Orientation Packet

For Students & Non-Employed Professionals

For use at the following Rochester Area Healthcare Organizations:

- ◆ **Rochester Psychiatric Center**
- ◆ **Rochester Regional Health**
- ◆ **UR Medicine**

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Orientation Packet for Student & Non-Employed Professionals

Fire and Life Safety

It is important to remember this concept for all aspects of Fire and Life Safety:

R = Rescue anyone in immediate danger of smoke or fire
A = Activate alarm; notify the switchboard operator
C = Confine the smoke or fire by closing all doors
E = Extinguish if the fire is confinable, and you have been trained, or Evacuate, if directed to do so

If you discover smoke, fumes, or fire:

1. Remove anyone in immediate danger and initiate the fire alarm by pulling nearest manual station.

2. Call the switchboard operator. Know the number at your assigned clinical facility; usually the number is posted on or by the phone. The Fire Department is called for every suspected fire emergency.

3. Close doors and windows to prevent spread of fire or smoke.

4. Evacuate, or *if trained*, use the appropriately labeled fire extinguisher, if the fire is small and confinable.

   A = trash, wood, paper fire
   B = liquids, grease fire
   C = electrical fire

5. Utilize the PASS technique for extinguishing fires

   P = Pull the pin
   A = Aim hose at the base of the fire
   S = Squeeze the trigger
   S = Sweep at the base of the fire

6. Shut off fans and air conditioners.

7. Before turning off oxygen and electrical equipment, account for patients depending on oxygen and electrical supply. The charge nurse, with the assistance of the Fire Marshall, will make the decision about shutting off the oxygen supply.

8. Report to the instructor, preceptor or charge nurse for instructions.

9. Use the nearest horizontal exits and stairways, not elevators, if it becomes necessary to evacuate. Follow lighted exit signs.

10. Keep Calm. Speak quietly with patients. ∎

Fire Safety in the Home

1. Keep calm.

2. If the fire is in the same room as the patient:

   - Attempt to move the patient to safety.
   - Extinguish the fire on the patient by using blankets, etc. to smother the fire.
   - When attempts to move the patient from the fire fail, leave and **_CALL 911_** immediately from a safe location to notify fire department of location of patient. ***Note*:** When calling **911**, give your name, address of fire, location of fire in the building/home. Never hang up first!

3. If the fire is in another room, apartment or floor:

   - **CALL 911** immediately. See ***Note*** above.
   - Assess the ability to rescue the patient to safety.
   - If patient cannot be moved safely, (for patient and caregiver), secure the environment by closing doors, laying towels or clothes at door/floor.
   - Leave and get help.

4. Always feel the door before you open it. If the door is not hot near the top, brace your foot against it before opening it to investigate conditions. If the door *is* hot, **DO NOT OPEN IT**.

   - If it is not safe to leave the room, stuff bedding (wet, if water is available) along the bottom of the door to keep smoke out, and yell or call for help.

   - If there is smoke in the room, creep along the floor for better breathing.
   - Move to a window area. If fire is in another room, floor, or apartment, open window for ventilation and communication with rescuers, or as an emergency exit.

5. If you are in a high-rise apartment building, follow the building's fire plan, usually found on the back of the apartment door. If there is not a fire plan, take the patient, if possible, to the nearest stairwell so that both of you may leave the building. If there is a fire warden on your floor, follow their instructions. **DO NOT USE THE ELEVATOR!**

6. When the fire fighters or rescuers arrive, give them the exact location and condition of the patient.

7. If not done already, notify your organization of the situation.

8. **NEVER RE-ENTER A BURNING BUILDING** under any circumstances.

9. Fire Prevention

   - Hazards
     - Be alert to the smell of gas. If it is present, you and the patient should leave the home **immediately** and call the local gas and electric service from a neighbor's phone.

Fire Safety in the Home (continued)

- ♦ **NEVER** use the phone in the home in which you smell gas.
- Always check the stove/oven before you leave to be sure all burners are turned off.
- Remind your patient that the oven should not be used for heat.
- If you work in an apartment area, ask the patient or building manager for fire instructions.
- Have the patient keep a list of emergency phone numbers near the telephone. Include reporting information such as:
  - ♦ Patient name
  - ♦ Address (including apartment number and floor number), Town

- ♦ Any nearby landmarks.
- Review FIRE SAFETY with the patient:
  - ♦ Review safety material in the patient packet at service opening, with family and caregivers.
  - ♦ If you observe unsafe practices such as: smoking in bed, inappropriate use of extension cords (frayed, under carpets), overflowing ash-trays, poorly lit or cluttered exits and entrances: THEN, educate the patient, family or care-giver, note in the patient record and notify the physician and Clinical Leader of non- compliance.
  - ♦ In the case of non-compliance of patient and/ or family, refer to agency Discharge Policy and Procedure. ∎

Emergency Management:Disaster Policy

A hospital must have a plan in place to efficiently and effectively deal with any catastrophe, should a disaster occur within the institution or community. The Emergency Management Plan also provides a system to evaluate the emergency, determine how it will impact the hospital and initiate the response needed to protect life and property. Hospitals are now required to have plans that direct operations in the event of "patient surge," as well as a plan to evacuate the entire hospital in the event of a disaster such as flood. It is essential that all personnel understand their role in maintaining patient safety and the prevention of injury.

Each hospital is required to follow the National Incident Management System (NIMS) which provides a systematic, proactive approach to guide departments and agencies at all levels of government, nongovernmental organizations, and the private sector to work seamlessly to prevent, protect against, respond to, recover from, and mitigate the effects of incidents, regardless of cause, size, location, or complexity, in order to reduce the loss of life and property and harm to the environment.

Examples of disasters, which would activate this plan, include external disasters such as fire or weather disasters, hazardous material or radiation exposure, or massive casualties in the community. Internal disasters could include the loss of heat, water, electricity, or a hazardous material incident.

Hospitals currently are working with County and State Emergency Agencies to develop more fail-safe plans in the event of a bio-terrorism emergency. It is important that anyone working in a hospital report any suspicious package or letter to hospital security personnel. Points to remember if you receive a suspicious letter or package:

- **Do Not Open** the envelope or package
- Leave the item as is and evacuate the room

- Wash hands with soap and water
- Call Security or Public Safety
- Keep others from entering the room
- Remain on the premises until responders arrive

In the event of a known or suspected disaster, the Nursing Director, Security, Switchboard Operator, Engineering, and the Emergency Department will be notified. In the event of an actual emergency, the operator will make an overhead announcement, designating a Personnel Alert, or disaster alert plan.

Unified Command will be used when another responding agency(ies) for the incident is present. (i.e. Fire Dept. responding for an evacuation incident) This approach will have senior leadership from the hospital and responding agency(ies) co- located and make decisions together as they analyze available information and establish a common set of objectives and strategies for a single Incident Action Plan.

Multi-Agency Coordination System (MACS)

When the scope of an incident requires, the county may establish a multi-agency coordination system (MACS). During a large-scale or widespread event, such as a natural disaster, disease outbreak, or terrorist attack, a MACS serves to support incident management policies and priorities across the entire county, a large area, or several individual events; facilitates logistics support and resource tracking; makes resource allocation decisions based on incident management priorities; coordinates incident-related information; and coordinates inter- agency and inter-governmental issues. The MACS would be established and coordinated by the county's Office of Emergency Management (OEM), and would serve to integrate the varied activities of other agency and organization emergency operations centers across the region. Hospitals may be asked to participate or assign a liaison.

Emergency Management: Disaster Policy (continued)

Multi-Agency Coordination System (MACS) (continued)

As needed, the hospital will communicate its ability to share resources and assets as outlined in the Hospital Mutual Aid Plan with other health care organizations outside the community in the event of a regional or prolonged incident.

Public Information System & Joint Information Center

During an incident involving multiple agencies or organizations, it is vital that public information be communicated using "one voice," that is, a consistent message delivered across all participating community response entities. A public information system (PIS) provides accurate, timely, and coordinated information to incident leadership and the public.

At the discretion of the county OEM or Department of Health, this may be accomplished using a Joint Information Center (JIC). In a JIC, the public information officers of all health care partners and jurisdictional authorities, co-locate and develop a joint public information message for dissemination. Under those circumstances, all media releases would be coordinated through the JIC.

Students should not come to the assigned hospital if a Personnel Alert or Disaster Plan has been activated. If a student is in the hospital, when the disaster policy is put into effect, directions will come from the instructor, preceptor, or supervisor. A student/faculty may be asked to assist in transport of patients, delivery of trays, or other activities within the scope of that role. ∎

Hazardous Communication

Hospitals use many chemicals and other forms of hazardous substances. These hazardous materials can be defined as any substance or material in a quantity or form which poses a risk to safety, health, or property. Substances that are hazardous may be poisonous, toxic, caustic, corrosive, flammable or combustible; or they may react with other materials or have the potential to cause adverse health effects.

When a potentially hazardous spill is discovered, the procedure to follow is:

1. Call the switchboard operator to report the suspected spill, the amount, and the location. Most facilities want the person making the report to use a STAT number or emergency priority number.

2. Restrict the area; close doors to prevent the spread of possible fumes.

3. Attempt to contain the spill if it is safe to do so.

4. A specially trained spill team will clean the spill until the vapor or other readings are at an acceptable level, and the hazard is removed.

5. Staff in adjacent areas should check for evidence of spread of the spill.

The Right to Know Law mandates that all personnel must be informed of hazardous materials in the work place before confronted with their use. Hospitals have a comprehensive program on maintaining a hazardous material inventory, labeling program, and communication policies.

To be in compliance with the Occupational Safety and Health Administration (OSHA), files of inventoried hazardous substances are maintained. A Safety Data Sheet (SDS) for each item listed on the inventory is kept, and must be reviewed by anyone who comes in contact with that substance. The SDS contains information about the hazards including component data, emergency spill information, and emergency treatment if exposed, and precautions or personal protective equipment to use when handling the chemical. Know the location of the hazardous materials inventory and the SDS in your facility.

All chemicals must be labeled directly by the manufacturer or with a label that identifies the chemical name, health rating, flammability rating, reactivity, safety precautions and immediate first aid measures.

Regulatory agencies require that hospitals have, and communicate, policies regarding safe sharps disposal. Remember never to recap used sharps, and to dispose of them in puncture resistant containers. Most facilities use safety-sheathing sharps devices. Clean needles may only be recapped using a one- handed scoop method or a re-sheathing device.

Practice Standard Precautions and use appropriate Personal Protective Equipment (PPE) when dealing with any biological hazard. Anyone exposed is isolated and follows the instructions of the Fire Marshal or other designated personnel until the appropriate decontamination is completed. ∎

Prevention of Newborn/ Child Abduction

Specific monitoring activities are used for all admitted infants and children while receiving care the health care facility and include evaluating the risk of abduction. Minimum monitoring activities include:

- documentation when an infant or child leaves an area for approved purposes
- providing and documenting a visual check regularly

- notification to procedure areas when the minor will not be accompanied by a staff member
- conducting tests of specific entrance and exit access control devices (as applicable)

Staff identifying a potential security risk for abduction of an infant or child should confer with the appropriate individuals/ departments for that facility. ■

Violence in the Workplace

Crime and violence in the workplace has risen alarmingly in the United States. Hospitals in the Rochester and surrounding areas have security management programs designed to maintain the safety and welfare of patients, visitors, employees and staff while they are carrying out their responsibilities.

Remember:
- Always wear appropriate identification that demonstrates you are authorized to be in patient care areas.
- Lock up all property; do NOT bring valuables to clinical setting.
- Report any suspicious people in or around the clinical area.

Some facilities offer escort services are available to safely transport staff to and from their vehicles when traveling after dark, or if a staff member feels that she/he is in jeopardy. Parking lots have been equipped with a lighting system, and hospitals have installed emergency phones.

In a security incident, know the emergency number for each facility. For those hospitals that have one, call the security department in the hospital. If there is no facility-specific security department, or you are in an offsite location or in someone's home, call 911. Report the following information, and stay on the phone until an officer responds:

1. Type of problem
2. Location of the incident
3. Details &description of person(s) causing trouble.

There are some patient care areas of the hospital that are identified as security sensitive, where extra precautions are taken to assure patient, visitor, and staff safety. The Emergency Department, Obstetrics, Pediatrics and Pharmacy are some areas where special security measures may be in place, but staff in all areas must have a plan to act in the case of actual or potential violence.

No firearms or weapons are permitted anywhere in the facility as required by law. Law enforcement officers, including correctional officers and armored car personnel, when on duty, are exempt to this requirement. No patient, visitor, or staff member may carry a weapon. If anyone notices a firearm, call the Security Department immediately to report the situation.

If a prisoner is hospitalized, the attending forensic (police) officers are oriented to appropriate policy and procedures as man- dated by regulatory agencies. Nursing staff assures prisoner- patient safety by demonstrating call light systems and other necessary procedures to the forensic officers. ■

Violence in the Home

CRITERIA FOR USE of a Visiting Nurse Service (VNS) FIELD SECURITY ESCORT:

- Staff is strongly encouraged to use escorts any time they feel unsafe or at risk. Field security escorts are available, upon request, 24 hours per day, seven days per week.
- Escorts are off-duty, active or retired law enforcement officers, civilians who meet the New York State requirements and are registered security guards, and a contract security guard company to meet the needs of VNS staff.
- To access immediate security assistance 24 hours per day, call 787-8333.
- To achieve the greatest success in timing and location of service, schedule use of an escort in advance, if he/she

knows that an escort will be necessary for any reason.
- EMPLOYEE SAFETY IS OF GREATEST CONCERN. In any case that staff feels they are in danger, call in for help. Do not make the visit without support.
- Staff in immediate danger shall call 911.
- **When contacting ANY security escort,** provide the following:
    1. Patient's name and number
    2. Address or location of expected service
    3. Date and time escort service is expected
    4. The name of the staff or volunteer requiring service
    5. Mutual location to meet (if not the patient's address)
- It is at the discretion of staff to decide if he/she would prefer to have the escort travel with him/her in his/her own vehicle or separately.

FIELD SECURITY ESCORT RESPONSIBILITIES

- Once a mutual location is established with staff, escorts will report to that location within ½ hour (30 minutes).
- Mutual locations will be well-lit, safe locations, from which the escort and staff may proceed to the patient's home.
- The Security Escort's first priority is safety of staff. Should safety of staff be compromised, the escort must get the care giver out of harm's way using only as much force as necessary. Any use of physical force must comply with the penal law section on physical force, article 35.
- The escort shall protect staff from harm, due to a patient or third party's actions or environment.
- The escort will not ask questions of staff regarding his or her duties or the patient's condition or personal information.

Escorts are bound to maintain the confidentiality of all patient information.

- The Security Escort will assist staff by entering the vehicle last and exiting the vehicle first. When escorting staff to and from vehicles or buildings, the Security Escort will stay with the staff until they are completely in the building or in the vehicle and under way.
- Escorts who are active duty law enforcement officers, or licensed NYS Armed Security Guards may carry a firearm, only under the following conditions:
  1. The firearm must be concealed at all times.
  2. The penal law regarding deadly force, Article 35, is observed at all times. ∎

Community- Wide Plain Language Codes

In an effort to standardize emergency code terminology, all Rochester Area Healthcare organizations have adopted emergency plain-language codes.

Each facility has specific procedures and phone numbers that will be utilized in the occurrence of any of the conditions below

Plain Language	Condition
Fire Alert (followed by location)	Fire alarm received/Investigation of a Fire
Fire Alert confirmed (followed by location)	Actual or Confirmed fire condition
Code Team (followed by location)	Adult cardiac/respiratory emergency
Code Team Pediatric (followed by location)	Pediatric cardiac/respiratory emergency
AMBER Alert (followed by infant, child, adolescent, then age)	Child under 18 years taken without authorization or suspected abduction
Assistance needed STAT (followed by location)	Behavioral/Uncontrolled person incident
Critical Security incident (followed by location)	Critical security incident (weapon, bomb threat, active shooter)
Command Center activated (staff to implement disaster plans. Leadership or Command Team to report to designated area)	Disaster (Internal or community, natural or manmade)
All Clear	Situation resolved

Human Trafficking

New York State passed legislation to address human trafficking as this is a growing issue. NY Consolidated Laws, Public Health Law—PPH § 2805-y states "Healthcare facilities across the treatment spectrum must provide for the identification, assessment and appropriate treatment or referral of persons suspected of human trafficking victims."

"Human Trafficking" is defined as compelling another to engage in labor or prostitution, or recruiting, enticing, harboring, or transporting another person by means of

providing the person with controlled substances with intent to impair the person's judgment: requiring that the labor or prostitution be performed to repay a real or purported debt incurred with an intent to defraud the person: withholding or destroying government ID documents; using force; or using threats to compel the person.

While in a healthcare facility if there are concerns that arise during patient interactions, notify leadership in that area to ensure that policy, patient safety and protocols are met to address the concern.

No SMOKING Regulations

Hospitals across all counties comply with New York State and JOINT COMMISSION or DNV regulations with regard to "No Smoking Ordinances". More importantly, each organization is committed to the promotion of health. Smoking is a major cause of preventable disease and death in this country. For this reason, and for the health and comfort of the majority of patients, visitors, employees, and staff who are nonsmokers, healthcare organizations play an active role in disease prevention by restricting the use of tobacco.

The inhalation of second-hand smoke has a negative effect on non-smokers. It increases high blood pressure, heart rate, and the level of carbon monoxide in the blood. Smoking Cessation courses and information are offered across New York State and found on the NYS Department of Health website.

RRH and UR facilities prohibit smoking on the campuses of these facilities. This initiative called "Smoke Free, Inside and Out" is consistent with the direction many health facilities are taking. This impacts patients, employees and visitors while on the campuses of those participating in these efforts to promote health, and pre- vent disease. Efforts are ongoing to provide services, such as smoking cessation classes and nicotine replacement therapy to assist patients, visitors and staff to be in compliance with these policies. ∎

Electrical Safety

All personnel are responsible for electrical safety. Sources of electrical current, which can be considered hazardous, are:

1. Broken or frayed electrical cords
2. Broken electrical plugs or grounding prong broken off
3. Defective equipment

Patient susceptibility to electricity in hospitals is categorized by:

- **Non Patient Area**
  Administrative areas where patients have little or no con- tact with electricity and electronic equipment.

- **Patient Area**
  Patients may have direct or indirect contact with non- invasive therapy and/or electrical, monitoring equipment.

- **Electrically Susceptible Patient Area (ESPA)**
  Patients may be subjected to invasive monitoring or therapy using direct pathways to the cardiac musculature, e.g. ICU, OR.

- **Non-Acute Patient Area**
  Special arrangements can be made to adapt to the needs of long-term patients, e.g. ALC.

- **Electronic Equipment Inspection**
  - Check for a dated inspection sticker prior to using clinical equipment.
  - All clinical equipment is to be inspected by the Bio- Medical Engineering Department prior to use, and at periodic intervals to protect safe use.
  - Non-clinical equipment is to be inspected by the Engineering Department prior to use in some facilities. Most hospitals do not require regular inspection of non -clinical equipment.
  - Do not use equipment if a hazard is obvious or suspected. Take the item out of service and report the equipment default to the charge nurse. The item will be tagged according to policy.
  - Three to two wire adapters or "cheater" plugs and ex- tension cords *are prohibited.*
  - Cellular phones are no longer considered dangerous devices in patient care areas. Check the specific policy in each facility regarding cell phone use.
  - Patient owned electrical devices, e.g. blow dryers; curling irons *are prohibited* in most patient care areas, except in long-term care agencies.
  - Hospitals may require that a patient's own electrical device be first inspected by the Engineering Department prior to use; check the facility policy. ∎

Safe Medical Device Act

A "medical device" is any machine or equipment used in the diagnosis or treatment of any patient. This includes items such as x-ray machines, intra-aortic balloons, IV infusion devices and IV tubing. The Food and Drug Administration (FDA) requires that any actual or potential life-threatening situation that occurs while a medical device is being used on a patient must be reported.

The Safe Medical Device Act also requires healthcare facilities to have policies and procedures in effect that facilitate effective identification of problems. If any malfunction of medical equipment is suspected, immediately assure the safety of patients, visitors, and staff. The instructor or preceptor is contacted to secure the equipment, tag it and associated tubing, and prepare the necessary reports. Check on facility specific procedures to report the malfunction. Whenever a death or injury is believed to have been associated with the use of a medical device, the preceptor or supervisor must complete a facility incident report. Information regarding the type of device, manufacturer, and serial number must be included. The instrument or device is taken out of circulation, and secured until proper inspection is completed. The incident report along with any hospital specific forms is forwarded to the designated administrative person who makes the report to the FDA.

Safe use of medical equipment

- Students, faculty or preceptors should use only equipment they have been deemed competent to use.
- All medical equipment should be checked for a current inspection or "approved for use" sticker (minimum of once a year) before operating the equipment.
- Activate and check all alarms to ensure they are operative prior to attaching device to patient. Alarms on equipment when in use must be activated, audible and responded to promptly.

- Operator manuals and related procedures should be available in the area for reference.
- All medical equipment must be in good physical condition, wired with a chassis ground via a separate third wire in the appropriately sized power cord, and have a hospital-grade plug attached.
- New, borrowed, leased, physician owned equipment, and equipment being returned from loan must receive an "incoming safety and performance" inspection by Biomedical Engineering before being placed in use.

Repair and upkeep of medical equipment

- Replace and tag broken equipment. If applicable, attach the disposables and packaging; these may help identify the cause of the problem.
- If you find an out-of-date inspection sticker, or you experience a medical equipment failure or problem, call the appropriate facilities' Biomedical Engineering Department.
- Report patient/staff/visitor injuries or harm due to medical equipment per the appropriate reporting process for the facility.

Use of the patient's personal home equipment

- Use of patient-provided medical equipment should be discontinued as soon as possible after admission to a hospital. Comparable hospital-owned devices that staff, students, and faculty have been trained to use should be substituted for the patient-provided device.
- If a comparable facility-owned device is not available, Biomedical Engineering must be called to inspect the patient-provided device. Staff and students/faculty must be trained on how to use the equipment and appropriate documentation of training kept in the department. ■

Safe Patient Handling
Transfer Assessment Guidelines

Agency Standards:

1. Caregivers must be able to maintain good body mechanics throughout patient transfer and positioning.

2. Caregiver should not be required to lift any more than 35 pounds per NYS Safe Patient Handling Regulations.

3. Transfer and patient mobility methods must be developed for one person only.

4. Transfer and patient mobility methods must be easily duplicated safely by multiple caregivers

5. Transfer and patient mobility must be completed safely by the caregiver, prior to adding to the Aide Care Plan.

Assessment Points:

1. Environment

   a. Bed height
   b. Floor surface
   c. Obstacles, space available
   d. Sides of bed accessible
   e. Bathroom space adequate, if transfers occur there

2. Transfer Technique

   a. How is caregiver preparing patient for transfer?
   b. What patient positioning is required prior to transfer?
   c. Is patient ever at risk in transfer process?

2. Transfer Technique (continued)

   d. Does transfer require minimal patient lifting?
   e. What distance and over what surfaces must patient be moved?
   f. How often is transfer performed during a visit?
   g. Does transfer frequency increase risk of injury due to fatigue?
   h. What patient positioning is required following transfer?
      1) Appropriate seating
      2) Minimize repositioning
      3) Monitor skin shearing
      4) Monitor caregiver lifting and body mechanics required

Follow Up:

1. Update Aide Care Plan with written transfer instructions in the home.
2. Document in the patient record: what was taught, who was taught and response to teaching.
3. Monthly reassessment of procedures and follow through in home unless intervention needed sooner.
4. Reassessment of transfer procedures to be a priority if injury occurs.
5. If unsure transfer is safe or unable to be performed, REFER to REHAB Services.
6. Do not put or leave unsafe transfer on care plan. ■

Safe Patient Handling
Lifting & Transfers: Posture & Body Mechanics

General Information

1. What is good posture?

   • Standing: Head straight up with chin in
   Shoulders back
   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
   Feet resting flat on floor or footrests

   NOTE: Take frequent breaks to change position and stretch, reversing any prolonged postures.

2. Why is good posture important?
   • Keeps bones and joints in the correct alignment so that muscles are being used properly
   • Decreases the stress on the ligaments holding the joints of the spine together
   • Prevents the spine from becoming fixed in abnormal positions
   • Prevents backache and muscular pain
   • Decreases the probability of back injuries during lifting or heavy exertion

3. What are the results of poor posture?
   • Muscles are in weakened positions
   • Increased potential for injury
   • Pain and discomfort

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.

   NOTE: 1) Ask for help before you need it.
   2) Utilize Safe Patient Handling Equipment for patient transfers, repositioning and mobility when necessary.

General Transfer Guidelines

1. Determine the needs of the patient by using facility specific Safe Patient Handling guidelines.

2. Request assistance from other staff. Two individuals needed at minimum.

3. Prepare the patient; explain what you are going to do and how they can help.

4. Set up the equipment to be utilized. Use assistive technology (for example, transfer belts, portable lift, Air assisted technology, ceiling lift). This is a requirement for any patients greater than 35 pounds who cannot assist in their transfer.

5. Prepare everyone involved in the transfer. The patient and all assistants need to know how and when the transfer is going to take place. Ask the patient to help.

6. Perform the transfer.

   NOTE: 1) Transfer belts may be available check with facility policy or facility staff member.
   2) Ask for help before you need it.

References/Useful Websites

https://www.health.ny.gov/statistics/safe_patient_handling/docs/sph_report.pdf ∎

Safe Patient Handling
Incident Reporting

The Incident/Occurrence Reporting process is a basic component of an effective patient safety and risk management pro- gram. Incident/Occurrence reporting is the process that occurs when an unexpected event takes place that is harmful or potentially harmful to any patient, visitor, or staff, including students and instructors, within the healthcare facility. An incident/occurrence is any unintended or undesirable development or event related to care or services provided to patients, families or visitors that takes place on the premises of the healthcare facility.

Timely and thorough documentation of incidents is necessary if healthcare facilities are to ensure that patients receive quality care in a safe environment. The purpose of an Incident Report is to confirm that information surrounding an incident is collected, analyzed and acted upon, if necessary, to minimize the risk of injury or harm to patients, visitors, and staff. Incident Reports (facility specific forms or a facility electronic report) are located in each patient care area and are completed by the member of the healthcare team who discovers or is aware of the incident. Incident Reports include an accurate and objective description of the event. Incident reports are part of the Quality Assurance process. Neither the report, nor the fact that an occurrence report has been completed is to be placed or documented in the patient's medical record.

Adverse drug reactions are also considered an unexpected event and are reported through the events reporting system. If the reaction is considered a new allergy, it must be documented in the patient's medical record.

Students, faculty and staff are encouraged to report events known as "near misses", which are incidents that did not result in harm but were avoided by last minute intervention. Tracking and trending near misses can assist in identifying potential risks and fixing problems before harm comes to a patient, visitor, student or employee.

If deemed necessary by a hospital administrator, the event may need to be reported to the New York State Department of Health, Office of Health Systems Management (OHSM). Incidents that are considered statutory events and are reportable to the local office of the Department of Health include:

1. Fires or other internal disasters in the facility which disrupt the provision of patient care services or cause harm to the staff.

2. Equipment malfunction during the treatment or diagnosis of a patient, which did or could have adversely, affected a patient or healthcare provider.

3. Poisoning occurring within the facility.

4. Strikes.

5. Disasters or other emergency situations external to the hospital environment which affect health facility operations.

6. Termination of any services vital to the continued safe operation of the healthcare facility or to the health and safety of its patients and personnel.

7. Unexpected deaths not associated with the underlying illness, or incorrect invasive procedure.

The Department of Health requires the hospital to have a system of tracking certain patient related events and providing trending and root cause analysis of patient related incidents. The Department of Health now has the capability of providing hospitals with comparative incident summary data. This will help hospitals to work together to minimize risk of injury or other harm to patients, visitors, and staff. ∎

The New York State Department of Health requires that a copy of the Patient's Rights be posted in designated areas, and given to patients upon admission, or when receiving outpatient or emergency care. Hospitals make this information available in different languages, Braille, and in a signed format.

A designated person must meet with the patient about their rights, and document that the patient has received all the information needed to understand their rights. It is the responsibility of the hospital staff to safeguard and preserve the patient's rights.

In addition, patients receiving psychiatric or substance abuse treatment also have rights established by the New York State Office of Mental Health (NYS OMH) and the New York State Office of Substance Abuse Services (NYS OASAS). Copies of rights specific to patients receiving psychiatric or substance abuse treatment are given to patients or their representatives when they receive treatment in an OMH and OASAS-licensed setting. OMH and OASAS-licensed programs are Psychiatry Department programs that include:

- Comprehensive Psychiatric Emergency Program (CPEP),
- Adult and Child and Adolescent Inpatient Psychiatry,
- Strong Ties Clinic and ACT Team,
- Adult and Adolescent Partial Hospital Programs,
- Adult Ambulatory Clinic Services
- Chemical Dependency and Methadone Treatment Programs

The **Patient's Bill of Rights** assures each patient has the right to:

1. Understand and use these rights. If for any reason they do not understand or they need help, the hospital must provide assistance, including an interpreter.

2. Receive treatment without discrimination as to race, age, color, religion, sex, national origin, disability, sexual orientation, or source of payment.

3. Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.

4. Receive emergency care if they need it.

5. Be informed of the name and position of the doctor who will be in charge of their care in the hospital.

6. Know the names, positions, and functions of any hospital staff involved in their care and refuse their treatment, examination, or observation.

7. A no smoking room.

8. Receive complete information about their diagnosis, treatment, and prognosis.

9. Receive all the information they need to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.

10. Receive all the information they need to give informed consent for an order not to resuscitate. They also have the right to designate an individual to give this consent for them if they are too ill to do so. If they would like addition- al information, a copy of the pamphlet "Do Not Resuscitate Orders – A Guide for Patients and Families" should be provided.

11. Refuse treatment and be told what effect this may have on their health.

12. Refuse to take part in research. In deciding whether or not to participate, they have the right to a full explanation.

13. Privacy while in the hospital and confidentiality of all information and records regarding their care.

14. Participate in all decisions about their treatment and discharge from the hospital. The hospital must provide them with a written discharge plan and written description of how they can appeal their discharge.

15. Review their medical records and obtain copies of their medical records, (for which the hospital can charge a reasonable fee). They cannot be denied a copy solely because they cannot afford to pay.

16. Receive an itemized bill and explanation of all charges.

17. Formulate advance directives and appoint a health care proxy.

18. Participate in the consideration of ethical issues that arise in their care.

19. Authorize those family members and other adults who will be given priority to visit consistent with their ability to receive visitors.

20. Make known their wishes in regard to anatomical gifts. Patients may document their wishes in their health care proxy or on a donor card, available from the hospital.

21. Receive timely assessment and treatment of pain, including education about how to manage their pain.

22. Complain without fear of reprisal about the care and services they are receiving and to have the hospital respond to them and, if they request it, a written response. They should first speak to the nurse or doctor caring for them and if they are not satisfied with the hospital's response, they can request review by The Grievance Committee or complain to the New York State Department of Health. The hospital must provide them with the Department of Health phone number. If concerns cannot be resolved through the hospital or Department of Health patients may contact

- The Joint Commission at 1- 630-792-5000 or via email to:
  OQM@jointcommission.org

- (or) the DNV at 1-866-496-9647 at the DNV website: http://dnvglhealthcare.com/patient-complaint-report ∎

Complaint Process

Complaint policies for healthcare facilities assure the right of all patients to express, either through written or verbal means, complaints about their care or service provided, and to have the healthcare facility investigate such complaints.

Complaints from a patient or his/her designee initially are referred to the Nurse Manager and Leadership team or charge nurse. Resolution with the patient or family member is sought, and documentation of the process and outcome is completed, in a timely manner. The nature of the complaint, investigation and findings are reviewed with the appropriate personnel and submitted to Administration for tracking.

The healthcare facility shall provide the patient or designee with a written response, if requested by the patient. The findings of the investigation are summarized, along with any actions taken to rectify the problem, if needed.

The healthcare facility is responsible to notify the patient, that if the patient or designee is not satisfied with the facility's response, the patient may take the complaint through a facility grievance process/committee or they may complain directly to the New York State Department of Health. The facility is required to provide the telephone number of the local NYSDOH office to the patient or designee. ∎

Corporate Compliance

Corporate Compliance is a program that most healthcare facilities have implemented to assure that they and their employees are always working within the established guidelines of federal laws and regulations. The intent of these laws is to decrease the possibility of fraudulent or abusive practices in the healthcare industry. Facilities and individuals could be liable for substantial fines and penalties for any failure to comply with applicable laws and regulations. Healthcare facilities are com- mitted to full compliance with all state and federal laws, as well as applicable regulations. Expectations of this commitment are described in the organization's code of organizational and business ethics statements or policies in each facility.

Your Role in Compliance
Healthcare facilities expect you to conduct yourself according to the highest ethical standards and comply with all state and federal regulations and institution policies. Any confirmed act of non-compliance could result in corrective action or discipline, including termination of your affiliation with the organization.

Reporting Non-Compliant Behavior:
You have the responsibility to report suspected illegal or non-compliant activities to your manager, faculty or to the organization's Compliance Office. Examples of reportable incidents are:

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

Healthcare facilities have developed a Corporate Compliance Plan, one major purpose of which is to make sure that the bills sent to our patients' insurance carriers are accurate.
Organizations need to demonstrate that:

1. The medical care provided to patients is necessary.
   - Is there a proper diagnosis and medical history?
   - Is this care part of the Medical Care Plan?

2. The patient's care is ordered by a proper practitioner.
   - Is there a complete order, including signature, date and time?
   - Are physician assistant orders countersigned?
   - Are verbal orders countersigned?

3. Each element of care is provided as ordered.
   - Is there proper documentation in the record, progress notes and/or flow sheets?

4. The patient's care, as documented, in their record, is properly coded for reimbursement.
   - Does the code reflect only what is contained in our patient record?

5. The bill sent to patients accurately reflects 1 – 4 above.
   - Proper documentation is obtained in a timely way be-fore the bill is sent.

The penalties for improper billing for patient care can be severe, including fines and in some cases, criminal charges. Employees who knowingly participate in improper practices are subject to discipline including discharge. Staff has a responsibility to understand how what we do might impact a patient's bill. We also have a responsibility to report improper practices so they can be fixed. Should you have a concern, discuss it with your instructor or supervisor/preceptor. ∎

Discharge Planning

The role of healthcare providers in discharge planning is critical. At the time of every patient's admission, the initial assessment will include consideration of bio-physical, psychosocial, financial, functional, religious, spiritual, cultural, educational, and discharge planning factors.

Planning each patient's discharge is a multidisciplinary process. Factors to be considered when developing a post-discharge plan include the need for any hospital, clinic, or home care services, rehabilitation, nutritional guidance, transportation and financial assistance. Early consultation with the patient's physician is essential to planning discharge and managing length of stay. Clinical pathways frequently serve as a standard to trigger aspects of care and discharge planning. Patient and family education should take place to manage a smooth transition to the home or extended care facility.

Staff has a responsibility to understand how what we do might impact a patient's bill.

Examples of educational needs include:

- the safe and effective use of medication
- a comparison and reconciliation (review and agreement) of the patient's admission medication list
- the safe and effective use of medical equipment
- instruction on potential drug/food interactions and counseling on nutritional intervention and modified diets
- instruction in rehabilitation techniques to facilitate adaptation to and promotion of functional independence in the environment
- instruction in basic health practices
- pain management
- access to available community resources
- when and how to obtain further treatment
- the patient's and family's responsibilities in the patient's care

All discharge instructions are documented and given to the patient or patient designee, or to the agency that will be responsible for the continuing care of the patient. The patient or patient designee documents their understanding of discharge instructions. ∎

Discharge Appeal Process

New York State regulations require hospitals to inform patients of their right to:

- a written discharge plan, completed and signed by the nurse and physician written notice on admission of their rights with a description of the review process
- a notice at least 24 hours prior to discharge, reviewing
- the discharge plan and the patient's right to appeal

If a patient chooses to appeal the discharge decision, an independent agent is assigned by the Department of Health to review the situation. The patient may remain hospitalized until the review is completed, and the hospital is liable for the cost of hospitalization during the review period. ∎

21st Century Cures Act

The 21st Century Cures Act became law on 12/13/2016. The Cures Act covers many topics mostly on streamlining and accelerating the discovery of new drugs and medical devices. It includes provisions to improve mental health and substance abuse treatment as well as patient access to new therapies. This law also establishes programs and oversight to promote health information operability and ease of access to patient information and prohibit information blocking practices.

"Information Blocking" is broadly defined as any practice that is likely to interfere with prevent or materially discourage access exchange or use of electronic health information (EHI). Electronic Health Information (EHI) or Electronic personal health information (ePHI) was originally defined under Health Insurance Portability and Accountability Act (HIPAA) and is basically the digital version of a patient's paper chart contained in the Electronic Health Record (EHR). EHRs are real time patient centered records that can make information available instantly and securely to authorized users.

When individuals have access to their health information they can better coordinate their care and have greater control over their health and wellbeing.

Inviting patients to read and review their health information is an important way to improve communication between patients and health professionals and to enhance engagement in their own care.

Research continues to show that engaged patients have better health outcomes. Patients who read their notes report that they:

- have improved understanding of their health and medical conditions
- recall their care plan more accurately
- are better prepared for visits
- feel more in control of their care
- take better care of themselves
- take their medications as prescribed more frequently
- and have more successful conversations and stronger relationships with their doctors

The eight (8) types of clinical notes that must be shared are outlined in the United States Core Data for Interoperability (USCDI) and include:

- consultation notes
- discharge summary notes
- history & physical
- imaging narratives
- laboratory report narratives
- pathology report narratives
- procedure notes and
- progress notes

In some situations, there may be reasons why individual notes should not be released. The 21st Century Cures Act states that notes can be blocked from release to Prevent Harm and/or to maintain patient privacy.

The Preventing Harm Exception states that it will not be information blocking if not sharing the note is reasonable and necessary to prevent significant harm to a patient or another person, provided certain conditions are met.

Additional resources are available at www.opennotes.org and Information Blocking | HealthIT.gov∎

Advance Directives

All healthcare institutions receiving Medicare and Medicaid reimbursements are required by the Patient Self Determination Act, a federal regulation, to give written information to all individuals receiving healthcare regarding their right to make decisions about medical treatment. This law also requires healthcare organizations to provide ongoing education about Advance Directives to the community.

All patients, both inpatient and outpatient, are given information about their rights to formulate Advance Directives, such as a Health Care Proxy or Living Will, in addition to the right to consent to a **Do Not Resuscitate (DNR) Order.** Healthcare decisions that should be considered in advance include the right to accept or refuse treatment, the right to withdraw treatment, and the right to decide about life-sustaining or resuscitative measures.

Health Care Proxy: This is a document which delegates the authority to another adult (called the agent) to make the healthcare decisions on behalf of the patient when that adult is incapacitated and unable to make his own decisions. The proxy may include specific instructions about artificial hydration and nutrition, if desired.

Living Will: This is an advance directive which provides specific instructions concerning an adult's wishes about the type of healthcare choices and treatments he does or does not wish to receive. It does not designate an agent to make decisions.

MOLST: Medical Orders for Life Sustaining Treatment. The MOLST form contains valid orders regarding DNR and life-sustaining or resuscitative measures.

and only apply when decision-making capacity is lost. The MOLST applies right now and is not conditional on losing capacity. The attending physician must review the MOLST/DNR for appropriateness at least every 7 days for inpatients and at least every 60 days for patients on an Alternate Level of Care.

Non-Hospital DNR orders must be reviewed by the attending physician each time the patient is examined, whether in the hospital or not, at least every 90 days.

A patient or healthcare agent may revoke or change an Advance Directive at any time, either in writing or verbally to a member of the healthcare team. The declaration is documented in the medical record, the attending physician is notified and the patient is assisted with additional information. If necessary a new Advance Directive is completed.

If a patient for whom a MOLST/ DNR order has been issued is transferred from another hospital, nursing home, or hospice; that order remains in effect until the attending physician ex- amines the patient. It is renewed either based on the documented consent and wishes of the patient, or canceled if no previous consent is documented. Emergency Department personnel must honor MOLST/DNR orders unless it was revoked, or the physician in charge determines that medical circumstances warrant disregarding the order

It is recognized that there are many medical situations in which cure or recovery is not possible. A challenging part of medicine is caring for patients at the end of their lives. Priorities for end of life care are to develop a plan of care which educates patients as to options for care and to provide methods for a dignified, pain and symptom controlled death. Multidisciplinary care is most supportive with medical providers recommending interventions and educating patients and families about actions that are available and possible consequences. Diverse cultural needs influence what certain individuals desire for end of life care. Common cultural issues to consider are language, trust, pain relief, and family decision-making.

Patients in end of life care will be provided the highest quality of care based on the principles below:

- The patient's wishes for medical care will be ascertained and honored to the fullest extent possible.

It is not intended to re- place traditional Advanced Directives.

Traditional Advanced Directives are completed ahead of time and only apply when decision-making capacity is lost. The MOLST applies right now and is not conditional on losing capacity. The attending physician must review the MOLST/DNR for appropriateness at least every 7 days for inpatients and at least every 60 days for patients on an Alternate Level of Care.

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- If the patient has not already done so, they will be offered the opportunity to designate a health care agent to make medical decisions in the event that the patient becomes unable to make medical decisions for him/herself.

- Patient care strategies will be implemented in accordance with the patient's stated wishes and will give priority to comfort, including effective pain control and symptom management.

- Patients should receive palliative measures (pain and symptom management, psychological, social and spiritual sup- port) whether or not they choose to forgo active treatment of the disease. Regardless of the type of pain, a patient's discomfort should never be ignored or minimized as an expected part of the disease and/or dying patients.

- Family members and significant others will be allowed to remain with the patient and participate in care if desired and consistent with the wishes of the patient, to the fullest extent.

- All staff will respect the dignity, privacy and confidentiality of the patient and the family throughout the process.

- The patient and the family will be offered comfort, emotion-al and spiritual support through Social Work, Chaplaincy Services, the care provider and others to ease the burden and support bereavement, including follow-up.

- The patient will be cared for in the setting best able to meet the patient's wishes and needs. Consideration will be given to providing a private room; discontinuing tests, vital signs and dietary restrictions; keeping interruptions to a mini- mum; and other, similar adjustments, as appropriate.

Donation of Anatomical Gifts (Organs & Tissue)

New York State Department of Health regulations require that consent for an anatomical donation must be requested of families of all deceased patients. Procedures to determine medical suitability have been changed in an effort to increase availability of donated tissues and organs. A request for donation is made of families of <u>all </u>deceased patients, unless the organ procurement agency rules out the deceased patient as a suitable donor based on agency criteria.

The regional Donor Recovery Network hot line number: Donor Recovery Network (1-800-774-2729) or Connect Life (1-800-227-4771) must be called within an hour of all actual and for imminent deaths in hospitals regardless of intent to donate or suitability of the donor. Follow unit procedures for calling organ donation service. Admitting or nursing personnel review information regarding the patient with the procurement agency, and consent for donation is sought from the patient's family by a trained requestor or trained staff from the procurement agency, once it has been determined that the deceased meets organ and/or tissue donation criteria per the procurement agency.

- Religious and cultural practices related to end of life care will be respected and supported. Caregivers will continually assess patient and family needs to assure they are met.

- An organization's Ethics Committee is available to patients, families and providers to aid in the discussion or resolution of issues that may arise in the course of care. ■

Some exceptions to donation are:

- an actual notice of contrary intention or opposition by the decedent or an authorized family member
- reasons to believe that an anatomical gift is contrary to the decedent's religious or moral beliefs
- the decedent is deemed medically unsuitable by the procurement agency
- when no family member can be located unless a previous consent for donation by the decedent is in evidence

Potential organ donors are those who experience brain death, and are maintained on mechanical ventilation and treated under specific protocols until organs, such as the heart, lungs, liver, kidneys can be recovered.

Those who experience cardio-pulmonary death, and are not able to be resuscitated, are still potentially suitable donors for tissues, such as eyes, skin, bone, and veins. ■

HIPAA Privacy & Security

HIPAA, the Health Insurance Portability and Accountability Act, was created by Congress in 1996 to help patients maintain their medical history when moving between locations and to have control over how that information is used and shared (verbal, written and electronic).

All healthcare organizations as well as organizations that bill or pay for medical care (such as insurance companies) need to follow HIPAA and train their employees in these regulations.

PHI, Protected Health Information, is defined as individually identifiable information:

- About the physical or mental health or condition of an individual
- About how that health care is delivered and
- Regarding payment for the healthcare of an individual

As a **staff member, volunteer or student**, you are responsible for making sure you do not release PHI to anyone who does not need to know it as part of his or her work. You must also protect PHI that is kept in an electronic format (ePHI) by safeguarding any computer, hand-held electronic device, digital camera or other device that you are responsible for so that PHI is not seen by anyone who does not need the information as part of their job. There are many security policies and procedures organizations must adhere to in order to secure the electronic storage and transmission of ePHI. You also have a responsibility to only release the **minimum necessary information** (the least reasonable amount needed for the purpose) to that person or organization that needs it to do their job.

Under HIPAA, a Patient:

- Must be told (in writing) how their health care information (PHI) may be used
- Has a right to see or obtain copies of their medical records
- Has a right to request an amendment (change) of incorrect/ incomplete information in their records
- Must give authorization before information is released (with a few exceptions)
- Has a right to complain formally if they feel their privacy was not protected

The HIPAA regulations are "a call to action" in the sharing of private information and the creation of safeguards to ensure and guarantee that those people or entities that have a real need for PHI have access and use it responsibly. These regulations work alongside state law, standards of the Joint Commission and the Center for Medicare/Medicaid Services (CMS) that protect patient rights.

Compliance is Mandatory:
Civil monetary penalties range from $100 per violation, with a maximum penalty not to exceed $25,000 per year for each violation.

Criminal penalties for knowing violations include:

> Wrongful disclosure	$50,000 and/or 1 year in prison
> Obtaining information under false pretenses	$100,000 and/or up to 5 years in prison
> Intent to sell	$250,000 and/or up to 10 years in prison.

A confidentiality violation may also result in a Type I recommendation from JOINT COMMISSION or DNV and a citation from CMS.

Minimum Necessary:
Policies must be implemented to limit the uses and disclosures of PHI to the "minimum necessary" amount to achieve the intended purpose. One exception to the minimum necessary requirement is use or disclosure for treatment of the individual.

Privacy Regulations – PHI can be released:
- For treatment, payment or healthcare operations
- By patient authorization
- For required disclosures regardless of a patient's wishes

Exception: Patients must grant authority to disclose PHI when receiving research related care, such as a drug trial.

PHI Released by Patient Authorization
Some examples of release of PHI with signed patient authorization may include:
- For marketing purposes
- For legal purposes
- For research related care (drug trials)
- For disclosures to schools

PHI Released Unless the Patient Directs Otherwise:

- If a patient is listed in the facility's directory, his or her name, location and condition can be released to those who ask for the patient by name.
- If a patient chooses to declare a religious affiliation, the religious clergy can receive limited directory information.
- To a family member or person identified by the patient as being involved in the patient's care.

PHI Released for Required Disclosures Regardless of the Patient's Wishes:

- Child abuse is suspected
- Public Health issues are identified
- Specified law enforcement purposes
- Medical devices/supplies are recalled

Notice of Privacy Practices:

Patients must receive a copy of the Notice of Privacy Practices which outlines:

- How their PHI will be used or disclosed for provision of care, billing purposes and healthcare operations.
- Their right to inspect and request amendments to their healthcare records, and
- How to file a complaint to the Secretary of Health and Human Services, if they suspect violations of the Privacy Rule have occurred.

REMEMBER … any information related to a patient's health cannot be used unless authorized by either the patient or someone acting on the patient's behalf, or unless permitted by regulation.

ACTIVITIES TO WATCH AS YOU WORK WITH PHI

SEEING – What might others see when:
- You have a schedule on a clipboard in the open?
- You send a fax containing PHI?
- Your computer screen is faced outward?
- Printed material is not hidden?
- Schedules are on public walls?
- Patient-related documents are not face down on your desk?
- You leave a copier unattended?
- You are discarding confidential records?

TALKING – What might others hear when:
- You communicate PHI in an open area?
- Don't ask to whom you are speaking to on the phone?
- You share information with someone who doesn't have a need to know?
- Leave a message containing details regarding tests?

HEARING – What might you hear when:
- Overhead pages say names and facts?
- Others do not speak softly or in private places?
- Others are speaking about patients in an open area?

MEDICAL RECORDS – How might others see PHI when:
- PHI is used to find out non-work related information?
- Your password is not a secret?
- You do not check the ID of a person you do not know?
- Your file rooms or cabinets are not kept locked?
- Your computer files are open on your screen?

PORTABLE DEVICES i.e. cell phones, laptop computers, CDs and flash/thumb drives
- **Password protect** your portable devices and change your password frequently.
- **Student cannot store confidential data** on a portable device or medium.
- Exercise great care to **physically protect** portable devices.
- Apply these steps to **all** devices and media, whether **School Of Nursing or privately owned**.
- Students should not use hand held devices for personal use in view of the patients. Cell phones may be used in conference rooms or locker rooms.

Do not take photos of patients or post patient information on social media sites.

Reference: Ramona Nelson, B., Joos, I., & Wolf, N.D. (2012). *Social media for nurses: Educating practitioners and patients in a networked world*. Springer Publishing Company.

De-identification of Protected Health Information

Health information meeting the standard and requirements for de-identification, as defined by the HIPAA privacy regulations, is considered to be health information which is not individually identifiable, and thus is not protected health information (PHI). HIPAA privacy regulation requirements do not apply to de-identified information.

De-identified information does not:
- relate to any individual; and
- cannot be attributed to a specific individual (patient or research subject), and
- there is no reasonable basis to believe that the information can be used to identify an individual—alone or in combination with other information—who is the subject of the information, including relatives, employers or household members of the individual.

Information is considered to be de-identified under HIPAA if **all** of the following 18 identifiers are removed:
1. Names;
2. All geographic subdivisions smaller than a State, including: street address, city, county, precinct, zip codes and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly-available data from the Bureau of Census:
   - the geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000; and the initial three digits of the zip code for all such geo- graphic units containing 20,000 or fewer people is changed to 000.

3. All elements of dates (except year) for dates directly related to an individual, including: birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;
4. Telephone numbers;
5. Fax numbers;
6. E-mail addresses;
7. Social Security numbers;
8. Medical record numbers;
9. Health plan beneficiary numbers;
10. Account numbers;
11. Certificate/license numbers;
12. Vehicle identifiers and serial numbers, including license plate numbers;
13. Device identifiers and serial numbers;
14. Web Universal Resource Locators (URLs);
15. Internet Protocol (IP) address numbers;
16. Biometric identifiers, including finger and voice prints;
17. Full face photographic images and any comparable images; and
18. Any other unique identifying numbers, characteristics or codes ■

Breach of Unsecured PHI

Breach of Unsecured PHI

A breach is the unauthorized acquisition, access, use or disclosure of PHI which compromises the security or privacy of such information.

If a workforce member becomes aware of a possible breach of PHI, the workforce member must **immediately notify** their supervisor or area administrator, who in turn will contact their Privacy Officer, who will determine any necessary reporting requirements.

Possible breaches of PHI may include, but are not limited to the following examples:
- Unauthorized acquisition, access, use or disclosure of PHI without a legitimate business related reason for doing so e.g.,' snooping' in records of friends or family members.

- Lost or stolen computers, data storage devices, paper files etc. containing PHI.
- Evidence of 'hacking' to computer files or websites.
- Misdirected mail, email or faxes.
- Postings to social networking sites, blogs, or text messages.
- Improper disposal of unsecured PHI (computer files, paper, video tapes, discs, medication containers, photos, etc.).

Breaches have consequences:
- For the **patient**, whose privacy and trust in us have been compromised.
- For our **organization**, whose reputation has been tarnished and may have to report the breach to the federal and/or state government.
- For **YOU**, who may be disciplined? ■

Social Media

Web logs, called "blogs," and personal networking online sites (Facebook, YouTube, Twitter, etc.) are a potential source of inappropriate disclosures of protected health information (PHI). Posting information about a patient, **even without using a name**, is a potential violation of HIPAA. This type of disclosure of PHI is not per-mitted without a HIPAA-compliant authorization signed by the patient.

Health care workers who write about their clinical experiences must understand the risk of inappropriately using or disclosing PHI. Even when, for example, the tone of a physician or nurse or student blog is polite or favorable, it can still be a HIPAA violation. Any reference to patient information must be de-identified.

Workforce members who plan to blog or post information to social networking sites must consider their goals and the corresponding risks.

If information is truly de-identified with absolutely no ability to identify the patient, posts about clinical experiences could possibly be permitted, depending on the specific situation. (See De-identification of Protected Health Information above) Remember that the last identifier listed, "any other unique identifying numbers, characteristics or codes," can be any information either alone or together with other data that permits the patient to be identified.

Some individuals have had their place of employment identified through a photo taken at the institution; even references to things like current weather, etc., can begin to zero in on a particular facility. ■

Confidentiality of Patient Related Information

Every patient has a right to privacy and a right to know that the hospital personnel providing care will not share medical information with persons or students not involved in that care. Any information concerning the patient including source of payment, facts documented in the medical record, and information learned from other sources, is to be kept confidential.

Any patient information to which hospital personnel are ex-posed during the course of their work may not be discussed outside the realm of one's work responsibilities.

It is the healthcare worker's responsibility to respect the patient's privacy, and to understand that the patient's right to confidentiality is protected by federal and state statute. Failure to maintain confidentiality can result in disciplinary measures being taken by the hospital. Refrain from discussing patients in public areas or social settings such as corridors, elevators, and cafeterias. It is also the healthcare worker's responsibility to report to the Department Manager any breach of confidential information they encounter.

Confidentiality extends to all forms and formats in which information is maintained and stored. Examples include photocopy, facsimile, electronic and hard copy formats of patient related information. Do not leave medical records open and unattended, or patient data showing on computer screens when un-attended, do not forward patient related information unless authorized to do so (re: via electronic mail) and do not give computer passwords to others. Hospitals have security policies and procedures in place to protect information and promote appropriate use of computer systems including access hard-ware/software, sanctioning data users, Internet use and other aspects of the system. System users must go through educational training to gain access to the system.

Many hospitals require employees, staff, students, and volunteers to review this policy and sign a statement reflecting their understanding of patient confidentiality upon orientation. ■

Confidentiality of HIV Related Information

The following persons are required to understand legal requirements prohibiting unauthorized disclosure of HIV-related information:

Those who order HIV-related tests.

- Those who receive confidential HIV-related information in the course of providing any health or social services
- Those who receive confidential HIV-related information pursuant to a release
- Those who disclose any confidential HIV-related information in the course of providing any health or social services

It is required that hospitals have a policy that includes the following provisions:

- Confidential HIV-related information must be recorded in the medical record so that it is readily accessible to provide proper care and treatment.
- No person who obtains confidential HIV-related information, in the course of providing any health or social service or prior to obtaining a release of confidential HIV-related information, may disclose or be compelled to disclose such information, except as permitted by law.

- All employees, contracted individuals, students, or affiliated persons at the hospital who may have HIV-related information disclosed to them in the course of their duties will receive inservice education regarding the policy.

- A list of job titles and specific employee functions within those titles for which employees are authorized to access such information is maintained by hospital administration. This describes the limits of such access to information, and employees receive this information during orientation, as required by law.

- Only employees, contracted employees, and students who have received such inservice education will be allowed access to confidential HIV-related information while performing authorized functions at a hospital.

The New York State Department of Health is now HIV-testing all newborn PKU samples. This requires hospitals to have a mechanism for written consent by the mother for the testing and the release of information.

Patients are entitled to have pre- and post-test counseling and may choose to have confidential or anonymous HIV testing.

Patients must sign a written consent for HIV testing and release of HIV-related information. There are some exceptions when testing is done without patient consent such as court-ordered testing or testing prior to organ and/or tissue donation. ■

Identifying Suspected Abuse & Neglect

Healthcare providers have the responsibility to identify suspected cases of abuse and provide treatment and means for follow-up, both physically and emotionally. Hospitals must have policies and procedures that direct the caregiver in reporting suspected abuse and caring for patients while pre- serving potential evidence. Child abuse, domestic violence, elder abuse, physical and/or sexual assault are situations that require coordinated efforts of members of the healthcare team, as well as potentially the Department of Social Services and the Police Department.

Child Abuse:

Certain individuals are legally required to report suspected cases of child abuse. The duty to report arises when there is reasonable cause to suspect that a child is being abused, maltreated, or neglected. The reporter does not have to prove that the child is a victim of abuse. Physicians, RNs, social workers, and other designated hospital personnel are mandated to report by law. Students or other affiliated personnel should report objective data to the Nurse Manager or Charge Nurse.

Domestic Violence:

Hospitals are required to assess patients and clients for the possibility of victimization. If any sign of suspected violence is present, hospitals have policies that describe the process to offer assistance to the victim, such as referral to community agencies or the employee's Employee Assistance Program (EAP).

Elder Abuse:

Acts or behavior by a family member or a person providing care, which results in physical or mental harm or neglect of an elderly person, is not uncommon. Adult Protective Services is a community resource that is available to help in these situations. Suspected abuse or neglect should be reported to the instructor and Charge Nurse/Nurse Manager.

Physical Assault:

The hospital's Security Department or local police force, will investigate all incidents in which physical contact with the intent to cause injury is witnessed or reported.

Sexual Assault – Rape:

Healthcare personnel must act sensitively and quickly for successful collection of evidence if a victim has been sexually assaulted. The victim should not be left alone, and specific procedures must be followed for handling the victim's clothes, and when the victim can shower. Rape victims have reported that the collection of evidence can be as traumatic an experience as the sexual assault itself. Specially trained staff is critical to this process. Referral to the Rape Crisis Center or another appropriate community agency is helpful. ■
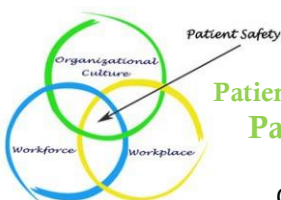
Pain Management

Pain Management standards have been established by the Joint Commission in order to remove barriers to good pain management in healthcare settings. Studies have determined that up to 50% of pain experienced by patients in healthcare settings is not relieved. Pain is often under treated in spite of the availability of effective therapies and pharmacologic treatments.

The Joint Commission and DNV standards recommend that healthcare organizations:

- Recognize the right of patients to appropriate assessment and management of pain

- Assess pain in all patients

- Record the assessment in a way that facilitates regular assessment and follow up

- Educate providers, patients and families about pain and symptom management

- Establish policies that support appropriate prescription or ordering of pain medicines

- Include patient needs for symptom control in discharge planning

- Collect data to monitor effectiveness and appropriateness of pain management

In support of these standards, healthcare organizations are committed to:

- Assessing pain on admission for all patients entering the system using an appropriate pain scale for each of those patients, please see your facilities approved Pain Scales.

- Screening for unrecognized pain with the appropriate scale whenever other vital signs (BP, pulse, temperature, and respiratory rate) are assessed. Pain is recognized as a "Vital Sign".

- Treating moderate to severe levels of pain according to World Health Organization standards.

- Educating patients, families and staff about the patient's right to expect and receive excellent pain management.

- Understanding that, patients almost never (<1%) become addicted to opioids used to intensively treat pain in the acute hospital setting.

- Understanding that pain is whatever the patient says it is.

In Summary:

- Patients and families should be educated and reassured that we are committed to addressing and relieving their pain management problems using all available treatments.

- It is critical to document pain levels and document the reassessment of pain after an intervention.

- Good pain management is associated with improved quality outcomes such as higher patient satisfaction, improved quality of life, earlier mobilization and earlier discharge. ∎

Patient Safety
Patient Safety Goals & General Patient Care

Our healthcare organizations are committed to the improvement of health- care safety and the reduction of medical/healthcare errors by creating cultures of safety. Many organizations are creating cultures of safety through the following:

- Implementation of a non-punitive medical error reporting process. Processes and systems cannot be "fixed" if individuals are fearful of reporting errors or potential errors/near misses.

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

- Refer to, distribution and use, when applicable, y o u r facility's accrediting body guidelines and recommendations.

- Providing patients with educational opportunities to understand how to partner in their healthcare.

- With serious occurrences and near misses, using Root- Cause Analysis methodologies to evaluate and recommend process changes.

- Surveying patients and employees to identify safety improvement opportunities.

Organizations must track, trend, analyze and identify areas where improvements to safety can be implemented.. You have a responsibility to assure a safe environment for patients, visitors, and employees and to report any safety concerns to the charge nurse or department manager. ∎

2022 Hospital National Patient Safety Goals

The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in health care safety and how to solve them.

Identify patients correctly

NPSG.01.01.01
Use at least two ways to identify patients. For example, use the patient's name *and* date of birth. This is done to make sure that each patient gets the correct medicine and treatment.

Improve staff communication

NPSG.02.03.01
Get important test results to the right staff person on time.

Use medicines safely

NPSG.03.04.01
Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.

NPSG.03.05.01
Take extra care with patients who take medicines to thin their blood.

NPSG.03.06.01
Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Give the patient written information about the medicines they need to take. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.

Use alarms safely

NPSG.06.01.01
Make improvements to ensure that alarms on medical equipment are heard and responded to on time.

Prevent infection

NPSG.07.01.01
Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.

Identify patient safety risks

NPSG.15.01.01
Reduce the risk for suicide.

Prevent mistakes in surgery

UP.01.01.01
Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.

UP.01.02.01
Mark the correct place on the patient's body where the surgery is to be done.

UP.01.03.01
Pause before the surgery to make sure that a mistake is not being made.

The Joint Commission

2022 Critical Access Hospital National Patient Safety Goals

The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in health care safety and how to solve them.

Identify patients correctly

NPSG.01.01.01 — Use at least two ways to identify patients. For example, use the patient's name *and* date of birth. This is done to make sure that each patient gets the correct medicine and treatment.

Improve staff communication

NPSG.02.03.01 — Get important test results to the right staff person on time.

Use medicines safely

NPSG.03.04.01 — Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.

NPSG.03.05.01 — Take extra care with patients who take medicines to thin their blood.

NPSG.03.06.01 — Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Give the patient written information about the medicines they need to take. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.

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UP.01.03.01 — Pause before the surgery to make sure that a mistake is not being made.

The Joint Commission

Handoff Communication Policy

"Handoff" communication will take place whenever patient care responsibilities are handed over to another caregiver. This may include temporary or time limited situations.

Description

1. The primary objective of "handoff" communication is to provide accurate information about a patient's care, treatment, current condition, and any recent or anticipated changes in a standardized approach that includes the opportunity to ask questions.

2. Methods for effective handoff communications should include, but are not limited to:

   a. Use of one of the process tools depending on the handoff situation (see below)

   b. Highlighting relevant patient/client historical data, which may include previous care, treatment and services (e.g. medical record current or old)

   c. Face to face communications that include:

      1) A method for the giver to verify the received information including repeat back or read back techniques.
      2) An opportunity for questioning between the giver and the receiver of patient information to review.

   d. If face to face exchange is not possible, some other form of interactive communication e.g. phone call from nurse on sending unit/area to nurse on receiving unit/area utilizing a common source of information e.g. Electronic Medical Record

   e. Minimizing interruptions during hand offs

   f. Electronic documentation with up-to-date information regarding the patient's care, treatment, medications, services and any recent or anticipated changes.

3. If further information or clarification is needed, the clinician can call the person giving report from the sending unit/area/service. At routine shift changes, these should be time allowed for oncoming personnel to ask questions prior to the outgoing staff leaving.

4. Types of handoff situations and relevant process tools defining content:

   a. Temporary Handoff – the example of a temporary handoff is the transfer of pertinent information when a patient is going to and from tests. The primary team responsible for the patient remains un-changed. Pertinent risks that may be identified are: allergies, Isolation / Precautions, risk for fall and any new or recent changes. The process tool for this type of handoff is "SBAR".

      S Situation
      B Background
      A Assessment
      R Recommendation (s)

   b. Shift to Shift – this type of handoff is the most common form that occurs between many types of care-givers including but not limited to; nurses, physicians, and respiratory therapists. The shift to shift handoff is the complete transfer of responsibility for the care and treatment of the patient for a defined period of time. This hand-off is to be done at the bedside.

   c. Service to Service – The service to service handoff requires more detail as a patient is transferring complete responsibility from one provider or service to another. The example of this handoff is ED to inpatient, medicine to surgery, outpatient to inpatient team, or discharge of a patient to a new provider.

   d. Critical Handoff – This type of handoff is designated for the unstable patient that transfers for the OR to the ICU, ICU to the OR, or ED to OR / ICU. ∎

Patient Safety
Anticoagulation Safety

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.

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.

- Check with the unit educator/CNS/leadership or the Affiliated School Coordinator to see which disciplines provide anticoagulation education to patients. All anticoagulation education must be documented on the patient education record in the electronic medical record. ∎

Patient Safety
Prevention of Central Line Associated Bloodstream Infections

An estimated 14,000-28,000 deaths occur annually due to CLABSIs. Bloodstream infections are often serious enough to cause a prolongation of 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. 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

It Is CRUCIAL To Remember:

- CLABSIs are often serious enough to cause a prolongation of 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. ∎

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Physical Restraints & Seclusion

A restraint 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 patients freedom of movement and is not a standard treatment or dosage for the patient's condition.

Items considered weapons by the Centers for Medicare and Medicaid Services (CMS) may not be used on patients in health care settings in the application of restraint or seclusion. According to CMS, "weapons" include but are not limited to pepper gel, batons and also defense techniques such as knee jabs and nerve strikes. These restrictions do not apply to people in the custody of law enforcement or corrections. The use of handcuffs, manacles, shackles, other chain type restraint devices, and defensive techniques such as mandibular holds, hypoglossal holds or arm bar holds, also **may not be** used on patients in health care settings in the application of restraint or seclusion. These restrictions do not apply to people in the custody of law enforcement or corrections.

Physical restraints are applied only after alternatives for modifying patient behavior have been attempted and failed. The least restrictive restraint that achieves safety is used.

- Alternatives that can avoid or minimize restraint use include devices to impede the patient getting up without assistance or chair and bed alarms that notify nursing staff that the patient is trying to get up without assistance.

If restraints are indicated, the provider must be notified and an order obtained. A provider, who determines the necessity for restraint, based on a specific indications must examine the patient per OMH and Joint Commission/DNV regulations.

The provider will write an order for application of the restraints, including the type of restraint needed and will specify a limited period of time for which it is to be used. Restraint orders used for non-violent or non-self-destructive reasons may be valid up to 24 hours.

An assessment of the patient's physical condition is to be completed every 30 minutes or more frequently as warranted by the reason for restraint and type of device used. Physical restraints must be released every two hours and the restrained area assessed. Behavioral restraints, as well as seclusion, require more frequent, every 15 minute, monitoring. Facility policies should be reviewed when caring for a patient in restraint.

Documentation may be on a designated form or in a progress note and includes:

- Description of the behavior that led to the need for restraint
- Description of alternatives to restraints attempted
- Type of restraint as well as date and time of application
- Specific and limited period of time during which the patient is restrained, unless reassessed; and there is no longer a need for restraint
- Explanation given to the patient and/or family
- Frequency of observation and removal of restraint
- Skin condition, hygiene and comfort needs addressed
- Evaluation of ongoing need for restraint

In an emergency a restraint may be applied by a RN, who documents the circumstances requiring the use of restraints. In such emergencies, the hospital has policies regarding immediate provider notification. ∎

Professional Misconduct & the Impaired Professional

New York State Law requires that all actual or suspected cases of professional misconduct be reported to the Office of Professional Medical Conduct; Department of Health (for medical personnel and other licensed professionals); or the Office of Professional Discipline, Department of Education (for nurses). This law applies to licensed professionals who are employed by or in any way associated with the hospital.

Professional misconduct is defined by the New York State Department of Education, and includes the following examples:

- Practicing fraudulently (without a License), negligently, or incompetently
- Practicing while being impaired by alcohol, drugs, or mental instability
- Being convicted of a crime

- Refusing to provide professional service to a person because of such person's gender, race, ethnic or national origin, marital status, sexual orientation, or handicap
- Permitting or assisting an unlicensed person to perform activities requiring a license
- Willfully violating the requirement to report suspected professional misconduct on the part of another professional
- Failure to use appropriate infection control techniques
- Willfully harassing, abusing, or intimidating a patient, either physically or verbally
- Failing to exercise appropriate supervision over persons who are authorized to practice only under the supervision of the licensed professional

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Professional misconduct involves investigation by the office of Professional Discipline, and depending upon the case, may result in suspension or revocation of one's license. It is possible for a professional to be found guilty of professional misconduct even when the issue of negligence has not been proven. ■

Rather than look for acceptable thresholds of error, hospitals seek to do the right thing the first time, reducing waste and redundancy. Statistical methods and measurement tools are used so that clinical decision making is data driven.

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 instructor. Possible indications of impairment include:

- Unkempt appearance, poor hygiene
- Trembling, slurred speech
- Bloodshot or bleary eyes
- Complaints by patients and nurses
- Arguments, bizarre behavior
- Irritability, depression, mood swings
- Irresponsibility, poor memory, poor concentration
- Unexplained accidents or injuries to self
- Neglect of family, isolation from friends
- DWI arrest or DUI violations
- Financial and/or legal problems

- Difficult to contact; won't answer phone or return calls
- Missed appointments, unexplained absences
- Loss of interest in professional activities, social or community affairs
- Neglect of patients, incomplete charting, or neglect of other duties
- Inappropriate treatment or dangerous
- Excessive prescription writing
- Unusually high doses or wastage noted in drug logs
- Noticeable dependency on alcohol or drugs to relieve stress
- Intoxicated at social events or odor of alcohol on breath while on duty

If you suspect someone of professional misconduct or a person who may be impaired, the circumstances should be discussed with the instructor or supervisor/manager. ■

Improving Organizational Performance/Risk Management

Healthcare organizations operate in a rapidly changing environment of managed care and competition. It is required that hospitals regularly measure organizational performance so that customer satisfaction and quality clinical out- comes can be achieved. Performance Improvement is the on- going evaluation process designed and implemented to secure the excellence of healthcare and to meet or exceed the public's perception of quality versus cost of healthcare. In most institutions, the quality of care is measured against pre-established standards of care set forth by a professional agency, a bench- mark institution, or other national data.

Hospitals, in order to be accredited by the Joint Commission, must have a performance improvement plan that focuses on the continuous efforts to improve the quality of care. Continuous Quality Improvement is a system of leadership and performance management that challenges organizations to assess and continuously improve patient care, across several dimensions such as efficiency, effectiveness, timeliness, and respectfulness.

Quality care or service is everyone's responsibility. 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.

Core principles of continuous quality improvement include:

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

The process for improvement that is supported by the Joint Commission is the Plan, Do, Check, Act (PDCA or PDSA) Cycle. When an opportunity for improvement is undertaken:

Plan = Collect data, select an idea on how to improve, set a goal
Do = Implement the Plan

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Check or Study = Collect and evaluate data
Act = Standardize the change, hold the gain

Hospital and departmental quality plans link risk management with the continuous improvement initiatives. Assessment of risk seeks to identify and prevent circumstances that pose a threat to the safety and comfort of patients, visitors, and staff, and to promote wellbeing. Improvements in areas such as medication errors, patient/visitor falls, needle sticks, and back injuries are examples of ways in which the Risk Management program is linked to continuous improvement cycle.

Infection Prevention

1. **General Infection Prevention Practices** safeguard both patients and personnel.
   A. *Infections are transmitted by several different routes* depending upon the specific infection. Infection Prevention policies and precautions are designed to interrupt the transmission by these routes. Some examples of transmission routes are:
   contact: transmission via contaminated hands, needles, contaminated objects. Most infections are spread from person to person on our hands. Examples are staph infections, the common cold, and herpes. Hand hygiene is essential before and after every patient contact **airborne:** transmission via droplets in air produced by coughing or sneezing. Examples are tuberculosis, influenza, and chicken pox.
   vehicle-borne: transmission via contaminated food, water, medications, and IV fluids.
   vector-borne: transmission via insect carriers. Examples are malaria (mosquitoes) and Lyme disease (ticks).

   B. *The system of infection prevention precautions*
   - Includes Universal/Standard Precautions which apply to all patients, and transmission based precautions which apply only to certain patients with particular diseases. These include:
     - contact isolation
     - Enhanced contact isolation
     - respiratory isolation/airborne precautions
     - modified respiratory isolation
     - droplet precautions

   - When in effect, these isolation precautions apply to **all personnel** and are clearly specified on isolation signs located outside the door to the patient's room and at some hospitals, in the patient's chart.

   C. *The purpose of hand washing* is to prevent the spread of infection to patients and employees. Hand washing, the most important method to use to prevent the spread of infection, is done:

- Before and after direct contact with any patient
- Before and after contact with wounds, whether surgical, traumatic, or associated with an invasive procedure
- After direct contact with a patient's blood, secretions, excretions, or drainage
- After contact with articles contaminated with blood, secretions, excretions, or drainage
- Before performing an invasive procedure
- After removing gloves
- After using toilet facilities
- At the start of a shift in a patient care area

Proper Hand Washing:
- Use only hospital-approved, hand-washing products
- Bar soap is not used for personnel hand washing
- Friction is the most important part of hand washing; rub hands together briskly for at least 10 seconds
- Rinse and dry hands thoroughly
- Use only hand lotion that is hospital approved
- Use a hand towel to turn off the hand controls of the faucet
- Personnel are encouraged to use the hospital- approved, waterless hand-washing product (when available). Hand washing using running water and the appropriate hospital-approved soap must be accomplished as soon as possible and is necessary when there is visible soiling of the hand, after using restroom facilities, and after approximately 10 applications of the waterless product.

D. **Fingernail Polish, Artificial/ Enhanced Fingernails, Natural nails**
- Wearing of nail polish is discouraged, including gel polish
- If nail polish is worn, it must be meticulously maintained
- Artificial or enhanced fingernails are prohibited
- Length of natural nail is no longer than ¼ inch from the finger tip

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- The individual staff member and supervisor must assure meticulous hand hygiene

E. **Influenza vaccination** is indicated and strongly recommended for:
- Persons aged > 65 years
- Children 6 to 23 months
- Residents of nursing homes or other long-term care facilities
- Persons of any age with chronic medical conditions including cardiovascular or pulmonary disease, including asthma
- Persons of any age with chronic metabolic diseases: diabetes, renal disease,
- Hemoglobinopathies, or immunosuppression
- Children & adolescents (6 months to 18 years) receiving long-term aspirin therapy
- Pregnant women (all trimesters)

Infection Prevention (continued)
- Healthcare workers
  - Individuals who will be present in any clinical setting during flu season will be required to either have been vaccinated against flu according to current public health guidelines, or provide proof of a medical contraindication to influenza vaccine and wear a surgical or procedure mask whenever they are in an area where they may have contact with a patient.

2. **OSHA Bloodborne Pathogens Standards**
   The Occupational Safety and Health Administration (OSHA) of the federal government requires all hospitals to have policies to protect employees from infection with bloodborne pathogens, especially the viruses which cause AIDS (HIV), hepatitis B, and hepatitis C. These policies are called the Exposure Control Plan. All health care workers are required to comply with these policies and should know where/how to access this in- formation.

   A. The following are key elements of the Exposure Control Plan:
   - *Universal/Standard Precautions* are used with all patients and this means that the blood and body fluids of **all** persons must be considered dangerous. The blood of anyone may be infected with bloodborne pathogens including hepatitis B virus, hepatitis C virus, or HIV, the virus that causes AIDS.
     - **Wash your hands (or if available- use an alcohol based hand solution)** before and after contact with every patient or after handling blood or body fluids.
     - **Gloves** are worn when there is a risk of contact with blood or body fluids. Gloves are worn for invasive procedures (including drawing blood and inserting

IVs), touching mucous membranes, or having contact with open wounds. Hands must be washed after removing gloves.
- **Gowns or Aprons** are worn when there is a risk of soiling clothing with blood or body fluids or when splashing or splattering of blood/body fluids may occur. Water-resistant, cloth isolation gowns and plastic aprons are readily available on all patient units.
- **Face masks and goggles** are worn when splashing, splattering, or spraying of blood or body fluids toward the face may occur. Acceptable eye protection includes goggles, face shields, or glasses with solid shields on the sides (ordinary glasses are **not** acceptable).
- Gloves, gowns, aprons, face masks, and goggles are available in all patient care areas.

- *Sharps* - Accidental needle sticks and other blood exposures are reported among hospital personnel every year. Each exposure means some risk of infection with HIV, hepatitis B, or hepatitis C.

Simple measures will eliminate many needle sticks and injuries with other sharp objects.
- **Do not recap needles**. Many needle sticks occur during attempted recapping of needles. **Exceptions:** *recapping of needles is unavoidable in some situations.* **A one-handed technique** is used for safe re- capping of the needle.
  - Place needle cap on countertop
  - Take hand away from cap and away from needle
  - Holding only the syringe, guide needle into cap
  - Lift up syringe so cap is sitting on needle hub
  - Secure needle cap into place
- **Dispose of all sharps in hospital-provided, hard plastic sharps containers.** Sharps include needles, lancets, scalpel blades, surgical staples and wires, broken/contaminated glass, slides or any other item likely to puncture a bag. Sharps containers are wall-mounted in all patient rooms, and in all other patient care areas. In some hospitals, large, free standing sharps containers are used in selected high volume areas such as ICUs, ORs and Dialysis.
- Everyone is responsible for the proper disposal of sharps which they have used. **Never** leave sharps on bedside tables, in bedding, or on procedures trays for someone else to pick up. **Never** discard sharps into the trash.

- *Blood and body fluid exposure* - If you experience a needle stick or other exposure to blood or body fluids into the mouth, eyes, a cut, or broken skin:
  - **Cleanse** skin with soap and water. For a needle stick, cut, or exposure through broken skin, wash affected area with soap and water, and then rinse

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with hydrogen peroxide, chlorhexidine, or iodophor (betadine). For oral exposure, rinse mouth well with hydrogen peroxide and then water. For eyes, rinse well with sterile saline (after removing contact lenses).

- **Post-exposure evaluation and follow-up** is essential after any exposure. Please report all blood and body fluid exposures underlined immediately.

- *Hepatitis B vaccination*
  - Hepatitis B is a serious bloodborne infection that is preventable by vaccination.
  - The vaccine is highly effective in preventing infection and is very safe.

3. Tuberculosis (TB)

A. TB Transmission

Tuberculosis or TB, is a bacterial infection caused by *Mycobacterium tuberculosis*. The airborne route transmits TB; when a person with active TB infection in the lungs coughs, TB organisms are spread into the surrounding air, and other persons may inhale the TB organisms.

The risk of TB transmission is highest for persons who spend the greatest amount of time near another person with active TB, especially sharing the same household.

B. TB Infection and Disease

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

C. TB Control Program:

- ***Tuberculin blood testing (traditionally T spot or Quantiferon) is*** required of health care workers at the time of employment and is reviewed for need at least annually thereafter.
- You must report to **your instructor** if you have had an unprotected exposure (without mask) to any person with active TB inside or outside the health care facility. Exposures place you at risk for TB, and repeat testing may be necessary

Counseling of health care workers regarding TB:

- Health Care Workers (HCWs) need to know their HIV status if they are at risk for HIV infection and they work in settings where patients who have infectious TB may be encountered, especially drug-resistant TB.
- HCWs who have severely impaired immunity and who

You should be alert to the symptoms of TB. These include persistent cough, fevers, weight loss, night sweats, and coughing up blood. Their physician should see any employee or student with these symptoms.

D. Isolation

a) **Who should be isolated for TB?** Patients who may have pulmonary or laryngeal TB are placed on **Respiratory Isolation /Airborne Precautions.** Clinical criteria which may suggest active pulmonary or laryngeal TB include:

- Productive cough for 3 weeks or longer
- Bloody sputum
- Unexplained night sweats, fever, and/or weight loss
- Cavitary disease on chest X-ray
- Undiagnosed pulmonary disease in a patient with HIV infection or other severe impairment of cell-mediated immunity
- History of exposure to a case of active TB
- History of a positive PPD skin test
- History of previous active TB
- Epidemiological risk factors for TB (imprisonment, homelessness, or from geographic area with high prevalence of TB)

E. Respiratory Isolation/Airborne Precautions re-quires the patient be placed in a negative-pressure isolation room, and particulate respirator masks must be worn by persons entering the room.

- The negative-pressure isolation room helps to prevent flow of contaminated air from the patient's room out into the corridor.
- The particulate respirator mask is designed for high effectiveness. Staff that care for patients with known or suspected TB are evaluated for ability to wear a particulate respirator (N95 mask), fit tested with the N95 mask and educated regarding enhanced respiratory precautions and the appropriate use of respiratory protection. Staff that have not been fit tested and trained for an appropriate respirator do not enter room areas being used for enhanced respiratory isolation.
- For any patient with suspected or known active TB, the door to the room must be kept closed, and the patient must be reminded to cover his/ her mouth when coughing.

Principles of Treatment

- Patients with confirmed or highly suspected active TB are started promptly on appropriate treatment.

Revised: 4/2016, 7/2016, 2/2019, 5/2020, 3/2021, 8/2022; 10/2023; 1/24/2024

COVID-19 Vaccines: per NYS guidelines, all healthcare workers and student performing clinical in New York State, including staff at hospitals and long-term care facilities (LTCF), including nursing homes, adult care, and other congregate care settings, will be required to be vaccinated against COVID-19. The State Department of Health has issued orders requiring all hospital, LTC, and nursing homes mandating employee vaccinations, with limited exceptions.

COVID-19 exposure: The following guidance and process are for any employee that has been directed to occupational (employee) health because of potential COVID-19 exposure, has symptoms of COVID-19, and/or has tested positive for COVID-19.

Process/Guidance

Call your institution's employee health department for clarification on quarantine information, self-monitoring, and return to school/work/clinical. If you travel, per New York State guidelines, you can work as long as you are asymptomatic. After returning from travel, get a COVID-19 test as needed or per current recommendations

CDC Donning & Doffing Procedure
　　　　Click here to watch:
　　　　CDC donning video: https://youtu.be/H4jQUBAlBrI
　　　　CDC doffing video https://youtu.be/PQxOc13DxvQ

1. Guidelines for universal use of masks and face shields:
　　A. Perform hand hygiene
　　B. Put on mask
　　C. Put on your face shield* when entering an aerosolizing procedure

2. If you enter an isolation room for an Aerosolizing procedure

　　A. Take face mask off and put on N95 mask, place face shield on top.

　　B. After exiting room clean face shield and follow re-use instructions for n95.

　　C.

3. Best practices for-use:
　　A. Put on your mask and leave it on.
　　B. Face shields can help protect your mask from being contaminated.
　　C. Avoid touching your masks.

　　D. Discard mask when:

　　　　Contaminated hands have touched inside Wet, soiled, or damaged

Appropriate fit is not maintained

4. Discard face shield, goggles or PAPR shield when:

　　A. Inside cannot be cleaned
　　B. Damaged in any manner
　　C. Foam batting damaged/soiled
　　D. Face shield cracked/ripped
　　E. Chin cuff of PAPR shield not snug to skin

5. Surgical Face Masks

(If facemask must be removed during day):

　　A. Perform hand hygiene.

　　B. Remove mask using ear loops, avoiding touching the exterior of mask

　　C. Assess mask for discard criteria

MASK WORN THE... Wrong way / Correct way

and disinfected with Lysol or diluted household bleach (one part bleach to nine parts water).

A. Hand Washing

1) VNS provides soap and paper towels for use in place of the patient's soap and towels.

   - Hands should be washed when visibly soiled, after removing gloves before and after the care of any patient in the patient's home.

2) Soap and water should be used for hand washing before and after any invasive procedure, dressing change, or contact with patient's blood, secretions or excretions.

3) Waterless hand sanitizer may be used when hands are not visibly soiled, when moving between the laptop and patient, when water is not available, and before entering the home care bag for supplies. Hands should be washed with soap and water as soon as possible.

B. Gloves

1) Disposable gloves should be worn for handling blood, body fluids or when providing direct care for a patient with an open wound, fecal incontinence, diarrhea, or urinary drainage systems.

2) Health care workers with dermatitis, open wounds or exudative lesions on their hands should wear gloves when having direct patient contact.

3) Gloves are recommended for routine diaper changing with infants *in* keeping with Universal Precautions.

4) For antibiotic resistant organisms, determine the site of infection then utilize decision trees to deter- mine *whether contact precautions are needed*

C. Aprons

Disposable aprons will be worn if soiling of clothing caused by splatter with blood or body fluids is likely.

D. Masks, goggles and eyeglasses

1) Masks, goggles or eyeglasses are recommended in settings where spattering of blood or body fluids is likely to occur, or if there is potential for spattering. They are not usually necessary in the home setting unless high-risk procedures are being performed. Masks are recommended for visiting staff when the patient or the caregiver has a productive cough or undiagnosed upper respiratory symptoms.

2) Masks should be used by health care workers if the patient is diagnosed with droplet type infection. For tuberculosis patients that are considered infectious, TB masks are required. Special fit testing is required for use of these masks, known as N-95.

E. Bathrooms

Bathrooms may be shared with other family members. Visibly contaminated toilet facilities should be cleaned

F. Equipment and Environmental Surfaces

1) Disposable items (e.g. blood pressure cuff, stethoscope) should be used whenever possible, especially with patients with VRE, MRSA or ORSA.

2) Non-invasive, reusable equipment that comes in direct contact with patients should be cleaned and disinfected with diluted household bleach, alcohol, or commercial disinfectant cleaning cloths. The nurse will use his/her discretion when this is needed giving consideration to patient's skin integrity, risk of body fluid contamination, etc.

3) Blood or body fluids that have contaminated environmental surfaces should first be removed with absorbent dis- posable toweling. The surfaces should then be cleaned with soap and water or detergent, and decontaminated with fresh germicidal chemical such as Lysol or diluted household bleach. Gloves should be worn during cleaning and decontamination procedures.

G. Waste Disposal

A container lined with an impermeable bag (e.g. plastic) should be available in the patient's room for disposal of dressings, tissues and other disposable items (including BG chemstrips, Ketodiastix; excluding sharps). Waste should be double bagged, secured and placed in a garbage can for disposal.

H. Needles and Syringes Disposal

1) Care should be taken to avoid accidental injury with used needles and sharps, (including lancets, razor blades). Used needles and syringes are not to be re-capped, bent, clipped or broken by hand. Insulin pen needles should be re-capped by the patient whenever possible; if not, caregiver should use one-handed scoop technique to recap the needle for removal. Staff (HHA and PHV) are instructed to use safety lancets in place of patient lancing devices

2) *Professional Disposal of Sharps*
The Agency provides Sharps container with red top for professional use in disposing of all sharps used in the home. Needles, syringes, and safety lancets should immediately be placed in a red puncture-resistant container after use. When filled, the sharps container should be closed to prevent leakage and sent to VNS Supply Dept.

3) *Family Disposal of Sharps*
Professional caregivers will educate patients and families regarding safe disposal of sharps. Puncture resistant containers recommended for home use include plastic detergent and fabric softener bottles with lid secured to avoid accidental exposures.

Revised: 4/2016, 7/2016, 2/2019, 5/2020, 3/2021, 8/2022; 10/2023; 1/24/2024

Infection Prevention in the Home (continued)

Education should include no recapping of needles, immediate disposal of all sharps including lancets, keeping out of reach of children, securing tops to prevent leakage.

3) *Family Disposal of Sharps (continued)*

Disposal of Sharps: Patients and/or family members may take their used sharps to any hospital or nursing home in NYS. They should be instructed to call first for dates and times. Some communities and trash collectors have specific plans in place to pick up medical waste. If an HHA is performing the enhanced task of BG checks, safety lancets are to be disposed of in the patient's sharps container.

I. The Home Care Bag

1) Field staff carry the home care bag into the patient's home on every visit unless one or more of the following conditions exists:

- Poor hygiene and unsanitary conditions identified within the patient's home.
- Rodent or insect infestation identified within the patient's home.
- The patient refuses or makes a request that the bag not be brought into the home.
- The patient suffers from a condition in which presence of the home care bag with therapeutic interaction between patient and staff (i.e. mental illness).
- There is a resistant organism that requires equipment be designated for single patient use only and the environment is likely to be contaminated with the organism.

2) If the home care bag cannot be brought into the patient's home due to one of the above conditions staff making the home visit shall carry all essential items for the visit into the home in a disposable paper bag.

3) In cases where equipment must be dedicated for individual patient use only, (i.e., presence of resistant organisms) a temporary bag of disposable items will remain in the patient's home for staff use at each visit (Contact Precautions Starter Kit). This temporary bag will contain items necessary to make a standard visit such as, but not limited to:

- Disposable blood pressure cuff
- Disposable Stethoscope
- Gloves
- Gowns
- Thermometer
- Hand washing supplies
- Alcohol hand sanitizer

4) Hand washing supplies shall be kept in an easily accessible area of the home care bag. Hands must be washed or sanitized before entering the bag

5) When traveling, the home care bag should be located in the trunk or in an area that is not readily visible or accessible to other persons. The bag should not be left in the vehicle in extreme temperatures, overnight or when the vehicle is unlocked.

6) According to the CDC, there is no evidence suggesting a barrier is needed underneath the home care bag, although a paper barrier can be used per patient request.

7) Techniques to be used with the home care bag:

- One area of the bag shall be dedicated to reusable items such as blood pressure cuffs.
- One area of the bag shall be dedicated to clean, not reusable items such as dressing supplies. Items re-moved from this section of the bag shall not be re-turned to this section.
- After entering the patient's home, place the bag on a clean, dry surface with a barrier between the bag and surface. Avoid soiled areas such as kitchen counters with soiled dishes and food items. Keep out of the reach of children and pets.
- Do not place the bag on the floor.
- Wash hands prior to removing any equipment or supplies from the bag.
- Remove all the necessary equipment for the visit at the start of the visit. Enter the bag as few times as possible.
- Zip the bag closed after removing the necessary items.
- Do not place soiled items/supplies, such as dressings, into the bag. Dispose of such items properly in the patient's home.
- Wash hands before returning items to the proper section of the home care bag and bag is zippered securely.
- Place sharps used during the visit in the sharps container in the reusable section of the home care bag. ∎

Medication Administration

Safe medication administration at all times is paramount. Medications have become a complex industry in which all doctors, licensed practitioners, nurses, and pharmacists must remain diligent at all times in their role in the medication process. A safe and efficient medication process involves safety in all steps: ordering, dispensing, administering and observing of the patient after the medication administration. Medications are only to be pulled from the Medication dispensing system for one patient at a time.

All student nurses who will be administering medications to patients in the student's clinical setting will be expected to have researched the minimum information about the medication(s) prior to the administration that includes: desired action/indications, route and administration options, side effects/adverse reactions, usual dose for patient's age. Your clinical instructor will be reviewing this with you prior to all medication administration.

All student nurses will administer medications under the direct supervision of their clinical instructor from medication preparation to witnessing the administration at the bedside. The clinical instructor is to cosign all student nurse documentation on the medication administration record. Medication administration will be expected using the six "R"s– right patient, right drug, right dose, right route, right time and right documentation.

For RN Capstone/Preceptorship Students: The RN preceptor will oversee a student's medication administration during the capstone or preceptorship experience. The staff nurse is then to cosign the medication administration record with the student.

At no time are student nurses, permitted to:

- Adjust PCA, CADD or epidural medicated pumps
- Administer I.V. push medications (certain hospitals will allow RN students to administer IV push with a faculty member present. Check hospital-specific policy on this prior to any IV push medication).
- hang I.V. medication drip infusions that are listed in policy of the facility to be an R.N. only function
- administer chemotherapy medications

Most facilities have injection needles with the syringes that protect you from needle sticks after the administration of a subcutaneous or intramuscular injection. All students and clinical instructors will be expected to use safety needle devices for medication administration. ∎

Medication Reconciliation & Adverse Medication Reporting

Medication reconciliation, Joint Commission National Patient Safety Goal 03.06.01, requires that healthcare providers "Implement a process for obtaining and documenting a complete list of the patient's current medications upon the patient's admission to the organization and with the involvement of the patient. Medication reconciliation is the process of comparing a patients medication orders to all of the medications the patient has been taking. It should be done at every transition of care in which medications are ordered or existing orders are re-written.

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.

The medication reconciliation process is comprised of five steps:

1) Develop a list of current medications (the Home Medication List)

2) Develop a list of medications to be prescribed (the Medication Reconciliation Order Form)

3) Compare the medications on the two lists

4) Make clinical decisions based on the comparison

5) Communicate the new list to appropriate caregivers and to the patient.

Medication reconciliation involves:

- Verification (collecting an accurate medication history)
- Clarification (ensuring that the medications and doses are appropriate
- Reconciliation (documenting every single change and making sure it is appropriate with all the other medication

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Medication Reconciliation & Adverse Medication Reporting

Information).

It is important to note the full scope of this safety goal: "…across the continuum of care." This means medication reconciliation applies to all care settings—including ambulatory, emergency and urgent care, long-term care, and home care—as well as inpatient service.

It is important to note the full scope of this safety goal: "…across the continuum of care." This means medication reconciliation applies to all care settings—including ambulatory, emergency and urgent care, long-term care, and home care—as well as inpatient services.

Adverse drug reaction (**ADR**) is a term to describe the unwanted, negative consequences sometimes associated with the use of medications. 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. ADR is a particular type of adverse effect. Alternative terms with equivalent meaning to ADR include: **side effect**, adverse event, adverse effect, *etc*.

Consistent with this definition, an allergic reaction (an unusual sensitivity to a medication) and an idiosyncratic reaction (an abnormal susceptibility of an individual to a particular medication) are also ADRs.

Monitoring and reporting ADRs is an imperative component of the hospital's Medication Management process. Tracking and

Examples of ADRs include, but are not limited to:

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

trending ADRs leads to process improvements in medication use which impacts patient safety. For instance, if a hospital notices an increased incidence of falls, by tracking and trending ADR reports, it may be found that certain sedatives are being used inappropriately or in the wrong patient population. Changes can then be made to decrease falls by changing drug therapy. ■

ARE YOU Joint Commission READY?

What is JC?

JC stands for The Joint Commission. The Joint Commission evaluates how well heath 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 Com- mission reviewers comes to health care facilities and observes how care is provided and ensures the organization meets their standards. These surveys are unannounced so organizations, employees, and students need to be ready at all times.

What Do *YOU* Need to *DO*?

Be sure that you:

- Wear your ID badge

- Know the emergency page codes for the facility

- Know the National Patient Safety Goals (NPSGs) and be able to tell and/or show the surveyors how NPSGs are practiced at the facility

- Know the fire safety and emergency information for the facility

- Follow hand hygiene procedures

What Do *YOU* Need to *KNOW*?

- You need to know and follow the hospital policies and procedures.

- You need to know the National Patient Safety Goals. They are available from your instructor and can be found on the Internet through the Joint Commission web-site. You need to know how you comply with the goals in your role.

- Surveyors will meet with all types of hospital staff as they follow or "trace" selected patients as they are moving through the hospital. This review process is called the "tracer methodology."

- If asked a question by the surveyors, be sure that you under-stand the question before answering it. Answer honestly as it relates to the work that you do. Only provide the information asked for—nothing more. 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."

- Patients and staff have the right to complain to the Joint Commission if they have issues or questions about patient safety or services that have been provided by the hospital. Employees have the right to complain to Joint Commission without fear of reprisal from their employer for having re-ported quality of care concerns. ■

DNV READINESS

Are YOU DNV ready?

What is DNV?

DNV stands for Det Norske Veritas, an organization founded in Oslo, Norway in 1864. Originally focused on the marine shipping and safety industry, DNV has grown into a worldwide quality assurance and risk management company aimed at safeguarding life, property and the environment.

With regards to healthcare, DNV ensures we continually deliver high quality safe patient care. The method used to evaluate how well an organization is providing safe, high quality care is a survey. A team of DNV reviewers come to health care facilities and observe how care is provided and ensure the organization meets their standards. DNV's NIAHO standards are approved by CMS and are utilized to measure how well an organization provides patient care services. These surveys are unannounced so organizations, employees and students need to be ready at all times.

What do YOU need to do?
Be sure that you:
- Wear your ID badge
- Know the emergency page codes for the facility
- Know the Performance Improvement activities occurring in your department and/or facility
- Know the fire safety and emergency information for the facility
- Follow hand hygiene procedures
- services that have been provided by the hospital. Employees have the right to complain as well without fear of reprisal from their employer for having reported quality of care concerns.

What YOU need to know?
- You need to know and follow all RRH, facility specific, and department level policies and procedures.
- Surveyors will meet with all types of hospital staff as they follow or "trace" selected patients as they are moving through the hospital.

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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. Only provide the information asked for- nothing more. 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."

Patients and staff have the right to complain to DNV, Joint Commission, DOH, or Medicare. ■

Professional Boundaries in Behavioral Health

While it is recognized that students may not be employed by the health system nor yet have a license, they are required to adhere to and understand professional boundaries in programs that serve a vulnerable population, such as mental health and addiction recovery.

Professional boundaries must be maintained at all times, including when a patient is no longer an active patient and/or when a rotation has ended.

conduct that is considered outside of professional boundaries and therefore prohibited includes, but is not limited to sexual contact, abusive language, harmful physical contact or contact outside of the work setting in person, phone, email or social media).

If a pre-existing relationship exists with a patient or if a student is unclear if conduct is considered outside of professional boundaries, the student should consult with their program or instructor. ■

Reporting Sexual Harassment, Sexual Assault
(for students at URMC only)

The University encourages all individuals who believe they have been subject to sexual harassment or discrimination—including sexual assault, dating violence, domestic violence, and/or stalking—to promptly report the alleged incident to University Public Safety, the Title IX Coordinator, or the Dean (or Dean of Students Office) of any of the University's schools. The Title IX Coordinator can help individuals understand their options, rights, and available support services on-campus, and can assist with the on-campus reporting process; University Public Safety can assist in making a report to other area law enforcement agencies.

The Title IX Coordinator
Julia Green is the Title IX Coordinator for the University. She can be reached by phone at 585-275-1654 or via e-mail at julia.green@rochester.edu. Ms. Green is available to students, staff, and faculty to help clarify the process for making

complaints, and to help address questions or reports regarding sexual harassment and assault, including dating and domestic violence and stalking. Ms. Green can provide information about how to report an incident to either the police or to a University official.

As Title IX Coordinator, Ms. Green and her staff educate the University community about sexual harassment and assault issues and can be consulted about questions or concerns regarding the relevant policies and processes.

Relevant Policies
The University Title IX Policy outlines the policies and procedures that govern the University's grievance process to address complaints of Sexual Harassment, as that term is defined in the Title IX Regulations (34 C.F.R. Part 106) and in the University

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Title IX Policy.

The University's Student Sexual Misconduct Policy (SSMP) describes additional, prohibited sex-based student behaviors that are not covered by the University Title IX Policy, as well as the policies and procedures that govern investigation and decision making for complaints alleging these behaviors by students.

The University Policy Against Discrimination and Harassment (PADH) prohibits discrimination and harassment based on a number of protected classes, including sex. The PADH outlines the process the University uses to investigate complaints of harassment and discrimination against faculty, staff, visitors, patients and guests, to the extent the behavior is not covered by the Title IX Policy. This includes complaints brought by students, but not against students.

Overview of investigation and decision-making processes
In general, upon receiving a report the University may conduct an investigation, depending in part on the complaining party's wishes. University investigations are prompt, fair and impartial, overseen by the Title IX Coordinator and/or Director of EEO Investigations (PADH), and conducted by investigators who receive annual training on, among other relevant topics, relevant University policies and issues related to sexual harassment, dating and domestic violence, sexual assault, and stalking (behaviors referred to as sexual misconduct). These investigators are trained in conducting investigations in a manner that protects the safety of parties and promotes accountability.

In Title IX and SSMP matters, after gathering all of the relevant information and evidence from a variety of sources, as applicable, the investigators will create an investigation report summarizing all such information and evidence. In some cases, that report is submitted to a decision maker for adjudication, either through a live hearing or an administrative hearing; the type of hearing depends on a number of factors, including the type of misconduct alleged and status of involved parties. Other cases may be resolved through an informal process with all parties' voluntary consent and agreement, again depending on the type of misconduct alleged and status of involved parties. In cases that proceed to a hearing, the decision maker/adjudicator evaluates the investigation report and evidence and may take testimony from parties and witnesses, and then uses the preponderance of evidence standard (more likely than not) to determine whether or not the conduct occurred as alleged, and if so, whether that
conduct violates University policies.

The process for PADH matters differs in that the investigators evaluate whether the allegations are or are not substantiated by a preponderance of the evidence gathered and present these findings in an investigation report. The report is provided to a

Revised: 4/2016, 7/2016, 2/2019, 5/2020, 3/2021, 8/2022; 10/2023; 1/24/2024

determination panel, which then applies the PADH to the factual findings to decide whether University policy was violated.

Potential Outcomes
Student violations of the Title IX Policy or Student Sexual Misconduct Policy may result in outcomes including, but not limited to: probation, suspension or expulsion from the University.

Employee violations of the Title IX Policy may result in outcomes including, but not limited to: training, discipline, suspension, demotion or termination from the University. Employee violations of the PADH may result in outcomes including, but not limited to: adverse employment action including, but not limited to, written discipline through termination of employment and a ban from University of Rochester property.

On-campus Confidential Resources
The University Counseling Center, the Employee Assistance Program and the Chaplains are also available to discuss questions or problems concerning personal relationships and/or sexual harassment, sexual assault, dating or domestic violence and stalking. These counseling services offer confidential, personal counseling and do not have the authority to discipline, expel or prosecute individuals.

External Confidential Resources
Students, faculty and staff who wish to seek confidential assistance without the University's involvement may contact a number of Rochester area resources including:

- Lifeline 585-275-5151 or Dial 2-1-1
- RESTORE 585-546-2777
- Willow Domestic Violence Center 585-222-7233
- RESOLVE 585-425-1580
- Rochester Police Victim Assistance Unit 585-428-6630

Definitions
SEXUAL HARASSMENT
The University's definition of sexual harassment is defined in the University's Title IX Policy, Policy Against Discrimination and Harassment and in the Student Sexual Misconduct Policy, all of which are available online.

Depending on the facts and circumstances, the following behaviors may constitute sexual harassment:

- sexually degrading words or gestures
- verbal sexual abuse or harassment
- offensive sexual graffiti, pictures, or cartoons
- subtle pressure for sexual activity
- leering or ogling

- disparaging remarks to a person about their gender or gender identity
- unnecessary touching, patting, pinching, or brushing
- stalking, telephone, and/or computer harassment
- forced sexual contact including sexual assault and rape
- dating or domestic violence

SEXUAL ASSAULT

University Policy defines sexual assault as any sexual act directed against another person, without the consent of that person, including instances where the person is incapable of giving consent. Sexual assault includes: rape (the penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of that person), fondling (the touching of the private body parts of another person for the purpose of sexual gratification, without the consent of that person), incest (sexual intercourse between persons who are related to each other within the degrees wherein marriage is prohibited by law), statutory rape (sexual intercourse with a person who is under the statutory age of consent. In New York, the statutory age of consent is 17 years old.)

Forcing someone to have sexual intercourse or engage in sexual contact is against the law. According to New York State law, rape occurs when a person is forced to have sexual intercourse or if she or he is nonconsenting, unable to consent, or fearful for life and safety. The force can be any amount, real or threatened, that places a person in fear of injury or fear for their life. A perpetrator does not have to use a weapon or cause physical harm to make the victim fear for her or his safety. A person is legally unable to consent if incapacitated due to drug or alcohol consumption, or being physically helpless, mentally incompetent, asleep, unconscious, or less than 17 years old. Depending on the age of those involved, amount of force used, type of sexual contact, and other factors, a perpetrator may be charged with sexual misconduct, rape, sodomy, and/or sexual abuse. These are crimes with penalties up to 25 years imprisonment and $5,000 fine.

DOMESTIC/DATING VIOLENCE

University Policy defines dating violence as violence committed by a person who is or has been in a social relationship of a romantic or intimate nature with the victim. The existence of such a relationship shall be determined based on a consideration of the following factors: the length of the relationship, the type of the relationship, and the frequency of interaction between the persons involved in the relationship.

University Policy defines domestic violence as felony or misdemeanor crimes of violence committed by: a current or former spouse or intimate partner of the victim, a person with whom the victim shares a child in common, a person who is cohabitating with or has cohabitated with the victim as a spouse or intimate partner, a person similarly situated to a spouse of the victim under the domestic or family violence laws of the jurisdiction receiving grant monies, or any other person against an adult or youth victim who is protected from that person's acts under the domestic or family violence laws of the jurisdiction.

According to New York State law, dating/domestic violence can be defined as any offense that a person might be charged with when one member in a household/relationship inflicts harm against another. Charges may include assault and attempted assault, menacing, harassment/aggravated harassment, disorderly conduct, stalking, reckless endangerment and more. Penalties will depend on severity of injuries, if any, whether minors were present, and if restraining or protective orders were violated.

STALKING

University Policy defines stalking as engaging in a course of conduct directed at a specific person that would cause a reasonable person to fear for their safety or the safety of others; or suffer substantial emotional distress.

According to New York State law, stalking can be defined as engaging in a course of conduct directed at a specific person which is likely to cause fear of harm to the physical health, safety or property of such person. Conduct may consist of following, telephoning or initiating communication or contact. Sanctions range from up to 3 months in jail, to up to 7 years in prison, depending upon severity of offense.

If you have been subjected to dating violence, domestic violence, sexual assault or stalking…

- Call Public Safety at 585-275-3333 if you are on campus or the local police at 911 if you are off campus. You can notify Public Safety and the police even if you do not wish to file an official report or pursue criminal charges. Specially selected University Public Safety staff are available to work with you throughout the process.
- Get medical care as soon as possible. Do not shower, bathe, douche, change your clothes, brush your teeth, or eat until after you have been examined for physical injury and have discussed your medical options.
- If you believe you are the victim of stalking, seek a protective order limiting the ability of the alleged stalker to contact you in any way. University Public Safety (585-275-3333), the Rochester Police Department's Victim Assistance Unit (585-428-6630) and Legal Aid Society (585-295-5751) can assist you in obtaining a protective order from Criminal or Family Court. If you obtain an order of protection, you must bring the order to University Public Safety as quickly as possible. Upon notice of the order, the University will enforce the any

provisions that apply on campus. The Judicial Officer for the University or the Title IX Coordinator can also issue Active Avoidance Orders that set expectations for no contact between you and the alleged stalker on campus.

Please note that Active Avoidance Orders are not legal instruments and are only enforceable through the University's internal adjudication processes.

Office of the Medicaid Inspector General (OMIG) Information
(for students at URMedicine only)

For information on the University of Rochester's Compliance Program and to comply with new OMIG regulations, please visit https://www.urmc.rochester.edu/compliance-office/vendors-contractors.aspx

Please click on the hospital that you will be visiting.