This includes claims submitted to Medicare or Medicaid.

Health care providers and their employees can be subject to civil monetary penalties of \$5,500 to \$11,500 for EACH false claim submitted. They can be required to pay three times the amount of damages sustained by the US government and they may also be excluded from participation in Medicare and Medicaid.

Does New York State have a False Claims Act?

Yes. In April 2007, New York State enacted its own false claims act that applies to most claims submitted to the State, including claims submitted to Medicaid.

What kinds of conduct may violate the State and Federal False Claims Acts?

Examples of practices that may violate the False Claims Acts, if done knowingly and intentionally, include but are not limited to:

- Billing for services not rendered.
- Knowingly submitting inaccurate claims for services.
- Taking or giving a kickback for a referral.

All of the above examples could be considered fraudulent. Billing fraud is a serious crime that may be punishable by imprisonment.

How is the University of Rochester Medical Center (URMC) preventing violations of the False Claims Acts?

The Compliance Office has an extensive program for detecting and preventing fraud, waste and abuse as well as violations of the State and Federal False Claims Acts. These policies are described on the Compliance Office website at <http://www.urmc.rochester.edu/urmc/compliance/>.

How can I help avoid violations of the False Claims Acts?

There are several things you can do to reduce the risk of False Claims Act liability:

You should make sure you understand the rules that relate to the services and goods being billed. Information contained in any claim must be as accurate and complete as possible. Specifics about correct billing may be obtained from:

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FALSE CLAIMS PREVENTION (FALSE CLAIMS ACT) continued

- The Centers for Medicare and Medicaid Services (www.cms.hhs.gov)
- The New York State Medicaid program (www.emedny.org)
- Medicare administrative contractor (www.ngsmedicare.com/ngsmedicare/HomePage.aspx)
- The New York State Department of Health (www.health.state.ny.us)

You may also receive assistance from the Compliance Office by calling 275-1609.

If you become aware of a potential billing problem, you should immediately notify your supervisor, the Compliance Office or the Integrity Hotline (756-8888). It is important to act swiftly so the matter can be reviewed and the proper action taken. Potential actions include:

- Making changes to prevent the problem from continuing
- Making arrangements to repay any overpayments
- When appropriate, disclosing the problem to appropriate state and federal officials

By voluntarily disclosing such information, the URMC may avoid or limit liability under the False Claims Acts.

Am I protected from retaliation?

State and Federal law and URMC policy contain protections against retaliation for disclosing potential billing problems. These protections may include employment reinstatement and back pay. Additionally, the Compliance Office operates a hotline (Integrity Hotline at 756-8888) that makes it possible for you to make your concerns known without disclosing your identity.

The False Claims Acts also include “qui tam” provisions that allow any person with actual knowledge of a False Claims Act violation to file a lawsuit on behalf of the State or Federal Government. If the government determines that the lawsuit has merit and decides to join, the government will direct the prosecution of the lawsuit. If the government decides not to join in the lawsuit, the person who filed the lawsuit on behalf of the government may continue the lawsuit on his or her own.

FIRE SAFETY

Subject Matter Experts: **SMH:** Mark Cavanaugh (275-8412), **HH:** Joe Coon (341-6833)

For complete information on this topic, please go to:

<http://intranet.urmc-sh.rochester.edu/policy/EmergPrepManual/1/1-12.PDF>

or http://intranet.highlandhospital.org/Policy/envCare/FirePlanssec5_8.pdf at Highland

When pages or alarms sound:

Fire Condition/Alarm	SMH Condition 3-0 and Condition 1-3	HH 1-2-3 Red
In area of the fire	Follow RACE (Rescue, Alarm, Contain, Extinguish)	
Other location outside immediate fire area	a. Close all doors/clear corridors; avoid telephone use unless an emergency. b. Do not use elevators, especially if they're in vicinity of fire alert. c. Stay where you are unless job responsibilities require a specific response. d. When "All Clear" page sounds, resume normal activities.	

Fire Extinguishers are Classified into Four Basic Types:

1. Type **A** – Pressurized water; used on fires involving normal combustible materials (wood, paper, and trash). *Must not be used on electrical, gas or oil fires.*
2. Type **BC** – used on energized electrical or flammable or combustible liquid fires. (For an electrical fire, interrupt the power: pull the plug or shut off the circuit breaker.)
3. Type **ABC** – Multipurpose dry chemical that can be used on all classes of fire. Care should be taken to avoid inhaling the powder or unnecessary contact with the chemical.
4. Type **K**– wet chemical extinguishing agent that can be used on deep-fat cooking operations using vegetable oils.

Extinguisher operation-PASS:

(1) **P**ull the pin, (2) **A**im the horn or hose at the **base** of the fire, (3) **S**queeze the handle and (4) **S**weep at the base of the fire.

Never spend more than 30 seconds attempting to extinguish a fire. If you are unable to completely extinguish the fire within this time frame, evacuate immediately.

Evacuation:

1. **All health care providers should know the evacuation plan and location of the nearest fire exit, relocation site, fire alarm and fire extinguishers in their work areas.**
2. The Charge Nurse is responsible for overall operations during an evacuation.
3. If the room(s) is evacuated, obtain chalk from the nearest fire extinguisher cabinet and chalk the lower hinge side of the door with a slash.

For techniques for removing limited mobility patients, see:

www.safety.rochester.edu/fire/EvacuationCarry.html

HAZARD COMMUNICATION STANDARD OSHA STANDARD 29 CFR 1910.1200

Subject Matter Experts: **SMH:** Bob Passalugo (275-3016), **HH:** Joe Coon (341-6833)

For full information on this topic, go to:

- SMH:** <http://intranet.urmc.rochester.edu/policy/smholicies/section13/13-11.PDF>
<http://www.safety.rochester.edu/pdf/hazcom.pdf>.
<http://www.safety.rochester.edu/ih/hazcomnurses.html>.
- HH:** <http://intranet.highlandhospital.org/policy/envCare>

Requirements

- **Hazardous Chemicals:** Chemicals that pose a physical and/or health hazard are considered hazardous chemicals. Health hazards from exposures may range from irritation to serious health problems. Many chemicals may pose more than one hazard. OSHA has deemed many drugs (liquids and those that can be placed into solution) hazardous chemicals.
- **UR's Written Hazard Communication Program:** Two written programs have been prepared to comply with OSHA's Hazard Communication Standard and are available at <http://www.safety.rochester.edu/pdf/hazcom.pdf>. A *Hazard Communication Guide for Nurses and Medical Care Staff* is also available at <http://www.safety.rochester.edu/ih/hazcomnurses.html>.
- **Highland's Written Hazard Communication Program:**
The document describing the program to comply with the OSHA Hazard Communication Standard can be found in the *Highland Environment of Care Manual* (<http://intranet.highlandhospital.org/policy/envCare>).
- **Employee Information and Training:**
Employees are trained on the hazards of chemicals, requirements of the OSHA Hazard Communication Standard, how to use Material Safety Data Sheets (MSDSs), proper labels, how to protect themselves from exposure, and what to do in the event of an emergency.
- **The employer will provide:**
 1. Employee information on the hazardous chemicals with which they may come in contact at the hospital.
 2. Access to the hospital's written Hazard Communication Program noted above.
- **Material Safety Data Sheets (MSDS) and Chemical Inventories:** MSDSs are available to employees for all chemicals used. Employees should become familiar with the information contained on these MSDSs. This information includes but is not limited to:
 - Manufacturer information
 - Hazardous ingredients/identity information.
 - Fire and explosive hazard data.
 - Health hazard information and signs/symptoms of exposure.
 - Exposure controls and personal protection.
 - Precautions for safety measures.
 - Accidental release measures (spills).

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HAZARD COMMUNICATION STANDARD OSHA STANDARD 29 CFR 1910.1200 (continued)

Departments must maintain ready access to MSDS sheets for all hazardous chemicals used in their departments. Departments must maintain a list of the chemicals within their department which can be kept as an index of the department's MSDS sheets.

Copies of Material Safety Data Sheets (MSDSs) for chemicals are available to all employees upon their request and online at <http://www.safety.rochester.edu/msds.html>:

SMH	HIGHLAND
<p>SMH departments maintain electronic chemical inventories/matching MSDS sheets.</p> <p>Staff may request a copy of an MSDS by using the above website, calling the Poison Center at x5-3232, or calling EH&S at x5-3241.</p>	<p>Master copies are kept in Support Services and can be accessed by nursing supervisors off-shift.</p> <p>Department-specific copies are kept in the department and are available to the employee at all times while on duty.</p>

Disposal of hazardous waste or chemicals must be in accordance with proper disposal guidelines. For additional information at SMH, contact the Hazardous Waste Management Unit at x5-2056; at Highland, contact Environmental Services or Security at **1-SERV**.

- **Labels: The Department of Transportation label must remain intact on bulk quantities (drums and cases) of chemicals.** Departments must attach labels to in-use containers of all hazardous materials that includes the following information:
 - The identity of hazardous chemicals.
 - Hazard warnings.
 - The name and address of the chemical manufacturer.
- **Storage and Inventories:** Chemicals must be stored properly. Assistance regarding storage at SMH is available from EH&S at x5-3241. The electronic inventory must be updated at least annually and will be available through the web in the event of an emergency.
- **Protective Measures:** Employees must understand the hazards of the chemicals they use and be familiar with methods or observations that can be used to detect hazardous chemicals, such as odors or irritation and being aware of monitors which detect chemicals.

Chemical exposures may occur through inhalation, skin contact, ingestion, and injection. Refer to the label and the MSDS for the agent to establish the proper work practices to follow to prevent exposures. In addition, employees must use the proper Personal Protective Equipment (PPE) to prevent exposures. This equipment can include:

- Gloves
- Eye protection
- Protective clothing and footwear
- Head coverings
- Respirators (SMH employees required to wear respirators need to be enrolled in the UR's Respiratory Protection Program).

PPE is available free of charge through the supervisor/manager, or contact SMH EH&S at x5-3241 or Support Services at 1-SERV for HH.

- **Medical Assistance:** Employees who are exposed to a hazardous chemical must take immediate action to minimize possible health effects. Immediate first aid may include rinsing of eyes or the skin at the point of contact for at least 15 minutes and seeking medical attention. The supervisor/manager should be made aware of the exposure and assure that medical assistance is available:

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HAZARD COMMUNICATION STANDARD OSHA STANDARD 29 CFR 1910.1200 (continued)

	SMH	Highland
Regular business hours	University Health Service 275-1164	Employee Health 341-8017
After regular business hrs.	Emergency Dept. 275-4551	Emergency Dept. 341-6555

- **Other Emergency Actions:** Small spills can be cleaned by personnel who are aware of the hazards of the material that has spilled. The proper PPE must be utilized. For larger spills, an employee who is aware of the hazards of the material should remain at a safe distance and keep others out of the area until emergency personnel can arrive.

If a chemical is involved in a large spill or if sufficiently trained personnel are not available, immediately call:

SMH On-site:	University Security at x13
URMC Off-sites:	x9-1-1
Highland emergency number:	x1-6666

If a chemical is involved in a fire situation, call in the fire immediately to:

SMH On-site:	University Security at x13
URMC Off-sites:	x9-1-1
Highland emergency number:	x1-6666

Follow the **RACE** procedure outlined in the Fire Safety section of this booklet:

- R**=Rescue
- A**=Alarm
- C**=Confine
- E**=Extinguish.

HIPAA PRIVACY & SECURITY AND CONFIDENTIALITY OF INFORMATION

Subject Matter Experts

Privacy: SMH: Patricia Beato (784-6154), HH: Patricia Keane (341-6467)
Security: SMH and HH: Chip Nimick (784-6115)

Patients have a number of rights under the Privacy regulations, including the right to:

- Complain if they believe their privacy rights have been violated. Refer them to the **Strong Integrity Hotline at 585-756-8888**, not directly to the Privacy Officer.
- Inspect and receive a copy of their medical record. For any questions on patient access, contact the Health Information Management (HIM) Department.
- Request an amendment to their medical record. Refer any patient who requests an amendment or correction to their record to the HIM Department.
- Not be listed in the hospital's directory. These are known as "no information" patients and their presence in the hospital cannot be acknowledged to the public.
- Identify family or friends they want to be involved in the patient's care, even if they have chosen to be a no-information patient. See HIPAA Policy 23.2.
- Request a restriction on disclosure of their PHI; in general, restriction requests are not accepted. For any questions, contact your Privacy Officer.
- Receive an accounting of disclosures made of their PHI, subject to certain conditions. If a patient requests an accounting, refer the patient to the HIM Department.

Authorizations:

- When an authorization is required to **disclose PHI**, the authorization must be HIPAA-compliant; they are not needed for disclosures for treatment/payment/healthcare operations.
- **Research** under HIPAA requires that one of 6 conditions be satisfied—see HIPAA Policy 0P25 for a list of these before you use or disclose PHI for research.
- **E-mailing** PHI between patients and providers first requires a signed consent by both the patient and provider in the patient record—see HIPAA Policy 0P29 for more info.
- E-mail containing PHI must be sent securely. See HIPAA Policy 0P29 and: <http://intranet.urmc.rochester.edu/InfoSystems/HelpResources/Security/securityfaq.asp#secureemail>
- **Business associate agreements** are required when PHI will be disclosed to a third party that will be performing a service to SMH or HH. Contact Purchasing or your Privacy Officer for details.

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HIPAA PRIVACY & SECURITY AND CONFIDENTIALITY OF INFORMATION (continued)

- Patients must be given a **Notice of Privacy Practices** on their first encounter at a URMC site, with an acknowledgement signed.
- Certain types of disclosures require workforce members to make an **accounting** (e.g., law enforcement or a research waiver of authorization). See HIPAA Policy 0P9.

Security:

- Do not share your computer **password** with anyone; you are responsible for all access made using your computer account/password.
- **Do not copy PHI** to any portable computer, PDA/smart phone, storage device (USB drive, etc.), or medium (CD, DVD, etc.) without the written approval of your department head. If you are approved to make such copies, you must encrypt the PHI on the device or medium.
- Properly erase PHI before transferring computers, storage devices, or media to others not authorized to access that PHI. See HIPAA Policy 0S2.
- Do not open e-mail attachments that you were not expecting. Do not click on links in e-mail messages that you were not expecting. Do not access Web sites that are not work-related or not well-known brands.
- Notify your supervisor immediately of any computer or portable device theft.

HIV/AIDS CONFIDENTIALITY REQUIREMENTS

Subject Matter Experts: **SMH:** Patty Ross (275-0111), **HH:** Ann Marie Pettis (341-6853)

For more information on this topic, go to:

<http://intranet.urmc.rochester.edu/policy/smhpolices/section06/6-2-2.pdf>

What Is Confidential HIV Material According to New York State Public Health Law 27-F?

All HIV-related material is confidential. This includes any references in the Medical Record to:

- 1) s or results of any HIV-related test even if negative (CD4, Elisa). HIV or AIDS
- 2) Information that identifies or could identify someone as having HIV infection or illness or AIDS.
- 3) Information that identifies someone as receiving pre-test counseling and/or who has been tested for HIV.
- 4) Test

Circumstances Where a Special HIV Release Form Is Not Required

HIV-related information may be transferred without a special HIV release form to:

1. Individuals who need to know the information in order to provide medical care and services.
2. Insurers, if necessary, to obtain payment for care and treatment rendered (however, a general release *is* required).
3. Public health officials when required by law.
4. Satisfy a special court order.

NOTE: When in doubt, don't release the information without a specific HIV authorization. Please contact the appropriate person below if you have questions.

	SMH		Highland	
Disclosure of HIV-Related Info.	Office of Counsel to the Medical Center (during regular business hours)	758-7606	Health Information Management Department	341-6429
	Health Information Management Department, Release of Information section	275-2605	HH Privacy Officer	341-6467
	SMH Privacy Officer	784-6154		
Identification of HIV-Related Info.	SMH AIDS Center	275-0526	Infection Preventionist	341-6853

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HIV/AIDS CONFIDENTIALITY REQUIREMENTS (continued)

Consequences of Inappropriate Disclosures

The consequences of an **inadvertent disclosure** of HIV-related information will be an appropriate amount of education/re-education and counseling consistent with the circumstances surrounding the disclosure. Repeated inadvertent disclosures will result in disciplinary action consistent with the circumstances, up to and including dismissal.

Intentional disclosures of HIV-related information will result in appropriate disciplinary action, up to and including dismissal. In addition, the unauthorized release and/or disclosure of HIV-related information are punishable under NYS Law by a fine of up to \$5,000 and a jail term of up to one year.

If you become aware of an inadvertent or intentional disclosure of HIV-related information, please notify your hospital's Privacy Officer.

Resources:

SMH: *SMH Policy 6.2.2*

Highland: *Infection Control Manual*

INFECTION PREVENTION AND CONTROL

(including updates on OSHA Bloodborne Pathogen Standards and Tuberculosis)

Subject Matter Experts: S

SMH: Dr. Paul Graman (275-5871), Ann Marie Pettis (341-6853)

HH: Ann Marie Pettis (341-6853)

The Infection Prevention and Control Manual is accessible online on the UR Intranet from all patient units:

SMH: <http://intranet.urmc.rochester.edu/policy/infcontrol/>

HH: <http://intranet.highlandhospital.org/Policy/InfectionControl>

A. General Infection Prevention and Control Practices safeguard both patients and personnel.

1. *Infections are transmitted by several different routes* depending on the specific infection. Infection Prevention policies and precaution categories are designed to interrupt the transmission by these routes. Some examples of transmission routes are:

Contact, Airborne, Vehicle-borne, Vector-borne, Droplet

2. *The system of infection prevention and control precautions*
 - Includes Standard Precautions which apply to all patients, and additional enhanced precautions categories which apply only to patients with particular diseases. These isolation categories, beyond the Standard Precautions, include contact precautions, airborne precautions, droplet precautions, etc.
 - When in effect, these isolation precautions apply to **all personnel** and are clearly specified on isolation signs located outside the patient's room and on the front of the patient's chart.
3. *The purpose of hand hygiene* is to prevent the spread of infection to patients and employees. Hand hygiene, the most important method of preventing the spread of infection, is performed before and after contact with any patient., or their wounds, whether surgical, traumatic, or associated with an invasive procedure; after contact with a patient's blood, secretions, excretions, or drainage or articles contaminated with blood, secretions, excretions, or drainage. Hand hygiene is also crucial before performing an invasive procedure; after removing gloves, or after using toilet facilities, at the start of a shift in a patient care area, and before administering medications.

Proper hand hygiene - waterless:

Personnel are encouraged to use hospital-approved alcohol hand sanitizer if there is no proteinaceous material on the hands. Hands must be washed at a sink with soap and water when visibly soiled or after using restroom facilities. At Highland, patients are provided with and encouraged to use antiseptic towelettes after personal hygiene and before eating.

At a Sink with **Soap and Water:**

- Use only hospital-approved, hand-washing products (bar soap is not used for personnel hand washing).
- Friction is the most important part of hand washing; rub hands together briskly for at least 15 seconds.
- Rinse and dry hands thoroughly, using a paper towel to turn off the hand controls of the faucet.
- Use only hand lotion that is hospital-approved.

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INFECTION PREVENTION AND CONTROL (continued)

Fingernails:

- Nail polish is discouraged. If worn, it must be meticulously maintained.
 - Artificial or enhanced fingernails are prohibited in all healthcare personnel with direct patient contact. (SPD and food handlers are included in this group at Highland Hospital)
 - The length of natural nails must be no longer than ¼ inch from the fingertip.
4. *Respiratory hygiene* – Serious respiratory illnesses like influenza, respiratory syncytial virus (RSV), whooping cough and Severe Acute Respiratory Syndrome (SARS) are spread by coughing or sneezing and unclean hands. The following steps will help prevent the spread of germs that cause these illnesses.
- Cover your nose and mouth with a tissue when you sneeze or cough **or**
 - Cough or sneeze into your upper sleeve, not your hands.
 - Dispose of your used tissue in a wastebasket.
 - Wear a surgical mask if you have a cough or a runny nose.
 - Clean hands with alcohol sanitizer or wash with soap and water.

B. OSHA Bloodborne Pathogens Standards

The Occupational Safety and Health Administration (OSHA) of the federal government requires all hospitals to have policies to protect employees from infection with bloodborne pathogens, especially the viruses which cause AIDS (HIV), hepatitis B, and hepatitis C. These policies are called the Bloodborne Exposure Control Plan. All employees are required to comply with these policies. All employees at risk should have received OSHA training; if you have not received OSHA Bloodborne Pathogens training, contact your supervisor or department head.

The Bloodborne Exposure Control Plan for each site is located as follows:

SMH: <http://www.safety.rochester.edu/ih/bbpindex.html>

HH: <http://intranet.highlandhospital.org/Policy/InfectionControl/8-0.pdf>

The following are key elements of the Bloodborne Exposure Control Plan:

1. *Standard precautions* are in effect at SMH & HH. The blood and body fluids of **all** persons must be considered dangerous. The blood of anyone may be infected with bloodborne pathogens including hepatitis B virus, hepatitis C virus, or HIV, the virus that causes AIDS. Standard Precautions apply to **all patients**.
- **Hand hygiene** is performed before and after contact with every patient or after handling blood or body fluids. (Use of alcohol hand sanitizer or soap/water at sink.)
 - **Gloves** are worn when there is a risk of contact with blood or body fluids. Gloves are worn for invasive procedures (including drawing blood and inserting IVs), touching mucous membranes, or having contact with open wounds. Hands must be sanitized after removing gloves.
 - **Glove Selection** – If it is anticipated that there will be exposure to a large volume of blood/body fluids, latex or nitrile gloves, rather than vinyl, must be worn. Nitrile and latex gloves provide better protection when significant exposure to blood or body fluids is anticipated.
 - **Gowns or Aprons** are worn when there is a risk of soiling clothing with blood or body fluids or when splashing or splattering of blood/body fluids may occur. Water-resistant isolation gowns and plastic aprons are readily available on all patient units.

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INFECTION PREVENTION AND CONTROL (continued)

- **Face masks and goggles** are worn when splashing, splattering, or spraying of blood or body fluids toward the face may occur. Acceptable eye protection includes goggles, face shields, or glasses with solid shields on the sides (ordinary glasses are **not** acceptable).
- Gloves, gowns, aprons, face masks, and goggles are available in all patient care areas.

Removing PPE – The proper sequence for removing PPE is as follows:

Gloves: The outside of glove is contaminated.

- Grasp outside of glove with opposite gloved hand, peel off.
- Hold removed glove in gloved hand.
- Slide fingers of ungloved hand under remaining glove at wrist.
- Peel glove off over first glove.
- Discard gloves in waste container

Goggles/Face Shield: Outside of goggles/face shield is contaminated.

- To remove, handle by headband or ear pieces.
- Place in designated receptacle for reprocessing or in waste container.

Gown: Gown front and sleeves are contaminated.

- Unfasten ties.
- Pull away from neck and shoulder, touching inside of gown only.
- Turn gown inside out.
- Fold or roll into a bundle and discard.

Masks or Respirator: Front of mask/respirator is contaminated—DO NOT TOUCH.

- Grasp bottom, then top ties or elastics and remove.
- Discard in waste container.

Use hand hygiene after removing; this is to guard against being contaminated as PPE is removed.

2. *Sharps* - Accidental needle sticks and other blood exposures continue to occur in hospital personnel every year. Each exposure involves potential risk of infection with HIV, hepatitis B, or hepatitis C. Simple measures will eliminate many needle sticks and injuries with other sharp objects.
 - **Do not recap needles.** Many needle sticks occur during attempted recapping of needles. **Exceptions:** *recapping of needles is unavoidable in some situations.* A **one-handed technique** is used for safe recapping of the needle.
 - Place needle cap on countertop
 - Take hand away from cap and away from needle
 - Holding only the syringe, guide needle into cap
 - Lift up syringe so cap is sitting on needle hub
 - Secure needle cap into place
 - **Dispose of all sharps in hospital-provided, hard plastic sharps containers.** Sharps include needles, lancets, scalpel blades, surgical staples and wires, broken/contaminated glass, slides or any other item likely to puncture a bag. Sharps containers are wall-mounted in all patient rooms (except in R-Wing at SMH) and in all other patient care areas. Large, free-standing sharps containers are used in selected high-volume areas such as ICUs, ORs, and Dialysis.
 - Everyone is responsible for the proper disposal of their own sharps. **Never** leave sharps on bedside tables, in bedding, or on procedures trays for someone else to pick up. **Never** discard sharps in the trash.

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INFECTION PREVENTION AND CONTROL (continued)

3. *Blood and body fluid exposure* - If you experience a needle stick or other exposure to blood or body fluids into the mouth, eyes, a cut, or broken skin:
 - **Cleanse** skin with soap and water. For a needle stick, cut, or exposure through broken skin, wash affected area with soap and water. For oral exposure, rinse mouth well with water. For eyes, rinse well with sterile saline or tap water (after removing contact lenses). Eye wash station should be used if possible.
 - **Report the exposure** for your own protection as soon as possible:
 - **SMH:** immediately call University Health Service (UHS) at x5-1164. Complete an Employee Incident Report Form (SMH 115) online at <http://www.safety.rochester.edu/SMH115.html>. Include the type and brand involved in all sharps injuries (e.g., safety glide syringe, BD.)
 - **Highland:** call Employee Health at x1-8017 or off-shift notify the Nursing Supervisor, and complete an Employee Incident Report Form.
 - Notify your supervisor/manager
 - **Post-exposure evaluation and follow-up** is essential. Please report all blood and body fluid exposures **immediately**, documenting type and brand of sharp involved in the injury, if applicable. You will be offered testing, counseling, and treatment, if required. Follow-up is provided by UHS at SMH or Employee Health at Highland, or by either of the health services in conjunction with your own doctor.
4. *Hepatitis B vaccination*
 - Hepatitis B is a serious bloodborne infection that is preventable by vaccination.
 - The vaccine is highly effective in preventing infection and is very safe.
 - SMH & HH provide vaccination at no cost. Vaccination is strongly recommended for anyone at risk for exposure to blood or body fluids at work.

C. Tuberculosis (TB):

1. *TB Transmission*

Tuberculosis (TB) is a bacterial infection caused by *Mycobacterium tuberculosis*. TB is transmitted by the airborne route; when a person with active TB infection in the lungs coughs, TB organisms are spread into the surrounding air, and other persons may inhale the TB organisms. The risk of TB transmission is highest for persons who spend the greatest amount of time near another person with active TB, especially sharing the same household.
2. *TB Infection and Disease*

Most of the time, infection with TB does not cause any illness, but the TB silently remains in the body and may cause illness ("active TB") at any point during the rest of a person's life. One in ten people infected with TB will develop illness, or active TB, during their lives, affecting either the lungs or other body sites, including bones, joints, kidneys, or brain. Persons with HIV infection or other conditions which impair immunity are at increased risk for developing active TB. The risk of developing active TB is dramatically reduced when treatment with the TB drug, INH, is begun after the initial asymptomatic TB infection has occurred.
3. *The TB Control Program Has Several Components:*
 - a. *Tuberculin skin testing (PPD)* is required of personnel at the time of employment and at least annually thereafter.

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INFECTION PREVENTION AND CONTROL (continued)

- b. *You must report to Infection Prevention* if you have had an unprotected exposure (without mask) to any person with active TB inside or outside the health care facility. You must also immediately report to Infection Prevention or UHS at SMH or Employee Health at Highland if you have a positive PPD skin test, if symptoms develop that could be caused by TB (see item d below), or if you have been diagnosed with active TB.
- c. *Counseling of health care workers regarding TB:*
 - Health Care Workers (HCWs) need to know their HIV status if they are at risk for HIV infection and they work in settings where patients who have infectious TB may be encountered, especially drug-resistant TB.
 - HCWs who have severely impaired immunity and who may be exposed to TB will be encouraged to consider a voluntary change of job setting to avoid such exposure.
 - HCWs who are known to be immunocompromised will be referred to UHS at Strong or Employee Health at HH for individual counseling regarding their risk for TB. HCWs who are at high risk for HIV disease should know their HIV status if there is potential for exposure to TB.
- d. *Be alert to the symptoms of TB:* persistent cough, fevers, weight loss, night sweats, and coughing up blood. Any employee with these symptoms should be seen by their physician, or at UHS at Strong, or Employee Health at Highland without delay.
- e. *Isolation*
 - **Respiratory Precautions** require the patient be placed in a negative-pressure isolation room; particulate respirator masks (N95) must be worn by persons entering the room.
 - The negative-pressure isolation room helps to prevent flow of contaminated air from the patient's room out into the corridor. Negative pressure rooms have daily monitoring with a smoke test and/or sensor/electronic device. If an electronic device is used, a confirmatory smoke test is done monthly at Strong Memorial Hospital and daily at Highland Hospital. Staff who care for patients with known or suspected TB are evaluated for ability to wear a particulate respirator (N95 mask), fit tested with the N95 mask annually and educated regarding TB precautions and the appropriate use of respiratory protection. Staff who have not been fit tested/trained for an appropriate respirator do not enter rooms being used for TB isolation.
 - For any patient with suspected or known active TB, the door to the room must be kept closed, and the patient must be reminded to cover his/her mouth when coughing. If a patient must leave the room for testing, etc., he or she must wear a surgical mask to reduce the expulsion of droplet nuclei into the air.

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Infection Prevention and Control Questions/Problems

	<i>SMH</i>	<i>Highland</i>
Infection Control Program Staff	Paul Graman, M.D. (pager 2021) Ann Marie Pettis, R.N. (pager 8-8160) Carol Wisner, R.N. (pager 1942) Lynn Fine, Ph.D. (pager 1012) Cathy Thompson, R.N. (pager 6439)	Mark Shelly, M.D (pager 8-8111) Ann Marie Pettis, R.N. (pager 8-8160) Abby Chodoff, R.N. 341-0288, (pager 8-5419)
Phone Numbers	Infection Prevention 275-7716 Direct Page: 275-1616 Off-hours: Page Operator for on-call staff member. 275-2222	341-6853 Page Operator: 473-2200

INFLUENZA—WHAT YOU SHOULD KNOW

Subject Matter Experts:

SMH: Dr. Paul Graman (275-5871), **SMH/HH:**Ann Marie Pettis (341-6853)

For full information on this topic, please go to:

SMH: <http://intranet.urmc.rochester.edu/policy/infcontrol/>

HH: <http://intranet.highlandhospital.org/Policy/envCare/>

Why You Should Get Flu Vaccine Every Year

- The best way to prevent flu is to get the vaccine annually prior to the flu season. It is crucial for healthcare workers, not only to protect themselves against flu, but also to protect the vulnerable patients around them.
- You may spread the flu virus to other people 1-2 days before you realize that you are sick.

How the Flu Is Spread

Flu is spread between people by:

- Droplets sprayed into the air when a person with flu coughs or sneezes (usually within 3 feet) or by aerosols of tiny virus particles that can travel longer distances from the coughing person and be inhaled (for example, across a room or down a corridor).
- Touching surfaces like a doorknob or telephone that have been contaminated with respiratory secretions from a person with flu, and then touching your nose or mouth.

How to Prevent Spread of the Flu

There are several ways to prevent the spread of influenza:

- Get the flu vaccine every single year—the most important measure to prevent seasonal flu. A new vaccine is produced every year to match the latest flu strains.
- During a flu outbreak, antiviral medications may be recommended to prevent flu in people who have not been vaccinated.
- Stay home if you are sick during the flu season with flu symptoms: fever, cough, sore throat, body aches, headache, runny nose or congestion.
- Cover your cough. Always cover your nose and mouth with a tissue when you cough or sneeze and dispose of the tissue, or use your upper sleeve (not your hands) to cover your cough.
- Hand hygiene: always use alcohol hand gel or wash hands before and after touching any patient, and frequently during the course of the day.
- Patients with flu should be placed in a private room. When private rooms are not available, patients with flu may be placed together in a room.
- Always wear a mask when you are within 3 feet of the patient. Surgical masks are used for typical seasonal flu; N-95 masks and gloves may be recommended in a severe pandemic.
- Place a surgical mask on any patient with flu symptoms whenever they are in a waiting room or outside of their room in the hospital.

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INFLUENZA—WHAT YOU SHOULD KNOW (continued)

How We Are Preparing For Flu

The Pandemic Flu Teams at Strong and Highland Hospitals are developing plans and strategies for all of us to cope with pandemic flu should it strike. These plans address concerns such as:

- Shortages of hospital beds, supplies and shortages of personnel.
- Triage of patients in emergency and other outpatient areas.
- Isolation of flu patients and dispensing of medications or vaccines to hospital staff.
- Effective communications to staff and community.
- Limited access to the Medical Center which may be necessary during a flu pandemic, including screening of visitors and staff for flu symptoms before entry.
- Training plans to mobilize staff, volunteers, and students to assist with patient care or other hospital activities as needed.

INFORMATION FOR CLINICAL DECISION MAKING

Subject Matter Experts:

- SMH:** Julia Sollenberger (275-5194) or call Miner Library Reference Desk, 275-2487
HH: Pamela White (341-0378 or 341-6761)

For more information, please go to:

Miner Library Online (<http://www.urmc.rochester.edu/miner/>) at **SMH** or **Williams Health Sciences Library Online** (<http://www.urmc.rochester.edu/hh/library/>) at **HH**.

SMH and HH providers can ask librarians at Miner, Bibby, and Williams Libraries to help them find information they need for clinical care.

- Click the “Ask a Librarian” link on the Miner Library, Bibby Library, or Williams Library home pages, then select “Request a Literature Search.” ~or~
- Call 275-2487 (Miner Library); 275-5010 (Bibby Library at Eastman Dental Center); or 341-6761 (Williams Library at Highland Hospital).

The most important resources and services are listed below:

Resources	
Medline (Pubmed)	World’s largest database covering biomedical journal literature; available in two versions: <ul style="list-style-type: none"> ▪ PubMed@UR – customized version of the easy-to-use PubMed database with links to UR full-text journal articles. ▪ Ovid Medline – robust search engine with links to UR full-text journal articles.
CINAHL	Database covering nursing and allied health literature with links to UR full-text journal articles.
Micromedex	Comprehensive, unbiased source of drug and toxicology information from independent reviewers.
UpToDate	Online medical textbook provides concise, practical answers to clinical questions. Available <i>on-site</i> at URMC and Highland Hospital and at ambulatory offices on the URMC network.
Evidence-Based Medicine Resources	<p>Cochrane Database of Systematic Reviews - Gold standard of evidence-based literature. Identifies, appraises and synthesizes all relevant studies on a particular clinical topic.</p> <p>Essential Evidence Plus – A unique evidence-based medical information system in two parts:</p> <ul style="list-style-type: none"> ▪ A collection of resources (Cochrane abstracts, practice guidelines, clinical rules and calculators) that can be searched on the Web or downloaded to a PDA. ▪ A synopsis of clinically relevant research studies called POEMs that are delivered to you via e-mail each day. <p>Clinical Evidence – Compilation of current evidence on prevention and treatment of common clinical conditions.</p> <p>PIER – A peer-reviewed tool in a concise, structured format designed to be the clinician’s manual for the standard of care. Evidence ratings included.</p>

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INFORMATION FOR CLINICAL DECISION MAKING (continued)

Resources	
Full-text Journal Articles	Links to full-text electronic journals from PubMed@UR, Ovid Medline or CINAHL; E-journals are also listed alphabetically
Contact for Problems Accessing Electronic Resources	SMH – Michele Shipley, 275-6878 HH - Pamela White, 341-0378
Services	
Database/Literature / Subject Searches	Librarian-mediated searches in databases such as PubMed@UR/Medline, CINAHL, PsycINFO (others also available) on clinical, educational, and research topics. No fee for UR and Highland affiliates.
<u>Ask a Librarian</u>	Submit a question 24/7 via phone or e-mail and receive a response Monday-Friday 8:30 am – 5 pm. (8:30 am –4:00 pm at HH).
Document Delivery/ Interlibrary Loan	Electronic delivery service for articles in the URMC libraries' collection or obtained from an external library. Use <u>ILLiad</u> online system to request materials. SMH: fee-based. HH: no fee.
Housecalls	Librarian consultation at your worksite, customized to your needs for using electronic resources. Service also provides strategies on how to “stay current” in your discipline.
<u>Classes</u>	Classes available on a wide range of topics including database searching and bibliographic management. No fee for UR and Highland affiliates.
Questions about Services	SMH -Donna Berryman, 275-6877, 273-4860; Dentistry – Elizabeth Kettell, 275-3247 HH – Pamela White, 341-0378

INTERPRETER SERVICES

Subject Matter Experts:

SMH: Kathy Miraglia (275-4778), **HH:** Michael Sullivan (341-6718)

For more information, please go to:

Spoken Languages other than English-

<http://intranet.urmc-sh.rochester.edu/policy/smhpolicies/section11/11-5-1.PDF>

Interpreters for Deaf or Hard of Hearing-

<http://intranet.urmc-sh.rochester.edu/policy/smhpolicies/section11/11-5-2.PDF>

The University of Rochester Medical Center–Strong and Highland Hospitals ~~Health~~ have a commitment to provide interpreter services to persons who do not speak English. The provision of comprehensive interpreter services is also required by the New York State Health Code. Regulations require that the service be available within specific time limits: 20 minutes for nonemergency patients; 10 minutes for ED patients. This requires a concentrated effort by all employees to ensure that we are in compliance with this regulation.

SMH-Specific Interpreter Services

Interpreter services are coordinated through Strong Care Management in the Medical Center. For both Spanish-speaking persons and persons who communicate through Sign Language, 24-hour coverage is available. If you know the doctor will be doing rounds at a specific time, arrange for the interpreter an hour before (URMC-SMH) or with 24-hour advance notice (HH) for nonemergent situations.

- M-F, *Days* (8:30 a.m. – 5:00 p.m.) on-site full-time in Med. Ctr.

Spanish: x5-4778	Sign Language: x5-4778
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Emergency Situations: Page Operator x5-2222

- M-F, *Nights* (5:00 p.m. – 8:30 a.m.) plus 24 hours on weekends and holidays, on-call interpreters available. Call the Page Operator at x5-2222.

Note: Interpreters are not located in the hospital; they need to be paged as soon as possible to allow travel time.

- Other spoken language interpreters - 140 different languages
Med. Center now subscribes to CyraCom International telephonic interpretation service
 - Available 24 hours/day, 7 days/week
 - x5-4778 to set up in-service training for your area
- Outpatient appointments: contact the Interpreter Services office when the appointment is being made to ensure the interpreter will be available.

Assistive Listening Devices and/or Adaptive Equipment

- **SMH-Specific**
 - Public TDD pay phones are located in the ED lobby and the Main Lobby.
 - TDDs, amplified telephones and other equipment for inpatient areas are now available through the Patient Telephone Service at x5-0143.

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INTERPRETER SERVICES (continued)

- After hours and weekends, these devices may be requested via the Patient Information Operator at x5-2181.
- Consultations regarding hearing/hearing aid status of patients should be directed to Audiology at x5-2501.

Highland-Specific Interpreter Services

- Sign Language Interpreters – Call Social Work Dept x1-6718
 - M-F, *Days* (7:30 AM – 4:00 PM) *Nonemergency*
Include following information with your request:
 - Patient name
 - Date/time of request
 - Length of time interpreter needed
 - Procedure patient is having
 - Location
 - Specify if male or female interpreter needed
 - M-F, *Days* (8 AM – 4:00 PM) *Emergency*. Call Patient Social Work Dept x1-6718.
Note: If unable to reach SWK Dept, page Social Work Director at 220-8319.
 - Evenings (4:00 PM – 8 AM), Nights/Weekends, SMH paging operator (275-2222)
- Foreign Language Interpreters – Call Social Work Department x1-6718
 - M-F, *Days* (7:30 AM – 4:00 PM); Nursing Supervisor, Evenings/Nights.
 - Highland subscribes to Language Line - 140 different languages
 - Available 24 hours per day, 7 days per week. See information on your unit.
 - Dual handset phones are found throughout the hospital
 - Call x1-6718 to set up an in-service training program in your area.
- **Highland Specific**
 - Telecommunications Operator (0) for TDD, amplifier telephones, Language Line phones, other assistive listening devices or adaptive equipment.

LIFTING and TRANSFERS: POSTURE and BODY MECHANICS

Subject Matter Experts

SMH: Kathleen Owens (341-9000), **HH:** Becky Perrone 341-8280

References/Useful Websites

www.visn8.med.va.gov/patientsafetycenter (Bariatric Resource Guide)

www.clevelandclinic.org/spine/patient/posture.htm (Healthy Back Info)

www.spineunivers.com (Healthy Back Info)

www.hovermatt.com (Air assisted transfer device)

www.medical-supplies-equipment-company.com (Mechanical Lift)

www.mtsmedequip.com (Lateral transfer slide & gurney)

www.allegromedical.com (transfer belts)

www.osha.gov/SLTC/ergonomics/index.html

General Information

1. What is good posture?
 - Standing: Head straight up with chin in; shoulders back and pelvis in neutral position (tighten abdominal muscles)
 - Sitting: Head straight up with chin in; shoulders back, all three curves should be present in back. If possible, elbows resting on armrests and relaxing shoulders and feet resting flat on floor or footrests.
 - Take frequent breaks to change position and stretch, reversing any prolonged postures.
2. Why is good posture important?
 - Keeps bones and joints in the correct alignment so that muscles are being used properly.
 - Helps decrease the abnormal wearing of joint surfaces.
 - Decreases the stress on the ligaments holding the joints of the spine together.
 - Prevents the spine from becoming fixed in abnormal positions.
 - Prevents backache and muscular pain.
 - Decreases the probability of back injuries during lifting or heavy exertion.
3. What are the results of poor posture?
 - Muscles are in weakened positions.
 - Increased potential for injury.
 - Pain and discomfort.

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LIFTING and TRANSFERS: POSTURE and BODY MECHANICS (continued)

General Lifting Guidelines

1. Back Posture: Always try to keep the three curves of your spine in line—especially your lumbar curve. Try not to twist.
2. Where to Bend: Bend at the hips, knees and ankles—not the spine. Use those leg muscles. The muscles in your legs are bigger and stronger than the muscles in your back.
3. Base of support: Feet should be shoulder width apart with the load positioned at midline.
4. Keep the load as close to the body as possible. Avoid reaching—keep objects between shoulder and waist height

General Transfer Guidelines

1. Determine the needs of the patient.
2. Prepare the patient; explain what you are going to do and how they can help.
3. Set up the equipment to be utilized. Use assistive technology to save your back (for example, transfer belts,* hoyer lift, hover mat, plastic sheeting and slideboards).
4. Prepare the environment. Check to make sure the room is free of clutter, the lights are on, the floor is dry, and minimize distractions when possible.
5. Prepare everyone involved in the transfer.* The patient and all assistants need to know how and when the transfer is going to take place. Ask the patient to help.
6. Perform the transfer.

* Transfer belts are available at URMC-SMH through Hospital Stores.

** Ask for help before you need it.

MANAGEMENT OF SUSPECTED ABUSE AND NEGLECT (Domestic Violence/Elder Abuse/Child Abuse)

Subject Matter Experts:

SMH: Carla LeVant (273-5445), **HH:** Michael Sullivan (341-6718)

For more information, go to:

SMH

Policy 9.11.1 at <http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/documents/9-11-1.pdf>

Policy 9.11.4 at <http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/documents/9-11-4.pdf>

HH

Policy 3.5 at <http://intranet.highlandhospital.org/Policy/HHpolicy/3-5.pdf>

Policy 4.19 at <http://intranet.highlandhospital.org/policy/HHpolicy/4-19.pdf>

Health care providers have a **legal** responsibility to identify and intervene in cases of suspected abuse or neglect of patients. Resources are available in the hospital(s) and the community to address the needs and safety of patients who are abused or maltreated.

For suspected child abuse/maltreatment only: Physicians, nurses, dentists, social workers and other health care providers are mandated by New York State Social Services to report any and all suspicions of child abuse or neglect to the NYS Child Central Registry. Reporters need only reasonable cause to suspect that a child has been neglected or abused to make a report. Proof of abuse is not essential for the filing of a report.

	SMH	Highland
Policies Regarding Abuse and Neglect Situations	9.11.1 Suspected Child Abuse or Maltreatment 9.11.2 Contacts with Law Enforcement Agencies in Matters of Child Abuse or Maltreatment 9.11.4 Adult Domestic Violence 9.7 Sexual Assault	<i>Highland Policy Manual:</i> 3.5 Child Abuse 4.19 Domestic Violence 3.8 Elder Abuse 3.10 Physical Assault 4.7 Sexual Assault
Management of Suspected Child Abuse or Neglect	1. Alert social worker immediately (available 24 hours a day via Page Office). 2. Social worker and/or medical team members determine the need for REACH Consult* 3. Social Worker (in conjunction with medical team): <ul style="list-style-type: none"> ▪ Coordinates with team members, law enforcement or social services agencies as needed. ▪ Initiates formal referral to Child Protective Services. ▪ Coordinates safe discharge. 	Contact : Days: Director of Social Work pager 220-8319 After Hours: Social Worker on call (via pager) with medical team: <ul style="list-style-type: none"> ▪ Facilitates: referral to Monroe County DSS Child Protective Services (461-5690) and law enforcement ▪ Documentation of objective facts and phone referral in patient chart. ▪ Notifies Director of Social Work of report ▪ Coordinates safe discharge

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MANAGEMENT OF SUSPECTED ABUSE AND NEGLECT (DOMESTIC VIOLENCE / ELDER ABUSE / CHILD ABUSE) continued

	SMH	Highland
Management of Suspected Domestic Violence or Elder Abuse	<p>Domestic Violence and Elder Abuse</p> <ol style="list-style-type: none"> Alert social worker immediately (available 24 hours a day via Page Office). Social Worker: <ul style="list-style-type: none"> Assesses for patient and dependent safety. Initiates appropriate reporting activities. Provides referral information to patient. 	<p>Domestic Violence and Elder Abuse:</p> <ol style="list-style-type: none"> Alert Social Worker immediately (unit social worker or on-call social worker via pager). Social Worker: <ul style="list-style-type: none"> Assesses for patient and dependent safety Initiates appropriate reporting activities Provides referral information to patient <p>See policies for detail.</p>
Management of Sexual Assault	<ol style="list-style-type: none"> Follow protocol for documentation and evidence gathering processes (URMC-SMH 9.7). Alert social worker (available 24 hours a day via Page Office). For victims under the age of 18, refer to URMC-SMH Policy 9.11.1. 	<ol style="list-style-type: none"> Follow protocol for documentation and evidence gathering processes. Ensure that the patient is never alone. Contact social worker assigned to the area or via the nursing supervisor for the on-call social worker.

* REACH (Referral and Evaluation of Abused Children) is a University of Rochester Medical Center Strong Hospital-based program staffed by medical experts in the evaluation of physical and/or sexual abuse. They are available for telephone consultation 24 hours a day via the SMH Page Office.

MEAL AND REST BREAKS

Subject Matter Experts: SMH: Peg Lee (275-2537), HH: Kathleen Gallucci (341-0118)

Meal Breaks

Every employee who works a shift of more than six hours must be provided an uninterrupted, 30-minute meal period. This meal break is required by New York State Labor Law.

- The meal break **must be at least 30 minutes long** (regardless of the timing of when the meal break is scheduled to begin or end).
- The employee must be completely relieved of all duties.
- The employee must be free to leave the work area, although an employee can be required to stay on University/Highland property.

If any of these conditions are **not** met, then the meal break is considered hours worked and **must be paid**.

While occurrences of less than 30-minute meal periods or interrupted meal periods should be infrequent, the employee should follow department/unit procedures to ensure that he or she is paid accurately for all time worked. Supervisors need to ensure employees are able to take a 30-minute, uninterrupted meal break.

An additional meal period of at least 20 minutes must be provided between 5:00 p.m. and 7:00 p.m. when an employee begins work before 11:00 a.m. and continues working past 7:00 p.m. Scheduling of meal breaks will occur at times convenient to department operations.

Rest Periods

University/Highland Hospital policy provides that, where operationally possible, employees **working continuously** for 3.5 to 4 hours will be provided with paid rest periods of not more than 15 minutes.

Scheduling of rest periods will occur at times convenient to departmental operations.

Note: Individuals covered by collective bargaining agreements should refer to their collective bargaining agreement.

MEDICAL EQUIPMENT

Subject Matter Expert SMH and HH: Stephen Zigelstein (275-5501)

For more information on this topic, please go to:

SMH: http://intranet.urmc-sh.rochester.edu/policy/ambcaremanual/2/Equipment-Prev_Maintenance.pdf

HH: http://intranet.highlandhospital.org/Policy/envCare/sec7_1.pdf

Safe Use of Medical Equipment

- Staff should use only equipment they have been trained to use.
- All medical equipment should be checked for an up-to-date inspection or “Approved for Use” sticker before operating the equipment.
- Operator manuals and related procedures should be available in the area for reference.
- All medical equipment must be in good physical condition, and if appropriate, wired with a 3-pronged chassis grounded plug.
- As appropriate, perform recommended equipment safety checks and affirm alarms are programmed and audible prior to medical equipment use.

Inspection of All Medical Equipment

All direct care providers should check for an “Inspection” sticker or an “Approved for Use” sticker on a piece of clinical equipment **before** placing it into use. Inspection intervals are based on manufacturers’ recommendations, risk analysis and service history of the specific manufacturer/model combination. Based on that analysis, a device will be labeled with one of the following stickers:

- Blue "**Approved for Use**" sticker: inspect only when new, after repair, or upon request. (**No date will be noted on the sticker.**)
- Green "**Inspection**" sticker: device is used for direct patient care and inspected at regular intervals. (mm/dd/yy of the inspection will be noted on the sticker; mm/yy of inspection **due** will be noted on the sticker.)
- Purple "**REL Inspection**" sticker: placed on nonhospital owned devices (Rental, Evaluation, or Loan Equipment) with the date of inspection noted. Since it is assumed the REL equipment will only be in the Hospital for a short period of time, no inspection due date is recorded.

The expiration date for an inspection is noted with a specific month and year. The inspection is valid **through the end of the month** noted on the sticker (for example, a sticker reading October 2007 or 10/07 is valid through 10/31/07). *Expired equipment must be re-inspected before using it for direct patient care.*

New, borrowed, leased, physician-owned equipment, and equipment being returned from loan must receive an incoming safety and performance inspection by Clinical Engineering at SMH or the Clinical Engineering Department at Highland, before being placed in use.

If you find a piece of equipment with an overdue inspection, please take the following steps:

- Put the equipment aside
- Contact Clinical Engineering at x5-5501 (SMH) or x1-7378 (HH)
- Request an inspection.

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MEDICAL EQUIPMENT (continued)

If you find a piece of equipment with an overdue inspection that is distributed by the Service Center/Stores (for example, SCDs, PCA Pumps, Alaris Medley Pumps), please take the following steps:

- Put the equipment aside.
- Contact the Service Center at (SMH) at x5-8211 or (HH) at x1-6341 to request a replacement device.
- The Service Center will deliver a replacement device and forward the equipment overdue for inspection to Clinical Engineering.

Repair and Upkeep of Medical Equipment

- Replace and tag broken equipment. If applicable, attach the disposables and packaging; these may help identify the cause of the problem.
- Report patient/staff/visitor injuries or harm due to medical equipment per the appropriate event/occurrence reporting process.

Use of the Patient's Personal Home Equipment

- Use of patient-provided medical equipment should be discontinued as soon as possible after admission (except insulin pumps and CPAP machines). Comparable hospital-owned devices that staff have been trained to use should be substituted for the patient-provided device.
- If a comparable hospital-owned device is not available, Clinical Engineering at SMH or the Clinical Engineering Department at Highland must be called to inspect the patient-provided device. Staff must be trained on how to use the equipment.

Note: Exception at HH and SMH– patients' own insulin pumps, refer to appropriate policy and protocol.

References:

Highland Environment of Care Manual, Medical Equipment Management Plan.

Strong Memorial Hospital Environment of Care Manual, Medical Equipment Management Plan.

SMH Policy 10.15

MEDICAL ORDERS FOR LIFE-SUSTAINING TREATMENT (MOLST)

Subject Matter Experts:

SMH: Timothy Quill, MD (273-1154), **HH:** Richard Magnussen, MD (341-6867)

For more information, please go to:

http://www.compassionandsupport.org/index.php/for_professionals/molst_training_center or
<http://intranet.highlandhospital.org/Policy/HHpolicy/4-5.pdf>

The Medical Orders for Life-Sustaining Treatment (MOLST) form is a document which provides guidance regarding the use of life-sustaining therapies across settings (hospital, home, nursing home, and ambulance) throughout New York State.

Note: The MOLST form does not necessarily mean that the patient has chosen DNR (Do Not Resuscitate) or DNI (Do Not Intubate) status. One can learn about a patient's preferences about DNR, DNI or other potentially life-sustaining therapies by carefully reading the MOLST form in the chart.

The following **MOLST Facts and Misconceptions** will help you to better understand how to use the new MOLST form.

Facts

1. The new MOLST form is consistent with New York State law and approved by the New York State Department of Health for use at all nursing homes, hospitals, other medical facilities, at home, or elsewhere in the community in New York State.
2. The MOLST form is recognized and honored by EMT personnel in New York State as an out-of-hospital DNR form.
3. The DNI section of the MOLST form is recorded on page 2. DNI decisions can be made by patients with capacity, by designated health care proxies, or by families if they have **clear evidence** of the patient's wishes.

Note: All patients who lack decision-making capacity must have **both** the basic MOLST designating the specific limitations (such as DNR or DNI) **and** either the MOLST Supplemental Form for Adult Patients Without Capacity or the MOLST Supplemental Form for Minors (designating how the surrogate decision maker was selected). These supplemental forms are essentially unchanged from the prior version.

4. The original pink MOLST form(s) should travel with the patient who is going home, to a nursing home, or other facility from the hospital. A photocopy of the MOLST form should be left in the patient's medical record.
5. For patients admitted with an existing MOLST form, the admitting team should confirm that it still reflects the patient's preferences and then sign and date the "Review of the MOLST" section of the form on page 3. A new form does not need to be filled out unless there are substantive changes, in which case the form must be voided and a new one completed.

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MEDICAL ORDERS FOR LIFE-SUSTAINING TREATMENT (MOLST) – continued

Misconceptions

1. *A MOLST form must be filled out even if the patient wants full CPR and no limitations.*

False! The MOLST generally designates limitations on treatment, though it is unclear what the limitations are without carefully reading the form. Full CPR is the default position if no form is present or if there is uncertainty about the patient's preferences.

2. *The presence of a pink MOLST form means that the patient is DNR (Do Not Resuscitate) or DNI (Do Not Intubate).*

False! The MOLST form designates the patient's current preferences about life-sustaining therapies. For example, some patients might want full CPR if they experience an arrhythmia, but not want a feeding tube if they lose the ability to eat. In the event of a cardiac or pulmonary arrest, page 1 must be carefully reviewed for current DNR preference and page 2 for DNI preference.

3. *A patient who has the DNR or DNI sections of the MOLST form completed needs no other orders written to ensure these orders are activated.*

False! Although the MOLST can serve as an actionable medical order at the patient's home or in a nursing home, specific orders must be written, and at SMH, entered into the CIS to designate DNR or DNI after the MOLST is completed. If a patient arrives in the emergency department with a MOLST that designates DNR or DNI and there is no reason to doubt that the form accurately expresses the patient's preferences, these preferences should be followed even if no formal order has yet to be written (and entered into the CIS at SMH). An order should then be written (and entered into the CIS at SMH) as soon as possible.

4. *Any provider may issue a DNR order*

False! A DNR order can only be entered by the attending physician, personally or through a verbal order entered by a resident or a mid-level provider and cosigned by the attending physician within 24 hours.

5. *All patients who are DNR should also be DNI.*

False! DNR applies to patients who experience acute cardiopulmonary arrest. DNI applies only to intubation for patients who experience respiratory failure, but are not in full cardiac arrest. Some patients choose to be DNR, but not DNI. For example, a patient with chronic pulmonary disease might not want cardiopulmonary resuscitation (and therefore be DNR), but might desire a trial of ventilatory support if they experience an acute respiratory problem (and therefore might not be DNI). On the other hand, all patients who are DNI should generally also be DNR (since intubation is required for cardiopulmonary resuscitation).

6. *The new MOLST can serve as a Healthcare Proxy or Living Will document.*

False! The MOLST form documents the preferences of the patient (or their surrogate if the patient is incapable of decision making) about potentially life-sustaining therapies. The MOLST form has a section on page 1 to designate the presence or absence of Healthcare Proxy or Living Will documents, but these are separate documents that, if completed, should also be placed in the patient's chart. A Healthcare Proxy documents the person(s) the patient would like to represent them in medical decision making should they lose capacity to make their own decisions in the future. A Living Will documents the patient's preferences about treatment, but unlike the MOLST, it is only activated when and if patients lose capacity to make decisions for themselves in the future.

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MEDICAL ORDERS FOR LIFE-SUSTAINING TREATMENT (MOLST) – continued

7. *Only the supplemental MOLST forms are needed for a patient who lacks decision-making capacity*

False! The main MOLST form is needed on all patients when a limitation of life-sustaining therapy is being designated. It suffices by itself when a patient has full capacity, but must be backed up with the appropriate supplemental form if the patient lacks capacity or is a minor. The supplemental forms document lack of capacity and how the surrogate decision maker was selected as required by New York law.

SITE-SPECIFIC REFERENCES

	Strong Memorial Hospital	Highland Hospital
References	SMH policies: 9.3 (Advance Directives) 9.3.1 (Health Care Proxies) 9.3.2 (DNR & DNI) 9.3.3 (Withholding or Withdrawing Unwanted Life-Sustaining Medical Treatment).	HH Policies: 4.2 (Advance Directives) 4.14 (Health Care Proxies) 4.4 (DNR & DNI) 4.5 (Withholding or Withdrawing Unwanted Life-Sustaining Medical Treatment)
Phone Numbers for Questions	Palliative Care Program 273-1154 Clinical Ethics Program 275-5800	Palliative Care Program 341-6770 Clinical Ethics Program 341-6760
Forms (for both sites)	Forms are available on any inpatient medical floor and if necessary, can be ordered through the usual forms ordering process from Moore Wallace. Sample MOLST forms and explanations can be viewed by going to the site: http://www.compassionandsupport.org/pdfs/professionals/molst/molst_form.pdf	

MEDICATION RECONCILIATION AND ADVERSE DRUG REACTION (ADR) REPORTING

Subject Matter Experts:

- SMH:** Medication Reconciliation, Lori DellaPenna (276-3149)
ADR, Curtis Haas, PharmD (275-8337)
- HH:** Matt Groth, PharmD, MS (341-6929)

For more info, go to:

SMH Policy Manual:

http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/documents/7-1_000.doc

SMH Ambulatory Care Manual:

http://intranet.urmc-sh.rochester.edu/policy/ambcaremanual/3/Med_Reconciliation.pdf

Highland Hospital Policy: <http://intranet.highlandhospital.org/policy/HHpolicy/2-79.pdf>

The Joint Commission National Patient Safety Goals:

http://www.jointcommission.org/NR/rdonlyres/31666E86-E7F4-423E-9BE8-F05BD1CB0AA8/0/HAP_NPSG.pdf

Medication Reconciliation

Healthcare providers are required to accurately and completely reconcile medications across the continuum of care. This applies to all patient encounters. The medication reconciliation process requires providers to:

- **Create and document a complete list of medications the patient is taking at home** (including dose, route, frequency). The patient and/or family, if possible, are involved in creating the list.
- **Compare and reconcile any discrepancies** (omissions, duplications, adjustments, deletions, additions) between the home medication list and medications ordered for the patient while under the care of the medical facility upon admission, transfer and discharge. Reasons for any changes or differences between the previous and current medications must be documented. (Ambulatory/ED areas where medications are used minimally, or prescribed for a short duration, refer to your departmental policy to see if modified medication reconciliation processes are applicable.)
- When a patient leaves the medical facility the most **current reconciled medication list is communicated to the next provider of service**, when known, or the PCP either within or outside the hospital, and the communication is documented.
- When the patient leaves the medical facility the **current list of reconciled medications is provided and explained to the patient** and, as needed, the family. Patients and families are reminded to discard old lists and to update any records with all medication providers or retail pharmacies.

Medication reconciliation is designed to avoid the most common medication errors:

- Omission of home medications during inpatient stays.
- Failure to restart medications stopped during the inpatient stay.
- Therapeutic duplication of medication classes OR of the same by both generic and brand name.
- Harmful interactions between newly started and current meds.

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Adverse Drug Reaction Reporting

An **adverse drug reaction (ADR)** is a term used to describe the unwanted, negative consequences sometimes associated with the use of medications. An ADR is also noted to be a noxious and unintended result of a medication which occurs at the normal dose given for treatment of disease, or for disease prevention. An ADR is a particular type of adverse effect. Alternative terms with equivalent meaning to ADR include: **side effect**, adverse event, adverse effect, etc.

Examples of ADRs include, but are not limited to:

- Rash or hives
- Unexpected drop in blood pressure
- Itching
- Shortness of breath or trouble breathing
- Hallucinations
- Uncontrollable twitching
- Fever

Consistent with this definition, an unforeseen allergic reaction (an unusual sensitivity to a medication) and an idiosyncratic reaction (an abnormal susceptibility of an individual to a particular medication) are also ADRs. In contrast, an allergic reaction to an agent when the patient has a known documented reaction to that agent or a medication that can cross react, is an adverse event from a medication error.

Monitoring and reporting ADRs is an imperative component of the hospital's Medication Management Process. Tracking and trending ADRs leads to process improvements in medication use which improve patient safety. For instance, if a hospital notices an increased incidence of falls, by tracking and trending ADR reports, it may be found that certain sedatives are being used inappropriately or in the wrong patient population. Changes can then be made to decrease falls by changing drug therapy.

What tools do we have for recording or documenting suspected adverse drug reactions?

ADR's should be reported in the hospital's electronic reporting system at <https://qxpert.quantros.com/urmc/>.

What information is needed to follow up on the event?

- Patient name and second identifier
- Patient location at time of incident
- Date and time of suspected reaction
- Name of suspected medication(s)
- What was the patient side effect?
- Was intervention of any type, medication or otherwise, needed for supportive therapy?
- If so, what was the medication or supportive therapy used?

A pharmacist should also be contacted to provide additional support or investigation into the incident. If upon investigation the ADR is considered to be a new allergy, an order should be entered into CPOE indicating a new allergy has been detected. Pharmacy will also document the new allergy in the pharmacy information system. This documentation must also be entered into the patient's permanent chart.

OCCURRENCE AND CLAIM REPORTING

Subject Matter Experts:

SMH: Spencer Studwell (758-7602), **HH:** Sharon Johnson (341-8399)

For full information on this topic, go to:

- SMH:** Event (Occurrence) Reporting – Patients and Visitors – 9.1
<http://intranet.urmc.rochester.edu/Policy/SMHPolicies/9-1.pdf>
Reporting of Actual and Potential Medical Events – 9.1.1
<http://intranet.urmc.rochester.edu/Policy/SMHPolicies/9-1-1.pdf>
- HH:** *HH Policy Manual, 3.14, Occurrence Reporting*
<http://intranet.highlandhospital.org/Policy/HHpolicy/3-14.pdf>
Reporting of Actual and Potential Medical Errors and Events
<http://intranet.highlandhospital.org/Policy/HHpolicy/3-23.pdf>

I. Hospital Occurrences

Definition: any unintended and undesirable development or event related to care or services provided to patients, families, or visitors that takes place on the premises.

Timely reporting and thorough documentation of occurrences is necessary to maintain patient safety. A report must be entered into the University of Rochester Medical Center Event Reporting System (SRM) for all occurrences. Reportable occurrences include accidents as well as situations that *could* have resulted in an accident (near misses). Additionally, you may need to notify your immediate supervisor and the Risk Management Department at SMH or the Quality Management Department at HH.

Occurrence Reporting at Strong Memorial Hospital

A report must be made for any patient or visitor-related occurrence that is not consistent with the routine operation of the hospital or the routine care of the patient. Reportable occurrences include accidents as well as situations that *could* have resulted in an accident (near misses). In all cases where an injury has occurred, the occurrence must be entered into the event reporting system, SRM, later than the end of the shift during which the occurrence happened or was first discovered.

Serious occurrences meeting State Reporting or Joint Commission criteria must be reported by telephone immediately to the Risk Management Department, with a report to the SRM system to follow. Occurrence reports are confidential documents used for quality assurance purposes. They should *not* be placed in the patient's medical record, nor should the fact that a report was completed be documented in the patient's medical record.

Occurrence Reporting at Highland Hospital

Any member of the health care team, who is aware of an occurrence or a condition that may result in an occurrence, should promptly bring the information to the attention of the person in charge of the area. The following must be entered in SRM.

- Patient/visitor occurrences
- Theft, loss, or damage of property
- Department of Health occurrence reporting requirements
- Patient/family complaint or concern
- Near miss event reporting

Serious occurrences must be reported immediately to the Quality Management Department.

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OCCURRENCE AND CLAIM REPORTING (continued)

II. External Reporting Requirements

Certain patient occurrences must be reported to the New York State Department of Health (DOH) under its “NYPORTS” program, or to other regulatory agencies.

External reporting is coordinated at Strong by the Office of Counsel and at Highland by Quality Management, and should **not** be done without consultation with the appropriate coordinating office.

NYPORTS Reporting

There are two types of reports that must be sent to the DOH.

1. Short Form Reports: these reports allow for tracking and trending of certain minor occurrences. “Short Form” reportable events must be reported by entry into SRM, or calling your department’s Quality Assurance Representative at SMH or the Quality Management Department at Highland.
2. Root Cause Analysis (RCA) Reports: Certain more serious patient occurrences must be immediately reported since the DOH requires notification of these occurrences from the Hospital within 24 hours of their discovery. Serious occurrences requiring DOH notification and a subsequent RCA report include the events listed on the *NYPORTS Includes/Excludes Occurrences List – Appendix A – Version 2.0*. **Do not delay reporting while your own investigation is being completed. You should also enter the event into the event reporting system (SRM).**

Occurrences requiring a Root Cause Analysis (RCA) which take place after business hours or on the weekend should be reported as follows:

Strong: The Hospital Administrator On Call should be notified. The AOC will contact the Office of Counsel to the Medical Center. **Note:** The AOC should be notified immediately of major events or service disruptions.

Highland: The Nursing Supervisor and/or Administrator On Call should be notified. Occurrences reported through this process will be reviewed as part of the Hospital’s Quality Assurance/Improvement Program.

III. Other External Reporting Requirements

Medical Devices and Equipment:

Federal Law requires the hospital to notify the manufacturer or the FDA of any medical device or equipment-related occurrence that caused or contributed to a serious injury or death of a patient, visitor or employee, or that would have caused a serious injury in the absence of medical or surgical intervention. All device or equipment-related injuries should be entered as an occurrence into SRM and must be reported immediately.

Sentinel Events:

The hospital identifies and addresses certain serious occurrences through the use of a Root Cause Analysis. At a minimum, occurrences that meet any one of the following criteria must be addressed through this process.

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OCCURRENCE AND CLAIM REPORTING (continued)

- ✓ The event resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition.
- ✓ Examples of events include, but are not limited to:
 - Suicide during round-the-clock care or within 72 hours of discharge.
 - Unanticipated death of a full-term infant.
 - Abduction of any individual receiving care, treatment, or services or discharge of an infant to the wrong family.
 - Hemolytic transfusion reaction involving the administration of blood or blood components
 - Surgery on the wrong patient or wrong body part.

The Joint Commission expects that the hospital will identify sentinel events and complete a Root Cause Analysis. We do not report our sentinel events to the Joint Commission, but these are reported to the NYS Department of Health. Therefore, all such occurrences should be entered into SRM and must immediately be reported.

IV. Professional or General Liability Claims

In some instances of patient or visitor injury, a claim against the institution or a health care provider may result. The Office of Counsel to the Medical Center is the designated representative for all claims asserted against SMH, HH and those clinicians insured through the University of Rochester malpractice insurance program. The Office of Counsel at SMH should be immediately notified of all instances where the potential for such a claim exists; at Highland, the Quality Management Department should be promptly notified. Any claim letters or lawsuits received should also promptly be forwarded to the Office of Counsel at SMH or the Quality Management Department at Highland.

ORGAN AND TISSUE DONATION

Subject Matter Experts:

SMH: Michele F. Smits (455-5883)

HH: Diana Pfersick (341-6223)

Federal (42 CFR 482) and State (Public Health Law 4351-A) regulations require that all patient deaths, imminent deaths, and withdrawals of life-sustaining therapies be called into the Donor Hotline at 1-800-774-2729 or 275-2729.

Organ Donation - Finger Lakes Donor Recovery Network (FLDRN)

If the patient has a heartbeat **and** is on a ventilator at the time of the referral, the call will be triaged to FLDRN.

- All referrals must be made within 2 hours of a vented patient with a grave prognosis meeting the following Clinical Triggers:
 - Patient has a severe neurologic insult or injury (including anoxic encephalopathy) with a Glasgow coma scale rating of less than or equal to 5
 - At least two of the following brainstem reflexes are absent or diminished
 - Pupillary or corneal reflex
 - Cough
 - Gag
 - Response to painful stimuli
 - Spontaneous Respirations
 - When being evaluated for brain death
 - Patient is being considered for withdrawal of life supporting therapies (ventilatory or pharmacological support)
- Call must be made before patient is terminally extubated
- Consent conversations will be initiated by Finger Lakes Donor Recovery Network staff only.

Eye and Tissue Donation - Rochester Eye and Tissue Bank (RE&TB)

If the referral has been made following cardiopulmonary death, the call will be triaged to RE&TB. Patient care unit staff are responsible for:

- Providing RE&TB with patient demographics/history and next-of-kin information.
- Providing families/guardians with the RE&TB Condolence Card or ICU Grief brochure when the patient is a suitable candidate for eye and tissue donation.
- Obtaining next-of-kin telephone contact information where the family may be reached within a few hours of leaving the hospital.
- Completing documentation of the referral call in the medical record.
- Performing donor preparation when necessary.

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ORGAN AND TISSUE DONATION (continued)

RE&TB personnel document the outcome of donation requests on the appropriate hospital consent form and will advise and communicate directly with Admitting, Unit Clerk, HH Operator, and other hospital staff regarding when to hold the deceased for the eye and/or tissue recovery or release decedent to the funeral home.

Reference Policies:

	Strong Memorial	Highland
Anatomical Gifts	<p>For whole body donations, please refer to <i>SMH Policy 5.6.1 (Anatomical Gift Program)</i>. Medical Examiner cases or whole body donations do not preclude offering the option for tissue donation.</p> <p><i>SMH Policy 5.6.2 (Donation of Organs and Tissues)</i>.</p>	<p><i>Hospital Policy Anatomical Gifts 4.12</i> <i>Organ Donation After Cardiac Death 4.13</i></p> <p><i>Nursing Practice Standards: Protocol for the Management of Patients Who Have Died 14.0</i></p>

PATIENT PRISONER POPULATION (SMH Specific)

Subject Matter Expert: Lorraine McTarnaghan (275-2500)

For more information, please go to:

<http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/documents/9-10.pdf>

<http://intranet.urmc-sh.rochester.edu/nurses/policy/adminManual/Section8/8-18.pdf>

Definition

The Hospital provides care for patients who are under arrest, in the process of being arrested, or a resident of a correctional facility, but will not accept responsibility for guarding such patients.

Security Plan

All admitted patient prisoners have a security plan. (See SMH form 877MR—*Inpatient Patient Prisoner Security Plan Checklist*.)

Exception: Patient prisoners on medical leave of absence (LOA) may not require a security plan. The correctional facility is responsible for communicating this LOA status. (LOA patients are screened by the correctional facility and are not considered a risk due to their medical status and/or disciplinary history.)

Admission/Discharge

Patient prisoners may be under a managed care program. As with any HMO, certain procedures may be required regarding admission and discharge. Check with Admitting, Social work, Financial Services, Utilization Review and/or your supervisor. If you receive a phone call from a managed care organization, refer them to Utilization Review at 275-3185.

As with any patient, visitor or staff member, maintain professionalism at all times and report situations involving threats or aggressive behavior to area leadership and/or Security Services.

- Review the Inpatient Patient Prisoner Security Plan Checklist.
- Do not tell the patient prisoner personal information such as where you live or your telephone number. Do not give gifts to patient prisoners and do not accept gifts from them.
- Never be alone in a room with an inmate.
- Specific departments may have additional policies.

For Additional Information or Assistance

- If you have questions or concerns, contact the area leadership.
- Nonmedical security-related questions should be referred to Security Services.
- For **emergencies**, call Security at **x13**

PATIENT RIGHTS, ETHICS, COMPLAINT POLICY

Subject Matter Experts:

SMH: Jim Murphy (275- 5722), **HH:** Dottie Haelen (341-8058)

For a complete list of rights, go to:

SMH: <http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/index.asp> (Section 11) and

HH: <http://intranet.highlandhospital.org/Policy/HHpolicy/3-11.pdf>

Summary of Patient Rights:

Patient Rights include, but are not limited to:

- **Privacy** while in the hospital and confidentiality of all information and records regarding care, including authorization of those family members and other adults who will be given priority to visit consistent with the patient ability to receive visitors.
- Receive **treatment without discrimination** as to race, color, religion, sex, national origin, disability, sexual orientation, or source of payment, including considerate and respectful care in a clean and safe environment free of unnecessary restraints.
- **Be informed** of the name and position of the doctor who will be in charge of their care in the hospital and the names, positions, and functions of any hospital staff involved in their care and refuse their treatment, examination or observation.
- **Receive complete information** about the diagnosis, treatment and prognosis, including all the information needed to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.
- Participate in the consideration of **ethical issues** that arise in their care.
- Receive all the information needed to **give informed consent** for an order not to resuscitate. Patients also have the right to designate an individual to give this consent for them if they are too ill to do so. Additional information is contained in the *Do Not Resuscitate Orders - A Guide for Patients and Families*.
- Make known their wishes in regard to **anatomical gifts**. Patient wishes can be documented in the health care proxy or on a donor card, available from the hospital.
- Receive timely assessment and **treatment of pain**, including education about how to manage pain.
- **Complain** without fear of reprisal about the care and services received; have the hospital respond and if requested, a written response. Patients or families can complain to the New York State Health Department. The hospital must provide the Health Department phone number.
- Participate in all decisions about treatment and **discharge** from the hospital. The hospital must provide a written discharge plan and written description of how a patient can appeal their discharge.

If the patient or family has questions about patient rights, advise them to please speak with a staff member, especially the doctor or nurse caring for them.

PATIENT SAFETY, TEAM COMMUNICATION, and MEDICAL-HEALTH CARE ERROR REDUCTION

Subject Matter Experts:

SMH: Lori DellaPenna (276-3149), **HH:** Sharon Johnson (341-8399)

For details on the Joint Commission National Patient Safety Goals and Requirements, go to: http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/07_hap_cah_npsgs.htm

Joint Commission National Patient Safety Goals and Requirements.

- Goal 1: Improve the accuracy of patient identification
- Goal 2: Improve the effectiveness of communication among caregivers
- Goal 3: Improve the safety of using medications
- Goal 3E: Reduce the likelihood of patient harm associated with the use of anticoagulation therapy (new for 2008)
- Goal 4: Reduce the risk of health care-associated infection
- Goal 5: Accurately and completely reconcile medications across the continuum of care
- Goal 6: Reduce the risk of patient harm resulting from falls
- Goal 7: Encourage patients' active involvement in their own care as a patient safety strategy
- Goal 8: The organization identifies safety risks inherent in its patient population
- Goal 16: Improve recognition and response to changes in a patient's condition by enabling health care staff members to directly request additional assistance from a specially trained individual(s) when the patient's condition appears to be worsening.

Team Communication

The Joint Commission has found that **ineffective communication** is the #1 root cause of serious patient events that are reported to them. Suggestions/goals for improving communication include:

- Use of the two(2)-patient identifier process
- Write down, read back of verbal orders and critical test results
- Universal protocol elements
- Standardization of hand-off communications
- **Do Not Use Abbreviations:** The following abbreviations are NEVER allowed in any medical record documentation (U, IU, QD, QOD, trailing zero X.0 mg, Lack of leading zero .Xmg, MS, MSO₄, MgSO₄, u g, T.I.W., A.S., A.D., A.U.)

POLICY AGAINST DISCRIMINATION AND HARASSMENT

Subject Matter Experts

SMH: Peg Lee (275-2537), **HH:** Kathleen Gallucci (341-0118)

Policy Against Discrimination and Harassment

For the complete version of:

UR Policy 106, go to: www.rochester.edu/working/hr/policies/

HH Policy 130 go to:

http://intranet.highlandhospital.org/Policy/HRpolicy/documents/HR130-nonharassment_000.pdf

Any behavior, including verbal or physical conduct that constitutes, in any form, discrimination against or harassment of any member or guest of the University and Highland Hospital, is prohibited. Retaliation in any form against a person because he or she complained about an act of discrimination or harassment is prohibited.

All members of the University and Highland Hospital community (including faculty, staff and students) and all visitors to the campus and at University and Highland Hospital sponsored activities (including parents and vendors) must comply with this policy.

If you feel you are being discriminated or harassed, you should take action which may include any/all of the following:

- Speak with the individual and let him or her know that the behavior is unwelcome and unacceptable.
- Talk with your supervisor/manager or contact any of the resources below.

	SMH	Highland
Intercessor's Office - (Trained counselors appointed by the University to handle complaints or questions dealing with sexual harassment.)	Kathy Sweetland x5-9125 (staff and students) Ruth Lawrence, MD, x5-4354 (faculty)	
Human Resources	Peg Lee x5-2537 (staff)	Kathleen Gallucci, x1-0118 (faculty and staff)
Security	Emergency x13 Nonemergency x5-3333	Emergency x1-6666 Nonemergency x1-SERV
Office of Counsel	Office of Counsel to the Medical Center x5-8571	Office of Counsel to the Medical Center x5-8571

RADIATION SAFETY

Subject Matter Experts:

SMH: Thomas Morgan, Ph.D., CHP (275-3781), **HH:** Ahmad Matloubieh (341-6750)

The following areas use radioactivity:

SMH	HIGHLAND
<ul style="list-style-type: none"> ▪ Radiation Oncology ▪ Nuclear Medicine ▪ Nuclear Cardiology ▪ Operating Rooms ▪ 6-1400 area (for radioactive implant patients and radio-iodine patients) ▪ Research laboratories marked with the radiation symbol. 	<ul style="list-style-type: none"> ▪ Radiation Oncology ▪ Nuclear Medicine ▪ Operating Rooms ▪ Cardiology ▪ West 7 ▪ East 5

Shipment Information:

SMH	HIGHLAND
<p>Shipments delivered to:</p> <ul style="list-style-type: none"> ▪ 477-C Elmwood Ave loading dock (Radiation Safety) ▪ Nuclear Medicine Hot Lab (G-3256) ▪ Nuclear Cardiology Hot Lab (G-0397) 	<p>Brought to Emergency Department or Information Desk.</p> <p>Security is notified.</p> <p>Container brought directly to departmental storage areas.</p>

For More Information About Radiation Safety:

	SMH	HIGHLAND
Contact	Thomas Morgan, Ph.D., CHP Radiation Safety Officer 275-3781 (after hours, call Security)	Ahmad Matloubieh Chief Physicist 341-6750 Or Joe Coon Safety Officer 341-6833
Copy of NYS Health Department Radiation Safety Regulations	Maintained by Radiation Safety, available to all departments.	Contact Ahmad Matloubieh for a copy.

RESTRAINT USE

Subject Matter Experts:

- SMH:** Chris O'Brien (275-8200), Heather O'Brien (273-2560), and JoAnn Popovich (275-6937)
HH: Laurie McGuire (341-8451)

- SMH:** Policy 10.2: <http://intranet.urmc-sh.rochester.edu/Policy/smhpolicies/10-2.pdf>
 Nursing Policy 12.2: <http://intranet.urmc-sh.rochester.edu/nurses/Policy/PPManual/Section12/12-2.PDF>
 Psychiatry Policy 5.3: http://intranet.urmc-sh.rochester.edu/depts/psych/policy/5.3_Restraint-Seclusion%20Policy_11202007.pdf
HH: <http://intranet.highlandhospital.org/Policy/nursingPolicy/GPP/41-0.pdf>

NONVIOLENT RESTRAINT (MEDICAL REASONS)			
Reasons for Application	Types of Restraint	CIS Orders	Observation/Assessment
<ul style="list-style-type: none"> ▪ Fall prevention ▪ Patient personal safety ▪ Environmental protection 	<ul style="list-style-type: none"> ▪ Vest ▪ Soft wrist/ankle ▪ Leather wrist/ankle ▪ 4-point restraint ▪ Canopy Bed 	<ul style="list-style-type: none"> ▪ Authorized in writing by Provider* after physical exam of patient ▪ Orders specify why it is indicated, alternatives utilized, and length of time ▪ Renewal: <ul style="list-style-type: none"> – Vest, 1- or 2-extremity: every 24 hours – 4-Point: every 8 hours – Canopy Bed: every 24 hours ▪ Emergency Situation: RN initiates and requests immediate provider assessment 	<ul style="list-style-type: none"> ▪ Vest/2-point extremity: every 30 min. ▪ 4-Point: observe every 15 min., document pertinent assessments every 15 min., document interventions every 2 hours ▪ Vital signs: Every 8 hours, more often if needed/ordered ▪ Continual 1:1: Supervision required if applied under direction of RN, until MD/NP assessment

*NP/PA to consult treating physician as soon as possible

AVOID RESTRAINT - Try One of These Interventions First	
<ul style="list-style-type: none"> ▪ Assess and treat underlying causes of distress ▪ Distract or use diversions like: TV/Video, music, games, books, stories ▪ 1:1 behavioral monitoring ▪ Use of prn medications ▪ Allow wandering if possible and safe ▪ Reposition with pillows and other aids ▪ Toileting when needed or toileting plan ▪ Massage/warm bath ▪ Family visiting, assisting with distraction ▪ Use of lap trays or Velcro seat belts 	<ul style="list-style-type: none"> ▪ Verbal support and encouragement ▪ Active listening ▪ Frequent re-orientation if needed ▪ Allow choices in activities ▪ Allow time to make choices ▪ Encourage physical activity: ▪ Utilize PT, ROM exercises, walking ▪ Provide nutrition/provide hydration ▪ Bed alarms/chair alarms ▪ Provide a structured, consistent and quiet environment

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RESTRAINT USE (continued)

VIOLENCE (PSYCHIATRIC/BEHAVIORAL HEALTH REASONS)			
Reasons for Application	Types of Restraint	Orders	Observation/Assessment
When there is imminent risk of harm to self or others and when all less restrictive measures have failed.	<ul style="list-style-type: none"> ▪ Seclusion ▪ Posey® Connected TAT Velcro® Restraints ▪ Posey®TAT ▪ Velcro® Restraints ▪ 5-point restraint using Posey® Velcro® chest restraint 	<ul style="list-style-type: none"> ▪ Authorized in writing by MD only ▪ Orders specify why it is indicated, alternatives utilized ▪ Individuals with a MR diagnosis may only be secluded if they also have a primary psychiatric Dx. ▪ Restraint/Seclusion Renewal: 18 yrs & Up: every 4 hrs 9 yrs-17yrs: every 2 hrs Under 9 yrs: every 1 hr ▪ RN can initiate restraint. MD is notified immediately ▪ MD will respond to unit in person no later than 1 hr to assess patient even if restrain has been discontinued. ▪ If MD does not arrive within 30 min., MD must document on SMH763MR reason for delay. 	<ul style="list-style-type: none"> ▪ 4-Point/5-Point/Full Sheet: continuous 1:1 monitoring with documentation of pertinent assessments every 15 min. ▪ Seclusion: 1:1 continuous monitoring at door for first hour, then 1:1 monitoring via AV equip. OK. Documentation of pertinent assessments every 15 mins. Room entered hourly. ▪ Vital Signs: every 2 hrs, unless sleeping, more often if needed. ▪ Release: 4-Point/5-Point/: every 2 hours. ▪ Seclusion: every 2 hrs

Key Points:

- ♦ Ensure patient has full head mobility & avoid restraining in the prone position
- ♦ Fasten restraints securely, do not impair circulation
- ♦ Restraints should not tighten around extremity when pulled
- ♦ Loop knots should be used for quick release
- ♦ When securing restraints, tie to moveable part of the *bed frame* NOT *side rails*

THE STRONG COMMITMENT

Subject Matter Expert: Jacqueline Beckerman (275-8794)

For more information, go to:

<http://intranet.urmc-sh.rochester.edu/policy/strongcommitment/>

The Strong Commitment

As a member of our team, every word you speak and action you take makes an impression on those who trust us to provide them the best possible care. We are committed to exceeding their expectations and serving their needs with compassion, respect and exceptional health care.

Core Competencies for Service Excellence

Appearance and Language

- Wear neat, proper dress, including a visible ID badge
- Use words and tones appropriate to a health care setting

Greeting and Assistance

- Greet others warmly
- Introduce yourself and explain your role
- Offer assistance and escort guests to their destination if needed

Ownership and Hospitality

- Keep our hospital clean (report spills, pick up trash and reduce clutter)
- Always give patients and families priority (in elevators, lines, parking lots)

Respect and Recover

- Respect every person's privacy (knock before entering a room, pull privacy curtains where possible)
- Acknowledge situations; apologize for any inconveniences; correct when possible

Teamwork and Innovation

- Solve problems rather than blame others or offer excuses
- Value and support your co-workers and actively participate in team success
- Be flexible and willing to listen to ideas that are different from your own

It's essential that every Strong employee—managers, staff and physicians—is familiar with our Strong Commitment values, and that they are put into practice every day. This commitment requires a lot from each of us. How can Strong ensure that these standards are understood and met?

Training program materials are available to you in a variety of formats, starting with the Strong Commitment website <http://intranet.urmc.rochester.edu/Policy/StrongCommitment/> to make access and participation easy. In addition, CDs and DVDs containing the training materials and instructions specific to your needs can be obtained from The Strong Commitment office (x5-8794) or from the Director's Office of each hospital department. Training programs also can be viewed over CCTV, the hospital's closed-circuit TV station. Directions for viewing a training video are available:

<http://intranet.urmc.rochester.edu/Policy/StrongCommitment/learning/cctv.asp>

WASTE MANAGEMENT - SMH

Subject Matter Expert: SMH: Pete Castronovo (275-8405)

Waste Type	Examples	Disposal Method
General Refuse	Non-recyclable paper, food wrappings, paper towels, etc.	Clear or dark bag
Nonregulated medical waste (generated during treatment/ diagnosis of patients but not classified as biohazardous by NYS DOH)	Gloves, IV bags, tubing, etc., that are <i>not saturated to the point of dripping</i> with blood or body fluids.	Clear or dark bag
Biohazardous or Infectious Waste (medical waste defined by NYS as having a higher risk of being infectious.)	Sharps (patient and personal) Blood/body fluids Clinical lab <i>unbroken</i> blood tubes, or any other biohazardous glass from patient treatment areas. Broken glass is put in sharp's containers if it fits.	SMH approved sharps container (hard plastic with tight-fitting top) Discard <i>carefully</i> into designated flush sink/hopper (<i>not handwashing sinks</i>). Special cardboard box designed for these items
Recyclable Waste	Office paper Batteries including household types and "button" batteries	Blue bin/blue toter (where available) Drop-off points: soiled utility cart in inpatient units, Info. Desk in Main Lobby, Photo Illustration, Engineering Stores.
Confidential Documents	Patient Records; all HIPPA-related documents and information	Department shredder or: SMD – locked green toter with slotted top for Environmental Services pickup; SMH– locked small gray metal container.
Nonsharp Biohazardous Waste	Items <i>saturated</i> to the point of dripping with blood/body fluids (other than feces and most urine). Human pathological waste (recognizable body parts, organs.) Laboratory waste known to be in contact with infectious agents. Chest drainage canisters Animal waste (bedding, carcasses) known to be contaminated Suction canisters (keep upright in red bag)	Must be put into red bags.

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WASTE MANAGEMENT – SMH

Waste Type	Examples	Disposal Method
Pathological Waste		Special handling - See your Dept. Head for details (most goes to on-site Crematory)
Chemotherapeutic Waste Chemo waste must be separated from all other types of waste.	Nonsharp waste from a patient being treated with cancer-fighting drugs including gloves, gowns, etc. Sharps and glass containers used for patients being treated with cancer fighting drugs.	Yellow bag labeled “Caution Chemotherapy Waste” Yellow plastic sharps container labeled “Caution! Hazardous Drug Waste” or “Caution! Chemotherapy Waste”
Creutzfeldt-Jakob Disease (CJD) Waste	Waste from patients known or suspected to have CJD	Yellow Chemo sharps container w/ CJD sticker placed over Chemo label for sharps
Mercury Waste Do not throw items containing mercury in the trash	Button batteries, thermometers	On inpatient units, label and place on soiled utility carts. All other areas—check procedure for your specific areas.
Hazardous Chemical Waste	Halogenated solvents, corrosives, heavy metals, waste oils, etc.	Keep different kinds of chemical wastes separated. Place in tightly closed containers that are properly and clearly marked. Fill out a Hazardous Waste Tag and promptly call the Hazardous Waste Management Unit .
Radioactive Waste	Includes a variety of long- and short-lived radioactive materials mixed in with research and clinical apparatus such as pipettes, test tubes, examination gloves, paper, etc. All waste from patients receiving oral solution of iodine 131.	Keep different types of radioactive waste separate from each other and place in proper containers that are clearly and properly labeled with a Radioactive Waste Tag ; drop off at or pickup by Radiation Safety Office . Special boxes for these materials; pickup by Radiation Safety . F-18, Tc-99m, In-111m and Tl-201 wastes may be stored for decay within department with approval of Radiation Safety Officer.

WORKPLACE VIOLENCE / DEFUSING POTENTIAL VIOLENCE

Subject Matter Experts:

SMH: Lorraine McTarnaghan (275-2500), **HH:** Joe Coon (341-6833)

For more information, go to:

SMH: <http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/documents/10-14.pdf>
<http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/2-3.pdf>
<http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/documents/2-9.pdf>

HH: <http://intranet.highlandhospital.org/Policy/HHpolicy/3-21.pdf>

Hospital Policy:

Both Strong and Highland Hospitals strive for a safe and violence-free environment. Acts or threats of violence are serious and will not be tolerated.

The signs of potential violence (what you might see or hear):

- Visible stress
- Tense muscles
- Fidgeting
- Glaring
- Pacing
- Threats
- Loud, fast speech
- Demanding, blaming statements
- Refusal to follow rules
- Throwing, slamming objects
- Verbal outbursts
- Unrealistic expectations

How to respond to potential violence:

- **If a threat is immediate, call:**
 - University Security Services at extension 13
 - Highland Hospital Security at extension 1-6666
 - 9-1-1 for off-site locations
- If a threat is not imminent, notify your supervisor/manager and appropriate security service to help develop an action plan.

If a traumatic event happens:

- Report the event to your supervisor/manager.
- Address staff emotional needs and review the incident with all involved.
- Document the event through a report to Security and staff/visitor incident/occurrence report; the report will be promptly investigated and will be kept confidential if possible.
- Any act or threat of violence initiated by an employee will be grounds for termination per policy.