ANNUAL MANDATORY EDUCATION 2018
Directions

- Review each slide of the presentation.
- To advance to the next slide, either:
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  - use the navigation arrows found toward the bottom of your browser.
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* - indicates updated for 2018
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
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.
The patient has the right to...

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

Patients May Contact The Joint Commission by dialing 1-800-994-6610.
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
● 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 alphanumerical 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)
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, mark the site/side and complete the universal protocol check list on time-out
Any Questions?
Thank You

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
Objectives

All Staff will be able to:

1. Identify Joint Commission National Patient Safety Goals (NPSG06.01.01)
2. Recognize alarm fatigue and its 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
Alarm Management

- 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 Management
AACN Practice Alert

- 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.
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.
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 Action Pak: Alarm Management Practice Alert  
  www.aacn.org/actionpak
- AACN Protocols for Practice: Noninvasive Monitoring, 2nd ed (Burns SM, ed: Sudbury, MA: Jones and Bartlett; 2006
- AACN Practice Alert: Non-invasive Blood Pressure Monitoring  
  www.aacn.org/AACN/practiceAlert
- UHB Policy: CLINICAL ALARM SAFETY; No. PTSAF–10
SUNY Downstate’s Corporate Compliance Program is mandated by the State of New York’s Office of Medicaid Inspector General.

DMC’s Compliance Program provides a framework of policies, procedures and assessment activities designed to help prevent and detect violations of laws and regulations.
Corporate Compliance provides the framework to help DMC meet requirements established by Federal, State and Local regulations.

- **Internal Controls**: We identify process deficiencies to foster performance improvement.
- **Central Coordination of Laws & Regs**: We create P&Ps based on laws & regulations.
- **Prevention & Detection of Waste/Fraud/Abuse**: We monitor high risk areas to prevent and detect costly errors.
In order to ensure that DMC’s program is effective, 8 elements of the Program have been established....


2. DMC’s Compliance Officer: The VP for the Office of Compliance & Audit Services (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: The Table of Organization /contact info. is available on our website. You can also call or web-report (confidentially and anonymously) through the Compliance Hotline.

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

6. 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.

7. Investigation and Remediation: OCAS works closely with many other departments including Human Resources, Labor Relations, IT and Counsel’s Office to investigate 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 wherever 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:

- **Vice President**
  - Office of Compliance & Audit Services
  - x4033

  - **Clinical Reimbursement Division**
    - x4327

  - **HIPAA**
    - x4033

  - **Internal Audit Division**
    - x4033

  - **Research Compliance Division**
    - x7470

  - **Internal Control Program**
    - x4033

  - **Compliance Coordination Division**
    - x095

Visit our Website
www.downstate.edu/compliance
Code of Conduct Guidelines

Click on the Code of Ethics and Business Conduct brochure below to see the full document.

- 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
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

These laws establish liability for any person who engages in unlawful acts with respect to Federal, State or local government.

A false claim is a violation of State and Federal Law. Civil, administrative and criminal penalties may be levied based on 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 $21,553 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.

*Downstate Medical Center is a component of the State University of New York, and thus is a State agency. The United States Supreme Court has held that private persons may NOT be eligible to file qui tam/whistleblower lawsuits against State agencies and may NOT be entitled to a share of the proceeds of any FCA recoveries.
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.
Reporting Violations

Employees must report real or suspected violations regarding:

- Code of Ethics & Business Conduct;
- Detection, Prevention of Fraud, Waste & Abuse (DRA);
- Violations of law.

Reports can be made to:

- Supervisor or responsible VP;
- Chief Compliance Officer;
- SUNY Counsel’s Office; or
- DMC’s Compliance Hotline (anonymous).

<table>
<thead>
<tr>
<th>Concerns Regarding:</th>
<th>Department</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal Issues</td>
<td>University Counsel</td>
<td>270-4628</td>
</tr>
<tr>
<td>Disciplinary Issues</td>
<td>Human Resources</td>
<td>270-1191</td>
</tr>
<tr>
<td>Patient Confidentiality</td>
<td>HIPAA Privacy Officer</td>
<td>270-7470</td>
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<tr>
<td>Security of Information Systems</td>
<td>Information Security Officer</td>
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<tr>
<td>Patient Abuse</td>
<td>Patient Relations</td>
<td>270-1111</td>
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<td>EEO/Diversity Issues</td>
<td>Office of Opportunity &amp; Diversity</td>
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<tr>
<td>Research</td>
<td>Research Administration</td>
<td>270-8202</td>
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<tr>
<td>Environmental Health &amp; Safety</td>
<td>Facilities Management &amp; Development/Environmental Safety</td>
<td>270-1216</td>
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<tr>
<td>Threats &amp; Physical Violence</td>
<td>University Police</td>
<td>270-2626</td>
</tr>
<tr>
<td>Compliance Hotline</td>
<td>Click here for Web-based reporting</td>
<td>877-349-SUNY</td>
</tr>
</tbody>
</table>
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.
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
- Birthdate
- 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?

Should the nurses be discussing protected health information in an environment where others can overhear?
• 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)...
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.
DOCTOR: Sam listen I'm sorry I don't have the test results in yet. I know you're anxious but the reports should be in by... Monday and I will call you just as soon as I've looked them over.

SAM: By Monday I'll be on my way to France. Why don't you just send me an e-mail when it's over?

DOCTOR: We don't, we don't use e-mail in the practice...

SAM: Don't you have a personal e-mail address? Look, I've been seeing you professionally for at least 10 years and we've been friends for about that long. What's the problem?

DOCTOR: I guess you're right, what's your e-mail address again?

Is it ever acceptable to send PHI via unencrypted e-mail?
• Unencrypted email does not secure the information being transmitted. Unencrypted email from cell phones, computers, smartphones and other devices can be intercepted by unauthorized persons.

• PHI contained in emails including names, addresses, credit card numbers, or even lab results can then be used by criminals for identity theft or other harmful purposes.

• Make sure you always follow DMC’s technical safeguards and procedures for electronic PHI. If you are authorized to send work-related emails from your home computer, make sure you follow the policies for working offsite. Check with DMC’s HIPAA Security Officer if you do not understand any of the procedures or whether they apply to you.

Under certain circumstances – pursuant to DMC Policy - a patient themselves may authorize that we communicate their PHI through unencrypted email. This is only permissible when the patient has acknowledged the risks associated with unencrypted transmission and provided written documentation of their authorization to do so.
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 – Downstate’s Office Outlook 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....
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SAFEGUARDS

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

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

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
Report HIPAA Violations: Compliance Hotline

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
The Academy of Pediatrics recognizes breastfeeding as the optimal food of choice for infants.

*Exclusive breastfeeding for six months and continuing for 1 year or more is recommended* with the introduction of complementary food at 6 months.
Success with breastfeeding starts with skin to skin:

- Placing a naked newborn onto mothers’ bare chest immediately after a vaginal birth and as soon as mother is able to respond in a C/Section birth.

- Skin to skin helps baby to thermo regulate, keeps baby calm and helps to regulate its breathing and heart rate.
Mothers are encouraged to room-in with babies 24 hours a day:

* Permits recognition of infant’s need for feeding
* Facilitates feeding baby on demand
Benefits of Breast Feeding:

Infants

* lower risk of ear infection, diarrhea, pneumonia certain childhood cancers.

Mothers

* lower risk of developing breast cancer, ovarian cancer decrease the severity of post partum depression
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.
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 (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
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 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 ENFERMERAantes 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 ENFERMERÁ ANTES DE ENTRAR A LA HABITACIÓN

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
SPREAD 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 gold neon 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.
UHB
FALLS AND INJURY PREVENTION
PROGRAM
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 gold ID 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>1. All Admitted Patients</th>
<th>Implement Universal interventions for all hospitalized patients.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Communication</td>
<td>Orient patient to surroundings and hospital routines</td>
</tr>
<tr>
<td></td>
<td>Very important to point out location of the bathroom</td>
</tr>
<tr>
<td></td>
<td>If patient is confused, orientation is an ongoing process</td>
</tr>
<tr>
<td></td>
<td>Call light in easy reach – make sure patient is able to use it</td>
</tr>
<tr>
<td></td>
<td>Instruct patient to call for assistance prior to ambulating if necessary</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”.

### Make rounds every hour -

## 3. Toileting

### Implement hourly rounding program.

- Instruct patient to use hand rails in bathrooms and showers
- Provide a commode at bedside (if appropriate).
- Urinal/bedpan should be within easy reach (if appropriate).
<table>
<thead>
<tr>
<th>4. Medicating</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ Evaluate medications for potential side effects.</td>
</tr>
<tr>
<td>➢ Consider peak effect that affects level of consciousness, gait and elimination when planning patient’s care.</td>
</tr>
<tr>
<td>Instruct patient to sit up slowly prior to ambulation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ Bed</td>
</tr>
<tr>
<td>▪ Low position with brakes locked, document number of side rails.</td>
</tr>
<tr>
<td>▪ 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.</td>
</tr>
<tr>
<td>➢ Bedside stand/bedside table</td>
</tr>
<tr>
<td>▪ Personal belongings within reach.</td>
</tr>
<tr>
<td>➢ Room “clutter” - Remove unnecessary equipment and furniture</td>
</tr>
<tr>
<td>▪ Ensure pathway to the bathroom is free of obstacles and is lighted.</td>
</tr>
<tr>
<td>▪ Consider placing patient in the bed that is close to the bathroom.</td>
</tr>
<tr>
<td>➢ Hallways – instruct patient to use hand rails in hallways as needed</td>
</tr>
<tr>
<td>Recommend use of non skid slippers or shoes when ambulating</td>
</tr>
<tr>
<td>Use a night light at bedtime and as appropriate.</td>
</tr>
</tbody>
</table>
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

• Patient Fall Analysis Tool
  • (Targeted Solution Tool for piloted units NS 74/61/82)

• Complete Incident Report

• Review and revise care plan if necessary

• Document fall occurrence, nursing assessment, post falls interventions, and patient response in a FOCUS note
Management of the Environment of Care

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
SAFETY IN-SERVICE

DOWNSTATE MEDICAL CENTER

ENVIRONMENTAL HEALTH & SAFETY OFFICE

BSB3-136 x1216

SAFETY IN-SERVICE

2017
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
LEARNING OBJECTIVES

- 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.
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
- 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:

“ABC” 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!
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

- Training
- Written Program
- Chemical List
- Labeling
- Maintain Safety Data Sheets
The Right-To-Know Law or Hazard Communication Standard require employers to provide 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.
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.
- 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
Personal Protective Equipment
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>
</tbody>
</table>

| Environment (Non-Mandatory) | | |
|-------------------------------| | |
| | | |
**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.

**Hazard Pictograms**

**Signal Word**
Danger

**Hazard Statement**
Highly flammable liquid and vapor.
May cause liver and kidney damage.

**Supplemental Information**
Directions for use
______________________________
______________________________
Fill weight: _________ Lot Number:_____
Gross weight: _________ Fill Date: ______
Expiration Date: _______
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
Regulated Medical Waste

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

Any item that has the bio-hazard symbol on it
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.
Procurement of radioactive materials and disposal of radioactive waste are coordinated by the Office of Radiation Physics @ x1423.
EQUIPMENT SAFETY
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
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
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 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
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
CMS Final Rule on Emergency Preparedness

SUNY UHB Emergency Preparedness
CMS Final Rule

- Goals:
  - Address systematic gaps in past responses
  - Establish consistent framework for all healthcare entities
  - Encourage coordination
CMS Final Rule

- Emergency Prep part of CMS since 11/16/16
- Providers must be compliant by 11/16/17
CMS Final Rule

• Emergency Prep part of CMS since 11/16/16

• Providers must be compliant by 11/16/17

• Non-compliance: Remediation and Termination
Components

• 40+ different requirement areas, applying to 17 types of providers

• GNYHA identified 9 areas relevant to most hospitals

• Additional requirement areas for transplant centers
The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.

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<tr>
<td>Need an emergency prep plan that is specific to facility, is reviewed annually and considers particular hazards most likely to occur. Natural disasters Man-made disasters Facility-based disasters</td>
<td>• Request to see copy of the plan and review it</td>
<td>• Ask faculty leadership to identify the hazards in the RA and how RA was conducted</td>
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<td></td>
<td>• Verify it has been updated annually</td>
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The facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:

1. Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.

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<td>The facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:</td>
<td>Similar to previous</td>
<td>• Request to see copy of the plan and review it</td>
</tr>
<tr>
<td>(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.</td>
<td></td>
<td>• Ask faculty leadership to identify the hazards in the RA and how RA was conducted</td>
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<pre><code>                                                                                             |                         | • Verify it has been updated annually                                  |
                                                                                             |                         | • Verify RA is based on facility-specific all-hazards approach           |
</code></pre>
The plan must do the following:

(1) Address patient/client population, including but not limited to, patients at risk; the types of services the facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.

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<tr>
<td>The plan must do the following:</td>
<td>Emergency plan must specify pop served by facility, esp <strong>AT-RISK</strong>.</td>
<td>Interview leadership to describe:</td>
</tr>
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</table>
| (1) Address patient/client population, including but not limited to, patients at risk; the types of services the facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. | Emergency plan must include succession planning and continuity of operations | • At-risk population in facility  
• Strategies for addressing their needs  
• Services facility can provide during emergency  
• Plans to continue operations during emergency  
• Succession plans |
### Sustenance Needs

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<tr>
<td>At a minimum, the policies and procedures must address the following:</td>
<td>Facilities must be able to provide subsistence of all patients and staff</td>
<td>- Verify emergency plan includes policies for subsistence needs</td>
</tr>
<tr>
<td>(1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, including:</td>
<td>Alternative sources of energy depend on facility</td>
<td>- Verify emergency plan includes policies to maintain temperature, lighting, fire detection, and sewage.</td>
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<tr>
<td>(i) Food, water, medical and pharmaceutical supplies</td>
<td></td>
<td></td>
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<tr>
<td>(ii) Alternate sources of energy to maintain:</td>
<td></td>
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<tr>
<td>(A) Temperatures to protect patient health and storage of provisions.</td>
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<tr>
<td>(B) Emergency lighting.</td>
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<td></td>
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<tr>
<td>(C) Fire detection, extinguishing, and alarm systems.</td>
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<td>(D) Sewage and waste disposal.</td>
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## Evacuation Policies/Procedures

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<tr>
<td>At a minimum, the policies and procedures must address the following:</td>
<td><strong>Must have evacuation protocols for staff, patients, family members, volunteers, and other</strong></td>
<td>• Review the emergency plan to verify it includes policies and procedures for safe evacuation from the facility and that it includes all of the required elements.</td>
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<td><strong>These protocols must address transportation services</strong></td>
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<td><strong>Policies for evacuation triage and communication of patients’ records</strong></td>
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<td></td>
<td><strong>Outline primary and alternative methods of communication with external sources of assistance</strong></td>
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| The hospital must (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the hospital experiences an actual natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise - A second full-scale exercise that is community-based or individual, facility-based. - A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospital’s response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the hospital’s emergency plan, as needed. | Must conduct at least a tabletop drill AND a full-scale exercise annually Drill can be community-based or individual facility-based Must document compliance and lessons learned from drills in last 3 years | • Ask to see documentation of annual tabletop and full-scale exercises  
• Ask to see efforts to identify full-scale community based exercise  
• Request documentation of facility’s analysis and response, as well as update to emergency plan |
The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) 62 of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section.

Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code, Life Safety Code, and NFPA 110.

Emergency generator inspection and testing. The hospital must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.

Emergency generator fuel. Hospitals that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.

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<td>Hospitals must comply with NFPA 101 (LSC) and NTPA 99 requirements, plus implement emergency and standby power systems to meet subsistence needs based on facility’s established emerg plan</td>
<td>• Verify that the hospital has the required emergency and standby power systems to meet the requirements of the facility’s emergency plan and corresponding policies and procedures</td>
<td>• Review the emergency plan for “shelter in place” and evacuation plans.</td>
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Integrated Health Systems

<table>
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<tbody>
<tr>
<td>If a hospital is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the hospital may choose to participate in the healthcare system’s coordinated emergency preparedness program.</td>
<td>If desired, healthcare systems with multiple facilities can develop single unified EP plan.</td>
<td></td>
</tr>
<tr>
<td>(1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program.</td>
<td>Unified plan must address the unique circumstances at each facility and include coordinated communication and training plan.</td>
<td>Verify if the facility has opted to be part of its healthcare system’s unified and integrated EP program and check documentation.</td>
</tr>
<tr>
<td>(2) Be developed and maintained in a manner that takes into account each separately certified facility’s unique circumstances, patient populations, and services offered.</td>
<td></td>
<td>Ask to see a copy of the entire integrated and unified EP program and all required components (emergency plan, policies and procedures, communication plan, training and testing program)</td>
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<tr>
<td>(3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance.</td>
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<tr>
<td>(4) The unified and integrated emergency plan must also be based on and include a documented community-based risk assessment and facility-based risk assessment, utilizing an all-hazards approach.</td>
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<tr>
<td>(5) Include a coordinated communication plan, and training and testing programs.</td>
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Transplant/ESRD Centers
A transplant center must have policies and procedures that address emergency preparedness. These policies and procedures must be included in the hospital’s emergency preparedness program.

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<td>The transplant center’s EP plans must be included in the hospital’s emergency plan and be involved in hospital’s risk assessment. A representative from each transplant center must be actively involved in development of hospital’s EP plan.</td>
<td>• Verify the transplant center has EP policies and procedures. • Verify that the transplant center’s EP policies and procedures are included in the hospital’s EP program. • Verify hospital documentation that a representative from each transplant center participated in development of EP plan.</td>
<td></td>
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</tbody>
</table>
The dialysis facility must comply with all applicable Federal, State, and local emergency preparedness requirements. These emergencies include, but are not limited to, fire, equipment or power failures, care related emergencies, water supply interruption, and natural disasters likely to occur in the facility’s geographic area. The dialysis facility must establish and maintain an emergency preparedness program that meets the requirements of this section.

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<td>The ESRD facility must develop and update an EP plan that meets all the health and safety needs of their patient population during an emergency.</td>
<td>• Ask to see written or electronic documentation of the program.</td>
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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
Remember ...

- 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 the case.
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
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 Ð 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, 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
Family First Program

- 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
Neonate and Infant
-Interventions for Caregivers

- 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 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
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 airway 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
• **Policy:**
  - The written informed consent of the patient or in the case of a minor his/her parent or legal guardian, is required prior to the performance of any medical or surgical procedure except in emergency, life threatening situations. New York State law defines the parameter of professional practice and SUNY Downstate sets forth the policies and procedures which implement these parameters.
Consent

• The New York State Mental Hygiene Regulations prescribe a separate procedure for obtaining consent from a patient with a psychiatric admission status who lacks capacity to make treatment decisions for him or herself.

• Therefore, when questions arise, the Risk Manager or Administrator on Duty (AOD) should be contacted in relation to the performance of medical procedures requiring consent for psychiatric patients.
Consent

• General Consent
  – Governs the performance of any routine procedure or treatment
  – Signature must be witnessed by an adult employee of the facility
  – Provisions for patient with LEP
    • Need to include Interpreter

• Valid Informed Consent
  – Legally and mentally capable of making health care decisions
  – Patient has sufficient information to make health care decisions

• Who is legally responsible for explaining and obtaining the Informed Consent?
  • Licensed Independent Practitioner
WHO CAN CONSENT TO CARE?

A PERSON WITH DECISIONAL CAPACITY WHO IS:

- Adult (18 years old or older); or
- Married person of any age; or
- Minor who is living independently from parents or who has a child can consent for:
  - Himself or herself or
  - For the child.

Also, minors can consent for specific types of care, e.g., sexual and reproductive care, out-patient
Refusal of Care

• Parents cannot refuse life-saving treatment for a minor child
• Patients and their surrogates have the right to refuse care
• A patient’s or surrogate’s refusal of life-sustaining care must be followed
  – Refusal can be written or oral (if properly witnessed).
• The legal requirements for refusal of life-sustaining treatment are satisfied by using the hospital forms, “Patient Consent to Withdraw or Withhold Life-Sustaining Treatment,” “Health Care Agent or Surrogate Consent to Withhold or Withdraw Life-Sustaining Treatment,” and “Withholding or Withdrawing Life-Sustaining Treatment When Patient Lacks Health Care Agent/Surrogate.”
WHEN PATIENT LACKS CAPACITY

The Rules May Have Changed Since the Last Time You Looked

• 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 known, decisions are to be made in the patient’s best interests, considering

• The patient’s 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, 2010, 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 individuals is unable to do so him/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 Proxy 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 patients 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 family and other loved ones 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

#5

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 a licensed independent practitioner
  – Nurse Practitioner and MD (PGY-2 and above)
  – A Resident Physician practices under the supervision of an Attending Physician therefore a co-signature within 24 hours is required for written orders
  – New: PAs may order Restraints under the Supervision of an Attending Physician
What is a Restraint?

- Included in this definition are:
- **Full side rails** (Only considered restraint if the patient is unable to independently lower the rail or rails in order to get out of bed).
- *Mittens* (infant, Pediatric, Adult)
- **Elbow restraints** (Pediatric only)
- **Table-top chairs** (only if the patient is unable to release).
- *Vest restraints*
- **Lap Belts** (only if the patient is unable to release).
- **Soft wrist and ankle restraints**
- *Leather restraints* (only for behavior (violent) management)
Physician Assistant’s Role

• A Physician’s Assistant is not a Licensed Independent Practitioner. However, a Physician’s Assistant is authorized to write orders for restraint under the supervision of an attending physician.

• The Physician’s Assistant must be able to demonstrate competency through orientation and on an annual basis thereafter.

• A PA may evaluate the patient within one hour of the initiation of restraint or seclusion, provided that they are trained and that they consult with the attending physician or other LIP as soon as possible after their evaluation as required by CMS’s Interim Final Rule for Patient Rights, effective 1/8/07.
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 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 a PGY2 or above within 1 hour of restraint application
- An RN or PA may evaluate the patient within 1 hour of institution of restraint or seclusion and the attending physician or other LIP responsible for the care of the patient must be notified and consulted as soon as possible.
- Family notification is required by the physician or nurse within 2 hours of the application (at whatever hour it occurs).
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 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**

1 mL “lavender” top

**USE**

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.

Must fill out & sign the pick up book at the Blood Bank.
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, hypo-perfusion, 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.
Annual Mandatory Education
Diabetes Management & Nutrition Support

2018
### Diabetes Patient Assessment

<table>
<thead>
<tr>
<th>Type of Diabetes</th>
<th>Reason for admission</th>
<th>Medication prior to admission</th>
<th>Is patient new to insulin or glucose lowering oral agents?</th>
<th>Assess insulin injection technique (if not new to insulin)</th>
<th>Barriers to diabetes management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 1, Type 2, Gestational</td>
<td>New diagnosis DKA, HHS, Hyperglycemia or hypoglycemia</td>
<td>DM secondary diagnosis</td>
<td></td>
<td>review insulin injection measurement &amp; injection technique during the point of care</td>
<td></td>
</tr>
</tbody>
</table>
**Basal Insulin: “Background insulin”** Long Acting or intermediate acting
- Aims to keeps blood glucose in target between meal
- 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**
- **UHB Formulary**: glargine (Lantus); Novolin N; and Novolin 70/30 (70% NPH & 30% regular 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
- **UHB Formulary**: Novolin R or aspart (Novolog)

**Correction Dose**: Corrects hyperglycemia: based on Correction Scale ordered (Low, Moderate, High Dose Regimens)
- Administer as per schedule: Pre meals, q 6 hr, q 4 hr, etc.
- 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
- **UHB Formulary**: Novolin R or aspart (Novolog)
<table>
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<th></th>
<th>Onset</th>
<th>Peak</th>
<th>Duration</th>
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<tbody>
<tr>
<td>Glargine (Lantus)</td>
<td>0-15 min</td>
<td>0.5-1.5 h</td>
<td>3-5 h</td>
</tr>
<tr>
<td>Aspart (Novolog)</td>
<td>30-60 min</td>
<td>2-12 h</td>
<td>16-24 h</td>
</tr>
<tr>
<td>NPH (Novolin N)</td>
<td>1-2 h</td>
<td>4-12 h</td>
<td>12-18 h</td>
</tr>
<tr>
<td>Regular (Novolin R)</td>
<td>30-60 min</td>
<td>2-4 h</td>
<td>8-12 h</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>20-24 h</td>
</tr>
</tbody>
</table>
Insulin High Risk Situations

• When a prescribed insulin dose is not given – for example: patient not on unit; patient refusing; RN concern; NPO, etc.
  – Notify provider immediately
  – Document name of provider you spoke with & outcome in HealthBridge
  – Follow-up/reschedule dose as appropriate & communicate during handoff; may need a new order from prescriber

• **Note:** Patients with Type 1 DM must always have insulin on board - even if they are NPO.
  – DKA may result when patient is insulin deficient

• **Review previous 24 hour insulin administration – especially glargine / long acting insulins**
Hypoglycemia

Neurogenic (Autonomic) symptoms:
- Trembling
- Palpitations
- Sweating
- Anxiety
- Hunger
- Tingling

Neuroglycopenic symptoms:
- Cognitive impairments
- Altered concentration/thinking, confusion, behavior changes
- Speaking difficulties
- Tiredness/weakness
- Headache
- Seizures, LOC
Hypoglycemia Pointers

• Once a patient has a hypoglycemic event in the hospital, the risk increases for future events

• **High Risk of Developing Hypoglycemia**
  – Renal insufficiency, hemodialysis
  – Advanced age
  – Malnutrition
  – Liver disease
  – Septic shock
  – Hemodialysis
  – Heart failure
  – Stroke, malignancy
  – Hypoglycemia unawareness
  – Sudden change in caloric intake
  – Alteration in parenteral or enteral nutrition
  – Mismatch between timing of FS glucose, insulin and meal
New
For FS < 50 mg/dL
No longer necessary to:
1) Infuse IV D5W after treatment
2) Obtain a serum blood glucose specimen for lab
NEW For FS < 50 mg/dL:
No longer necessary to obtain a serum blood glucose specimen for lab
Critical Hyperglycemia: >450 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
  - If results were obtained > 60 minutes before pre meal/correction insulin is due, check FS again
Key Points for Safe Discharge

• Begin patient/family education as soon as possible
  – Free Diabetes Patient Education Channel 33

• Teach/assess insulin injection technique when insulin dose is due
  • New patients need to inject insulin prior to discharge
  – Use vial of water to teach *(not for injections)* how to draw up dose with syringe

• Review insulin prescriptions:
  – Insulin vials and syringes (1 mL, or ½ mL)
  – 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
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

• UHB’s Policy addresses when the patient is admitted wearing an insulin Infusion pump and wishes to continue its use while hospitalized.
Continuous Insulin Infusion Pumps
Definitions

- **Insulin infusion pump** – a battery operated, external computerized device containing an insulin filled reservoir
- One type of Insulin is infused subcutaneously through a plastic or metal cannula attached from the pump reservoir to the patient (subcutaneous)
- Infuses insulin 24 hours a day; continuously delivers set rates for basal
- Patient delivers bolus pre meals and or if hyperglycemic

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
### Which Patients Can Use Their Pumps In the Hospital?

#### Candidate
- has all the necessary supplies to use insulin pump therapy in the hospital
- will change the insulin reservoir/cartridge with hospital provided insulin within 24 hours of admission & every 48-72 hours or more frequently as needed
- allows the nurse to check the infusion site for any signs of inflammation or infection
- reports any signs of skin irritation, redness, swelling, or leakage
- allows the nurse to observe administration of bolus insulin
- agrees to use UHB approved glucose meter for monitoring
- agrees to make changes to pump settings recommended by the Endocrinologist
- reports signs of low blood sugar to the nurse
- reports any pump problems to the nurse or physician
- removes the pump if it will be exposed to electromagnetic fields or ionizing radiation

#### Not a Candidate
- has an altered state of consciousness
- is severely hypoglycemic and/or is unable to manage the pump
- is critically ill (e.g., DKA, sepsis, trauma)
- refuses or is unable to participate in insulin pump therapy self-care due to current medical conditions
- does not have appropriate supplies for the insulin pump
- is at risk for suicide (PSY-2 Subject: Identification and Management of Patient at Risk for Suicide)
- has other condition(s) or circumstance(s) identified by a physician that makes use of the insulin pump therapy use during this hospitalization unsafe
Nursing Role

- Documents presence of insulin pump in the Admission Profile & notifies primary medical team
- Assesses patient’s cognition & ability to operate insulin pump; notifies physician immediately regarding any change in patient status
- Reports patient’s insulin pump status at each shift report (SBAR), transfer & hand off
- Monitors POC glucose with UHB-approved blood glucose monitor
- Requests a new insulin vial for patient from Pharmacy Department at the time for filling reservoir; vial will be returned to the Pharmacy for disposal after one-time use
- Observes patient administering insulin boluses & documents in EHR
- Assesses infusion site upon admission & each shift
- If patient's blood glucose is more than 300 mg/dL for two or more consecutive hourly values, notify the Primary Team
- Checks fingerstick glucose before patient leaves unit and upon returning to unit from any procedures
Insulin pump should not be exposed to electromagnetic fields or ionizing radiation

- Temporarily remove pump by patient/surrogate prior to any procedure that may cause such exposure (e.g. MRI, CT scan, PET scan, Intravenous Pyelogram, Mammogram, C-Ray, Nuclear Medicine Studies or Radiation Therapy).

- If the infusion catheter is metal, the infusion set must also be removed prior to MRI testing.
  - Ask patient if infusion catheter is plastic or metal.

- Patient will give pump to either a family member or RN to place pump in a locked area on the unit (Policy & Procedure, “Safeguarding Property Brought to the Hospital by Patient” (PTBR-9)).

- 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 in an attempt to stop the pump while it is still attached to the patient. Place pump in area on unit or give to family member.
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 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 PN

- Adult Nutrition Support Team places order M-F & reviews order with unit RN
- Weekend orders are written on Fridays for the weekend
- Unit 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 within 1 hr.
- PN infusions are started 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
- Review Nursing Orders in HealthBridge
- Document in I & O
PN Order Summary – Filed in the Physician Orders Section in the Medical Record

Sample Copy filed in Physician Order Section – use for 2 RN verification when hanging new PN bag

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<td>1,000 ml/hr</td>
<td>100</td>
<td>100 ml/hr</td>
<td>2 hours</td>
<td>09:00 AM</td>
<td>11:00 AM</td>
<td>Room Temp</td>
<td>Intravenous</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ingredients List</th>
<th>Amount</th>
<th>pHOM</th>
<th>Per</th>
</tr>
</thead>
<tbody>
<tr>
<td>[redacted]</td>
<td>[redacted]</td>
<td>[redacted]</td>
<td>[redacted]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type: [redacted]</td>
</tr>
</tbody>
</table>

2 RN’s Verify:
- Pt identification: name & DOB
- Rate
- Electrolytes
- Insulin
- Famotidine
- Review Comments

2 RN’s Document in Electronic Health Record

Verify this with PN Label
PN Solution Label – Prior to Hanging New PN Bag, Verify with Order Summary

2 Independent RN Verification
2 RN Documentation in HealthBridge
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.
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.
- **Use Clinical Practice Guidelines “Parenteral Nutrition” in Health Bridge.**
The Nova Stat Strip Blood Glucose meter is UHB’s approved Glucometer for patient testing

Operator certification status must be kept current

Use Universal Precautions when testing as per hospital policy

Follow patient identification procedures when testing as per hospital policy

Run two level of Quality Control on every 24 hours

Clean and Disinfect meter after every patient testing
• Nova StatStrip Meters are assigned to nursing units by the Point of Care Lab

• Staff should NOT move meters from their assigned units

• If a meter is needed in a particular unit, contact the Point of Care Lab immediately
Nova StatStrip Test: Strip Vials

STATSTRIP VIALS:
• Contain a desiccant to **protect against humidity**
• Must be **CLOSED** with its lid when not in use
• **Store at room temperature** between 15 to 40 degrees Centigrade (59 to 104 degrees Fahrenheit)
• **When opening a new vial** of strips, **write** on vial:
  • Date **Opened AND Date Expired**
  • Expiration date is **180 days from opening** or label expiration date, whichever is first
  • Initials **do not need** to be written on vial
When To Perform Quality Control Testing?

- Every **24 hours** for each Meter (2 levels of Control – Level 1 and Level 3)
- When a **NEW VIAL** of test strips is **OPENED**
- After major maintenance or repair of the meter, i.e. **battery change**.
- When the **meter is dropped**
- When a **new meter** is used
- When **results are questionable** based on clinical signs & symptoms
- Whenever **problems** (storage, operator, instrument) are identified or anytime there is a concern
Control Solutions and Testing

- **Store at room temperature**, 15-30°C (59-86°F)
- Control vials **must be covered** with their lids when not in use
- When opening a new Control Solution **write on bottle:**
  - **Date Opened AND Date Expired**
  - Expiration Date is **90 days** from opening or label expiration date - whichever is first
  - Initials do **NOT need to be written on vial**
- Run **Level 1 and Level 3** controls each 24 hour period on each meter
- To test **Gently Mix** control solution vial before using
  - **Discard 1st drop** of Control Solution
  - **Use 2nd drop** of solution for testing
- After Control Testing select **“Meter Cleaned”** comment
If a control level test is out of range:
• **REPEAT CONTROL** level test

If control level test results are **AGAIN** out of range:
• **OPEN** a **New Control vial** and run test

If control test results **CONTINUE** to be out of range:
• Open a **New Strip vial** and run test

If control test results are **STILL** out of range:
• Call Point of Care at ext. 1679 or the Bay Ridge Laboratory at 718 567-1158 for assistance during the day
• **Off hours:** Go to Lab (2nd floor) and obtain a new meter
Patient Testing

• Starting a Test
  • Enter patient 7 digit identifier (Financial #)
  • Identify specimen source (capillary, venous or arterial)

• Applying Blood Sample to Strip
  Maintain meter in a horizontal position to keep blood out of the meter
  • Discard 1st drop of blood. Use 2nd drop of blood.
  • Allow blood drop to touch the tip of the strip. Fill strip completely
  • Do not move finger from strip until meter countdown begins
  • NO re-application of blood once the testing has started

• Enter Comments After Each Patient Test
  • Can choose up to 3 comments
  • Highlight ALL desired comments AT ONCE and ‘Accept’
  • MUST select ‘Clean /Disinfect Meter’ as a comment
  • Always verify comments display on patient result screen and Accept again.
Patient Testing

- If Results Are Outside Unit Specific Action Range
  - Select Comment “Repeat test”
  - Test **MUST** be repeated to confirm results.
  - After confirmed repeat select needed comment(s) such as:
    - Clean/Disinfected
    - Initiate Hypoglycemia Protocol
    - Caregiver Notified
    - Send to lab
  - Follow appropriate protocol
**Unit Specific Action Ranges**

- **Pediatrics**: Less than 70 mg/dL – more than 200 mg/dL
- **NICU**: Less than 45 mg/dL – more than 150 mg/dL
- **Newborns on L&D and Mother/Baby Unit**
  - Less than 25 mg/dL: birth to the 1st 4 hours of age
  - Less than 35 mg/dL: 4 to 24 hours of age
- **Ambulatory**: Less than 70 mg/dL – more than 450 mg/dL
- **CTICU**: Less than 60 mg/dL – more than 120 mg/dL
- **Adult Medical/Surgical**: Less than 70 mg/dL – 450 mg/dL

<table>
<thead>
<tr>
<th>Action Range</th>
<th>Comment Code</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out of Instrument Reportable Range</td>
<td>Repeat Test</td>
<td>Repeat test to confirm result</td>
</tr>
<tr>
<td>&lt; 10 or &gt; 600 mg/dL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confirmed Result</td>
<td>Caregiver Notified and Send to Lab</td>
<td>Send specimen to Laboratory</td>
</tr>
</tbody>
</table>
### Use of Common Codes For Action Ranges

<table>
<thead>
<tr>
<th>Unit</th>
<th>Action Range</th>
<th>Comment Code</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult - Inpatient</td>
<td>&lt; 70 or &gt; 450mg/dL</td>
<td>Repeat Test</td>
<td>Repeat test to confirm result</td>
</tr>
<tr>
<td></td>
<td>Confirmed Result</td>
<td>Caregiver Notified</td>
<td>Initiate Inpatient Hypo/Hyperglycemia Protocol</td>
</tr>
<tr>
<td>NICU</td>
<td>&lt; 45 or &gt; 150mg/dL</td>
<td>Repeat Test</td>
<td>Repeat test to confirm result</td>
</tr>
<tr>
<td></td>
<td>Confirmed Result</td>
<td>Caregiver Notified</td>
<td>Initiate NICU Hypo/Hyperglycemia Protocol</td>
</tr>
<tr>
<td>Newborn</td>
<td>&lt; 25 or &gt; 150mg/dL 0 - 4 hrs</td>
<td>Repeat Test</td>
<td>Repeat test to confirm result</td>
</tr>
<tr>
<td></td>
<td>&lt; 35 or &gt; 150 mg/dL 4-24 hrs</td>
<td></td>
<td>Initiate Newborn Hypo/Hyperglycemia Protocol</td>
</tr>
<tr>
<td></td>
<td>Confirmed Result</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatric</td>
<td>&lt; 70 or &gt; 200mg/dL</td>
<td>Repeat Test</td>
<td>Repeat test to confirm result</td>
</tr>
<tr>
<td></td>
<td>Confirmed Result</td>
<td>Caregiver Notified</td>
<td>Initiate Pediatric Hypo/Hyperglycemia Protocol</td>
</tr>
<tr>
<td>CTICU</td>
<td>&lt; 60 or &gt; 120mg/dL</td>
<td>Repeat Test</td>
<td>Repeat test to confirm result</td>
</tr>
<tr>
<td></td>
<td>Confirmed Result</td>
<td>Caregiver Notified</td>
<td>Initiate CTICU Intensive Insulin Infusion Protocol</td>
</tr>
</tbody>
</table>
Clean & Disinfect Meter

Clean & Disinfect Meter With Hospital Approved Disinfectant  *After Each Patient Test A 2-Step Process*

<table>
<thead>
<tr>
<th>Clean Meter</th>
<th>Disinfect Meter</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Wear protective gloves</td>
<td>• Use fresh Clorox bleach germicidal wipe, thoroughly wipe surface of the meter (top, bottom, left &amp; right sides)</td>
</tr>
<tr>
<td>• Make sure test strip is removed from meter</td>
<td>• Avoid the bar code scanner &amp; electrical connector when wiping</td>
</tr>
<tr>
<td>• Lay meter on flat surface</td>
<td>• Ensure meter surfaces stay wet for a minimum of 3 minutes and is allowed surfaces to air dry for an additional 1 minute</td>
</tr>
<tr>
<td>• Obtain a fresh germicidal wipe or Clorox Bleach (hospital approved)</td>
<td>• Dispose gloves into appropriate container</td>
</tr>
<tr>
<td>• Wipe external surface of meter thoroughly with the fresh wipe</td>
<td></td>
</tr>
<tr>
<td>• Discard used wipe &amp; gloves into appropriate container</td>
<td></td>
</tr>
</tbody>
</table>
Isolation Precautions

- Use Universal Precautions

- Clean and Disinfect Statstrip Glucometer **AFTER EACH PATIENT** use

- Use a separate Statstrip meter based on clinical situations (e.g. Hemodialysis)
POCT Glucose Results Documentation

Results & interventions are documented in HealthBridge Flowsheet /Point of Care Testing
Critically Ill Patients
For the Purposes of Glucose Point of Care Testing

*CAPILLARY sample testing (finger stick blood) may **NOT** be used*

**For the Purposes of Glucose Point of Care Testing:**

“Critically Ill” patients are those with:

- **Unstable hemodynamics** – low perfusion index, use of vasopressor, presence of edema and low mean arterial pressure
- **Decompensated heart failure** New York Heart Association Class IV
- **Severe Dehydration** as a result of diabetic ketoacidosis or hyperglycemic hyperosmolar non-ketotic syndrome
- **Arterial occlusive disease**
• Collect **Arterial or Venous** blood sample
• Perform glucose on the Nova Stat Strip

**Procedure:**
- Collect blood in a **lithium heparin collection device** (ABG syringe)
- Draw **appropriate discard sample** to clear the arterial or venous line before drawing a blood sample for testing.
- Sample must be tested **within 30 minutes** from collection.
- **Identify specimen source** as Arterial or Venous
- Place blood sample on Nova Stat Strip and follow testing procedure
Send a whole blood specimen to the Lab

Procedure:

• Collect blood in a grey top tube or add on a glucose test to an arterial or venous blood gas sent to lab.

• Draw appropriate discard sample to clear the arterial or venous line before drawing a blood sample for testing.
Fingerstick Glucose: When to Check?

- Morning fingerstick glucose is checked at or after 7:00 a.m., unless clinically indicated or per unit policy or prescriber’s order (Rehabilitation, OB, Critical Care, etc.).

- **Finger stick glucose must be checked:**
  - Within 1 hour prior to administering prandial or correction insulin.
  - If it is more than 1 hour since the time of the test and insulin administration, test again.
Care of Visitors and Employees

- Use of the Glucose Meter is **Not** for Screening

- **Do NOT** use the Glucose Meter to check a visitor’s or employee’s blood glucose

  - Employees or visitors who are **ill** **MUST be Referred** to the **ED immediately**
All Operators must follow the re-certification schedule and recertification test performance requirements:
1. Initial Certification
2. Renew in 6 months, and then again in 6 months, then....
3. Annually

Re-certification Steps
Step 1: Review the Re-certification presentation
Step 2: Complete the Post Test
Step 3: Upon successfully completion of the Post test, print you Certificate of Completion for your records.
Step 4: Complete two levels of controls and one patient test on your unit immediately after completing the exam.
### Troubleshooting Meters and Patient Identification

<table>
<thead>
<tr>
<th>Possible Problem</th>
<th>Recommended Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scanning of barcode or manual entry of strip lot number, QC lot number or Operator ID number in error</td>
<td>Check and re-scan or manually re-enter Patient Financial Number</td>
</tr>
<tr>
<td>Scanning or manual entry of Patient Medical Record Number instead of Patient Financial Number</td>
<td>Check and re-scan or manually re-enter Patient Financial Number</td>
</tr>
<tr>
<td>Glucometer did not obtain patient registration information from Hospital Registration System because meter was not docked (wired) or battery low preventing communication (wireless).</td>
<td>Dock meter to allow glucometer to obtain updated patient registration and financial identifier information.</td>
</tr>
<tr>
<td>Error in manual entry of Patient Financial Number</td>
<td>Check and re-scan or manually re-enter Patient Financial Number</td>
</tr>
<tr>
<td>Use of an unreadable or damaged Patient Financial Number barcode</td>
<td>Check, reprint Patient ID barcode and re-scan or manually re-enter Patient Financial Number</td>
</tr>
</tbody>
</table>
| Glucometer testing must be performed prior to patient registration because of an **Emergency situation** | **Applies ONLY to ED, NICU, L&D and CATH Lab areas.** Non-Registered Patient Procedure to be followed.  
**ALL other units may NOT perform testing with INVALID, NEW or NOT IN SYSTEM patient financial numbers. Operator MUST investigate and correct before testing.** |
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 provider 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  “SEE” and “SAY”
   IF YOU “S”EE SOMETHING, “S”AY “S”OMETHING;
   “S”EAK ASSISTANCE

C  “C”ALL FOR HELP; “C”OLLABORATE; “C”OMMUNICATE
   “A”SSESS & RE-“A”SSESS

AL  “L”OOK, “L”ISTEN, & FEEL:
   “LIVE”, “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
You are now completed.

Nursing staff, please click HERE to take the License Professional Direct Care Providers Post Test.

All other staff, please click HERE to take the License Professional Direct Care Providers Post Test.