

**PLEASE Do Not Write In This
Booklet..!!**

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University of Rochester Medical Center

*Strong Memorial Hospital
Highland Hospital*

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**MANDATORY
IN-SERVICE
EDUCATION
MANUAL**

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UNIVERSITY of
ROCHESTER
MEDICAL CENTER

MEDICINE of THE HIGHEST ORDER

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MODULE 1

Fire Safety – Lesson 1

Preventing Fires

Fire prevention should be paramount in everyone's mind!

1. Our number-one life safety finding is improper storage of materials in corridors and stairwells.
2. The number-two finding is life safety equipment blocked because of storage.
3. Be on the alert for conditions that may lead to rapid fire spread or hinder safe evacuation, including obstructed corridors, openings in walls and ceilings, propped open or blocked fire doors, and blocked extinguishers, pull stations or gas shut-off valves.
4. Be aware of excessive use of extension cords, faulty electrical devices, or frayed electrical cords. These can easily start a fire.

Interim Life Safety Measures

Life safety features, like fire alarm systems, 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 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. For instance, a fire watch would be established and employees would physically patrol the area for signs of smoke or fire.

Patient Fires

For patient fires, extinguish with a bed covering such as a bedspread, blanket, or sheet.

1. Protect yourself by wrapping your hands inside the material.
2. Lean tight against the bed to prevent flashback.
3. Quickly drape the extinguishing material completely over the patient.

Remember 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 fire or other emergency.

Page or Alarm Sounds

If there is a fire...You will hear the fire alarm with the fire alert or confirmed location.

If you are in the area of the fire...Follow RACE (Rescue, Alarm, Contain, Extinguish/Evacuate).

If you are at another location outside the immediate fire area...

- Close all doors and clear corridors; avoid telephone use unless for an emergency
- Do not use elevators, especially if they're in the vicinity of the fire alert
- Stay where you are, unless job responsibilities require a specific response
- When the "All Clear" page sounds, resume normal activities

RACE

Rescue anyone in immediate danger, and relocate him or her to a safe area. Below waist level, the air is relatively cool and clean, allowing for escape by staying low and moving quickly.

Alarm everyone whenever there is evidence of fire, by using a pull station. Call 13 at URMCSMH or 1-6666 at Highland; state your name, the nature of the problem and the location.

Confine 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, without endangering yourself or others. A clear exit path should be maintained to prevent being trapped by rapidly spreading fire.

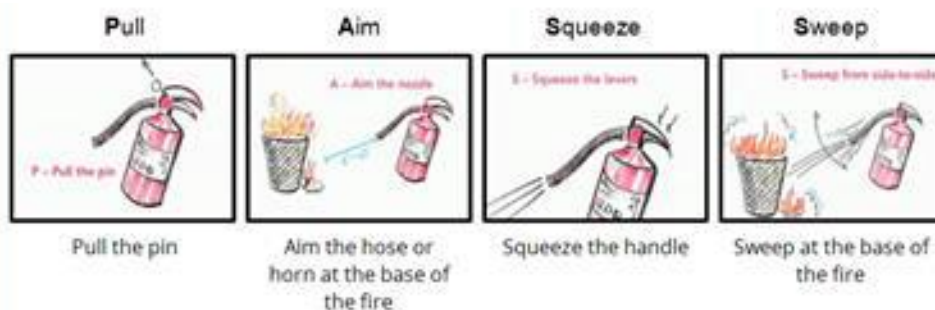
P.A.S.S.

Pull - Pull the pin

Aim - Aim the hose or horn at the base of the fire

Squeeze - Squeeze the handle

Sweep - Sweep at the base of the fire



Extinguisher Types



Wet Chemical:

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

Water Mist:

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

Pressurized Water:

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



Carbon Dioxide:

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

Dry Chemical:

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



At Highland a CleanGuard extinguisher is also used

- Ideal for ORs, laboratories, pharmacies, and critical areas
- Rated for Class A, B, and C fires
- Extinguisher agent leaves no residue and requires no cleanup after discharge

When to Evacuate

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

1. Fire has spread to the structure such as walls or ceiling
2. Several items of furnishings are involved in the fire
3. Smoke appears to be spreading unchecked from the room of origin
4. Orders are received from a person listed as qualified to call an evacuation

If the room(s) is evacuated, obtain chalk/marker from the nearest fire extinguisher cabinet and chalk/mark the lower, hinged side of the door with a slash.

1. (1-1)

What is the number-one Life Safety deficiency finding?

- A. Blocked safety equipment
- B. Improper storage of materials in corridors, stairwells
- C. Propped open/blocked fire safety doors
- D. Excessive use of extension cords

2. (1-1)

When failure, maintenance, renovations or construction cause the hospital to be unable to maintain life safety building features that are normally in place, what must be implemented?

- A. Evacuation
- B. Interim Life Safety Measures
- C. Fire Watch
- D. Additional fire extinguishers

3. (1-1)

A Patient Care Tech is evacuating a patient from their room and needs to get a piece of chalk/marker to mark the door. Where would he or she find the chalk/marker?

- A. Nurses' station
- B. Pyxis
- C. The nearest fire extinguisher cabinet
- D. Taped above the door

4. (1-1)

A nurse on a patient care unit notices smoke coming out of a patient's room. She takes action to move the patient to a safe area designated by her department's emergency procedures. What should she do next?

- A. Try to find the source of the fire and extinguish it, if it is safe to do so, until the fire department arrives
- B. Open the windows to air out the smoke
- C. Alarm everyone there is evidence of a fire by using the pull station
- D. Read the Emergency Preparedness Manual to find out next steps

Firearms/Weapons – Lesson 2

Firearms/Weapons at UR

Firearms and other dangerous weapons are not permitted at any University of Rochester Medical Center - Strong Hospital, Highland Hospital, or University premise, except for a select number of Sworn UR DPS Peace Officers who will be authorized to care a firearm in the course of their duties at the UR Medical Center Campus or as required by law.

Effective February 6, 2017, select and armed, highly trained UR DPS Peace Officers will be assigned to various interior and exterior areas and pre-determined posts throughout the Medical Center main campus at all times including fixed posts in the Emergency Department, a roving foot patrol, and an officer in in a UR DPS vehicle who will patrol the exterior of the Hospital. These officers have undergone extensive law enforcement firearms safety and proficiency training, have been sworn and certified by the NYS Division of Criminal Justice Services, and have arrest authority.

In addition, law enforcement agencies and armed courier services personnel may be required by law to carry firearms while engaging 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 the UR Department of Public Safety (URDPS)/HH Security for further direction.

Discovering a Firearm or Weapon

Staff discovering a firearm or weapon not in the possession of a URDPS Peace Officer or law enforcement agency personnel should not touch the weapon, but should immediately notify URPDS/HH Security for appropriate action.

5. (1-2)

A staff member notices what appears to be a gun underneath the jacket of a man who does not appear to be UR DPS or law enforcement agency officer. What should the staff member do?

- A. Tell the person we need to secure the weapon until they leave the premises
- B. Call UR Department of Public Safety or HH Security immediately, with a description of the man and where he is or where you think he is headed
- C. Call a Code Blue 100 and fill out an incident report
- D. Ask the person to return the weapon to their car and explain our policy

Disaster Preparedness – Lesson 3

Defining a Disaster

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/Radiological materials nature severely impact any part of the hospital community (such as the receipt of a suspicious letter or package)

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

Sequence of Events

Step 1

The Emergency Department (ED) will routinely be the first to be notified.

Step 2

The ED charge nurse, or hospital Administrator-on-Call (AOC), will notify the Page Office at URM-Strong Hospital, or Telecommunications at Highland Hospital.

Step 3

The Page Operator will notify hospital staff with the overhead page and pagers.

Step 4

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.

Step 5

Once identified, the location of an institutional Hospital Command Center will be paged. Wear your ID badge so that you can access all necessary areas!

- URM-STRONG: the Ambulatory Care Center conference room A&B or as determined by AOC
- Highland: the Gleason Room or as determined by the senior administrator

Preparing for a Disaster Response

To be prepared for any disaster affecting URM-Strong or Highland facilities, know where your emergency management plan is located. Review your department's disaster/emergency response plan to understand your role and respond appropriately. When a disaster has been declared, you cannot leave work until approved by your supervisor.

If you are an Independent Licensed Practitioner

An Independent Licensed Practitioner (IL) who does not have a specific assignment in the Emergency Preparedness Plan, should review the following links to review your emergency response role and where to report in an emergency.

SMH: <https://sites.urmc.rochester.edu/departments/emergency-preparedness-manual-smh/>

HH: <http://sites.mc.rochester.edu/highland/policies-and-manuals/plans/emergency-preparedness-plan/>

In the Event of a Disaster:

If on duty, follow your department plan/directions from your leadership.

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.

Have a personal emergency preparedness plan.

6. (1-3)

When a disaster response is required, staff should:

- A. Follow their department-specific disaster response plan.
- B. Respond to the area they feel needs the most help.
- C. Report to the hospital lobby.
- D. Continue to use the telephone and elevators for routine business needs.

Workplace Violence/Defusing Potential Violence – Lesson 4

Signs of Potential Violence

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

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

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

Responding to Potential Violence

If a threat is immediate, call:

- UR Department of Public Safety (UR DPS) at x13
- Highland Hospital Security at x1-6666
- Off-site locations 9-1-1

If a threat is not imminent, notify your supervisor/manager and UR DPS/HH Security to help develop an action plan.

If a Traumatic Event Happens

Report the event to your supervisor/manager.

Address staff emotional needs and review the incident with all involved.

Document the event by reporting 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.

Calming a Potentially Violent Person

To help calm a potentially violent person:

1. Give your full attention to the person, maintain a safe distance, and 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, and then redefine the problem to ensure your full understanding.
4. Offer reasonable choices to diffuse the situation.

7. (1-4)

A visitor has become loud and is making threats against the health care providers who are taking care of their family member. No one seems to be able to calm the person; in fact, the person actually appears to be escalating their threats. What should you do?

- A. Call the UR Department of Public Safety (x-13 at SMH) or HH Security Services (x1-6666 at HH)
- B. If you are in an off-site location, call 9-1-1
- C. Don't be defensive; speak in a calm voice and be aware of your body language
- D. All of the above

Patient Prisoner Population: SMH — Lesson 5

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 Plan

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

Exception: Patient prisoners on medical leave of absence may not require a security plan.

1. Check with the nurse caring for the patient prisoner before interacting with the patient.
2. Upon patient prisoner arrival at any treatment location, the law enforcement officer should be asked to sign the Forensic Staff Log and be given the *Informational Guidelines for Forensic Staff*.
3. Let other staff/departments know the person is a patient prisoner, if necessary. (For example, Food and Nutrition needs to know to supply plastic tableware)
4. Do NOT inform inmate of future follow-up appointment dates, times, days of the week or other scheduling information.

Phone inquiries: inform the patient's guarding officer of the call and that no information is to be given out.

More Security Information

- Maintain professionalism at all times
- Report threats or aggressive behavior to area leadership and/or UR Department of Public Safety
- Do not give the patient any personal information (your address, phone number, etc.)
- 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 the UR Department of Public Safety (UR DPS)

- For emergencies, call UR DPS at x13

8. (1-5)

When caring for patient prisoners, staff should:

- Discuss the security plan with the nurse caring for the patient before approaching the patient
- Inform patient prisoners of future follow-up appointments, dates, times, etc.
- Transfer phone inquiries to the patient prisoner
- Tell the patient prisoner your personal address and phone number

Emergency Page Codes — Lesson 6

Common Codes

Fire Alert - Investigation of fire/smoke

Fire Alert Confirmed - Confirmed fire, flood, etc.

Assistance Needed STAT - Patient and/or visitor is posing a safety threat; immediate assistance is needed

Critical Security Incident - Incident involving hostages and/or weapons

Adult Code Team - Cardiac or respiratory arrest

Pediatric Code Team - Pediatric cardiac or respiratory arrest

MERT - Medical assistance

AMBER Alert - (SMH age, location; HH: all buildings) Abduction of infant, child, adolescent

Command Center Activated - External/internal disaster

Utility Alert - Utility failure

Calling in an Emergency Page Code

Inpatient Medical Emergency & STAT Pages

All inpatient medical emergency and STAT pages are placed by calling the Communications Center at x5-7828 or x5-STAT.

The pages are executed using five overhead tones and followed by an announcement in the form of "Pediatric Code Team, call for specific location." Call means "go-to" location.

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

Noninpatient or Non-Life-Threatening Medical Emergencies

Noninpatient or non-life-threatening medical emergencies, facilities & personal safety emergencies can be placed by contacting the UR Department of Public Safety (UR DPS) Communication Center at x13.

The pages are executed using 3 overhead page tones, followed by an announcement indicating code/type and location of the emergency.

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

External/Internal Disaster: x5-STAT

Calling in an Emergency Page Code - HH

Rapid Response Team: not an overhead page; call x1-6932

Emergencies are placed by calling x1-6666.

The pages are executed using 2 overhead page tones.

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

9. (1-6)

What is the applicable code for Hostage Situation and/or Weapon Involved?

- A. Adult Code Team
- B. Command Center Activated
- C. Critical Security Incident
- D. AMBER Alert

Professional Conduct Event Education — Lesson 7

Leaders Address Unprofessional Conduct By:

- Regularly evaluating the culture of safety and quality, and 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.

Unprofessional Conduct Examples

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

- Insulting or verbal attacks
- Frequent outbursts or anger
- Throwing instruments or charts
- Criticizing a team member in front of patients

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.

Reporting Unprofessional Conduct

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.

Faculty and staff should report unprofessional conduct as soon as possible through appropriate channels.

SMH

1. 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.
2. 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.
3. 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.

HH

1. Faculty and staff should report unprofessional conduct in RL Solutions (the hospital's reporting system) as soon as possible; events can be entered anonymously, if preferred.
2. 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.
3. 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.

10. (1-7)

What should a faculty or staff member do if unprofessional conduct is witnessed?

- A. If several people witnessed the event, let the most senior person report it
- B. Immediately report the unprofessional conduct through appropriate channels
- C. Talk to the person who is involved in the event; find a resolution together
- D. Report the event only if it occurs again

AMBER Alert — Lesson 8

If Threatened By the Abductor

Allow the person to leave, get a good description, watch their direction of travel, and contact UR DPS or HH Security.

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

Infants and Children

SMH

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.

HH

See the link below for the HH Abduction of Newborn policy:

http://sharepoint.mc.rochester.edu/sites/HHPolicies/Environment_of_Care/Policy%20Manual/1%20%20Safety%20Management%20Program/Abduction%20of%20a%20Newborn%201_5.pdf

AMBER Alert Page

All departments in the facility should secure exits for which they are responsible.

Monitor the nearest perimeter door in your area until the “AMBER Alert, All Clear” overhead page is announced.

No information should be given to the press regarding the incident.

AMBER Alert Page (In Abduction Area)

If an AMBER Alert is needed:

- Immediately contact UR Department of Public Safety (UR DPS) at x13 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/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 of the AMBER Alert 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).

AMBER Alert Page (Not In Abduction Area)

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 Medical Center Parking Garage Link
- Ground Floor-Medical Center 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

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.

11. (1-8)

An AMBER Alert has been paged; what is each person's responsibility for their unit/department?

- A. Monitor any exits your department is responsible for watching
- B. Allow visitors and staff to leave only from ground-level exits; be sure they are not with a child
- C. Report suspicious person(s) to 9-1-1, including a complete description
- D. Provide information to the press as clearly as you can so that the media can put out a bulletin and assist in finding the child

MODULE 2

Bloodborne Pathogens Standard — Lesson 1

OSHA Bloodborne Pathogens Standard

The Occupational Safety and Health Administration (OSHA) of the federal government requires all hospitals to have policies to protect employees from infection with bloodborne pathogens, especially the viruses which cause AIDS (HIV), hepatitis B, and hepatitis C.

These policies are found in a document called the “Bloodborne Exposure Control Plan” which is located on the Environmental Health and Safety website. 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.

Preventing Exposures

Every needlestick or other exposure to blood or body fluids involves potential risk of infection with HIV, Hepatitis C, or Hepatitis B!

Use safety sharps and activate safety devices immediately after use

- Example: 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 Operating Room. Always know how to operate a safety device **before** you use it.
- Follow Standard Precautions: treat the blood and body fluids of **ALL** persons as if they contain bloodborne pathogens.

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 pickup schedule, at SMH call Environmental Services at 275-6255, or at HH call Environmental Services at 341-7378
- Never leave sharps on tables or procedure trays for someone else to pick up. Never discard sharps in the trash.

Wear Personal Protective Equipment.

- Gloves, gowns, goggles/face shields
- 25% of blood exposures are splashes. Prevent splashes of blood or body fluids to the mucous membranes by wearing splash protection

Wash, Call, Report

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

WASH or irrigate the exposed area immediately.

CALL ASAP:

- SMH: The Blood Exposure Hotline at 275-1164
- HH: Employee Health at 341-8017, or off shift, call 341-6263 or page the Nursing Supervisor at 51616, enter pager number

Post-exposure evaluation and follow-up including testing, counseling, and potential treatment will be offered.

REPORT the incident online at:

SMH: <http://www.safety.rochester.edu/SMH115.html>

HH: <https://www.urmc.rochester.edu/highland/secure/eif.aspx>

HH Exposure Control Plan:

http://sharepoint.mc.rochester.edu/sites/HHPolicies/Infection_Prevention/SECTION%208%20EXPOSURE%20CONTROL/Bloodborne%20Pathogens%20Exposure%20Plan,%208-0.pdf

12. (2-1)

How can you reduce your risk of exposure to bloodborne pathogens?

- A. Cover your eyes with splash protection
- B. Follow WASH, CALL, REPORT precautions
- C. Activate safety devices
- D. A and C

Infection Prevention—Ebola Virus Disease — Lesson 2

Ebola Virus Disease

Ebola Virus Disease (EVD) is a relatively rare and often fatal infection caused by a filovirus which has historically caused isolated outbreaks of disease in sub-Saharan Africa. The largest outbreak of Ebola began in west Africa in March of 2014 and peaked in the fall of 2014.

Transmission occurs primarily through contact with the blood or body fluids of a symptomatic infected person. Exposure to Ebola can occur in healthcare settings, however the proper donning and doffing of personal protective equipment (PPE) for a suspected or confirmed EVD patient is critical. Since meticulous donning and doffing of PPE is imperative to protect healthcare providers, periodic training of staff who would care for an EVD patient is required. Routine screening of all patients for international travel is now part of the intake process in all areas of UR Medicine and must continue indefinitely. This consists of asking the patient if they have traveled internationally.

For additional up-to-date information on EVD, refer to the CDC (<http://www.cdc.gov/vhf/ebola/index.html>) or NYSDOH (<http://www.health.ny.gov/diseases/communicable/ebola/>) websites.

13. (2-2)

The most important measure for health care personnel to protect themselves from Ebola while caring for an Ebola-infected patient is which of the following:

- A. Proper donning and doffing of personal protective equipment
- B. Testing people who have traveled internationally for the Ebola virus
- C. Requesting that patients cover their cough
- D. Receiving Ebola vaccination

Hand Hygiene — Lesson 3

Why You Should Wash Your Hands

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.

Hand Hygiene Guidelines

The Joint Commission requires each organization to select and fully implement the World Health Organization (WHO) or the Centers for Disease Control (CDC) hand hygiene guidelines. SMH and HH have chosen to follow the WHO's hand hygiene guidelines, which are based on "My Five Moments of Hand Hygiene."

The recommended amount of time for adequate hand hygiene is 15-20 seconds or the amount of time it takes to sing "Happy Birthday" twice. Remember that friction is most important.

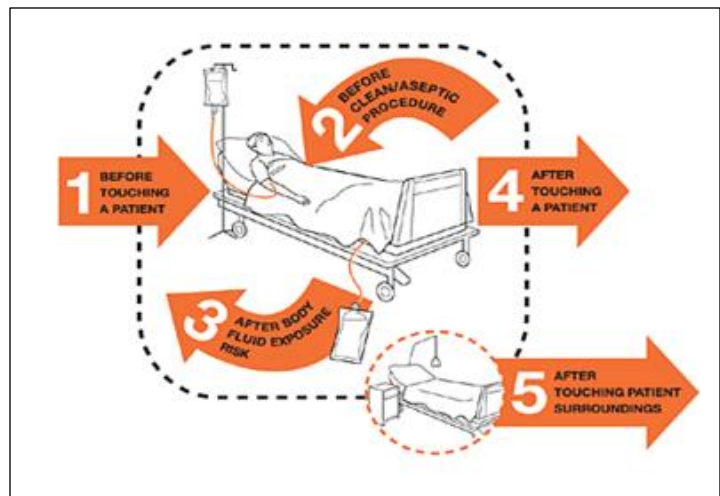
During cold weather, the integrity of our skin can become compromised with frequent hand hygiene. Therefore, the use of hospital-approved hand lotion is encouraged. Unapproved lotion is not allowed.

Be sure the patient and/or their family see you perform hand hygiene!

Hand Hygiene Guidelines

One of the key components of the WHO hand hygiene guidelines is "My Five Moments of Hand Hygiene," which outlines when health care workers are to sanitize their hands. They are as follows:

1. Before Touching a Patient
2. Before Clean/Aseptic Procedure
3. After Body Fluid Exposure Risk
4. After Touching a Patient
5. After Touching Patient Surroundings



Patients' Hand Hygiene

As important as it is for HCWs to use proper hand hygiene to protect our patients from healthcare-associated infections (HAIs), it is 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. It is important to remind patients to wash their hands with soap and water (not alcohol-based hand rub) before eating and after using the restroom or a bedpan.

14. (2-3)

In which situation listed below should you use soap and water instead of alcohol-based hand rub (ABHR)?

- A. After using the restroom
- B. Before contact with a patient
- C. After contact with a patient
- D. Before performing a procedure that requires aseptic technique

Hazard Communication — Lesson 4

Global Harmonization Standard

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

The purpose is 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 via 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.

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

HH employees should call the Highland Safety Officer at x1-7378

Hazardous Chemicals

Hazardous chemicals are any chemicals classified as: Health Hazard, Physical Hazard, or Hazard Not Otherwise Classified.

Health Hazard:

- 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

Physical Hazard:

- Explosives
- Flammable gases, liquids, solids and aerosols
- Oxidized 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

Not Otherwise Classified:

A recognized hazard that does not meet the specific criteria of the other categories.

Labeling

Labels are required on **all** chemical containers, except those under the continuous control of the user and for immediate use.

- Labels must be legible and maintained. Do not deface or remove manufacturer's labels
- The 2012 update to the Hazard Communication Standard requires six label elements



Pictograms

Pictograms facilitate communication globally by reducing language barriers. You need to recognize and understand these 9 Hazard Communication Standard Pictograms.

See the chart on the next page.

Health Hazard  • Carcinogen • Mutagenicity • Reproductive Toxicity • Respiratory Sensitizer • Target Organ Toxicity • Aspiration Toxicity	Flame  • Flammables • Pyrophorics • Self-Heating • Emits Flammable Gas • Self Reactives • Organic Peroxides	Exclamation Mark  • Irritant (skin and eye) • Skin Sensitizer • Acute Toxicity (harmful) • Narcotic Effects • Respiratory Tract Irritant • Hazardous to Ozone Layer (Non-Mandatory)
Gas Cylinder  • Gases under pressure	Corrosion  • Skin Corrosion/ Burns • Eye Damage • Corrosive to Metals	Exploding Bomb  • Explosives • Self-Reactives • Organic Peroxides
Flame Over Circle  • Oxidizers	Environment (Non-Mandatory)  • Aquatic Toxicity	Skull and Crossbones  • Acute Toxicity (fatal or toxic)

Safety Data Sheets

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 maintain an inventory of chemicals used within their area. This inventory 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 [online](#) for SMH employees. For HH, SDS sheets are available in each department, or in the Support Services Office (call x1-7378).

Safety Data Sheet Sections

Safety Data Sheets (formerly known as MSDSs, Material Safety Data Sheets), are now required to conform to a standard format.

Every SDS will have the same 16 sections, in the same order, and with the same titles. This should assist users in becoming familiar with where to look for the information they are seeking.

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 & Storage
8. Exposure Controls/Personal Protection
9. Physical & Chemical Properties
10. Stability & Reactivity
11. Toxicological Information
12. Ecological Information
13. Disposal Considerations
14. Transport Information
15. Regulatory Information
16. Other Information

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

Spills

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 PPE must be utilized.

Large Spills:

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.

15. (2-4)

Which of the following will always appear in Section 7 of the newly formatted Safety Data Sheets?

- A. Other agencies that regulate this information
- B. Precautions for safe storage, including incompatibilities
- C. Emergency procedures, personal protective equipment
- D. Information about exposure symptoms and required treatment

16. (2-4)

Departments/Supervisors are responsible for:

- A. Conducting Hazard Assessments
- B. Maintaining a list of chemicals used in their departments
- C. Chemical-specific employee training
- D. All of the above

17. (2-4)

Safety Data Sheets:

- A. Are available only to supervisors
- B. Provide a summary of health, safety, and environmental information in a standard (16 section) format
- C. Are required to be attached to chemical containers
- D. Are not related to Material Safety Data Sheets

18. (2-4)

The pictogram may indicate which one of the following hazards?

- A. Explosive
- B. Skin corrosion/burns
- C. Acute toxicity
- D. Carcinogenicity



HIV/AIDS Confidentiality — Lesson 5

What Info Is Confidential?

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, HIV viral load, HIV test)

What Info Is Reported?

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.

These results are generally reported by the laboratory to the NYSDOH via an electronic reporting system.

- Positive HIV test results (initial determinations, diagnosis or monitoring of HIV infection)
- Viral Load tests
- Genotypic Resistance tests
- Diagnoses of HIV-related illnesses
- All CD4 test results (unless for monitoring other diseases)
- AIDS

Disclosure

What is disclosure?

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.

When is it appropriate?

Generally, disclosure of HIV-related information is appropriate only with a special HIV release form (HYS DOH #2557) or OCA Official Form 960 (if initialed on the appropriate line), signed by the patient, with instructions as to the identity of the recipient.

What are the consequences of inappropriate disclosure?

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.

What if I'm still unsure?

When in doubt, don't release the information without 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		
	SMH Privacy Officer	275-7059	HH Privacy Officer	341-6467
Identification of HIV-Related Info.	SMH AIDS Center	275-0526	Infection Preventionist	341-0288

19. (2-5)

What form needs to be completed to release a copy of a record to a patient's attorney if the record contains negative HIV test results?

- A. SH 48MR Authorization for release of medical care
- B. NYS DOH 2557
- C. Official Form 960
- D. Either B or C

Influenza – What You Should Know – Lesson 6

Types of Flu

Seasonal

Influenza, or "flu," is a respiratory infection caused by the influenza virus which is spread from person to person.

The flu that strikes every winter is called "seasonal" flu.

Most people who get the flu will recover within a week, but flu and its complications can be life-threatening for the elderly, newborn babies, and people with 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 Spreads

Flu can be spread from person to person by:

- Droplets released into the air when a person with flu coughs or sneezes (usually within 3 to 6 feet of another person)
- Occasionally by aerosols of tiny virus particles that can travel longer distances from the coughing person and be inhaled (for example, across a room or down a corridor)
- Touching surfaces, like a doorknob or telephone, that have been contaminated with respiratory secretions from a person with flu, and then touching your eyes, nose or mouth

How to Prevent Getting the Flu

To help prevent the flu:

- The best way to prevent the flu is to receive flu vaccine prior to the flu season
- **Stay home if you are sick** - Fever (temperature of 37.8C or 100F or greater), cough, sore throat, diarrhea, nausea/vomiting, body aches and headache
- **Cover your cough.** Always cover your nose and mouth with a tissue when you cough or sneeze and dispose of the tissue, or use your upper sleeve (not hands) to cover your cough.
- **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 to 6 feet of patients with symptoms

- Surgical masks are used for 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 the 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.

20. (2-6)

How is the flu spread?

- A. By droplets released into the air when a person (usually within 3 to 6 feet) with the flu coughs or sneezes
- B. By getting a flu shot
- C. By touching surfaces, like a doorknob or telephone, that have been contaminated with respiratory secretions from a person with flu, and then touching your eyes, nose or mouth
- D. A and C

21. (2-6)

How can you help prevent the spread of flu?

- A. Get a flu shot every five years
- B. Cover your cough (nose and mouth) with a tissue and immediately dispose of it
- C. Wash your hands frequently, especially before and after touching a patient
- D. B and C

22. (2-6)

I should not be at work if I have which of the following symptoms?

- A. Diarrhea
- B. Nausea/vomiting
- C. Fever of 37.8C (100F) or greater
- D. Any of the above

Waste Management — Lesson 7

Improper Handling/Disposing of Waste

Improper handling or disposal of certain types of waste could be illegal and create unsafe conditions.

Improper sharps disposal is a major concern; 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.

Waste Disposal Methods

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.

Waste Type	Examples	Disposal Method
Recyclable Waste	Office paper, newspapers, magazines, catalogs, books, paperboard boxes (flattened)	Blue bin/blue recycling toter (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 toter (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 toter 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 hazardous RX waste. If a syringe/needle has RX waste left, use a special 2-gallon wall bracket or tabletop black sharps shelter. 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.

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.
Chemotherapeutic Waste Chemo waste must be separated from all other types of waste.	Nonsharp waste from a patient being treated with cancer-fighting drugs including gloves, gowns, etc. Sharps and glass containers used for patients being treated with cancer fighting drugs.	Yellow bag labeled “Caution Chemotherapy Waste” Yellow plastic sharps container labeled “Caution! Hazardous Drug Waste” or “Caution! Chemotherapy Waste”
Creutzfeldt-Jakob Disease (CJD) Waste	Waste from patients known or suspected to have CJD	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.”

For Questions or to Schedule Pickup

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

23. (2-7)

Yellow bags and yellow sharps containers are used for:

- A. All blood and body fluids
- B. All biohazard waste
- C. Waste from patients being treated with chemotherapeutic drugs
- D. Both B & C

24. (2-7)

A nurse has just given her patient two different IV Meds. She should dispose of the sharps by:

- A. Placing them in red bags in dirty utility rooms
- B. Leaving them on the patient's tray to be taken away and disposed
- C. Immediately placing them in an approved hard plastic sharps container without recapping the needles
- D. Labeling and separating the two sharps for pickup by the appropriate persons

Electrical Safety – Lesson 8

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.
- Report any loose plug caps in wall receptacles.
- Defective plug caps (hot to the touch) must be taken out of service. Call URM-Strong Facilities at x3-4567 or Highland Maintenance at x1-7378 immediately for repair.
- HH-Specific Electrical Safety: adapters must be approved by Clinical Engineering.
- In the event of a major power outage, an independent power source will be activated.

Location of receptacles on emergency and nonemergency power.

	SMH	HH
Receptacles on emergency power (generators) ONLY PATIENT CARE RELATED EQUIPMENT SHOULD BE PLUGGED INTO THESE RECEPTACLES	Red (Critical Life Support Equipment) Located in ICU, ORs, Emergency depts., or other patient care areas.	Red
	White (General Patient Care Equipment — beds, call systems, etc.)	
	Orange (Individual Patient Care Equipment) Life-support equipment located in ICUs, ORs, 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	Ivory, Brown, White, Grey, and Orange

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.

Cords and Grounds

- 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.
- Use properly grounded electrical devices.
- Never roll a bed, cart etc., over an electrical cord; keep all objects off electrical cords.
- Do not position cords in traffic areas. This could lead to someone tripping and/or damaging a cord.

- 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 URMC-Strong.
- Do not plug additional plug strips into an existing plug strip.

Nonpatient Care Electrical Equipment

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.

HH

Highland Nonpatient Care Equipment is defined as electrical equipment that is not directly related or involved in patient care.

All nonpatient care equipment used in the hospital must be in good physical condition, have been wired with a chassis group via a separate third-wire ground with a hospital-grade plug attached, or be double insulated.

This equipment should have the appropriate UL listing for its type and use.

Shock Avoidance

Avoid getting shocked!

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

Electrical Distribution System

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.

Reporting Malfunctioning Equipment

To report malfunctioning patient care equipment, call Clinical Engineering:

URMC-SMH x5-5501

HH x1-7378

To report malfunctioning nonpatient care equipment, call Facilities Customer Service Operations:

URMC-SMH x3-4567

HH x1-7378

25. (2-8)

In the event of a major power outage:

- A. Staff should leave the facility immediately.
- B. An independent power source will be activated.
- C. Staff should call the Information Desk.
- D. All patient care equipment should be plugged into gray and brown outlets.

MODULE 3

Diversity and Inclusion – Lesson 1

Our Philosophy

At the University and Highland Hospital, we believe that everyone is unique and brings different talents and abilities to our workforce. This diversity is essential to providing excellent service to our customers, the organization, and the community.

To thrive in our diverse workforce we must seek to understand our differences.

By examining our own attitudes, values, and behaviors (as well as those of others), we can ensure that we can fulfill our highest potential as a team and as individuals.

Meeting the Needs of Others

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

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

Stereotypical views of others limit our ability to understand those different from us.

As every human being is unique we need to create an environment where all employees feel they can contribute to their fullest potential.

Teamwork

Teamwork is essential in a diverse work force. Qualified and diverse team members learn to respect each other's differences and understand how those differences contribute to the overall mission of our organization.

When each member of a team feels respected, morale improves and the productivity of the organization and the quality of service are 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.

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.

Interpersonal relations and organizational effectiveness are improved through encouraging new ideas and perspectives.

26. (3-1)

Diversity means:

- A. Remaining closed-minded when it comes to respecting the uniqueness of others
- B. Everyone is unique and has different talents
- C. Only a cultural dimension
- D. Creating an environment where some employees may feel uncomfortable

27. (3-1)

Inclusion is defined as:

- A. Making sure that some staff are included in training
- B. Creating an environment where everyone feels they contribute to their fullest potential
- C. Another way to define diversity
- D. Creating an environment where only a select few are comfortable

Interactions Between URM and Industry – Lesson 2

Interactions With Industry

The University of Rochester Medical Center (URMC) and affiliates, including Highland Hospital (HH), have numerous interactions with 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.

Conflict of Interest

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.

Gifts and Comp - Gifts and compensation, including meals, from industry or its representatives should not be accepted.

Samples/Grants - 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 - Site access by sales and marketing reps can only occur by appointment in both patient care and nonpatient care areas.

Please see the policy for more information on:

- Scholarships and educational funds for students and trainees
- Support for educational and other professional activities
- Disclosure of relationships with industry

28. (3-2)

You are approached by a sales representative who wants the hospital to start using a new product they are promoting. The sales rep invites you to dinner after work at a nice restaurant to tell you about the product. He will be giving the presentation and you can bring along a group of your colleagues to attend. What is the correct response to this request?

- A. You should prepare a poster and display it in your work area so all colleagues have an equal opportunity to attend
- B. You should inform the rep that you cannot accept the free dinner because this is not allowed, according to the URM/HH vendor policy
- C. You should attend the dinner to know more about the product before making a decision about whether we should stock it at URM/HH
- D. You should attend the dinner after making a formal request to stock the product

Meal Periods & Rest Breaks – Lesson 3

Not Applicable to Volunteers Continue to Lesson 4

Meal Periods

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. HRMS automatically deducts the 30 minutes. (45 minutes or 60 minutes can also be programmed.)

Scheduling of meal periods will occur at times convenient to department operations.

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.

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

The employee must be completely relieved of all duties and not be interrupted. If interrupted, every effort must be made to provide another 30-minute, uninterrupted meal period during the shift.

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.

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.

29. (3-3)

A secretary would like to work through her meal period every day while her co-worker is out on maternity for 6 weeks. Is this acceptable?

- A. No, every employee who works a shift of more than 6 hours must be provided an uninterrupted, 60-minute meal period each day
- B. Yes, as long as the secretary gets written approval from the department head
- C. Yes, this is a special circumstance and a daily override can be marked in HRMS
- D. No, skipping a meal period is allowed only in rare emergency circumstances; the department needs to figure out coverage

30. (3-3)

Each University of Rochester Medical Center or Highland Hospital hourly paid employee should:

- A. Report missed or interrupted meal periods via department procedures
- B. Be paid for all time worked
- C. Contact their supervisor or Human Resources if not getting an appropriate meal period or not being properly compensated
- D. All of the above

Obtaining Security Services – Lesson 4

Incidents

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.

Other reportable incidents include but are not limited to:

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

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

Calling for Help

To contact UR DPS or Highland Hospital Security:

SMH (UR DPS)

Emergencies: x13 from inside UR or any Blue Light Emergency Phone (BLEP)

Nonemergencies: x5-3333 (from inside UR)

May use 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)

HH

Emergencies: x1-6666

Nonemergencies: 1-SERV or Page Operator from inside the hospital

473-2200 (page operator) from outside the hospital

31. (3-4)

When notifying UR DPS of an emergency situation, what number should you call from within the URM?

- A. X5-0000
- B. X-13
- C. 9-1-1
- D. None of the above

Policy Against Discrimination and Harassment – Lesson 5

Policy Against Discrimination and Harassment

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, marital status, military/veteran status, national origin, race, religion/creed, sex, sexual orientation, or any other status protected by law.

Defining Discrimination

Discrimination involves an adverse action or decision, or harassing treatment of a person or class of persons because of a legally protected status (e.g., age, gender, race, etc.) or because of perceived or actual affiliation/association with other individuals in a protected class. Unfair or inappropriate behavior, not based on a protected class and which does not meet the definition of discrimination under University Policy 106 or Highland Policy 130, must be addressed through Human Resources, your supervisor, or the Intercessor.

Defining Harassment

Harassment is a form of discrimination, which involves:

1. Unwelcome verbal, written, or electronic conduct
2. That which is intended to cause or which could reasonably be expected to cause an individual or group to feel intimidated, demeaned, abused, or fearful, or to have concern for their personal safety
3. A protected class.

Harassment also must be sufficiently severe or pervasive and objectively and subjectively unreasonable with the environment.

Reporting Discrimination or Harassment

If you feel you are being discriminated against or harassed as a result of being in a protected class 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
- University — Utilize Complaint Form found in Policy 106
- Highland — Follow Complaint Procedures in Policy 130
- Contact any of these resources

Resources	SMH	Highland
Intercessor's Office - (Employees who specialize in conflict and informal resolution of harassment and discrimination concerns)	275-9125 (staff and students)	
Human Resources	EO Compliance 275-7814 or Dept. Chair or Dean's office	341-0118 (faculty and staff)
UR Dept. of Public Safety – SMH or HH Security	Emergency x13 Nonemergency 275-3333	Emergency 341-6666 Nonemergency x1-SERV
Office of Counsel	273-2167	273-2167

Taking adverse action against a person because that person complained about or participated in a complaint about discrimination or harassment is considered retaliation and prohibited by law and policy.

32. (3-5)

If you feel you are being discriminated against or harassed as a result of being in a protected class, or are aware of such conduct occurring to another:

- A. Tell the individual causing the harassment the behavior is not welcome and not acceptable
- B. Speak with your supervisor/manager
- C. Speak with Human Resources and/or the University Intercessor, or utilize Policy 106 Complaint Form or Highland Policy 130 Complaint Procedures
- D. All of the above

Quality Safety Performance Improvement – Lesson 6

Our Missions, Visions and Obligations

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

SMH

Mission: 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.

Vision and Obligation: 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.

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

HH

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

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

Goals

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)
- 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)

Safe Culture per Joint Commission

According to the Joint Commission a Safe Culture is:

- 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.

NYS Dept. of Health/Joint Commission Surveyors Expect Staff Members to Know and 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.

Performance Improvement

Performance is the key to high quality healthcare. 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.

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 system problem that can be fixed, but needs a team to solve it.
- Observe someone who is acting in a disrespectful or inappropriate way.

Core Principles/Concepts of Continuous Quality Improvement

The core principles/concepts of continuous quality improvement are:

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

Quality Care/Service

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

Fundamental Questions:

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?

Plan – Plan the change

Do – Implement the change

Study – Study the results of the planned change

Act – Hold the gains or continuously improve

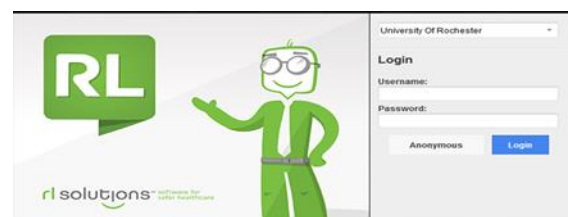


Patient Safety Event Reporting System (RL Solutions)

URMC and Highland Hospital encourage active reporting of errors, near-misses, unsafe conditions and any adverse outcomes.

- All employees can report patient safety incidents and can also do so anonymously.
- Event reports are a critical component of quality improvement focused on identifying and addressing system problems that may result in harm to patients.
- The early identification of such occurrences allows the hospital to immediately investigate the circumstances of the event and if necessary, institute corrective action to prevent similar occurrences in the future.

Safety event reporting should focus on the facts. It should not include judgment as to the cause of the event or blame individuals who may have been involved.



33. (3-6)

Each staff member must be able to explain all the following to surveyors except:

- A. Tell how your job supports the mission of the hospital
- B. Job safety procedures
- C. The hospital's reimbursement and operating margins
- D. Your role in departmental performance improvements and safety activities

34. (3-6)

What kind of events can be entered into the RL Solutions event reporting system?

- A. Only events that result in a serious injury to the patient
- B. Injuries or bodily fluid exposure to hospital employees
- C. Events that may or may not have resulted in harm or reached the patient, but may have resulted in harm under different circumstances
- D. Concern about hospital billing.

35. (3-6)

When entering an event into the RL Solutions event reporting system, you should provide a brief description of the event that includes which of the following?

- A. The names and titles of every staff member who was involved in the event and whether you think it was their fault.
- B. A summary of the event that will provide a factual description of what occurred and how the event impacted the patient.
- C. A comprehensive step-by-step timeline of the event
- D. All of the above

36. (3-6)

What kind of event can be entered into the RL Solutions event reporting system?

- A. Only events that result in a serious injury to the patient
- B. Injuries or bodily fluid exposures for hospital employees
- C. Events that may not have resulted in harm or reached the patient, but may have resulted in harm under different circumstances
- D. Concerns about hospital billing

DUPLICATE-DO NOT ANSWER

Smoke Free Campus Inside & Out – Lesson 7

Sale of Smoking Materials

The sale of tobacco material is prohibited at all HH, SMH, and URM and affiliated properties.

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](#) for locations.

A smoking outpost is no longer available at Highland.

Maintaining a Smoke Free Environment

Maintaining

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

To help outpatients, visitors, and staff to be more comfortable while complying with the policy at both SMH and HH:

- 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

Noncompliance

If you see a person smoking within either campus' perimeter 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

Faculty, staff and students should be aware they are subject to corrective action if they do not comply with the smoke-free policy.

37. (3-7)

Who is responsible for ensuring compliance with the Smoke-Free Policy? (choose best answer)

- A. All faculty and staff
- B. Nursing
- C. UR Dept. of Public Safety/HH Security
- D. Parking

38. (3-7)

What should you do if a person fails to comply with a request to stop smoking within the perimeter?

- A. State the policy
- B. Ask the person to take the remainder of their smoking material with them when they are done so others do not think it is okay to smoke at that location.
- C. Inform them nicotine replacement products can be purchased at various locations to help them be more comfortable while complying with the policy.
- D. All of the above

The ICARE Commitment – Lesson 8

The ICARE Commitment

Every word you speak, and action you take, including your body language, makes an impression, especially 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 (integrity, compassion, accountability, respect and excellence), ensuring our words and actions are consistent with these values.

You are expected to embrace the ICARE values, and make it central to your work life each and every day.

How do I learn more about our ICARE values?

Resources are available to you on the PFCC/ICARE intranet website.

[PFCC/ICARE Intranet Website](#)

Learning is grouped on the site according to your role and responsibilities as a manager or a staff member.

ICARE Values

Why are they important?

These values provide us a better place to learn, heal and grow. They guide us in how we treat each other – and ourselves. They show our commitment to patients, families, colleagues and students. And they provide five of the very best ways we can become “Ever Better.”

Demonstrate **Integrity**

- Be honest and ethical
- Act in a fair and trustworthy manner
- Uphold professional standards

Show **Compassion**

- Act with kindness
- Offer empathy
- Be responsive to individual needs

Take personal **Accountability**

- Lead by example
- Take responsibility for my actions
- Support the efforts of my team

Treat all with **Respect**

- Embrace diversity
- Be accepting and understanding
- Treat each person with dignity and sensitivity

Strive for **Excellence**

- Rise above the ordinary
- Seek innovative approaches
- Meliora – Ever Better



The ICARE 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

Compassion

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

Accountability

- Answer questions clearly — ask about and address concerns, explain next steps
- Involve and update — patients, families, and colleagues

Respect

- Be courteous and friendly — to all patients, families, and colleagues throughout the institution
- Speak positively — about your colleagues, other departments and the Medical Center

Excellence

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

The ICARE Commitment – Service Recovery Using the LEARN Protocol

What is LEARN? A simple, consistent approach to handling concerns and complaints.

Goal: To turn potentially negative situations into positive ones and make things right for our “customers.”

The *order matters* when using LEARN!

1. Listen to the customer
2. Empathize with how the customer is feeling
3. Apologize for the poor experience
4. Respond to the problem
5. Notify the appropriate person(s)

39. (3-8)

ICARE is about how we treat:

- A. Colleagues
- B. Patients, families, students
- C. Ourselves
- D. All of the above

40. (3-8)

When using the L.E.A.R.N. Service Recovery approach to address concerns and complaints, what are the three steps most critical to complete *first* before you respond to the issue?

- A. Learn, educate, acknowledge
- B. Apologize, Respond, Notify
- C. Empathize, Apologize, Respond
- D. Listen, Empathize, Apologize

MODULE 4

Code of Organizational and Business Ethics — Lesson 1

12 Principles

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.

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 healthcare 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.

Patients' suffering must always be addressed. Treatment for relief of symptoms and curative treatment are both treated with importance.

Principle 3 — Communication With Patients

A diagnosis is not just an identification of a disease, but may also carry with it serious emotional, social, and financial burdens for patients and those close to them, including the burden of making and living with difficult choices.

It is our responsibility to offer support and assistance by providing patients and their families with all the information they need to make sound decisions. This includes the timely sharing of information about the expected or unexpected outcomes of care with the patient or family.

Principle 4 — Confidentiality of Patient Information

Patient information is confidential and should not be disclosed without the patient's consent, except as provided by law. All information must be recorded accurately and communicated responsibly.

Patient identity is to be protected, especially in all public places, including hallways, elevators, and waiting rooms. Those with access to patient information have an obligation to protect patient privacy.

Principle 5 - Patient Access to Healthcare

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, treatments, 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.

Principal 8 – Preventive Healthcare

Disease prevention is an essential part of our mission. Through public education, community prevention 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 concern to produce and preserve a healthy environment.

Principal 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.

Principal 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 requires special care to avoid manipulating people made vulnerable by illness.

Ethical marketing requires providing accurate and unbiased information in all of our communications, public relations, and advertising.

41. (4-1)

According to the Code of Organizational and Business Ethics:

- A. We will provide timely sharing of information about outcomes of care, both expected and unexpected, to patients and their families when the patient consents
- B. We limit our care based on age or ability to pay
- C. Ethics consultation is not available to patients, their families, our staff, and faculty
- D. Disciplines work distinctly separate for the welfare of patients

Lifting and Transfers: Posture and Body Mechanics — Lesson 2

Good Posture

Why is good posture important?

It keeps bones and joints in the correct alignment and muscles are properly used. It decreases abnormal wearing of joint surfaces and stress on the ligaments holding the joints of the spine together.

It prevents the spine from becoming fixed in abnormal positions, backache and muscular pain, and decreases the potential of back injuries during lifting or heavy exertion.

Standing: Head straight up with chin in, shoulders back, and pelvis in neutral position (tighten abdominal muscles).

Sitting: Head straight up with chin in, shoulders back; all three curves should be present in back. Adjust chair height if needed. Rest elbows on armrests, relax shoulders, rest feet flat on floor or footrest.

Alternating sitting and standing can reduce fatigue and improve posture.

Poor Posture

What are the results of poor posture?

- Muscles are in weakened positions
- Increased potential for injury
- Pain, discomfort

Remember to take frequent breaks to change position and stretch, reversing any prolonged postures!

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 ankle. Avoid flexing forward at 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.
6. Ask for help before you need it.
7. Use assistive technology to save your back (for example, transfer belts, ceiling lift, Hoyer lift, hover mat, plastic sheeting, slide boards). If you provide direct patient care, assistive technology must be used for patients (or lifting tasks greater than 35 pounds) who are immobile or require assistance with transfers or repositioning.

General Transfer Guidelines

1. Determine the patient's needs by performing a mobility assessment.
2. Prepare the patient; explain what you are doing, how they can help.
3. Set up equipment to be used.
4. If the patient or lifting task is greater than 35 pounds, use assistive technology, such as transfer belts (available through Hospital Stores at SMH and on nursing units at HH), ceiling lifts, Hoyer lift, Hover mat, sit to stand devices, 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 if able.
7. Perform the transfer utilizing the recommended number of staff to transfer safely. This number depends on the type of transfer and equipment utilized. Minimally 2 staff members should be present for transfers unless utilizing assistive technology.

42. (4-2)

Why is good posture important?

- A. Prevents muscular pain
- B. Decreases injury
- C. Decreases stress on joints
- D. All of the above

43. (4-2)

A nurse needs to transfer a patient for transport to Imaging Sciences. The patient weighs over 270 pounds. What should the nurse do to prevent injury?

- A. Wait until a stronger person can do the lift in her place
- B. Keep her legs straight to lift
- C. Use assistive technology
- D. Use her large back muscles for lifting

Compliance — Lesson 3

Compliance Goals and Tools

The goals of the UR Compliance Program are to:

- Establish standards of performance for employees to conduct business with honesty and integrity.
- Promote correct billing for all health care services.
- Prevent Fraud, Waste, and Abuse
- Ensure compliance with laws related to Medicare, Medicaid, and other federal programs.

The Compliance Office provides tools to ensure compliance, including:

- A Code of Conduct, Compliance Plan, and Policies and Procedures
- An expert staff to answer questions about billing, coding, documentation, etc.
- Education and training
- Auditing and monitoring to prevent noncompliance

More information about the program, including policies and contacts, is available at:

<https://www.urmc.rochester.edu/compliance-office.aspx>. Every employee should review this site.

Code of Conduct

The Code of Conduct requires all employees to:

- Act ethically, legally and responsibly.
- Report violations of the law, the Code of Conduct and billing problems.
- Report acts of fraud, waste and abuse.
- Not retaliate against anyone who reports a potential compliance issue.

Failure to meet these obligations can lead to discipline, including termination.

Reporting Noncompliance

Reports of suspected noncompliance at any UR Medicine site may be made:

- To a supervisor.
- To the Compliance Office 275-1609.
- Anonymously to the **Integrity Hotline** 756-8888.

The Code of Conduct and the law prohibit retaliation against those who report problems.

Fraud, Waste and Abuse

Health Care Fraud is a crime. It involves wrongful attempts to secure undeserved payments from Medicare or Medicaid and other federal programs. Examples include:

- Intentionally billing for services that were not provided
- Knowingly submitting false billing information to obtain a greater payment

Overpayments that result from honest mistakes are **not** Fraud. However, the overpayments need to be returned.

Waste and Abuse involve acts that unnecessarily increase costs to Medicare or Medicaid such as prescribing unnecessary drugs or services. Preventing Waste and Abuse is **everyone's** responsibility.

Four Key Compliance Principles

All employees and staff must know Four Key Compliance Principles; employees can use the initials “**S-I-C-K**” to remember them.

“**S**” stands for **Sanctions**.

- Sanctions include exclusion from Medicare and Medicaid by the government.
- Sanctioned individuals or entities did something wrong. They may have committed Fraud, lost their license, or defaulted on a student loan.
- Sanctioned individuals cannot provide or order services paid by Medicare or Medicaid.
- If you suspect someone is sanctioned, report your concern to the Compliance Office.

“**I**” stands for **Inducements**.

- Inducements are gifts, benefits or payments given to patients to influence their choices.
- It is not permitted to give **anything to a patient** that would make it more likely for the patient to obtain treatment covered by Medicare or Medicaid from a particular health care provider.
- This rule generally forbids waivers of Medicare coinsurance, co-payments and deductibles.
- However, patients who cannot pay their bills and who qualify for financial assistance may be assisted.
- Also, inexpensive items may be given to Medicare or Medicaid patients to encourage or reward them for receiving certain preventive services such as breast or colon cancer screening.
- Check with the Compliance Office before giving something to Medicare or Medicaid patients.

“C” Stands for the Civil False Claims:

- The Civil False Claims Act imposes **treble damages** and **extremely large** penalties on health care providers who:
 - Knowingly submit false claims to Medicare or Medicaid or
 - Knowingly retain Medicare or Medicaid overpayments for more than 60 days.
- The three best ways to avoid liability for penalties and treble damages are:
 - Know and follow Medicare and Medicaid billing rules.
 - Promptly refund any **individual** overpayments that are received.
 - Report **recurring billing problems or overpayments** to the Compliance Office.
- If you are contacted about any overpayment issue by a law enforcement agency, you **must immediately** notify the Compliance Office (275-1609) or Office of Counsel (758-7600).

“K” stands for “Kickbacks”

- Kickbacks are benefits or payments given **to anyone in exchange for** ordering a service, prescribing a drug or referring a patient to a particular health care provider.
- Kickbacks may include anything of value such as cash or gifts.
- Offering, paying, asking for, or receiving a kickback **in exchange for** a referral involving a Medicare or Medicaid patient can result in civil or criminal liability.
- Suspected kickbacks should be reported to the Compliance Office.
- To avoid kickback law violations or other legal problems, all financial arrangements between health care providers who make referrals to each other should be reviewed by the Office of Counsel.

44. (4-3)

Which of the following are examples of noncompliant behavior?

- A. A laboratory bills Medicaid for lab tests it did not perform
- B. A surgeon sends expensive gifts to physicians to thank them for recommending her to their Medicare patients for surgeries
- C. A hospital does not collect a deductible from a cancer patient who cannot afford to pay his bills
- D. A and B

45. (4-3)

Sam works in a billing office. He believes his department is not billing correctly. He reports his concerns to his supervisor. If Sam is correct, the department would owe a very large refund to Medicare. Which of the following should his supervisor NOT do?

- A. Research the billing issue carefully
- B. Review submitted claims to see whether they were billed correctly
- C. Ask the Compliance Office for assistance
- D. Terminate Sam for reporting the problem

46. (4-3)

Dr. X always bills correctly. However, she recently discovered Medicare paid her more than it was supposed to for certain services she provided. Which of the following is true?

- A. Dr. X committed Fraud
- B. Dr. X committed Waste or Abuse
- C. Dr. X may be liable for treble damages and penalties under the Civil False Claims Act if she keeps the overpayments.
- D. Dr. X may keep the overpayments because she was not at fault

Joint Commission Readiness — Lesson 4

What Is the Joint Commission?

The Joint Commission is a private 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.

Visits, called surveys, are unannounced, so we need to be ready at all times.

Are You Joint Commission Ready?

Wear your ID Badge, and at SMH, the white badge card with the emergency page codes, at all times.

Know how you comply with the National Patient Safety Goals as they relate to your job.

Know where to find information on the intranet; e.g., policy and procedure manuals, clinical practice guidelines, and 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 Concerns

Staff:

Staff are encouraged to report concerns about care and safety through their management structure or by calling the Medical Director's Hotline (3-CARE) at SMH.

At Highland, staff members may 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:

Patients/families are encouraged to participate actively in their care and report any safety or quality concerns to their caregiver or to the Patient and Family Relations Coordinator.

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 to complaint@jointcommission.org.

47. (4-4)

Which of the following is a true statement?

- A. If a Joint Commission surveyor asks you a question, you should tell him or her to speak with your supervisor.
- B. Patients and their families should leave all aspects of their care up to the doctors and nurses caring for them.
- C. A Joint Commission surveyor can ask how you comply with the National Patient Safety Goals as related to your job duties.
- D. The first step a staff member with a care or safety concern should take is to call the Joint Commission.

48. (4-4)

What do all staff need to do to be prepared, at all times, for a Joint Commission survey?

- A. Memorize the emergency codes
- B. Answer all Joint Commission surveyor questions, even if you have to make up an answer
- C. Always wear their ID badge
- D. Memorize all the National Patient Safety Goals

Patient Identification — Lesson 5

Patient Identification

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.

Goals

The use of two identifiers in 2 places equals safe patient care.

Examples include:

- Patient name and birth date, 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

Goals:

- Ensure the correct patient receives the correct health care procedure
- Eliminate transfusion errors related to patient misidentification

49. (4-5)

Comparing the patient's stated name with the name on the lab requisition constitutes two identifiers.

- A. True
- B. False

50. (4-5)

Two identifiers are used to confirm the patient's identity before any health care procedure or treatment.

- A. True
- B. False

Patient Rights/Ethics/Complaint Process— Lesson 6

Patient Rights

NYS defines patients' 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.

For a complete list of patient rights click on the SMH policy link (Section 11.1.1).

<http://sharepoint.mc.rochester.edu/sites/smhpolicy/Pol/SitePages/Home.aspx>

Reporting 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.

What if I am unable to respond to a complaint?

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.

What if the patient is still not satisfied?

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 Department of Health, or Joint Commission.

What else can I do?

- 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

51. (4-6)

Patients have the right to complain to and receive a response from:

- A. Patient and Family Relations Office
- B. Department heads, supervisors or managers, or any staff member
- C. NYS Department of Health
- D. All of the above

Professional Misconduct Reporting & the Impaired Professional — Lesson 7

What is Professional Misconduct?

Examples of Professional Misconduct:

1. Fraudulently obtaining a license or practicing the profession while the license is suspended/inactive
2. Practicing while impaired by alcohol, drugs, or mental disability
3. 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
4. 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
5. 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
6. 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
7. 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

[Highland Policy 1.14, Code of Conduct](#) (See the actual link on the next page)

http://sites.mc.rochester.edu/umbraco/Surface/Sharepoint/spDownload?spPath=%2Fsites%2FHHPolicies%2FHospital_Policy_Manual%2F1%20GENERAL%20INFORMATION&spFileName=Code%20of%20Conduct%2C%201_4.pdf&spWeb=http%3A%2F%2Fsharepoint.mc.rochester.edu%2Fsites%2FHHPolicies%2FHospital_Policy_Manual%2F

Impaired Professional

Anyone witnessing behavior of an individual suggesting that the individual may have been practicing while impaired is legally obligated to notify the appropriate manager/supervisor and/or Director of Nursing and 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



To Report Misconduct Concerns

URMC-SMH

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

If concern involves a supervisor or departmental leader, staff should directly contact the Office of Counsel to the Medical Center at 275-9019.

HH

Contact the Quality Management Department through departmental channels.

If 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.

52. (4-7)

What is considered professional misconduct?

- A. Delegating responsibility only to professionally qualified staff
- B. Refusing to accept a fee from a third party for referral of a patient
- C. Using appropriate infection control techniques
- D. Practicing while impaired by alcohol or drugs

Active Shooter Emergency Recommendations — Lesson 8

Active Shooter Event – What to Do

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 that you should 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 direct impact on survival.

Run, Hide, Fight

Run

- 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

Hide

- 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

Fight

- If no other option is available 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

Calling For Help

When notifying 911/UR Public Safety or HH Security...

Call:

- 9-1-1
- 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

53. (4-8)

You are working at your assigned unit/work area and you hear a very loud noise, which sounds like a gunshot. You Should:

- A. Run to where the noise is coming from to figure out what is going on
- B. Determine if it is safe to run and make sure you take your belongings with you, especially your phone
- C. Hide if you cannot run, lock and barricade the door, get out of the shooters view, and silence electronic devices
- D. Stay where you are and yell for help

54. (4-8)

The best option for you to consider to survive an active shooter situation is:

- A. Be aware of your surroundings, exit points, and what items could potentially be used to fight off an active shooter
- B. Call 911 and/or UR Public Safety/HH Security (if safe to do so)
- C. Run (if safe), Hide (if you are able), and Fight (as a last resort)
- D. All of the above



MODULE 5

Care of Patient Personal Belongings and Valuables — Lesson 1

Patient Belongings and Valuables

Patients should be informed that neither Strong Memorial Hospital nor Highland Hospital will assume responsibility for any personal belongings or valuables 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.

Patients should be encouraged to leave at home or send home upon admission valuables such as jewelry, watches, clothing, money, credit cards, medications, electronic devices, cell phones, computers, etc.

Items that remain with the patient are the responsibility of the patient.

If it is not possible for the valuables to be left or sent home, the valuables are inventoried and deposited in the Cashier's Office for safekeeping.

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.

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. 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. 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. 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 Patients

Deceased patient belongings and valuables should be given to the family.

SMH

At SMH, if any personal belongings remain, they will be inventoried by unit staff and sent to the Cashier's Office for safekeeping and final disposition.

HH

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, or jewelry remain, they will be inventoried and sent to the Cashier's Office.

55. (5-1)

Upon admission, staff encouraged the patient to send all valuables home, but the patient elected to keep his wedding band with him. While still in our care, the patient passed away. Staff should give the wedding band to the family. However, if the family is not present:

- A. The wedding band should be safely stored in the medications room or in the nurse manager's office until the family arrives
- B. The wedding band should be inventoried and placed in a gray valuables bag and secured to the body of the deceased
- C. UR Department of Public Safety should be called to remove and take custody of the wedding band
- D. The wedding band should be inventoried and sent to the Cashier's Office

eRecord Down Procedures – Lesson 2

Not Applicable to Volunteers Continue to Lesson 3

Scheduled Downtime

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

Notification is sent to end-users 1 week in advance, and again 1 to 2 days prior to the downtime.

This is scheduled for the third Sunday of each month at 2:00 a.m.

Unplanned Outages

For an unplanned eRecord outage, follow these steps:

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

Icon 1- (Read Only)

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

Icon 2- (Reports Only)

- Limited data set in report format
 - Inpatient reports include a clinical summary and the MAR
 - Allied services have specialized reports
3. If eRecord is still not accessible, then a Downtime PC is available on each unit and at Ambulatory practices that see patients more than two days per week; 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

Once logged onto the computer, click on the “Downtime Printing” icon and use your eRecord login and password to gain access to the reports.

If the downtime lasts more than 2 hours:

- Each unit/practice has downtime forms in a tote or filing cabinet
- The forms are service-level specific
- There is enough paperwork for 24 hours’ worth of documenting in each tote

Large-Scale Major Issues

In the event of a large-scale major downtime issue:

- The Help Desk will update the regular greeting to state the system that is down and provide additional information as it becomes known.
- The Intranet System Status information will be updated.
- E-mails will be sent to clinicians, notifying them of the system outage.
- The Hospital Administrator On Call may determine to send an overhead page announcing critical system(s) outages.
- 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.

56. (5-2)

In what order should you attempt to use the eRecord system if the main eRecord system is not available?

- Icon 1 (Read Only), Icon 2 (Reports Only), Downtime PC
- Downtime PC, Downtime Forms, Icon 1 (Read Only), Icon 2 (Reports Only)
- Downtime Tote, Downtime PC, Icon 1 (Read Only), Icon 2 (Reports Only)
- Icon 2 (Reports Only), Icon 1 (Read Only), Downtime PC, Downtime Tote

57. (5-2)

During an eRecord downtime, which of the following is False?

- Icon 2 (Reports Only) - used when an unplanned eRecord system downtime occurs; reports include a clinical summary and the MAR
- Icon 1 (Read Only) - used first when an unplanned eRecord system downtime occurs; looks identical to the Clinical System, except cannot document, and displays all information up to the moment downtime began
- The downtime PC is used first when an unplanned eRecord system downtime occurs
- If the eRecord production system suddenly becomes unavailable, or if during a scheduled planned downtime, eRecord Icon 1 (Read Only) is not available, staff should report this to the ISD Help Desk immediately.

58. (5-2)

Where would you find information to guide staff in documentation if eRecord is down?

- Unit file drawer
- Downtime Tote
- Intranet
- All of the above

HIPAA Privacy & Security and Confidentiality of Information — Lesson 3

What Is HIPAA?

The Health Insurance Portability and Accountability Act (HIPAA) is a federal regulation that mandates standards to protect the privacy and security of patients' medical information.

Privacy refers to maintaining confidentiality and safeguards of all Protected Health Information (PHI), whether in electronic, written, or oral form.

Any use or disclosure of PHI must be permitted by the Privacy regulations. Security refers to the measures that are taken to protect electronic protected health information (ePHI) from loss, theft, damage or unauthorized access.

HIPAA and You

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) Integrity Hotline at 585-756-8888 to report concerns, complaints, or violations.

You must have a job-related reason, or be permitted by policy, to access any patient's PHI. You are not permitted to access PHI of any patient that is a family member or friend, because they have asked you to, or because you hold a power of attorney or a health care proxy. MyChart is available to patients to access their health information or give proxy access to someone else for MyChart only.

HIPAA Security

Passwords

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.

E-mail

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.

Secure Storage of PHI

PHI must be stored securely wherever it is stored. URM shared drives and UR's Box Service are examples of secure storage places. All devices containing PHI must be encrypted. Contact your Help Desk or HIPAA Security Official to determine the most appropriate and secure storage mechanism. The use of cloud storage, portable media or other unencrypted storage mechanism must first be approved by the HIPAA Security Official.

59. (5-3)

You have saved a list of patients' contact information to conduct follow-up appointment reminders. Which of the following may be an acceptable place to store this data?

- A. Shared drive
- B. UR's Box service
- C. DropBox.com
- D. A and B

60. (5-3)

Which of the following would be considered a job-related reason to look at a patient's PHI?

- A. Looking up a phone number to call a patient about their results
- B. Reviewing your former spouse's billing records
- C. Looking up your boss's record because she or he has been out ill and you are concerned
- D. Accessing the lab work of a relative for whom you hold power of attorney

Management of Suspected Abuse and Neglect — Lesson 4

Reporting Suspected Child Abuse/Neglect

1. Immediately alert social workers. (NYS Social Law requires health care providers to report any and all suspicions of child abuse or maltreatment to the NYS Child Registry or Monroe County child abuse and neglect hotline.

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



SMH - Available 24 hours a day, via Page Office

HH - Days, page Social Work Director at 220-8319; after hours, page Social Workers on call with medical team

2. SMH — 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)
3. Social worker with medical team initiates formal referral to Child Protective Services (461-5690) and law enforcement
4. Objective facts and phone referral documented in patient record
5. Social worker coordinates safe discharge

Reporting Suspected Domestic Violence or Elder Abuse

1. Immediately alert social worker

SMH: Available 24 hours a 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

In the Event of Sexual Assault

SMH

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 — Suspected Child Abuse or Maltreatment

HH

- Follow protocol for documentation and evidence-gathering processes
- Ensure the patient is never alone
- Contact social worker assigned to the area, or via the nursing supervisor for the on-call social worker

61. (5-4)

In the case of suspected child abuse/maltreatment, which of the following is true:

- A. Social Work is notified after patient discharge
- B. Physicians, nurses, dentists, social workers and other health care providers are mandated by NYS Social Services to make a report to the NYS Child Central Registry
- C. A pediatric consultation must be requested after patient discharge
- D. Reporters must have clear evidence of maltreatment, neglect or abuse to make a report

Occurrence/Claim Reporting — Lesson 5

Defining an Occurrence

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.

Internal Reporting

SMH 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, 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.

HH 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
- 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.

[HH policy 3.14 Occurrence Reporting](#)

[3.14 Appendix A](#), [3.14 Appendix B](#), [3.14 Appendix C and D](#)

Immediately report serious occurrences to the HH Quality Management Department (341-8399) or the Nursing Supervisor (off-hours).

External Reporting

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.

Making an external report:

- URM/SMH: Consult with Office of Counsel before making an external report.
- Highland: The Quality Management Department is responsible for submitting reports to the DOH or other regulatory agencies.

External Reporting to DOH

Two types of reports must be sent to the DOH.

Short Form:

- 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)

- Do not delay reporting in SRM/RL Solutions, or to the URM/SMH 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.
- 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 — Medical Devices/Equipment

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
- HH: contact the Quality Management Department

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 or damage to a bodily structure
- An illness or injury necessitating medical or surgical intervention to prevent permanent impairment of a bodily function or permanent damage to a bodily structure

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 or 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

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.

62. (5-5)

An event reporting system (SRM/RL Solutions) report must be completed:

- A. By the end of the month, if it requires a Root Cause Analysis
- B. And documented in the patient's medical record
- C. For actual or potential situations that could have resulted in an accident
- D. Only for NYS Department of Health reporting requirements

63. (5-5)

During a critical operation, a piece of equipment shorted out and harmed a patient and the technician using the equipment. This incident should be reported to:

- A. Supervisor/department manager
- B. Risk Management at SMH or Quality Management at Highland
- C. The manufacturer or the FDA by the designated hospital officer
- D. All of the above

Patient Safety, Team Communication, and Medical-Health Care Error Reduction — Lesson 6

SMH/HH Safety Culture

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

- Using a nonpunitive medical error reporting process.
- Using an electronic event reporting system (RL Solutions) for actual occurrences and near misses, so unsafe trends can be tracked and eliminated to reduce future events.
- Following Joint Commission National Patient Safety Goals/Requirements.

Patient Safety Goals Examples:



- Use two 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, and properly cleaning patient care equipment after use.
- Reduce likelihood of patient harm in use of anticoagulation therapy.
- Improved recognition and response to changes in patient's condition.

Joint Commission National Safety Goals

2017 Joint Commission Universal Protocol Requirements:

- UP 01.1 Conduct a pre-procedure verification process
- UP 01.2 Mark the procedure site
- UP 01.3 A time-out is performed before the procedure

2017 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 6: Make improvements to ensure alarms on medical equipment are heard/responded to on time
- Goal 7: Reduce the risk of healthcare-associated infection
- Goal 15: Identify patients at risk for suicide

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, medication, 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.

All actual events and near misses should be entered in the electronic reporting system (RL Solutions) so unsafe trends can be tracked and eliminated.

64. (5-6)

Effective handoff communication includes:

- A. Patient history, medications
- B. Current condition, anticipated changes
- C. Plan of care
- D. All of the above

65. (5-6)

“Do Not Use” abbreviations are:

- A. Never allowed in medical record documentation
- B. Allowed in medical record documentation when handwriting a note
- C. Allowed in medical record documentation for outpatient records but not inpatient
- D. Never allowed in medical record documentation except for “QD”

Interpreter Services — Lesson 7

Interpreter Services Requirements

Interpreter services must be available for all Limited English Proficient (LEP) and Deaf patients and their families.

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.

Sign Language or Spanish-speaking persons: interpreters available 24 hours; for nonemergency cases, arrange 1 hour before MD rounds (SMH) or 24 hours before (HH).

NYS Health Code requires interpreter services must be available within 20 minutes for non-ED patients, 10 minutes for ED patients.

Contacting an Interpreter

Contact the appropriate interpreter service as soon as you know an interpreter is needed; not all interpreters are on-site at all hours.

CyraCom International language service (blue phones) is available for spoken languages. Directions for use are in all clinical areas or contact the unit’s Nurse Manager.

SMH

- Go to intranet for contact and process information
- Book Interpreters in advance when scheduling patients
- Assistive Devices: Call Communications Center at 275-2222

HH

- Highland Hospital has a full-time Sign Language Interpreter available on weekdays.
- 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

When 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...”
- They 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.

66. (5-7)

Interpreters:

- A. When offered or used, require documentation of the offer or use in the patient’s medical record
- B. Will interpret everything said in the presence of a patient.
- C. Are a requirement for all Limited English Proficient (LEP) and Deaf patients and families
- D. Are available at all times for spoken languages through CyraCom International Language Service (blue phone)
- E. All of the above

MODULE 6

Providing Better Care for People With Intellectual/Developmental Disabilities (IDD) — Lesson 1

Intellectual and Developmental Disabilities

Developmental disabilities (DDs) are 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.

How Having IDD Impacts the Person

How are people with IDD impacted by their disability?

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

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.

Communicating With Someone With IDD

When communicating with someone 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 disabilities.

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

67. (6-1)

Providing care for people with IDD consists of the same elements as providing care for people without disabilities.

- A. True
- B. False

68. (6-1)

Adrian is a 5-year-old boy with autism. He comes to the lab with his mother to have a blood draw. He has been waiting in the clinic room for 15 minutes. He is displaying fear of needles and becoming more anxious as time passes. The phlebotomist should:

- A. Use restraints
- B. Tell Adrian's mother to calm him down
- C. Find out how Adrian communicates and help him understand what to expect
- D. Call security

Stroke Recognition – Lesson 2

Comprehensive Stroke Center

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 awarded the Gold Seal for Stroke care.

At either institution, stroke is an emergency and all potential treatments must be provided quickly.

Recognizing a Stroke

A stroke can be recognized by sudden onset:

- 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.

FAST

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

If Someone Is Having a Stroke

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

SMH: If inside the hospital:

- STAT page through the page office
- For a patient: Stroke Alert
- For anyone else: MERT response

HH: If inside the hospital:

- For a patient: Inform a RN on the floor who will call a Rapid Response
- For anyone else: Call the page office for a MERT Response

If **outside either hospital:** Call 9-1-1

69. (6-2)

When using the acronym “FAST” to recognize a stroke, the letters F-A-S-T stand for:

- A. Forgetful, Agitated, Sleepy, Tremor
- B. Face, Arm, Speech, Time
- C. Fall, Arm, Speech, Tongue
- D. Face, Arm, Sick, Talk

Minimum Standards for Programs for Minors — Lesson 3

Covered/Uncovered Programs

Programs that accept transfer of responsibility for supervision and control of minors and children from parents or guardians to the University.

Covered

- 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.
- Programs conducted by University employees using their University title with the University's knowledge.

- Programs or services that are conducted or provided by an outside entity while on University premises.
- Programs that are conducted or provided on behalf of, or for the University.

Not Covered

- 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 subdivision hosting the program. (Approver should be an authorized University Program Administrator.)

The Program Administrator must ensure the program is designed in compliance with the University's minimum standards for minors before approval.

Registration Process

Program Registration:

- 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 (the Program Sponsor).
- Shall include a description of the program and the Program Administrator's signature.
- Shall include contact information for the Program Sponsor.

Participant Registration:

- All minors must be registered and have provided necessary information required by the policy before the activity or event begins.
- All minors must be 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.

Procedures

Procedure involves:

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. For still unanswered questions, the Administrator or HR Business Partner should contact Mary Goldenberg in the Risk Management Department for assistance.

70. (6-3)

Which of the following are not considered covered programs for minors?

- A. Activities, workshops, laboratories and events that serve children, whether for academic, athletic, recreational or other purposes
- B. Programs that are held on or off University premises (all properties owned, leased or controlled by the University)
- C. Programs held off University premises if the University is a sponsor or participant
- D. University events such as fairs, festivals or other events that are open to people of all age groups in which children may participate

71. (6-3)

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:

- A. Completing a self-disclosure form of past criminal convictions
- B. Checking felony conviction records
- C. Checking relevant applicable sexual offense registries
- D. All of the above