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|   | Strong Memorial Hospital               |
|   | Highland Hospital                     |
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This manual and accompanying test are available for viewing or printing on SharePoint at: http://inside.mc.rochester.edu/sites/Inservice/default.aspx.

An online, interactive version of the manual and tests is available on Blackboard. Self-enroll at: http://bb.rochester.edu/enroll/user_enroll.cfm?enrollmentID=2a2j

Or, you can take your copy card to the URMC Copy Center on the ground floor of SMH to request copies of the manual.
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## 2013 Mandatory In-Service Education Manual

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Preface

2013 Mandatory In-Service Education Program for University of Rochester Medical Center–SMH and Highland Hospital Faculty and Staff

This program is:

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

As in 2012, there is only **ONE** compliance test which is separated into **four** designated sections for participants to complete based on their job role; some participants may need to complete multiple sections. Anyone uncertain of their role should consult their department chair, supervisor/manager, or nurse leader to assist them.

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

Regardless of which sections of the test are required, participants must pass as follows:

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* Please review the topics in the second section of the Manual to identify if this pertains to your role or ask your supervisor/manager to clarify

---

**Online Compliance Test**

Online Blackboard users need to follow the testing instructions on Blackboard. To self-enroll in the online program, see the instructions located at:


The Blackboard online process is described on the next page.

.....continues....
1. For faculty and staff using the Blackboard online program:

New this year is a brief Preassessment of Roles in which employees will answer some questions that will guide them to the appropriate test section(s) they need to complete (up to 4) based on their job role(s). Blackboard will automatically score each required test section and upon obtaining a passing score for one section, the next required test section (if applicable) or step will appear. Also new this year in Blackboard: failing a test section will require repeating only that section, not any other sections that were previously passed. In addition, there is a final Role Confirmation step that is required to initiate course completion and automatic credit in the employee’s HRMS training record.

2. Faculty/staff members who do not use the online program:

Give the completed competency answer submission sheet to your manager/supervisor or compliance administrator to correct and retain in the department file. When a passing score is obtained, compliance will need to be manually recorded in HRMS by the individual’s department. Call Annette Schillaci at 267-4092 for questions concerning access to enter compliance data in HRMS.

3. Staff members transferring into your department:

- The previous supervisor should have entered their record of compliance in HRMS.
- If applicable, ask the new staff member for verification of their test compliance to be placed into their new department file.

4. Staff members transferring from your department:

- Make certain their compliance has been entered into HRMS.
- If applicable, provide verification of their test compliance for them to take to their new supervisor.

---

**HH Faculty/Staff Working Exclusively at Highland Hospital**

Go to [www.carelearning.com](http://www.carelearning.com) and click on “student login” to login with your student ID and password. Contact your manager if you do not have this information.

**HH Physicians Working Exclusively at Highland Hospital**

Will need to read the Mandatory Manual and access the Highland Hospital quiz at: [http://intranet.urmc-sh.rochester.edu/Highland/Medical-Staff/Mandatory-Training-Program.asp](http://intranet.urmc-sh.rochester.edu/Highland/Medical-Staff/Mandatory-Training-Program.asp)

**HH Documentation of Compliance**

1. Employees should sign off on their 2012-2013 Personal Education Record that all mandatory topics are completed.

2. Individual employee transcripts for online courses and some in-services are available at: [http://intranet.urmc-sh.rochester.edu/Highland/Depts/Education/CareLearning/eRegistrar](http://intranet.urmc-sh.rochester.edu/Highland/Depts/Education/CareLearning/eRegistrar)

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For additional information or concerns regarding specific topics, please contact the Subject Matter Experts listed at the beginning of each topic.

Thank you to all who have contributed to developing the University of Rochester Medical Center and Highland Hospital 2013 Mandatory In-Service Education Program!
Section 1:

GENERAL TOPICS

FOR

EVERYONE REGARDLESS

OF DUTIES/POSITION
AMBER ALERT

Subject Matter Experts:

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

For more information, please go to:

SMH: http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/section02/2-8.pdf
SMH: http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/section03/3-3.pdf

SMH: Protection of Minor Patients and Assessment for Abduction

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.

SMH and HH: In the Event of a Suspected Infant or Child Abduction

If you are in the area where the abduction occurred, immediately contact UR Security Services at extension 13 or HH Security at 1-6666, and request an AMBER Alert:

- Give the location, age of infant/child/adolescent, description of infant/child/adolescent and of the abductor, if known.
- Remain on the phone with Security Services until all necessary information is communicated.
- Page you will hear:
  - SMH: AMBER Alert (age/location)
  - HH: AMBER Alert (all buildings)

Other staff in the immediate area should not allow anyone to enter or leave the area where the abduction took place; staff should search the area and identify all witnesses (separate if possible). All departments in the facility should secure exits for which they are responsible.

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

- SMH: report suspicious activity or persons to Security at x13 and direct persons attempting to exit with a child, package, or appearing to be pregnant to the exits that Security will be monitoring: Main Lobby—First floor Med. Ctr. Parking Garage Link, Ground floor—Med. Ctr. Parking Garage Link, Patient Discharge, and 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.

At no time should an employee jeopardize his or her own security. If threatened, allow the person to leave, get a good description, watch their direction of travel, and contact Security.

...continues...
AMBER ALERT (continued)

**IT IS CRUCIAL TO REMEMBER:**

- Report suspicious activity or persons to UR Security at extension 13 or HH Security at 1-6666.
- Monitor the nearest perimeter door in your area until the "AMBER Alert, All Clear" overhead page is announced.
- You should not place yourself in danger by attempting to detain a suspicious person. If you encounter a suspicious person, immediately **call UR Security at extension 13 or HH Security at 1-6666** with a description of that person and their direction of travel.
- No information should be given to the press regarding the incident.
BLOODBORNE PATHOGENS STANDARD 29 CFR 1910.1030

Subject Matter Experts:
SMH: Anne Schmidlin (275-9809)  
HH: Vivian Condello (341-8017)

For full information on this topic, go to:

OSHA Bloodborne Pathogens Standard:


Bloodborne Pathogens Exposure Control Plan:

URMC: www.safety.rochester.edu/ih/bbpindex.html
    ▪ Questions about bloodborne pathogens from URMC employees will be answered 24/7 by calling 275-1164.

HH: http://intranet.urmc-sh.rochester.edu/highland/policy/infectioncontrol
    ▪ Questions about bloodborne pathogens for HH employees will be answered Monday-Friday, 8 a.m. – 4:15 p.m. by calling 341-8017 and other hours by paging the nursing supervisor at 51616, and entering the number where you are to receive a call back.

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

Prevent Exposures:

▪ Use safety sharps and activate safety devices immediately after use.
▪ Practice safe work practices; for example, use the “safe zone” in the OR
▪ Dispose of all sharps in hard-plastic sharps containers
    ○ Sharps include needles, lancets, scalpels, surgical staples/wires, broken/contaminated glass, slides or any other item likely to puncture a bag.
    ○ Replace sharps containers before they are ¾ full. To request a more frequent pick-up schedule, at URMC 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
    – 20% of blood exposures are splashes. Prevent splashes of blood or body fluids to the mucous membranes by wearing splash protection.
▪ Follow Standard Precautions: treat the blood and body fluids of ALL persons as if they contain bloodborne pathogens.

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


HH: [http://intranet.urmc-sh.rochester.edu/highland/Policy/InfectionControl/6-12.pdf](http://intranet.urmc-sh.rochester.edu/highland/Policy/InfectionControl/6-12.pdf)

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

- **REPORT** the incident online at:
  - URMC: [www.safety.rochester.edu/SMH115.html](http://www.safety.rochester.edu/SMH115.html)

**IT IS CRUCIAL TO REMEMBER:**

- **Every** needlestick or other exposure to blood or body fluids involves potential risk of infection with HIV, Hepatitis C, or Hepatitis B.
- Activate safety devices **immediately** after use.
- **Wear eye protection.** 20% of blood exposures are splashes.
- Dispose of **All** sharps in hard-plastic sharps containers
The twelve principles of the Code of Ethics that guide the behavior of all employees and representatives of our institution are:

**Principle 1 – Respect for Patients**
Respect for the people for whom we are privileged to care is our first and greatest concern. We will provide health care without regard to race, creed, color, gender, sexual orientation, national origin, age, or ability to pay, and will respect each patient’s unique background, culture, beliefs, and needs. Each of us bears a moral obligation to our patients to respect the value and dignity of human life, and this duty outweighs our own personal and financial interests. The Hospital has a Charity Care Program to support this principle.

**Principle 2 – Relief of Suffering**
Curing disease, reducing suffering and achieving an acceptable quality of life as defined by the patient are central goals of our institution. Patient suffering must always be addressed. Treatment for relief of symptoms and curative treatment are both treated with importance.

**Principle 3 – Communication With Patients**
A diagnosis is not just an identification of a disease, but may also carry with it serious emotional, social and financial burdens for patients and those close to them, including the burden of making and living with difficult choices. It is our responsibility to offer support and assistance by providing patients and their families with all the information they need to make sound decisions. This includes the timely sharing of information about the expected or unexpected outcomes of care with the patient or family.

**Principle 4 – Confidentiality of Patient Information**
Patient information is confidential and should not be disclosed without the patient’s consent, except as provided by law. All information must be recorded accurately and communicated responsibly. Patient identity is to be protected especially in all public places, including hallways, elevators, and waiting rooms. Those with access to patient information have an obligation to protect patient privacy.

**Principle 5 – Patient Access to Health Care**
Registration, admission, transfer and discharge of patients are based on the patient’s welfare and personal preferences, without regard to their ability to pay. Out of respect for patients and their concerns, we have established procedures to expeditiously and fairly resolve patient concerns or disputes arising over registration, admission, transfer, discharge, billing and payment. We will do all we can to help patients find resources to cover the cost of their care and the optimal setting for that care.

**Principle 6 – Interdisciplinary Relations**
Good patient care requires the collaboration of many different people providing a range of services, and effective communication and coordination between the care providers 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.

.....continues.....
Principle 7 – Conflicts of Interest
All clinical decisions, including tests, treatment, procedures, and follow-up care will be based on the patient’s needs, and not on the financial interests of the hospital or its leaders, managers, staff or practitioners.

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

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

Principle 8 – Preventive Health Care
Disease prevention is an essential part of our mission. Through public education, community preventive service and research, we can reduce the incidence of illness and thus serve people who may never be our patients. Our responsibility to our neighbors and community also extends to a concern to produce and preserve a healthy environment.

Principle 9 - Education and Ethics
Education is both an investment in a better future and a tribute to past generations of patients and scholars. We commit ourselves to further progress against disease by sharing the knowledge, skills and ethical values that are the foundation of this institution. Educational programs and Ethics consultation are available to patients, their families, the community and our staff, volunteers, and faculty.

Principle 10 - Research Ethics
Basic and clinical research are central to our mission. They are fundamental to the prevention, diagnosis, treatment and ultimately, to the eradication of disease. Research requires activities that are anticipated to improve patient care in the future, and participants who are fully and adequately informed about the risks and benefits, including all reasonable alternatives. Research must reflect the highest standards of integrity including accurately collected, precisely analyzed and honestly reported data.

Principle 11 – Cost Containment and Allocation of Resources
Medical care, disease prevention and medical education and research are costly endeavors demanding conscientious stewardship; however, financial considerations should not dictate the quality of care offered to each patient. When the hospital must address the fair distribution of limited health care resources, the relative efficacy and financial costs will be considered, with the goal of maximizing health benefits using available resources. We will use both financial and natural resources conservatively, not wastefully. Quality assurance procedures will be followed to control costs and avoid unnecessary tests, treatments, or procedures.

......continues.....
Principle 12 – Marketing Practices
Marketing practices for medical services carry a unique responsibility that requires special care to avoid manipulating people made vulnerable by illness. Ethical marketing requires providing accurate and unbiased information in all of our communications, public relations and advertising.

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

References:
Strong Health Code of Conduct
COMPLIANCE: EVERYONE’S RESPONSIBILITY

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

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

The Compliance Office
The Compliance Office supports employees, providers and management in providing effective, quality care while performing their responsibilities ethically and within the bounds of the law. Some of the services and tools available through the Compliance Office are:

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

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

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

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

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

IT IS CRUCIAL TO REMEMBER:
You can report any compliance concerns without fear of retribution by:

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

Subject Matter Experts:

SMH: Mark Cavanaugh (275-8412)  
HH: Joe Coon (341-6833)

For full information on this topic for each department, go to the HIMS (Comprehensive Emergency Management Plan):
- Highland: http://intranet.urmc-sh.rochester.edu/Highland/Policy/EmergencyPrep/

Definition
A disaster occurs when events:

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

The occurrence of any of the above may result in the Hospital activating its disaster response plan.

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

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

How to Prepare for a Disaster Response
To be prepared for any disaster affecting URMCH-Strong or Highland facilities, know where your emergency management plan is located, and review your department’s disaster/emergency response plan to understand your role so you can respond appropriately.

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

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

......continues......
DISASTER PREPAREDNESS (continued)

**IT IS CRUCIAL TO REMEMBER:**

- If on duty, follow your department plan/directions from your leadership; make sure you are wearing your ID badge so that you can access all necessary areas.
- Do not use hospital phones/elevators except for emergency or disaster activities, if 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.
DISRUPTIVE EVENT EDUCATION

Subject Matter Experts:

SMH: Peg Lee (275-2537), Pat Reagan Webster (273-1554)

HH: Kathy Gallucci (341-0118)

For more information, go to:

SMH: Blackboard Self-Enrollment Course:
http://bb.rochester.edu/enroll/user_enroll.cfm?enrollmentID=1emb

HH: Code of Conduct Policy #1.4
http://intranet.urmc-sh.rochester.edu/highland/Policy/HHpolicy/1-4.pdf

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. Disruptive events that intimidate others and affect morale or staff turnover can be harmful to patient care when one or more team members feel they are no longer a respected member of that team.

Leaders address disruptive behavior of individuals working at all levels of the hospital by:

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

Examples of disruptive events include (but are not limited to) insulting or verbal attacks, frequent outbursts of anger, throwing instruments or charts, and criticizing a team member in front of patients.

Reporting of Disruptive Events:

SMH - Faculty and staff should report disruptive events in Quantros (the hospital’s electronic reporting system) as soon as possible; events can be entered anonymously if preferred. Or, the event can be reported on the Integrity Hotline at 756-8888.

Your CONFIDENTIAL report is reviewed by Human Resources and is then given to the best person to handle resolution of that event. If you use your name when reporting the event, you will receive confirmation that your report has been seen and is being reviewed.

Each event will be handled on a case-by-case basis, so there is no standard time frame for resolution of the event, but each event will be reviewed within 14 days of being reported. If you used your name when reporting the event, you should receive a confirmation in approximately 14 days. However, if you did not use your name when reporting the event, there is no mechanism in place to notify you that it has been received and is being reviewed.

HH - Individuals, employees, physicians and other independent practitioners observing disruptive/inappropriate behavior must report it immediately to the Chief of Service or Associate Medical Director, Nursing Department Manager, or Department Manager (non-nursing units). Staff may also report disruptive/inappropriate behavior to Human Resources. It is expected that individuals receiving a report contact the Director of Human Resources or designee to communicate the event occurrence within (14) days of receiving the report. There is no standard time for resolution as each event is unique and will be handled on a case-by-case basis.

.....continues.....
DISRUPTIVE EVENT EDUCATION (continued)

**IT IS CRUCIAL TO REMEMBER:**

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

Subject Matter Experts:

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

Philosophy

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

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

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

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

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

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

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

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

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

IT IS CRUCIAL TO REMEMBER:

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

Subject Matter Experts:

SMH: Michael Rink (275-4810)  HH: John Griffiths (341-0120)

For more information, see:

SMH: http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/index.asp
HH: http://intranet.urmc-sh.rochester.edu/highland/Policy/envCare/electrical%20safety%207.6.pdf

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.

Nonpatient Care Electrical Equipment

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

Highland 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.

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

IT IS CRUCIAL TO REMEMBER:

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

Subject Matter Experts:

**SMH**: Lorraine McTarnaghan (275-2500), Naomi Smith (275-6004)

**HH**: Joe Coon (341-6894), Dennis Scibetta (341-0859)

For full information on codes, go to:

**SMH**: [http://intranet.urmc.rochester.edu/Policy/SMHpolicies/](http://intranet.urmc.rochester.edu/Policy/SMHpolicies/)

**HH**: [http://intranet.urmc.rochester.edu/Highland/Policy](http://intranet.urmc.rochester.edu/Highland/Policy)

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

<table>
<thead>
<tr>
<th>Emergency</th>
<th>SMH Phone #</th>
<th>HH Phone #</th>
<th>Page Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investigation of a fire/smoke</td>
<td>x-13</td>
<td>x-1-6666</td>
<td>Fire Alert (location)</td>
</tr>
<tr>
<td>Confirmed fire, flood, etc.</td>
<td>x 13</td>
<td>x-1-6666</td>
<td>Fire Alert Confirmed (location)</td>
</tr>
<tr>
<td>Patient and/or visitor posing a safety threat and immediate assistance is needed.</td>
<td>x-13</td>
<td>x-1-6666</td>
<td>Assistance Needed STAT (location)</td>
</tr>
<tr>
<td>Incident involving hostages and/or weapons</td>
<td>x-13</td>
<td>x-1-6666</td>
<td>Critical Security Incident (location)</td>
</tr>
<tr>
<td>Cardiac or respiratory arrest</td>
<td>x5-STAT</td>
<td>x-1-6666</td>
<td>Code Team (location)</td>
</tr>
<tr>
<td></td>
<td>x5-7828</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatric cardiac or respiratory arrest</td>
<td>x5-STAT</td>
<td>x-1-6666</td>
<td>Code Team Pediatric (location)</td>
</tr>
<tr>
<td></td>
<td>x5-7828</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical assistance</td>
<td>x-13</td>
<td>x-1-6666</td>
<td>MERT (location)</td>
</tr>
<tr>
<td>Abduction of infant, child, adolescent</td>
<td>x-13</td>
<td>x-1-6666</td>
<td>Amber Alert (SMH: age, location; HH: all buildings)</td>
</tr>
<tr>
<td>External/internal disaster</td>
<td>x5-STAT</td>
<td>x-1-6666</td>
<td>Command Center Activated</td>
</tr>
<tr>
<td></td>
<td>Disaster Emerg. Ops. Ctr.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>x5-0500</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utility Failure</td>
<td>x-13</td>
<td>x-1-6666</td>
<td>Utility Alert (location, type of utility affected)</td>
</tr>
</tbody>
</table>

**IT IS CRUCIAL TO REMEMBER:**

**HH**:

- For all emergencies except Rapid Response Team, call 1-6666; pages are executed using 2 overhead tones.
- Rapid Response Team is not an overhead page; call 1-6932.
EMERGENCY PAGE CODES (continued)

SMH
- All inpatient medical emergency and STAT pages are placed by calling the Communications Center at x5-7828 or x5-STAT.
- Inpatient medical emergency and STAT pages are executed using five overhead tones and followed by an announcement in the form of “Code Team Pediatric, call a specific location.” Call means “go-to” location.
- All pages other than STAT or inpatient medical emergency pages may be executed using the pager identification code (PIC) listed on the URMC home page under Faculty/Staff Directory, Additional Resources, Paging Directory at https://info.rochester.edu/FacultyStaffDirectory/Default.aspx or calling 275-1616.
- Noninpatient or nonlife-threatening medical emergencies, facility and personal safety emergencies are placed by contacting the Security Services Communication Center at x13.
- Noninpatient or nonlife-threatening medical emergencies, facility and personal safety emergencies are executed using 3 overhead page tones, followed by an announcement indicating code/type and location of the emergency.

SMH/HH:
- When a facility or personal safety emergency has been resolved, a follow-up overhead page will indicate the event is “all clear.”
eRECORD DOWNTIME TESTING PROCEDURE

Subject Matter Experts:

**SMH:** Kathee Tyo (756-4029), Deb Phillips (275-5463)

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

For more information, go to:

**SMH:** Emergency Preparedness Plan: Downtime Procedures, Section 8, 8.30 eRecord Downtime Procedures

**HH:** HH Policies and Manuals, Downtime Procedures IT eRecord and Integrated Systems Downtime Procedure http://intranet.urmc-sh.rochester.edu/Highland/policy/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 2:30 a.m.

For an unplanned eRecord outage, follow these steps:

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

  **Read Only – also known as SRO (Supports Read Only)**
  - eRecord screens and content; no ability to enter.
  - Displays all data that was available up until the point of the downtime

  **Reports Only – also known as BCA-Web**
  - A limited data set in report format
  - Inpatient reports include a clinical summary and the MAR
  - Allied services have specialized reports

- If eRecord is not accessible through 1 and 2 above, a Downtime PC (BCA-PC) is available on one unit-based PC; printable report-based clinical data (only partial data). Note: BCA-Web and BCA-PC will contain the same reports.
- eRecord downtime procedures are available on the Intranet at the Web sites listed above.
- What if the downtime lasts more than 2 hours?
  - Each unit has a downtime tote.
  - The tote contains specific unit- and service-level documentation tools.
  - There is one shift’s worth of paperwork available in the tote on most units.
  - Additional stock is available at the service level in case of a very extended downtime.

......continues.....
eRECORD DOWNTIME TESTING PROCEDURE (continued)

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

- The Help Desk will update the regular greeting message to state the system that is down and additional information as it becomes known.
- The System Status information on the Intranet will be updated.
- E-mails will be sent to clinicians notifying them of the system outage.
- The Hospital Administrator On Call may determine to send an overhead page announcing critical system(s) outages (this is only considered if the system outage is over 30 minutes).
- Web Pages may be generated to the clinical groups.
- The eRecord login screen "Message of the Day" will be updated to describe the current issue:

![Message of the Day](image)

IT IS CRUCIAL TO REMEMBER:

- Scheduled downtimes occur on the third Sunday of each month at 2:30 a.m.
- If an unplanned eRecord system outage occurs, end-users should call the Help Desk and attempt to access clinical data in this order: eRecord 1 (SRO—Supports Read Only), eRecord 2 (Reports Only--BCA-Web). If eRecord is still not available via 1 and 2, a Downtime PC (BCA-PC) is available on one unit-based PC.
- If the downtime lasts more than 2 hours, go to the unit-specific downtime tote for unit- and service-level documentation tools.
- In the event of a large-scale major downtime issue, the Help Desk will update the message of the day stating the system is down and provide updates as available, the Intranet System Status information will be updated, and clinicians will receive e-mails notifying them of the outage.
FALSE CLAIMS PREVENTION (FALSE CLAIMS ACTS)

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

For complete information regarding policies that cover employees’ responsibilities and rights in assisting their employer in complying with all legal and regulatory requirements, go to Policy 114, Compliance Education, in the University of Rochester Personnel Policy Procedure Manual at www.rochester.edu/working/hr/policies/pdfpolicies/114.pdf and Policy 133, Compliance, in the Highland Hospital Human Resources Policy Manual at: http://intranet.urmc-sh.rochester.edu/highland/Policy/HRpolicy/documents/HR133-Compliance.pdf

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

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

Examples of practices that may violate the False Claims Acts, if done knowingly and intentionally, include but are not limited to: billing for services not rendered, knowingly submitting inaccurate claims for services, or taking or giving a kickback for a referral.

IT IS CRUCIAL TO REMEMBER:

- You should understand the rules that relate to the services and goods being billed. Information contained in any claim must be as accurate and complete as possible. Specifics about correct billing may be obtained from several websites, including: The Centers for Medicare and Medicaid Services (www.cms.hhs.gov) and the New York State Department of Health (www.health.state.ny.us). You may call the Compliance Office at 275-1609 for assistance.

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

- Potential actions include: making changes to prevent the problem from continuing, making arrangements to repay any overpayments, and when appropriate, disclosing the problem to appropriate state and federal officials.

- By voluntarily disclosing such information, the University of Rochester Medical Center (URMC) may avoid or limit liability under the False Claims Acts.

- State and federal law and URMC policy contain protections against retaliation for disclosing potential billing problems.

- The False Claims Acts include “qui tam” provisions that allow any person with actual knowledge of a False Claims Act violation to file a lawsuit on behalf of the state or federal government.
FIREARMS / WEAPONS

Subject Matter Experts:

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

For more information, go to:

SMH: http://intranet.urmc-sh.rochester.edu/policy/smhpolicies/section10/10-10.PDF (SMH Policy 10.10)


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

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

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

IT IS CRUCIAL TO REMEMBER:

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

Subject Matter Experts:

SMH: Mark Cavanaugh (275-8412)
HH: Dennis Scibetta (341-0859)

For complete information on this topic, please go to:

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

FIRE PREVENTION

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

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

PATIENT FIRES

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

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

When pages or alarms sound:

<table>
<thead>
<tr>
<th>Fire Alert/Alarm</th>
<th>Fire Alert (location) and Fire Alert Confirmed (location)</th>
</tr>
</thead>
<tbody>
<tr>
<td>In area of the fire</td>
<td>Follow RACE (Rescue, Alarm, Contain, Extinguish/Evacuate)</td>
</tr>
<tr>
<td>Other location outside immediate fire area</td>
<td>a. Close all doors/clear corridors; avoid telephone use unless an emergency.</td>
</tr>
<tr>
<td></td>
<td>b. Do not use elevators, especially if they’re in the vicinity of the fire alert.</td>
</tr>
<tr>
<td></td>
<td>c. Stay where you are unless job responsibilities require a specific response.</td>
</tr>
<tr>
<td></td>
<td>d. When the “All Clear” page sounds, resume normal activities.</td>
</tr>
</tbody>
</table>

.....continues.....
FIRE SAFETY (continued)

**IT IS CRUCIAL TO REMEMBER:**

**RACE:**

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

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

- **Confine** the fire by closing all doors immediately upon discovery of fire. The door leading to the room of origin should be closed immediately and kept closed. Do not open windows.

- **Extinguish** a small contained fire *if trained*, but without endangering yourself or others. A clear exit path should be maintained to prevent being trapped by rapidly spreading fire.

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

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

**Fire Extinguisher Operation: PASS**

- **Pull** the pin
- **Aim** the horn or hose at the base of the fire
- **Squeeze** the handle
- **Sweep** at the base of the fire

**Fire Extinguishers Are Classified into Four Basic Types:**

1. Type A – Pressurized water; used on fires involving normal combustible materials (wood, paper, and trash). *Must not be used on electrical, gas or oil fires.*

2. Type BC – used on energized electrical or flammable or combustible liquid fires. (For an electrical fire, interrupt the power: pull the plug or shut off the circuit breaker.)

3. Type ABC – Multipurpose dry chemical that can be used on all classes of fire. Care should be taken to avoid inhaling the powder or unnecessary contact with the chemical.

4. Type K– wet chemical extinguishing agent that can be used on deep fat cooking operations using vegetable oils.
HAND HYGIENE---SIMPLE, BUT EFFECTIVE

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

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 continues to be a problem in the United States and around the world.

The Joint Commission requires each organization to select and fully implement either the World Health Organization (WHO) or the Centers for Disease Control (CDC) hand hygiene guidelines.

Both Strong Memorial and Highland hospitals have chosen to follow the WHO 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 procedures
3. After body fluid exposure/risk
4. After touching a patient
5. After contact with the patient’s environment

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

- After using the restroom
- Before eating
- When hands are visibly soiled
- When a patient is found to have Clostridium difficile infection (CDI), hand hygiene with soap and water is currently preferred and can be used alone or in addition to ABHR.

......continues.....
HAND HYGIENE—SIMPLE, BUT EFFECTIVE (continued)

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, and we must not short-cut the process. 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.

As important as it is for HCWs to use proper hand hygiene to protect our patients from healthcare-associated infections (HAIs), it may be equally important that patients themselves use frequent hand hygiene as well. Hand sanitizer pads are provided on all meal trays at Highland, and small bottles of hand rub are available to distribute to patients, if appropriate from a safety standpoint. Reminding patients to clean their hands before eating and after using the restroom or a bedpan is a necessity.

IT IS CRUCIAL TO REMEMBER:

- Frequent and thorough hand hygiene is the single most effective thing we can do to protect our patients, ourselves, and our loved ones from infection.
- Sanitize your hands before touching a patient, before clean/aseptic procedures, after body fluid exposure/risk, after touching a patient and contact with the patient’s environment.
- The amount of time for adequate hand hygiene is 15-20 seconds (singing “Happy Birthday” twice).
- Waterless ABHR or soap and water at a sink can be used for hand hygiene, but the primary method health care workers should use for hand hygiene is ABHR unless the patient is known to have Cdiff.
- The exceptions for use of ABHR are after using the restroom, before eating, or when hands are visibly soiled.
- Remind patients to use frequent hand hygiene as well, especially before eating and after using the restroom or a bedpan.
- Be sure the patient and/or their family see you perform hand hygiene.
HAZARD COMMUNICATION STANDARD (New OSHA Standard)
OSHA STANDARD 29 CFR 1910.1200

Subject Matter Experts:
SMH: Anne Schmidlin (275-9809)
HH: Joe Coon (341-6833)

For full information and education on this topic, go to:
SMH: http://intranet.urmc.rochester.edu/policy/smhpolcies/section13/13-11.PDF
http://www.safety.rochester.edu/ih/hazcom/hazcomindex.html
http://www.safety.rochester.edu/ih/hazcommnurses.html
HH: http://intranet.urmc-sh.rochester.edu/highland/policy/envCare


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

Employee Training: Supervisors are responsible for chemical-specific training within their areas of supervision. Supervisors conduct hazard assessments to identify hazards and appropriate personal protective equipment and other control measures necessary to reduce risk from defined tasks. Supervisors train employees on the hazards of the chemicals inside the work area and how to prevent exposure through inhalation, skin contact, ingestion or injection, including the information contained on the chemical labels and within the Safety Data Sheets. URMC supervisors may direct questions to the Occupational Safety Unit of Environmental Health and Safety at 275-3241 or look on the EHS website: www.safety.rochester.edu.

- Hazardous Chemical: Any chemical which is classified as a physical hazard or a health hazard, a simple asphyxiant, combustible dust, pyrophoric gas, or hazard not otherwise classified.

- Hazard Classification: Each type of hazard covered is considered a “hazard class” (e.g. acute toxicity, carcinogenicity.) Most hazard classes are also subdivided into “hazard categories” to reflect the degree of severity of the effect. This is the concept of “classification.” Rather than just determining that there is a hazardous effect (e.g., carcinogenicity) there is also a finding of how severe that effect might be (Category 1 or 2.).

### Health Hazards

<table>
<thead>
<tr>
<th>Hazard Class</th>
<th>Highest level</th>
<th>Hazard Category</th>
<th>&gt; Lowest level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Toxicity</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Skin Corrosion/Irritation</td>
<td>1A</td>
<td>1B</td>
<td>1C</td>
</tr>
<tr>
<td>Serious Eye Damage / Eye Irritation</td>
<td>1</td>
<td>2A</td>
<td>2B</td>
</tr>
<tr>
<td>Respiratory or Skin Sensitization</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Germ Cell Mutagenicity</td>
<td>1A</td>
<td>1B</td>
<td>2</td>
</tr>
<tr>
<td>Carcinogenicity</td>
<td>1A</td>
<td>1B</td>
<td>2</td>
</tr>
<tr>
<td>Reproductive Toxicity</td>
<td>1A</td>
<td>1B</td>
<td>2</td>
</tr>
<tr>
<td>STOT – Single Exposure</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>STOT – Repeated Exposure</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Aspiration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Simple Asphyxiants</td>
<td></td>
<td></td>
<td>Single Category</td>
</tr>
</tbody>
</table>

.....continues.....
HAZARD COMMUNICATION STANDARD (continued)

Chemical Hazards

<table>
<thead>
<tr>
<th>Hazard Class</th>
<th>Highest Level</th>
<th>&lt; Hazard Category &gt;</th>
<th>Lowest Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explosives</td>
<td>Unstable</td>
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<td>Div 1.1</td>
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<td></td>
<td>Explosives</td>
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<td>Div 1.2</td>
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<td>Div 1.3</td>
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<td>Div 1.4</td>
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<td></td>
<td>Div 1.5</td>
<td></td>
<td>Div 1.6</td>
</tr>
<tr>
<td>Flammable Gases</td>
<td>1</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Flammable Aerosols</td>
<td>1</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Oxidizing Gases</td>
<td>1</td>
<td></td>
<td></td>
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<tr>
<td>Gases under Pressure</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• Compressed Gases</td>
<td></td>
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<tr>
<td>• Liquefied Gases</td>
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<tr>
<td>• Refrigerated Liquefied Gases</td>
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<tr>
<td>• Dissolved Gases</td>
<td></td>
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</tr>
<tr>
<td>Flammable Liquids</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
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<td></td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Reactive Chemicals</td>
<td>Type A</td>
<td>Type B</td>
<td>Type C</td>
</tr>
<tr>
<td></td>
<td>Type D</td>
<td>Type E</td>
<td>Type F</td>
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<td></td>
<td>Type G</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pyrophoric Liquids</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pyrophoric Solid</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pyrophoric Gases</td>
<td>Single Category</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-heating Chemicals</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Chemicals which, in contact with water, emit flammable gases</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Oxidizing Liquids</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Oxidizing Solids</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Organic Peroxides</td>
<td>Type A</td>
<td>Type B</td>
<td>Type C</td>
</tr>
<tr>
<td></td>
<td>Type D</td>
<td>Type E</td>
<td>Type F</td>
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<td></td>
<td>Type G</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corrosive to Metals</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Combustible Dusts</td>
<td>Single Category</td>
<td></td>
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</table>

Labeling. Labels must be legible and maintained on containers including, but not limited to, tanks, totes and drums. The six required label elements are:
- Product identifier
- Signal words
- Hazard statements
- Pictograms
- Precautionary statements
- Name, address & phone number of the chemical manufacturer or other responsible party.
HAZARD COMMUNICATION STANDARD (continued)

- What do the Pictograms stand for?

### HCS Pictograms and Hazards

<table>
<thead>
<tr>
<th>Health Hazard</th>
<th>Flame</th>
<th>Exclamation Mark</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Carcinogen</td>
<td>• Flammables</td>
<td>• Irritant (skin and eye)</td>
</tr>
<tr>
<td>• Mutagenicity</td>
<td>• Pyrophorics</td>
<td>• Skin Sensitizer</td>
</tr>
<tr>
<td>• Reproductive Toxicity</td>
<td>• Self-Heating</td>
<td>• Acute Toxicity (haarmful)</td>
</tr>
<tr>
<td>• Respiratory Sensitizer</td>
<td>• Emits Flammable Gas</td>
<td>• Narcotic Effects</td>
</tr>
<tr>
<td>• Target Organ Toxicity</td>
<td>• Self Reactives</td>
<td>• Respiratory Tract</td>
</tr>
<tr>
<td>• Aspiration Toxicity</td>
<td>• Organic Peroxides</td>
<td>• Irritant</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gas Cylinder</th>
<th>Corrosion</th>
<th>Exploding Bomb</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Gases under pressure</td>
<td>• Skin Corrosion/ Burns</td>
<td>• Explosives</td>
</tr>
<tr>
<td></td>
<td>• Eye Damage</td>
<td>• Self-Reactivities</td>
</tr>
<tr>
<td></td>
<td>• Corrosive to Metals</td>
<td>• Organic Peroxides</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Flame Over Circle</th>
<th>Environment</th>
<th>Skull and Crossbones</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Oxidizers</td>
<td>• Aquatic Toxicity</td>
<td>• Acute Toxicity (fatal or toxic)</td>
</tr>
</tbody>
</table>

- **Signal words:** The signal words used are "danger" and "warning." "Danger" is used for the more severe hazards, while "warning" is used for less severe hazards.
- **Hazard Statement:** a statement assigned to a hazard class and category that describes the nature of the hazard(s) of a chemical, including, where appropriate, the degree of hazard.
- **Precautionary Statement:** a phrase that describes recommended measures to be taken to minimize or prevent adverse effects resulting from exposure to a hazardous chemical or improper storage or handling of a hazardous chemical.
- **Safety Data Sheets (SDS) and Chemical Inventories:** Safety Data Sheets (SDS) are available to employees for all chemicals used. Departments must maintain ready access to Safety Data Sheets for all hazardous chemicals used in their departments. Departments must maintain a list of the chemicals within their department which can be kept as an index of the department’s Safety Data Sheets. Copies of Safety Data Sheets (SDS) for chemicals are available to all employees upon their request and online for SMH employees at [http://www.safety.rochester.edu/restricted/msds.html](http://www.safety.rochester.edu/restricted/msds.html).

<table>
<thead>
<tr>
<th>SMH</th>
<th>HIGHLAND</th>
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</thead>
<tbody>
<tr>
<td>SMH departments maintain electronic chemical inventories/Material Safety Data Sheets (MSDS). Staff may request a copy of an MSDS by using the above website, calling the Poison Center (275-3232) or calling EH&amp;S (275-3241).</td>
<td>Master copies are kept in Support Services and can be accessed by nursing supervisors off-shift. Department-specific copies are kept in the department and are available to the employee at all times while on duty.</td>
</tr>
</tbody>
</table>

.....continues.....
HAZARD COMMUNICATION STANDARD (continued)

- Globally Harmonized Safety Data Sheets use a specified order of information as well as title descriptions in 16 sections. All SDS use this format, improving comprehensibility and consistency of information. The 16 SDS sections are:
  - Section 1, Identification
  - Section 2, Hazard(s) identification.
  - Section 3, Composition/information on ingredients
  - Section 4, First-aid measures
  - Section 5, Fire-fighting measures
  - Section 6, Accidental release measures
  - Section 7, Handling and storage
  - Section 8, Exposure controls/personal protection
  - Section 9, Physical and chemical properties
  - Section 10, Stability and reactivity
  - Section 11, Toxicological information
  - Section 12, Ecological information*
  - Section 13, Disposal considerations*
  - Section 14, Transport information*
  - Section 15, Regulatory information*
  - Section 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)].

IT IS CRUCIAL TO REMEMBER:

1. The transmission of critical information about chemicals is accomplished by reading labels and Safety Data Sheets (SDS) and through employee training.
2. Hazardous chemicals are chemicals that have been classified as health hazards or physical hazards. Classification includes first determining what type of effect the chemical has (Hazard Class) and also how severe the effect may be (Hazard Category.)
3. The updated Hazard Communication Standard of 2012 requires that chemical labels contain 6 elements: Product Identifier, Signal Words, Hazard Statements, Pictograms, Precautionary Statements, and contact information for the chemical manufacturer.
5. Safety Data Sheets (formerly MSDS) will now all follow the same format according to the updated standard. Every SDS will have the same 16 sections, in the same order, and with the same titles.
6. 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.
7. Small spills can be cleaned by personnel who are aware of the hazards of the spilled material. The proper PPE must be utilized.
8. For large chemical spills or if sufficiently trained personnel are not available, immediately leave the area and call Security at x13 at SMH or x1-6666 at Highland Hospital if the spill is on-site. If off-site, call 9-1-1. An employee should remain at a safe distance and keep others out of the area until emergency personnel can arrive.
HIPAA PRIVACY and SECURITY, and CONFIDENTIALITY of INFORMATION

Subject Matter Experts:

Privacy: SMH: Patty Keane (275-7059)  HH: Jan Taylor (341-6467)
Security: SMH: Rob Schrack (276-8023)  HH: Joseph Kody (784-2436)

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

IT IS CRUCIAL TO REMEMBER:

- You have an ethical and legal responsibility to 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 Protected Health Information. You are not permitted to access PHI of any patient that is a family member or friend because they have asked you to, or because you hold a power of attorney or a health care proxy. MyChart is available to patients to access their health information or give proxy access to someone else for MyChart only.
- Your password is your electronic signature. You must never share your password with anyone, for any reason, ever. Each user is responsible for all information accessed or entered under his or her user ID/password. Do not leave your computer session unlocked or unattended.
- Do not open e-mail attachments you were not expecting. Do not click on links in e-mail messages you were not expecting. Do not access Web sites that are not work-related or not well-known brands. Taking these actions may lead to your system becoming infected with malware.
- You should consider more secure alternatives (on servers, use of Virtual Private Network, etc.) before storing any PHI on a portable device such as a laptop computer or USB/jump drive or on media such as CDs or DVDs. If you must store PHI on a portable device or media, it must be encrypted.

Resources

HIPAA  Policies and Training: http://intranet.urmc-sh.rochester.edu/policy/HIPAA
HIV/AIDS CONFIDENTIALITY REQUIREMENTS

Subject Matter Experts:

SMH: Donna Galloway (275-7728)  HH: Lynne Brown (341-0856)

For more information on this topic, go to:
SMH: [http://intranet.urmc.rochester.edu/policy/smhpolicies/section06/6-2-2.pdf](http://intranet.urmc.rochester.edu/policy/smhpolicies/section06/6-2-2.pdf)
HH: [http://intranet.urmc.rochester.edu/highland/Policy/HHpolicy/2-16-1.pdf](http://intranet.urmc.rochester.edu/highland/Policy/HHpolicy/2-16-1.pdf)

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

All HIV-related material is confidential. This includes any references in the Medical Record to:
1) HIV or AIDS.
2) Information that identifies or could identify someone as having HIV infection or illness or AIDS.
3) Information that identifies someone as receiving pre-test counseling and/or who has been tested for HIV.
4) Tests or results of any HIV-related test even if negative (CD4, Elisa).

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

New York State’s HIV case name reporting and partner notification law requires that physicians and laboratories report the following results to the New York State Department of Health:
- Positive HIV test results
- Diagnoses of HIV-related illnesses
- Viral Load tests
- All CD4 test results (6/05)
- Genotypic Resistance tests (6/05)
- AIDS

What Is Disclosure and When Is It Appropriate?

Disclosure is the communication of any HIV-related information to any person (other than the patient) or entity. Generally, disclosure of HIV-related information is appropriate only with a special HIV release form (NYS DOH #2557 at [www.health.state.ny.us/forms/doh-2557.pdf](http://www.health.state.ny.us/forms/doh-2557.pdf) or OCA Official Form 960) signed by the patient with instructions as to the identity of the recipient.

Consequences of Inappropriate Disclosures - The consequences will be an appropriate amount of education/re-education and counseling consistent with the circumstances surrounding the disclosure. Repeated inadvertent disclosures will result in disciplinary action consistent with the circumstances, up to and including dismissal. In addition, fines of up to $5,000 and a jail term of up to one year can be levied if the disclosure was intentional.

IT IS CRUCIAL TO REMEMBER:
- All HIV-related material is confidential.
- NYS HIV case name reporting and partner notification law requires that physicians and laboratories report certain results (including but not limited to positive HIV test results and all CD4 test results) to the NYS DOH.
- Inappropriate disclosure will result in education and counseling consistent with the circumstances (when unintended) but if intentional, termination and fines may occur.
INFECTION PREVENTION
(including updates on OSHA Bloodborne Pathogen Standards and Tuberculosis)

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

The Infection Prevention Manual is accessible online on the UR Intranet from all patient units:
SMH:  http://intranet.urmc.rochester.edu/policy/infcontrol/
HH:   http://intranet.urmc-sh.rochester.edu/highland/policy/infectioncontrol/

General Infection Prevention practices safeguard both patients and personnel.
Infections are transmitted by several different routes. The specific route of transmission is dependent on the germ involved. Infection Prevention policies and isolation precautions are designed to interrupt transmission. Standard Precautions is a prevention strategy which applies to all patients. There are additional enhanced or “transmission-based” precaution categories which apply only to patients with particular diseases. When in effect, these enhanced precautions must be followed by all personnel even if they do not plan on coming in contact with the patient’s environment, and are clearly specified on isolation signs located outside the patient's room and documented in the patient's medical record. See the Infection Prevention Manual for details.

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

Report any exposure as soon as possible and notify your supervisor/manager.
SMH:  immediately call Occupational & Environmental Medicine at 275-1164. Complete an Employee Incident Report Form (SMH 115) online at http://www.safety.rochester.edu/SMH115.html. Include the type and brand involved in all sharps injuries (e.g., safety glide syringe, BD.)
Highland: call Employee Health at 341-8017, or off-shift notify the Nursing Supervisor, and complete an Employee Incident Report Form.

IT IS CRUCIAL TO REMEMBER:

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

…..continues…..
INFECTION PREVENTION (continued)

- **Do not recap needles.** Many needle sticks occur during the process of recappping needles. **Exceptions:** recappping of needles is unavoidable in some situations. A **one-handed technique** is used for safe recappping of the needle when necessary.

- If you experience skin exposure to blood or body fluids, **cleanse** skin with soap and water. For a needle stick, cut, or exposure through broken skin, wash affected area with soap and water. For oral exposure, rinse mouth well with water. For eyes, rinse well with sterile saline or tap water (after removing contact lenses). An eyewash station should be used if possible. Report any exposure as soon as possible using the appropriate form for your organization and notify your supervisor/manager.

- All staff should be vaccinated against influenza every year.

- Annual fit testing is required for staff who wear N95 masks for respiratory protection. An annual Tuberculin Skin Test (TST/PPD) is required for all staff.

- A private room with negative pressure and a closed door are used to prevent the transmission of TB.
INFLUENZA—WHAT YOU SHOULD KNOW

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

For full information on this topic, please go to:

**SMH:** [http://intranet.urmc.rochester.edu/policy/infcontrol/](http://intranet.urmc.rochester.edu/policy/infcontrol/)

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

**Both locations:** [URMC FLU SOURCE](http://intranet.urmc.rochester.edu/policy/infcontrol/) (You must be on the URMC network to access this content.)

### Seasonal Flu

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

### Pandemic Flu

Pandemic flu is 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 recent pandemic affected a preponderance of the young and healthy up to 25 years of age. Pregnancy was also a risk factor for more severe disease.

### How the Flu Is Spread

Flu is spread between people by:

- Droplets released into the air when a person with flu coughs or sneezes (usually within 3 - 6 feet) or 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.

### IT IS CRUCIAL TO REMEMBER:

1. The best way to prevent flu is to get the vaccine annually prior to the flu season.
2. Stay home if you are sick: for example, fever (temperature of 37.8 C or 100 F 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.
3. 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.
4. Always wear a mask when you are within 3–6 feet of patients with the 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.
INTERPRETER SERVICES

Subject Matter Experts:

| SMH: Elizabeth Ballard (276-5972) | HH: Michael Sullivan (341-6718) |

For more information, please go to:

Spoken Languages Other Than English –


HH: [http://intranet.urmc-sh.rochester.edu/Highland/Policy/HHpolicy/3-16-1.pdf](http://intranet.urmc-sh.rochester.edu/Highland/Policy/HHpolicy/3-16-1.pdf)

Interpreters for Deaf or Hard of Hearing –


HH: [http://intranet.urmc-sh.rochester.edu/Highland/Policy/HHpolicy/3-16.pdf](http://intranet.urmc-sh.rochester.edu/Highland/Policy/HHpolicy/3-16.pdf)

Telecommunication Services for the Deaf and Hard-of-Hearing-


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

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

For both Spanish-speaking persons and persons who communicate through Sign Language, 24-hour coverage is available. If you know the doctor will be doing rounds at a specific time, arrange for the interpreter an hour before (URMC-SMH) or with 24-hour advance notice (HH) for non-emergent situations.

Using an Interpreter

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

Speaking With Deaf and Hard of Hearing Patients

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

.....continues.....
INTERPRETER SERVICES (continued)

**IT IS CRUCIAL TO REMEMBER:**

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

Subject Matter Experts:

**SMH:** Ann Peterson (276-6065), JoAnn Popovich (275-6937)

**HH:** Sharon Johnson (341-8399)

For more information, go to:

**SMH:** [http://intranet.urmc-sh.rochester.edu/Depts/jcreadiness/](http://intranet.urmc-sh.rochester.edu/Depts/jcreadiness/)


ARE YOU JOINT COMMISSION READY?

What is the Joint Commission?

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

IT IS CRUCIAL TO REMEMBER:

- To wear your ID Badge at all times, and at SMH your white badge card with the emergency page codes.
- You must know the National Patient Safety Goals. They are available from your manager and can be found on the intranet on the Joint Commission Readiness site. You need to know how you comply with these goals as they relate to your job.
- Where to find information on the intranet; for example, policy and procedure manuals, clinical practice guidelines, safety alerts.
- If asked a question by the surveyors, be sure that you understand the question before answering it. Answer honestly as it relates to the work that you do. If you do not know the answer it is fine to say, “I don’t know the answer, but I do know where to find it.”
- Staff are encouraged to report concerns about care and safety through their management structure by calling the Medical Director’s Hotline (3-CARE) for SMH or Quality Management (1-8399) for Highland Hospital staff. If a staff member is still not satisfied, they may report their concern to the Joint Commission at 1-800-994-6610 or via e-mail at complaint@jointcommission.org.
- Patients/families are encouraged to participate actively in their care and to report any safety or quality concerns to their caregivers or to the Patient 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 at complaint@jointcommission.org.
LIFTING AND TRANSFERS: POSTURE AND BODY MECHANICS

Subject Matter Experts:

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

References/Useful Websites

www.clevelandclinic.org/spine/patient/posture.htm (Healthy Back Info)
www.spineuniverse.com (Healthy Back Info)
www.hovermatt.com (Air-assisted Transfer Device)
www.medical-supplies-equipment-company.com (Mechanical Lift)
www.mtsmedequip.com (Lateral Transfer Slide & Gurney)
www.allegromedical.com (Transfer Belts)
www.osha.gov/SLTC/ergonomics/index.html

General Lifting Guidelines

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

Good Posture

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

IT IS CRUCIAL TO REMEMBER:

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

Subject Matter Experts:

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

For more information, go to:

SMH
Policy 9.11.1 at http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/section09/9-11-1.pdf
Policy 9.11.4 at http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/section09/9-11-4.pdf

HH
Policy 3.5 at http://intranet.urmc-sh.rochester.edu/highland/Policy/HHpolicy/3-5.pdf

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

Resources are available in the hospital(s) and the community to address the needs and safety of patients who are abused or maltreated.

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

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

IT IS CRUCIAL TO REMEMBER:

1. Abuse and Neglect include:
   - Suspected Child Abuse or Maltreatment
   - Elder Abuse
   - Adult Domestic Violence
   - Sexual Assault

2. Health care providers are mandated by New York State Social Service law to report any and all suspicions of child abuse or neglect to the NYS Child Central Registry or to the Monroe County child abuse and neglect hotline.

3. See the Department Resource Guide for Mandatory Training – 2013 for all policies and procedures related to this topic.
MEAL AND REST BREAKS

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

For more information on this topic, go to:
SMH:  http://www.rochester.edu/working/hr/policies/pdfpolicies/172.pdf

Meal Breaks

Every employee who works a shift of more than six hours must be provided an uninterrupted 30-minute meal period per New York State Labor Law. An additional meal period of at least 20 minutes must be provided between 5:00 p.m. and 7:00 p.m. when an employee begins work before 11:00 a.m. and continues working past 7:00 p.m. Scheduling of meal breaks will occur at times convenient to department operations.

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

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

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

Rest Periods

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

IT IS CRUCIAL TO REMEMBER:

1. It is the University/Highland Hospital intent that every employee receives a meal break as required by New York State Labor Law.

2. In the event that emergency situations arise where an hourly paid employee does not get an uninterrupted meal break of at least 30 minutes, then the entire meal break must be paid and an edit must occur in HRMS (SMH) and ETime (HH) to negate the automatic deduction. While occurrences of less than 30-minute meal periods or interrupted meal periods should be infrequent, the employee should follow department/unit procedures to ensure that he or she is paid accurately for all time worked.

3. If an employee feels he or she is not getting an appropriate meal break, or is not being properly compensated in accordance with this policy, the employee should contact a supervisor or Human Resources.
OBTAINING SECURITY SERVICES

Subject Matter Experts:

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

For more information, please go to

SMH:  http://intranet.urmc-sh.rochester.edu/policy/smh/policies/SECTION02/2-6.pdf
HH:  http://intranet.urmc-sh.rochester.edu/highland/Policy/envCare/#2

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

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

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

IT IS CRUCIAL TO REMEMBER:

To Contact University Security Services or Highland Hospital Security:

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<th>SMH</th>
<th>Highland</th>
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<tbody>
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<td>x13 from inside UR or any Blue Light Emergency Phone (BLEP)</td>
<td>x1-6666</td>
</tr>
<tr>
<td><strong>Nonemergencies</strong></td>
<td>x5-3333 (from inside UR)</td>
<td>1-SERV or Page Operator from inside the hospital.</td>
</tr>
<tr>
<td></td>
<td>May use any Blue Light Emergency Phone (BLEP) located on or near pathways, parking lots, and each level of the MC ramp garage.</td>
<td>473-2200 (page operator) from outside the hospital.</td>
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OCCURRENCE AND CLAIM REPORTING

Subject Matter Experts:

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

For full information on this topic, go to:

SMH: Event (Occurrence) Reporting – Patients and Visitors – 9.1  
http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/section09/9-1.pdf

Reporting of Actual and Potential Medical Events – 9.1.1  
http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/section09/9-1-1.pdf

HH: Event (Occurrence) Reporting  

Reporting of Actual and Potential Medical Errors and Events  
http://intranet.urmc-sh.rochester.edu/highland/Policy/HHpolicy/3-23.pdf

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

Timely reporting and thorough documentation of occurrences are necessary to maintain patient safety. A report must be entered into the security and risk management event reporting system (SRM/Quantros) for all occurrences. Additionally, you may need to notify your immediate supervisor or others who may be relevant in the investigation.

Internal Occurrence Reporting at Strong Memorial Hospital – Overview (See Department Resource Guide for Mandatory Training - 2013 for details)

A report must be made for any patient or visitor-related occurrence that is not consistent with the routine operation of the hospital or routine care of the patient. Reportable occurrences include accidents as well as situations that could have resulted in an accident (near misses). In all cases where an injury has occurred, the occurrence must be entered into SRM no later than the end of the shift during which the occurrence happened or was first discovered.

Serious occurrences meeting State Reporting or Joint Commission criteria must be reported by telephone immediately to the Risk Management Department, with a report in the SRM system to follow.

Internal Occurrence Reporting at Highland Hospital

Any member of the health care team, who is aware of an occurrence or a condition that may result in an occurrence, should promptly report it. The following must be entered into the electronic event reporting system:

- Patient/visitor occurrences
- Theft, loss, or damage of property
- Department of Health occurrence reporting requirements
- Patient/family complaint or concern
- Near misses (Situations that could have resulted in an occurrence)

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

.....continues.....
OCCURRENCE AND CLAIM REPORTING (continued)

External Reporting Requirements – Overview  (See Department Resource Guide for Mandatory Training – 2013 for details)

Certain patient occurrences must be reported to the New York State Department of Health (DOH) under its “NYPORTS” program, or to other regulatory agencies. External reporting is coordinated at Strong by the Office of Counsel and at Highland by Quality Management, and should not be done without consultation with the appropriate coordinating office.

Other External Reporting Requirements — Medical Devices and Equipment

All device and equipment-related incidents resulting in serious injury must be reported immediately to the Office of Counsel to the Medical Center at SMH. The Office of Counsel will coordinate reporting to external entities. At Highland, such incidents should be reported to the Quality Management Department.

1. For all incidents involving medical devices and equipment, the department responsible for maintenance of the device or equipment (e.g., Clinical Engineering or Facilities) should be notified immediately. An online report should also be completed.

2. According to federal law, any medical device or equipment-related incident that caused or contributed to a serious injury to or death of a patient, visitor or employee must also be reported to the device or equipment manufacturer or the Food and Drug Administration. For purposes of device and equipment-related incidents, a serious injury is defined as:
   - An illness or injury that is life-threatening or that results in either permanent impairment of a bodily function.
   - Permanent damage to a bodily structure.
   - An illness or injury that necessitates medical or surgical intervention to preclude permanent impairment of a bodily function or permanent damage to a bodily structure.

IT IS CRUCIAL TO REMEMBER:

- Timely reporting and thorough documentation of occurrences are necessary to maintain patient safety. A report must be entered into the electronic event reporting system (SRM system/Quantros) for all occurrences and near misses.
- In all cases where an injury has occurred, the occurrence must be entered into SRM/Quantros no later than the end of the shift during which the occurrence happened or was first discovered.
- External reporting is coordinated at Strong by the Office of Counsel and at Highland by Quality Management, and should not be done without consultation with the appropriate coordinating office.
PATIENT PRISONER POPULATION (SMH Specific)

Subject Matter Expert: Lorraine McTarnaghan (275-2500)

For more information, please go to:
http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/section09/9-10.pdf

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

Security Plan
- All admitted patient prisoners have a security plan. (See SMH form 877MR—Inpatient Patient Prisoner Security Plan Checklist.)
  - Exception: Patient prisoners on medical leave of absence (LOA) may not require a security plan. The correctional facility is responsible for communicating this LOA status.
- Before interacting with a patient prisoner, check with the nurse caring for the patient.
- Communicate the security plan to other Hospital staff/departments as appropriate. For example, the inpatient unit may need to notify Food and Nutrition Services that a patient needs plastic tableware.
- Guidelines for corrections officers have been developed and are included in the nursing education resource packet. Copies of these guidelines as well as emergency information should be kept on hand and provided to corrections officers upon arrival at the patient’s treatment location.
- For security reasons, inmates should NOT be informed of future follow-up appointment dates, times, days of the week or other scheduling information.
- Phone inquiries: staff shall inform the patient’s facility/guarding officer and no information shall be provided.

IT IS CRUCIAL TO REMEMBER:
- Before interacting with a patient prisoner, check with the nurse caring for the patient.
- For security reasons, inmates should NOT be informed of future follow-up appointment dates, times, days of the week or other scheduling information.
- For your own personal safety, do not tell the patient prisoner personal information such as where you live or your telephone number.
- Never be alone in a room with an inmate.
- If you have questions or concerns, contact the area leadership.
- Nonmedical security-related questions should be referred to Security Services.
- For emergencies, call Security at x13
PATIENT RIGHTS/ETHICS/COMPLAINT PROCESS

Subject Matter Experts:

SMH: Elizabeth Gajary-Coots (275-5418)  HH: Dottie Haelen (341-8058)

For more information, go to:

SMH:  http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/index.asp (Section 11)
HH:  http://intranet.urmc-sh.rochester.edu/highland/Policy/HHpolicy/3-11.pdf

Rights

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

Staff should be familiar with all the items listed in the Patients’ Bill of Rights (a summary is listed in the Department Resource Guide Mandatory Training 2013) and use them as they apply to their particular roles in support of patient care.

Ethical Concerns:

Both the University of Rochester Medical Center-Strong Memorial Hospital and Highland Hospital have formal processes to assist with ethical dilemmas and concerns as requested by physicians, staff, patients or family. To request an informal perspective on an issue, employees at Highland can approach a member of the Ethics Committee or call 341-6718; Strong employees can contact the SMH Ethics Consultation Service at 275-5800.

IT IS CRUCIAL TO REMEMBER:

- Treat the patient with respect, including the use of names and courtesy titles, such as Mr. and Ms. Before entering a patient’s room, knock, and identify yourself. Keep your voice down and encourage visitors to do so.

- Patients also have the right to know your name and role. Introduce yourself and explain what you do. Wear your identification badge where it can be readily seen. Provide your name and title during telephone contact.

- Patients also have the right to complain about the care and services provided. We encourage patients and their families to voice their concerns when they occur so issues can be dealt with in a timely fashion and at the point of origin.

- If you are unable to respond to a patient’s complaint, if it involves another department, or if the patient is not satisfied with your response, promptly refer it to your supervisor/manager. For complaints not resolved through these initial steps, patients may request the assistance of the Patient Relations Office.

- If a patient is not satisfied by the response of the Patient Relations Office, she or he will be advised of the right to take the complaint to the Grievance Committee in the hospital, or to the New York State Department of Health at 899-894-5447. They may also pursue the issue with the Joint Commission at 1-800-994-6610 or via e-mail to: complaint@jointcommission.org
PATIENT SAFETY, TEAM COMMUNICATION, AND MEDICAL-HEALTH CARE ERROR REDUCTION

Subject Matter Experts:

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

For details on the Joint Commission National Patient Safety Goals and Requirements, go to:
http://www.jointcommission.org/assets/1/6/NPSG_Chapter_Jan2012_HAP.pdf

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

- Implementation of a nonpunitive medical error reporting process.
- Implementation of an automated occurrence reporting process to increase ease in reporting occurrences and near misses.

Examples of Patient Safety Goals:

- Use two (2) patient identifiers when providing direct or indirect patient care or services.
- Improve the effectiveness of communication among caregivers, especially during hand-offs in patient care.
- Encourage patients’ active involvement in their own care.
- Improve the safety of using medications, including accurately and completely reconciling medications across the continuum of care.
- Reduce the likelihood of hospital-acquired infections by using proper hand hygiene, appropriate isolation precautions when needed, and properly cleaning patient care equipment after use.
- Reduce the likelihood of patient harm associated with the use of anticoagulation therapy.
- Improve recognition and response to changes in a patient’s condition

Team Communication

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

- Standardization of hand-off communications such as SBAR (Situation, Background, Assessment, and Recommendation) at SMH or DATAS (Descriptive identification of patient, Active patient issues, To-Do and follow-up issues, Anticipated potential problems and interventions, and Special instructions) at HH.
- Medication reconciliation process
- Do Not Use Abbreviations -- The following abbreviations are NEVER allowed in any medical record documentation: U, IU, QD, QOD, trailing zero X.0 mg, Lack of leading zero .Xmg, MS, MSO₄, MgSO₄, u g, T.I.W., A.S., A.D., A.U.

.....continues.....
IT IS CRUCIAL TO REMEMBER:

1. A culture of safety needs everyone’s involvement, which includes accurate and timely team communication; this would begin to reduce the #1 root cause of serious patient events.

2. All actual events and near misses should be entered in the electronic event reporting system (Quantros/SRM) so that unsafe trends can be tracked and eliminated.

3. **NEVER** use these abbreviations in any medical record documentation (U, IU, QD, QOD, trailing zero X.0 mg, Lack of leading zero .Xmg, MS, MSO₄, MgSO₄, u g, T.I.W., A.S., A.D., A.U.).

4. Effective communication involves repeating back information to ensure it was heard correctly, communicating with respect, and listening to understand.
POLICY AGAINST DISCRIMINATION AND HARASSMENT

Subject Matter Experts:

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

Policy Against Discrimination and Harassment

For the complete version of UR Policy 106, go to www.rochester.edu/working/hr/policies/
For the complete version of HH Policy 130 go to:  
http://intranet.urmc-sh.rochester.edu/Highland/Depts/HR/documents/HR130-NONHARASSMENT.pdf

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

Definitions

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

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

IT IS CRUCIAL TO REMEMBER:

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

- Speak with the individual and let him or her know that the behavior is unwelcome and unacceptable.
- Talk with your supervisor/manager.
- Contact Human Resources, the Intercessors Office, Security, or the Office of Counsel.
PROFESSIONAL MISCONDUCT REPORTING AND THE IMPAIRED PROFESSIONAL

Subject Matter Experts:

| SMH: Spencer Studwell (273-4575) | HH: Sharon Johnson (341-8399) |

For Complete Policy Information, Go To:

- SMH: [http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/section01/1-7-1.pdf](http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/section01/1-7-1.pdf)
- HH: [http://intranet.urmc-sh.rochester.edu/highland/Policy/HHpolicy/3-1.pdf](http://intranet.urmc-sh.rochester.edu/highland/Policy/HHpolicy/3-1.pdf) and [http://intranet.urmc-sh.rochester.edu/highland/depts/hr/documents/HR128-SUBSTANCEABUSE.pdf](http://intranet.urmc-sh.rochester.edu/highland/depts/hr/documents/HR128-SUBSTANCEABUSE.pdf)

Examples of Professional Misconduct:

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

Impaired Professional

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

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

IT IS CRUCIAL TO REMEMBER:

- To report misconduct concerns at the University of Rochester Medical Center-SMH contact the Office of Counsel to the Medical Center through departmental channels. If a concern involves a supervisor or departmental leader, staff should directly contact the Office of Counsel to the Medical Center at 275-8019.
- To report misconduct concerns at HH: All misconduct concerns should be reported to the Quality Management Department through departmental channels. If a concern involves a department leader, staff should directly contact the Quality Management Department at 341-8399. For weekends or evening/night shifts, the Nursing Supervisor and/or Administrator-On-Call should be notified.
QUALITY, SAFETY, AND PERFORMANCE IMPROVEMENT

Subject Matter Experts:

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

**HH:** Sharon Johnson (341-8399)

For more information, go to:

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

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

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

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

Each of us is a part of a system that supports patient care, education or research, and we each have an **obligation** to our customers, our team, and ourselves to speak up when we have an improvement idea.

According to the Institute of Medicine (IOM), quality in health care has six dimensions:

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

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.

Performance improvement is the key to high quality care; a performance improvement philosophy pervades today’s leading healthcare organizations. It is a system designed to reduce (or eliminate) chances for error which is then monitored for improvement opportunities over time. It highlights errors when they happen, empowering staff to speak up and offer suggestions for improvement!

**IT IS CRUCIAL TO REMEMBER:**

You should speak up when you:

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

Subject Matter Experts:

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

For additional information and the perimeter maps, go to:

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

HH:    http://intranet.urmc-sh.rochester.edu/highland/Policy/HHpolicy/2-35.pdf
       http://intranet.urmc-sh.rochester.edu/highland/Policy/HHpolicy/2-35-1.pdf

As providers of health care and promoters for the physical well-being of the community, the sale of smoking materials is prohibited in all areas of Highland Hospital, Strong Memorial Hospital and the Medical Center campus including Eastman Institute for Oral Health (Eastman Dental Center), School of Medicine and Dentistry, the School of Nursing, and the Saunders Research Building. In addition, smoking by faculty, staff, volunteers, students, patients and visitors is prohibited within the established perimeters for each organization, except in the designated outposts as indicated on the perimeter maps at the above links for URMC-SMH and HH.

The nonsmoking perimeters for each campus area include parking lots/areas. Smoking in personal vehicles within the perimeter areas is not allowed, and smoking in URMC-SMH and HH neighborhoods is also prohibited.

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

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

IT IS CRUCIAL TO REMEMBER:

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

Subject Matter Expert: Jacqueline Beckerman (275-8794)

For more information, go to: http://intranet.urmc-sh.rochester.edu/policy/strongcommitment/

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

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

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

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

IT IS CRUCIAL TO REMEMBER:
Strong Commitment Means I CARE

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

Service Recovery
Service Recovery is a tool to recognize, prevent, and correct unmet customer expectations. The goal is to turn potentially negative situations into positive ones and make things right for our customers.

Use the Learn Protocol to turn things around.

- LISTEN to the customer
- EMPATHIZE with how the customer is feeling
- APOLOGIZE for not meeting their expectations
- RESPOND to the problem
- NOTIFY the appropriate person(s)

For additional information, view Service Recovery modules I and II under “Learning” at the link above.
WASTE MANAGEMENT

Subject Matter Experts:    SMH: Pete Castronovo (275-8405)    HH: Franklin Allen (341-0313)

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

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

IT IS CRUCIAL TO REMEMBER:
All site-specific waste management information such as shown in the example below. See additional information in the Department Resource Guide for Mandatory Training 2013.

<table>
<thead>
<tr>
<th>Waste Type</th>
<th>Examples</th>
<th>Disposal Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemotherapeutic Waste</td>
<td>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.</td>
<td>Yellow bag labeled “Caution Chemotherapy Waste” Yellow plastic sharps container labeled “Caution! Hazardous Drug Waste” or “Caution! Chemotherapy Waste”</td>
</tr>
<tr>
<td>Creutzfeldt-Jakob Disease (CJD) Waste</td>
<td>Waste from patients known or suspected to have CJD</td>
<td>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.”</td>
</tr>
</tbody>
</table>
WORKPLACE VIOLENCE / DEFUSING POTENTIAL VIOLENCE

Subject Matter Experts:

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

For more information, go to:

SMH: http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/section10/10-14.pdf

Hospital Policy:

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

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

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

How to respond to potential violence:

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

IT IS CRUCIAL TO REMEMBER:

To help calm a potentially violent person:

1. Give your full attention to the person, 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.
YOUR ROLE IN QUALITY / PERFORMANCE IMPROVEMENT

Subject Matter Experts:

SMH: Judy Burkman (276-3148)  HH: Sharon Johnson (341-8399)

Mission Statements:

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

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

Goals:

**Strong Memorial (According to the Strong Memorial Hospital Management Plan)**

- Quality and Safety (High Quality, Safe and Effective Care)
- Patient/Family-Centered Care (Patient Centered, Timely, and Efficient)
- Growth (Capacity Management)
- People (Human Resource Services, Staff/Leadership Development and Employee Engagement)
- Financial Responsibility (Achieve Operating Targets)
- Infrastructure (Upgrade as Appropriate to Achieve Goals)
- System Integration (Reduce Unnecessary Hospitalizations by Community-Based Health Initiatives)

**Highland Hospital**

- Quality and Safety (High Quality, Safe and Effective Care)
- Service Excellence/Patient- and Family-Centered Care (Timely and Efficient Patient/Family-Centered Care)
- People (Staff/Leadership Development and Employee Engagement)
- Growth (Volume Growth and Capacity Management)
- Finance (Achieve Operating Targets)
- System Integration (Reduce Unnecessary Hospitalizations by Community-Based Health Initiatives)

**Quality Improvement/Performance Improvement Concepts**

Core principles/concepts of continuous quality improvement include:

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

......continues.....
YOUR ROLE IN QUALITY/PERFORMANCE IMPROVEMENT (continued)

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

Model for Improvement Including PDSA

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

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

IT IS CRUCIAL TO REMEMBER:

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

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

Take a moment to think about these items. If you are unsure about what you would say, please discuss this with your supervisor or manager.
Section 2:

TOPICS FOR FACULTY AND STAFF WITH PATIENT CARE RESPONSIBILITIES OR WHO ENTER A PATIENT ROOM*

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

Subject Matter Experts:

SMH: Curtis Haas, Pharm.D (275-6145)
HH: Jeff Huntress, Pharm.D (341-6792)

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

The medications that are utilized for anticoagulation therapy include heparin, warfarin, dalteparin or enoxaparin, fondaparinux, dabigatran, rivaroxaban, argatroban, lepirudin, and bivalirudin.

There are several key elements of performance that both Strong Memorial and Highland Hospital have implemented and follow in order to ensure compliance with this National Patient Safety Goal. It is important for all clinical staff to be aware of these key elements:

1. Only individually packaged dosage forms, prefilled syringes, or premixed infusion bags of anticoagulation medications are used throughout the hospital.

2. Guidelines and protocols have been developed to assist with the initiation and maintenance of anticoagulant therapy. These guidelines and protocols can be found on the Anticoagulation SharePoint intranet website at [http://inside.mc.rochester.edu/sites/Anticoagulation/default.aspx](http://inside.mc.rochester.edu/sites/Anticoagulation/default.aspx). These guidelines include information about baseline and ongoing laboratory tests that are required for anticoagulation therapies.

3. Food-drug interactions with warfarin while an inpatient are not a significant concern since any diet available does not contain any more than the FDA-recommended, daily amount of Vitamin K. A URMC patient education brochure has been created that all patients receiving warfarin should receive and have reviewed with them prior to discharge. This brochure contains information about the management of potential food-drug interactions that patients must be aware of after discharge. This brochure is available for ordering from RR Donnelly, can be printed from a link within eRecord, or can be downloaded from the Anticoagulation SharePoint intranet site. Clinical Dietitians or Pharmacists are available for counseling patients regarding potential food-drug interactions upon request of either a provider or nurse.

4. Whenever heparin, argatroban, lepirudin, or bivalirudin are administered intravenously via continuous infusion, Alaris infusion pumps are used to provide consistent and accurate dosing.

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5. Education is provided to hospital staff on anticoagulation therapy by pharmacists and physicians throughout the year via in-service presentations, newsletters, and clinical grand rounds. Education is provided to families and patients during their admission and prior to their discharge. Patient and family education includes information on the importance of medication compliance, drug-food interactions, and the potential for adverse drug reactions and interactions. Patient education is provided by either nursing staff or pharmacists utilizing the URMC Warfarin Patient Education Brochure and is documented in eRecord.

IT IS CRUCIAL TO REMEMBER:

- Anticoagulation therapy is used for the treatment of a number of conditions, the most common of which are atrial fibrillation, deep vein thrombosis, pulmonary embolism, and mechanical heart valve implantation.

- The key reason why ensuring the safe use of this class of medications is important is because anticoagulation medications have the highest potential to cause serious harm due to complex dosing, insufficient monitoring, and poor patient compliance.

- Only individually packaged dosage forms, prefilled syringes, or premixed infusion bags of anticoagulation medications are used throughout the hospital.

- Education is provided to hospital staff on anticoagulation therapy by pharmacists and physicians throughout the year via in-service presentations, newsletters, and clinical grand rounds.

- Patient education is provided by either nursing staff or pharmacists utilizing the URMC Warfarin Patient Education Brochure and is documented in eRecord.
CARE OF PATIENT PERSONAL BELONGINGS AND VALUABLES

Subject Matter Experts:

SMH: Elizabeth Gajary-Coots (275-5418)
HH: Amy Eisenhauer (341-0677), Dottie Haelen (341-8058)

For more information, go to:

SMH: http://intranet.urmc-sh.rochester.edu/policy/smhpolicies/section11/11-4.PDF

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

Patients are encouraged to leave at home valuables such as jewelry, watches, clothing, money, credit cards, medications brought to the hospital, electronic devices, cell phones, computers, etc., or to have them sent home upon admission. If this is not possible, the valuables are inventoried and deposited in the Cashier’s Office for safekeeping.

Patients are informed that the hospital will not assume responsibility for items not deposited at the Cashier’s Office or for personal belongings that are kept in patient rooms. Items remaining with the patient are the responsibility of the patient.

Using the electronic or transfer forms, unit staff members are responsible for logging on and off the unit glasses, hearing aids, dentures or prosthetics which accompany the patient during a transfer.

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

IT IS CRUCIAL TO REMEMBER:

- Patients should be encouraged to leave valuables at home, or to have them sent home upon admission.
- Items that remain with the patient are the responsibility of the patient.
- Patients should let staff know if they have dentures, glasses and/or hearing aids. If these items are not needed, patients are strongly encouraged to leave/send them home. If these items are necessary, they need to be properly secured during the patient’s stay.
  - Dentures should be stored in a denture cup supplied by the hospital and labeled with the patient’s name.
  - Glasses and hearing aids should be stored in the cases supplied when purchased and labeled with the patient’s name.
  - Patients should be informed not to place any of these items on a meal tray, on the bed, unprotected on the bedside table, or in any concealed place where they may be lost or accidentally thrown out.

.....continues.....
CARE OF PATIENT PERSONAL BELONGINGS AND VALUABLES (continued)

- Patients should be informed that neither Strong Memorial Hospital nor Highland Hospital will assume responsibility for any personal belongings kept with the patient or in the patient’s room.
- Patients are given a copy of the hospital booklet, Admission Information, which states this policy.
- If the patient is deceased, staff should give belongings and valuables to the family.
- At SMH if any personal belongings remain with the deceased, they are inventoried by unit staff and sent to the Cashier’s Office for safekeeping and final disposition.
- At HH if any personal belongings remain, they will be inventoried by unit staff and sent to the Security Office for safekeeping and final disposition; if valuables such as money, credit cards, and jewelry remain, they are inventoried and sent to the Cashier’s Office.
CONFLICT OF CARE

Subject Matter Experts:

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

Policy

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

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

For additional information, see:


**IT IS CRUCIAL TO REMEMBER:**

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

Subject Matter Experts:
SMH: Carla LeVant (273-5445)   HH: Michael Sullivan (341-6718)

For more information, go to:
SMH policy 8.1.4 at http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/section08/8-1-4.pdf
HH policy 1.16 at http://intranet.urmc-sh.rochester.edu/highland/Policy/HHpolicy/1-16.pdf

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

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

1. Patients and families are introduced to each member of the treatment team as service is provided. The patient is informed of the name of the physician principally responsible for their care and can easily arrange to communicate with the physician.

2. All patient/family continuity of care planning and implementation incorporates the patient’s beliefs, capacities, and competencies, including decision making with respect to their care, discharge, and continuity planning as plans are made, changed, and implemented.

3. Patient/family questions and concerns about continuity of care are addressed rapidly and effectively by healthcare team members. The purpose of each transfer of care and information about the site itself (services, providers, location, etc.) are fully explained.

IT IS CRUCIAL TO REMEMBER:

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

1. Patients and families will be introduced to each member of the treatment team.
2. Patients and families will be involved in all decision making.
3. Patient and family concerns will be addressed rapidly and effectively.
DO NOT RESUSCITATE (DNR)

Subject Matter Experts:

<table>
<thead>
<tr>
<th>SMH</th>
<th>HH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laura Wilson (275-7279)</td>
<td>Dottie Haelen (341-8058)</td>
</tr>
</tbody>
</table>

While in the Hospital, a patient must consent to a DNR order before it may be issued except when consent is obtained from a surrogate (for patients without capacity as noted below); or the patient has previously consented to a DNR order, presently lacks the capacity to consent, and the order has been appropriately reviewed to confirm that the patient’s medical condition has not changed.

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

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

A list of permissible persons to give consent to the DNR order on behalf of a patient who lacks decision-making capacity can also be found in SMH Policy 9.3.3 or HH Policy Manual, Do Not Resuscitate 4.4. (See links below.)

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

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

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

Whenever a dispute is submitted for mediation, a DNR order may not be issued, or if already issued, shall be revoked until the dispute resolution process has concluded or 72 hours have elapsed, whichever is earlier.

Patients or their surrogates may revoke their consent to a DNR order at any time.

For additional information on DNR, Non-Hospital DNR, Revocation of DNR, Dispute Resolution, see:

- SMH Policy 9.3.3 [http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/section09/9-3-3.pdf](http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/section09/9-3-3.pdf)
END OF LIFE CARE

Subject Matter Experts:

SMH: Rev. Robin Franklin (275-2187)    HH: Rev. Don Marlar (341-6890)

For more information, go to:

SMH: http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/section08/8-14.pdf
HH: http://intranet.urmc-sh.rochester.edu/highland/Policy/HHpolicy/2-57.pdf

There are many medical situations in which cure or recovery is not possible, and the care of patients at the end of their lives can be challenging. The priorities for end-of-life care are (1) to educate patients and families regarding medically appropriate options for care; (2) to respect patients’ and families’ wishes and decisions for care; (3) to respect patients’ and families’ cultural and religious beliefs and traditions; and (4) to provide for patients’ comfort including effective pain control and symptom management.

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

The Palliative Care Consultation Service (SMH/HH), the Ethics Consultation Service (SMH), the Ethics Committee (HH), and Chaplaincy Services (SMH/HH) are all available to patients, families, providers, and caregivers to aid in the provision of care and/or discussion and resolution of issues that may arise in the course of end-of-life care. Appropriate hospice services are also available for patients’ care and support.

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

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

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END OF LIFE CARE (continued)

**IT IS CRUCIAL TO REMEMBER:**

- Priorities for end-of-life care include education of patients and families regarding options for care and respect for patients’ and families’ wishes and decision for care.

- A Healthcare Proxy or agent may be designated to make medical decisions and only in the event that a patient is unable to make decisions regarding his or care.

- A patient’s pain, discomfort, or symptom management should never be ignored or minimized regardless of the treatment being given.

- Diverse cultural and religious beliefs and traditions may influence what some patients and/or families desire for end-of-life care and those wishes should be ascertained and honored to the fullest extent possible.
ENSURING COMPREHENSIVE HANDOFF (ECHO)

Subject Matter Experts:

SMH: Anna Lambert (276-3506), Michael S. Leonard, MD (276-4113)
HH: Sharon Johnson (341-8399)

For additional information, please see:

SMH: http://intranet.urmc-sh.rochester.edu/Policy/smhpolicies/section08/8-0.pdf
HH: http://intranet.urmc-sh.rochester.edu/highland/Policy/HHpolicy/2-77.pdf

Topic Summary:

The Joint Commission estimates that nearly 70% of sentinel events resulting in permanent harm or mortality are the result of communication failures, and approximately half of these occur at the time of handoff. According to the Agency for Healthcare Research and Quality (AHRQ), a handoff is “the transfer of information (along with authority and responsibility) during transitions in care across the continuum, to include an opportunity to ask questions, clarify, and confirm. Examples of transitions in care include shift changes, physicians transferring complete responsibility, and patient transfers.”

The primary objective of a handoff is to provide accurate information about a patient’s care, treatment, and services; current condition; and any recent or anticipated changes. The information communicated during a handoff must be accurate in order to meet the National Patient Safety Goals as defined by the Joint Commission.

The rationale for using a standardized process for handoffs is three-fold: (1) to improve communications among hospital staff, (2) to promote teamwork to improve efficiency, and (3) to develop a culture of safety.

Implementation of a standardized process for transferring knowledge and responsibility from one caregiver to the next reduces errors and increases patient and staff satisfaction.

There Are Three Distinct Types of Handoffs Within the Hospital Environment

1. Temporary Handoffs: this typically occurs when a patient travels off the primary location or unit for testing. Complete responsibility is not transferred, however, important patient information must be communicated. The acronyms, SBAR (Situation, Background, Assessment, Recommendation) at SMH or DATAS (see #2 below) at HH, best ensure communication of these elements.

2. Shift to Shift: this is the most prevalent type of handoff and occurs between all levels of staff. Complete responsibility is transferred from one caregiver to another. The key elements are best described using the acronym, DATAS: Description, Active Issues, To Do, Anticipate, Special Needs.

3. Service to Service: this is the most comprehensive type of handoff occurring between providers. Complete responsibility is transferred from one attending service to another, such as from the Emergency Department to an Inpatient Unit, from Medicine to Surgery. The acronym, CHAMPION (Chief Complaint, History, Allergies/Adverse Reactions, Medications, Physical and Lab Findings, Impression, Orders, New or Anticipated Changes) should be utilized to ensure communication of all necessary key and pertinent information.

.....continues.....
ENSURING COMPREHENSIVE HANDOFF (ECHO) continued

IT IS CRUCIAL TO REMEMBER:

An effective handoff includes all of the following:

- Interactive communication that allows for the opportunity for questions and discussion between the giver and receiver of patient information.
- Up-to-date information regarding the patient’s condition, care, treatment, medications, services, and any recent or anticipated changes.
- A method to verify the received information, including repeat-back or read-back techniques.
- An opportunity for the receiver of the handoff information to review relevant patient historical data which may include previous care, treatment, and services.
- Limited interruptions during the handoff process to minimize the possibility that information fails to be conveyed or is omitted.
HEALTH CARE PROXY

Subject Matter Experts:

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

For more information on this topic, see:

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

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

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

- The proxy document may include any special instructions, limits of authority, expiration date, and may provide for the appointment of an alternate representative.

- The determination that a patient lacks capacity must be made by the attending physician and confirmed by a second physician. Special guidelines must be followed when the determination involves a psychiatric or developmentally disabled patient.

- A patient may revoke his or her proxy document at any time by notifying the representative or the health care provider in writing, orally, or by any other act, even if the patient lacks capacity.

- If a nonphysician is informed of or provided with a revocation, he or she must immediately notify a physician.

- A health care proxy is not valid if completed by the patient who lacks capacity.

IT IS CRUCIAL TO REMEMBER:

- A proxy must be signed and dated by the competent adult patient, and be signed by two adult witnesses who must include a statement attesting that the patient completed the proxy document willingly and free from duress.

- The patient should provide a copy of his or her proxy for inclusion in his or her medical record.

- The determination that a patient lacks capacity must be made by the attending physician and confirmed by a second physician.
INFORMATION FOR CLINICAL DECISION MAKING

Subject Matter Experts:

SMH: Michele Shipley (275-6878)
HH: Lorraine Porcello (341-0378)

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

IT IS CRUCIAL TO REMEMBER:

- It is an INSTITUTIONAL EXPECTATION THAT PROVIDERS WILL USE THE BEST AVAILABLE EVIDENCE WHEN CARING FOR PATIENTS. Patient care providers need to integrate information into their clinical practice and processes. They should (1) stay current with new evidence in their field, and (2) know how to find specific evidence for a particular patient.

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

- SMH and HH providers can ask librarians at Miner, Bibby, and Williams Libraries to help them find information they need for clinical care. Librarians will conduct literature searches at no charge or help providers conduct a search of their own. Simply click on “Ask a Librarian” from the Miner (URMC), Bibby (Eastman Institute for Oral Health), and Williams (Highland Hospital) library websites. Additional contact information (phone numbers, e-mail) is also listed on the websites.

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1 Spencer Studwell, Director, Risk Management, URMC Office of Counsel.
Safe Use of Medical Equipment

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

Inspection of All Medical Equipment

All direct care providers should check for an “Inspection” sticker or an “Approved for Use” sticker on a piece of clinical equipment before placing it into use. Please see the Department Resource Guide for Mandatory Training 2013 for details.

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

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

Use of the Patient’s Personal Home Equipment

- For Inpatients: use of patient-provided medical equipment should be discontinued as soon as possible after admission (except personal infusion devices, insulin pumps and CPAP/BiPAP machines). Comparable hospital-owned devices that staff have been trained to use should be substituted for the patient-provided device.
- If a comparable hospital-owned device (other than a CPAP/BiPAP device) is not available, Clinical Engineering at SMH or the Clinical Engineering Department at Highland must be called to inspect the patient-provided device. Staff must be trained on how to use the equipment. Patient-owned CPAP/BiPAP devices must be inspected and documented by Respiratory Therapy.
  
  Note: Exception at HH and SMH - patient’s own insulin pumps, refer to the appropriate policy and protocol.

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

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MEDICAL EQUIPMENT (continued)

IT IS CRUCIAL TO REMEMBER:

- All medical equipment must be in good physical condition, and if appropriate, wired with a 3-pronged chassis grounded plug.
- Staff should use only equipment they have been trained to use.
- All direct care providers should check for an “Inspection” sticker or an “Approved for Use” sticker on a piece of clinical equipment before placing it into use.
- Use of patient-provided medical equipment should be discontinued as soon as possible after admission.
MEDICAL ORDERS FOR LIFE-SUSTAINING TREATMENT (MOLST)

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

For more information, please go to:
http://www.compassionandsupport.org/index.php/for_professionals/molst_training_center or
http://intranet.urmc-sh.rochester.edu/highland/Policy/HHpolicy/4-5.pdf

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

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

The following Facts will help you to better understand how to use the MOLST form.

FACTS THAT ARE CRUCIAL TO REMEMBER:

1. The MOLST form is consistent with NYS law and approved by the NYSDOH for use at all nursing homes, hospitals, other medical facilities, at home or elsewhere in the community throughout New York state. DNR, DNI and other decisions about other potentially life-prolonging therapies can be made by patients with capacity. If the patient has lost decision-making capacity and does not already have a MOLST form filled out, decisions about DNR, DNI and other potentially life-prolonging therapies can be made by designated health care proxies or by family members based on what is known about the patient's wishes. Specific guidelines and checklists (which are recommended but not legally required) for making these decisions are available at the following website: http://www.compassionandsupport.org/index.php/for_professionals/molst_training_center

2. For patients admitted with a MOLST form, the admitting team should confirm that it still reflects the patient’s preferences, sign and date the "Review of the MOLST” section.

3. The MOLST form does not necessarily mean that the patient has chosen DNR (Do Not Resuscitate) or DNI (Do Not Intubate) status. The form must be carefully read to see if any limitations on treatment have been ordered.

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

5. In the absence of a MOLST form, in an emergency it is assumed that the patient wants full cardiopulmonary resuscitation unless there is clear and convincing evidence otherwise.

6. The pink MOLST form should travel with the patient wherever he or she goes. A copy of the MOLST should stay in the patient’s medical record.
MEDICAL RECORD DOCUMENTATION FOR CLINICAL STAFF

Subject Matter Expert:
SMH and HH: Donna Barnard (275-2606)
Additional Resource Experts:
SMH - Anne Silkey (275-5137) and HH – Rochelle Nichols (341-6429)

Documentation Rules to Follow:

- Verbal orders must be authenticated (verified, signed, dated and timed, electronically or in writing) within 48 hours of being given by a credentialed member of the provider team caring for the patient.
- Documentation must be legible; if two different people cannot read hand-written notes, information is considered illegible.
- ALL medical record entries must be dated, timed, signed, and include your professional status.
- Immediate post-op progress note is required immediately after surgery and must include name of surgeon and assistants, procedure performed, description of findings, estimated blood loss, specimens removed, and post-op diagnosis.
- All surgical/procedural patients (e.g., inpatients, ambulatory surgery patients and same-day admission patients, and other significant procedure patients) must have a history and physical exam no more than 30 days prior to the surgery/procedure, except when it is not possible to do so for an emergency surgery/procedure. The history and physical must be entered into the patient’s record on or prior to admission, signed, dated, and timed by the responsible physician or other credentialed practitioner. If the history and physical is done by someone other than an attending physician (e.g., resident or advanced practice provider) it shall be reviewed and countersigned by an attending physician.

A significant procedure is defined as one that carries an operative or anesthetic risk or requires highly trained personnel or special facilities or equipment. Examples include cardiac catheterization, angiography, endoscopy, super voltage radiation therapy, and debridement.

- An update to the patient’s condition must be documented in the medical record prior to surgery. See policies below for details of these requirements.
  
  SMH: [http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/Section06/6-1.pdf](http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/Section06/6-1.pdf)
  

- A summary list is initiated for outpatients by the third visit, including significant medical diagnoses, significant operative procedures, and any adverse or allergic drug reactions. The current medication list, including prescriptions, over-the-counter medications and herbal preparations, is completed by the patient’s FIRST visit.

- DO NOT USE ABBREVIATIONS = U, IU, Q.D., Q.O.D., MS, MSO₄, MgSO₄, µg, T.I.W., A.S., A.D., A.U. Never write a zero by itself after a decimal point and always use a zero before a decimal point. An abbreviation on this DO NOT USE LIST should not be used in any of its forms: upper or lower case, with or without periods. See:
  
  SMH: [http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/Section08/8.1%20attachment%20H.pdf](http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/Section08/8.1%20attachment%20H.pdf)
  
  HH: [http://intranet.urmc-sh.rochester.edu/Highland/Policy/HHpolicy/2-58.pdf](http://intranet.urmc-sh.rochester.edu/Highland/Policy/HHpolicy/2-58.pdf)

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MEDICAL RECORD DOCUMENTATION FOR CLINICAL STAFF (continued)

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

**IT IS CRUCIAL TO REMEMBER:**

- ALL medical record entries must be dated, timed, signed, and include your professional status.
- DO NOT USE ABBREVIATIONS = U, IU, Q.D., Q.O.D., MS, MSO₄, MgSO₄, µg, T.I.W., A.S., A.D., A.U. Never write a zero by itself after a decimal point and always use a zero before a decimal point. An abbreviation on this Do Not Use List should not be used in any of its forms.
- For outpatients, the current medication list including prescriptions, over-the-counter medications and herbal preparations is completed by the patient’s FIRST visit.
MEDICATION RECONCILIATION AND 
ADVERSE DRUG REACTION (ADR) REPORTING

Subject Matter Experts:

SMH: Medication Reconciliation, Ann Peterson (276-6065)
ADR, Curtis Haas, Pharm.D (275-8337)

HH: Matt Groth, PharmD, MS (341-6929)

For more info, go to:

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

SMH Ambulatory Care Manual:

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

The Joint Commission National Patient Safety Goals:
http://www.jointcommission.org/assets/1/6/NPSG_Chapter_Jan2012_HAP.pdf

IT IS CRUCIAL TO REMEMBER:

Medication Reconciliation

Patients are at high risk for harm from adverse drug events when communication about medication is not clear. Medication reconciliation, Joint Commission National Patient Safety Goal #3, requires healthcare providers to accurately and completely reconcile medications across the continuum of care. This applies to all patient encounters. The medication reconciliation process requires providers to:

- Create and document a complete list of medications the patient is taking at home. The type of medication information collected (e.g., dose, route, frequency) is specified by the care area. The patient and/or family, if possible, are involved in creating the list.

- Compare and reconcile any discrepancies (omissions, duplications, adjustments, deletions, additions) between the home medication list and medications ordered for the patient while under the care of the medical facility upon admission, transfer and discharge. Reasons for any changes or differences between the previous and current medications must be documented. Ambulatory/ED areas where medications are used minimally, or prescribed for a short duration, refer to your departmental policy to see if modified medication reconciliation processes are applicable.

- When the patient leaves the medical facility, the current list of reconciled medications is provided and explained to the patient and, as needed, the family. Patients and families are educated about the importance of maintaining a copy of their current medication list and reminded to discard old lists and to update any records with all medication providers or retail pharmacies.

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

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

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Adverse Drug Reaction Reporting

An adverse drug reaction (ADR) describes the unwanted, negative consequences sometimes associated with the use of medications. An ADR is also noted to be a noxious and unintended result of a medication which occurs at the normal dose given for treatment of disease, or for disease prevention. An ADR is a particular type of adverse effect. Alternative terms with equivalent meaning to ADR include: side effect, adverse event, adverse effect, etc. Examples of ADRs include, but are not limited to: rash or hives, unexpected drop in blood pressure, shortness of breath, trouble breathing, or fever.

Monitoring and reporting of ADRs are imperative components of the hospital’s Medication Management Process. Tracking and trending of ADRs lead to process improvements in medication use which improve patient safety. ADR’s should be reported in the hospital’s electronic reporting system at [https://qexpert.quantros.com/urmc/](https://qexpert.quantros.com/urmc/). You do not need a login or password to report an ADR; just select the appropriate facility in the drop-down box in the center of this page and you will be given access to the form you need to complete.
ORGAN AND TISSUE DONATION

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

The Donor Hotline should be called in two instances:

1. The first is within two hours if the Clinical Triggers have been met regardless of diagnosis. The Clinical Triggers pertain to referring any ventilated patient with a grave prognosis and ANY of the following:
   - A severe neurologic insult or injury, including anoxic encephalopathy with a Glasgow Coma Scale Rating of less than or equal to 5
   - At least 2 of the following brainstem reflexes are absent or diminished: pupillary or corneal reflex, cough, gag, response to painful stimuli, spontaneous respirations
   - When being evaluated for brain death
   - Patient is being considered for withdrawal of life-sustaining therapies (ventilatory or pharmacological support)
   - Call before any patient is terminally extubated

2. The second instance the donor hotline should be called is within one hour in the event of an actual patient (cardiopulmonary) death.

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

- **FLDRN (Finger Lakes Donor Recovery Network)** will make a preliminary determination of suitability for organ donation. Organ function and contraindications will be evaluated and FLDRN will determine how to proceed. If and when it is appropriate to approach the family about organ donation, FLDRN coordinators conduct the consent process and offer the option of donation to families. Finger Lakes Donor Recovery Network works collaboratively with hospital staff to determine the best plan to have a conversation with a potential donor family regarding consent for organ donation. All conversations regarding the consent for organ donation must be authorized by Finger Lakes Donor Recovery Network. Health care practitioners involved in the patient’s care are always welcome and encouraged to be present during the consent discussion between the family and the FLDRN coordinator.

- **Rochester Eye and Tissue Bank (RETB)** personnel are the only “Designated Requestors” to approach families/guardians at Strong and Highland Hospitals to offer eye/tissue donation.

**IT IS CRUCIAL TO REMEMBER:**

- Your primary role with Organ, Eye and Tissue Donation is to ensure all deaths, imminent deaths and withdrawals of care are called to the Donor Hotline so that families may be offered the opportunity for donation.

- FLDRN and RETB determine what needs to happen after the referral and will contact you if necessary for more information.

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ORGAN AND TISSUE DONATION (continued)

- Document all referral calls in the patient’s medical record.
- Do **not** ask families for consent to donate without the inclusion and authorization by Finger Lakes Donor Recovery Network. FLDRN will collaborate with hospital staff to facilitate a team approach to best serve the potential donor family.
PAIN MANAGEMENT

Subject Matter Experts:

SMH: Timothy Quill, M.D. (273-1154); Kimberly Ziegler (273-2896)
HH: Laurie Ernest, MS, RN, WHNP-C (341-8057)

For more information see:

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

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

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

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

Pain may be managed through various modalities:

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

IT IS CRUCIAL TO REMEMBER:

1. Patients should be assessed for the presence and severity of pain at least as often as routine vital signs are performed, and more frequently following the identification of pain, treatment of pain, or after a potentially painful procedure.
2. Moderate to severe pain (above patient-specific threshold) should be further assessed by a nurse and if necessary, a mid-level provider or physician, with follow-up management as appropriate.
3. Once a treatment has been provided, a reassessment must be completed and documented in the patient’s medical record no later than one hour after an intravenous or intramuscular analgesic is administered or no later than two hours after an oral analgesic is administered. If nonpharmacologic treatment is started, the effectiveness should be assessed and documented at an interval appropriate to the treatment.
4. For any patients from 6 - 12 years of age, cognitively impaired, unable to read or communicate in English, pain assessment using the FPR-S (FACES) scale is appropriate. The FLACC scale or other pain assessment tools should be used in children less than 6 years of age.
5. A nurse must assess and verify the patient’s symptoms prior to administering pain treatment.
PATIENT IDENTIFICATION

Subject Matter Experts:

SMH: Robert Panzer, M.D. (273-4438), JoAnn Popovich (275-6937)
HH: Sharon Johnson (341-8399)

For details on Joint Commission National Patient Safety Goal #1 – Improve the Accuracy of Patient Identification go to:

http://www.jointcommission.org/patientsafety/nationalpatientsafetygoals or

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

HH Policy 2.65, Patient Identification

The goal is to ensure the correct patient is receiving the correct health care procedure by using two patient identifiers and, in particular, to eliminate transfusion errors related to patient misidentification.

- This includes both major and minor “procedures.”

- Procedures may include, but are not limited to:
  - Administering medication
  - Transfusing blood / blood products
  - Obtaining blood or other specimens from the patient
  - Performing a treatment
  - Performing a diagnostic test
  - Sending or transferring a patient to another unit or area.

IT IS CRUCIAL TO REMEMBER:

- The use of two identifiers in 2 places equals safe patient care. Examples include:
  - Patient name and birthdate using patient statement and lab requisition
  - Scanning the barcode on a patient’s ID band, the medication, and verifying the correct patient’s MAR opened up when administering any medication.

- The patient should be actively involved in the identification process whenever possible.

- All lab/specimen containers should be labeled in the presence of the patient.
PATIENT SELF-DETERMINATION RIGHTS

Subject Matter Experts:

SMH: Laura Wilson (275-7279)  
HH: Dottie Haeleen (341-8058)

For more information, please go to:

SMH: http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/index.asp  
HH: http://intranet.urmc-sh.rochester.edu/highland/Policy/HHpolicy/

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

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

IT IS CRUCIAL TO REMEMBER:

- Members of the health care team who are presented with a written advance directive from a patient must notify the patient’s attending physician and place a copy in the patient’s medical record.
- If the patient revokes the directive orally or in writing, it also must be noted in the patient’s medical record and the attending physician must be notified.
- If an incapacitated patient has previously orally expressed a treatment preference, either before or during hospitalization, the attending physician must be notified of the patient’s statement. If such a statement(s) is clear and convincing and was made at a time when the patient was competent, the preference expressed may be relied upon by the patient’s attending physician.
- In any case where there is a question as to whether the patient’s statement is clear and convincing, contact the Office of Counsel to the Medical Center at SMH (275-2059) or the Highland Hospital Office of Quality Management (341-6768).
Prevention of Surgical Site Infections

Subject Matter Expert:

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

Postoperative infection is a major cause of patient injury, mortality and health care costs:

- An estimated 2.6 percent of nearly 30 million operations are complicated by surgical wound infections (SWIs) each year.
- Infection rates up to 11% are reported for certain types of operations.
- Each infection is estimated to increase a hospital stay by an average of 7 days and adds $3,000 to $26,000 extra charges per SWI. The total price tag for treating these infections is 130 to 845 million dollars annually.

Reducing SWIs is an important goal of all healthcare institutions. Integrating evidence-based infection prevention strategies such as preoperative administration of antibiotics and eliminating pre-op shaving of hair have shown to be effective in preventing infection.

Prophylactic Antibiotic Therapy

Includes appropriate selection, timing and discontinuation of antibiotic prophylaxis.

- Most prophylactic antibiotics must be initiated, but not necessarily completed, within one hour prior to surgical incision. Vancomycin and fluoroquinolones can be initiated up to 2 hours prior to incision.
- Prophylactic antibiotics must be discontinued within 24 hrs after surgery end time (or provider must document the reason if continued). An exception to this rule would be cardiac surgery cases which can have antibiotics continued for up to 48 hours.
- There is a list of antibiotics that have been approved for use in various surgical specialties.

Glucose control has been shown to prevent SWI in cardiac surgery. There is also growing evidence that hyperglycemia can contribute to increased risk of infection in other surgical procedures as well.

- POD#1 and POD #2 controlled 6 am post-operative serum glucose levels must be below 200.

Normothermia

Hypothermia has been associated with a number of adverse consequences, including increased susceptibility to infection, impaired coagulation and transfusion requirements, post-anesthesia shivering and thermal discomfort.

- Temp control must begin in the pre-anesthesia area: use passive insulation (warm blankets, socks, and head covering); limit skin exposure during pre-op procedures; if the patient is hypothermic on admission to pre-anesthesia, apply a forced-air warming system and increase passive insulation; keep room temperature around 70 degrees.
- Intra-operative measures: consider warming the operating room until patient is prepped and draped; passive insulation (warm blankets, socks, and head covering); institute active warming measures (e.g., a forced-air warming system); warm fluids for IV or irrigation; temperature should be above 36C/98F when patient leaves the operating room.
- Post-anesthesia care: same as pre-anesthesia measures.
Appropriate Hair Removal

- Ideally hair should not be removed. If it must be removed, then a razor must not be used.* Clippers or a depilatory can be used outside the OR and as close to the time of surgery as possible if necessary.

*Exceptions: cases of traumatic head injury or scrotal surgery may have hair removed with a razor if deemed necessary by the surgeon.

General Infection Prevention Measures

- Scrupulous hand hygiene and pre-op scrubbing is imperative
- Appropriate surgical attire is worn during surgery
- Patient skin prep and draping of the operative site is done
- Removal of urinary catheters should occur prior to post-op day 2

IT IS CRUCIAL TO REMEMBER:

- Postoperative infection is a major cause of patient injury, mortality and health care costs; each infection is estimated to increase a hospital stay by an average of 7 days and adds $3,000 to $26,000 extra charges per SWI.
- Proper prophylactic antibiotic therapy includes appropriate selection, timing and discontinuation of antibiotic prophylaxis.
- Hypothermia has been associated with a number of adverse consequences; temperature control must begin in the pre-anesthesia area.
- Ideally hair should not be removed. If it must be removed, then a razor must not be used unless traumatic head injury or scrotal surgery are involved and the surgeon deems it necessary.
RADIATION SAFETY

Subject Matter Experts:

SMH: Frederic Mis, Ph.D., CHP (275-1473),
HH: Ahmad Matloubieh (341-6750)

For more information on this topic, go to: http://www.health.ny.gov/publications/4402/

The following areas use radioactivity:

<table>
<thead>
<tr>
<th>SMH</th>
<th>HIGHLAND</th>
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<tbody>
<tr>
<td>Radiation Oncology</td>
<td>Radiation Oncology</td>
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<tr>
<td>Nuclear Medicine</td>
<td>Nuclear Medicine</td>
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<tr>
<td>Nuclear Cardiology</td>
<td>Operating Rooms</td>
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<tr>
<td>Operating Rooms</td>
<td>Cardiology</td>
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<tr>
<td>6-1400 area (for radioactive implant patients and radio-iodine patients)</td>
<td>West 7 (inpatient unit for patients who have received radiation implants)</td>
</tr>
<tr>
<td>Research laboratories marked with the radiation symbol</td>
<td>East 5</td>
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</tbody>
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Other areas may use radioactivity for treatment or diagnostic testing. Each has a storage room specially built to house their radioactive supplies. Cans, boxes, or rooms containing radioactivity are always well marked. Shipments containing radioactive substances for these departments are either delivered to Radiation Safety (at SMH only) or are routed from the receiving dock directly to these departments during regular hours.

Patient Rooms

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

Risks From Minor Exposure To Radiation

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

IT IS CRUCIAL TO REMEMBER:

To minimize your exposure to radiation:

- **Distance** - The dose of radiation received is inverse square proportional to the distance from the source. The person who stands close to the source is getting more radiation than the person who is 10 feet away. If a person doubles his or her distance from the radiation source, their radiation exposure is reduced by a factor of 4.

- **Time** - The dose of radiation received is directly proportional to time. The person who stands in the area for 30 minutes is getting more radiation than the person who is there for 5 minutes.

- **Shielding** - A lead apron is effective against some radioactive materials, but not all! For example, lead will stop 95% of the radiation from an x-ray but only 5% of the radiation from the radioactive iodine given to some patients. Review safety guidelines before using radioactive materials.
RAPID RESPONSE TEAM

Subject Matter Experts:

SMH: Mark Ott (275-5924)
HH: Jennifer Jesske (341-6932)

For more information, go to:

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

Rapid response teams enable healthcare staff members to directly request additional assistance from appropriate clinical experts when the inpatient’s condition appears to be worsening.

Rapid response teams were developed to provide:

- A quick multidisciplinary medical team approach to assess and treat a patient whose condition is deteriorating. In addition, the focus of this team will be to provide support and education to staff as needed.
- Early and rapid intervention in order to promote better outcomes such as reduced cardiac and/or respiratory arrests, reduced or timelier transfers to a higher level of care, reduced patient intubations, and reduction in hospital mortality.

Indications:

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

Contraindications:

- Patient status warrants activation of the Code Team

Patient Outcomes:

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

Criteria for Activating RRT

1. Staff member concerned/worried about patient and/or:
   - Acute change in heart rate from baseline (e.g., <40 or >150)
   - Acute change in systolic blood pressure (BP) from baseline (e.g., <90mmHg or MAP <65)
   - Acute change in respiratory rate (< 10 or > 30) or threatened airway
   - Acute change in oxygen saturation (level is less than 90%)
   - Acute change in level of consciousness
   - Acute significant bleeding
   - New, repeated or prolonged seizures
   - Failure of patient to respond to treatment for an acute problem/symptoms
   - Signs and symptoms of a stroke (for Highland Hospital only)

2. Floor team (providers) unable to respond in a timely manner to the above triggers

.....continues.....
RAPID RESPONSE TEAM (continued)

To request an adult RRT at SMH: Contact the page office at x5-2222

To request a RRT at HH: for inpatients only, call x1-6932, request RRT, and give floor and room number.

Paperwork to Complete:
- SMH: eRecord documentation completed by sender
- HH: eRecord, doc flowsheets, rapid response
RESTRAINT USE

Subject Matter Experts:

SMH: Chris O’Brien (275-8200), Heather O’Brien (273-2560), JoAnn Popovich (275-6937)

HH: Kristen Berns (341-0929)

For more information, go to:

SMH: http://intranet.urmc-sh.rochester.edu/Policy/SMHPolicies/section10/10-2.pdf
     http://intranet.urmc-sh.rochester.edu/nurses/Policy/PPManual/Section12/12-2.PDF
     http://inside.mc.rochester.edu/sites/Psych/Policies/5.3%20Restraint-Seclusion%20Policy.pdf

HH: http://intranet.urmc-sh.rochester.edu/highland/Policy/HHPolicy/2-24.pdf

Definition

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

A restraint per 42CRF482.13 is any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely; or a drug or medication when it is used as a restriction to manage the patient’s behavior or restrict the patient’s freedom of movement and is not a standard treatment or dosage for the patient’s condition.

This definition does not include devices such as orthopedically prescribed devices, surgical dressing or bandages, protective helmets, or other methods that involve physically holding a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of harm. Shackles applied by correctional officers are not considered restraints under this policy.

The use of side rails (all 4 up) to prevent a patient from getting out of bed is considered a restraint. If the side rails are used to prevent the patient from falling out of bed (e.g., post-op patient, stretcher transfer) or the patient is not physically able to get out of bed, raising all 4 side rails is not considered a restraint.

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

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

Criteria for Restraint Use is based upon the behaviors exhibited by the patient regardless of cause.

Nonviolent, Non-Self-Destructive Behavior Criteria (Medical Restraint)

To prevent patients from inadvertently hurting themselves or others (e.g., falling, wandering, pulling out tubes, or removing medical devices)

Violent Self-Destructive Behavior Criteria

1. To prevent patient from hurting self (e.g., cutting, scratching, suicidal behavior)
2. To prevent patients from hurting others (e.g., aggression, threat of assault, assault hitting, kicking or scratching)

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

## NONVIOLENT, NONSELF-DESTRUCTIVE RESTRAINT

<table>
<thead>
<tr>
<th>Reasons for Application</th>
<th>Types of Restraint</th>
<th>Orders</th>
<th>Observation/Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Fall prevention</td>
<td>Vest (SMH only)</td>
<td>Authorized in writing by Provider* after physical exam and assessment of patient behaviors</td>
<td>Vest/2-point extremity/canopy bed/ side rails: every 30 min.; document interventions at least every 2 hours</td>
</tr>
<tr>
<td></td>
<td>Soft wrist/ankle</td>
<td>Orders specify why it is indicated, alternatives utilized, and length of time</td>
<td>4-Point: observe every 15 min., document pertinent assessments every 15 min., document interventions every 2 hours</td>
</tr>
<tr>
<td></td>
<td>Leather wrist/ankle</td>
<td>Renewal:</td>
<td>Vital signs: every 8 hours, more often if needed/ordered</td>
</tr>
<tr>
<td></td>
<td>4-point restraint</td>
<td>– Vest, 1- or 2-extremity: every 24 hours</td>
<td>**Continual 1:1 Supervision required if applied under direction of RN, until MD/NP assessment</td>
</tr>
<tr>
<td></td>
<td>Canopy Bed (SMH only)</td>
<td>– 4-Point: every 8 hours</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Side rails** (all 4 raised)</td>
<td>– Canopy bed, side rails: every 24 hours</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mitts—only if tied down***</td>
<td>– Emergency Situation: RN initiates and requests immediate provider assessment</td>
<td></td>
</tr>
<tr>
<td>If all other interventions have failed.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **The use of all 4 side rails to prevent a patient from getting out of bed is considered a restraint and requires an order. If the side rails are used to prevent the patient from falling (e.g., post-op patient, transporting on a stretcher) or the patient is not physically able to get out of bed, raising all 4 side rails is not considered a restraint.

- **For SMH & HH (HH ICU exempt) — Untied hand mitts will require a written provider order after discussion about other alternatives. Order must be discontinued at completion of use. Further restraint documentation is not required, as they are not considered a restraint in these circumstances.

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

### VIOLENT, SELF-DESTRUCTIVE RESTRAINTS

<table>
<thead>
<tr>
<th>Reasons for Application</th>
<th>Types of Restraint</th>
<th>Orders</th>
<th>Observation/Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>When there is imminent risk of harm to self or others and when all less restrictive measures have failed.</td>
<td>Vest (SMH Only)</td>
<td>Authorized in writing by Provider*</td>
<td>All: Documentation of pertinent assessments every 15 min (1:1 continuous monitoring, as deemed necessary). Document interventions every 2 hours, or more often as required by patient status.</td>
</tr>
<tr>
<td></td>
<td>Soft/Leather wrist/ankle</td>
<td>Orders specify why it is indicated, alternatives utilized</td>
<td>Vital Signs: every 2 hrs, unless sleeping; more often if needed (SMH). -Every 8 hours, or more often as required by patient status (HH)</td>
</tr>
<tr>
<td></td>
<td>4 point restraints</td>
<td>Restraint Renewal:</td>
<td><strong>Release: every 2 hours.</strong></td>
</tr>
<tr>
<td></td>
<td>Posey Twice-as-Tough Velcro (HH only)</td>
<td>18 yrs &amp; Up: every 4 hrs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5 point (SMH only)</td>
<td>9 yrs-17yrs: every 2 hrs</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Under 9 yrs: every 1 hr</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>RN can initiate restraint. Provider is notified immediately.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provider will respond to unit in person no later than 30 min to assess patient even if restraint has been discontinued.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>If Provider does not arrive within 30 min., provider must document in eRecord the reason for delay.</td>
<td></td>
</tr>
</tbody>
</table>

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

- **For SMH & HH (HH ICU exempt) — Untied hand mitts will require a written provider order after discussion about other alternatives. Order must be discontinued at completion of use. Further restraint documentation is not required, as they are not considered a restraint in these circumstances.

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*Continues*
RESTRAINT USE (continued)

### VIOLENT, SELF-DESTRUCTIVE RESTRAINTS (cont.)

<table>
<thead>
<tr>
<th>BH Reasons for Application</th>
<th>BH Types of Restraint</th>
<th>BH Orders</th>
<th>BH Observations/Assessments</th>
</tr>
</thead>
<tbody>
<tr>
<td>When there is imminent risk of harm to self or others and when all less restrictive measures have failed</td>
<td>Single limb Velcro® restraints</td>
<td>SMH Behavioral Health Units – orders must by authorized in writing by MD only</td>
<td>4-Point/5-Point Restraint: Pt. has 1:1 continuous monitoring Nurse/Psych Tech documents pertinent observations/behaviors every 15 min. Nurses document assessment/rationale for continued restraint every hour. <strong>Vital Signs:</strong> every 2 hrs, unless sleeping; more often if needed. <strong>Release:</strong> 4-Point/5-Point: every 2 hours.</td>
</tr>
<tr>
<td></td>
<td>Double limb Velcro® restraint</td>
<td>Orders specify why it is indicated, alternatives utilized</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Velcro® chest restraint</td>
<td>Restraint/Seclusion Renewal: 18 yrs &amp; Up: every 4 hrs 9 yrs-17yrs: every 2 hrs Under 9 yrs: every 1 hr</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Seclusion</td>
<td>RN can initiate restraint/seclusion. MD is notified immediately.</td>
<td><strong>Seclusion</strong> Pt has 1:1 monitoring via AV equip. Nurse/Psych Tech documents pertinent observations/behaviors every 15 mins. Nurse documents assessment/rationale for continued restraint every hour.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MD will respond to unit in person no later than 30 min to assess patient even if restraint has been discontinued.</td>
<td><strong>Room entered hourly</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>If MD does not arrive within 30 min., MD must document in eRecord the reason for delay.</td>
<td><strong>Release Seclusion:</strong> every 2 hrs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Individuals with a developmental disability diagnosis may only be secluded if they also have a primary psychiatric Dx.</td>
<td></td>
</tr>
</tbody>
</table>

#### Ordering Restraints

In the event of an emergency in which the patient poses a threat to himself or another, a registered nurse may initiate the use of restraints. A **face-to-face assessment and order** must be completed within **one hour** by a Physician, Nurse Practitioner or Physician Assistant. (For Behavioral Health orders, physician assessment is required.) Orders for nonviolent and/or non-self-destructive behaviors (2-point restraints, vest, canopy bed or side rails) are good for 24 hours; orders for nonviolent and/or non-self-destructive (4-point restraints) are good for 8 hours. Orders for violent and/or self-destructive behavior restraints are good for 4 hours for patients 18 years and older, 2 hours for patients between 9 years to 17 years and 1 hour for patients under 9 years.

When restraints are necessary past these time frames, order renewals with a face-to-face assessment by the Physician, Nurse Practitioner, or Physician’s Assistant are needed. Documentation is required in the patient’s medical record that describes the findings of this assessment and the patient behaviors that support the use of restraints. The use of restraints must also be documented in the patient’s plan of care or treatment plan. The attending physician (if not the ordering physician) should be notified of the order for and use of restraints as soon as possible.

.....continues.....
RESTRAINT USE (continued)

IT IS CRUCIAL TO REMEMBER:

- Use the safest, least restrictive restraint methods, remembering that restraints must be released every 2 hours and can be reapplied with a new order as necessary.
- Restraints are always tied in a quick-release knot to the moveable part of the bed frame (does not include side rails). Never tie restraints to side rails, toilets or commodes.
- A face-to-face assessment and order must be completed and documented within one hour by a Provider when nonviolent/non-self-destructive restraints have been initiated, and within ½ hour by a Provider* for violent/self-destructive restraints. *NOTE: In Behavioral Health only a physician can do this.
- A face-to-face assessment is also required for any restraint order renewal.
- Avoid restraining in the supine and prone positions.
- Discontinue restraints at the earliest possible time.
- Failure to obtain an order/renewal is viewed as the application of a restraint without an order.
WRITE DOWN AND READ BACK FOR VERBAL ORDERS OR CRITICAL RESULTS

Subject Matter Experts

SMH: Ann Peterson (276-6065), JoAnn Popovich (275-6937)
HH: Sharon Johnson (341-8399)

For emergency verbal or telephone orders and reporting of telephone critical test results, the person receiving the order or result must follow a process for writing down and reading back the information. This is a Joint Commission requirement to ensure patient safety.

Follow These Steps for Verbal Orders

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

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

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

IT IS CRUCIAL TO REMEMBER:

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

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

HIGHLAND-SPECIFIC TOPICS

(FOR URMC-STRONG FACULTY AND STAFF WHO ALSO WORK AT HIGHLAND)
CODE OF ORGANIZATIONAL AND BUSINESS ETHICS (HH Specific)

Subject Matter Expert:
HH: Janet Taylor (341-6467)

IT IS CRUCIAL TO REMEMBER:

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

**Principle 1 – Respect for Patients**
We will provide health care without regard to race, creed, color, gender, sexual orientation, national origin, age or ability to pay, and respect each patient’s unique background, culture, beliefs and needs. We respect the patient’s right to participate in ethical questions that arise in the course of care.

**Principle 2 – Relief of Suffering**
Curing disease, reducing suffering and achieving an acceptable quality of life as defined by the patient are central goals of our institution.

**Principle 3 – Communication With Patients**
It is our responsibility to offer support and assistance by providing patients and their families with the timely information about outcomes of care, both expected and unexpected, that they need to make sound decisions.

**Principle 4 – Confidentiality of Patient Information**
Patient information is confidential and should not be disclosed without the patient’s consent, except as provided by law.

**Principle 5 – Patient Access to Health Care**
Registration, admission, transfer and discharge of patients are based on the patient’s condition and personal preferences, without regard to their ability to pay.

**Principle 6 – Interdisciplinary Relations**
We affirm the need to demonstrate mutual respect and to acknowledge our interdependence as co-workers from diverse specialties and professional backgrounds responsible for the welfare of patients.

**Principle 7 – Recognition of Potential Conflicts of Interest**
It is our policy to request the disclosure of potential conflicts of interest so that appropriate action may be taken to ensure that such conflict does not inappropriately influence important decisions.

**Principle 8 – Marketing and Fair Billing Practices**
Highland and its medical staff will invoice patients or third parties only for services actually provided to patients and will provide assistance to patients seeking to understand the cost relative to their care.

**Principle 9 – Collaborative Relationships**
Highland works collaboratively with other health care providers and payers in providing quality and cost-effective patient care.
FORENSICS (Highland Specific)

Subject Matter Expert:
HH: Joe Coon (341-6833)

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

General Rules (for safety purposes):

1. Custodial patients’ (CP) names shall not be recorded on the patient room or locator.

2. ANY phone inquiries are to be referred to the Custodial Officer, also known as Forensic Staff. Highland staff are not to release information to callers; the Custodial Officer will ask for a one-time arrangement if the CP is allowed to receive a call.

3. The Custodial Officer must maintain visual contact of the Custodial Patient at all times.

4. Handcuffs and leg cuffs are used at the discretion of the Custodial Officer. Any clinical issues with the hand or leg cuffs need to be resolved with the Custodial Officer/Agency and/or referred to your manager.

5. The Custodial Officer should never be asked to assist in patient care activities or transport of the CP.

6. The Custodial Patient is never told the time or date of discharge or of any treatments or exams that may be cause for leaving the room.

7. All equipment and supplies not in use are to be removed from the room.

8. All mail is to be given to the Officer, not the Custodial Patient.

9. No visitors are permitted unless the Custodial Officer has approved.

10. Do not give any Custodial Patient your address or phone number. Personal contact is prohibited. Do not buy gifts for the Custodial Patient.

11. Custodial Officers will wait in the Custodial Patient’s room for instruction from the charge nurse in the event of an emergency.

12. Forensic Staff members will receive a copy of the policy, Forensic Staff Orientation/Management of Patients from Custodial Agencies, found in the Highland Policy Manual, which includes the chain of command and emergency codes from the Security Department in inpatient areas or satellite staff in outpatient areas.

13. Security will always be the first resource to answer questions on nonclinical issues.

Refer to Highland policy, Forensic Staff Orientation/Management of Patients from Custodial Agencies, found in the Highland Policy Manual for more specifics.
HIGHLAND PROMISE STANDARDS AND GLOBAL BEHAVIORS
(HH Specific)

Subject Matter Expert:
HH: Kathleen Gallucci (341-0118)

Highland's Mission/Vision/Values

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

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

Values: Integrity, Compassion, Accountability, Respect, Excellence

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

IT IS CRUCIAL TO REMEMBER:

Promise Standards

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

I CARE Values and Behaviors

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

Subject Matter Expert:
   HH: Joe Coon (341-6833)

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

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

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

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

IT IS CRUCIAL TO REMEMBER:

- Appropriate ID is required for all employees, patients, and visitors.
- Access to the building between 8:00 p.m. and 6:00 a.m. is only through the Emergency Department post.
- Sensitive areas of the building are designated as Pharmacy, Emergency, Family Maternity Center, and Cashier’s Office.
- Our Safety Management Program and Safety Committee are established to continually perform, monitor and improve various processes which may impact employee, visitor, and patient safety.
- To contact HH Security in an emergency, dial 1-6666.
Section 4:

PROVIDER ONLY TOPICS

(NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, PHYSICIANS)
FALL PREVENTION

Subject Matter Experts:

SMH: Robert Panzer, M.D. (273-4438), JoAnn Popovich (275-6937)
HH: Barbara Schrage (341-6850), Kristen Berns (341-0929)

For Additional Information, Go To:

CDC: http://www.cdc.gov/homeandrecreationalsafety/falls/index.html
VA National Center for Patient Safety:
   http://www.patientsafety.gov/CogAids/FallPrevention/index.html#page=page-1

Some online and published resources from the Joint Commission include:

- The National Guideline Clearinghouse (enter "fall prevention" in the search field)

Falls

More than one-third of adults 65 and over fall each year, and falls are the leading cause of injury, deaths, and hospital admissions for trauma in this age group (CDC, 2005). According to the Joint Commission (2009), falls also account for a significant portion of injuries in patients hospitalized for other reasons.

Falls are the result of many complicated and interrelated risk factors—identifying patients at risk for falls provides the opportunity to institute measures to help prevent falls.

Upon admission or with any change in condition, all patients should be assessed for risk of falling/injury and a safety plan created.

Assessments Include But Are Not Limited To:

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

.....continues.....
FALL PREVENTION (continued)

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

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

- Review medications for side effects/interventions and consider medication or dose changes
- Refer to Physical Therapy or Occupational Therapy, if indicated, to assist mobility, strength training, gait training or assistive devices
- Refer to appropriate specialist/department to assist with managing hearing or visual deficits
- Discuss with interdisciplinary team a fall safety plan and any fall to identify the root cause
- Assess effectiveness of interventions/orders during interdisciplinary rounds

MCIC-Sponsored Fall Prevention Program
SMH and HH are participating in an MCIC (Medical Center Insurance Company Vermont, Inc.) sponsored Fall Prevention Program that includes the following:

- Initial and ongoing assessments of fall risk, risk for injury, leading to targeted interventions to reduce the risk
- Targeted rounding on inpatient units to help minimize patients getting up on their own
- Investigation of all falls with careful review by nursing staff
- Inclusion of patients and family members in the fall safety plan
- Identifying patients at risk of falling with signage on their room and/or having them wear red slippers (SMH only). Patients identified as high risk for falls with “stop signs” outside their rooms (HH).
- Use of bed alarms (SMH and HH) or Posey canopy bed (SMH only) for appropriate patients at risk of falling.
- Handoff communication about fall risk.

IT IS CRUCIAL TO REMEMBER:

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

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

Clostridium difficile (C-diff) Infection (CDI)

C-diff are spore-forming bacteria that cause antibiotic-associated diarrhea. The extent of disease that results from Clostridium Difficile Infection (CDI) ranges from mild discomfort and diarrhea to pseudomembranous colitis, toxic megacolon, sepsis, and sometimes death.

Symptoms of CDI are diarrhea, fever, loss of appetite, nausea and abdominal pain/tenderness. It is diagnosed by stool culture or toxin testing. Patients at increased risk for CDI include those with antibiotic exposure, extended hospitalization, advanced age, weakened immune system, or serious underlying illness.

C-diff can be transmitted in the health care setting in various ways such as contaminated equipment (commodes, thermometers) and on the hands of health care workers who have touched a contaminated surface.

C-diff transmission can be prevented by:
- Using contact precautions which consist of a private room, gowning and gloving by all who enter the room.
- Meticulous hand hygiene with soap and water; while alcohol-based hand rub may also be used with the soap and water, some studies have suggested that alcohol hand rub may not be as effective against spore-forming bacteria.
- Dedicated patient equipment (such as thermometers and stethoscopes) and disinfection of surfaces and equipment with a bleach-containing product.

Patients with CDI infection are usually treated with a 10- to 14-day course of oral antibiotics such as metronidazole (flagyl) or vancomycin.

Families and visitors should perform hand hygiene before and after visiting, be encouraged to wear gowns and gloves to enter, and to not go into other patients’ rooms.

Extended Spectrum Beta-Lactamase Producing Organisms (ESBLs)

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

Organisms most commonly found to produce beta lactamases are:
- E. coli
- Klebsiella pneumoniae
- Pseudomonas aeruginosa
- Enterobacter
- Citrobacter
- Proteus
- Acinetobacter

.....continues.....
MULTIDRUG-RESISTANT ORGANISMS (continued)

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

Risk factors for acquiring an ESBL include:
- Recent stay in an ICU
- Weakened immune system
- Recent transplant surgery
- Premature birth
- Frequent/long-term antibiotic therapy
- Having an indwelling urinary catheter present
- Recent surgical procedures

Methicillin Resistant Staphylococcus Aureus (MRSA)

*Staphylococcus aureus* are common bacteria found on someone’s skin or in their nose. Methicillin Resistant *Staphylococcus aureus*, or MRSA, is *Staphylococcus aureus* that has become resistant to treatment with antibiotics such as penicillin or methicillin.

MRSA occurs most frequently among patients in health care facilities who have weakened immune systems, experienced prolonged antibiotic therapy, or who have undergone invasive medical procedures. MRSA can be harmless unless it invades tissue through a wound or a break in the skin and can then cause serious and potentially life-threatening illness such as bloodstream infections, surgical-site infections or pneumonia.

The hands of health care workers or contact with contaminated surfaces and medical equipment can be primary sources of transmission of MRSA and other drug-resistant organisms in the health care setting. Hands may become contaminated with MRSA by contact with infected or colonized patients.

The spread of MRSA can be prevented by using contact isolation precautions which consist of a private room and gowning and gloving by all health care workers who enter the room, meticulous hand hygiene, as well as dedicated patient equipment (e.g., thermometers and stethoscopes). If the equipment must be shared, then cleaning must be done with a hospital-approved disinfectant before it is moved to the next patient.

Vancomycin Resistant Enterococcus (VRE)

*Enterococcus* are bacteria that are normally present in the human intestines and in the female genital tract; these bacteria can sometimes cause infection. Vancomycin is an antibiotic that is often used to treat infections caused by *Enterococcus*. In some instances, *Enterococcus* have become resistant to this drug and thus are called vancomycin-resistant *Enterococci* (VRE).

VRE infections occur most frequently in those who are hospitalized, especially if they have been in the hospital a long time or if they have compromised immune systems, open wounds, catheters, or drainage tubes. VRE most commonly infects the skin, urinary tract, and bloodstream but can occur anywhere in the body. VRE can also be present without causing infection; this is known as colonization.

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MULTIDRUG-RESISTANT ORGANISMS (continued)

The main source of transmission in a healthcare setting is by the hands of health care workers and contact with contaminated surfaces and medical equipment. Hands may become contaminated with VRE by contact with infected or colonized patients.

The spread of VRE can be prevented by using contact isolation precautions, which mean a private room, gowning and gloving by all health care workers, meticulous hand hygiene, and dedicated patient equipment (e.g., thermometers and stethoscopes). If the equipment must be shared, then cleaning with a hospital-approved disinfectant must be done.

IT IS CRUCIAL TO REMEMBER:

- *C-diff* are spore-forming bacteria that cause antibiotic-associated diarrhea.
- *C-diff* transmission can be prevented by:
  - Using contact precautions which consist of a private room, gowning, and gloving by all health care workers who enter the room.
  - Encouraging meticulous hand hygiene with soap and water since some studies have suggested that alcohol hand rub may not be as effective against spore-forming bacteria.
  - Dedicated patient equipment (such as thermometers and stethoscopes) and disinfection of surfaces and equipment with a bleach-containing product in the inpatient setting (not in NICU).
- Extended-spectrum beta-lactamases (ESBLs) are enzymes that confer resistance to commonly used beta-lactam antibiotics, including penicillins, cephalosporins, and others.
- Transmission of ESBLs can be prevented by:
  - Scrupulous hand hygiene.
  - Using contact isolation precautions with patients with ESBL infections such as putting on a gown and gloves when entering the room and then removing and discarding the gown and gloves when exiting.
- Methicillin Resistant *Staphylococcus aureus*, or MRSA, is *Staphylococcus aureus* (bacteria found on someone’s skin or in their nose) that has become resistant to treatment with antibiotics such as penicillin or methicillin.
- The spread of MRSA can be prevented by:
  - Using contact isolation precautions consisting of a private room, gowning and gloving by all health care workers who enter the room, meticulous hand hygiene, as well as dedicated patient equipment (e.g., thermometers and stethoscopes).
  - If the equipment must be shared, then cleaning must be done with a hospital-approved disinfectant.
- Vancomycin Resistant *Enterococcus* (VRE) refers to *Enterococci* (bacteria normally present in the human intestines and in the female genital tract) that has become resistant to the antibiotic, vancomycin.
- The spread of VRE can be prevented by:
  - Using contact isolation precautions: a private room, gowning and gloving by all health care workers, meticulous hand hygiene, and dedicated patient equipment (e.g., thermometers and stethoscopes).
  - If the equipment must be shared, then cleaning with a hospital-approved disinfectant must be done.
PREVENTION OF CENTRAL LINE ASSOCIATED BLOODSTREAM INFECTIONS (CLABSIs)

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

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

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

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

Central Line Insertion Bundle Includes:
- Scrupulous hand hygiene.
- Maximal sterile drape (covers patient head to toe).
- Full barrier precautions (sterile gown and gloves, head cover and face mask).
- Skin prepped with at least 2% clorhexidine using back and forth strokes for 30 seconds (unless contraindicated) and allowed to air dry for same amount of time.
- Avoid femoral insertion site in adults if at all possible.
- Assess the need for the central line daily.
- Discontinue central line ASAP if no longer indicated (requires provider order).

Central Line Maintenance Bundle Includes:
- Scrupulous hand hygiene before and after all contact including medication administration and site assessment.
- Performing dressing change and site care using aseptic technique.
- Assessing site and document every 24 hrs/prn
- Scrubbing insertion site with at least 2% clorhexidine (unless contraindicated) for 30 seconds using back and forth strokes and allowing site to dry equal amount of time to ensure adequate antimicrobial activity.
- Applying transparent semipermeable dressing over insertion site and changing dressing every 7 days and prn. Note: loose or soiled dressings must be replaced and not reinforced.
- Applying gauze dressing over insertion site only with bleeding/oozing site, and then changing dressing within 24 hrs (SMH) to 48 hrs (HH); change immediately if moist or soiled.
- Replacing dressing if damp, loosened or visibly soiled. Performing site care as described above each time dressing is replaced.

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PREVENTION OF CENTRAL LINE ASSOCIATED BLOODSTREAM INFECTIONS (continued)

- When accessing the central line, use VIGOROUS FRICTION to “scrub the hub” or access device. Scrub with alcohol for at least 15 seconds, or 10 times with equal dry time, every time you make or break a connection.
- Tubing is changed at least every 96 hrs. Change IV fluids and all access devices with tubing change, including stopcocks, extension tubing, blood-saving devices, and needleless access devices.
- Flush all lumens per policy to maintain patency.

Drawing Blood Cultures from Central Lines

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

IT IS CRUCIAL TO REMEMBER:

- CLABSIs are often serious enough to cause an extension of the hospital stay as well as increased cost and risk of mortality.
- CLABSIs can be prevented through proper placement and management of the line.
- CLABSIs can occur due to disruption of the integrity of the skin and can cause an infection that may then spread to the bloodstream.
- Prevention of CLABSIs focuses on insertion, maintenance and removal of the line.
PROVIDER PERFORMED POINT OF CARE TESTING/MICROSCOPY

Subject Matter Experts:
SMH: Robert Mooney, PhD. (275-7811), Melissa Allen (275-7675)
HH: Susan Dailey (341-8458)

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

PPT (provider performed testing) and PPM (provider performed microscopy) include the following tests:
1. Fecal WBC Microscopy
2. Fern Test Microscopy
3. Nasal Eosinophil Microscopy
4. Nitrazine Paper Testing
5. Occult Blood Testing
6. pH Testing
7. Pinworm Microscopy
8. Qualitative Semen Microscopy
9. 10% KOH Microscopy
10. Urinalysis (Manual Urine Dipstick)
11. Urine Sediment Microscopy
12. Vaginal Wet Mount Microscopy

For Additional Information
SMH: SMH Policy 8.12, Provider Performed Testing at:
http://intranet.urmc-sh.rochester.edu/policy/SMHPolicies/
Or visit the POCT Website https://intranet-secure.urmc.rochester.edu/depts/path/POCT/PPT.aspx

HH: Pathology & Department of Laboratory Medicine intranet site at:

Annual Online Competency Assessment Program (SMH Only)
New providers must enroll in the annual online competency assessment program and complete annual competency assessment(s) for all tests performed.

To enroll in the online program, Medical Training Solutions (MTS), please follow up with your department administrator or the POCT office. Competency testing occurs on an annual basis and the testing cycle begins each year on February 1. An e-mail notice to providers informing them of the testing requirement, providing the URL, and providing a user name and a password for the testing site are sent through MTS and triggered by a test administrator.

Note: Any instrument testing will necessitate additional training and competency review. Contact the POCT office at 275-0229 for information about instrument training.