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UR
MEDICINE

HIGHLAND
HOSPITAL

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HIGHLAND HOSPITAL
**MANDATORY
IN-SERVICE
EDUCATION
MANUAL**

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2016 Mandatory In-Service Education Manual

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Preface

2016 Mandatory In-Service Education Program for Highland Hospital Staff & Community Providers

This program is:

1. **Required** of all staff and associated health care providers of the Highland Hospital.
2. **Mandated** by Highland Hospital policies and/or national, state and Joint Commission regulations.

It is recommended that participants read the manual first, but people may choose to take the required competency test without reading the topics; however, topics do change from year to year.

The compliance test is separated into sections for participants to complete based on their job role; some participants may need to complete multiple sections. Anyone uncertain of their role should consult their department chief, program administrator, or supervisor/manager to assist them.

Regardless of which sections of the test are required based on the individual's job role, **participants must pass each required section with a score of 100%:**

Manual Sections*

General Topics for Everyone, Regardless of Duties/Position* (combined information for HH & SMH; you may skip the SMH-specific topics if you do not ever go to SMH)

Faculty , Staff, and Physicians With Patient Care Responsibilities*

Faculty , Staff, & Physicians Who Work at Highland (information for HH only; if you work at Highland, you must review this section)

Providers Only (Nurse Practitioners, Physician Assistants, Physicians With Patient Care Responsibilities)

* Please review the topics in the section of the Manual for Faculty/Staff/Physicians With Patient Care Responsibilities to identify if this pertains to your role or ask the supervisor/manager of your department to clarify.

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Documentation of Compliance

1. Staff member documentation of compliance

Give the completed competency quiz to your manager/supervisor or designee to correct and retain in the department file. A passing score of 100% must be obtained for each required section; remediation of incorrect responses must be done and documented on the competency quiz.

2. Community physician documentation of compliance

Complete the training questionnaire found at this link: (also provided in the email notification you received for this training requirement.) Instructions for submission of your completed questionnaire answer sheet can also be found on this website.

Questions?

Procedures	Karen Scott 585-341-6805
Topic Content	Subject Matter Expert(s) listed at top of topic

Thank you to all who have contributed to developing the University of Rochester Medical Center and Highland Hospital 2016 Mandatory In-Service Education Program!

Section 1:

GENERAL TOPICS

FOR

EVERYONE REGARDLESS

OF DUTIES/POSITION

ACTIVE SHOOTER EMERGENCY RECOMMENDATIONS

Subject Matter Experts:

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

Recommendations During an Active Shooter Event

- If you find yourself involved in an Active Shooter situation, try to remain calm and use these guidelines to help you plan a strategy for survival.
- Remember, do not wait to be told what to do if an active shooter is in your area.
- Decisions made (or not) and actions taken (or not) will have a direct impact on your survival.

Run, Hide, Fight

Run	Hide	Fight
<ul style="list-style-type: none">• Escape if you can• Encourage others to follow• Prevent others from entering the area• Leave your belongings behind• Call 911 or UR Public Safety/HH Security as soon as you are safe• Keep your hands empty and visible when approaching law enforcement	<ul style="list-style-type: none">• Hide in an area out of the shooter's view• Lock/block the doors• Remain quiet and silence all electronic devices• Stay away from windows and doors	<ul style="list-style-type: none">• If no other option and your life is in danger, FIGHT• Act with aggression and attempt to incapacitate the shooter(s)• Use improvised weapons and throw objects at the shooter(s)• Your life depends on it so commit yourself to your actions

When notifying 911/UR Public Safety or HH Security

Call:

911

SMH: x13 or 275-3333

HH: x1-6666

Provide:

- Location of the suspect(s)
- Injuries
- Number and descriptions of shooter(s)
- Type of weapon used
- Safest route for responding law enforcement
- If using a cell phone try to stay on the line as long as possible

...continues...

ACTIVE SHOOTER EMERGENCY RECOMMENDATIONS (continued)

For More Information

URMC/SMH:

<http://intranet.urmc-sh.rochester.edu/Policy/EmergPrepManual/1/1-19.pdf>

HH:

Violent Incident Plan Policy 2.14.1

<http://intranet.urmc-sh.rochester.edu/Highland/Policy/EmergencyPrep/>

AMBER ALERT

Subject Matter Experts:

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

- All admitted infants and children while receiving care at the 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. 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.

If you are in the area where the abduction occurred:

- Immediately contact the UR Department of Public Safety (UR DPS) at extension 13 or HH Security at 1-6666, and request an **AMBER Alert**.
- Give the location, age of infant/child/adolescent, description of infant/child/adolescent and of the abductor, if known. Remain on the phone with UR DPS or HH Security until all necessary information is communicated.
- Page you will hear:
 - SMH:** AMBER Alert (age/location)
 - HH:** AMBER Alert (all buildings)

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 (separate if possible).
- All departments in the facility should monitor exits for which they are responsible

Staff in an area other than the site of the abduction:

- **SMH:** report suspicious activity or persons to UR DPS at x13 and direct persons attempting to exit with a child, package, or appearing to be pregnant to the exits that UR DPS will be monitoring:
 - Main Lobby—First floor Med. Ctr. Parking Garage Link
 - Ground floor—Med. Ctr. Parking Garage Link, Patient Discharge, Children's Tower-First Floor entrance at Upper Loop, Cancer Center- Entrance at Upper Loop, and G-5000 near the Clinical Research Center

...continues...

AMBER ALERT (continued)

- **HH:** Individuals will be assigned to secure ground-level exits in their vicinity, and to request anyone leaving to remain there until interviewed by HH Security or the Rochester Police Department.

At no time should an employee jeopardize his or her own security!

- If threatened, allow the person to leave, get a good description, watch their direction of travel, and contact UR DPS/HH Security.

For more information:

SMH: Policy [2.8](#)

Policy [3.3](#) Protection and Monitoring of Minor Inpatients

HH: [Abduction of Newborn Policy](#) in *Environment of Care Manual, Safety Management*

It is important to remember:

- Report suspicious activity or persons to UR DPS at x-13 or HH Security at x1-6666.
- Monitor the nearest perimeter door in your area until the "AMBER Alert, 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 UR DPS at x-13 or HH Security at x1-6666 with a description of that person and their direction of travel.
- No information should be given to the press regarding the incident.

BLOODBORNE PATHOGENS STANDARD 29 CFR 1910.1030

Subject Matter Experts:

- SMH:** Anne Schmidlin (275-9809), Laura Caruso (275-3622)
HH: Vivian Condello (341-8017)
-

- Every needle stick or other exposure to blood or body fluids involves potential risk of HIV, Hepatitis C, or Hepatitis B infection.
- Follow Standard Precautions: treat the blood and body fluids of ALL persons as if they contain bloodborne pathogens.

Prevent Exposures:

- Use safety sharps and activate safety devices **immediately** after use.
 - Examples: use needleless blood transfer kits (NOT 18g needles), activate the push button while in the vein when using the butterfly needle
 - Practice engaging safety cap with one-handed technique
- Practice safe work practices; for example, use the “safe zone” in the OR, always know how to operate a safety device **before** you use it!
- Dispose of all sharps in hard-plastic sharps containers
 - Sharps include needles, lancets, scalpel blades, surgical staples/wires, broken/contaminated glass, slides or any other item likely to puncture a bag
- Replace sharps containers before they are $\frac{3}{4}$ full. To request a more frequent pick-up schedule, call Environmental Services:
 - **URMC** call 275-6255
 - **HH** call 341-7378
- Never leave sharps on tables, procedure trays or the floor for someone else to pick up.
- Never discard sharps in the trash.
- Wear Personal Protective Equipment
 - Gloves, gowns, goggles/face shields
 - 20% of blood exposures are splashes. Prevent splashes of blood or body fluids to the mucous membranes by wearing splash protection.

If you are exposed to blood or body fluids, follow the WASH, CALL, REPORT protocol:

- WASH or irrigate the exposed area immediately;
- CALL
 - **URMC:** the Blood Exposure Hotline at 275-1164 ASAP
 - **HH:** Employee Health at 341-8017, or off shift, call 341-6263 or page the Nursing Supervisor at 51616, enter pager number. Follow the BBF exposure protocol on the Employee Health website .Post-exposure evaluation and follow-up including testing, counseling, and potential treatment will be offered.

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BLOODBORNE PATHOGENS STANDARD 29 CFR 1910.1030 (continued)

- REPORT the incident online at:
 - URM: www.safety.rochester.edu/SMH115.html
 - HH: <http://intranet.urmc-sh.rochester.edu/Highland/Depts/HR/HHIncidentReport/>

It is important to remember:

- Every needle stick or other exposure to blood or body fluids involves potential risk of HIV, Hepatitis C, or Hepatitis B infection.
- Activate safety devices immediately after use
- Wear eye protection; 20% of blood exposures are splashes
- Dispose of **all** sharps in hard-plastic sharps containers

CARE OF PATIENT PERSONAL BELONGINGS AND VALUABLES

Subject Matter Experts:

SMH: Joan Romano (275-5418) **HH:** Amy Eisenhauer (341-0677)

Strong Memorial Hospital and Highland Hospital do not assume responsibility for any personal belongings or valuables kept with the patient or in the patient's room.

- Patients are encouraged to leave at home valuables such as jewelry, watches, clothing, money, credit cards, medications brought to the hospital, electronic devices, cell phones, computers, etc., or to have them sent home upon admission. If this is not possible, the valuables are inventoried and deposited in the Cashier's Office for safekeeping
- Items that remain with the patient are the responsibility of the patient.
- Patients are informed that the hospital will not assume responsibility for items not deposited at the Cashier's Office or for personal belongings that are kept in patient rooms. Items remaining with the patient are the responsibility of the patient.
- Using the electronic or transfer forms, unit staff members are responsible for logging on and off the unit glasses, hearing aids, dentures or prosthetics which accompany the patient during a transfer.

Deceased patient belongings

- Deceased patient belongings and valuables should be given to the family.
- If any personal belongings remain, at:
 - **SMH**, they will be inventoried by unit staff and sent to the Cashier's Office for safekeeping and final disposition.
 - **HH**, they will be inventoried by unit staff and sent to the Security Office for safekeeping and final disposition. If valuables such as money, credit cards, or jewelry remain, they will be inventoried and sent to the Cashier's Office.

Patients should let staff know if they have dentures, glasses and/or hearing aids.

- If these items are not needed, patients are strongly encouraged to leave/send them home.
- If these items are necessary, they need to be properly secured during the patient's stay.
 - Dentures should be stored in a denture cup supplied by the hospital and labeled with the patient's name.
 - Glasses and hearing aids should be stored in the cases supplied when purchased and labeled with the patient's name.
- Patients should be informed not to place any of these items on a meal tray, on the bed, unprotected on the bedside table, or in any concealed place where they may be lost or accidentally thrown out.

.....continues.....

It is important to remember:

- Encourage patients to leave valuables at home, or to have them sent home upon admission.
- Items that remain with the patient are the responsibility of the patient.
- Patients should let staff know if they have dentures, glasses and/or hearing aids. If these items are not needed, patients are strongly encouraged to leave/send them home. If these items are necessary, they need to be properly secured during the patient's stay.
- Dentures should be stored in a denture cup supplied by the hospital and labeled with the patient's name.
- Glasses and hearing aids should be stored in the cases supplied when purchased and labeled with the patient's name.
- Patients should be informed not to place any of these items on a meal tray, on the bed, unprotected on the bedside table, or in any concealed place where they may be lost or accidentally thrown out.
- Patients should be informed that neither Strong Memorial Hospital nor Highland Hospital will assume responsibility for any personal belongings kept with the patient or in the patient's room.
- Patients are given a copy of the hospital booklet, *Admission Information*, which states this policy.
- If the patient is deceased, staff should give belongings and valuables to the family.
 - At SMH if any personal belongings remain with the deceased, they are inventoried by unit staff and sent to the Cashier's Office for safekeeping and final disposition.
 - At HH if any personal belongings remain, they will be inventoried by unit staff and sent to the Security Office for safekeeping and final disposition. If valuables such as money, credit cards, and jewelry remain, they are inventoried and sent to the Cashier's Office.

CODE of ORGANIZATIONAL AND BUSINESS ETHICS (SMH Specific)

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

The mission statement and 12 principles of the Code of Organizational and Business Ethics are displayed in the admissions offices of Strong Memorial Hospital and are printed in Orientation literature for all employees.

The 12 principles of the Code of Ethics are as follows:

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.

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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 are 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.

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.

- **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.

- **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, payers 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.

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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.

Principle 12 – Marketing Practices

- Marketing practices for medical services carry a unique responsibility that require 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.

COMPLIANCE: EVERYONE'S RESPONSIBILITY

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

University of Rochester Medical Center (URMC) policy requires all employees and affiliated professional staff to fully comply 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

- Supports employees, clinical 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 clinical 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.

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:

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

It is important 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)

Definition

A disaster occurs when events:

- Overload the capacity and/or ability of the ED or Hospital units to care for the injured or ill, causing significant disruption to normal Hospital operations.
- Cause other community agencies to request support from URM-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 result in 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 will confer with the Administrator-on-Call (AOC) and then notify the Page Office at URM-Strong Hospital or Telecommunications at Highland Hospital.
2. The Page Operator will notify hospital staff by means of the overhead page and pagers.
3. Pre-identified staff will be notified via a call service and 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:
 - URM-Strong: the Ambulatory Care Center conference room A&B or as determined by the AOC
 - Highland: the Gleason Room or as determined by the senior administrator

How to Prepare for a Disaster Response

- To be prepared for any disaster affecting URM-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.
- Independent Licensed Practitioners (ILPs) who do not have a specific assignment in the Emergency Preparedness Plan, please review the following link for your role in an emergency response and where to report in an emergency.

SMH: <https://intranet-secure.urmc.rochester.edu/Policy/EmergPrepManual/4/4-20.pdf>

HH: <http://intranet.urmc-sh.rochester.edu/Highland/Policy/EmergencyPrep/>

.....continues.....

DISASTER PREPAREDNESS (continued)

It is important 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 appropriate.
- 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.
- When a disaster has been declared you cannot leave work until approved by your supervisor.
- Have a personal emergency preparedness plan. For additional information, go to www.safety.rochester.edu/ep/pdf/URprepared.pdf

DIVERSITY AND INCLUSION

Subject Matter Experts:

SMH: Stanley Byrd (275-0425)

HH: Kathleen Gallucci (341-0118)

Philosophy

At the University of Rochester and Highland Hospital 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.

Dimensions of Diversity

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	Physical or mental abilities
Race	Culture
Ethnicity	Sexual orientation
Gender	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

- 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.

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DIVERSITY AND INCLUSION (continued)

It is important 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: Jerry Brower (273-2194), Arnie Spezzano (273-3683)

HH: John Griffiths (341-0120)

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

• URMC-SMH

- 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

- Defined as electrical equipment that is not directly related or involved in patient care.
- All non-patient care equipment used in the hospital must be in good physical condition, have been wired with a chassis ground 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.

Plugs and Receptacles

- Plug caps should fit securely in receptacle outlets.
- Grasp the plug cap and pull it out of the outlet. Never pull the cord.
- Do not reset a ground fault indicator outlet with an item plugged in.
- In the event of a major power outage, an independent power source will be activated.
- Highland-Specific Electrical Safety
 - Adapters must be approved by Clinical Engineering.


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ELECTRICAL SAFETY (continued)

Receptacle Identification

The following table describes the location of receptacles on emergency and nonemergency power.

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

Receptacles on emergency power (generators) ONLY PATIENT CARE RELATED EQUIPMENT SHOULD BE PLUGGED INTO THESE RECEPTACLES	At Highland
	Red 
Receptacles NOT on emergency power (normal house power)	Ivory, Brown, White, Grey, and Orange

Cords/Grounds

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

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ELECTRICAL SAFETY (continued)

- Do not use extension cords or “cheaters” (used to connect 3-pronged plugs to 2-pronged)
 - Exception: the exception to using extension cords is during a Code Team at SMH
- Do not plug additional plug strips into an existing plug strip.

Shock Avoidance

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

Report malfunctioning patient care equipment:

Clinical Engineering

- URMCM-SMH x5-5501
- HH x1-7378

Report malfunctioning non-patient care equipment

Facilities Customer Service Operations

- URMCM-SMH x3-4567
- HH x1-7378

It is important 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 URMCM-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 Code Team at URMCM-Strong.
- Do not plug additional plug strips into an existing plug strip.

EMERGENCY PAGE CODES

Subject Matter Experts:

SMH: Lorraine McTarnaghan (275-2500), Erik Olsen (275-2170),
Mary Pat Callahan (275-0291)

HH: Joe Coon (341-6894), Harry Aunkst (341- 0859)

Common Codes

Emergency	Page Code
Investigation of a fire/smoke	Fire Alert (location)
Confirmed fire, flood, etc.	Fire Alert Confirmed (location)
Patient and/or visitor posing a safety threat and immediate assistance is needed.	Assistance Needed STAT (location)
Incident involving hostages and/or weapons	Critical Security Incident (location)

SMH Phone #
X-13

HH Phone #
X-16666

Emergency	Page Code
Cardiac or respiratory arrest	Code Team (location)
Pediatric cardiac or respiratory arrest	Pediatric Code Team (location)

SMH Phone #
x5-STAT
x5-7828

HH Phone #
x-1-6666

Emergency	Page Code
Medical assistance	MERT Response (location)
Abduction of infant, child, adolescent	Amber Alert (SMH: age, location; HH: all buildings)
External/internal disaster	Command Center Activated
Utility Failure	Utility Alert (location, type of utility affected)

SMH Phone #
x-13

**External/Internal
Disaster:**
x5-STAT
Disaster Emerg. Ops. Ctr.
x5-0500

HH Phone #
x-1-6666

EMERGENCY PAGE CODES (continued)

It is important to remember:

SMH

Inpatient:

- 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 Code Team, call a *specific location*.” Call means “go-to” location.

Non-inpatient:

- Non-inpatient or nonlife-threatening medical emergencies, facility and personal safety emergencies are placed by contacting the UR Department of Public Safety (UR DPS) Communication Center at x13.
- Non-inpatient or nonlife-threatening medical emergencies, facility and personal safety emergencies are executed using 3 overhead page tones, followed by an announcement indicating code/type and location of the emergency.

All pages other than STAT or inpatient medical emergency pages may be executed using Web paging (use the link to the main intranet page) or by calling 275-2222.

HH

- For all emergencies except Rapid Response Team, call x1-6666; pages use 2 overhead tones.
- Rapid Response Team: not an overhead page; call x1-6932

SMH/HH:

- When a facility or personal safety emergency has been resolved, a follow-up overhead page will indicate the event is “all clear.”

FALSE CLAIMS PREVENTION (FALSE CLAIMS ACTS)

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

These policies cover employees' responsibilities and rights in assisting their employer in complying with all legal and regulatory requirements:

- Policy 114, Compliance Education, in the University of Rochester Personnel Policy Procedure Manual at www.rochester.edu/working/hr/policies/pdfpolicies/114.pdf
- Policy 133, Compliance, in the Highland Hospital Human Resources Policy Manual <http://intranet.urmc-sh.rochester.edu/highland/Policy/HRpolicy/documents/HR133-Compliance.pdf>

The Federal False Claims Act

This 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
Taking or giving a kickback for a referral	

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

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

It is important 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.

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FALSE CLAIMS PREVENTION (continued)

- 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
 - 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 Claims 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)

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 UR Department of Public Safety (UR DPS)/HH Security for further direction.

Staff discovering a firearm or weapon

- Do not touch the weapon
- Notify UR DPS/HH Security immediately for appropriate action.

It is important to remember:

- Firearms and other dangerous weapons are not permitted at any URMC-Strong, Highland Hospital site, or University premise except as required by law.
- Staff discovering a firearm or weapon should not touch the weapon.
- Notify UR DPS/HH Security 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: Harry Aunkst (341- 0859)

For more information:

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

HH: <http://intranet.urmc-sh.rochester.edu/highland/Policy/envCare> (Section 1)

Fire Prevention

- Fire prevention should be paramount in everyone's mind.
- Our number-one life safety finding is improper storage of materials in the corridor or stairwells.
- The number-two finding is blocked life safety equipment because of this storage.
- Be aware of excessive use of extension cords, faulty electrical devices or frayed electrical cords; these can easily start a fire.
- Be on the alert for conditions that may lead to rapid fire spread or hinder safe evacuation.
 - Obstructed corridors
 - Openings in walls and ceilings
 - Propped open or blocked fire doors
 - Blocked extinguishers, pull stations, or gas shut-off valves

Interim Life Safety Measures (ILSM)

- Life safety features (for example, a fire alarm system) are put into place to protect individuals working in the building.
- When the hospital is unable to maintain a life safety feature due to construction, maintenance, renovations, or the device/system fails, an *Interim* Life Safety Measure (ILSM) must be implemented. For example:
 - If the fire alarm system was malfunctioning, the hospital would be required to take other measures to ensure the safety of the occupants
 - In that instance, a fire watch could be established where employees would be physically patrolling the area for signs of smoke or fire

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 flashback
- 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.

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When Pages or Alarms Sound

Fire Alert/Alarm	Fire Alert (location) and Fire Alert Confirmed (location)
In area of the fire	Follow RACE (Rescue, Alarm, Contain, Extinguish/Evacuate)
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 the vicinity of the fire alert. c. Stay where you are unless job responsibilities require a specific response. d. When the "All Clear" page sounds, resume normal activities.

It is important to remember RACE:

Rescue anyone in immediate danger, 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 URMC-SMH or 1-6666 at Highland; state your name, the nature of problem and the location.

Confine the 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.

It is important to remember Evacuation Guidelines:

- If fire conditions seem to be worsening, evacuation should be assessed.
- Guidelines for determining evacuation are as follows:
 - Fire has spread to the structure such as walls or ceiling.
 - Several items of furnishings are involved in the fire.
 - Smoke appears to be spreading unchecked from the room of origin.
 - Orders are received from a person listed as qualified to call an evacuation.
- 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.

It is important to remember 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

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Types of Fire Extinguishers



Dry Chemical:

- Works by eliminating oxygen.
- Works on Class A and B fires (combustibles and flammable liquids)
- Most widely used type and is also recognized as a multi-purpose ABC fire extinguisher.



Carbon Dioxide:

- Works by separating oxygen and heat.
- Works on Class B or C fires. (oil/gasoline/fuel and electrical fires)



Pressurized Water:

- Works by cooling fire and coating the fuel.
- Works on Class A fires (wood, paper, trash, plastics, etc.)



Water Mist

- Works by taking away the heat element of the fire tetrahedron. Alternative to the clean agent extinguishers where contamination is a concern.
- Effective for Class A fires, although they are safe for use on Class C fires as well.



Wet Chemical:

- Works by forming a soapy foam blanket over the burning material and cooling it below its ignition temperature.
- Designed for commercial or restaurant-type kitchens.

HAND HYGIENE---SIMPLE, BUT EFFECTIVE

Subject Matter Expert:

SMH and HH: Ann Marie Pettis (275-5056 / 341-6853)

Hand Hygiene

- Frequent and thorough hand hygiene is the single most effective thing we can do to protect our patients, ourselves, and our loved ones from infection.
- Although the action of hand hygiene is simple, the lack of compliance on the part of the health care worker (HCW) continues to be a problem in the United States and around the world.
- The Joint Commission requires each organization to select and fully implement either the World Health Organization (WHO) or the Centers for Disease Control (CDC) hand hygiene guidelines.
- URMC has chosen to follow the WHO's hand hygiene guidelines which are based on "My Five Moments of Hand Hygiene."

"My Five Moments of Hand Hygiene"



Hand Hygiene Methods

- Either waterless, alcohol-based hand rub (ABHR) or soap and water at a sink can be used when performing hand hygiene.
- However, both WHO and CDC say that the use of alcohol-based hand rub (ABHR) should be the primary method health care workers (HCWs) use to sanitize their hands with the following exceptions:
 - After using the restroom
 - Before eating
 - When hands are visibly soiled

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HAND HYGIENE---SIMPLE, BUT EFFECTIVE (continued)

- Recommended amount of time for adequate hand hygiene is 15-20 seconds (the amount of time it takes to sing “Happy Birthday” twice).
- Remember that friction is most important, and we must not short-cut the process.
- During cold weather the integrity of our skin can become compromised with frequent hand hygiene. Use hospital-approved hand lotion. Unapproved lotion is not allowed.

Patient Hand Hygiene

As important as it is for HCWs to use proper hand hygiene to protect our patients from healthcare-associated infections (HAIs), it may be equally important that patients themselves use frequent hand hygiene as well.

- Hand sanitizer pads are provided on all meal trays, and small bottles of hand rub are available to distribute to patients, if appropriate from a safety standpoint.
- Reminding patients to clean their hands before eating and after using the restroom or a bedpan is a necessity.

It is important to remember:

- Frequent and thorough hand hygiene is the single most effective thing we can do to protect our patients, ourselves, and our loved ones from infection.
- Sanitize your hands:
 - Before touching a patient
 - Before clean/aseptic procedures
 - After body fluid exposure/risk
 - After touching a patient and contact with the patient’s environment
- The amount of time for adequate hand hygiene is 15-20 seconds (singing “Happy Birthday” twice).
- Waterless ABHR or soap and water at a sink can be used for hand hygiene, but the primary method health care workers should use for hand hygiene is ABHR.
- The exceptions for use of ABHR are after using the restroom, before eating, or when hands are visibly soiled.
- Remind patients to use frequent hand hygiene as well, especially before eating and after using the restroom or a bedpan.
- Be sure the patient and/or their family see you perform hand hygiene.

HAZARD COMMUNICATION STANDARD

OSHA STANDARD 29 CFR 1910.1200

Subject Matter Experts:

SMH: John Coniglio (273-3409), Katherine Root (275-3241)

HH: Joe Coon (341-6833)

The Hazard Communication Standard was revised in 2012 to align with the United Nations Globally Harmonized System of Chemical Classification and Labeling (GHS).

Purpose:

To ensure the hazards of all chemicals are evaluated and information concerning their hazards is transmitted to employers and employees. This transmission of information is accomplished by container labeling, safety data sheets, and employee training.

Employee Training

Area-specific employee training is provided by **Supervisors** who:

- Conduct **hazard assessments** to identify hazards and appropriate personal protective equipment and other necessary control measures.
- Review information on chemical labels and in Safety Data Sheets (SDSs).
- **Train employees** on the hazards of the chemicals used in the work area and how to prevent exposure through inhalation, skin contact, ingestion or injection.

Direct questions to:

SMH: Occupational Safety Unit of Environmental Health and Safety at 275-3241 or look on the EHS website: www.safety.rochester.edu.

HH: Call the Highland Safety Officer at x1-7378.

What is a Hazardous Chemical?

Any chemical classified as a:

- Health hazard
- Physical hazard
- Hazard not otherwise classified: a recognized hazard that does not meet the specific criteria of the above categories

Health Hazard Categories:

- Acute toxicity
- Corrosive or irritating to skin
- Serious damage/irritation to eyes
- Respiratory or skin sensitization
- Germ cell mutagen
- Carcinogen
- Reproductive toxicity
- Target organ toxicity
- Aspiration hazard

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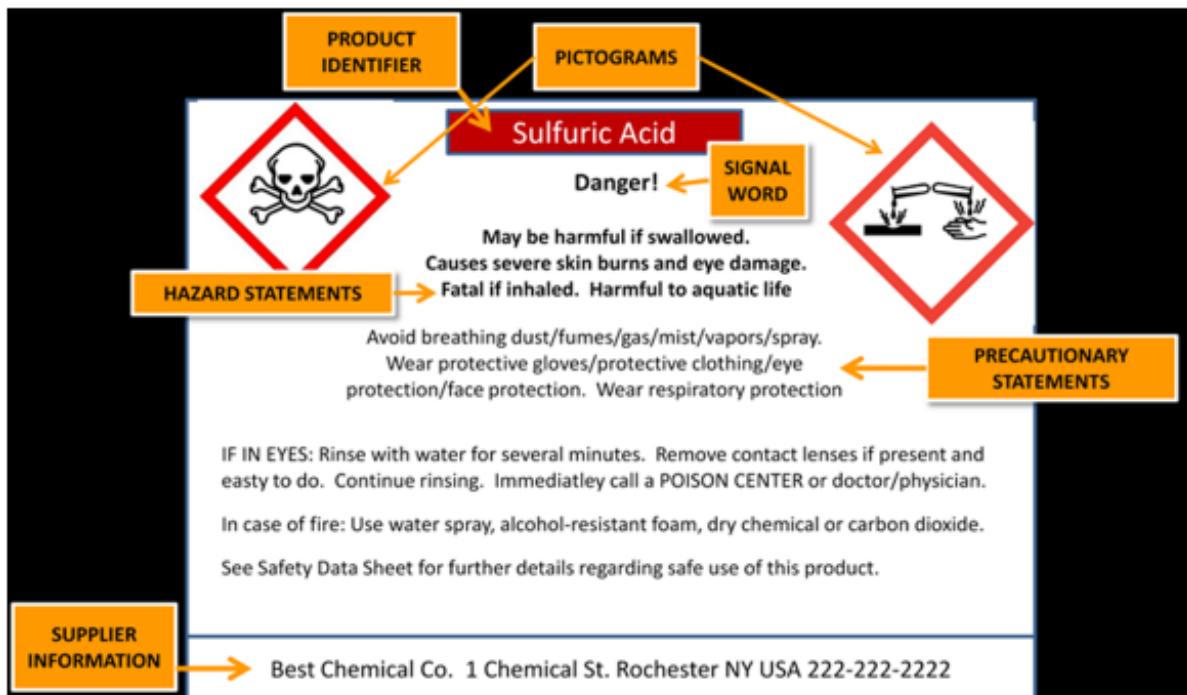
HAZARD COMMUNICATION STANDARD (continued)

Physical Hazard Categories:

- Explosives
- Flammable gases, liquids, solids and aerosols
- Oxidizing gases, liquids and solids
- Gases under pressure
- Self-reactive
- Pyrophoric liquids or solids
- Self-heating
- Contact with water emits flammable gas
- Organic peroxide
- Corrosive to metal

Labels:



- **Required on ALL chemical containers**, except those under the continuous control of the user, and for immediate use.
- Must be legible and maintained. Do not deface or remove manufacturers' labels.
- The 2012 update to the Hazard Communication Standard (HCS) requires six label elements:



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HAZARD COMMUNICATION STANDARD (continued)

- HCS Label Pictograms and Hazards

<p>Health Hazard</p>  <ul style="list-style-type: none"> • Carcinogen • Mutagenicity • Reproductive Toxicity • Respiratory Sensitizer • Target Organ Toxicity • Aspiration Toxicity 	<p>Flame</p>  <ul style="list-style-type: none"> • Flammables • Pyrophorics • Self-Heating • Emits Flammable Gas • Self Reactives • Organic Peroxides 	<p>Exclamation Mark</p>  <ul style="list-style-type: none"> • Irritant (skin and eye) • Skin Sensitizer • Acute Toxicity (harmful) • Narcotic Effects • Respiratory Tract Irritant • Hazardous to Ozone Layer (Non-Mandatory)
<p>Gas Cylinder</p>  <ul style="list-style-type: none"> • Gases under pressure 	<p>Corrosion</p>  <ul style="list-style-type: none"> • Skin Corrosion/ Burns • Eye Damage • Corrosive to Metals 	<p>Exploding Bomb</p>  <ul style="list-style-type: none"> • Explosives • Self-Reactives • Organic Peroxides
<p>Flame Over Circle</p>  <ul style="list-style-type: none"> • Oxidizers 	<p>Environment (Non-Mandatory)</p>  <ul style="list-style-type: none"> • Aquatic Toxicity 	<p>Skull and Crossbones</p>  <ul style="list-style-type: none"> • Acute Toxicity (fatal or toxic)

Safety Data Sheets (SDS) and Chemical Inventories:

- Safety Data Sheets (SDS) provide a summary of health, safety and environmental information for hazardous chemicals.
- Departments must maintain ready access to Safety Data Sheets for all hazardous chemicals used in their areas.
- Departments must also maintain an inventory of chemicals used within their area, which can be kept as an index of the department's Safety Data Sheets.
- Copies of Safety Data Sheets (SDS) for chemicals are available to all employees upon their request and:

SMH: online at <http://www.safety.rochester.edu/restricted/msds.html>

HH: in each department or in the Support Services Office, x1-7378

2012 Revision: the Safety Data Sheets

- Safety Data Sheets (formerly known as MSDSs, Material Safety Data Sheets), are now required to conform to a standard format.
- All SDSs are comprised of 16 sections, in the same order, with the same titles. Assists users in becoming familiar with where to look for the information they need.

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Globally Harmonized Safety Data Sheets

*Note: Since other Agencies regulate this information, OSHA will not be enforcing Sections 12 through 15[29 CFR 1910.1200(g) (2)].

The 16 SDS sections are:

1. Identification	2. Hazard (s) identification	3. Composition/information on ingredients	4. First-aid measures
5. Fire-fighting measures	6. Accidental release measures	7. Handling and storage	8. Exposure controls/personal protection
9. Physical and chemical properties	10. Stability and reactivity	11. Toxicological information	12. Ecological information
13. Disposal considerations	14. Transport information	15. Regulatory information	16. Other information

It is important to remember:

- Transmission of critical information about chemicals is accomplished by reading labels and Safety Data Sheets (SDS) and through employee training.
- Hazardous chemicals are chemicals that have been classified as health hazards or physical hazards.
- The updated Hazard Communication Standard of 2012 requires **all** chemical labels contain 6 elements:

Product Identifier	Signal Words	Hazard Statements
Pictograms	Precautionary Statements	Chemical manufacturer contact information

- Pictograms facilitate communication globally by reducing language barriers. You need to recognize and understand the 9 Hazard Communication Standard Pictograms.
- Safety Data Sheets (formerly MSDSs) will now follow the same format according to the updated standard. Every SDS will have the same 16 sections, in the same order, and with the same titles.
- 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.
- Small spills can be cleaned by personnel who are aware of the hazards of the spilled material. The proper personal protective equipment must be used.
- For large chemical spills, or if sufficiently trained personnel are not available, immediately leave the area and call the Department of Public Safety at x13 at SMH or Security at x1-6666 at Highland Hospital if the spill is on-site. If off-site, call 9-1-1. An employee should remain at a safe distance and keep others out of the area until emergency personnel can arrive.

HIPAA PRIVACY and SECURITY, and CONFIDENTIALITY of INFORMATION

Subject Matter Experts:

Privacy: SMH: Patricia Keane (275-7059) **HH:** Janet Taylor (341-6467)
Security: SMH: James Purvis (758-0922) **HH:** Jeffrey DeToro (341-0403)

URMC HIPAA website link that contains the HIPAA Policy Manual, *HIPAA Highlights* & other training materials: <http://intranet.urmc-sh.rochester.edu/policy/HIPAA/index.asp>

The Health Insurance Portability and Accountability Act (HIPAA)

- 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.

PHI and Incoming/Outgoing Employees

- When an employee is joining or departing the organization, it is essential to properly manage all issues related to PHI.
- Incoming employees must be notified about their responsibilities related to PHI they may have had in their previous position and which they may wish to bring their new position.
- All PHI that is created or maintained is the property of Highland Hospital and may not be copied, removed, shared, or released without permission of the institution or as required by law.
- Consideration should be given to departing employees to determine whether there is any risk in the particular situation that could compromise the protection of PHI.
- Departing practitioners are not permitted to take any patient information, including patient lists, when they depart.
- When appropriate, letters or written communication to patients concerning the departure will be sent by the department.

It is important to remember:

- You have an ethical and legal responsibility to protect 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) Integriity 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 PHI. You are not permitted to access PHI of any patient who 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. MyChart is available to patients to access their health information or give proxy access to someone else for MyChart only.

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HIPAA PRIVACY & SECURITY, AND CONFIDENTIALITY OF INFORMATION (continued)

- Your password is your electronic signature. You must never share your password with anyone, for any reason, ever. Each user is responsible for all information accessed or entered under his or her user ID/password. Do not leave your computer session unlocked or unattended.
- Do not open e-mail attachments you were not expecting. Do not click on links in e-mail messages you were not expecting. Do not access Web sites that are not work-related or not well-known brands. Taking these actions may lead to your system becoming infected with malware.
- You should consider more secure alternatives (on servers, use of Virtual Private Network, etc.) before storing any PHI on a portable device such as a laptop computer or USB/jump drive or on media such as CDs or DVDs. If you must store PHI on a portable device or media, it must be encrypted.

HIV/AIDS CONFIDENTIALITY REQUIREMENTS

Subject Matter Experts:

SMH: Donna Galloway (275-7728) **HH:** Steven Fine, MD (279-4600 or 423-2879)

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:

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

What HIV Information Must 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 (initial determinations, diagnosis or monitoring of HIV infection)	Diagnoses of HIV-related illnesses
Viral Load tests	All CD4 test results (unless for monitoring other diseases)
Genotypic Resistance tests	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 to another health care provider to care for the patient) or entity.
- Generally, disclosure of HIV-related information is appropriate only with a special HIV release form (NYS DOH #2557 at www.health.state.ny.us/forms/doh-2557.pdf or OCA Official Form 960) 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.

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HIV/AIDS CONFIDENTIALITY REQUIREMENTS (continued)

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

	SMH		Highland	
Disclosure of HIV-Related Info.	Office of Counsel to the Medical Center (during regular business hours)	758-7606	Health Information Management Department	341-6766
	Health Information Management Department, Release of Information section	275-2605	HH Privacy Officer	341-6467
	SMH Privacy Officer	275-7059		
Identification of HIV-Related Info.	SMH AIDS Center	275-0526	Infection Preventionist	341-0288

It is important 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 NYS DOH.
- Inappropriate disclosure will result in education and counseling consistent with the circumstances (when unintended) but if intentional, termination and fines may occur.

INFECTION PREVENTION

(including updates on OSHA Bloodborne Pathogen Standards and Tuberculosis)

Subject Matter Expert:

SMH and HH: Ann Marie Pettis (SMH: 275-5056 and HH: 341-6853)

General Infection Prevention Practices Safeguard Both Patients and Personnel.

- Infections are transmitted by several different routes. The specific route of transmission is dependent on the germ involved.
- Infection Prevention policies and isolation precautions are designed to interrupt transmission.

Standard Precautions

- A prevention strategy which applies to all patients.
- There are additional enhanced or “transmission-based” precaution categories which apply only to patients with particular diseases.
- When in effect, these enhanced precautions:
 - Must be followed by all personnel as well as family and visitors even if they do not plan on coming in contact with the patient’s environment.
 - Are clearly specified on isolation signs located outside the patient’s room and documented in the patient’s medical record.

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 caused by bloodborne pathogens, especially the viruses which cause AIDS (HIV), hepatitis B, and hepatitis C.
- These policies are found in a document 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 Occupational & Environmental Medicine at 275-1164.
- 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 341-8017, or off-shift notify the Nursing Supervisor
- Complete an Employee Incident Report Form.

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It is important 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 potentially infectious. Standard Precautions apply to all patients.
- Do not recap needles. Many needle sticks occur during the process of recapping needles. Exceptions: recapping of needles is unavoidable in some situations. A one-handed technique is used for safe recapping of the needle when necessary.
- If you experience skin exposure to blood or body fluids, cleanse skin with soap and water.
 - For a needle stick, cut, or exposure through broken skin, wash the 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.
 - Report any exposure as soon as possible using the appropriate form for your organization and notify your supervisor/manager.
- All staff should be vaccinated against influenza every year.
- Annual fit testing is required for staff who wear N95 masks for respiratory protection.
- An annual Tuberculin Skin Test (TST/PPD) is required for all staff.
- A private room with negative pressure and a closed door are used to prevent the transmission of TB.

For more information:

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

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

HH: <http://intranet.urmc-sh.rochester.edu/highland/policy/infectioncontrol/>

INFLUENZA—WHAT YOU SHOULD KNOW

Subject Matter Expert SMH and HH: Ann Marie Pettis (SMH: 275-5056 and HH: 341-6853)

For More Information:

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

HH: <http://intranet.urmc-sh.rochester.edu/Highland/Policy/EmergencyPrep/>
(See Section 2, “Pandemic Influenza Plan”)

Both locations:

[URMC FLU SOURCE](#) (You must be on the URMCC network to access this content.)

Types of Flu

- Seasonal Flu
 - Influenza or “flu” is a respiratory infection caused by influenza virus 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 chronic illness.
- Pandemic Flu
 - Caused by a new strain of influenza A virus that causes a global (or pandemic) outbreak of serious illness which may be accompanied by high rates of death.
 - Because there is little natural immunity, the disease can spread easily from person to person.
 - The influenza A virus which caused the 2009 pandemic affected a preponderance of young and healthy individuals. Pregnancy was also a risk factor for more severe disease.

How the Flu Is Spread

Flu can be spread from person to person by:

- Droplets released into the air when a person with flu coughs or sneezes within 3 - 6 feet of another person.
- Occasionally by aerosols of tiny virus particles that can travel longer than 3-6 feet from the coughing person and then are inhaled (e.g., across a room or down a corridor).
- Touching surfaces such as a doorknob or telephone contaminated with respiratory secretions from a person with flu, and then touching your eyes, nose or mouth.

It is important to remember:

- The best way to prevent flu is to receive flu vaccine prior to the flu season.
- Stay home if you are sick:
 - Fever (temperature of 37.8 C or 100 F or greater), cough, sore throat, diarrhea, nausea/vomiting, body aches and headache.

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INFLUENZA—WHAT YOU SHOULD KNOW (continued)

- Cover your cough.
 - Always cover your nose and mouth with a tissue when you cough or sneeze and dispose of the tissue
 - Use your upper sleeve (not hands) to cover your cough if tissue is not available.
- Hand hygiene
 - Always use alcohol-based hand rub (ABHR) or wash hands before and after touching any patient or their environment.
 - Use hand hygiene frequently during the course of the day and avoid touching your face.
- Always wear a mask when you are within 3–6 feet of patients with symptoms.
 - Surgical masks are used during typical seasonal flu.
 - N-95 masks are recommended during aerosol-generating procedures such as intubation or extubation, bronchoscopy, or open suctioning.
- Health care workers who have not received flu vaccine must wear a surgical mask whenever they come within 6 feet of a patient. This requirement goes into effect when the NYS Health Commissioner determines that flu is widespread.

INTERACTIONS BETWEEN URM/HH and INDUSTRY

Subject Matter Experts:

URMC/SMH : Robert Panzer, MD (273-4438) HH: Bilal Ahmed, MD (341-6770)

For More Information:

URMC:

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

HH:

http://intranet.urmc-sh.rochester.edu/Highland/Policy/HHpolicy/documents/2.71_11_000.pdf

Interactions Between URM/HH & Industry

- The University of Rochester Medical Center (URMC) and affiliates, including Highland Hospital (HH), have numerous interactions with the various Industries and their representatives. These interactions are mostly positive and benefit URM/HH and their patients, promoting in various ways all of our missions.
- While beneficial in many instances, some interactions with industry can create conflicts of interest when industry promotes use of a product that may not be in the best clinical or financial interest for URM/HH and their patients.
- Hospital policy states URM/HH faculty, staff, and students may not accept gifts (including meals) from industry or its representatives.
- While the policy does not prohibit use of medication samples, educational grants, or industry support of public conferences and continuing education events, some restrictions are imposed to ensure they are free from potential for bias.
- Site access by sales and marketing reps can only occur by appointment in both patient care and non-patient care areas.
- The policy also contains information on disclosure of relationships with industry.

It is important to remember:

- Gifts and compensation, including meals, from industry or its representatives should not be accepted.
- Sales and marketing representative visits can occur only by appointment in both patient care and non-patient care areas.
- The policy also contains information on:
 - Scholarships and educational funds for students and trainees
 - Support for educational and other professional activities
 - Disclosure of relationships with industry

INTERPRETER SERVICES

Subject Matter Experts:

SMH: Elizabeth Ballard (276-5972)

HH: Michael Sullivan (341-6718)

For more information:

- Spoken Languages Other Than English
SMH: <http://intranet.urmc-sh.rochester.edu/policy/smhpolicies/section11/11-5-1.PDF>
HH: <http://intranet.urmc-sh.rochester.edu/Highland/Policy/HHpolicy/3-16-1.pdf>
- Interpreters for Deaf or Hard of Hearing
SMH: <http://intranet.urmc-sh.rochester.edu/policy/smhpolicies/section11/11-5-2.PDF>
HH: <http://intranet.urmc-sh.rochester.edu/Highland/Policy/HHpolicy/3-16.pdf>
- Telecommunication Services for the Deaf and Hard-of-Hearing
SMH: <http://intranet.urmc-sh.rochester.edu/policy/smhpolicies/section11/11-6.PDF>

Interpreter Services

- Must be available for all Limited English Proficient (LEP) and Deaf patients and their families.
- NYS Health Code requires interpreter services must be available within 20 mins. for non-ED patients, 10 minutes for ED patients.
- Contact the appropriate interpreter service as soon as you know an interpreter is needed; not all interpreters are on-site at all hours.
- Hospital policy requires the use of only hospital-designated interpreters.
- Always offer an interpreter if you think it is needed.
- Document in patient's record: offer, response, use if interpreter accepted.
- Spoken languages other than English, use CyraCom International language service (blue phones). Directions for use are in all clinical areas or contact unit's Nurse Manager.
- Sign Language or non-English speaking persons: interpreters available 24 hours; for nonemergency cases, arrange 1 hour before MD rounds (SMH) or 24 hours before (HH).

Contacts

SMH: Go to <http://intranet.urmc-sh.rochester.edu/depts/caremanagement/CCCM/interp.asp> for contact and process information.

Assistive Devices: call Communications Center at 275-2222

HH:

Sign Language: Days, call Social Work, 341-6718
Evenings (after 4 pm), call Nursing Supervisor

Foreign Language: Days, call Social Work, 341-6718
Evenings, nights, call Nursing Supervisor

Assistive Devices: call Telecommunications Operator at extension 0

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INTERPRETER SERVICES (continued)

Using an Interpreter

- Stand next to the interpreter, look directly at patient so he/she can see your facial expressions.
- Speak in first person, not “tell him or her.....”
- Interpreters will convey everything that is said; do not say anything you do not want the patient to know until you leave the room.
- Do not assume hard of hearing or deaf patients using Sign Language with “good speech” can lip read and fully understand the conversation; offer the use of a SL interpreter.

It is important 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); look and speak directly to the patient.
- If a patient uses Sign Language as their primary mode of communication, be sure to offer interpreter services; don't assume they can lip-read and fully understand the conversation.
- Interpreters will convey everything that is said; do not say anything you do not want the patient to know until you leave the room.
- Do not assume hard of hearing or deaf patients using Sign Language with “good speech” can lip read and fully understand the conversation; offer the use of a SL interpreter.

JOINT COMMISSION READINESS

Subject Matter Experts:

SMH: Ann Peterson Ottman (276-6065)

HH: Sharon Johnson (341-8399)

For more information, go to:

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

HH: <http://intranet.urmc-sh.rochester.edu/highland/depts/Quality/Joint-Commission/>

What is the Joint Commission?

- The Joint Commission, is an agency that evaluates how well healthcare organizations provide safe and high quality patient care.
- Joint Commission reviewers periodically visit our facilities to observe how we provide care and to ensure we are meeting the Joint Commission standards. They also survey on behalf of the Centers for Medicare and Medicaid Services (CMS). We are currently eligible for a visit.
- Visits, called surveys, are unannounced so we need to be ready at all times.

Be Ready for a Joint Commission Visit:

- Wear your ID Badge, and at SMH the white badge card with the emergency page codes, at all times.
- Be able to discuss how your role supports quality and safe patient care. Be familiar with the National Patient Safety Goals and how you are compliant with them.
- Know the mission and vision of the organization.
- Know where to find information on the intranet—e.g., policy and procedure manuals, clinical practice guidelines, safety alerts.
- Be sure you understand a surveyor's question before answering.
- 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."

Reporting Care and Safety Concerns:

- Staff are encouraged to report concerns about care and safety through their management structure or at:
 - SMH:** call the Medical Director's Hotline (3-CARE).
 - Highland:** call Administration or Quality Management (341-8423).
- If a staff member is still not satisfied, they may report their concern to the Joint Commission at 1-800-994-6610 or via e-mail at complaint@jointcommission.org.
- Patients/families are encouraged to participate actively in their care and report any safety or quality concerns to their caregivers or to the Patient and Family Relations Coordinator.

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JOINT COMMISSION READINESS (continued)

- Families may also initiate a Rapid Response if they have concerns regarding the changing condition of the patient.
- If a patient is still not satisfied, they may report their concern to the Joint Commission at 1-800-994-6610 or via e-mail at complaint@jointcommission.org.

LIFTING AND TRANSFERS: POSTURE AND BODY MECHANICS

Subject Matter Experts:

SMH: Kathleen Owens (341-9000) **HH:** James Tempest (341-8280)

For More Information: References/Useful Websites

http://my.clevelandclinic.org/health/ns_overview/hic_Posture_for_a_Healthy_Back (Healthy Back Info)

www.spineuniverse.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

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 your back. If possible, elbows should rest on armrests, shoulders should be relaxed, and feet should rest flat on the floor or a footrest.
 - 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 properly used.
 - Decreases abnormal wearing of joint surfaces.
 - Decreases stress on the ligaments holding the joints of the spine together.
 - Prevents the spine from becoming fixed in abnormal positions.
 - Prevents backache and muscular pain.
 - Decreases the probability of back injuries during lifting or heavy exertion.
3. What is the result of poor posture?
 - Muscles are in weakened positions
 - Increased potential for injury
 - Pain, discomfort

General Lifting Guidelines

1. Keep the three curves of your spine in line—especially your lumbar curve. Try not to twist.
2. Bend at the hips, knees and ankles—not the spine.
3. Use leg muscles. Leg muscles are bigger and stronger than back muscles.
4. Feet should be shoulder-width apart with the load positioned at midline.
5. 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.

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LIFTING AND TRANSFERS: (POSTURE & BODY MECHANICS (continued))

6. Ask for help before you need it. Perform a two-person or team lift when possible to help prevent injury.
7. Use assistive technology to save your back (for example, transfer belts, Hoyer lift, hover mat, plastic sheeting, slide boards).

General Transfer Guidelines

1. Determine the patient's needs.
2. Prepare the patient; explain what you are doing, how they can help.
3. Set up equipment to be used.
4. To save your back, use assistive technology such as transfer belts (available through Hospital Stores at SMH and on nursing units at HH), Hoyer lift, hover mat, plastic sheeting and slide boards.
5. Prepare the environment: room free of clutter, lights on, floor dry, minimize distractions.
6. Prepare everyone involved in the transfer. Ask for help before you need it. The patient and all assistants need to know how and when the transfer will occur; ask the patient to help.
7. Perform the transfer.

It is important to remember:

- Ask for help before you need it
- Perform a two-person or team lift when possible to prevent injury
- Use assistive technology to save your back
- Good posture prevents muscular pain, decreases injury and stress on joints

MEAL PERIODS AND REST BREAKS

Subject Matter Experts: **SMH:** Christopher Walsh (758-2032)

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.urmc-sh.rochester.edu/Highland/Depts/HR/documents/HR178-LUNCH-RESTPERIODS_001.pdf

Meal Periods

1. 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. The payroll system automatically deducts the 30 minutes.
2. An additional paid meal period of at least 20 minutes must be provided between 5:00 p.m. and 7:00 p.m. if the employee begins work before 11:00 a.m. and continues working past 7:00 p.m.
3. The employee must be free to leave the work area, although can be required to stay on University/Highland property.
4. The employee must be completely relieved of all duties and not be interrupted.
5. If interrupted, every effort must be made to provide another 30-minute, uninterrupted meal period during the shift.
6. In the rare instance that a full, uninterrupted meal period cannot be provided in the shift, for hourly employees the 30 minutes **must be paid** following appropriate department procedures for missed or interrupted meal periods.
7. Scheduling of meal periods will occur at times convenient to department operations.
8. If the employee feels he or she is not being paid in accordance with policy, the employee should contact a supervisor or Human Resources.

Rest Breaks

University/HH policy provides that, where operationally possible, employees working continuously for 3.5 to 4 hours are given a paid rest period (of 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.

MINIMUM STANDARDS FOR PROGRAMS FOR MINORS AND CHILDREN (SMH Specific)

Subject Matter Expert: Stanley Byrd, Ed. D. (275-0425)

For more information: <http://www.rochester.edu/counsel/documents/MinorsPrograms.pdf>

Covered Programs Definition

Programs that accept transfer of responsibility for supervision and control of minors and children from parents or guardians to the University, such as:

- Activities, workshops, laboratories and events that serve children, whether for academic, athletic, recreational or other purposes.
- Programs that are held on or off University premises (all properties owned, leased or controlled by the University).
- Programs held off University premises if the University is a sponsor or participant.

Uncovered Programs Definition

Do Not Include:

- Any University undergraduate or graduate academic programs in which students enrolled at the University (or another institution of higher learning) are the only minors participating.
- University events such as fairs, festivals or other events that are open to people of all age groups in which children may participate.
- Events at which children are accompanied at all times by a parent or guardian.

Program Approval

- All programs for minors must be evaluated and approved by the division (or the division's delegated department or subdivision) hosting the program (using an authorized University Program Administrator).
- The Program Administrator must ensure the program is designed in compliance with the University's minimum standards for Programs for Minors *before* approval.

Program Registration Process

All programs for minors:

- Must be registered with the University by filing a registration form with the Office of Counsel's Risk Management Department.
- Should be completed by the University employee who is responsible for program oversight.
- Shall include a description of the program and the Program Administrator's signature.
- Shall include contact information for the Program Sponsor.

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Participant Registration Process

All program participants in the Programs for Minors must be:

- Registered and have provided necessary information required by the policy *before* the activity or event begins.
- On a list of registered participants that includes his or her name, gender, age, phone number, parent or legal guardian, and emergency contact information.

Employee Background Checks

All adult employees* who have direct, regular and frequent contact with minors while performing their job or assigned role in the Program for Minors are required to have a background check on record (within the last three years) that will include a minimum of:

- Checking relevant applicable sexual offense registries
- Checking felony conviction records
- Completing a self-disclosure form of past criminal convictions

*The term “employee” applies to all employees of the University including staff, faculty, medical and nursing students, student employees, and volunteers.

Procedure

1. Staff members should first read and review the complete Minimum Standards for Programs for Minors and Children at:
<http://www.rochester.edu/counsel/documents/MinorsPrograms.pdf>
2. Direct any unanswered questions to their manager or supervisor.
3. Managers/supervisors should review the Minimum Standards and refer any unanswered questions to the Department Administrator and/or HR Business Partner.
4. For still unanswered questions, the Administrator or HR Business Partner should contact Mary Goldenberg in the Risk Management Department for assistance.

OBTAINING UR DEPT. OF PUBLIC SAFETY (UR DPS) OR HH SECURITY SERVICES

Subject Matter Experts:

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

For more information:

SMH:

<http://intranet.urmc-sh.rochester.edu/policy/smhpolices/documents/2.6ObtainingSecurityAssistance.pdf>

HH:

<http://intranet.urmc-sh.rochester.edu/highland/Policy/envCare/#2>

Obtaining UR DPS or HH Security Services

1. Incidents involving personal safety of students, volunteers, patients, employees and visitors should be immediately reported to UR Department of Public Safety (UR DPS) or HH Security, regardless of the facility you are in.
2. **UR DPS and Highland Hospital Security can be contacted 24 hours a day, 7 days a week.**
3. Other reportable 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

It is important to remember:

To Contact UR DPS or Highland Hospital Security:

	SMH	Highland
Emergencies	x13 from inside UR or any Blue Light Emergency Phone (BLEP)	x1-6666
Non-emergencies	x5-3333 (from inside UR) Any Blue Light Emergency Phone (BLEP) 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 more information:

SMH: Event (Occurrence) Reporting – Patients and Visitors – 9.1

<http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/documents/9.1IncidentReports-PatientsandVisitors.pdf>

Reporting of Actual and Potential Medical Events – 9.1.1

<http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/section09/9-1-1.pdf>

HH: Event (Occurrence) Reporting

<http://intranet.urmc-sh.rochester.edu/highland/Policy/HHpolicy/3-14.pdf>

Reporting of Actual and Potential Medical Errors and Events

<http://intranet.urmc-sh.rochester.edu/highland/Policy/HHpolicy/3-23.pdf>

Occurrence/Claim Reporting

- 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.
- Reportable occurrences include accidents as well as situations that *could* have resulted in an occurrence (near misses).
- A timely, thorough occurrence report must be entered into the security/risk management event reporting system (SRM/RL Solutions) for all occurrences.
- You may need to notify your immediate supervisor or others who may be relevant in the investigation.

SMH Internal Occurrence/Claim Reporting

- Report any patient or visitor-related occurrence or near miss that is not consistent with routine operation of the hospital or routine care of the patient by entering the event in the online reporting system SRM/RL Solutions.
- All cases involving injury must be entered into SRM/RL Solutions no later than the end of the shift during which the occurrence happened or was first discovered.
- Serious occurrences meeting NYS Reporting or Joint Commission criteria must be reported by telephone immediately to the Risk Management Department at SMH or Quality Management at Highland, with a follow-up report in the SRM system.
- If a clinically significant event occurs, document that in the patient's medical record, but do not reference that a separate occurrence report has been completed.

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HH Internal Occurrence/Claim Reporting

- Any member of the health care team aware of an occurrence, or a condition that may result in an occurrence, should promptly report it to the person in charge of the area.
- Enter the following in 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 misses (situations that could have resulted in an occurrence)
 - See the Highland Occurrence Reporting Policy for a more specific list of all required, reportable events.
 - Immediately report serious occurrences to the HH Quality Management Department (341-8399) or the Nursing Supervisor (off-hours).

NYPORTS External Reporting Requirements

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

- Consult with the appropriate coordinating office shown below **before** making an external report.
 - UPMC/SMH: Office of Counsel
 - Highland: Quality Management Department.
- Two types of reports may be sent to the DOH:
 - Short Form
 - Root Cause Analysis

Short Form NYPORTS External Report

These reports track and trend certain minor occurrences.

- Report by:
 - Entering into SRM
 - or
 - Calling your SMH department’s Quality Assurance Rep or your HH Quality Management Department.
- *SMH Office of Counsel or HH Quality Management Department will coordinate reporting to DOH NYPORTS.*

Root Cause Analysis (RCA) NYPORTS External Report

- Do not delay reporting in SRM/RL Solutions or to the UPMC Office of Counsel or Highland Quality Management Department incidents requiring RCA reports while conducting your own investigation. *Office of Counsel and the Quality Management Department will coordinate filing with DOH.*

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OCCURRENCE AND CLAIM REPORTING (continued)

- RCA must be filed with the DOH for certain more serious patient occurrences (also called Sentinel Events) and within 24 hours of their discovery. See the NYPORTS Includes/Excludes Occurrence List, Appendix A, version 2.0 for a complete list of reportable events.
- RCA occurrences that take place after business hours or on weekends:
 - SMH: immediately notify the hospital administrator on call who will notify the Medical Center Office of Counsel.
 - HH: notify the nursing supervisor and/or administrator on call; the Quality Management Department will review.

External Reporting Requirements—Medical Devices/Equipment

A serious injury resulting from an equipment-related incident is defined as:

- A life-threatening illness or injury resulting in either permanent:
 - Impairment of a bodily function
 - Damage to a bodily structure
- An illness or injury necessitating medical or surgical intervention to prevent permanent impairment of a bodily function, permanent damage to a bodily structure.

Reporting Medical Device or Equipment Occurrences

- **Immediately report all** device/equipment-related incidents resulting in serious injury or death of a patient, visitor, or employee:
 - Enter in SRM/RL Solutions reporting system
 - SMH: contact the Office of Counsel to the Medical Center
 - Highland: contact the Quality Management Department
- Immediately notify the department responsible for maintenance of the device/equipment (e.g., Clinical Engineering or Facilities) of any incident.
- According to federal law, any medical device or equipment-related incident causing or contributing to a serious injury or death of a patient, visitor or employee must also be reported to the:
 - Device or equipment manufacturer
 - Food and Drug Administration
 - SMH Office of Counsel and HH leaders from Supply Chain and Value Analysis will coordinate reporting to outside agencies.**

Professional/General Liability Claims

- The Office of Counsel to the Medical Center is the designated representative for all claims asserted against:
 - SMH
 - HH
 - Clinicians insured through the UR malpractice insurance program

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OCCURRENCE AND CLAIM REPORTING (continued)

- For instances in which the potential exists for such a claim, immediately notify the SMH Office of Counsel or Highland Quality Management Department.
- Promptly forward any claim letters or lawsuits received to the appropriate office as listed above.

It is important to remember:

- A timely and thorough report of all occurrence and near misses must be entered into the electronic event reporting system (SRM/RL Solutions).
- In all cases of injury, the occurrence must be entered into SRM/RL Solutions no later than the end of the shift during which the occurrence happened or was discovered.
- External reporting is coordinated by the URMC Office of Counsel and Highland Quality Management.
- External reporting should **not** be done without consultation with the appropriate coordinating office.

PATIENT IDENTIFICATION

Subject Matter Experts:

SMH: Robert Panzer, M.D. (273- 4438), Cindy Berry (275-6937)

HH: Sharon Johnson (341-8399)

For More Information:

Details on Joint Commission National Patient Safety Goal #1 – Improve the Accuracy of Patient Identification: <http://www.jointcommission.org/patientsafety/nationalpatientsafetygoals>

SMH Policy 10.1.1 Patient Identification and Allergy Bands:
<http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/section10/10-1-1.pdf>

HH Policy 2.65, Patient Identification:
<http://intranet.urmc-sh.rochester.edu/highland/policy/HHpolicy/2-65.pdf>

Patient Identification

- Goals:
 1. Ensure the correct patient receives the correct health care procedure
 2. Eliminate transfusion errors related to patient misidentification
- The use of **two identifiers in 2 places** equals safe patient care.
Examples include:
 - Patient name **and** birthdate, **using** patient statement **and** lab requisition
 - Scanning the barcode on a patient's ID band, the medication, and verifying the correct patient's MAR opened up when administering any medication.
- The patient should be actively involved in the identification process whenever possible.
- All lab/specimen containers should be labeled in the presence of the patient.

PATIENT PRISONER POPULATION (SMH Specific)

Subject Matter Expert: Lorraine McTarnaghan (275-2500)

For more information:

Policy 9.10 (Prisoner Patients)

<http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/section09/9-10.pdf>

Nursing Practice Administration Policy 8.18 (Patient Prisoner Resources)

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

Admission/Discharge

- If the patient prisoner is under a managed care program, check with Admitting, Social Work, Financial Services, Utilization Review, and/or your supervisor.
- If you receive a phone call from a managed care organization, refer the caller to Utilization Review at 275-3185.

Security Procedures

- 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 may not require a plan
- Check with the nurse caring for the patient prisoner **before** interacting with the patient.
- Upon arrival at any treatment location for the patient prisoner, the forensic officer should be asked to sign the Forensic Staff Log and be given the *Informational Guidelines for Forensic Staff*.
- Let other staff/departments know the person is a patient prisoner, if necessary. (For example, Food & Nutrition needs to know to supply plastic tableware.)
- Maintain professionalism at all times, report threats or aggressive behavior to area leadership and/or UR Dept. of Public Safety.
- Do not inform inmates of future appointments or other scheduling information.
- Phone inquiries: inform the patient's guarding officer of the call and that no information is to be given out.
- Never be alone in a room with a patient prisoner.
- Do not give the patient any personal info (your address, phone number, etc.).

It is important 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.

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PATIENT PRISONER POPULATION--SMH Specific (continued)

- 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 UR Department of Public Safety (UR DPS).
- For **emergencies**, call UR DPS at **x13**

PATIENT RIGHTS/ETHICS/COMPLAINT PROCESS

Subject Matter Experts:

SMH: Joan Romano (275-5418)

HH: Amy Eisenhauer (341-0677)

For more information:

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

HH: <http://intranet.urmc-sh.rochester.edu/highland/Policy/HHpolicy/3-11.pdf>

Patient Rights

- NYS defines patient rights and staff must be familiar with how they apply to their role.
- Patient Rights are prominently displayed in all patient care areas, including hospital-affiliated, off-site locations; a copy must be given to every patient.
- See the policy link (Section 11.1.1 at SMH or Policy 3.11 at HH) above for a complete list of patient rights.

Ethical Concerns

UR Medicine and Highland have formal processes to address ethical concerns and dilemmas brought up by physicians, staff, patients, or families.

Contact the SMH Ethics Consultation Service at 275-5800 or the Highland Ethics Committee at 341-6718.

Patient Complaint Process

Patients have the right to complain about the care and services provided.

Patient concerns should be dealt with right away so issues can be resolved in a timely fashion at the point of origin.

If you can't respond to a patient's complaint or if the patient is not satisfied with your response, quickly refer it to your manager or supervisor.

If the patient is still not satisfied, he or she may contact the Patient and Family Relations Office and will be advised they can take the complaint to the hospital Grievance Committee, NYS Dept. of Health, or the Joint Commission.

It is important to remember:

- Knock before entering the patient's room, identify yourself, and explain what you do.
- Wear your ID badge so it can be prominently seen.
- Treat patients with respect, using the patient's title and last name (e.g., Mr., Mrs., Ms. Jones).
- Keep your voice low, encourage visitors to do so.

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PATIENT RIGHTS/ETHICS/COMPLAINT PROCESS (continued)

- Realize patients are encouraged to voice any concerns they have about care and services provided and try to resolve the issue.
- If you are unable to respond to a complaint, it involves another department, or if the patient is unsatisfied with your response, promptly refer it to your manager/supervisor.
- For still unresolved complaints, refer the patient/family to the Patient and Family Relations Office.
- Patient and Family Relations will advise patients they have the right to take the complaint to the hospital grievance committee, NYS Dept. of Health, or Joint Commission.

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

Subject Matter Experts:

SMH: Ann Peterson Ottman (276-6065) **HH:** Sharon Johnson (341-8399)

For more information:

Details on the Joint Commission National Patient Safety Goals and Requirements:

http://www.jointcommission.org/assets/1/6/2016_NPSG_HAP_ER.pdf

Cultures of Safety

Strong Memorial Hospital and Highland Hospital are committed to creating cultures of safety by:

- Using a nonpunitive medical error reporting process.
- Using an electronic occurrence reporting process for actual occurrences and near misses to reduce future events.
- Following Joint Commission National Patient Safety Goals/Requirements.

2016 Joint Commission National Safety Goals

Goal 01: Improve the accuracy of patient identification

Goal 02: Report critical results in a timely manner

Goal 03: Improve medication safety by properly labeling medications, containers

Goal 3.5: Reduce likelihood of patient harm associated with the use of anticoagulation therapy

Goal 3.6: Accurately, completely reconcile medications across the continuum of care

Goal 7: Reduce the risk of healthcare-associated infection

Goal 15: Identify patients at risk for suicide

Universal Protocol: Assure correct procedures, correct sites and correct patients are identified prior to procedures

Patient Safety Goals Examples

- Use 2 patient identifiers when providing direct or indirect patient care.
- Encourage patients' active involvement in their own care.
- Accurately, completely reconcile medications across the continuum of care.
- Reduce hospital-acquired infections by use of proper hand hygiene, appropriate isolation precautions, properly cleaning patient care equipment after use.
- Reduce likelihood of patient harm in use of anticoagulation therapy.
- Improve recognition and response to changes in patient's condition.

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2016 Joint Commission Universal Protocol Requirements

- UP01.1 Conduct a pre-procedure verification process
- UP 01.2 Mark the procedure site
- UP 01.3 A time-out is performed before the procedure

Team Communication

Per the Joint Commission, ineffective communication is the #1 root cause of serious patient events. To improve communication:

- Standardize handoffs in care: include patient history, medications, current condition, anticipated changes, plan of care.
- Write down, read back verbal orders and critical test results.
- Use a medication reconciliation process.
- Do not use these abbreviations in 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 important to remember:

- A culture of safety needs the entire team's involvement in providing accurate, timely communication to reduce the #1 root cause of serious patient events.
- All actual events and near misses should be entered in the electronic event reporting system (RL Solutions) so unsafe trends can be tracked and eliminated.
- 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.).
- Effective communication involves writing down and reading back information to ensure it was correctly heard, communicating with respect, and listening to understand.

POLICY AGAINST DISCRIMINATION AND HARASSMENT

Subject Matter Experts:

SMH: Christopher Walsh (758-2032)

HH: Kathleen Gallucci (341-0118)

For more information:

UR Policy 106: www.rochester.edu/working/hr/policies/pdfpolicies/106.pdf

HH Policy 130:

<http://intranet.urmc-sh.rochester.edu/Highland/Depts/HR/documents/HR130-NONHARASSMENT.pdf>

Both the University and Highland Hospital prohibit and will not engage in discrimination and harassment on the basis of age, color, disability, domestic violence status, ethnicity, gender identity or expression, genetic information, marital status, military/veteran status, national origin, race, religion/creed, sex, sexual orientation, or any other status protected by law.

Principles of Policy

- Any behavior, including verbal or physical conduct, that involves, in any form, discrimination or harassment against any member or guest of the University or Highland Hospital is prohibited.
- Retaliation, in any form, against a person complaining about an act of discrimination or harassment is prohibited.

Definition of Discrimination

- Any behavior, whether anonymous or overt, limiting, segregating or classifying a person or group in a way that deprives them of the opportunity to fully function or participate as a member of the University/Highland Hospital community.
- Includes any behavior that might reasonably be considered unlawful discrimination under applicable NYS and/or federal law.
- If unfair or inappropriate behavior, not based on a protected class listed above, does not meet the definition of discrimination under hospital policy, it must be addressed through Human Resources, your supervisor, or (at SMH) the Intercessor.

Definition of Harassment

- Any behavior, whether anonymous or overt, 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.
- Includes any behavior that might reasonably be considered unlawful harassment under applicable NYS and/or federal law.
- Harassment is a form of discrimination, which involves:
 - Unwelcome verbal, written, or electronic conduct.
 - A protected class. Harassment also be sufficiently severe or pervasive and objectively and subjectively unreasonable with the environment.

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POLICY AGAINST DISCRIMINATION AND HARASSMENT (continued)

It is important to know:

If you feel you are being discriminated against or harassed, or notice it happening to another person, you should take action that includes any/all of the following:

- Tell the individual the behavior is unwelcome and unacceptable.
- Talk with your supervisor or manager.
- Contact any of the following resources.

Resources	SMH	Highland
Intercessor's Office - (Trained counselors appointed by the University to handle complaints or questions dealing with sexual harassment.)	275-9125 (staff and students)	
Human Resources	EO Compliance 275-7814 or Dept. Chair or Dean's Office	Kathleen Gallucci, 341-0118 (faculty and staff)
-Security	Emergency x13 Nonemergency 275-3333	Emergency 341-6666 Nonemergency x1-SERV
Office of Counsel	Office of Counsel to the Medical Center 275-8571	Office of Counsel to the Medical Center 275-8571

PROFESSIONAL CONDUCT EVENT EDUCATION

Subject Matter Experts:

SMH: Christopher Walsh (758-2032), Pat Reagan Webster (273-1554)

HH: Kathy Gallucci (341-0118)

Patient- and family-centered care and quality thrive in an environment that supports teamwork and respect for other people, regardless of their position in the hospital. Unprofessional conduct that intimidates others and affects morale or staff turnover can be harmful to patient care when one or more team members feel they are no longer a respected member of that team.

Leaders Address Unprofessional Conduct By:

- Regularly evaluating the culture of safety and quality, implementing changes to improve safety and quality.
- Adhering to a code of conduct that defines unacceptable, unprofessional conduct or inappropriate events that compromise quality and safety.
- Creating and implementing a process for managing unprofessional conduct and inappropriate events

Examples of unprofessional conduct include (but are not limited to):

insulting or verbal attacks	throwing instruments or charts
frequent outbursts of anger	criticizing a team member in front of patients

Reporting Unprofessional Conduct

SMH –

- Faculty and staff should report unprofessional conduct in RL Solutions (the hospital's electronic reporting system) as soon as possible; events can be entered anonymously if preferred. Or, the event can be reported on the Integrity Hotline at 756-8888.
- Your CONFIDENTIAL report is reviewed by Human Resources and is then given to the best person to handle resolution of that event. If you use your name when reporting the event, you will receive confirmation that your report has been seen and is being reviewed.
- Each event will be handled on a case-by-case basis, so there is no standard time frame for resolution of the event, but each event will be reviewed within 14 days of being reported. If you used your name when reporting the event, you should receive a confirmation in approximately 14 days. However, if you did not use your name when reporting the event, there is no mechanism in place to notify you that it has been received and is being reviewed.

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PROFESSIONAL CONDUCT EVENT EDUCATION (continued)

HH –

- Faculty and staff should report unprofessional conduct in RL Solutions (the hospital's electronic reporting system) as soon as possible; events can be entered anonymously if preferred.
- Your CONFIDENTIAL report is reviewed by Human Resources and is then given to the best person to handle resolution of that event. If you use your name when reporting the event, you will receive confirmation that your report has been seen and is being reviewed.
- Each event will be handled on a case-by-case basis, so there is no standard time frame for resolution of the event, but each event will be reviewed within 14 days of being reported. If you used your name when reporting the event, you should receive a confirmation in approximately 14 days. However, if you did not use your name when reporting the event, there is no mechanism in place to notify you that it has been received and is being reviewed.

It is important to remember:

- Patient- and family-centered care and quality thrive in an environment that supports teamwork and respect for other people, regardless of their position in the hospital.
- Unprofessional conduct that intimidates others and affect morale or staff turnover can be harmful to patient care.
- Faculty and staff should report unprofessional conduct as soon as possible through appropriate channels.

PROFESSIONAL MISCONDUCT REPORTING AND THE IMPAIRED PROFESSIONAL

Subject Matter Experts:

SMH: Spencer Studwell (273-4575)

HH: Sharon Johnson (341-8399)

For more information:

SMH:

<http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/documents/1.7.1CodeofConduct.pdf>

HH:

<http://intranet.urmc-sh.rochester.edu/highland/Policy/HHpolicy/3-1.pdf>

<http://intranet.urmc-sh.rochester.edu/highland/depts/hr/documents/HR128-SUBSTANCEABUSE.pdf>

Examples of Professional Misconduct

- Fraudulently obtaining a license 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 the person's race, creed, color, or national origin; includes 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 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 excessive tests, treatment, or use of treatment facilities not warranted by the condition of the patient

Impaired Professional

Anyone witnessing behavior of an individual suspected of being impaired is **legally obligated** 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

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It is important to remember:

To Report Misconduct Concerns:

URMC-SMH:

Contact the Office of Counsel to the Medical Center through departmental channels.

If the concern involves a supervisor or departmental leader, staff should directly contact the Office of Counsel to the Medical Center at 275-8019.

HH:

Contact the Quality Management Department through departmental channels.

If the concern involves a department leader, staff should directly contact the Quality Management Department at 341-8399.

For weekends or evening/night shifts, the Nursing Supervisor and/or Administrator-On-Call should be notified.

PROVIDING BETTER CARE FOR PEOPLE WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES THROUGH COMMUNICATION

Subject Matter Experts:

SMH: Steven Sulkes, MD (275-2986)

HH: Daniel Mendelson, MD (341-0888)

Objectives

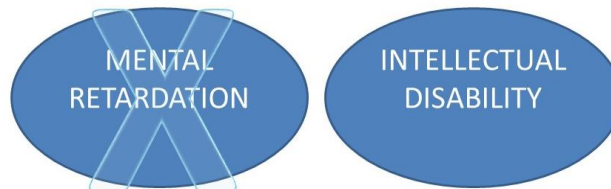
1. Increase awareness of communicating with people with intellectual and developmental disabilities.
2. Provide some strategies for improving communication and service.

Intellectual and Developmental Disabilities

- **Developmental disabilities** (DDs) are severe chronic conditions that can be cognitive, physical or both. DDs are marked by impairment in physical, learning, language, or behavior areas and occur before the age of 21.
- **Intellectual disabilities** (IDs) are characterized by difficulties in intellectual functioning and adaptive behavior.
- People with intellectual and/or developmental disabilities (**IDD**) include those with cerebral palsy, autism spectrum disorders, epilepsy, and many other syndromes and conditions.

Preferred Terminology

In recent years, the term “Intellectual Disability” has replaced the stigmatizing term “Mental Retardation.”



How Are People With IDD Impacted by Their Disability?

Impacts of IDD vary from person to person and can include difficulties with:

- Mobility
- Learning
- Communication
- Adaptive skills

An individual’s disability is not always visible.

Each person with an intellectual or developmental disability has his or her own unique interests, strengths and challenges.

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Communicating With an Individual With IDD

- Find out how the person best communicates. For example, some people benefit from picture communication
- Speak directly to the person, instead of the parent or caregiver
- Simplify language
- Allow time for the patient to process information; check in with the patient to ensure understanding
- Be truthful: “The shot will hurt a little, not a lot.”
- Use People First Language: “Kevin is a 14-year-old boy with autism” not “The autistic boy.”

Health Care for People With IDD

- Having a disability does not mean a person is not healthy.
But people with IDD have been shown to have poorer health and dental care than people without IDD
- Health conditions experienced by people with IDD are not necessarily related to their disability.
- Providing healthcare for people with IDD consists of the same elements as providing healthcare for people without disabilities:
 - Involving the patient
 - Obtaining information to identify a diagnosis
 - Communicating treatment plans and preventive measures

Resources

Health Care for Adults with Intellectual and Developmental Disabilities Toolkit
<http://vkc.mc.vanderbilt.edu/etoolkit/>

Developmental Disabilities information from the American Academy of Pediatrics
<http://www.healthychildren.org/English/health-issues/conditions/developmental-disabilities/Pages/default.aspx>

QUALITY, SAFETY, AND PERFORMANCE IMPROVEMENT

Subject Matter Experts:

SMH: Judy Burkman (276-3148), Pat Reagan Webster (273-1554)

HH: Sharon Johnson (341-8399)

For more information:

SMH: [SMH Policy 1.7.1](#) Code of Conduct

HH: [HH Policy 1.4](#), Code of Conduct

Mandatory In-Service Topic: Patient Safety, Team Communication, Medical-Health Care Error Reduction

Other resources:

- IHI Website: www.ihl.org/ihl
- Institute of Medicine: www.iom.edu/
- Integrity Hotline: 756-8888
- Joint Commission: www.jointcommission.org/patientsafety/nationalpatientsafetygoals/
- Patient Safety Classes: contact H. Poltorak/R. Panzer
- SMH Quality Officers: [SMH Quality Assurance Dept](#)
- SMH Education Committee: contact T. Smith
- SMH Unit-based Performance Program: contact Pat Reagan Webster
- Strong PFCC/Strong Commitment Modules: contact J. Beckerman
- TeamSTEPPS Training: contact H. Poltorak/Dr. Panzer
- Lean Performance Improvement: contact Tricia Hough
- HH Quality Management Department
- HH PFCC: contact Amy Eisenhauer

Mission Statements

Strong Memorial Hospital:

We improve the well-being of patients and communities by delivering innovative, compassionate, patient- and family-centered health care enriched by education, science, and technology.

Highland Hospital:

Commitment to excellence in health care, with patients and their families at the heart of all we do.

Visions and Obligation

SMH Vision: We will define and deliver *Medicine of the Highest Order* and set the standard for compassion and innovation, always placing patients and their families first.

HH Vision: We deliver *Medicine of the Highest Order* in a community hospital where compassion, quality, and patient- and family-centered 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.

Each of us is a part of a system that supports patient care, education or research.

We each have an **obligation** to our customers, our team, and ourselves to speak up when we have an improvement idea.

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SMH Goals (According to SMH Management Plan)

- Quality, Safety (High quality, safe and effective care)
- Patient/family-centered care (patient centered, timely, efficient)
- Growth (capacity management)
- People (human resource services, staff/leadership development, employee engagement)
- Financial Responsibility (achieve operating targets)
- Infrastructure (upgrade as appropriate to achieve goals)
- System Integration (reduce unnecessary hospitalizations by community-based health initiatives)

HH Goals

- Quality, Safety (High quality; safe, effective care)
- Service Excellence/Patient/Family-Centered Care (timely, efficient patient/family-centered care)
- People (staff/leadership development, employee engagement)
- Growth (volume growth, capacity management)
- Financial Responsibility (achieve operating targets)
- Infrastructure (upgrade as appropriate to achieve goals)
- System Integration (reduce unnecessary hospitalizations by community-based health initiatives)

Six Dimensions of Quality in Health Care (per Institute of Medicine)

1. **Safety** – a property of any system, not just everyone “working carefully”
2. **Effectiveness** – the right technique/resources for the illness or event
3. **Patient-centeredness** – the patient plays an active role in making decisions
4. **Timeliness** - unintended waiting is a system defect
5. **Efficiency** - seeking to reduce the waste in supplies, equipment, space, capital, etc.
6. **Equity** - race, ethnicity, gender, and income do not prevent anyone from receiving care

A Safe Culture (per Joint Commission)

- Expressed in the beliefs, attitudes and values of an organization’s physicians/staff.
- Characterized by a continual drive toward the goal of maximum attainable safety.
- A place where everyone is sensitive to operations and understands change management.
- Strengthened when work processes allow leaders and staff to discuss and learn together.

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Performance Improvement

- Key to high quality health care
- Performance improvement philosophy pervades leading healthcare organizations
- A system designed to reduce or eliminate chances for error, monitored for improvement opportunities over time
- Highlights errors when they happen, empowering staff to speak up and offer improvement suggestions

Core Principles/Concepts of Continuous Quality Improvement

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

Quality Care/Service Is Everyone's Job

- The patient's or customer's needs must be first in our minds
- Quality or performance improvement means working together
 - Often in teams within or across departments
 - To improve processes and resolve issues

Model for Improvement Using PDSA

Fundamental Questions

- What are we trying to accomplish?
- How will we know a change is an improvement?
- 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

NYS Dept. of Health/Joint Commission Surveyors Expect Staff Members to Explain:

- How your job supports the Hospital's mission
- Your involvement in department performance improvement/safety activities
- Fire safety and emergency responses, use of universal precautions, hand hygiene, equipment and reagent safety, safety of the workplace
- How the hospital's approach to implementing the National Patient Safety Goals affects care in your area

Ask your supervisor if you are unsure how you would answer these questions.

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QUALITY, SAFETY, AND PERFORMANCE IMPROVEMENT (continued)

You should speak up when you:

- See an opportunity to improve a process or reduce an error in your work.
- Identify an opportunity to eliminate waste in your work environment.
- Observe an issue that needs to be addressed.
- Think there is a systems problem that can be fixed, but needs a team to solve it.
- Observe someone who is acting in a disrespectful or inappropriate way.

SMOKE-FREE CAMPUS, INSIDE AND OUT

Subject Matter Experts:

SMH: Lorraine McTarnaghan (275-2500)

HH: Joe Coon (341-6833)

For more information:

SMH: Smoke-Free Intranet Site

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

HH: HH Policy 2.35, Smoke Free Campus

<http://intranet.urmc-sh.rochester.edu/highland/Policy/HHpolicy/2-35.pdf>

Sale of smoking materials is prohibited in all areas of:

- Highland Hospital
- Strong Memorial Hospital and the Medical Center campus including:
 - Eastman Institute for Oral Health (Eastman Dental Center)
 - School of Medicine and Dentistry
 - School of Nursing
 - Saunders Research Building
 - Kornberg Medical Research Bldg. & Del Monte Neuro-medicine Institute

Smoking Perimeters

Smoking by faculty, staff, volunteers, students, patients and visitors is prohibited within the established perimeters for each organization,* including:

- Parking lots/areas
- Personal vehicles within the perimeter areas
- URM/SMH and HH neighborhoods

* At this time, URM/SMH does provide designated smoking outposts within the perimeter. See the map at <http://intranet.urmc-sh.rochester.edu/policy/smokefree/> for locations

Maintaining a Smoke-Free Campus

ALL faculty, staff, and students are expected to:

- Follow the policy
- Inform persons smoking within the perimeter of the Smoke-Free policy
- Be aware they are subject to corrective action if they do not comply with the smoke-free policy

Support resources are available to assist in complying with the smoke-free policy including smoking cessation programs and nicotine replacement products available for purchase at various locations.

A comprehensive nicotine replacement therapy protocol is provided for all inpatients.

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Failure to Comply With Policy at Either Campus

If you see a person smoking within the perimeter of either campus and outside the smoking outposts at SMH:

- Inform the person of the no-smoking policy and request they cease smoking
- If they refuse, request they take the remainder of their smoking material with them so others do not think it is OK to smoke in that location
- Indicate smoking replacement materials are available for sale

It is important to remember:

- A smoking outpost is no longer available at Highland.
- Many support resources are available to help community members comply with the Smoke-Free Policy (e.g., smoking cessation programs, nicotine replacement products).
- A comprehensive nicotine replacement therapy protocol is provided for all inpatients.
- Nicotine replacement products are available for purchase at various locations to help 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 smoke-free policy.

STROKE RECOGNITION

Subject Matter Experts:

SMH: Ann Leonhardt (273-2861)

HH: Meghan Reddy (341-6932)

Stroke Centers

- Strong Memorial Hospital is a Joint Commission Certified Comprehensive Stroke Center. This means we are recognized for providing highly specialized care to the most complex stroke patients.
- Highland is a New York State designated Stroke Center. We have also been rewarded the Gold Seal for Stroke care.
- At either institution, Stroke is an emergency and all potential treatments must be provided quickly.

Sudden Onset Recognition

- Weakness or numbness of face, arm, or leg (especially when isolated to one side of the body)
- Confusion, trouble speaking or understanding, slurred speech
- Trouble seeing in one or both eyes, double vision
- Trouble walking, dizziness, loss of balance or coordination
- Severe headache with no known cause

Remember “FAST” to Recognize Stroke

The American Heart Association/American Stroke Association recommends remembering “FAST” to help recognize stroke:

Use FAST to remember warning signs of stroke:

- FACE:** Ask the person to smile. Does one side of the face droop?
- ARMS:** Ask the person to raise both arms. Does one arm drift downward?
- SPEECH:** Ask the person to repeat a simple phrase. Is their speech slurred or strange?
- TIME:** If you observe any of these signs, **call 9-1-1 immediately.**

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STROKE RECOGNITION (continued)

Immediately Call For Help

If you witness someone having a suspected stroke, immediately call for help:

Strong Memorial Hospital	Highland Hospital
Inside either hospital:	
<ul style="list-style-type: none">• STAT page through the page office• For a patient: Stroke Alert• For anyone else: MERT response	<ul style="list-style-type: none">• For a patient: Inform an RN on the floor who will call a Rapid Response• For anyone else: Call page office for a MERT Response
Outside either hospital, call 9-1-1	

It is important to remember:

Signs of a stroke may include:

- Weakness or numbness of face, arm, or leg (especially when isolated to one side of the body)
- Confusion, trouble speaking or understanding, slurred speech
- Trouble seeing in one or both eyes, double vision
- Trouble walking, dizziness, loss of balance or coordination
- Severe headache with no known cause

It is critical to recognize and treat stroke very quickly.

Remember “FAST”:

Face, Arm, Speech, Time

THE STRONG COMMITMENT (SMH Specific)

Subject Matter Expert: Jacqueline Beckerman (275-8794)

For more information:

Strong Commitment Website

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

Learning Materials

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

View Learning Materials Over CCTV

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

The Strong Commitment

Every word you speak, 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.

- Every employee must make a personal commitment to the values we share, ensuring our words and actions are consistent with those values.
- You are expected to embrace this commitment and make it central to your work life at Strong, every day.
- To help in that process, learning resources are available to you on the PFCC/ICARE intranet website.
 - Learning is grouped on the site according to your role and responsibilities as a manager or staff member.

The Strong Commitment Means I CARE

Integrity –	I will conduct myself in a fair, responsible and trustworthy manner and uphold professional and ethical standards
Compassion –	I will act with empathy, understanding, and attentiveness toward all others.
Accountability –	I have an obligation to take responsibility for my actions and to join with my colleagues in realizing the hospital's vision.
Respect –	I will treat patients, families and colleagues with dignity and sensitivity, valuing their differences.
Excellence –	I will rise above the ordinary through my personal efforts and those of my team.

The Strong Commitment – Expected Behaviors

The Global ICARE Behaviors are:

Integrity

- Introduce yourself – greet, say your name, explain your role
- Be mindful of your actions – conversation topic, tone, volume, body language

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THE STRONG COMMITMENT—SMH Specific (continued)

Compassion

- Communicate with warmth- use preferred names, smile, make eye contact, listen attentively
- Respond to feelings – show empathy and kindness

Accountability

- Answer question clearly- ask about and address concerns, explain next steps
- Invoice and update- patients, families, and colleagues

Respect

- Be courteous and friendly- to all patients, families, and colleagues across all departments
- Speak positively- about your colleagues, other departments, and the institution

Excellence

- Take initiative to help- ask if there is anything else you can do to assist your colleagues
- Recognize your colleagues – thank them for their efforts

Service Recovery

- Tool to recognize, prevent, and correct unmet customer expectations
- Goal: to turn potentially negative situations into positive ones and make things right for our customers
- Use the ***Learn Protocol*** to turn things around:
 - LISTEN** to the customer
 - EMPATHIZE** with how the customer is feeling
 - APOLOGIZE** for not meeting their expectations
 - RESPOND** to the problem
 - NOTIFY** the appropriate person(s)

WASTE MANAGEMENT

Subject Matter Experts: SMH: Bradley Miller (275-4699)

HH: Horace Little (341-0313)

Waste Management

- 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.

Who to Contact

Important Numbers	SMH	HH
General waste questions, schedule pickups or service	Environmental Services x5-6255	Environmental Services x1-7378
Biohazardous Waste	Technical questions, to voice concerns, call Environmental Health & Safety x5-8405.	Environmental Services x1-7378
Chemotherapeutic Waste Info.	Technical questions, 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	Paper, cardboard, confidential document disposal, call Environmental Services x5-6255. Used electronic equipment: e-mail University IT at itequipmentrecovery@rochester.edu . Batteries, call x5-2056 Furniture, medical equipment: Facilities Surplus x5-8875	Environmental Services x1-7378

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WASTE MANAGEMENT (continued)

Waste Disposal Method Examples

Waste Type	Examples	Disposal Method
General Refuse	Nonrecyclable paper, food wrappings, paper towels, etc.	SMH: Clear or dark bag HH: Clear bag
Nonregulated medical waste (generated during treatment/diagnosis of patients but not classified as biohazardous by NYS DOH)	Gloves, IV bags, tubing, etc., that are <i>not saturated to the point of dripping</i> with blood or body fluids.	Clear or dark bag
Biohazardous or Infectious Waste (medical waste defined by NYS as having a higher risk of being infectious.)	Sharps (patient and personal)	Approved sharps container (hard plastic with tight-fitting top)
	Blood/body fluids	Discard <i>carefully</i> into designated flush sink/hopper (<i>not handwashing sinks</i>)
	Blood bags that cannot be safely drained, disposed	Empty, 8-gallon, free-standing sharps container and label container for blood bags only. Do not put sharps in this container and keep it upright.
	Items <i>saturated</i> to the point of dripping with blood/body fluids (other than feces and most urine). Human pathological waste (recognizable body parts, organs) Laboratory waste known to be in contact with infectious agents. Chest drainage canisters Animal waste (bedding, carcasses) known to be contaminated. Suction canisters (keep upright in red bag)	Must be put into red bags.
	Clinical lab <i>unbroken</i> blood tubes, or any other biohazardous glass from patient treatment areas. Broken glass is put in sharps containers if it fits.	Special cardboard box designed for these items.

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WASTE MANAGEMENT (continued)

Waste Type	Examples	Disposal Method
Recyclable Waste	Office paper, newspapers, magazines, catalogs, books, paperboard boxes (flattened)	Blue bin/blue recycling tote (where available)
	Cardboard (clean, flattened)	Consolidated in designated areas and brought down to compactor at waste dock
	Clean and empty plastic #1, 1-7, aluminum and tin cans, glass bottles/containers, milk/juice cartons	Bin with green label/green tote (where available)
	Button batteries, nickel cadmium, lithium ion, nickel metal hydride and any other battery type except alkaline.	Battery drop-off points: soiled utility cart in inpatient units; also, at SMH: Parking Office Service counter, Photo Illustration, Engineering Stores.
Confidential Documents	Patient Records; all HIPPA-related documents and information	Department shredder or: SMH – locked small gray metal container. SMD – locked green tote with slotted top for Environmental Services pickup. HH : locked gray container.
Pathological Waste	Body parts/organs/tissues removed through surgical procedures	Special handling – See your Dept. Head for details (most goes to on-site Crematory)
Pharmaceutical Waste	IV bags with RX drugs still left in them Syringe/needles with RX drugs still in them	Special floor-placed, 8-gallon blue containers for nonhazardous RX waste and a special floor-placed 8-gallon black container for <i>hazardous</i> RX waste. If a syringe/needle has RX waste left, use a special 2-gallon wall bracket or tabletop <i>black sharps shelter</i> . These are either in the med rooms or soiled utility rooms on the units. For SMH areas such as Radiology and the OR that generate a large amount of sharps (including syringes) there are special floor-placed 8-gallon purple containers available for this purpose if there is residual RX material in the sharp. NOTE: Some Rx waste could be reactive or called “noncompatible.” This RX waste must be sent back to the Pharmacy. In SMH this is placed in a special purple plastic bag that will be placed on the Pharmacy cart for return.

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WASTE MANAGEMENT (continued)

Waste Type	Examples	Disposal Method
Mercury Waste Do not throw items containing mercury in the trash	Button batteries, thermometers	On inpatient units, label and place on soiled utility carts. All other areas—check procedure for your specific areas.
Hazardous Chemical Waste	Halogenated solvents, corrosives, heavy metals, waste oils, etc.	Keep different kinds of chemical wastes separated. Place in tightly closed containers that are properly and clearly marked. Fill out a Hazardous Waste Tag and promptly call the Hazardous Waste Management Unit (x52056) .
Radioactive Waste	Includes a variety of long- and short-lived radioactive materials mixed in with research and clinical apparatus such as pipettes, test tubes, examination gloves, paper, etc. All waste from patients receiving oral solution of iodine 131.	Keep different types of radioactive waste separate from each other and place in proper containers that are clearly and properly labeled with a Radioactive Waste Tag ; drop off at or pickup by Radiation Safety Office . Special boxes for these materials; pickup by Radiation Safety . F-18, Tc-99m, In-111m and Tl-201 wastes may be stored for decay within department with approval of Radiation Safety Officer.

It is important to remember (Info on previous charts plus below):

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	Sharps: SMH and HH: Yellow Chemo sharps container with CJD stickers placed over Chemo labels. Nonsharps: SMH: Orange bags with CJD sticker placed on the bag. HH: 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:

SMH:

<http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/documents/10.14ManagementofViolentActorsTreatsofViolence.pdf>

<http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/section02/2-3.pdf>

<http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/section02/2.9%20Critical%20Security%20Incident.pdf>

Related Strong Commitment training materials can be obtained from The Strong Commitment Office (x5-8794) or from the Director's Office.

HH: <http://intranet.urmc-sh.rochester.edu/highland/policy/HHpolicy/3-21.pdf>

Hospital Policy

Both the URMC-SMH and Highland strive for a safe, violence-free environment. Acts or threats of violence will not be tolerated.

Signs of Potential Violence

What You Might See or Hear	
Visible stress	Loud, fast speech
Tense muscles	Demanding, blaming statements
Fidgeting	Refusal to follow rules
Glaring	Throwing, slamming objects
Pacing	Verbal outbursts
Threats	Unrealistic expectations

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Responding to Potential Violence

Immediate Threat, Call:	Not An Immediate Threat:
UR Dept. of Public Safety (UR DPS) x-13	Notify your supervisor/manager and UR DPS or HH Security to help develop an action plan
Highland Hospital Security x1-6666	
Off-Site Locations 9-1-1	

If a Traumatic Event Happens....

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

To Calm A Potentially Violent Person

1. Give your full attention to the person; maintain a safe distance; give yourself the ability 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; redefine the problem to ensure your full understanding.
4. Offer reasonable choices to diffuse the situation.

Section 2:

**TOPICS FOR FACULTY,
STAFF, & PHYSICIANS
WITH PATIENT CARE
RESPONSIBILITIES***

*Please review these topics to identify if this pertains to your role or ask your supervisor/manager to clarify.

ANTICOAGULATION SAFETY

Subject Matter Experts:

SMH: Curtis Haas, Pharm.D (275-6145)

HH: Jeff Huntress, Pharm.D (341-6792)

Anticoagulation Therapy

One of the Joint Commission National Patient Safety Goals is to reduce the likelihood of harm associated with the use of anticoagulant therapy.

- Anticoagulation therapy is used for the treatment of a number of conditions, the most common of which are atrial fibrillation, deep vein thrombosis, pulmonary embolism, and mechanical heart valve implantation.
- The key reason why ensuring the safe use of this class of medications is important is because anticoagulation medications have the highest potential to cause serious harm due to complex dosing, insufficient monitoring, and poor patient compliance

Medications Used for Anticoagulation Therapy

- Heparin
- Warfarin
- Dalteparin or enoxaparin
- Fondaparinux
- Abigatran
- Rivaroxaban
- Apixaban
- Argatroban
- Lepirudin
- Bivalurudin

Key Elements of Performance

Both Strong Memorial and Highland Hospital have implemented and follow several key elements of performance to ensure compliance with the National Patient Safety Goal. It is important for all clinical staff to be aware of these key elements:

1. Only individually packaged dosage forms, prefilled syringes, or premixed infusion bags of anticoagulation medications are used throughout the hospital.
2. Guidelines and protocols have been developed to assist with the initiation and maintenance of anticoagulant therapy. These guidelines and protocols are located on the Anticoagulation SharePoint intranet website at <http://inside.mc.rochester.edu/sites/Anticoagulation/default.aspx>

These guidelines include information about baseline and ongoing laboratory tests required for anticoagulation therapies.

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ANTICOAGULATION SAFETY (continued)

3. Food-drug interactions with warfarin while an inpatient are not a significant concern since any diet available does not contain any more than the FDA-recommended, daily amount of Vitamin K.
 - A URM patient education brochure has been created that all patients receiving warfarin as well as any other coagulant should receive and have reviewed with them prior to discharge.
 - These brochures contain information about the management of potential food-drug interactions and other safety concerns that patients must be aware of after discharge.
 - The brochure can be ordered from RR Donnelly, printed from a link within either the MAR or in the Anticoagulation Patient Education Record, or downloaded from the Anticoagulation SharePoint intranet site.
 - Clinical Dietitians or Pharmacists are available for counseling patients regarding potential food-drug interactions upon request of either a provider or nurse.
- a. Whenever heparin, argatroban, lepirudin, or bivalirudin are administered intravenously via continuous infusion, Alaris infusion pumps are used to provide consistent and accurate dosing. Each of these medications is administered per nursing protocols when ordered from providers and requires a 2 RN double check to confirm accuracy of any dosing changes.
- b. Education is provided to hospital staff on anticoagulation therapy by pharmacists and physicians throughout the year via in-service presentations, newsletters, and clinical grand rounds.
 - Education is provided to families and patients during their admission and prior to their discharge. Patient and family education includes information on the importance of medication compliance, drug-food interactions, and the potential for adverse drug reactions and interactions.
 - Patient education is provided by either nursing staff or pharmacists utilizing the URM educational brochures and is documented in the Anticoagulation Patient Education Record.

It is important to remember:

- Anticoagulation therapy is used for the treatment of a number of conditions, the most common of which are atrial fibrillation, deep vein thrombosis, pulmonary embolism, and mechanical heart valve implantation.
- The key reason why ensuring the safe use of this class of medications is important is because anticoagulation medications have the highest potential to cause serious harm due to complex dosing, insufficient monitoring, and poor patient compliance.
- Only individually packaged dosage forms, prefilled syringes, or premixed infusion bags of anticoagulation medications are used throughout the hospital.
- Education is provided to hospital staff on anticoagulation therapy by pharmacists and physicians throughout the year via in-service presentations, newsletters, and clinical grand rounds.
- Patient education is provided by either nursing staff or pharmacists utilizing the URM Warfarin Patient Education Brochure and is documented in eRecord.

CLINICAL ALARM MANAGEMENT (SMH specific)

Subject Matter Expert:

SMH: Ann Ottman (276-6065)

For more information:

<http://sharepoint.mc.rochester.edu/sites/smhpolicy/Pol/Shared%20Documents/8.09%20Clinical%20Alarms%20Management.pdf>

Clinical Alarm Management

- This policy has information that applies to all alarm-enabled patient-care medical devices identified as high priority, except when patients are monitored one-on-one by anesthesia provider in the operating room. For specific details about managing alarms, refer to the medical device specific policy/guideline, where available.
- Clinical Alarm systems are intended to alert caregivers of potential patient problems, and if not properly managed can compromise patient safety. Clinical alarm systems include a full spectrum of alarms that are designed to alert staff of a change in a patient's physiologic condition or a medical device equipment issue.
- Note: Clinical alarm management was identified as a priority by Strong Memorial Hospital (SMH) June 2014 and was added to the Quality Improvement Goals effective July 1, 2014.

Definitions

- **Alarm/Alert** - an audible or visual signal intended to get someone's attention
- **Primary Notification** - Notification of device status from the alarm-enabled patient care medical device (e.g. ventilator, physiologic monitor, bed exit)
- **Secondary Notification** - Notification of device status from an alarm-enabled, patient care medical device other than the primary notification device (e.g. central monitor, pager, phone, nurse call system, hallway waveform screen).
- **Alarm Management Middleware** - Software that enables management and communication of alarm data between distributed clinical applications (patient monitoring systems, Nurse Call, secondary notification systems/devices).

Responsibilities – SMH Clinical Alarm Management Committee

The SMH Clinical Alarm Management Committee is responsible for:

1. Setting alarm default parameters
2. Reviewing request from units or departments to change alarm default parameters
3. Determination if default alarm settings may be customized or non-modifiable
4. Maintaining an inventory of default physiologic monitor alarms
5. Maintaining an inventory of high priority, inpatient alarm-enabled, patient care medical devices

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CLINICAL ALARM MANAGEMENT (continued)

6. Reviewing regular physiologic monitor alarm reports
7. Using alarm reports as a guide to identify new risks, recommend changes to device default settings to eliminate non-significant alarm signals, and for continuing education of clinicians
8. Recommending secondary alarm notification systems that may be useful based on unit layout, workflow, and staffing.
9. Advising units on default parameters that will result in the least amount of alarm burden
10. Developing a structure for and reviewing request to alter alarm-enabled medical device default settings
11. Identifying strategies to reduce excessive alarms with unit medical and nursing leadership
12. Identify education needs of clinical staff in conjunction with medical directors and nurse managers related to proper alarm settings and alarm customization. Education may be developed and communicated at the system level or local level. Reviewing any adverse events related to alarm management and participate on RCA teams as requested by Quality Assurance.

Responsibilities – Clinical Engineering

Clinical Engineering is responsible for:

1. Having a preventative maintenance program.
2. Inventory and inspect all alarm-enabled patient care medical devices prior to implementation on clinical areas.
3. Consulting with Clinical Alarm Management Committee on alarm default settings.

Responsibilities – Medical Directors, Nurse Managers, Service/Department Clinical Leaders

Medical Directors, Nurse Managers and service/department clinical leaders are responsible to work collaboratively with the assistance of the appropriate Clinical Alarm Management team member to accomplish the following:

1. Establish a culture of alarm safety which includes assuring unit alarm accountability.
2. Identifying the most important clinical alarms to manage based on their workflow and layout of work area.
3. Identifying a secondary notification system/plan for clinical alarms as appropriate.
4. Identifying strategies to reduce clinically non-significant alarm signals.
5. Determining who has primary responsibility for responding to a patient's alarm.
6. Determining if a secondary/back-up response is needed based on the type of alarm.
7. Establishing tiers of response coverage, where appropriate.
8. Establishing a culture of alarm safety which includes a requirement to check individual alarms signals for accurate settings, proper operation and detectability.

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CLINICAL ALARM MANAGEMENT (continued)

9. Providing education on the alarm-enabled medical devices deemed most important to manage on the unit.
10. Requests to Change Default Alarm Parameters:
 - a. Unit managers may request changes to the alarm default settings by submitting a request to the Clinical Alarm Management Committee.
 - b. These change requests will be reviewed and approved by the committee.

Responsibilities – Clinical Staff

Clinical staff, within the confines of their scope of practice/license are responsible for:

1. Responding to clinical alarms, as appropriate.
2. Checking individual alarm signals for accurate settings, proper operation and detectability.
3. Troubleshooting clinical alarms as indicated by alarming device.
4. Explaining to patients/family the purpose of alarms and their role in alarm management.

It is crucial to remember:

- Orders are needed for cardiac monitoring to initiate and discontinue after 48 hours unless level I indications are met.
- Nurses may initiate cardiac monitoring in an emergent situation. An order should be obtained as soon as possible after initiation.
- Nurses must customize alarm limits for patients based on patient's clinical condition.
- Nurses check individual alarm signals for accurate settings, proper operation and detectability

CODE OF eCONDUCT

Subject Matter Experts:

SMH: Robert Panzer, MD (273-4438) **HH:** Bilal Ahmed, MD (341-6770)

Purpose

To promote safe patient care through minimizing the distractions of eDevices (e.g., iPhone, Blackberry, iPad, laptops) in the workplace while allowing for optimal use of electronic support in the care and treatment of patients and families.

Clinical Practice Guideline:

<http://intranet.urmc-sh.rochester.edu/policy/clinicalguidelines/code%20of%20econduct%20at%20urmc/code%20of%20econduct%20at%20urmc.pdf>

Minimal Standard Practice for Use of eDevices

- All devices including, but not limited to, Smart phones and cell phones, other than hospital-issued pager/urgent on-call communication devices, should be in “silent” mode whenever in a patient room or discussing patient information with the patient/family.
- Clinicians will refrain from using computers and eDevices at clinical work stations to conduct personal business. Use of computers and eDevices for necessary personal use is allowable in break room/break areas out of view of patients and families. (Please refer to the SMH electronic device use policy).
- Use of personal and business eDevices in the clinical setting for collection and transmission of protected health information will be through approved, secure networks in accordance with University of Rochester Medical Center HIPAA policies. Protected health information (PHI) transmitted through or to secured business eDevices will not be stored on personal eDevices.

Optimal Practice for Use of eDevices

- Rounding: departments should create guidelines that provide clear delineation of roles for clinicians when rounding, including use of eDevices.
- The most senior rounding clinician (Round Leader) is in the primary role of communicating with the patient and teaching others during rounding. As such, the leader should refrain from computer and/or eDevice use while in patient rooms with the exception of using eDevices during the course of teaching or explaining to the patient and family their diagnosis and plan of care.
- Clinicians should introduce the function and use of eDevices for medical management to patients and families upon admission and when first introducing themselves to the patient and family.
- Clinicians should have a separate eDevice or device with the technology that allows for the separation of work-related and personal communication. Work issued phones/blackberries, computers and “smart” devices, etc., should not be used for personal use in patient care and clinical work areas.

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It is important to remember:

- Devices should be in silent mode whenever in a patient room or discussing patient information with the patient/family.
- Clinicians will refrain from using computers and eDevices at clinical work stations to conduct personal business.
- Use of personal and business eDevices in the clinical setting for collection and transmission of protected health information will be through approved, secure networks in accordance with University of Rochester Medical Center HIPAA policies.

CONFLICT OF CARE

Subject Matter Experts:

SMH: Christopher Walsh (758-2032) **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/department 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.

Contact the Appropriate Person

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

	SMH	Highland
Contact Person/ Department/ Phone No.	Department Manager	Department Manager and Human Resources x1-6332
Written Resource (Policy Manual to reference)	<i>SMH Policy Manual, Policy 13.6: Employee and Medical Staff Right to Not Participate in Specific Health Care or Research Activities</i>	<i>Human Resources Personnel Policy Manual, 341, Conflict of Care</i>
Procedures Specific to Site		<i>HR Personnel Policy 341 outlines the procedures and provides a sample of the “Request to be Excused From Providing Patient Treatment/Care” form.</i>

Links

SMH Policy Manual, Policy 13.6, *Employee and Medical Staff Right to Not Participate in Specific Health Care or Research Activities*:

<http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/section13/13-6.pdf>

HH Human Resources Personnel Policy Manual, Policy 341, *Conflict of Care* (includes a sample of the “Request to be Excused From Providing Patient Treatment/Care” form):

<http://intranet.urmc-sh.rochester.edu/highland/depts/hr/documents/HR341-CONFLICTOFCARE.pdf> .

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CONFLICT OF CARE (continued)

It is important 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/Department 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)

Links

SMH policy 8.1.4 (<http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/section08/8-1-4.pdf>)

HH policy 1.16 (<http://intranet.urmc-sh.rochester.edu/highland/Policy/HHpolicy/1-16.pdf>)

Integrated Delivery Network

Strong Memorial and Highland hospitals are components of the University of Rochester Medical Center, an integrated delivery network of care that encompasses:

- the Hospitals
- 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
- Eastman Dental Center
- URMC-affiliated primary care and specialty physicians

The primary care and specialist physicians affiliated with the University of Rochester Medical Center also constitute part of our network of services.

Standards

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.

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It is important to remember:

It is important we maintain the highest standards of patient and family involvement and satisfaction; this is, in part, accomplished through clear communication 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 (DNR)

Subject Matter Experts:

SMH: Laura Wilson (275-7279)

HH: Sharon Johnson (341-8399)

Links

SMH Policy 9.3.3: <http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/section09/9-3-3.pdf>

HH Policy DNR 4.4: <http://intranet.urmc-sh.rochester.edu/highland/Policy/HHpolicy/4-4.pdf>

While in the Hospital

A patient must consent to a DNR order before it may be issued except when consent is obtained from a surrogate (for patients without capacity); 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.

Review of DNR Orders

The attending physician must review a hospital DNR order for a hospitalized patient 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.

Capacity to Consent to a DNR Order

- 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 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 medical record.
- Information regarding 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 9.3.3 or HH Policy Manual, Do Not Resuscitate 4.4.

Issuing 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.

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When a DNR Status Dispute Arises

- **SMH:** the attending physician must inform the Administrator-on-Call. The AOC shall refer the dispute to the Ethics Review Committee who shall attempt to facilitate agreement among the interested persons.
- **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 Social Work 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.

END OF LIFE CARE

Subject Matter Experts:

SMH: Rev. Robin Franklin (275-2187)

HH: Rev. Don Marlar (341-6890)

For more information:

SMH: <http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/section08/8-14.pdf>

HH: <http://intranet.urmc-sh.rochester.edu/highland/Policy/HHpolicy/2-57.pdf>

Priorities for End of Life Care

There are many medical situations in which cure or recovery is not possible, and the care of patients at the end of their lives can be challenging. The priorities for end-of-life care are to:

1. Educate patients and families regarding medically appropriate options for care
2. Respect patients' and families' wishes and decisions for care
3. Respect patients' and families' cultural and religious beliefs and traditions
4. Provide for patients' comfort including effective pain control and symptom management

Beliefs and Practices

Diverse cultural and religious beliefs and practices may often be unfamiliar to staff but also may be an important determinant of what a patient will require of end-of-life care. There are a number of issues that might be important to a patient at the end of life, and it is important that staff be in conversation with patients and their families about those issues.

Available Services

The following services are all available to patients, families, providers and caregivers to aid in the provision of care and/or discussion and resolution of issues that may arise in the course of end-of-life care:

- Palliative Care Consultation Service (SMH/HH)
- Ethics Consultation Service (SMH), the Ethics Committee (HH)
- Chaplaincy Services (SMH/HH)

Appropriate hospice services are also available for patients' care and support.

Principles of Quality in End of Life Care

Patients in end-of-life care will be provided the highest dignity and quality of care. Some of the principles that need to be followed are:

- 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, he or she will be offered the opportunity to designate a Healthcare Proxy in the event that the patient becomes unable to make decisions regarding his or her care.

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END OF LIFE CARE (continued)

- New York state law prescribes a formula for establishing a healthcare agent to make medical decisions in the event that the patient becomes unable to make medical decisions regarding his or her care and has not designated a Healthcare Proxy.
- All staff will respect the patient's and family's privacy and confidentiality as well as their cultural and religious beliefs and traditions throughout the process.
- To the fullest extent possible, family members and significant others will be allowed to remain with the patient and to participate in care if desired and if consistent with the wishes of the patient.
- A patient's pain, discomfort, and/or symptom management should always be addressed and never minimized or ignored.
- Patients should be offered psychological, social and spiritual interventions and support whether or not they choose to forgo active medical treatment.

It is important to remember:

- Priorities for end-of-life care include education of patients and families regarding options for care and respect for patients' and families' wishes and decision for care.
- A Healthcare Proxy or agent may be designated to make medical decisions and only in the event that a patient is unable to make decisions regarding his or care.
- A patient's pain, discomfort, or symptom management should never be ignored or minimized regardless of the treatment being given.
- Diverse cultural and religious beliefs and traditions may influence what some patients and/or families desire for end-of-life care and those wishes should be ascertained and honored to the fullest extent possible.

ENSURING COMPREHENSIVE HANDOFF (ECHO)

Subject Matter Experts:

SMH: Anna Lambert (276-3506), Michael S. Leonard, MD (276-4113)

HH: Sharon Johnson (341-8399)

For additional information:

SMH: http://intranet.urmc-sh.rochester.edu/Policy/ClinicalGuidelines/documents/Hand-OffCommunicationStandards_000.pdf

HH: <http://intranet.urmc-sh.rochester.edu/Highland/Policy/HHpolicy/2-77.pdf>

Topic Summary:

- Communication is the process by which information is exchanged between individuals.
- It is the sender's responsibility to present a clear message.
- It is the receiver's responsibility to hear, interpret, evaluate and respond to the message.
- The Joint Commission estimates that nearly 70% of serious potential and actual adverse events are the result of communication failures. Approximately half of these communication failures occur at the time of handoff.

A Hand-Off...

- Is the communication process that supports the transfer of care and responsibility for a patient from one clinician to another.
- Must occur at all transitions of care, such as change of shift, admission from the emergency department, and transfer to and from an intensive care unit.
- Must include the opportunity to ask questions.
- Involves a standardized process that enhances communication across hospital personnel, encourages teamwork, improves efficiency and promotes a culture of patient safety. In addition, a standardized handoff process is required by regulatory agencies including the Joint Commission and the Accreditation Council for Graduate Medical Education (ACGME).

URMC's Minimum Standards for the Handoff Process

1. A handoff communication will occur between the sender and receiver for all transfers of patient care responsibility. URM C acknowledges that for some clinical workflows, the receiver is not always available or known at the time of physical transfer of the patient. In such scenarios, the receiver will contact the sender to initiate the handoff communication.
2. The handoff process will include verbal communication, use of an on-screen clinical summary and/or a printable report to facilitate exchange of information between the sender and receiver. The Patient Story report(s) in eRecord provides key information that is concise, up to date and easy to read. The elements of this report link to more detailed clinical information. Patient Story reports will be visible to all clinical staff.

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ENSURING COMPREHENSIVE HANDOFF (ECHO) continued

3. The handoff communication will occur with minimal interruptions. Services will identify designated handoff times. Handoffs should be interrupted for emergent and urgent issues only. Text paging rather than numeric paging should be utilized. The text page should, at minimum, include a phone number and the name of the person to contact. Preferably, a brief message summarizing the question or concern should be included to enable the receiver to appropriately triage/prioritize calls.
4. Handoffs will occur in an appropriate environment conducive to good communication. The sender and receiver should, when possible, have eRecord access at the time of the handoff communication. For handoffs that do not occur at the bedside, a dedicated space that is quiet and out of patients' earshot should be available.
5. The sender of the handoff communication will have sufficient knowledge of the patient to effectively communicate the key and pertinent information to the receiver. The sender will have personally evaluated the patient prior to the handoff communication. The handoff communication will include, at minimum, the patient's historical data, medications, condition, care, treatment, services, and recent or anticipated changes.
6. The primary service providers and nurses responsible for a patient will be clearly and accurately identified in the electronic medical record. eRecord provides the following fields to support this standard:
 - Covering Provider = the first-call provider responsible for the patient
 - Current Attending = the attending physician responsible for the patient
 - Registered Nurse = the bedside nurse responsible for the patient

It is important to remember:

Minimal standards for the handoff process include:

- Handoff communication will occur between the sender and receiver for all transfers of patient care responsibility.
- Verbal communication, use of an on-screen clinical summary and/or a printable report.
- An environment conducive to good communication, and designated handoff times with minimal interruptions.
- eRecord access when possible at the time of handoff and if not occurring at the bedside, a quiet dedicated space out of patients' earshot.
- At a minimum, the patient's historical data, medications, condition, care, treatment, services, and recent or anticipated changes.
- Clear and accurate identity in the electronic medical record of the primary service providers and nurses responsible for a patient.

eRECORD DOWNTIME TESTING PROCEDURE

Subject Matter Experts:

SMH: Kathee Tyo (463-2955), Deb Phillips (275-5463)

HH: Susan Simeone (341-0239), Ann Wool (784-8312)

Once a month, the eRecord system may incur a scheduled downtime.

- Notification: sent to end-users 1 week in advance and again 1 to 2 days prior to the downtime.
- Scheduled for the third Sunday of each month at 2:00 a.m.

For an unplanned eRecord outage, follow these steps:

- Call the Help Desk whenever there is an issue of access to the system.
- While the initial assessment is occurring in ISD, end-users should attempt access to clinical data through other means in this order (end-users use their eRecord login and password to access all of these):

Icon 1 (Read Only)



- eRecord screens and content; no ability to enter.
- Displays all data that was available up until the point of the downtime

Icon 2 (Reports Only)



- A limited data set in report format
 - Inpatient reports include a clinical summary and the MAR
 - Allied services have specialized reports
- If eRecord is not accessible through **Icon 1** or **Icon 2**, then a Downtime PC is available on one unit-based PC; report-based clinical data (only partial data). Note: Icon 2 (Reports Only) and Downtime PC will contain the same reports.
 - To log in to the Downtime PC, use the PC name as the login and obtain the password by calling:
 - INPATIENT: 275-1588
 - AMBULATORY: 274-3712

What if the downtime lasts more than 2 hours?

- Each unit/location has a downtime tote.
- The tote contains specific unit- and service-level documentation tools.
- There is one shift's worth of paperwork available in the tote on most units.
- Additional stock is available at the service level in case of a very extended downtime.

How will I know the eRecord system is down for a large-scale major issue?

- The Help Desk will update the regular greeting message to state the system that is down and additional information as it becomes known.
- The System Status information on the Intranet will be updated.
- E-mails will be sent to clinicians notifying them of the system outage.

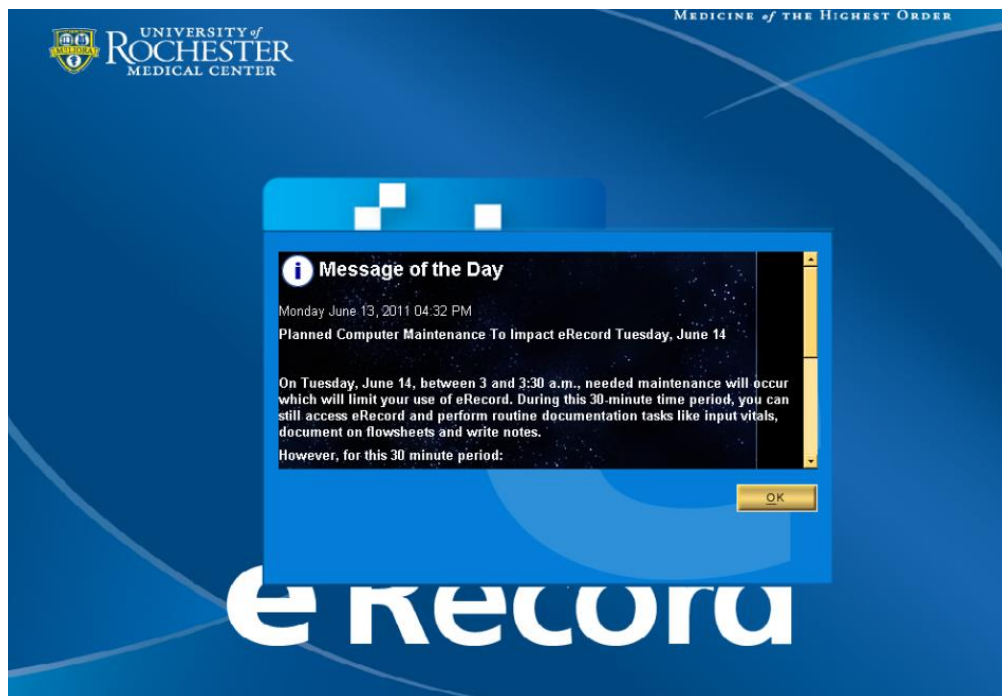
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eRECORD DOWNTIME TESTING PROCEDURE (continued)

- The Hospital Administrator On Call may determine to send an overhead page announcing critical system(s) outages (this is only considered if the system outage is over 30 minutes).
- Web Pages may be generated to the clinical groups.
- The eRecord login screen "Message of the Day" will be updated to describe the current issue:

It is important to remember:

- Scheduled downtimes occur on the third Sunday of each month at 2:00 a.m.
- If an unplanned eRecord system outage occurs, end-users should call the Help Desk and attempt to access clinical data in this order: Icon 1 (Read Only), Icon 2 (Reports Only). If eRecord is still not available via Icon 1 and Icon 2, a Downtime PC is available on one unit-based PC.
- If the downtime lasts more than 2 hours, go to the downtime tote for unit- and service-level documentation tools.
- In the event of a large-scale major downtime issue, the Help Desk will update the message of the day stating the system is down and provide updates as available, the Intranet System Status information will be updated, and clinicians will receive e-mails notifying them of the outage.



FALL PREVENTION

Subject Matter Experts:

SMH: Robert Panzer, M.D. (273-4438)

HH: Barbara Schrage (341-6850), Kristen Berns (341-0929)

Falls

- Falls are the largest single category of reported incidents in hospitals and the second most frequent cause of patient harm.
- The majority of hospital beds in the developed nations are occupied by older people, many of whom have been admitted because of mobility problems, falls, or injury from falls.
- According to the National Patient Safety Agency, falls in the acute care setting that result in some injury range from 30% to 51%. Falls resulting in fracture range from 1% to 3% with reports of hip fracture ranging from 1.1% to 2%. Proximal femoral fractures caused by falls that occur in the hospital setting have been found to result in poorer health outcomes.
- Patient falls within the acute care setting can be the sign of worsening frailty, new medical conditions, or worsening status of a patient's ability to perform activities of daily living.

Assessments Include But Are Not Limited To:

- Past history of falls
- Age ≥65
- Perceptual problems; e.g., impaired hearing and/or sight, neuropathies, dizziness/vertigo
- Orthopedic conditions; e.g., arthritis, knee, hip or joint pain/disability
- Neuromuscular conditions; e.g., CVA, Parkinson's disease, lower-extremity weakness
- Medication side effects; e.g., postural hypotension, sedation, extra-pyramidal effects
- Risk factors for injury
- Medication interactions—more than 3-4 medications
- Fluid and/or electrolyte imbalance
- Delirium, cognitive decline, disorientation, wandering or Alzheimer's Disease
- Restraints
- Confusion/disorientation
- Poorly fitting footwear
- Unfamiliar environment
- Dysrhythmias
- Syncope
- Incontinence of bowel and/or bladder
- Sleep disorders

Fall Risk Screening

- During the admission process, a provider will make an initial assessment of fall and injury risks, based on medical comorbidities and H&P findings, and write any orders based on the assessment.
- Admitted adult inpatients will also have a Fall and Injury Prevention Risk Assessment completed and documented upon admission, by a registered nurse utilizing the evidence-based fall risk screen.
- A multidisciplinary fall and injury prevention plan of care will be developed and implemented based on the nursing risk assessment and provider H&P.

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Frequency of Nursing Assessment

Admitted adult patients are assessed for fall and injury risk and an individualized plan of care established based on patient-specific risk factors. This assessment and plan are to be completed and documented on the appropriate flow sheet/location in the EMR/patient record by a registered professional nurse.

Strong Memorial Hospital

- Within twenty-four hours of admission
- Daily
- Promptly after a patient fall
- Upon transfer from one unit to a new unit
- Significant changes in patient status that may put the patient at higher risk of falling; for example:
 - Post-operative
 - Onset of confusion, delirium, change in mental status/ability to follow instructions
 - Sudden change in mobility
- Plan of Care
 - Includes interventions to minimize preventable falls and injuries
 - Reviewed each shift and updated based upon shift assessment and patient's status
 - Communicated with each nursing hand-off, including any recent revisions

Highland Hospital

- On admission
- Minimally every 24 hours
- Upon transfer to a unit
- With a change in condition (e.g., MI, PE, CVA, delirium, etc.)
 - Post-operative
 - Onset of confusion, delirium, change in mental status/ability to follow instructions
 - Sudden change in mobility
- After a fall
- Plan of Care
 - Includes interventions to minimize preventable falls and injuries
 - Reviewed each shift and updated based upon shift assessment and patient's status
 - Communicated with each nursing hand-off, including any recent revisions

Patient Care Orders/Interventions

Specific patient care orders/interventions should be based on the assessment findings and become part of an interdisciplinary safety plan for the patient.

Orders/interventions include but are not limited to the following:

- Review medications for side effects/interventions and consider medication or dose changes.
- Implement strategies to prevent and treat early signs of acute onset delirium.
- Refer to Physical Therapy or Occupational Therapy, if indicated, to assist mobility, strength training, gait training or assistive devices.
- Refer to appropriate specialist/department to assist with managing hearing or visual deficits.

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FALL PREVENTION (continued)

- Discuss with interdisciplinary team a fall safety plan including safety equipment that can be used to prevent injury; for example, hip protectors, helmets and enclosure beds (SMH only), floor mats, low beds, bed and chair alarms as appropriate.
- If a patient has sustained a fall, work with the patient to identify what they were doing at the time of the fall. Put a plan in place to address the cause of the fall if possible.
- Assess effectiveness of interventions/orders during interdisciplinary rounds.
- Include the patient and family in discussion about the fall prevention plan and importance of safety interventions.
- Post-Fall Huddle (HH)—include available multidisciplinary team members, to address the fall-related factors and additional preventative interventions

Fall Risk Communication and Visual Cues

Communication of Fall Risk

- Hand-off Report
- Unit Safety Briefings
- Admission and ongoing communication with patient and family
- *Consider documentation on white board in patient room, to document patient ambulation needs*

Visual Cues/Signage—Highland Hospital

- Limit use of door signage for patients who:
 - Have experienced a fall during the current hospitalization
 - Have been admitted due to a fall
 - Are at high risk (Morse score of > 45) of falling **and** at risk of fall-related injury



Fall Precautions and Patient and Family Education

An order for falls precautions shall indicate the implementation of a multidisciplinary fall and injury prevention plan of care based on patient risk factors.

- All patients and families (as appropriate) are educated on fall and injury prevention interventions which are part of the patient's safety plan. The patient education is documented in the record.
- For patients who sustain a fall, the provider is notified and the patient's plan of care is reviewed and updated as appropriate.

Morse Fall Risk Screening Tool

The fall risk screening tool utilized by the RN identifies patients at risk for falls based on the domains of:

Morse Falls Assessment
History of Falling
Secondary Diagnosis
Ambulatory Aids
IV / IV Access
Gait/Transferring
Mental Status
Score
Morse Fall Risk Level
Morse Fall Risk Override

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FALL PREVENTION (continued)

Moderate to High Fall Risk Interventions

Potential interventions to incorporate into the patient's safety care plan are:

Fall Risk Interventions (Score >24)
Patient room close to nursing station
Assisted devices within reach
Safe Exit Side
Toileting Plan Established
Gait Belt
Orthostatic BPs Checked
Visual Cues
Bed Alarm
Chair Alarm
Bedside Observation/Monitoring
Other

Fall Injury Prevention Assessment

Injury risk assessment completed by RN.

Fall Injury Prevention Assessment
Age >85 or Frail due to clinical condition
Patients at high risk for bone fractures
Anticoagulation
Surgery - Post-surgical patients
Repetitive Falls
Fall Injury Score

Fall Injury Prevention Interventions for ≥1 Risk Factor

Injury prevention interventions to consider based on the patient's risk factor are:

Condition: > 0
Suggested rows
..... Hip protectors (Group:)
..... Floor Mats (Group:)
..... Low bed (Group:)
..... Medication review (Group:)
..... Helmets (Group:)
..... Canopy Bed (Group:)
..... Stay with patient during toileting (Group:)
..... Positioning Aids (While out of bed) (Group:)
..... Other

Hip protectors, helmets, canopy beds are available at SMH only.

Additional Considerations

- Strategies to prevent and treat early signs of acute onset delirium should be considered.
- Consider referrals to Physical or Occupational Therapy to assist patients with impaired mobility in need of strength training, gait training or need of assistive devices. Of note, this goes beyond basic ambulation.
- Refer appropriate specialist/department to assist with managing hearing or visual deficits.
- A post-fall shift event note located on the doc flow sheet should be completed if a patient sustained a fall. Obtaining a description of what the patient was doing at the time of the fall, how they felt, is critical in identifying additional modifiable risk factors.
- A provider should be contacted to assess and order diagnosis tic of additional safety interventions for a patient, especially if fracture or head bleed is suspected.

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FALL PREVENTION (continued)

For more information:

SMH Policy

<http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/Section10/10.23%20Adult%20Fall%20and%20Injury%20Prevention.pdf>

Highland Policy

http://intranet.urmc-sh.rochester.edu/highland/Policy/nursingPolicy/Standards/06-07_SOC_Fall_Prevention.pdf

CDC: <http://www.patientsafety.va.gov/professionals/onthejob/falls.asp>

VA National Center for Patient Safety:

<http://www.patientsafety.va.gov/SafetyTopics/fallstoolkit/index.html>

Some online and published resources from the Joint Commission include: [The National Guideline Clearinghouse](#) (enter "fall prevention" in the search field)

It is important to remember:

- According to the CDC, falls are the leading cause of injury, deaths, and hospital admissions for trauma among adults 65 years and over.
- Identifying patients at risk for falls provides the opportunity to institute measures to help prevent falls.
- Upon admission or with any change in condition, all patients should be assessed for risk of falling/injury and a safety plan created.
- Specific patient care orders/interventions should be based on the assessment findings and become part of an interdisciplinary safety plan for the patient.

HEALTH CARE PROXY

Subject Matter Experts:

SMH: Laura Wilson (275-7279) **HH:** Sharon Johnson (341-8399)

For more information:

SMH: <http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/section09/9-3-1.pdf>

HH: <http://intranet.urmc-sh.rochester.edu/highland//Policy/HHpolicy/4-14.pdf>

Purpose

- 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 health care decisions when the patient is unable to make such decisions.
- 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.
- The proxy document may include any special instructions, limits of authority, expiration date, and may provide for the appointment of an alternate representative.
- 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.

Capacity

- 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.
- 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.

Upon Admission

- On admission, each patient or a designee will be given a copy of the NYS DOH 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.

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HEALTH CARE PROXY (continued)

It is important 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.

INFORMATION FOR CLINICAL DECISION MAKING

Subject Matter Experts:

- SMH:** Donna Berryman (275-6877)
HH: Lorraine Porcello (341-0378)
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For more information:

- SMH: Miner Library online <http://www.urmc.rochester.edu/miner/>
HH: Williams Health Sciences Library online
<http://www.urmc.rochester.edu/libraries/williams/>

Avoiding Malpractice Claims

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.

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

- Click the “Ask a Librarian” link on the Miner Library, Bibby Library, or Williams Library home pages ~or~
- Call 275-2487 (Miner Library); 275-5010 (Bibby Library at Eastman Institute for Oral Health); or 341-6761 (Williams Library at Highland Hospital).

Expectations

- 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.

Resources

- Patient care providers should be familiar with the content and use of resources available in Miner Library online (www.urmc.rochester.edu/miner/) at the University of Rochester Medical Center (URMC-SMH) or the Williams Health Sciences Library online at Highland (www.urmc.rochester.edu/libraries/williams/).
- Access to electronic journals, books, drug information, evidence-based medicine resources and databases is available at URMC and Highland Hospital, and at offices and clinics on the URMC network. They are also available remotely with a Medical Center Active Directory account (URMC network and e-mail login) or UR NetID.
- Remote access to UpToDate is available for all URMC and Highland Hospital employees and students.

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

INFORMATION FOR CLINICAL DECISION MAKING (continued)

- On their websites Miner, Bibby and Williams Libraries provide access to evidence-based resources such as Essential Evidence Plus, Cochrane Library, UpToDate and Lexicomp.

Ask a Librarian

- 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.
- Simply click on “Ask a Librarian” from the Miner (URMC), Bibby (Eastman Institute for Oral Health), and Williams (Highland Hospital) library websites. Additional contact information (phone numbers, e-mail) is also listed on the websites.

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:

SMH

Policy 9.11.1 (Suspected Child Abuse or Maltreatment):

<http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/section09/9.11.1%20Suspected%20Child%20Abuse%20or%20Mistreatment.pdf>

Policy 9.11.2 (Contacts With Law Enforcement Agencies):

<http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/section09/9-11-2.pdf>

Policy 9.11.4 (Adult Domestic Abuse):

<http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/section09/9-11-4.pdf>

Policy 9.7 (Sexual Assault):

<http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/section09/9-7.pdf>

HH

Policy 3.5 (Child Abuse):

<http://intranet.urmc-sh.rochester.edu/highland/Policy/HHpolicy/3-5.pdf>

Policy 4.19 (Domestic Violence):

<http://intranet.urmc-sh.rochester.edu/highland/policy/HHpolicy/4-19.pdf>

Policy 3.8 (Elder Abuse):

<http://intranet.urmc-sh.rochester.edu/highland/Policy/HHpolicy/3-8.pdf>

Policy 3.10 (Physical Assault):

<http://intranet.urmc-sh.rochester.edu/highland/Policy/HHpolicy/3-10.pdf>

Policy 4.7 (Sexual Assault):

<http://intranet.urmc-sh.rochester.edu/highland/Policy/HHpolicy/4-7.pdf>

Abuse and Neglect include:

- Suspected Child Abuse or Maltreatment
- Elder Abuse
- Adult Domestic Violence
- Sexual Assault

Child Abuse Reporting Required

NYS Social Law **requires** health care providers to report any and all suspicions of child abuse or maltreatment to:

- NYS Child Central Registry
- Or Monroe County child abuse and neglect hotline

Only reasonable cause, not proof, is essential to file a report.

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Reporting Process—Suspected Abuse/Neglect

1. Immediately alert social worker
 - SMH**—available 24 hrs/day via Page Office. Social worker and/or medical team determine the need for a REACH (Referral and Evaluation of Abused Children) consult (staffed by medical experts in evaluation of physical and/or sexual abuse)
 - HH**—days, page Social Work Director at 220-8319; after hours, page Social Worker on call with medical team
2. Social worker with medical team initiates formal referral to Child Protective Services (461-5690) and law enforcement
3. Objective facts and phone referral documented in patient record.
4. Social worker coordinates safe discharge

Reporting Process—Suspected Domestic Violence or Elder Abuse

1. Immediately alert social worker
 - SMH**—available 24 hrs/day via Page Office
 - HH**—unit social worker or on-call social worker via pager
2. Social worker assesses for patient and dependent safety
3. Initiates appropriate reporting activities
4. Provides referral information to patient

Management of Sexual Assault

SMH	Highland
<ol style="list-style-type: none">1. Follow protocol for documentation and evidence gathering processes (URMC-SMH 9.7).2. Alert social worker (available 24 hours a day via Page Office).3. For victims under the age of 18, refer to URMC-SMH Policy 9.11.1.	<ol style="list-style-type: none">1. Follow protocol for documentation and evidence gathering processes.2. Ensure the patient is never alone.3. Contact social worker assigned to the area or via the nursing supervisor for the on-call social worker.

It is important to remember:

1. Abuse and neglect include:
 - Suspected child abuse or maltreatment
 - Elder abuse
 - Adult domestic violence
 - Sexual assault
2. NYS Social Service Law mandates that health care providers report any and all suspicions of child abuse or neglect to the NYS Child Central Registry or the Monroe Co. child/abuse neglect hotline.

MEDICAL EQUIPMENT

Subject Matter Experts:

SMH: Don S. DiVita (275-5964)

HH: Rob John (341-6833)

For more information:

URMC-SMH (Policy 2.3):

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

HH: <http://intranet.urmc-sh.rochester.edu/Highland/Policy/envCare/documents/2010-2011MedicalequipmentManagementPlan-HH20100908.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.

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

- Put the equipment aside
- Contact Clinical Engineering at 275-5501 (SMH) or 341-7378 (HH)
- Request an inspection

Use of the Patient’s Personal Home Equipment

Inpatients: Use of patient-provided medical equipment should be discontinued as soon as possible after admission (except personal infusion devices, insulin pumps and CPAP/BiPAP 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 (other than a CPAP/BiPAP device) is not available, Clinical Engineering at SMH or the Clinical Engineering Department at Highland must be called to inspect the patient-provided device. Staff must be trained on how to use the equipment. Patient-owned CPAP/BiPAP devices must be inspected and documented by Respiratory Therapy.

Note: Exception at HH and SMH - patient’s own insulin pumps, refer to the appropriate policy and protocol.

Ambulatory Patients: use of CPAP/BiPAP requires an inspection and completion of CPAP/BiPAP checklist by Respiratory Therapy or Nursing at off-site locations.

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MEDICAL EQUIPMENT (continued)

It is important 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: Bilal Ahmed, MD (341-6776)

For more information, please go to:

http://www.compassionandsupport.org/index.php/for_professionals/molst_training_center or

<http://intranet.urmc-sh.rochester.edu/highland/Policy/HHpolicy/4-5.pdf>

The MOLST Form

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 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 medical record.

Misconceptions About MOLST:

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

False! The MOLST generally designates limitations on treatment but not always. It is unclear what, if any, limitations there are on medical treatment without carefully reading the form. Full CPR is the default position if no form is present or if there is uncertainty about the patient's preferences.

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

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

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

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

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MEDICAL ORDERS FOR LIFE-SUSTAINING TREATMENT (continued)

4. Any provider may issue a DNR order

False! A DNR order can be entered only by the attending physician, personally or through a verbal order from the attending and then entered on the MOLST and the EMR by a resident or a mid-level provider. Such verbal orders must be cosigned on the MOLST by the attending physician within 24 hours.

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

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

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

False! The MOLST form documents the patient's current preferences (or their surrogate's view of the patient's preferences if the patient is incapable of decision making) about potentially life-sustaining therapies. The MOLST form has a section on the bottom of page 1 to designate the presence or absence of Healthcare Proxy or Living Will documents, but these are separate documents that, if completed, should also be placed in the patient's medical record. A Healthcare Proxy documents the person(s) the patient would like to represent them in medical decision making in the future should they lose capacity to make their own decisions. A Living Will documents the patient's future preferences about treatment, but unlike the MOLST, it is only activated when and if patients lose capacity to make decisions for themselves in the future. Unlike the MOLST, neither the Living Will or the Healthcare Proxy documents are actionable medical orders.

7. The supplemental MOLST form is needed for a patient who lacks decision-making capacity.

False! With the latest MOLST revision, only the main MOLST form is needed on all patients when a limitation of life-sustaining therapy is being designated, whether they have or lack decision-making capacity. The main MOLST suffices by itself in both situations, but must be backed up with the appropriate documentation in the medical record, especially if the patient lacks capacity or is a minor. The MOLST checklists are available to guide the clinician in appropriate documentation.

Facts to Remember

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. DNR, DNI and other decisions about other potentially life-prolonging therapies can be made by patients with capacity. If the patient has lost decision-making capacity and does not already have a MOLST form filled out, decisions about DNR, DNI and other potentially life-prolonging therapies can be made by designated health care proxies or by family members based on what is known about the patient's wishes. Specific guidelines and checklists (which are recommended but not legally required) for making these decisions are available at the following website:

http://www.compassionandsupport.org/index.php/for_professionals/molst_training_center

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MEDICAL ORDERS FOR LIFE-SUSTAINING TREATMENT (continued)

2. 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.
3. The MOLST form does not necessarily mean that the patient has chosen DNR (Do Not Resuscitate) or DNI (Do Not Intubate) status. The form must be carefully read to see if any limitations on treatment have been ordered.
4. A DNR order can be entered only by the attending physician, personally or through a verbal order entered by a resident or a mid-level provider and cosigned by the attending physician within 24 hours.
5. 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.
6. The pink MOLST form should travel with the patient wherever he or she goes. A copy of the MOLST should stay in the patient's medical record.

MEDICAL RECORD DOCUMENTATION FOR CLINICAL STAFF

Subject Matter Expert:

SMH and HH: Donna Barnard (275-2606)

Additional Resource Experts:

SMH – Kristen Dilg (275-5137) and HH – Rochelle Nichols (341-6429)

For more information:

SMH:

[http://intranet.urmc-](http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/documents/6.1MedicalRecordContentandDocumentation.pdf)

[sh.rochester.edu/Policy/SMHPolicies/documents/6.1MedicalRecordContentandDocumentation.pdf](http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/documents/6.1MedicalRecordContentandDocumentation.pdf)

<http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/Section08/8.1%20attachment%20II.pdf>

HH:

<http://intranet.urmc-sh.rochester.edu/highland/Policy/HHpolicy/2-15.pdf>

<http://intranet.urmc-sh.rochester.edu/Highland/Policy/HHpolicy/2-58.pdf>

Documentation Rules

- Verbal orders must be authenticated (verified, signed, dated and timed, electronically or in writing) within 48 hours of being given by a credentialed member of the provider team caring for the patient.
- Documentation must be legible; if two different people cannot read hand-written notes, information is considered illegible.
- ALL medical record entries must be dated, timed, signed, and include your professional status.
- Post-op progress note is required immediately after surgery. Must include name of surgeon and assistants, procedure performed, description of findings, estimated blood loss, specimens removed, post-op diagnosis, and any unanticipated events or complications.
- All surgical/procedural patients (e.g., inpatients, ambulatory surgery patients and same-day admission patients, and other significant procedure* patients) must have a history and physical exam no more than 30 days prior to the surgery/procedure. The history and physical must be entered into the patient's record on or prior to admission, signed, dated, and timed by the responsible physician or other credentialed practitioner. If the history/physical is completed by someone other than an attending physician, it must be reviewed and countersigned by an attending physician.
 - *A significant procedure is defined as one that carries an operative or anesthetic risk or requires highly trained personnel or special facilities or equipment. E.g., cardiac catheterization, angiography, endoscopy, super voltage radiation therapy, and debridement.
- Prior to surgery, an update to the patient's condition must be documented in the medical record.
- A summary list is initiated for outpatients by the third visit. The current medication list including prescriptions, over-the-counter medications, and herbal preparations, is completed by the patient's **FIRST visit**.

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MEDICAL RECORD DOCUMENTATION FOR CLINICAL STAFF (continued)

- Do Not Use Abbreviations

U, IU, Q.D., Q.O.D., MS, MSO₄, MgSO₄, µg, T.I.W., A.S., A.D., A.U.

Never use an abbreviation on this list in any form (upper or lower case, with or without periods)

Never write a zero by itself after a decimal point

Always use a zero before a decimal point

- Health care directives and MOLST forms are scanned into eRecord under Health Care Directives in the Media tab. The header of the patient's electronic record notes the code status of the patient and has a hyperlink to take you to the Advance Directive Activity and Code Order reports.

It is important to remember:

- All medical record entries must be dated, timed, signed, and include your professional status.

- Do Not Use Abbreviations

U, IU, Q.D., Q.O.D., MS, MSO₄, MgSO₄, µg, T.I.W., A.S., A.D., A.U.

Never use an abbreviation on this list in any form (upper or lower case, with or without periods)

Never write a zero by itself after a decimal point

Always use a zero before a decimal point

- For outpatients, the current medication list including prescriptions, over-the-counter medications, and herbal preparations is completed by the patient's *first* visit.

MEDICATION RECONCILIATION AND ADVERSE DRUG REACTION (ADR) REPORTING

Subject Matter Experts:

- SMH:** Medication Reconciliation, Ann Peterson Ottman (276-6065)
ADR, Curtis Haas, Pharm.D (275-8337)
- HH:** Jeff Huntress, PharmD (341-6792)
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For more information:

SMH Policy Manual:

<http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/section07/7-3.pdf>

SMH Ambulatory Care Manual:

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

Highland Hospital Policy: <http://intranet.urmc-sh.rochester.edu/highland/Policy/HHpolicy/2-79.pdf>

The Joint Commission National Patient Safety Goals:

http://intranet.urmc-sh.rochester.edu/depts/JCReadiness/NPSG_Chapter_Jan2013_HAP.pdf

Joint Commission National Patient Safety Goal #3

The Medication Reconciliation Process and Joint Commission National Patient Safety Goal #3 require providers to:

- Consult with the patient and family to create and document a complete list of medications the patient is taking at home.
- Compare and reconcile any discrepancies between the home medication list and medications ordered while the patient is under the care of the medical facility.
Ambulatory/ED areas minimally using medications or prescribing for a short duration, refer to your department policy.
- 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 educated about importance of maintaining a current medication list, to discard any old versions, and update any records with all medication providers or retail pharmacies.

Medication Reconciliation Avoids 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 generic and brand name.
- Harmful interactions between newly started and current medications. 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.

Adverse Drug Reaction (ADR) Reporting

- Describes unwanted, negative consequences sometimes associated with medication use.

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MEDICATION RECONCILIATION AND ADVERSE DRUG REACTION (ADR) REPORTING (continued)

- Adverse drug reaction is a noxious and unintended result of a medication occurring at the normal dose given for treatment of disease or disease prevention
- Examples include, but not limited to:
 - Rash/hives
 - Unexpected blood pressure drop
 - Shortness of breath, trouble breathing
 - Fever
- Tracking/trending of ADRs lead to medication use process improvements which improve patient safety.
- Report ADRs in the hospital electronic reporting system at:
http://rl6app.urmc-sh.rochester.edu/rl6_prod/
- Also contact a pharmacist to provide support or investigation into the incident

MRI SAFETY (SMH specific)

Subject Matter Experts:

SMH: Julie Moeller (275-8656)

What is Magnetic Resonance Imaging (MRI)?

- MRI is a diagnostic imaging test that uses a very large and strong magnet to produce images of the human body.
- The MRI systems used today vary in strength with the strongest scanners rated at 3 Tesla. Tesla magnets are strong enough to pick up a car.
- MRI scanners are ALWAYS on, even when there is no patient being imaged.

Screening Process

- It is very important to properly screen all patients, visitors, and staff prior to entering Zone 3. This is to assure that all metallic objects such as jewelry, cell phones, hearing aids, scissors, etc. have been removed to prevent items from becoming projectile and to identify/prevent disruption of any metallic surgical implants.
- This process is achieved through written and verbal communication by a healthcare professional prior to any MRI scan.

MRI Zones

The MRI department/sites are divided into 4 zones to ensure public and patient safety.

- Zone 1: includes all areas freely accessible to the general public, such as a main hallway.
- Zone 2: Are where patients are safely screened, change into metal free clothing and secure their belongings.
- Zone 3: Is the MRI control area. Access is strictly limited to MRI personnel and patients who have been screened and changed.
- Zone 4: Is the MRI MAGNET room that contains the VERY strong magnetic field. Access is strictly limited to MRI personnel and patients undergoing their scan.

ORGAN AND TISSUE DONATION

Subject Matter Experts:

SMH: Nancy J. Ryan (272-4930)

HH: Melissa Bourne (341-6806)

For more information:

SMH: *Policy 5.6.2 (Donation of Organs and Tissues)*

HH:

Hospital Policy Anatomical Gifts 4.12

Organ Donation After Cardiac Death 4.13

Brain Death Determination 4.9

Brain Death Determination by Neurological Criteria Checklist 4.9-1

Nursing Practice Standards:

Protocol for the Management of Patients Who Have Died 14.0

Whole Body Donation (SMH only)

Refer to *SMH Policy 5.6.1 (Anatomical Gift Program)*.

Medical Examiner cases or whole body donations do not preclude offering the option for tissue donation

Finger Lakes Donor Recovery Network Education (password required: fldrn2014)

<http://www.donorrecovery.org/fldrn2014/>

Federal and State Regulations Require:

All patient deaths, imminent deaths, withdrawals of life-sustaining therapies must be called into the Donor Hotline at 1-800-774-2729, (per Federal Regulation 42 CFR 482 and NYS Public Health Law 4351-A).

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.

Call the Donor Hotline

- Within 2 hours if a ventilated patient with a grave prognosis and regardless of diagnosis meets any of the following Clinical Triggers:
 - 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
- Within 1 hour in the event of an actual patient (cardiopulmonary) death

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Donor Hotline Referrals Then Triage

- Finger Lakes Donor Recovery Network (FLDRN)
 - A preliminary determination of suitability for organ donation is made.
 - 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.** Finger Lakes Donor Recovery Network personnel are the “Designated Requestors” of donation but work collaboratively with hospital staff to determine the best plan to have a conversation with a potential donor family regarding consent for organ donation. All conversations regarding the consent for organ donation must be authorized by Finger Lakes Donor Recovery Network. Health care practitioners involved in the patient’s care are always welcome and encouraged to be present during the consent discussion between the family and the FLDRN coordinator.
- Eye Donation*
 - Lions Eye Bank of Rochester (LEBR)
- Tissue Donation*
 - Musculoskeletal Tissue Foundation (MTF)
- *LEBR and MTF personnel are the only “designated requestors” to approach families to offer eye/tissue donation

It is important to remember:

- Your primary role with Organ, Eye and Tissue Donation is to ensure all deaths, imminent deaths, withdrawals of care, and actual deaths are called to the Donor Hotline so that families may be offered the opportunity for donation.
- FLDRN, LEBR, and MTF will make all determinations of donor suitability and contact you for more information.
- Document all referral calls in the patient’s medical record.
- Do **not** ask families for consent to donate organs. Finger Lakes Donor Recovery Network will collaborate with hospital staff to facilitate a team approach to best serve the potential donor family.

PAIN MANAGEMENT

Subject Matter Experts:

- SMH:** Timothy Quill, M.D. (273-1154); Kimberly Ziegler (273-2896)
HH: Laurie Ernest (341-8057), Nancy Ryan (272-4930)
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For more information see:

- SMH:** <http://intranet.urmc-sh.rochester.edu/policy/smhpolicies/section08/8-15.PDF>
HH: <http://intranet.urmc-sh.rochester.edu/highland/Policy/nursingPolicy/standards/10-3.pdf>

Managing Patient Pain

- Patients have the right, consistent with applicable laws, to receive timely assessment and treatment of pain, including education about managing their pain.
- The SMH Pain Management Program and HH pain management policies/protocols assist providers in preventing and/or optimally managing pain in all patients, across all settings. In collaboration with patients and families, providers will work toward 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
 - Clear documentation

Pain Management Modalities

- Pharmacologic (oral, intravenous, transdermal or via alternative routes)
- 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 important to remember:

- Patients should be assessed for the presence/severity of pain at least every 4 hours; more frequently following the identification of pain, treatment of pain, or after a potentially painful procedure.
- 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.
- Once a treatment has been provided, a reassessment must be completed and documented in the patient's medical record within 30-60 minutes.
- For patients from 6 - 12 years of age, cognitively impaired, unable to read or communicate in English, pain assessment using the FPR-S (FACES) scale is appropriate. The FLACC scale or other pain assessment tools should be used in children less than 6 years of age.
- 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:** Sharon Johnson (341-8399)

For more information:

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

HH: <http://intranet.urmc-sh.rochester.edu/highland/Policy/HHpolicy/>

Advance Directive

- 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.
 - Includes a preference as to whether to continue or refuse life-sustaining treatment, in the event that he or she becomes incapacitated.
- The law requires the hospital to legally honor 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 important to remember:

- Members of the health care team presented with a patient's written advance directive 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 the 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 (275-2059) or the Highland Hospital Office of Quality Management (341-8399).

PREVENTION OF SURGICAL SITE INFECTIONS

Subject Matter Expert:

SMH and HH: Ann Marie Pettis (SMH: 275-5056 and HH: 341-6853)

Surgical Site Infection (SSI) Is Major Cause of Patient Injury, Mortality, Increased Cost

- Each year 160,000-300,000 patients who undergo surgery develop an SSI
- SSIs are now the most common and very costly healthcare-associated infection (HAI)
- Each infection is estimated to increase a hospital stay by an average of 7-10 days and adds \$10,000 to \$25,500 extra charges. The total price tag for treating these infections is estimated to be \$10 billion annually.
- Patients with an SSI have a 2-11 times higher risk of death compared to operative patients without infection.
- Reducing SSIs is an important goal for all healthcare institutions. Up to 60% are estimated to be preventable by using evidence-based guidelines such as preoperative administration of antibiotics and eliminating pre-op shaving of hair.

Prophylactic Antibiotic Therapy

- Includes appropriate selection, timing, and discontinuation of antibiotic prophylaxis.
- Most prophylactic antibiotics must be initiated, but not necessarily completed, within one hour prior to surgical incision. Vancomycin and fluoroquinolones should be initiated within 2 hours prior to incision.
- Prophylactic antibiotics must be discontinued within 24 hrs. after surgery end time (or provider must document the appropriate reason if continued). CDC now recommends that they be stopped upon closure of the incision.
 - Exception: cardiac surgery cases which can have antibiotics continued for up to 48 hours.
- There is a list of antibiotics that have been approved for use in various surgical specialties.

Glucose Control and Surgery

- Glucose control has been shown to prevent SSI in cardiac surgery.
- There is also growing evidence that hyperglycemia contributes to increased risk of infection in other surgical procedures as well.
- Maintain plasma glucose of ≤ 180 mg/dl (CDC recommends ≤ 200) throughout the perioperative period for diabetics and nondiabetics.

Normothermia

- Hypothermia has been associated with a number of adverse consequences, including:
 - Increased susceptibility to infection
 - Impaired coagulation and increased transfusion requirements, both of which can increase the risk of SSI.
 - Post-anesthesia shivering and thermal discomfort

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PREVENTION OF SURGICAL SITE INFECTIONS (continued)

- Temp control must begin in the pre-anesthesia area:
 - Use passive insulation (warm blankets, socks, and head covering)
 - Limit skin exposure during pre-op procedures
 - If the patient is hypothermic on admission to pre-anesthesia, apply a forced-air warming system and increase passive insulation
 - Keep room temperature around 70 degrees
- Intra-operative measures:
 - Consider warming the operating room until the patient is prepped, draped
 - Passive insulation (warm blankets, socks, and head covering)
 - Institute active warming measures (e.g., a forced-air warming system)
 - Warm fluids for IV or irrigation
 - Patient temperature should be $\geq 36^{\circ}\text{C}/98^{\circ}\text{F}$ throughout the perioperative period
 - Post-anesthesia care is the same as pre-anesthesia measures

Appropriate Hair Removal

- Ideally hair should not be removed. If it must be removed, then a razor must not be used.
 - Exceptions: cases of traumatic head injury or scrotal surgery may have hair removed with a razor if deemed necessary by the surgeon
- If hair must be removed it should ideally occur outside the operating room.

General Infection Prevention Measures

- Scrupulous hand hygiene and pre-op scrubbing is imperative
- Appropriate surgical attire worn during surgery
- Patient skin prep and draping of the operative site is carried out
- Removal of urinary catheters occurs no later than 24-48 hours after the end of surgery

It is important to remember:

- Postoperative infection is a major cause of patient injury, mortality, and health care costs; each infection is estimated to increase a hospital stay by an average of 7 days and adds \$10,000-\$25,500 extra charges per SSI.
- Proper prophylactic antibiotic therapy includes appropriate selection, timing and discontinuation of antibiotic prophylaxis.
- Hypothermia has been associated with a number of adverse consequences; temperature control must begin in the pre-anesthesia area.
- Ideally hair should not be removed. If it must be removed, then a razor must not be used unless traumatic head injury or scrotal surgery are involved and the surgeon deems it necessary. Hair removal if necessary should occur outside the OR if at all possible.

RADIATION SAFETY

Subject Matter Experts:

SMH: Frederic Mis, Ph.D., CHP (275-1473),

HH: Ahmad Matloubieh (341-6750)

For more information:

NYS DOH: <http://www.health.ny.gov/publications/4402/>

Contact:

SMH: Frederic Mis, Radiation Safety Officer, 275-1473 (after hours, call Security)

HH: Ahmad Matloubieh, Chief Physicist, 341-6750
Joe Coon, Safety Officer, 341-6833

Copy of NYS Health Dept. Radiation Safety Regulations:

SMH: available to all departments from Radiation Safety

HH: contact Ahmad Matloubieh for a copy

Areas Using Radioactive Materials

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 (inpatient unit for patients who have received radiation implants)

Other Areas Using Radioactive Materials

- Treatment, diagnostic testing
- Some areas have a storage room specially built to house radioactive supplies.
- Cans, boxes, rooms containing radioactivity are always well marked.
- Shipments containing radioactive substances for these departments during regular business hours are delivered to:

SMH only: Radiation Safety loading dock

HH: These departments directly from Shipping & Receiving

Patient Rooms

- Some patients receive large doses of radiation for treatment.
- Their rooms are posted with the radiation symbol.
- Do not enter these rooms 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").

Minor Radiation Exposure Risks

- There are no expected health risks from minor exposure

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RADIATION SAFETY (continued)

- 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, contact Radiation Safety and speak with a staff health physicist or (at HH) Radiation Safety Officer about your questions or concerns.

It is important to remember:

To minimize your exposure to radiation:

- **Distance** - The dose of radiation received is inverse square proportional to 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. If a person doubles his or her distance from the radiation source, their radiation exposure is reduced by a factor of 4.
- **Time** - The dose of radiation received is directly proportional to 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 radiation, 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.

RAPID RESPONSE TEAM

Subject Matter Experts:

SMH: Mark Ott (275-5924)

HH: Jennifer Jesske (341-6932)

For more information:

SMH: <http://intranet.urmc-sh.rochester.edu/Policy/smhpolicies/Section02/2-0.pdf>

HH: <http://intranet.urmc-sh.rochester.edu/highland/policy/nursingpolicy/Standards/4-8.pdf>

Rapid Response Teams Provide:

- A quick, multidisciplinary medical team approach to assess and treat a patient whose condition is deteriorating.
- Support and education to staff as needed.
- Early and rapid intervention to promote better outcomes
 - Reduced cardiac and/or respiratory arrests
 - Reduced or timelier transfers to a higher level of care
 - Reduced patient intubations
 - Reduction in hospital mortality

Indications, Contraindications, Patient Outcomes

Indications:

- Staff have a concern and perceive a need for clinical experts in critical care to evaluate the patient.
- Patient (inpatient) exhibits signs/symptoms consistent with defined clinical criteria for activating RRT

Contraindications:

- Patient status warrants activation of the Code Team

Patient Outcomes:

- Assess and stabilize patient to prevent deterioration to cardiopulmonary arrest.
- Prevent deaths in patients who are failing outside intensive care settings.

Criteria for Activating RRTs

1. Staff member concerned/worried about patient and/or:
 - Acute change in heart rate from baseline (e.g., <40 or >150)
 - Acute change in systolic blood pressure (BP) from baseline (e.g., <90mmHG or MAP <65)
 - Acute change in respiratory rate (< 10 or > 30) or threatened airway
 - Acute change in oxygen saturation (level is less than 90%)
 - Acute change in level of consciousness

.....continues.....

RAPID RESPONSE TEAM (continued)

- Acute significant bleeding
 - New, repeated or prolonged seizures
 - Failure of patient to respond to treatment for an acute problem/symptoms
 - Signs and symptoms of a stroke (for Highland Hospital only)
2. Floor team (providers) unable to respond in a timely manner to the above triggers

Requesting a Rapid Response Team

SMH (adult RRT): Contact the page office at x5-2222

HH: For inpatients only, call x1-6932, request RRT, give floor and room number.

Required Paperwork

SMH: eRecord documentation completed by responder

HH: eRecord, doc flowsheets, rapid response

SEPSIS MANAGEMENT

Subject Matter Experts:

SMH: Mark Ott (275-5924)

HH: Bilal Ahmed, MD (341-6776)

For complete information:

SMH (ADULT SEPSIS):

[http://intranet.urmc-sh.rochester.edu/Policy/ClinicalGuidelines/Protocol/Protocols/Sepsis/SMH%20ADULT%20SEPSIS%20PROTOCOL%20\(9.2013\).pdf](http://intranet.urmc-sh.rochester.edu/Policy/ClinicalGuidelines/Protocol/Protocols/Sepsis/SMH%20ADULT%20SEPSIS%20PROTOCOL%20(9.2013).pdf)

SMH (PEDIATRIC SEPSIS):

[http://intranet.urmc-sh.rochester.edu/Policy/ClinicalGuidelines/Protocol/Protocols/Sepsis/SMH%20PEDIATRIC%20SEPSIS%20PROTOCOL%20\(9%202013\).pdf](http://intranet.urmc-sh.rochester.edu/Policy/ClinicalGuidelines/Protocol/Protocols/Sepsis/SMH%20PEDIATRIC%20SEPSIS%20PROTOCOL%20(9%202013).pdf)

HH Sepsis:

http://intranet.urmc-sh.rochester.edu/Highland/Depts/Quality/documents/SepsisAlgorithm8_13.pdf

Sepsis

- A systemic, deleterious host response to infection leading to severe sepsis (acute organ dysfunction secondary to documented or suspected infection) and septic shock (severe sepsis plus hypotension not reversed with fluid resuscitation).
- Severe sepsis and septic shock are major healthcare problems, affecting millions of people around the world each year, killing one in four (and often more), and increasing in incidence.
- Similar to polytrauma, acute myocardial infarction, or stroke, the speed and appropriateness of therapy administered in the initial hours after severe sepsis develops are likely to influence outcome.
- See *Surviving Sepsis Campaign 2012* <http://www.sccm.org/Documents/SSC-Guidelines.pdf>

Sepsis Protocols Designed to Provide:

- A standard approach to the treatment of patients identified as being septic
- Evidence-based, early goal-directed therapy
- Early identification and treatment of septic patients, promoting better outcomes such as reduced mortality and reduced length of stay
- Identification of potentially septic patients in both the Emergency Department and Inpatient settings

Protocol Indications

- Any patient with a known or suspected infection and at least 2/4 SIRS criteria should be considered septic
- If the patient has a lactate >4 (adult), is hypotensive despite a 30mL/kg fluid bolus or has signs of end organ dysfunction, the patient has severe sepsis
- Septic shock occurs when hypotension and/or cardiac dysfunction persist despite adequate fluid resuscitation

.....continues.....

Contraindications

All ED/Inpatients are eligible for age-appropriate sepsis protocol unless:

- Patients for whom interventions in the protocol are clinically contraindicated.
- Patients with advanced directives in place at the time of care which preclude any protocol interventions.
- Patient or surrogate decision maker declined or is unwilling to consent to protocol interventions.
- Enrollees in IRB-approved clinical trials for which interventions are inconsistent with established protocols.
- Newborns and infants in the NICU.

All exclusions must clearly be documented in the patient record.

It is important to remember:

For patients with sepsis, any patient with a lactate >4 or SBP <90 despite 30mL/kg fluid, qualifies for the severe sepsis/septic shock protocol.

Within 1 hour of suspecting severe sepsis/septic shock all patients must have:

- Blood cultures
- Lactate Level (Adults)
- IV Antibiotics
- If hypotensive or lactate ≥ 4
 - IVF bolus (30 ml/kg)

WRITE DOWN AND READ BACK FOR VERBAL ORDERS OR CRITICAL RESULTS

Subject Matter Experts

SMH: Ann Peterson Ottman (276-6065)

HH: Sharon Johnson (341-8399)

Steps to Follow for Taking Verbal Orders

- Verbal orders can only be taken in emergencies.
- The receiver must be an RN, RPh, dietitian, or physical, occupational, speech language or respiratory therapist (in accordance with applicable scope of practice provisions for these practitioners)
- Verify 2 patient identifiers.
- The receiver of the information must **write down the complete order** or enter it into a computer.
- **Read it back; simply repeating back is not sufficient.** If you don't read it back, we are noncompliant!
- Receive confirmation that the order is correct.

Steps to Follow for Critical Test Results Called to Unit/Department/Provider

- Verify 2 patient identifiers
- The receiver must **write down the results** or enter them directly into a computer.
- **Read it back; simply repeating back is not sufficient.** If you don't read it back, we are noncompliant!
- Receive confirmation from the person who conveyed the result.
- At SMH, the person accepting the results must communicate the results to the patient's care provider (if you are not the provider who needs to act on the results) and document notification of provider in eRecord.
- At Highland, critical test results are **ONLY** called to the provider, not the unit.

It is important to remember:

Follow the write down/read back process for telephone/verbal orders and critical test results:

1. Verify 2 patient identifiers.
2. Write down the complete information.
3. Read back the information.
4. Confirm that the information was correct.
5. Notify provider(s) of any critical test results, or implement order protocol, if appropriate.

Section 3:

**HIGHLAND-SPECIFIC
TOPICS**

**(FOR ANYONE WHO WORKS
AT HIGHLAND)**

CODE OF ORGANIZATIONAL AND BUSINESS ETHICS (HH Specific)

Subject Matter Expert: Janet Taylor (341-6467)

It is important 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.

Principles

Principle 1 – Respect for Patients

We will provide health care without regard to race, creed, color, gender, gender identity, 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, that 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 co-workers 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.

FORENSICS (HH Specific)

Subject Matter Expert: Joe Coon (341-6833)

For more information:

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

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.

HIGHLAND PROMISE STANDARDS AND GLOBAL BEHAVIORS

(HH Specific)

Subject Matter Expert: Kathleen Gallucci (341-0118)

Mission: Commitment to service excellence in health care, with patients and their families at the heart of all we do.

Vision: We deliver *Medicine of the Highest Order* in a community hospital where compassion, quality, and patient- and family-centered 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 care.

Values: Integrity, Compassion, Accountability, Respect, Excellence

Employee Responsibility

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 Values and Global Behaviors.

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.

I CARE Values and Global Behaviors

- Integrity** — I will conduct myself in a fair, trustworthy manner and uphold professional and ethical standards. Behavior: Introduce yourself and explain your role
- Compassion** — I will act with empathy, understanding and attentiveness toward all others. Behavior: Communicate with warmth—use names, smile, make eye contact, listen attentively
- Accountability** — I will take responsibility for my actions and join with my colleagues to deliver *Medicine of the Highest Order*. Behavior: Answer questions clearly, explain what will happen next and when they can expect to hear from you again
- Respect** — will always treat patients, families, and colleagues with dignity and sensitivity, valuing their diversity. Behavior: Respond promptly with courtesy and kindness to individuals' feelings and concerns
- Excellence** — I will lead by example, rising above the ordinary through my personal efforts and those of my team. Behavior: Exceed expectations—ask if there is anything else you can do for them

RESTRAINT USE (HH specific- Patient Care Staff Only)

Subject Matter Expert:

HH: Kristen Berns (341-0929)

Overview

- While Highland Hospital is considered a restraint free organization, there are rare occasions when restraint application is required as a last resort to maintain safety.
- There are strict regulatory standards on the use of restraints including length of application, written orders, face-to-face provider assessment, and care of the patient with proper documentation.
- Highland restraint policy and documentation revisions have been made to align with new regulatory guidelines.
- More detailed information about nursing responsibilities and documentation will follow in a separate module.

What is a restraint?

- **Physical restraint:** Any manual method, physical or mechanical device, material or equipment that reduces the ability of a patient to move his or her arms, legs, body or head freely
 - All 4 side rails up to prevent patient from getting out of bed
 - Soft limb restraints
 - Twice as Tough restraints (ED and ICU only)
 - Synthetic leather restraints (ED only)
- **Chemical restraint:** A drug or medication when it is used to manage the patient's behavior or restrict the patient freedom of movement and is not a standard treatment or dosage for the patient's condition

What is NOT a restraint?

- Hand mitts that are not tied down or restrictive
- All 4 side rails up to protect from falling off bed
- Safety Devices
 - Used for medical, diagnostic, or surgical procedures and standard practice for the procedure (safety belt in the OR)
- Supportive Devices
 - Used to meet the assessed needs of a patient who requires adaptive support (postural support, orthopedic appliances, lap belts, arm boards)
- Mechanical Protective Devices
 - Used for protective safety based on the assessed needs of the patient (helmets, tabletop chairs, bed rails)
- Shackles applied by correctional officers

Patient Behaviors & Restraint Options

- Non Violent, Non Self-Destructive
 - Behaviors: pulling at lines/tubes, confusion, dementia, fall prevention
 - Restraint Options:
 - Soft limb 2 point restraints and/or
 - All 4 side rails up to prevent patient from getting out of bed
 - Restrain movement and prevent injuries

.....continues.....

RESTRAINT USE (continued)

- Violent, Self-Destructive
 - Behaviors: Hitting, kicking, throwing items, self-injury
 - Restraint Options:
 - Soft limb 4 point restraints
 - Twice as Tough 4 point restraints (ED & ICU only)
 - Synthetic leather 4 point restraints (ED only)
 - Reserved for managing an acute episode of violent or aggressive behavior, where the patient poses an imminent risk of harm to themselves or others

Ordering Restraints

- In the event of an emergency an RN may initiate the use of restraints when the patient poses a threat to himself or another,
- A **face-to-face assessment and order** must be completed within **one hour** by a Physician, Nurse Practitioner or Physician Assistant.
- The Attending Physician must be notified as soon as possible by the ordering provider
- No PRN, verbal, or standing orders is permissible
- Order selected is based on patient behavior:
 - non-violent/non self-destructive, or
 - violent/self-destructive
- The patient must be kept under 1:1 supervision until provider assessment is done

Renewing Restraints

- *Non Violent, Non Self-Destructive* restraint orders must be renewed every:
 - **24 hours** for patients of all ages
- *Violent, Self-Destructive* restraint orders must be renewed every:
 - **4 hours** for patients 18 years and older
 - **2 hours** for patients between 9 years to 17 years
 - **1 hour** for patients under 9 years
- Renewal of restraint orders require face-to-face assessment by Provider and documentation of findings to support continued use of restraints.
- If restraints are removed due to a change in behavior, a new order is required if necessary to reapply restraints.

Remember...

- The least restrictive, safest, and most effective method of restraint should be used as a last resort for safety
- Consider restraint alternatives (such as diversional activities, room close to nurse's station, 1:1 supervision)
- Attempt to alleviate the cause (such as hypoxia, electrolyte imbalance, medications, pain, need to void)
- Restraints are always attached using a **quick-release buckle** to a moveable part of the bed frame (not side rails, toilets, or commodes).
- Restraints must be released every 2 hours
- Hand mitts (not a restraint) require a Provider order which is good for 72 hours (excluding ICU)

SECURITY AND SAFETY MANAGEMENT PROGRAMS AT HIGHLAND (HH Specific)

Subject Matter Expert: Joe Coon (341-6833)

Security Management Program

- 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 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 given authorization to gain access to those 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 by:
 - Working together continuously to promote safe work practices
 - Observing all rules and regulations
 - 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 important to remember:

- To contact HH Security in an emergency, dial 1-6666.
- Appropriate ID (HH photo ID) is required for all employees, patients, and visitors.
- Access to the building between 8:00 p.m. and 6:00 a.m. 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 continually perform, monitor and improve various processes which may impact employee, visitor, and patient safety.

Section 4:

PROVIDER ONLY TOPICS

(NURSE PRACTITIONERS,

PHYSICIAN ASSISTANTS,

PHYSICIANS WITH

PATIENT CARE

RESPONSIBILITIES)

MULTIDRUG-RESISTANT ORGANISMS

Subject Matter Expert:

SMH and HH: Ann Marie Pettis (SMH: 275-5056 and HH: 341-6853)

Clostridium difficile (C-diff) Infection (CDI)

- C-diff is a spore-forming bacteria that causes antibiotic-associated diarrhea. The extent of disease ranges from mild discomfort and diarrhea to pseudomembranous colitis, toxic megacolon, sepsis, and sometimes death.
- Symptoms of CDI are diarrhea, fever, loss of appetite, nausea and abdominal pain/tenderness. It is diagnosed by stool culture or toxin testing.
- Patients at increased risk for CDI include those with antibiotic exposure, extended hospitalization, advanced age, weakened immune system, or serious underlying illness.
- C-diff can be transmitted in the health care setting by contaminated equipment (commodes, thermometers) and on the hands of health care workers who have touched a contaminated surface.

Prevent C-diff Transmission

- Use contact precautions which consist of a private room, gowning and gloving by all who enter the room.
- Perform meticulous hand hygiene. Some experts recommend soap and water rather than alcohol-based hand rub (ABHR) since some studies have suggested that ABHR may not be as effective against spore-forming bacteria.
- Use dedicated patient equipment (such as thermometers and stethoscopes) and disinfect surfaces and equipment with an EPA-approved disinfectant with a C.diff kill claim.
- Patients with CDI are usually treated with a 10- to 14-day course of oral antibiotics such as metronidazole (flagyl) or vancomycin.
- Families and visitors should perform hand hygiene before and after visiting, be encouraged to wear gowns and gloves to enter the patient's room, and to not have contact with other patients.
- Please refer to the *CDI Testing Guidelines* for more detailed information about when and how to test for C.diff.

Extended Spectrum Beta-Lactamase Producing Organisms (ESBLs)

- These are enzymes that confer resistance to commonly used beta-lactam antibiotics, including penicillins, cephalosporins, and others. Infections caused by these organisms create additional challenges for health care providers in finding effective treatments.
- These infections have also been associated with poor outcomes.
- The prevalence of ESBLs depends on geography, and their occurrence is rapidly increasing.

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Organisms Most Commonly Found to Produce Beta Lactamases

- E. coli
- Klebsiella pneumoniae
- Pseudomonas aeruginosa
- Enterobacter
- Citrobacter
- Proteus
- Acinetobacter

Facts About ESBL

- ESBLs have the ability to break down beta-lactam antibiotics and are able to transfer their resistant enzymes to other microorganisms.
- They are often found in the bowel movements of people who are infected or colonized.
- People become infected when they touch equipment or surfaces that are contaminated with stool and then touch their mouth and swallow the germ.
- ESBLs can also be spread when the germ is on the hands of the patient or the health care worker.
- Scrupulous hand hygiene should be used to prevent the transmission of ESBLs.
- Contact isolation precautions are used for patients with ESBL infections.

Risk Factors for Acquiring an ESBL

- Recent stay in an ICU
- Weakened immune system
- Recent transplant surgery
- Premature birth
- Frequent/long-term antibiotic therapy
- Having an indwelling urinary catheter present
- Recent surgical procedures

Methicillin Resistant Staphylococcus Aureus (MRSA)

- Staphylococcus aureus are common bacteria found on someone's skin or in their nose.
- Methicillin Resistant Staphylococcus aureus, or MRSA, is Staphylococcus aureus that has become resistant to treatment with antibiotics such as penicillin or methicillin.
- MRSA occurs most frequently among patients in health care facilities who have weakened immune systems, experienced prolonged antibiotic therapy, or who have undergone invasive medical procedures.
- MRSA can be harmless unless it invades tissue through a wound or a break in the skin and can then cause serious and potentially life-threatening illness such as bloodstream infections, surgical-site infections or pneumonia.
- Sources of transmission
 - The hands of health care workers or contact with contaminated surfaces and medical equipment can be primary sources of transmission of MRSA and other drug-resistant organisms in the health care setting.
 - Hands may become contaminated with MRSA by contact with infected or colonized patients.
- Prevent the spread of MRSA
 - Use meticulous hand hygiene, and sanitize equipment which goes from patient to patient (e.g., thermometers, stethoscopes, pulse oximeters, etc.).
 - Sanitizing must be done with a hospital-approved disinfectant before equipment is used on the next patient.

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Vancomycin Resistant Enterococcus (VRE)

- Enterococci are bacteria normally present in the human intestines and in the female genital tract; these bacteria can sometimes cause infection.
- Vancomycin is an antibiotic that is often used to treat infections caused by Enterococci. In some instances, Enterococci have become resistant to this drug and thus are called vancomycin-resistant Enterococci (VRE).
- VRE infections occur most frequently in those who are hospitalized, especially if they have been in the hospital a long time or if they have compromised immune systems, open wounds, catheters, or drainage tubes.
- VRE most commonly infects the skin, urinary tract, and blood stream but can occur anywhere in the body.
- VRE can also be present without causing infection; this is known as colonization.

It is important to remember:

C-diff

- Spore-forming bacteria that cause antibiotic-associated diarrhea.
- Transmission can be prevented by:
 - Using contact precautions: a private room, gowning, and gloving by all who enter the room.
 - Meticulous hand hygiene.
 - Dedicated patient equipment (such as thermometers and stethoscopes) and disinfection of surfaces and equipment with a bleach-containing product in the inpatient setting (not necessary to use in NICU, OR, OB/Gyn or outpatient setting).

Extended-spectrum beta-lactamases (ESBLs)

- Enzymes that confer resistance to commonly used beta-lactam antibiotics, including penicillins, cephalosporins, and others.
- Transmission can be prevented by:
 - Scrupulous hand hygiene.
 - Using contact isolation precautions: a private room, gown and gloves when entering the room and then removing and discarding them when exiting.

Methicillin Resistant Staphylococcus aureus (MRSA)

- A strain of Staphylococcus aureus resistant to treatment with antibiotics such as penicillin or methicillin.
 - The spread of MRSA can be prevented by dedicated patient equipment (e.g. thermometers and stethoscopes). If the equipment must be shared, then cleaning must be done with hospital-approved disinfectant before it is moved to the next patient.

Vancomycin Resistant Enterococcus (VRE)

- Enterococci are bacteria normally present in the human intestines and in the female genital tract) that have become resistant to the antibiotic, vancomycin.
- The spread of VRE can be prevented by *horizontal prevention strategies* such as:
 - Meticulous hand hygiene
 - Sanitizing equipment which goes from patient to patient with a hospital approved disinfectant.
 - Standard precautions—*contact isolation* is no longer required.

PREVENTION OF CENTRAL LINE ASSOCIATED BLOODSTREAM INFECTIONS (CLABSIs)

Subject Matter Expert:

SMH and HH: Ann Marie Pettis (SMH: 275-5056 and HH: 341-6853)

Deaths/Costs Due to CLABSIs

An estimated 14,000 - 28,000 deaths occur annually due to CLABSIs. Bloodstream infections are often serious enough to cause an extended hospital stay as well as increased cost and risk of mortality. The estimated cost per bloodstream infection ranges from \$4,000 to \$40,000. CLABSIs can be prevented through proper placement and management of a central line.

Causes/Prevention of CLABSIs

CLABSIs can occur due to disruption of the integrity of the skin. Infection may then spread to the bloodstream. Sepsis can lead to hemodynamic changes, organ dysfunction, and sometimes death.

- Prevention of CLABSI focuses on: insertion, maintenance and removal of the line.
- Attachment and migration of bacteria to the line can occur at the time of insertion or in the days following insertion.
- Cutaneous contamination is the most common source of catheter infection when catheters are in place for <10 days.
- Aseptic technique must be maintained during insertion and dressing changes.
- Maximal barrier precautions are used: face mask, cap, sterile gloves, sterile gown, full body sterile drape for patient.
- The necessity of the line must be regularly assessed. No line = No CLABSI.

Inserting Central Line Bundle

- Scrupulous hand hygiene.
- Maximal sterile drape (covers patient head to toe).
- Full barrier precautions when inserting (sterile gown and gloves, head cover and face mask).
- Skin prepped with at least 2% chlorhexidine gluconate (CHG) using back and forth strokes for 30 seconds (unless contraindicated; e.g., neonates with low birth weight, allergy, etc.) and allowed to air dry for same amount of time.
- If any of the above elements are missing or done incorrectly, the HCW observing the insertion should “stop the line.”
- Apply CHG-impregnated sponge dressing (Biopatch) on all central and arterial lines.
- Place alcohol caps on all needleless access devices and tubing ports.
- Avoid femoral insertion site in adults if obese.
- Assess the need for the central line daily.
- Discontinue central line ASAP if no longer indicated (requires provider order).

Maintaining Central Line Bundle

- Scrupulous hand hygiene before and after all contact including before medication administration and site assessment.
- Perform dressing change and site care using aseptic technique.

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PREVENTION OF CENTRAL LINE ASSOCIATED BLOODSTREAM INFECTIONS (continued)

- Assess site and document every 24 hrs. and prn.
- Scrub needleless access device with at least 2% CHG (unless contraindicated) for 15 seconds using back and forth strokes and allowing site to dry equal amount of time if alcohol cap is not present or if accessing the line multiple times during a single-access episode.
- Apply transparent semipermeable dressing over insertion site and change dressing every 7 days and prn. *Note: loose or soiled dressings must be replaced and not reinforced.*
- Apply gauze dressing rather than semipermeable dressing over insertion site if there is bleeding/oozing at the site, and then change dressing within 48 hrs; change immediately if moist or soiled.
- Bathe all patients over 2 months of age with a CHG preparation on a daily basis.
- Replace dressing if damp, loose or visibly soiled. Perform site care as described above each time dressing is replaced.
- Change tubing at least every 96 hrs. Change IV fluids and all access devices with tubing change, including stopcocks, extension tubing, blood-saving devices, and needleless access devices.
- Flush all lumens per policy to maintain patency.

Blood Cultures

- Cultures may be drawn from the central line when a central line infection is suspected or the source of the bloodstream infection is unknown. Lines in place <5 days are infrequently infected and therefore should not routinely be cultured.
- If there is another source suspected (e.g., intra-abdominal, cellulitis, pneumonia, wound, UTI), blood cultures should be drawn from a peripheral site.
- In rare instances where access for peripheral blood draw is limited, one set may be drawn from the line and the other by percutaneous venipuncture. **Note:** An order from the attending physician must be obtained before drawing a blood culture from the central line.
- Please refer to the *Blood Culture Guidelines* for additional details.

Drawing Blood Cultures from Central Lines

- Scrupulous hand hygiene.
- If needleless access device is attached to catheter hub, blood samples for culturing should be obtained through this device.
- Use vigorous friction to scrub the hub or needleless access device with alcohol for at least 10-15 seconds (or 10 times) and allow to dry at least 30 seconds every time you make or break connection.
- Obtain sample per policy.
- Flush central line per nursing policy.

NOTE: Blood culture by peripheral venipuncture is always preferred except when the line is suspected as the source of infection. If the central line is suspected or unknown source, then draw one peripheral venipuncture and one sample from each port of device.

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Replacing C-VADS

- Lines should be removed as soon as possible
- Routine C-VAD guidewire exchange or site rotation is not recommended.*
- Guidewire exchange is acceptable for replacing a malfunctioning catheter or downsizing a pulmonary artery catheter to a central venous catheter.
- Patients who clearly have a CLABSI should not undergo a guidewire exchange.
- Selected patients with suspected blood stream infections and limited venous access may have their catheter exchanged over a guidewire and the catheter tip should be cultured. Before handling the new catheter, switch to a new set of sterile gloves.

*Eyer, et. al. *Crit. Care Med.* 1990;18 (10): 1073-9

It is important to remember:

- CLABSIs are often serious enough to cause an extension of the hospital stay as well as increased risk of morbidity and mortality.
- CLABSIs can be prevented by proper placement and management of the line.
- CLABSIs can occur as a result of disruption of the integrity of the skin leading to an infection that may then spread to the bloodstream.
- Prevention of CLABSIs requires a focus on proper insertion and maintenance of the line as well as removal as soon as possible.

PROVIDER PERFORMED POINT OF CARE TESTING/MICROSCOPY

Subject Matter Experts:

SMH: Robert Mooney, PhD. (275-7811), Melissa Allen (275-7675)

HH: Jennifer Kasaraneni (341-8313)

For Additional Information

SMH: SMH Policy 8.12, Provider Performed Testing at:
<http://intranet.urmc-sh.rochester.edu/policy/SMHPolicies/>

Or visit the POCT Website

<https://intranet-secure.urmc.rochester.edu/depts/path/POCT/PPT.aspx>

HH: Pathology & Department of Laboratory Medicine intranet site at:
<http://intranet.urmc-sh.rochester.edu/Highland/Depts?Lab?POCT-Procedure-Manual.asp>

Policy

To meet Joint Commission and NYS DOH regulations, all URMC providers who perform point-of-care lab tests or microscopy as part of clinical care, must complete orientation, training, and annually take and pass a Web-based competency assessment.

In addition, all second year OBGYN residents will need to have an initial and 6-month direct observation by the Chief of OBGYN or designee.

Provider Performed Testing (PPT) and Provider Performed Microscopy (PPM)

Fecal WBC Microscopy	Pinworm Microscopy
Fern Test Microscopy	Qualitative Semen Microscopy
Nasal Eosinophil Microscopy	10% KOH Microscopy
pH Testing	Urine Sediment Microscopy
Pinworm Microscopy	Vaginal Wet Mount Microscopy

Annual Online Competency Assessment Program (SMH Only)

- New providers must enroll in the annual online competency assessment program and complete annual competency assessment(s) for all tests performed.
- To enroll in the online program, Medical Training Solutions (MTS), please follow up with your department administrator or the POCT office. Competency testing occurs on an annual basis and the testing cycle begins each year on February 1. An e-mail notice to providers informing them of the testing requirement, providing the URL, and providing a user name and a password for the testing site are sent through MTS and triggered by a test administrator.
- **Note:** Any instrument testing will necessitate additional training and competency review. Contact the POCT office at 275-0229 for information about instrument training