

---

---

---

---

# UPSTATE

## MEDICAL UNIVERSITY

# Safety at Work (SAW)

Please return this book to:  
Organizational Training & Development (OTD)  
Jacobsen Hall, RM 417

HR/Organizational Training & Development (OTD)  
Revision 10/2013, 4/2014, 10/2014, 4/2015, 10/2015, 4/2016, 10/2016, 3/2017, 10/2017,  
3/2018, 10/2018, 11/2019

---

---

---

---

# SAW TABLE OF CONTENTS

## **Section I: (All University Hospital employees)**

Introduction to SAW .....	1
Our Mission, Vision, Values .....	2
Code of Conduct and Social Media.....	4
Advance Directives.....	7
Breastfeeding Education.....	8
Compressed Gas Cylinder Safety .....	9
Disaster/CEMP & Emergency Preparedness Response Actions .....	10
DNV-GL Accreditation .....	12
DNV-GL and ISO 9001 .....	16
Domestic Violence .....	19
Drug Diversion.....	21
Emergency Codes.....	23
Emergency OB and Neonatal Codes (Community Campus Only).....	24
EMTALA/Emergency Medical Response .....	26
Ethics Consultations.....	30
Fire and Life Safety.....	31
Gender Identity Awareness .....	35
General Security.....	39
Hazardous Drugs .....	40
Hazardous Materials & Waste .....	44
Hospital Evacuation Plan .....	46
Human Trafficking.....	47
Identification of Patient Risk.....	48
Infection Control .....	49
Institutional Compliance.....	57
Interpreter Services .....	58
Latex Sensitivity/Allergy.....	60
Medical Equipment.....	62
Missing of an Infant/Child or Patient.....	65
Patient Abuse.....	67
Patient Identity Theft Prevention .....	70
Patient Rights.....	71
Patients in Custody .....	76
Privacy and Security.....	79
Private Encounter .....	82
Quality Improvement.....	84
Risk Management .....	86
Sensitive Treatment of Patients Who Suffer with Obesity.....	88
Service Excellence Standards.....	90
Sexual Harassment.....	91
Sexual Violence .....	94
Stroke, Recognizing it F.A.S.T.....	96
U-Turn/ Healthy Workforce .....	98
Violence Education Prevention Outreach Program (VEPOP) .....	100
Workplace Diversity.....	102
Workplace Violence .....	104

## **Section II: (All licensed University Hospital employees who provide regular patient care)**

Clinical Research .....	107
Dysphagia Patients.....	110
HIV Clinical Care .....	112
Infection Control, Clinical.....	114
Medical Record Documentation .....	117
Medication Administration .....	121
Nursing Case Management.....	123
Patient Education/Teach-Back.....	124
Procedure Verification .....	127
Social Work .....	129
<b>NEW</b> Substance Use Disorder (SUD) .....	131
Utilization Management .....	134

## **CAMPUS SAW – TABLE OF CONTENTS**

### **Section III: (Upstate Medical University Campus Staff)**

Introduction to SAW .....	135
Our Mission, Vision, Values .....	136
Code of Conduct and Social Media .....	138
Campus Disasters.....	141
Compressed Gas Cylinder Safety .....	143
Domestic Violence .....	144
Drug Diversion .....	146
EMTALA/Emergency Medical Response .....	148
Fire and Life Safety.....	152
Gender Identify Awareness .....	155
General Security.....	159
Hazardous Materials & Waste .....	160
Institutional Compliance .....	162
Latex Sensitivity/Allergy.....	163
Service Excellence Standards.....	165
Sexual Harassment.....	166
Sexual Violence .....	169
U-Turn/ Healthy Workforce .....	173
Workplace Diversity .....	175
Workplace Violence .....	177

**INTRODUCTION**  
**SAFETY AT WORK (SAW)**  
**EDUCATION FOR ALL**  
**UPSTATE UNIVERSITY HOSPITAL EMPLOYEES**

**I. SAFETY AT WORK (SAW):**

Provides education that promotes patient and personal safety

**II. WHO MUST COMPLETE:**

All University Hospital employees are required to complete Safety at Work (SAW) yearly

**III. POST TEST EVALUATION:**

Review the Safety at Work (SAW) education content  
Complete the posttest, scoring at least 80%

**IV. POLICY AND PROCEDURE MANUALS:**

Policies listed in this self study can be found on the Upstate Medical University Intranet (internal/on campus or off campus log in access only) located at <http://www.upstate.edu/ipage/intra/>

Click Policies and Forms icon:



POLICIES & FORMS

# UPSTATE

## MEDICAL UNIVERSITY

### Our Mission, Vision & Values

#### I. **MISSION:**

The mission of SUNY Upstate Medical University is to improve the health of the communities we serve through education, biomedical research and patient care.

#### II. **VISION:**

United in expertise, compassion and hope to create a healthier world for all.

#### III. **UNIVERSITY HOSPITAL'S VISION STATEMENT:**

- University Hospital will provide comprehensive, seamless and innovative patient and family centered health care to improve the health status of the communities we serve.
- University Hospital will be the preferred area employer by offering an environment where employees and volunteers are personally and professionally valued, recognized and supported.
- University Hospital will be a clinical center of educational and research excellence by continuously evaluating and adopting innovative practices in technology and health care.

#### IV. **OUR SHARED VALUES:**

##### **We drive innovation and discovery**

by empowering our university family to bring forth new ideas and to ensure quality.

##### **We respect people**

by treating all with grace and dignity.

*We serve our community*

by living our mission.

##### **We value integrity**

by being open and honest to build trust and teamwork and to embrace diversity and inclusion.





## COMMITMENT TO Diversity

**A commitment to diversity** is essential for Upstate Medical University to fulfill its mission of improving the health of the communities we serve through education, biomedical research, health care and service.

One of Upstate's core values is to respect people by treating all with grace and dignity and embracing diversity. Consistent with our mission and consistent with our values, one of our primary goals is to attract and cultivate a dynamic and culturally sensitive faculty, staff and student body that exemplifies, promotes and celebrates diversity. This definition of diversity includes recognition and appreciation of the uniqueness of each individual. Our community includes persons of various race, ethnicity, gender, sexual orientation, socio-economic status, age, physical and cognitive ability, religion and political belief. We are committed to valuing and sharing the strength of our differences in a safe, positive and nurturing environment.

An inclusive and open-minded community that engages excellence and embraces diversity is fundamental to the Upstate vision to become the leading regional academic medical center in the nation.

**UPSTATE**  
MEDICAL UNIVERSITY

# **THE UPSTATE CODE OF CONDUCT AND SOCIAL MEDIA**

**POLICY: UW C-02** (<https://upstate.ellucid.com/documents/view/2943>)

**AND UW S-07** (<https://upstate.ellucid.com/documents/view/3030>)

In order to promote and support the mission and values of Upstate Medical University, all members of the Upstate community are expected to maintain the highest level of professional behavior, ethics, integrity, and honesty, regardless of position or status.

Social media sites and applications for social networking such as Facebook, YouTube, LinkedIn, blogs, online forums, Snapchat, Instagram and more, are useful resources for collaboration, learning and social interaction. In the course of using these sites, if you choose to identify yourself as an employee or affiliate (including students, volunteers and vendors) of any part of Upstate Medical University while using social media, others may view you as a representative of Upstate and not as an individual. Accordingly, you should be aware that some of the same restrictions policies that apply to your conduct and speech while working at Upstate also apply when you use social networking sites.

## **ALL MEMBERS OF THE UPSTATE COMMUNITY ARE RESPONSIBLE FOR:**

- Helping to maintain a safe and respectful work environment.
- Reporting inappropriate and disruptive behaviors requiring formal resolution as soon as it is feasible to the appropriate person or office.
- Being mindful of the boundary between that of an employee of Upstate and personal acquaintance of the patient on social media when accepting a “friend” request from a patient or otherwise engaging in communication with a patient, current or former, for whom the employee has been a caregiver or is otherwise knowledgeable of the patient’s health information by virtue of their employment at SUNY Upstate.
- Protecting patient privacy. Employees should not post information related to any patient’s health information or treatments.

Retaliatory action is prohibited against any individual acting in good faith who reports incidents and/or cooperates in the investigation of intimidating, disruptive and other unprofessional behavior.

## **EXPECTED AND ACCEPTABLE BEHAVIORS FOSTER MUTUAL RESPECT, THIS INCLUDES, BUT IS NOT LIMITED TO:**

- Holding yourself and others accountable to our mission, vision and values.
- Interacting with others in a considerate, patient and courteous manner.
- Promoting equality and acceptance of people from diverse backgrounds.
- Demonstrating a caring and positive attitude: smile, greet and acknowledge others, make eye contact, say please and thank you. Give recognition and praise.

- Respecting confidentiality and privacy at all times.
- Providing a secure, clean and safe environment for patients and fellow staff.
- Working together by promoting cooperation, participation, and sharing of ideas and information to promote team success. Foster open and honest communication.
- Actively listening to the perspective of others and seek to resolve conflicts promptly. Apologizing when mistakes are made or misunderstandings have occurred.
- Utilizing proper channels to express dissatisfaction with policies and administrative or supervisory actions and without fear of retaliation.
- Being honest and truthful at all times.
- Being knowledgeable with and following applicable policies and procedures (e.g., Customer Service Standards, Workplace Violence Policy, Student Code of Conduct, Infection Control, etc.).
- If your social media posting violates patient privacy, don't post it.

**EXAMPLES OF INAPPROPRIATE AND DISRUPTIVE COMMUNICATIONS/ BEHAVIORS\*, INCLUDE, BUT ARE NOT LIMITED TO:**

- Using abusive language, including repetitive sarcasm.
- Sexually harassing and making comments, jokes, or innuendoes of a sexual nature.
- Making direct or indirect threats of violence, revenge, legal action, or financial harm.
- Using racial, ethnic, or religious slurs.
- Displaying behavior that would be considered by others to be intimidating, disrespectful, or dismissive.
- Exhibiting behavior that threatens or results in verbal and/or physical abuse.
- Using foul or insulting language, shouting, and rudeness.
- Criticizing of co-workers or other staff in the presence of others in the workplace or in the presence of patients.
- Publicly shaming others.
- Disregarding or being insensitive to the personal space or boundaries of others.
- Destruction of Upstate property.
- Being impaired (e.g., use of alcohol or drugs) in the workplace or academic environment.
- Failing to be knowledgeable with and follow applicable policies and procedures (e.g., Customer Service Standards, Workplace Violence Policy, Student Code of Conduct, Infection Control, etc.).
- Harassing, bullying, intimidating or discriminating against other employees or anyone affiliated with Upstate via social media.

\*Communication and/or behavior in any format, including, but not limited to, oral, written, visual, literary, electronic, recorded, or symbolic.



## **THE UPSTATE CODE OF CONDUCT REPORTING PROCEDURE:**

Whenever possible, clear, direct, and immediate communication between the parties involved is viewed as the best way to resolve problems. This is frequently very effective and may eliminate the need for further action.

In matters where this type of informal resolution is not appropriate or possible, such as in cases of dangerous, disruptive, illegal or unethical behavior, the reporting party should immediately notify his/her supervisor and provide the following information:

1. A description of the event, including any statements made, names of individuals involved, as well as any witnesses to the event, dates, environmental factors, and any other relevant information; and
2. A listing of the parties who have been notified of the event; and
3. A summary of the response(s) or action(s) taken to date to address the issue.

If the concerning communication and/or behavior is exhibited by an individual's supervisor, and the individual believes a formal resolution may be appropriate, s/he should report the incident to his/her supervisor's supervisor.

Individuals who do not believe their complaint(s) have been resolved, through either informal or formal means, should report this up their chain of command. For example, if an individual reports an incident to his/her supervisor concerning an incident that occurred involving a co-worker, and s/he believes the matter has not been resolved, s/he should report this to his/her supervisor's supervisor.

Individuals that do not believe their complaint(s) have been resolved, through either informal or formal means, should report this up their chain of command. For example, if an individual reports an incident to his/her supervisor concerning an incident that occurred involving a co-worker, and s/he believes the matter has not been resolved, s/he should report this to his/her supervisor's supervisor.

# ADVANCE DIRECTIVES

Policy CM A-25, Advance Directives, Management of:

<https://upstate.ellucid.com/documents/view/3639>

## I. WHAT ARE ADVANCE DIRECTIVES:

- a. Advance Directives include:
  - i. Health Care Proxy (HCP)
  - ii. Living will or other written form or verbal instructions regarding health care
  - iii. Do not resuscitate (DNR)/Non-hospital DNR
  - iv. Medical Orders for Life Sustaining Treatment (MOLST)

## II. DOCUMENTATION:

- a. The presence or absence of a Health Care Proxy should be documented in the Electronic Medical Record on admission
  - i. Patients can complete a HCP during their admission
- b. Form 3909 is the Health Care Proxy acknowledgment form

## III. RESOURCES TO ASSIST WITH ADVANCE DIRECTIVE ISSUES:

- a. Social Work
- b. Spiritual Care
- c. Palliative Care
- d. Ethics Consultation Services

## IV. IF A PATIENT DOES NOT HAVE A HEALTH CARE PROXY PHYSICALLY PRESENT AND LACKS DECISIONAL CAPACITY

- a. Social Work to make effort to locate Advance Directive/HCP by asking family if they have a copy of directive, calling Primary Care Physician, other Hospitals, Skilled Nursing Facility.
- b. Refer to The Family Health Care Decisions Act for authorized decision maker/surrogate decision maker
- c. Refer to policy C-07 Informed Consent/Refusal for further information  
<https://upstate.ellucid.com/documents/view/1189>

# University Hospital Breastfeeding Education

## UPSTATE BREASTFEEDING SUPPORT & RESOURCES:

**Breastfeeding Medicine Program:** for questions related to lactation process and exposures (radiation, infection, etc.) call 315-464-2192.

### Inpatient Lactation Support:

- Community Campus Lactation Consult: call 315-492-5577
- Downtown Campus Lactation Consult: call Breastfeeding Medicine Program Office 315-464-2192

### Outpatient Lactation Support:

- Breastfeeding Medicine Program Office (550 Harrison Street): call 315-464-2192
- CNY Breastfeeding Connection Community Resource Guide <https://upstate.ellucid.com/documents/view/9015>

Breastfeeding: Safety and Quality Measure	Safety Rationale
<p>1. <b>UW L-04 Staff Breast Pumping Policy</b> <a href="https://upstate.ellucid.com/documents/view/2998">https://upstate.ellucid.com/documents/view/2998</a>  <b>Breastfeeding and Returning to Work Brochure (F87485)</b> <a href="https://upstate.ellucid.com/documents/view/5217">https://upstate.ellucid.com/documents/view/5217</a></p>	<ul style="list-style-type: none"> <li>• To maintain adequate milk supply to support optimum growth, nutrition, and health.</li> <li>• To provide an environment to enable breastfeeding mothers to express their milk during work hours.</li> </ul>
<p>2. <b>NYS Breastfeeding Mothers Bill of Rights</b> <a href="https://upstate.ellucid.com/documents/view/5406">https://upstate.ellucid.com/documents/view/5406</a></p>	<ul style="list-style-type: none"> <li>• To protect, promote, and support breastfeeding and the rights of breastfeeding mothers and children</li> </ul>
<p>3. <b>CB B-20: Hospital-Wide Breastfeeding Policy</b> <a href="https://upstate.ellucid.com/documents/view/5947">https://upstate.ellucid.com/documents/view/5947</a></p>	<ul style="list-style-type: none"> <li>• To provide feeding evaluations and lactation services/follow up as needed to ensure safe feeding practices and care</li> <li>• To provide needed equipment and services as needed to avoid engorgement/mastitis</li> <li>• To maintain maternal milk supply to avoid infant weight loss and dehydration</li> <li>• To review medications as needed for safe infant feeding</li> </ul>
<p>4. <b>CM B-16: Care of the Lactating Mother on a Non-OB Unit</b> <a href="https://upstate.ellucid.com/documents/view/3657">https://upstate.ellucid.com/documents/view/3657</a></p> <p>a. If a lactating mother's breastfeeding child is staying with her or coming in for feedings, the mother cannot be the primary caretaker for the child. The child must be accompanied by a responsible adult caretaker other than the mother while visiting.</p>	<ul style="list-style-type: none"> <li>• To provide a safe environment for the mother to continue to breastfeed her nursing child while in a therapeutic environment for her medical state/healing.</li> </ul>
<p>5. <b>CM M-31 Guidelines for Collection, Storage and Use of Human Milk for the Hospitalized Patient</b> <a href="https://upstate.ellucid.com/documents/view/5946">https://upstate.ellucid.com/documents/view/5946</a></p> <p>a. Each storage container must be labeled by the mother/staff immediately following collection with a purple "Human milk" sticker and hospital supplied 2D barcode label.</p> <p>b. Pumped breast milk will be stored by healthcare personnel in designated refrigerator/freezers only.</p> <p>c. Verification of the correct patient/infant and labeled container will occur in EPIC by scanning the container label and the patient's ID band each time a breast milk container is brought to the patient room.</p>	<ul style="list-style-type: none"> <li>• Safe labeling and storage ensures that breast milk is distributed/ fed to the correct patient/child and that milk is maintained in a safe environment to minimize pathogenic growth.</li> </ul>

# COMPRESSED GAS CYLINDER SAFETY

“What you need to know”

- ✓ Proper handling and storage of gas cylinders

IMPROPER HANDLING AND STORAGE OF COMPRESSED GAS CYLINDERS CAN PRESENT A SIGNIFICANT RISK OF SERIOUS INJURY OR DEATH.

**ALWAYS HANDLE AND STORE PROPERLY!**

## I. DO:

- Cylinders must be secured at all times in an approved cart or holder. Empty cylinders must also be secured because they can have residual pressure and product.
- Remember to secure cylinders in an approved cart or holder whether they are in storage, in use next to a bed or stretcher or being utilized during a transport.
- Keep valve protective caps in place when the cylinder is not in use.
- Empty and full cylinders must be stored in a separately labeled cart or tagged to indicate that they are full or empty. (EMPTY AND FULL CYLINDERS MUST BE CLEARLY SEPERATED OR TAGGED)
- Store no more than 12 E-cylinders (small oxygen cylinders), that are not in use, in a given area. (*In-use cylinders secured properly on beds/stretchers and wheelchairs and empty cylinders do not have to be included in the 12-cylinder count*).

## II. DON'T:

- Never store a cylinder in an unsecured manner such as on the floor, in a corner of the room, on top of a bed, or next to a patient (even when empty).
- Never carry a cylinder by the valve.

**At University Hospital Downtown Campus Contact: Environmental Health and Safety at 315-464-5782 (during normal business hours)**  
**University Police at 315-464-4000 (after hours)**

**At University Hospital Community Campus Contact: Environmental Health and Safety at 315-492-5683 or 315-464-5782 (during normal business hours)**  
**University Police at 315-492-5511 (after hours)**

# DISASTER/COMPREHENSIVE EMERGENCY MANAGEMENT PLAN (CEMP) & EMERGENCY PREPAREDNESS RESPONSE ACTIONS

## *“What you need to know”*

- ✓ Where your unit specific disaster plans are located
- ✓ How staff will be made aware that an emergency event has occurred
- ✓ Initial staff actions at the time of a disaster activation

## **I. WHAT IS AN EMERGENCY EVENT?**

- a. An emergency is an INTERNAL or EXTERNAL event that may disrupt the resources, personnel, and patient care services provided by University Hospital. The emergency may be a natural event, such as an ice storm, or pandemic/epidemic. A disaster may be human related, such as a train accident, or riot. A third category can be a hazardous material event that involves a radiological or chemical contamination of individuals. Lastly it may be a technological issue such as water failure or information systems failure. The top 5 hazards prioritized by University Hospital Emergency Management Committee are listed in DIS M-46

## **II. HOW WILL I BE NOTIFIED?**

- a. At work you may receive an email or hear an overhead page that indicates a specific code or that Incident Command is active

## **III. WHAT DO I DO?**

- a. At Work
  - i. Stay calm
  - ii. Return to assigned work area immediately
  - iii. Be aware of changes in your surroundings
  - iv. Continue normal operations unless told to do otherwise
  - v. Monitor e-mail for disaster-related communications
  - vi. Activate Department Specific Disaster plan as appropriate
- b. At Home
  - i. If called to work, report to the space designated as the Labor Pool for assignment to an area of need.

#### **IV. EMERGENCY MANAGEMENT**

- a. The hospital manages all disaster events through the Hospital Incident Command System (HICS).
  - i. Organized system to manage events
  - ii. Individuals assigned to specific areas that may be outside their normal roles.
  - iii. Each job has a job description called “Job Action Sheet” which lists the tasks to perform, who to report to, and how to contact this person
- b. “Incident Command: What It Means To You” is a video on the Emergency Management iPage that describes the Incident Command System at University Hospital

#### **V. COMMUNICATIONS**

- a. Operator will page ***THREE*** times – “**Attention all Hospital Personnel. Incident Command has been activated. Please return to your assigned work area.**”
- b. Incident Command Emergency Number is (at UUH x4-8888 at UUH-Community 492-5338) (DO NOT CALL OPERATOR)

#### **VI. DEPARTMENT/UNIT DISASTER PLANS**

- a. Each department/unit will have information specific and unique to the unit in each Departmental Disaster Plan. Each Department Disaster Plan should be reviewed annually by each department manager. Also each downtime computer has an icon located on the desktop that allows the user to access important disaster policies during internet outages.

#### **VII. HOSPITAL EMERGENCY MANAGEMENT WEBSITE**

- a. Visit the Hospital Emergency Management Website at <http://www.upstate.edu/emergencymgt/> for additional information on how UH has prepared for disaster related events.

**For UHCC Staff – Refer to Policy UHCC B-05: Building Safety**  
<https://upstate.ellucid.com/documents/view/1365>

# DNV GL ACCREDITATION

## **DNV GL:**

DNV GL is an independent, not-for-profit organization authorized by CMS to review hospitals for CMS compliance. DNV GL surveys hospitals for CMS accreditation as well as for specialty certifications. For overall hospital accreditation they conduct unannounced tracers to assess compliance with CMS and Quality ISO standards. DNV GL surveys the hospital annually for our hospital overall compliance with the CMS conditions of participation and serves as the reviewing body for our inpatient psychiatric unit OMH certifications, our ISO Certification, our Hip and Knee Replacement Certification and Comprehensive Stroke Center certification. For your review, DNV GL NIAHO standards are on the hospital's intranet at <http://www.upstate.edu/ihospital/intra/accreditation/index.php>

## **Top Questions Every Staff Member Should Know the Answer to:**

- 1. What changes have been made to improve patient safety in our organization and what quality improvements has your areas made that are supporting the institution's strategic goals?**
  - a. Know what improvements have been made in your dept. or unit and know what the institution's key quality goals are.
  
- 2. How do you verify the identity of patients before medication administration, collecting blood or other specimens, administering blood or other products, or performing other procedures or treatments?**
  - a. Two patient identifiers:
    - i. Inpatients and Outpatients = FULL Name and Date of Birth
    - ii. Compare ID band or patient's verbal response to "can you tell me your full name and date of birth?" with paperwork such as MAR, demographic sheet or test order
  
- 3. When must you wash your hands with soap and water?**
  - a. The policy is in the Infection Control manual is IC-D01 [http://www.upstate.edu/intra/policy/pdf/IC\\_D-01.pdf](http://www.upstate.edu/intra/policy/pdf/IC_D-01.pdf)
  - b. Hand washing is necessary before and after situations in which hands are likely to become contaminated, especially when hands have had contact with mucous membranes, blood and body fluids, secretions or excretions, and after touching contaminated items such as urine-measuring devices.
  - c. Personnel should always practice hand hygiene:
    - i. Before taking care of patients
    - ii. After taking care of patients

- iii. Between patient contacts and between contact with different sites on the same patient
  - iv. After removing gloves
  - v. After eating, sneezing, coughing, or using the bathroom
  - vi. Before and after food preparation and eating
- d. The generally accepted correct hand washing time and method is a 15-second vigorous rubbing together of all lathered surfaces followed by rinsing in a flowing stream of water. Antimicrobial hand-gels or foams can be used for hand hygiene **EXCEPT** when hands are visibly soiled or you have had contact with C-Diff patient. Washing with soap and water is recommended however after using the bathroom and before eating.

**4. What is your role in a disaster that results in an influx of patients to our organization?**

- a. See department specific Disaster Plan (Located in Disaster Manual – online/ in department). During a disaster return to your unit/dept. for instructions. Every other year at least staff should review their department disaster plan and record this in tracker.

**5. What is the procedure for reporting a safety problem?**

- a. Contact your supervisor immediately for completing the required occurrence report or the appropriate incident form as required.

**OR**

- b. Contact the hospital's Safety Officer at #464-5782 or call the Patient Safety Hotline 464-7233 ( 4-SAFE)

**6. Describe the steps you should take if you discover a fire:**

- a. R.A.C.E. and know where fire pull stations are located and nearest fire extinguishers

**7. How were you trained in Infection Control, Fire Safety, Emergency Management, and other core competencies?**

- a. New Employee Orientation (NEO)
- b. Department-specific training that should include a review at least every other year of your department's evacuation plan and a documented review of emergency and safety procedures for any worksites assigned to including documentation that you have had proper PPE training if applicable.
- c. Annual Safety-At-Work (SAW) Training or other department-specific training
- d. Staff training on how to access needed policies and procedures.

**8. The patient's right to personal privacy is ensured how?**

- a. Patient Bill of Rights
- b. Grievance Committee Privilege



- c. HIPAA / secure patient information / sign off computers when not in use
- d. Keep patient records and documentation confidential as well as being mindful of who is present when discussing patient care issues.
- e. Privacy Officer oversight

**9. If applicable, know how gas cylinders should be safely stored and transported and where gas shut off valves are.**

- a. Review with your supervisor for your work area. Cylinders need to be stored securely in holders or racks and labeled.

**10. Staff should know where to find the DNV accreditation standards and what standards are applicable to their position.**

- a. Standards can be found online at: <http://www.upstate.edu/ihospital/intra/accreditation/index.php> Review with your supervisor standards relevant to your work area.

**11. For safety be sure all chemicals containers are labeled appropriately.**

- a. Review with supervisor and know where chemical safety data sheets are on the hospital website.

**12. Know where to find and how to review and retrieve policies in the organization.**

- a. See MCN on iPage at <http://www.upstate.edu/policies/intra/>

**REVIEW LIST FOR ACCREDITATION SURVEY READINESS:**

- Make sure all patients have ID band on.
- Close and lock all medication room doors.
- Make sure all meds are secured and there are no outdated meds or outdated supplies or formulas.
- Make sure med rooms are clean - no dirty pill crushers or food in area.
- Make sure all syringes and other sharps are locked up or under constant staff surveillance.
- Make sure hallways are cleared of non-immediate patient care equipment. (ie. beds, commodes, computers on wheels not being used and chairs in hall are not allowed.)
- Make sure all staff wears their ID badges. Patients have the right to know the names of their caregivers.
- Make sure all items in the pantry refrigerators are labeled and dated. No staff food can be in patient refrigerators. Toss out all items if not labeled/dated or expired. Food brought in by a patient or visitor should be discarded within 24hrs
- Make sure all refrigerator temperature logs show proper temperature monitoring where applicable.
- Close any doors that are propped open, do not use door wedges.
- Make sure any eyewash stations or emergency showers are checked at least weekly.

- Be sure Emergency Carts have been checked and are current. Have ready 12 months of logs available for inspection.
- If patients have been identified as fall risk, make sure they are wearing the correct precaution bracelet. Make sure that other appropriate precautions (non-skid slippers, bed alarms, etc.) are in place.
- Check for items that are too close to the ceiling (less than 18 inches from the ceiling).
- Check that gas cylinders are secured and do not exceed the limit of 12 E cylinders per room.
- Make sure to check for two Patient Identifiers before interacting with a patient: full patient name and date of birth.
- Remind staff to be sure to use proper hand hygiene: surveyors will be watching for this.
- Make sure that Sharps containers and dirty linen bins are no more than 2/3 full.
- Know how and when to obtain an interpreter for a patient or family member.
- Be sure all mandatory training is up to date on all staff, included contracted staff and volunteers.
- Remove food from patient care areas like the med room or the unit's communication station.
- Make sure the Glucometer kit control supplies and testing strips are properly dated when opened and not expired.
- Make sure all patients' have an updated plan of care and that patient education provided is documented.
- Make sure linen is stored properly and covered.
- Know the where your nearest fire exit is located and where the nearest fire pull station is in relation to your work area.
- Know that you must wear your hospital identification badges at all times in the hospital or other article 28 sites.
- Know how to report a malfunctioning piece of medical equipment.
- Know how to report an injury to a patient.
- Know how to look up policies.
- Know how to look up safety data sheets.
- Know the dwell time for cleaning products that you use.
- Make sure all mandatory training is up to date and all performance reviews are done timely (at least every 12 months)
- Review our Survey Information  
Guidebook: <https://upstate.ellucid.com/documents/view/4682>

**Have an Accreditation Question? Call #464-4253**

# DNV-GL AND ISO 9001

## ***“What you need to know”***

- ✓ What is ISO 9001
- ✓ Who is our ISO 9001 representative
- ✓ What are the 3 C’s of ISO 9001
- ✓ Where can you find Upstate’s Quality Manual
- ✓ What are the 6 required ISO 9001 policies
- ✓ What you should be aware of regarding performance improvement
- ✓ What you need to remember when a surveyor comes to visit

### **I. DNV-GL AND ISO 9001**

- a. In September 2010, Upstate University Hospital began utilizing DNV-GL as its formal accrediting agency
- b. We chose to change from the Joint Commission because of DNV-GL’s adherence to ISO 9001 continuous quality improvement standards
- c. DNV –GL is fully approved by The Centers for Medicare and Medicaid Services (CMS)

### **II. DNV-GL IS OUR ACCREDITING BODY**

- a. They come annually to survey us utilizing the Medicare and Medicaid Conditions of Participation/ NIAHO Standards and the ISO 9001: 2015 Standards
- b. ISO 9001 is a Quality Management System that utilizes best practice for achieving systematic high quality

### **III. OUR ISO 9001 MANAGEMENT REPRESENTATIVE**

- a. Our representative is Aimee Goulette
  - i. It is our representatives responsibility to make certain:
    1. Our quality processes are reported appropriately to our quality governance committee
    2. We are following the guiding principles of ISO 9001: 2015

### **IV. ISO 9001 HAS 3 “C’S” AS ITS MAIN PRINCIPLES; THEY ARE:**

- a. Provide Consistent service
- b. Improve patient/Customer satisfaction
- c. Continually improve the organization

**V. ISO 9001 has moved toward risk based thinking and supports the connection of quality management systems to organizations processes.**

**VI. UPSTATE UNIVERSITY HOSPITAL'S QUALITY MANUAL**

- a. Is located within MCN, Upstate's Policy Management System
- b. The Quality Manual consists of:
  - i. The scope of our quality management system
  - ii. Our quality policy: this is an important because it acts as the driver for the Quality Management System.

**VII. UPSTATE'S 6 ISO 9001 POLICIES ARE:**

- a. Located within MCN, our policy management system; they are:
  - i. Control of Documents
  - ii. Control of Records
  - iii. Internal audits
  - iv. Control of Non conforming product
  - v. Correction Action and
  - vi. Preventive Action
- b. These ISO 9001 are the policies that help us to be consistent in our practices and help with continual improvement
- c. As part of ISO 9001 "Control of Documents" policy and Hospital policy UW P-18, <https://upstate.ellucid.com/documents/view/3011>, all policies and forms must be reviewed every 2 years:
  - i. P-18 is also our improved policy on policies
    - 1. You will now see that ALL policies have a box just below the title that tells us what exactly has been changed if the policy has changes made to it
- d. If a person needs to see/utilize a policy they should always access the iPage when the policy is needed
  - i. We should NOT have policies in binders, on bulletin boards, in medication rooms or in our lockers for use at a later time
  - ii. The most current version is only on MCN and that is the version we should always be practicing from

**VIII. BE AWARE OF PERFORMANCE IMPROVEMENT THAT EITHER THE HOSPITAL OR YOUR DEPARTMENT IS WORKING ON**

- a. Performance Improvement is the same as quality improvement
  - i. It is what ISO 9001 is all about!!
- b. As a hospital we are working on Improving Patient Satisfaction, Patient Safety, Staff Satisfaction through initiatives such as:

- i. Hourly rounding
  - ii. Quiet hours
  - iii. Cards on the beds after room cleaning is complete
  - iv. Training on the Patient Experience for enhanced empathy and customer service
  - v. Fostering a culture of accountability through holding ourselves and each other accountable
- c. Decreasing hospital acquired infections through:
  - i. Hand-washing
  - ii. Appropriate cleaning techniques
  - iii. Proper use of personal protective equipment (gowns, gloves, masks)
- d. Improving turnaround times for:
  - i. Patient care items
  - ii. Equipment
  - iii. Medications
  - iv. Patient Flow

**IX.** Upstate's policies and procedures are in place to ensure compliance with standards and regulatory requirements; therefore you need to adhere to our policies.

- a. Remember when the surveyors come to visit us that you should:
  - i. "say what you do"
  - ii. "do what you say"
  - iii. "prove it"
  - iv. Always strive to "improve it"!!

# DOMESTIC VIOLENCE AND THE WORKPLACE

## *“What you need to know”*

- ✓ The definition of Domestic Violence
- ✓ Why Domestic Violence is a workplace issue
- ✓ Supports available at Upstate related to Domestic Violence
- ✓ Supports available in the community related to Domestic Violence

## **I. DOMESTIC VIOLENCE**

- a. Domestic Violence is a pattern of coercive tactics which can include physical, psychological, sexual, economic and emotional abuse, perpetuated by one person against an adult intimate partner with the goal of establishing and maintaining power and control over the victim.
- b. An ‘Intimate Partner’ includes persons legally married to one another; persons formerly married to one another; persons who have a child in common, regardless of whether such persons are married or have lived together at any time; couples who are in an intimate relationship, including but not limited to, couples who live together or have lived together; or persons who are dating or who have dated in the past, including same-sex couples.
- c. Both men and women can be victims of Domestic Violence or abusers/batterers.

## **II. DOMESTIC VIOLENCE IN THE WORKPLACE**

- a. One in four women will experience some level of domestic violence in their lifetime.
- b. There are over 82,000 women employed by NY State and make up 48.9% of the state workforce.
- c. At least one million women and 371,000 men are victims of stalking in the US every year. Stalkers often follow victims to the workplace.
- d. The national health care costs of domestic violence – direct medical and mental health services for victims – amounts to nearly \$4.1 billion annually.
- e. 37% of women who experienced domestic violence reported that the abuse had an impact on their work in the form of lateness, missed work, keeping a job, or career promotions.
- f. 41% of batterers had job performance problems and 48% had difficulty concentrating on the job as a result of their abusive behaviors.
- g. The Center for Disease Control and Prevention estimates the annual cost of lost productivity due to Domestic Violence equals \$727.8 million, with more than 7.9 million paid workdays lost each year.

### III. SUPPORTS AT UPSTATE RELATED TO DOMESTIC VIOLENCE

- a. New York State Governor's Office created 'Executive Order #19' which requires that all state agencies have a policy and procedure, including a workplace safety response plan, related to Domestic Violence.
- b. Upstate's **Domestic Violence and the Workplace Policy UW V-01**, <https://upstate.ellucid.com/documents/view/3034>, is available for review on the policy web page.
- c. Designated liaisons, persons who can assist with support and care related to Domestic Violence issues, at Upstate are the:
  - i. Employee Assistance Program, 315-464-5760
  - ii. Human Resource Benefits Leave Office, 315-464-4943
  - iii. University Police Department, 315-464-4000
  - iv. Upstate complies and assists with enforcement of all known valid court orders of protection that are brought to the attention of Upstate.
    1. Employees are encouraged to bring their orders of protection to the attention of the University Police Department.
    2. A University Police Officer or designee will work with the employee to formulate a plan on how to best proceed to ensure the safest possible work environment.

### IV. COMMUNITY SUPPORTS FOR DOMESTIC VIOLENCE ISSUES

- a. Agencies specializing in supports and services are available in all counties:
  - i. NYS Domestic & Sexual Violence Hotline:
    1. English 1-800-942-6906 or TTY 1-800-818-0656
    2. Spanish 1-800-942-6908 or TTY 1-800-780-7660
  - ii. Elder Abuse Information Line: 1-800-342-3009
  - iii. Cayuga/Seneca County: Cayuga County Action Program/Domestic Violence Intervention Program 1-800-253-3358
  - iv. Cortland County: Aid to Victims of Violence 1-800-336-9622 or 607-756-6363
  - v. Herkimer County: Stepping Stones to End Violence 315-866-0458
  - vi. Jefferson County: Women's Center 315-782-1855
  - vii. Madison County: Victims of Violence 315-366-5000 (collect calls within the county are accepted)
  - viii. Oneida County: YWCA Hall House 315-797-7740
  - ix. Onondaga County: Vera House 315-468-3260
  - x. Oswego County: Services to Aid Families 315-342-1600 (collect calls within the county are accepted)
  - xi. Wayne County: The Victim Resource Center 1-800-456-1172

# DRUG DIVERSION PREVENTION

## ***“What you need to know”***

- ✓ The definition of Drug Diversion
- ✓ What is at stake when Diversion occurs
- ✓ How you can help prevent Diversion
- ✓ Where can you obtain more information about Diversion
- ✓ Who to contact about suspected Drug Diversion

## **I. WHAT IS DIVERSION**

- a. Drug Diversion is the transfer of any legally prescribed medication from the individual for whom it was prescribed to another person for any illicit use.

## **II. RISKS ASSOCIATED WITH DRUG DIVERSION**

- a. Employee
  - i. Personal health, death
  - ii. Progression of abuse leads to risky behaviors, lowers rehab chances
  - iii. Loss of employment, reputation, professional license
  - iv. Legal penalty, jail
- b. Patient
  - i. Compromised care, inadequate/subtherapeutic pain control
  - ii. Patient care by impaired employee = UNSAFE and DANGEROUS
  - iii. Infection risk to patient from contaminated products
- c. Institution
  - i. Civil and Regulatory liability - HUGE fines
  - ii. Reputation, brand at risk
  - iii. CMS penalties, loss of accreditation

## **III. HOW AND WHEN TO PREVENT DRUG DIVERSION**

- a. Drug Diversion Prevention is already built into our day to day policies and procedures. By maintaining FULL 100% compliance within your responsibilities and duties, you are automatically helping to prevent drug diversion. Education and awareness of Drug Diversion will help to ensure and strengthen our prevention program.
- b. Policies
  - i. C-10 - Suspicion of Criminal Activity / Medication Diversion  
- <https://upstate.ellucid.com/documents/view/1191>
  - ii. CM M-03 - Medication Administration/Dispensing - General  
- <https://upstate.ellucid.com/documents/view/3761>



- iii. CM M-26 - Medication Management - Security  
- <https://upstate.ellucid.com/documents/view/3778>
- iv. CM P-18 - Automated Dispensing Cabinets  
- <https://upstate.ellucid.com/documents/view/3811>

**IV.** Where to learn more about Drug Diversion Prevention and Compliance

- a. References - IHFDA, NADDI, CDC, DEA
- b. Upstate Hospital Drug Diversion Prevention Specialist, Derek Empey  
([empeyd@upstate.edu](mailto:empeyd@upstate.edu))

**V. HOW TO REPORT CONCERNS OF SUSPECTED DRUG DIVERSION**

- i. It your duty and legal obligation to report any suspicious diversion activity.
- ii. Any one of the following methods will activate our Diversion Response Team:
  - 1. Anonymous SI Event: Medication-related issues / Drug diversion/theft
  - 2. Email - [Diversion@upstate.edu](mailto:Diversion@upstate.edu)
  - 3. Compliance - 464-6444
  - 4. Direct Report to Nurse Manager

# EMERGENCY CODES

Policy DIS J-19, <https://upstate.ellucid.com/documents/view/1450>

SUNY Upstate Medical University and University Hospital utilize a standard set of emergency codes for announcing critical events while minimizing the alarm to non-staff present in the facility.

<b>EMERGENCY CODE:</b>	<b>DESCRIPTION:</b>
<b>Code Red</b>	Fire, smoke, or the odor of something burning.
<b>Code Amber</b>	Code Amber is activated when an infant/child is confirmed missing.
<b>Code Yellow</b>	Bomb Threat has been received or potential explosive device has been discovered.
<b>Code Black</b>	Severe weather that potentially endangers the hospital.
<b>Code Orange</b>	Contaminated patients from an external hazardous materials spill are presenting the Emergency Department and require decontamination prior to receiving treatment.
<b>Code White</b>	Pediatric Medical Emergency.
<b>Code Blue</b>	Adult Medical Emergency.
<b>Code Silver</b>	Person with a weapon and/or an individual is being held against their will by an unarmed/armed perpetrator.
<b>Code Grey</b>	An adult patient is missing from the hospital.
<b>Code Clear</b>	Situation had been resolved.

# EMERGENCY OB AND NEONATAL CODES (COMMUNITY CAMPUS ONLY)

## “What you need to know”

- ✓ What are Code C and Code Pink
- ✓ When would you implement a Code C or a Code Pink
- ✓ How are Code Stork and Code Pink implemented
- ✓ To what areas do the Code C and Code Pink C teams respond
- ✓ Who responds to Code C or Code Pink

## CODE C:

1. “Code C” is activated for patients/non-patients (at the Community campus only) in Hospital proper, including Family Birth Center, E.D./Peds After Hours and Traffic Circle for following criteria:
  - a. Imminent delivery (i.e.: crowning, bulging perineum, inexorable urge to push)
    - ❖ *OUTSIDE THE FAMILY BIRTH CENTER ONLY*
  - b. Uncontrolled maternal hemorrhage
  - c. Emergency (STAT) Cesarean Section (i.e.: fetal intolerance, umbilical cord prolapse)
  - d. Maternal Hypertensive Crisis
  - e. Maternal Eclampsia/Seizures

## CODE C RESPONSE TEAM INCLUDES:

1. OB Hospitalist – Team Leader
2. Midwife
3. OB RN
4. Anesthesia
5. Surgical PA
6. Newborn NP with Neonatal Resuscitation
7. Adult SWAT RN with ACLS
8. Respiratory Therapy
9. Administrative Supervisor
10. University Police (to maintain privacy and safety of mother and newborn)

**The Code C team will immediately respond to the mother in need of care.**

## “CODE PINK”

1. The “Code Pink” Team responds to infant emergencies within the Family Birth Center for infants with the following criteria:
  - a. No pulse
  - b. Not breathing/inadequate breathing/sever hypoxia
  - c. Actual or perceived threat to the airway
  - d. Unexpected change in perfusion or color
  - e. Any seizure activity

- f. Any other life threatening event

### **CODE PINK RESPONSE TEAM INCLUDES:**

1. Newborn NP with Neonatal Resuscitation – Team Leader
2. Family Birth Center RN with Neonatal Resuscitation
3. Respiratory Therapy
4. Administrative Supervisor
5. University Police
6. Pharmacist – Resource (designated days/times) with PALS

**The Code Pink team will immediately respond to the care of the infant.**

### **IMPLEMENTING AN OB EMERGENCY CODE (CODE C OR CODE PINK)**

1. Staff member pushes/holds the Vocera button and states: “Code Pink/Code C in RM \_\_\_\_\_, someone call a Code Pink/Code C.”
2. Staff member pulls “Code Alarm” lever (where applicable).
3. A different staff member staff dials x2211 on nearest hospital phone and requests Code Pink/Code C Team to unit/area, room #, extension callback #.
4. If a lever is pulled, the Connexall system automates notifications to Code Pink/Code C Team and Switchboard.
5. The Operator issues “Urgent Broadcast” by dialing Vocera system:
  - a. Vocera genie states “Urgent Broadcast to Code \_\_\_\_”.
  - b. Operator announces Code Pink/Code C Team 2X consecutively utilizing Phonetic Alphabet.
  - c. The Broadcast is sent to Code Team members immediately.
6. The Operator activates Code pagers to Code Team members.
  - a. In the event of a Code C, the Operator will contact the OR to request Anesthesia to report to the unit/area
7. The Operator overhead pages Code Pink Team or Code C 2X consecutively utilizing Phonetic Alphabet.
8. The Code Pink or Code C Team immediately responds to location.

For more information, contact Gretchen Lipp, RN at 315-492-5269 or [lippg@upstate.edu](mailto:lippg@upstate.edu)

# EMTALA/EMERGENCY MEDICAL RESPONSE

## WHAT IS EMTALA?

- ✓ Emergency Medical Treatment and Labor Act (EMTALA)
- ✓ EMTALA is a federally mandated standard of care for hospitals and physicians

**UPSTATE UNIVERSITY HOSPITAL WILL PROVIDE EMERGENCY SERVICES AND CARE TO ANY INDIVIDUAL PRESENTING TO UNIVERSITY HOSPITAL (UH) MAIN BUILDINGS OR ON HOSPITAL PROPERTY WHEN A REQUEST IS MADE BY THE INDIVIDUAL OR BY SOMEONE ELSE ON THEIR BEHALF OR WHO DEMONSTRATES SIGNS/SYMPTOMS INDICATIVE OF A POTENTIAL MEDICAL EMERGENCY WITHOUT REGARD TO AN INDIVIDUAL'S RACE, ETHNICITY, AGE, GENDER, SEXUAL ORIENTATION, NATIONAL ORIGIN, PRE-EXISTING MEDICAL CONDITION OR HANDICAP OR OTHER DISABILITY, INSURANCE STATUS OR ABILITY TO PAY FOR SERVICE.**

## I. EMERGENT SITUATIONS:

- a. If any person is on or around hospital property, and request (or appear in need of) emergent care, all employees must know the process to get help.
- b. This means that any person in a parking lot, on a sidewalk, in a driveway, or anywhere around hospital's property requesting, or is in evident need of help, must be provided a medical screening exam, and if necessary, stabilized to meet EMTALA standards.

## II. PROCESS FOR HELP:

- a. All employees must know the process for getting help as outlined in policy CM E-15 Emergency Medical Response Teams: Code Blue/Code White/Code C/Code Pink/EMS (<https://upstate.ellucid.com/documents/view/3714>)
- b. Depending on location, response is by:
  - i. Internal Code Team (ext. 4-4444 DT OR ext. 2211 CC)  
OR
  - ii. Emergency Medical System (EMS) – 911

## III. CODE TEAMS DT CAMPUS (ext. 4-4444):

- a. Adult Code Blue Team/Pediatric Code White Team will respond to medical emergencies for patients, visitors, staff in:
  - i. Hospital Proper
  - ii. Cancer Center
  - iii. Tunnel connecting University Hospital and Crouse Hospital
  - iv. Gamma Knife

- b. Immediately outside of hospital and Cancer Center, including:
  - i. Front Traffic Circle
  - ii. ED Parking Lot
  - iii. Golisano Children's Hospital Circle
  - iv. Bridge to Parking Garage East
  - v. Sidewalks on South Side of Adams Street from corner of Almond Street to Irving Avenue
- c. **Exclusions:**
  - i. Emergency Department, with the exception of boarded/admitted patients

#### **IV. CODE TEAM COMMUNITY CAMPUS (ext 2211):**

- a. Adult Code Blue Team/Pediatric Code White Team/Code C Team will respond to medical emergencies for patients, visitors, staff in:
  - i. Hospital Proper
  - ii. Traffic Circle
- b. **Exclusions:**
  - i. Emergency Department
- c. Code Pink Team will respond to infant emergencies for patients in:
  - i. Family Birth Center (FBC).

# Emergency Medical Response

Tracker Code: EMERGENTMEDICAL

## Downtown Campus

How to call for emergency medical assistance at the following locations:

Code Blue/Code White Team will respond to medical emergencies for patients, visitors, staff located in:

- Hospital Proper
- Cancer Center
- Tunnel connecting UH and Crouse Hospital
- Gamma Knife
- Immediately outside of UH and Cancer Center, including:
  - Front Traffic Circle
  - ED Parking Lot
  - Golisano Children's Hospital Circle
  - Bridge to Parking Garage East
  - Sidewalks on south side of Adams Street (from corner of Almond Street to Irving Avenue)

 Call **x 4-4444**

 Request Code Blue or  
Code White

 Give location/call back #

UH main buildings NOT located at 750 East Adams Street:

- Building 49
- CAB
- Clark Tower
- Computer Warehouse Building (CWB)
- IHP
- Jacobsen Hall
- Parking Garages/Parking lots
- Weiskotten Hall /Addition, including Setnor Hall, Silverman Hall, New Academic Building (NAB)

 Call **911**

 Give location

 State situation

# Emergency Medical Response

## Community Campus


How to call for emergency medical assistance at the following locations:

Code Blue/Code White/Code C Team will respond to medical emergencies for patients, visitors, and staff located in:

- Hospital Proper
- Traffic Circle


Code Pink Team will respond to infant emergencies for patients in:

- FBC (Family Birth Center)

- 
- ☎ Call **x 2211**
  - ☎ Request Code Team
  - ☎ Give location/call back #

Other UH Community Campus buildings:

- Parking Garages
- Parking Lots
- Hematology Oncology Associates of Onondaga Hill
- POB (Physician Office Building) - North and South
- Cord Blood Bank Center

- 
- ☎ Call **911**
  - ☎ Give location
  - ☎ State situation



# ETHICS CONSULTATIONS

## ***“What you need to know”***

- ✓ What an Ethics Consultation is
- ✓ How to arrange an Ethics Consultation
- ✓ Examples of ethical problems that you would contact the Ethics Consult Service for

### **I. ETHICS CONSULTATIONS:**

- a. Ethics consultations help those who must make an ethical decision think through their options and the possible consequences of their choices.
- b. Available 8am-5pm, 7 days a week; to speak with the consultant on call, contact the Hospital Operator (“0” internally; #315-464-5540 from the outside). Please do not use EPIC to request consult.

### **II. MODEL OF ETHICS CONSULTATION:**

- a. Anyone directly involved in the particular issue may call for a consult. This includes nurses, attendings, staff, medical students, social workers, patients, and families.
- b. We do not “rule” on what should be done:
  - i. The ethical decision remains that of those involved in the case.
  - ii. The ethics consultant makes clear to people where there is ethical consensus, what the relevant literature, policy, and law might be, and help them think through possible choices and their consequences.
- c. Informal, unofficial questions are welcome.

### **III. WHAT YOU SHOULD EXPECT IF AN ETHICS CONSULT IS REQUESTED:**

- a. Consultant will assess situation within 24 hours (sooner, if necessary).
- b. A physical meeting or conference call between all relevant parties often occurs
- c. A written note will be left in patient’s chart or letter mailed to the person requesting the consult.

### **IV. WHO WILL PROVIDE THE CONSULT?**

- a. We have a team of bioethicists who provide the consults. They have degrees in several disciplines, including philosophy, medicine, nursing, and law.
- b. The consult service is directed by Thomas Curran, MD, who can be reached at 315.420.0612 (during office hours) or through the hospital operator.

### **V. EXAMPLES OF ETHICAL ISSUES:**

- a. Husband designated as health care proxy thought not to be making decisions in patient’s best interests
- b. Prisoner without family previously refused all medical treatment; now incompetent, but has no DNR order
- c. Man with schizophrenia refuses surgery for bilateral retinal detachments
- d. Should a mother jailed for (but not convicted of) child abuse make medical decisions for the abused child?
- e. Daughters of an incompetent patient disagree with their mother’s health care proxy’s decision regarding where the patient should live after hospital discharge.

# FIRE AND LIFE SAFETY

Policy F-01: Fire Safety Procedures, <https://upstate.ellucid.com/documents/view/1232>

## “What you need to know”

- ✓ What RACE stands for
- ✓ Where and what the evacuation plan is for your department/unit
- ✓ What “Code RED” is throughout the hospital?
- ✓ The word that helps you remember how to use a fire extinguisher

**Should a FIRE occur – respond by using R.A.C.E.**

**R**ESCUE or relocate endangered people to a safe place

**A**CTIVATE the fire alarm system and call x4-5555 for Upstate Medical University (UMU) and Upstate University Hospital (UUH); for leased properties call 9-911, for Upstate University Hospital Community Campus (UUHCC) ACTIVATE the fire alarm and call X2211 for the main hospital and any upstate unit/departments in the POB North and South; for private physician offices and private telephone numbers in the POB North and South dial 911.

1. Give fire location
2. STAY ON THE PHONE – DO NOT HANG UP

**C**ONTAIN fire by closing ALL doors and any open windows

1. DO NOT turn off oxygen unless told to – note Oxygen Shut Off valve locations
2. Unplug any appliances – touch the cord only – if equipment appears to be overheating/ smoking

**E**VACUATE or extinguish

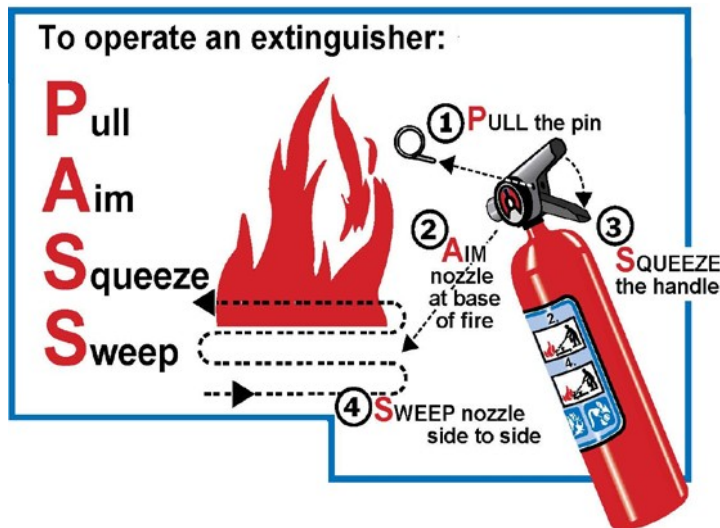
1. Evacuate the area as quickly as possible
2. Extinguish the flames with extinguisher if trained and the fire has not left its source.

## I. DEPARTMENT EMPLOYEE RESPONSIBILITIES

- a. Know location of fire extinguishers
- b. Know when to use a fire extinguisher
  - i. DO NOT FIGHT A FIRE UNLESS YOU HAVE BEEN TRAINED IN THE USE OF A PORTABLE FIRE EXTINGUISHER

- ii. You activate the fire alarm system FIRST
  - iii. You use a buddy system
  - iv. The fire is SMALL and has not left its source
  - v. You can GET OUT FAST
  - vi. You won't be trapped, make sure the fire is NOT between you and your exit
  - vii. You have the CORRECT extinguisher
  - viii. Test the fire extinguisher to ensure it works, PRIOR to attacking the fire
  - ix. If ONE (1) extinguisher doesn't put out flames – EVACUATE
  - x. Stay low and avoid smoke
- c. "At the UUH and UMU Campus contact the Fire Marshal to provide information about the fire incident and to obtain a replacement fire extinguisher(s), (\*\*for leased properties – i.e. UHCC, 550 Harrison/Harrison Center, Wide Waters, and other leased properties - contact the property/building manager to replace fire extinguishers).
- d. At the UH Community Campus (CC) contact the Manager of Plant Operation or designee to provide information about the fire incident and to obtain a replacement fire extinguishers.

## II. TO OPERATE AN EXTINGUISHER



## III. FIRE ANNOUNCEMENTS

### a. CODE RED:

- i. Tells you a fire alarm has been activated. The operator will announce on the public address system the building and location of the alarm activation.
- ii. Each department and nursing unit
- iii. Close ALL doors that are open (patients, service room, fire, and smoke doors)
- iv. Close ALL windows

- v. Clear hallway of ALL equipment
  - vi. Check EXIT areas for clear path
  - vii. Turn on hallway lights
  - viii. Tell visitors to stay in patient's room or visiting areas
  - ix. Listen for additional announcements
- b. **ALL CLEAR**
- i. Tells you fire alarm is over
  - ii. Resume normal activity
- c. **PUBLIC ADDRESS SYSTEM**
- i. Tells you to EVACUATE patient care area
  - ii. This announcement is stated THREE times
  - iii. Tells you the location to be evacuated
  - iv. WALK to the nearest exit
  - v. Fire Department will direct and supervise elevator use ONLY
  - vi. Supervisor in Charge:
- d. Check that ALL staff, visitors, and patients have been evacuated
- e. Advise University Police Department and Fire Department of any patients, staff, or visitors that are unaccounted for

#### IV. FIRE EVACUATION PLAN

- a. Evacuation Procedures are put into action by:
- i. Registered Nurse in Charge
  - ii. Hospital Administration
  - iii. Fire Marshall at UUH and UMU Campus/Manager of Plant Operations or designee at UUHCC Campus"
  - iv. Chief of University Police Department or designee for both campuses".
  - v. Fire Department
  - vi. Is located on the wall of each unit/floor
  - vii. Includes the location of fire extinguishers
  - viii. Includes fire alarm pull stations
  - ix. Shut **off** OXYGEN in patient rooms:
- b. In the event of a fire in a location with oxygen in use, do the following:
- i. If the oxygen administration device is not in danger of catching fire then the oxygen flow should be interrupted by removing the device from the wall outlet.
  - ii. If the oxygen device is in danger of catching fire, remove device from the wall.
  - iii. If the oxygen device is on fire, the zone valve supplying the room should be shut off. NOTE: the person closing the zone valve should be aware that this will interrupt oxygen to the entire unit supplied by the zone valve.
  - iv. The zone valve can be shut off by RT or Charge RN in conjunction with Plant

- Operations Community Campus (CC) or HVAC Downtown Campus (DT).
- v. The Respiratory Therapy department should be contacted any time these situations occur.
- c. Respiratory Therapy will send therapist to the area of alarm if it is a patient care area
- d. Evacuation Routes
  - i. Will depend on fire location
  - ii. **FIRST:** Move patients to safe area, behind fire doors - stay on the same floor
  - iii. **SECOND:** Move down one flight of stairs, unless told to go to another floor
  - iv. **Always use the stairs** – unless told by Fire Department

## Know Your Department's Evacuation Plan

### V. LARGE SCALE PATIENT EVACUATION GUIDELINES

- a. Evacuation Procedures are put into action by the Incident Command System (ICS).
- b. Authority to evacuate the entire facility is given to the designated Incident Commander.
- c. Authority to relocate a unit to a safe area is given to the Person in Charge of the unit or department.
- d. All patients and staff return to their unit/department during an evacuation.
- e. Employees may not leave the premises without checking in with the Department Manager or Person in Charge of the Department.
- f. Visitors and vendors will be directed to the nearest exit and asked to evacuate the facility.
  - i. A visitor or vendor may remain on site at the decision of the person in charge of the unit/department.
- g. Patients/staff/visitors in the most danger should be moved first, followed by (in order):
  - i. Ambulatory and wheelchair patients
  - ii. Then bed ridden patients
  - iii. Then patients connected to life-saving devices
- h. Remember to take patient charts and medications
- i. Notify fire department if assistance is needed evacuating
- j. A designated staff person should stay with the patients once they reach a safe place.

# Gender Identity Awareness

## “What you need to know”

- ✓ Ask patients for their preferred name and accept/do not question the answer.
- ✓ Ask patients for their preferred pronoun and accept /do not question the answer.
- ✓ If a ‘preferred name’ is documented, refer to the patient by the preferred name.
- ✓ If a ‘preferred pronoun’ is documented, refer to the patient by the preferred pronoun (he, she, or they.)
- ✓ If you have any confusion about whether a patient is male or female, respectfully request clarification by asking the patient what their preferred pronoun is (he, she, or they.)
- ✓ When two identifiers are required, legal name and date of birth should be used, not sex.

## TERMINOLOGY:

**Agendered:** Person is internally ungendered.

**Ally:** An individual that supports the struggles of a group; not part of the group him/herself. Adapted from: Adams, M., Bell, L., & Griffin, P. (2007). Teaching for Diversity and Social Justice (2nd ed.). New York: Routledge. In the LGBTQ\* context, a person who supports and honors sexual and gender diversity, acts against heterosexist, and transphobic remarks and behaviors, and is willing to explore and understand these forms of bias within himself.

**Androgyne:** Person appearing and/or identifying as neither man nor woman, presenting a gender either mixed or neutral.

**Asexual:** Anyone without sexual drive and/or attraction. Many asexual individuals have deep and meaningful relationships with others exclusive of sexual intimacy. The term is also sometimes used as a “gender identity” by those who believe their lack of sexual attraction places them outside the standard definitions of gender.

**Bigendered:** A person whose gender identity is a combination of male/man and female/woman.

**Biphobia:** The fear of, discrimination against, or hatred of bisexuals by people of any sexual orientation. Biphobic stereotypes may include promiscuity or confusion towards their sexual orientation. IN some cases, bisexuals are accused of bringing sexually transmitted disease into the heterosexual community. Gays and lesbians who express biphobia might accuse bisexuals of maintaining heterosexual privilege and collaborating with homophobes. The belief that bisexuality does not truly exist is another example of biphobia.

**Birth Sex:** The sex (male or female) assigned a child at birth, based on a child’s genitalia.

**Bisexual:** A person emotionally, physically, and/or sexually attracted to members of the same sex, as well as members of the opposite sex. Adapted from: Green, E. R., & Peterson, E. N. (2006). LGBTTSQI Terminology. In Trans-Academics.org. Retrieved June 4, 2014, from <http://www.trans-academics.org/lgbttsqiterminology.pdf>

**Cisgender:** Cisgender is a term used to describe people who, for the most part, identify as the gender they were assigned at birth. For example, if a doctor said “it’s a boy!” when you were born, and you identify as a man, then you could be described as cisgender. Source: Basic Rights Oregon. (2011, October 9). Trans 101: Cisgender. In Basic Rights Oregon. Retrieved June 9, 2014, from <http://www.basicrights.org/uncategorized/trans-101-cisgender>

**Cross-dressing:** The act of dressing in clothes typically associated with another gender. This may be the extent of the gender-bending behavior, or it may be one step on a path of changing sex or gender. The words transvestite and transvestism have been used in the past to describe this activity or interest. Adapted from: Adams, M., Bell, L., & Griffin, P. (2007). Appendix 9B: Answers to Gender and Sexuality Definitions Quiz. In Teaching for Diversity and Social Justice (2nd ed.). New York: Routledge.

**Female-to-Male (FTM) or Transgender Man:** A person born with female genitalia at birth who feels they are male/a man and lives as male/a man. Some will just use the term male.

**Gender Attribution:** The way we perceive others’ gender, which affects the way we relate to that person, typically without thought. **Gender dysphoria:** DSM-5 diagnosis for individuals who have a strong and persistent cross-gender identification and a persistent discomfort with his or her sex, or sense of inappropriateness in the gender role of that sex

**Gender Expression/Role:** The way a person acts, dresses, speaks and behaves in order to show their gender as feminine, masculine, both, or neither.

**Gender Identity:** A person’s internal sense of being a man, woman, both, or neither. Gender identity usually develops at a young age.

**Gender-Neutral:** Nondiscriminatory language usage that can apply equal to people of any gender identity. “Spouse” and “Partner” are gender neutral alternatives to the gender specific words “husband,” “wife,” “boyfriend,” and “girlfriend.” The use of the gender neutral pronouns “ze” (instead of she/he) and “hir” (instead of his/her) are preferred by some as a way to be inclusive of all genders in language use.

**Gender Non-Conforming:** People who express their gender differently than what is culturally expected of them. A gender non-conforming person is not necessarily transgender (for example, a woman who dresses in a masculine style but who identifies as female; a boy who likes to play with girl dolls but identifies himself as a boy, etc.).

**Genderqueer:** A relatively new term, genderqueer is used by some individuals who do not identify as either male or female; or identify as both male and female.

**Heterosexism:** 1. Social structures and practices which serve to elevate and enforce heterosexuality while subordinating or suppressing other forms of sexuality. 2. Societal, cultural, institutional, and individual beliefs and practices that assume that heterosexuality is the only natural, normal, acceptable sexual orientation. Adapted from: Griffin, P. (2007). Sexism, Heterosexism, and Transgender Oppression. In M. Adams, L. Bell, & P. Griffin (Eds.), Teaching for Diversity and Social Justice (2nd ed., pp. 167-172). New York: Routledge. Parvis, L. (2013). Understanding Cultural Diversity in Today's Complex World (5th ed., p. 164). Embrace Publications.

**Heterosexual:** A person primarily emotionally, physically, and/or sexually attracted to members of the opposite sex. Adapted from: Sullivan, N. (2003). A Critical Introduction to Queer Theory (p. 119). New York: New York University Press.

**Heterosexual Privilege:** Those benefits and advantages heterosexuals or those perceived to be heterosexual, receive in a heterosexist culture. Source: Adams, M., Bell, L., & Griffin, P. (2007). Teaching for Diversity and Social Justice (2nd ed.). New York: Routledge.

**Hir:** The gender-neutral pronoun for his or her.

**Male-to-Female (MTF) or Transgender Woman:** A person born with male genitalia who feels they are female/a woman and lives as female/a woman. Some will just use the term female.

**Pansexual:** A person for whom sex and gender are less significant in determining attraction. They may identify as being fluid in their own sexual orientation and/or gender or sex identity.

**Polyamory:** The practice of having or being open to having, multiple romantic relationships.

**Preferred Name:** Use an individual's preferred name, pronoun and title, regardless of the individual's sex assigned at birth, anatomy, gender, medical history, appearance, or the sex indicated on the individual's identification.

**Sexual Orientation:** Sexual orientation is about how people identify their physical and emotional attraction to others. It is not related to gender identity. Transgender people can be any sexual orientation (gay, lesbian, bisexual, heterosexual/straight, no label at all, or some other self-described label).

**Trans:** Abbreviation for transgender.

**Transgender:** People whose gender identity is not the same as the sex they were assigned at birth.

**Transition/Gender Affirmation Process:** For transgender people, this refers to the process of coming to recognize, accept, and express one's gender identity. Most often, this refers to the period when a person makes social, legal, and/or medical changes, such as changing their clothing, name, sex designation, and using medical interventions. This process is often called gender affirmation, because it allows people to affirm their gender identity by making outward



changes. Gender affirmation/transition can greatly improve a transgender person’s mental health and general well-being.

**Transsexual:** A term used to describe a subset of transgender individuals who have transitioned to the opposite sex, often but not always through a combination of hormonal therapy and sexual reassignment surgery.

**\*Terms to Avoid!** *The following terms are considered offensive by most and should not be used: she-male, he-she, it, tranny, “real” woman or “real” man.*

BEST PRACTICES	EXAMPLES
<u>When addressing patients, avoid using gender terms like “sir” or “ma’am.”</u>	<u>“How may I help you today?”</u>
<u>When talking about patients, avoid pronouns and other gender terms. Or, use gender neutral words such as “they.” Never refer to someone as “it”.</u>	<u>“Your patient is here in the waiting room.”</u> <u>“They are here for their 3 o’clock appointment.”</u>
<u>Politely ask if you are unsure about a patient’s preferred name.</u>	<u>“What name would you like us to use?”</u> <u>“I would like to be respectful—how would you like to be addressed?”</u>
<u>Ask respectfully about names if they do not match in your records.</u>	<u>“Could your chart be under another name?”</u> <u>“What is the name on your insurance?”</u>
<u>Did you goof? Politely apologize.</u>	<u>“I apologize for using the wrong pronoun. I did not mean to disrespect you.”</u>
<u>Only ask information that is required.</u>	<u>Ask yourself: What do I know? What do I need to know? How can I ask in a sensitive way?</u>

**Clearly, it is not always possible to avoid mistakes, and simple apologies can go a long way. If you do slip, you can say something like: “I apologize for using the wrong pronoun/name. I did not mean to disrespect you.”**

If you have questions or would like more information please contact:  
Office of Diversity & Inclusion Jacobsen Hall, suite 711, 464-5234, [diversity@upstate.edu](mailto:diversity@upstate.edu)

# GENERAL SECURITY

## ***“What you need to know”***

- ✓ When to wear your employee identification badge
- ✓ How to report suspicious activities
- ✓ How to report patients who have an Order of Protection
- ✓ How to request a Personal Safety Escort

I. Our University Police Department Staff is trained and knowledgeable in protecting staff, patients, and visitors

## **II. INDIVIDUAL RESPONSIBILITIES**

- a. Wear your employee identification badge at all times while on Upstate property, includes owned and leased areas.
- b. Report unauthorized persons (anyone without visible ID/badge)
- c. Report suspicious activities
  - i. Include a brief description of suspicious activity
  - ii. Include detailed description of person
  - iii. Include location

## **III. REPORT ACCIDENTS AND INJURIES**

- a. Involving visitors, students, and employees

## **IV. EMERGENCY SITUATIONS**

- a. Cooperate with University Police Department Staff
- b. Examples:
  - i. Disaster Drills
  - ii. Fire Alarms

## **V. ORDER OF PROTECTION**

- a. If patient indicates that a Order of Protection is in place, get a copy
- b. Copies go in Medical Record and to the University Police Department
- c. Provide the University Police Department a copy of the Order of Protection and a photograph of the subject(s) whenever possible.

## **VI. PERSONAL SAFETY ESCORTS**

- a. Call University Police Department for Safety Escorts to any place on Campus.
- b. Escorts are provided 24 hours a day, 7 days a week via walking and vehicle.

# HAZARDOUS DRUGS

Reference Policy CM H-26: Handling and Precautions for Hazardous Drugs

<https://upstateellucidcom/documents/view/3736>

## ***“What you need to know”***

- ✓ The definition of a Hazardous Drug
- ✓ Why are drugs considered Hazardous
- ✓ Where to find the list of Hazardous Drugs
- ✓ How do staff know patients are receiving Hazardous Drugs
- ✓ When are staff supposed to wear PPE
- ✓ How to dispose of PPE
- ✓ If pregnant or trying to get pregnant what should I do

### **I. HAZARDOUS DRUG**

- a. Hazardous drugs are defined by the National Institute for Occupational Safety and Health (NIOSH)
- b. These drugs exhibit one or more of the following six characteristics in humans and animals
  - i. Carcinogenic (may cause cancer)
  - ii. Teratogenicity (may cause birth defects)
  - iii. Reproductive Toxicity (may not able to get pregnant)
  - iv. Organ toxicity at low doses (may cause damage to internal organs)
  - v. Genotoxicity (may cause damage to genes)
  - vi. Structure and toxicity profiles of new drugs that mimic existing drugs are determined hazardous by the above criteria

### **II. WHY DRUGS ARE CONSIDERED HAZARDOUS**

- a. Coming into skin, eye, or mucosal contact with these drugs may cause cancer, may cause harm to a baby before birth, may cause problems for a couple trying to have a baby, or may cause organ damage to the staff member
- b. Coming into contact with body fluids (i.e. urine, blood, etc.) from patients within 72 hours of receiving a hazardous drug is to be avoided for the same reason

### **III. WHERE TO FIND THE HAZARDOUS DRUG LIST?**

- a. Go to the iPage > Clinical Launch Pad > Upstate Hazardous Medication List

### **IV. HOW DO STAFF KNOW IF PATIENTS ARE RECEIVING HAZARDOUS DRUGS?**

- a. For those patients receiving Hazardous Drugs, a warning sign “Hazardous Drug Precautions” or “Chemotherapy Precautions” should be posted on the door of the patient’s room.

- i. In pediatric patients, if privacy concerns exist due to reproductive rights, then deviation from posting signage may be reasonable. Associated documentation should be placed in the electronic medical record (EMR)
- b. For treatment areas where a hazardous drug is being administered as an aerosol, the treatment area should be posted with a warning sign and nonessential personnel should not be admitted to the area

## **V. WHEN ARE STAFF SUPPOSED TO WEAR PPE**

- a. When handling the body wastes and fluids of patients receiving hazardous drugs
- b. When hanging IV Hazardous drugs
- c. When there is potential for splashing of liquid oral hazardous drugs
  - i. Performing activities at or above eye level increases the risk of splash onto healthcare personnel
- d. **Environmental Services employees should avoid direct contact with body wastes and fluids from a patient receiving hazardous drugs**
  - i. Handling soiled linen of patients on hazardous drugs is defined in policy EVS P-50, Patient Care: Chemotherapy Linen Handling  
- <https://upstateellucidcom/documents/view/1894>
- e. Reproductive Category Employees should always follow the highest level of PPE recommended for a drug

## **VI. DISPOSAL OF PPE:**

- a. PPE should be discarded after each use or immediately when contaminated
- b. Gloves are always considered contaminated and disposed of in yellow chemotherapy waste bins
- c. Protective gowns, goggles, face shields, and N-95 masks that are not visibly soiled or in contact with hazardous drugs/body waste/fluid, can be disposed of in the regular trash
- d. Protective gowns, goggles, face shields, and N-95 masks that that are visibly soiled or otherwise contaminated with hazardous drugs/body waste/fluid, must be placed in yellow chemotherapy waste bins

**Employees must wash their hands thoroughly with soap and water before and after administering hazardous drugs and whenever gloves are changed**

## VII. PPE GUIDELINES:

<b>NON-CLINICAL: Personal Protective Equipment (PPE) Guidelines</b>					
Formulation (All hazardous drug risk levels)	Activity	Double nitrile gloves	Protective gown	Eye/Face protection (Goggles & Full face shield)	N95 Mask (Prevents inhalational exposure)
All formulations	Patient transport	Yes	No	No	No
Patient body fluids	Disposal and cleaning	Yes	Yes	Yes (only if liquid that could splash)	Yes (only if there is inhalation potential)
Patient waste (Environmental services)	Disposal and cleaning	Yes	Yes	Yes (only if liquid that could splash)	Yes (only if there is inhalation potential)
Spills	Cleaning	Yes	Yes	Yes	Yes

<b>LABORATORY ANALYSIS: Personal Protective Equipment (PPE) Guidelines</b>					
Formulation (All hazardous drug risk levels)	Activity	Double nitrile gloves	Protective gown	Eye/Face protection (Goggles & Full face shield)	N95 Mask (Prevents inhalational exposure)
All formulations	Analysis of patient specimens	No (single only)	Yes (Clinical pathology lab coat, OK Blue paper coats, NOT acceptable)	Yes	No

<b>CLINICAL CARE GIVERS: Personal Protective Equipment (PPE) Guidelines</b>					
Formulation (All hazardous drug risk levels)	Activity	Double nitrile gloves	Protective gown	Eye/Face Protection (Goggles & Full face shield)	N95 Mask (Prevents inhalational exposure)
Intact tablet or capsule	Administration	No, single pair of nitrile gloves	No	Yes (only if there is vomit/spit up potential)	No
Oral liquid drug or feeding tube	Administration	Yes	Yes	Yes (only if there is vomit/spit up potential)	No
Topical drug	Administration	Yes	Yes	Yes (only if liquid that could splash)	Yes (only if there is inhalation potential)
SQ / IM Injection	Administration	Yes	Yes	Yes (only if liquid that could splash)	No
Intravenous (push, piggyback or large volume)	Administration	Yes	Yes	Yes (only if liquid that could splash)	No

## CLINICAL CARE GIVERS: Personal Protective Equipment (PPE) Guidelines (continued)

Formulation (All hazardous drug risk levels)	Activity	Double nitrile gloves	Protective gown	Eye/Face Protection (Goggles & Full face shield)	N95 Mask (Prevents inhalational exposure)
Irrigation solution	Administration	Yes	Yes	Yes	Yes
Inhalation/Aerosol of solution/powder	Aerosol Administration	Yes	Yes	Yes	Yes
Inhalation/Aerosol of solution/powder (continued)	Nebulization administration	Yes	Yes	Yes (only if liquid that could splash)	Yes (only if there is inhalation potential)
Split tablet (Pharmacy to provide split tablet)	Administration	No, single pair of nitrile gloves	No	Yes (only if there is vomit / spit up potential)	No
Crushed tablet (Pharmacy to provide crushed tablet)	Administration	Yes	Yes	Yes (only if there is vomit / spit up potential)	No
All formulations	Patient transport	Yes	No	No	No
Patient body fluids	Disposal and cleaning	Yes	Yes	Yes (only if liquid that could splash)	Yes (only if there is inhalation potential)
Patient waste (Environmental services)	Disposal and cleaning	Yes	Yes	Yes (only if liquid that could splash)	Yes (only if there is inhalation potential)
Spills	Cleaning	Yes	Yes	Yes	Yes

# HAZARDOUS MATERIALS & WASTE

## “What you need to know”

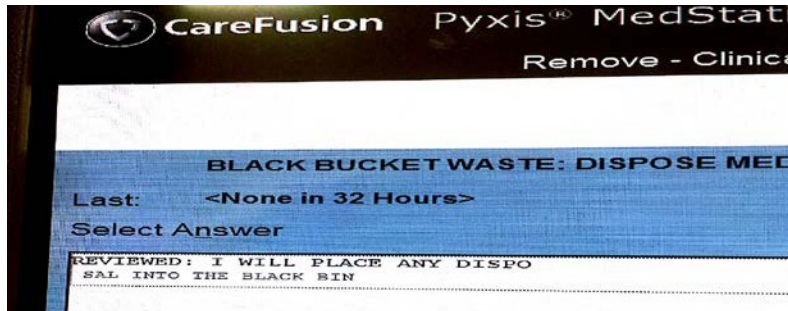
- ✓ What to do if a hazardous material is spilled in your work area
- ✓ How to properly dispose of Regulated Medical Waste (RMW)

### I. HAZARDOUS MATERIALS SPILLS


- a. Services to be contacted in case of a spill:
  - i. Blood –
    1. Downtown Campus: Call Environmental Services at x4-6576
    2. Community Campus: Call Environmental Services at 492-5994
  - ii. Chemicals/Medications –
    1. Downtown Campus: Call Environmental Health and Safety at x4-5782  
Nights and weekends: Call University Police Department at x4-4000
    2. Community Campus Call Environmental Health and Safety at x4-5782  
Nights and weekends: Call University Police Department at 492-5511
  - iii. Radioactive Materials –
    1. Downtown Campus: Call Radiation Safety at x4-6510
    2. Community Campus: Call Radiology at 492-5015 or 492-5526
  - iv. Persons exposed to hazardous spills are to be directed to the Emergency Department with the applicable Safety Data sheet (SDS), which are available on from the iPage → click the Policies & Forms icon → click the Safety Data Sheets (SDS) link in the column to the left of the page
- b. Hazardous Material (HAZMAT) spills that cannot be contained require:
  - i. Remove persons from the spill danger and notify others in the area to leave.
  - ii. Notify –
    1. Downtown Campus: Call Environmental Health and Safety at x4-5782
      - a. Nights and weekends: Call University Police Department at x4-4000
      - b. Community Campus Call Environmental Health and Safety at x4-5782
      - c. Nights and weekends: Call University Police Department at 492-5511.
    2. Give your name, exact location of the spill, and the type of spill, if known

## II. REGULATED MEDICATION WASTE DISPOSAL

- a. Regulated Medications are drugs that are toxic to the environment if they are not handled and disposed of properly. When used as prescribed, these drugs do not pose a risk for the nurse or patient. When they go un-used, or partially used, they must be handled differently than non-regulated medications.
  - i. You will receive a notification from the automated dispensing cabinet relating to any medication that is considered a regulated medication.



- ii. These drugs will also be labeled as such if they are dispensed directly from the pharmacy department as Hazardous Waste - black bin disposal.
- iii. Waste (any partially used or un-used regulated medication) will be disposed of in a labeled black bucket that will be located in the dirty utility rooms on each unit.
- iv. If you have any questions regarding regulated medication collection and disposal, please contact Environmental Health and Safety at 4-5782. At the Community Campus, contact Pharmacy at 492-5503 or Environmental Services at 492-5064.

CAUTION: CHEMOTHERAPY		
<b>Beacon, Jfdtest</b>		ONCOLOGYCCTR
AGE: 51 y.o.	MRN: 6058045	Ord#380069269
DOB: 1/12/1967		Patient Weight: 95.3kg
<b>cyclophosphamide (CYTOXAN) capsule 50 mg</b>	Oral, Daily	
Dispense: 1 capsule		
<b>Dose: 1 capsule (1 x 50 mg capsule)</b>		
Antineoplastic Hazardous Drug - follow precautions		
Hazardous Waste - black bin disposal		
[FD:1st REPRINT] 0925-1511		



# HOSPITAL EVACUATION PLAN

## ***“What you need to know”***

- ✓ How to be prepared for an evacuation of a patient care area.
- ✓ Procedures for moving patients off the unit.

## **I. UNIVERSITY HOSPITAL’S EMERGENCY EVACUATION PLAN**

- a. In the event that the hospital needs to be evacuated, the decision to evacuate all or a section of the hospital will be managed through Incident Command.
- b. The goal of the evacuation plan is the safety and protection of patients and staff.

## **II. STAFF ROLES AND RESPONSIBILITIES FOR EVACUATION**

- a. Be aware of the designated horizontal staging and evacuation plans designated in each unit specific disaster plan
- b. Be familiar with evacuation equipment that is available:
  - i. Know the location where the equipment is stored (See Evacuation Plan policy DIS M-40 for exact locations, <https://upstate.ellucid.com/documents/view/1474>)
- c. Check with your supervisor regarding responsibilities at time of evacuation:
  - i. Non-admitted patients and visitors may be sent home
  - ii. Unassigned staff will report to the Labor Pool
  - iii. Patients will be categorized for evacuation by color code based on acuity and transportation needs.
  - iv. Do not use elevators unless directed by emergency response personnel.

## **III. WHEN MOVING A PATIENT**

- a. Include printed copy of the electronic medical record
- b. Move personal possessions with the patient
- c. Ensure the patient’s ID band matches the patient, the medical record, and the MAR
- d. Move only equipment that is necessary to sustain patient
- e. Once off the clinical unit, roster check all patients

***Remember: Incident Command will direct all aspects of the evacuation***

**\*\*EMPLOYEES NOT PHYSICALLY LOCATED AT UNIVERSITY HOSPITAL DOWNTOWN OR COMMUNITY CAMPUSES SHOULD CHECK WITH THEIR MANAGERS TO DETERMINE THE BUILDING SPECIFIC EVACUATION PLAN\*\***

# HUMAN TRAFFICKING

Policy CM H-31, Identification and Treatment of Victims of Human Trafficking:

<https://upstate.ellucid.com/documents/view/9945>

## ***“What you need to know”***

- ✓ What is Human Trafficking?
- ✓ What to do if you suspect Human Trafficking?
- ✓ Notifications

### **I. WHAT IS HUMAN TRAFFICKING?**

- a. Human trafficking is the recruitment, transportation, transfer, harboring or receipt of person by improper means, such as force, abduction, fraud or coercion, for an improper purpose including forced labor or commercial sexual exploitation.

### **II. WHAT TO DO IF YOU SUSPECT HUMAN TRAFFICKING**

- a. Medical staff or nursing will assess for red flag indicators.
- b. If staff suspects that issues of human trafficking may exist, a referral to social work will occur.
- c. Social work will conduct an in-depth screening and assess for safe discharge.
- d. Medical staff will assess for non-consensual sexual activity within the past 96 hours and consult Vera House (315-468-3260) for advocacy and SANE as appropriate.
- e. Medical staff will perform evaluation and provide treatment as necessary.

### **III. NOTIFICATIONS**

- a. If the person is over the age of 18 and requests or consents to law enforcement, UPD, or 911 will be called as appropriate.
- b. If the patient is under the age of 18, staff will ensure to the immediate safety of the patient and refer to Policy C-06, Medical Management of Suspected Abused or Neglected Child, Including Physician Taking Protective Custody: <https://upstate.ellucid.com/documents/view/1188>
- c. Contact social work with questions.

# IDENTIFICATION OF PATIENT RISK

## Policy (I02) Identification of Patients

<https://upstate.ellucid.com/documents/view/1247>

- I. All inpatients, outpatients & Emergency Department patients will be asked to provide identification upon presentation to the hospital
  - a. Photo ID requested of all patients 18 years or older at time of registration
  - b. ID scanned into EMR

## II. NURSING ASSESSMENT OF PATIENT RISK (SPECIAL ALERT BANDS)

- a. Any patient that, during the Nursing Assessment, demonstrates one of the following risks will have **a colored band placed on the same extremity as the patient identification band.**
- b. The following represents which risk is identified by the color band:
  - i. Limb Alert = **Pink**
  - ii. Do Not Resuscitate (DNR) = **Purple**
  - iii. Fall Risk = **Yellow**

# INFECTION CONTROL

## ***“What you need to know”***

- ✓ What guideline do we follow for hand hygiene
- ✓ When you should wash your hands
- ✓ When is it OK to use an alcohol-based waterless hand sanitizer to clean hands
- ✓ What the Blood Borne Pathogen Standard is
- ✓ What kind of protective clothing you wear if you are handling blood
- ✓ Where you put used sharps and needles
- ✓ What Biohazard Symbols are
- ✓ What you do if you have a blood or body fluid exposure
- ✓ Where you can give feedback on safety devices used at University Hospital
- ✓ What is Standard Precautions
- ✓ What is the contact time(s) for hospital approved disinfectant wipes
- ✓ What are Transmission-Based Precautions
- ✓ What kind of mask is required to enter an airborne precaution room
- ✓ What kind of mask is required for care of a patient on droplet precautions
- ✓ What is Modified Pulmonary Contact Precautions
- ✓ What Clostridium Difficile diarrhea is
- ✓ What Tuberculosis (TB) is

***HAND HYGIENE is one of the most effective ways to reduce the number of Hospital – Associated Infections***

## **I. HAND HYGIENE**

- a. Upstate University Hospital follows the Centers for Disease Control and Prevention Guideline for Hand Hygiene in Health-Care Settings
- b. Failure to follow appropriate infection prevention techniques in healthcare practice can be considered evidence of professional misconduct for licensed professionals – this applies to Hand Hygiene.

## **II. PERFORM HAND HYGIENE**

- a. Upon entering the patient’s environment (i.e. before entering or immediately upon entering the patient’s room)
- b. Upon leaving the patient’s environment
- c. Before and after eating
- d. After removing gloves
- e. After sneezing, coughing, or using the bathroom
- f. Between patient contacts and between contact with different sites on the same patient

### III. HAND WASHING SKILL

- a. Wet hands with warm water
- b. Apply soap
- c. Wash hands using friction
- d. Wash for at least 15 -20 seconds (Use 20 seconds during Flu season)
- e. Dry thoroughly

Washing your hands properly takes as long as singing the “Happy Birthday” song twice

### IV. ALCOHOL-BASED WATERLESS HAND SANITIZERS

- a. Use only if hands are not visibly soiled
- b. Dispense gel/foam into palm of hand
- c. Rub both hands together using friction till dry

### V. EMPLOYEES WHO ARE REQUIRED TO WEAR GLOVES

- a. Artificial nails are not acceptable – anything that is not your natural nail
- b. Natural nails should be short.
- c. Nail polish must be in good repair.
- d. Refer to Hand Hygiene Policy/Procedure (Policy IC D-01/Hand Hygiene Policy/Procedure, <https://upstate.ellucid.com/documents/view/275>)

### VI. THE BLOOD BORNE PATHOGEN STANDARD

**Questions on this training? 24/7 call 464-7233 (SAFE)**

- a. The Blood Borne Pathogen Standard was established to protect health care workers. It was developed to make Health Care Workers (HCWs) aware of the risks of getting hepatitis and AIDS at work and to identify safe work practices that prevent the spread of these blood borne viruses
- b. Staff are encouraged to review:
  - i. Exposure Control Plan, Policy IC G-01/ <https://upstate.ellucid.com/documents/view/300>
  - ii. 29 CFR Blood borne pathogens.-1910.1030 at [www.osha.gov](http://www.osha.gov)
- c. Methods of Compliance:
  - i. Standard Precautions (hand hygiene, use of barriers)
  - ii. Engineering and Work Practice Controls (e. g. safety devices, working sinks, labeling with biohazard symbol or color red to identify contamination and need for barrier use)
  - iii. Personal Protective Equipment - PPE (determine exposure potential; needed barriers)
  - iv. Environmental Cleaning (blood spills, decontaminating patient equipment)
- d. Exposure Control Plan (ECP) 1910.1030(c):
  - i. The ECP must include:

1. List of currently available products at Upstate that reduce/eliminate exposure (e.g. safety devices), go to:  
<http://www.upstate.edu/ehs/intra/biosafety.php> (listed under Risk Assessment Tools).
  2. Annual documentation of consideration and implementation of safer medical devices
- ii. Solicitation of input from non-managerial employees (representative sample of staff responsible for direct patient care) for evaluation process for new devices
  - iii. Compliance with ECP:
    1. Safe Medical Device Evaluation Subcommittee:
      - a. Assess current sharps safety/exposure prevention
      - b. Make recommendations for new devices
      - c. Review data to evaluate effectiveness of safety devices in use
    2. Evaluation of safe medical device(s) process will include:
      - a. The solicitation of non-managerial staff by direct handling of the device and submission of a written evaluation during new product evaluations
      - b. Feedback will be encouraged from all staff on current device use and recommendations for new products
      - c. Print and complete Safety Medical Device Survey Form at <http://www.upstate.edu/ehs/intra/biosafety.php> (listed under Risk Assessment Tools). Return forms to your Infection Control Department:
        - i. Downtown: Jacobson Hall, Rm. 506
        - ii. Community Campus: Rm. 400

## **VII. BLOOD-BORNE DISEASES**

- a. Diseases carried in blood and body fluids
- b. Types:
  - i. Hepatitis B – vaccine available – free to health care workers
  - ii. Hepatitis C – no vaccine available
  - iii. HIV – no vaccine available
- c. You can get a Blood-Borne Disease by:
  - i. Sexual contact
  - ii. Women to infant during birth process and breast feeding
  - iii. Sharing needles among IV drug users
  - iv. Transfusions of infected blood products
  - v. Needle sticks with infected blood

- vi. Infected blood contact to mucus membranes or non-intact skin

*Staff with occupational exposure to blood and body fluids should be vaccinated for Hepatitis B. Available free-of-charge in the Employee Health Office.*

## **VIII. EXPOSURE TO BLOOD/BODY FLUIDS**

- a. Intact skin – (no breaks in skin)
  - i. Wash area with soap and water
  - ii. This is not a blood/body fluid exposure
- b. Non-intact skin – (breaks in skin)
  - i. Wash area with soap and water and report injury
- c. Needle Sticks and other sharps injuries
  - i. Wash area with soap and water and report injury
- d. Splashes to mucus membranes of eyes, nose, or mouth
  - i. Flush/rinse area with water and report injury
  - ii. Large volume splash – report to Emergency Department for eye irrigation

## **IX. REPORTING BLOOD/BODY FLUID EXPOSURES**

- a. Monday through Friday, 7:30AM to 4PM contact your Employee/Student Health Office - Downtown: 315-464-4260; Community Campus: 315-492-5624
- b. All other times, weekends and holidays - report to your Emergency Department for evaluation and care.
- c. Refer to Management of Employee Exposure to Communicable Diseases-Policy IC E-01, <https://upstate.ellucid.com/documents/view/284>

## **X. REPORTING COMMUNICABLE DISEASE EXPOSURES**

- a. Report the exposure (e.g. chickenpox, measles, scabies, tuberculosis, influenza, pertussis, gastrointestinal illness) to:
  - i. Monday through Friday, 7:30AM to 4PM contact your Employee Health Office – Downtown: 315-464-4260; Community Campus: 315-492-5624
  - ii. All other times, weekends and holidays contact the Administrative Supervisor –via the hospital operator or use Vocera: Downtown: call Vocera @ 315-464-1400; Community Campus: call Vocera @ 315-464-4200
  - iii. Refer to Management of Employee Exposure to Communicable Diseases-Policy IC E-01, <https://upstate.ellucid.com/documents/view/284>

## **XI. BIOHAZARD SYMBOLS**

- a. This symbol tells staff that something has blood/body fluid on it that could be harmful to them – contaminated
- b. The color RED is another signal for contamination with blood/body fluids (e.g. instrument bin.)



## XII. STANDARD PRECAUTIONS

- a. Infection prevention practices are used to protect both the healthcare worker and the patient
- b. Applies to all patients for handling blood & body fluids, excretions and secretions
- c. Include the use of hand hygiene and personal protective equipment (PPE)
- d. Basic Barrier Precautions includes:
  - i. Gloves
  - ii. Gowns
  - iii. Masks/attached visor
  - iv. Protective eyewear
- e. Use a resuscitation mask/ambu bag if your patient can't breathe
- f. Sharps and needles are placed in special containers; staff using sharps should:
  - i. Eliminate or reduce the use of needles and other sharps (e.g. needleless IV connectors)
  - ii. Use safety devices whenever possible (safety butterflies, safety IV catheters, safety lancets, etc.)
  - iii. Use transfer devices for filling blood tubes directly
  - iv. Plan for sharps disposal before starting a procedure
  - v. Never use bed/stretcher as a work surface /potential for loose needles in linen places workers at risk
  - vi. **NEVER** recap used needles
- g. Soiled or dirty linen is placed in a plastic bag for transport to laundry
- h. Body waste is discarded into hopper or toilet: if chance of splashing, wear eye protection/masks.
- i. If soiled with blood/body fluids, reusable equipment is surface wiped down with hospital-approved germicide wipes and then placed in dirty utility/soiled staging area for pick-up.
- j. Spills: wipe up gross material with paper towels, and then clean area with a hospital-approved germicide. Clean spills immediately.
  - i. Wear gloves
  - ii. Watch for sharps
  - iii. Large spill clean-up:
    - 1. Flood large spills with germicide before wiping up
    - 2. Vocera "housekeeping supervisor": Downtown 315-464-1400 or Community Campus- 315-464-4200
- k. Empty trash carefully, holding it away from your body, never push trash down with your hand or foot

## XIII. EQUIPMENT CLEANING

- a. Refer to Policy CM C-22 Patient Care Equipment Cleaning, <https://upstate.ellucid.com/documents/view/3669>
  - i. follow manufacturer's recommendation for product use on label



- ii. Cleaning is a two-step process, the first is to clean visibly dirty surfaces and the second is to disinfect the surface. Disinfectant wipes must remain visibly wet for correct contact time to achieve disinfection. The use of multiple wipes may be required to keep the surface wet.
- iii. Contact time for hospital approved disinfectant wipes:
  - 1. Cavi-wipes and Bleach wipes must remain visibly wet for 3 minutes to achieve disinfection
  - 2. PDI wipes must remain visibly wet for 2 minutes to achieve disinfection
  - 3. Staff are responsible to know contact time for the product in use

#### **XIV. TRANSMISSION-BASED PRECAUTIONS (USED IN ADDITION TO STANDARD PRECAUTIONS)**

- a. Airborne Precautions (green sign)
  - i. Required for small particle sized bacteria and some viral illnesses that remain in the air
  - ii. Policy Requires:
    - 1. Negative pressure room (special ventilation) – door closed
    - 2. N-95 particulate respirator mask must be used by healthcare worker entering room. Staff must be fit-tested to wear this mask.
    - 3. Remove mask after leaving room and perform hand hygiene
- b. Droplet Precautions (orange sign)
  - i. Required for germs that travel short distances in large droplets to make contact with mucus membranes of eyes, nose or mouth
  - ii. Policy Requires:
    - 1. Private Room
    - 2. Ear-loop surgical mask for everyone entering room
    - 3. Remove mask and perform hand hygiene when leaving room
- c. Contact Precautions (blue sign)
  - i. Required for touching patient and patient environment
  - ii. Policy Requires:
    - 1. Wear gloves and gown when entering room
    - 2. Patient care equipment is kept in room and not shared
    - 3. Remove gloves, gown, and perform hand hygiene when leaving room
- d. Contact Precautions PLUS (yellow sign)
  - i. Required for touching patient and patient environment for patients with Clostridium difficile (C-diff) diarrhea
  - ii. Policy Requires:
    - 1. Do not use waterless products for hand hygiene
    - 2. Antimicrobial soap and water hand wash for all patient care
    - 3. Enhanced cleaning procedure using dilute bleach solution and use of ultraviolet light technology

4. Substitute bleach-based germicidal wipes in patient room for routine cleaning
  5. Wear gloves and gown when entering room
  6. Patient care equipment is kept in room and not shared
  7. Remove gloves, gown and wash hands before leaving room
  8. Call Environmental Services (ES) to disinfect and clean any floor contamination
- e. Modified Pulmonary Contact Precautions (white sign)
- i. New sign used for Cystic Fibrosis patients
    1. View sign at : <https://upstate.ellucid.com/documents/view/9269>
    2. Refer to Policy POP-B-08: Infection Control Policy for Patients with Cystic Fibrosis Upstate Medical University Cystic Fibrosis Center
  - ii. Policy requires:
    1. Healthcare workers wear gown, gloves for every patient encounter
    2. Healthcare workers do not need to wear a mask
    3. Patient wears a mask outside exam room or inpatient room
    4. Spatial separation of 6 feet maintained from other patients on Modified Pulmonary Contact Precautions
- f. Special Precautions for Creutzfeldt-Jakob Disease (CJD)
- i. Rapidly progressive neurological disease
  - ii. Prion protein is causative agent
  - iii. Refer to Guidelines for the Care of Patients with Known or Suspected Prion Diseases (Policy CM P-58, <https://upstate.ellucid.com/documents/view/3842>) for:
    1. Notification to Infection Control for suspect or confirmed case
    2. Infective material
    3. Handling of items in contact with infective material/tissues
    4. Labeling for laboratory specimens
    5. Post-mortem care
  - iv. Refer to Guidelines for Care of Patients with Known or Suspected Prion Disease in the OR (PROC CM P-58A, <https://upstate.ellucid.com/documents/view/4208>) for:
    1. Scheduling brain biopsies
    2. Precautions specific to the OR
    3. Room decontamination/cleaning
    4. Potential CJD exposure in the OR

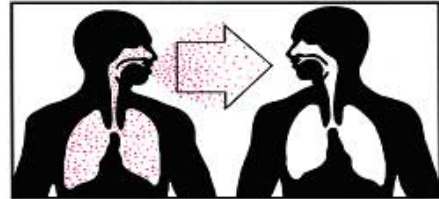
## **XV. CLOSTRIDIUM DIFFICILE (C. diff) DIARRHEA**

- a. Spore-forming, gram positive bacteria
- b. Produces toxin A and toxin B
- c. Spreads by: fecal-oral transmission; from a contaminated environment (surfaces); person-to-person contact; unwashed hands of healthcare personnel

- d. Infected person sheds bacteria to their surrounding environment
- e. Inactive spores can survive on surfaces for long periods of time if not cleaned and disinfected
- f. Associated with antibiotic use and other medications that disrupt normal intestinal flora
- g. Refer to Infection Control Policy:
  - i. IC D-03 Clostridium Difficile Policy/Procedure,  
<https://upstate.ellucid.com/documents/view/277>

## TUBERCULOSIS

- h. Disease spread by inhaling small particle sized bacteria that can remain in the air
- i. Tuberculosis (TB) is an airborne disease
- j. People at Risk for TB:
  - i. Elderly
  - ii. Prison inmates
  - iii. People with a chronic illness – e.g. diabetes
  - iv. People whose immune systems are lowered by certain medications/chemotherapy or diseases like HIV/AIDS
  - v. Alcoholics, people with poor nutrition, IV drug users
  - vi. People from countries with a high rate of TB
  - vii. Homeless
- k. TB Control Measures
  - i. Rapid identification, diagnosis, and treatment of those likely to have TB
  - ii. Medical clearance and mask fit testing required via Employee Health Office
  - iii. Educating, training, and counseling health care workers (HCW) about TB
  - iv. Yearly TB testing of HCW



# INSTITUTIONAL COMPLIANCE & ETHICS

## ***“What you need to know”***

- ✓ The definition of compliance
- ✓ When compliance is your responsibility
- ✓ Where to get additional information about compliance
- ✓ How to contact the Compliance Office

### **I. WHAT COMPLIANCE IS**

- a. Compliance means “doing the right thing,” both legally and ethically, by following all local, State and Federal laws, regulations, policies, contracts and professional standards that govern our daily business activities.
- b. The Institutional Compliance program is intended to promote adherence to applicable rules and regulations and prevention of fraud, waste and abuse through education, monitoring, and corrective action that supports the mission, philosophy, and values of Upstate Medical University.
- c. Basically: No Lying, No Cheating, No Stealing

### **II. WHEN COMPLIANCE IS YOUR RESPONSIBILITY**

- a. Always! In order to maintain the status of the institution as a reliable, honest, trustworthy health care provider, all persons associated with Upstate Medical University have an obligation to report, without fear of retaliation, known or suspected:
  - i. Fraud
  - ii. Abuse
  - iii. Waste
  - iv. Improper, illegal, or unethical activities

### **III. WHY WE HAVE A CODE OF CONDUCT**

- a. The Code of Conduct outlines measures whereby persons associated with Upstate Medical University are obligated to conduct themselves at the highest level of professional and ethical standards.
- b. Code of Conduct: <https://upstate.ellucid.com/documents/view/411/13139>
- c. Code of Ethics: <https://upstate.ellucid.com/documents/view/1227>

### **IV. WHERE YOU CAN OBTAIN MORE INFORMATION ABOUT COMPLIANCE**

- a. Go to: <http://www.upstate.edu/compliance/>, information available includes:
  - i. Compliance Plan
  - ii. Code of Conduct
  - iii. Contact Information
  - iv. Whistleblower Protection
  - v. Reference Materials
  - vi. Training Materials
  - vii. Healthcare Fraud & Abuse
  - viii. Conflicts of Interest

### **V. HOW YOU CONTACT THE COMPLIANCE & ETHICS OFFICE**

- a. You can use any one of the following methods:
  - i. Anonymous Hotline: 464-6444; Fax: 464-4342
  - ii. Compliance Office: 464-6600
  - iii. E-Mail: [harrislo@upstate.edu](mailto:harrislo@upstate.edu)
  - iv. Chief Ethics & Compliance Officer, 750 E. Adams St., CAB Rm. 330, Syracuse, NY 13210

# INTERPRETER SERVICES: NON-ENGLISH SPEAKING OR DEAF PATIENTS/FAMILIES

## *“What you need to know”*

- ✓ What interpreter services are available and how to access.

### **I. INTERPRETER SERVICES:**

- Upon entry into the system, the patient will be assessed for the ability to speak and understand English, and their literacy level for reading printed materials. Use interpreter services phones, video remote interpreting (VRI), or in person interpreters when needed, there are translated materials available on the Upstate Patient Education Website.
- Interpreting is a service paid for by the hospital and is free to patients, and anyone who accompanies them. It is the mutual decision of the healthcare professionals and the patient to decide type of services needed (phone, video, live). Consider the use of Video Remote Interpreter when possible if the patient can hear and speak.
- Please do not require, suggest, or encourage the use of staff, friends, minor children, or family members to act as an interpreter. It is against the Americans with Disabilities Act (ADA) and Section 1557 of the Affordable Care Act. If the situation is life threatening, then with agreement from all parties, another individual can interpreter until a qualified interpreter becomes available. This must be documented in the patient’s records as well.
- The patients do have the right to refuse hospital interpreter services and this must be documented in the medical record. Patients also have the right to request and use a family member (If they refuse hospital interpreter services). This must also be documented in the medical record.
- Documentation must be done for each patient interaction, whether done through phone, live, or Video Remote Interpreter (VRI) regardless of language or completed via sign language interpreter. Documentation should include: Patient Name, MR #, Interpreter Agency, Interpreter Name, Time started (Hour: Minutes), Time ended (Hour: Minutes). If start time and end time are not know, simply document the Interpreter was at bedside during encounter.

## **II. PHONE VENDORS ARE AVAILABLE 24/7 FOR LANGUAGE INTERPRETATION:**

- a. Phones give immediate access to a language interpreter. They can be used for medical professional and patient/family interactions, reminder phone calls, follow-up calls and conference calls, and to identify a patient's primary language. Phone vendor information is available on the Interpreter Services website at <http://www.upstate.edu/interpreter/intra/pdf/contact-numbers-information-Phones-Video-and-In-person-Interpreters.pdf>

## **III. IN-PERSON LANGUAGE AND SIGN LANGUAGE INTERPRETERS ARE AVAILABLE BY REQUEST FOR PATIENTS WHO ARE DEAF OR HARD-OF-HEARING, OR IF IT IS MEDICALLY NECESSARY (SUCH AS MRI, OR TO PROVIDE BETTER PATIENT CARE):**

- a. Call the Interpreter Hotline @ (315) 464-1454 to set up an appointments if there is less than 48 hours advance notice or after 2:30pm, also, this information must be entered into the Self-Serve/Application/ Interpreter/New Request. We ask that all in person interpreter requests, interpreter complaints, or issues of any kind are also entered into the Self Serve /Application /Interpreter system.

## **IV. VIDEO REMOTE INTERPRETING FOR LANGUAGE AND AMERICAN SIGN**

- a. Call or email Sue Freeman at [freemasu@upstate.edu](mailto:freemasu@upstate.edu) or call the Interpreter Line @ (315) 464-1454 for questions about VRI. Eighty (80) Video Remote Interpreter (interpreters on wheels – IOW's) devices are available in and around the hospital. Currently the IOW's are located in the Emergency Depts. Downtown (Adult and Peds) and the Community Campus Emergency Dept and 550 Harrison (all clinics), UHCC – all clinics. One page directions are on the devices (Language Line IPAD on wheels).

## **V. ADDITIONAL INFORMATION:**

- a. Website: <http://www.upstate.edu/interpreter/intra/>
- b. Questions/Concerns: Contact Sue Freeman, 315- 464-6175 or [freemasu@upstate.edu](mailto:freemasu@upstate.edu)

*Policy I-07, Interpreter Services for Patients with Limited English Proficiency (LEP) or Hearing/Visual or Speech Impairments:* <https://upstate.ellucid.com/documents/view/1255>

# LATEX SENSITIVITY/ALLERGY

## ***“What you need to know”***

- ✓ What is a latex allergy
- ✓ What are the signs and symptoms
- ✓ Who is at risk

### **I. WHAT IS LATEX ALLERGY**

- a. A reaction resulting from contact with the latex containing products. This allergic response occurs after developing sensitivity to the natural rubber protein in latex.

### **II. METHODS OF EXPOSURE**

- a. Direct contact with skin or mucous membranes
- b. Breathing or coming in contact with airborne particles

### **III. REACTIONS:**

#### **a. Contact with skin:**

- i. Rash (non-itch)
- ii. Dermatitis
- iii. Urticaria (itch)
- iv. Flushing (red skin)

#### **b. Airborne:**

- i. Bronchospasm (difficulty breathing)
- ii. Nasal itching
- iii. Conjunctivitis (tearing/eye irritation)
- iv. Sneezing
- v. Asthma/Wheezing
- vi. Dyspnea (shortness of breath)

#### **c. Systemic:**

- i. Hypotension (low blood pressure)
- ii. Tachycardia (racing heart)
- iii. Nausea/vomiting/diarrhea-abdominal cramping
- iv. Anaphylactic shock

### **IV. PATIENTS AND EMPLOYEES AT RISK:**

- a. People with frequent exposure, patients and Health Care Workers
- b. Patients who have had multiple hospitalizations and or surgeries
- c. Individuals with a history of allergic reactions particularly severe reactions
- d. Individuals with food allergies, specifically kiwi, banana, avocado, or chestnuts
- e. Individuals with a history of positive latex testing

## **V. PROCEDURES AND RESPONSIBILITIES:**

### **a. Patient Care:**

- i. Initial patient assessment must include an inquiry about latex allergy.
- ii. Central Stores maintain latex free gloves for latex sensitive patients and staff. If a question remains about a product's safety, Central Stores will research the product content through the manufacturer.
- iii. Central Distribution provides latex free gloves and equipment for latex sensitive patients and staff and will research product safety profile upon request.
- iv. Operating Room area has BioGel Eclipse "Latex" gloves available.

### **b. Employee Care:**

- i. Pre-employment assessment includes latex allergy evaluation. Guidelines and education are provided if a latex allergy is identified.
- ii. Employees need to notify their supervisor of a latex allergy.
- iii. If an employee develops symptoms of allergy and latex reaction is suspected, the employee should report to Employee Health
- iv. If an employee develops severe symptoms or breathing problems and latex allergy reaction is suspected, the employee should report to the Emergency Department for immediate care.
- v. If symptoms of allergic response persist, testing may be indicated by a primary care provider, dermatologist, or allergist.
- vi. After diagnosis, the employee should avoid all latex/rubber products.
- vii. For general patient care, latex free nitrile gloves are supplied from Central Stores and Central Distribution.



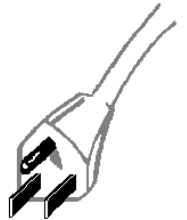
# MEDICAL EQUIPMENT

## ***“What you need to know”***

- ✓ How to get immediate assistance with equipment that is broken and/or possibly dangerous
- ✓ How to use medical equipment in your area safely

### **I. ELECTRICAL EQUIPMENT RESTRICTIONS**

- a. Electrical equipment that comes in direct contact with patients or is used in a patient environment must have a GROUNDED (***three-wire*** cord AND ***three-prong plug***) or be UL approved double insulated.
- b. The following items are NOT allowed in the vicinity of patients:
  - i. Three-to-Two prong adaptors (“Cheater” plugs).
  - ii. Extension cords that do not have hospital grade plugs and receptacles.
  - iii. Power strips that do not have hospital grade plugs, receptacles and inline fuse



### **II. THE CLINICAL ENGINEERING DEPARTMENT PROVIDES THE FOLLOWING SERVICES RELATED TO CLINICAL EQUIPMENT**

- a. Safety inspection and performance verification of electrical/electronic medical equipment.
- b. Safety inspection and performance verification of electrical/electronic rental, loaner, and patient provided medical equipment. (Respiratory Therapy inspects CPAP devices.)
- c. Maintenance of hospital owned electrical/electronic medical equipment.
- d. Oversight of vendor services related to maintenance and inspection of electrical/electronic medical equipment.
- e. Medical equipment ordered by physicians must be inspected by Clinical Engineering

### **III. DANGEROUS, MALFUNCTIONING OR BROKEN (POTENTIALLY DEFECTIVE) MEDICAL EQUIPMENT**

- a. Report failures to the Clinical Engineering Department
  - i. At the Downtown Campus
    1. Call Clinical Engineering at x4-6067 immediately for ALL cases
  - ii. At the Community Campus:
    1. Submit an online Service Request from the Community Campus Home Page.
    2. Call 5067 or have Operator radio page On Call Tech. for emergency service

- a. Clinical Engineering Off-Hours-support is available on an on-call basis for emergencies with patient care equipment
  - b. Physical Plant is available 24-hours/day for facility/utility problems that are or might be impacting medical equipment performance
- b. Potentially defective equipment must be removed from patient vicinity immediately unless it is life sustaining and capable of continuing to function and NO alternative is available
- c. Potentially defective equipment should be labeled with a Red “DO NOT USE” Tag with the following information:
  - i. Name of reporting person
  - ii. Date
  - iii. Time
  - iv. Location where problem occurred
  - v. Description of problem (Please be descriptive don’t just say Broken)
- d. Technical groups, including Clinical Engineering, Operating Room, Medical Imaging, and Pharmacy, are responsible for procuring back up equipment, as required, by obtaining loaner equipment from suppliers or other hospitals.
- e. Purchase of new or replacement equipment will be through the Purchasing Department following established procedures.

#### **IV. ROUTINE MEDICAL EQUIPMENT PROCEDURES AND CHECK**

- a. Each Department is responsible for their unit-owned equipment
- b. Departments needing interim replacement equipment will be responsible to identify spare equipment from other Departments.
- c. Pre-use and daily checks of all equipment should occur according to unit policies (example: daily defibrillator checks)
- d. Spare accessories should be available and located in a common area for staff

#### **V. BATTERY-POWERED EQUIPMENT**

- a. Keep plugged in when NOT in use, if device has rechargeable batteries
- b. Make sure battery is charging DAILY (example: defibrillator, transport monitors, vital sign monitors)
- c. Battery rotation system and documentation is the responsibility of the user department

#### **VI. INSPECT ALL EQUIPMENT FOR:**

- a. Broken or damaged plugs (bent pins, cracked plug, burn marks, melting, etc)
- b. Frayed line cords, exposed wires
- c. Abnormal operation including failure of any indicator lights or other alarm
- d. Obvious physical damage (cracks, dents, missing pieces/knobs)

- e. Overheating/sparks
- f. Burning odor

## **VII. EQUIPMENT CRITICAL TO PATIENT AND/OR SAFETY**

- a. The Clinical Department identifies equipment that is necessary for patient life and/or safety, along with sources of back up equipment and alternate treatment procedures, to be used if that equipment is unavailable for use.

## **VIII. EQUIPMENT-RELATED INCIDENTS**

- a. Attempt to identify if equipment has malfunctioned or if user error was involved
- b. Equipment and ALL accessories involved in incidents are to be removed from the patient vicinity and preserved with all settings, connections, and supplies intact
- c. When an Incident or Medication error occurs, an Occurrence Report must be initiated that includes unique equipment identification (Control or Serial Number) and an equipment repair work order should be initiated as soon as possible following the event.

## **IX. NON-HOSPITAL OWNED EQUIPMENT**

- a. Equipment used in patient care or in the patient vicinity, whether leased, rented, borrowed or on loan as a demo, is subject to the same controls, testing, and management as described above and in Hospital Administration and Clinical Policies

# MISSING OF AN INFANT/CHILD OR PATIENT

## *“What you need to know”*

- ✓ Staff actions in the event of a missing child
- ✓ What the page “Code Amber” means
- ✓ What the page “Code Grey” means

## **I. SITE OF MISSING OR ABDUCTED CHILD (UNDER AGE 19) REF. POLICY M-03, <https://upstate.ellucid.com/documents/view/1268>**

- a. If an infant or child is discovered to be missing or abducted from a patient care unit, treatment, or visitor area, staff will perform the following actions:
  - i. Staff call University Police (at UUH X44000 at UUH-Community x5511) to report **‘CODE AMBER’**
    - 1. Report last known location of child
    - 2. A description of child (age, sex and race)
    - 3. Person last seen with child
    - 4. Direction of travel
    - 5. Any order of protection
    - 6. Any important medical information
  - ii. Staff then call Operator
    - 1. Give operator location from which abduction occurred
    - 2. Give operator age, sex and race of child
    - 3. Operator will overhead page **‘CODE AMBER’** and include descriptive information
  - iii. Remain at incident scene until released by responding Police or Administrative Supervisor
  - iv. Ensure that scene of incident remains untouched
  - v. Make sure a staff member stays with the family of the abducted/missing person
  - vi. Close all doors
  - vii. Encourage patients and visitors to return or remain in respective rooms.
  - viii. Check all patients ID bracelets and visitor badges

## **II. ALL HOSPITAL STAFF – UPON HEARING ‘CODE AMBER’ OVERHEAD PAGE**

- i. Monitor hallways and stairway exits in the immediate area of your location
- ii. Standby exit doors leading out of the facility, or any public area such as the hospital lobby or cafeteria
- iii. Look for anything suspicious or out of the ordinary such as an individual carrying a large parcel or forcibly struggling with a child

- iv. Call University Police (at UUH X44000 at UUH-Community x5511)
- v. Provide a description of the suspicious individual to include race, approximate age, clothing description, vehicle description, and plate number if applicable. DO NOT intervene or prompt a physical confrontation.
- vi. Further direction will be provided for all staff. When the situation is resolved, a **'CODE AMBER ALL CLEAR'** will be announced. The NY ALERT system may be utilized during a Code Amber event to provide campus wide awareness and direction.
- vii. Incident Command may be activated in situations where child is not located.

### **III. SITE OF MISSING ADULT PATIENT (AGE 19 OR OLDER) REF. POLICY M-03, <https://upstate.ellucid.com/documents/view/1268>**

- a. All patients will have a safety assessment in accordance with policy CM D-03, <https://upstate.ellucid.com/documents/view/3689>
- b. If a patient is assessed to be “High Risk” and is missing
  - i. Staff call University Police (at UUH X44000 at UUH-Community x5511) to report
  - ii. Search surrounding area
  - iii. Report **'CODE GREY'**
    - 1. Report last known location of patient
    - 2. A description of patient (age, sex and race)
    - 3. Direction of travel
    - 4. Any order of protection
    - 5. Any important medical information
  - iv. Staff then call Operator
    - 1. Give operator location from which incident occurred
    - 2. Give operator age, sex and race of patient
    - 3. Operator will overhead page **'CODE GREY'** and include descriptive information
  - v. Remain at incident scene until released by responding Police or Administrative Supervisor
  - vi. Ensure that scene of incident remains untouched
  - vii. Make sure a staff member stays with the family of the missing person

### **IV. ALL HOSPITAL STAFF – UPON HEARING **'CODE GREY'** OVERHEAD PAGE**

- a. Remain alert in your area of concern to missing patient event and description
- b. If patient is seen, contact UPD (at UUH X44000 at UUH-Community x5511) to provide location/direction of travel.

# PATIENT ABUSE

## ***“What you need to know”***

- ✓ What to do if you suspect family violence
- ✓ The seven elements of abuse prevention for employees having interactions with patients on the Transitional Care Unit (TCU)

### **I. ABUSE, MALTREATMENT, AND NEGLECT CAN INCLUDE:**

- a. Physical Injuries
- b. Psychological Harm
- c. Sexual Abuse
- d. Starvation
- e. Lack of Supervision

### **II. TYPES OF ABUSE, MALTREATMENT, AND NEGLECT**

- a. Domestic Violence and/or Family Violence
- b. Child Abuse
- c. Elder Abuse
- d. Partner Abuse
- e. Human Trafficking

### **III. HOSPITAL PERSONNEL ARE REQUIRED:**

- a. **If necessary – notify downtown University Police Department at x4-4000 and Community Campus University Police Department at 5511**
- b. **If patient is under age 18, refer to policy C-06, Management of Child Abuse and Maltreated Children - <https://upstate.ellucid.com/documents/view/1188>**
  - i. Keep patient safe
  - ii. All suspected child abuse MUST be, by law, reported to Child Protective Services by mandated reporters that have knowledge of or suspect abuse.
  - iii. Social Work Department makes the Hotline call and completes documentation; other staff involved must be readily available to provide information directly to C.P.S. if requested.
- c. **If patient is age 18 or older, refer to policy V-11 - Victims of Violence, Abuse, or Neglect, <https://upstate.ellucid.com/documents/view/1357>**
  - i. Keep patient safe
  - ii. Notify attending physician of concerns
  - iii. Make a referral to the Social Worker assigned to that service

### **IV. ORDERS OF PROTECTION, TRESPASSING, AND LETTERS OF PERSONA NON GRATA (AN UNACCEPTABLE OR UNWELCOME PERSON)**

- a. Monitored by University Police Department
- b. If patient is **under the age of 19** – obtain status of custody and access to the patient
- c. Place a copy of the order-of-protection in medical record

## **V. ELDER ABUSE: SEVEN ELEMENTS OF ABUSE PREVENTION**

### **a. Employee Screening:**

- i. Employees working in the Transitional Care Unit (TCU) will be screened for a history of abuse, neglect, or mistreatment of residents through a review of application documents and criminal background investigation before being appointed to the TCU

### **b. Training Employees About:**

- i. Dealing with difficult resident behaviors
- ii. Reporting their knowledge of allegations of abuse
- iii. Recognizing signs of burnout, frustration, and stress that may lead to abuse
- iv. What constitutes abuse, neglect, and misappropriation of resident property

### **c. Prevention Programs:**

- i. Encourage residents, families, and staff to report their concerns, incidents and grievances
- ii. Provide feedback regarding the concerns that have been expressed
- iii. Identify, correct, and intervene in situations in which abuse, neglect, and misappropriation of resident property are more likely to occur
- iv. Local programs include:
  1. Onondaga County Adult Protective Services 315-435-2815
  2. Vera House 24-hour Crisis & Support Line 315-468-3260
  3. Onondaga County Department of Aging & Youth 315-435-2362

### **d. Identification of any situation, occurrence, pattern, or trend that may constitute abuse to determine the direction of the investigation, such as:**

- i. Unexplained injuries, bruises, burns
- ii. Excessive fear, agitation, anxiety, helplessness or depression
- iii. Sudden inability to pay bills, buy food or personal items
- iv. Isolation and withdrawal from people and activities
- v. Changes in appetite; unusual weight gain or loss
- vi. Poor personal hygiene
- vii. Unaware of personal finances
- viii. Changes in behavior around family member/caregiver
- ix. Unexpected changes in health
- x. Frequent use of emergency services
- xi. Suicidal ideation, attempts
- xii. Is mentally competent but is excluded from decisions regarding their own health, welfare, lifestyle, or finances
- xiii. Does not receive own mail; it is sent elsewhere
- xiv. Usually happens by people we the elderly love, trust and rely on (adult children, spouse/partner, grandchildren, family members, friends, neighbors)
- xv. Physical abuse – inflict physical pain or injury; taking away basic needs
- xvi. Emotional abuse – causing mental pain through verbal or nonverbal acts
- xvii. Sexual abuse – sexual contact of any kind without consent
- xviii. Unfair Treatment – illegally taking money or property without approval
- xix. Neglect – failure by those responsible to provide a safe environment including food, shelter, healthcare, emotional needs and protection

- xx. Abandoning an elder – by anyone who has assumed the responsibility of their care or custody
- e. **Aggressive Investigation of different types of incidents and reporting of the result to the proper authorities.**
  - i. If suspicion of elderly abuse:
    - 1. Staff will immediately ensure the safety and protection of the elderly patient at the point they become aware of any concerns.
    - 2. Once the staff determines the patient is safe, the staff will contact the unit Medical Director, Administrator, Nursing Director/Manager, Administrative Supervisor or University Police @ 315-464-4000 or Community Campus 315-492-5511
- f. **Protection of residents from harm during an incident.**
  - i. Do not harm
  - ii. Treat elders with honesty, compassion and respect
  - iii. Interest of the elder is the priority
  - iv. Respect diversity
  - v. Involve the senior in their plan of care
  - vi. Use family and informal support
  - vii. In the absence of known wishes, act in the best interest of the elder
  - viii. Recognize the elders right to make their own decisions
  - ix. Understand your duty is to protect the safety of the vulnerable elderly
- g. **Reporting of substantiated incidents to the appropriate local/state/federal agencies and taking all necessary corrective actions depending on the result of the investigation**
  - i. Report to the State nurse aide registry or licensing authorities any knowledge it has of any actions by a court of law which would indicate an employee is unfit for service
  - ii. Analyze the occurrences to determine what changes are needed, if any, to policies and procedures to prevent further occurrences
  - iii. If any incident, or suspicion of incident occurs, immediately contact the unit Medical Director, Administrator, Nursing Director/Manager, Administrative Supervisor or University Police @ 315-464-4000 or Community Campus 315-492-5511
  - iv. Risk Management maintains documentation of events
  - v. If the elder abuse happens on a Psych Unit, staff is required to contact the Justice Center for the Protection of People with Special Needs Vulnerable Persons Central Register (VPCR) Hotline at 1-855-373-2122.
  - vi. Reports involving Nursing Homes will be made to the DOH Nursing Home Hotline at 1-888-201-4563. The Hotline is staffed from 8:30 a.m. through 5:00 p.m. weekdays and on-call personnel are available 7 days a week during non-office hours. Refer to policy C-10 - Suspicion of Criminal Activity- Suspected Patient Abuse or Neglect-Medication Diversion ~ Involving a Staff Member, <https://upstate.ellucid.com/documents/view/1191>

**Reference Policy TCU E-01 Elder Abuse – Transitional Care Unit (TCU) for further details**  
<https://upstate.ellucid.com/documents/view/2801>



# PATIENT IDENTIFY THEFT PREVENTION

(Policy Number: I-20, <https://upstate.ellucid.com/documents/view/1259>)

## “What you need to know”

- ✓ The identification requirements for patient registration
- ✓ Warning signs or “red flags” to watch for
- ✓ What to do if you believe a “red flag” has occurred or may be occurring

### 1. DEFINITIONS:

- a. **Medical Identity Theft:** When someone uses your personal information to collect money, prescription drugs, goods, or health services.
- b. **Red Flags:** Warning flags, patterns, practices, or specific activities that could indicate medical identity theft.

### 2. PATIENT REGISTRATION:

- a. If the patient has not been to the facility before, patient registration will request two forms of identification with matching information to verify the patient’s identity.
- b. For any outpatient visits, patient registration will request two forms of identification with matching information to verify the patient’s identity.
- c. A patient account will be verified upon registration to uniquely identify the patient and will be used for any subsequent visits.

### 3. THE RED FLAGS GENERALLY FALL WITHIN ONE OF THE FOLLOWING FOUR CATEGORIES:

- a. **Suspicious Documents:** Documents provided for identification appear to have been altered or forged;
- b. **Suspicious Personal Identifying Information:** Information provided by the patient is not consistent with other personal identifying information maintained by the hospital.
  - i. **Example:** there is a lack of correlation between the Patient Name, Insurance Identification, Social Security Number (SSN), and/or Date of Birth;
- c. **Suspicious or Unusual Use Information:** Records showing medical treatment that is inconsistent with a physical examination or with a medical history as reported by the patient
  - i. **Example:** inconsistent blood type; and
- d. **Alerts from Others:** Complaint/inquiry from an individual (e.g. patient, identity theft victim, or law enforcement) based on receipt of:
  - i. A bill for another individual
  - ii. A bill for a product or service that the patient denies receiving
  - iii. A bill from a health care provider that the patient never patronized
  - iv. A notice of insurance benefits (or Explanation of Benefits ) for health services never received

### 4. REPORTING:

- a. If there are any inconsistencies noticed with patient information or documents provided appear to be forged or altered, staff must immediately contact the Department Manager or designee to perform an investigation.

# PATIENTS' BILL OF RIGHTS IN A HOSPITAL

## **As a patient in a hospital in New York State, you have the right, consistent with law, to:**

- (1) Understand and use these rights. If for any reason you do not understand or you need help, the hospital **MUST** provide assistance, including an interpreter.
- (2) Receive treatment without discrimination as to race, color, religion, sex, gender identity, national origin, disability, sexual orientation, age 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 in the hospital.
- (6) Know the names, positions and functions of any hospital staff involved in your care and refuse their treatment, examination or observation.
- (7) Identify a caregiver who will be included in your discharge planning and sharing of post-discharge care information or instruction.
- (8) Receive complete information about your diagnosis, treatment and prognosis.
- (9) Receive all the information that you need to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.
- (10) Receive all the information you need to give informed consent for an order not to resuscitate. You also have the right to designate an individual to give this consent for you if you are too ill to do so. If you would like additional information, please ask for a copy of the pamphlet "Deciding About Health Care — A Guide for Patients and Families."
- (11) Refuse treatment and be told what effect this may have on your health.
- (12) Refuse to take part in research. In deciding whether or not to participate, you have the right to a full explanation.
- (13) Privacy while in the hospital and confidentiality of all information and records regarding your care.
- (14) 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) Review your medical record without charge and, obtain a copy of your medical record for which the hospital can charge a reasonable fee. You cannot be denied a copy solely because you cannot afford to pay.
- (16) Receive an itemized bill and explanation of all charges.
- (17) View a list of the hospital's standard charges for items and services and the health plans the hospital participates with.
- (18) Challenge an unexpected bill through the Independent Dispute Resolution process.
- (19) Complain without fear of reprisals about the care and services you are receiving and to have the hospital respond to you and if you request it, a written response. If you are not satisfied with the hospital's response, you can complain to the New York State Health Department. The hospital must provide you with the State Health Department telephone number.
- (20) Authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors.
- (21) Make known your wishes in regard to anatomical gifts. Persons sixteen years of age or older may document their consent to donate their organs, eyes and/or tissues, upon their death, by enrolling in the NYS Donate Life Registry or by documenting their authorization for organ and/or tissue donation in writing in a number of ways (such as a health care proxy, will, donor card, or other signed paper). The health care proxy is available from the hospital.

Public Health Law(PHL)2803 (1)(g)Patient's Rights, 10NYCRR, 405.7,405.7(a)(1),405.7(c)

# PARENTS' BILL OF RIGHTS

**As a parent, legal guardian or person with decision-making authority for a pediatric patient receiving care in this hospital, you have the right, consistent with the law, to the following:**

- 1) To inform the hospital of the name of your child's primary care provider, if known, and have this information documented in your child's medical record.
- 2) To be assured our hospital will only admit pediatric patients to the extent consistent with our hospital's ability to provide qualified staff, space and size appropriate equipment necessary for the unique needs of pediatric patients.
- 3) To allow at least one parent or guardian to remain with your child at all times, to the extent possible given your child's health and safety needs.
- 4) That all test results completed during your child's admission or emergency room visit be reviewed by a physician, physician assistant, or nurse practitioner who is familiar with your child's presenting condition.
- 5) For your child not to be discharged from our hospital or emergency room until any tests that could reasonably be expected to yield critical value results are reviewed by a physician, physician assistant, and/or nurse practitioner and communicated to you or other decision makers, and your child, if appropriate. Critical value results are results that suggest a life-threatening or otherwise significant condition that requires immediate medical attention.
- 6) For your child not to be discharged from our hospital or emergency room until you or your child, if appropriate, receives a written discharge plan, which will also be verbally communicated to you and your child or other medical decision makers. The written discharge plan will specifically identify any critical results of laboratory or other diagnostic tests ordered during your child's stay and will identify any other tests that have not yet been concluded.
- 7) To be provided critical value results and the discharge plan for your child in a manner that reasonably ensures that you, your child (if appropriate), or other medical decision makers understand the health information provided in order to make appropriate health decisions.
- 8) For your child's primary care provider, if known, to be provided all laboratory results of this hospitalization or emergency room visit.
- 9) To request information about the diagnosis or possible diagnoses that were considered during this episode of care and complications that could develop as well as information about any contact that was made with your child's primary care provider.
- 10) To be provided, upon discharge of your child from the hospital or emergency department, with a phone number that you can call for advice in the event that complications or questions arise concerning your child's condition.

Public Health Law (PHL) 2803(i)(g) Patients' Rights 10NYCRR, Section 405.7



# Breastfeeding Mothers' Bill of Rights

Choosing how to feed her new baby is one of the important decisions a mother can make in preparing for her infant's arrival. Doctors agree that for most women, breastfeeding is the safest and healthiest choice. It is your right to be informed about the benefits of breastfeeding, and to have your health care provider, maternal health care facility, and child day care facility encourage and support breastfeeding. You have the right to make your own choice about breastfeeding. Whether you choose to breastfeed or not, you have the rights listed below, regardless of your race, creed, national origin, sexual orientation, gender identity or expression, or source of payment for your health care. Maternal health care facilities have a responsibility to ensure that you understand these rights. They must provide this information clearly for you, and must provide an interpreter, if necessary. These rights may be limited only in cases where your health or the health of your baby requires it. If any of the following things are not medically right for you or your baby, you should be fully informed of the facts and be consulted.

## (1) Before You Deliver:

If you attend prenatal childbirth education classes (those provided by the maternal health care facility and by all hospital clinics and diagnostic and treatment centers providing prenatal services in accordance with Article 28 of the Public Health Law), then you must receive the Breastfeeding Mothers' Bill of Rights. Each maternal health care facility shall provide the maternity information leaflet, including the Breastfeeding Mothers' Bill of Rights, to each patient or to the appointed personal representative at the time of prebooking or time of admission to a maternal health care facility.

You have the right to receive complete information about the benefits of breastfeeding for yourself and your baby. This will help you make an informed choice on how to feed your baby.

You have the right to receive information that is free of commercial interests and includes:

- How breastfeeding benefits you and your baby nutritionally, medically and emotionally;
- How to prepare yourself for breastfeeding;
- How to understand some of the problems you may face and how to solve them.

## (2) In The Maternal Health Care Facility:

- You have the right to have your baby stay with you right after birth, whether you deliver vaginally or by cesarean section.
- You have the right to begin breastfeeding within one hour after birth.
- You have the right to get help from someone who is trained in breastfeeding.
- You have the right to have your baby not receive any bottle feeding or pacifiers.
- You have the right to know about and refuse any drugs that may dry up your milk.
- You have the right to have your baby in your room with you 24 hours a day.
- You have the right to breastfeed your baby at any time day or night.



- You have the right to know if your doctor or your baby's pediatrician is advising against breastfeeding before any feeding decisions are made.
- You have the right to have a sign on your baby's crib clearly stating that your baby is breastfeeding and that no bottle feeding of any type is to be offered.
- You have the right to receive full information about how you are doing with breastfeeding, and to get help on how to improve.
- You have the right to breastfeed your baby in the neonatal intensive care unit. If nursing is not possible, every attempt will be made to have your baby receive your pumped or expressed milk.
- If you – or your baby – are re-hospitalized in a maternal health care facility after the initial delivery stay, the hospital will make every effort to continue to support breastfeeding, and to provide hospital-grade electric pumps and rooming-in facilities.
- You have the right to get help from someone specially trained in breastfeeding support, if your baby has special needs.
- You have the right to have a family member or friend receive breastfeeding information from a staff member, if you request it.

### (3) When You Leave The Maternal Health Care Facility:

- You have the right to printed breastfeeding information free of commercial material.
- You have the right, unless specifically requested by you, and available at the facility, to be discharged from the facility without discharge packs containing infant formula, or formula coupons unless ordered by your baby's health care provider.
- You have the right to get information about breastfeeding resources in your community, including information on availability of breastfeeding consultants, support groups, and breast pumps.
- You have the right to have the facility give you information to help you choose a medical provider for your baby, and to help you understand the importance of a follow-up appointment.
- You have the right to receive information about safely collecting and storing your breast milk.
- You have the right to breastfeed your baby in any location, public or private, where you are otherwise authorized to be. Complaints can be directed to the New York State Division of Human Rights.
- You have a right to breastfeed your baby at your place of employment or child day care center in an environment that does not discourage breastfeeding or the provision of breast milk.
- Under section 206-c of the Labor Law, for up to three years following childbirth, you have the right to take reasonable unpaid break time or to use paid break time or meal time each day, so that you can express breast milk at work. Your employer must make reasonable efforts to provide a room or another location, in close proximity to your work area, where you can express breast milk in private. Your employer may not discriminate against you based on your decision to express breast milk at work. Complaints can be directed to the New York State Department of Labor.

These are your rights. If the maternal health care facility does not honor these rights, you can seek help by contacting the New York State Department of Health, or by contacting the hospital complaint hotline at **1-800-804-5447**; or via email at [hospinfo@health.ny.gov](mailto:hospinfo@health.ny.gov).



**Department  
of Health**

# Patient Rights

For all residents of facilities or programs operated or licensed by the New York Office of Mental Health

- New York State Office of Mental Health Psychiatric Centers
- Article 28 General Hospital Psychiatric Units
- Article 31 Private Psychiatric Hospitals
- Residential Treatment Facilities (RTFs) for Children and Youth
- Comprehensive Psychiatric Emergency Programs (CPEPs)

**You have the right to bring any questions and/or complaints to:**

**NYS OMH Customer Relations** (800) 597-8481

**Board of Visitors** (NYS OMH PCs Only)

---

---

---

---

**NYS Justice Center for the Protection of People with Special Needs**

Information/Referral (800) 624-4143

Abuse/Neglect (855) 373-2122

TTY (855) 373-2123

**Disability Rights New York** (800) 993-8982

**Joint Commission** (630) 792-5800

**Mental Hygiene Legal Service**

---

---

---

While you are in this program or hospital, you have rights which may be limited only for clinical reasons.

**These rights include:**

- A safe and sanitary environment.
- A balanced and nutritious diet.
- Appropriate personal clothing.
- Practice the religion of your choice, or no religion.
- Freedom from abuse and mistreatment by employees or other residents.
- Adequate grooming and personal hygiene supplies.
- A reasonable amount of safe storage space for clothing and other personal property.
- A reasonable degree of privacy in sleeping, bathing and toileting areas.
- Receiving visitors at reasonable times, having privacy when visited and communicating freely with people inside or outside the psychiatric center.
- Appropriate medical and dental care.
- An individualized plan for treatment and active participation in developing that plan.



**Office of  
Mental Health**

# PATIENTS IN CUSTODY

(Policy Number: P-11, <https://upstate.ellucid.com/documents/view/1283>)

## **“What you need to know”**

- ✓ Inmates are cared for in multiple settings within University Hospital and ambulatory sites.
- ✓ When working with or around Patients in Custody, is it important to ensure a safe environment.

### **I. CORRECTIONS OFFICER (CO)**

- a. CO may refer to a DOCCS (Department of Corrections and Community Supervision) officer or other external agency, such as Justice Center Officer or County Officer
  - i. If concerns arise with:
    - 1. CO from the Dept. of Corrections, contact the 7U Sargent on Duty at 4-9700 or 6A/7U Nurse Manager at 4-6556
    - 2. Officers from other external agencies, contact UPD at 4-4000

### **II. CORRECTIONS OFFICER RESPONSIBILITIES**

- a. Corrections Officer (CO) must remain in the room with the patient at all times.
- b. CO may be stationed outside room on 7U while the room is locked, but must enter the room and remain at the bedside with staff.
- c. For patients on non-secure units: restrain patients at all times according to agency policy unless there is a medical reason preventing it.
- d. According to agency policy, determine if patient is allowed to make phone calls or have visitors- communicate this policy to bedside nurse.
- e. When transporting to testing areas or other units, secure patient per agency policy.
- f. Officers to inspect all food trays prior to delivery to the patient and upon removal. (Patients should have styrofoam plates and safety utensils only (including digestible utensils per DOCCS/Agency guidelines as needed).
- g. For patients in ambulatory care areas: officers are to remain with patients AT ALL TIMES and patients should be secured with safety restraints. The only exception to this rule is medical contraindications, which must be documented in the medical record by, or on behalf of a physician. Agencies are expected to follow their normal policies and procedures in regards to patient security.

### **III. STAFF RESPONSIBILITIES**

- a. Ensure all patients admitted to floors other than 7U are coded “Patient in Custody” via the visitor restriction option. Nursing should enter this into the EMR as soon as a patient in custody is admitted to the unit. Also add into the comments section, “Contact Hospital Security for any visitation questions.” Hospital Security will check with the custodial agency regarding the visitation.
- b. Keep track of all supplies used in patient care areas.

- c. Supplies and equipment taken INTO room are taken OUT.
- d. DO NOT leave supplies and/or equipment unattended.
- e. Maintain strict control of sharps and dispose of immediately outside of room.
- f. Staff should lock supplies in a cabinet or room whenever available.
- g. Do not hand any item to patients without first obtaining permission from the CO; this includes seemingly harmless items like gum, paper, pens, etc.
- h. NEVER agree to pass along information, make telephone calls, or mail items for patients. If a patient in custody attempts to contact hospital staff (mail, email, etc.) staff should not open the mail, but immediately contact UPD.
- i. DO NOT share personal information with patients or within their hearing.
- j. Staff is responsible for maintaining STRICT control of their personal electronic devices and keeping them in their possession at all times. Patients are prohibited from having access to communication or electronic devices at all times.
- k. Do not discuss discharge dates in front of patients until immediately prior to discharge. Follow-up appointment dates and times should never be discussed with or in front of patients. This is to avoid potentially harmful pre-planning on the part of the patient.
- l. Staff will provide transportation to testing areas when the patient is properly secured and accompanied by the CO.
- m. Promptly notify catering of the necessity for Styrofoam plates and safety utensils during meal times for all patients in custody. This should be entered by nursing in the EMR.

#### **IV. PATIENT RIGHTS**

- a. Patients in custody have the SAME RIGHTS as every other patient (i.e. appealing discharge, leaving AMA, etc).

#### **V. SAFETY MAY OVERRIDE CONFIDENTIALITY**

- a. All decisions related to appointment specifics and transportation are made by correctional facilities and not shared with patients. Any discussion from patients about these topics should be considered suspicious and should immediately be reported to the CO.
- b. Any non-approved items in a patient's possession are considered suspicious and should immediately be reported to the CO.
- c. CO's are bound to uphold confidentiality of the patient. Suspected violations of this legal obligation must be reported to University Police Department or 7U Unit Director.

#### **VI. HOSTAGE SITUATION**

- a. Initiate the alarm notification process: "Code Silver" has been designated as the alarm.



- b. Notify University Police by calling ext. 464-4000 (Downtown Campus) or ext. 492-5511 (Community Campus) and give location.
- c. Contain area and prepare for possible evacuation of patients.
- d. Be ready to evacuate patients according to the instructions of University Police Department, Department of Corrections and Community Supervision (DOCCS).
- e. For detailed information, see the Hostage Policy H-11, <https://upstate.ellucid.com/documents/view/1243>.

# PRIVACY AND SECURITY

## ***“What you need to know”***

- ✓ Who is responsible for protecting the confidentiality of patient information
- ✓ How to protect patient information

### **1. UNDERSTANDING YOUR RESPONSIBILITY**

- a. All workforce members of Upstate Medical University have a responsibility to protect the privacy and security of all confidential patient information using appropriate safeguards to ensure the information is available when needed for patient care but protected from inappropriate access, use and disclosure.

### **2. PROTECTING PATIENT PRIVACY**

- a. Only access patient information that is needed for your job – only the minimum amount necessary. Unauthorized access will result in termination of employment regardless of any other factors.
- b. Ask patients permission to discuss patient information in front of, or with, the patient’s family, friends, or visitors.
- c. Limit discussions of confidential information in public areas such as, for example, the cafeteria, elevators, and hallways and use reasonable safeguards to minimize chance others can overhear.
- d. Use reasonable safeguards when discussing information with a patient in a semi-private area, such as pulling the curtain between beds, closing the door to the room, asking the other patient’s visitors to step out of the room, speaking to the patient at the bedside using a lowered voice volume, and taking the patient to a private area if possible.
- e. Always verify that anyone requesting patient information is entitled to receive it for a permitted use
- f. Patient records or notes from the electronic medical record should not be printed. If printing is necessary for extenuating circumstances, they must be disposed of properly – SHRED paper containing patient information when no longer needed.
- g. Always check with your supervisor if you are unsure as to appropriate procedures for using, disclosing, safeguarding, storage, or disposal of any confidential patient information.
- h. Always verify the recipient’s fax numbers before sending paper fax correspondence and verify receipt by checking the transmittal report.
- i. Do not use a personal recording device to take pictures of patients or their information except in limited circumstances as outlined in University Hospital

policy P-46 (Patient Consent for Photography or Other Visual or Audio Recordings by Upstate Staff, <https://upstate.ellucid.com/documents/view/1308>).

- j. Do not post or discuss patient-related information on social networking sites even if the patient is the only person who may be able to identify him or herself on the basis of the posted information.
- k. Always verify the patient's identity before providing him/her with copies of any patient information including, but not limited to, inpatient and ambulatory after visit and discharge summaries.
- l. The protected health information of employees seeking care as a patient cannot be accessed unless it is for care and treatment and may not be disclosed to the employee's co-workers or supervisor without authorization of the employee.
- m. Report anything you see or hear that could be a violation of patient privacy to the UUH Privacy Office at:
  - i. Downtown Campus and Community Campus-  
Cynthia Nappa, 464-6135 or [nappac@upstate.edu](mailto:nappac@upstate.edu)

### 3. SECURING ELECTRONIC PATIENT INFORMATION

- a. Patients expect their confidential health information in our computer systems will be appropriately secured.
- b. **Computer safeguards to secure confidential health information include:**
  - i. Protect your access by **NOT SHARING YOUR ACCOUNT AND/OR PASSWORD** with others. Passwords are the most common form of authentication at Upstate and are often the only barrier for access to our sensitive and/or confidential information. Passwords selected must be strong passwords that are difficult to guess and must remain confidential.
  - ii. **Log-off or secure** your computer when you walk away from it. Even if you only step away from the computer for a few minutes, it's enough time for someone else to use your logon and access information.
  - iii. Employees must not transmit and/or store confidential health information in consumer grade texting (SMS) software. As a result, you may be disclosing patient information to unauthorized individuals outside of Upstate.
  - iv. Any patient information copied and/or stored on CD/DVDs, USB Flash Drives, Smartphones, or other portable devices must be secured using encryption or password protection to secure device contents in the event of loss or theft.
  - v. Clinical areas should not engage in email and/or text messaging communication with patients due to risks related to privacy and security. Each clinical area choosing to communicate with patients electronically must use Epic MyChart for all patient correspondence. The one exception to this policy is for texting appointment reminders to patients. Patient consent (opt-in) to receive text messages must be obtained and patients

must provide an authorized contact number where text messages will be sent. Text message reminders should only include the following information: Patient's first name, Date of the Appointment, Time of the Appointment, Location of the Appointment (Building only), and a return phone number for the patient to call back for more specific appointment information, or to change or cancel.

- vi. Employees should only use approved Upstate cloud services to store sensitive and/or confidential information. If you use an unapproved service (e.g. Dropbox, Google storage, Amazon), you may be giving unauthorized individual's access that may breach the security of this information.
- vii. If electronic information must be taken outside of Upstate, you should be aware that on-site security precautions are no longer present at off-site locations. (e.g. when traveling or at home)
- viii. Back up your files if your computer or mobile device is stolen to avoid losing all the information. Make backups of any important information and store the backups in a separate location, preferably on the Upstate network.
- ix. Phishing refers to an e-mail sent to trick someone into clicking on a web link or opening a file attachment. The end goal of phishing is to steal valuable information, such as usernames and passwords, install unauthorized software on systems, or even take sensitive patient or personal information from our systems. If you receive any unrecognized or suspicious email, report it immediately to the IMT Help Desk and/or Information Security Officer.
- x. Ransomware is malicious software that cyber "hackers" use to lock your computer files for ransom, demanding payment from you to get your files back. There is a variety of ways ransomware can get onto a person's computer. These techniques usually are a result of responding to a phishing email message or software vulnerabilities on unpatched computer systems. If you receive a ransomware message on your computer, report it **immediately** to the IMT Help Desk.
- xi. **NEVER** disable or remove the virus detection software
- xii. Report all cyber security incidents to the Upstate Information Security Officer, Shawn O'Reilly, at #464-4093 or via e-mail at [oreillys@upstate.edu](mailto:oreillys@upstate.edu)

#### 4. AUDITS AND MONITORING

- a. All computer systems record all your activity. Information you view and access using your account leaves a digital trail of information – where you go and what you do
- b. Upstate audits and monitors access to confidential patient information on a regular basis
- c. **ONLY** access information that YOU NEED-TO-KNOW TO DO YOUR JOB

# PRIVATE ENCOUNTER

## ***“What you need to know”***

- ✓ Who is responsible for protecting the confidentiality of patient information
- ✓ How to protect patient information

Note: Patient shall not be “Unidentified/Anonymous” (refer to policy U-01, Unidentified Patient) for the purpose of protecting the identity of a patient in the Hospital Information System.

### **I. WHAT DOES HAVING “PRIVATE ENCOUNTER” MARKED IN THE MEDICAL RECORD INDICATE AND WHO CAN AUTHORIZE THIS?**

- a. There are two types of private encounter situations.
  - i. The first situation is for privacy. The patient opts out of the Upstate directory. The patient does not want to receive phone calls or information given out. The patient may or may not want visitor restrictions. The patient’s visitors do **NOT** have a **gray** bracelet. Nursing white boards identify the patient as PRI A. An additional private encounter patient on that unit would be PRI B.
- b. Private encounter for safety is the second situation. Listing the patient’s name in the directory could pose a threat to the patient and or staff. Assigning for safety is under the direction of the Administrative Supervisor. The visitors’ name is added to EPIC under the patient FYI flag. **The patient and their visitors wear gray bracelets.**

### **II. HOW WILL STAFF KNOW THE PATIENT IS PRIVATE ENCOUNTER FOR SAFETY?**

- a. The patient’s bracelet will be gray; patient will also be wearing a regular patient arm band.
- b. Patient Access will deliver the bracelet to the patient’s nursing unit Monday–Friday, 7 a.m. to 4 p.m.
- c. After 4 p.m. and on Holidays and weekends, the nursing unit will pick up the bracelet Downtown in the Admitting Office
- d. After 11 p.m., nursing must go to Emergency Department to pick up ID bands

### **III. HOW WILL THE VISITOR OF A PRIVATE ENCOUNTER FOR SAFETY PATIENT BE IDENTIFIED?**

- a. The patient is limited to four visitors during hospitalization

- b. The approved visitor will wear a gray bracelet which includes the visitor's name, and the patient's medical record number and date of birth
- c. If all approved visitors are not present at the same time to obtain the gray bracelet, the bracelet(s) for the absent approved visitors will be held on the unit to be issued by the RN.

#### **IV. WHEN MAY A PATIENT SUBMIT A "PRIVATE ENCOUNTER" REQUEST?**

- a. During the admissions process with Patient Access
- b. Anytime during their stay

#### **V. WHAT INFORMATION WILL THE PATIENT BE AWARE OF RELATED TO THE "PRIVATE ENCOUNTER?"**

- a. The Private Encounter status will be in effect for the current admission/registration only
- b. The Private Encounter status expires upon discharge
  - i. Approved visitors not listed will not be given access to the patient
  - ii. Patient & Visitor education
- c. Approved visitor(s) must bring/show photo identification on each visit or they will not be allowed to visit patient
- d. Visitors not listed in EPIC even if accompanied by approved visitor will not be given access to patient

Refer to Administrative policy A-12 Private Encounter/Alias Name, <https://upstate.ellucid.com/documents/view/1176>

## QUALITY IMPROVEMENT

### “What you need to know”

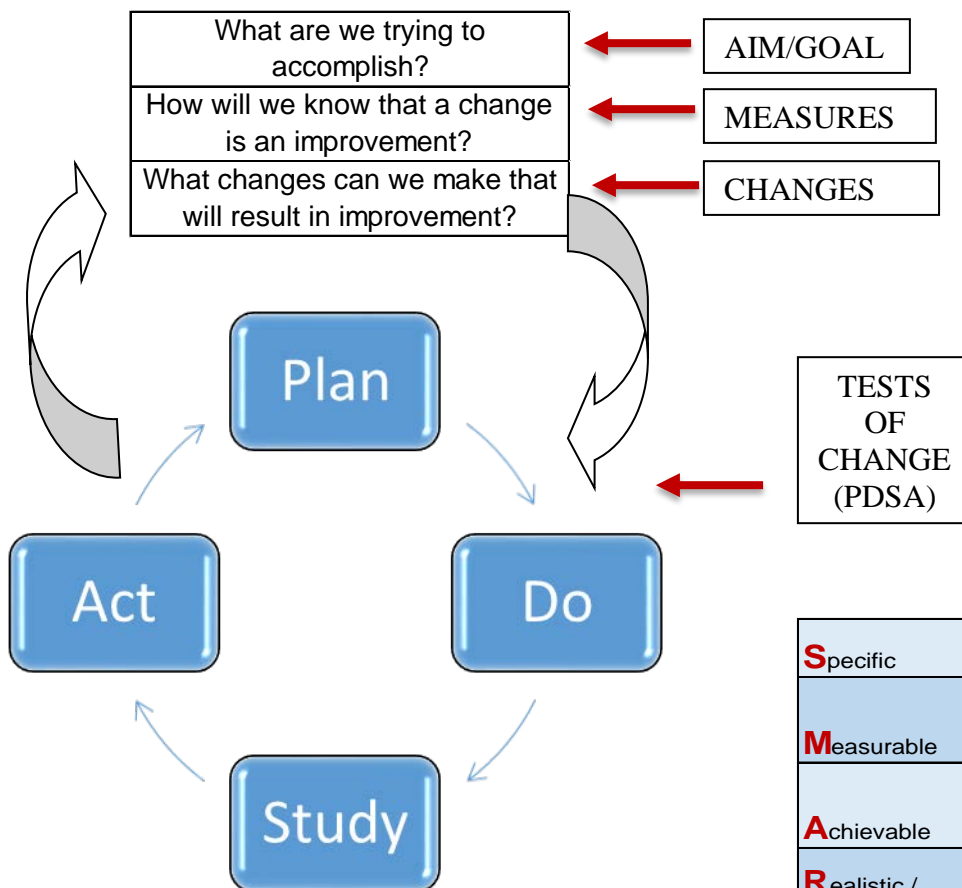
- ✓ What is PDSA (PLAN–DO–STUDY–ACT) and your role
- ✓ The procedure to follow when completing a PDSA
- ✓ Where to find the forms for completing a PDSA quality improvement project

Quality Improvement is everyone’s job! There are always opportunities to improve your practices and processes in your area. Bring your ideas forward for improvement. Using a consistent method to address quality improvement, such as the Model for Improvement/PDSA, we can most effectively share our knowledge and continuing improvements across the enterprise using a structured action oriented learning process.

This also involves the use of standardized forms for documentation to communicate with the same quality improvement “language” while also streamlining our efforts to minimize redundancy throughout the organization.

Standard PDSA forms for your PDSA quality improvement projects are available on MCN: **PDSA Form F94101**, <https://upstate.ellucid.com/documents/view/10316>, and **PDSA Planning Table Form F94100**, <https://upstate.ellucid.com/documents/view/10315>

### Model for Improvement/PDSA



### AIM SMART!!

<b>S</b> pecific	Is the AIM statement precise about what the team hopes to achieve?
<b>M</b> easurable	Are the objectives measurable? Will you know whether the changes resulted in improvement?
<b>A</b> chievable	Is this doable in the time you have? Are you attempting too much? Could you do more?
<b>R</b> ealistic / Relevant	Do you have the resources needed (people, time, support?) Aligns with mission?
<b>T</b> imely	Do you identify the timeline for the project - when will you accomplish each part?

### **Step 1: Plan**

#### **Plan the observation, including plan for collecting data**

- Describe the change/improvement you want to test
- Make predictions about what will happen and why (improvement theory)
- Clearly develop the action plan including who, what, where, when and what data needs to be collected

### **Step 2: DO**

#### **Try out the test on a small scale**

- Carry out the test
- Document problems and unexpected observations
- Record data

### **Step 3: STUDY**

#### **Set aside time to analyze the data and check the results**

- Complete the analysis of the data using control or run charts
- Compare data to your predictions/improvement theory

### **Step 4: ACT**

#### **Act on what was learned and sum it all up**

- Adapt-Improve the change and continue testing. Plan changes for another test PDSA cycle
- Adopt-Select the change to implement, implement on larger scale and plan for sustainability.
- Abandon- Discard this change idea and try a new one

Watch a short video clip on Model for Improvement/PDSA!

<https://www.youtube.com/watch?v=SCYghxtioIY&feature=youtu.be>



# RISK MANAGEMENT

## ***“What you need to know”***

- ✓ Responsibilities for the department of Risk Management
- ✓ Strategies to reduce risk
- ✓ How to report an Event

Risk Management is the preventative process for managing risks. This involves identifying risks, strategizing ways to avoid or mitigate those risks and developing a contingency plan in cases where risks cannot be prevented or avoided. Identification of the risk is very important. Filing an Event Report is one way to identify an issue that requires attention and follow up.

### **I. THE DEPARTMENT OF RISK MANAGEMENT**

- a. Hospital wide program responsible for the monitoring, controlling, and prevention of potential liability exposure
- b. Enhances the safety of patients, visitors, and employees, and,
- c. Seeks to prevent liability through a process of education, feedback, and early response

### **II. CLAIMS MANAGEMENT**

- a. Claims Handling – Medical Malpractice
- b. Interface with NYS Attorney General
- c. Receiver of Legal Requests
- d. Coordinator of Investigations
- e. Processing Event Reports
- f. Processing Medication Events

### **III. REGULATORY FUNCTIONS**

- a. Department of Health NYPORTS & DOH Complaint Investigations (back up for Quality Services)
- b. Justice Center/ Office of Mental Health Reporting and Investigations (back up for Quality Services)
- c. Office of Professional Discipline Reporting for Licensed Personnel
- d. EMTALA/COBRA Case Reviews and Regulatory Reporting

### **IV. EVENT AND INJURY REPORTING**

- a. Policy Number I-03: Event/Occurrence & Injury Reports, Patients & Visitors, <https://upstate.ellucid.com/documents/view/1252>
- b. All University Hospital workforce members are to notify Risk Management upon identification of various events/occurrences including safety hazards, near misses,

- accidents, adverse events, medical events, or injuries within 24 hours of the event
- c. **The Upstate University Hospital Intranet Web Event Reporting System is available on the Novell Applications Window at every computer terminal via the Safety Alert System icon**
  - d. The Patient Safety Hotline is available for reporting by calling 4-SAFE (4-7233)
  - e. If the event involves a visitor, University Police must be contacted
  - f. If the event involves employees or volunteers, Injury Report Form #F83120 (<https://upstate.ellucid.com/documents/view/4340>) must be submitted to Human Resources Benefits Office within 24 hours of the event
  - g. For a significant adverse event or outcome identified following review of the facts, a Root Cause Analysis (RCA) will be initiated to determine what causal factors contributed to the event and what improvements can reduce the likelihood of recurrence. R-19 Regulatory Reporting (<https://upstate.ellucid.com/documents/view/6797>)

### **RISK MANAGEMENT OFFICES:**

**DOWNTOWN- Jacobsen Hall 914**

**PHONE: 315-464-6177**

**FAX: 315-464-1890**

**COMMUNITY- SUITE 1129**

**PHONE: 315-492-5963**

**FAX: 315-492-5990**

**EMAIL: [georgep@upstate.edu](mailto:georgep@upstate.edu)**

# SENSITIVE TREATMENT OF PATIENTS WHO SUFFER WITH OBESITY

## *“What you need to know”*

- ✓ How to communicate appropriately
- ✓ How to access support and education

### **I. OBESITY IS ONE OF THE LEADING CAUSES OF PREVENTABLE DEATH IN THE U.S.**

- a. Obesity is a chronic and relapsing illness that dramatically increases the risk of developing Heart Disease, Diabetes, Sleep Apnea and other health related co-morbidities.
- b. Upstate Medical University has a Bariatric and Metabolic Surgery (Weight Loss Surgery) Program. We also care for other patients, both medical and surgical, who suffer from the disease of morbid obesity.
- c. Health care workers are responsible to provide unbiased care that includes sensitive communication when interacting with those who suffer with obesity.

### **II. STRATEGIES TO PROVIDE APPROPRIATE CARE FOR PATIENTS WITH OBESITY**

- a. To promote comfort:
  - i. Know the weight capacity of the equipment you use for patient care.
    1. Most manufactures are now listing weight limits on the equipment itself.
    2. Should the manufacture not placed this information on the equipment, Upstate has a process to ensure weight limits are displayed on the equipment.
  - ii. Provide the appropriate sized equipment for the patient you are caring for (do not use a bariatric wheelchair for a non-bariatric patient and don't expect a bariatric patient to fit into a non-bariatric wheelchair, just because the appropriate equipment is not readily available)
  - iii. Utilize safe patient handling practices to move the patient
  - iv. If hospital owned equipment is all in use, contact your manager or equipment services to obtain the appropriate equipment to care for the patient

### **III. COMMUNICATION MUST BE UNBIASED AND CARING**

- a. Strategies to provide communication that is unbiased and caring:
  - i. Recognize that being overweight is a product of many factors

- ii. Examine and understand your own bias for providing care to a patient who suffers from the disease of obesity
- iii. When talking with, make direct eye contact, and employ good listening skills
- iv. Ask the patient how you can best assist them
- v. Do not provide unsolicited advice to lose weight
- vi. Avoid idle conversations that are unprofessional and are often overheard by patients:
  - 1. “they can lose weight if they want to”
  - 2. “how am I suppose to move that patient, it will take all of the staff”
  - 3. “they need to provide us with motorized equipment if we have to push this patient around”
  - 4. “we will have to make this a private room, no other patient will fit in the room with the fat people equipment”

#### **IV. FOR ADDITIONAL SUPPORT**

- a. Bariatric Program Coordinator: Casey Hammerle, MSN, RN, CBN  
Phone: (315) 492-5934 | E-mail: [hammerlc@upstate.edu](mailto:hammerlc@upstate.edu)

#### **V. ADDITIONAL STAFF EDUCATION**

- a. Go to Blackboard course “Caring the Bariatric Patients” for further education related to:
  - i. Sensitivity to Size
  - ii. Caring for Obese Patients
  - iii. Bariatric Surgery
  - iv. Safe Patient Handling

# SERVICE EXCELLENCE STANDARDS

Service Excellence is at the core of our organization's commitment to delivering quality care and service. The people we serve include patients, their families, physicians, co-workers, visitors, students, and volunteers. *Thank you for your commitment to service excellence and dedication to superior patient care.*

## **MAKE A POSITIVE IMPRESSION; I WILL**

- Strive to exceed our patient/customer and colleague's expectations in all I do.
- Always look professional in appearance and dress. First impressions matter.
- Treat patients, families and colleagues with compassion, patience, respect and courtesy.
- Be honest and ethical.
- Value and seek to understand different viewpoints.
- Notice if anyone looks lost and help them to find their way, provide thorough directions and when possible, escort customers personally.
- Provide privacy and assure dignity for all.

## **EXEMPLIFY TEAMWORK AND RESPECTFUL RELATIONSHIPS; I WILL**

- Value each other as individuals.
- Embrace the diversity of background, gender, ideas and other differences.
- Anticipate what others need before they ask and freely offer help to others.
- Always assume the best and speak positively about our colleagues and organization, and not discuss internal issues in front of patients and visitors.
- Commit to finding solutions to problems rather than pointing blame and complaining.
- Accept responsibility for my actions and will not blame others.
- Choose a positive attitude every day because it is the right thing to do.

## **ICARE ABOUT COMMUNICATION; I WILL USE ICARE**

- **I: Introduce** yourself by name and title and let the patient/family know a little about you.
- **C: Connect** with the patient and family. If possible, sit down when you are talking.
- **A: Acknowledge** what the patient said; articulate what you have found and what you think is going on using key words.
- **R: Review** the plan of care including what tests and treatments are to be accomplished and the time it will take to complete.
- **E: Educate** on what to expect and ensure understanding from the patient; express gratitude and say "thank you" to our patients for choosing Upstate.

## **I WILL TAKE RESPONSIBILITY FOR THE EXPERIENCES OF THE PEOPLE THAT WE SERVE**

- Acknowledging the patient's problem means working on great active listening skills.
- It's important to apologize and to say "I'm sorry" with empathy and sincerity.
- The expectation is that *everyone* is responsible for service recovery.
  - If there is a patient complaint that you cannot resolve, please contact the Patient Relations Department at 464-5597 or via e-mail at [patientrelations@upstate.edu](mailto:patientrelations@upstate.edu)

## **TAKE CARE OF OUR ENVIRONMENT; I WILL**

- Provide and maintain an environment that is clean, safe, and pleasing to patients.
- Reduce noise in patient care areas; a quiet environment is a healing environment.
- Protect patient privacy by always speaking in an appropriate tone and never discuss patient information in public areas.
- Create a safe work environment and notify Security whenever I have a concern.

# SEXUAL HARASSMENT

## “What you need to know”

- ✓ The definition of sexual harassment
- ✓ What to do if sexual harassment occurs
- ✓ Other types of harassment and discrimination

### I. DEFINE SEXUAL HARASSMENT

- a. Sexual harassment is a form of sex discrimination that violates Title VII of the Civil Rights Act of 1964, NYS Human Rights Law, Executive Order 19, Title IX of the Education Amendments of 1972, and the policy of Upstate Medical University.
- b. Sexual harassment is defined as unwelcome verbal or physical sexual advances or statements made by someone in the workplace or academic setting, which:
  - c. Is **offensive** or **objectionable** to the recipient
  - d. Causes the recipient **discomfort** or **humiliation**
  - e. **Interferes** with the recipient’s job performance
- f. Sexual harassment may consist of words, signs, jokes, pranks, pictures, touching, exposing oneself, threats, intimidation, texting, or physical violence of a sexual nature. Sexual harassment also consists of any unwanted verbal or physical advances, sexually explicit derogatory statements or sexually discriminatory remarks made by someone which are offensive or objectionable to the recipient, which cause the recipient discomfort or humiliation, which interfere with the recipient’s job performance.
- g. Sexual harassment becomes illegal when it is severe or frequent enough to adversely affect a term or condition of an individual’s employment.
- h. This same definition applies to harassment on the basis of other protected categories such as race, national origin, age, or religion.

### II. THERE ARE TWO TYPES OF SEXUAL HARASSMENT

- a. **Quid Pro Quo:**
  - i. Is an abuse of power and authority, such as by a supervisor or manager
  - ii. Results in a tangible employment action (such as firing, demotion, or denial of promotion)
  - iii. Strictly liable for the action.
  - iv. One act is enough to find QPQ sexual harassment.
  - v. Example:
    - Supervisor fires a subordinate for refusing to be sexually cooperative.

- Person in authority tries to trade job benefits for sexual favors. This can include hiring, promotion, continued employment or any other terms, conditions or privileges of employment.

**b. Hostile Environment:**

- i. Results from unwelcome conduct that is based on gender
- ii. Supervisors, co-workers, customers, visitors, or anyone else that an employee interacts with on the job can create a hostile environment
- iii. Example: an employee displays pornographic photos in the workplace, makes sexual innuendos, send texts with sexual statements or photographs.

**III. SEXUAL HARASSMENT CAN OCCUR IN A VARIETY OF CIRCUMSTANCES**

- a. The victim as well as the harasser may be a man or woman
- b. The victim does not have to be of the opposite sex
- c. The harasser can be the victim's supervisor, an agent of the employer, a supervisor in another area, and a co-worker, or a non-employee, or a third party on the premises. (independent contractor, contract worker, vendor, client, customer or visitor)
- d. The victim does not have to be the person harassed, but could be anyone affected by the offensive conduct.

**IV. HARASSMENT ON THE BASIS OTHER THAN SEX**

- a. Upstate Medical University does not tolerate sexual harassment or other illegal types of harassment or discrimination based on sex, age, race, color, disability, marital status, national origin, religion, sexual orientation, gender identity, veteran status, status as a victim of domestic violence, or any other category protected by law.
  - i. Example: an employee uses racially offensive language in reference to another person or group.
- b. Those in violation of the law are subject to appropriate sanctions, including disciplinary action up to and including dismissal.

**V. STEPS TO TAKE IN RESPONSE TO SEXUAL HARASSMENT OR OTHER FORMS OF DISCRIMINATION:**

- a. If possible, tell the person(s) directly that their behavior is unwelcome and must stop. However, this is not necessary.
- b. Speak to your supervisor, and if necessary, consult their supervisor for assistance.
- c. Individuals who experience or witness sexual harassment or other forms of illegal discrimination should contact the Office of Diversity and Inclusion (#464-5234) to schedule an appointment to discuss your options.
- d. Contact the Title IX Coordinator in the Office of Diversity at 315.464.5234

- e. Reports of sexual harassment may be made verbally or in writing. File a written discrimination complaint using the internal complaint procedure available. Written complaints must be filed within 90 calendar days following the alleged sexual harassment. Every effort will be made to protect the privacy and confidentiality of all individuals throughout the complaint investigation and resolution process.

## **VI. RETALIATION**

- a. Retaliation against an individual who files a complaint, or assists in an investigation, proceeding, or hearing is illegal and not tolerated at Upstate
- b. Unlawful retaliation can be any action that would keep a worker from coming forward to make or support a sexual harassment claim. Adverse action need not be job-related or occur in the workplace to constitute unlawful retaliation.
- c. Such retaliation is unlawful under federal, state, and (where applicable) local law. The New York State Human Rights Law protects any individual who has engaged in “protected activity.” Protected activity occurs when a person has:
  - i. filed a complaint of sexual harassment, either internally or with any anti-discrimination agency;
  - ii. testified or assisted in a proceeding involving sexual harassment under the Human Rights Law or other anti-discrimination law;
  - iii. opposed sexual harassment by making a verbal or informal complaint to management, or by simply informing a supervisor or manager of harassment;
  - iv. complained that another employee has been sexually harassed; or
  - v. Encouraged a fellow employee to report harassment.

## **VII. CONSENSUAL RELATIONSHIPS POLICY (UW C05)**

- a. [http://www.upstate.edu/policies/documents/intra/UW\\_C-05.pdf](http://www.upstate.edu/policies/documents/intra/UW_C-05.pdf)
  - i. Become familiar with and follow the policy
  - ii. Be aware that such relationships have the potential to result in claims of sexual harassment, including third party sexual harassment.



# SEXUAL VIOLENCE

## ***“What you need to know”***

- ✓ The definition of sexual violence
- ✓ The definition of consent
- ✓ What to do if sexual violence occurs
- ✓ Available resources:
  - Download the Upstate Reachout Mobile App at <https://www.captivation.com/>
  - Contact the Title IX Coordinator in the Office of Diversity and Inclusion at 464.5234

## **I. DEFINE SEXUAL VIOLENCE**

- a. Sexual violence is a form of sexual harassment. Sexual violence refers to sexual acts perpetrated against a person’s will or where a person is incapable of giving consent (e.g., due to a person’s age or use of drugs or alcohol or an intellectual or other disability that prevents the person from having the capacity to consent).
- b. Sexual Violence includes intimate partner violence, dating violence, stalking, rape, sexual assault, sexual battery, sexual abuse, and sexual coercion.
  - i. Sexual assault includes any actual or attempted nonconsensual sexual activity including but not limited to: sexual intercourse, or sexual touching, committed with coercion, threat, or intimidation (actual or implied) with or without physical force; exhibitionism or sexual language of a threatening nature by a person (s) known or unknown to the victim. Forcible touching, a form of sexual assault, which is defined as intentionally, and for no legitimate purpose, forcibly touching the sexual or other intimate parts of another person for the purpose of degrading or abusing such person or for gratifying sexual desires.
  - ii. Rape- sexual intercourse without consent, committed with coercion, threat, or intimidation (actual or implied), with or without physical force by a person(s) known or unknown to the victim. Sexual intercourse can involve anal, oral, or vaginal penetration, no matter how slight.
- c. Intoxication of the accused cannot be used as a defense to an alleged incident involving sexual violence.

## **II. DEFINE CONSENT**

- a. Affirmative Consent: Affirmative consent is a knowing, voluntary, and mutual decision among all participants to engage in sexual activity. Consent can be given by words or actions, as long as those words or actions create clear permission regarding willingness to engage in the sexual activity. Silence or lack of resistance, in and of itself, does not demonstrate consent. The definition of consent does not vary based upon a participant’s sex, sexual orientation, gender identity, or gender expression.
  - i. Consent to any sexual act or prior consensual sexual activity between or with any party does not necessarily constitute consent to any other sexual act.

- ii. Consent is required regardless of whether the person initiating the act is under the influence of drugs and /or alcohol.
- iii. Consent may be initially given but withdrawn at any time.
- iv. Consent cannot be given when a person is incapacitated, which occurs when an individual lacks the ability to knowingly choose to participate in sexual activity. Incapacitation may be caused by the lack of consciousness of being asleep, being involuntarily restrained, or if an individual otherwise cannot consent.
- v. Consent cannot be give when it is the result of any coercion, intimidation, force, or threat of harm.
- vi. When consent is withdrawn or can no longer be given, sexual activity must stop.
- vii. View the Consent Tea video: <https://www.youtube.com/watch?v=u7Nii5w2Fal>

### **III. STEPS TO TAKE IN RESPONSE TO SEXUAL VIOLENCE:**

- a. Get to a safe place as soon as possible
- b. Try to preserve all physical evidence; do not bathe, douche or change clothes
- c. Contact SUNY Upstate Medical University Campus Police at 464-4000, or CALL 911 (Syracuse POLICE) or 435-3016 (Abused Persons Unit).
- d. You may also CONTACT State Police on the dedicated 24-hour hotline at 1-844-845-7269.

### **IV. REPORTING OPTIONS**

- a. Contact an employee with the authority to address complaints, including the Title IX Coordinator (4-5234, [norcrosd@upstate.edu](mailto:norcrosd@upstate.edu)), the Chief Diversity Officer (4—4392, [lopezg@upstate.edu](mailto:lopezg@upstate.edu)) or University Police (4-4000)
- b. If you learn of an assault after it has happened, refer the victim to appropriate medical services (Emergency Department, 4-5611)
- c. Refer the victim to counseling services (Employee Assistance Program, 4-5760)

### **V. RETALIATION**

- a. Retaliation against an individual who files a complaint, or assists in an investigation, proceeding, or hearing is illegal.

### **VI. CONFIDENTIAL COMMUNITY SUPPORTS AND RESOURCES**

- a. Vera House 24/7 crisis and support hotline
  - i. Phone: (315)468-3260
  - ii. TTY: (315) 484-7263 during business
- b. NYS Coalition Against Sexual Assault Hotline, **1-800-942-6906**
- c. RAINN- National Sexual Assault Hotline, 1-800-656-HOPE (4673)
- d. New York State Domestic and Sexual Violence Hotline, 1-800-942-6906

# STROKE: RECOGNIZING IT F.A.S.T.

## “What you need to know”

- ✓ What is a Stroke?
- ✓ What does **F.A.S.T** mean
- ✓ Five common symptoms of a stroke
- ✓ What to do if a patient exhibits **sudden** onset of stroke symptoms
- ✓ The goal of in-house stroke alert

## I. WHAT IS A STROKE?

- a. A stroke is interruption of blood flow to the brain
  - i. An **ischemic** stroke is the most common type of stroke and occurs when a blood clot or emboli blocks blood flow to an area of the brain. Every minute that the blocked area of the brain is without blood/oxygen, 1.9 million neurons/nerve cells die.
  - ii. A **hemorrhagic** stroke occurs when bleeding occurs inside or around the brain (intra-cerebral hemorrhage or subarachnoid hemorrhage).
- b. Alteplase (tPA) is the only FDA-approved “clot-busting” drug used to treat acute ischemic stroke.
  - i. The treatment window for tPA is within 3 hours of symptom onset (in some cases the window can be extended up to 4.5 hours)
  - ii. The **sooner the patient receives tPA, the better the potential outcome** for the patient.
- c. **Stroke is an emergency** and may require neurosurgical/neurointervention. Intervention may include a clot retrieval procedure (thrombectomy) where the clot blocking the artery is removed to restore blood flow. Recent trials have seen positive benefits when used up to 24 hours after the patient was last known to be well.
- d. It is expected that patients who are hospitalized have the same opportunity for rapid identification and treatment of stroke as those patients brought to the emergency room
- e. If an inpatient *suddenly* develops stroke symptoms, the expectation is that assessment and care of the patient occur immediately

## II. WHAT IS F.A.S.T.?

- a. **F** = FACE: facial drooping or weakness
- b. **A** = ARM: Arm weakness or drift
- c. **S** = SPEECH: difficulty speaking or slurring words
- d. **T** = TIME: Time to call help/Time last known well



## III. WHAT ARE FIVE COMMON SYMPTOMS OF A STROKE?

- a. *Sudden* numbness or weakness, especially on one side

- b. *Sudden* confusion or trouble speaking
- c. *Sudden* trouble seeing in one or both eyes
- d. *Sudden* trouble walking or dizziness
- e. *Sudden* severe headache with no known cause

#### **IV. WHAT DO I DO IF THE PATIENT EXHIBITS *SUDDEN* ONSET OF STROKE SYMPTOMS?**

- a. At the Downtown campus dial 4-4444 to activate a stroke code, provide unit and room number.
- b. At the Community Campus dial 2211 to activate a stroke code.
- c. Notify the patient's primary service attending or house staff.
- d. If you are in Jacobsen Hall, CAB, Clark Tower, Parking Garages/Parking lots, Campus West Building (CWB), Weiskotten Hall or IHP, Building 49 dial 911 per policy CM E-15, <https://upstate.ellucid.com/documents/view/3714>.

#### **V. WHAT HAPPENS ONCE I CALL A STROKE CODE IN UNIVERSITY HOSPITAL, DOWNTOWN CAMPUS?**

- a. The Neuroscience Resource Nurse and stroke team resident responds to the designated unit/area to assess patient
- b. If a stroke code is activated, a blast page goes to Stroke Neurology, Administrative Supervisor, CT Scan, Lab, and Pharmacy. Neurology will respond and assess the patient. Radiology will clear the CT scanner to be ready to scan the patient. Pharmacy gets ready to mix tPA medication. Administrative Supervisor will evaluate bed availability.

**ALL PATIENTS DIAGNOSED /SUSPECTED WITH STROKE ARE NOT ALLOWED ANYTHING BY MOUTH, INCLUDING MEDICATIONS, UNTIL A DYSPHAGIA (SWALLOW) SCREEN IS COMPLETED**

#### **VI. GOAL OF AN IN-HOUSE STROKE CODE IS TO GET THE PATIENT EVALUATED AS QUICKLY AS POSSIBLE TO ENSURE MAXIMUM OXYGENATION AND PERFUSION TO THE BRAIN.**

- a. **You should be aware that the minimum time target expectations given by NYS Department of Health from initial discovery of symptoms for stroke evaluation and treatment are:**
  - i. symptom onset to neuro evaluation **15 minutes**
  - ii. symptom onset to CT scan **25 minutes**
  - iii. symptom onset to CT results **45 minutes**
  - iv. symptom onset to lab results **45 minutes**
  - v. symptom onset to needle **60 minutes**

**Remember, think F.A.S.T when you think a stroke!**

# U-TURN/HEALTHY WORKPLACE

## “What you need to know”

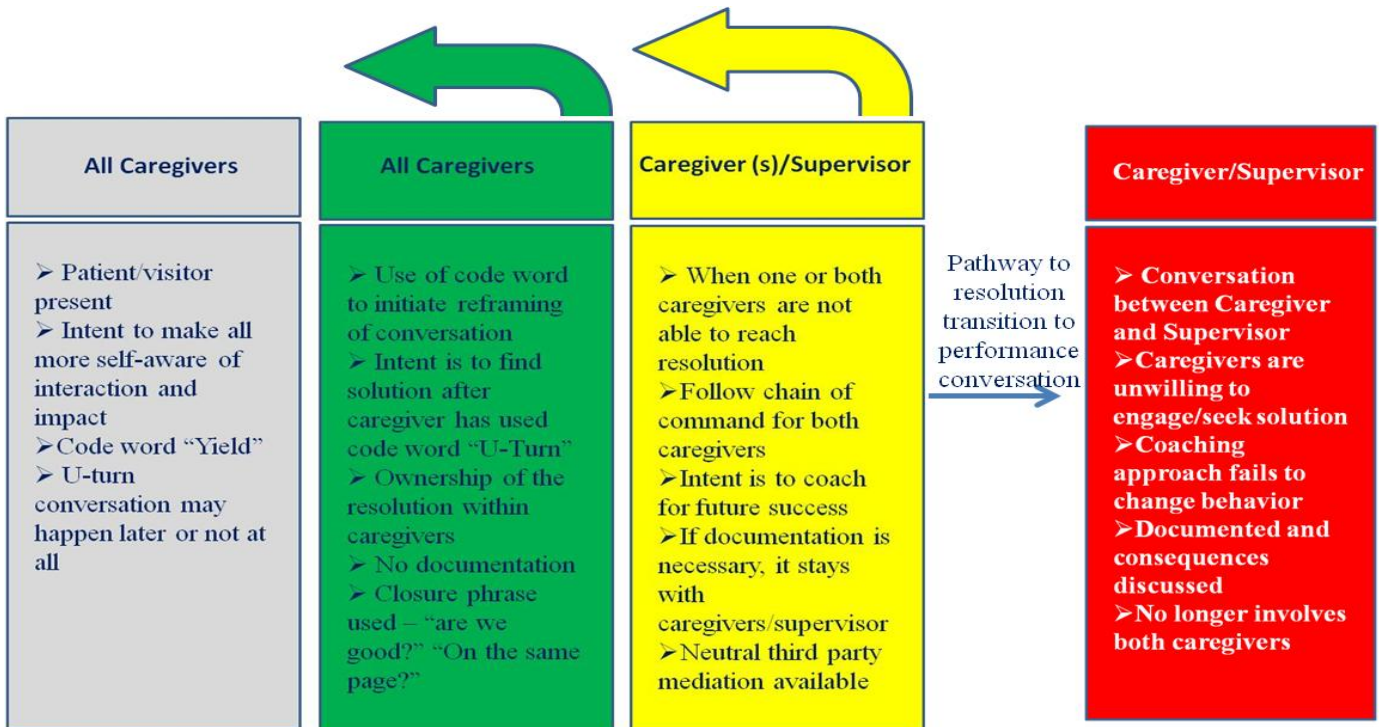
- ✓ What is the U-Turn Process
- ✓ How to request a third-party mediator
- ✓ Healthy Workplace Environment Policy

### I. U-TURN PROCESS

- a. We recognize that interactions may not always be best between staff
- b. A three phase approach, the U-Turn process, asks that staff stop unhealthy conversations and ask to restart in order to maintain present and/or future healthy communication

### II. THREE U-TURN CONVERSATIONS:

- a. Grey: “Yield” is the word to stop a conversation in the presence of a patient or visitor
- b. Green: “U-Turn” is the word used when staff recognize they need to re-start the conversation. This gives staff the time to calm and restate their positions in a manner that has the best interest of all in mind
- c. Yellow: When staff have not been successful with “u-turning” the discussion, supervisors/managers are asked to serve as a mediator to resolve conflict so that it does not escalate



### III. WHAT IF YOU NEED NEUTRAL OUTSIDE HELP?

- a. We have a team of certified workplace mediators who will assist staff when they are “stuck” and unable to resolve conflict
- b. You can request a mediator via this link: <http://www.upstate.edu/uturn/intra/mediators.php>

#### **IV. HOW DOES THIS IMPACT MY PERSONNEL RECORD?**

- a. When a third-party mediator is requested, no record of the meeting(s) is ever in your personnel folder. This is considered a benefit for staff.
- b. If agreements are identified via the mediated conversation, those agreements may be written and shared between the two staff involved and their manager simply to help guide future interaction; but may not be used in counseling, discipline, or performance programs.

# Violence Education Prevention Outreach Program (VEPOP)

## “What you need to know”

- ✓ What is VEPOP
- ✓ What are the goals of VEPOP
- ✓ What the risk factors are
- ✓ The various supports that Upstate Medical University provides to patients and families

### I. ABOUT VEPOP:

- a. Identifies victims of violent crime and capitalizes on the “teachable moment”
- b. Identifies risk factors for subsequent violent injury, needs, and support
- c. Partners with community agencies and organizations for on-going support
- d. Makes appropriate referrals
- e. Follows up with patients to ensure continuity of care

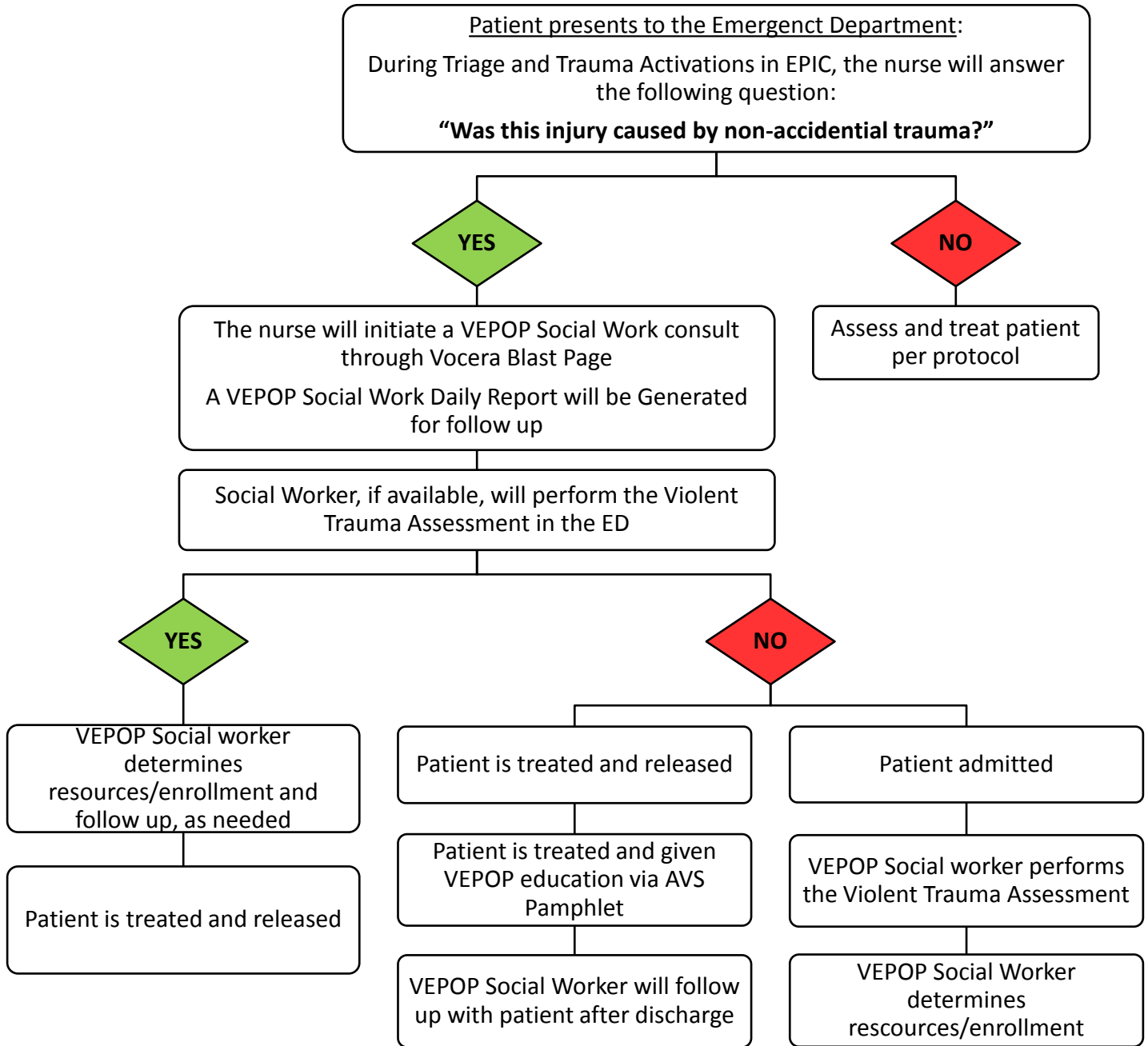
### II. GOALS OF THE VEPOP:

- a. Reduce the rate of recurrence of violent trauma
- b. Promote alternatives to violent lifestyles
- c. Create opportunities for patients to achieve their goals

### III. VEPOP CONSULT:

- a. Nurse will initiate a VEPOP Social Work consult, per Amion schedule

## IV. VEPOP PROCESS:



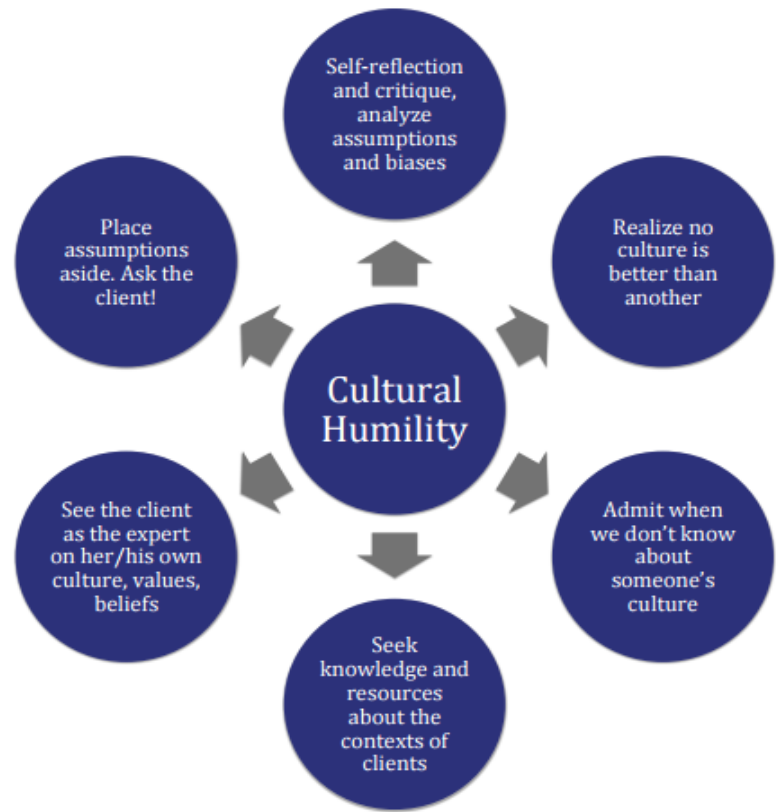


# WORKPLACE DIVERSITY & CREATING A CULTURALLY INCLUSIVE ENVIRONMENT:

## “What you need to know”

- ✓ Workplace diversity and inclusion is about acknowledging the diverse skills and perspectives that people may contribute because of their gender, age, language, ethnicity, cultural background, disability, religious belief, sexual orientation, working style, educational level, professional skills, work and life experiences, social-economic background, job function, geographic location, and other dimensions of diversity.
- ✓ We aspire to recognize and embrace the diversity each person brings to the organization. Creating a culturally inclusive environment allows all employees to effectively collaborate in the ongoing development and delivery of healthcare, education, research and outreach.
- ✓ A culturally inclusive environment requires mutual respect, effective relationships, clear communication, explicit understandings about expectations and critical reflection. In an inclusive environment, people of all cultural orientations can:
  - Freely express who they are, their own opinions and points of view.
  - Fully participate in teaching, learning, work and social activities.
  - Feel safe from abuse, harassment or unfair criticism or maltreatment.

**Cultural Humility:** To practice cultural humility is to maintain a willingness to suspend what you think you know about a person based on generalizations or stereotypes.



Erica E. Hartwell, University of Ohio

**Inclusive Practice:** Students, faculty, staff, patients, and guests can benefit from culturally inclusive practice and experience diversity as a resource that enriches our teaching, learning, research and service. If we don't adopt inclusive practices, the result is that some people and communities will feel marginalized, isolated and discouraged. Inclusive environments on campus contribute to making Upstate Medical University a safe, enjoyable and productive place for everyone in the organization and enhance

our interactions with the wider community we serve.

**Respectful Relationships:** Respecting diversity entails more than tolerance. The term ‘tolerance’ implies that something must be endured, or ‘put up with’. When genuine acknowledgment, appreciation of,

and interest in diversity is experienced, respectful relationships develop. Engaging in respectful relationships means demonstrating a positive appreciation of people and their cultural values.

**Workplace diversity & inclusion is everybody’s responsibility. Expect all employees to foster and promote a work environment that is inclusive and reflects the significant diversity within the region we serve. Some ways we can do this are:**

- ◆ Becoming consciously aware of our own multidimensional cultural identities and background.
- ◆ Treat people the way they want to be treated.
- ◆ Ask preferences before acting.
- ◆ Recognize that not all people within a particular background feel, think, or act the same.
- ◆ Taking time to learn about and understand the impact of another person’s uniqueness and culture on the healthcare or workplace interaction.
- ◆ Reminding ourselves that our culture is one of many cultures, and that there is no “right” or “wrong” way to think or believe.
- ◆ Not making assumptions about what people think or why they act in a certain way; keeping an open mind. Be humble enough to let go of the false sense of security that stereotyping brings.
- ◆ Always treating individuals of all cultures with dignity and respecting their differences. Provide access to interpreters, diverse patient education materials, and create and maintain an environment that is welcoming and inclusive of diverse populations.
- ◆ Above all, becoming aware of our own biases through self-reflection and commitment to a lifelong learning process and finding ways to resolve our biases so they do not negatively affect our treatment of, and respect for, others.
- ◆ Becoming cognizant of the power differential between patients and providers, including our limited knowledge regarding patients’ health beliefs and life experiences, and our unintentional and intentional expressions and actions of bias in regard to all the “isms”, including racism, classism, sexism, ageism, ableism, weight bias, and homophobia.

For more information on workplace diversity and creating a culturally inclusive environment contact: Office of Diversity & Inclusion, Jacobsen Hall, suite 711, 464-5234, [diversity@upstate.edu](mailto:diversity@upstate.edu)

# WORKPLACE VIOLENCE

## “What you need to know”

- ✓ The NYS Labor Law Section 27-b related to workplace violence
- ✓ The definition of workplace violence
- ✓ What the risk factors are
- ✓ Supports and training Upstate Medical University provides

### I. NYS Labor Law Section 27-B:

- a. NYS Labor Law 27-b is the ‘Public Employer Safety and Health Act’ that requires Upstate Medical University to:
  - i. Record and report work-related death, injuries and illnesses, which may include incidents of workplace violence
  - ii. Record an injury or illness that results in death, days away from work, restricted work or transfer to another job, medical treatment beyond First Aid or loss of consciousness
  - iii. Provide a ‘Workplace Violence Prevention’ program, including but not limited to Policy UW V-03, <https://upstate.ellucid.com/documents/view/3036>, training, and other supports within Upstate Medical University

### II. WORKPLACE VIOLENCE

- a. Workplace violence is any physical assault, threatening behavior, or verbal abuse occurring in the work setting:
  - i. This includes, but is not limited to, the buildings and the surrounding property, including the parking lots

### III. WORKPLACE VIOLENCE INCLUDES

- a. The use of force with the intent to cause harm (i.e. physical attacks, any unwanted contact such as hitting, fighting, pushing, or throwing objects)
- b. Behavior that diminishes the dignity of others through sexual, racial, religious, or ethnic harassment
- c. Acts or threats which are intended to intimidate, harass, threaten, bully, coerce, or cause fear of harm – directly or indirectly
- d. Acts or threats made directly or indirectly by oral or written words, gestures, or symbols that communicate a direct or indirect threat of physical or mental harm

### IV. RISK FACTORS FOR WORKPLACE VIOLENCE:

- a. Violence may occur anywhere in the Upstate Campus. The most frequent areas include:
  - i. Areas with contact to the public
  - ii. Areas with late night or early morning hours
  - iii. Psychiatric units
  - iv. Emergency rooms

- v. Waiting rooms
- vi. Hospital units with geriatric or head injured patients
- vii. Areas where money is exchanged with the public
- viii. Areas where employees work alone or in small numbers
- ix. Poorly-lighted areas
- x. Uncontrolled access into the workplace

## V. SAFETY TIPS FOR UPSTATE EMPLOYEES

- a. Watch for signals that may be associated with impending violence:
  - i. Body language such as threatening gestures
  - ii. Signs of drug or alcohol use
  - iii. Presence of a weapon
  - iv. Verbal expressions of anger and frustration
- b. Maintain behavior that helps diffuse anger:
  - i. Present a calm, caring attitude
  - ii. Acknowledge the person's feelings (for example, "I know you are frustrated")
  - iii. Be alert throughout the encounter
  - iv. Avoid any behavior that may be interpreted as aggressive (for example, moving rapidly, getting too close, touching, or speaking loudly)
  - v. Don't give orders
  - vi. Don't match the threats
  - vii. Evaluate each situation for potential violence
  - viii. Always keep an open path for exiting (don't let a potentially violent person stand between you and the door)

## VI. ADDITIONAL HELP, TRAINING, AND FOLLOW-UP INFORMATION

- a. **Contact the Employee Assistance Program (EAP) Office during normal business hours at 315-464-5760.**
  - i. After normal business hours, leave a message and someone will return your call the next day
- b. **Workplace Violence: CPI Nonviolent Physical Crisis Intervention' training is available to all employees.**
- c. For more information, contact Organizational Training and Development (OTD) or visit <http://www.upstate.edu/hr/intra/training/register/index.php?searchtext=cpi>

### **HOW TO REPORT A WORKPLACE VIOLENCE INCIDENT**

Employee/Labor Relations @ **315-464-5872**

Employee Assistance Program @ **315-464-5760**

Office of Diversity and Inclusion @ **315-464-5234**

Patient Safety Hotline @ **315-464-SAFE**

University Police @ **315-464-4000** or Community Campus **315-492-5511**

# **This Section is Required for All Upstate University Hospital *LICENSED Staff That Provide Regular Care to Patients***

*Examples: Nursing staff, therapists, social workers, etc.*



# CLINICAL RESEARCH

Clinical Research occurs in ALL settings at University Hospital

## **“What you need to know”**

- ✓ Your role when caring for a patient who is taking part in a research study
- ✓ Resources available to assist the staff with questions related to a research study

## **I. STAFF RESPONSIBILITIES**

### **a. Staff should receive information about his/her role in:**

- i. Collecting data
- ii. Providing a study intervention
- iii. Monitoring the patient’s response to the intervention

### **b. Staff should seek out resources as needed:**

- i. The main resource for study specific information is the Principal Investigator (PI)
- ii. The PI is responsible for managing all aspects of a research protocol
- iii. If you do not know who the PI is, the Clinical Trials Office (CTO) or the Institutional Review Board (IRB) can assist you; they may be reached at x4-5004 and x4-4317, respectively
- iv. Under direction of the PI, Research Coordinators often assist in carrying out parts of the research protocol
- v. Concerns can be confidentially voiced by calling the IRB Office and speaking with Marti Benedict, x4-4317
- vi. Other resources are listed below

### **c. Any Faculty, Staff, or Students involved in the conduct of a research study are REQUIRED to complete educational training.**

## **II. RESOURCES**

- a. **Policy R-08 Guidelines for Obtaining Research Support for University Hospital** (<https://upstate.ellucid.com/documents/view/1320>) outlines steps for starting a research protocol in UH
- b. **The Nurse Research Scientist or Nursing Designee**, will work with PIs and study coordinators to obtain the review and approval by nursing leadership of all research studies which involve the participation of Nursing Department nursing staff.
- c. **The Research Development Office** assists faculty to identify extramural and intramural resources for clinical research projects. The office maintains a web site at [http://www.upstate.edu/researchadmin/sponsored\\_programs/funding](http://www.upstate.edu/researchadmin/sponsored_programs/funding) and can be reached at 4-4322.
- d. **The Research Compliance Office of Research Administration**, assures that all research conducted at Upstate complies with governmental regulations and

institutional policies; they also maintain a website at <http://www.upstate.edu/researchadmin/compliance/> or can be reached at x4-4317.

- e. The Institutional Review Board for the Protection of Human Subjects (IRB) is an administrative body:**
- i. The IRB protects the rights and welfare of human research subjects recruited to participate in research activities conducted at/or under the support of Upstate.
  - ii. All human subject research requires the approval of the IRB prior to initiation.
  - iii. The IRB Administrator and Chief Compliance Officer for Research is Marti Benedict; she may be reached at x4-4317 or [benedicm@upstate.edu](mailto:benedicm@upstate.edu). The IRB maintains a web page at <http://www.upstate.edu/researchadmin/compliance/irb/>
  - iv. This site includes multiple resources, including guidelines and policies.
- f. The Clinical Trials Office (CTO) of Research Administration provides administrative services necessary to conduct and promote clinical research.**
- i. The CTO reviews, revises and signs all clinical trial agreements.
  - ii. The CTO maintains a database of clinical trials taking place on campus.
  - iii. Clinical Trials Administrator is Danielle Doll
  - iv. The CTO maintains a web page at <http://www.upstate.edu/researchadmin/clintrials/>
- g. The Quality Assessment and Improvement Program (QAIP):**
- i. The QAIP is a post (IRB) approval monitoring program aimed at providing subjects with an extra level of protection by reviewing the conduct of the study in real time. The program also provides assistance and ongoing education to investigators and their staff with regard to human subject research and compliance issues.
  - ii. Due to the complexities of the research process, investigators are encouraged to contact the Quality Assessment & Improvement Program Coordinator if any questions arise during the conduct of a trial or if in doubt about any compliance issue.
  - iii. The QAIP maintains a web page at <http://www.upstate.edu/researchadmin/compliance/qaip/>
- h. The Clinical Research Unit (CRU) is an Upstate Medical University supported specialized unit dedicated to conducting outpatient clinical research:**
- i. The CRU is located on the first floor of the IHP.
  - ii. CRU staff includes Certified Research RNs who are dedicated exclusively to conducting research, and an experienced laboratory technician. Services of a research Nurse Practitioner and CRA are also available.
  - iii. The CRU contains a large nurse's station, 10 private rooms, and a room for meeting with sponsors, a room for PIs and coordinators, and a laboratory for processing specimens. Locked refrigerators and cabinets, -20C and -80C

freezers, dry ice, supply storage, and EKG and IV equipment are available. DXA and meeting areas are adjacent, and parking is available.

iv. For more information, you can contact the CRU Nurse Manager or visit their website at <http://www.upstate.edu/cru>

i. **The Research Integrity Office provides advice concerning possible misconduct in research and oversees institutional policies for the review of potential research misconduct at Upstate Medical University.**

i. All employees involved in research studies at Upstate Medical University should review policy UW R-10 - Policy for Responding to Allegations of Research Misconduct at <https://upstate.ellucid.com/documents/view/3023>

ii. All employees of Upstate Medical University are obligated to report research misconduct to the research integrity officer and to cooperate with a research misconduct proceeding.

iii. For more information, contact the Research Integrity Office at 315-464-4292 or [rio@upstate.edu](mailto:rio@upstate.edu)

iv. The Research Integrity Office maintains a web page  
- <http://upstate.edu/researchadmin/compliance/rio/index.php>



# DYSPHAGIA PATIENTS, IDENTIFICATION OF

## ***“What you need to know”***

- ✓ What is Dysphagia
- ✓ What are the characteristics of Dysphagia
- ✓ How are Dysphagia patients identified
- ✓ What does a Mechanically Modified Diet consist of

## **I. WHAT IS DYSPHAGIA**

- a. Dysphagia is difficulty swallowing
  - i. Swallowing and chewing difficulties put patients at risk for aspiration
  - ii. Dysphagia compromises a patients nutritional status due to the inability to consume an adequate volume of solids or liquids
  - iii. Correct identification of Dysphagia patients is vital

## **II. CHARACTERISTICS OF DYSPHAGIA**

- a. Coughing/choking/gagging on food
- b. Drooling
- c. Patient complains food “stuck” in throat
- d. Pockets food in mouth
- e. Prolonged swallow
- f. Weak voluntary cough
- g. Wet voice

## **III. IDENTIFIED DYSPHAGIA PATIENTS**

- a. Patients identified with Dysphagia will be placed on mechanically modified diets.
- b. Patients can be identified with Dysphagia if:
  - i. Patient is admitted with known mechanically modified diet or swallowing/chewing/ feeding issue (i.e. comes from nursing home)
  - ii. Patient is having a problem swallowing/chewing/feeding and/or is a risk for aspiration, Speech and Language (SLP) consult for evaluation is recommended
    1. If the swallow evaluation identifies a risk for swallowing difficulties, SLP will write a nursing order
- c. If a patient is identified, STOP and check the medical records for a nursing or physician order for diet and/or feeding precautions

**BEFORE FEEDING A PATIENT VERIFY THAT PATIENT IS NOT ON A MECHANICALLY MODIFIED DIET OR HAVING DIFFICULTY SWALLOWING/CHEWING**

## IV. MECHANICALLY MODIFIED DIETS

- a. Pureed foods
  - i. Foods that have a consistency of a soft, smooth thick paste; have moist pudding-like consistency; easy to swallow, minimum amount of mouth manipulation
    - 1. Smooth puddings, custards, yogurt, pureed fruits, mashed bananas, smooth soufflés, cooked cereals as farina
    - 2. Avoid sticky foods like peanut butter
- b. Mechanical ground foods
  - i. Foods that are moist and soft-textured, meats are ground or minced no larger than one-quarter inch pieces; chewing ability is required
    - 1. Soft, well-cooked vegetables, ground meat, poached or scrambled eggs, casseroles without rice, cottage cheese, moist macaroni and cheese, cooked cereals as oatmeal, fresh, soft, ripe bananas
- c. Dental Soft foods
  - i. Consists of nearly regular textures with the exception of very hard, sticky, or crunchy foods
  - ii. Still need to be moist and should be in “bite-size” pieces
  - iii. Can be a transition to regular diet
    - 1. Soft, peeled fresh fruit as peaches, cantaloupe, nectarines; casseroles with small chunks of meat, well, moistened breads, muffins
- d. Thickened Liquids
  - i. Nectars, honey and pudding thick chocolate milk, cream soups,
- e. Nectar-Thick Liquids
  - i. Tomato juice
- f. Honey-Thick Liquids
  - i. Liquids thickened to honey consistency; pourable, but not runny
    - 1. Yogurt, thick cream soup
- g. Pudding-Thick Liquids
  - i. Pudding, custard, hot cereal, liquid thickened to pudding consistency and eaten with spoon

# HIV CLINICAL CARE

## *“What you need to know”*

- ✓ NYS Department of Health laws related to HIV counseling, testing, consenting and reporting
- ✓ University Hospital’s policies and procedures related to HIV-related Testing and Mandatory Reporting for Inpatients and Outpatients, and Confidentiality of HIV-related information

## **I. HIV COUNSELING AND TESTING IN NYS**

- a. HIV testing is voluntary except in limited circumstances as authorized by NYS law.
- b. HIV tests may be ordered by registered nurses under non-patient specific protocols, as long as patients are informed that HIV testing will be done and have the opportunity to decline.
- c. NYS law requires that patients aged 13 and older receiving hospital, emergency department, or primary care outpatient services be offered HIV testing, or that routine opt-out HIV testing be incorporated into care in these settings. The offer for routine HIV testing is required only once, unless the provider determines evidence of risk factors. Patients may request testing at any time.
- d. Written consent for HIV testing is no longer required in NYS, and HIV testing should be considered a part of routine care. Patients or their legal representatives must be—at a minimum—informed that an HIV test is going to be performed, and must be allowed to decline. The NYS Department of Health “7 Points of Education” must be provided to or displayed for all patients receiving HIV testing. Providing information contained in the “7 Points of HIV Education” fulfills pre-test counseling requirements.
- e. In the case of a needle stick injury in which the source patient is not capable of consent and no legal representative is available, HIV testing may be ordered by an attending physician and conducted on the source patient without consent; the clinical laboratory should be contacted prior to sending a sample to determine proper sample ordering and labeling.
- f. The NYS Department of Health requires mandatory reporting of all initial determinations or diagnoses of HIV infection, HIV-related illness, and AIDS. Newly diagnosed patients (who have positive preliminary and confirmatory tests for HIV) should be referred **as soon as possible, within 72 hours**, to an infectious disease specialist. **Upstate Pediatric Infectious Disease** (infancy through age 24) and **Inclusive Health Services** (age 18 and up) will rapidly accommodate new patients into their clinical schedules in order to promote timely care linkage and initiation of antiretroviral medications. Pediatric Infectious Disease and Inclusive Health Services will also assist providers in completing mandatory NYS case reporting.

- g. Contact notification is also a component of the reporting requirement, and known contacts, including a known spouse will be reported, and the patient will be requested to cooperate in contact notification.

## **II. HIV INFORMATION/RESOURCES:**

- a. Upstate Inclusive Health Services, a NYS Designated AIDS Center at University Hospital (315-464-5533) may be contacted for HIV-related questions, concerns, or guidance.
- b. For additional information, please review University Hospital Administrative Policy H0-3: HIV-Related testing and Mandatory Reporting for Inpatients and Outpatients, <https://upstate.ellucid.com/documents/view/1241>.

# INFECTION CONTROL, *CLINICAL*

## ***“What you need to know”***

- ✓ What are the strategies to stop transmission of MDRO
- ✓ What has changed in managing MRSA and VRE patients
- ✓ What are the strategies to prevent CLABSI
- ✓ What are the strategies to prevent SSI
- ✓ What are the strategies to prevent CAUTI
- ✓ What are the Centers for Diseases Control (CDC) Guidelines for Safe Injection Practices

## **I. PREVENTION OF HEALTH-CARE ASSOCIATED INFECTIONS (HAI)**

- a. Prevention strategies are evidence-based best practice
- b. Upstate University Hospital incorporates best practice from, but not limited to, the Institute of Healthcare Improvement (IHI), Children’s Hospital Association, University Healthcare Consortium (UHC), Centers for Disease Control (CDC)
- c. Health care workers are responsible to know the strategies for preventing HAI
- d. The Infection Control department reports infection rates monthly on nursing unit quality grids, to the Infection Control Committee (ICC), and surgical site infections to the surgical services and ICC.

## **II. MULTI DRUG RESISTANT ORGANISMS (MDRO)**

- a. Strategies to prevent the spread of MDROS include:
  - i. Compliance with Hand Hygiene
  - ii. Contact Precautions for MDROS per policy
  - iii. Contact Precautions Plus for *C. difficile*
  - iv. Dedicated equipment for patients on precautions
  - v. Disinfectant wipes in all patient rooms to perform surface cleaning & disinfection for furniture and equipment surfaces
  - vi. Cleaning procedures target high touch surfaces (siderails, etc.)
  - vii. MDRO infection rates -reported on quality grids to all nursing units and the Infection Control Committee
  - viii. Laboratory report identifies need for precautions; test results display in EMR
  - ix. Electronic alert code for MRSA, VRE and other MDRO displays in EMR header infection field
- b. Changes in management of MRSA and VRE patients:
  - i. Precaution category changed to Standard Precautions for adults
  - ii. Pediatric patients - continue use of Contact Precautions
  - iii. Uncontained MRSA/VRE infected wound with dressing changes >2 in an 8 hour period – use Contact Precautions
  - iv. Refer to IC C-04 Disease Reference Chart for new MRSA/VRE algorithm for use of contact precautions

### **III. CENTRAL LINE ASSOCIATED BLOODSTREAM INFECTIONS (CLABSI)**

- a. Strategies to prevent CLABSI include:
  - i. Insertion Bundle Approach –
    1. Compliance with Hand Hygiene
    2. Maximum Barrier Precaution Carts for Insertion (right supplies at right time)
    3. Procedural checklist for insertion of central lines
    4. Skin prep with CHG (Chlorhexidine Gluconate)
    5. Right site selection (avoid femoral vein in adult patients)
    6. Daily Review of lines for prompt removal
  - ii. Maintenance of line –
    1. Compliance with Hand Hygiene
    2. Disinfect hubs and injection ports before access
    3. Use available engineering controls (port protectors)
    4. Dressing integrity (review central line policies)

### **IV. SURGICAL SITE INFECTIONS (SSI)**

- a. Strategies to prevent SSI include:
  - i. Follow Surgical Care Improvement Project (SCIP) Principles
    1. Antibiotic Management
      - a. Doctors order appropriate pre-op antibiotic and dose
      - b. Pre-op antibiotic given within one hour of incision
      - c. Antibiotic discontinued 24 hours after surgery (48 hours after cardiac surgery)
    2. Temperature Management to control hypothermia (low body temperature)
    3. No shave policy
    4. Remove urinary catheter within 48 hours post-op
    5. Monitor and control post-op blood sugar levels for cardiac patients

### **V. CATHETER-ASSOCIATED URINARY TRACT INFECTIONS (CAUTI)**

- a. Strategies to prevent CAUTI include:
  - i. Insert catheters only for appropriate indications, assess need daily and remove promptly
  - ii. Proper techniques for urinary catheter insertion: requires two trained personnel
    1. trained personnel perform procedure for insertion
    2. use insertion observation tool to ensure and document proper technique
    3. use aseptic technique & sterile equipment
    4. perform hand hygiene before and after insertion and for any manipulation of catheter or site
  - iii. Proper techniques for Urinary Catheter Maintenance
    1. maintain closed drainage system

2. maintain unobstructed urine flow (catheter & tubing free from kinking, collection bag below level of bladder, bag off floor/ monitor for unobstructed urine flow during transport)
3. empty collection bag regularly and before transport or ambulation
4. use proper catheter securement (avoid catheter movement and urethral traction)
5. periurethral hygiene with soap and water will be performed at least every 8 hours and PRN as needed
6. Use standard precautions (gloves/gowns as needed) for any manipulation of catheter or collecting system

## VI. SAFE INJECTION PRACTICES

- a. The CDC and the New York State Health Department have defined Safe Injection Practice as described below in response to: a) national outbreaks of Hepatitis B virus and Hepatitis C Virus and b) investigation of post-myelography bacterial meningitis cases that concluded clinicians did not wear facemasks during the procedure and droplet transmission of oralpharyngeal flora was likely. All licensed personnel must comply with these standards. This applies to: use of needles, cannula that replace needles, and intravenous delivery systems.

- b. Injection Safety Guidelines

- i. Never administer medications from the same syringe to more than one patient, even if the needle is changed.
- ii. After a syringe or needle has been used to enter or connect to a patient's IV it is contaminated and should not be used on another patient or to enter a medication vial.
- iii. Never enter a vial with a used syringe or needle.
- iv. Never use medications packaged as single-dose vials for more than one patient.
- v. Limit the use of multi-dose vials and assign medications packaged as multi-dose vials to a single patient whenever possible.
- vi. Do not use bags or bottles of intravenous solution as a common source of supply for more than one patient.
- vii. Follow proper infection control practices during the preparation and administration of injected medications.
- viii. Wear a surgical mask when placing a catheter or injecting material into the spinal canal or subdural space (i.e. myelograms, lumbar puncture and spinal or epidural anesthesia).



## VII. PATIENT EDUCATION

- a. Go to: <http://www.upstate.edu/uhpated/intra/>
- b. click on Infection Control for selection of handouts to print

# MEDICAL RECORD DOCUMENTATION

## *“What you need to know”*

- ✓ The requirements for medical record entries & key factors to good documentation
- ✓ The requirements for medical record additions and corrections
- ✓ What the Unacceptable Abbreviations/Do Not Use List is
- ✓ Medical record completion expectations

## I. MEDICAL RECORD ENTRIES

- a. All entries in the medical record should be chronological and made at the time of patient care as to not compromise patient care, patient safety, and the integrity of your documentation.
- b. Entries must be legible, printed/stamped name along with signature and credentials, dated, and timed for compliance with accreditation and federal standards and signed timely as notes in Epic cannot be seen by others until they are signed.
- c. Use Epic Smart Text and Notewriter to efficiently document a complete note with all required fields.
- d. Entries on paper should be recorded in black ink to facilitate quality reproduction and each page of the medical record must contain the patient’s name, date of birth, and medical record number.
- e. If there are electronic signatures from approved hospital systems, the electronic signature is considered acceptable and represents your legal signature.
- f. Pended notes in the electronic medical record must be completed and signed or deleted if the note was started in error.
- g. **Proper documentation is essential for quality patient care and to protect against unfavorable outcomes; if documentation is incomplete or non-existent, medical necessity and care may be questioned.**

## II. KEY FACTORS TO GOOD DOCUMENTATION

- a. Documentation must include the following:
  - i. An authenticated physician order for services
  - ii. Required consents
  - iii. Physician’s documentation as well as any consulting physician documentation
  - iv. Nursing notes
  - v. Test results
  - vi. Demographic information
  - vii. Treatment
  - viii. An updated Problem List of the patient’s diagnoses
- b. Clinical documentation, including nursing and physician documentation, must include the following elements:



- i. Time and means of arrival
- ii. Pertinent history of illness or injury, including place of occurrence and physical findings to include the patient's vital signs, emergency care given to the patient prior to arrival, and those conditions present upon arrival
- iii. Clinical observations, including results of treatment
- iv. Diagnostic impressions
- v. Progress, response to and changes in treatment
- vi. Condition of patient on discharge or transfer
- vii. Conclusions at the termination of treatment, including final disposition, condition, and instructions for follow up

### III. WHY IS YOUR PATIENT IN THE HOSPITAL?

- a. Please keep these points in mind when documenting:
  - i. In the History & Physical, list a diagnosis for every home medication
  - ii. In the progress notes, list a diagnosis for every lab, test or x-ray ordered
  - iii. Justify in the progress notes why the patient remains in the hospital today
  - iv. Daily progress notes do not have to reflect admitting information stated previously in the H&P or progress notes.

**The Principal Diagnosis is the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.**



**CHRONIC medical conditions** requiring ongoing and continuous management deserve a place in the current problem list. Although they may not have precipitated the patient's admission, they are still subject to your ***management efforts*** and ***medical decision-making***.

Document ***chronic medical conditions*** as an **active problem**, if only to say, "Currently stable."

**DOCUMENTING ACUTE AS WELL AS CHRONIC CONDITIONS  
WILL MORE ACCURATELY REFLECT THE  
SEVERITY OF ILLNESS AND RISK OF MORTALITY OF YOUR PATIENTS**

### IV. MEDICAL RECORD ENTRY ADDITIONS & CORRECTIONS

- a. All Correction of Errors:
  - i. The author of an entry may cross out the inaccurate material with a single line, note the date and time of the correction, initial the correction, add a marginal note as to why the correction was made, and sign.

- ii. Chart corrections in the electronic medical record are to be made by the author of the original note following the erroneous procedures for this process. If a note is greater than 30 days, it becomes review only and the correction has to be made in Health Information Management.
- b. Addendums:
  - i. When an error of omission has occurred and is discovered (while the patient is in-house or immediately following outpatient treatment), write “addendum,” the date and time of the addendum note, record the information, and sign the entry.
- c. Late Entries:
  - i. Late entries are defined as entries made after the patient has been discharged. Note “Late Entry,” date and time of the late entry, record the information, and sign the entry.

## V. UNACCEPTABLE ABBREVIATIONS

- a. It is not acceptable to have “do not use” abbreviations anywhere in the medical record
- b. Please refer to the unacceptable listing frequently to double-check your entries.
  - i. Many common forms now have unacceptable abbreviation listing reminders
- c. Be aware of the unacceptable abbreviation listing/ “Do Not Use List”:
  - i. Drugs: ARRA; AZT; HCT; HCTZ; MgSO4; MSO4; MS; MXT; Norflox; TAC; ZnSO4; CPZ
  - ii. Directions: IU; QD; QOD; U; X3D; X4D; µg
  - iii. Apothecary Symbols
  - iv. No trailing ‘0’ after decimal (i.e., do not use 5.0)
  - v. Need to have leading ‘0’ prior to decimal (i.e., 0.1 not .1)

## VI. MEDICAL RECORD COMPLETION EXPECTATIONS:

- a. **History & Physical (H&P) Examination**
  - i. Completed no more than 30 days before or 24 hours after admission, but prior to surgery
  - ii. When a medical history and physical has been completed within 30 days before admission or outpatient surgery, the H&P must be updated and authenticated within 24 hours after admission or prior to surgery or procedure requiring anesthesia
- b. **Consultation**
  - i. Completed within 24 hours of consult and signed within 7 days
- c. **Operative Note**
  - i. A brief operative note to be documented immediately following the operation completing all of the data fields:
    1. The names of surgeons and assistants
    2. Pre op and post op diagnosis

3. Procedure performed
  4. Specimens removed
  5. Estimated blood loss
  6. Any complications
  7. Type of anesthesia administered
  8. Grafts or implants
- ii. If any of the above items are not relevant, they still must be addressed as "NA." If a template is used, blanks on any operative reports are not acceptable
  - iii. A comprehensive note needs to be completed within 24 hours of the operation and signed within 7 days
- d. **Discharge Summary**
- i. Completed within 24 hours of discharge and signed within 7 days
- e. **Verbal Orders**
- i. Signed within 48 hours

**Best practices should be used to protect the integrity of the patient's health information.**

**The HEART of the matter = PATIENT SAFETY**



# MEDICATION ADMINISTRATION

## “What you need to know”

- ✓ The Medication Administration/Dispensing policy number
- ✓ The “Six Rights” of patients
- ✓ The general medication administration practices

## I. ALL LICENSED PROFESSIONALS WHO ADMINISTER & DISPENSE MEDICATIONS

### MUST:

- a. Follow Policy Number: CM M-03 (Medication Administration/Dispensing–General <https://upstate.ellucid.com/documents/view/3761>)
- b. Maintain at all times the “Six Rights” of patients and they are: **right patient, right medication, right dose, right time, right route, and right documentation**

## II. NURSING PERSONNEL

- a. Are required to implement the order of practitioners, including medication administration in accordance with such orders and standards of nursing and medical practice

## III. GENERAL MEDICATION ADMINISTRATION PRACTICES

- a. Medication orders must include: the name of the drug, dose, route, start date or time, frequency, and if p.r.n., the reason for administering the medication
- b. Medication shall not be left unattended
- c. Before administration, high alert medication must be double checked and documented per policy CM M-03 Medication Administration/Dispensing-General
- d. When administering medication, access the electronic medical record (EMR) via the workstation on wheels (WOW). The WOW must be taken to the bedside to ensure accurate administration of the drug and identification of the patient
- e. Medications must be signed off by the professional who administers them immediately and only after the drug is administered
- f. Patient identification must occur prior to administration of medication as appropriate with the patient/parent/caregiver by checking/scanning patient identification bracelet and verbally confirming patient identity with the patient/parent/caregiver as appropriate to patient status
- g. If administering an injection, documentation of the injection site is required
- h. Assessment and evaluation of a patient’s response to medication shall be documented within the medical record
- i. If part of a controlled substance is to be wasted (not including PCA/epidurals), the actual wasting of the medication must be witnessed visually and entered into the PYXIS machine. Wasting of controlled substances is to occur immediately after access if a partial dose is to be administered or immediately after does administration if entire dose was not administered to patient
- j. If PCA/EPIDURAL, controlled substances needs to be wasted the actual wasting of the medication must be witnessed visually, measured accurately, discarded appropriately, and documented in EPIC correctly

- k. Medications should be administered in a timely fashion relative to scheduled administration times. This is especially important for first dose antibiotics and medications designated per policy and flagged within the MAR as time critical medications

# NURSING CASE MANAGEMENT

## ***“What you need to know”***

- ✓ Case managers are experienced registered nurses who facilitate the discharge process of all patients to next appropriate level of care
- ✓ Case managers work collaboratively with the client, caregivers, health care providers, payers and community partners to meet the client’s healthcare needs.
- ✓ Case managers assist the family, caregivers and treatment team in understanding community resources, treatment options, insurance benefits so timely and informed decisions can be made.
- ✓ Case managers coordinate resources needed for hospital discharge from skilled nursing facility placement to home care to arranging for medical equipment for home
- ✓ Case managers are available to help facilitate the discharge of any medically complex patient who needs extensive coordination of services.

## **I. DISCHARGE AND DISCHARGE PLANNING**

### **a. Before and During Admission**

- i. Discharge planning begins at the time of admission
- ii. Assessment of patient’s needs
- iii. Plan of care during and after hospital stay

### **b. During Hospital Stay**

- i. Members of the health care team work together to make sure the patient’s needs are met from admission through discharge
- ii. Patient and their family are included as part of the team
- iii. Patient and family should always be given information about the patient’s condition, care, and treatment choices

### **c. At the Time of Discharge**

- i. Discharges should be prior to 11:00 AM
- ii. An anticipated date of discharge should be developed and shared with the patient and caregivers as soon as possible.
- iii. Bedside nurse presents information and education regarding treatment plans, medications, and services after discharge if applicable
- iv. **Discharge Appeal** can be made by the patient if they feel they are being discharged too soon

### **d. Discharge – Against Medical Advice (AMA)**

- i. Patient demands to be discharged against medical advice from their doctor
- ii. Health care providers must inform patient of consequences and options for care
- iii. Contact the social worker assigned to your area/unit to see the patient per policy

# PATIENT EDUCATION

## ***“What you need to know”***

- ✓ How to access multidisciplinary patient education tools and materials that are standardized and consistent across campuses for patient, family, and visitor education.

### **I. PATIENT EDUCATION WEBSITE (PUBLIC – WWW.UPSTATE.EDU/PATIENTED)**

- a. [http://www.upstate.edu/hospital/patients/pated\\_doc.php](http://www.upstate.edu/hospital/patients/pated_doc.php)
- b. Public access to our patient education and informational resources for patients and visitors, off the University Hospital /Patient & Visitor /Patient Education available on their devices before, during, or after their stay.

### **II. PATIENT EDUCATION WEBSITE (INTRANET):**

- a. <http://web.upstate.edu/pated/intra>
- b. Website for healthcare professionals to access and print Upstate handouts and publications. Linked from Epic under Clinical References.

### **III. HANDOUTS AND VIDEOS:**

- a. Handouts by vendors: LexiComp (Medication Education Use and Side Effects), Krames-on-Demand - over 5000 + Patient Education Handout Titles in both English and Spanish as well as other languages for select items and are searchable by keyword, subject, or language.
- b. Handouts: Upstate internally created handouts, booklets and brochures can be accessed in MCN <https://upstate.ellucid.com/home>
- c. Translated Education: Handouts can be found in multiple languages: From Patient Education website- Link to “Translated Education” on the left side of page. Links to websites that have patient education in other languages. [http://www.upstate.edu/interpreter/intra/translated\\_ed.php](http://www.upstate.edu/interpreter/intra/translated_ed.php)
- d. Educational Videos:
  - i. Inpatients, from the Upstate Patient Education webpage, click “Education TV” on the right side of the page, <http://www.upstate.edu/pated/intra>
  - ii. Outpatients, go to <http://www.thepatientchannelnow.com/>
  - iii. Upstate Medical University has the following Patient Education Television available from The Wellness Network:
    - 1. Community Campus:
      - a. Patient Channel, Channel 51, password: 06760 <http://www.thepatientchannelnow.com>
      - b. Heart Care Channel, Channel 52, password: 06760 <http://www.heartcarechannelnow.com>
      - c. Newborn Channel, Channel 50, password: 07840 <http://www.thenewbornchannelnow.com>

2. Downtown Campus:
  - a. Patient Channel, Channel 59, password:  
06760 <http://www.thepatientchannelnow.com>
  - b. Heart Care Channel, Channel 60, password:  
06760 <http://www.heartcarechannelnow.com>
  - c. MedSerenity Channel, Channel 61, password:  
06760 <http://www.medserenitychannelnow.com>

#### **IV. DOCUMENT TEACHING IN THE ELECTRONIC MEDICAL RECORD**

- a. Epic Inpatient–Patient Education is documented in the activity tab marked “Patient Education”. Teaching points and comments are documented in the patient’s individual care plan after the patient’s care plan and corresponding topics are created.
- b. Epic Outpatient and Emergency Room documents patient education in “Notes” Tab.



# PATIENT EDUCATION TEACH-BACK

## *“What you need to know”*

- ✓ What is teach-back, how to use and document the teach-back method when educating

### **WHAT IS TEACH-BACK?**

- a. Teach-back is a proven method to confirm the healthcare provider has explained the information in a way the patient can understand.
  - i. Studies have shown that 40-80% of the medical information patients receive is forgotten immediately, and half of the information retained is incorrect.
- b. The patients will verify their understanding by restating the information in their own words.
- c. The goal of teach-back is to provide effective teaching at the literacy level of the patient or family members. This is not a test of the patient’s knowledge but rather a test of how well staff has explained the concept.

### **II. HOW TO USE TEACH-BACK:**

- a. Explain: Speak slowly and clearly. Use plain language. Avoid medical jargon. Make eye contact. Be specific and concrete. Provide written material along with the verbal instructions. Include drawings or pictures if needed. Avoid using questions that could be answered as “Yes” or “No”
- b. Plan your approach: Think about how you will ask your patient to teach-back information based on the topic you are reviewing. Keep in mind that some situations will not be appropriate for using the teach-back method
- c. Use handouts: Review materials to reinforce the teaching points that were already discussed
- d. Clarify: “I want to be sure I explained everything clearly, please tell me in your own words what you heard me say.” If patients cannot remember or accurately repeat what you asked them, clarify the information or directions and allow them to teach it back again.
- e. Practice: It may take some getting used to, but once teach-back is established as part of routine care, it does not take long to perform.

### **III. DOCUMENTING TEACH-BACK:**

- a. Clearly document the name and relationship of those being taught and/or demonstrating. For example: “patient” “patient’s wife, Lilly”
- b. Document what was taught or demonstrated.
- c. Document the outcome of patient/caregiver understanding.

# PROCEDURE VERIFICATION

Policy S-19 Procedure Verification for Surgical & Invasive Procedures, <https://upstate.ellucid.com/documents/view/1332>

## ***“What you need to know”***

- ✓ What procedure verification is
- ✓ The procedural verification steps
- ✓ Where procedure verification is documented

## **I. PROCEDURE VERIFICATION**

- a. To promote patient safety, strict adherence to the procedure verification process is required to ensure the correct procedure is done on the correct patient on the correct site
- b. Is required prior to the beginning of all surgical and invasive procedures including, but not limited to, those that require a written informed consent
- c. Setting where the site verification process is indicated include, but are not limited to, all operating room suites, the emergency department, inpatient units, intensive care units, outpatient areas, and ancillary procedure areas such as endoscopy suites, catheterization laboratories, and radiology
- d. Must include active involvement and effective verbal communication among anyone assisting in any way in an operative or non-operative procedure, including the patient or authorized decision maker
- e. Patients with physical or cognitive barriers to hearing or understanding the surgical/procedural processes must be provided with whatever aids or supports are necessary to facilitate understanding
- f. For more detailed information, review Administrative Policy S-19 Procedure Verification for Surgical & Invasive Procedures, <https://upstate.ellucid.com/documents/view/1332>

## **II. PROCEDURE VERIFICATION STEPS**

- a. **Scheduling for procedures – The following information is required:**
  - i. At least two patient identifiers
  - ii. Entire procedure/surgery description to include exact site, level, digit, and side; no abbreviations are to be used
  - iii. Specific implant/implant system or special equipment required
  - iv. Specific information on remove of device if applicable
  - v. Specific information on harvest or donor site if applicable
  - vi. Specific diagnostic images/reports germane to procedure that need to be available to assist with procedure verification
- b. **Consent for Diagnostic, Therapeutic, Invasive, or Surgical Procedures** is complete and consistent with plan for procedure, site and/or side, and/or digit, and/or spine level, and/or end location of catheter, reservoir, and/or device
- c. **Pre-procedure verification:**
  - i. Verification of the correct patient utilizing two identifiers – patient’s first and last name and date of birth and medical record number, if available

- ii. Confirm relevant documentation is present, including a current History and Physical as per requirements
  - iii. If applicable, pertinent diagnostic reports/studies germane to procedure are available and any images are accurately displayed for correct patient, procedure, site, laterality, spine level or digit and are displayed in the correct orientation, identified by markers on the image
  - iv. Scheduled procedure is consistent with consent form and is verbally confirmed with the patient or decision maker
- d. Site marking:**
- i. Must involve the patient if possible
  - ii. Surgeon/proceduralist must do site marking using his/her own initials at or near the procedural site
  - iii. Non procedure site(s) should not be marked
  - iv. Site is marked and initialed using an FDA approved marker
    - 1. Exceptions to site marking and for use of Anatomical Surgical/Procedural Site Marking form – refer to Administrative Policy S-19 Procedure Verification for Surgical & Invasive Procedures, <https://upstate.ellucid.com/documents/view/1332>
- e. Time out is the final procedure verification:**
- i. Time Out is the required, active, and verbal step which occurs among all members involved with the procedure/surgery immediately before starting procedure or making the incision
  - ii. Time Out confirmation includes the verification of:
    - 1. Correct patient identity utilizing two identifiers
    - 2. University Hospital wrist band matches the medical chart
    - 3. Correct side and site and spinal level and/or digit, and/or end location of catheter, reservoir, and device harvest and donor site
    - 4. Agreement on the procedure to be done
    - 5. Correct patient position
    - 6. Availability of correct implants, special equipment, and radiographic films if applicable
    - 7. Confirmation with Surgeon/Proceduralist that images germane to procedure have been reviewed immediately prior to incision or/procedure
      - a. Any discrepancy or disagreement in information needs to be resolved prior to proceeding with procedure/surgery
      - b. There are no exceptions to the **'TIME OUT'** requirement

### **III. DOCUMENTATION OF SITE VERIFICATION AND TIME OUT**

- a. Pre-procedure verification, Site verification, and Time Out processes must be documented on the Procedure Verification Checklist in EPIC for all invasive procedures. During downtime use the Surgical and Invasive Procedure Checklist, Form 41019, <https://upstate.ellucid.com/documents/view/1960>

# SOCIAL WORK

## ***“What you need to know”***

- ✓ What the Social Work Department is responsible for
- ✓ When an urgent consult should be requested

### **I. SOCIAL WORK DEPARTMENT IS RESPONSIBLE FOR**

#### **a. Discharge – Against Medical Advice (AMA)**

- i. Patient requests to be discharged against medical advice from their doctor
- ii. Health care providers must inform patient of consequences and options for care
- iii. Contact Social Work

#### **b. Advance Care Planning – Assistance with Advance Directives**

- i. Assistance with conversations/decision making assistance regarding Health Care Proxies, MOLST, Living Wills, and DNR
- ii. Education for staff and patients
- iii. Any Upstate staff can witness a Health Care Proxy

#### **c. Substance use Evaluation and Referrals**

- i. Contact Social Work for + substance use screen or part of Alcohol Withdrawal Protocol
- ii. Social work will perform an in-depth substance use assessment and provide substance use screening and brief intervention for trauma patients
- iii. Social work will facilitate referrals to inpatient or outpatient treatment
- iv. The Social Work Department Substance Use Resource list will be offered

#### **d. Crisis & Trauma Response**

- i. Ascertain identity of patient
- ii. Assist with contacting the authorized decision maker
- iii. Family support in conjunction with Spiritual Care
- iv. Adjustment to illness
- v. Refer to Violence Education Prevention Outpatient Program as appropriate

#### **e. Psychosocial Assessments**

- i. All inpatient psychiatric admissions
- ii. Annual assessments of all patients of the Immune Health Services downtown campus
- iii. Patients meeting high-risk criteria

**f. Housing Arrangements for Out-Of-Town Guests**

- i. Ronald McDonald House assessment/referral
- ii. After hours hotel and Sarah's Guest House arrangements

**g. Transportation Arrangements**

- i. After hours transportation arrangement for discharged patient

**h. Conflict Resolution**

- i. Facilitate communication between patients, family members, and the treatment team

**i. Discharge Planning, Consultation and Assistance**

- i. Discharge planning for patients being discharged to OMH, OPWDD, substance use treatment facilities and psychiatric facilities

**II. SOCIAL WORK URGENT CONSULTS**

- a. Patients requesting to leave AMA
- b. Suspected family violence, including child neglect and physical or sexual abuse
- c. Facilitate Psychiatric Placement for patients in the Emergency Department requiring inpatient placement
- d. Maternity patients with substance use or mental health issues and/or adoption plans (community campus)
- e. Trauma: identification of patient/authorized decision-maker or emotional support
- f. Victim of Human Trafficking

# SUD – SUBSTANCE USE DISORDER

## ***“What you need to know”***

- ✓ The definition of SUD
- ✓ Who is screened for SUD
- ✓ Who to contact if patients screen positive for SUD
- ✓ What resources are given to patients regarding SUD
- ✓ Where can more information be obtained about SUD
- ✓ Information about Opioid prescribing, administration, and safety

## **I. WHAT IS SUD**

- a. Substance Use Disorder, also known as addiction, is a disease that affects a person's brain and behavior and leads to an inability to control the use of a substance, either illicit or prescribed. Substances such as alcohol, marijuana, and nicotine also are considered drugs. When addicted, individuals may continue using the drug despite the harm it causes.

## **II. WHO IS SCREENED FOR SUD**

- a. Upstate will screen all patients age 11 and over (Inpatient, Ambulatory, and Emergency Department)

## **III. WHO TO CONTACT IF PATIENTS SCREEN POSITIVE FOR SUD**

- a. The RN should notify the Primary Medical Team of a positive screen. A BPA for a Social Work referral will generate with a positive screen. Social Work will be able to place a pended Addiction Consult for review and signature by the team. This will NOT generate a consult to the Addiction team. The primary team must page for the consult.
- b. Social Work will work with the patient to determine desire for treatment and review treatment options. They may facilitate a telephone intake to a Treatment Agency to initiate the intake process in order to facilitate the patient's admission into a treatment program.
- c. If Social Work is unable to address the referral during the encounter, Social Work will follow-up after discharge with the patient and document in the EMR (this may happen more frequently in the ED and ambulatory areas). The on-call Social Worker may also be called for emergencies.

## **IV. WHAT RESOURCES ARE GIVEN TO PATIENTS REGARDING SUD**

- a. Substance Use Disorder educational materials will be provided verbally and in writing and documented throughout each encounter. The resource document

from the Office of Alcoholism and Substance Abuse Services (“OASAS”) should be given to patients in accordance with policy CM A-27. Please see [https://www.health.ny.gov/professionals/hospital\\_administrator/letters/2018/docs/educat\\_pamphlet\\_substance\\_disorders.pdf](https://www.health.ny.gov/professionals/hospital_administrator/letters/2018/docs/educat_pamphlet_substance_disorders.pdf)

## V. WHERE CAN MORE INFORMATION BE OBTAINED ABOUT SUD

- a. Please review the following:
  - i. CM A-27, Substance Use Screening, Assessment, Intervention, and Referral: <https://upstate.ellucid.com/documents/view/3641>
  - ii. CM P-26, Pain Assessment and Management: <https://upstate.ellucid.com/documents/view/3818>
  - iii. CM O-14, Opioid Safety Management: <https://upstate.ellucid.com/documents/view/3800>
- b. Related Policies:
  - i. P-59, Patient Belongings/Room Safety Search: <https://upstate.ellucid.com/documents/view/1316>
  - ii. EMER O-02, Opioid Overdose Education and Naloxone Distribution in the Upstate University Hospital Emergency Department: <https://upstate.ellucid.com/documents/view/8723>
  - iii. CM N-12, Naloxone (Narcan) Administration: <https://upstate.ellucid.com/documents/view/3788>
- c. Patient Education-Disposal Guidelines Sharps/Needles: <https://upstate.ellucid.com/documents/view/6487>
- d. Staff Education/Related Resource:
  - i. Video Patient Belongings and Room Safety Search Procedure-(Policy P-59): <https://upstate.rev.vbrick.com/#/videos/36e92d24-31b3-45bf-a7b0-5a53f874017b>

## VI. OPIOID PRESCRIBING, ADMINISTRATION, AND SAFETY

- a. Refer to Policy CM O-14, Opioid Safety Management: <https://upstate.ellucid.com/documents/view/3800> for definitions of Opioid tolerance, prescribing and administration considerations, opioid restrictions, etc. Contact Addiction and/Pain Services for assistance.
- b. If multiple prn opioids are ordered for pain, only one dose of one opioid medication can be given at one time. Ensure adjunct pain medications are also offered.
- c. Medications ordered for prn pain should be qualified for severity of pain using the identified qualifiers in EPIC. The dose administered must match the pain qualifier. If these do not match, the provider must be notified, followed by appropriate documentation.

- d. Addictive qualities of opioids and weaning of pain medications should be reviewed with all patients. Co-prescribing of Naloxone should be considered for all patients deemed high risk for overdose.
- e. Patients should be notified that they can dispose of unused medications at the DT campus outside of the Outpatient Pharmacy.



# UTILIZATION MANAGEMENT

## ***“What you need to know”***

- ✓ Utilization Management Nurses are Registered Nurses experienced in level of care, medical necessity review and documentation improvement.
- ✓ Utilization Management Nurses assist in cost containment, compliance, and quality initiatives across the continuum.
- ✓ Utilization Management Nurses provide staff education and are patient advocates for utilization of their healthcare benefits and plan during the hospital stay.

## **I. THE UTILIZATION MANAGEMENT PROGRAM:**

- a. During and After the Hospital Stay:
  - i. Conducts reviews of patients for the appropriate level of care and medical necessity.
  - ii. Consultants to Hospital Staff for high risk, complex discharges or insurance related concerns.
  - iii. Leads the Clinical Documentation Program through quality initiatives to accurately capture the Severity of Illness and Risk of Mortality of our patient population.
  - iv. Management of the inpatient denial and appeal processes related to financial reimbursement, compliance and regulatory guidelines.
  - v. Contributes to the financial integrity of the organization through identification, implementation and evaluation of cost effective practice.

## **II. THE UTILIZATION MANAGEMENT NURSE:**

- a. Services internal and external customers and works collaboratively with all disciplines in the hospital across multiple settings
- b. Provides continued education throughout the organization related to CMS regulatory and Federal guidelines.
- c. The Utilization Management Department conducts admission, concurrent, and retrospective reviews to evaluate the necessity, appropriateness, and efficiency of healthcare services. For medical necessity admission or level of care stays that do not meet current criteria, Utilization Management works directly with the Physician and Multi-Disciplinary Team to ensure that patients are at the appropriate level of care. The Utilization Review Committee provides direct oversight and final decision making in determinations related to level of care.
- d. The purpose of the Clinical Documentation Improvement (CDI) program is to initiate concurrent and/or retrospective reviews of inpatient health records for conflicting, incomplete, or non-specific provider documentation. The goal of these reviews is to identify clinical indicators to ensure that all diagnoses and procedures are supported by ICD-10 Codes. Verbal and electronic communications are methods utilized to query physicians and other providers. These efforts result in an improvement in documentation, coding, reimbursement, and severity of illness (SOI) and risk of mortality (ROM) classifications.



UPSTATE  
MEDICAL UNIVERSITY

*SAFETY-AT-WORK (SAW)*  
*FOR*  
*CAMPUS EMPLOYEES*

Revised 12/11, 10/12, 10/13, 4/14, 10/14, 4/15, 10/15, 4/16,  
10/16, 3/17, 10/17, 3/18, 10/18, 11/19

# CAMPUS SAW – TABLE OF CONTENTS

## **Section III: (Upstate Medical University Campus Staff)**

Introduction to SAW .....	135
Our Mission, Vision, Values .....	136
Code of Conduct and Social Media.....	138
Campus Disasters .....	141
Compressed Gas Cylinder Safety .....	143
Domestic Violence .....	144
Drug Diversion .....	146
EMTALA/Emergency Medical Response.....	148
Fire and Life Safety.....	152
Gender Identify Awareness .....	155
General Security.....	159
Hazardous Materials & Waste .....	160
Institutional Compliance.....	162
Latex Sensitivity/Allergy.....	163
Service Excellence Standards.....	165
Sexual Harassment.....	166
Sexual Violence .....	169
U-Turn/ Healthy Workforce .....	173
Workplace Diversity .....	175
Workplace Violence .....	177

**INTRODUCTION**  
**SAFETY AT WORK (SAW)**  
**EDUCATION FOR ALL**  
**UPSTATE MEDICAL UNIVERSITY CAMPUS**  
**EMPLOYEES**

**I. SAFETY AT WORK (SAW):**

Provides education that promotes patient and personal safety

**II. WHO MUST COMPLETE:**

All Upstate Medical University Campus employees are required to complete Safety at Work (SAW) yearly

**III. POST TEST EVALUATION:**

Review the Safety at Work (SAW) education content  
Complete the posttest, scoring at least 80%

**IV. POLICY AND PROCEDURE MANUALS:**

Policies listed in this self study can be found on the Upstate Medical University Intranet (internal/on campus or off campus log in access only) located at <http://www.upstate.edu/ipage/intra/>

Click Policies and Forms icon:



POLICIES & FORMS

# UPSTATE

## MEDICAL UNIVERSITY

### Our Mission, Vision & Values

#### I. **MISSION:**

The mission of SUNY Upstate Medical University is to improve the health of the communities we serve through education, biomedical research and patient care.

#### II. **VISION:**

United in expertise, compassion and hope to create a healthier world for all.

#### III. **UNIVERSITY HOSPITAL'S VISION STATEMENT:**

- University Hospital will provide comprehensive, seamless and innovative patient and family centered health care to improve the health status of the communities we serve.
- University Hospital will be the preferred area employer by offering an environment where employees and volunteers are personally and professionally valued, recognized and supported.
- University Hospital will be a clinical center of educational and research excellence by continuously evaluating and adopting innovative practices in technology and health care.

#### IV. **OUR SHARED VALUES:**

##### **We drive innovation and discovery**

by empowering our university family to bring forth new ideas and to ensure quality.

##### **We respect people**

by treating all with grace and dignity.

*We serve our community*

by living our mission.

##### **We value integrity**

by being open and honest to build trust and teamwork and to embrace diversity and inclusion.





## COMMITMENT TO Diversity

**A commitment to diversity** is essential for Upstate Medical University to fulfill its mission of improving the health of the communities we serve through education, biomedical research, health care and service.

One of Upstate's core values is to respect people by treating all with grace and dignity and embracing diversity. Consistent with our mission and consistent with our values, one of our primary goals is to attract and cultivate a dynamic and culturally sensitive faculty, staff and student body that exemplifies, promotes and celebrates diversity. This definition of diversity includes recognition and appreciation of the uniqueness of each individual. Our community includes persons of various race, ethnicity, gender, sexual orientation, socio-economic status, age, physical and cognitive ability, religion and political belief. We are committed to valuing and sharing the strength of our differences in a safe, positive and nurturing environment.

An inclusive and open-minded community that engages excellence and embraces diversity is fundamental to the Upstate vision to become the leading regional academic medical center in the nation.

**UPSTATE**  
MEDICAL UNIVERSITY

# **THE UPSTATE CODE OF CONDUCT AND SOCIAL MEDIA**

**POLICY: UW C-02** (<https://upstate.ellucid.com/documents/view/2943>)

**AND UW S-07** (<https://upstate.ellucid.com/documents/view/3030>)

In order to promote and support the mission and values of Upstate Medical University, all members of the Upstate community are expected to maintain the highest level of professional behavior, ethics, integrity, and honesty, regardless of position or status.

Social media sites and applications for social networking such as Facebook, YouTube, LinkedIn, blogs, online forums, Snapchat, Instagram and more, are useful resources for collaboration, learning and social interaction. In the course of using these sites, if you choose to identify yourself as an employee or affiliate (including students, volunteers and vendors) of any part of Upstate Medical University while using social media, others may view you as a representative of Upstate and not as an individual. Accordingly, you should be aware that some of the same restrictions policies that apply to your conduct and speech while working at Upstate also apply when you use social networking sites.

## **ALL MEMBERS OF THE UPSTATE COMMUNITY ARE RESPONSIBLE FOR:**

- Helping to maintain a safe and respectful work environment.
- Reporting inappropriate and disruptive behaviors requiring formal resolution as soon as it is feasible to the appropriate person or office.
- Being mindful of the boundary between that of an employee of Upstate and personal acquaintance of the patient on social media when accepting a “friend” request from a patient or otherwise engaging in communication with a patient, current or former, for whom the employee has been a caregiver or is otherwise knowledgeable of the patient’s health information by virtue of their employment at SUNY Upstate.
- Protecting patient privacy. Employees should not post information related to any patient’s health information or treatments.

Retaliatory action is prohibited against any individual acting in good faith who reports incidents and/or cooperates in the investigation of intimidating, disruptive and other unprofessional behavior.

## **EXPECTED AND ACCEPTABLE BEHAVIORS FOSTER MUTUAL RESPECT, THIS INCLUDES, BUT IS NOT LIMITED TO:**

- Holding yourself and others accountable to our mission, vision and values.
- Interacting with others in a considerate, patient and courteous manner.
- Promoting equality and acceptance of people from diverse backgrounds.
- Demonstrating a caring and positive attitude: smile, greet and acknowledge others, make eye contact, say please and thank you. Give recognition and praise.

- Respecting confidentiality and privacy at all times.
- Providing a secure, clean and safe environment for patients and fellow staff.
- Working together by promoting cooperation, participation, and sharing of ideas and information to promote team success. Foster open and honest communication.
- Actively listening to the perspective of others and seek to resolve conflicts promptly. Apologizing when mistakes are made or misunderstandings have occurred.
- Utilizing proper channels to express dissatisfaction with policies and administrative or supervisory actions and without fear of retaliation.
- Being honest and truthful at all times.
- Being knowledgeable with and following applicable policies and procedures (e.g., Customer Service Standards, Workplace Violence Policy, Student Code of Conduct, Infection Control, etc.).
- If your social media posting violates patient privacy, don't post it.

**EXAMPLES OF INAPPROPRIATE AND DISRUPTIVE COMMUNICATIONS/ BEHAVIORS\*, INCLUDE, BUT ARE NOT LIMITED TO:**

- Using abusive language, including repetitive sarcasm.
- Sexually harassing and making comments, jokes, or innuendoes of a sexual nature.
- Making direct or indirect threats of violence, revenge, legal action, or financial harm.
- Using racial, ethnic, or religious slurs.
- Displaying behavior that would be considered by others to be intimidating, disrespectful, or dismissive.
- Exhibiting behavior that threatens or results in verbal and/or physical abuse.
- Using foul or insulting language, shouting, and rudeness.
- Criticizing of co-workers or other staff in the presence of others in the workplace or in the presence of patients.
- Publicly shaming others.
- Disregarding or being insensitive to the personal space or boundaries of others.
- Destruction of Upstate property.
- Being impaired (e.g., use of alcohol or drugs) in the workplace or academic environment.
- Failing to be knowledgeable with and follow applicable policies and procedures (e.g., Customer Service Standards, Workplace Violence Policy, Student Code of Conduct, Infection Control, etc.).
- Harassing, bullying, intimidating or discriminating against other employees or anyone affiliated with Upstate via social media.

\*Communication and/or behavior in any format, including, but not limited to, oral, written, visual, literary, electronic, recorded, or symbolic.



## **THE UPSTATE CODE OF CONDUCT REPORTING PROCEDURE:**

Whenever possible, clear, direct, and immediate communication between the parties involved is viewed as the best way to resolve problems. This is frequently very effective and may eliminate the need for further action.

In matters where this type of informal resolution is not appropriate or possible, such as in cases of dangerous, disruptive, illegal or unethical behavior, the reporting party should immediately notify his/her supervisor and provide the following information:

1. A description of the event, including any statements made, names of individuals involved, as well as any witnesses to the event, dates, environmental factors, and any other relevant information; and
2. A listing of the parties who have been notified of the event; and
3. A summary of the response(s) or action(s) taken to date to address the issue.

If the concerning communication and/or behavior is exhibited by an individual's supervisor, and the individual believes a formal resolution may be appropriate, s/he should report the incident to his/her supervisor's supervisor.

Individuals who do not believe their complaint(s) have been resolved, through either informal or formal means, should report this up their chain of command. For example, if an individual reports an incident to his/her supervisor concerning an incident that occurred involving a co-worker, and s/he believes the matter has not been resolved, s/he should report this to his/her supervisor's supervisor.

Individuals that do not believe their complaint(s) have been resolved, through either informal or formal means, should report this up their chain of command. For example, if an individual reports an incident to his/her supervisor concerning an incident that occurred involving a co-worker, and s/he believes the matter has not been resolved, s/he should report this to his/her supervisor's supervisor.

# CAMPUS DISASTERS

## ***“What you need to know”***

- ✓ Where your unit specific Disaster/CEMP Plan is located
- ✓ How staff will be made aware that an emergency event has occurred
- ✓ Initial staff actions at the time of a disaster activation

### **I. WHAT IS AN ALL HAZARDS APPROACH?**

- a. Upstate Medical University’s plan addresses a wide variety of disasters through the implementation of a unified approach and Incident Command
- b. The plan adopts an "all hazards" approach in order to respond to all types of emergencies such as: Acts of Terrorism, Civil Disturbance, Explosion, Fire, Flooding, Food borne illness, Hazardous Material, Severe Storm and Utility Failure.

### **II. COMPREHENSIVE EMERGENCY MANAGEMENT PLAN (CEMP)**

- a. The Comprehensive Emergency Management Plan (CEMP) establishes the policies, procedures, and organizational structure to respond, control and recover from emergency situations.
- b. Campus disaster plan can be found on the Upstate Intranet Policies and Forms page under:
  - i. (CEMP) Disaster - Incident Command Manual:
  - ii. (DIS M20) Campus Disaster Plan- This section of the CEMP has been developed to address Campus Emergencies and is part of the institutions comprehensive plan.

### **III. WHAT IS THE INCIDENT COMMAND SYSTEM (ICS) AND HOW DOES IT WORK?**

- a. System for managing emergent and non-emergent situations
- b. Provides the Campus with required tools to address the event
- c. ICS initiated by an internal/external event
  - i. Flexible in scale
  - ii. Only those positions needed are activated
  - iii. Defined administrative personnel are assigned the role of Incident Commander

### **IV. HOW IS THE CAMPUS ICS ACTIVATED?**

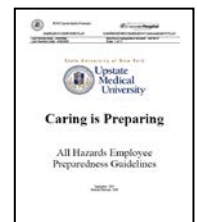
- a. Physical Plant and University Police must be notified immediately of any incident that might threaten human health, the environment, facilities or research materials.
  - i. Physical Plant and Facilities: 464-4448 or 464-4351 (24 hour on-call service)
  - ii. University Police: 464-4000 (24 hour on-call service)
- b. The Director of Physical Plant, University Police or designee will assess the situation.**
  - i. Activate Incident Command as indicated by the event.
  - ii. Initiate Internal and external communication as necessary.

## V. STAFF GENERAL ROLES AND RESPONSIBILITIES

- a. What are my immediate roles and responsibilities for emergencies such as fires, explosions, spills, or transportation accidents, the basic protocol is:
  - i. Rescue anyone immediately affected by the emergencies if you can do so safely.
  - ii. Notify the proper authorities:
    1. If the emergency involves a fire, use the manual pull box to activate the alarm.
    2. For other emergencies, contact University Police at 464-4000 from any campus phone and describe the emergency. Request Environmental Health and Safety response for biological/chemical emergencies; Radiation Safety Officer for radiological materials emergencies.
- b. Warn others in the area about the emergency and stay clear of the area. Account for all staff, student or volunteers by a taking a head count, to ensure that no one was left behind during an evacuation. Be prepared to provide the head count to emergency responders. (i.e. Syracuse Fire Department)
- c. From a safe location, provide first aid to victims if properly trained.
- d. Follow the directions of the Emergency Responders (i.e. Fire Department, University Police, Environmental Health and Safety or Radiation Safety).

## VI. WHAT IS MY ROLE IF INCIDENT COMMAND IS ACTIVATED?

- a. Know Staging and Evacuation Plans.
  - i. Evacuation Maps posted in all clinical areas
  - ii. Horizontal and vertical routes
- b. Be familiar with Evacuation Equipment.
  - i. Location
  - ii. Use
- c. Check with Supervisor for updates if role is not pre-assigned.
- d. Follow Direction of incident command.



## VII. STAFF ROLES & RESPONSIBILITIES

- a. Sign up for NY ALERT.
  - i. For More information and to sign up go to: [http://www.upstate.edu/emergencyinfo/ny\\_alert.php](http://www.upstate.edu/emergencyinfo/ny_alert.php)
- b. Plan for disasters at home: “Caring is Preparing”
- c. Additional Information: [http://www.upstate.edu/policies/documents/intra/DIS\\_M-37.pdf](http://www.upstate.edu/policies/documents/intra/DIS_M-37.pdf)

## VIII. HOW DO WE COMMUNICATE DURING A DISASTER EVENT?

- a. Redundant communication systems
  - i. Staff and Students
    1. Regular phones
    2. NY Alert
    3. Email
    4. Direct contact with those in affected areas
    5. Local media

# COMPRESSED GAS CYLINDER SAFETY

“What you need to know”

- ✓ Proper handling and storage of gas cylinders

IMPROPER HANDLING AND STORAGE OF COMPRESSED GAS CYLINDERS CAN PRESENT A SIGNIFICANT RISK OF SERIOUS INJURY OR DEATH.

**ALWAYS HANDLE AND STORE PROPERLY!**

## I. DO:

- Cylinders must be secured at all times in an approved cart or holder. Empty cylinders must also be secured because they can have residual pressure and product.
- Remember to secure cylinders in an approved cart or holder whether they are in storage, in use next to a bed or stretcher or being utilized during a transport.
- Keep valve protective caps in place when the cylinder is not in use.
- Empty and full cylinders must be stored in a separately labeled cart or tagged to indicate that they are full or empty. (EMPTY AND FULL CYLINDERS MUST BE CLEARLY SEPERATED OR TAGGED)
- Store no more than 12 E-cylinders (small oxygen cylinders), that are not in use, in a given area. (*In-use cylinders secured properly on beds/stretchers and wheelchairs and empty cylinders do not have to be included in the 12-cylinder count*).

## II. DON'T:

- Never store a cylinder in an unsecured manner such as on the floor, in a corner of the room, on top of a bed, or next to a patient (even when empty).
- Never carry a cylinder by the valve.

**At University Hospital Downtown Campus Contact: Environmental Health and Safety at 315-464-5782 (during normal business hours)**  
**University Police at 315-464-4000 (after hours)**

**At University Hospital Community Campus Contact: Environmental Health and Safety at 315-492-5683 or 315-464-5782 (during normal business hours)**  
**University Police at 315-492-5511 (after hours)**

# DOMESTIC VIOLENCE AND THE WORKPLACE

## *“What you need to know”*

- ✓ The definition of Domestic Violence
- ✓ Why Domestic Violence is a workplace issue
- ✓ Supports available at Upstate related to Domestic Violence
- ✓ Supports available in the community related to Domestic Violence

## **I. DOMESTIC VIOLENCE**

- a. Domestic Violence is a pattern of coercive tactics which can include physical, psychological, sexual, economic and emotional abuse, perpetuated by one person against an adult intimate partner with the goal of establishing and maintaining power and control over the victim.
- b. An ‘Intimate Partner’ includes persons legally married to one another; persons formerly married to one another; persons who have a child in common, regardless of whether such persons are married or have lived together at any time; couples who are in an intimate relationship, including but not limited to, couples who live together or have lived together; or persons who are dating or who have dated in the past, including same-sex couples.
- c. Both men and women can be victims of Domestic Violence or abusers/batterers.

## **II. DOMESTIC VIOLENCE IN THE WORKPLACE**

- a. One in four women will experience some level of domestic violence in their lifetime.
- b. There are over 82,000 women employed by NY State and make up 48.9% of the state workforce.
- c. At least one million women and 371,000 men are victims of stalking in the US every year. Stalkers often follow victims to the workplace.
- d. The national health care costs of domestic violence – direct medical and mental health services for victims – amounts to nearly \$4.1 billion annually.
- e. 37% of women who experienced domestic violence reported that the abuse had an impact on their work in the form of lateness, missed work, keeping a job, or career promotions.
- f. 41% of batterers had job performance problems and 48% had difficulty concentrating on the job as a result of their abusive behaviors.
- g. The Center for Disease Control and Prevention estimates the annual cost of lost productivity due to Domestic Violence equals \$727.8 million, with more than 7.9 million paid workdays lost each year.

### III. SUPPORTS AT UPSTATE RELATED TO DOMESTIC VIOLENCE

- a. New York State Governor's Office created 'Executive Order #19' which requires that all state agencies have a policy and procedure, including a workplace safety response plan, related to Domestic Violence.
- b. Upstate's **Domestic Violence and the Workplace Policy UW V-01**, <https://upstate.ellucid.com/documents/view/3034>, is available for review on the policy web page.
- c. Designated liaisons, persons who can assist with support and care related to Domestic Violence issues, at Upstate are the:
  - i. Employee Assistance Program, 315-464-5760
  - ii. Human Resource Benefits Leave Office, 315-464-4943
  - iii. University Police Department, 315-464-4000
  - iv. Upstate complies and assists with enforcement of all known valid court orders of protection that are brought to the attention of Upstate.
    1. Employees are encouraged to bring their orders of protection to the attention of the University Police Department.
    2. A University Police Officer or designee will work with the employee to formulate a plan on how to best proceed to ensure the safest possible work environment.

### IV. COMMUNITY SUPPORTS FOR DOMESTIC VIOLENCE ISSUES

- a. Agencies specializing in supports and services are available in all counties:
  - i. NYS Domestic & Sexual Violence Hotline:
    1. English 1-800-942-6906 or TTY 1-800-818-0656
    2. Spanish 1-800-942-6908 or TTY 1-800-780-7660
  - ii. Elder Abuse Information Line: 1-800-342-3009
  - iii. Cayuga/Seneca County: Cayuga County Action Program/Domestic Violence Intervention Program 1-800-253-3358
  - iv. Cortland County: Aid to Victims of Violence 1-800-336-9622 or 607-756-6363
  - v. Herkimer County: Stepping Stones to End Violence 315-866-0458
  - vi. Jefferson County: Women's Center 315-782-1855
  - vii. Madison County: Victims of Violence 315-366-5000 (collect calls within the county are accepted)
  - viii. Oneida County: YWCA Hall House 315-797-7740
  - ix. Onondaga County: Vera House 315-468-3260
  - x. Oswego County: Services to Aid Families 315-342-1600 (collect calls within the county are accepted)
  - xi. Wayne County: The Victim Resource Center 1-800-456-1172

# DRUG DIVERSION PREVENTION

## ***“What you need to know”***

- ✓ The definition of Drug Diversion
- ✓ What is at stake when Diversion occurs
- ✓ How you can help prevent Diversion
- ✓ Where can you obtain more information about Diversion
- ✓ Who to contact about suspected Drug Diversion

## **I. WHAT IS DIVERSION**

- a. Drug Diversion is the transfer of any legally prescribed medication from the individual for whom it was prescribed to another person for any illicit use.

## **II. RISKS ASSOCIATED WITH DRUG DIVERSION**

- a. Employee
  - i. Personal health, death
  - ii. Progression of abuse leads to risky behaviors, lowers rehab chances
  - iii. Loss of employment, reputation, professional license
  - iv. Legal penalty, jail
- b. Patient
  - i. Compromised care, inadequate/subtherapeutic pain control
  - ii. Patient care by impaired employee = UNSAFE and DANGEROUS
  - iii. Infection risk to patient from contaminated products
- c. Institution
  - i. Civil and Regulatory liability - HUGE fines
  - ii. Reputation, brand at risk
  - iii. CMS penalties, loss of accreditation

## **III. HOW AND WHEN TO PREVENT DRUG DIVERSION**

- a. Drug Diversion Prevention is already built into our day to day policies and procedures. By maintaining FULL 100% compliance within your responsibilities and duties, you are automatically helping to prevent drug diversion. Education and awareness of Drug Diversion will help to ensure and strengthen our prevention program.
- b. Policies
  - i. C-10 - Suspicion of Criminal Activity / Medication Diversion  
- <https://upstate.ellucid.com/documents/view/1191>
  - ii. CM M-03 - Medication Administration/Dispensing - General  
- <https://upstate.ellucid.com/documents/view/3761>

- iii. CM M-26 - Medication Management - Security  
- <https://upstate.ellucid.com/documents/view/3778>
- iv. CM P-18 - Automated Dispensing Cabinets  
- <https://upstate.ellucid.com/documents/view/3811>

**IV.** Where to learn more about Drug Diversion Prevention and Compliance

- a. References - IHFDA, NADDI, CDC, DEA
- b. Upstate Hospital Drug Diversion Prevention Specialist, Derek Empey  
([empeyd@upstate.edu](mailto:empeyd@upstate.edu))

**V. HOW TO REPORT CONCERNS OF SUSPECTED DRUG DIVERSION**

- i. It your duty and legal obligation to report any suspicious diversion activity.
- ii. Any one of the following methods will activate our Diversion Response Team:
  - 1. Anonymous SI Event: Medication-related issues / Drug diversion/theft
  - 2. Email - [Diversion@upstate.edu](mailto:Diversion@upstate.edu)
  - 3. Compliance - 464-6444
  - 4. Direct Report to Nurse Manager



# EMTALA/EMERGENCY MEDICAL RESPONSE

## WHAT IS EMTALA?

- ✓ Emergency Medical Treatment and Labor Act (EMTALA)
- ✓ EMTALA is a federally mandated standard of care for hospitals and physicians

**UPSTATE UNIVERSITY HOSPITAL WILL PROVIDE EMERGENCY SERVICES AND CARE TO ANY INDIVIDUAL PRESENTING TO UNIVERSITY HOSPITAL (UH) MAIN BUILDINGS OR ON HOSPITAL PROPERTY WHEN A REQUEST IS MADE BY THE INDIVIDUAL OR BY SOMEONE ELSE ON THEIR BEHALF OR WHO DEMONSTRATES SIGNS/SYMPTOMS INDICATIVE OF A POTENTIAL MEDICAL EMERGENCY WITHOUT REGARD TO AN INDIVIDUAL'S RACE, ETHNICITY, AGE, GENDER, SEXUAL ORIENTATION, NATIONAL ORIGIN, PRE-EXISTING MEDICAL CONDITION OR HANDICAP OR OTHER DISABILITY, INSURANCE STATUS OR ABILITY TO PAY FOR SERVICE.**

## I. EMERGENT SITUATIONS:

- a. If any person is on or around hospital property, and request (or appear in need of) emergent care, all employees must know the process to get help.
- b. This means that any person in a parking lot, on a sidewalk, in a driveway, or anywhere around hospital's property requesting, or is in evident need of help, must be provided a medical screening exam, and if necessary, stabilized to meet EMTALA standards.

## II. PROCESS FOR HELP:

- a. All employees must know the process for getting help as outlined in policy CM E-15 Emergency Medical Response Teams: Code Blue/Code White/Code C/Code Pink/EMS (<https://upstate.ellucid.com/documents/view/3714>)
- b. Depending on location, response is by:
  - i. Internal Code Team (ext. 4-4444 DT OR ext. 2211 CC)  
OR
  - ii. Emergency Medical System (EMS) – 911

## III. CODE TEAMS DT CAMPUS (ext. 4-4444):

- a. Adult Code Blue Team/Pediatric Code White Team will respond to medical emergencies for patients, visitors, staff in:
  - i. Hospital Proper
  - ii. Cancer Center
  - iii. Tunnel connecting University Hospital and Crouse Hospital
  - iv. Gamma Knife

- b. Immediately outside of hospital and Cancer Center, including:
  - i. Front Traffic Circle
  - ii. ED Parking Lot
  - iii. Golisano Children's Hospital Circle
  - iv. Bridge to Parking Garage East
  - v. Sidewalks on South Side of Adams Street from corner of Almond Street to Irving Avenue
- c. **Exclusions:**
  - i. Emergency Department, with the exception of boarded/admitted patients

#### **IV. CODE TEAM COMMUNITY CAMPUS (ext 2211):**

- a. Adult Code Blue Team/Pediatric Code White Team/Code C Team will respond to medical emergencies for patients, visitors, staff in:
  - i. Hospital Proper
  - ii. Traffic Circle
- b. **Exclusions:**
  - i. Emergency Department
- c. Code Pink Team will respond to infant emergencies for patients in:
  - i. Family Birth Center (FBC).

# Emergency Medical Response

Tracker Code: EMERGENTMEDICAL

## Downtown Campus

How to call for emergency medical assistance at the following locations:

Code Blue/Code White Team will respond to medical emergencies for patients, visitors, staff located in:

- Hospital Proper
- Cancer Center
- Tunnel connecting UH and Crouse Hospital
- Gamma Knife
- Immediately outside of UH and Cancer Center, including:
  - Front Traffic Circle
  - ED Parking Lot
  - Golisano Children's Hospital Circle
  - Bridge to Parking Garage East
  - Sidewalks on south side of Adams Street (from corner of Almond Street to Irving Avenue)

 Call **x 4-4444**

 Request Code Blue or  
Code White

 Give location/call back #

UH main buildings NOT located at 750 East Adams Street:

- Building 49
- CAB
- Clark Tower
- Computer Warehouse Building (CWB)
- IHP
- Jacobsen Hall
- Parking Garages/Parking lots
- Weiskotten Hall /Addition, including Setnor Hall, Silverman Hall, New Academic Building (NAB)

 Call **911**

 Give location

 State situation

# Emergency Medical Response

## Community Campus


How to call for emergency medical assistance at the following locations:

Code Blue/Code White/Code C Team will respond to medical emergencies for patients, visitors, and staff located in:

- Hospital Proper
- Traffic Circle


Code Pink Team will respond to infant emergencies for patients in:

- FBC (Family Birth Center)

- 
- ☎ Call **x 2211**
  - ☎ Request Code Team
  - ☎ Give location/call back #

Other UH Community Campus buildings:

- Parking Garages
- Parking Lots
- Hematology Oncology Associates of Onondaga Hill
- POB (Physician Office Building) - North and South
- Cord Blood Bank Center

- 
- ☎ Call **911**
  - ☎ Give location
  - ☎ State situation

# FIRE AND LIFE SAFETY

## ***“What you need to know”***

- ✓ Fire alarm pull box locations
- ✓ Location of fire-rated stairwells that will provide a protected path outside
- ✓ Sound of your building’s fire alarm, it could be bells, chimes, horns or a coded gong
- ✓ Make sure your floor has at least two unobstructed ways out
- ✓ Check the fire exits to make sure they are usable
- ✓ Do not use the elevators. They could become disabled, trapping you on the fire floor
- ✓ Post emergency numbers near all telephones

## **I. POLICY:**

- a. New York State Office of Fire Protection and Control (OFPC) and New York State law requires ALL occupants to evacuate buildings when a fire alarm is activated, whether it is a drill or not
- b. The University fire alarm system is a very important and effective means of alerting people to safely evacuate residence halls, administrative, academic, and research buildings during an emergency
- c. Upon a fire alarm activation, it is required by law that ALL building occupants evacuate and remain at a safe designated assembly area at least 50 feet from the building
- d. An all-clear signal will be given by the fire department, University Police, Environmental Health and Safety, or designated University authority when it is safe to return to the building

## **II. EVACUATION:**

- a. DO **NOT** ATTEMPT TO EXTINGUISH A FIRE
- b. In the event of a fire, proceed to the nearest pull station and activate the fire alarm
- c. In the event of a fire or alarm activation, immediately notify individuals in the area and evacuate to the nearest exit; if exits/stairwells are not clear or safe, go to the next closest exit/stairway
- d. ELEVATORS SHOULD **NOT** BE USED
- e. Doors should be closed and lights turned off as the last person leaves a room or area
- f. Evacuate the building quickly, but do not run or panic
  - i. People who walk slowly or need assistance should walk to the right side of stairwells
- g. Move to your building’s designated assembly area (see policy UW F-02, Campus Fire-Evacuation - <https://upstate.ellucid.com/documents/view/2975>):
  - i. *Bioethics Building = parking lot along fence line of Adams Street*
  - ii. *Biotech Accelerator Building = rear parking lot near the fence*

- iii. *Building 49 = loading zone parking area of CWB*
- iv. *Clark Hall = In front of CAB; in bad weather, inside CAB*
- v. *Campus Activities Building (CAB) = In front of CAB*
- vi. *Institute for Human Performance (IHP) = Across the street on Irving Ave*
- vii. *Jacobsen Hall = In front of CAB*
- viii. *Medical Library = Weiskotten front court yard, across from the L lot, V.A. side of the street*
- ix. *Setnor Academic Building = In front of building near stone wall on Irving Ave*
- x. *Silverman Hall = Parking lot across from the building*
- xi. *Weiskotten Hall (Old) = In front of building near stone wall on Irving Ave*
- xii. *Weiskotten Hall Addition = In the SUNY parking lot facing the VA Hospital*
- xiii. *New Academic Building = In parking lot south of Weiskotten Hall Addition*
- h. Try to account for the people in your work/class areas to ensure all occupants have left the building
  - i. If you suspect there are still people in the building, immediately notify University Police or emergency personnel
- i. Never re-enter a building unless authorized by the Fire Department, University Police, Environmental Health and Safety or a designated University authority

### **III. RESPONSIBILITIES:**

- a. We are all responsible for providing a safe learning environment; please review your evacuation plans by identifying your primary and secondary exits and assembly areas for your class/work groups
- b. FACULTY:**
  - i. All faculty members must immediately instruct students to evacuate and go to designated assembly areas when a fire alarm is activated
  - ii. New York State law requires ALL occupants to evacuate buildings when a fire alarm is activated whether it is a drill or not
  - iii. To ensure ALL students evacuate the building, take a student roster and perform a roll call once in the designated assembly area
  - iv. Should a faculty instructor find a roll call discrepancy, immediately notify University Police or emergency personnel.
- c. STUDENTS and EMPLOYEES:**
  - i. ALL students and employees must immediately evacuate the building and gather at least 50 feet from the building in the designated assembly area
  - ii. New York State law requires ALL occupants to evacuate buildings when a fire alarm is activated whether it is a drill or not

### **IV. EVACUATION OF INDIVIDUALS WITH DISABILITIES:**

- a. In the event you have an individual in your area that may have limited ability to evacuate in the event of a fire or other emergency, plan ahead. Contact the Upstate

Fire Marshal (464-7370) or Assistant Fire Marshal (464-4021) to explain and establish an individualized process for the individual with disabilities during a building evacuation.

- b. Whenever possible, identify a buddy to assist disabled individuals during an emergency
- c. Do **NOT** attempt to lift/carry disabled individuals; only professional rescue personnel should lift or carry disabled people
- d. If a disabled person is not able to exit a building, they should be assisted by a buddy to an area of refuge
  - i. The buddy should immediately notify University Police and rescue personnel, call 4-4000 from a University phone or 911 from a non-campus phone
  - ii. Identify the name of the disabled person(s) and their location (building, floor, and/or room number) of the designated refuge area
- e. An area of refuge should meet the following criteria:
  - i. Be an enclosed area, preferably with fire rated doors and walls
  - ii. Have a campus phone, if possible
  - iii. Be located in close proximity to exits, stairwells, or other access points for rescue personnel
  - iv. Be labeled with signage, "Area of Refuge."
    - 1. Currently the New Academic Building is the only building with "Area of Refuge" areas labeled with signs

# Gender Identity Awareness

## “What you need to know”

- ✓ Ask patients for their preferred name and accept/do not question the answer.
- ✓ Ask patients for their preferred pronoun and accept /do not question the answer.
- ✓ If a ‘preferred name’ is documented, refer to the patient by the preferred name.
- ✓ If a ‘preferred pronoun’ is documented, refer to the patient by the preferred pronoun (he, she, or they.)
- ✓ If you have any confusion about whether a patient is male or female, respectfully request clarification by asking the patient what their preferred pronoun is (he, she, or they.)
- ✓ When two identifiers are required, legal name and date of birth should be used, not sex.

## TERMINOLOGY:

**Agendered:** Person is internally ungendered.

**Ally:** An individual that supports the struggles of a group; not part of the group him/herself. Adapted from: Adams, M., Bell, L., & Griffin, P. (2007). Teaching for Diversity and Social Justice (2nd ed.). New York: Routledge. In the LGBTQ\* context, a person who supports and honors sexual and gender diversity, acts against heterosexist, and transphobic remarks and behaviors, and is willing to explore and understand these forms of bias within himself.

**Androgyne:** Person appearing and/or identifying as neither man nor woman, presenting a gender either mixed or neutral.

**Asexual:** Anyone without sexual drive and/or attraction. Many asexual individuals have deep and meaningful relationships with others exclusive of sexual intimacy. The term is also sometimes used as a “gender identity” by those who believe their lack of sexual attraction places them outside the standard definitions of gender.

**Bigendered:** A person whose gender identity is a combination of male/man and female/woman.

**Biphobia:** The fear of, discrimination against, or hatred of bisexuals by people of any sexual orientation. Biphobic stereotypes may include promiscuity or confusion towards their sexual orientation. IN some cases, bisexuals are accused of bringing sexually transmitted disease into the heterosexual community. Gays and lesbians who express biphobia might accuse bisexuals of maintaining heterosexual privilege and collaborating with homophobes. The belief that bisexuality does not truly exist is another example of biphobia.

**Birth Sex:** The sex (male or female) assigned a child at birth, based on a child’s genitalia.



**Bisexual:** A person emotionally, physically, and/or sexually attracted to members of the same sex, as well as members of the opposite sex. Adapted from: Green, E. R., & Peterson, E. N. (2006). LGBTTSQI Terminology. In Trans-Academics.org. Retrieved June 4, 2014, from <http://www.trans-academics.org/lgbttsqiterminology.pdf>

**Cisgender:** Cisgender is a term used to describe people who, for the most part, identify as the gender they were assigned at birth. For example, if a doctor said “it’s a boy!” when you were born, and you identify as a man, then you could be described as cisgender. Source: Basic Rights Oregon. (2011, October 9). Trans 101: Cisgender. In Basic Rights Oregon. Retrieved June 9, 2014, from <http://www.basicrights.org/uncategorized/trans-101-cisgender>

**Cross-dressing:** The act of dressing in clothes typically associated with another gender. This may be the extent of the gender-bending behavior, or it may be one step on a path of changing sex or gender. The words transvestite and transvestism have been used in the past to describe this activity or interest. Adapted from: Adams, M., Bell, L., & Griffin, P. (2007). Appendix 9B: Answers to Gender and Sexuality Definitions Quiz. In Teaching for Diversity and Social Justice (2nd ed.). New York: Routledge.

**Female-to-Male (FTM) or Transgender Man:** A person born with female genitalia at birth who feels they are male/a man and lives as male/a man. Some will just use the term male.

**Gender Attribution:** The way we perceive others’ gender, which affects the way we relate to that person, typically without thought. **Gender dysphoria:** DSM-5 diagnosis for individuals who have a strong and persistent cross-gender identification and a persistent discomfort with his or her sex, or sense of inappropriateness in the gender role of that sex

**Gender Expression/Role:** The way a person acts, dresses, speaks and behaves in order to show their gender as feminine, masculine, both, or neither.

**Gender Identity:** A person’s internal sense of being a man, woman, both, or neither. Gender identity usually develops at a young age.

**Gender-Neutral:** Nondiscriminatory language usage that can apply equal to people of any gender identity. “Spouse” and “Partner” are gender neutral alternatives to the gender specific words “husband,” “wife,” “boyfriend,” and “girlfriend.” The use of the gender neutral pronouns “ze” (instead of she/he) and “hir” (instead of his/her) are preferred by some as a way to be inclusive of all genders in language use.

**Gender Non-Conforming:** People who express their gender differently than what is culturally expected of them. A gender non-conforming person is not necessarily transgender (for example, a woman who dresses in a masculine style but who identifies as female; a boy who likes to play with girl dolls but identifies himself as a boy, etc.).

**Genderqueer:** A relatively new term, genderqueer is used by some individuals who do not identify as either male or female; or identify as both male and female.

**Heterosexism:** 1. Social structures and practices which serve to elevate and enforce heterosexuality while subordinating or suppressing other forms of sexuality. 2. Societal, cultural, institutional, and individual beliefs and practices that assume that heterosexuality is the only natural, normal, acceptable sexual orientation. Adapted from: Griffin, P. (2007). Sexism, Heterosexism, and Transgender Oppression. In M. Adams, L. Bell, & P. Griffin (Eds.), Teaching for Diversity and Social Justice (2nd ed., pp. 167-172). New York: Routledge. Parvis, L. (2013). Understanding Cultural Diversity in Today's Complex World (5th ed., p. 164). Embrace Publications.

**Heterosexual:** A person primarily emotionally, physically, and/or sexually attracted to members of the opposite sex. Adapted from: Sullivan, N. (2003). A Critical Introduction to Queer Theory (p. 119). New York: New York University Press.

**Heterosexual Privilege:** Those benefits and advantages heterosexuals or those perceived to be heterosexual, receive in a heterosexist culture. Source: Adams, M., Bell, L., & Griffin, P. (2007). Teaching for Diversity and Social Justice (2nd ed.). New York: Routledge.

**Hir:** The gender-neutral pronoun for his or her.

**Male-to-Female (MTF) or Transgender Woman:** A person born with male genitalia who feels they are female/a woman and lives as female/a woman. Some will just use the term female.

**Pansexual:** A person for whom sex and gender are less significant in determining attraction. They may identify as being fluid in their own sexual orientation and/or gender or sex identity.

**Polyamory:** The practice of having or being open to having, multiple romantic relationships.

**Preferred Name:** Use an individual's preferred name, pronoun and title, regardless of the individual's sex assigned at birth, anatomy, gender, medical history, appearance, or the sex indicated on the individual's identification.

**Sexual Orientation:** Sexual orientation is about how people identify their physical and emotional attraction to others. It is not related to gender identity. Transgender people can be any sexual orientation (gay, lesbian, bisexual, heterosexual/straight, no label at all, or some other self-described label).

**Trans:** Abbreviation for transgender.

**Transgender:** People whose gender identity is not the same as the sex they were assigned at birth.

**Transition/Gender Affirmation Process:** For transgender people, this refers to the process of coming to recognize, accept, and express one's gender identity. Most often, this refers to the period when a person makes social, legal, and/or medical changes, such as changing their clothing, name, sex designation, and using medical interventions. This process is often called gender affirmation, because it allows people to affirm their gender identity by making outward

changes. Gender affirmation/transition can greatly improve a transgender person’s mental health and general well-being.

**Transsexual:** A term used to describe a subset of transgender individuals who have transitioned to the opposite sex, often but not always through a combination of hormonal therapy and sexual reassignment surgery.

**\*Terms to Avoid!** *The following terms are considered offensive by most and should not be used: she-male, he-she, it, tranny, “real” woman or “real” man.*

BEST PRACTICES	EXAMPLES
<u>When addressing patients, avoid using gender terms like “sir” or “ma’am.”</u>	<u>“How may I help you today?”</u>
<u>When talking about patients, avoid pronouns and other gender terms. Or, use gender neutral words such as “they.” Never refer to someone as “it”.</u>	<u>“Your patient is here in the waiting room.”</u> <u>“They are here for their 3 o’clock appointment.”</u>
<u>Politely ask if you are unsure about a patient’s preferred name.</u>	<u>“What name would you like us to use?”</u> <u>“I would like to be respectful—how would you like to be addressed?”</u>
<u>Ask respectfully about names if they do not match in your records.</u>	<u>“Could your chart be under another name?”</u> <u>“What is the name on your insurance?”</u>
<u>Did you goof? Politely apologize.</u>	<u>“I apologize for using the wrong pronoun. I did not mean to disrespect you.”</u>
<u>Only ask information that is required.</u>	<u>Ask yourself: What do I know? What do I need to know? How can I ask in a sensitive way?</u>

**Clearly, it is not always possible to avoid mistakes, and simple apologies can go a long way. If you do slip, you can say something like: “I apologize for using the wrong pronoun/name. I did not mean to disrespect you.”**

If you have questions or would like more information please contact:  
Office of Diversity & Inclusion Jacobsen Hall, suite 711, 464-5234, [diversity@upstate.edu](mailto:diversity@upstate.edu)

# GENERAL SECURITY

## ***“What you need to know”***

- ✓ When to wear your employee identification badge
- ✓ How to report suspicious activities
- ✓ How to report patients who have an Order of Protection
- ✓ How to request a Personal Safety Escort

**I.** Our University Police Department Staff is trained and knowledgeable in protecting staff, patients, and visitors

## **II. INDIVIDUAL RESPONSIBILITIES**

- a. Wear your employee identification badge at all times while on Upstate property, includes owned and leased areas.
- b. Report unauthorized persons (anyone without visible ID/badge)
- c. Report suspicious activities
  - i. Include a brief description of suspicious activity
  - ii. Include detailed description of person
  - iii. Include location

## **III. REPORT ACCIDENTS AND INJURIES**

- a. Involving visitors, students, and employees

## **IV. EMERGENCY SITUATIONS**

- a. Cooperate with University Police Department Staff
- b. Examples:
  - i. Disaster Drills
  - ii. Fire Alarms

## **V. ORDER OF PROTECTION**

- a. If patient indicates that a Order of Protection is in place, get a copy
- b. Copies go in Medical Record and to the University Police Department
- c. Provide the University Police Department a copy of the Order of Protection and a photograph of the subject(s) whenever possible.

## **VI. PERSONAL SAFETY ESCORTS**

- a. Call University Police Department for Safety Escorts to any place on Campus.
- b. Escorts are provided 24 hours a day, 7 days a week via walking and vehicle.

# HAZARDOUS MATERIALS & WASTE

## “What you need to know”

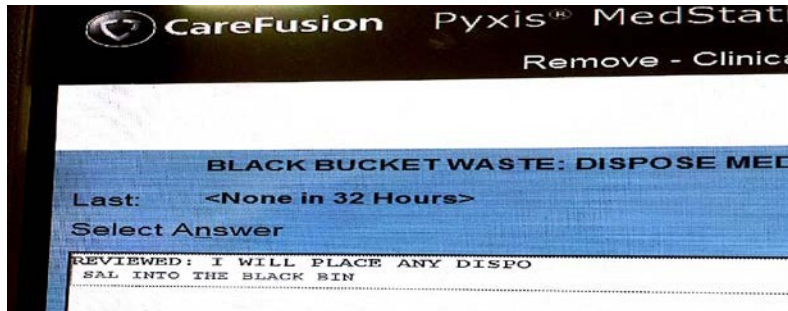
- ✓ What to do if a hazardous material is spilled in your work area
- ✓ How to properly dispose of Regulated Medical Waste (RMW)

### I. HAZARDOUS MATERIALS SPILLS


- a. Services to be contacted in case of a spill:
  - i. Blood –
    1. Downtown Campus: Call Environmental Services at x4-6576
    2. Community Campus: Call Environmental Services at 492-5994
  - ii. Chemicals/Medications –
    1. Downtown Campus: Call Environmental Health and Safety at x4-5782  
Nights and weekends: Call University Police Department at x4-4000
    2. Community Campus Call Environmental Health and Safety at x4-5782  
Nights and weekends: Call University Police Department at 492-5511
  - iii. Radioactive Materials –
    1. Downtown Campus: Call Radiation Safety at x4-6510
    2. Community Campus: Call Radiology at 492-5015 or 492-5526
  - iv. Persons exposed to hazardous spills are to be directed to the Emergency Department with the applicable Safety Data sheet (SDS), which are available on from the iPage → click the Policies & Forms icon → click the Safety Data Sheets (SDS) link in the column to the left of the page
- b. Hazardous Material (HAZMAT) spills that cannot be contained require:
  - i. Remove persons from the spill danger and notify others in the area to leave.
  - ii. Notify –
    1. Downtown Campus: Call Environmental Health and Safety at x4-5782
      - a. Nights and weekends: Call University Police Department at x4-4000
      - b. Community Campus Call Environmental Health and Safety at x4-5782
      - c. Nights and weekends: Call University Police Department at 492-5511.
    2. Give your name, exact location of the spill, and the type of spill, if known

## II. REGULATED MEDICATION WASTE DISPOSAL

- a. Regulated Medications are drugs that are toxic to the environment if they are not handled and disposed of properly. When used as prescribed, these drugs do not pose a risk for the nurse or patient. When they go un-used, or partially used, they must be handled differently than non-regulated medications.
  - i. You will receive a notification from the automated dispensing cabinet relating to any medication that is considered a regulated medication.



- ii. These drugs will also be labeled as such if they are dispensed directly from the pharmacy department as Hazardous Waste - black bin disposal.
  - iii. Waste (any partially used or un-used regulated medication) will be disposed of in a labeled black bucket that will be located in the dirty utility rooms on each unit.
  - iv. If you have any questions regarding regulated medication collection and disposal, please contact Environmental Health and Safety at 4-5782. At the Community Campus, contact Pharmacy at 492-5503 or Environmental Services at 492-5064.

CAUTION: CHEMOTHERAPY		
<b>Beacon, Jfdtest</b>		ONCOLOGYCCTR
AGE: 51 y.o.	MRN: 6058045	Ord#380069269
DOB: 1/12/1967		Patient Weight: 95.3kg
<b>cyclophosphamide (CYTOXAN) capsule 50 mg</b>	Oral, Daily	
Dispense: 1 capsule		
<b>Dose: 1 capsule (1 x 50 mg capsule)</b>		
Antineoplastic Hazardous Drug - follow precautions		
Hazardous Waste - black bin disposal		
[FD:1st REPRINT] 0925-1511		

# INSTITUTIONAL COMPLIANCE & ETHICS

## ***“What you need to know”***

- ✓ The definition of compliance
- ✓ When compliance is your responsibility
- ✓ Where to get additional information about compliance
- ✓ How to contact the Compliance Office

### **I. WHAT COMPLIANCE IS**

- a. Compliance means “doing the right thing,” both legally and ethically, by following all local, State and Federal laws, regulations, policies, contracts and professional standards that govern our daily business activities.
- b. The Institutional Compliance program is intended to promote adherence to applicable rules and regulations and prevention of fraud, waste and abuse through education, monitoring, and corrective action that supports the mission, philosophy, and values of Upstate Medical University.
- c. Basically: No Lying, No Cheating, No Stealing

### **II. WHEN COMPLIANCE IS YOUR RESPONSIBILITY**

- a. Always! In order to maintain the status of the institution as a reliable, honest, trustworthy health care provider, all persons associated with Upstate Medical University have an obligation to report, without fear of retaliation, known or suspected:
  - i. Fraud
  - ii. Abuse
  - iii. Waste
  - iv. Improper, illegal, or unethical activities

### **III. WHY WE HAVE A CODE OF CONDUCT**

- a. The Code of Conduct outlines measures whereby persons associated with Upstate Medical University are obligated to conduct themselves at the highest level of professional and ethical standards.
- b. Code of Conduct: <https://upstate.ellucid.com/documents/view/411/13139>
- c. Code of Ethics: <https://upstate.ellucid.com/documents/view/1227>

### **IV. WHERE YOU CAN OBTAIN MORE INFORMATION ABOUT COMPLIANCE**

- a. Go to: <http://www.upstate.edu/compliance/>, information available includes:
  - i. Compliance Plan
  - ii. Code of Conduct
  - iii. Contact Information
  - iv. Whistleblower Protection
  - v. Reference Materials
  - vi. Training Materials
  - vii. Healthcare Fraud & Abuse
  - viii. Conflicts of Interest

### **V. HOW YOU CONTACT THE COMPLIANCE & ETHICS OFFICE**

- a. You can use any one of the following methods:
  - i. Anonymous Hotline: 464-6444; Fax: 464-4342
  - ii. Compliance Office: 464-6600
  - iii. E-Mail: [harrislo@upstate.edu](mailto:harrislo@upstate.edu)
  - iv. Chief Ethics & Compliance Officer, 750 E. Adams St., CAB Rm. 330, Syracuse, NY 13210

# LATEX SENSITIVITY/ALLERGY

## ***“What you need to know”***

- ✓ What is a latex allergy
- ✓ What are the signs and symptoms
- ✓ Who is at risk

### **I. WHAT IS LATEX ALLERGY**

- a. A reaction resulting from contact with the latex containing products. This allergic response occurs after developing sensitivity to the natural rubber protein in latex.

### **II. METHODS OF EXPOSURE**

- a. Direct contact with skin or mucous membranes
- b. Breathing or coming in contact with airborne particles

### **III. REACTIONS:**

#### **a. Contact with skin:**

- i. Rash (non-itch)
- ii. Dermatitis
- iii. Urticaria (itch)
- iv. Flushing (red skin)

#### **b. Airborne:**

- i. Bronchospasm (difficulty breathing)
- ii. Nasal itching
- iii. Conjunctivitis (tearing/eye irritation)
- iv. Sneezing
- v. Asthma/Wheezing
- vi. Dyspnea (shortness of breath)

#### **c. Systemic:**

- i. Hypotension (low blood pressure)
- ii. Tachycardia (racing heart)
- iii. Nausea/vomiting/diarrhea-abdominal cramping
- iv. Anaphylactic shock

### **IV. PATIENTS AND EMPLOYEES AT RISK:**

- a. People with frequent exposure, patients and Health Care Workers
- b. Patients who have had multiple hospitalizations and or surgeries
- c. Individuals with a history of allergic reactions particularly severe reactions
- d. Individuals with food allergies, specifically kiwi, banana, avocado, or chestnuts
- e. Individuals with a history of positive latex testing



## **V. PROCEDURES AND RESPONSIBILITIES:**

### **a. Patient Care:**

- i. Initial patient assessment must include an inquiry about latex allergy.
- ii. Central Stores maintain latex free gloves for latex sensitive patients and staff. If a question remains about a product's safety, Central Stores will research the product content through the manufacturer.
- iii. Central Distribution provides latex free gloves and equipment for latex sensitive patients and staff and will research product safety profile upon request.
- iv. Operating Room area has BioGel Eclipse "Latex" gloves available.

### **b. Employee Care:**

- i. Pre-employment assessment includes latex allergy evaluation. Guidelines and education are provided if a latex allergy is identified.
- ii. Employees need to notify their supervisor of a latex allergy.
- iii. If an employee develops symptoms of allergy and latex reaction is suspected, the employee should report to Employee Health
- iv. If an employee develops severe symptoms or breathing problems and latex allergy reaction is suspected, the employee should report to the Emergency Department for immediate care.
- v. If symptoms of allergic response persist, testing may be indicated by a primary care provider, dermatologist, or allergist.
- vi. After diagnosis, the employee should avoid all latex/rubber products.
- vii. For general patient care, latex free nitrile gloves are supplied from Central Stores and Central Distribution.

# SERVICE EXCELLENCE STANDARDS

Service Excellence is at the core of our organization's commitment to delivering quality care and service. The people we serve include patients, their families, physicians, co-workers, visitors, students, and volunteers. *Thank you for your commitment to service excellence and dedication to superior patient care.*

## **MAKE A POSITIVE IMPRESSION; I WILL**

- Strive to exceed our patient/customer and colleague's expectations in all I do.
- Always look professional in appearance and dress. First impressions matter.
- Treat patients, families and colleagues with compassion, patience, respect and courtesy.
- Be honest and ethical.
- Value and seek to understand different viewpoints.
- Notice if anyone looks lost and help them to find their way, provide thorough directions and when possible, escort customers personally.
- Provide privacy and assure dignity for all.

## **EXEMPLIFY TEAMWORK AND RESPECTFUL RELATIONSHIPS; I WILL**

- Value each other as individuals.
- Embrace the diversity of background, gender, ideas and other differences.
- Anticipate what others need before they ask and freely offer help to others.
- Always assume the best and speak positively about our colleagues and organization, and not discuss internal issues in front of patients and visitors.
- Commit to finding solutions to problems rather than pointing blame and complaining.
- Accept responsibility for my actions and will not blame others.
- Choose a positive attitude every day because it is the right thing to do.

## **ICARE ABOUT COMMUNICATION; I WILL USE ICARE**

- **I: Introduce** yourself by name and title and let the patient/family know a little about you.
- **C: Connect** with the patient and family. If possible, sit down when you are talking.
- **A: Acknowledge** what the patient said; articulate what you have found and what you think is going on using key words.
- **R: Review** the plan of care including what tests and treatments are to be accomplished and the time it will take to complete.
- **E: Educate** on what to expect and ensure understanding from the patient; express gratitude and say "thank you" to our patients for choosing Upstate.

## **I WILL TAKE RESPONSIBILITY FOR THE EXPERIENCES OF THE PEOPLE THAT WE SERVE**

- Acknowledging the patient's problem means working on great active listening skills.
- It's important to apologize and to say "I'm sorry" with empathy and sincerity.
- The expectation is that *everyone* is responsible for service recovery.
  - If there is a patient complaint that you cannot resolve, please contact the Patient Relations Department at 464-5597 or via e-mail at [patientrelations@upstate.edu](mailto:patientrelations@upstate.edu)

## **TAKE CARE OF OUR ENVIRONMENT; I WILL**

- Provide and maintain an environment that is clean, safe, and pleasing to patients.
- Reduce noise in patient care areas; a quiet environment is a healing environment.
- Protect patient privacy by always speaking in an appropriate tone and never discuss patient information in public areas.
- Create a safe work environment and notify Security whenever I have a concern.

# SEXUAL HARASSMENT

## “What you need to know”

- ✓ The definition of sexual harassment
- ✓ What to do if sexual harassment occurs
- ✓ Other types of harassment and discrimination

### I. DEFINE SEXUAL HARASSMENT

- a. Sexual harassment is a form of sex discrimination that violates Title VII of the Civil Rights Act of 1964, NYS Human Rights Law, Executive Order 19, Title IX of the Education Amendments of 1972, and the policy of Upstate Medical University.
- b. Sexual harassment is defined as unwelcome verbal or physical sexual advances or statements made by someone in the workplace or academic setting, which:
  - c. Is **offensive** or **objectionable** to the recipient
  - d. Causes the recipient **discomfort** or **humiliation**
  - e. **Interferes** with the recipient’s job performance
- f. Sexual harassment may consist of words, signs, jokes, pranks, pictures, touching, exposing oneself, threats, intimidation, texting, or physical violence of a sexual nature. Sexual harassment also consists of any unwanted verbal or physical advances, sexually explicit derogatory statements or sexually discriminatory remarks made by someone which are offensive or objectionable to the recipient, which cause the recipient discomfort or humiliation, which interfere with the recipient’s job performance.
- g. Sexual harassment becomes illegal when it is severe or frequent enough to adversely affect a term or condition of an individual’s employment.
- h. This same definition applies to harassment on the basis of other protected categories such as race, national origin, age, or religion.

### II. THERE ARE TWO TYPES OF SEXUAL HARASSMENT

- a. **Quid Pro Quo:**
  - i. Is an abuse of power and authority, such as by a supervisor or manager
  - ii. Results in a tangible employment action (such as firing, demotion, or denial of promotion)
  - iii. Strictly liable for the action.
  - iv. One act is enough to find QPQ sexual harassment.
  - v. Example:
    - Supervisor fires a subordinate for refusing to be sexually cooperative.

- Person in authority tries to trade job benefits for sexual favors. This can include hiring, promotion, continued employment or any other terms, conditions or privileges of employment.

**b. Hostile Environment:**

- i. Results from unwelcome conduct that is based on gender
- ii. Supervisors, co-workers, customers, visitors, or anyone else that an employee interacts with on the job can create a hostile environment
- iii. Example: an employee displays pornographic photos in the workplace, makes sexual innuendos, send texts with sexual statements or photographs.

**III. SEXUAL HARASSMENT CAN OCCUR IN A VARIETY OF CIRCUMSTANCES**

- a. The victim as well as the harasser may be a man or woman
- b. The victim does not have to be of the opposite sex
- c. The harasser can be the victim's supervisor, an agent of the employer, a supervisor in another area, and a co-worker, or a non-employee, or a third party on the premises. (independent contractor, contract worker, vendor, client, customer or visitor)
- d. The victim does not have to be the person harassed, but could be anyone affected by the offensive conduct.

**IV. HARASSMENT ON THE BASIS OTHER THAN SEX**

- a. Upstate Medical University does not tolerate sexual harassment or other illegal types of harassment or discrimination based on sex, age, race, color, disability, marital status, national origin, religion, sexual orientation, gender identity, veteran status, status as a victim of domestic violence, or any other category protected by law.
  - i. Example: an employee uses racially offensive language in reference to another person or group.
- b. Those in violation of the law are subject to appropriate sanctions, including disciplinary action up to and including dismissal.

**V. STEPS TO TAKE IN RESPONSE TO SEXUAL HARASSMENT OR OTHER FORMS OF DISCRIMINATION:**

- a. If possible, tell the person(s) directly that their behavior is unwelcome and must stop. However, this is not necessary.
- b. Speak to your supervisor, and if necessary, consult their supervisor for assistance.
- c. Individuals who experience or witness sexual harassment or other forms of illegal discrimination should contact the Office of Diversity and Inclusion (#464-5234) to schedule an appointment to discuss your options.
- d. Contact the Title IX Coordinator in the Office of Diversity at 315.464.5234

- e. Reports of sexual harassment may be made verbally or in writing. File a written discrimination complaint using the internal complaint procedure available. Written complaints must be filed within 90 calendar days following the alleged sexual harassment. Every effort will be made to protect the privacy and confidentiality of all individuals throughout the complaint investigation and resolution process.

## **VI. RETALIATION**

- a. Retaliation against an individual who files a complaint, or assists in an investigation, proceeding, or hearing is illegal and not tolerated at Upstate
- b. Unlawful retaliation can be any action that would keep a worker from coming forward to make or support a sexual harassment claim. Adverse action need not be job-related or occur in the workplace to constitute unlawful retaliation.
- c. Such retaliation is unlawful under federal, state, and (where applicable) local law. The New York State Human Rights Law protects any individual who has engaged in “protected activity.” Protected activity occurs when a person has:
  - i. filed a complaint of sexual harassment, either internally or with any anti-discrimination agency;
  - ii. testified or assisted in a proceeding involving sexual harassment under the Human Rights Law or other anti-discrimination law;
  - iii. opposed sexual harassment by making a verbal or informal complaint to management, or by simply informing a supervisor or manager of harassment;
  - iv. complained that another employee has been sexually harassed; or
  - v. Encouraged a fellow employee to report harassment.

## **VII. CONSENSUAL RELATIONSHIPS POLICY (UW C05)**

- a. [http://www.upstate.edu/policies/documents/intra/UW\\_C-05.pdf](http://www.upstate.edu/policies/documents/intra/UW_C-05.pdf)
  - i. Become familiar with and follow the policy
  - ii. Be aware that such relationships have the potential to result in claims of sexual harassment, including third party sexual harassment.

# SEXUAL VIOLENCE

## ***“What you need to know”***

- ✓ The definition of sexual violence
- ✓ The definition of consent
- ✓ What to do if sexual violence occurs
- ✓ Available resources:
  - Download the Upstate Reachout Mobile App at <https://www.captivation.com/>
  - Contact the Title IX Coordinator in the Office of Diversity and Inclusion at 464.5234

## **I. DEFINE SEXUAL VIOLENCE**

- a. Sexual violence is a form of sexual harassment. Sexual violence refers to sexual acts perpetrated against a person’s will or where a person is incapable of giving consent (e.g., due to a person’s age or use of drugs or alcohol or an intellectual or other disability that prevents the person from having the capacity to consent).
- b. Sexual Violence includes intimate partner violence, dating violence, stalking, rape, sexual assault, sexual battery, sexual abuse, and sexual coercion.
  - i. Sexual assault includes any actual or attempted nonconsensual sexual activity including but not limited to: sexual intercourse, or sexual touching, committed with coercion, threat, or intimidation (actual or implied) with or without physical force; exhibitionism or sexual language of a threatening nature by a person (s) known or unknown to the victim. Forcible touching, a form of sexual assault, which is defined as intentionally, and for no legitimate purpose, forcibly touching the sexual or other intimate parts of another person for the purpose of degrading or abusing such person or for gratifying sexual desires.
  - ii. Rape- sexual intercourse without consent, committed with coercion, threat, or intimidation (actual or implied), with or without physical force by a person(s) known or unknown to the victim. Sexual intercourse can involve anal, oral, or vaginal penetration, no matter how slight.
- c. Intoxication of the accused cannot be used as a defense to an alleged incident involving sexual violence.

## **II. DEFINE CONSENT**

- a. Affirmative Consent: Affirmative consent is a knowing, voluntary, and mutual decision among all participants to engage in sexual activity. Consent can be given by words or actions, as long as those words or actions create clear permission regarding willingness to engage in the sexual activity. Silence or lack of resistance, in and of itself, does not demonstrate consent. The definition of consent does not vary based upon a participant’s sex, sexual orientation, gender identity, or gender expression.
  - i. Consent to any sexual act or prior consensual sexual activity between or with any party does not necessarily constitute consent to any other sexual act.

- ii. Consent is required regardless of whether the person initiating the act is under the influence of drugs and /or alcohol.
- iii. Consent may be initially given but withdrawn at any time.
- iv. Consent cannot be given when a person is incapacitated, which occurs when an individual lacks the ability to knowingly choose to participate in sexual activity. Incapacitation may be caused by the lack of consciousness of being asleep, being involuntarily restrained, or if an individual otherwise cannot consent.
- v. Consent cannot be give when it is the result of any coercion, intimidation, force, or threat of harm.
- vi. When consent is withdrawn or can no longer be given, sexual activity must stop.
- vii. View the Consent Tea video: <https://www.youtube.com/watch?v=u7Nii5w2Fal>

### **III. STEPS TO TAKE IN RESPONSE TO SEXUAL VIOLENCE:**

- a. Get to a safe place as soon as possible
- b. Try to preserve all physical evidence; do not bathe, douche or change clothes
- c. Contact SUNY Upstate Medical University Campus Police at 464-4000, or CALL 911 (Syracuse POLICE) or 435-3016 (Abused Persons Unit).
- d. You may also CONTACT State Police on the dedicated 24-hour hotline at 1-844-845-7269.

### **IV. REPORTING OPTIONS**

- a. Contact an employee with the authority to address complaints, including the Title IX Coordinator (4-5234, [norcrosd@upstate.edu](mailto:norcrosd@upstate.edu)), the Chief Diversity Officer (4—4392, [lopezg@upstate.edu](mailto:lopezg@upstate.edu)) or University Police (4-4000)
- b. If you learn of an assault after it has happened, refer the victim to appropriate medical services (Emergency Department, 4-5611)
- c. Refer the victim to counseling services (Employee Assistance Program, 4-5760)

### **V. RETALIATION**

- a. Retaliation against an individual who files a complaint, or assists in an investigation, proceeding, or hearing is illegal.

### **VI. CONFIDENTIAL COMMUNITY SUPPORTS AND RESOURCES**

- a. Vera House 24/7 crisis and support hotline
  - i. Phone: (315)468-3260
  - ii. TTY: (315) 484-7263 during business
- b. NYS Coalition Against Sexual Assault Hotline, **1-800-942-6906**
- c. RAINN- National Sexual Assault Hotline, 1-800-656-HOPE (4673)
- d. New York State Domestic and Sexual Violence Hotline, 1-800-942-6906

# STROKE: RECOGNIZING IT F.A.S.T.

## “What you need to know”

- ✓ What is a Stroke?
- ✓ What does **F.A.S.T** mean
- ✓ Five common symptoms of a stroke
- ✓ What to do if a patient exhibits **sudden** onset of stroke symptoms
- ✓ The goal of in-house stroke alert

## I. WHAT IS A STROKE?

- a. A stroke is interruption of blood flow to the brain
  - i. An **ischemic** stroke is the most common type of stroke and occurs when a blood clot or emboli blocks blood flow to an area of the brain. Every minute that the blocked area of the brain is without blood/oxygen, 1.9 million neurons/nerve cells die.
  - ii. A **hemorrhagic** stroke occurs when bleeding occurs inside or around the brain (intra-cerebral hemorrhage or subarachnoid hemorrhage).
- b. Alteplase (tPA) is the only FDA-approved “clot-busting” drug used to treat acute ischemic stroke.
  - i. The treatment window for tPA is within 3 hours of symptom onset (in some cases the window can be extended up to 4.5 hours)
  - ii. The **sooner the patient receives tPA, the better the potential outcome** for the patient.
- c. **Stroke is an emergency** and may require neurosurgical/neurointervention. Intervention may include a clot retrieval procedure (thrombectomy) where the clot blocking the artery is removed to restore blood flow. Recent trials have seen positive benefits when used up to 24 hours after the patient was last known to be well.
- d. It is expected that patients who are hospitalized have the same opportunity for rapid identification and treatment of stroke as those patients brought to the emergency room
- e. If an inpatient *suddenly* develops stroke symptoms, the expectation is that assessment and care of the patient occur immediately

## II. WHAT IS F.A.S.T.?

- a. **F** = FACE: facial drooping or weakness
- b. **A** = ARM: Arm weakness or drift
- c. **S** = SPEECH: difficulty speaking or slurring words
- d. **T** = TIME: Time to call help/Time last known well



## III. WHAT ARE FIVE COMMON SYMPTOMS OF A STROKE?

- a. *Sudden* numbness or weakness, especially on one side



- b. *Sudden* confusion or trouble speaking
- c. *Sudden* trouble seeing in one or both eyes
- d. *Sudden* trouble walking or dizziness
- e. *Sudden* severe headache with no known cause

#### **IV. WHAT DO I DO IF THE PATIENT EXHIBITS *SUDDEN* ONSET OF STROKE SYMPTOMS?**

- a. At the Downtown campus dial 4-4444 to activate a stroke code, provide unit and room number.
- b. At the Community Campus dial 2211 to activate a stroke code.
- c. Notify the patient's primary service attending or house staff.
- d. If you are in Jacobsen Hall, CAB, Clark Tower, Parking Garages/Parking lots, Campus West Building (CWB), Weiskotten Hall or IHP, Building 49 dial 911 per policy CM E-15, <https://upstate.ellucid.com/documents/view/3714>.

#### **V. WHAT HAPPENS ONCE I CALL A STROKE CODE IN UNIVERSITY HOSPITAL, DOWNTOWN CAMPUS?**

- a. The Neuroscience Resource Nurse and stroke team resident responds to the designated unit/area to assess patient
- b. If a stroke code is activated, a blast page goes to Stroke Neurology, Administrative Supervisor, CT Scan, Lab, and Pharmacy. Neurology will respond and assess the patient. Radiology will clear the CT scanner to be ready to scan the patient. Pharmacy gets ready to mix tPA medication. Administrative Supervisor will evaluate bed availability.

#### **ALL PATIENTS DIAGNOSED /SUSPECTED WITH STROKE ARE NOT ALLOWED ANYTHING BY MOUTH, INCLUDING MEDICATIONS, UNTIL A DYSPHAGIA (SWALLOW) SCREEN IS COMPLETED**

#### **VI. GOAL OF AN IN-HOUSE STROKE CODE IS TO GET THE PATIENT EVALUATED AS QUICKLY AS POSSIBLE TO ENSURE MAXIMUM OXYGENATION AND PERFUSION TO THE BRAIN.**

- a. **You should be aware that the minimum time target expectations given by NYS Department of Health from initial discovery of symptoms for stroke evaluation and treatment are:**
  - i. symptom onset to neuro evaluation **15 minutes**
  - ii. symptom onset to CT scan **25 minutes**
  - iii. symptom onset to CT results **45 minutes**
  - iv. symptom onset to lab results **45 minutes**
  - v. symptom onset to needle **60 minutes**

**Remember, think F.A.S.T when you think a stroke!**

# U-TURN/HEALTHY WORKPLACE

## “What you need to know”

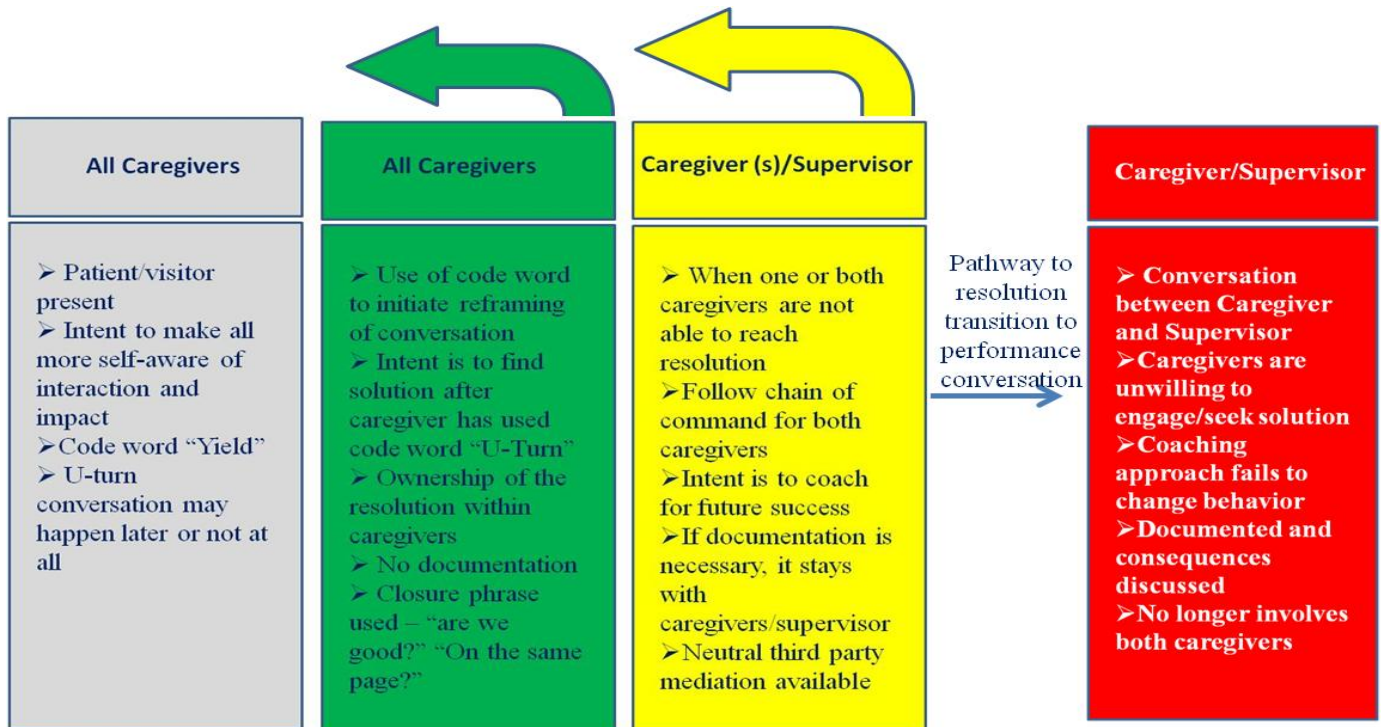
- ✓ What is the U-Turn Process
- ✓ How to request a third-party mediator
- ✓ Healthy Workplace Environment Policy

### I. U-TURN PROCESS

- a. We recognize that interactions may not always be best between staff
- b. A three phase approach, the U-Turn process, asks that staff stop unhealthy conversations and ask to restart in order to maintain present and/or future healthy communication

### II. THREE U-TURN CONVERSATIONS:

- a. Grey: “Yield” is the word to stop a conversation in the presence of a patient or visitor
- b. Green: “U-Turn” is the word used when staff recognize they need to re-start the conversation. This gives staff the time to calm and restate their positions in a manner that has the best interest of all in mind
- c. Yellow: When staff have not been successful with “u-turning” the discussion, supervisors/managers are asked to serve as a mediator to resolve conflict so that it does not escalate



### III. WHAT IF YOU NEED NEUTRAL OUTSIDE HELP?

- a. We have a team of certified workplace mediators who will assist staff when they are “stuck” and unable to resolve conflict
- b. You can request a mediator via this link: <http://www.upstate.edu/uturn/intra/mediators.php>

#### **IV. HOW DOES THIS IMPACT MY PERSONNEL RECORD?**

- a. When a third-party mediator is requested, no record of the meeting(s) is ever in your personnel folder. This is considered a benefit for staff.
- b. If agreements are identified via the mediated conversation, those agreements may be written and shared between the two staff involved and their manager simply to help guide future interaction; but may not be used in counseling, discipline, or performance programs.

# WORKPLACE DIVERSITY & CREATING A CULTURALLY INCLUSIVE ENVIRONMENT:

## “What you need to know”

- ✓ Workplace diversity and inclusion is about acknowledging the diverse skills and perspectives that people may contribute because of their gender, age, language, ethnicity, cultural background, disability, religious belief, sexual orientation, working style, educational level, professional skills, work and life experiences, social-economic background, job function, geographic location, and other dimensions of diversity.
- ✓ We aspire to recognize and embrace the diversity each person brings to the organization. Creating a culturally inclusive environment allows all employees to effectively collaborate in the ongoing development and delivery of healthcare, education, research and outreach.
- ✓ A culturally inclusive environment requires mutual respect, effective relationships, clear communication, explicit understandings about expectations and critical reflection. In an inclusive environment, people of all cultural orientations can:
  - Freely express who they are, their own opinions and points of view.
  - Fully participate in teaching, learning, work and social activities.
  - Feel safe from abuse, harassment or unfair criticism or maltreatment.

**Cultural Humility:** To practice cultural humility is to maintain a willingness to suspend what you think you know about a person based on generalizations or stereotypes.



Erica E. Hartwell, University of Ohio

**Inclusive Practice:** Students, faculty, staff, patients, and guests can benefit from culturally inclusive practice and experience diversity as a resource that enriches our teaching, learning, research and service. If we don't adopt inclusive practices, the result is that some people and communities will feel marginalized, isolated and discouraged. Inclusive environments on campus contribute to making Upstate Medical University a safe, enjoyable and productive place for everyone in the organization and enhance

our interactions with the wider community we serve.

**Respectful Relationships:** Respecting diversity entails more than tolerance. The term ‘tolerance’ implies that something must be endured, or ‘put up with’. When genuine acknowledgment, appreciation of,

and interest in diversity is experienced, respectful relationships develop. Engaging in respectful relationships means demonstrating a positive appreciation of people and their cultural values.

**Workplace diversity & inclusion is everybody’s responsibility. Expect all employees to foster and promote a work environment that is inclusive and reflects the significant diversity within the region we serve. Some ways we can do this are:**

- ◆ Becoming consciously aware of our own multidimensional cultural identities and background.
- ◆ Treat people the way they want to be treated.
- ◆ Ask preferences before acting.
- ◆ Recognize that not all people within a particular background feel, think, or act the same.
- ◆ Taking time to learn about and understand the impact of another person’s uniqueness and culture on the healthcare or workplace interaction.
- ◆ Reminding ourselves that our culture is one of many cultures, and that there is no “right” or “wrong” way to think or believe.
- ◆ Not making assumptions about what people think or why they act in a certain way; keeping an open mind. Be humble enough to let go of the false sense of security that stereotyping brings.
- ◆ Always treating individuals of all cultures with dignity and respecting their differences. Provide access to interpreters, diverse patient education materials, and create and maintain an environment that is welcoming and inclusive of diverse populations.
- ◆ Above all, becoming aware of our own biases through self-reflection and commitment to a lifelong learning process and finding ways to resolve our biases so they do not negatively affect our treatment of, and respect for, others.
- ◆ Becoming cognizant of the power differential between patients and providers, including our limited knowledge regarding patients’ health beliefs and life experiences, and our unintentional and intentional expressions and actions of bias in regard to all the “isms”, including racism, classism, sexism, ageism, ableism, weight bias, and homophobia.

For more information on workplace diversity and creating a culturally inclusive environment contact: Office of Diversity & Inclusion, Jacobsen Hall, suite 711, 464-5234, [diversity@upstate.edu](mailto:diversity@upstate.edu)

# WORKPLACE VIOLENCE

## “What you need to know”

- ✓ The NYS Labor Law Section 27-b related to workplace violence
- ✓ The definition of workplace violence
- ✓ What the risk factors are
- ✓ Supports and training Upstate Medical University provides

### I. NYS Labor Law Section 27-B:

- a. NYS Labor Law 27-b is the ‘Public Employer Safety and Health Act’ that requires Upstate Medical University to:
  - i. Record and report work-related death, injuries and illnesses, which may include incidents of workplace violence
  - ii. Record an injury or illness that results in death, days away from work, restricted work or transfer to another job, medical treatment beyond First Aid or loss of consciousness
  - iii. Provide a ‘Workplace Violence Prevention’ program, including but not limited to Policy UW V-03, <https://upstate.ellucid.com/documents/view/3036>, training, and other supports within Upstate Medical University

### II. WORKPLACE VIOLENCE

- a. Workplace violence is any physical assault, threatening behavior, or verbal abuse occurring in the work setting:
  - i. This includes, but is not limited to, the buildings and the surrounding property, including the parking lots

### III. WORKPLACE VIOLENCE INCLUDES

- a. The use of force with the intent to cause harm (i.e. physical attacks, any unwanted contact such as hitting, fighting, pushing, or throwing objects)
- b. Behavior that diminishes the dignity of others through sexual, racial, religious, or ethnic harassment
- c. Acts or threats which are intended to intimidate, harass, threaten, bully, coerce, or cause fear of harm – directly or indirectly
- d. Acts or threats made directly or indirectly by oral or written words, gestures, or symbols that communicate a direct or indirect threat of physical or mental harm

### IV. RISK FACTORS FOR WORKPLACE VIOLENCE:

- a. Violence may occur anywhere in the Upstate Campus. The most frequent areas include:
  - i. Areas with contact to the public
  - ii. Areas with late night or early morning hours
  - iii. Psychiatric units
  - iv. Emergency rooms

- v. Waiting rooms
- vi. Hospital units with geriatric or head injured patients
- vii. Areas where money is exchanged with the public
- viii. Areas where employees work alone or in small numbers
- ix. Poorly-lighted areas
- x. Uncontrolled access into the workplace

## V. SAFETY TIPS FOR UPSTATE EMPLOYEES

- a. Watch for signals that may be associated with impending violence:
  - i. Body language such as threatening gestures
  - ii. Signs of drug or alcohol use
  - iii. Presence of a weapon
  - iv. Verbal expressions of anger and frustration
- b. Maintain behavior that helps diffuse anger:
  - i. Present a calm, caring attitude
  - ii. Acknowledge the person's feelings (for example, "I know you are frustrated")
  - iii. Be alert throughout the encounter
  - iv. Avoid any behavior that may be interpreted as aggressive (for example, moving rapidly, getting too close, touching, or speaking loudly)
  - v. Don't give orders
  - vi. Don't match the threats
  - vii. Evaluate each situation for potential violence
  - viii. Always keep an open path for exiting (don't let a potentially violent person stand between you and the door)

## VI. ADDITIONAL HELP, TRAINING, AND FOLLOW-UP INFORMATION

- a. **Contact the Employee Assistance Program (EAP) Office during normal business hours at 315-464-5760.**
  - i. After normal business hours, leave a message and someone will return your call the next day
- b. **Workplace Violence: CPI Nonviolent Physical Crisis Intervention' training is available to all employees.**
- c. For more information, contact Organizational Training and Development (OTD) or visit <http://www.upstate.edu/hr/intra/training/register/index.php?searchtext=cpi>

### **HOW TO REPORT A WORKPLACE VIOLENCE INCIDENT**

Employee/Labor Relations @ **315-464-5872**

Employee Assistance Program @ **315-464-5760**

Office of Diversity and Inclusion @ **315-464-5234**

Patient Safety Hotline @ **315-464-SAFE**

University Police @ **315-464-4000** or Community Campus **315-492-5511**