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University of Rochester Medical Center

Strong Memorial Hospital

Highland Hospital

0

MANDATORY

IN-SERVICE

0

EDUCATION

MANUAL

9



UNIVERSITY of
ROCHESTER
MEDICAL CENTER

MEDICINE of THE HIGHEST ORDER

This manual and accompanying tests are available on the website,

www.urmc.rochester.edu/mandatory_inservice/

An online, interactive version of the manual and tests is available on Blackboard at

<http://bb.urmc.rochester.edu>

Or, you can take your copy card to the URMCCopy Center on the ground floor of SMH to request copies.

TABLE OF CONTENTS
2009 Mandatory In-Service Education Manual

Introduction

Table of Contents i
 Preface iii

General Topics for Everyone , Regardless of Duties/Position

Code of Organizational and Business Ethics (**SMH** specific) 1
 Code Pink Child/Infant Abduction (**SMH** specific) 4
 Compliance: Everyone’s Responsibility 5
 Disaster Preparedness 6
 Diversity and Inclusion 7
 Electrical Safety 8
 Emergency Page Codes (**SMH** specific) 9
 False Claims Prevention (False Claims Acts) 10
 Firearms/Weapons 11
 Fire Safety 12
 Hazard Communication 14
 HIPAA Privacy and Security, and Confidentiality of Information 15
 Infection Prevention and Control 16
 Influenza—What You Should Know 18
 Interpreter Services 19
 Joint Commission Readiness 20
 Lifting and Transfers: Posture and Body Mechanics 21
 Management of Suspected Abuse and Neglect 22
 Meal and Rest Breaks 23
 Obtaining Security Services 24
 Occurrence and Claim Reporting 25
 Patient Prisoner Population (**SMH** specific) 27
 Patient Rights/Ethics/Complaint Process 28
 Patient Safety, Team Communication, and Medical-Health Care Error Reduction 29
 Policy Against Discrimination and Harassment 30
 Professional Misconduct and the Impaired Professional 31
continues.....

TABLE OF CONTENTS for '08 Mandatory In-Service Education (continued)

Smoke-Free Campus, Inside and Out 32

The Strong Commitment (**SMH** specific)..... 33

Waste Management 34

Workplace Violence / Defusing Potential Violence..... 35

Your Role in Quality / Performance Improvement..... 36

TOPICS for Faculty and Staff With Patient Care Responsibilities or Who Enter a Patient

Room

Conflict of Care..... 41

Continuity of Care Through Interdisciplinary Communication..... 42

Do Not Resuscitate (DNR)..... 43

End of Life Care 44

Health Care Proxy..... 45

HIV/AIDS Confidentiality Requirements 46

Information for Clinical Decision Making 47

Medical Equipment 48

Medical Orders for Life-Sustaining Treatment (MOLST)..... 49

Medication Reconciliation/Adverse Drug Reaction (ADR) Reporting 51

Organ and Tissue Donation 53

Pain Management..... 54

Patient Self-Determination Rights..... 55

Radiation Safety 56

Restraint Use..... 57

Highland-Specific Topics

Abduction of Newborn (**HH** specific) 61

Code of Organizational and Business Ethics (**HH** specific)..... 62

Emergency Page Codes (**HH** specific) 63

Forensics (**HH** Specific)..... 64

Highland Promise Standards and Performance Behaviors (**HH** specific) 65

Security/Safety Management Programs at Highland (**HH** specific)..... 66

Preface

2009 Mandatory In-Service Education Program for University of Rochester Medical Center Faculty and Staff

This program is:

1. Required of all staff and associated health care providers of the University of Rochester Medical Center.
2. Mandated by University of Rochester Medical Center policies and/or national, state and Joint Commission regulations.


Information that is site-specific is noted by **SMH** for the University of Rochester Medical Center Strong Memorial Hospital and **HH** for Highland Hospital.

It is recommended that all staff review all topics; however, supervisors/managers have the responsibility for determining, based on relevancy to their staff members' positions and job responsibilities, the pertinent topic sections their staff need to review and which relevant test they need to take.

Staff Performing Work Exclusively at SMH		
Who	Manual	Online Training
Everyone, regardless of their duties or position	Review all in the General Topics section (e.g., URMCM-SMH fire safety, code of ethics) ONLY . Answer all questions on SMH Competency TEST A unless you have patient care responsibilities, then see below.	You will need a Blackboard Account to logon to Blackboard online training. Blackboard instructions can be obtained at www.urmc.rochester.edu/mandatory_inservice/ ; click on “step-by-step instructions” under Blackboard Interactive 2009 Mandatory In-Service Education Program.” Appropriate topics are accessed in Section 1 and all the questions answered on TEST A at http://bb.urmc.rochester.edu .
Everyone who has patient care responsibilities and/or enters a patient's room	IN ADDITION TO reading the General Topics section, read the section, Topics for Faculty and Staff with Patient Care Responsibilities or Who Enter a Patient Room (e.g., MOLST, DNR, etc.). Answer all questions on TEST B (which will include General Topic questions).	Same as above, except you will access Sections I and II and answer all questions on TEST B .

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SMH Staff Who Also Work at Highland Hospital		
Who	Manual	Online Training
Everyone who has patient care responsibilities, enters a patient room AND works at HH as well as URMC-SMH	Read the entire manual including all the sections: General Topics, Topics for Faculty and Staff with Patient Care Responsibilities or Who Enter a Patient Care Room, <i>and</i> the Highland-Specific Topics (e.g., HH fire safety, MOLST HH Conflict of Care) Answer all the questions in Test C .	Same as above, except you will access Sections I, II, and III and take TEST C .
Everyone who does NOT have patient care responsibilities but who does also work at HH	Read the General Topics section AND the Highland-Specific Topic section only. (e.g., URMC-SMH fire safety, code of ethics, HH Conflict of Care, HH fire codes). Answer all questions in Test D .	Same as above, except you will access Sections I and III and take TEST D .

 **SMH staff should give the completed competency answer sheet to their manager/supervisor to correct (online Blackboard is self-scoring), verify competency, and keep in the department files.**

Staff Who Work Exclusively at Highland Hospital		
Who	Manual	Online Training
Staff working exclusively at Highland	N/A	Go to www.carelearning.com and click on “student login” to login with your student ID and password. Contact your manager if you do not have this information.

Documentation

SMH supervisors: please document compliance for your staff members in the Human Resource Management System (HRMS). Call Annette Schillaci at 275-0326 if you need access to HRMS Training and Development or instructions on how to enter compliance data in HRMS. Reminder: if the test is taken and passed in Blackboard, compliance will automatically be transferred to HRMS; no department data entry will be required.

Highland staff should sign off on their 2008-2009 Personal Education Record that all mandatory topics are completed. Individual employee transcripts for online courses and some in-services are available at <http://intranet.highlandhospital.org/resources/ERegistrar/LogOn.aspx>

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Mandatory Process

	SMH Mandatory Process	HH Mandatory Process
WHAT	CONTACT	CONTACT
Procedures	Kristin Hocker 275-3481	Karen Scott 341-6805
SMH: electronic copy of appropriate Competency Test or Blackboard Instructions	Kristin Hocker 275-3481 www.urmc.rochester.edu/mandatory_inservice/	N/A
HH: online training	N/A	Access instructions for CareLearning at: http://intranet.highlandhospital.org/resources/careLearning/index.asp Lisa Miller 341-6709
Copy of manual	Available at website: www.urmc.rochester.edu/mandatory_inservice/ Purchase from Medical Center Copy Center 275-5076	N/A
Computerized Compliance Records	Annette Schillaci, 275-0326, to request access to enter compliance data in HRMS	http://intranet.highlandhospital.org/resources/intranetremoteprint/ Lisa Miller 341-6709
Blackboard technical issues	Blackboard Support at Blackboard@urmc.rochester.edu	N/A

For any additional information concerning specific topics, please contact the Subject Matter Experts listed at the beginning of each topic.

Thank you to all who have contributed to developing the 2009
University of Rochester Medical Center
Mandatory In-Service Education Program.

GENERAL TOPICS
FOR
EVERYONE REGARDLESS
OF DUTIES/POSITION

CODE of ORGANIZATIONAL and BUSINESS ETHICS (SMH Specific)

Subject Matter Expert: Richard Demme, MD (275-5800)

The twelve principles of the Code of Ethics that guide the behavior of all employees and representatives of our institution are:

Principle 1 – Respect for Patients

Respect for the people for whom we are privileged to care is our first and greatest concern. We will provide health care without regard to race, creed, color, gender, sexual orientation, national origin, age, or ability to pay, and will respect each patient's unique background, culture, beliefs, and needs. Each of us bears a moral obligation to our patients to respect the value and dignity of human life, and this duty outweighs our own personal and financial interests. The Hospital has a Charity Care Program to support this principle.

Principle 2 – Relief of Suffering

Curing disease, reducing suffering and achieving an acceptable quality of life as defined by the patient are central goals of our institution. Patient suffering must always be addressed. Treatment for relief of symptoms and curative treatment are both treated with importance.

Principle 3 – Communication with Patients

A diagnosis is not just an identification of a disease, but may also carry with it serious emotional, social and financial burdens for patients and those close to them, including the burden of making and living with difficult choices. It is our responsibility to offer support and assistance by providing patients and their families with all the information they need to make sound decisions. **This includes the timely sharing of information about the expected or unexpected outcomes of care with the patient or family.**

Principle 4 – Confidentiality of Patient Information

Patient information is confidential and should not be disclosed without the patient's consent, except as provided by law. All information must be recorded accurately and communicated responsibly. Patient identity is to be protected especially in all public places, including hallways, elevators, and waiting rooms. Those with access to patient information have an obligation to protect patient privacy.

Principle 5 – Patient Access to Health Care

Registration, admission, transfer and discharge of patients are based on the patient's welfare and personal preferences, without regard to their ability to pay. Out of respect for patients and their concerns, we have established procedures to expeditiously and fairly resolve patient concerns or disputes arising over registration, admission, transfer, discharge, billing and payment. We will do all we can to help patients find resources to cover the cost of their care and the optimal setting for that care.

Principle 6 – Interdisciplinary Relations

Good patient care requires the collaboration of many different people providing a range of services, and effective communication and coordination between the care providers is essential to the welfare of our patients. Such collaboration requires the mutual respect of all the employees, students, trainees, volunteers, and faculty who are involved in the care.

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Principle 7 – Conflicts of Interest

All clinical decisions, including tests, treatment, procedures, and follow-up care will be based on the patient’s needs, and not on the financial interests of the hospital or its leaders, managers, staff or practitioners.

A. Professional Integrity

Our faculty must disclose any ownership, employment, equity interest, stock options, or consulting relationship they or their immediate family members have with a company involved with a product they are using for patient care, research, or publication.

B. Corporate Integrity

We will pursue business relationships that are free from potential conflicts of interest in the practices and contractual relationships at all levels of the institution. Patients have the right to full disclosure about the existence of any business relationships among the hospitals, educational programs, providers, payors or networks that may influence the patient’s care and treatment plan.

Principle 8 – Preventive Health Care

Disease prevention is an essential part of our mission. Through public education, community preventive service and research, we can reduce the incidence of illness and thus serve people who may never be our patients. Our responsibility to our neighbors and community also extends to a concern to produce and preserve a healthy environment.

Principle 9 - Education and Ethics

Education is both an investment in a better future and a tribute to past generations of patients and scholars. We commit ourselves to further progress against disease by sharing the knowledge, skills and ethical values that are the foundation of this institution. Educational programs and Ethics consultation are available to patients, their families, the community and our staff, volunteers, and faculty.

Principle 10 - Research Ethics

Basic and clinical research are central to our mission. They are fundamental to the prevention, diagnosis, treatment and ultimately, to the eradication of disease. Research requires activities that are anticipated to improve patient care in the future, and participants who are fully and adequately informed about the risks and benefits, including all reasonable alternatives. Research must reflect the highest standards of integrity including accurately collected, precisely analyzed and honestly reported data.

Principle 11 – Cost Containment and Allocation of Resources

Medical care, disease prevention and medical education and research are costly endeavors demanding conscientious stewardship; however, financial considerations should not dictate the quality of care offered to each patient. When the hospital must address the fair distribution of limited health care resources, the relative efficacy and financial costs will be considered, with the goal of maximizing health benefits using available resources. We will use both financial and natural resources conservatively, not wastefully. Quality assurance procedures will be followed to control costs and avoid unnecessary tests, treatments, or procedures.

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Principle 12 – Marketing Practices

Marketing practices for medical services carry a unique responsibility that requires special care to avoid manipulating people made vulnerable by illness. Ethical marketing requires providing accurate and unbiased information in all of our communications, public relations and advertising.

The mission statement and 12 principles of the Code of Organizational and Business Ethics will be displayed in the admissions offices of Strong Memorial Hospital and will also be printed in Orientation literature for all employees. For questions concerning the Code of Ethics, contact the Chair of the Strong Health Ethics Committee, Richard Demme, MD, 275-5800.

References:

Accreditation Manual for Hospitals, JOINT COMMISSION, 1998.
Strong Health Code of Conduct

CODE PINK CHILD/INFANT ABDUCTION (SMH Specific)

Subject Matter Expert: Lorraine McTarnaghan (275-2500)

For more information, please 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 staff.

In the Event of a Suspected Infant or Child Abduction

If you are in the area where the abduction occurred, **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; staff should search the area and identify all witnesses (separately if possible). All departments in the facility should secure exits for which they are responsible.

Staff in an area other than the site of the abduction should report suspicious activity or persons to Security at x13 and direct persons attempting to exit with a child, package, or appearing to be pregnant to the exits that Security will be monitoring: Main Lobby—First floor Med Ctr Parking Garage Link, Ground floor—Med Ctr Parking Garage Link, Patient Discharge, and the Clinical Research Center.

IT IS CRUCIAL TO REMEMBER:

- Report suspicious activity or persons to Security at extension 13.
- Monitor the nearest perimeter door in your area until the "Code Pink, All Clear" overhead page is announced.
- You should not place yourself in danger by attempting to detain a suspicious person. If you encounter a suspicious person, immediately **call Security at extension 13** with a description of that person.
- No information should be given to the press regarding the incident.

COMPLIANCE: EVERYONE'S RESPONSIBILITY

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

It is policy of the University of Rochester Medical Center (URMC) that all employees and affiliated professional staff comply fully with state and federal laws and conduct themselves in accordance with the highest ethical standards. Any confirmed act of noncompliance could result in corrective action or discipline, including termination of employment.

The Compliance Office

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. Some of the services and tools available through the Compliance Office are:

- Education and training for employees and providers.
- Written guidance, including a Code of Conduct; compliance plans, policies and procedures; and newsletters covering critical compliance topics and new government policies.
- An **Integrity Hotline** (756-8888) where employees can report noncompliant activities.
- Auditing and monitoring programs to identify potential noncompliant activities.

More Information

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

Fred Holderle, Compliance Officer
Box 520
Phone 275-1609, fax 756-5584
E-mail Frederick_Holderle@urmc.rochester.edu

Reporting Noncompliant Behavior

You have the responsibility to report suspected illegal or noncompliant activities to your supervisor or to the Compliance Office. Examples of reportable incidents are:

- Breach of patient confidentiality
- Inappropriate billing practices
- Inaccurate record keeping
- Research fraud

IT IS CRUCIAL TO REMEMBER:

You can report any compliance 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.

DISASTER PREPAREDNESS

Subject Matter Experts:

SMH: Mark Cavanaugh (275-8412),

HH: Joe Coon (341-6833)

For full information on this topic for each department, go to the HIMS (Emergency Preparedness Plan) <http://intranet.urmc.rochester.edu/Policy/EmergPrepManual> at University of Rochester Medical Center (URMC)-Strong or <http://intranet.highlandhospital.org/Policy/envCare/index.asp#5> at Highland.

Definition

A disaster occurs when events:

- overload the capacity and/or ability of the ED or Hospital units to care for the injured, causing significant disruption to normal Hospital operations.
- cause other community agencies to request support from URMC-Strong or Highland Hospital departments.
- of a biological, chemical, or radiological materials nature severely impact any part of the hospital community (such as receipt of a suspicious letter or package).

The occurrence of any of the above may lead to the Hospital activating its disaster response plan.

Sequence of Events

The Emergency Department (ED) will routinely be the first to be notified, and:

1. The ED charge nurse, or hospital Administrator on Call (AOC) in some instances, will notify the Page Office at URMC-Strong Hospital or Telecommunications at Highland Hospital.
2. The Page Operator will notify hospital staff by means of the overhead page and pagers.
3. Individual departments will notify staff at home according to departmental disaster/emergency response plans; staff will report to their designated areas and implement their job action sheets.
4. Once identified, the location of an institutional Emergency Operations Center will be paged; *URMC-Strong*: the conference room in the Director's Office or *Highland*: the Gleason Room or as determined by the senior administrator.

How to Prepare for a Disaster Response

In order to be prepared for any disaster affecting URMC-Strong or Highland facilities, know where your emergency management plan is located, and review your department's disaster/emergency response plan to understand your role so you can respond appropriately.

IT IS CRUCIAL TO REMEMBER:

- If on duty, follow your department plan/directions from your leadership; make sure you are wearing your ID badge so that you can access all necessary areas.
- Do not use hospital phones/elevators except for emergency or disaster activities.
- If you are at home, remain there until contacted by the hospital. Come to the hospital if:
 - The TV or radio media request you to report.
 - Your department plan states you should report immediately.
- If called to report for duty, sign in when you report to work per facility procedure.

DIVERSITY AND INCLUSION

Subject Matter Experts:

SMH: Stanley Byrd (275-0425), **HH:** Kathleen Gallucci (341-0118)

Philosophy

At the University of Rochester, **diversity** means that we believe everyone is unique and has different talents and abilities. All of us contribute in various ways to provide our customers, the organization, and the community with excellent service. When we value diversity we can fulfill our highest potential as a team and as individuals.

In order to meet the needs of each person we interact with, we must be trained to understand the complex dimensions of diversity. These include, but are not limited to:

- Age
- Race
- Ethnicity
- Gender
- Physical or mental abilities
- Culture
- Sexual orientation
- Learning abilities

By examining our own attitudes, values, and behavior (as well as those of others), we begin to achieve real understanding.

Teamwork is essential in a diverse work force. Qualified and diverse team members learn to respect each other's differences. Job satisfaction will be greatly increased if each employee is valued and treated with respect. Every employee will become empowered to build strength for our team.

When each member of a team has high morale, the productivity of the organization and the quality of service will be enhanced. This leads to increased customer satisfaction and improved community relations. It is up to each of us to learn about others and address individual needs so we can work together to serve our customers. We are stronger through diversity.

Inclusion means creating an organizational environment and culture where every employee feels valued and is able to function at his or her best. The key to inclusion is harnessing the talents, strengths and personal motivation of each individual in our diverse workforce and aligning each person's talents, abilities and skills with the organization's goals, mission and values.

(For additional information, see the University of Rochester Diversity website at:

<http://www.rochester.edu/diversity/> .

IT IS CRUCIAL TO REMEMBER:

- Our workforce is diverse; we must respect differences and make them work for us.
- Interpersonal relations and organizational effectiveness are improved through encouraging new ideas and perspectives.
- Stereotypical views of others limit our ability to understand those different from us.
- Every human being is unique; we need to create an environment where all employees feel they can contribute to their fullest potential.

ELECTRICAL SAFETY IN HEALTH CARE FACILITIES — PROTECTION FOR YOURSELF AND PATIENTS

Subject Matter Experts:

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

For more information, see:

<http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/index.asp>

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

The adequacy and integrity of the electrical power distribution system and all emergency power supplies are monitored by the Maintenance Department at Highland and Facilities Operations Maintenance Department at the University of Rochester Medical Center (URMC)-Strong Hospital.

An independent emergency power source is provided to ensure essential electrical service when the normal power supply is interrupted.

Non-Patient Care Electrical Equipment

University of Rochester Medical Center-Strong Hospital is checked for electrical safety by Facilities Operations. The nursing staff will assist in requesting Facilities Operations to complete the inspection. Only radios, televisions, telephones, and VCRs provided by Strong Memorial Hospital are permitted in the Hospital, except on 5-1200, the Rehabilitation Unit, where special guidelines must be met.

Highland Non-Patient Care Equipment is defined as electrical equipment that is not directly related or involved in patient care. All nonpatient care equipment used in the hospital must be in good physical condition, have been wired with a chassis group via a separate third wire ground with a hospital-grade plug attached or be double insulated. This equipment should have the appropriate UL listing for its type and use.

Report **malfunctioning patient care equipment** to Clinical Engineering (URMC-SMH x5-5501 and HH x1-7378) and malfunctioning **nonpatient care equipment** to the Facilities Customer Service Operations (URMC-SMH x3-4567 and HH x1-7378).

IT IS CRUCIAL TO REMEMBER:

- Red, white/ivory and orange receptacles are for patient care equipment only and will run on emergency power.
- Gray and brown receptacles run on normal operating power.
- All plugs and outlets must be hospital-grade in patient care areas. Beware of broken outlets or loose plates. Electrical receptacles should be in good physical condition.
- Defective plug caps (hot to the touch) must be taken out of service. Call URMC-Strong Facilities at x3-4567 or Highland Maintenance at x1-7378 immediately for repair.
- Do not use extension cords or “cheaters” (used to connect 3-pronged plugs to 2-pronged). The exception to using extension cords is during a Blue 100 at URMC-Strong.

EMERGENCY PAGE CODES (SMH Specific)

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/>

The hospital overhead paging system is used to alert staff to a variety of emergencies or situations that occur. It is the responsibility of all staff to minimize the effect to patients and visitors when emergencies occur. Some of the more common codes are:

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 and immediate assistance is needed.	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)
External/internal disaster	x-13 Disaster Emerg Ops Ctr. x5-0500	HIMS Response
Utility Failure	x-13	Condition Utility (location and type of utility affected)

IT IS CRUCIAL TO REMEMBER:

- All inpatient medical emergency and STAT pages are placed by calling the Communications Center at x5-7828 or x5-STAT.
- Inpatient medical emergency and STAT pages are executed using five overhead tones and followed by an announcement in the form of “Pediatric Team, call a specific location.”
- Announced overhead with five STAT tones and a location “Call” means “go-to” in the hospital.
- All pages other than STAT or inpatient medical emergency pages may be executed using the pager identification code (PIC) listed in the pager directory in the Facility-Staff Telephone Directory and calling 275-1616 or using Web Paging located on URMC intranet home page.

FALSE CLAIMS PREVENTION (FALSE CLAIMS ACT)

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

For complete information regarding policies that cover employees' responsibilities and rights in assisting their employer in complying with all legal and regulatory requirements, go to 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>.

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.

New York State's False Claims Act, enacted in April 2007, applies to most claims submitted to the State, including claims submitted to Medicaid.

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, or taking or giving a kickback for a referral.

IT IS CRUCIAL TO REMEMBER:

- You should 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 several websites, including: The Centers for Medicare and Medicaid Services (www.cms.hhs.gov) and the New York State Department of Health (www.health.state.ny.us). You may call the Compliance Office at 275-1609 for assistance.
- If you become aware of a potential billing problem, 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 and when appropriate, disclosing the problem to appropriate state and federal officials.
- By voluntarily disclosing such information, the University of Rochester Medical Center (URMC) may avoid or limit liability under the False Claims Acts.
- State and Federal law and URMC policy contain protections against retaliation for disclosing potential billing problems.
- The False Claims Acts include "qui tam" provisions that allow any person with actual knowledge of a False Claim Act violation to file a lawsuit on behalf of the State or Federal Government.

FIREARMS / WEAPONS

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/smhpolices/section10/10-10.PDF> (SMH Policy 10.10)

HH: <http://intranet.highlandhospital.org/Policy/envCare/Weapons%202.18.pdf> (HH Environment of Care Manual, Security Management: Weapons)

Firearms and other dangerous weapons are not permitted at any University of Rochester Medical Center—Strong Hospital, Highland Hospital site or University premise except as required by law.

Law enforcement, forensic agencies and armored courier personnel may be required by law to carry firearms while engaged in the performance of their duties. If, however, the firearm is not essential to the performance of their duty, personnel from such agencies will be encouraged to contact Security for further direction.

Staff discovering a firearm or weapon should not touch the weapon and should notify the appropriate Security Service immediately for appropriate action.

IT IS CRUCIAL TO REMEMBER:

- Firearms and other dangerous weapons are not permitted at any URMCC-Strong, HighlandHospital site or University premise except as required by law.
- Staff discovering a firearm or weapon should not touch the weapon.
- Notify the appropriate Security Service immediately if a firearm or weapon is discovered or seen on a person who is not authorized to carry a weapon.

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

FIRE PREVENTION

Prevention of fires should be paramount in everyone's mind. To prevent fires, you should be aware our number-one life safety finding is improper storage of materials in the corridor or stairwells. You should also be aware of faulty electrical devices or frayed electrical cords. These can easily start a fire.

You should also be on the alert for conditions that may lead to rapid fire spread or hinder safe evacuation. These might include openings in wall and ceilings; propped open or blocked fire doors; blocked extinguishers, pull stations, or gas shut-off valves.

PATIENT FIRES

For patient fires, extinguish with a bed covering such as bedspread, blanket, or sheet. Protect yourself by wrapping your hands inside the material, lean tight against the bed to prevent backflash, and quickly drape the extinguishing material completely over the patient, remembering to protect the patient's face first and to tuck the material into every crevice formed by the patient's body (for example, between legs and under back).

Please see the *Emergency Preparedness Manual* for specifics pertaining to your department's procedures so you will know what to do in case of a fire or other emergency.

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.	

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IT IS CRUCIAL TO REMEMBER:

RACE:

- **Rescue** anyone in immediate danger and relocate him or her to a safe area. Below waist level, the air is relatively cool and clean, allowing for escape by staying low and moving quickly.
- **Alarm** everyone whenever there is evidence of fire, by using a pull station. Call **13 at URMCM-SMH** or **1-6666 at Highland**; state your name, the nature of problem and the location.
- **Confine** fire by closing **all** doors immediately upon discovery of fire. The door leading to the room of origin should be closed immediately and kept closed. Do not open windows.
- **Extinguish** a small, contained fire **if trained**, but without endangering yourself or others. A clear exit path should be maintained to prevent being trapped by rapidly spreading fire.

If fire conditions appear to be worsening, evacuation should be assessed. Guidelines for determining evacuation are as follows:

1. Fire has spread to the structure such as walls or ceiling.
2. Several items of furnishings are involved in the fire.
3. Smoke appears to be spreading unchecked from the room of origin.
4. Orders are received from a person listed as qualified to call an evacuation.
5. **If the room(s) is evacuated**, obtain chalk from the nearest fire extinguisher cabinet and chalk the lower hinged side of the door with a slash.

Fire Extinguisher Operation: PASS

Pull the pin

Aim the horn or hose at the base of the fire

Squeeze the handle

Sweep at the base of the fire

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.

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 and education on this topic, go to:

SMH: <http://intranet.urmc.rochester.edu/policy/smhpolices/section13/13-11.PDF>

<http://www.safety.rochester.edu/pdf/hazcom.pdf>

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

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

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.

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 information on hazardous chemicals with which employees may come in contact as well as access to the hospital's written Hazard Communication (found in the links above).

Material Safety Data Sheets (MSDS)/Chemical Inventories: MSDSs are available to employees for all chemicals used. Departments must also maintain a list of all hazardous chemicals used in their department as well as properly labeling all chemical containers.

At SMH departments maintain electronic chemical inventories/matching MSDS sheets. Staff may obtain a copy of an MSDS by clicking www.safety.rochester.edu/msds.html, calling the Poison Center at x5-3232, or calling EH&S at x5-3241. At Highland, Master copies are kept in Support Services and can be accessed by nursing supervisors off-shift. Department-specific copies are kept in the department and are available to the employee at all times while on duty.

IT IS CRUCIAL TO REMEMBER:

1. Chemical exposures may occur through inhalation, skin contact, ingestion, or injection. Employees must use the proper Personal Protective Equipment (PPE) to prevent exposures. This equipment can include:
 - Gloves and eye protection.
 - Protective clothing, head coverings and footwear.
 - Respirators (SMH employees required to wear respirators need to attend the UR's Respiratory Protection Program).
2. Employees exposed to a hazardous chemical must take immediate action to minimize possible health effects. Immediate first aid may include rinsing of eyes or skin (at the point the chemical made contact) for at least 15 minutes and seeking medical attention.
3. Small spills can be cleaned by personnel who are aware of the hazards of the spilled material. The proper PPE must be utilized.
4. 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.
5. For large chemical spills or if sufficiently trained personnel are not available, immediately call Security at x13 at SMH or x1-6666 at Highland Hospital if the spill is onsite. If offsite, call 911.

HIPAA PRIVACY and 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)

The Health Insurance Portability and Accountability Act (HIPAA) is a federal regulation that mandates standards to protect the privacy and security of patients' medical information. *Privacy* refers to maintaining confidentiality and safeguards of all protected health information (PHI) whether in electronic, written or oral form. Any use or disclosure of PHI must be permitted by the Privacy regulations. *Security* refers to the measures that are taken to protect electronic protected health information (ePHI) from loss, theft, damage or unauthorized access.

IT IS CRUCIAL TO REMEMBER:

- You have an ethical and legal responsibility to safeguard patient information (clinical, demographic and financial) and for reporting inappropriate behavior of others. Patients and workforce members should call the University of Rochester Medical Center (URMC) Integrity Hotline at **585-756-8888** to report concerns, complaints, or violations.
- You must have a job-related reason, or be permitted by policy, to access any patient's Protected Health Information. You **are not permitted to access** PHI of any patient that is a family member or friend because they have asked you to, or because you hold a power of attorney or a health care proxy.
- You must never share your password with anyone, for any reason, ever. **Each user is responsible** for all information accessed or entered under his/her user ID/password.
- You must have written permission from your department head to store PHI on a portable device, such as laptop computer or USB/jump drive, or on media, such as CD or DVD. The PHI must be encrypted on the device or media. The device must be password protected, if the feature is available.

Resources

HIPAA Policies and Training: <http://intranet.urmc-sh.rochester.edu/policy/HIPAA>

SMH: Policy 6.8 "Information Systems Security"
<http://intranet.urmc-sh.rochester.edu/Administrative/>

HH: Policy 3.4. "Confidentiality of Information,"
<http://intranet.highlandhospital.org/policy/hhpolicy>

Security Basics: <http://intranet.urmc-sh.rochester.edu/InfoSystems/HelpResources/Security/>

INFECTION PREVENTION AND CONTROL

(including updates on OSHA Bloodborne Pathogen Standards and Tuberculosis)

Subject Matter Experts:

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.uroch.rochester.edu/policy/infcontrol/>

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

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

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. Standard Precautions apply to all patients and there are additional enhanced precautions categories which apply only to patients with particular diseases. When in effect, these enhanced 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. See the *Infection Prevention and Control Manual* for details.

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; those at risk should have received OSHA training. If you have not received OSHA Bloodborne Pathogens training, contact your supervisor or department head.

Report any exposure as soon as possible and notify your supervisor/manager.

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.

IT IS CRUCIAL TO REMEMBER:

- **Hand hygiene** is the most important method of preventing the spread of infection.
- All equipment that goes from patient to patient **must** be sanitized before use.
- Respiratory hygiene, which means covering your nose and mouth with a tissue or your sleeve when you sneeze or cough, will also help prevent the spread of germs that cause illnesses like influenza and respiratory syncytial virus (RSV).
- The blood and body fluids of **all** persons must be considered dangerous. Standard Precautions apply to **all patients**.

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INFECTION PREVENTION AND CONTROL (continued)

- **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.
- 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). An eyewash station should be used if possible.
- All clinical staff should be vaccinated against influenza every year.
- Annual fit testing is now required for staff who wear N95 masks for respiratory protection. An annual PPD is required for all staff.
- A private room with negative pressure and a closed door is used to prevent the transmission of TB.

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/> (See Section 5 “Pandemic Influenza Plan”)

Seasonal Flu

Influenza or “flu” is a respiratory infection caused by influenza virus which is spread from person to person. The flu that strikes every winter is called “seasonal” flu. Most people who get the flu will recover within a week, but flu and its complications can be life-threatening for the elderly, newborn babies, and people with some chronic illnesses.

Pandemic Flu and Bird Flu

Pandemic flu is caused by a new strain of flu virus that causes a global (or pandemic) outbreak of serious illness with high rates of death. Because there is little natural immunity, the disease can spread easily from person to person. Experts are concerned that avian flu (bird flu) could become the next pandemic flu if the virus acquires the ability to spread easily between people.

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).
- By 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.

IT IS CRUCIAL TO REMEMBER:

1. The best way to prevent flu is to get the vaccine annually prior to the flu season.
2. Stay home if you are sick during the flu season with flu symptoms: fever, cough, sore throat, body aches, headache, runny nose or congestion.
3. 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 to cover your cough.
4. Hand hygiene: always use alcohol hand gel or wash hands before and after touching any patient, and frequently during the course of the day.
5. 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.

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 (URMC)-Strong and Highland Hospital 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.

It is hospital policy to use only hospital-designated interpreters. The use of family members and/or friends is discouraged due to concerns about confidentiality/comprehension. Always offer interpreter services to a patient if you think it is needed. The offer of the interpreter, the patient's response, and use of the interpreter (if accepted), should be documented in the patient's chart.

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.

Using an Interpreter

When using an interpreter, position yourself next to the interpreter (so the patient can read your facial expressions) and look and speak directly to the patient. Speak in the first person; avoid comments like, "Ask her...", or "Tell him this..." The interpreter is there to facilitate communication. Everything that is said will be interpreted to the patient. If there is something you don't want the patient to know, avoid discussing the subject until you have left the room.

Speaking With Deaf and Hard of Hearing Patients

When talking with patients who are hard of hearing, it is generally helpful to speak slowly at a loud conversational level, but not shouting, while allowing the patient to watch the speaker's face. A very common misconception is the assumption that if a deaf or hard-of-hearing (DHH) person has "good speech," you can get by without an interpreter. If a patient uses Sign Language as their primary mode of communication, we must be sure to offer interpreter services and not assume they can lip-read and fully understand the conversation.

IT IS CRUCIAL TO REMEMBER:

- The New York State Health Code states comprehensive interpreter services are required.
- It is hospital policy to use only hospital-designated interpreters.
- When using an interpreter, position yourself next to the interpreter (so the patient can read your facial expressions) and look and speak directly to the patient.
- If a patient uses Sign Language as their primary mode of communication, we must be sure to offer interpreter services and not assume they can lip-read and fully understand the conversation.

JOINT COMMISSION READINESS

Subject Matter Experts

SMH: Judy Burkman (276-3148) and Lori DellaPenna (276-3149)

HH: Sharon Johnson (341-8399)

For more info, go to:

SMH: <http://intranet.urmc-sh.rochester.edu/Depts/QA>

HH: <http://intranet.highlandhospital.org/departments/Jcaho/Index.asp>

ARE YOU JOINT COMMISSION READY?

What is the Joint Commission?

The Joint Commission is a private agency that evaluates how well health care organizations provide safe and high quality patient care. Standards are used to measure how well a health care organization provides patient care services. The method used to evaluate how well an organization is providing safe, high quality care is called a survey. A team of Joint Commission reviewers comes to our facilities and observes how we provide care and ensure we meet the Joint Commission standards. These surveys are unannounced so we need to be ready at all times.

IT IS CRUCIAL TO REMEMBER:

- To wear your ID Badge at all times and your white badge card with the emergency page codes.
- You must know the National Patient Safety Goals. They are available from your manager and can be found on the intranet. You need to know how **you** comply with these goals as they relate to your job.
- If asked a question by the surveyors, be sure that you understand the question before answering it. Answer honestly as it relates to the work that you do. If you do not know the answer it is fine to say, "I don't know the answer, but I do know where to find it."
- Staff and patients are encouraged to report concerns about care and safety, through their management structure, by calling the Medical Director's Hotline (3-CARE) for SMH staff or Quality Management (1-8399) for Highland Hospital staff. If a staff member or patient is still not satisfied, they may report their concern to the Joint Commission at 1-800-994-6601 or via e-mail at complaint@jointcommision.org .

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 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. The closer the object is to you, the less the torque on your back.

Good Posture

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.

IT IS CRUCIAL TO REMEMBER:

- Ask for help before you need it.
- Perform a two-person or team lift when possible to help prevent injury.
- Use assistive technology to save your back (for example, transfer belts, Hoyer lift, hover mat, plastic sheeting and slide boards).
- Good posture prevents muscular pain, decreases injury and stress on joints.

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 are mandated to assess and treat patients who are suspected to have been abused or neglected.

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.

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 URMCM-SMH Page Office.

IT IS CRUCIAL TO REMEMBER:

1. Abuse and Neglect includes:
 - Suspected Child Abuse or Maltreatment
 - Elder Abuse
 - Adult Domestic Violence
 - Sexual Assault
2. Health care providers are mandated by New York State Social Service law to report any and all suspicions of child abuse or neglect to the NYS Child Central Registry or to the Monroe County child abuse and neglect hotline.
3. See the *Department Resource Guide for Mandatory Training – 2009* for all policies and procedures related to this topic.

MEAL AND REST BREAKS

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

For more information on this topic, go to:

SMH: <http://www.rochester.edu/working/hr/policies/pdfpolicies/172.pdf>

HH: <http://intranet.highlandhospital.org/Policy/HRpolicy/documents/HR176-WAGEandSALARY.pdf>

Meal Breaks

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

For most hourly employees at the University/HH working shifts of more than 6 hours, the payroll system deducts 30 minutes automatically; it is assumed the employee took an unpaid 30-minute meal break. Per Federal Labor Law, unless the following three conditions are satisfied, meal breaks must be counted as time worked for nonexempt, hourly paid employees:

- 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, and
- The employee must be free to leave the work area, although can be required to stay on University/HH property.

If any of these conditions are not met, then the meal break is considered worked time and nonexempt hourly staff must be paid.

Rest Periods

University/HH policy provides that, where operationally possible, employees working continuously for 3.5 to 4 hours are given paid rest periods (not more than 15 minutes), at times convenient to departmental operations. **Note:** Individuals covered by collective bargaining agreements should refer to their collective bargaining agreement.

IT IS CRUCIAL TO REMEMBER:

1. It is the University/Highland Hospital intent that every employee receives a meal break as required by New York State Labor Law.
2. In the event that **emergency situations** arise where an hourly paid employee does not get an **uninterrupted** meal break of at least 30 minutes, then the entire meal break must be paid and an edit must occur in HRMS (SMH) and ETime (HH) to negate the automatic deduction. 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/she is paid accurately for all time worked.
3. If an employee feels he/she is not getting an appropriate meal break, or is not being properly compensated in accordance with this policy, the employee should contact a supervisor or Human Resources.

OBTAINING SECURITY SERVICES

Subject Matter Experts:

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

For more information, please go to

SMH: <http://intranet.urmc-sh.rochester.edu/policy/smhpolices/SECTION02/2-6.pdf>

HH: <http://intranet.highlandhospital.org/Policy/envCare/#2>

Regardless of the facility you are in, incidents that involve personal safety of students, volunteers, patients, employees and visitors should be reported to the appropriate Security service immediately. Other incidents include but are not limited to:

- | | |
|--|------------------------------------|
| ▪ Disturbances | ▪ Injuries |
| ▪ Structural failure | ▪ Loss of inventory |
| ▪ Fire/explosion | ▪ Traffic conditions/accidents |
| ▪ Utility emergency | ▪ Suspicious persons or activities |
| ▪ Chemical/biological/radiological contamination | ▪ Abduction |
| ▪ Medical emergencies | ▪ Patient disappearance |
| ▪ Bomb threat | ▪ Physical crimes |
| | ▪ Theft/weapons |

University Security Services and Highland Hospital Security can be contacted 24 hours a day, 7 days a week.

IT IS CRUCIAL TO REMEMBER:

To Contact University Security Services or Highland Hospital Security:

	SMH	Highland
Emergencies	x13 from inside UR or any Blue-Light Emergency phone	x1-6666
Nonemergencies	x5-3333 (from inside UR) May use any Blue-Light Emergency phone located on or near pathways, parking lots, and each level of the MC ramp garage. 275-3333 (outside UR)	1-SERV or Page Operator from inside the hospital. 473-2200 (page operator) from outside the hospital.

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.uroc.rochester.edu/Policy/SMHPolicies/9-1.pdf>

Reporting of Actual and Potential Medical Events – 9.1.1

<http://intranet.uroc.rochester.edu/Policy/SMHPolicies/9-1-1.pdf>

HH: Occurrence Reporting – 3.14

<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>

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 are 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 or others who may be relevant in the investigation.

Internal Occurrence Reporting at the University of Rochester Medical Center-Strong Memorial Hospital – Overview (See *Department Resource Guide for Mandatory Training - 2009* for details)

A report must be made for any patient or visitor-related occurrence that is not consistent with the routine operation of the hospital or routine care of the patient. In all cases where an injury has occurred, the occurrence must be entered into the event reporting system, SRM, no 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 in the SRM system to follow.

Internal 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 report it. The following must be entered into the electronic event reporting system:

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

A more specific list of all required events to be reported is attached to the hospital Occurrence Reporting Policy. Serious occurrences must also be reported immediately to the HH Quality Management Department (341-8399) or the Nursing Supervisor (off-hours).

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External Reporting Requirements – Overview (See *Department Resource Guide* for details)

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.

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 to your supervisor/manager.

IT IS CRUCIAL TO REMEMBER:

- Timely reporting and thorough documentation of occurrences is necessary to maintain patient safety. A report **must** be entered into the SRM system for all occurrences and near misses.
- In all cases where an injury has occurred, the occurrence must be entered into SRM no later than the end of the shift during which the occurrence happened or was first discovered.
- 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.

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.
- Before interacting with a patient prisoner, check with the nurse caring for the patient.
- Communicate the security plan to other Hospital staff/departments as appropriate. For example, the inpatient unit may need to notify Food and Nutrition Services that a patient needs plastic tableware.
- Guidelines for corrections officers have been developed and are included in the nursing education resource packet. Copies of these guidelines as well as emergency information should be kept on hand and provided to corrections officers upon arrival at the patient's treatment location.
- For security reasons, inmates should NOT be informed of future follow-up appointment dates, times, days of the week or other scheduling information.
- Phone inquiries: staff shall inform the patient's facility/guarding officer and no information shall be provided.

IT IS CRUCIAL TO REMEMBER:

- Before interacting with a patient prisoner, check with the nurse caring for the patient.
- For security reasons, inmates should NOT be informed of future follow-up appointment dates, times, days of the week or other scheduling information.
- For your own personal safety, do not tell the patient prisoner personal information such as where you live or your telephone number.
- Never be alone in a room with an inmate.
- 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 PROCESS

Subject Matter Experts:

SMH: Jim Murphy (275-5722)

HH: Dottie Haelen (341-8058)

For more information, go to:

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

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

Rights

The rights of patients as defined by New York State are posted in all patient care areas and in other conspicuous locations in the hospital. A copy of these rights must be given to every patient by the Admissions staff at Highland or the Nursing staff at Strong (Admission Information folder) or in the outpatient area where they are registering, including hospital-affiliated, off-site locations.

Staff should be familiar with all the items listed in the *Patients' Bill of Rights* (listed in the Mandatory In-Service *Department Resource Guide*) and use them as they apply to their particular roles in support of patient care.

Ethical Concerns:

Both the University of Rochester Medical Center-Strong Memorial Hospital and Highland Hospital have formal processes to assist with ethical dilemmas and concerns as requested by physicians, staff, patients or family. To request an informal perspective on an issue, employees at Highland can approach a member of the Ethics Committee or call 341-6718; Strong employees can contact the Ethics Consultation Service at SMH (275-5800). If the issue is in regard to patient care issues, it needs to be brought to the care team by the provider writing an order for a formal consultation. The only exception to this is if the patient and/or the family is requesting an ethics consult, in which case, the provider is notified but an order need not be written.

IT IS CRUCIAL TO REMEMBER:

- Treat the patient with respect, including the use of names and courtesy titles, such as Mr. and Ms. Before entering a patient's room, knock and identify yourself. Keep your voice down and encourage visitors to do so.
- Patients also have the right to know your name and role. Introduce yourself and explain what you do. Wear your identification badge where it can be readily seen. Provide your name and title during telephone contact.
- Patients also have the right to complain about the care and services provided. We encourage patients and their families to voice their concerns when they occur so issues can be dealt with in a timely fashion and at the point of origin.
- If you are unable to respond to a patient's complaint, if it involves another department, or if the patient is not satisfied with your response, promptly refer it to your supervisor/manager. For complaints not resolved through these initial steps, patients may request the assistance of the Patient Relations Office.
- If a patient is not satisfied by the response of the Patient Relations Office, she or he will be advised of the right to take the complaint to the Grievance Committee in the hospital, or to the New York State Department of Health and will be given the telephone number.

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

Both Highland and Strong Memorial Hospitals are committed to the improvement of health care safety and the reduction of medical and health care errors by creating cultures of safety. HH and SMH are creating cultures of safety through the following:

- Implementation of a nonpunitive medical error reporting process.
- Implementation of an automated occurrence reporting process to increase ease in reporting occurrences and near misses.
- Implementation of the Joint Commission National Patient Safety Goals/Requirements.

Examples of Patient Safety Goals:

- Improve the accuracy of patient identification
- Improve the effectiveness of communication among caregivers, including encouraging patients' active involvement in their own care as a patient safety strategy
- Improve the safety of using medications, including accurately and completely reconciling medications across the continuum of care
- Reduce the likelihood of patient harm associated with the use of anticoagulation therapy
- Improve recognition and response to changes in a patient's condition

Team Communication

Effective teamwork and communication result in patient safety. The Joint Commission has found that ineffective communication is the #1 root cause of serious patient events that are reported to them. Several of the National Patient Safety Goals and Requirements focus on improving communication; for example:

- Standardization of hand-off communications
- Medication reconciliation process
- 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.)

IT IS CRUCIAL TO REMEMBER:

1. A culture of safety needs everyone's involvement, which includes accurate and timely team communication; this would begin to reduce the #1 root cause of serious patient events.
2. All actual events and near misses should be entered in SRM so that unsafe trends can be tracked and eliminated.
3. **NEVER** use these abbreviations 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.).
4. Effective communication involves repeating back instructions or information to assure it was heard correctly, communicating with respect and listening to understand.

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/

For the complete version of 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.

Definitions

Discrimination is: any behavior (however manifested, and whether anonymous or overt) that limits, segregates or classifies an individual or group in such a way that might deprive them of the opportunity fully to function and participate as a member of the University/Highland Hospital community. Discrimination includes any behavior that might reasonably be considered unlawful discrimination under applicable NYS and/or federal law.

Harassment is: any behavior (however manifested, and whether anonymous or overt) that is intended to cause or could reasonably be expected to cause an individual or group to feel intimidated, demeaned, or abused, or fear or have concern for their personal safety. Harassment includes any behavior that might reasonably be considered unlawful harassment under applicable NYS and/or federal law

IT IS CRUCIAL TO REMEMBER:

If you feel you are being discriminated against 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.
- Contact Human Resources, the Intercessors Office, Security, or the Office of Counsel.

PROFESSIONAL MISCONDUCT REPORTING AND THE IMPAIRED PROFESSIONAL

Subject Matter Experts:

SMH: Spencer Studwell (273-4575),

HH: Sharon Johnson (341-8399)

For Complete Policy Information, Go To:

SMH: http://intranet.urmc.rochester.edu/Policy/SMHPolicies/1-7-1_000.pdf

HH: <http://intranet.highlandhospital.org/Policy/HHpolicy/3-1.pdf> and
<http://intranet.highlandhospital.org/Policy/HRpolicy/documents/HR128-SUBSTANCEABUSE.pdf>

Examples of Professional Misconduct:

- Obtaining a license fraudulently or practicing the profession while the license is suspended/inactive;
- Practicing while impaired by alcohol, drugs, or mental disability;
- Refusing to provide professional service to a person because of such person's race, creed, color, or national origin; including harassing, abusing, or intimidating a patient, either physically or verbally;
- Directly or indirectly offering, giving, soliciting or receiving or agreeing to receive, any fee or other consideration to or from a third party for the referral of a patient;
- Willfully making or filing a false report, or failing to file a report required by law, or willfully impeding or obstructing such filing, or inducing another person to do so;
- Practicing or offering to practice beyond the scope permitted by law except in an emergency situation where a person's life or health is in danger;
- Performing professional services which have not been duly authorized by the patient or his or her legal representative; including ordering of excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient

Impaired Professional

If an individual is suspected to be impaired, the person witnessing the behavior is obligated legally to notify the appropriate manager/supervisor and/or Director of Nursing and the Associate Medical Director. Possible indications of impairment include but are not limited to:

- Arguments, bizarre behavior, irritability, depression, mood swings
- Irresponsibility, poor memory, poor concentration
- Difficult to contact; won't answer phone or return calls
- Neglect of patients, incomplete charting, or neglect of other duties
- Inappropriate treatment or dangerous orders, including excessive prescription writing
- Unusually high doses or wastage noted in drug logs

IT IS CRUCIAL TO REMEMBER:

- To report misconduct concerns at the University of Rochester Medical Center-SMH contact the Office of Counsel to the Medical Center through departmental channels. If a concern involves a supervisor or departmental leader, staff should directly contact the Office of Counsel to the Medical Center at x5-8019.
- To report misconduct concerns at HH: All misconduct concerns should be reported to the Quality Management Department through departmental channels. If a concern involves a department leader, staff should directly contact the Quality Management Department at x1-8399.

SMOKE-FREE CAMPUS, INSIDE AND OUT

Subject Matter Experts:

SMH: Lorraine McTarnaghan (275-2500),

HH: Joe Coon (341-6833)

For additional information and the perimeter map, go to:

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

HH: <http://intranet.highlandhospital.org/newsEvents/SmokingCessation/index.asp>

As a provider of health care and promoter for the physical well-being of the community, smoking and the sale of smoking materials is prohibited in all areas of Highland Hospital, Strong Memorial Hospital and the Medical Center campus including Eastman Dental Center, School of Medicine and Dentistry and the School of Nursing. Smoking by faculty, staff, volunteers, students, patients and visitors is prohibited.

A smoking perimeter is established for the exterior surrounding property to each campus area. Smoking is prohibited inside the outlined perimeter including parking lots/areas. Smoking in personal vehicles within the perimeter area is not allowed, and smoking in URMCM-SMH and HH neighborhoods is also prohibited.

ALL faculty and staff are expected to achieve a smoke free campus by following the policy and informing persons smoking on the grounds of the Smoke Free policy. In addition, posted signs and information brochures (with perimeter map) are available for faculty, staff, students, patients and visitors.

If a visitor or patient fails to comply with a request to cease smoking within the perimeter, it is important to communicate to the person(s) that when they are done, they should take the remainder of their smoking material with them so others do not think it is permissible to smoke inside the perimeter.

IT IS CRUCIAL TO REMEMBER:

- Many support resources are available to assist members of the community in complying with the Smoke Free policy including smoking cessation programs and Nicotine Replacement products.
- A comprehensive nicotine replacement therapy protocol will be provided for all inpatients.
- Single-dose Nicotine Replacement products are available for purchase at various locations to assist outpatients, visitors, and staff to be more comfortable while complying with the policy at both SMH and HH.
- Faculty, staff and students should be aware they are subject to corrective action if they do not comply with the Smoking policy.

THE STRONG COMMITMENT (SMH Specific)

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.

We can honor this commitment only when every employee makes a personal commitment to the values we share, and when our words and actions are consistent with those values. We expect that you will embrace this commitment and make it central to your work life at Strong, every day.

To help in that process, an extensive collection of learning resources is available to you. Please go to the link above to access those resources. Learning is grouped according to your role and responsibilities at Strong—as a manager or a staff member—and is particularly well suited to the needs of each group. You are required to complete the Strong Commitment training program created for you.

We encourage you to take full advantage of these learning resources as we all strive to fulfill our Strong Commitment.

IT IS CRUCIAL TO REMEMBER:

Strong Commitment Means I CARE

- I**ntegrity – I will conduct myself in a fair, responsible and trustworthy manner.
- C**ompassion – I will act with empathy and understanding towards others.
- A**ccountability – I have an obligation to take responsibility for my actions and to join with my colleagues in realizing the hospital's vision.
- R**espect – I will treat patients, families and colleagues with dignity and sensitivity, valuing their differences.
- E**xcellence – I will rise above the ordinary through my personal efforts and those of my team.

WASTE MANAGEMENT

Subject Matter Experts:

SMH: Pete Castronovo (275-8405),

HH: Franklin Allen (341-0313)

Note:

Improper handling or disposal of certain types of waste could be illegal and create unsafe conditions. **Improper sharps disposal is a major concern as sharps could be misplaced onto patient food trays or into dirty linen and trash bags. Sharps *must* be immediately disposed of in approved sharps containers, without recapping the needle.**

Important Phone Numbers to Know:	SMH	Highland
General waste questions or to schedule pickups or service	Environmental Services x5-6255	Environmental Services x1-7378
Biohazardous Waste:	For technical questions or to voice concerns, call Environmental Health & Safety x5-8405.	Environmental Services x1-7378
Chemotherapeutic Waste Info.	For technical questions or to voice concerns, call Environmental Health & Safety x5-8405 or x5-9809.	Environmental Services x1-7378
Hazardous Chemical Waste (including mercury)	Hazardous Waste Management x5-2056	Support Services x1-7378
Radioactive Waste	Radiation Safety x5-3781	Radiation Safety Officer x1-6279
Recycling/ Confidential Documents	For paper, cardboard or confidential document disposal, call Environmental Services x5-6255. For used equipment, electronics, and furniture, call Facilities at x3-4567. For batteries call x5-2056	Environmental Services x1-7378

IT IS CRUCIAL TO REMEMBER:

All site-specific waste management information such as shown in the example below. See additional information in the *Department Resource Guide*.

Waste Type	Examples	Disposal Method
Chemotherapeutic Waste Chemo waste must be separated from all other types of waste.	Non-sharp 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	SMH (sharps): Yellow Chemo sharps container with CJD sticker placed over Chemo label. HH (nonsharp): Red bag labeled "CJD" placed into an autoclave bag marked "CJD."

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>

Also, Strong Commitment 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.

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

Hospital Policy:

Both the University of Rochester Medical Center-SMH and Highland 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 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.

IT IS CRUCIAL TO REMEMBER:

To help calm a potentially violent person:

1. Give your full attention to the person while maintaining a safe distance with ability for you to exit if necessary.
2. Don't be defensive; speak in a calm voice and be aware of your body language.
3. Ask for specific examples of what the person is upset about and then redefine the problem to ensure your full understanding.
4. Offer reasonable choices to diffuse the situation.

YOUR ROLE IN QUALITY / PERFORMANCE IMPROVEMENT

Subject Matter Experts:

SMH: Judy Cotterill (275-1127), **HH:** Sharon Johnson (341-8399)

Mission Statements:

Strong Memorial

To improve the well-being of patients and communities by delivering the highest quality healthcare in a safe, compassionate environment enriched by education, science and technology.

Highland Hospital

Commitment to service excellence in health care, one person at a time.

Goals:

Strong Memorial (According to Strong Leadership, these are called the U of R's Six Organizational Principles

- Quality Improvement and Safety
- Service Excellence
- Growth
- Commitment to People
- Financial Responsibility
- Emphasis of Community

Highland Hospital

- People (Human Resource Development)
- Service Excellence
- Quality Improvement
- Financial Responsibility
- Volume Growth/Market Enhancement
- System

Quality Improvement/Performance Improvement Concepts

Core principles/concepts of continuous quality improvement include:

- Identification of customer needs and expectations
- Commitment to teamwork
- Making decisions based on data
- Commitment to continuously improving processes

Quality care or service is everyone's job. We must keep the patient's or customer's needs first in our minds. Quality or performance improvement means working together, often in teams within or across departments, to improve processes and resolve issues.

.....continues.....

Model for Improvement Including PDSA

Fundamental questions:

1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What changes can we make that will result in improvement?

PDSA:

- Plan:** Plan the change
- Do:** Implement the change
- Study:** Study the results of the planned change
- Act:** Hold the gains or continuously improve

IT IS CRUCIAL TO REMEMBER:

From time to time, external surveyors, such as those from the NY State Department of Health or the Joint Commission, visit the Hospital to assess the quality of care provided. Surveyors frequently interview staff members from various departments. Each staff member must be able to:

- Tell how his or her job supports the mission of the hospital.
- Tell how he or she has been involved in departmental performance improvement/safety activities.
- Explain fire safety and emergency responses, use of universal precautions and hand hygiene, equipment and reagent/materials safety, and security of the workplace.
- Explain how the hospital's approach to implementation of National Patient Safety Goals affects care in your area and in your own daily practice. (See the topic, *Patient Safety, Team Communication, and Medical-Health Care Error Reduction.*)

Take a moment to think about these items. If you are unsure about what you would say, please discuss this with your supervisor or manager.

Topics for Faculty and
Staff With Patient Care
Responsibilities or
Who Enter a Patient Room

CONFLICT OF CARE

Subject Matter Experts:

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

Policy

The University of Rochester Medical Center–Strong and Highland hospitals recognize that on occasion, the need to provide care or treatment of a patient may be in conflict with an employee’s ethical, cultural or religious beliefs. On such an occasion, the employee may notify the nurse manager of any conflicts or potential conflicts and request not to participate in such care or treatment. However, to fulfill the hospital’s legal and ethical obligation to provide high quality care, staff must agree to provide care in any emergency circumstance; patient care cannot be abandoned.

In addition, at Highland Hospital, staff must obtain and fill out a form from HR per HH policy, to be put on file for official notification.

For additional information, see SMH Policy Manual, Policy 13.6: *Employee and Medical Staff Right to Non-Participation in Specific Health Care or Research Activities* at <http://intranet.urmc-sh.rochester.edu/policy/SMHPolicies/> or the HH Human Resources Personnel Policy Manual, Policy 341, *Conflict of Care*, that outlines HH procedures and provides a sample of the “Request to be Excused From Providing Patient Treatment/Care” form: <http://intranet.highlandhospital.org/Policy/HRpolicy/documents/HR341-CONFLICTOFCARE.pdf>.

IT IS CRUCIAL TO REMEMBER:

- An employee may choose not to assist in providing care or treatment if it is in conflict with his or her ethical, cultural or religious beliefs.
- The staff member can notify the Nurse Manager whenever there is a conflict.
- Staff **must agree** to provide care in any emergency circumstance; **patient care cannot be abandoned**.

CONTINUITY OF CARE THROUGH INTERDISCIPLINARY COMMUNICATION

Subject Matter Experts:

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

For more information, go to:

SMH policy 8.1.4 at http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/8-1-4_002.pdf

HH policy 1.16 at <http://intranet.highlandhospital.org/Policy/HHpolicy/1-16.pdf>

Strong Memorial and Highland Hospitals are components of the University of Rochester Medical Center, an integrated delivery network of care that encompasses the hospitals, the Golisano Children's Hospital at Strong, Visiting Nurse Service, School of Nursing, School of Medicine and Dentistry, Medical Faculty Group, James P. Wilmot Cancer Center, The Highlands, and Eastman Dental Center. The primary care and specialist physicians affiliated with the University of Rochester Medical Center also constitute part of our network of services.

As we provide care to patients across this continuum of care, it is important that we maintain the highest standards of patient and family involvement and satisfaction. The following is a summary of the standards that have been developed to serve as a guideline to all faculty and staff providing care to patients within each component of the network, as well as for those patients moving from one level of care to another with continuing care plans:

1. Patients and families are introduced to each member of the treatment team as service is provided. The patient is informed of the name of the physician principally responsible for their care and can easily arrange to communicate with the physician.
2. All patient/family continuity of care planning and implementation incorporates the patient's beliefs, capacities, and competencies, including decision-making with respect to their care, discharge, and continuity planning as plans are made, changed, and implemented.
3. Patient/family questions and concerns about continuity of care are addressed rapidly and effectively by healthcare team members. The purpose of each transfer of care and information about the site itself (services, providers, location, etc.) are fully explained.

IT IS CRUCIAL TO REMEMBER:

It is important that we maintain the highest standards of patient and family involvement and satisfaction; this is, in part, accomplished through clear communications across all services. Therefore:

1. Patients and families will be introduced to each member of the treatment team.
2. Patients and families will be involved in all decision-making.
3. Patient and family concerns will be addressed rapidly and effectively.

DO NOT RESUSCITATE

Subject Matter Experts:

SMH: Laura Wilson (275-7279), **HH:** Dottie Haelen (341-8058)

While in the Hospital, a patient must consent to a DNR order before it may be issued except in the following instances:

- If the attending physician and a second physician determine that the patient would suffer immediate and severe injury from a discussion; and the attending physician is able to ascertain the patient's wishes to the fullest extent possible without subjecting the patient to immediate and severe injury; and
- Consent is obtained from a surrogate (for patients without capacity as noted below); or the patient has previously consented to a DNR order, presently lacks the capacity to consent, and the order has been appropriately reviewed to confirm that the patient's medical condition has not changed.

A hospital DNR order for a hospitalized patient must be reviewed by the attending physician at least once every seven days. For ALC (alternate level of care) patients, the order must be reviewed each time the patient is examined, but no less than every 60 days. Nonhospital DNR orders must be reviewed by the attending physician each time the patient is examined, whether in the hospital or not, but no less than every 90 days, provided that the review need not occur more than once every 7 days.

Every patient is deemed to have the capacity to consent to a DNR order, unless the attending physician has determined the patient lacks capacity and a second physician selected by the Physician Chief of Service has concurred. The cause and nature of the incapacity, as well as its extent and probable duration, must be determined by personal examination and documented in the patient's chart.

A list of permissible persons to give consent to the DNR order on behalf of a patient who lacks decision-making capacity can also be found in *SMH Policy 9.3.2* or *Highland Hospital Policy Manual, Do Not Resuscitate 4.4*.

A nonhospital DNR order may be issued for a hospitalized patient to take effect after hospitalization or may be issued by a physician in his or her office for a person who is not a patient in, or a resident of, a hospital. A nonhospital DNR order can only be issued on a special DOH form. (See Medical Orders for Life-Sustaining Treatment following this section.)

When a dispute regarding DNR status arises at SMH, the attending physician must inform the Administrator-on-Call. The AOC shall refer the dispute to a designated mediator, who shall attempt to facilitate agreement among the interested persons.

At Highland, the health care team members should attempt to resolve any disputes regarding DNR status in collaboration with the patient and family. Should that effort fail, they have the option of consulting with the Ethics Committee which can be reached through the Patient Care Services Office or the Nursing Supervisor on off shifts.

Whenever a dispute is submitted for mediation, a DNR order may not be issued, or if already issued, shall be revoked until the dispute resolution process has concluded or 72 hours have elapsed, whichever is earlier. Patients or their surrogates may revoke their consent to a DNR order at any time.

For Further Information on DNR, Non-Hospital DNR, Revocation of DNR, Dispute Resolution, see:

SMH Policy 9.3.2

Highland Hospital Policy Manual, DNR 4.4

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. Multidisciplinary care is most supportive with medical providers recommending interventions and educating patients and families about actions that are available and possible consequences.

Diverse cultural needs influence what some individuals desire for end of life care. Common cultural issues to consider are language, trust, pain relief, and family decision making.

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.

Patients in end of life care will be provided the highest quality of care. Summarized below are the some of the principles that need to be followed:

- All staff will respect the dignity, privacy and confidentiality of the patient and the family throughout the process.
- Family members and significant others will be allowed to remain with the patient and participate in care if desired and consistent with the wishes of the patient, to the fullest extent.
- The patient's wishes for medical care will be ascertained and honored to the fullest extent possible.
- If the patient has not already done so, they will be offered the opportunity to designate a health care agent to make medical decisions in the event that the patient becomes unable to make his or her medical decisions.
- Patients should receive palliative measures (pain and symptom management, psychological, social and spiritual support) whether or not they choose to forgo active treatment of the disease. Regardless of the type of pain, a patient's discomfort should never be ignored or minimized.

IT IS CRUCIAL TO REMEMBER:

- Diverse cultural needs may influence what some individuals desire for end of life care; it is important to remember to consider this influence.
- A patient's discomfort should never be ignored or minimized, regardless of treatment being given.
- A health care agent may be designated to make medical decisions in the event the patient is unable to do so.
- Priorities for end of life care are to provide methods for a dignified, pain- and symptom-controlled death.

HEALTH CARE PROXY

Subject Matter Experts:

SMH: Laura Wilson (275-7279),

HH: Dottie Haelen (341-8058)

For more information on this topic, see:

SMH: <http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/documents/9-3-1.pdf>

HH: <http://intranet.highlandhospital.org/Policy/HHpolicy/4-14.pdf>

The University of Rochester Medical Center—Strong and Highland Hospitals must accept and comply with any properly authorized and executed health care proxy. The health care proxy is a form of an advance directive which appoints a health care representative/agent to make healthcare decisions when the patient is unable to make such decisions for themselves. The proxy document must identify the patient, the patient's agent, indicate that the patient intends to give health care decision-making authority to the agent, be signed and dated by the competent adult patient, and be signed by two adult witnesses who must include a statement attesting that the patient completed the proxy document willingly and free from duress.

On admission, each patient or a designee will be given a copy of the NYSDOH Proxy Law Summary Statement. If the patient has already completed a proxy document, the patient will provide a copy of the document for inclusion in his or her medical record. If the patient has not previously completed the document, she or he can be given assistance in completing the proxy.

- The proxy document may include any special instructions, limits of authority, expiration date, and may provide for the appointment of an alternate representative.
- The determination that a patient lacks capacity must be made by the attending physician and confirmed by a second physician. Special guidelines must be followed when the determination involves a psychiatric or developmentally disabled patient
- A patient may revoke his or her proxy document at any time by notifying the representative or the health care provider in writing, orally, or by any other act, even if the patient lacks capacity.
- If a nonphysician is informed of or provided with a revocation, he or she must immediately notify a physician.
- A health care proxy is not valid if completed by the patient who lacks capacity.

IT IS CRUCIAL TO REMEMBER:

- A Proxy must be signed and dated by the competent adult patient, and be signed by two adult witnesses who must include a statement attesting that the patient completed the proxy document willingly and free from duress.
- The patient should provide a copy of his or her Proxy for inclusion in his or her medical record.
- The determination that a patient lacks capacity must be made by the attending physician and confirmed by a second physician.

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/smhpolicies/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) 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) Tests or results of any HIV-related test even if negative (CD4, Elisa).

What HIV Information Is Required to be Reported to the New York State Department of Health?

New York State's HIV case name reporting and partner notification law requires that physicians and laboratories report the following results to the New York State Department of Health:

- | | |
|-------------------------------------|--------------------------------------|
| ▪ Positive HIV test results | ▪ Diagnoses of HIV-related illnesses |
| ▪ Viral Load tests | ▪ All CD4 test results (6/05) |
| ▪ Genotypic Resistance tests (6/05) | ▪ AIDS |

What Is Disclosure and When Is It Appropriate?

Disclosure is the communication of any HIV-related information to any person (other than the patient) or entity. Generally, disclosure of HIV-related information is appropriate only with a special HIV release form (NYS DOH #2557 6/05) signed by the patient with instructions as to the identity of the recipient.

Consequences of Inappropriate Disclosures - The consequences 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. In addition, fines of up to \$5,000 and a jail term of up to one year can be levied if the disclosure was intentional.

IT IS CRUCIAL TO REMEMBER:

- All HIV-related material is confidential.
- NYS HIV case name reporting and partner notification law requires that physicians and laboratories report certain results (including but not limited to positive HIV test results and all CD4 test results) to the NYSDOH.
- Inappropriate disclosure will result in education and counseling consistent with the circumstances (when unintended) but if intentional, termination and fines may occur.

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)

There is a growing trend in malpractice claims that targets “failure to use available information to aid in the process of differential diagnosis”¹ as the basis of the claim. The increase in online health information is leading to a growing number of malpractice claims alleging that diagnosis and treatment outcomes could have been improved by using accessible information.

IT IS CRUCIAL TO REMEMBER:

- It is an **INSTITUTIONAL EXPECTATION THAT PROVIDERS WILL USE THE BEST AVAILABLE EVIDENCE WHEN CARING FOR PATIENTS**. Patient care providers need to integrate information into their clinical practice and processes. They should (1) stay current with new evidence in their field, and (2) know how to find specific evidence for a particular patient.
- Patient care providers should be familiar with the content and use of resources available in Miner Library Online (<http://www.urmc.rochester.edu/miner/>) at the University of Rochester Medical Center (URMC)-SMH or Williams Health Sciences Library Online (<http://www.urmc.rochester.edu/hh/library/>) at HH. Access to electronic journals, books, drug information, evidence-based medicine resources and databases is available onsite at URMC and Highland Hospital, and at clinics on the URMC network. Except for UpToDate, they are also available remotely with a Miner Library login name and password.
- SMH and HH providers can ask librarians at Miner, Bibby, and Williams Libraries to help them find information they need for clinical care. Librarians will conduct literature searches at no charge or help providers conduct a search of their own. At URMC-SMH call 275-2487 or click on “Ask a Librarian” from the Miner Library web site. At HH call Pam White at 341-0378. At Eastman Dental Center, call Beth Kettell at Bibby Library, 275-3247.

¹ Spencer Studwell, Director, Risk Management, URMC Office of Counsel.

MEDICAL EQUIPMENT

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

For more information on this topic, please go to:

URMC-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.
- 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. Please see the *Department Resource Guide* for details.

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

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 must be called to inspect the patient-provided device. Staff must be trained on how to use the equipment.

IT IS CRUCIAL TO REMEMBER:

- All medical equipment must be in good physical condition, and if appropriate, wired with a 3-pronged chassis grounded plug.
- Staff should use only equipment they have been trained to use.
- 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.
- Use of patient-provided medical equipment should be discontinued as soon as possible after admission.

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 **Facts** will help you to better understand how to use the MOLST form. For a complete list of facts and misconceptions with full explanations, please refer to the *Department Resource Guide for Mandatory Training – 2009*.

Facts

1. The MOLST form is consistent with NYS law and approved by the NYSDOH for use at all nursing homes, hospitals, other medical facilities, at home or elsewhere in the community throughout New York state.
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.
3. For patients admitted with a MOLST form, the admitting team should confirm that it still reflects the patient's preferences, sign and date the "Review of the MOLST" section.

Misconceptions (Please refer to the *Department Resource Guide for Mandatory Training – 2009* for explanations)

1. A MOLST form must be filled out even if the patient wants full CPR and no limitations.
2. The presence of a pink MOLST form means that the patient is DNR (Do Not Resuscitate) or DNI (Do Not Intubate).
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.
4. Any provider may issue a DNR order.
5. All patients who are DNR should also be DNI.
6. The MOLST can serve as a Healthcare Proxy or Living Will document.
7. Only the supplemental MOLST forms are needed for a patient who lacks decision-making capacity.

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IT IS CRUCIAL TO REMEMBER:

- The MOLST form does not necessarily mean that the patient has chosen DNR (Do Not Resuscitate) or DNI (Do Not Intubate) status.
- 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.
- 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.
- In the absence of a MOLST form, in an emergency it is assumed that the patient wants full cardiopulmonary resuscitation unless there is clear and convincing evidence otherwise.

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)
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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

IT IS CRUCIAL TO REMEMBER:

Medication Reconciliation

Patients are at high risk for harm from adverse drug events when communication about medication is not clear. Medication reconciliation, Joint Commission National Patient Safety Goal #8, requires healthcare providers 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)** describes 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; shortness of breath, trouble breathing or fever.

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

ORGAN AND TISSUE DONATION

Subject Matter Experts:

SMH: Michele 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.

The Donor Hotline should be called in two instances:

1. The first is within two hours if the Clinical Triggers have been met regardless of diagnosis. The Clinical Triggers pertain to referring any ventilated patient with a grave prognosis and ANY of the following:
 - A severe neurologic insult or injury, including anoxic encephalopathy with a Glasgow Coma Scale Rating of less than or equal to 5
 - At least 2 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-sustaining therapies (ventilatory or pharmacological support)
 - Call before any patient is terminally extubated
2. The second instance the donor hotline should be called is within one hour in the event of an actual patient (cardiopulmonary) death.

Referrals to the Donor Hotline can be made by the unit secretary or any health care practitioner involved in the patient's care and should be documented in the patient's medical record. The referral will then be triaged to one of the following procurement agencies:

- **FLDRN** will make a preliminary determination of suitability for organ donation. Organ function and contraindications will be evaluated and FLDRN will determine how to proceed. **If and when it is appropriate to approach the family about organ donation, FLDRN coordinators conduct the consent process and offer the option of donation to families.** Health care practitioners involved in the patient's care are welcome and encouraged to be present during the consent discussion between the family and the FLDRN coordinator.
- **Rochester Eye and Tissue Bank (RE&TB)** personnel are the only "Designated Requestors" to approach families/guardians at Strong and Highland Hospitals to offer eye/tissue donation.

IT IS CRUCIAL TO REMEMBER:

- Your primary role with Organ, Eye and Tissue Donation is to ensure all deaths, imminent deaths and withdrawals of care are called to the Donor Hotline so that families may be offered the opportunity for donation.
- FLDRN and RE&TB determine what needs to happen after the referral and will contact you if necessary for more information.
- Document all referral calls in the patient's medical record.
- Do **not** ask families for consent to donate. Only procurement agency personnel are permitted to seek consent for donation.
- 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 is allowed.

PAIN MANAGEMENT

Subject Matter Experts:

SMH: Rajbala Thakur, M.D. (273- 4750), Laura A. Hogan, MS, NP (273-1154)

HH: Christine Franzese (341-0106), Barbara Schrage (341-6850)

For more information see:

SMH: <http://intranet.urmc-sh.rochester.edu/policy/smholicies/section08/8-15.PDF>

HH: <http://intranet.highlandhospital.org/Policy/nursingPolicy/GPP/documents/37-0.pdf>

Patients have the right, consistent with applicable laws, to receive timely assessment and treatment of pain, including education about how to manage their pain.

The Pain Management policies and protocols at Highland Hospital and the Pain Management Program at SMH assist providers in preventing and/or optimally managing pain in all patients, across all settings. In collaboration with patients and families, providers will work towards enhancing overall patient well-being and quality of life. The policies and protocols of the pain management program are characterized by:

- Timely pain assessments, interventions, and reassessments.
- Consistency in care delivery.
- Integration across the continuum of care (inpatient and outpatient).
- Clear documentation.

Pain may be managed through various modalities:

- Pharmacologic (oral, intravenous, transdermal or via alternative routes, analgesics)
- Interventional procedures (spinal or epidural analgesia, nerve blocks, etc.)
- Nonpharmacologic, including (1) Distraction (music, pet therapy, etc.), (2) Massage or (3) Cool or warm compresses, etc.

IT IS CRUCIAL TO REMEMBER:

1. Patients should be assessed for the presence and severity of pain at least as often as routine vital signs are performed, and more frequently following the identification of pain, treatment of pain, or after a potentially painful procedure.
2. Moderate to severe pain (above patient-specific threshold) should be further assessed by a nurse and if necessary, a mid-level provider or physician, with follow-up management as appropriate.
3. Once a treatment has been provided, a reassessment must be completed and documented in the patient's medical record.
4. Any patients that are younger than 12 years of age, cognitively impaired, unable to read or communicate in English should be assessed using the FLACC scale or other appropriate pain assessment tools.
5. A nurse must assess and verify the patient's symptoms prior to administering pain treatment.

PATIENT SELF-DETERMINATION RIGHTS

Subject Matter Experts:

SMH: Laura Wilson (275-7279), **HH:** Dottie Haelen (341-8058)

For more information, please go to:

SMH: <http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/index.asp>

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

New York State law requires that hospitals provide patients with a statement of the patient's right to make an advance directive. An advance directive is an oral or written expression, by a competent patient, of his or her preference regarding health care treatment, including a preference as to whether to continue or refuse life-sustaining treatment, in the event that he or she becomes incapacitated. The law requires that the Hospital honor legally enforceable advance directives made by competent patients. However, no patient shall be discriminated against based on whether he or she executed an advance directive.

The health care proxy is an example of an advance directive, as is a patient's consent to a Do Not Resuscitate order (see links above for more information on advance directives and DNRs).

IT IS CRUCIAL TO REMEMBER:

- Members of the health care team who are presented with a written advance directive from a patient must notify the patient's attending physician and place a copy in the patient's medical record.
- If the patient revokes the directive orally or in writing, it also must be noted in the patient's medical record and the attending physician must be notified.
- If an incapacitated patient has previously orally expressed a treatment preference, either before or during hospitalization, the attending physician must be notified of the patient's statement. If such a statement(s) is clear and convincing and was made at a time when the patient was competent, the preference expressed may be relied upon by the patient's attending physician.
- In any case where there is a question as to whether the patient's statement is clear and convincing, contact the Office of Counsel to the Medical Center at SMH (x5-2059) or the Highland Hospital Office of Quality Management (341-6768).

RADIATION SAFETY

Subject Matter Experts:

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

For more information on this topic, go to: <http://www.health.state.ny.us/healthaz/>

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 (inpatient unit for patients who have received radiation implants)▪ East 5

Other areas may use radioactivity for treatment or diagnostic testing. Each has a storage room specially built to house their radioactive supplies. Cans, boxes, or rooms containing radioactivity are always well marked. Shipments containing radioactive substances for these departments are either delivered to Radiation Safety (at SMH only) or are routed from the receiving dock directly to these departments during regular hours.

Patient Rooms

Some patients receive large doses of radiation for treatment; their rooms are posted with the radiation symbol and should not be entered unless you have had special training or are accompanied by a trained person. The sign will state when the danger has passed (for example, "Radioactive until 6:00 pm").

Risks From Minor Exposure To Radiation

There are no expected health risks from minor exposure to radiation; entering a laboratory posted with the radiation symbol, walking past a radioactive patient's room, or being near a department that uses x-rays is safe. If you have any questions about the health effects of working near radiation, you should contact Radiation Safety and speak with a staff health physicist about your questions or concerns.

IT IS CRUCIAL TO REMEMBER:

To minimize your exposure to radiation:

- **Distance** - The dose of radiation received is directly proportional to the time spent near the source, *and* the distance from the source. The person who stands close to the source is getting more radiation than the person who is 10 feet away.
- **Time** - The person who stands in the area for 30 minutes is getting more radiation than the person who is there for 5 minutes.
- **Shielding** - A lead apron is effective against some radioactive materials, but not all! For example, lead will stop 95% of the radiation from an x-ray but only 5% of the radiation from the radioactive iodine given to some patients. Review safety guidelines before using radioactive materials.

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)
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For more information, go to:

- SMH:** <http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/index.asp>
<http://intranet.urmc-sh.rochester.edu/nurses/Policy/PPManual/Section12/12-2.PDF>
- HH:** <http://intranet.highlandhospital.org/Policy/nursingPolicy/GPP/41-0.pdf>

Definition

The Joint Commission, the Center for Medicare and Medicaid Services, NYS Dept of Health, and the Office of Mental Health all have strict standards on the use of restraints including length of application, writing of orders and the assessment and care of the patient.

Restraints are any physical or mechanical device attached or adjacent to the patient's body that the patient cannot easily remove, which restricts freedom of movement, physical activity or normal access to his or her body. This definition does not include safety devices or medical protective devices. Practices that include temporary immobilization related to diagnostic procedures are not considered restraints.

The restraint standards for medical or surgical purposes apply when the primary reason for use directly supports medical healing. Behavioral health care reasons for the use of restraints are primarily to protect the patient against injury to self or others because of an emotional or behavioral disorder.

Shackles applied by Correctional Officers are not considered a restraint but a forensic restriction.

The least restrictive, and safest, most effective method of restraint should be used and only as a last resort.

Criteria for Restraint Use

Nonviolent Criteria (Medical Restraint)

1. To prevent patients from inadvertently hurting themselves or others (e.g., falling, wandering, pulling out tubes, or removing medical devices)
2. Inadvertently hurting others (e.g., confused, delirious, anxious) by hitting, kicking, scratching

Violent Criteria (Psychiatric/Behavioral Health)

1. Intentionally hurting self (e.g., cutting, scratching, suicidal behavior)
2. Intentionally hurting others (e.g., aggression, threat of assault, assault)

Restraints are always tied in a quick-release knot to the moveable part of the bed frame (does not include side rails). Never tie restraints to side rails, toilets, or commodes.

Ordering Restraints

In the event of an emergency in which the patient poses a threat to himself or another, a registered nurse may initiate the use of restraints. A **face-to-face assessment and order** must be completed within **one hour** by a Physician, Nurse Practitioner or Physician Assistant. (For Behavioral Health orders physician assessment is required.) Orders for 2-point restraints are good for 24 hours; orders for 4-point restraints are good for 8 hours. When restraints are necessary past these time frames, order renewals with a face-to-face assessment by the Physician, Nurse Practitioner, or Physician's Assistant are needed.

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IT IS CRUCIAL TO REMEMBER:

- Use the safest, least restrictive restraint methods, remembering that restraints must be **released every 2 hours** and can be reapplied with a new order as necessary.
- Restraints are always tied in a **quick-release knot** to the moveable part of the bed frame (does not include side rails). Never tie restraints to side rails, toilets or commodes.
- A **face-to-face assessment and order** must be completed within **one hour** by a Physician, Nurse Practitioner or Physician Assistant when restraints have been initiated.
- Avoid restraining in the supine and prone positions.

Highland- Specific Topics

**(For URMC-Strong
Faculty and Staff Who
Also Work at Highland)**

ABDUCTION OF NEWBORN (Highland Specific)

Subject Matter Expert:

HH: Joe Coon (341-6833)

IT IS CRUCIAL TO REMEMBER:

If an abduction occurs:

1. The telephone operator will activate the emergency tone three times and announce “Code A, All Buildings” three times over the hospital paging system.
2. Upon hearing announcement of “Code A, All Buildings,” all hospital employees will remain in their respective work areas until an “ALL CLEAR” is announced. All employees will check their respective work units or departments for the following:
 - Any suspicious persons
 - Any persons with small infants
 - Any persons carrying large packages

If any of these situations are observed, the employee calls 1-6666 and requests the telephone operator to page security “STAT” to their area.

3. Departments located on ground levels near exits will assign an individual to secure the exits in their vicinity to maintain security and prevent abduction.

This individual will be responsible to remain at this exit door and request anyone leaving to remain until interviewed by Highland Security or the Rochester Police Department. At no time should the employee jeopardize his or her safety. If threatened, allow the person to leave, getting a good description and watching their direction of travel.

4. No information will be given to the public regarding the incident. All inquiries shall be directed to the Public Relations Department or administrator-on-call.

Reference: *Abduction of Newborn Policy in Environment of Care Manual, Safety Management.*

CODE OF ORGANIZATIONAL AND BUSINESS ETHICS (HH Specific)

Subject Matter Expert:

HH: Sharon Johnson (341-8399)

IT IS CRUCIAL TO REMEMBER:

It is the responsibility of every member of the Highland Hospital organization to act in a manner that is consistent with the Code of Organizational and Business Ethics.

Principle 1 – Respect for Patients

We will provide health care without regard to race, creed, color, gender, sexual orientation, national origin, age or ability to pay, and respect each patient's unique background, culture, beliefs and needs. We respect the patient's right to participate in ethical questions that arise in the course of care.

Principle 2 – Relief of Suffering

Curing disease, reducing suffering and achieving an acceptable quality of life as defined by the patient are central goals of our institution.

Principle 3 – Communication with Patients

It is our responsibility to offer support and assistance by providing patients and their families with the timely information about outcomes of care, both expected and unexpected, they need to make sound decisions.

Principle 4 – Confidentiality of Patient Information

Patient information is confidential and should not be disclosed without the patient's consent, except as provided by law.

Principle 5 – Patient Access to Health Care

Registration, admission, transfer and discharge of patients are based on the patient's condition and personal preferences, without regard to their ability to pay.

Principle 6 – Interdisciplinary Relations

We affirm the need to demonstrate mutual respect and to acknowledge our interdependence as coworkers from diverse specialties and professional backgrounds responsible for the welfare of patients.

Principle 7 – Recognition of Potential Conflicts of Interest

It is our policy to request the disclosure of potential conflicts of interest so that appropriate action may be taken to ensure that such conflict does not inappropriately influence important decisions.

Principle 8 – Marketing and Fair Billing Practices

Highland and its medical staff will invoice patients or third parties only for services actually provided to patients and will provide assistance to patients seeking to understand the cost relative to their care.

Principle 9 – Collaborative Relationships

Highland works collaboratively with other health care providers and payers in providing quality and cost-effective patient care.

EMERGENCY PAGE CODES (HH Specific)

Subject Matter Expert:

HH: Joe Coon (341-6833)

For full information on Highland codes, go to <http://intranet.highlandhospital.org/HHCodes.pdf>

The hospital overhead paging system is used to alert staff to a variety of emergencies or situations that occur. It is the responsibility of all staff to minimize the effect to patients and visitors when emergencies occur. Some of the more common codes are:

EMERGENCY	PHONE #	PAGE CODE
Investigation of a fire/smoke alarm	X1-6666	1-2-3 Red (location)
Confirmed incident: fire, flood, etc.	X1-6666	1-2-3 Red (location)
Patient and/or visitor is posing a safety threat and immediate assistance is needed.	X1-6666	Security STAT (location)
Incident involving hostages and/or weapons	X1-6666	Code Silver
Cardiac or respiratory arrest	X1-6666	Blue 100 (location)
Pediatric cardiac or respiratory arrest	X1-6666	Pediatric Blue 100 (location)
Medical Assistance	X1-6666	MERT (location)
Infant Abduction	X1-6666	Code A All Buildings
Neonatal Cardiopulmonary Arrest	X1-6666	Baby Blue 100 (location)
External/internal disaster	X1-6666	HIMS Alert
Stroke Evaluation by the Stroke Team	X1-6666	Code 15 Response
Imminent birth outside of the Family Maternity Unit	X1-6666	Code OB (location)
Rapid Response Team	X1-6932	(Not an Overhead Page)

FORENSICS (Highland Specific)

Subject Matter Expert:

HH: Joe Coon (341-6833)

PHILOSOPHY: Custodial patients will receive the same level of care as other patients.

General Rules (for safety purposes):

1. Custodial patients' (CP) names shall *not* be recorded on the patient room or locator.
2. *ANY* phone inquiries are to be referred to the Custodial Officer, also known as Forensic Staff. Highland staff are not to release information to callers; the Custodial Officer will ask for a one-time arrangement if the CP is allowed to receive a call.
3. The Custodial Officer must maintain visual contact of the Custodial Patient at all times.
4. Handcuffs and leg cuffs are used at the discretion of the Custodial Officer. Any clinical issues with the hand or leg cuffs need to be resolved with the Custodial Officer/Agency and/or referred to your manager.
5. The Custodial Officer should never be asked to assist in patient care activities or transport of the CP.
6. The Custodial Patient is *never* told the time or date of discharge or of any treatments or exams that may be cause for leaving the room.
7. *All* equipment and supplies not in use are to be removed from the room.
8. *All* mail is to be given to the Officer, *not the Custodial Patient*.
9. *No visitors are permitted* unless the Custodial Officer has approved.
10. *Do not* give any Custodial Patient your address or phone number. *Personal contact* is prohibited. *Do not* buy gifts for the Custodial Patient.
11. Custodial Officers will wait in the Custodial Patient's room for instruction from the charge nurse in the event of an emergency.
12. Forensic Staff members will receive a copy of the policy, *Forensic Staff Orientation/Management of Patients from Custodial Agencies*, found in the *Highland Policy Manual*, which includes the chain of command and emergency codes from the Security Department in inpatient areas or satellite staff in outpatient areas.
13. Security will always be the first resource to answer questions on nonclinical issues.

Refer to Highland policy, *Forensic Staff Orientation/Management of Patients from Custodial Agencies*, found in the Highland Policy Manual for more specifics.

HIGHLAND PROMISE STANDARDS AND PERFORMANCE BEHAVIORS (HH Specific)

Subject Matter Expert:

HH: Kathleen Gallucci (341-0118)

Highland's Mission/Vision/Values

Mission:

Commitment to service excellence in health care, one person at a time.

Vision:

We will deliver Medicine of the Highest Order in a community hospital where compassion and quality health care are our guiding principles. Our affiliation with a world-class medical center will allow us to provide the best of both worlds—state-of-the-art medicine and personalized patient care.

Values:

- Integrity, Compassion, Accountability, Respect and Excellence.

All employees are responsible for the delivery of care and services that reflect the Highland Promise and are consistent with the following Highland Promise Standards and Highland Promise Performance Behaviors.

IT IS CRUCIAL TO REMEMBER:

Promise Standards

- We will present ourselves in a positive, professional manner.
- We will be respectful of each other and our patients.
- We will provide a safe and clean environment.
- We will provide excellent service.
- We will work as a team.

Performance Behaviors

- Always wear neat and proper attire, name identification, and be confident; say hello, make eye contact and smile; identify yourself and give your purpose when appropriate.
- Look forward and acknowledge others when walking in the halls.
- Keep conversation clean, quiet, and positive.
- Greet fellow employee by name, remembering to welcome new employees; say please and thank you.
- Knock before entering a room; acknowledge others in the room and offer privacy options.
- Wait for the next elevator when the current elevator is occupied by a patient; always allow people to exit the elevator before stepping on.
- Keep areas clear of clutter and unnecessary congestion.
- Provide escort; open and close doors and offer, “Is there anything else I can do for you?”
- No blaming or excuses; just resolve issues promptly.

SECURITY AND SAFETY MANAGEMENT PROGRAMS AT HIGHLAND

Subject Matter Expert:

HH: Joe Coon (341-6833)

Security Management Program

The general security concerns regarding patients, visitors, personnel and property are addressed and maintained through frequent and in-depth foot and vehicle patrols by Security personnel.

Appropriate identification of all patients, visitors, and staff is achieved through wristbands for patients, name tags for employees, and visitor passes issued to visitors as deemed necessary.

Access control of both the hospital buildings and sensitive areas within the hospital from 8:00 p.m. to 6:00 a.m. is monitored through the Emergency Department post. During these hours, all visitors entering must register and be cleared by the particular area that they want to visit. Before Security personnel allow access to a sensitive area (Pharmacy, Emergency, Family Maternity Center, or Cashier's Office), the person must be identified and authorized to gain access to such areas.

Safety Management Program

Accident prevention and the provision of efficient, effective patient service go hand in hand. Employees at all levels have a primary responsibility for the safety of all patients, visitors, and members of the hospital staff. This responsibility can be met by working together continuously to promote safe work practices, observing all rules and regulations, and consistently maintaining property and equipment in a safe working condition. For these reasons, the hospital has established a safety management program and encourages the participation of all personnel.

IT IS CRUCIAL TO REMEMBER:

- Appropriate ID is required for all employees, patients, and visitors.
- Access to the building between 8:00 pm and 6:00 am is only through the Emergency Department post.
- Sensitive areas of the building are designated as Pharmacy, Emergency, Family Maternity Center, and Cashier's Office
- Our Safety Management Program and Safety Committee are established to continually perform, monitor and improve various processes which may impact employee, visitor, and patient safety.
- To contact HH Security in an emergency, dial 1-6666.