ANNUAL MANDATORY EDUCATION

2017
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* - indicates updated for 2017
ORGANIZATIONAL OVERVIEW
SUNY Downstate Medical Center
Brooklyn's Academic Medical Center

Mission

- To provide outstanding education of physicians, scientists, nurses and other healthcare professionals.
- To advance knowledge through cutting edge research and translate it into practice.
- To care for and improve the lives of our globally diverse communities.
- To foster an environment that embraces cultural diversity.
SUNY Downstate Medical Center
Brooklyn's Academic Medical Center

Vision

SUNY Downstate will be nationally recognized for improving people's lives by providing excellent education for healthcare professionals, advancing research in biomedical science, health care and public health, and delivering the highest quality, patient-centered care.
SUNY Downstate Medical Center
Brooklyn's Academic Medical Center

**Values**
- **Pride**
  - to take satisfaction in the work we do every day, and to value our collective contributions to the Downstate community.

**Professionalism**
- We commit to the highest standards of ethical behavior and exemplary performance in education, research, and patient care.

**Respect**
- We value the contributions, ideas and opinions of our students, coworkers, colleagues, patients and partnering organizations.
SUNY Downstate Medical Center
Brooklyn's Academic Medical Center

Values
- Innovation
  - We research and develop new and creative approaches and services for the anticipated changes in healthcare.

Diversity
- We embrace our rich diversity and commit to an inclusive and nurturing environment.

Excellence
- We commit to providing the highest quality of education and service to our students, patients and community by holding ourselves, our coworkers and our leaders to high standards of performance.
STRATEGIC PLAN

Guided by our mission and vision, our strategic plan focuses on:

- community needs - by providing accessible, timely, appropriate, and fiscally sound health care services
- collaboration and partnership to strengthen our clinical enterprise and meeting our customers’ expectations
Performance Improvement means ..... 

- Doing the Right Thing and Doing the Right Thing Well!
- The goal of improving organizational performance is to continuously improve patient health outcomes by
  - the *availability* of appropriate care to meet the patient’s needs
  - the *timeliness* of care
  - the *effectiveness* of care to achieve desired health outcomes
  - the *continuity* of care provided to the patient in collaboration with other services, practitioners, and providers over time
PDCA

- How do we do this?
  - **Plan**
    - plan the improvement and the data collection.
  - **Do**
    - do the improvement and the data collection.
  - **Check**
    - check the results of the implementation.
  - **Act**
    - act to hold the gain and continue improvement.
Performance Improvement means that We work as part of a team!

- Teambuilding and interdisciplinary collaboration mean
  - involving other departments, services, and disciplines in addressing issues or problems that need improvement
    - team members may be ancillary, professional or administrative staff
  - working together to find solutions
  - making recommendations to the appropriate personnel
  - being responsible for monitoring recommendations when they are implemented
  - escalating problems/issues that need attention at a higher level
CORE COMPETENCIES
Our 7 Core Competencies Are

1. Customer Service
   demonstrating respect and courtesy to all

2. Communication
   communicating effectively with customers, visitors, patients, and staff

3. Quality Management
   Delivering the highest standard of care

4. Resource Management
   taking an active role in managing resources
Our 7 Core Competencies Are

5. **Personal and Professional Development**
   taking an active role in one’s own learning

6. **Civility**
   using ethical principals to guide decisions and actions consistent with DMC operating goals and objectives

7. **Safety Management**
   maintaining a safe and efficient work environment
PRINCIPLES OF BEHAVIOR
Service Excellence

• Pillars of Excellence
  – People
  – Service
  – Quality
  – Community
  – Finance
  – Growth

• Best Place for Patients to Receive Care
• Best Place for Employees to Work
• Best Place for Physicians to Practice Medicine

Principles of Behavior
Principles of Behavior

- Create positive first impressions
- Treat everyone with respect
- Communicate compassionately and effectively
- Acknowledge, Apologize, and Amend
- Maintain a safe environment
- Protect confidentiality and privacy
Corporate Compliance

The 8 Elements of DMC’s Compliance Program and Workforce responsibilities –
Presented by the Office of Compliance & Audit Services (OCAS)

1. **Written Policies & Procedures:** DMC’s Compliance Program Document and Code of Ethics & Business Conduct outline the general operations and employee responsibilities in maintaining compliance.

2. **DMC’s Compliance Officer:** The VP for OCAS is responsible for the daily operations of the Program and reports to the President of DMC as well as an executive committee.

3. **Training & Education:** General / specific training is conducted based on role. This presentation is part of your Compliance Education!

4. **Open Lines of Communication:** OCAS is a great resource if you have questions or need guidance. The dept.’s Table of Organization, including contact information is available on our website! You can also call or web-report (confidentially and anonymously) through the Compliance Hotline.

5. **Good Faith Participation:** All workforce members are required to participate in DMC’s Compliance Program. Disciplinary measures will be enforced for failure to report possible violations and/or non-compliant behavior.

6. **Auditing / Monitoring:** OCAS annual work plans are developed to identify compliance risk areas throughout the organization.

7. **Investigation and Remediation:** OCAS works closely with many other departments including Human Resources, Labor Relations, IT and Counsel’s Office to investigation and remedy identified issues.

8. **Non-Intimidation & Non-Retaliation:** OCAS works to protect the confidentiality and anonymity of reporters. Retaliation for good faith participation in DMC’s Compliance Program is not tolerated.
Welcome to OCAS - the Office of Compliance and Audit Service website

State University of New York Downstate Medical Center (SUNY DMC) is proud of its long tradition of ethical and responsible conduct and is committed to continuing to conduct its business lawfully and ethically. Each member of SUNY DMC is expected to adhere to this high standard whenever he or she acts on behalf of SUNY DMC. This includes, but is not limited to, when dealing with other employees, patients and their families, vendors, government regulators or the general public. Violations of legal or ethical requirements jeopardize the welfare of SUNY DMC, its employees, patients and the communities it serves.

The Compliance Program is intended to define the conduct expected of colleagues and employees, to provide guidance on how to resolve questions regarding legal and ethical issues, and to establish a mechanism for reporting of possible violations of law or ethical principles within SUNY DMC.

The Compliance Program applies to all SUNY DMC entities, including the Colleges of Medicine, Nursing and Health Related Professions, University Physicians of Brooklyn, Clinical Practice Management Plans, University Hospital of Brooklyn and the Research Foundation.

Please feel free to contact the Office of Compliance & Audit Services at (718) 270-4033 and use this website to support your compliance activities. Compliance is everyone's responsibility.

OCAS Divisions

The Office of Compliance and Audit Services (OCAS) serves the entire SUNY Downstate Medical Center and includes the following divisions:

- Clinical Reimbursement Division x4327
- HIPAA x0734
- Internal Audit Division x4033
- Research Compliance Division x7470
- Internal Control Program x4033
- Compliance Coordination Division x2095
Code of Conduct Guidelines

- Compliance with Laws and Regulations
- Adherence to Ethical Standards
- Patient Care
- Non-Discrimination
- Confidentiality
- Record Accuracy and Retention
- Protection of Assets
- Avoidance of Conflict of Interest
- Business Relationships
- Academic/Research Integrity
- Environmental Laws
- Occupational Safety
- Maintenance of a Drug and Alcohol Free Workplace
Code of Conduct: Discipline for Violations

DMC will take disciplinary action, including termination when appropriate, against any workforce member who violates legal requirements or institutional policies, including anyone who fails to report violations or retaliates against any individual for reporting a possible violation in good faith.
Deficit Reduction Act (DRA)  
Detection & Prevention of Fraud, Waste & Abuse

• DMC is committed to preventing the submission of false claims for payment from a Federally or State funded healthcare program (Medicare/ Medicaid).

• The DRA requires education on the Federal and State laws regarding fraud and abuse, whistleblower protections under these laws and DMC’s Compliance policies in preventing and detecting fraud, waste and abuse.
DRA Federal & State Laws

- Federal False Claims Act
- New York False Claims Act
- New York State Finance Law

A false claim is a violation of State and Federal Law. Civil, administrative and criminal penalties may be levied based on the assessment of the following factors:

- Knowingly presenting a false claim for payment
- Knowingly making, using or causing a false statement to get a false claim paid;
- Conspiring to defraud; or
- Knowingly making, using or causing a false statement to conceal, avoid or decrease an obligation to pay.

Violations may include up to $12,000 per false claim and exclusion from Federal health care programs.

Private persons are eligible to file qui tam/whistleblower lawsuits (without threat of employer retaliation) on behalf of the Federal government.

If successful, 15-30% of recoveries may be awarded.

These laws establish liability for any person who engages in unlawful acts with respect to Federal, State or local government.
DRA Federal & State Laws – Other Applicable Laws

- Federal Program Fraud Civil Remedies Act
- New York Social Services Law
- New York Penal Law
- New York Labor Law

**EXAMPLES OF FALSE CLAIMS:**
- A physician billing Medicare / Medicaid for medical services not provided;
- A government contractor who submits false records that indicate compliance with contractual or regulatory requirements;
- A hospital that retains interim payments from Medicare / Medicaid throughout the year and then knowingly files a false cost report at the end of the year in order to avoid making a refund.

True  False
Conflicts of Interest

A conflict of interest occurs when:

• An official's private interests may benefit from his/her public actions.

• The person is in a position of trust which requires him/her to exercise judgment on behalf of others (people, institutions, etc.) and also has interests or obligations of the sort that might interfere with the exercise of judgment, and which the person is morally required to either avoid or openly acknowledge.
Conflict of Interest

No Officer or Employee of a state agency...

• Should participate in any activity that may impair independence of judgment in the exercise of official duties
• Should participate in any activity that will require disclosure of confidential information
• Should disclose confidential information or use such information for personal interests or gains
• Should use their position to secure unwarranted privileges or exemptions
• Should engage in any activity that may have a direct or indirect financial interest and conflict with the exercise of official duties
• Should permit themselves to be improperly influenced in the exercise of official duties
• Should make personal investments that may pose a conflict of interest between conducting official duties and private interests
• Should pursue a course of conduct that will raise suspicion among the public that is likely to be perceived as a violation of trust
• Should engage in any activities that may result in personal financial gain that result from being an officer or employee of a state agency
Examples of Professional Misconduct include:

- Obtaining a license fraudulently.
- Practicing a profession while impaired by alcohol, drugs, physical, or mental disability.
- Having been found guilty of professional misconduct in another state.
- Permitting, aiding or abetting an unlicensed person to perform activities requiring a license.
- Practicing your profession with gross incompetence or gross negligence.
Reporting Violations

Employees must report real or suspected violations regarding:
• Code of Ethics & Business Conduct;
• Detection, Prevention of Fraud, Waste & Abuse (DRA);
• Conflicts of Interest; or
• Professional Misconduct.

Reports can be made to:
• Supervisor or responsible VP;
• Chief Compliance Officer;
• SUNY Counsel’s Office; or
• DMC’s Compliance Hotline (anonymous).
DMC’s confidential Compliance Line is a 24/7 hotline service available as an internal reporting mechanism for reporting illegal or unethical conduct.

If you become aware of a situation that may jeopardize DMC’s ethical integrity, it is up to you to report it!

• Call: Compliance Line (877)-349-SUNY; or
• Click on “Compliance Line” link on DMC webpage @ www.downstate.edu
Patient’s Bill of Rights
Patient’s Rights

- All patients have rights
- Health care institutions must
  - advise patients of their rights under state law and hospital policy
  - provide services to patients who have physical, hearing, and speech impairments

- If the patient is unable to make decisions for himself/herself, or if the patient is a minor, these rights can be exercised on the patient’s behalf by a designated surrogate or proxy decision maker.
1. Understand and use these rights. The hospital must provide assistance, including an interpreter, to help you understand your rights.

2. Receive treatment without discrimination as to race, 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 you need it.

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

6. Know the names, positions, and functions of any hospital staff involved in your care and refuse their treatment, examination, or observation.
The patient has the right to

... 

7. Receive complete information about your diagnosis, treatment, and prognosis.

8. Receive all information you need to give informed consent for any proposed treatment or procedure.

9. Receive all information you need to give informed consent for an order not to resuscitate.

10. Refuse treatment and be told what effect your decision may have on your health.

11. Refuse to take part in research.

12. Request privacy while in the hospital and confidentiality of all information and records regarding your care.
The patient has the right to ...

13. Participate in all decisions about your treatment and discharge from the hospital. The hospital must provide you with a written discharge plan and written description of how you can appeal your discharge.


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

16. Complain, without fear of reprisals, about the care and services you are receiving.

17. Authorize those family members who will be given priority to visit based on your ability to receive visitors.

18. Make known your wishes in regard to organ donation.
Patient Feedback
Patient Complaint Management

The policy for patient complaint management recognizes and supports the rights of the patients, their families and/or significant others to freely express concerns and/or complain about the care of services received.
Who Manages and Coordinates Patient Complaints?

- Director of Patient Relations (ext 1111)
- All Complaints are forwarded to appropriate department heads for review and action
- Handled accordingly to DMC policy on confidentiality
Responsibility of DMC Employees, Volunteers, and Contract Personnel

• All complaints are taken seriously and must be reported to immediate supervisor
• Addressing and resolving complaints must be facilitated at the unit, service or departmental level
• If attempts to resolve complaints fail, refer to Patient Relations
• There is a difference between a complaint and a grievance

  - **Complaint** – a request or concern that is resolved at the time of the complaint by the frontline or supervisory staff

  - **Grievance** – a complaint that is not resolved at the time of the complaint by the frontline or supervisory staff. Complaints alleging abuse/neglect, Medicare billing issues, or where the patient/family feels they are not receiving safe, quality care must be handled as grievances

    • **A written complaint is always considered a grievance**
Regulatory and Accreditation Agencies
Regulatory and Accreditation Agencies

- To protect the safety of patients and employees, the medical center must comply with the standards and guidelines set forth by the following regulatory and accreditation standards
  - The Joint Commission (TJC - formerly JCAHO)
  - NYS-DOH
  - CMS
  - EMTALA
EMTALA

- EMTALA stands for the Emergency Medical Treatment and Active Labor Act
  - Also known as the Patient Transfer Act or the Anti-Dumping Law

- Requires a hospital to provide an appropriate medical screening examination to any person who comes to the hospital emergency department and requests treatment or an examination for a medical condition
EMTALA

• If the examination reveals an emergency medical condition, the hospital must also provide either necessary stabilizing treatment or an appropriate transfer to another medical facility.

• Applies to all hospitals that participate in the Medicare program and offer emergency services and covers all patients treated at those hospitals, not just those who receive Medicare benefits.
EMTALA

• All SUNY Downstate Medical Center and University Hospital of Brooklyn employees, staff, and physicians are responsible for ensuring that EMTALA regulations are followed

• Examples of Emergency Medical Conditions
  - emergency condition
    • Acute MI (Heart Attack), Stroke, Seizure, Pain
  - condition that may place the patient’s health in jeopardy
    • psychiatric condition, substance abuse
  - condition that threatens to impair bodily functions unless immediate medical attention is provided
Medical Screening Examination (MSE) Process

- The MSE may never be delayed to inquire about financial or insurance information
- The MSE must be conducted by a qualified medical professional
- The facility must provide appropriate services to the patient in order to evaluate, treat or stabilize the emergency medical condition
- If the MSE reveals that no emergency medical condition exists, EMTALA regulations no longer apply
- Once a patient has been evaluated, treated, and admitted to the hospital for acute, inpatient care, EMTALA regulations no longer apply
Center for Medicare and Medicaid Services – CMS

A federal agency within the U.S. Department of Health and Human Services that is responsible for

– overseeing Medicare & Medicaid
– ensuring that hospitals comply with the conditions of participation for Medicare programs
New York State
Department of Health-NYSDOH

• The NYSDOH is charged with assessing hospital compliance with health care and safety-related Rules and Regulations through routine surveys, investigations of patient complaints, and/or incidents reported by the facility through NYPORTS (New York Patient Occurrence and Tracking System)

• All hospitals in New York State must comply with the established New York Code Rules and Regulations
The Joint Commission

The Joint Commission is an accreditation agency that assesses hospital compliance with established functions and guidelines related to:

- Ethics, Rights, and Responsibilities
- Provision of Care, Treatment, and Services
- Competency and Credentialing
- Medication Management
- Surveillance, Prevention, and Infection Control
- Leadership
- Management of the Environment of Care
- Management of Human Resources
- Management of Information
- Medical Staff
- Nursing Staff
Patient Safety Overview

Muhammad Islam, MBBS, MS, MCH, LSSBB
Director of Patient Safety
SUNY Downstate Medical Center
Definition:

- **Patient Safety** is defined as the avoidance and prevention of patient injuries or adverse events resulting from the processes of health care delivery
- **Patient Safety Event:** An event, incident, or condition that could have resulted or did result in harm to a patient

Patient Safety Program focuses on, but is not limited to:

- Assessing culture of safety in the hospital
- Identifying risk points, development & implementation of action plans, and sustaining the improvements
- Compliance with the Joint Commission standards for National Patient Safety Goals
Culture of Safety

- Conduct a Culture of Safety survey
- Disclosure of any adverse medical event to appropriate family member(s) of the patient
- Incident reporting process for medical event (Incident Report Form is available electronically on hospital desktops) (reporting of near-miss/ good catch to harmful event)
- Root Cause Analysis (RCA) to focus on the system, not to blame a person
- Failure Mode Effect Analysis to ensure system-based improvement.
- Staff participation is strongly encouraged in all patient safety activities
- Implementation of Behavioral Safety Program
Goal #1: Improve Accuracy of Patient Identification

Use at least two patient identifiers – preferably an alphanumeric process (Alphabetical- Patient’s Name, & Numerical- Pt’s Date of Birth) (NOT the Location or Room number) during:

- Prescribing / Administering Medication
- Treatment and/or ordering for any diagnostic procedures (i.e., CT-Scan, MRI, X-Ray, prior to initiating Hemodialysis)
- Labeling containers used for blood and other specimens in presence of a patient with the correct label
- Completing the request for Blood or Blood Component Order Form with the correct patient information to avoid any WBIT (wrong blood in tube)
National Patient Safety Goals 2017

are developed by the Joint Commission to identify & prevent the most common medical Errors that may cause patient harm during patient care.

Goal #1: Improve Accuracy of Patient Identification

* Patient Registration
* Patient’s Dietary request and food service
* Deceased Donor Tissue Identification, Recipient’s medical record tissue type and unique identifier
* Storage of Patient’s body in the Morgue
* Patient Transport
* Receiving patient at ED Triage
* Scheduling for clinic appointment and OR Reservation Form
Goal #2: Improve Communication Among Caregivers

- Timely reporting of critical results for tests or diagnostic procedures to the patient’s caregiver within an established time frame so the patient can be treated promptly.
  
  For verbal or telephone orders or for telephonic reporting of critical test results
  
  - Write down the order or test result
  - Verify the order or test result by having the person receiving the order or test result “read back” the complete order or test result

- Implement a standardized approach to “hand off” communication (i.e., including an opportunity to ask and respond to questions – SBAR- situation, background, assessment, and recommendation)

- Avoid use of unauthorized abbreviations in any part of the medical record:
  
  I. QD/ qd for daily
  II. U/u for unit
  III. QOD/ qod for every other day
  IV. Trailing zero after decimal (3.0 instead of 3), or missing the leading zero before the decimal (.3 instead of 0.3)
  V. mgSO4 (magnesium sulfate) and mSO4 (morphine sulfate)
Goal #3: Improve Medication Safety

- Label all medications and medication containers (syringes, medicine cups, basins) in perioperative and other procedural settings

- Reduce the likelihood of patient harm associated with the use of Anticoagulation Therapy Management Process (i.e., use a protocol for heparin & warfarin)

- Medication Reconciliation Process: Obtain, Maintain & Communicate medication information with the patient, through different levels of care. Provide a copy of patient’s current medication usage information to the next provider (complete admission and discharge medication reconciliation)
Goal #6: Reduce the Harm Associated with Clinical Alarm Systems

- Develop a policy to improve the safety of Clinical Alarm Systems and educate appropriate staff about the system
- Establish clinically appropriate alarm settings and identify responsible staff who can set or change the alarm settings
- Avoid any unnecessary alarms that may contribute to alarm fatigue
Goal #7: Reduce the Risk of Infections

- **Hand Hygiene**: Use of hand sanitizer (for dry hands), and use of soap and water (for soiled hands) before and after patient contact (wash your hands for at least 20 seconds). Also practice hand hygiene after using gloves.

- **Implement evidence-based practices to prevent health care-associated infections due to**:
  - Multi Drug Resistant Organisms
  - Central Line Associated Bloodstream Infections
  - Surgical Site Infections
  - Catheter Associated Urinary Tract Infection
Goal #15: Identifies Patient Safety Risks (Prevent patient harm from Suicidal Ideation)

- Identify the patients at risk for suicide by conducting a risk assessment and screening process (for inpatient, outpatient, ED and med-surge patients)

- Suicide Prevention Information & Crisis Hotline: 1-800-273-TALK (8255)
Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong person surgery

- Conduct a Time-out process immediately before initiation of an invasive or non-invasive procedure either inside the operating room or at patient’s bed-side, ensuring that the correct patient is selected for a correct procedure on the correct side and site of the body part (mark the correct site).

- Conduct a pre-procedure verification process and complete the universal protocol check list on time.
Any Questions?

References: The Joint Commission, AHRQ Culture of Safety Survey

Please contact: Department of Patient Safety
Located at UHB- Room# ALL1-362
Telephone: (718) 270-4237
Fax: (718) 613-8755
UNIVERSAL PROTOCOL (UP 1)

• Conduct a pre-procedure verification process to ensure …
  - Correct person
  - Correct side & site of the body part
  - Correct procedure

• Mark the operative site with INITIALS of the surgeon/interventionist

• Conduct a ACTIVE “time-out” immediately before starting the procedure

It's Not Just For The OR!!!!!
"Time-Out"

- Initiated by a designated member of the team (i.e., Registered Nurse)
- During a time-out
  - activities are suspended to the extent possible so that team members can focus on active confirmation of the patient, site, and procedure
  - it involves the immediate members of the procedure team, including the individual performing the procedure, the anesthesia providers, the circulating nurse, OR technician, etc.
Time-Out for Multiple Procedures

• When two or more procedures are being performed on the same patient, and the person performing the procedure changes, perform a time-out before each procedure is initiated.
  • During the time-out, the team members agree, at a minimum, on the following: a) Correct patient identity, b) Correct side & site, c) Correct procedure.
  • Document the completion of the time-out with the appropriate signature, time and date.
Sentinel Event

A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof, a “near miss”
What are Examples of Sentinel Events?

• Medication errors that result in harm to patients
• Wrong site Surgery
• Inpatient Suicide
• Infant Abduction
• Infant discharge to the wrong family
• Operative and post-operative complications
• Blood transfusion error
How do we investigate a sentinel event?

• The goal for a Root Cause Analysis is to find out
  – What happened
  – Why did it happen
  – What to do to prevent it from happening again.

• Root Cause Analysis is a tool for identifying prevention strategies. It is a process that is part of the effort to build a culture of safety and move beyond the culture of blame.

• Root Cause Analysis is:
  – Inter-disciplinary, involving experts from the frontline services
  – Involving of those who are the most familiar with the situation
  – Continually digging deeper by asking why, why, why at each level of cause and effect.
  – A process that identifies changes that need to be made to systems
  – A process that is as impartial as possible
Incidents/Occurrences/Near Misses

- An incident/occurrence is any event that is not consistent with the desired operation of the hospital, or the care of patients.
- A “near miss” is recognition of a situation that has potential to cause harm.
- All incidents must be reported to Risk Management by completing an Incident Report.
- The Incident Report can be downloaded from any hospital desktop.
- Risk Management should be called or paged 24/7 to report incidents involving serious harm to a patient.
Reporting Employee Accidents/Incidents

• Employee Accident and Investigation Report Form (E.A.R.)

• Employee incidents should be reported immediately to the supervisor of the employee involved
Failure Mode & Effects Analysis (FMEA)

• What is a failure modes and effect analysis?
  A failure modes and effect analysis (FMEA) is a simple technique which identifies the potential problem areas of a product or a process and initiates corrective action to reduce harm. We use FMEA’s in hospitals to identify processes that could result in patient harm.

• The steps in conducting an FMEA are:
  - Describe each part of a process
  - Identify what could go wrong
  - Identify how much harm could occur to a patient if something went wrong
  - Plan action to improve the process to reduce the likelihood of patient harm
Culture of Safety Survey

WE CONDUCT A CULTURE OF SAFETY SURVEY IN EVERY TWO YEARS ON THE BASIS OF “AHRQ” MODEL.

SURVEY RESULTS ARE SHARED WITH STAFF AND ENCOURAGE TO STRIDE FOR THE CONTINUOUS IMPROVEMENT

FOCUS AREAS ARE: WORK AREA, SUPERVISOR, COMMUNICATIONS, REPORTING OF AN EVENT, HOW YOU VALUE YOUR HOSPITAL CULTURE
Alarm Management

Objectives

All Staff will be able to:

1. Identify Joint Commission National Patient Safety Goals (NPSG06.01.01)
2. Recognize alarm fatigue and it causes/effects
3. Identify risks if essential alarms go unanswered
Alarm Management

Policy

Hospital staff or Medical Staff, will not bypass, shut off or adjust medical equipment alarm volumes to a level that cannot be readily heard when the alarm activates.

The unit staff member assigned to or treating the patient must immediately respond to medical equipment
Joint Commission National Patient Safety Goal (NPSG. 06.01.01): Improve the safety of clinical alarm systems.

- Requires all hospitals to:
  - reduce risks associated with mismanaged clinical alarms.
  - establish alarm system safety as a priority.
  - identify alarm hazards to be addressed.
  - develop and implement specific policies and procedures to combat identified hazards.
  - educate their staff accordingly.
Alarm fatigue develops when a person is exposed to an excessive number of alarms. This situation can result in sensory overload, which may cause the person to become desensitized to the alarms. Consequently, the response to alarms may be delayed, or alarms may be missed altogether.

Alarm Management: Priority Levels

- **High Priority (RED)** – life threatening audible alarms requiring immediate attention and could result in temporary or permanent harm (i.e. Asystole, Ventricular Fibrillation, Ventricular Tachycardia, Extreme Tachycardia, extreme Bradycardia)

- **Medium Priority (YELLOW)** – warning audible alarms that require attention, but inattention for several minutes is not likely to result in temporary or permanent harm; and

- **Low Priority (WHITE/BLUE)** – advisory audible or visual alarms meant to call attention to medical device or patient condition that needs re-assessment. A response is required but inattention for a short period is not likely to result in patient harm.
Strategies for Managing Alarm Fatigue

- Troubleshooting false alarms at the time they occur.
- Never disabling or turning off an alarm—rather, silencing the alarm while troubleshooting the problem.
- Tailoring alarm parameters to the individual patient and/or to the specific patient population.
- Ensuring all alarms are audible and visually displayed.
- Ensuring certain critical alarms (i.e., Arrhythmia: SVT, VT, VF, 3rd degree HB, Asystole, Fetal Heart monitor, Infant/Pediatric Abduction, Infusion Pump, Ventilator) are distinguishable over unit noises and other alarms.
Strategies for Managing Alarm Fatigue

- Individualizing the SpO2 alarm threshold to the individual patient’s condition.

- Using disposable, adhesive pulse–oximetry sensors and replacing them when they no longer properly adhere to the patient’s skin.

- Appropriately preparing the skin before applying ECG electrodes.

- Routinely replacing ECG electrodes every 24 hours to prevent them from drying out.
Proper skin prep for Electrode placement:

- Wash the isolated electrode area with soap and water.
- Wipe the electrode area with a rough washcloth or gauze to roughen a small area of skin.
- Clip/remove excessive hair in electrode area according to hospital policy.
- Select flat, non-muscular sites for electrode placement, avoiding joints and bony protrusions.
- Do not use alcohol for skin preparation (it dries out the skin, causing more impedance).
- Never use expired or dried out electrodes.
- Change the electrodes daily or more often if needed.
Electrodes

- Using evidence based practice (AACN Practice Alert):

  Practice change: change electrodes daily

  Effect:
  ....the average number of alarms per bed per day **decreased by 46%** simply by changing the ECG electrodes daily
Pulse Oximetry Monitoring

- Assessing the sensor for appropriate positioning based on circulatory status and patients’ activity levels. Choose the site with the best pulsatile vascular bed.
- Set alarm limits based on predetermined goals as per MD/NP/PA order.
- Assess appropriateness for patients with irregular or rapid heart rhythms, excessive movement such as shivering, extreme hyper or hypotension.
Alaris ® Infusion Pump

- Assess patient’s condition before silencing an alarm.
- Do not silence alarm if patient safety might be compromised.
- Verify that the alarm limits are appropriate for the patient before each use.
- The Alaris® System performs a self check during power up.
- The PC Unit should beep, no errors should occur, and if a module is connected, all LED segments should flash.
- If the Alaris® System fails the self check, remove the failing PC Unit or module from use.
- To sample alarm loudness level, select Audio Adjust from main screen, then press Test soft key. CAUTION: Setting the audio volume to the lowest level will lower all system alarms, including secondary alarms such as End of Infusion.
REFERENCES:

- ECRI Institute, Alarm related terms. Paper presented at: Medical Alarms Summit; October 4–5 2011; Herndon, VA
- The Joint Commission Standards: National Patient Safety Goals 06.01.01
- Sentinel Event Alert Issue 50: Medical device alarm safety in hospitals
- AACN Protocols for Practice: Noninvasive Monitoring, 2nd ed (Burns SM, ed: Sudbury, MA: Jones and Bartlett; 2006)
- UHB Policy: CLINICAL ALARM SAFETY; No. PTSAF–10
Corporate Compliance

The 8 Elements of DMC’s Compliance Program and Workforce responsibilities –
Presented by the Office of Compliance & Audit Services (OCAS)


2. **DMC’s Compliance Officer**: The VP for OCAS is responsible for the daily operations of the Program and reports to the President of DMC as well as an executive committee.

3. **Training & Education**: General / specific training is conducted based on role. This presentation is part of your Compliance Education!

4. **Open Lines of Communication**: OCAS is a great resource if you have questions or need guidance. The dept.'s Table of Organization, including contact information is available on our website! You can also call or web-report (confidentially and anonymously) through the Compliance Hotline.

5. **Good Faith Participation**: All workforce members are required to participate in DMC’s Compliance Program. Disciplinary measures will be enforced for failure to report possible violations and/or non-compliant behavior.

6. **Auditing / Monitoring**: OCAS annual work plans are developed to identify compliance risk areas throughout the organization.

7. **Investigation and Remediation**: OCAS works closely with many other departments including Human Resources, Labor Relations, IT and Counsel’s Office to investigation and remedy identified issues.

8. **Non-Intimidation & Non-Retaliation**: OCAS works to protect the confidentiality and anonymity of reporters. Retaliation for good faith participation in DMC’s Compliance Program is not tolerated.
Office of Compliance and Audit Services

Welcome to OCAS - the Office of Compliance and Audit Service website

State University of New York Downstate Medical Center (SUNY DMC) is proud of its long tradition of ethical and responsible conduct and is committed to continuing to conduct its business lawfully and ethically. Each member of SUNY DMC is expected to adhere to this high standard whenever he or she acts on behalf of SUNY DMC. This includes, but is not limited to, when dealing with other employees, patients and their families, vendors, government regulators or the general public. Violations of legal or ethical requirements jeopardize the welfare of SUNY DMC, its employees, patients and the communities it serves.

The Compliance Program is intended to define the conduct expected of colleagues and employees, to provide guidance on how to resolve questions regarding legal and ethical issues, and to establish a mechanism for reporting of possible violations of law or ethical principles within SUNY DMC.

The Compliance Program applies to all SUNY DMC entities, including the Colleges of Medicine, Nursing and Health Related Professions, University Physicians of Brooklyn, Clinical Practice Management Plan, University Hospital of Brooklyn and the Research Foundation.

Please feel free to contact the Office of Compliance & Audit Services at (718) 270-4033 and use this website to support your compliance activities. Compliance is everyone's responsibility.

OCAS Divisions

The Office of Compliance and Audit Services (OCAS) serves the entire SUNY Downstate Medical Center and includes the following divisions:

- Clinical Reimbursement Division x4327
- HIPAA x4734
- Internal Audit Division x4033
- Research Compliance Division x7470
- Internal Control Program x4033
- Compliance Coordination Division x2095
Code of Conduct Guidelines

- Compliance with Laws and Regulations
- Adherence to Ethical Standards
- Patient Care
- Non-Discrimination
- Confidentiality
- Record Accuracy and Retention
- Protection of Assets
- Avoidance of Conflict of Interest
- Business Relationships
- Academic/Research Integrity
- Environmental Laws
- Occupational Safety
- Maintenance of a Drug and Alcohol Free Workplace
Code of Conduct: Discipline for Violations

DMC will take disciplinary action, including termination when appropriate, against any workforce member who violates legal requirements or institutional policies, including anyone who fails to report violations or retaliates against any individual for reporting a possible violation in good faith.
Deficit Reduction Act (DRA)
Detection & Prevention of Fraud, Waste & Abuse

- DMC is committed to preventing the submission of false claims for payment from a Federally or State funded healthcare program (Medicare/ Medicaid).

- The DRA requires education on the Federal and State laws regarding fraud and abuse, whistleblower protections under these laws and DMC’s Compliance policies in preventing and detecting fraud, waste and abuse.
DRA Federal & State Laws

• Federal False Claims Act
• New York False Claims Act
• New York State Finance Law

A false claim is a violation of State and Federal Law. Civil, administrative and criminal penalties may be levied based assessment of the following factors:

- Knowingly presenting a false claim for payment
- Knowingly making, using or causing a false statement to get a false claim paid;
- Conspiring to defraud; or
- Knowingly making, using or causing a false statement to conceal, avoid or decrease an obligation to pay.

Violations may include up to $21,563 per false claim and exclusion from Federal health care programs.

Private persons are eligible to file qui tam/whistleblower lawsuits (without threat of employer retaliation) on behalf of the Federal government.

If successful, 15-30% of recoveries may be awarded.
DRA Federal & State Laws – Other Applicable Laws

- Federal Program Fraud Civil Remedies Act
- New York Social Services Law
- New York Penal Law
- New York Labor Law

**EXAMPLES OF FALSE CLAIMS:**

- A physician billing Medicare / Medicaid for medical services not provided;
- A government contractor who submits false records that indicate compliance with contractual or regulatory requirements;
- A hospital that retains interim payments from Medicare / Medicaid throughout the year and then knowingly files a false cost report at the end of the year in order to avoid making a refund.
Conflicts of Interest

A conflict of interest occurs when:

• An official's private interests may benefit from his/her public actions.

• The person is in a position of trust which requires him/her to exercise judgment on behalf of others (people, institutions, etc.) and also has interests or obligations of the sort that might interfere with the exercise of judgment, and which the person is morally required to either avoid or openly acknowledge.
Conflict of Interest

No Officer or Employee of a state agency...

- Should participate in any activity that may impair independence of judgment in the exercise of official duties
- Should participate in any activity that will require disclosure of confidential information
- Should disclose confidential information or use such information for personal interests or gains
- Should use their position to secure unwarranted privileges or exemptions
- Should engage in any activity that may have a direct or indirect financial interest and conflict with the exercise of official duties
- Should permit themselves to be improperly influenced in the exercise of official duties
- Should make personal investments that may pose a conflict of interest between conducting official duties and private interests
- Should pursue a course of conduct that will raise suspicion among the public that is likely to be perceived as a violation of trust
- Should engage in any activities that may result in personal financial gain that result from being an officer or employee of a state agency
Examples of Professional Misconduct include:

• Obtaining a license fraudulently.
• Practicing a profession while impaired by alcohol, drugs, physical, or mental disability.
• Having been found guilty of professional misconduct in another state.
• Permitting, aiding or abetting an unlicensed person to perform activities requiring a license.
• Practicing your profession with gross incompetence or gross negligence.
Reporting Violations

Employees must report real or suspected violations regarding:

• Code of Ethics & Business Conduct;
• Detection, Prevention of Fraud, Waste & Abuse (DRA);
• Conflicts of Interest; or
• Professional Misconduct.

Reports can be made to:

• Supervisor or responsible VP;
• Chief Compliance Officer;
• SUNY Counsel’s Office; or
• DMC’s Compliance Hotline (anonymous).
DMC’s confidential Compliance Line is a 24/7 hotline service available as an internal reporting mechanism for reporting illegal or unethical conduct.

If you become aware of a situation that may jeopardize DMC’s ethical integrity, it is up to you to report it!

• Call: Compliance Line (877)-349-SUNY; or
• Click on “Compliance Line” link on DMC webpage @ www.downstate.edu
HIPAA Refresher Training

Presented by:
The Office of Compliance & Audit Services
Information contained in a patient's health record must be handled securely and should not be accessed or shared in ANY manner unless there is a treatment, payment or other job related reason for doing so.

- Even then, the persons accessing and receiving the information must be authorized to do so under HIPAA.
- HIPAA includes specific rules for accessing information, sharing information and maintaining it in a secure environment.
- In general, only the patient or those who are specifically involved in the patient's treatment, payment or healthcare operations (TPO) have the right to see or hear the patient's PHI.
What Does HIPAA Protect?

Under HIPAA regulations, the health information we've been talking about is called Protected Health Information (PHI). HIPAA itemizes 19 identifiers that, when combined with health information, allow the identification of an individual. In this course, "PHI" means health information combined with one or more of these identifiers.

PHI identifiers include:

- Patient name
- Dates (DOB, admission/discharge date, etc)
- Address
- Social Security number
- Insurance information
- Payment information including credit card numbers
- Full face photos
NURSE #1: I'm having such a hard time with Maria Panelli. I know she's very ill but I just can't do anything right for that woman. She is SO cranky!

NURSE #2: Well, try not to take it personally. She's just received some very bad news - her cancer is inoperable.

HOSPITAL VISITOR: Mrs. Panelli?
Under HIPAA, you are required to take reasonable precautions to prevent disclosures that are not intended.

*Clearly the nurses did not think about their surroundings and spoke about protected health information (PHI) when an unknown person could clearly hear it. What if that person had been the patient's husband and he did not yet know of his wife's condition?*

You must always be aware of your surroundings when discussing PHI and ask yourself the following questions:

- **Am I in an environment where others can overhear?** Waiting rooms, hallways, elevators, cafeterias and shared hospital rooms are often not private and provide opportunities for others to overhear PHI being discussed. Check your surroundings before speaking.

- **Do I really need to disclose PHI?** If you are not in a private area, think about how much you really need to say. Maybe you don't need to identify the person you are discussing.

- **Can I adapt the physical space to increase privacy?** Asking bystanders to move further away, closing a door or curtain or utilizing an empty hallway for discussion are all reasonable precautions that help to protect patient PHI.
CAROL: Hey Lori, come on! We're waiting for you to go to lunch!

LORI: Look at this desk! I'm in the middle of a huge project straightening out all these patient accounts.

CAROL: And you've been sitting for hours. Come on! Aren't you hungry?

LORI: Ok. I'll come. My blood sugar probably is low, (looking over her cluttered desk)...

Should Lori have left patient files and computer data unattended and accessible on her desk?
Under HIPAA, protected health information (PHI) in your possession is your responsibility.

Lori's desk was cluttered with patient files and her computer screen was displaying open patient records. Anyone passing by could learn, acquire or change PHI on a number of patient records.

PHI should never be left in an uncontrolled situation.

To minimize risk, employ common sense practices like returning files to locked or secure storage at the end of each day and always make sure to follow DMC’s procedures for handling electronic PHI.
WORKER: I'm looking forward to getting this project finished. Do I have permission to take the data home this weekend?

BOSS: Yes, that request was approved. I'm transferring it right now to a portable flash drive. This will have everything you need, just plug it into your computer at home. Here you go! (The worker takes it and accidentally misses his coat pocket; the drive falls on the floor.)

WORKER: Oops! I missed that. (bending to pick up drive)

BOSS: Losing that would be a disaster! You better find a safe place to keep this. And don't forget to bring it back on Monday!

Are there any risks to transporting PHI on portable devices?
Flash drives are a convenient way to transport digital files -- but these small devices are also easy to lose or steal. Protected health information (PHI) can also be transported on devices like smartphones, cell phones, CD-ROMS, portable disk drives, servers, laptops or back-up tapes. All of these methods of data transportation present unique security issues.

When transporting any mobile device that contains PHI, follow DMC’s Mobile Device Usage policy available on the DMC IT website. Some guidelines include:

• Use reasonable safeguards including
  -- keeping all bags containing the devices with you at all times;
  -- never leaving devices in unsecured vehicles;
  -- never leaving devices powered up, accessible and unattended in your home if others live with you.

• Never send PHI via personal email – Lotus Notes must be used

• Encrypt PHI whenever possible – but always encrypt when transmitting via internet

• Patient images taken with mobile devices must be uploaded and immediately deleted before going off-site

• USB drives/ portable devices containing PHI may never be taken off-site or used for long term/ permanent storage unless they meet DMC encryption standards

*** Portable devices include laptops, notebooks, hand-held computers, tablets (iPads), Personal Digital Assistants, smart phones and USB drives ***
You have just reviewed several scenarios that may or may not include HIPAA violations.

Now identify which of the items listed to follow include HIPAA violations....
<table>
<thead>
<tr>
<th>Is this a HIPAA Violation?</th>
<th>Yes or No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accessing medical records of family members, friends, well known people without a job-related reason.</td>
<td></td>
</tr>
<tr>
<td>Leaving PHI in your locked desk drawer.</td>
<td></td>
</tr>
<tr>
<td>Sending unencrypted emails containing PHI from your home computer.</td>
<td></td>
</tr>
<tr>
<td>Transporting PHI on encrypted portable devices with appropriate security measures in place.</td>
<td></td>
</tr>
<tr>
<td>Looking up the PHI of the local star athlete for personal reasons or curiosity.</td>
<td></td>
</tr>
<tr>
<td>Releasing PHI to a patient's spouse without verifying the relationship or checking for appropriate authorization.</td>
<td></td>
</tr>
<tr>
<td>Discussing PHI with a coworker in an elevator when others present can hear.</td>
<td></td>
</tr>
<tr>
<td>Asking a patient to verify his or her Social Security number by writing it down for you.</td>
<td></td>
</tr>
<tr>
<td>Sharing medical information with your friend, a fellow employee, about another fellow employee when there is no job-related reason for your friend to know the information.</td>
<td></td>
</tr>
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</tr>
</tbody>
</table>
SAFEGUARDS

• Always avoid removing PHI from DMC’s premises unless absolutely necessary.

• Appropriate safeguards must be in place for all PHI in your possession or control, whether on-site or off-site.

Keep PHI Out of Sight and Out of Earshot!

• Professional conversations should never take place in public areas
• Semi-private rooms: use reasonable precautions (lower your voice)
• Voice messages/Intercom announcements: No info specific to patient’s service/conditions
• Monitors should be facing away from public view
• Sign-In Logs should have Name, Date & Time only
• Secure Patient Charts/Interoffice mail
• NEVER Leave PHI Unattended
• Check with patient or review his/her chart for consent before discussing care with visitors, including stating medications out loud
SAFEGUARDS

Keep Databases / Workstations on Lock!

• NEVER share passwords
• Exit / log-out before leaving a workstation
• Use privacy screens on monitors when necessary
• Restrict access to minimum necessary

Properly Dispose of PHI!

• NEVER dispose PHI in trash cans – Use secure bins or shredders
• All printed materials and copies including faxes, emails, or reports containing PHI must be shredded or placed in secure bins designated for shredding
• Diskettes and CD’s must also be disposed of properly; destroyed or placed in designated bins for shredding
• Properly and permanently delete PHI from electronic storage before disposal
• Follow role change / termination procedures to ensure PHI is returned, when appropriate
www.downstate.edu/hipaa

Check Downstate’s HIPAA website for Policies, Resources, and Contact Information

HIPAA - Health Insurance Portability and Accountability Act

Welcome to the Downstate HIPAA Web-Site

The purpose of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) is to improve the efficiency and effectiveness of the healthcare system by standardizing the electronic exchange of administrative and financial data and to protect the security and privacy of protected health information (PHI). As a healthcare provider who conducts transactions electronically, SUNY Downstate Medical Center is considered a covered entity under the rule and required by federal law to implement these standards and regulations.

The regulations are comprised of three essential areas:

- Privacy - Oversight Responsibility: Office of Compliance & Audit Services, (718) 270-4033/2095
- Transaction & Code Sets - Oversight Responsibility: Hospital Finance, (718) 826-4900
- Security - Oversight Responsibility: Information Services, (718) 270-2431

Staff

The Office of Compliance and Audit Services HIPAA Division is staffed by the following professionals:

RENEE PONCET - Vice President, Compliance and Audit
Vanessa Carter - Executive Assistant

SHOSHANA MILSTEIN, RHIA, CHP, CCS - Assistant Vice President, Compliance and Audit
Alexandra Bliss, CHC, CPHIT, CPEHR - Compliance Coordinator
Jessica Chen, AAS, RHIT - Compliance Training Specialist
DMC’s confidential Compliance Line is a 24/7 hotline service available as an internal reporting mechanism for reporting illegal or unethical conduct.

If you become aware of a breach of protected health information or other HIPAA violation, it is up to you to report it!

• Call: Compliance Line (877)-349-SUNY; or
• Click on “Compliance Line” link on DMC webpage @ www.downstate.edu
Customer Service occurs whenever a customer (patient, family, visitor) comes into contact with any aspect of DMC.
Who Are Our Customers?

Our customers come from diverse cultural, ethnic, linguistic, spiritual, educational, and social backgrounds.

Our customers include:

- Our Patients
- Their Families
- Each Other
- The Community
There are universal human needs that need to be recognized in all individuals. They include the need to:

- feel welcome and receive attention
- receive timely service
- feel comfortable
- be understood
- receive help or assistance when required
- be recognized and remembered as an individual
- feel appreciated
PROMOTING CUSTOMER SATISFACTION INCLUDES:

- Establishing rapport/friendly relationships
- Listening with accuracy
- Anticipating customer concerns and needs
- Demonstrating dedication and decorum
How can you create a positive impression for customers??

- Welcome/Greet the customer.
- Use customer’s name.
- Introduce self and role.
- Smile, make eye contact.
- Use touch
  - ask first !!!
  - handshake or touch customer’s arm, as appropriate
- Make customer comfortable—both physically and emotionally
- Be polite
- Treat customer with respect
- Recognize customer as an intelligent being
- Give full attention/listen
- Use appropriate language - do not talk down to the customer or speak over their heads
What are some techniques you can use to effectively communicate with Customers??

- Listen effectively/attentively
- Be sensitive to nonverbal clues
- Give positive cues to customer
- Express concern
- Nod in agreement
- Maintain direct eye contact
- Paraphrase their questions to confirm understanding
- Ask questions to clarify
- Speak clearly and slowly
- Reveal what you CAN do
- Explain reasons (avoid “it’s policy”)
- Explain process for care and procedures
- Work to educate and inform
- Offer alternative solutions
- Be authentic, genuine
Cultural Competency in Healthcare
What is Culture?

- “the learned and shared beliefs, values, and lifeways of a designated or particular group which are generally transmitted intergenerationally and influence one’s thinking and action modes” (Leininger, 1995)

- “health and illness states are strongly influenced and often primarily determined by the cultural background of an individual” (Leininger, 1970)
Our patients are diverse. Let’s see just how diverse they are.

- 30% of US population are ethnic minorities
  - By 2050, 50% of the U.S. population will be ethnic minorities
- 28 million are foreign born
- 47 million people speak a language other than English at home
  - Over 300 languages are spoken in the USA
- Ethnic minorities are poorly represented among US healthcare professionals
  - 6% of physicians
  - 9% of nurses
- This discrepancy leads to
  - Poor Health Outcomes
  - Health Disparities
What Is Culturally Congruent Care?

- refers to the use of sensitive and meaningful care to fit with a person's values, beliefs, and lifestyles. This may mean helping them with difficult life situations, disabilities, or death. (adapted from Leininger, 2002)
Why Do We Need To Become Culturally Competent Healthcare Providers?

- Misunderstandings may occur due to language barriers
- Poor communication can lead to medical errors and mistrust
- Doctor shopping, late presentation of disease, and inappropriate use of the ED can arise from mistrust of medicine and dissatisfaction with care that is not culturally responsive
- Lack of cultural competence and understanding of a patient’s health beliefs can contribute to non-compliance, poor health outcomes, and widespread racial/ethnic disparities
How do I become Culturally Competent?

- Being culturally competent **DOES NOT** mean you know everything about every cultural group you work with.
- Know your own cultural beliefs and practices—think about how your culture and upbringing affect you.
- Learn about the beliefs and values of other people from other cultures.
- Integrate these values into the plan of care.
- Treat each patient as an individual.
Standards and Guidelines

- The organizations below have developed Standards and Guidelines to ensure that we meet the culture care needs of patients and their families:

  - Institute of Medicine
    - Core Competencies for Health Care Professionals

  - Joint Commission
    - Standards for Cultural Competency in Health Care

  - Office of Minority Health
    - National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care
Culturally and Linguistically Appropriate Healthcare Services (CLAS Standards)
CLAS Standards

1. Effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

2. Strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

3. Staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.
CLAS Standards

4. Language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

5. Provide patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

6. Competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
CLAS Standards

7. Easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

8. Written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

9. Initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.
10. Data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

11. Current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

12. Participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.
CLAS Standards

13. Conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

14. Public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.
L.E.P.

Limited English Proficiency
Definitions of Language Services

- **Interpreter** - a multilingual employee
- **Language assistance coordinator** - responsible for carrying out, overseeing, and ensuring full implementation of language service policies and procedures
Definitions of Language Services

• LEP patient – patients whose primary language is not English and who cannot speak, read, write or understand the English language at a level sufficient to permit such patient to interact effectively with health care providers
Why Provide Language Services?

• Title VI of the 1964 Civil Rights Act
• Joint Commission Standards
• 405.7 Patient’s Rights
• State and Federal Regulations
• Less Risk for Healthcare Practitioners
What Populations Are Targeted?

- Limited English Proficient
- Vision Impaired and Deaf
- Persons with Mental, Developmental, and/or Physical Disabilities
  - Non-verbal
  - Limited verbal ability
  - Limited ability to comprehend and communicate complex medical information
L.E.P. Program

• Ensures all patients who require language assistance to receive interpretation at no cost to them

• Provides meaningful access to hospital services
  - Interpreters
  - Cyracom phones - If patient’s bedside phone is not turned on, dial 5300
  - Translated documents
  - Deaf Talk - For patients who are deaf
  - TTY [telephone telegraphy]
Requirements

• Language Assistance Coordinator
• Development of Policies and Procedures for the Plan
• Management of skilled interpreters for L.E.P. patients and with vision and/or deaf individuals
• Annual needs assessment of area population
• Translation of significant hospital forms and instructions will be available for languages serving our communities’ needs, i.e. Spanish, Haitian Creole
Meeting an L.E.P. Patient, What to Do?

- Inform Patients of Their Right to Free Language Assistance Services
- Identify a L.E.P. Patient’s Language
- Time Limit on Securing Language Assistance Services
- Documenting Services Provided in Patient’s Chart
What Happens If A Patient Refuses Our Interpreting Services?

• If a patient refuses our services
  • Bi-lingual Staff Interpreter
  • Cyracom Phone
  • Agency Interpreter

- DOCUMENT, DOCUMENT, DOCUMENT!
What Not to Do!

• **DO NOT** ask children younger than 16 years of age to interpreter  
  - EXCEPTION TO THE RULE  
    • Only in an Emergency

• **DO NOT** use family members, friends or non-hospital personnel as interpreters, unless;  
  - the patient agrees to their use  
  - free interpreter services have been offered and patient refuses
Infection Prevention & Control Requirements
Hand Hygiene
Isolation
Flu Mask Regulations
Cleaning Reusable Equipment

REQUIRED BY
HOSPITAL POLICY & PROCEDURE
CMS
THE JOINT COMMISSION; NEW YORK STATE DEPARTMENT OF HEALTH & NEW YORK CITY DEPARTMENT OF HEALTH & MENTAL HYGIENE
INFECTION CONTROL

• This section contains the following topics:
  – Hand Hygiene
  – Transmission of Infection
  – Standard/Universal Precautions
  – Isolation Procedures
  – Safe Injection Practices
Compliance with Hand Hygiene and Isolation Precautions

• Hand Hygiene is the most important way to prevent the transmission of infections

• Compliance with isolation procedure reduces the potential for the spread of communicable diseases and multi-drug resistant pathogens

• All personal protective equipment (PPE) including shoe covers must be removed before leaving the patient care area where it was donned.
Wash/Sanitize Your Hands Before & After Each Patient Contact, Before Donning and After Removing Gloves

• Use a waterless product if hands are not visibly soiled before contact with the patient and/or equipment (e.g. monitors, bedside table, or other equipment in the patients’ environment)

AND

• Use a waterless product, **ONLY** if hands are not visibly soiled, after contact with the patient and/or equipment (e.g. monitors, bedside table, or other equipment in the patients’ environment).
Wash/Sanitize Your Hands Before & After Each Patient Contact, Before Donning and After Removing Gloves

• Use soap & water if hands are visibly soiled or if the patient has a spore forming pathogen such as *C. difficile*

• Wash your hands for 20 seconds each time (say 1:1000 through 1:2000 or the happy birthday song twice).
Clean/Sanitize All Reusable Equipment After Each Patient

Include: Glucometer, thermometer, blood pressure cuff, etc.

• Clean with soap & water if visibly soiled

• Sanitize – Wipe down with the available germicidal disposable wipe (PDI Sani-Cloth AF3 must remain wet for 3 minutes).
Isolation Precautions Requirements

Isolation signs updated 1/2015

- **Use Respiratory Airborne Precautions – color coded BLUE:**

  - diseases known to be transmitted via the airborne route - TB, Varicella Zoster

- **Single Room** - Airborne Infection Isolation Room (AIIR) with negative pressure or portable HEPA filter

- Wash/sanitize hands before and after patient contact, (N95 Respirator required for TB; fluid resistant gown ONLY to be worn when performing procedures where soiling is anticipated.
AIRBORNE Precautions

WASH/SANITIZE HANDS/95
LAVARSE/LIMPIAR LAS MANOS
LAVE MEN OU/DESENFECTE

MASK
MASCARA
MASK

GLOVES
GUANTES
GAN

VISITORS: SPEAK WITH THE NURSE BEFORE ENTERING THE ROOM

VISITANTES: HABLAR CON LA ENFERMERA ANTES DE ENTRAR A LA HABITACIÓN

VISITE`: PALE AK ENFIMYE` A ANVAN OU RANTRE NAN CHANM PASYAN AN
Isolation Precautions Requirements

Isolation signs updated 1/2015

• **Use Droplet Precautions – Color code Green:**
  diseases known to be transmitted via respiratory droplets  - Invasive meningiococcal disease, pertussis, H1N1

• Single room preferred, can cohort. Maintain spatial separation of 3 feet.

• Wash/sanitize hands before and after each patient contact; surgical mask is required – (N95 Respirator required for H1N1), fluid resistant gown ONLY worn when performing procedures where soiling is anticipated.
DROPLET Precautions

WASH/SANITIZE HANDS  
LAVARSE/LIMPIAR LAS MANOS  
LAVE MEN OU/DESENFEKTE

MASK  
MASCARA  
MASK

GLOVES  
GUANTES  
GAN

VISITORS: SPEAK WITH THE NURSE BEFORE ENTERING THE ROOM

VISITANTES: HABLAR CON LA ENFERMERA ANTES DE ENTRAR A LA HABITACION

VISITE`: PALE AK ENFIMYE` A ANVAN OU RANTRE NAN CHANM PASYAN AN
Isolation Precautions Requirements

Isolation signs updated 1/2015

• **Contact Precautions – Color coded Orange:**
  • patients with multi-drug resistant pathogens including MRSA, VRE, ESBL, CRE, KPC, *C. difficile*, or with diseases known to be transmitted by direct contact or indirect contact with contaminated objects.

• Single room preferred, can cohort. Maintain spatial separation of 3 feet. Cohort C diff only with another patient with C diff

• Wash/Sanitize hands before and after each patient contact; gowns are worn for close contact when entering patients’ room. Fluid resistant mask/face shield, fluid resistant gown worn when performing procedures where splashing & soiling is anticipated.
contact Precautions

WASH/SANITIZE HANDS
LAVARSE/LIMPIAR LAS MANOS
LAVE MEN OU/DESENFECTE

GOWN
BATA
ROB LOPITAL

GLOVES
GUANTES
GAN

VISITORS: SPEAK WITH THE NURSE BEFORE ENTERING THE ROOM

VISITANTES: HABLAR CON LA ENFERMERA ANTES DE ENTRAR A LA HABITACION

VISITE`: PALE AK ENFIMYE` A ANVAN OU RANTRE NAN CHANM PASYAN AN
Flu Mask Regulations

• NYS Law require all healthcare personnel who did not receive the Flu vaccine during the current Flu season when the Commissioner of Health has declared that Flu is prevalent must wear a **surgical mask** when they are in the patient care areas.
• Mask must be tied at both the top of the head and at the nape of the neck and snugly cover mouth and nostrils.
• N95 Mask should only be used for patients on Airborne Isolation.
• Managers/supervisors in the clinical areas must enforce this requirement.
N95 Respirator Mask

Surgical Mask
Sources of Infection

- Sources of infection include:
  - patients, employees, or visitors with active disease, incubating or in a carrier state
  - Contaminated objects may also be a potential source of infection
What is the Chain of Infection?

For infections to spread you need a(n)

1. Infectious Agent
2. Source/Reservoir
3. Means of transmission
   - Contact, indirect contact, droplets, airborne, common vehicle or vector
4. A susceptible host
5. Portal of entry
6. Portal of exit
STANDARD/Universal PRECAUTIONS

• are used when caring for **ALL** patients
• includes hand washing/hand hygiene regardless of whether gloves are worn
• wearing gloves when handling all body fluids, secretions, and when handling items soiled with blood or body fluids
• requires the use of protective equipment (gloves, masks, gowns, goggles) when performing procedures that may require contact with
  • blood
  • body fluids
  • secretions (except sweat)
  • non-intact skin and mucous membranes, or
  • any item soiled or contaminated with any of these substances

• changing gloves after each patient contact
• take precautions to prevent injuries when using needles or other sharp instruments
• making sure immunizations are up to date
• Implement evidence-based practices to prevent indwelling catheter urinary tract infections (CAUTI); and Central Line Associated Blood Stream Infection (CLABSI)
Safe Injection Practices
“One Needle, One Syringe, Only One Time”

• Providers Shall:
• Never administer medications from the same syringe to more than one patient, even if the needle is changed
• Never use the same syringe or needle to administer IV medications to more than one patient
• Do not administer medications from single-dose vials or ampules to multiple patients or combine leftovers for later use.
• If multi-dose vials must be used, both the needle and the syringe used for accessing the multi-dose vials must be sterile.
Safe Injection Practices

• The rubber septum should be disinfected with alcohol prior to piercing.
• Do not use intravenous solutions in bags or bottles as a common source of supply for multiple patients.
• Medication vials should be discarded upon expiration or any time there are concerns regarding sterility.
• Ensure proper hand hygiene before handling medications.
Catheter Associated Blood Stream Infections (CLABSI) Procedure

• Insert central lines using Aseptic technique, donning gloves, masks, gowns & caps
• Use CLABS Bundle checklist to ensure adherence
• Prep skin to reduce micro-organisms
• Apply BioPatch impregnated dressing over the central line
• Review and Document the continued need for the central line daily.
• Use Port Protectors (Swab Caps) over injection ports
• Change dressing on Central Lines every 7 days, or more often if open/soiled
• **Avoid using PICC lines for ROUTINE blood draw**
Catheter Associated Urinary Tract Infections (CAUTI)
Prevention Procedure

• Only catheterize when necessary, always using aseptic technique & sterile equipment.
• Discontinue catheter promptly when not needed.
• Secure the catheter using the catheter to the leg securement device (Stat Lock) to prevent shearing
• Obtain specimens aseptically
• Prevent kinking of tube
• Keep the collection bag below the bladder level & NEVER on floor
MDROs Management/Prevention (Multiple drug resistant organism)

We minimize them by:

• Prompt identification and communication of the MDRO’s to appropriate clinicians
• Instituting appropriate contact precautions and posting signage
• Educate the patient(s) & their visitor(s)
• Terminal cleaning of the room(s) after the patient with C-Difficile has vacated-This includes steam cleaning of areas
Surgical Site Infections (SSI’s) Prevention Procedure

• Chlorhexadine Bath the night before and the morning of surgery
• Remove hair from the surgical site only when necessary using electric clippers
• Elective operation on patient with remote site infections should be postponed until infection(s) has resolved
• When indicated, prophylactic IV antibiotic(s) should be administered within 30 minutes of incision
PREVENTION IS PRIMARY!

Protect patients…protect healthcare personnel…

promote quality healthcare!

Hand Hygiene is Primary
FALLS PREVENTION IS Everybody’s Business
Fall Definition

“A sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor or other surface.”

This includes:

- Falling into other people
- Being lowered to the floor
- Loss of balance
- Legs giving away

Slips and Trips may lead to “Falls”
When You See This “Rose”, Think Falls Prevention !!!
High Risk For Falls

Recharging Our Safety Efforts
Recharging Our Safety Efforts

Common Elements of Fall Risk Assessment:

- History of recent falls
- Depression
- Confusion/Disorientation
- Altered elimination
- Dizziness/Vertigo
- Alteration in functional mobility
  - Amputations
  - Musculoskeletal impairments
- Medications (For Example)
  - Antihypertensives
  - Antidepressives
  - Anticoagulants
  - Diuretics
- IV lines/equipment attached to patient
- Environmental hazards: spills, wires/cords, broken tiles/flooring
Recharging Our Safety Efforts

• Change culture.
• Assess/reassess fall risk every shift.
• Assess/reassess when patient’s condition changes
• Report environmental hazards
• Identify patient at risk for falls
• Educate the family.
• Develop a team approach to fall assessment and reassessment

• Patients who are at Risk for Falls …
  – Wear non-skid red foot wear/socks
  – Wear a yellow wrist band
  – Have a “Rose” sign posted at the patient’s room door or over the patient’s bed
  – Patients being transported to/from procedural areas will have the “Rose” sign affixed to the front of the chart.
  – The patient’s chart **MUST** be sent with the patient when the patient leaves the unit for procedures, surgery, transfer, etc.
OBJECTIVES

• At the end of this module, the nurse will be able to:
  • Interpret a patient’s fall risk level by using the Morse Fall Scale accurately.
  • Assess individual risk factors based on Morse Scale score
  • Screen for injury risk factors
Fall & Injury Prevention Management

• All Patients are screened for fall risk, assessed for personal risk factors (based on screening scores) and screened for injury risk on admission.

• In the ambulatory setting patients are screened for fall risk at the initial encounter and upon any change in health status.

• In the inpatient areas, patients are screened every shift, upon transfer and if there is a change in the patient’s clinical condition.
Fall & Injury Prevention Management

- The Morse Fall Risk Scale is utilized to screen the adult inpatient population.
- In pediatrics, the Humpty Dumpty Fall Risk Scale criteria is used.
- Universal Fall prevention protocols will be initiated on all patients.
- Fall prevention protocols and plans of care will be initiated based on level of risk and injury and assessment of personal risk factors.
Fall & Injury Prevention Management

• Initial screening is documented in the Nursing Assessment Data base.
• Ongoing risk screening/rescreening is noted on the Morse and Humpty Dumpty Fall Risk Tools.
• The Tool includes the risk score. Interventions will be implemented based on the score.
Fall & Injury Prevention Management

• If a patient is screened as high risk for falls or injury, the nurse will notify the physician of the patient’s fall and injury risk status.

• The Nursing staff places the fall signage Rose (Recharging Our Safety Efforts) over the patient’s bed, on the patient’s room door and in front the patient’s chart for all patients determined to be at moderate or high risk of falling.
Fall & Injury Prevention Management

• A yellow wrist band with the ROSE insignia
• red treaded non skid socks will be worn by the patient to communicate patient’s high risk status to all staff intra and inter departments, including ancillary services staff, and to patient’s family and visitors. This includes patients going to and from procedures or on transfer from one unit to another.
Fall & Injury Prevention Management

• The exception is patients going to Rehab for physical therapy. These patients are exempt from wearing the red socks because they wear sneakers with grip to therapy. However, all other fall signage must accompany these patients.

• Humpty Dumpty stickers will be placed on the pediatric patient’s door, in front of the Patient’s chart and over the patient’s bed

• The patient and family will be educated on fall prevention and the UHB Fall Prevention Program. Education will be documented on the Patient Education Record in Health Bridge
# Universal Falls Prevention Protocol

## Prevention Interventions:

<table>
<thead>
<tr>
<th>Prevention Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. All Admitted Patients</strong> - Implement Universal interventions for all hospitalized patients.</td>
</tr>
<tr>
<td><strong>2. Communication</strong></td>
</tr>
<tr>
<td>➢ Orient patient to surroundings and hospital routines</td>
</tr>
<tr>
<td>Very important to point out location of the bathroom</td>
</tr>
<tr>
<td>If patient is confused, orientation is an ongoing process</td>
</tr>
<tr>
<td>Call light in easy reach – make sure patient is able to use it</td>
</tr>
<tr>
<td>Instruct patient to call for assistance prior to ambulating if necessary</td>
</tr>
<tr>
<td><strong>3. Toileting</strong></td>
</tr>
<tr>
<td>➢ Implement hourly rounding program</td>
</tr>
<tr>
<td>➢ Instruct patient to use hand rails in bathrooms and showers</td>
</tr>
<tr>
<td>➢ Provide a commode at bedside (if appropriate).</td>
</tr>
<tr>
<td>➢ Urinal/bedpan should be within easy reach (if appropriate).</td>
</tr>
</tbody>
</table>

**Patient/Family Education**

- Verbally inform patient and family of fall prevention interventions.

**Shift Report**

- Communicate the patient’s “at risk” status using SBAR report

**Plan of Care**

- Collaborate with multi-disciplinary team members in planning care.
- Healthcare team should tailor patient-specific prevention strategies. Inadequate to write “Fall Precautions”.
# Universal Falls Prevention Protocol

## 4. Medicating
- Evaluate medications for potential side effects.
- Consider peak effect that affects level of consciousness, gait and elimination when planning patient’s care.

Instruct patient to sit up slowly prior to ambulation.

## 5. Environment
### Bed
- Low position with brakes locked, document number of side rails.
- Regardless of score, side rails must be kept in upward position to provide protection for patients who are over 65, receiving narcotics or sedation, or who require the use of protective devices.

### Bedside stand/bedside table
- Personal belongings within reach.

### Room “clutter” - Remove unnecessary equipment and furniture
- Ensure pathway to the bathroom is free of obstacles and is lighted.
  - Consider placing patient in the bed that is close to the bathroom.

### Hallways – instruct patient to use hand rails in hallways as needed
- Recommend use of non skid slippers or shoes when ambulating

Use a night light at bedtime and as appropriate.
Falls Risk Screening vs. Falls Risk Assessment
Why do we need both?

• There is a direct relationship between a patient’s level of falls risk and their probability for falling

• Therefore, we first conduct a general screening using the Morse scale, then an assessment of individual risk factors and lastly, an screening for injury risk factors.
What is the Morse Scale?

- The Morse Fall Scale (MFS) is a reliable and simple method of assessing a patient’s likelihood of falling. A large national majority of nurses (82.9%) rate the scale as “quick and easy to use” and 54% estimate that it takes less than 3 minutes to rate a patient. The scale consists of six variables that are quick and easy to score, and provides consistent fall assessments with accurate targeting of interventions.
  - History of falling
  - Secondary diagnosis
  - Ambulatory aid
  - IV therapy/ heparin (saline) lock
  - Gait
  - Mental status
Falls Risk and Medications

These medications, or conditions they treat, are commonly associated with falls. Drugs may affect balance, blood pressure, or sedation.

**Benzodiazepines** (ex: Lorazepam, Midazolam)

**Diuretics** (ex: Furosemide, Hydrochlorothiazide)

**Antihypertensives** (ex: Labetalol, Carvedilol, Terazosin, Nitrates, Hydralazine)

**Hypnotics** (ex: Zolpidem, Diphenhydramine)

**Anticonvulsants** (ex: Phenytoin, Levetiracetam)

**Antipsychotics** (ex: Haloperidol, Ziprasidone, Risperidone)

**Opiates** (ex: Morphine, Fentanyl)

**Antidepressants** (ex: Amitriptyline, Trazodone)

**Oral Hypoglycemics** (ex: Glyburide, Glipizide)

**Did you know**

4 or MORE of ANY medications is associated with higher risk for falls?
IF THE PATIENT FALLS

• Immediately post fall
• Assess for injuries and provide reassurance (do not move patient until injury has been ruled out)
• Notify physician, nurse manager or charge nurse, nursing supervisor (on off shift)
• Assist patient back to bed when safe
• Initiate neuro observations if head injury suspected, if patient was witnessed to hit head, if level of consciousness has changed
• Ensure that patient’s family is notified
IF THE PATIENT FALLS

• Conduct Post Falls Huddle

• Complete the following forms
  – Joint Commission (TJC) Targeted Solution Tool
    “Fall Event Data Collection Form”
  – Patient Incident Report form

• Review and revise care plan if necessary

• Document fall occurrence, nursing assessment, post falls interventions, and patient response in a KBC EVENT note
This section of your Annual Mandatory Education Program includes the following topics:

- Fire Safety
- Electrical Safety
- Hazard Communication
- Radiation Safety
- Disaster/Emergency Preparedness
- Security Management
- Environmental Safety
- Magnetic Resonance Imaging – Safety Issues
This presentation provides an overview of occupational safety topics that you need to be aware of while working or volunteering at the SUNY Downstate Medical Center.
FIRE SAFETY
State the three elements that complete the fire triangle and how to prevent fire.

Describe the steps to take during a fire using A.R.C.E. and P.A.S.S.

State your responsibilities during a fire:
- pulling the alarm, alert occupants, and dialing x2626 and reporting the location of the fire.
FIRE TRIANGLE

Fire Triangle

Oxygen

Heat

Chemical Reaction

Fuel
Oxygen, heat, and fuel are frequently referred to as the "fire triangle."

The important thing to remember is: take any of these elements away and you will not have a fire or the fire will be extinguished.

Fire extinguishers put out fire by taking away one or more elements of the fire triangle.
Fire safety, at its most basic, is based upon the principle of keeping fuel sources and ignition sources separate.
What Do We Do When We Discover A Fire?
Any employee discovering fire or the presence of heat and/or smoke must immediately cause an alarm by shouting “code red” and activating the fire alarm.

Go to the nearest pull station and pull on the lever. Dial x2626, identify yourself and give the operator the exact location of the fire: building, floor, room number and your name.
Let everyone know that a fire exists.

- Shouting “**Code Red**”
- Pull a fire alarm box
- Call **x2626** for the University Police
R-ESCUE/R-EMOVE

- **Rescue/Remove** anyone in immediate danger
- Make certain that all patients or employees are removed from immediate danger of fire or smoke, if possible
C-ONTAIN

- Don’t allow smoke and fire to spread
- **Contain** fire by closing doors and windows
- Move combustible materials away from the fire area
- Close all doors and windows to confine the fire, smoke, heat or gases.
- Keep office doors closed
In the event that an evacuation is necessary, the first stage is a horizontal evacuation to the adjacent compartment (i.e. east/west across the double corridors doors)

A vertical evacuation maybe required an executed at the direction of the Fire Marshal

Employees, clients and visitors are moved downward and out of the building

Elevators are not to be used for evacuation
If the fire is small, you may attempt to put it out with the appropriate extinguisher.

Use an extinguisher only after you have initiated an alarm and rescued anyone in danger.

Do not attempt to extinguish the fire if in doing so you endanger yourself or anyone else.
The most common type of fire extinguisher on our campus is: “A,B,C” Dry chemical Fire Extinguisher. They can be used on the following types of fires:

- ordinary combustible fires
- flammable liquid fires
- electrical equipment fires
CLASS A FIRES

- Ordinary combustibles
  - Wood
  - Paper
  - Plastic
  - Garbage
Flammable liquids

- Gasoline
- Kerosene
- Solvents
- Oil
Energized electrical equipment
- Appliances
- Switches
- Panel boxes
- Power tools
HOW TO USE A FIRE EXTINGUISHER

- Pull
- Aim
- Squeeze
- Sweep
When a fire situation is discovered the term “Code Red” shall be called out loud by any personnel.

Any person hearing the phrase “Code Red” shall go to the aid of that person calling the “Code Red”

Any person in the area upon hearing “Code Red” called out loud shall pull the fire alarm.

If the alarms are inoperative call/dial “x2626”. State “Code Red”
Procedures Used in Case of a Fire Alarm

- Do not use elevators
- Do not transport patients until code race is cleared
- Close all doors and windows
- Keep telephone lines clear (answer only)
- Wait for “all clear” signal
- Nursing personnel must know location of unit’s oxygen shut off valve
- The charge nurse is responsible for turning off the oxygen shut off valve in case of a fire emergency
In the event of fire alarm activation (pull-station, heat detector, corridor smoke detector or water flow-sprinkler)

- Strobes flash, alarm sounds and a pre-recorded voice message on the fire alarm activation compartment, as well as the adjacent compartments.

- The notification will be as follows:

"Code Red, Code Red, Hospital Building, 4th Floor, Nurse Station 42." – REPEATED THREE TIMES –
An alarm condition will annunciate *(audible and visual indication)* at each Nurses Station annunciator panel. Nursing Staff on the floors adjacent compartment will respond and assist the affected Nursing Station.
The affected compartment will investigate and prepare for horizontal evacuation.

The adjacent compartment will prepare corridors for evacuating patients.

“Attention... Your attention please... An emergency condition has been reported in your area. Affected areas prepare for horizontal evacuation. If asked to evacuate, walk, do not use elevator. Walk, do not use elevator.”
“Attention... Your attention please... An emergency condition has been reported in your area.

Affected areas prepare for horizontal evacuation. If asked to evacuate, walk, do not use elevator. Walk, do not use elevator.”
“Attention... Your attention please... The building emergency condition has been cleared...you may return to your normal activities...the building emergency condition has been cleared... you may return to your normal activities.”
Don’t waste time. While someone is activating the alarm, other personnel should begin to remove individuals from the area of immediate danger, close windows and doors.

Always remain as calm as possible.

Communicate and work together as a team.
HAZARD COMMUNICATIONS

YOU HAVE A RIGHT-TO-KNOW!
LEARNING OBJECTIVES

- Define a hazardous chemical.
- Recognize physical and health hazard warnings on container labels.
- Locate and review Safety Data Sheets (SDS), to identify health and safety risks associated with chemicals.
- Identify requirements for proper secondary container labeling, chemical spill clean-up, and personal protective equipment.
Hazard Communication Program Elements

- Written Program
- Chemical List
- Maintain Safety Data Sheets
- Labeling
- Training

HazCom Program
The Right-To-Know Law or Hazard Communication Standard require employers to provided training upon initial assignment and when new chemical hazard is introduced.

Give information pertaining to hazardous materials in the workplace. Upon an employee’s request, the employer shall provide a safety data sheet (SDS) specific to the chemical.
The Safety Data Sheet or SDS, is a document supplied by the chemical manufacturer that describes the characteristics of their products.
How to Gain Access to Downstate Medical Center Safety Data Sheet (SDS) On-line

Please follow all instructions carefully. If any difficulties are encountered while trying to gain access to this information, please call the Environmental Health & Safety Office at x1216.

1. Go to www.downstate.edu
2. On the left side of the computer screen, there is a list of services offered by SUNY. Click on the "Administration"
3. Scroll Down to "Intranet"
4. Click On: "Safety Data Sheets"
5. A search page comes-up with the following information:
   
   | Common Name: | __________________________________________ |
   | Manufacture Name: | __________________________________________ |
   | Full Text: | __________________________________________ |

6. Type in name of chemical or the manufacturers’ name, whichever is applicable/available. Then click on the ‘Search option’
7. If no results came up when using the name of the chemical or the manufacturer’s name, a full-text search with name of the chemical can also be done to find the available information.
Safety Data Sheets (SDS)

- Obtain SDS for all hazardous chemicals present or produced
- Obtain from manufacturer, distributor, retailer, or on-line resources
- Organize SDS so they may be located quickly
- SDS must be readily accessible to employees during all shifts
Chemicals can only cause health effects when they come into contact with your body.

**Routes of Entry**
- Skin contact (absorption through the skin or damage on contact to skin or eyes)
- Inhalation
- Ingestion
- Injection
How are Hazards Communicated – Label Elements

- **Signal word** – Indicate the relative level of severity of hazard and alerts the reader to a potential hazard on the label
  - *Danger* – used for more severe hazards
  - *Warning* – used for less severe

- **Hazard statement** – Describes the nature of the hazard(s) of a chemical, including, where appropriate, the degree of hazard
  - Toxic if inhaled
  - Causes severe burns and eye damage
  - Extremely flammable liquid

- **Pictograms**
# GHS Pictograms

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

<table>
<thead>
<tr>
<th>Gas Cylinder</th>
<th>Corrosion</th>
<th>Exploding Bomb</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Gases Under Pressure</td>
<td>- Skin Corrosion/Burns</td>
<td>- Explosives</td>
</tr>
<tr>
<td></td>
<td>- Eye Damage</td>
<td>- Self-Reactives</td>
</tr>
<tr>
<td></td>
<td>- Corrosive to Metals</td>
<td>- Organic Peroxides</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Flame Over Circle</th>
<th>Environment</th>
<th>Skull and Crossbones</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Oxidizers</td>
<td>- Aquatic Toxicity</td>
<td>- Acute Toxicity (fatal or toxic)</td>
</tr>
<tr>
<td></td>
<td>(Non-Mandatory)</td>
<td></td>
</tr>
</tbody>
</table>
Product Identifier
CODE __________________________
Product Name ____________________

Supplier Identification
Company Name ____________________
Street Address ____________________
City __________________ State ______
Postal Code __________ Country ______
Emergency Phone Number __________

Precautionary Statements
Keep container tightly closed. Store in cool, well ventilated place that is locked.
Keep away from heat/sparks/open flame. No smoking.
Only use non-sparking tools.
Use explosion-proof electrical equipment.
Take precautionary measure against static discharge.
Ground and bond container and receiving equipment.
Do not breathe vapors.
Wear Protective gloves.
Do not eat, drink or smoke when using this product.
Wash hands thoroughly after handling.
Dispose of in accordance with local, regional, national, international regulations as specified.

In Case of Fire: use dry chemical (BC) or Carbon dioxide (CO₂) fire extinguisher to extinguish.

First Aid
If exposed call Poison Center.
If on skin (on hair): Take off immediately any contaminated clothing.
Rinse skin with water.
You have the right to work in an environment that is free from recognized hazards that are likely to cause death or serious harm.

You also have the right to:
- information about workplace hazards,
- exercise your rights without discrimination or reprisal.
– request your medical examination and exposure monitoring results.

- Receive hazard communication training upon hire and refresher training as needed thereafter.
Use personal protective equipment as required.
Inform your supervisor of accidents, chemical exposure symptoms, unlabeled containers, and malfunctioning or unsafe equipment.
Follow safety procedures including container labeling, safe use, storage and disposal.
HAZARDOUS MATERIALS AND WASTE
LEARNING OBJECTIVES

- Identify the key components of the Hazard communication program: Right-to-Know, Safety Data Sheets (SDS) and PPE’s.

- Identify the different types of waste streams in the Hospitals and Health Centers and how to properly dispose of waste.
Hazardous waste consist of the following categories:

- regulated medical waste or infectious waste
- chemical waste
- radioactive waste
The General Categories of regulated medical waste are:

- Clinical sharps that include but are not limited to:
  - *Medical needles*
  - *Scalpel blades*
  - *Glass slides*
  - *Blood vials*
Human blood and blood products, including plasma and blood-soaked materials.

Human pathological materials:

- **Body tissues**
- **Organs**
- ** Fluids**
Regulated Medical Waste

Culture and stocks of:

- *Infectious agents*
- *Vaccines*
- *And the items contaminated by these materials*
Regulated Medical Waste

- Animal pathological materials:
  - Animal tissues
  - Organs
  - Body fluids
  - Carcasses
  - And beddings

- Any item that has the bio-hazard symbol on it
Handling Regulated Medical Waste

- Regulated medical wastes are placed in red bags, specially designed and marked containers and removed from site for decontamination or destruction.
- Regulated medical waste is never mixed with regular garbage.
Chemical wastes are any liquid, solid or gaseous substances which are flammable, have toxic properties, can cause air and water pollution if released into the atmosphere, or produce adverse physiological reaction.
Disposal of chemical wastes is handled by the Office of Environmental Health & Safety @ x1216 or x3389.

The waste must be in appropriate containers with labels of the waste’s identity or composition.
Radioactive materials are solid, liquid, or gaseous substances that emit ionizing radiation. When they lose their radioactive properties, they can be disposed of as chemical waste.
Handling of Radioactive Waste

- Procurement of radioactive materials and disposal of radioactive waste are coordinated by the Office of Radiation Physics @ x1423.
Electrical Safety

- Check to ensure equipment maintenance sticker is current prior to use.
- Extension cord use is **prohibited**.
- Power strips with a circuit breaker are permitted.
- Inspect all equipment and cords for damaged wiring, plugs, cords, EKG leads, etc.
Electrical Safety

- Use caution when operating electrically powered equipment around sources of water (sinks & wet floors)
- If equipment does not operate properly, turn it off, unplug it, affix a defective tag, notify supervisor and send equipment for repair
Any equipment or Biomedical device (purchased, rented and loaned) must be inspected by the Scientific Measurement, Instrumentation & Calibration Department (SMIC) prior to use.

Send all malfunctioning medical equipment to SMIC Department or call x2385.
Emergency Generator Outlet System

- Provides emergency power if an electrical failure occurs.
- The **red outlets** are used for life support equipment such as ventilators, cardiac monitors etc.
- Always disconnect plugs from the wall by grasping the safety plug and not the power cord.
RADIATION SAFETY
Radiation Safety

The guidelines for radiation safety include:
• The less time in contact with the source, the less exposure
• “Maximum Exposure” allowed is ½ hour per provider shift
• A film badge or dosimeter should be worn by all employees in close proximity to patients
Radiation Safety

- In general pregnant health care providers receiving diagnostic or therapeutic treatments should not care for patients with implants or assist with x-ray examinations.
- Consult the Radiation Office at x1423 for specific instructions.
- Children under 18 are not allowed to visit patients with implants or work radiation devices unless enrolled in a specific course.
Radiation Safety

- Personal Safety Measures:
  - Wear a film badge when performing all duties which involve x-ray machines and radioactive sealed or unsealed sources.
  - Wear only the film badge assigned to you. Do not exchange badges with co-workers.
  - Report lost or misplaced film badges to the Radiation Office so that a replacement can be issued.
Radiation Safety

- Do not interchange film badges or wear both badges, if working at more than one institution.
- Do not wear film badge while receiving medical or dental x-rays.
- Do not expose film badges to extreme heat.
- Do not wear film badge under lead or shielding aprons.
Radiation Safety

- Wear appropriate shielding when assisting patients.
- Leave the room or stand 6 feet from the source while portable x-rays are taken, unless wearing protective gear.
Disaster/Emergency Preparedness
Emergency Preparedness Plan

- The emergency preparedness plan outlines your role and responsibilities should a disaster occur in the hospital or in the community.
- Be sure to learn and follow your department’s specific disaster and call back plan.
- In the event that you receive a bomb threat, you MUST notify:
  - University Police at x2626
  - and your immediate supervisor.
Who Ya Gonna Call for other codes?

CODE BUSTERS
FOR CARDIAC ARREST (aka CODE 99) and EARLY ACTIVATION CODE 66
CALL x2323 - adult
CALL x4040 - child

The operator will announce this as a “Code 99” - a notification that a patient, visitor, or staff member is experiencing a medical emergency.
DO WE HAVE OTHER CODES?
Yes!

- **Code D**
  - Full Disaster

- **Code H**
  - Acute Chest Pain (Dial x2323)

- **Code M (MOM)**
  - Maternal Hemorrhage/Emergency (Dial extension 2323)

- **Code PINK**
  - Infant Abduction (Dial x2121)

- **Code N**
  - Neonatal Emergency (Dial x4040)

- **Code S**
  - Acute Stroke (Dial x2323)

- **Code SI**
  - Acute Stroke Intervention (Dial x2323)

- **Code Ice**
  - Induced hypothermia for post cardiac arrest victims via EMS (Dial x2323)
What if I need Security STAT call ext 2626
Identification Cards

- Wearing an identification card maintains a safe and secure hospital environment
- Patients have the right to know who is providing care for them (It is the law!)
- Co-workers have the right to know your name, title, and department
Reporting a Security Incident

- All UHB staff who witness physical altercations, theft, observe anyone with a weapon, and any other incidents must immediately call University Police at x2626
Environmental Safety

- **Spills**
  - Wet floors are one of the most common reasons people fall

- **Falls**
  - Prevent falls by
    - Identifying people at risk for falls
    - Reporting dangerous situations such as wet floors or wires/cables on the floor

- **The Environment**
  - Make sure the environment is
    - clear of clutter, wires, and spills
    - well lighted

- **Pushing Carts**
  - Always be able to see over the cart that you are pushing
  - Items **MUST NOT** be above eye level
  - Make sure to remove any objects that may obstruct your view
  - Just like driving a car, **KEEP YOUR EYES ON THE ROAD** at all times so you are able to see where you are going
**Report Spills and Prevent Falls**

- **Reporting Spills**
  - Notify your manager and the appropriate emergency responders immediately
  - Contact Environmental Services Department Monday – Friday: 7:00 AM – 5:00 PM at x2997 or x2998
    - After 5:00 PM: in the event voicemail picks up, call the Page Operator (x2121) and have them contact the housekeeping supervisor on the shift
    - Weekends: in the event voicemail picks up, contact the Page Operator (x2121) and have a housekeeping supervisor contacted
  - **Information to Report:**
    - Name and extension of person reporting the spill
    - Exact location of the spill
    - What instrument was broken
    - Amount of water or liquid
    - What action has been taken so far

- **Precautions Taken By Cleaner:**
  - Caution signs are placed
  - Gloves are worn
  - Safety Glasses or Goggles are used
For your safety and the safety of your patients, please remember

- **THE MAGNET IS ALWAYS ON!!!!!!**

Failure to maintain safety in this restricted area can result in serious injury or death

The primary danger related to MRI is the powerful magnetic field that will attract iron–containing objects and may cause them to move suddenly

- This sudden movement is called the Missile Effect and poses a risk to the patient or anyone in an object’s flight path
Magnetic Resonance Imaging

The following items **CANNOT** be brought into the area where the MRI system is located

- Screwdrivers
- Hammers
- Knives
- Keys
- IV poles
- Mops/Metal buckets

- Oxygen tanks
- Watches
- Jewelry
- Items/clothing that may have metallic threads or fasteners
- Patients with
  - implants (surgical clips, orthopedic hardware, pacemakers, ICDs)
  - Nicotine patches
  - tattoos
How Do I Respond to the Media

- Refer the media (newspaper, radio, reporters, TV) inquires/questions to Institutional Advancement at x1176 or to the administrator-on-duty on off-tours, weekends, and holidays
Workplace Safety
Protect Your Back; Protect Your Patients
Proper Body Mechanics

Definition: Body mechanics is the utilization of correct muscles to complete a task safely and efficiently, without undue strain on any muscle or joint.
Principles of Good Body Mechanics

- Maintain a stable center of gravity
  - Keep your center of gravity low
  - Keep your back straight
  - Bend at the knees and hips

- Maintain a Wide Base of Support. This will provide you with maximum stability while lifting
  - Keep your feet apart
  - Place one foot slightly ahead of the other
  - Flex your knees to absorb jolts
  - Turn with your feet

- Maintain the Line of Gravity. The line should pass vertically through the base of support
  - Keep your back straight
  - Keep the object being lifted close to your body

- Maintain Proper Body Alignment.
  - Tuck in your buttocks
  - Pull your abdomen in and up
  - Keep your back flat
  - Keep your head up
  - Keep your chin in
  - Keep your weight forward and supported on the outside of your feet
Techniques of Good Body Mechanics

- **Lifting**
  - Use the stronger leg muscles for lifting
  - Bend at the knees and hips; keep your back straight
  - Lift straight upward, in one smooth motion

- **Reaching**
  - Stand directly in front of and close to the object
  - Avoid twisting or stretching
  - Use a stool or ladder for high objects
  - Maintain a good balance and a firm base of support
  - Before moving the object, be sure that it is not too large or too heavy

- **Pivoting**
  - Place one foot slightly ahead of the other
  - Turn both feet at the same time, pivoting on the heel of one foot and the toe of the other
  - Maintain a good center of gravity while holding or carrying the object

- **Avoid Stooping**
  - Squat (bending at the hips and knees)
  - Avoid stooping (bending at the waist)
  - Use your leg muscles to return to an upright position
General Considerations

- It is easier to pull, push, or roll an object than it is to lift it.
- Movements should be smooth and coordinated.
- Less energy or force is required to keep an object moving than it is to start and stop it.
- Use the arm and leg muscles as much as possible, the back muscles as little as possible.
- Keep the work as close as possible to your body. It puts less of a strain on your back, legs, and arms.
- Rock backward or forward on your feet to use your body weight as a pushing or pulling force.
- Keep the work at a comfortable height to avoid excessive bending at the waist.
- Keep your body in good physical condition to reduce the chance of injury.
When lifting or moving patients, there are a number of factors which can lead to the development or aggravation of back injuries, including:

1. *Physical demands of work*
2. *Equipment and facilities*
3. *Work practices or administrative issues*
4. *Personal factors*
Be cautious of
Bending, twisting or reaching when:
Attaching gait or transfer belts with handles (e.g., the bed or chair is too low or far away)
Providing in-bed medical care (e.g., the bed is too low and side rails up)
Washing patient’s legs and feet in a shower chair (e.g., the shower chair is too low and access is limited)
Dressing or undressing patients or residents
Repositioning or turning patients in bed (e.g., the side rails are up, bed is too low, and the provider reaches across patient or resident)
Performing stand-pivot transfers (e.g., the wheelchair is too far from the bed and the providers twist their bodies instead of moving their feet)
Top: Incorrect lifting technique
Bottom: Proper lifting technique

- Pick up load and bring it close to you
- Lift by using your legs and buttocks and push up to straighten your body
- If turning, **DON’T** twist. Turn your feet by taking small steps
Use proper body mechanics in order to avoid the following:

- Excessive fatigue
- Muscle strains or tears
- Skeletal injuries
- Injury to the patient
- Injury to assisting staff members
Abuse, Neglect, and Exploitation
Mandated Reporters

- Physician
- Registered physician's assistant
- Surgeon
- Medical examiner
- Coroner
- Dentist
- Dental hygienist
- Osteopath
- Optometrist
- Chiropractor
- Podiatrist
- Resident
- Intern
- Psychologist
- Registered nurse
- Social worker
- Emergency medical technician
- Licensed creative arts therapist
- Licensed marriage and family therapist
- Licensed mental health counselor
- Licensed psychoanalyst
- Hospital personnel engaged in the admission, examination, care, or treatment of persons
- Christian Science practitioner
- Alcoholism counselor

- All persons credentialed by the office of alcoholism and substance abuse services
- School official, including (but is not limited to):
  - school teacher
  - school guidance counselor
  - school psychologist
  - school social worker
  - school nurse
  - school administrator or other school personnel required to hold a teaching or administrative license or certificate
- Social services worker *
- Day care center worker
- School-age child care worker
- Provider of family or group family day care
- Employee or volunteer in a residential care facility for children
- Any other child care or foster care worker
- Mental health professional
- Substance abuse counselor
- Peace officer
- Police officer
- District attorney or assistant district attorney
- Investigator employed in the office of the district attorney
- Any other law enforcement official
Child Abuse

Reporting of Suspected Child Abuse or Maltreatment
CHILD ABUSE

• Each hospital shall have a designated staff member to coordinate reporting activities and to accept reports from mandated reporters within the hospital who have direct knowledge of and/or suspect the abuse or maltreatment.

• In this institution, the Social Work Department is contacted to facilitate this process.
Definition of an Abused Child

- Child under 18 years of age who:
- Has been inflicted with physical injury by other than accidental means which has caused risk of death, disfigurement, physical or emotional health problems or loss or impairment of bodily functions
- Has had a sex offense committed against him/her
- Has been allowed or encouraged to engage in acts of prostitution or other sexual acts.

» Social Services Law, Sec. 412
Guidelines for Mandated DMC Hospital Staff to Respond to Suspected Child Abuse or Maltreatment Cases

• In accordance with New York State Law, University Hospital of Brooklyn will report all cases of suspected child abuse and ensure the welfare and safety of any child brought to the hospital for treatment.
Reporting Requirements for Mandated Reporters

• Chapter 193 of the Laws of 2007 amended The Social Services Law, section 413 regarding the reporting requirements for mandated reporters who have direct knowledge of or reasonable cause to suspect child abuse or maltreatment.

• This law states that any mandated reporter who works for a medical institution **MUST PERSONALLY REPORT** any case of suspected child abuse or maltreatment to the State Central Register (SCR) of the Administration for Children’s Services (ACS).

• This new obligation to personally report eliminates the opportunity for facilities to utilize a designated reporter who does not have personal knowledge of
Reporting Requirements for Mandated Reporters

• Once one mandated reporter makes the report, any other mandated reporters with direct knowledge of the possible abuse or maltreatment who know that a report was made are not required to make a separate additional report.

• The person making the report must immediately notify the designated agent of the person in charge and provide the information reported to the SCR, including other persons:
  • with knowledge of the abuse/maltreatment
  • having reasonable cause to suspect child abuse or maltreatment

• The mandated reporter must inform other mandated reporters that the report was made to the SCR and whether the report was accepted or not.
A maltreated or neglected child

- A child under 18 years whose:
  - Mental or emotional condition has been impaired or is in danger of becoming impaired as a result of failure or unwillingness of his/her parent or legal guardian to provide a minimum degree of care:
    - Not providing food, shelter, clothing, education, medical or surgical care though financially able to do so or offered the means to do so.
    - Inflicts harm or corporal punishment
    - Misuses a drug on a child
    - Abandons the child
  » Family Court Act, Sec 1012 (e)
Reasonable Cause

Certainty or proof is not required before reporting suspected child abuse or neglect.

- The law purposely requires only “reasonable cause to suspect” that a child is abused or maltreated.

- Based on what you have observed or been told, combined with your training and experience, you feel that harm or imminent danger of harm to the child could be the result of an act or omission by the person legally responsible for the child.
Where to Call to Make a Report

New York State Central Register:

- Mandated Reporter (800)-635-1522
- Website: www.ocfs.state.ny.us
- Available 24/7
- **Anonymous report** - not required to notify the parents or legal guardians before or after you make the call
Legal Protections for Mandated Reporters

- **Immunity**: Any person, officials or institutions who in good faith make a report, take photographs and/or take protective custody have immunity from civil or criminal liability.

- **Confidentiality**: Identity of the person who made the report will not be released without consent.

- No medical, public or private institution, school, facility or agency shall take any action against an employee who makes a report to the NYSCR.
Consequences for Failing to Report

Mandated reporters who willfully fail to report:

- **Legal Repercussions**
  - May be guilty of a Class A misdemeanor
  - May be civilly liable for the damages caused by such failure to report

- **Societal Repercussions**
  - Child Protective Service cannot act until a report is made
  - Help cannot be offered to family and child cannot be protected from further abuse
Abuse

• Calling the State Central Register
  • Mandated Reporter Hotline: 1-800-635-1522
  • Telephone call must be made immediately

• Child Abuse Reporting Form: DSS-2221-A
Social Service Department

• The Social Work Department will continue to follow the case and coordinate the disposition process.

• No child will be discharged from the hospital without appropriate communication between the social worker, ACS and the medical team.
What YOU Know About Domestic Violence Can Save A Life !!!!!
Give Me The Facts!!!!!!!

✓ 1 in 4 households are involved in active abuse
✓ Domestic violence carries over into the workplace
Could I Be a Victim of Domestic Violence?

✓ Does my Partner:
  ✓ constantly criticize me
  ✓ behave in an over-protective or jealous manner
  ✓ threaten to hurt me or my children
  ✓ prevent me from seeing my family
  ✓ get suddenly angry or “lose temper”
  ✓ destroy personal property/throw things around
  ✓ deny me access to bank accounts, credit cards, car
  ✓ hit, punch, slap, kick, shove, choke me
  ✓ use intimidation or manipulation
  ✓ humiliate or embarrass me
DOMESTIC VIOLENCE in the WORKPLACE

Domestic violence is a pattern of controlling behavior which can be physical, sexual, economic, emotional, and/or psychological.

TACTICS OF CONTROL
a. physical violence
b. sexual violence
c. emotional/psychological abuse
d. isolation, coercion, threats
e. minimizing, denying and blaming
f. using children
g. using male privilege
h. economic abuse
Signs of Domestic Violence

- Unexplained injuries
- Stories that don't make sense
- Excessive absences and medical appointments
- Anxiousness
- Startles easily
- Difficulty making decisions
- Changes in appearance, behavior

Places to contact for help outside UHB:
- Safe Horizon’s Domestic Violence Hotline:
  800.621.HOPE (4673)
- NYC Domestic Violence Hotline (all languages)
  (800) 621-4673 TDD: (866) 604-5350
Am I the Only One? Can somebody HELP?

✓ Support Groups will enable you to talk to other women who are in your situation
✓ 24 hour HOTLINES:

✓ NY Coalition Against Domestic Violence 1-800-942-6906

✓ NY Spanish Speaking Hotline 1-800-942-6908

✓ NYC Domestic Violence Shelter Unit 1-800-621-HOPE
What is Exploitation?

☑ Any attempt by any individual, whether immediate family member, relative, friend or acquaintance, to take financial or emotional advantage of and over the patient or any physical threat based on financial pressure towards the patient
Elder Abuse

- Elder Abuse and Neglect has been around for centuries
- It is the most recent form of family violence to come to public attention
- Abuse may be physical abuse, physical neglect, psychological abuse, financial or material abuse, violation of personal rights
- It occurs among men and women of all racial, ethnic and socioeconomic groups
- The perpetrator of abuse is often the spouse, an adult child, or informal caregivers
Report Suspected Cases of Abuse to Your Supervisor
WORKPLACE VIOLENCE:
Awareness, Prevention, Response
Workplace Violence

Did you know that

- 1 out of 4 employees were attacked, threatened, or harassed at work in the last year

Policy

- All employees have a right to work in an environment free from discrimination, verbal abuse, sexual harassment, and violence
TYPES OF VIOLENCE

- HITTING
- SHOVING
- PUSHING
- KICKING
- SEXUAL ASSAULTS

SOURCES OF VIOLENCE

**Internal**
comes from within the organization and is caused by employees or former employees

**External**
comes from outside the organization such as angry visitors and patients
CAUSES OF VIOLENCE

- Unstable economy
- Widespread job layoffs
- Rigid, authoritarian style of management
- Insensitive terminations
- Pressure for increased productivity
- Psychological instability
- Lack of individual responsibility

PATIENT AND VISITOR CAUSES

- They aren’t satisfied with the service
- They have to wait
- Mistakes are made
- Promises aren’t kept
KNOW THE WARNING SIGNS

- Direct threats
  - “I’ll get even with him”

- Veiled threats
  - “This place would shut down for days if the mainframe crashed and the backup was damaged”

- Conditional threats
  - “If I’m fired they will be really sorry”

- Is usually argumentative
- Doesn’t cooperate well with others
- Has a problem with authority figures
- Frequently blames others for problems
- Demonstrates extreme or bizarre behavior
- Frequently appears depressed
- Is involved in alcohol or drug abuse
- Has a history of violence
DEFINITIONS

Workplace Violence

Unwelcome physical or psychological forms of harassment, threats or attacks that cause fear, mental or physical harm or unreasonable stress in the workplace.

Harassment

The act of someone creating a hostile work environment through unwelcome words, actions or physical contact or stalking behavior NOT resulting in physical harm.

Bullying

Negative actions committed repeatedly and over time, on the part of one or more other persons to another person or group. “Negative actions” can be understood as "when a person intentionally inflicts injury or discomfort upon another person, through physical contact, through words or in other ways.”
THREAT

An expression of an intent to cause physical harm at that time or in the future. Any words, slurs, gestures, stalking behavior or display of weapons which are perceived by the worker as a clear and real threat to her or his safety and which may cause fear, anxiety or the inability to perform job functions.

Physical Attack

With or without the use of a weapon, a physical attack is any aggressive act of hitting, kicking, pushing, biting, scratching, sexual attack or any other such physical act directed to the worker by a co-worker, patient, client, relative or associated individual which arises during or as a result of the performance of duties and which results in death or physical injury.
Profile + Observable Warning Signs + Shotgun + Triggering Event = Always Lethal

Profile (of potentially violent persons):

1. Previous history of violence, toward the vulnerable, e.g., women, children, animals
2. Loner, withdrawn; feels nobody listens to him; views change with fear
3. Emotional problems, e.g., substance abuse, depression, low self-esteem
4. Career Frustration – either significant tenure on the same job OR migratory job history
5. Antagonistic relationships with others
6. Some type of obsession, e.g., weapons, other acts of violence, romantic/sexual, zealot (political, religious, racial), the job itself, neatness and order
Profile + Observable Warning Signs + Shotgun + Triggering Event = Always Lethal

Observable Warning Signs (often newly acquired negative traits):
1. Violent and Threatening Behavior, hostility, approval of the use of violence
2. "Strange" Behavior, e.g., becoming reclusive, deteriorating appearance/ hygiene, erratic behavior
3. Emotional Problems, e.g., drug/alcohol abuse, under unusual stress, depression, inappropriate emotional display
4. Performance Problems, including problems with attendance or tardiness
5. Interpersonal Problems, e.g., numerous conflicts, hyper-sensitivity, resentment
6. "At the end of his rope", e.g., indicators of impending suicide, has an unspecified plan to "solve all problems"
Profile + Observable Warning Signs + Shotgun + Triggering Event = Always Lethal

**Triggering Event** (the last straw, no way out, no more options):
1. Being fired, laid off or suspended; passed over for promotion
2. Disciplinary action, poor performance review, criticism from boss or coworkers
3. Bank or court action (e.g., foreclosure, restraining order, custody hearing)
4. Benchmark date (e.g., company anniversary, chronological age, Hitler's birthday ß as was the case for Columbine)
5. Failed or spurned romance; personal crisis (e.g., divorce, death in family)
HOW TO PROTECT YOURSELF IF CONFRONTED WITH A POTENTIALLY VIOLENT PERSON?

1. Understand the mindset of the hostile or potentially violent person
2. Practice "Active Listening"

3. Avoid confrontation. Instead, build trust and provide help
4. Allow a total airing of the grievance without comment or judgment
5. Allow the aggrieved party to suggest a solution
6. Move toward a win-win resolution
REPORTING WORKPLACE VIOLENCE

- All staff and volunteers are required to promptly report any incidence of workplace violence including threats and menacing behavior to their immediate supervisor and Security.
- All incidents must be recorded on an Employee Workplace Incident Report form.
- There is an interdisciplinary task force charged with analyzing and tracking incidents of workplace violence, reviewing security measures and procedures, and evaluating workplace safety hazards.
UHB Management is committed to the emotional and physical safety of all DMC personnel as well as UHB patients and to a respectful workplace.
Identification and Management of Patients At Risk For Suicide

• Policy PSY-2:
  – **ALL** healthcare providers are responsible for recognizing and observing patient’s suicidal feelings and behavior

  – **ALL** UHB staff are responsible for reporting observations of patient’s suicidal feelings and behavior to the appropriate health care provide immediately (RN, LPN, MD)
Identification and Management of Patients At Risk For Suicide

- Risk Factors for Suicide
  - Current suicidal ideation, intention, plan or suicidal behavior
  - Poor impulse control or poor frustration tolerance
  - Withdrawn or isolative behavior
  - Current symptoms of depression, anxiety, agitation of psychosis
  - Current hallucinations, especially command hallucinations and delirium
  - Presence of borderline personality disorder, especially with self-destructive tendencies
  - History of suicide attempts/ self-harm
  - Recent significant loss (e.g., spouse, job, etc)
  - Chronic serious mental illness
  - Excessive guilt or remorse
  - Family history of suicide
  - Feelings of hopelessness, worthlessness or helplessness
  - Marked change in behavior at home, job and/or leisure activities
  - Sudden improvement in mood
Identification and Management of Patients At Risk For Suicide

- Licensed Nursing and Medical Staff are responsible for:
  - Conducting a suicide risk assessment on admission and ongoing throughout length of stay (change in behavior/ideation)
  - Completing nursing admission note addendum (see side 2)
  - Initiating suicide observation (1:1), as per policy
  - Notifying MD immediately to obtain a Psychiatric consultation
  - Searching patient and environment for unsafe objects and
    Removing those objects from the environment (e.g. razors, nail files, glass objects, belts, ties, pantyhose, medications, matches, lighters, cords, breakable utensils, antiseptic solutions, alcohol, lotion, gauze, kling)

- Unlicensed Staff are responsible for:
  - Reporting observations of suicidal behavior or ideation immediately to RN/Charge Nurse, LPN, or MD
Identification and Management of Patients At Risk For Suicide

• Documentation:
  – **Progress Notes must include:**
    • At risk behaviors
    • MD notification: name of MD, time
    • Note: Face-to-Face Psychiatric consultation and evaluation of the patient must occur within 1 hour
  – Interventions (e.g., institution of 1:1 observation)
  – Patient response
  – Resources provided to patient/family
  – Patient/family teaching
  – Discharge planning

  – **One-To-One Observation Record**
    • Complete Form as per policy
Identification and Management of Patients At Risk For Suicide

- Assessment
  - Complete Suicide Initial Risk Assessment Form
    - Contained within the Nursing Admission Database
  - Q-Shift Re-assessment form
  - 1:1 Observation Form (See Below)
- For patients who were identified to be at risk or new risk identified
- Place Patient on 1:1 Observation for Suicide Precautions
  - Complete 1:1 Observation Record For Suicide/Self-Harm
- Search patient and room for contraband that might be used to harm self or others
- Request Psychiatric consult within 1 hour to assess patient
- Notify Patient Safety Department at extension 3709
- Provide patient/family/significant other with written Crisis Prevention information
Stroke - Basics
Warning Signs of Stroke

- Sudden weakness or numbness of the face, arm or leg (especially on one side of the body).
- Sudden trouble seeing in one or both eyes.
- Sudden confusion trouble speaking or understanding.
- Trouble walking, dizziness, loss of balance or coordination.
- Sudden severe headache with no known cause.
- If you see someone with these signs, call ext. 2323, for help immediately.
Suspected Stroke

In Patient

- Activate Stroke Code "S" via ext. 2323 – Page Neuro Stroke Team (Fellow, Resident, Stroke Coordinator will respond).
- Have available for Stroke Team:
  - Note: Time patient was last seen normal (or at baseline)
  - Note: Time Symptoms were discovered (time signs and symptoms were first observed)
  - Vital signs
  - Oxygen via nasal cannula
  - HOB 0-30 degrees
  - Start two IV access at least one 18 gauge
  - Prepare to send the patient to CT Scan
  - Have available the most recent laboratory results
  - Neuro assessment (NIHSS) to be done by Neurologist before CT Scan
- Time loss is Brain loss - Patient should be in CT Scan within 25 minutes of discovery time
Our program is modeled after the Condition H program at Johns Hopkins.

The program was developed by the mother of 2 year old Josie King who died an unexpected death due to lack of communication.

It is designed for a patient, family or visitor to obtain assistance when necessary.
Families May Call If ...

- There is an emergency and you cannot get the attention of the hospital staff.
- You see a change in the patient’s condition and the health care team is not recognizing the concern.
- You have spoken to hospital staff and you continue to have serious concerns about the patient’s care.
- There is a breakdown on how care is given or uncertainty over what needs to be done.
Rapid Response Team Initiated by the Patient or Family Member/Visitor

- Patient, family/visitor contacts the primary RN and requests he/she call the Family First response.
- Can also directly dial **Ext. 5120** and request the Operator to call the Family First RN to the patient’s room.
- During Tour II, the page will be answered by the Critical Care Nurse Manager carrying the code beeper.
- Tours I and III will be covered by the WHEN Tour Supervisors.
- Goal is to arrive in the patient’s room within 5 minutes.
Age-Appropriate/Population Specific Care
Age-Specific Care

Each age group has specific needs that health care providers should recognize and address when interacting with patients and family.

Being sensitive and knowledgeable of the various stages of the patient’s life cycle helps the caregiver to respond more appropriately to the specific needs of their patient.
Age Groups

- Neonate (First 4 weeks of life)
- Infant (1 month to 1 year)
- Toddler (1 – 3 years)
- Pre-school Child (3 – 5 years)
- School age Child (6 – 12 years)
- Adolescent (13 – 18 years)
- Young Adult (19 – 40 years)
- Middle age Adult (41 – 65 years)
- Older Adult (over 65 years)
Age-Specific Needs

Age-specific needs for all age groups must focus on the:

- physical
- motor/sensory responses
- cognitive/knowledge level
- psychosocial needs of the patient and parents and/or significant other(s)
Age-Specific Needs

As a child reaches school age and moves into adolescence, young adulthood, and older adulthood, other factors will influence the needs of the patient. These include:

- Growth and Development
- Psychosocial tasks
- Developmental tasks
- Significant persons in their life
- Major fears/stressors
- Communication level
- Safety
Neonate (1st 4 weeks)
Infant (1 month to 1 year)

Physical Development
- Grows at a rapid rate, especially the brain

Motor/sensory Responses
- Responds to light and sound
- Towards middle of year able to; raise head, roll over, bring hand to mouth
- Towards end of year able to; crawl, stand alone, may be walking with assistance or by themselves

Cognitive/Knowledge
- Toward middle of year, able to recognize familiar objects and people.

Psychosocial
- Significant persons are the primary caregivers or parents
- Develops a sense of trust and security if needs are met
- Fears unfamiliar situations
- 7 – 8 months; fear of strangers, 9 – 10 months; separation anxiety
Involve parents in procedures/encourage parents to assist in the daily care of their infant, as appropriate.

Limit the number of strangers caring for infant.

Keep environment safe, keep side-rails up at all times.

Provide opportunity for parents to return and demonstrate procedures.

Allow time for parents to ask questions.

Speak softly and smile at infant.
Toddler (1 to 3 years)

Physical
- Growth rate decreases, has intermittent growth spurts
- By about 18 months: bowel control, by 2 – 3 years: bladder control

Motor/Sensory Response
- Walks independently, progressing to running, jumping and climbing
- Able to feed self

Cognitive
- Able to use language
- Short attention span
- Can understand simple directions and requests

Psychosocial
- Parents are the significant persons
- Becomes independent, develops a sense of will, temper
- Attached to security objects, toys
- Skills may regress due to illness or hospitalization
Toddler

-Interventions for Caregivers

- Encourage child to communicate
- Use distraction as a way to minimize fear and or pain
- Give one direction at a time
- Prepare child shortly before a procedure, let them touch equipment, use a doll
- Allow for rest periods based on home routine if possible
- Maintain a safe environment at all times
- Involve parent in care if possible
Pre School (3-5 years) and School-Age Child (6-12 years)

- Interventions for Caregivers

- Explain procedures, demonstrate use of equipment
- Focus on one thing at a time
- Encourage child to verbalize
- Involve the child whenever possible
- Maintain safety at all times
- Give permission to express feelings
- Provide for control over privacy
- Praise for good behavior
Adolescent (13 – 18 years)

- **Growth and Development:**
  - Physical – grows in spurt, matures physically
  - Mental – abstract thinker, chooses own values
  - Social/Emotional – Develops own identity, builds close relationships, challenges authority

- **Psychosocial Tasks:**
  - Concerned with body image and flaws
  - Learning to relate to opposite sex
  - Behavior may be inconsistent, unpredictable
  - Makes own decisions independent of parents
Adolescent (13 - 18 years)

**Significant persons**
- Peer group acceptance, relationships start with members of opposite sex

**Major Fears/Stressors**
- Appearance, school performance, rejection
- Need time to adjust and cope with change
Adolescent Interventions for Caregivers

- Assist patient in dealing with concerns with body image
- Involve in decision-making
- Encourage questions
- Provide acceptance, privacy and respect
- Discourage risk taking behavior
Young Adult (19 to 40 Years)  
- Intervention for Caregivers

- This age group forms relationships with members of same and opposite sex, sets career goals, starts own family
- Assist with struggles of balancing family, work and health issues
- Allow for as much decision making as possible
Middle Age Adult (41 - 65 years)

**Growth and Development:**
- Begins to age, develop chronic health problems, women experience menopause
- Use life experiences to solve problems

**Psychosocial Tasks:**
- May have concurrent responsibilities for their children and aging parents

**Significant Persons:**
- Spouse, friends, aging parents

**Major Fears/Stressors:**
- Major life decisions to make, mid-life crisis
- Losing youthfulness, vitality, death of spouse
Middle Age Adult (41 – 65 years)

- Interventions for Caregivers

- Provide information and education
- Provide decision making opportunities
- Allow choices
- Address age related changes
- Encourage self care and health screening
Older Adult (65 till...)

Growth and Development:
- Ages gradually, decline in abilities
- Memory skills may start to decline
- Balances independence and dependence

Psychosocial Tasks:
- Adjusting to advanced age, illness, disability

Significant Persons:
- Spouse, adult children, friends

Major Fears/Stressors:
- Declining health, loss of spouse, change in social and economical status
Older Adult (65 years till...) - Interventions for Caregivers

- Give respect
- Provide information on aging
- Recognize hearing, visual, mobility and mental disabilities/limitations that may impact on health care
- Implement measures to provide hospital safety
- Promote home safety
Medication Management

- Component of the palliative, symptomatic, and curative treatment of diseases and conditions
  - Prescribing selection and procurement
  - Storage
  - Ordering and transcribing
  - Preparing and dispensing
  - Administration
  - Monitoring
Medication Management System

- Reducing practice variation, errors and misuse.
- Monitoring medication management processes in regard to safety, efficacy, quality and efficiency.
- Standardizing equipment and processes across the hospital.
- Using evidence-based practice.
- Managing critical processes.
- Handling all medications in the same manner.
Medication Management Indicators

- Pyxis Medstations
- Audits
- EMAR
  - CPOE
- Just in time follow-up
- Implementation of IV admixture program
How Can You Reduce Risks With High-Alert Medications?

*High-alert medications have a heightened risk of significant patient harm when involved in medication errors.*

- Patient identification using double identifier (first, last name and date of birth)
- Include brand and generic names in medication orders.
- Perform an independent double-check of dosage calculations for high-risk populations.
- Prepare medications in standard concentrations.
- Double check the drug, dose, and route when dispensing or retrieving drugs from storage areas.
- Look for these reminders: **HIGH ALERT, NAME ALERT, CHEMOTHERAPY**
- Double check the Five Rights (right patient, drug, dose, route, time) when administering medications.
- Infuse intravenous preparations using smart pumps with Guardrails® drug library.
- Partner up to perform an independent double-check when administering infusions of high-alert medications. Look for the reminder:
Take the 3-step approach with the Five Rights with each new order, change in drug bag or syringe, or change in dose.

Compare the medication order, drug product, and pump setting each time.
# High Alert Medications

<table>
<thead>
<tr>
<th>Category</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antineoplastic Agents</td>
<td>Opiates</td>
</tr>
<tr>
<td>Adrenergic Agonists, IV</td>
<td>Neuromuscular Blockers</td>
</tr>
<tr>
<td>Inotropic Agents, IV</td>
<td>Sedatives, IV</td>
</tr>
<tr>
<td>Antithrombotic Agents</td>
<td>Potassium Preparations, IV</td>
</tr>
<tr>
<td>Thrombolytics</td>
<td>Magnesium Preparations, IV</td>
</tr>
<tr>
<td>Insulins</td>
<td>Parenteral Nutrition</td>
</tr>
</tbody>
</table>

*Along with, any drug requiring continuous blood level monitoring*
"Double-Check Required" Reminder on eMAR
# How To Handle Multi-Dose Vials in Patient Care Areas

<table>
<thead>
<tr>
<th>DOs</th>
<th>DON’Ts</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Use a NEW needle and syringe with each puncture of the vial.</td>
<td>▪ Reuse the needle and syringe, even for the same patient during the same procedure.</td>
</tr>
<tr>
<td>▪ Disinfect the vial stopper with an alcohol pad. Wait for the alcohol to dry completely prior to puncture.</td>
<td>▪ Reuse the needle and syringe, even if medication is injected into IV tubing or a bag instead of directly to a patient.</td>
</tr>
<tr>
<td>▪ Discard any vials after one patient use if the vial has been used in an immediate patient treatment area (such as an anesthesia cart, patient room, or workstation on wheels).</td>
<td>▪ Pool leftover medications from vials to combine for one dose later.</td>
</tr>
<tr>
<td>▪ Insulin vials for syringes prepared in a medication room are labeled with a 28-day expiration/beyond-use date.</td>
<td>▪ Leave a needle in the vial septum to draw up doses into multiple syringes.</td>
</tr>
<tr>
<td>▪ Multi-dose vials used to prepare syringes in separate clinic/office rooms without patient exposure, shall be labeled with a 28-day beyond-use date upon first puncture. Label the syringes accordingly.</td>
<td>▪ Prepare syringes in advance prior to the procedure or administration time – Syringes must be used within one hour of preparation time.</td>
</tr>
<tr>
<td>▪ Prepare syringes in advance prior to the procedure or administration time – Syringes must be used within one hour of preparation time.</td>
<td>▪ Use any opened multi-dose vials that are found without a label for the 28-day expiration date, as it is unknown when the vial was opened.</td>
</tr>
<tr>
<td>▪ Leave a needle in the vial septum to draw up doses into multiple syringes.</td>
<td>▪ Save intravenous solutions mixing drugs for multiple products.</td>
</tr>
</tbody>
</table>
Antimicrobial Stewardship Program (ASP)

SUNY Downstate Medical Center
How are antibiotics misused in the hospital?

• Given when not needed
  - Example: Antibiotics are unnecessarily given for viral infections

• Continued for longer than they should be

• Prescribed at inappropriate doses

• Broad spectrum antibiotics given when a narrow spectrum antibiotic can be used

• The wrong antibiotic is prescribed
Why is misusing antibiotics a problem?

• Poor patient outcomes and increased mortality
  • Increase rate of multidrug resistant bacteria
  • Increase rate of *Clostridium difficile* infection (CDI)
  • Increase hospital length of stay
• Unnecessary health care costs
What are multidrug resistant bacteria?

Bacteria that are very difficult to treat because they are resistant to multiple antibiotics

- MRSA (Methicillin-resistant *Staphylococcus aureus*)
- VRE (Vancomycin-resistant Enterococci)
- ESBL (Extended-spectrum beta-lactamase) gram negative bacteria
- CRE (Carbapenem-resistant Enterobacteriaceae)
- “Superbugs”
Estimated minimum number of illnesses and deaths caused by antibiotic resistance*:

At least 2,049,442 illnesses, 23,000 deaths

*bacteria and fungus included in this report

CDC
2013
What is *Clostridium difficile* infection (CDI)?

• An infection caused by *Clostridium difficile* bacteria that results in:
  - Fever
  - Diarrhea
  - Abdominal pain

• Antibiotic exposure is the most important risk factor for CDI
  - 85% of patients with CDI were prescribed antibiotics in the 28 days before infection
CLOSTRIDIUM DIFFICILE

250,000 INFECTIONS PER YEAR
14,000 DEATHS

$1,000,000,000 IN EXCESS MEDICAL COSTS PER YEAR
What is an Antimicrobial Stewardship Program (ASP)?

A program to improve antibiotics use by ensuring that patients receive:

• The right antibiotic
• At the right dose
• At the right time
• For the right duration
ASP Goals

• Improve infection cure rates
• Decrease rates of multidrug resistant bacteria
• Decrease rate of CDI (Clostridium difficile infections)
• Decrease side effects of antibiotics
• Improve patient morbidity and mortality
• Decrease hospital length of stay
• Decrease re-admission rates
• Decrease unnecessary hospital costs
Broad ASP Interventions

• **Prior authorization:**
  • Certain antibiotics must be approved by an infectious disease expert (Infectious Diseases team) after they have been prescribed by any clinician

• **Prospective audit and feedback:**
  • The ASP team reviews the antibiotics prescribed and gives feedback and recommendations to the clinicians to change, de-escalate, or stop the antibiotics

• **Antibiotic “Time out”:**
  • The clinicians themselves review the appropriateness of the antibiotics after the initial order when the clinical picture is clearer
Pharmacy-driven ASP Interventions

• **Changes from intravenous to oral antibiotic therapy** for antibiotics with good oral absorption in appropriate situations

• **Dose optimization** including dose adjustments based on therapeutic drug monitoring or bacterial susceptibility

• **Time-sensitive automatic stop orders**

• **Detection and prevention of antibiotic-related drug-drug interactions**
ASP Guidelines

The ASP provides guidelines to help clinicians in treating certain infections such as:

- Community-acquired pneumonia
- Urinary tract infections (UTIs)
- Skin and soft tissue infections
- Empiric coverage of Methicillin-resistant *Staphylococcus aureus* (MRSA) infections
- *Clostridium difficile* infections
- Culture proven invasive infections
The Many Parts of the ASP Team

- Nursing
- Information Systems Specialist
- Microbiology
- Epidemiology
- Hospital Administration
- Infectious Disease Physician
- Infectious Disease Pharm D.
Our ASP Team at SUNY Downstate

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• Stephan Kohlhoff, M.D., Pediatric Infectious Diseases
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• Densley Francois, PharmD, BCPS, BCPPS, Pediatric Clinical Pharmacist
  -densley.francois@downstate.edu
Resources

• Core Elements of Hospital Antibiotic Stewardship Programs

• "Implementing an Antibiotic Stewardship Program: Guidelines by the Infectious Diseases Society of America and the Society for Healthcare Epidemiology of America"

• Antibiotic Stewardship SUNY Downstate Medical Center Website (Coming soon)
Pain Management

• Pain relief is everyone’s priority
• Patients have the **RIGHT** to have their pain
  - Assessed
  - Reassessed, and
  - Managed

- Nursing and medical staff must recognize that pain is a priority and act accordingly
- All staff in the hospital must be sensitive to patient pain and report it to the appropriate staff member

Any staff member who comes into contact with a patient complaining of pain **MUST** report it
Pain Management Patient’s Rights

As a patient at SUNY Downstate Medical Center you have the right to

a. Describe your pain in a manner that is accepted and respected by the staff as the best indicator of your pain
b. Be seen by competent staff who will help you deal with your pain
c. Have your pain addressed promptly
d. Get information about pain and how to relieve it
e. Be informed and participate in your pain management plan of care
f. Receive pain care that is continuously monitored and evaluated by staff dedicated to relieve pain
g. Request changes in your pain management plan of care
h. Help your doctor or nurse measure your pain
i. Talk to your doctor or nurse about your pain relief choices
j. Ask for pain relief when your pain starts
k. Tell your doctor or nurse if your pain is not relieved
l. Tell your doctor or nurse any worries you have about taking pain medication
Pain Scales

- What pain rating scales are used at University Hospital of Brooklyn?
  - Pain Intensity scales
  - Numeric pain scale
  - Wong-Baker Face Scale
    - Recommended for children > 3 years old
  - Behavioral Scale/Indicators for pre-verbal or non-verbal patients
Pain Re-Assessment

• The following delineates the revised pain reassessment protocol based on route of pain medication administration:
  • PO, IM, SQ or Rectal: within 60 minutes
  • IV Bolus, IV Push: within 30 minutes
  • IV infusion: initial reassessment within 30 minutes and then at least every hour
  • Epidural (continuous or bolus/clinician dose): within 30 minutes and then at least every hour
  • Transdermal: within 4 – 6 hours
Pain Management

• **Patient Education**
  - Patients and their families must be informed and educated about pain management strategies and alternatives
    - Print
    - Audio/visual
    - Discussion
  - Patient and their families must understand that the management of pain is critical to the healing process
  - Patient and their families must understand that we care about their pain

• **Discharge Planning**
  - Pain and symptom management must be included in **ALL** discharge planning
  - Documentation of this process is critical in the continuity of care of our patients
  Patients should have a list of resource and contact numbers to call when they are home
Moderate Sedation

- **Definition:**
  - a drug-induced depression of consciousness during which patients respond purposefully to verbal commands.
Sedation and Analgesia by Non-Anesthesiologist Policy

- All persons who administer sedation and analgesia must be privileged and credentialed
- **Requirements:**
  - Knowledge of pharmacology of the sedative and analgesic agents
  - Training in the recognition of respiratory and cardiovascular side effects
- Recognition of air way obstruction
- Skills to manage compromised airway
- Completion of educational program by the chairman of the Department of Anesthesiology
- Good judgment and discretion of individual patient needs
- Evaluation prior to performing sedation and Analgesia
- Assessment and Reassessment of patient
Consent

• General Consent governs the performance of any routine procedure or treatment.

• Informed consent is required prior to the performance of any invasive or surgical procedures except in emergent, life threatening situations.

• Informed consent requires discussion between practitioner and patient of the proposed procedure, including risk, benefits and alternatives. The patient then makes an informed decision to undergo or refuse the proposed procedure.
WHO CAN CONSENT TO CARE?

• Adults (18 years old or older) are presumed to have capacity to make health care decisions and give informed consent.
  – If an adult does not have mental or decisional capacity, a surrogate or health care proxy can give informed consent.
• Married person of any age;
• Minor who is living independently from parents or who has a child can consent for:
  – Himself or herself
  – For the child.
• Minors can consent for specific types of care, e.g., sexual and reproductive care, mental health, drug/alcohol related care.
• Provisions must be made to facilitate consent for any patient with Limited English Proficiency (LEP). Interpreter need to be included.
Refusal of Care

• Parents cannot refuse life-saving treatment for a minor child

• Adult patients have the right to refuse care

• If refusal of care involves withdrawing or withholding life-sustaining treatment, conditions must be met as delineated in one of the following health-care decision forms, which must be completed in this situation.

• The forms are titled:
  – “Patient Consent to Withdraw or Withhold Life-Sustaining Treatment”
  – “Health Care Agent or Surrogate Consent to Withhold or Withdraw Life-Sustaining Treatment”
  – “Withholding or Withdrawing Life-Sustaining Treatment When Patient Lacks Health Care Agent/Surrogate”.

WHEN PATIENT LACKS CAPACITY

- Either parent can consent for minor child
- For adults, the attending MD must identify a surrogate in this order of priority:
  - **Health care agent** *(written document must be in medical record)*
  - Legal guardian with health care decision-making powers *(court papers must be in medical record)*
  - The spouse or **domestic partner** if not legally separated *(for domestic partner, consider evidence of mutual dependence, children together, common householding, length of relationship)*
  - An adult child
  - A parent
  - An adult sibling
  - A **close adult friend** *(includes relatives not listed above and friend who has maintained regular contact the patient so as to be familiar with patient’s activities, health, religious or moral beliefs and presents signed statement to that effect to be placed in the medical record)*
Health Care Agent/Surrogate Decision-making Standard

- Health care decisions are to be made according to the patient’s wishes, including the patient’s religious or moral beliefs, but if the patient’s wishes are not reasonably known, then decisions are to be made in the patient’s best interests.

- Assessment of best interest includes consideration of the dignity and uniqueness of every person, the possibility and extent of preserving the patient’s life, the preservation, improvement or restoration of the patient’s health or functioning, the relief of suffering, and any medical condition and such other concerns and values as a reasonable person in the patient’s circumstances would wish to consider.
New HIV Testing LAW

- As of July 30, 2014, New York State legislation amending the public health law, Article 27F, requires the routine offer of an HIV test to all patients, ages 13 to 64, in primary care settings, emergency departments and inpatient settings.

- At UHB, all patients (inpatient and outpatient), including the Emergency Department, ≥ 12 years old must be asked if they wish to have an HIV test.

- Consent for testing and documentation of process has been included in all Nursing Admission Databases.
Advance Directives (Health Care Proxy)

- **Purpose:**
  - The Patient Self-Determination Act of 1990 (U.S. PL 1102-508, sec. 4206) requires hospitals and other health care providers to provide written information to adult patients, at the time of admission to the hospital, regarding their right to participate in and make treatment decisions for themselves, and their right to prepare an advance directive as recognized under State Law and to provide education for staff and community on the issues concerning advance directives.
Advance Directives

(Health Care Proxy)

• **Definitions:**
  - **Adult:** defined as a person eighteen years of age or older, or who is married, or who is the parent of a child
  - **Health Care Proxy:** a form that designates that an agent may make decisions on the principle’s behalf in the event that the individual is unable to do so himself/herself
  - **Advance Directive:** is an instruction or set of instructions regarding health care treatment decisions to be made on behalf of an individual if he/she should become incapable of making such decisions
Advance Directives (Health Care Proxy)

• **Policy:**
  - Patients have the right to
    - refuse or consent to present or future health care including, but not limited to, forgoing or withdrawing life-sustaining treatment
    - appoint a Health Care Agent to act on their behalf in the event they are unable to make health care decisions and assistance in executing wishes by naming an agent, if they so desire
    - consent to a hospital or non-hospital DO NOT RESUSCITATE (DNR) order effective in the hospital and community
Palliative Care

- Death and dying are not easy to deal with. Many of our patients face illnesses that cannot be cured.
- This can be hard to deal with for everyone involved – the dying patient, their family and loved ones and health care providers too.

**All patients with prognoses of 6-12 months of life should be referred to Palliative Care Services.**
What is palliative care?

- **Palliative care ...**
  - Means taking care of the whole person – body, mind and spirit – heart and soul.
  - Is a way to ease pain and make life better for people who are dying and for their loved ones.
  - Is interdisciplinary.
  - Is for patients of ALL ages.
PALLIATIVE CARE

• Defined by NYS law as treatment and consultation with patients and family to prevent or relieve pain and suffering and to enhance the patient’s quality of life.
• Includes interdisciplinary end-of-life care and consultation and
• Includes hospice care
• Is appropriate at any stage of serious illness, whether potentially curable, chronic or life-threatening
• Providing palliative care services is a best practice, and is required by law in certain circumstances
PALLIATIVE CARE AND THE LAW

• Physicians and NP’s are legally required to offer to provide terminally ill patients with information and counseling about palliative care and end-of-life options.
  – “Terminal illness” means reasonably expected to cause death within 6 months;
  – The law is intended to ensure that patients are fully informed of their treatment options, and is not intended to limit those options;
  – Patients may pursue palliative care AND aggressive treatment or life-prolonging care at the same time;
  – The law is not intended to discourage conversations about palliative care with patients whose life expectancy is greater than 6 months.

• The hospital must facilitate access to palliative care counseling and services for all patient with advanced life-limiting conditions—not just terminal illness.
The 5 Principles of Palliative Care

# 1

• Palliative care respects the goals, likes and choices of the dying person
  – Respects the patient’s needs and wants
  – Determines who the patient wants to help plan and give care (advance directives, health care proxies)
  – Helps the patient and family understand the patient’s illness
  – Helps the patient and family to work in partnership with the healthcare team
PALLIATIVE CARE

#2

Palliative care looks after the medical, emotional, social, and spiritual needs of the dying patient

– Assesses pain and provides interventions to keep the patient as pain free as possible (pain is one of the greatest fears dying patients have)

– Helps the patient to obtain pastoral, social or other needed services
PALLIATIVE CARE

#3

Palliative care supports family members

– The health care team offers support services to families and assesses their need for rest, need to be with the patient, need for information about the patient’s condition, and need for maintaining close communication

– Provides information to help plan the costs of caregiving.

– Helps families cope with their feelings as they grieve.
PALLIATIVE CARE

#4

Palliative care helps gain access to needed health care providers and appropriate settings.

- Uses the entire health care team to plan care – doctors, nurses, pharmacists, clergy, social workers, nutritionists and others.
- Helps patients to access home care, hospice and other services.
Palliative care builds ways to provide excellent care at the end of life

- Provides education and support for caregivers to learn the best ways to care for dying people
- Works to make sure there are good policies and laws in place
- Seeks funding by private health insurers, health plans and government agencies.
Restraints Policy

• The restraint/seclusion of a patient is determined by the individual’s needs
• Restraints will be removed as soon as possible after criteria for discontinuing are met
• Less restrictive measures must be considered and/or used prior to applying restraints
• Restraints/Seclusion are ordered by an attending physician or his / her designee.
  – Nurse Practitioner and MD (designated by the medical staff By-laws.)
What is a Restraint?

• Included in this definition are:
• **Full side rails** (Only considered restraint if 4 side rails are used and the patient is unable to independently lower the rail or rails in order to get out of bed).

• *Mittens* (infant, Pediatric, Adult)

• **Soft wrist and ankle restraints**
Med-Surg Alert!!!!

• When a patient in any medical/surgical unit becomes violent (i.e. kicking, punching, spitting, etc.) the patient may need a 4-point restraint to protect self and/or others and behavioral management requirements will be implemented.

• An order for 4-point restraints must be written by a Physician or his/her designee and a face to face assessment must be done within 30 minutes of application.
Restraints Policy

• In an emergency situation
  • an RN may initiate the application of restraints
  • the RN must notify the physician immediately
  • a face to face assessment must be done and a medical order for the restraints must be written by an “attending MD or his /her designee” as per medical staff By-laws. above within 1 hour of restraint application

• Family notification is required: to be done by a physician or his /her designee after application of restraint.
Restraints

• **Medical/Surgical Management**
  – Interference with medical procedures or dislodging necessary medical devices/invasive lines

• **Restraint Orders**
  – Must be renewed every 24 hours

• **Behavioral Management**
  – Demonstrated behavior that presents a physical danger to the patient and/or others:
    • Demonstrates Violence
    • Dangerous to Self/Other
    • Suicidal Ideation

• **Restraint Orders**
  – Must be renewed
    • Every 4 hours for persons 18 years or older
    • Every 2 hours for adolescents 9 – 17 years
    • Every 1 hour for children under 9 years old
Blood Transfusion Reaction
Signs and Symptoms

1. **HEMOLYTIC REACTION:**
   - Rapid onset of symptoms, chills, fever, dyspnea and/or cyanosis, headache, backache, chest pains, oliguria, tachycardia, tachypnea, hypotension, nausea or vomiting, vascular collapse, hemoglobinuria, bleeding, acute renal failure or even cardiac arrest.

2. **BACTERIA (SEPTIC) REACTION:**
   - Rapid onset of chills, fever, flushing, malaise, headache, red shock (skin warm, dry and pink due to peripheral vasodilatation) Lumbar pain, hematemesis and diarrhea, nausea or vomiting.

3. **MILD ALLERGIC REACTION:**
   - Itching, uticaria, hives/petechiae, mild edema.

4. **SEVERE ALLERGIC REACTION (ANAPHYLAXIS)**
   - Hypotension, respiratory wheezing, distress or failure, nausea and vomiting, loss of bowel and/or bladder function with or without the symptoms/signs in Mild Allergic Reaction above.
Blood Transfusion Reaction
Signs and Symptoms

5. **FEBRILE, NON-HEMOLYTIC REACTION (MOST COMMON):**
   - Sudden chills, fever spike greater than 1 degree C (2 degrees F) rise in temperature, headache, flushing, anxiety and muscle pain.

6. **CIRCULATORY OVERLOAD:**
   - Tachycardia, dyspnea, coughing frothy and pink tinged sputum, edema, elevated jugular venous pressure.

7. **TRANSFUSION ASSOCIATED ACUTE LUNG INJURY (TRALI):**
   - Dyspnea, coughing, fever, hypotension, normal jugular venous pressure, bilateral “butterfly” infiltrates on chest x-ray, within 2 to 6 hours post transfusion.

8. **Patient must be assessed 30 minutes after completion of each blood transfusion for signs and symptoms of transfusion reaction.**
Blood Tubes for Type and Cross

- For the collection of Blood for type and Cross match the tube colors have been changed from red and purple to pink (lavender for pediatrics) for all routine Blood Bank testing.

**DO NOT USE**

![DO NOT USE Image]

**USE**

![USE Image]

1 mL “lavender” top  
6 mL pink top
Blood Tubes for Type and Cross

Now draw,
- two 6 mL pink top tubes for pre-admission testing (PAT) specimens.
- one 6 mL pink top tube for routine Blood Bank testing for adults.
- two 1 mL pediatric lavender top pediatric tubes for children < 2 years old.
- one 6 mL pink top tube for cord blood samples.
- Remember that all Blood Bank specimens must still be:
  - labeled with the Cerner bar-coded labels.
  - initialed and dated by the person collecting the patient’s specimen at the bedside.
  - sent with the REQUEST FOR BLOOD COMPONENTS form (a.k.a. the orange requisition form)
  - with the proper patient information, signed and stamped by the ordering physician and signed by
  - the person collecting the patient’s specimen.
Transportation of Blood Products

- Must wear SUNY Hospital Identification.
- Must have white Request for Blood Release card filled out & signed by MD/Nurse.
- Use the handle on the clear plastic bag to transport blood.
- Deliver the blood immediately to the assigned area.
- Handle the blood gently.
- Do NOT place blood on warm areas (e.g. radiator).
- If there is damage (puncture, leak) to the blood unit, return product immediately to the Blood Bank.

REQUEST FOR BLOOD RELEASE

This card must be presented to the blood bank to ensure positive identification of the patient, before any blood (component) is dispensed for transfusion.

Date: ________________  Time: ________________  Location: ________________________

Patient's Name: ____________________________

Medical Record Number: ________________________
(Not Patient Account #)

Blood Component Requested: ________________________

Signature of M.D./Registered Nurse: ________________________

BLOOD BANK - UNIVERSITY HOSPITAL OF BROOKLYN
450 Clarkson Avenue • Box 37 • Brooklyn, NY 11203-2098

Revised June 12, 1987

- Must fill out & sign the pick up book at the Blood Bank.
Blood Labeling and Collection of Blood Specimen

**Purpose:** To ensure that the process for venipuncture and blood specimen collections are followed and are consistent with established guidelines and safety protocols.

**Blood Labeling and Collection:** Must meet regulatory standards as set forth by The Joint Commission (National Patient Safety 01.01.01 Use at least two patient identifiers when providing care, treatment, and services.

**Procedures/Guidelines**

1. **Patient Identification**
   - Properly identify the patient using name, and date of birth, and compare to the information on the wristband. Compare the name, DOB, and Medical Record Number to the information on the wristband. If an inpatient does not have a wristband, immediately report it to the nurse. Do not proceed with specimen collection until a wristband is placed on the patient.

   **For Outpatients** – properly identify the patient to state their name and date of birth and compare the information to a source document (i.e. Eagle registration, prescription, etc.).

   **If the patient does not speak English and there is no interpreter around, use the cyracom Language services phone.**
1. **Proper Labeling**

The patient and the patient’s blood sample must be positively identified at the time of collection. Blood samples must be obtained in stopper tubes and identified with a firmly attached barcode label, this includes:

- The patient’s first and last name
- Date of birth
- A medical record number
- The collection date
- The time of collection
- First initial and last name of the phlebotomist or person collecting specimen or CERNER ID.

**Infection Control Practices**

- Hand Hygiene must be performed in accordance with hospital and CDC guidelines. Hand-washing must be done for 20 seconds before and after donning and doffing of your gloves.

2. **Assemble Supplies**

- Retrieve the LIS-generated printed labels from the nursing unit or outpatient laboratory printer
- Review the label/s against the order to verify that all of the printed labels retrieved correspond to the correct patient and correct order test/s.
- Ensure that the information on the labels match the patient’s name and medical record number
- Gather all needed supplies and check for expiration dates on all tubes

3. **Proper Placement of Labels**

   a. The specimen label must be placed on the tubes using the white label of the tube provided by the manufacturer as a guide.

   b. Place the patient’s last name at the top of the tube right under the cap. To achieve this, hold the specimen in your left hand by the cap and with your right hand, place the label with the last name at the cap end. This will ensure that all labels are put in the same direction, see example

   ![Label Placement Example](example_image)

   c. The person collected the specimen must label the tube(s)

   d. Last name and first initial are the preferred choice of acceptable collector ID. It is a legal proof that you verified the patient identification and you are saying that the blood specimen is in-fact, of this patient.

   e. Document immediately in the Electronic Medical Record

   **Note:** The label must be placed on the tube before leaving the side of the patient.

**Any specimen Mislabeled or Not labeled will be Discarded**

The standards and UHB’s policy on blood labeling, collection of blood specimen and recording of time of blood specimen collection have been reviewed with me. I understand the requirements and demonstrated blood specimen collection, labeling, and recording of time consistent with established guidelines and safety protocols.
Early Signs and Symptoms of Shock

- *Decreased pulse pressure* due to catecholamine effect. The reduced pulse pressure signifies a reduction in stroke volume.
- *Decreased urine output* as renal vasoconstriction and anti-diuretic hormone effects conserve water and sodium.
- *Decrease in urinary sodium* due to ADH and aldosterone effects.
Early Signs and Symptoms of Shock

- *Respiratory alkalosis* related to hyperventilation. Catecholamine produce a *fight or flight* response, causing increased respiratory rate.
- *Restlessness and anxiety* may be present as a result of catecholamine secretion.
- *Increase* in heart rate occurs but may still be within normal limits
  - *Heart Rate may not increase in patients* …
    - *With Neurological impairments/Neurogenic Shock*
    - *Receiving Beta-Blockers and/or Calcium Channel Blockers*
Late Signs of Shock

- Decreased systolic blood pressure
- Metabolic acidosis
- Decreased level of consciousness
- Cool, clammy skin, and prolonged capillary refill time
- Vasoconstriction and increased systemic vascular resistance
- Oliguria to anuria
- Decreased cardiac output
Hemorrhagic Shock

- **Neurological**
  - Change in LOC
  - Confusion
  - Anxiety
  - Restlessness
  - Dull Eyes

- **Cardiovascular**
  - Rapid Heart Rate/Pulse
  - Low Blood Pressure
  - Weak Pulse
  - Delayed Capillary Refill

- **Respiratory**
  - Rapid Breathing
  - Shallow Breathing

- **Integumentary**
  - Cool/Clammy Skin
  - Pale Skin
  - Dry Mouth
  - Poor Skin Turgor

- **Musculoskeletal**
  - Weakness
  - Fatigue

- **Fluid Status**
  - Thirst
  - Reduced Urine Output

- **Thermoregulation**
  - Hypothermia
Sepsis

• Definition:
  - Invasion of microorganisms into normally sterile tissue causing a Systemic Inflammatory Response Syndrome (SIRS)
  - Infection can be localized or systemic
Overview of Sepsis

- Sepsis is a serious medical condition which can result in septic shock, sepsis induced hypotension, hypoperfusion, multiple organ dysfunction syndrome (MODS), and eventually death.
- Starts with an infection, bacteria then spreads to the bloodstream resulting in Bacteremia.
- Toxins released by the bacteria cause the cells in the body to release substances that triggers an inflammatory response (Systemic Inflammatory Response Syndrome (SIRS), this can result in uncontrolled vasodilation.
Sepsis Signs and Symptoms

- Tachycardia
- Tachypnea
- Hypoxemia
- Unexplained alternations in mental status
- Chills
- Alteration in temperature
- Cutaneous
  - Skin mottling
  - Decreased skin perfusion
  - Poor capillary refill
Sepsis Signs and Symptoms

- Decreased urine output
- Decreased platelets
- Petechiae/purpura
- Altered WBC count
- Low Systemic Vascular Resistance
- Hyperglycemia
- Increased cardiac output
- Decreased CVP
Adult Code Team
Activation Criteria

• IF THE PATIENT MEETS ANY OF THE FOLLOWING CRITERIA,* CLINICAL STAFF SHOULD CALL A CODE - x2323

• DO NOT WAIT UNTIL IT'S TOO LATE!
Criteria

• **Respiratory Rate:**
  - <8 or >36;
• **New onset difficulty breathing;**
• **New pulse oximeter reading less than 85% for more than 5 minutes that is not easily corrected with oxygen administration (unless patient known to have chronic hypoxemia).**
• **Heart rate:**
  - <40 or >140 with symptoms or any rate >160.
• **Blood Pressure:**
  - <80 or >200 systolic or >110 diastolic with symptoms.
Acute Neurological Change

- Acute loss of consciousness.
- New onset lethargy or narcan use without immediate response.
- Seizure (outside of seizure monitoring unit).
- Sudden loss of movement (or weakness) of face, arm or leg; sudden loss of speech.
Other

- Chest pain unresponsive to nitroglycerine or doctor unavailable.
- Color change (of patient or extremity): pale, dusky, gray or blue.
- Unexplained agitation more than 10 minutes.
- Suicide attempt.
- Uncontrolled bleeding.
- A new critical lab value that the available clinical staff are not able to address in a timely fashion.
- The nurse or other clinician is very worried about the patient.
Diabetes AME

• Identify the components of a diabetes patient assessment.
• List the types of insulin on UHB’s formulary and identify high risk situations involving insulin.
• List what patients/family with diabetes need to know prior to discharge regarding diabetes management.
• Describe the UHB Hypoglycemia Protocol.
• Become familiar with UHB’s Insulin Infusion Pump Policy.
Diabetes Patient Assessment

- Type of Diabetes
  - Type 1, Type 2, Gestational

- Was patient admitted with a new diagnosis of DM?

- Is patient new to insulin?

- Is this admission for uncontrolled DM?

- Medications Prior to Admission
  - New to insulin and/or oral agents
  - Even if not new to insulin, all patients should be assessed for their injection measurement and administration technique.
  - Problems with medication adherence
**Insulin Definitions**

**Basal Insulin**: “Background insulin” Long Acting or intermediate acting
- Aims to keep blood glucose in target between meals
- Needed to prevent diabetes ketoacidosis in Type 1 DM - even if patient is NPO
- If ordered for HS administration and FS is < 100 mg/dL, consult physician
- **Do not hold insulin without discussing with medical/surgical team**
- Basal Insulin: glargine (Lantus); Novolin N; and Novolin 70/30 (contains 30% prandial insulin)

**Prandial/Nutritional**: Covers nutrition - Short and rapid acting insulin
- If not eating, hold - notify provider
- If FS 70 - 80 mg/dL - patient to eat first, then administer insulin
- Prandial Insulin: Novolin R or aspart (Novolog)

**Correction Dose**: Corrects hyperglycemia: based on Correction Scale ordered (Low, Moderate, High Dose Regimens)
- Can be added to prandial dose if prandial dose is ordered
- Administer with meals - food must be in front of the patient or
- Can be ordered if patient is NPO as per correction schedule
- Correction Insulin: Novolin R or aspart (Novolog)
<table>
<thead>
<tr>
<th>Duration</th>
<th>Onset</th>
<th>Peak</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glargine</td>
<td>20-24 h</td>
<td></td>
</tr>
<tr>
<td>(Lantus)</td>
<td>0-15 min</td>
<td>0.5-1.5 h</td>
</tr>
<tr>
<td>Aspart</td>
<td>30-60 min</td>
<td>2-12 h</td>
</tr>
<tr>
<td>(Novolog)</td>
<td>1-2 h</td>
<td>4-12 h</td>
</tr>
<tr>
<td>70/30</td>
<td>30-60 min</td>
<td>2-12 h</td>
</tr>
<tr>
<td>24 h</td>
<td>1-2 h</td>
<td>4-12 h</td>
</tr>
<tr>
<td>(Novolin 70/30)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NPH</td>
<td>30-60 min</td>
<td>2-4 h</td>
</tr>
<tr>
<td>(Novolin N)</td>
<td>1-2 h</td>
<td>4-12 h</td>
</tr>
<tr>
<td>Regular</td>
<td>30-60 min</td>
<td>2-4 h</td>
</tr>
<tr>
<td>12 h</td>
<td>1-2 h</td>
<td>4-12 h</td>
</tr>
</tbody>
</table>
High Risk Situations

- When a prescribed insulin dose is not given - for example: patient not on unit; patient refusing; RN concern; Pt. NPO, etc.
  - Notify provider immediately.
  - Document name of provider and outcome in HealthBridge.
  - Follow-up/reschedule dose as appropriate & communicate during handoff.
  - Note: Patients with Type 1 DM must always have insulin on board - even if NPO. DKA may result when patient is insulin deficient.

Insulin is a high-risk (or high-alert) medication due to risk of harm with potential errors!
Hypoglycemia:

- Hypoglycemia can be life-threatening
- Common causes of hypoglycemia in the hospital include:
  - Too much insulin or insulin given out of sync with meals
  - Inadequate food intake, vomiting
  - Oral hypoglycemic agents, with or without insulin, continued with changes in eating status (i.e., NPO)
  - Unexpected transport off unit after insulin given

Hypoglycemia = BG <70 mg/dL
UHB Critical POC hypoglycemia = BG <50 mg/dL

Symptoms: Neurogenic (Autonomic)
- Trembling, palpitations, Sweating, Anxiety, Hunger, Tingling, Dry mouth

Symptoms: Neuroglycopenic
- Cognitive impairments, Altered concentration/thinking, Confusion, Behavior changes, Speaking difficulties, Tiredness/weakness, Headache, Seizures, LOC

Finger Stick Glucose (FS) < 70 mg/dL
- Repeat Fingerstick, if still <70 mg/dL
- Treat Pt. as per Hypoglycemia Protocol
- Notify physician ASAP
- Check FS 15 minutes post treatment

Goal: FS >70mg/dL x 2, obtained 15 minutes apart
If FS <70 mg/dL, repeat treatment

Critical Hypoglycemic FS < 50 mg/dL
- Implement Protocol...then
- Draw serum sample for lab (grey top tube)
- Check FS in 15 minutes; If FS <70 mg/dL, repeat treatment

Goal: FS >70mg/dL x 2, obtained 15 minutes apart
If FS remains <50 mg/dL in a patient with no IV access, or no physician available, Call Rapid Response
Hypoglycemia Treatment Protocol

**Oral Treatment**

For:
- < 70 mg/dL
- < 50 mg/dL (if able to take PO, treat first with oral followed by D50% IV push.

Each dose = 15 grams carbohydrate

4/18/17

**If NPO, FS < 50 mg/dL or Unable to Treat Oral Treatment**

- Administer IV Dextrose 50% (50 mL)
- Hang D5W to infuse @100 ml/hr until provider gives additional orders

**BUT, if < 70 mg/dL AND no IV access**

- Administer Glucagon Intramuscular
Critical Hyperglycemia: >599 mg/dL

- Draw serum sample (grey top tube) & send to lab
- Notify physician
- Wait for further orders
Blood Glucose Checks & Insulin Administration

- If FS is ordered for AM or pre meals:
  - check at or after 7:00 AM, except:
    - in units with early breakfast delivery
    - when clinically indicated and/or ordered

- Safety and Accuracy
  - Use FS values that were obtained within 60 minutes of administering prescribed pre meal insulin.
  - If results were obtained > 60 minutes before pre meal insulin is due, check FS again.
Glucose Monitoring

- Nova Stat Blood Glucose Monitor is UHB’s glucose meter for patient testing.
- All operators’ certification status must be current.
- Use universal precautions and follow patient identification as per hospital policy.
- Quality Control testing, with 2 levels of control solution (High and Low), is performed every 24 hours.
  - Cleaning the meter is performed after control testing with hospital approved germicidal wipe.
  - After daily Control Testing is performed: Enter “Meter Cleaned” in Comments.
Glucose Monitoring

After Each Patient Test

- Clean and disinfect meter after each patient test using 2 step process.

- Enter 3 Mandatory Comments:
  1. Choose specimen source “Capillary or Arterial/Venous Sample”
  2. “Clean & Disinfect Meter”
  3. “Accept” results
    - Add additional Comments if necessary, e.g. Caregiver Notified, etc.

- Enter glucose results in Flowchart/Point of Care Section.

2 Step Cleaning & Disinfecting

- Step 1
  - Wear protective gloves.
  - Wipe external surface of meter thoroughly with the hospital approved germicidal wipe.

- Step 2
  - Use a new, fresh germicidal wipe, & thoroughly wipe the surface of the meter (top, bottom, left & right sides) a minimum of 3 times horizontally followed by 3 times vertically.
  - Avoid the bar code scanner & electrical connector.
  - Discard used wipe into appropriate container.
  - Ensure meter surfaces stay wet for a minimum of 3 minutes.
  - Allow surfaces to air dry for an additional minute.
  - After patient testing is performed: Enter “Clean & Disinfect” in Comments.
  - Dispose gloves into appropriate container.
  - Sanitize / Wash hands.
Patient/Family Patient Education – Choose Clinical Practice Guidelines (Type 1, Type 2, or Gestational DM)

Need to Know Diabetes Self Management Skills

- Name(s) of medication (insulin and oral agents)
- Dose
- Time(s) to take
- Identification, treatment and prevention of hypoglycemia
- Meal planning (Dietary Referral)

For those patients taking insulin:

- Measuring dose in syringe (low dose $\frac{1}{2}$ mL, or 1 mL syringe)
- Site selection
- Injection technique

Storage - room temperature once vial opened- good for 28 days for most Insulin

Safety and syringe/needle disposal

- Consider Visiting Nurse, Place Social Work Referral
Key Points for Safe Discharge

• Begin patient/family education upon admission
• Ask patients to demonstrate their insulin injection technique when insulin administration is due
• For patients new to insulin:
  - Use each insulin administration time as an opportunity to teach patient/family
  - Patients/family need to inject insulin prior to discharge
  - For practice: Use vial of water to teach (not for injections)
• Review insulin prescriptions:
  - Insulin vials and syringes
  - When appropriate, insulin pens & pen needles, glucose monitors, test strips, lancets.
Patient Education Brochures
From Patient Education, ext. 3739.
You can print the brochures.

http://www.downstate.edu/
University Hospital SUNY Downstate
Department of Nursing Services>
Patient Education

DIABETES
DISCHARGE
INSTRUCTIONS

DIABETES
INSTRUCCIONES
ALTA

DYABÈT
ENSTRIKSYON
POU EGZEYAT
Ambulatory Insulin Infusion Pump

• What happens if your patient is admitted wearing an insulin infusion pump?
  - If patient was using an insulin infusion pump prior to being admitted, they may continue to use the pump while they are hospitalized...under certain conditions.

• What is UHB’s policy? This policy addresses when the patient is admitted wearing an insulin Infusion pump and wants to continue its use while...
Continuous Insulin Infusion Pumps Definition

Insulin infusion pump – a battery operated, external computerized device containing an insulin filled reservoir.

Insulin is infused subcutaneously through a plastic or metal cannula attached from the pump reservoir to the patient.

Infuses insulin 24 hours a day; continuously delivers insulin for basal and bolus doses.

Two Types of Pumps – 1) Tubeless

Insulin pump with attached Cannula; which infuses insulin into the subcutaneous area. Separate programmer for pump functions.

2) With Tubing:
Clear tubing attached from insulin reservoir in pump to infusion set with needle delivering insulin subcutaneously.
<table>
<thead>
<tr>
<th>Candidate</th>
<th>Not a Candidate</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Can perform all pump tasks</td>
<td>• Altered mental status</td>
</tr>
<tr>
<td>• Has all pump supplies</td>
<td>• Critically ill, DKA</td>
</tr>
<tr>
<td>• Signs Pump Agreement</td>
<td>• Severely hypoglycemic</td>
</tr>
<tr>
<td>• Allows RN to observe bolus doses &amp; infusion set changes</td>
<td>• Suicide risk</td>
</tr>
<tr>
<td>• Allows nurse to check FS with UHB glucose monitor</td>
<td>• Circumstance have been identified by team which make use of the pump unsafe</td>
</tr>
<tr>
<td>• Removes pump when warranted (MRI, X-ray, surgery, etc.)</td>
<td>• Does not have supplies</td>
</tr>
<tr>
<td>• Agrees to report all hypoglycemia to RN</td>
<td>• Refuses to sign Pump Agreement</td>
</tr>
<tr>
<td>• Allows all pump setting changes to be done with Endocrine Team present at bedside</td>
<td>• Refuses hospital’s blood glucose meter to check FS</td>
</tr>
</tbody>
</table>
Scans

- Pump must be disconnected from patient
- If the infusion catheter is metal, the infusion set must also be removed prior to MRI testing
  - Ask patient if catheter is plastic or metal
  - Patient will give pump to either a family member or RN or
    - RN will follow Policy & Procedure, "Safeguarding Property Brought to the Hospital by Patient" (PTBR-9) and place pump in a locked area on the unit.
  - Upon return to the Nursing Unit, pump will be returned to the patient so insulin pump therapy can be resumed
Insulin Pumps & Hypoglycemia

If patient’s blood glucose is less than 70 mg/dL:
- Implement UHB Hypoglycemia Protocol & notify the primary team physician
- Primary team will request re-evaluation by Endocrinology, as needed
- The nurse shall disconnect/remove the pump & immediately contact a physician when patient:
  - is not responding to hypoglycemia treatment
  - becomes unresponsive or confused
  - is unable to manage the pump due to hypoglycemia or any other medical condition
  - does not know how to suspend the insulin pump

How to Remove Insulin Pump

Loosen the anchoring adhesive tape attaching the pump tubing & cannula (metal or plastic cannula) to the patient & pull out the pump cannula. Do not push any pump buttons or pump while it is still attached to the patient. Place in area on unit or give to family member.
Nursing Role

- Documents presence of insulin pump in Admission Profile
- Communicates presence of pump to Primary Team
- Communicates patient’s pump status during all hand-off encounters
- Documents presence of pump in Admission Profile
- Communicates presence of pump to Primary Team
- Communicates patient’s pump status during all hand-off encounters
- Document FS results from UHB blood glucose meters
- Requests from Pharmacy, a vial of insulin, when patient needs to change and fill insulin pump reservoir (one time use vial - send back to pharmacy)
- Documents in HealthBridge
  - Insulin is infusing via insulin pump (Intake/Output Flowchart)
  - Site assessment q shift
  - When patient changes infusion set & reservoir is filled
  - Bolus dose is administered
  - Point of Care glucose value
  - Hypoglycemia/hyperglycemia and treatment when indicated
Health Care Team Responsibilities

Primary Team’s Role

• Assess the patient for contraindications to pump use.
• Contact Endocrine Team
• If deemed acceptable & patient does not need an immediate pump catheter or insulin reservoir change - Patient may continue to infuse the insulin that is currently in the pump until Endocrine Team evaluates.
• Obtain consent on the “Insulin Pump Patient/Pump Surrogate Agreement” & initiate pump orders. Places order: “patient may use own insulin pump in the hospital”
• Orders a vial of insulin in HealthBridge for insulin pump use when requested by RN for insulin pump reservoir changes.

Endocrinologist Role

• Evaluates patient within 24 hours of consultation request.
• If patient/surrogate deemed acceptable to use pump therapy while hospitalized, obtains signature for “Inpatient Insulin Pump Patient/Pump Surrogate Agreement” and files it in the Consent Section in the Medical Record (if not done previously by primary team).
• Reviews patient’s pump responsibilities with patient/surrogate.
• Reviews Primary Team’s orders.
• Changes in Pump settings will be made with the Endocrine Team at the patient’s
Pharmacist Role in Pump Therapy

- Reviews and profiles order for one vial of insulin in HealthBridge.
- Processes RN request for one vial of insulin.
- Insulin vial will be delivered to the Medication Room.

- Inputs pump orders in HealthBridge
  - Continuous insulin infusion via insulin infusion pump
  - Bolus Insulin (type of insulin)
- Discontinue Insulin Pump
Adult Parenteral Nutrition Support

- Describe parenteral nutrition support therapy and guidelines used at UHB.
Parenteral Nutrition (PN)

- PN is the provision of nutritional therapy administered through a peripheral (PPN) or central access line (TPN).

- **Purpose:**
  - to correct specific nutrient deficiencies
  - to prevent the adverse effects of malnutrition when the gastrointestinal tract cannot be used or when oral/enteral feedings are insufficient to meet the patient’s needs

- PN is included in the category of “High-alert (or high-risk) medications.” Drugs that bear a heightened risk of causing significant patient harm when they are used in error” (see Policy PHA-29 HIGH-ALERT MEDICATIONS).
Adult Parenteral Nutrition Ordering

- Team places order M-F & reviews with RN. Weekend orders are written on Fridays.
- RN reviews Physician’s Order Form (Hard Copy) & Order Summary (filed in the Medical Record).

Sample Physician’s Order

- RN obtains pump tubing with 0.22-micron filter from Central Supply.
- Pharmacy delivers PN to unit (signature required).
- RN places PN in refrigerator if PN will not be infused in 1 hr.
- **Start all PN infusions at 6:00 P.M.(18:00).**
- Do not allow solution to hang for >24 hours.
- Do not attempt to catch up to titrate to save solution.
- Do not abruptly stop PN, unless ordered by physician.
### Sample Label Report

**12/29/2015 05:09**

**Details**
- **Patient Name:** test, test  
- **Class:** Adult (15-65)  
- **Customer Name:** SUNY Downstate Medical Center  
- **Patient:** 6789  
- **Template Name:** Adult Individual Formula  
- **Product Group:** TPN ADULT  
- **Order Vol MLS:** 1000  
- **Overfill MLS:** 100  
- **Duration:** 24 Hours  
- **Flow Rate:** 42 ml/hr  
- **Rx #:** 2611-8369  
- **Route of Admin:** Intravenous Central  
- **Attending Phys:** tt000  
- **Prescribed By:** Dresser, Lisa MD  
- **Wt:** 0 Kg  
- **Ht:** 0 cm  
- **Sex:** F  
- **Birth DT:** 07/08/1985  
- **Caps Rx #:** 2611-8369  
- **Status:** Needs Validation

**Balance**
- **Method:** Acetate  
- **Acetate:** 100 %  
- **Chloride:** 0 %  
- **Cation:** Sodium  
- **QS Amt MLS:** 360.21  
- **Exclude Lipids:** No  
- **Min Volume:** No  
- **Calc w/Ints:** Yes  
- **Use CaCl:** No

**Ingredients List**

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<tr>
<th>Item</th>
<th>Amount</th>
<th>UOM</th>
<th>Per</th>
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</thead>
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<tr>
<td>Amino Acids</td>
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<td>%</td>
<td>Order</td>
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<tr>
<td>Dextrose</td>
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<td>%</td>
<td>Order</td>
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<td>Sodium Chloride</td>
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<tr>
<td>Potassium Phosphate</td>
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</tr>
<tr>
<td>Magnesium Sulfate</td>
<td>5</td>
<td>mEq</td>
<td>L</td>
</tr>
<tr>
<td>Multivitamins</td>
<td>10</td>
<td>ml</td>
<td>Order</td>
</tr>
<tr>
<td>TRACE ELEMENTS 5</td>
<td>3</td>
<td>ml</td>
<td>Order</td>
</tr>
<tr>
<td>Insulin Human R</td>
<td>5</td>
<td>unit(s)</td>
<td>Order</td>
</tr>
</tbody>
</table>

**Instructions**
- **Instruction Text**
  - **Type**
  - **Admin**
    - **USE A 0.22 MICRON FILTER**
When Hanging PN: Cross Reference PN Label with PN Order Summary (Filed in Chart)

- Verify orders
  - Patient name
  - Two patient identifiers
  - Check expiration date
  - Electrolytes/insulin/famotidine
  - Rate per hour

- Provide and document an “Independent double-check” prior to administration for PN and intralipids. Two nurses document in HealthBridge when hanging PN.
  - Intralipids (usually ordered with PN) are ordered in HealthBridge and also require an Independent double check prior to administration.
Parenteral Nutrition-Ongoing Care

- Communicate PN status during all hand-off communications
- **Do not** administer anything other than PN or intralipids through the designated line (e.g. IV piggyback, blood or blood products).
- **Do not** draw any blood from PN IV access.
- **Do not** abruptly stop PN (unless ordered by a prescribing clinician in case of an emergency).
- Hang Dextrose 10% and infuses at current rate of PN - if PN solution runs out or if PN is suddenly discontinued.
- Continue PN infusion if patient leaves unit (surgery/procedures/testing) unless ordered by physician.
- Refer to Policy: Adult Parenteral Nutrition Support-NUT-12.
- **Use Clinical Practice Guidelines “Parenteral Nutrition” in Health Bridge.**
RECOGNIZING imPAiRED PRACTITIONERS
Early warning signs

- Interpersonal difficulties with family, friends and co-workers
- Ability to practice is impaired and patient safety may be compromised
- The issue of identifying a health care practitioner as ill or impaired should be considered in light of the individual’s known personality and professional conduct
- Anytime, if patient health and safety is a concern, staff must report their observations to their immediate supervisor
Overview

- Physicians and other health personnel work in very stressful environments and conditions.
- Sometimes, physicians, nurses, and other practitioners turn to unhealthy ways to cope with stress.
- Mental illness, substance abuse, and chemical dependency are disorders that could impair a practitioner’s health and ability to practice medicine (nursing, etc).
- Mental illness, substance abuse and chemical dependency are diseases that can be successfully treated.
- Recognizing patterns of impairment will protect patients’ safety and can help save an individual’s career and possibly his/her life.
indications of Impairment

- Unkempt appearance, poor hygiene
- Trembling, slurred speech
- Bloodshot or bleary eyes
- Complaints by patients and staff
- Arguments, bizarre behavior
- Financial or legal problems
- Difficult to contact; won’t answer phone or return calls
- Neglect of patients, incomplete charting, or neglect of other hospital duties

- Irritability, depression, mood swings
- Irresponsibility, poor memory, poor concentration
- Unexplained accidents to self
- Neglect of family, isolation from friends
- DWI arrest or DUI violations
- Inappropriate treatment or dangerous orders
- Unusually high doses or wastage of narcotics noted in drug logs
- Odor of alcohol on breath while on duty
Programs to help practitioners

- **For nurses**
  contact New York State Board of Nursing

- **For physicians, residents, medical students, and physician assistants**
  contact New York State Medical Society through the Committee for Physician’s Health (CPH)
Referral Process

- Anyone can make a confidential referral to CPH. Most referrals (75%) come from colleagues or physicians seeking help for themselves.
- The toll free telephone number in NYS is 1-800-338-1833.
- Individual treatment plans are developed under the supervision of the CPH Medical Director. Both inpatient and outpatient services for detoxification, rehabilitation, and psychiatric care in addition to attendance at self-help or peer support groups are offered.
- Assistance and emotional support for families is also provided.
CONFidentiality

- The confidentiality of the CPH program participants, referral sources, and CPH records are protected by NYS and Federal laws.

- Anyone who makes a referral shall not be liable for actions taken in good faith and without malice.

- CPH does not refer physicians to the NYS DOH Office of Professional Misconduct as long as the physician agrees to participate, stays with the program, is helped by treatment, and does not present an imminent danger to the public.
Joint Commission Standard on Physician Health

The Joint Commission Standard on Physician Health (MS 4.80) requires that:

- hospitals manage physician health matters separately from disciplinary matters
- establishes a process for handling potential physician impairment
- trains physicians and other hospital staff members to recognize physician impairment
- endorses utilization of a statewide system, which in NYS is the CPH
ORGAN DONATION

LiveOnNY

Caring for New Yorkers through Organ Donation
Did You Know That …

- 15 Americans die each day waiting for an organ to become available
- More than 75,000 men, women, and children now wait for a transplant to replace a failing heart, liver, lung or pancreas

- Each day about 70 people receive an organ transplant
  - BUT another 16 people on the waiting list die
- Every 16 minutes another person joins the waiting list
- Someone dies every 96 minutes because there aren’t enough organs to go around
**STEP 1: Sign Your Driver's License or Non-Driver ID.** - sign the section on the back of your New York State driver's license where you agree to make an "anatomical gift." Be sure to have two people witness your signature, preferably your closest family members so that their names can be easily verified if the need arises.

**STEP 2: Enroll in the New York State Organ and Tissue Donor Registry**

**STEP 3: Discuss your decision with your family. Why do I need to tell my family?** The New York Organ Donor Network requests consent from next of kin of all medically suitable organ and tissue donors. Family discussion beforehand allows next of kin to make decisions about organ and tissue donation that meets the specific wishes of their loved ones.
Role of the Health Care Professional

- The role of the health care professional is critical to the success of organ and tissue donation.
- Nurses, physicians, and other health care professionals are the vital link between the New York Organ Donor Network and organ and tissue donors.
- It is this partnership that ensures that families of potential donors are given the opportunity to make informed decisions about donation.
What is the policy and procedure at SUNY Downstate Medical Center?

- All deaths and imminent deaths are to be referred to the Organ Donor Network (ODN)
- Within 1 hour of every patient death, the Charge Nurse or designee will contact NYODN to inform them of the expiration.
- In the opinion of the health care team, cardiopulmonary death will likely occur within 60 minutes of the withdrawal of life support the physician will contact NYODN to advise them that the hospital has a potential DCD donor. The physician will also notify the admitting department that the Organ Donor Network was contacted.
- When necessary, the Nursing Supervisor will provide ODN with necessary clinical information.
Identification and Management of Patients At Risk For Suicide

- **Policy PSY-2:**
  - **ALL** healthcare providers are responsible for recognizing and observing patient’s suicidal feelings and behavior.
  
  - **ALL** UHB staff are responsible for reporting observations of patient’s suicidal feelings and behavior to the appropriate health care providers immediately (RN, LPN, MD).
Identification and Management of Patients At Risk For Suicide

- **Licensed Nursing and Medical Staff are responsible for:**
  - **Conducting** a suicide risk assessment on admission and ongoing throughout length of stay (change in behavior/ideation)
  - **Completing** nursing admission note addendum (see side 2)
  - **Initiating** suicide observation (1:1), as per policy
  - **Notifying** MD immediately to obtain a Psychiatric consultation
  - **Searching** patient and environment for unsafe objects and Removing those objects from the environment (e.g. razors, nail files, glass objects, belts, ties, pantyhose, medications, matches, lighters, cords, breakable utensils, antiseptic solutions, alcohol, lotion, gauze, kling)

- **Unlicensed Staff are responsible for:**
  - **Reporting** observations of suicidal behavior or ideation immediately to RN/Charge Nurse, LPN, or MD
Identification and Management of Patients At Risk For Suicide

- **Documentation:**
  - **Progress Notes must include:**
    - At risk behaviors
    - MD notification: name of MD, time
    - Note: Face-to-Face Psychiatric consultation and evaluation of the patient must occur within 1 hour
  - Interventions (e.g., institution of 1:1 observation)
  - Patient response
  - Resources provided to patient/family
  - Patient/family teaching
  - Discharge planning

- **One-To-One Observation Record**
  - Complete Form as per policy
Escalation/Chain of Command

REAWAKENING OUR PASSION FOR CARING
Escalation/Chain of Command

- First, Do No Harm!
- If You See Something, Say Something: COMMUNICATE – ESCALATE.
- YOU are the Strongest Link in the Patient’s Chain of Survival.
- The Chain of Command is only as strong as its weakest link: Don’t be the “Weak Link” in Patient Safety ... ESCALATE.
Escalation/Chain of Command

E
"E"xamine your patient; "E"arly recognition;
"E"arly activation (extension 2323)

S
"S"ee and "S"ay
If you "S"ee something, "S"ay "S"omething;
"S"eek assistance

C
"C"all for help; "C"ollaborate; "C"ommunicate
"A"ssess & re-"A"ssess

L
"L"ook, "L"isten, & feel:
"L"ive, "L"ove, and "L"earn from the experience

A
"A"sk questions

T
"T"eamwork; "T"reat the patient using evidence-based best practices

E
"E"valuate patient outcomes and team performance
What is DSRIP?

- What does it mean at University Hospital of Brooklyn?
- Downstate Medical Center?
Where does DSRIP come from?

**Delivery System Reform Incentive Payment**

- Revenue stream $\text{ }$
- For a five year period(2014-2020)
- funded by the Federal government
- and administered by the NYS Department of Health (NYSDOH)
- plan to transform healthcare delivery and reduce *avoidable* inpatient admissions by 25%.
Delivery System Reform Incentive Payment ...

- Program that promotes
  - Patient access to high quality, respectful care
  - Care coordination through the continuum of care (inpatient/outpatient)
  - Preventive care
  - Patient Empowerment
• New York State has 25 Preferred Provider Systems (PPS)
• The largest is our Preferred Provider System (PPS):
  • Is a subsidiary of HHC
  • OneCity Health (eligible to receive 1.2 Billion Dollars over 5 years)
• Our Downstate PPO is OneCity Health
• 657,070 DSRIP-attributed Medicaid Lives
• Patients speak>30 Languages
• Organized into 4 HUBS: Brooklyn, Bronx, Manhattan and Queens
• 220+ partners= 12,000 providers
• Workforce>119,600
Underlying ALL Transformation Initiatives:

1. **Customer Service/ Cultural Competency**
   Demonstrating respect and courtesy to all

2. **Communication/Health Literacy**
   Communicating effectively with customers, visitors, patients, and staff

3. **Quality Management**
   Delivering the highest standard of care

4. **Customer Satisfaction/Empowerment**
   Patients taking an active role in managing their health / adopting a healthy lifestyle
Determinants of Health: Diet, Sleep, Exercise, Family, Stress, Medical Care...
Transformation Initiatives

Clinical Champion

Work Flows/ Work Plans

Work Groups

- Patient Activation Measure PAM
- Transition of Care
- HIV PrEP
- Palliative Care
- Asthma Remediation
- ED Triage

Team Approach to optimize and prioritize Care Coordination

Evidence-Based Care to enhance Quality of Care for all patients

Increased Patient Access, Cultural Competency/Health Literacy, Enhanced Patient Experience
Specific Transformation Initiatives:

- **Project 11**: Patient Activation Measure (PAM), Uninsured members of our community-engage and empower the patient; Connect the patient to insurance, their Primary Care Provider, Care Coordinator for high risk patients.

- **Transition Of Care (TOC)**: seamless transition from the inpatient to the patient’s primary care provider or/ Transition of Care Clinic followed closely by a Transition of Care Team for high risk patients; Care Coordination services provided in the short term and when indicated.

- **ED Triage**: Patient discharged from the Emergency Room with a PCP appointment...if needed, Care Coordination services.
Specific Transformation Initiatives...

- **Pediatric Asthma**: Asthma control, Evidence Based-Care, Asthma Action Plan (AAP)Community Health Worker Home Assessment, Environmental Remediation; Reinforcement of Education and Medication Use to prevent Asthma exacerbation

- **PCBH Collaborative Care Initiative**: Behavioral Medicine integrated into Primary Care, treatment and care coordination.

- **CVD**: Motivational Interviewing, Prevent Heart Attack and Stroke- education & self-management of disease processes-the patient is the active participation in care planning.
Specific Transformation Initiatives…

- **HIV: PrEP**: Prevent HIV; Maintain ongoing in treatment; Linkage to community based organization as needed.
- **Integrated Delivery System**: Primary Care Medical Home status; HEALTHIX accessible; EMR, staff and providers all communicates easily across the continuum of care.
- **Palliative Care**: Patient with an Advanced Directive, Pain management & control, and, end of life management.

Transformation Phased In Stages

Old System

New system

Patient Centered Evidence-based System-wide Care Coordination

University Hospital of Brooklyn

SUNY Downstate Medical Center
Special Considerations for DSRIP Compliance

- [http://downstate.edu/compliance/cp_ethics.html](http://downstate.edu/compliance/cp_ethics.html)


- Adhere to DMC’s Compliance, Audit and Internal Control Programs.

- Report Ethical/Legal Concerns:
  - To your supervisor;
  - To the DMC Office of Compliance & Audit Services:
    - **Renee Poncet, VP**
    - Main Office: (718)270-4033
    - [compliance@downstate.edu](mailto:compliance@downstate.edu)
    - SUNY Downstate Office of Compliance & Audit Services, 450 Clarkson Ave MSC 1248, Bklyn, NY 11203
Special Considerations for DSRIP Compliance...

- To the NYC Health + Hospitals OneCity Health
  **Mr. Wayne McNulty, Sr. AVP & Chief Corporate Compliance Officer**
  (646) 458-5632/ (646)458-5624
  wayne.mcnulty@nychhc.org or compliance@nychhc.org
  NYC Health + Hospitals, Office of Corporate Compliance, 160 Water St., Suite 1129, New York, NY 10038

- Via DMC’s Compliance Line: (877)-349-SUNY or via website at www.downstate.edu. Click on “Compliance Line” link at bottom of page.

- Via OneCityHealth/DSRIP Help Line at 844-805-0105 or online at at https://helphhc.alertline.com/gcs/welcome and select “NYC Health + Hospitals OneCityHealth” as the location of the issue.
DSRIP Belongs to all of us....

- Who we are!!!
- What we do...
- Do it together
- Begins and ends... with our patients
- DSRIP/Transformation is everyone’s JOB!

Thank You
You are now completed.

Click HERE to take the License Professional Direct Care Providers Post Test.