



2012 Annual Mandates

Self-Learning Module

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BELLEVUE HOSPITAL CENTER

MISSION, VISION & VALUES STATEMENT

MISSION: Bellevue's mission is to provide the highest quality of care to New York's neediest populations and to deliver health care to every patient with dignity, cultural sensitivity and compassion, regardless of ability to pay.

VISION: Our vision is to be one of the 10 ten safest hospitals in the nation.

VALUES:

- To provide care within a culture that is based on trust, respect, human rights and forgiveness.
- To promote individual and shared acceptance of responsibility and accountability for the safe delivery of quality care.
- To treat patients and their families as partners in care design, delivery and assessment.

Section One

Environment of Care
Life / Fire Safety
Oxygen / Medical Gases
Emergency Preparedness
Security Management
Utilities Management
Medical Equipment Management
Incidents / Accidents / Injuries / Needlesticks
MSDS / Right to Know
Radiation Safety

ENVIRONMENT OF CARE

General Safety Tips

- Follow hospital and departmental safety policies and procedures. Don't take short cuts.
- Report all injuries to your supervisor.
- Prevent Needle Sticks/Blood Borne Pathogen Exposures:
 - Use safety devices correctly.
 - If you are stuck with a contaminated needle wash the wound with soap and water (do not squeeze).
 - Go to OHS (Occupational Health Service) H building, 14 E 8am-4pm, or the AES when OHS is closed.
- Prevent back injuries:
 - Sitting – Try to keep one or both knees higher than your hips. Rest your feet on a book or binder on the floor if necessary. Avoid twisting and turning. Place frequently used items such as the telephone within easy reach.
 - Lifting – Make sure you lift properly. Bend your knees and use your leg muscles to lift. Keep the load close to your body and try to carry the load in the space between your shoulders and your waist. Get help or use a dolly or a forklift if needed.
- Prevent Workplace Violence:
 - Report workplace violence to Hospital Police and complete an Occurrence Report.
 - If confronted by a violent person get help. Call for a supervisor or manager. Call Hospital Police ext. 6191.
 - If you are in a room with an aggressive or potentially violent person make sure you have an escape route. Remain near the door and do not allow the person to block your exit.
- Removed tripping hazards from the floor such as cables and cords, loose rugs, boxes, etc.
- Walk; don't run. Use handrails on stairs. Be cautious approaching doors, corners, and congested areas.
- Keep corridors and safety equipment such as medical gas valves and fire extinguishers free of any and all obstructions.
- Maintain good lighting. Call Facilities Management when light bulbs need replacement.
- Observe closely the condition of the floors and walk carefully. Report loose, wet and defective floor surface areas to Facilities Management.
- Do not stack boxes, books, etc. high on top of cabinets where they can fall over and hit someone.
- Close cabinets and drawers when not in use.
- Use the right tools and equipment for the job; use them in the safe prescribed manner.
- Wear PPE (Personal Protective Equipment) when specified, such as rubber gloves, aprons, masks and gowns.

CODE RED: FIRE SAFETY

Remember: Bellevue is a smoke-free facility. There is no smoking allowed in any building, grounds, sidewalks, and within 15 feet of hospital property, entrances and exits, and adjacent walkways.
No exceptions!

Employee's Role in a fire – “Code Red”

In the event of a fire, or smoke, quick action is imperative.

Never shout fire! The code word for the event is **CODE RED**. Shout “Code Red!”

Follow the **R.A.C.E.** Procedure:

RESCUE

Remove patients or others in immediate danger, and close door behind you. If you are busy in the rescue effort, shout “CODE RED” so other employees can pull the alarm.

ALARM

The alarm must be sounded before any other action is taken unless there is someone in immediate danger. Shout “Code Red”. Pull the nearest alarm box and call Stat Operator by dialing “6-6”. Tell the operator the location of the fire. Alarm boxes are located by every stairwell / exit door. Learn the fire code for your work area.

CONTAIN

Contain the fire by closing doors and windows.

EXTINGUISH / EVACUATE

Extinguish fire if possible. Use correct extinguisher for the type of fire. Evacuate all persons to a safe area, if necessary. Follow directions of Safety Officer, Fire Department or Nursing Supervisor. Elevators cannot be used to evacuate except with the permission of the FDNY. Extinguish only when a fire is in the incipient or very early stage. If the fire is more severe wait for help to arrive.

Learn your evacuation procedure, routes and destination location.

The procedure for use of any fire extinguisher is **P.A.S.S.**: (stand 8-10 feet away from the fire)

Pull Pin (from handles)

Aim at base of fire

Squeeze handles

Sweep nozzle or hose from side to side

TYPES OF FIRES AND EXTINGUISHERS

- A** Ordinary combustibles (paper, cloth, mattress, etc.) Use water (A) or Dry Chemical (ABC)
- B** Flammable liquids (alcohol, grease, etc) Use CO2 (BC) or Dry Chemical (ABC)
- C** Electrical (motors, computers, etc) Use CO2 (BC) or Dry Chemical (ABC)



FIRE SAFETY DOS

- 1 – Do keep doors closed and secured in all hazardous areas, like storage rooms, soiled utility rooms, medication workrooms, and housekeeping closets and hopper rooms.
- 2 – Do close all corridor and patient room doors during fire alarms.
- 3 – Do report damaged or missing fire safety equipment.
- 4 – Do report damaged/broken fire safety building components, such as doors and latches.

FIRE SAFETY DON'TS

- 1 – Do not tape over door latches to prevent doors from locking.
- 2 – Do not block doors with chairs, beds, waste containers or any other item.
- 3 – Do not leave obstructions or storage in corridors or means of egress.
- 4 – Do not block smoke/fire doors, fire extinguishers and fire hoses with any items.

FIRE DRILLS

Fire drills are held every quarter on every shift. There is no difference between a fire alarm and a drill. All employees are expected to respond to every alarm.

For more information, consult the **Code Red Manual** available on every unit or service.

DEFEND IN PLACE

“**Defend in place**” means to isolate patients and staff from fire and smoke by crossing to another smoke compartment while emergency personnel respond to the situation.

What is a smoke compartment? A smoke compartment is a space within a building enclosed by smoke barriers on all sides, top and bottom. Each floor has several compartments. In order for it to work properly, the doors and windows must be closed completely, thus it is important that these doors must never be chocked or tied open. In addition, be sure that nothing is placed in their path that will interfere with their operation.

HORIZONTAL EVACUATION

If you are told to horizontally evacuate by Hospital Police or Fire Safety personnel, move through a double door that is labeled as a fire door (“F”) or a smoke door (“S.”) You will know if the corridor doors are fire or smoke doors by the placards that are affixed to the door frames.

ELECTRICAL FIRE SAFETY

To avoid potential electrical fires, be sure to follow the tips below:

- Do not “daisy chain” or plug multiple power strips into each other
- Do not overload outlets with the addition of “cheater” or dual input plugs.
- Open coil devices such as toasters, toaster ovens and space heaters are strictly prohibited.

OXYGEN & OTHER MEDICAL GASES

1. What is the difference between natural gas and medical gas?
 - Natural gas is the gas that is used for fuel in the kitchen area or heating systems.
 - Medical gas is used to support medical treatment or biomedical equipment.
 - These medical gases are color coded on the gas supply lines and at the bedside outlets:
 - Oxygen – green
 - Vacuum – white
 - Air - yellow
2. The shut off (zone) valves for oxygen, nitrous oxide and medical vacuum, which are found in corridor walls, may only be operated by a Registered Nurse or a Respiratory Therapist or the FDNY.
 - Zone valves are labeled with the room numbers that they serve.
 - Make sure patients on life support are switched to portable O2 before turning off zone valve.
 - To access zone valves, place your finger in the ring on the plastic window and pull toward you.
 - When the window is removed, grasp the valve and pull towards you until the handle is at a 90 degree angle to the wall. This will stop gas or vacuum flow to all rooms listed.
3. If there is a low oxygen flow, a light will signal the Nurses Station panel and the alarm will ring. Take the following action:
 - Check your patient
 - Have the operator page Respiratory Therapy for medical assistance.
 - Call Engineering at ext. 6295 to report the problem.

EMERGENCY PREPAREDNESS

EXTERNAL / INTERNAL DISASTERS “HICS ALERT LEVELS”

In a disaster HICS (Hospital Emergency Command System) is activated. It is a management system that helps the hospital utilize resources efficiently in response to any type of disaster or unusual event, whether it has occurred externally in the community outside the hospital, or internally within the hospital.

1. In case of a disaster you will be notified by your supervisors, overhead announcements and in the most severe situation the fire alarm rings in the sequence 7-7-7.
2. Both External and Internal Disasters are announced by disaster pager system announcing HICS Alert
Levels 1, 2, 3 or 4. There will be an overhead announcement:
 - a. HICS Level 1- notification
 - b. HICS Level 2 – actual incident, minor impact
 - c. HICS Level 3 – actual incident, moderate impact
 - d. HICS Level 4 – severe impact (fire alarm will sound in the sequence 7 – 7 – 7).
3. Continue your normal job function unless you are instructed otherwise by your supervisor.
4. Do not leave your workplace until you are relieved of duty by your supervisor.
5. Check e-mail frequently if you have it available.
6. Do not use the phone except for necessary hospital business.
7. Consult your DEOPS (Departmental Emergency Operations Plan) posted on your unit.
8. When HICS is activated, a Command Center is opened in the Emergency Department Conference room (ED-131), ext. 4702.
9. The Hospital EOP (Emergency Operations Plan) is available on the Bellevue Intranet. On the homepage click on “Emergency Management”.
10. Bellevue Hospital manages disasters using an Incident Command System called Hospital Incident Command System (HICS). It is an all hazards organizational structure designed to expand or contract based on the scope and nature of the disaster and follows a clear chain of command and communication.
11. Everyone has a role to play during a disaster condition and will be part of the hospital’s labor pool.
Unless you are instructed otherwise by a supervisor, continue at your regular work assignment.
12. In the event of a failure or malfunction of the hospital’s telecommunication system either intra-hospital or externally, communication is maintained by using land-line red phones, overhead voice page, the use of public telephones located throughout the hospital, walkie-talkies, long range beepers, cell phones and the use of messengers/runners.
13. When the Disaster is over there will be an All Clear announced via pagers and the overhead paging system. “Attention Attention, Code Clear, Code HICS has been secured”
14. To learn more about emergency management and policies and procedures consult the Emergency Management Operations Plan located in each department or nursing unit or on the BHC Intranet under *Emergency Management*.
15. Examples of a disaster include: power failure, hospital fire, loss of communication system, water loss, mass casualty incidents, hurricanes, blizzards, terrorist attack, transit strike, influx of infectious patients, explosion.

SECURITY

HOSPITAL POLICE

- Sworn New York State peace officers
- Charged with enforcement of all New York applicable laws
- Charged with enforcing all HHC and hospital rules and regulations

WHEN TO CALL HOSPITAL POLICE

- To report acts of criminal, violent or malicious nature
- Incidents of workplace violence – both physical and verbal
- Fights/altercations
- Infant/child abduction (or attempted abduction)
- You observe someone with a weapon / you find a weapon
- You observe suspicious people or behavior
- You find lost/stolen property
- You observe someone damaging corporate property
- You hear/receive a bomb threat
- Any unusual circumstance that seems to need attention

Hospital police telephone numbers

- For all emergent calls
 - inside the hospital – Ext 6191
 - outside the hospital – 212-562-6191
- For identification card info
 - Ext 2345 or Ext 6191
- Hospital police supervisors
 - Ext 6191

Security is Everyone's Job

- HHC operating procedure 20-25 requires **all employees to wear their identification card while on HHC premises**
- HHC facilities are **smoke free facilities**
 - **Smoking is not permitted anywhere in the facility**

EMPLOYEE'S ROLE IN THE SECURITY MANAGEMENT PLAN

1. Always wear your identification badge. Your photo must be facing outward and be easily visible.
2. For routine security issues call ext. 6191
3. If you observe a stranger not wearing a hospital identification badge or visitor pass:
 - Ask if you can assist them (if you feel safe to do so)
 - Then direct them appropriately
 - Only if they resist or act suspiciously or you feel uneasy should you call Hospital Police at ext. 6191.
4. If you are confronted by a threatening situation (aggressive behavior, etc.) call Hospital Police at ext. 6191
5. In High Risk Areas (e.g. Psychiatry, Pulmonary/Chest, Pediatric Units, Emergency Department) know the security precautions in place.
6. Be careful, alert, and prudent and take precautions when working /walking alone in remote locations (keep office doors locked). Keep your personal belongings secured.
7. If you are working in an isolated location or working late, sign in on the off hour log book located at the Hospital Police Desk (ground floor Administration Building, adjacent to the Ambulatory Care building in Room AG-14).
8. If you are threatened or assaulted by anyone notify Hospital Police immediately at ext. 6191 and seek medical attention if needed.
9. In the event property is lost or stolen, notify Hospital Police (ext. 6191). A crime report is filled out and a follow up investigation is done.
10. Hospital police conduct crime prevention awareness throughout the hospital.
11. Always remember that the welfare and healthcare of our patients, families, visitors and staff are dependent on everyone working together to provide a safe environment.
12. Common sense and a positive attitude will greatly contribute to these objectives.

UTILITY MANAGEMENT

Facilities Management at Bellevue Hospital facilitates a Utilities Management program designed to ensure the operational reliability, address the special risks and immediately respond to failures of all utility systems and their associated sub-components that support the patient care environment. The Engineering Department maintains and operates the Physical Plant. This includes the heating, air conditioning, and ventilation (HVAC) systems.

Utilities management is a collection of policies, procedures and plans used to control the environment in which we work. Examples include:

- Steam
- Hot and Cold Water
- Medical and Natural Gas
- Electricity
- Telephone and Communication Systems
- Air Conditioning
- Ventilation Systems
- Computer Network

The Department is also responsible for maintenance of the Fire Alarm System, the Emergency Diesel Generators, the back up Electric Boilers, and various computers and controls associated with this equipment. Services are provided with the equipment in seven different mechanical rooms, as well as several smaller mechanical spaces throughout the complex.

You can help maintain safe utilities systems:

- Keep wet material away from electrical equipment.
- Never remove a plug from an outlet by pulling on the line cord. Grasp the plug and pull straight out.
- Don't use an outlet or electric cord that has any defect even if it is taped, and do not use a cracked outlet.
- All equipment attached to a patient must be plugged into a common ground.
- Extension cords are not allowed.
- Electricity is supplied to the hospital by Con Edison. If there is a Con Edison failure or loss of power the hospital has emergency generators that will continue to provide power for critical services and areas.
- A red outlet means that if there is a Con Ed failure, emergency power will immediately be provided with no interruption. Patient care equipment should be plugged into a red outlet to ensure there will be continuous power even if there is a Con Ed failure or black-out.

What do we do when a utility fails?

If you experience an unexpected utility failure or loss (a power outage, breakdown to water, steam, natural or medical gas, telephone system, ventilation or heating and air conditioning) call the Facilities Management Help Line at ext 4779.

What are considered emergency repairs?

- Floods or leaking pipes
- Broken glass in windows or doors
- Steam leaks
- Medical gas problems
- Electrical outage (no power)
- Refrigerator and freezer (temperature variation)
- Heating (winter season)
- Air conditioning (summer season)

In the event of an emergency problem with any utilities systems you can contact x4779, 24/7.

What do I do if it is not an emergency?

Submit a work order to facilities management by calling x4779.

What is emergency power?

Emergency power is produced by independent diesel powered emergency generators. In the event of an interruption in the normal power supply, the generators provide electricity to ensure the operation of all life support and essential services necessary to maintain hospital functions.

What should be connected to emergency power?

Some of the items that need to be connected to emergency power are:

- Ventilators
- Life support equipment
- Elevators
- Kitchen equipment
- Fire alarm systems
- Stairwell and exit lights
- Nurse call systems
- Means of egress lighting

MEDICAL EQUIPMENT MANAGEMENT

1. If you detect a problem during use or testing of a piece of medical equipment or it does not operate the way you expect, take it out of service immediately and place a “not functioning/out of order” sign on it.
2. Notify your supervisor.
3. Notify Biomedical Engineering Mon-Fri, 8 am - 5 pm ext. 6531. At other times contact the AOD, ext. 4438.
4. Each device should have a Biomedical Engineering sticker on it that tells you the date of its last inspection and the date the next inspection is due. If the device inspection date is past due, do not use it and notify Biomedical Engineering immediately, ext. 6531. Notify your supervisor.
5. If you have any questions contact Biomedical Engineering, ext. 6531.

INCIDENTS / ACCIDENTS / INJURIES

1. If you witness a co-worker or visitor who appears to be in medical distress such as not breathing, unconscious or having a seizure, call RRT (Rapid Response Team) by dialing the STAT operator, ext. 66, state name and provide the exact location.
2. Complete an HHC 407 Confidential Report of Occurrence Form and submit it to Risk Management, ME-22. (The form is available on nursing units or call the Safety Department at ext. 6520, M-F, 9 am - 5 pm.)

If you are injured on the job:

1. Notify your supervisor.
2. Complete Supervisors Report of Injury.

Report to Occupational Health Service Mon – Fri, (12th Floor East) 8 am – 4 pm.
At other times go to the Emergency Department.

NEEDLESTICK EXPOSURE TO BLOOD BORNE PATHOGENS

IF YOU ARE STUCK BY A CONTAMINATED NEEDLE OR OTHER MEDICAL SHARPS:

1. Wash the wound with soap and water (do not squeeze).
2. Notify your supervisor immediately.
3. Seek medical care at the facility where you are working at the time of the injury (within 2 hours of the exposure).

A – If you are at Bellevue go to Occupational Health Service (OHS),
Hospital Building, 12 east (M – F, 8 am – 4 pm).
When OHS is closed, go to the Emergency Department.

B – If you are at NYU Langone go to Employee Health Service (EHS),
660 First Ave. (corner 38th St.) 2nd floor.
When EHS is closed go to the Emergency Department.
4. If you receive your initial care in the Emergency Department, follow up with OHS / EHS as soon as you can (the next business day).

HAZARDOUS COMMUNICATION & RIGHT TO KNOW

MATERIAL SAFETY DATA SHEET

1. Employees have a right to receive information on any hazardous substance they are routinely exposed to on the job. You do not have to use the product until the MSDS is provided to you.
2. This information is available on a Material Safety Data Sheet (MSDS). The MSDS provides health and safety information on every product / chemical in use, such as how to use it safely, health hazards associated with the product, if personal protective equipment is needed, how to store and dispose of it, etc.
3. Personal protective equipment is used to prevent exposure to hazardous chemicals: gowns, gloves, aprons, goggles, booties, respirators, face shields.
4. If you have a question about a chemical that you work with you have the right to an answer within 72 hours.
5. If you think that you are having some type of reaction to a chemical, inform your Supervisor and go to Employee Health Service.
6. Health information on pharmaceuticals (drugs) can be found in the Physician's Desk Reference available on line (Bellevue Intranet), or by calling Pharmacy, ext 6501 (24 / 7).
7. **If there is a chemical spill and you have NOT been trained to clean it do the following:**
 - Isolate and secure the area as much as possible and remove anyone from the immediate vicinity.
 - Notify your supervisor.
 - Notify the Safety Dept, ext. 6520, M-F, 9 am - 5 pm At other times notify the AOD, ext. 4438 or call operator, ext. 4311, and ask her to page the AOD.

Get the MSDS (Material Safety Data Sheet) for the chemical if known. This will provide health and safety information about the chemical. There is an MSDS binder on each unit or access the MSDS on-line by doing the following:

- Go to the BHC Intranet homepage.
 - Click on the icon of a yellow binder in the right hand column.
 - Enter the information you have (name, manufacturer, etc) about the chemical or product.
 - Follow the system prompt to reach the MSDS you want.
8. In the event of a SPILL OF A CHEMICAL that is extremely hazardous or of Unknown origin, follow these steps:
 - Evacuate the immediate area
 - Restrict access to the area
 - Contact the safety department (or the administrator on duty in off-hours)
 - Contact the departmental hazardous material coordinator
 - Review the MSDS spill procedures (if the material is known)

RADIATION SAFETY

DIAGNOSTIC PROCEDURE:

A. PORTABLE X-RAYS

NURSING

All personnel will normally stand minimally six (6) feet away from the patient when a mobile radiograph is taken. In the event that the employee remains closer than six (6) feet, because of patient needs, a lead apron will be worn. All personnel who assist in the use of mobile fluoroscopy will wear lead aprons. Radiation badges are required for operators of x-ray equipment (i.e. x-ray technologists and physicians) and are recommended for personnel who stand alongside the physician operator during fluoroscopy. Badges are not required for circulating staff or individuals who do not spend significant time near the x-ray unit.

PATIENTS

When a patient cannot be moved six feet away from another patient receiving a mobile X-ray, the nursing and radiology departments shall exercise good judgment and shield adjacent patients with the use of a lead shield or lead apron if available.

B. NUCLEAR MEDICINE DIAGNOSTICS

Universal precautions are required following administration of radioactive materials to patients for diagnostic purposes. Radiation badges are not necessary. Transport containers, syringes and/or any other residuals from radioactive material administration should be moved to a secure place and be removed by the Nuclear Medicine Service. Although these items are not significant radiation sources, they may be contaminated and should be handled with gloves. Consumption of food or drink is prohibited in areas where radioactive materials are used.

C. ROUTINE RADIOISOTOPE THERAPY

1. Iodine 125 seeds for prostate and Iodine 131 for hyperthyroidism
 - a. *No special room assignment or preparation
 - b. *No special precautions unless indicated in the chart by (RSO)
 - c. Follow universal precautions. Do not handle dislodged seeds with bare hands. Contain vomitus of I-131 patients. Direct all questions to RSO or designee.
2. Iodine 131 for cancer therapy
 - a. *Patient in single room
 - b. *Follow "strict" standard precautions
 - c. *Set up room prior to radioactive treatment administration to patient
 - d. Plastic dishes & utensils
 - e. Linen and plastic linen bags (enough for three (3) days) in room
 - f. Gown and glove cart outside room
 - g. Precautions
 - i. Read chart for special instructions
 - ii. Post appropriate signage at the door
 - iii. Organize to maximize patient care, while minimizing exposure time
 - iv. Pregnant women should be disallowed entry
 - v. Use appropriate clothing, in the event of accidental exposure from patient excreta
 - vi. Call the RSO if patient vomits
 - vii. Ensure the timeliness of patient discharge has been discussed with the RSO
 - viii. Have room and all of its contents cleared by the RSO before allowing housekeeping to clean the room in preparation for re-occupancy.

SECTION TWO

Patients' Rights

HIPAA

Patient Advocacy

Advance Directives

Pain Management

Palliative Care

Patient Safety

Medication Administration / Events

Patient Education

PATIENTS' RIGHTS

PATIENTS' BILL OF RIGHTS

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, national origin, disability, sexual orientation or source of payment.
3. Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.
4. Receive emergency care if you need it.
5. Be informed of the name and position of the doctor who will be in charge of your care 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. A no smoking room.
8. Receive complete information about your diagnosis, treatment and prognosis.
9. Receive all the information that you need to give informed consent for a 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 "Do Not Resuscitate Orders – 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. 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. Complain without fear of reprisals about the care and services you are receiving and to have the hospital responds 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 Health Department telephone number.
18. Authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors.
19. Make known your wishes in regard to anatomical gifts. You may document your wishes in your health care proxy or on a donor card, available from the hospital.

HIPAA

HIPAA is a Federal Law that Governs Healthcare Information

- HIPAA has many sub-titles that cover many aspects of our information assets at SMHN. The two that have the greatest impact on us address patient information. They are the Privacy & Security regulations
- The goal of the HIPAA Privacy & Security regulations is to maintain the confidentiality, integrity & availability of our Patient Health Information
- The law impacts any workforce member who may have knowledge of our patients or their health information (ie: everyone at Bellevue)
- The Privacy regulations address how we may use our patients' health information and how we must safeguard it.
- The Security regulations are technical & practical measures to protect health information while it is in our information systems

***** For further information on HIPAA refer to the Hospital's Intranet site under "Resources" and look up policies and procedures HI-6 through HI-9 *****

The following are a few examples from the regulations of things you should be doing to help safeguard patient health information



#1 Disclosing Patient Information

When can I released PHI without Patient Consent?



Treatment



Payment



Hospital Operations



EVERYTHING ELSE

Note: there are exception but they must all go through the medical records dept.



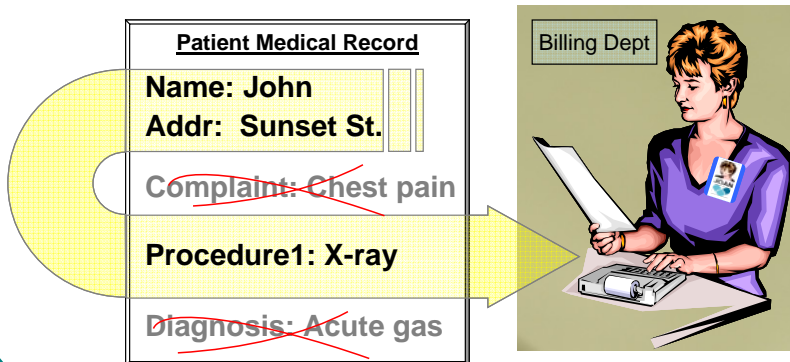
#2 Speak in a Discrete Manner

When Consulting With Patient and
In a Private Setting Where Possible

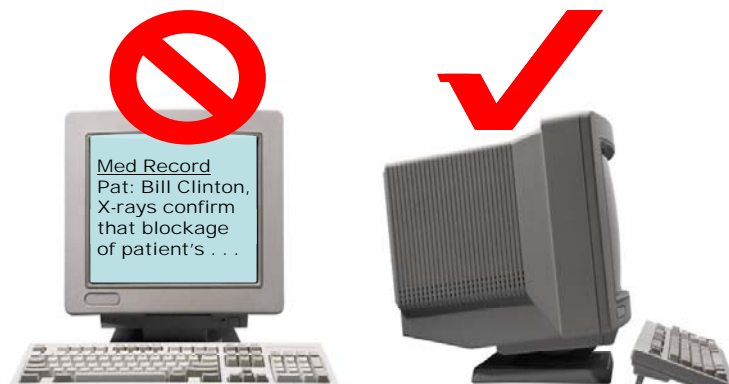


#3 Need to Know Rule

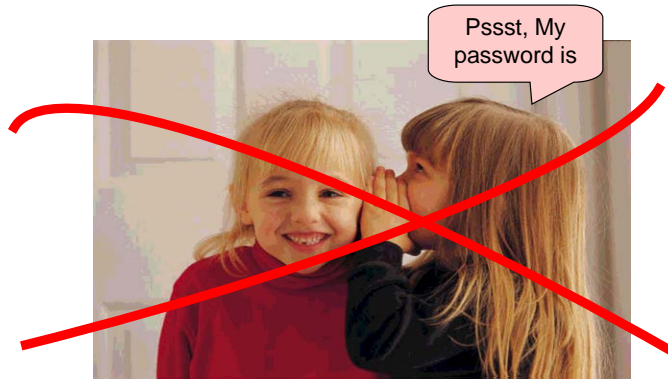
Only get the patient information you need to do your job.
Only view records of cases you are directly involved in.
Only give others what they need to do their job.



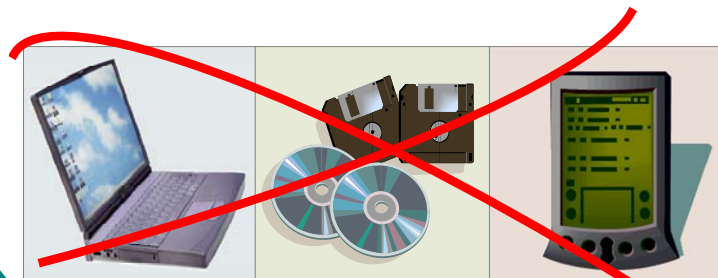
#4 Turn monitors away from public view



#5 Do not share passwords



#6 Do not store patient information on portable devices or media.

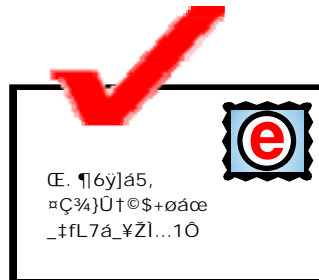
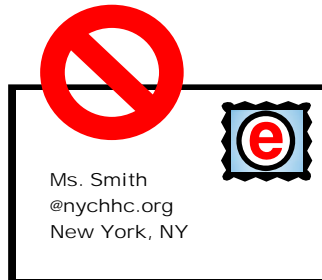


#7 Do not load unauthorized software

(Screen savers, games, programs like Tubotax, etc. could contain unwanted malicious viruses)



#8 Do not send patient information in emails unless it is encrypted

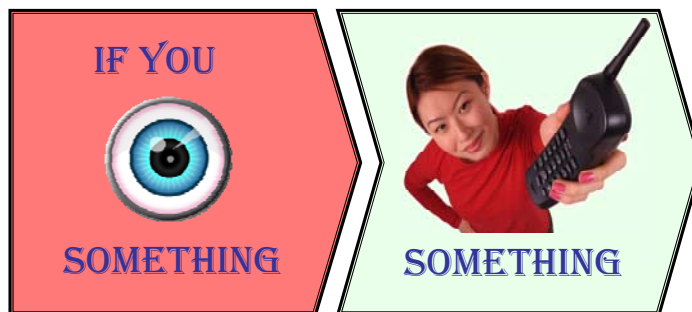


#9 Do not Discard Equipment

Return Unwanted Computer Equip to MIS



#10 Securing Patient Information
is Everyone's Responsibility



Report problems to the Facility Privacy Officer or Security Officer

PATIENT ADVOCACY

The Patient Advocacy Department's major role is to assist patients and their families. If a patient or family member has a concern, complaint or request that a staff member can not assist them with, please send the person to the **Patient Advocacy Office**, located on the ground floor, **Room F-11**. Or they can call us at **212-562-6071**. If the patient is admitted to an Inpatient Unit, staff can call the Patient Advocacy Office and a Patient Advocate will come and speak with the patient/family member. We are open **Monday through Friday from 9am to 5pm**. After those hours the Duty Officer can assist the patient or family member.

The Patient Advocates also educate and assist patients in completing their Health Care Proxy.

ADVANCE DIRECTIVES

Advance directives are defined as written or oral instructions concerning the provision of health care when a patient no longer has the capacity to make such decisions.

There are 3 types of Advance Directives:

1. **Health Care Proxy:** Appointing a person who would make health care decisions for the patient when the patient cannot make decisions for himself/herself.
2. **Living Will:** Advance instructions provided by the patient about their future course of medical treatment when they no longer have the capacity to make such decisions.
3. **DNR (Do Not Resuscitate):** Advance instructions by the patient stating that he/she refuses to be brought back to life in case their vital organ system fails.

Health Care Proxy forms are available in the Patient Advocacy Office, F-11 or you can go to:

Please go to:

<http://www.health.state.ny.us/home.html>

Click on Health Care Professionals and Patient Safety. Then scroll down to Patients and Their Families and click on health Care Proxy – Who Will Speak For You

This will give you a description of advance directives and forms that may be downloaded. Forms are available in English, Spanish, Chinese and Russian.

PAIN MANAGEMENT

BELLEVUE HOSPITAL CENTER PAIN TREATMENT CENTER

What is Pain?

Pain is an unpleasant sensory and emotional experience associated with actual or potential damage, or described in terms of such damage.

International Association for the Study of Pain, 1992

Pain is whatever the experiencing person says it is, existing whenever he says it does.

Margo McCaffery, 1968

Patients have the right to appropriate assessment and management of pain.

- Assess pain upon the first contact with the patient.
- Evaluate the intensity and quality of the patient's pain. Is the pain acute or chronic? Include: location, radiation, duration, precipitating & relieving factors.
- Utilize a standard scale for assessment of the intensity of pain. Some examples are: 0-10 numerical rating scales, FACES scale, word descriptor scale, non-verbal behavioral scale.
- Manage pain to prevent interference with optimal level of function or participation in rehabilitation.
- Reassess pain regularly according to patient condition, policy, and setting.
- Plan for continuity of care when patients change care settings.

Patients are taught that pain management is a part of treatment.

- The most valid measure of pain is the patient's self-report.
- Involve patients and families in decisions about pain management.
- Teach patients and families about their roles in managing pain, as well as the potential limitations and side effects of pain treatments.

BILL OF RIGHTS FOR PATIENTS IN PAIN

You have a right to pain relief. When you receive care at Bellevue, you will be asked about pain. If you have pain, you will be evaluated by the doctors and nurses taking care of you to learn more about your pain. We recognize pain relief can play an important role in helping you get better and are dedicated to treating it effectively.

When you receive care at Bellevue:

- You will receive an initial evaluation that includes questions about pain.
- We will work together with you to find out why you are having pain and establish goals for pain relief.
- You will be involved in the decision making process and ways to relieve your pain will be discussed with you.
- You will be evaluated for your response to pain treatment.
- If your pain is not adequately relieved, your doctors and nurses will work with you to change the treatment to control your pain.
- You may be referred to appropriate specialists to evaluate and treat your physical, emotional and spiritual needs that may be associated with pain.

2/9/2012

THE BELLEVUE HOSPITAL PALLIATIVE CARE PROGRAM

The Palliative Care Program aims to improve quality of life and identify, address, and minimize suffering for patients and families facing the challenges of serious or life limiting illness. This is achieved through the efforts of an interdisciplinary team comprised of physicians, nurses, social workers, psychologists, chaplains, child life specialists, creative arts therapists, and through collaboration with other services such as Bioethics and Pain Management. The service sees patients of all ages and at various stages in disease course, including during active disease-targeted treatment. We see patients across care settings with both an inpatient consultation service and an outpatient clinic.

The Palliative Care Team provides comprehensive and culturally sensitive assessments and treatment of patient's needs in collaboration with the primary treating team. Services may include:

- Expert pain and symptom management
- Identification of appropriate decision maker and support for complex medical decision making
- Psychosocial and psychiatric assessment and treatment
- Review and implementation of advanced directives
- Spiritual support
- Bereavement support

The palliative care program main phone number is 212-562-5278.

The main pager is 917-884-0571 Consultation can be placed by entering an order into Quadramed AND calling the above numbers.

MEDICATION ADMINISTRATION

With the growing reliance on medication therapy as the primary intervention for most illnesses, patients receiving medication interventions are exposed to patient harm as well as benefit. Benefits are effective management of the illness/disease, slowed progression of the disease, and improved patient outcomes with few if any errors. Harm from medications can arise from unintended consequences as well as medication error (wrong medication, wrong time, wrong dose, etc.).

One commonly used definition of medication error is “any preventable event that may cause or lead to inappropriate medical use or patient harm while the medication is in the control of the health care professional, patient or consumer. Such events may be related to professional practice, healthcare products, procedures, and systems, including prescribing; order communication; product labeling, packaging and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use.

There are several stages of the medication process:

- Ordering/prescribing
- Transcribing and verifying
- Dispensing and delivering
- Administering

Strategies to improve medication administration safety include requiring two RNs to verify and sign off when administering high alert medications.

Bellevue’s Medication Administration Policy:

- A patient’s response to the first dose of a new medication is monitored.
- A patient’s response to pain medication is monitored.
- There is a documented diagnosis, condition or indication for each medication order.
- Patients are involved in obtaining and documenting a complete list of their current medications including herbals and over the counter medications.
- Multi-dose vials are good for 28 days from date when first opened, unless discoloration and unusual particles are observed.
- The code cart and defibrillator are checked once every 24 hours by the designated tour either day or night.
- Code carts are secured with a numbered lock at all times; locks are controlled only by the pharmacy.
- A medication event form should be completed for all medication errors. This form is located on all nursing stations.
- Report all adverse drug reactions by completing an Adverse Drug Reaction form, or by calling the Adverse Drug Reaction Hotline at 212-562-2940. Leave the patient’s name, medical record number, location, suspected ADR, suspected agent, treatment given, name of reporter, and contact numbers.
- Computerized Physician Order Entry (CPOE) is an electronic ordering system that allows physicians to check patients’ medication allergies, provides alerts for drug interactions and contraindications, checks usual dose ranges based on weight, and provides alerts to herbal-drug interactions.

MEDICATION EVENTS

CONFIDENTIAL

BELLEVUE HOSPITAL CENTER

QUALITY MANAGEMENT/PATIENT SAFETY

MEDICATION EVENT TOOL

CATEGORY OF OCCURRENCE (CHECK ALL THAT APPLY)

<input type="checkbox"/> Charting Error	<input type="checkbox"/> Omission Error	<input type="checkbox"/> Wrong Patient
<input type="checkbox"/> Drug Preparation Error	<input type="checkbox"/> Prescription Error	<input type="checkbox"/> Wrong Rate
<input type="checkbox"/> Deteriorated/Expired Drug	<input type="checkbox"/> Deteriorated/Expired Drug	<input type="checkbox"/> Wrong Route
<input type="checkbox"/> Equipment Problem	<input type="checkbox"/> Unauthorized Drug Use	<input type="checkbox"/> Wrong Medication Dispensed
<input type="checkbox"/> Labeling Error	<input type="checkbox"/> Wrong Time	<input type="checkbox"/> Wrong Medication Administered
<input type="checkbox"/> Wrong Admin. Technique	<input type="checkbox"/> Wrong Dose	<input type="checkbox"/> Medication Order Error
<input type="checkbox"/> Unavailable Drug	<input type="checkbox"/> Other _____	

DESCRIPTION OF OCCURRENCE

DATE ____/____/____ TIME: ____:____ AM/PM SHIFT _____ PATIENT
UNIT _____

PATIENT NAME: _____ MR# _____

DRUG PRESCRIBED _____

DESCRIPTION OF OCCURRENCE: _____

REPORTER'S
NAME/TITLE

(PRINT) _____ SIGNATURE _____ DATE: _____

PATIENT MANAGEMENT

FINDING/TREATMENT: _____

MD NAME _____ MD
SIGNATURE _____ DATE _____

DEFINITION OF CATEGORIES OF MEDICATION EVENTS

Charting Error	Incorrect charting of drug, administration or dosage.
Drug Preparation Error	Drug product incorrectly formulated or manipulated before administration.
Expired Drug Error	Administration of a drug for which the expiration has passed.
Equipment Problem	The error was the result of mishandling or malfunctions of medication administration equipment.
Labeling Error	The error was the result of mislabeling of a drug product by company or pharmacy.
Medication Order Error	The error occurred as the result of an unclear or incorrectly written medication order.
Omission Error	The failure to administer an ordered dose to a patient (assumes no prescribing error).
Prescribing Error	Inappropriate drug selection (based on indications, contraindications, known allergies, existing drug therapy and other factors), dose, dosage form, quantity, route, concentration, rate of administration or instructions for use of a drug product ordered or authorized by physician (or other legitimate prescriber).
Wrong Dose Error	Administration or dispensing to the patient a dose that is greater than or less than the amount ordered by the prescriber.
Wrong Med. Dispensed	The medication delivered to the unit was not the medication ordered.
Wrong Med. Administered	The medication administered to the patient was not the medication ordered.
Wrong Patient	A drug product was administered to the wrong patient.
Wrong Rate Error	Incorrect rate of administration of a drug product to a patient.
Wrong Route	Use of wrong route of administration of the correct drug, e.g. intravenous instead of intramuscular.
Wrong Time Error	The failure to administer a medication dose within a predefined interval from its scheduled administration time.
Unauthorized Drug Error	Medication that was not authorized by a legitimate prescriber was dispensed and/or administered.

Rev. 6/11/02

PATIENT EDUCATION

What you need to know in 2012

Learning Objectives:

After reading this section, you should be able to:

- 1) *Discuss the Patient/Family Education Standards.*
- 2) *Identify at least 3 resources which can be used to help in providing patient/family education.*
- 3) *Describe your role in the provision and documentation of patient education in your practice setting.*

The Joint Commission (TJC) states:

“Patient and family education is one of the MOST IMPORTANT SERVICES A HOSPITAL CAN PROVIDE.”

“Chronic disease is on the rise, and patients are becoming increasingly responsible for MANAGING THEIR OWN HEALTH AT HOME....Patients are often discharged or released from health care settings with instructions for self-care that can range from changing bandages to caring for drains to home infusion.... As a consequence, patient education continues to take on greater importance in influencing the patient’s outcome and in promoting healthy behaviors.”

Patient education:

- Gives patients knowledge and skills to help them care for themselves
- Improves patient outcomes and promotes overall health
- Decreases readmissions
- Prevents complications and minimizes errors
- Reduces fear and anxiety
- Increases patient satisfaction
- Supports decision-making
- Empowers patients to care for themselves and take an active role in their health care

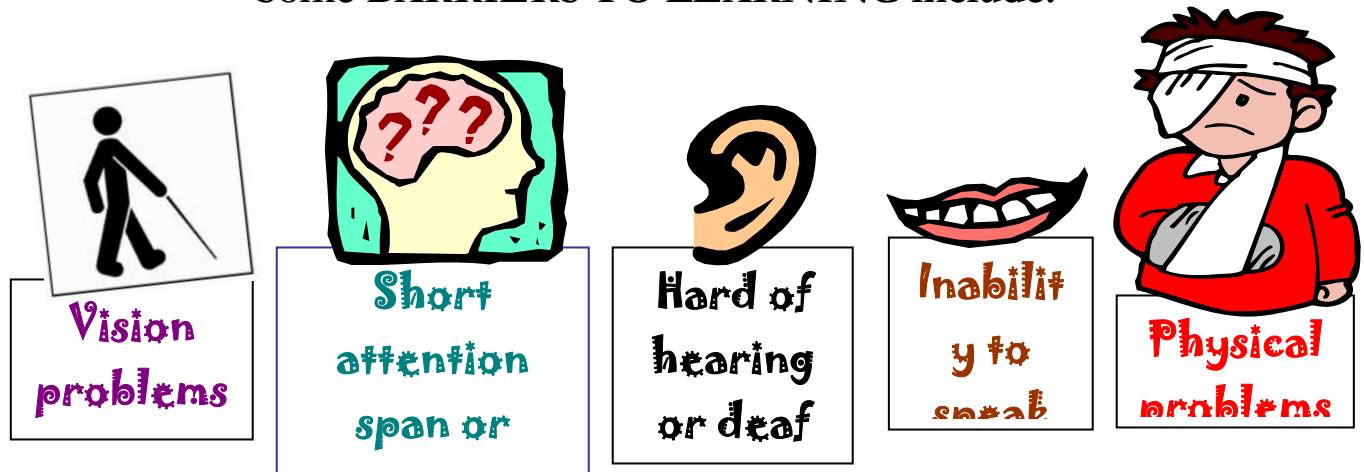
TJC STANDARD: The hospital performs a learning needs assessment for each patient, which includes the patient’s CULTURAL AND RELIGIOUS BELIEFS, EMOTIONAL BARRIERS, DESIRE AND MOTIVATION TO LEARN, PHYSICAL OR COGNITIVE LIMITATIONS, AND BARRIERS TO COMMUNICATION.

- The hospital provides education and training to the patient based on his or her assessed NEEDS.
- The hospital COORDINATES the patient education and training provided by all disciplines involved in the patient’s care, treatment, and services.
- The hospital EVALUATES the patient’s understanding of the education and training it provided.
- The hospital provides the patient education on how to communicate concerns about patient safety issues that occur before, during, and after care is received.

TJC STANDARD: Before the hospital discharges or transfers a patient, it informs and educates the patient about his or her follow-up care, treatment, and services. The hospital provides WRITTEN DISCHARGE INSTRUCTIONS in a manner that the patient and/or the patient's family or caregiver can understand.

TJC talks about BARRIERS TO LEARNING—what are examples?

Some BARRIERS TO LEARNING include:



Most of the time, these are NOT true barriers, and can be overcome. They are actually considerations or challenges to keep in mind when providing education.

For example:

- Consider readiness to learn—may need to wait if patient is in pain or too sleepy or agitated until the patient feels better or is more comfortable
- For vision problems, have family bring in glasses if possible
- Consider language preference and obtain interpreter; use sign language interpreter for deaf patient
- If the patient can't read, use pictures, drawings, and “plain English” verbal explanations.
- For short attention span, teach in short segments, repeat and reinforce information.

After assessing, plan what and how to teach, provide the education and evaluate learning. Evaluate comprehension. One way to do this: have the patient explain in their own words (“teach back”), or demonstrate a skill (show back) to you. Provide practice for any skills. Ask the patient questions for specific information or “what if” questions to see if patient can apply knowledge.

Inpatient assessment / documentation is done on the **MULTIDISCIPLINARY PATIENT/ SIGNIFICANT OTHER EDUCATION FORM**, which has now been customized with pre-printed teaching points for some conditions, and in the OPD, is available in a different format in Misys. **THE ADMITTING NURSE DOES THE EDUCATIONAL ASSESSMENT ON ADMISSION.**

What do we teach about?

- Illness/condition and how the patient can manage these conditions
- Medications—esp. new meds
- Diet, nutrition, food-drug Interactions
- Plan of care
- Medical Equipment & Supplies
- Rehabilitation
- Basic health practices: self care, oral care
- Pain scales, risk for pain and pain management
- Rights and Responsibilities
- Handwashing & preventing infection (like Surgical Site Infection)
- Safety (e.g., fall prevention) & prevention of errors
- *Speaking up* about care, concerns and patient safety

Some other specific situations in which patient education must be given, *according to TJC STANDARDS:*

- ANTICOAGULANT THERAPY— Because there is a danger of harm, the patient needs to know how to take ANTICOAGULANTS safely. Patient/family education includes:
 - The importance of follow-up monitoring
 - Compliance
 - Drug-food interactions
 - The potential for adverse drug reactions and interactions

There are warfarin handouts available in several languages, as well as food and drug interaction information sheets on the use of warfarin.

- INFECTION CONTROL AND PREVENTION
 - “Educate patients and their families as needed, who are infected or colonized with a multidrug-resistant organism about HEALTH CARE–ASSOCIATED INFECTION STRATEGIES.”
 - “Prior to insertion of a central venous catheter, educate patients and, as needed, their families about CENTRAL LINE–ASSOCIATED BLOODSTREAM INFECTION PREVENTION.”
 - “Educate patients and their families as needed, who are undergoing a surgical procedure about SURGICAL SITE INFECTION PREVENTION.”

Infection Control and Prevention has developed handouts on these three topics.

RESOURCES FOR PATIENT AND FAMILY EDUCATION

Educational handouts can be found:

- Online in the Patient Education Materials Section on the Bellevue Intranet in several languages. Example: asthma, diabetes, pain, heart disease handouts.
- Online at the HHC CLAS/ LEP (Limited English Proficiency) Website in up to 11 languages. Example: “Preventing DVT” handout
- Online in the form of Micromedex CareNotes™ in English and Spanish on medications, diagnoses, self-care, emergency care and discharge instructions

Other Resources:

- Classes/Educational Programs -- Examples: Childbirth Education, HIV Harm Reduction Groups, Cancer support groups
- Picture Talk Communication Tool (on the Patient Education Intranet)
- Diabetes Educators in Diabetes Clinic and Primary Care Clinic

Pt. Ed. Revised: 5/10D. Spurgiasz

Section Three

**Victims of Abuse
Domestic Violence
Elder Abuse
Sexual Assault
Crime Victims
Child Protection**

BELLEVUE HOSPITAL CENTER VICTIM SERVICES PROGRAM

The Mission of Bellevue Hospital Center's Victim Services Program is to empower and educate adult victims of crime, domestic violence, elder abuse, and sexual assault (ages 18 and over), and their family members about their rights, as well as the range of comprehensive services available to them following a life altering trauma. In order to help facilitate the recovery process, we provide confidential and empathic services for a diverse survivor community. We work in collaboration with the Emergency Department, sexual assault forensic examiners, and other hospital services to provide comprehensive medical and supportive social work services to survivors of crime.

Comprehensive Services include:

- Emergency Medical care, follow-up treatment, forensic sexual assault exams, services of trained rape crisis counselors, and medications for prevention of STI
- Professional social work services, including assessment and crisis intervention
- Counseling, individual psychotherapy, and support groups
- Information and advocacy about victims' rights
- Advocacy with law enforcement and the District Attorney's Office, as needed
- Safety assessment and safety planning
- Referrals for on-site hospital services and community resources
- Assistance with applications for compensation through the New York State Office of Victim Services

The Bellevue Hospital Center Victim Services Program serves as an integral part of the victimization response, and functions in collaboration with a range of interdisciplinary personnel, in order to provide victims of crime with high quality and clinically sound care. The program encompasses three specialized programs; crime victims, domestic violence, and sexual assault. The program provides comprehensive services to adult victims and to secondary victims and takes a lead role in ensuring that victims of crime receive services in ways that are sensitive, non-judgmental, and client-centered. The program ensures that victims' rights are

addressed and that every patient that presents as a victim of a crime has had a safety assessment and was provided with information, referrals, and alternatives.

The Victim Services Program provides services to all victims of crime over the age of eighteen which includes individuals who have been a victim of an **assault, domestic violence, elder abuse, gunshot wounds, hate crimes, homicide, stab wounds, sexual assault, childhood sexual abuse, stalking, and motor vehicle hit and run, and drunk driving.**

- Services are provided to all individuals who have experienced a victimization
- The term "crime victim" generally refers to any person, group, or entity who has suffered injury or loss due to illegal activity. The harm can be physical, psychological, or economic. Besides "primary crime victims", there are also "secondary crime victims" who experience the harm second hand, such as intimate partners or significant others of victim of crime. (Karmen, A. (1992) *Crime Victims*.)
- All victims of crime in New York State must be informed of their rights as victim of crime. One of the rights includes compensation. It is the policy and procedure of the Bellevue Hospital Center Victim Services Program to inform individuals of this right that is available through the New York State Office of Victim Services. The staff of the Program informs the patients who are victims of crime about their eligibility. The New York State Office of Victim Services may be able to reimburse for direct out-of-pocket expenses caused by the crime. These expenses may include the repair or replacement of essential personal property, loss of earnings or support, medical bills including the cost of therapy, vocational rehabilitation, crime scene cleanup or funeral bills. (OVS Handbook). Additionally, the staff will assist with the application process for OVS and will provide ongoing advocacy in order for patients to have success in obtaining this benefit and right.

Domestic Violence, Elder Abuse, and Sexual Assault are more specifically defined on the following pages.

DOMESTIC VIOLENCE

Domestic violence is a pattern of coercive behavior which can include physical, sexual, economic, emotional and/or psychological abuse exerted by an intimate partner or family member against another with the goal of establishing and maintaining power and control. Domestic Violence is also known as partner abuse, spouse abuse, or battering. Domestic Violence includes relationships of heterosexuals, gay men, lesbians, bisexuals, and transgendered individuals, whether those relationships include dating, marriage, or cohabitation. Domestic Violence also includes children, teenagers, and the elderly.

CLINICAL INDICATORS TO IDENTIFY DOMESTIC VIOLENCE

The following injuries, symptoms and other physical and psychological complaints may be a sign of an ongoing abusive situation. It is important to find out the cause of an injury.

INJURY - Common types of injury include:

- Contusions, abrasions, lacerations, ecchymoses, stab wounds, burns, human bites, gunshot wounds, as well as fractures or sprains
- Certain wounds that are life threatening such as gunshots, stab wounds and burns, must be reported as stated in Mandatory Report of Injury in New York Penal Code Section 265.25-26.
 - Injuries to the head, neck, chest, breasts, abdomen, or genital area
 - Injuries during pregnancy
 - Multiple sites of injury
 - Repeated or chronic injuries
 - History of falls
 - Injuries in multiple stages of healing
 - Evidence of sexual assault

MEDICAL FINDINGS:

- Chronic pain, psychogenic pain due to diffuse trauma without visible evidence of injury
- Physical symptoms related to stress, chronic Post Traumatic Stress Disorder, other anxiety disorders or depression
- Sleep and appetite disturbances

- Fatigue, decreased concentration, sexual dysfunction
- Chronic headaches
- Abdominal and GI complaints
- Palpitations, dizziness, paresthesia, dyspnea, chest pain
- Gynecologic problems - frequent vaginal and urinary tract infections, dyspareunia, pelvic pain
- Frequent use of prescribed benzodiazepines or analgesics
- Frequent visits with vague complaints or symptoms without evidence or physiologic abnormality
- Exacerbation or poor control of chronic illnesses such as asthma, seizure disorders, diabetes, arthritis, hypertension and heart disease

MENTAL HEALTH/PSYCHIATRIC SYMPTOMS:

- Feelings of isolation and inability to cope
- Suicide attempts or gestures
- Depression
- Panic attacks and other anxiety symptoms
- Alcohol or drug abuse
- Post-Traumatic Stress reaction and/or disorder

PREGNANCY:

- Because of the risks to the mother and fetus, assessment for abuse may be incorporated into routine prenatal and postpartum care. Presentations include the following:
 - Injuries, particularly to the breast, abdomen and genital area or unexplained pain
 - Substance abuse, poor nutrition, depression and late or sporadic access to prenatal care
 - Spontaneous” abortions, miscarriages and premature labor

ELDER ABUSE

Elder abuse is defined as the physical, emotional or financial mistreatment and/or neglect of a person, 60 years of age or older, by another person, such as a family member or non-related caregivers. Victims of suspected elder abuse come from diverse ethnic and socioeconomic backgrounds. They may have been hurt by the violent act of another person, by intentional or unintentional neglect, or because of their own frailty and inability to care for themselves. According to the New York State Office of Children and Family Services, the following are types of elder abuse and mistreatment: physical abuse, sexual abuse, emotional abuse, financial exploitation, active and passive neglect, and self neglect.

CLINICAL INDICATORS TO IDENTIFY ELDER ABUSE

Elder abuse affects 1-10% of the elderly population and cuts across the boundaries of race, class and economic status. One of the greatest barriers to providing help to victims of abuse is their reluctance to disclose the problem caused by shame, fear or lack of acknowledgment that the pattern is actually an abusive one. ***There are a number of psychodynamics present in Elder Abuse.***

Types of Elder Abuse

Physical Abuse: Physical abuse occurs when an elderly person is subjected to pain, injury or impairment that is intentionally imposed. Forms of this abuse may include: choking, hitting, slapping, kicking, biting, burning or using a weapon.

Signs may include:

- Bruises, scratches, bite marks, burns, missing teeth, fractures, dislocated bones, and welts.
- Victims of these attacks may offer a different scenario when questioned about the injury, but x-rays frequently reveal injuries in differing stages of healing.

Financial Abuse: Occurs when the abuser misuses an elder's funds, property or other resources. It may include robbery, misuse of credit cards, sale of an elder's property without consent and forging signatures on checks.

Signs may include:

- The elder has an inaccurate knowledge of finances. The elder is unable to pay for things, which were easily affordable in the past. The elder experiences fear or anxiety when discussing finances. Financial

documentation is missing, i.e., missing bank books, stock certificates, and bonds.

Psychological Abuse: This type of abuse includes the willful infliction of mental or emotional anguish by means of threats, humiliation or fear.

Signs may include:

- Confusion, insomnia, sleep deprivation or need for excessive amounts of sleep; weight gain or loss, withdrawal and depression, anxiety about leaving the house, and fear in discussing such matters with family and/or friends.

Neglect: Deprivation of adequate resources to maintain a safe and healthy lifestyle, including food, water, medication, dental and hearing aids. In addition, the home may lack running water, heat and necessary locks, and theft protection devices.

Signs may include:

- Malnourishment, dehydration, unkempt appearance, untreated illnesses, and excessive dirt or odor remaining on the person.

Sexual Abuse: The elder is forced into sexual contact or exposure without consent. Abuse can take place when the elder does not have the capacity to give consent. Elders may be forced to observe pornographic material.

Signs may include:

- Torn or stained underclothing, difficulty in walking or sitting, pain or itching in the genital area, and/or the presence of a sexually transmitted disease when the elder has claimed celibacy as a lifestyle.

In all situations, discreet, sensitive intervention is required. Within the interdisciplinary team model, the over-all responsibility rests with social work to assure case coordination and continuity.

SEXUAL ASSAULT

Screening for Sexual Assault

Sexual assault can happen to women, men, and children. Not all patients readily report or have the capacity to report sexual violence. Therefore, hospital providers should screen patients for the possibility of acute and past sexual assault. There are certain injuries, signs, and symptoms that may indicate sexual assault. This includes: genital and non-genital injuries (though injuries are rare), torn clothing, dried secretions or debris on the body or clothing, broken fingernails, complaints of genital, pelvic, or rectal discomfort, and non-specific somatic complaints. Some indicators of suspected drug-facilitated sexual assault include: memory loss, dizziness, drowsiness, confusion, impaired motor skills, impaired judgment, reduced inhibition, or intoxication disproportionate to the amount of alcohol consumed.

What is a Provider's Role in Treating Sexual Assault Victims?

Hospital personnel provide assessment, evidence collection, and treatment for reported or suspected sexual assault. **It is not the role or responsibility of hospital staff to determine whether a sexual assault has occurred.** This determination is made within the law enforcement and criminal justice systems. Care decisions are made on the basis of the patient's report and concerns.

What is Sexual Assault?

Sexual assault is any sexual contact between a victim and offender which is forcible and/or non-consenting, or in which the victim is incapacitated. It includes:

- vaginal penetration (no matter how slight) by an offender's penis
- contact between penis and mouth, penis and anus (rectum), mouth and anus, or mouth and vaginal area
- insertion of a finger or an object into the vagina, urethra, penis, or rectum
- the touching of sexual or intimate parts of the victim's body by the offender or forcing the victim to touch sexual or intimate body parts of the offender

Drug-facilitated sexual assault occurs when an offender knowingly and unlawfully possesses a controlled substance and administers this substance without a person's consent, with the intent to commit sexual assault when the victim is incapacitated.

Privileged Sexual Offense Evidence is evidence associated with the hospital's treatment of trauma and injuries sustained as a result of a sexual offense. **Police should not be notified without the patient's consent, unless** the patient sustained a gunshot wound, a life-threatening stab wound (inflicted by a knife or other potentially lethal weapon), or certain burn injuries (Penal Code Section 265.25-26). Only information about a gunshot, life-threatening stab wounds, or certain burn injuries can be disclosed without consent. Information about the sexual assault remains privileged.

Sexual Offense Evidence That Is Not Privileged is evidence obtained from victims of suspected child abuse/neglect. In cases of suspected child sexual abuse, physical abuse, neglect, or other maltreatment, consult with the hospital's Child Protection Team.

What Constitutes Lack of Consent?

Forcible Compulsion

- actual physical force
- the threat of physical force, expressed or implied, that puts the victim in fear of being physically harmed or of another person being physically harmed
- the threat to kidnap the victim or a third person

Physically Helpless

- physically unable to indicate a lack of consent
 - due to unconsciousness
 - because of a physical disability that makes one unable to physically or verbally communicate lack of consent

Under 17 Years of Age

New York law states that a person less than 17 years of age is legally incapable of consenting to sexual intercourse or other sexual contact. These laws are typically known as statutory rape laws. The general statutory age guidelines are:

- victim is under 13 and defendant is at least 18
- victim is under 15 and defendant is at least 18 - unless defendant is less than 4 years older and can present an affirmative defense

Mentally Incapacitated

- victim is made temporarily incapable of understanding or controlling his or her conduct because a drug or other intoxicating substance (e.g. alcohol) was given to them without their consent (Drug-Facilitated Sexual Assault)

Mentally Disabled

- victim suffers from a mental illness or a condition that renders them incapable of understanding consent

Inmate

- person who is literally or physically under the control of others, and therefore cannot freely give consent due to power differentials
- Examples:
 - Inmate of a correctional facility
 - Patient committed to a psychiatric institution
 - Juvenile held in any facility, if the perpetrator is anyone employed at that facility
 - Patient of a health care provider or mental health provider
 - Client in a facility administered by the Office of Children and Family Services

Interventions and Treatment Options after Acute Sexual Assault

Evidence Collection Options

- Sexual Offense Evidence Collection Kit
 - option up to **96 hours post-assault**
- DFSA Kit (Drug Facilitated Sexual Assault)
 - option up to **96 hours post-assault**
- Photographs of visible injuries

Prophylactic Medication Options

- Emergency contraception
 - option up to **120 hours** post-assault
- HIV prophylaxis
 - option up to **72 hours** post assault
- Hepatitis B prophylaxis
 - option up to **14 days** post assault
- STI prophylaxis
- Tetanus prophylaxis

Counseling, Advocacy, and Referral Services

- Offered through the hospital's Victim Services Program (ext. 3755)
- Available 24 hours per day (after-hours, provided by volunteer Rape Crisis Advocates, in collaboration with Emergency Department social workers)

NORMAL TRAUMA RESPONSES

After a trauma, people go through a wide range of normal responses. Such reactions are experienced not only by people who were involved in the trauma first hand, but also by those who have wither witnessed, heard about, or had different kinds of involvement with the person immediately affected. Many reactions tend to be triggered by persons, places, or things associated with the trauma. Some reactions may appear totally unrelated. Here is a list of common physical and emotional reactions to trauma. These are NORMAL reactions to ABNORMAL events.

Physical Reactions

- Aches and pains, e.g., headaches, backaches, stomachaches
- Sudden sweating and/or heart palpitations (fluttering)
- Sleep or eating disturbances
- Constipation or diarrhea
- Startle responses to unexpected noise or touch
- Increased susceptibility to colds and illnesses

Emotional Reactions

- Generalized fear
- Depression
- Self-blame
- Anxiety and panic reactions
- Crying spells
- Grief
- Denial
- Hyper-alertness or hypervigilance
- Fear of going out alone
- Irritability and/or restlessness
- Difficulty concentrating
- Outbursts of anger or rage
- Mood swings
- Increased worry or ruminating
- Intrusive thoughts of the trauma
- Nightmares
- Flashbacks
- Feelings of helplessness
- Feelings of lack of control
- Increased need to control everyday experiences
- Attempts to minimize the traumatic experience
- Attempts to avoid anything associated with trauma
- Tendency to isolate oneself

The above symptoms are normal reactions to trauma and may impair functioning. Counseling or psychotherapy may help the post victimization recovery process.

REFERRING TO VICTIM SERVICES PROGRAM

All patients should be provided with a confidential area to speak to the provider and the language line should be used when necessary. Family members or any individual who accompanies the patient should not be used to interpret or be present when screening and assessing a patient for any history or current victimizations.

All patients who are 18 and over and disclose any type of victimization can be referred to the Victim Services Program at ext. 3755 and after regular business hours, call the Emergency Department Social Work Office at ext. 4730.

Domestic Violence and Elder Abuse patients screened by the Interdisciplinary Team should be consulted with the Victim Services Program

- **During regular business hours**, contact Bellevue's Victim Services Program at ext. **3755** or ext. **4693**
- **After regular business hours**, call the Emergency Department Social Work office at ext. **4730**.

Sexual Assault Cases - For Disclosures within 96 hours of Sexual Assault

- Preserve potential evidence, (i.e., have the patient remain in his/her clothing, encourage the patient to defer urination and defecation, encourage the patient not to eat, drink, or rinse mouth, defer treatment of minor injuries until photographs can be taken, etc.).
- **During regular business hours**, contact Bellevue's Victim Services Program at ext. **3755** or ext. **3435**
- **After regular business hours**, call the Emergency Department Social Work office at ext. **4730**. A volunteer Rape Crisis Advocate will respond and provide services, in collaboration with the social worker.
- For evidence collection, contact the **Manhattan SART** (Sexual Assault Response Team) at **212-423-SART** (24 hours per day). A certified Sexual Assault Forensic Examiner will respond and conduct the forensic examination.

CHILD PROTECTION AT BELLEVUE 2012

Mandated Reporters ▪ As Bellevue employees we are all mandated reporters.

Mandated reporters are required to report suspected child abuse or maltreatment when, in their official or professional role, they are presented with a reasonable cause to suspect child abuse or maltreatment. Reasonable cause means that based on your rational observations and professional training you have a suspicion that a legal guardian for a child is placing a child in imminent danger.

All suspected cases of child abuse or neglect get called into the State Central Registry (SCR):

- 1-800-635-1522. The official form is called a 2221 and needs to be turned into the Child Protection Center. See below for steps on how to make a report.

How do I know when it is appropriate to report a child abuse and maltreatment case?

There is a team of people at Bellevue who can help you decide whether or not to call in case of child abuse and maltreatment. They are the **Child Protection Team**:

- Kim Fitzpatrick, L.C.S.W., Ph.D., Associate Director of Social Work for Maternal-Child Health & Child Protection Coordinator, x 5762, 917-442-2131
- Margaret McHugh, M.D., M.P.H., Director of the Child Protection Center and Pediatric Attending, x 2493, beeper 917-884-3341
- Lori Legano, M.D., Pediatric Attending, x 6344, beeper 917-884-4540
- Vincent Palusci, M.D., Pediatric Attending, x 4050, beeper 917-313-0310

Child Protection Rounds: Tuesdays 1-3 in the Child Protection Center, GC 65

Outside of calling any of us directly, you may present your concerns about a particular case at Child Protection Rounds. During Child Protection Rounds, anyone in the hospital who has made a child abuse report in the previous week presents the case to the Child Protection Team. Steps for follow-up are recommended during that time. Additionally, anyone who just has concerns about

a case that might need child welfare involvement (call to SCR) in the future can discuss their case in this meeting.

Steps to making a child abuse report:

1. The person who received the disclosure of abuse is the one that must make the report to the State Central Registry (SCR) in Albany. ***We cannot make the report for you.*** SCR is the call center for all child abuse and maltreatment cases in NY State.
2. Fill out 2221 “Report of Suspected Child Abuse or Maltreatment”. Call the State Central Registry; they will ask for all the information in the 2221. If the case is accepted as a report, be sure to get the Call I.D. #. Make sure that you sign the 2221.
3. Return the completed 2221 to the Child Protection Center, GC 65 (in the C&D building).
4. The case will be assigned to one of NYC’s Administration for Children’s Services (ACS) Borough Field Office. A child protective specialist will contact you so that an investigation can begin.

Child Protection Center:

The Child Protection Center provides comprehensive child abuse evaluations using a team approach. The Center is staffed with pediatricians, social workers, child life staff, and psychologists. The director of the Center, Dr. McHugh, is a leader in the field of child abuse, and started the Center many years ago. The purpose of the Center is to provide evaluations in a child-focused environment to reduce unnecessary trauma caused by repeated medical exams and interviews. Services include:

- Coordinate with law enforcement
- Provide medical exams
- Psychosocial assessments and interviews
- Forensic child sexual abuse assessment
- Expert testimony
- Social Work Staff see child abuse cases in the PES

Where do referrals come from?

- Bellevue services, such as 21S and clinic
- D.A.’s office
- ACS
- Foster Care Agencies
- PES
- Family Court

Section Four

Performance Improvement / Breakthrough

National Patient Safety Goals

Building a Just Culture

Team STEPPS

Conflict Resolution

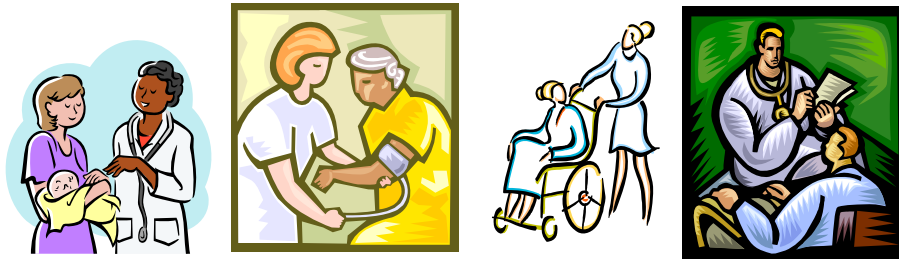
Teamwork

Staffing Effectiveness

Staff Competency

PERFORMANCE IMPROVEMENT

And Patient Safety



What is Your Role in Fulfilling Bellevue's Mission?

- To provide safe and appropriate care, treatment and services to our patients at each and every encounter.

What is Performance Improvement (PI)?

- PI is the planned, systematic method used by the Hospital to improve safety and patient outcomes.
- PI is the mechanism by which all staff work as a team to improve performance on a hospital-wide or unit based level. **We are all responsible for performance improvement!**
- Breakthrough is the PI methodology used at Bellevue.



What is the Breakthrough PI Methodology?

- Team-based problem solving approach.
- Engages staff in removing the non-value added tasks, steps and activities from work processes.
- Uses **A3** (lean) thinking with a 9-box summary tool

A3 – Breakthrough (Lean) Improvement Tool

A3 Thinking			Header	Title, Date, Revision, Team Members & Review Team
1. Problem Solving & Communication tool that follows a logical and standard structure	Box 1 – Reason for Action		State chief complaint or problem statement	
2. Transfer Tools, Techniques and Beliefs	Box 2 – Initial State		Describe graphically (data) and in words the initial state	
3. Record the approach taken, results achieved, captures the knowledge	Box 3 – Target State		Describe graphically (data) and in words the target state	
4. Manage the plan, sustainment and benefit tracking	Box 4 – Gap Analysis		Identify opportunities to fill the gap (initial-v-target)	
5. Tells a story – like a story board for a film	Box 5 – Solution Approach		Develop high level hypothesis to resolve this gap	
6. “A3” is a metric nomenclature for a paper size, equal to 11’ x 17’	Box 6 – Rapid Experiments		Verify solution approach (Try-storming/Plan-Do-Study-Act)	
7. Includes a header and nine boxes	Box 7 – Completion Plans		List follow-up actions to implement solution approach	
	Box 8 – Confirmed State		Track metrics to confirm target state is achieved	
	Box 9 - Insights		List key lessons learned	

Header		
Strategic Alignment	Learn by Doing	Accountability & Reflections

Sample A3 Template:

Breakthrough		Name:	Value Stream ID:	Site / Location:	Bellevue	Event Number:	Revision:	1																														
		Sponsor:	Process Owner:	Facilitator:																																		
Event Date:	Team Members:	1. REASON FOR ACTION		4. GAP ANALYSIS		7. COMPLETION PLAN																																
		<p>Name: What is the problem? Why do we need to do anything?</p> <p>Aim: Briefly describe the goals and objectives of the project.</p> <p>Scope: Identify the particular area that you will be working in and/or the specific target group.</p> <p>Boundaries: (Trigger) to (End) Define where the flow begins and ends.</p> <p>Define Value: What is the added value to staff, patients and/or the organization by addressing this problem?</p>		<ul style="list-style-type: none"> Describe the barriers that are keeping us from reaching the target state Use 5 whys (ask why something happens 5 times) to drill down to the root cause of a problem <table border="1"> <thead> <tr> <th>PROBLEM</th> <th>ACTIONABLE ROOT CAUSE</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>		PROBLEM	ACTIONABLE ROOT CAUSE							<ul style="list-style-type: none"> List what remains to be done. Identify who is responsible for doing it. State date by when is it expected to be completed. <table border="1"> <thead> <tr> <th>WHAT</th> <th>WHO</th> <th>BY WHEN</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>			WHAT	WHO	BY WHEN																			
PROBLEM	ACTIONABLE ROOT CAUSE																																					
WHAT	WHO	BY WHEN																																				
Event Date:	Team Members:	2. INITIAL STATE		5. SOLUTION APPROACH		8. CONFIRMED STATE																																
		<p>Describe the current state</p> <ul style="list-style-type: none"> List the circumstances or symptoms that tell you what your current set of circumstances are, that give the details about the problem <p>Quantify the current state</p> <ul style="list-style-type: none"> How often does the problem occur? How long does the problem last? How much time is spent addressing the problem? 		<ul style="list-style-type: none"> Identify ideas to close the gap and have an impact on the problem (i.e. list each solution idea and its impact) <table border="1"> <thead> <tr> <th>IF WE...</th> <th>THEN WE...</th> </tr> </thead> <tbody> <tr> <td>Countermeasure – if we try this proposed idea or solution to this problem</td> <td>Hypothesis – then we expect to get this result</td> </tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>		IF WE...	THEN WE...	Countermeasure – if we try this proposed idea or solution to this problem	Hypothesis – then we expect to get this result					<ul style="list-style-type: none"> What will you measure to know that you have made an improvement? Are there any balancing measures that might tell you if there is an adverse effect? On a monthly basis, graph the progress of the improvements that were implemented (for at least 12 months) <table border="1"> <thead> <tr> <th>Metrics</th> <th>Baseline</th> <th>Target</th> <th>30-day Actual</th> <th>60-day Actual</th> <th>90-day Actual</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>			Metrics	Baseline	Target	30-day Actual	60-day Actual	90-day Actual																
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		<ul style="list-style-type: none"> Describe the improved state Quantify the target state (date each item in the Target State directly to one in the Initial State) 		<ul style="list-style-type: none"> Test ideas from the solution approach and implement if feasible Use the PDCA (PLAN, DO, STUDY, ACT) approach to plan and test each actionable idea Document key changes <table border="1"> <thead> <tr> <th>PLAN</th> <th>EXPECTED RESULT</th> <th>ACTUAL RESULT</th> </tr> </thead> <tbody> <tr> <td>Plan: Identify the change idea to be implemented?</td> <td>Study: document what happens and compare to what you predicted</td> <td>Act: Use actual results to establish needed follow-up (Adopt, Adapt or Abandon)</td> </tr> <tr><td>Do: Determine who will carry out the change, when and how</td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>		PLAN	EXPECTED RESULT	ACTUAL RESULT	Plan: Identify the change idea to be implemented?	Study: document what happens and compare to what you predicted	Act: Use actual results to establish needed follow-up (Adopt, Adapt or Abandon)	Do: Determine who will carry out the change, when and how						<ul style="list-style-type: none"> Share insights regarding process, improvements, impact, learnings, etc. in each category as is relevant <table border="1"> <thead> <tr> <th>WHAT WENT WELL</th> <th>WHAT NEEDS IMPROVEMENT</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table> <table border="1"> <thead> <tr> <th>WHAT HELPED</th> <th>WHAT HINDERED</th> </tr> </thead> <tbody> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </tbody> </table>			WHAT WENT WELL	WHAT NEEDS IMPROVEMENT							WHAT HELPED	WHAT HINDERED								
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What are the Breakthrough Strategic Goals for PI?

- The Breakthrough strategic goals are known as True North Metrics:

TRUE NORTH METRICS (Breakthrough PI Strategic Goals)	
Quality and Safety	Provide the highest quality services while striving for no errors
Human Development	Develop the ability of staff to maximize skills and problem solve to improve patient and staff satisfaction
Delivery and Throughput	Improve the timeliness and outcomes of care delivery
Costs	Promote cost effectiveness to delivery quality care in the least waste way
Growth	Expand capacity to care for more patients

What are the Key Principles of PI?

- Review processes and systems
- Use data to prioritize activities and to focus on solving the most problematic issues and concerns
- Involve multi-disciplinary staff at all levels
- Avoid finger pointing and blame (focus on the process not the person)
- Take actions to make improvements
- Use data to evaluate effectiveness of actions taken



What are the Dimensions of PI?

- Efficacy
- Appropriateness
- Accessibility
- Timeliness
- Continuity
- Safety
- Efficiency
- Patient Perception of Care

2012 NATIONAL PATIENT SAFETY GOALS

Goal 1 – Identify patients correctly

- Use at least two ways to identify patients. For example, use the patient's name *and* date of birth. This is done to make sure that each patient gets the correct medicine and treatment.
- Make sure that the correct patient gets the correct blood when they get a blood transfusion

Goal 2 – Report critical results of tests/diagnostic procedures in a timely manner

- Critical results typically fall outside the normal range and may indicate a life-threatening situation.
- Develop, implement, and evaluate written procedures.
- Treat the patient promptly by providing the licensed caregiver with these critical results within an established time frame.

Goal 3 – Use medications safely

- Label medications and solutions that are not immediately administered and are transferred from its original packaging to another container. Verify all labels both verbally and visually with two individuals qualified to participate in the procedure. The person preparing the medication/solution is not the one administering it.
- Take extra care with blood thinning medication. Use proper protocol to initiate and maintain therapies using this type of medication.
- Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Make sure the patient knows which medicines to take when they are home. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor

Goal 7 – Prevent the spread of infection

- Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals and improve compliance with hand hygiene guidelines.
- Use proven guidelines to prevent health care-associated infections that are difficult to treat. Strategies include hand hygiene, cleaning/disinfecting patient care equipment and the environment, and contact precautions.
- Use proven guidelines to prevent central line-associated bloodstream infections.
- Use proven guidelines to prevent surgical site infections.
- Use proven guidelines to prevent ventilator-associated pneumonia (VAP)

- Use proven guidelines to prevent catheter-associated urinary tract infections (CAUTI) when inserting and managing indwelling catheters.

Goal 15 – Identify patient safety risks

- Find out which patients are most likely to try to commit suicide. Conduct a risk assessment, address immediate safety needs and determine the most appropriate setting for treatment. Provide suicide prevention information to the patient and family when the patient leaves the hospital.

UNIVERSAL PROTOCOL

Prevent mistakes in surgery

- Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body
- Mark the correct place on the patient's body where the surgery is to be done, and if possible, involve the patient.
- Pause before the surgery to make sure that a mistake is not being made

THE THREE DUTIES

Every employee is expected to perform three duties when they come to work:

1- The duty to avoid causing unjustifiable or inexcusable risk or harm to our patients and colleagues

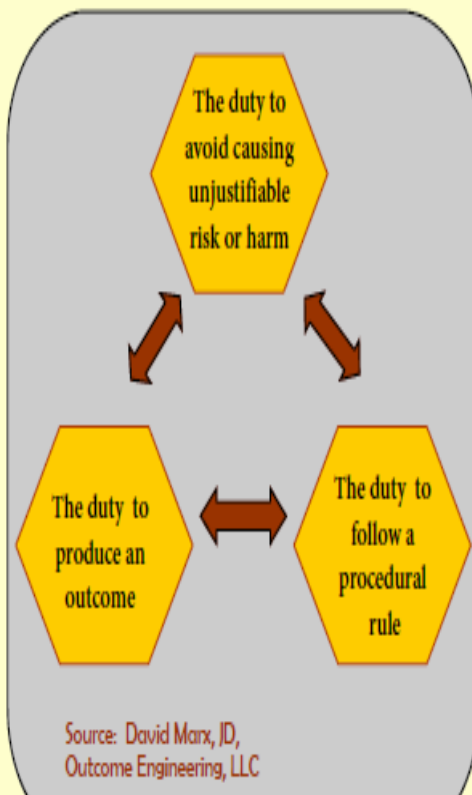
Did you put your patients or colleagues in harm's way?

2- The duty to follow your facility's policies and procedures

Did you skip a step (take a short cut) and not follow the policy and procedure established by your facility?

3- The duty to produce an outcome

Did you accomplish your duties in accordance with your job expectations?



Just Culture Teaches Us That:

- ✓ To err is human
- ✓ To drift is human
- ✓ Risk is everywhere
- ✓ We are **ALL** accountable

ORGANIZATIONAL RESPONSIBILITY:

HHC, as a large learning organization, recognizes that human error is sometimes inevitable.

As a result, we strive to design systems that are "hardwired" to facilitate employees making safe decisions/choices that prevent harm.

EMPLOYEE'S RESPONSIBILITY:

All members of the HHC community, as part of their jobs, are responsible to communicate any mistake, error, harm or potential harm through appropriate channels.

All members of the HHC community, are accountable for their own performance in accordance with their job responsibilities and their profession.



For more information on Patient Safety, please visit <http://patientsafety.nychhc.org>

Published by the Office of Patient Safety

Created by: Mei Kong, Senior Director
Design: Vanita Vogeshwar, Associate Director

SAFE BEHAVIORAL CHOICES AND ACCOUNTABILITY



A Quick Overview

HHC's Patient Safety Vision

Our vision is to sustain an organization-wide culture that is just, fair and dedicated to increasing patient safety so that HHC is acknowledged as one of the safest healthcare systems in the nation.



PATIENT SAFETY AND THE JUST CULTURE

"Just Culture" is a balanced approach to individual and organizational accountability. It uses an objective, reliable approach to determine when a mistake or error is due to a systems failure or when it is an individual responsibility.

A "Just" organizational culture recognizes that even competent people make mistakes. The goal is to prevent employees from "moving away from safe practices" (drifting) or, taking "short-cuts." Such actions may cause harm to the patient.

TRADITIONAL CULTURE

- Who did it?
- Focus on the individual
- Reactive
- No communication
- Silence about events



JUST CULTURE



- What happened?
- Focus on systems
- Proactive
- Open communication
- Honest disclosure

What is a Just Culture ?

A Just Culture embodies four important principles:

1. A culture of continuous learning that strives to produce the best possible patient outcomes.
2. An open and fair culture in which staff feels comfortable and compelled to come forward to report mistakes, errors, good catches (near misses) and risks to patient safety so that the organization may improve its performance.
3. Design of safe systems that help to prevent errors from occurring.
4. A commitment by all members of the organization to making safe behavioral choices to prevent harm to patients, colleagues, and visitors.

The Just Culture concept fosters an environment that encourages open reporting and learning. The behavioral choices that an individual makes, rather than the severity of the mistake, determine the action that should be taken. The behavioral choices are categorized into three (3) levels:

- i. Human Error
- ii. At-Risk Behavior
- iii. Reckless Behavior.

Human Error

Unintentional or non-deliberate action: slip, lapse, mistake. A product of our current system design.

Manage through changes in:

- Processes
- Procedures
- Training
- Design
- Environment



Action → Console

At-Risk Behavior

A behavioral choice: risk believed to be insignificant or justified



Manage through:

- Removing incentives for at-risk behaviors
- Creating incentives for healthy behaviors
- Increasing situational awareness

Action → Coach

Reckless Behavior

Conscious disregard of unjustifiable risk

Manage through:

- Remedial action
- Disciplinary action



Action → Punish

Team Strategies & Tools to Enhance Performance and Patient Safety

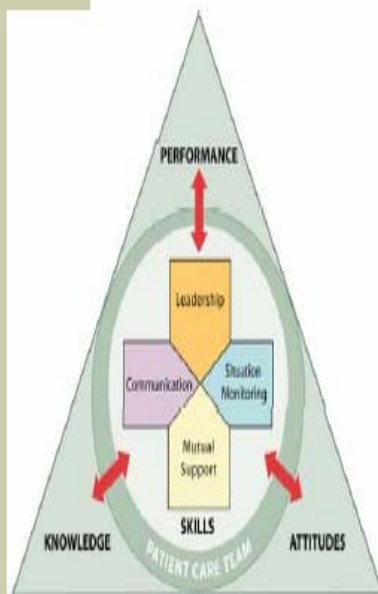
Team STEPPS is an evidence-based teamwork system aimed at optimizing patient outcomes by improving communication and other teamwork skills among healthcare professionals.

Team STEPPS was developed by the Department of Defense (DoD) Patient Safety Program, in collaboration with the Agency for Healthcare Research and Quality (AHRQ).

The goal of Team STEPPS is to produce highly effective teams that optimize the use of information, people, and resources to achieve the best clinical outcomes for their patients. TeamSTEPPS is scientifically-rooted in over 20 years of research and lessons learned from the application of teamwork principles in High-Reliability Organizations (HROs).

TeamSTEPPS is comprised of four teachable-learnable skills:

- Leadership
- Situation Monitoring
- Mutual Support
- Communication



LEADERSHIP

Leadership is the ability to coordinate the activities of team member by ensuring team actions are understood, changes in information are shared, and that team members have the necessary resources.



- Planning

- **Brief** - Short session prior to start to discuss team formation; assign essential roles; establish expectations and climate; anticipate outcomes and likely contingencies

- Problem Solving

- **Huddle** - Ad hoc planning to reestablish situation awareness; reinforcing plans already in place; and assessing the need to adjust the plan

- Process Improvement

- **Debrief** - informal information exchange session designed to improve team performance and effectiveness; after action review

TOPIC	
Communication clear?	<input checked="" type="checkbox"/>
Roles and responsibilities understood?	<input checked="" type="checkbox"/>
Situation awareness maintained?	<input checked="" type="checkbox"/>
Workload distributed?	<input checked="" type="checkbox"/>
Did we ask for or offer assistance?	<input checked="" type="checkbox"/>
Team errors made or avoided?	<input checked="" type="checkbox"/>
What went well, what should change, what can improve?	<input checked="" type="checkbox"/>

MAKE TEAMS STRONGER!
USE BRIEFS, HUDDLES,
DEBRIEFS AND CHECKLISTS



SITUATION MONITORING

- Situation monitoring is the process of continually scanning and assessing what is going on around you to maintain situation awareness
- Situation awareness is "knowing what is going on around you"
- With a shared mental model, all team members are "on the same page"



MUTUAL SUPPORT

I am **C**oncerned!
I am **U**ncomfortable!
This is a **S**afety Issue!



Two-Challenge Rule:

When initial assertion is ignored:

- It is your responsibility to assertively voice your concern at least **TWO TIMES** to ensure it has been heard
- The team member being challenged must acknowledge
- If the outcome is still not acceptable:
 - Take a stronger course of action
 - Utilize supervisor or chain of command



Empowers all team members to **"stop the line"** if they sense or discover an essential safety breach

**"True collaboration is a process,
not an event"**

COMMUNICATION

• SBAR

A technique for communicating critical information that requires immediate attention and action concerning a patient's condition

- **S**ituation – What is going on with the patient?
 - **B**ackground – What is the clinical background or context?
 - **A**ssessment – What do I think the problem is?
 - **R**ecommendation – What would I do to correct it?
- *Check-back, read-back, and closed-loop communication* with verification are communication methods used to ensure that information conveyed by the sender is understood by the receiver as intended
 - *Hand-off* is the transfer of information (along with authority and responsibility) during transitions in care across the continuum; to include an opportunity to ask questions, clarify, and confirm



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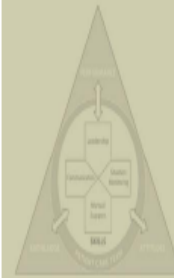
AHRQ
Agency for Healthcare Research and Quality
Advancing Evidence in Health Care • www.ahrq.gov

PATIENT
SAFETY



TRICARE

Published by the Office of Patient Safety



TeamSTEPPS™

Strategies and Tools

A Quick Overview



HHC NEW YORK CITY
HEALTH AND
HOSPITALS
CORPORATION
nyc.gov/hhc

Conflict Resolution Strategies

1 – Two-Challenge Rule – This is used to address information conflict. It was developed to prevent disasters caused when otherwise excellent decision makers experience momentary lapses in judgment. In the clinical environment, team members should challenge colleagues if requesting clarification and confirmation does not alleviate the concern regarding potential harm to a patient.

It is important to voice your concern by advocating and asserting your statement at least twice if the initial assertion is ignored (thus the name “Two Challenge Rule”). These two attempts may come from the same person or two different team members. The first challenge should be in the form of a question. The second challenge should provide some support for your concern. Remember this is about advocating for the patient. The “Two Challenge” tactic ensures that an expressed concern has been heard, understood and acknowledged (HOOAH!)

There may be times when an initial assertion is ignored. If after two attempts the concern is still disregarded, but the member believes patient or staff safety is or may be severely compromised, the Two Challenge rule mandates taking a stronger course of action or using a supervisor or chain of command. This overcomes our natural tendency

To believe the medical team leader must always know what he or she is doing, even when the actions taken depart from established guidelines. When invoking this rule and moving up the chain, it is essential to communicate to the entire medical team that additional input has been solicited.

2 – CUS – Using the CUS technique provides another framework for conflict resolution, advocacy and mutual support. Signal words such as “danger”, “warning” and “caution” are common in the medical arena. They catch the reader’s attention. “CUS” and several other signal phrases have a similar effect in verbal communication. When they are spoken, all team members will understand clearly not only the issue but also the magnitude of the issue.

- First, state your concern.
- Then state why you are uncomfortable.
- If the conflict is not resolved, state that there is a safety issue. Discuss in what way the concern is related to safety. If the safety issue is not acknowledged, a supervisor should be notified.

3 – DESC Script – This is used to address personal conflict. The DESC script can be used to communicate effectively during all types of conflict, and is most effective in resolving personal conflict. The DESC script is used in the more conflicting scenarios

in which behaviors aren't practiced, hostile or harassing behaviors are ongoing, and safe patient care is suffering.

DESC is a mnemonic for:

- D = Describe the specific situation
- E = Express your concerns about the action
- S = Suggest other alternatives
- C = Consequences should be stated

Ultimately, consensus should be reached.

Hands-on Process for Resolving Conflict

Why Should You Understand Conflict?

- Hospital X did not have a chest pain protocol
- Nursing submitted a draft protocol to the Chief of Service and ED physicians
- For 9 months the ED physicians refused to finalize the protocol
- Impact on patient safety and quality
 - Delayed treatments of patients who may be suffering from a heart attack
 - Potential death
- Failures of Leadership
 - Failed to manage conflict between the ED physicians and Nursing
 - Medical Staff leaders did not address the conflict
 - The medical staff did not work together with the ED physicians and the Nursing staff to develop written policy and/or protocol to serve as a guide for staff in maintaining safety or quality of care, treatment and services.

Keep the Conflict Constructive

- Leaders need to ensure that the conflict remains constructive. They must stimulate task oriented disagreement and debate while trying to minimize interpersonal conflict.
- Remember, the skill of engaging in conflict resolution takes time to learn.

Guidelines

- Establish ground rules for the conversation
- Build mutual respect through your words and actions
- Stay focused on the process of the conversation
- Attend to hurt feelings and damaged relationships immediately
- Try to keep the decision-making process transparent
- Become aware of what works for you in conflict resolution

A Process For Constructive Conflict

- Identify positions
- Ask clarifying questions
- Drill deeper to discover underlying issues and motivations
- View the situation from a new perspective
- Present ideas and data in new ways so as to enhance understanding and spark new branches of discussion
- Restate basic facts and assumptions when the conversation gets stuck
- Discuss how each solution would affect each side and figure out compromises
- Agree on a solution
- Re-evaluate the solution as necessary

Communication Principles

- During the conflict discussion, you can use these communication principles:
 - Yes, and ...
You accept (not agree) what they say, and build on it resulting in collaboration
 - Commit
Give 100% to a task
 - Make your partner look good
Creates an atmosphere of trust and discovery
 - Mistakes are gifts
 - Reveals new opportunities

TEAM DEVELOPMENT

Teamwork is.....

- Having a common vision / goal
- Accepting individual differences and cultural diversities
- Working together
- Understanding each other's role in patient centered care
- Being courteous to each other (staff / co-workers)
- Being responsive to patient / family / visitors / co-workers,
peers
- Communication with one another
- Being collegial
- Everyone keeping the work area orderly and organized
- Having fun

*Realize everything each of us does has some effect on the
bottom line!*

STAFFING EFFECTIVENESS

The Hospital Compiles and Analyzes Data on Staffing Effectiveness

Elements of Performance

EP 12. When the organization identifies undesirable patterns, trends or variation in its performance related to safety or quality of care, it includes the adequacy of staffing, including nurse staffing, in its analysis of possible causes.

- Adequacy of staffing includes number, skill mix and competency of all staff.
- Consider workflow, competency assessment, credentialing, supervision, orientation, training and education.

EP 13. When analysis reveals a problem with adequacy of staffing, the leaders responsible for the organization-wide safety program are informed of the results and actions taken to resolve the problems.

EP 14. At least once a year, the leaders responsible for the organization-wide safety program review a written report on the results of any analyses related to adequacy of staffing and any actions taken.

STAFF COMPETENCY

Employee competency is ensured through:

- Verification of credentials; network-wide and department specific orientation
- Annual mandatory training
- Staff development and ongoing training when new procedures or equipment are introduced
- Initial competency assessment
- Ongoing competency assessment and annual performance evaluation
- Background investigative checks
- References
- Licenses, registrations, or certifications in specialties
- Education achievements

Employee competency is validated by:

- Demonstration of skills
- Verbalized knowledge
- Direct observation
- Quizzes

Employee Competency must measure how staff are able to safely carry out their responsibilities based on job functions, requirements and the patient population served (age-specific, cultural and spiritual).

When patient care conflicts with provider or staff's cultural, ethical or religious values, notify the Department Director in writing in advance. Remain with assignments until the request is addressed.

Section Five

Risk Management Occurrence Reports

(Forms may be found on each unit and clinic. Nursing staff are happy to assist you in completing the form when necessary)

Reporting of Concerns - APR 9 Sentinel Events

RISK MANAGEMENT GUIDELINES

What is Risk Management?

RISK MANAGEMENT consists of clinical and administrative activities that BHC undertakes to identify, evaluate, and reduce the risk of injury to patients, residents, staff, and visitors and the risk of loss to the organization itself. The RM office is located in room ME-22; the telephone extension is 5031. The RM staff is available 24 hours per day, for discussion of medical/legal matters. The regular hours of operation are Monday through Friday, 8:00am to 5:00 pm; at other times Risk Management can be contacted through the Duty Office or at (917) 884-0223.

GOALS OF RISK MANAGEMENT:

- To improve the quality of care and enhance patient safety.
- To integrate risk reduction strategies into the delivery of care to each patient.

PRINCIPLES OF RISK MANAGEMENT:

- The highest priority is the prevention of adverse (undesirable) events/occurrences.
- Continuous communication, accurate reporting and ongoing analysis is essential to develop strategies to prevent or minimize the likelihood of future occurrences.
- Staff involvement is critical in the promotion of a safe environment.

WHO CAN REPORT AN OCCURRENCE?

- Anyone can report an occurrence-it is every employee's responsibility.

WAYS TO REPORT:

- Tell your supervisor, physician or Risk Manager.
- Complete an Occurrence Report or "Medication Event Tool".
- File an anonymous report on the BHC "Patient Safety Hotline".

TYPES OF OCCURRENCES (INCIDENTS):

- **Occurrence (Incident):** An unusual event or situation affecting the safety and well-being of a patient, resident, visitor or employee.
- **Near Miss (Good Catch):** Any event that has the **potential** for causing any injury, but did not because the error was identified before it caused harm to the patient, resident, visitor or staff.
- **Sentinel Event:** An unexpected occurrence involving death or serious physical or psychological injury. Examples include an unanticipated patient death from other than the normal course of illness or surgery on the wrong person or wrong body part.

OCCURRENCE REPORTING INFORMATION:

- **Who** was involved?
- **What** happened?
- **When** did it happen?
- **Where** did it happen?
- **How** did it happen?
- **Actions** taken?

OCCURRENCE DOCUMENTATION TIPS:

- Documentation should be thorough, clear and accurate
- Document facts, details - what was reported/witnessed
- Do not draw conclusions or make judgments-no opinions
- Do not write in the medical record that an occurrence report was completed.

Remember: “If you see something, say something”

All occurrences are reviewed by Nursing and forwarded to Risk Management for review and entry into various databases. Depending upon the type of occurrence, a detailed investigation called a “Root Cause Analysis” will be initiated.

LEGAL ACTIONS:

It is an unhappy fact that staff members may become involved in a lawsuit against the hospital. All HHC staff is “indemnified” – covered for medical malpractice lawsuits – and are provided with free legal representation. Risk Management coordinates all legal activities, provides medical record information and coordinates all necessary responses to attorneys. Please call our office for more information.

INFORMED CONSENT:

Patients have the right to decide what medical care they want. In order to make the best decision, the health care providers must explain the treatments available and discuss the risks, benefits, alternatives and benefits to the alternatives. **Remember- an “informed consent” is the process- not the form.**

ADVANCE DIRECTIVES:

If a patient becomes too ill to make decisions about medical treatment or life-sustaining treatments, they can appoint a trusted friend or relative to make these medical decisions. This person, known as a “Health Care Proxy”, is authorized to make decisions on a patient’s behalf when they do not have the mental ability to do so. A “Do Not Resuscitate” form must be completed and the Department of Patient Advocacy will assist in the completion of the forms.

MEDICAL RECORD/CONFIDENTIALITY:

The patient’s medical record is a legal document and is used by the health care professionals to record a patient’s history, diagnosis, prognosis and treatment plan. It serves as a “map” for other professionals involved with the patient’s care, to also be able to follow the patient’s progress. It is a confidential document only to be viewed by those directly involved in the patient’s care. Staff should not discuss patient information in public areas (i.e. elevators, or corridors), or with anyone not directly involved in the patient’s care. Only the Department of Medical Records and Risk Management are authorized to provide a copy of a medical record.

POLICIES AND PROCEDURES:

It is very important for each staff member to be thoroughly familiar with the policies and procedures related to his/her department. If you are unsure of what to do in a specific situation, ask your supervisor (i.e. fire drill). You can also refer to a copy of the hospital-wide policy and procedure manual.

If you are concerned...APR 9

Bellevue staff can report patient safety or quality of care concerns to their immediate supervisors, the Patient Safety Hotline, or by directly contacting the Joint Commission (without fear of retaliation or disciplinary action) at **1-800-994-6610**.

SENTINEL EVENT REPORTING

What is a Sentinel Event?

A 'Sentinel Event' is an unexpected occurrence involving death or serious physical or psychological injury (e.g. loss of limb or function) or risk thereof (i.e. a serious adverse outcome almost occurred).

Examples of Sentinel Events include, but are not limited to, the following:

- Events that result in an unanticipated death or major permanent loss of function not related to the natural course of the patient's illness or underlying condition.
- Infant abduction or discharge to the wrong family.
- Surgery on the wrong patient or wrong body parts.
- Hemolytic transfusion reaction involving administration of incompatible blood.
- Rape by patient or staff.
- Medication error resulting in impairment or death.

What does the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) require hospitals to do when a Sentinel Event occurs?

The JCAHO requires that each hospital identify "Sentinel Events" and conduct a thorough review or 'Root Cause Analysis' of these events to identify the causes of the event and implement changes to prevent them from happening again. This requirement is separate from and in addition to the reporting requirement to the New York State Department of Health (DOH).

How are Sentinel Events reported at BHC?

Any staff member who identifies an occurrence that may be a 'sentinel event' should do the following:

- Manage the event (e.g., ensure that the injured patient, visitor or employee receives appropriate care, etc.);
- Notify your immediate supervisor or the Administrator on Duty during evening hours, holidays and weekends who will notify Department of Risk Management
- Complete a 'Report of Occurrence' form and give it to your supervisor.

The Department of Risk Management will determine if the event is reported to DOH and/or meets the criteria for a 'Sentinel Event' and take appropriate steps to fulfill mandated reporting requirements. If an occurrence is a 'Sentinel Event', the Department of Risk Management and the Sentinel Event Team will investigate the event within 24 hours, conduct a 'Root Cause Analysis', and develop a Plan of Corrections and Measures of Effectiveness to will improve quality of patient care delivery within 45 days.

Please call the Department of Risk Management at 212-562-5031 with any questions regarding 'Sentinel Events'.

Section Six

**Rules of the Board of Regents - Part 29,
Unprofessional Conduct
Behavior Which Undermines A Culture Of Safety
Workplace Violence / Combative Patient**

NYS RULES OF THE BOARD OF REGENTS - ESSENTIALS OF UNPROFESSIONAL CONDUCT

1. Willful or grossly negligent failure to comply with substantial provisions of Federal, State or local laws, rules or regulations governing the practice of the profession;
2. Exercising undue influence on the patient or client, including the promotion of the sale of services, goods, appliances or drugs in such manner as to exploit the patient or client for the financial gain of the practitioner or of a third party;
3. Directly or indirectly offering, giving, soliciting, or receiving or agreeing to receive, any fee or other consideration to or from a third party for the referral of a patient or client or in connection with the performance of professional services;
4. Permitting any person to share in the fees for professional services, other than: a partner, employee, associate in a professional firm or corporation, professional subcontractor or consultant authorized to practice the same profession, or a legally authorized trainee practicing under the supervision of a licensed practitioner. This prohibition shall include any arrangement or agreement whereby the amount received in payment for furnishing space, facilities, equipment or personnel services used by a professional licensee constitutes a percentage of, or is otherwise dependent upon, the income or receipts of the licensee from such practice, except as otherwise provided by law with respect to a facility licensed pursuant to Article 28 of the Public Health Law or Article 13 of the Mental Hygiene Law;
5. conduct in the practice of a profession which evidences moral unfitness to practice the profession;
6. willfully making or filing a false report, or failing to file a report required by law or by the Education Department, or willfully impeding or obstructing such filing, or inducing another person to do so;
7. failing to make available to a patient or client, upon request, copies of documents in the possession or under the control of the licensee which have been prepared for and paid for by the patient or client;
8. revealing of personally identifiable facts, data or information obtained in a professional capacity without the prior consent of the patient or client, except as authorized or required by law;
9. practicing or offering to practice beyond the scope permitted by law, or accepting and performing professional responsibilities which the licensee knows or has reason to know that he or she is not competent to perform, or performing without adequate supervision professional services which the licensee is authorized to perform only under the supervision of a licensed professional, except in an emergency situation where a person's life or health is in danger.

Please visit: www.op.nysed.gov/title8/part29.htm for more rules

BEHAVIOR WHICH UNDERMINES A CULTURE OF SAFETY

The Policy

It is the policy of Bellevue Hospital that all individuals be treated with dignity and respect, regardless of position or authority.

All staff, volunteers, students, residents, and affiliates are not to behave in ways that:

- Threaten a safe work environment and disrupt teamwork and patient-centered care
- Disrupt performance of the healthcare team
- Result, via actions and/or decisions, in a reckless disregard for the safety of patients, staff and visitors



Desired behaviors or conduct

Being courteous and respectful toward patients, patients' families, staff, peers, supervisors, practitioners and visitors and treating them with dignity

- Collaborating with clinical and administrative staff alike
- Practicing teamwork and communicating openly with, and among, all levels of staff, regardless of title or position
- Staff modeling the behavior they expect in others
- Managing and resolving conflict(s) in a direct and respectful manner
- Resolving interpersonal conflict(s) informally via discussion, etc., if possible
- Promoting a culture of safety and respect



Unacceptable Behaviors

- Actions or decisions involving a reckless disregard for the safety of patients, staff, visitors, practitioners and/or management
- Actions that may be threatening including non-verbal posturing or physical contact
- Profane, rude, threatening, intense, explosive and/or disrespectful language with or without expletives
- Throwing medical instruments, charts, and other objects
- Ignoring team members, refusing to listen to team members and/or dismissing team members
- Yelling, screaming, and using verbally abusive language and name calling
- Deliberate failure to adequately address safety concerns or patient care needs expressed by another caregiver
- Refusing to work collaboratively or cooperatively with staff, colleagues, subordinates and/or supervisors
- Retaliation against any member of the healthcare team who has reported a violation of code of conduct or participated in the investigation of a violation
- Refusal or reluctance to answer questions, return phone calls or pages, or communicate regarding patient care
- Causing fear in people through outbursts of rage
- Failure to communicate in a manner that is understood by patients, family members, team members and other staff members
- Deliberate failure to adhere to organizational policies



Actions to Be Performed

All staff have a responsibility to report behavior which undermines a culture of safety. Some staff have additional responsibilities. Please refer to the following slides and identify what duties apply to your job position.



All Staff

Any staff member may report behavior which undermines a culture of safety to his/her supervisor, manager, administrator, Chief of Service, Human Resources, or the designee of the Executive Director of the facility. Intimidation or retribution towards those who report or cooperate in the investigation of such behavior will not be tolerated, and may result in disciplinary action.

Patients and Families

Patients or families subjected to behavior which undermines a culture of safety may report to the Patient Representative or any staff member. This information will be shared with Human Resources, Patient Relations, and the Medical Director, and Risk Management in the case of harm to the patient.

Specific Job Titles have additional responsibilities regarding intimidating, disruptive, and unacceptable behaviors.



Please refer to the associated HR Policy or contact Lois Penn in Human Resources at 212-562-7527.

WORKPLACE VIOLENCE / COMBATIVE PATIENT

If you are confronted by a violent situation or a combative patient get help – call a Supervisor, Manager or Hospital Police, ext. 6191.

1 - The Crisis Management Team is available 24 / 7 to assist with aggressive, combative patients on any in-patient unit who are creating a danger to self or others. Call ext. 66 and request the "Crisis Management Team". Provide your name and exact location.

2 - Use the "panic button" if one is available and readily accessible in your location.

3 - If you are in a room with a patient who is becoming aggressive and potentially violent do the following:

- Try to remain near a door and have an escape route available.
- Try not to allow the patient to block your way out.
- If possible keep a barrier such as a desk, counter or table between yourself and the patient.
- Leave the room before the situation escalates.

4 - Make sure someone knows where you are if you are aware that the patient or other person could become violent, or arrange to have someone else there with you.

5 - Call Hospital Police, ext. 6191, to report incidents of workplace violence whether they are physical or verbal. Also submit HHC 407 Confidential Report of Occurrence Form to Risk Mgt, ME-22. (Form is available on Nursing Units or call Safety ext. 6520 M - F, 9 am - 5 pm)

Section Seven

HIV Confidentiality

HIV/AIDS CONFIDENTIALITY

Bellevue Hospital Center mandates that all employees receive annual training on HIV confidentiality and understand the basics of the New York State HIV confidentiality law.

Please note the following:

- Employees should never discuss a patient's or other employee's HIV-related information unless they are directly involved in their care.
- HIV testing of newborns is mandatory. All newborns born in New York State will be tested for HIV without signed consent. However, the mother cannot be tested without her consent.
- A signed form specifying the release of HIV information is required to provide HIV information to an outside agency.
- In the case of an occupational exposure, if the source patient is capable of consenting, the patient must agree to testing by signing a consent form before the test can be ordered. If the patient is unable to give consent, the patient's health care proxy or legal guardian can provide consent. If there is no health care proxy or legal guardian, a surrogate can be used if the patient will be incapable of consenting for an extending period of time. There are limited situations in which a source patient can be tested anonymously without consent.

What is Confidential HIV-related Information?

Any information that indicates that a person:

- has had an HIV-related test (even if the test is negative.) This includes all HIV-related tests.
- has an HIV-infection, HIV-related illness, or AIDS
- has been exposed to HIV, the virus that causes AIDS

Release of HIV Information

- To release HIV-related information, completion of the *NYCHHC HIPAA Authorization to Disclose Health Information* form is required. This is found on the Bellevue intranet: http://clas.nychhc.org/Uploads/English_HHCAZ071505_FINAL%20VERS_DJ.pdf

Who can Consent to an HIV Test?

- Any person, regardless of age, can consent to an HIV test, but the person must demonstrate understanding of the purpose of the test, the meaning of the HIV-related test results, and available options for care and treatment.
- For a person who lacks the capacity to consent, the health care proxy, or legal guardian of that person can consent. If neither is available, a surrogate of that person (as defined by the Family Health Care Decisions Act of 2010/NYS PHL Article 29CC) may consent.

HIV Counseling & Testing

- Bellevue is required to offer HIV tests to all patients aged 13-64 in inpatient, emergency and primary care clinic areas (with limited exceptions).
- Patients must be provided with seven points of information as required by Public Health Law 27F prior to testing. This is available on the intranet.
- HIV Counselors are available to provide comprehensive counseling by referral.
- Consent for HIV testing is required. The patient can sign a consent form, or give consent orally. Verbal consent must be documented in the patient's medical record. Written consent is required for prisoners.

HIV/AIDS Names Reporting

- Health care providers and labs in NYS are required by law to report initial cases of HIV infection, HIV-related illnesses, and AIDS to the NYS Department of Health (DOH).
- The purpose of the law is to allow surveillance of HIV/AIDS in NYS and to enhance partner/contact notification efforts.
- This information is kept in strict confidence by the DOH Office of HIV/AIDS Surveillance, and it is not shared with any other agency or other departments of the DOH.

Partner/Contact Notification

- There are a number of options available to HIV-infected patients to help them notify partners about their HIV status. These are: Self-notification, assisted or dual notification, contract notification and Contact Notification Assistance Program (CNAP) notification.
- HIV Counseling and Testing Service can help patients with notification. HIV Counselors can also be called on to assist providers who are aware of a patient's partner when the provider believes the patient has not self-disclosed his/her HIV status. Contact 212-562-8484 for assistance.

Occupational Exposure

- Exposures or potential exposures to blood or body fluids can include needlesticks, or other percutaneous or mucosal exposures.
- Anyone working at Bellevue in *any* capacity who suffer an exposure must **IMMEDIATELY** wash the site of exposure and notify their supervisor.
- Following an exposure, exposed individuals must quickly report to Occupational Health Service (OHS) ("H" Building, 12th floor). When OHS is closed, they report to Bellevue Adult Emergency Service (AES). OHS or AES will initiate appropriate care including assessment of need for medication and will start employee on medication immediately if appropriate.
- Departments are expected to provide appropriate back-up to enable exposed individuals to be relieved of their duties **IMMEDIATELY** following an exposure.
- OHS and AES will work with Virology HIV Counselors or Attending Physicians to initiate source patient counseling. They will encourage testing, provide HIV counseling, obtain consent and initiate testing when appropriate.
- To make a referral for HIV Counseling and Testing for INPATIENTS, please call the Inpatient HIV Counselor at X4001
- To make a referral for HIV Counseling and Testing for OUTPATIENTS, please call the Virology reception desk at X4038 or the Assistant Director for HIV Counseling and Testing at X8484.

**Please refer all questions about HIV Confidentiality
to the Department of Virology Services at X3906 or X8484**

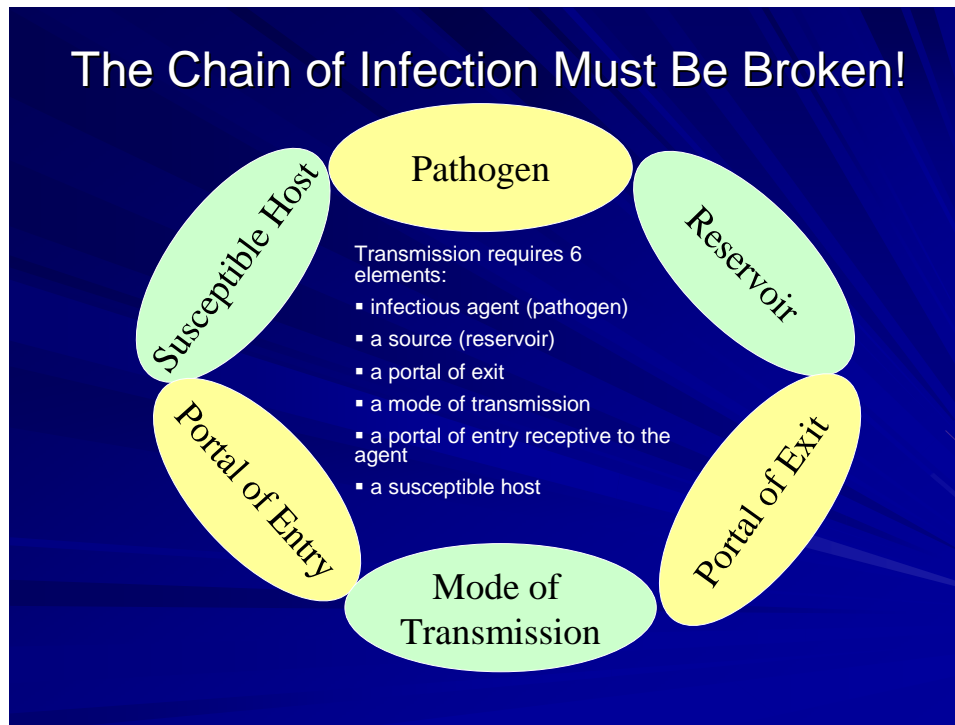
Section Eight

Infection Prevention & Control

BELLEVUE HOSPITAL CENTER

INFECTION CONTROL

- Infection Prevention and Control is a program designed to prevent or minimize the transmission and/or spread of infectious organisms.
- General policies and procedures found in the Infection Control Manual are available on the Infection Control website on the Bellevue intranet.
- Specific policies and procedures can be found in their respective departmental offices.



- **HAND HYGIENE** is the most effective method to prevent the transmission of any infection.
 - Wash Hands or apply an antiseptic hand rub. Wash for 10-15 seconds using running water, soap, and friction (rubbing hands together). If using an alcohol based hand sanitizer, apply to palms and rub hands together covering all surfaces, until dry.
- Long fingernails and nail treatments harbor organisms and put patients at risk.
 - Artificial nail enhancements should not be permitted.
 - Natural nails should be no longer than ¼ inch.
- **NO food or drink in patient care or clinical areas**
 - Consuming food or drinks while working increases the risk of cross infection and when discarded, encourages vermin
 - Please keep coffee cups, water bottles and food items in the designated break rooms

- All staff are required to use **STANDARD PRECAUTIONS for all patients:**
 - Wear appropriate personal protective equipment (ie: gloves, gowns, masks, face or eye shields) for potential or actual contact with blood and/or body fluids
 - Perform hand hygiene before and after caring for the patient, and after discarding the gloves
 - Wash hands with soap and water when visibly soiled
 - Perform hand hygiene between contact with different patients
- **Use of Transmission-Based Precautions for Selected Patients:**
 - **Airborne**– for patients who have or are suspected of having a disease with organisms that can float in the air (ie: tuberculosis, chicken pox)
 - A Particulate Respirator (an N-95 class) is worn by staff and visitors to enter the room of a patient on Airborne Precautions
 - OSHA laws requires staff to be “fit-tested” prior to using the respirator
 - Staff will teach the visitors how to put on the respirator
 - A **blue** Airborne Precautions sign will be posted on the outside of the patient’s door
 - **Droplet**– for patients with diseases spread by large droplets that settle out of the air (ie: bacterial meningitis, influenza)
 - A **green** Droplet Precautions sign will be posted on the outside of the patient’s door
 - **Contact**– for patients with diseases or **multi-drug resistant organisms (MDROs) with a portal of exit** (ie: Foley catheter, draining wounds, tracheostomies requiring frequent suctioning) that can be spread by contact with the patient or his environment
 - **Multi-drug resistant organisms (MDROs)** are organisms which are resistant to more than one of the primary antibiotics of choice
 - Examples of **MDROs** include **MRSA** (methicillin resistant *Staphylococcus aureus*), **VRE** (vancomycin resistant enterococcus) and **resistant gram negative bacteria** such as *Klebsiella pneumoniae* and *Acinetobacter*
 - A **yellow** Contact Precautions sign will be posted on the outside of the patient’s door
 - A **red** Contact Precautions sign will be posted on the outside of the patient’s door who are infected with *C. difficile*
 - **For patients with *C. difficile* infection, wash hands with soap and water and use bleach for cleaning the patient’s environment**
- **DEVICE ASSOCIATED INFECTIONS**
 - **Central Line Associated Bloodstream Infections (CLABs)**
 - A central line is a tube (catheter) that is placed into a patient’s large vein (neck, chest, arm or groin) that is often used to draw blood or give fluids or medications
 - A bloodstream infection can occur when bacteria or other germs travel down a central line and enter the blood
 - **Catheter Associated Urinary Tract Infections (caUTIs)**
 - A urinary catheter is a thin tube placed in the bladder to drain urine which collects in a bag
 - A urinary tract infection is an infection of the urinary system which includes the bladder and kidneys
 - Germs do not normally live in these areas, but a urinary catheter can introduce these germs into the urinary system and an infection can occur

- **Ventilator Associated Pneumonia (VAP)**
 - A ventilator is a machine that helps a patient breathe by giving oxygen through a tube; the tube can be placed in a patient's mouth, nose or through a hole in the front of the neck
 - A ventilator associated pneumonia (VAP) is a lung infection that develops in a person who is on a ventilator
- **Prevention of Device Associated Infections**
 - At Bellevue we've implemented **"bundles"** to prevent and/or reduce hospital associated infections
 - **A "bundle" is a set of interventions or best practices , that when grouped or implemented together, promote best outcomes with a greater impact than if performed individually**
 - Examples of best practices to prevent device associated infections are as follows:
 - Sterile technique should be used for all device insertion
 - Hands should always be cleaned before and after inserting, handling and removing these devices
 - Clean (aseptic) technique should be used when maintaining or accessing the device
 - Assess the need for the device on a daily basis
 - If the device is not needed, it should be removed as promptly as possible
- **SURGICAL SITE INFECTIONS (SSIs)**
 - A surgical site infection is an infection that occurs after surgery in the part of the body where the surgery took place
 - Surgical procedures result in breaches in the skin and create an increased risk of infection
 - Some of the practices that are used to prevent SSIs include:
 - Hand hygiene
 - Pre-operative patient showering with an antiseptic
 - Proper hair removal (outside of the OR and never with a razor)
 - Surgical skin antisepsis with Chlorhexidine
 - Timely administration of antibiotic prophylaxis prior to surgery
 - Maintaining the patient's serum glucose level below 200mg/dL
 - Avoidance of flash sterilization
 - Optimal surgical technique
 - Sterile dressing placement and limited post-op dressing manipulation
- **OSHA BLOODBORNE PATHOGEN (BBP) STANDARD**
 - Developed in 1991, it was designed to reduce occupational exposure of healthcare workers to bloodborne pathogens
 - Requires institutions to write specific exposure control plans
 - **Key elements of the Bellevue Exposure Control Plan are: standard precautions, Hepatitis B vaccine, personal protective equipment (PPE), engineering controls, work practice controls and post exposure management**
 - Bloodborne pathogens include HIV, Hepatitis B and C, syphilis and malaria

- **EXPOSURE TO BLOOD AND/OR BODY FLUIDS**
 - If a staff member (including physicians and volunteers) gets a needle stick, laceration, or splash of blood/body fluids in a mucous membrane (eyes, mouth, nose) or on broken skin, they need to:
 1. wash the site, report to their supervisor and fill out an incident report
 2. go to Occupational Health Services (OHS) or Adult Emergency Services (AES) within 2 hours so the doctors can determine if antiviral medication is indicated and can start it immediately
 - If seen in AES, you must report to OHS on the next business day for follow up
- The Blood Borne Pathogen (BBP) Exposure Control Plan and the Respiratory Protection Plan are references available in the Infection Control Manual.
- **Occupational Health Service (OHS) plays a vital role in infection prevention** of all healthcare workers by providing **annual health assessments** which includes **PPD screening and fit testing for N95 respirators**. They also **evaluate illnesses and exposures** and **provide necessary immunizations** (ie: pre-employment – measles, mumps rubella, Hepatitis B and influenza).
- **INFLUENZA IMMUNIZATION**
 - **The best way to protect against the flu is with an annual influenza vaccination**
 - Because the flu vaccine is made from an inactivated virus, you CANNOT get the flu from the vaccine
 - Symptoms of the flu include fever, headache, sore throat, body aches, malaise, dry cough and nasal congestion
 - **Prevention of Influenza**
 - Droplet precautions
 - Hand Hygiene
 - Vaccinate healthcare providers and patients with flu vaccine each year
 - Cough etiquette / Respiratory hygiene - Cover your cough and/or sneeze!
 - If you have influenza, stay home
- **THE JOINT COMMISSION NATIONAL PATIENT SAFETY GOAL #7**
 - **Reduce the risk of healthcare associated infections (HAIs)**
 - **Top ten prevention tips to reduce HAIs**
 1. Hand Hygiene/No artificial nails
 2. Isolation/Precautions
 3. Personal Protective Equipment (PPE)
 4. Respiratory Protection/N95 fit testing
 5. Clean patient care equipment between patients - “Green means Clean!”
 6. Separation and storage of clean and dirty supplies
 7. Education - MDROs, Device Associated Infections, SSIs
 8. OSHA Bloodborne Pathogen Standard
 9. Influenza prevention
 10. Infection Prevention and Control Resources: Infection Control Practitioners and the Infection Prevention & Control Manual on the Bellevue intranet

Section Nine

**NYC Conflicts of Interest Law
Corporate Compliance**

NYC CONFLICTS OF INTEREST LAW

1. **Misuse of Office**
You may not take action or fail to take an action as a public servant if doing so might financially benefit you, a family member, or anyone with whom you have a business or financial relationship.
2. **Misuse of City Resources**
You may not use City letterhead, personnel, equipment, supplies, or resources for a non-City purpose, nor may you pursue personal or private activities during times when you are required to work for the City.
3. **Gifts**
You may not accept anything of value for less than its fair market value from anyone that you know or should know is seeking or receiving anything of value from the City.
4. **Gratuities**
You may not accept anything from anyone other than the City for doing your City job.
5. **Seeking Other Jobs**
You may not seek or obtain a non-City job with anyone you are dealing with in your City job.
6. **Moonlighting**
You may not have a job with anyone that you know or should know does business with the City or receives a license, permit, grant, or benefit from the City.
7. **Owning Businesses**
You may not own any part of a business or firm that you know or should know does business with the City or receives a license, permit, grant, or benefit from the City, nor may your spouse, nor your domestic partner, nor any of your children if they are under 18.
8. **Confidential Information**
You may not disclose confidential City information or use it for any non-City purpose, even after you leave City service.
9. **Appearances**
You may not accept anything from anyone other than the City for communicating with any City agency or for appearing anywhere on a matter involving the City.
10. **Lawyers and Experts**
You may not receive anything from anyone to act as a lawyer or expert against the City's interests in any lawsuit brought by or against the City.
11. **Buying office or Promotion**
You may not give or promise to give anything to anyone for being elected or appointed to City service or for receiving a promotion or raise.
12. **Business with Subordinates**
You may not enter into any business or financial dealings with a subordinate or superior.
13. **Political Solicitation of Subordinates**
You may not directly or indirectly ask a subordinate to make a political contribution or to do any political activity.
14. **Coercive Political Activity**
You may not force or try to force anyone to do any political activity.
15. **Coercive Political Solicitation**
You may not directly or indirectly threaten anyone or promise anything to anyone in order to obtain a political contribution.

16. Political Activities by High-Level Officials

If you are an elected official, deputy mayor, agency head, deputy or assistant agency head, chief of staff, or director or member of a board or commission, you may not hold political party office or ask anyone to contribute to the political campaign of a City officer or City employee or to the political campaign of anyone running for City office.

17. Post-Employment One-Year Ban

For one year after you leave City service, you may not accept anything from anyone, including the City, for communicating with your former City agency.

18. Post-Employment One-Year Ban for High-Level Officials

If you are an elected official, deputy mayor, chair of the city planning commission, or head of the office of management and budget, law department, or department of citywide administrative services, finance, or investigation, for one year after you leave City service, you may not accept anything from anyone, including the City, for communicating with your former branch of City government.

19. Post-Employment Particular Matter Bar

After you leave City service, you may never work on a particular matter you personally and substantially worked on for the City

20. Improper Conduct

You may not take any action or have any position or interest, as defined by the Conflicts of Interest Board, that conflicts with your City duties.

21. Inducement of Others

You may not cause, try to cause, or help another public servant to do anything that would violate the Code of Ethics.

22. Disclosure and Recusal

As soon as you face a possible conflict of interest under this Code of Ethics, you must disclose the conflict to the Conflicts of Interest Board and recuse yourself from dealing with the matter.

23. Volunteer Activities

You may be an officer or director of a not-for-profit with business dealings with the City if you do this work on your own time, you are unpaid, the not-for-profit has no dealings with your City agency (unless your agency head approves), and you are in no way involved in the not-for-profit's business with the City.

**FOR ADDITIONAL INFORMATION, CONTACT
NYCHHC OFFICE OF LEGAL AFFAIRS
125 WORTH STREET, ROOM 527, NEW YORK, NY 10003
212-788-3300 (FAX 212-267-6905)**

OR

**NEW YORK CITY CONFLICTS OF INTEREST BOARD
2 LAFAYETTE STREET, SUITE 1010, NEW YORK, NY 10007
212-442-1400 (TDD 212-442-1443)**

[HTTP://NYC.GOV/ETHICS](http://nyc.gov/ethics)

CORPORATE COMPLIANCE

ALWAYS REMEMBER: The Compliance Program will not work without YOU! COMPLIANCE is a TEAM EFFORT When in doubt, ASK!

Serious Adverse Events (aka Never Events)

New York State recently passed a law that prohibits payments for certain avoidable hospital complications and medical errors that are identifiable, preventable and serious in their consequences to patients. Examples of Never Events include surgery performed on the wrong body part or the wrong patient.

Document Integrity and Retention HHC's Operating Procedure (OP) 120-19 states that all employees are responsible for the integrity and accuracy of all documents and records to ensure that accurate documents are maintained in accordance with regulatory and legal requirements. No one may alter or falsify information on any HHC record or document. All records, including medical and business ones, must be retained and destroyed in accordance with the law and HHC's record retention policy.

The 7 General Principles of Documentation

1. The medical record is complete and legible
2. Each encounter includes:
 - Reason for encounter and relevant history; physical examination findings; prior test results
 - Assessment: clinical impression or diagnosis
 - Plan for care
 - Date, time and legible identity of observer
3. The rationale for ordering diagnostic tests and ancillary services is easily inferred if not documented
4. Past and present diagnoses are accessible to the treating and/or consulting physician
5. Health risk factors are identified
6. The patient's progress and changes in diagnosis are documented
7. There is documentation supporting CPT, ICD and DRG codes that are reported on billing statements

Quality, honesty and integrity in everything we do are important values to all of us at HHC. We are committed to providing quality health care and services to our patients consistent with our mission and values and in compliance with all laws, rules and regulations. The HHC Compliance Program is designed to assist us in this process.

What is Compliance?

Compliance is the system to promote the prevention, detection and resolution of conduct that does not conform to Federal law and State law and HHC's ethical and business policies. It is HHC's way of preventing and responding to fraud, waste and abuse.

What is Fraud, Waste and Abuse?

Fraud is:

- An intentional misrepresentation that the individual or an entity makes knowing that the misrepresentation could result in some unauthorized benefit to the individual or the entity or to some other party.
- An intentionally made false statement, misrepresentation or deliberate omission that affects the determination of benefits payable by the government.
- **An example of fraud is billing for a chest x-ray that was never performed.**

Waste is:

- Spending that can be eliminated without reducing the quality of care.
- Practices that result in unnecessary increased costs or utilization of medical services or products.
- **An example of waste is having to perform a chest x-ray twice because of malfunctioning equipment or a lost test result.**

Abuse is:

- Substandard quality of care.
- Restriction of patient choice.
- **An example of abuse is performing a chest x-ray on every patient, regardless of whether they need it.**

What are the goals of the Compliance Program?

Despite all the rules and regulations and our best efforts to prevent errors, we are all human and sometimes mistakes happen. It is critical to detect these errors as quickly as possible, and to correct them before they become a pattern of fraud. This is only possible if ALL employees are free to ask questions without fear or retaliation.

What are the consequences of non-compliance?

Failure to comply with Federal and State regulations, as well as HHC's internal policies could result in:

- Potential harm to our patients and/or employees
- Serious damage to our reputation
- Government action against HHC and its employees
- Exclusion from the Medicare and Medicaid programs
- Criminal charges against HHC or our employees
- Disciplinary action up to and including termination
-

What are your responsibilities?

HHC's code of conduct states that all employees have a duty to:

- **Follow all laws, regulations and policies.**
- **Report knowledge or suspicion of a violation of laws regulations or policies.**
- **Direct any questions or concerns to their supervisor, anyone in management or the Compliance Team.**
- **If you are not sure about something, it is your duty to ask.**

Emergency Medical Treatment and Active Labor Act (EMTALA)

EMTALA requires all hospitals to provide emergency care to anyone in need, **regardless of their ability to pay or immigration status**. Under EMTALA, hospitals must identify if an emergency medical condition exists and stabilize the patient prior to determining the patient's ability to pay. If the hospital does not have the capability to treat the condition, the hospital must transfer the patient to another facility with such capability, once the patient has been stabilized.

Stark Law and Anti-Kickback Statute (AKS)

The **Stark Law** prohibits physicians from making referrals for certain "designated health service"(payable by Medicaid or Medicare) to an entity where the physician or a close relative has a **financial relationship**, such as an ownership interest or compensation arrangement. Designated health services include lab services, physical therapy and durable medical equipment, to name a few. The **Anti-Kickback Statute** makes it illegal for providers to **knowingly** and **willfully** accept bribes or any form of payment in return for generating Medicare, Medicaid or other federal healthcare program business. Violations of these laws can result in serious penalties, including imprisonment and exclusion from participation in government programs.

Excluded Providers Federal and state law prohibit the government from paying for items/services furnished by individuals or entities that have been excluded from government programs. HHC monitors the government's exclusion lists to ensure that such individuals do not provide services to our patients.

Health Insurance Portability and Accessibility Act (HIPAA)

According to HHC Operating Procedures (240 and 250 series), all employees must maintain the confidentiality and security of patient information in accordance with the HIPAA. HHC employees have access to confidential, sensitive and proprietary information. The inappropriate release of this information could be injurious to the Corporation, our patients and business partners. Employees are advised to contact HHC's HIPAA Privacy and Security Officers with any questions or concerns about possible violations of HIPAA.

New York City's Conflict of Interest Law

As an employee of the City of New York, you are required to adhere to the Conflicts of Interest Law. The conflicts of interest law was enacted to preserve the public trust, to promote public confidence in government, to protect the integrity of government decision-making, and to enhance efficiency.

It established a basic set of rules regarding, among other things: **Gifts; Moonlighting/Part-Time Jobs; Volunteer Activities; Post-City Employment; Use of Confidential Information; Political Activities; Use of City Position for Personal Gain; Ownership Interest in Firms Doing Business with the City; and Relationships Between Employees & Supervisors.**

Special Notice on Gifts: You are not permitted to accept gifts, gratuities or any remunerations from vendors or patients. In some cases, vendors may provide financial support for Continuing Medical Education. HHC OP 20-55 details specific restrictions and allowances related to support provided by vendors for continuing medical education.

How do you report a compliance issue?

1. **Talk to your supervisor or a member of management**
2. **Call your Compliance Team**
3. **Call the Compliance Helpline at 866 –HELP –HHC***
4. **Go to compliance.nychhc.org to submit a Fraud & Abuse form***

*If you feel uncomfortable speaking to HHC staff, you may remain anonymous when calling or completing the form.

*OP 50-1 provides that Compliance Officers are independent reporting directly to the Corporate Compliance Officer who reports directly to HHC's President.

HHC's policy on Retaliation

HHC strictly prohibits retaliation in any form against any individual making a report, complaint, or inquiry in good faith, concerning suspected fraud, waste or abuse or other suspected violation of law or HHC policy.

- "In good faith" means that you believe the information reported to be true.
- Acts of retaliation are subject to discipline, up to and including dismissal from employment or termination of the business relationship with HHC.
- Employees cannot, however, exempt themselves from disciplinary action by reporting their own misconduct.
- Supervisors are required by Operating Procedure 20-43 to create a work environment that encourages the reporting of compliance issues without fear of retaliation.

Who cares if we are compliant?

Everyone should! We have an obligation to our employees, patients and the taxpayers of New York City to conduct our business in accordance with the law and to prevent fraudulent activities and wasteful expenditures of tax payer dollars. In addition, the federal government, through its Office of the Inspector General (OIG) has many initiatives that target fraudulent behavior by health care providers. The state government, through its offices of the Medicaid Inspector General (OMIG) and Medicaid Fraud Control Unit (MFCU) also targets fraudulent activity.

Federal and State Enforcement

- **OIG:** The Federal Office of the Inspector General has been investigating healthcare fraud for decades. The OIG focuses primarily on violations of the False Claims Act, the Stark Law and the Anti-Kickback statute. The OIG has reported savings and expected recoveries of \$26 Billion for fiscal year 2010.
- **OMIG:** The NY State Office of the Medicaid Inspector General has recently been tasked with recouping inappropriate overpayments of \$1.2 Billion for FY 2010. OMIG mandates compliance programs for healthcare entities receiving over \$500,000 annually in Medicaid payments.
- **Contractors (RACs, MICs, ZPICs):** The government uses private contractors to review the billing records of providers. The **Recovery Audit Contractors, Medicaid Integrity Contractors and Zone Program Integrity Contractors** review hospital records to assess whether billing was appropriate and supported by the medical record. These contractors identify and recoup for the government overpayments made to providers.

Important Regulations & Guidance:

False Claims Act (FCA): The FCA was passed in 1863 during the Civil War to help prevent defense contractors from fraudulently billing the government. It is the federal government's most powerful weapon to fight healthcare fraud. It is so important that New York passed its own FCA in 2007. The FCA imposes liability on any person or entity that submits a claim to the government that he/she **knows** to be false. **Honest mistakes are not considered fraud.** However, any overpayment from the government can be considered a violation of the FCA, if not returned to the government within 60 days of its discovery. Additionally, the FCA provides protection for whistleblowers, or *qui tam* plaintiffs. *Qui tam* lawsuits allow private citizens to file lawsuits on behalf of the government and to share in the government's recovery.

Areas of risk under the FCA include:

- **Upcoding / DRG Creep:** billing a case with a higher payment code than is supported by documentation in the patient's record
- **Duplicate billing:** submitting more than one claim for reimbursement for the same service
- **Unbundling:** submitting multiple bills in fragments in order to maximize reimbursement for services that should have been billed together⁵

The Patient Protection and Affordable Care Act (aka "PPACA" or the "Affordable Care Act")

PPACA was passed in March 2010 as part of President Obama's healthcare reform plan. In addition to providing expanded coverage for the "under"insured and the uninsured, PPACA also contains numerous provisions increasing federal and state enforcement initiatives to fight health care fraud and abuse. To support this increased focus on fraud, PPACA provides for an additional funding of \$350 million dollars.

Section Ten

Information Management
&
Record of Care

INFORMATION MANAGEMENT AT BELLEVUE

The JCAHO IM & RC Standards in Plain English



IM Standard 1 Information Management Planning

IM planning is based on a thorough assessment of what IT platform will best support the hospital's goal of providing quality health care.

IM planning is an ongoing process done in a consultative manner with all stakeholders.

Example at BHC: The IM decision making process at BHC is coordinated by the IM steering committee. Members, from virtually every department, bring issues from various subcommittees that they represent.

System failure processes are in place to ensure business continuity and that critical information is not lost.

Example at BHC: When systems fail, dept have downtime procedures so critical business functions can continue. "DART" provides a downtime alternative to the patient med record.



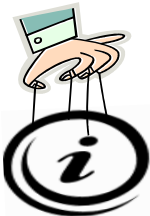
IM Standard 2 Confidentiality, Security, Integrity and Availability

All staff are knowledgeable in the policies and practices to safeguard confidential information. Everyone is responsible to protect it and compliance is monitored.

Example at BHC: Policies A-2 & S-17 provide general guidelines to access, usage & security of all IT resources. The hospital requires all staff to attend Hipaa privacy & security training classes and to sign a confidentiality acknowledgement form. The IS dept provides classroom training on QuadraMed/Misys and Unity for any staff when granted access.

Systems are designed and utilized in a manner to safeguard information and quality assurance processes are in place.

Example at BHC: Our data assets are protected with passwords, anti-virus software, redundancy & daily back-ups; transmitted data is encrypted, intrusion detection monitors network traffic, remote access is controlled thru VPN (Virtual Private Network).



Data & processes are standardized to promote simplicity & facilitate aggregation.

Processes are in place to avoid mistakes caused by common abbreviations & terminology.

Example at BHC: We adhere to the ICD-9 & CPT-4 coding standards. A list of prohibited dangerous abbreviations is posted on the intranet.

Processes are in place to get information into the hands of the people that need it.

Information is accurate, timely & organized.

Example at BHC: QuadraMed/Misys ancillary service provide results as they become available to any place in the hospital. Groupwise email & office automation allows staff to easily share information.



IM Standard 3 Knowledge-based Information

Knowledge-based information is made available to the people that need it & it is kept up to date.

Example at BHC: Ovid & friends medical library, Micromedex, unrestricted medical websites, all of which are available on the Bellevue intranet. BHC also has an internally developed robust and extensive patient education application.



IM Standard 4 Maintain Accurate Information

Processes are in place to verify that patient information is accurate.

Example at BHC: The accuracy of the medical record is reviewed at several points. The QuadraMed/Misys system has many built-in edit checks to validate data as it is entered. The Medical Records department validates entries as part of their regular work routines. The Quality Management department performs periodic audits to ensure that information contained in the patient medical record is accurate.

Patient-Specific Data and Information



RC Standard 1 Patient Medical Record

A medical record is maintained to facilitate quality patient care & satisfy regulatory requirements as follows:

- Maintain complete and accurate Medical Records
- Entries are authenticated and documented
- Entries, changes or updates are done in timely manner
- Regularly check medical records for compliance with above 3 items
- Medical records are retained in accordance with laws

RC Standard 2 Patient Medical Record

The medical should contain clinical information, treatment records and provide for continuity of care as follows:

- Must contain documentation of all patient demographics and communication
- Must contain documentation of all care, treatment and service
- Emergency care requires time & means of arrival, conclusions of treatment, final disposition, condition at discharge, follow-up instructions & if care refused
- Document operation, high risk procedures and sedation
- Document the use of any restraints or seclusion
- Maintain a summary list for patients requiring continuing Ambcare treatment
- Qualified Staff record verbal orders
- Provide discharge & history info to promote continuity of care

Example at BHC: QuadraMed/ Misys is the central repository of patient clinical information. The SMHN Information Systems Clinical Apps Team, working with hospital clinical staff, provided design, development and support services to ensure that the system meets all the above requirements

SECTION ELEVEN

Cultural Competency

LGBT Services

CLAS Standards

Language Services

CULTURAL COMPETENCY

What is Culture?

“Integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social groups”

– www.omhrc.gov

Culture and Language May Influence...

- Health, healing, and wellness belief systems
- How illness, disease, and their causes are perceived
- The behaviors of patients/residents who are seeking health care and their attitudes toward health care providers
- The delivery of services by the provider who looks at the world through his or her own limited set of values, which can compromise access for patients from other cultures

Cultural Competency in Healthcare

- To work effectively in cross-cultural situations.
- To adapt our behavior to meet the needs of patients or residents from different cultures.
- To reduce or eliminate the disparities in healthcare: patients and healthcare providers can talk about health concerns without being hindered by cultural differences.

Title VI of the Civil Rights Act of 1964

No person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance

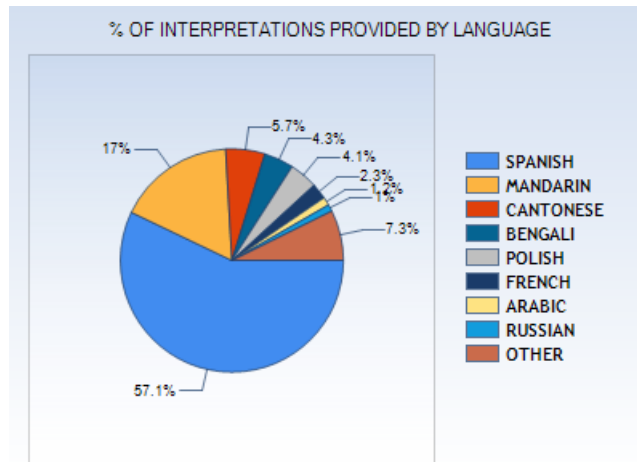
Executive Order 120 (NYC)

- All city agencies must use telephonic, written and oral services to provide interpretation for the city's limited English proficiency (LEP) residents
- All city agencies that have direct interaction with New Yorkers must translate essential public documents into the six most commonly spoken languages:
 - Spanish, Chinese, Russian, Korean, Italian, and Haitian Creole

LANGUAGE SERVICES

LEP PATIENTS

Bellevue Hospital Center recognizes the special needs and concerns of individuals who are members of linguistic and cultural minority groups and have Limited English Proficiency (LEP). At present, Bellevue's 10 top language requests are: Spanish, Mandarin, Cantonese, Bengali, Polish, French, Arabic, Russian, Korean, and Haitian Creole.



OUR OBLIGATION

Bellevue Hospital Center *must* comply with the following laws by providing free access to an Interpreter for LEP patients:

Title VI of the 1964 Civil Rights Act, and the regulations promulgated thereunder;
N.Y. Public Health Law §§2801-c and 2803, and the regulations promulgated thereunder;
10 N.Y.C.R.R. §405.7;
N.Y.C. Admin. Code §17-174;
Executive Order 120.

OUR RESPONSE

We provide free interpreter services to enable patients to communicate effectively with their healthcare providers.

YOUR RESPONSIBILITY:

1. **Use an interpreter** when you communicate medical information to LEP patients *every time* and whenever the patient requests the assistance of an interpreter.
2. **Note the interpreter's ID number** in the patient's chart *every time*.
3. Do not ask family members to interpret.

KEY TERMS

Medical Interpreter: A staff member fluent in English and other language(s) who has been assessed and deemed qualified to provide medical interpretation.

LEP Patient: A person whose *preferred* language is not English and who cannot speak, read, write or understand English well enough to communicate effectively with the health care provider. This can include deaf patients.

AVAILABLE RESOURCES

Phone interpreters

Interpreters are available over the phone 24/7 in over 195 languages. They can interpret for you and the patient in patient care areas, when calling patients at home, on their cell phone, or even in another country..

In-person interpreters

Some *rare* situations might warrant having an interpreter in person.

For example:

- Patients who are hard-of-hearing but are not deaf.
- Patients who are too weak to hold a phone.
- Patients who are too ill to speak loudly enough to be heard by phone.
- Patients who have other psychiatric conditions that make using a phone interpreter impossible..
- Family sessions.
- Sessions with teams of providers.

For situations such as these, staff interpreters are available Monday through Friday from 8 a.m. to 6 p.m. in Spanish, Mandarin, Cantonese, Fukienese, Polish, Bengali, French, and Haitian Creole.

WHAT TO DO

To access an interpreter for an LEP patient:

1. To determine whether the patient or person involved in making decisions regarding patient's care has limited English proficiency, ask a question that requires an answer other than "yes" or "no".
2. Use the printed Language List to identify the patient's preferred language..
3. Note "LEP" and the patient's preferred language in the patient's medical record.
4. Dial ext. 1500 from any hospital phone and follow the prompts to reach an interpreter.
5. Provide all medically necessary information, such as consent forms, written notices about patients' rights, health care proxy, etc, in the patient's preferred language. If the document is not available in the LEP patient's language, have the written document interpreted to the patient by the interpreter.
6. Document in the medical record *every time* you use an interpreter and include the interpreter's ID number.

IN EMERGENCIES

In an urgent or emergent situation where the patient's treatment might be compromised by waiting for an interpreter, you should render any necessary and appropriate medical treatment.

BILINGUAL STAFF

All bilingual staff members **must** have their proficiency assessed *before* they can use their languages to communicate medical information to patients.

Only staff interpreters and other trained staff can interpret for others.

Contact the Assistant Director of Language Services at ext. 4277 to use your languages with patients.

ALL STAFF CAN COMMUNICATE **NON-MEDICAL** INFORMATION IN OTHER LANGUAGES.

DEAF AND HARD-OF-HEARING PATIENTS

OUR OBLIGATION

Deaf patients are protected under the Americans with Disabilities Act (ADA). They can also be LEP patients.

Upon request by the patient, a family member, the patient's representative, or a Bellevue Hospital staff member, Bellevue staff must provide access to a sign language interpreter in the in-patient, out-patient or Emergency setting.

DO'S AND DON'T'S

To communication with a deaf patient:

- DO NOT write notes.
- Do not ask family members to interpret.
- If the patient does not want an interpreter, DO make note of it, at each instance, in the patient's chart.
- Note "Deaf" and the patient's preferred means of communication in the patient's medical record.
- DO use a sign language interpreter *every time* you treat the patient.
- Do NOTE in the medical record *each time* you use an interpreter and include the interpreter's ID number.

To access a sign language interpreter:

1. *During regular business hours (Monday – Friday, 9 AM – 5 PM):* Call ext. 1500 and follow the prompts to request an ASL interpreter (press the pound sign #). The on-site interpreter or the ASL rover (a webcam on wheels to connect to a sign language interpreter over the internet) will be sent to the patient's location as soon as possible. Language Services and the duty office maintain a list of rover-ready rooms. Reserve the ASL interpreter in advance whenever possible.
 - a. *For surgeries,* the Surgical Coordinating Center (SCC) will call ext. 1500 to request a sign language interpreter as soon as the surgery date has been assigned.
2. *At the end of regular business hours,* the daytime interpreter will stay to complete the interpretation up to an additional hour. If an interpreter is needed beyond 6:00 PM and if they cannot stay, they will set up the ASL rover, wherever possible, or ensure that the duty officer has requested an emergency after-hours interpreter to replace them.
3. *After hours, on weekends, and holidays:* Page the duty officer at ext. 4311. The Duty Officer will then do one of the following:
 - a. Coordinate the use of an ASL rover -or-
 - b. Request an on-call sign language interpreter to be dispatched to the location from a vendor.

WELCOMING LESBIAN, GAY, BISEXUAL AND TRANSGENDER (LGBT) INDIVIDUALS INTO HEALTHCARE

HHC's mission

“To extend equally to all New Yorkers...comprehensive health services of the highest quality in an atmosphere of human care, dignity and respect”

Goals

- Define LGBT identities and issues
- Examine the particular hurdles and challenges that LGBT people face in accessing health care
- Provide simple steps you can take to remove barriers to care
- Answer questions, provoke discussion

How many LGBT patients are in HHC facilities? Too many to ignore!

- HHC serves about **983,000** adolescent and adult New Yorkers each year
- And approximately **5-10%** of all New Yorkers are lesbian, gay, bisexual or transgender...
- Then, **49,000-98,000** LGBT patients are seen in HHC facilities yearly
- Assume that you see LGBT patients daily

Why we need to know our LGBT patients

- Increase knowledge about patient's health risks
- Accurately assess client's support system
- Support better health: LGBT people who fear discrimination and stigma delay or decline services
 - Those who 'come out' are more likely to access health care, adhere to treatment, and develop trust in the facility

Good news: You don't have to be an expert on LGBT culture to offer culturally competent care;

You just need:

- Basic information.
- A willingness to learn
- An openness to hear what your patient is trying to tell you

Defining Our Terms

- Sex
- Gender
- Sexual orientation
- Gender identity

Sex vs. Gender

- Sex – a biological classification
 - Refers to hormones, chromosomes, genital and reproductive anatomy
- Gender - socially constructed classification
 - Refers to concepts of femininity and masculinity
- For a particular individual these may not be the same
 - A person with male anatomy may dress, speak and behave in a feminine manner.

Sexual Orientation

- **Lesbian**- identity label for women with primary sexual, romantic, relational ties to other women.
- **Gay**- identity label for men who have primary sexual, romantic and relational ties to other men.
- **Bisexual**- an identity label for people who partner with either men or women.

According to the APA...

Sexual orientation is...

- Not a choice
- Not an illness or emotional problem
- Not changeable by therapy
- Determined by many factors, usually at a very early age
- Different from sexual behavior

Gender Identity

- Refers to a person's *internal self-awareness* of being male or female or something in between.
- For most people, their gender identity is the same as their sex
 - Example: A female who has a gender identity as a woman
- Genderqueer – Term for gender identity other than “man” or “woman”

Transgender

- People who identify as transgender have a gender identity--a persistent sense of self-- that does not match the sex assigned at birth.
- Some choose surgery or hormones to change their bodies so sex and gender identity are harmonized.
- Others choose not to make changes but define themselves as transgender and use pronouns that match gender identity.

Traditional Gender Model—strictly dichotomous

1. Sex:	Male	or	Female
2. Gender Role:	Masculine	or	Feminine
3. Gender Identity:	Man	or	Woman
4. Sexual Orientation:	Heterosexual, homosexual, bisexual		

But it is more realistic to think in terms of **continuum**:

1. Sex:	Male	<-	Intersex	->	Female
2. Gender Role:	Masculine	<-	Androgynous	->	Feminine
3. Gender Identity:	Same as biological sex	->	Gender- queer	->	Transgender
4. Sexual Orientation:	Same sex	<-	Bisexual	->	Other sex

Remember: It's not always obvious who is LGBT!

- Forms will not tell you what you need to know
- Ask sensitive questions about partners, gender, preferred pronouns, language used for body parts.
- It is normal to feel awkward as you learn how to ask

Barriers to care for LGBT people

- Providers' “I treat everyone the same” thinking
 - Providers lack information and knowledge about LGBT health needs and risks
- Lack of LGBT-specific research, policies and procedures

- Previous negative experiences in healthcare settings
- Multiple stigmas: race, ability, citizenship, etc.

LGBT-specific risks and concerns

- Alcohol abuse estimated in up to 45% of those in the LGBT community
- 50-200% more likely to be addicted to tobacco than the general public.
- Elevated risk for depression, anxiety, and suicide
- Increased cancer risks, coupled with decreased rates of screenings

Creating a welcoming environment and overcoming barriers

Practitioners should craft their language

1. Say, “... your partner, he or she...”
 - Mirror the language people use for themselves, their partners and their body parts
2. Instead of “Are you married?”
 - “Are you in a relationship?”
 - “Are you seeing anyone right now?”
 - “Do you have a significant other?”
3. Instead of “Who is his mother and father?”
 - “Who are the parents?”

Other practitioner tips

4. Instead of using the name/gender found on the forms, ask
 - “What name would you prefer I call you?”
 - “What pronouns do you prefer, if any?”
5. Show openness
 - Wear a pin, e.g., “I’m straight but not narrow” or rainbow sticker or pin
 - Assure confidential, safe coming out
6. Learn more about LGBT
 - Read more about the community
 - Learn about LGBT families and health risks
 - Form an LGBT study group

Ideas for facility-level changes

- Visible LGBT symbols and literature in waiting rooms and offices
- LGBT-defined “family” members included in treatment and recovery process
- List of LGBT referrals available
- Site or departmental LGBT task force or committee

Other suggested changes

- Post and enforce LGBT-inclusive non-discrimination policies. Joint Commission will require the inclusion soon.
- Offer continuing education on LGBT health
- Hire LGBT staff
- Conduct research on LGBT health

Be aware that discrimination is real and legally sanctioned

- In 29 states it still legal to fire a worker for being lesbian, gay or bisexual
- And in 38 states, a person can be fired just for being transgender

***And EVERY LGBT person in this country lives it**

New legislation and policies:

- **Non-discrimination**
 - All hospitals in America need to have a non-discrimination policy that includes LGBT persons, according to the Joint Commission.
- **Visitation**
 - Hospitals cannot deny visitation on the basis of sexual orientation, according to an Obama memorandum.
- **Inpatient room assignment**
 - Transgender patients can be in single rooms, if requested, according to HHC managers.

Case Examples:

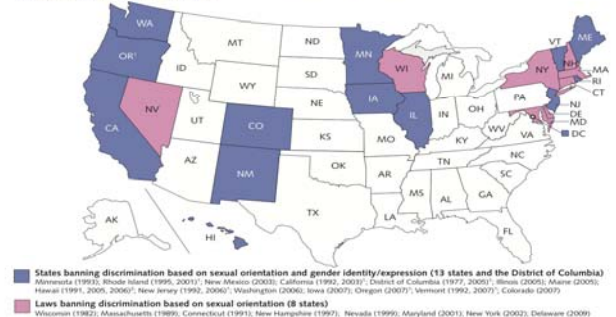
- A 21-year old man is recovering from appendicitis. A staff person walks by and sees him and his boyfriend exchange a kiss. The staff person walks into the room and says, “You can’t do that here. A hospital is not the place for making out!”
What would you do? What would you say to the staff person? What would you say to the patient?
- Ellen was assigned male at birth, but transitioned to female many years ago. She is now 58. Ellen hadn’t kept up with all the appropriate male health screenings and was just diagnosed with prostate cancer. She is told that, being female, her insurance refuses to pay for surgery.
What would you do? What would you say to Ellen?

In Summary:

- There are many LGBT patients in HHC facilities
- It is not always obvious who is LGBT
- It is important to know who your LGBT patients are
- It is OK to ask and it is OK to be awkward at first.

State Nondiscrimination Laws in the U.S.

This map was last updated on July 1, 2009



*California, DC, New Jersey, Rhode Island and Vermont first passed sexual orientation nondiscrimination laws, then later passed gender identity/expression laws.
†In 1991, Hawaii enacted a law prohibiting sexual orientation discrimination in employment. In 2005, it enacted a law prohibiting sexual orientation and gender identity/expression discrimination in housing. In 2006, public accommodations protections were added for sexual orientation and gender identity/expression.

National Gay and Lesbian
Task Force
www.theTaskForce.org

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Healthcare

Standard 4:

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

Standard 5:

Healthcare organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6:

- Healthcare organizations must assure the competence of interpreters and bilingual staff providing language assistance to patients with Limited English Proficiency.
- Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Standard 7:

- Healthcare organizations must make available easily understood patient-related materials and post signage in the languages of groups represented in the service area.

Obligations for serving patients with LEP

- The appropriate timeframe for getting an interpreter is 10 minutes in an emergency; 20 minutes under regular circumstances.
- Interpretation is free of charge to patients.
- We must inform the patients of the availability of free interpretation services.
- Materials must be provided to the patient in the preferred language whenever possible, AND
- We must use trained and certified interpreters only.

Section Twelve

**EEO
Sexual Harassment**

AFFIRMATIVE ACTION AND EQUAL EMPLOYMENT OPPORTUNITY

Title VII of the Civil Rights Act of 1964, as amended by the Equal Employment Opportunity Act of 1972, and other City, State and Federal laws and Executive Orders, prohibit discrimination in employment on the basis of race, religion, national origin, color, age, handicap, sexual preference, marital status or veteran's status.

Bellevue Hospital Center is also committed to maintaining a work environment free from sexual harassment in accordance with established Title VII guidelines.

Consistent with Corporate policy, Bellevue Hospital Center reaffirms its commitment to EEO. The Hospital's policy regarding EEO applies to all phases of the personnel process, including recruitment, hiring, placement, promotion, reassignment, training, disciplines and all other terms, conditions and benefits.

Bellevue has an informal complain procedure for addressing allegations of discrimination. If you require information or wish to file an informal EEO complaint you may contact the EEO Officer in Human Resources.

All complaints will be investigated confidentially and every effort will be made to resolve the situation informally.

All employees are expected to demonstrate sensitivity to and respect for patients and colleagues.

If you have any questions regarding Bellevue's EEO Policy, contact Lois Penn at ext 7527.

PREVENTING SEXUAL HARASSMENT

Learning Objectives:

1. Define sexual harassment
2. Verbalize three forms in which sexual harassment may take place.
3. List three ways to take action in case of sexual harassment.

What is sexual harassment?

It's any unwelcome words or actions of a sexual nature.

Why learn about Sexual Harassment?

Because it's unprofessional and illegal!!!

Federal Law Says

- That sexual harassment is a form of sex discrimination, according to Title VII of the Civil Rights Act of 1964
- Illegal, according to the 1980 guidelines of the Equal Employment Opportunities Commission (EEOC).
- In general that any unwelcome sexual conduct or attention is sexual harassment if:
 - ✓ Your job depends on your response
 - ✓ Raises or promotions depend on your response
 - ✓ The conduct makes it more difficult for you to do your job

Sexual Harassment Can Take Many Forms

1. Verbal:

- Requests or demands for sexual favors
- Telling vulgar or sexist jokes
- Sexually patronizing comments (e.g. “babe” or “honey”)
- Repeated, unsolicited, derogatory sexual comments
- Pressure for dates
- Commenting on body parts; making obscene or suggestive sounds or gestures.



2. Visual:

Displaying sexually offensive:

- Posters, pictures, cartoons
- Magazines
- Drawings, graffiti
- E-mail messages



3. Physical:

- Rape or attempted rape
- Cornering or trapping
- Unwelcome touching (e.g., hugging, kissing, grabbing, patting, rubbing, massage, brushing up against an individual)

4. Written:

- Notes
- Invitation
- Greeting cards
- Love letters



Key Elements of Sexual Harassment

- Unwelcome (not the same as “voluntary”)
- Verbal, written, physical, or visual
- Of a sexual nature
- Severe or pervasive
- Occurs in the course of employment

Preventing Sexual Harassment

- Sexual harassment depends on how the person being harassed is affected and **NOT** on the intent of the harasser. “**Giving in**” does not necessarily mean that the conduct was welcome.
- Sexual harassment is about **POWER**, not sex.

Rights and Responsibilities of Supervisors

- To maintain a work environment free from sexual harassment
- Clearly state that sexual harassment will not be tolerated in any form
- Once you know of a sexual harassment episode take immediate corrective action
- Immediately report the incident to the EEO officer
- Make sure the harassment stops
- Take prompt and effective remedial action (e.g., take the offensive sign down, speak with the alleged harasser)
- Ensure that your work environment is both professional and businesslike.
- Management should create a safe workplace and all staff is trained on preventing sexual harassment policy.



Taking Action

- Speak directly to the harasser and tell him/her to stop
- Discuss with friend, family member or co-worker if you feel the need to do so
- If the behavior does not stop, contact your EEO Officer.
- Keep a written record/diary at home of what happened
- See if there are any witnesses
- If the problem is not resolved to your satisfaction, you may contact the City or State Human Rights Commission, EEOC, or an attorney



SECTION THIRTEEN

**Rapid Response Team
Weight Sensitivity
Fall Prevention
Medication Administration
Blood Bank
Restraints
Clinical Wellness Program
Prevention of Workplace Injuries
Suicide
Unauthorized Capturing of Patient Images
Patient Centered Medical Home
Hospital Consumer Assessment of Healthcare
Providers and Systems (HCAHPS)**

RAPID RESPONSE TEAMS

A Rapid Response Team is a team of clinicians who bring critical care expertise to the patient bedside (or wherever it is needed). The Rapid Response Team is not intended to take the place of immediate consultation with the physician if needed. The intention is to help patients in the time window of clinical instability and not to replace physician involvement in that process.

Early warning signs often precede cardiac and respiratory arrests. If these signs are recognized and acted upon quickly enough, codes can be prevented and lives can be saved.

In every model, there are three key features of the team members:

- The team members must be available to respond immediately when called, and not be constrained by competing responsibilities. At Bellevue, the team is active around the clock throughout inpatient and outpatient units.
- They must be onsite and accessible. Each member of the Bellevue RRT team carries a text pager, which indicates the room number of the patient in distress. The operator also makes an overhead announcement when the RRT is needed.
- They must have the critical care skills necessary to assess and respond.

Staff must feel comfortable calling the Rapid Response Team. Bellevue's team is composed of an ICU RN, Respiratory Therapist, Medical Consult and Patient Transporter. Any staff member can initiate a call and calls made to the Rapid Response Team must be responded to with the same sense of urgency as a cardiac arrest. Immediate notification of the team is a vital process that must be reliable. The team is activated by dialing 66 (stat operator) and requesting that the RRT team be directed to a specific room.

What are the responsibilities of the Rapid Response Team?

- Go to the bedside as quickly as possible
- Thank the RN or MD for calling, regardless of the patient's condition. It's always okay to call the RRT.
- Work with the primary care team to assess and stabilize the patient
- Stay with the patient as long as needed.
- Help with transfer to the ICU if necessary.

Call the patient's primary care team, attending and intern (if the intern is not already at the bedside) and tell them what has happened.

WEIGHT SENSITIVITY

Obesity Bias and Stigmatization

The social consequences of being overweight and obese are serious and pervasive. Overweight and obese individuals are often targets of bias and stigma, and they are vulnerable to negative attitudes in multiple domains of living including places of employment, educational institutions, medical facilities, the mass media, and interpersonal relationships.

What is weight stigma?

Stigma and bias generally refer to negative attitudes that affect our interpersonal interactions and activities in a detrimental way. Stigma may come in several forms, including verbal types of bias (such as ridicule, teasing, insults, stereotypes, derogatory names, or pejorative language), physical stigma (such as touching, grabbing, or other aggressive behaviors), or other barriers and obstacles due to weight (such as medical equipment that is too small for obese patients, chairs or seats in public venues which do not accommodate obese persons, or stores which do not carry clothing in large sizes). In an extreme form, stigma can result in both subtle and overt forms of discrimination, such as employment discrimination where an obese employee is denied a position or promotion due to his or her appearance, despite being appropriately qualified.

Where does weight stigma occur?

Weight stigma occurs in multiple settings by a range of individuals. For example, in employment settings, overweight people may face bias from several sources. Experimental studies have found that when a resume is accompanied by a picture or video of an overweight person (compared to an "average" weight person), the overweight applicant is rated more negatively and is less likely to be hired. Other research shows that overweight employees are ascribed multiple negative stereotypes including being lazy, sloppy, less competent, lacking in self-discipline, disagreeable, less conscientious, and poor role models. In addition, overweight employees may suffer wage penalties, as they tend to be paid less for the same jobs, are more likely to have lower paying jobs, and are less likely to get promoted than thin people with the same qualifications.

In school settings, students who are overweight or obese can face harassment and ridicule from peers, as well as negative attitudes from teachers and other educators. At the college level, some research shows that qualified overweight students, particularly females, are less likely to be accepted to college than their normal weight peers.

In medical facilities, biased attitudes toward obese patients have been documented among physicians, nurses, psychologists, dietitians, and medical students, and include perceptions that obese patients are unintelligent, unsuccessful, weak-willed, unpleasant, overindulgent, and lazy. One alarming consequence of negative attitudes by health care professionals is that obese patients may avoid obtaining medical care because of these negative experiences. Research has demonstrated that heavier patients are more likely to cancel and delay appointments and preventive health care services, particularly among women who are overweight or obese.

What are the consequences of weight stigma?

For obese adults, research has documented that individuals who experience weight stigmatization have higher rates of depression, anxiety, social isolation, and poorer psychological adjustment. Some obese adults may react to weight stigma by internalizing and accepting negative attitudes against them, which may in turn increase their vulnerability to low self-esteem. Because societal messages often perpetuate beliefs that weight is under personal control, obese persons may be less likely to challenge stereotypes because they can attempt to escape stigma by losing weight. Stigma may also have negative consequences for eating behaviors by interfering with weight loss attempts and leading some adults to eat more food in response to stigmatizing encounters. Stigma also has implications for physical health in the context of avoidance of health care services due to bias in medical settings. It is not known whether, or to what degree, stigma exacerbates poor self-care behaviors or contributes to additional complications and comorbidities of obesity.

How are children affected by weight stigma?

Children who are overweight and obese are also targets of stigma and may be especially vulnerable to the consequences of bias. Negative attitudes towards obese youth develop in children as young as three years old, and children attribute multiple negative characteristics to overweight peers including being mean, stupid, ugly, unhappy, lazy, and having few friends. Peers are common perpetrators of weight-related teasing and derogatory names, and school is a frequent venue where stigma occurs.

Bias and stigma have negative implications for emotional well-being in children. Research shows that children who are targets of weight stigma internalize negative attitudes and engage in self-blame for the negative social experiences that they confront. Research on adolescents has documented that weight-based teasing is associated with low self-esteem and depression, and that overweight teens are more likely to be socially isolated. Most alarming are recent studies demonstrating a positive association between obesity and suicidal attempts among youth.

How can weight stigma be reduced?

Professionals in the obesity field, both researchers and clinicians, can employ a variety of strategies to help reduce weight stigma and improve attitudes. Health professionals can make a difference by becoming aware of their own biases, developing empathy, and working to address the needs and concerns of obese patients.

Some specific strategies for health professionals are outlined below:

1. Consider that patients may have had negative experiences with other health professionals regarding their weight, and approach patients with sensitivity
2. Recognize the complex etiology of obesity and communicate this to colleagues and patients to avoid stereotypes that obesity is attributable to personal willpower
3. Explore all causes of presenting problems, not just weight
4. Recognize that many patients have tried to lose weight repeatedly
5. Emphasize behavior changes rather than just the number on the scale
6. Offer concrete advice, e.g., start an exercise program, eat at home, etc., rather than simply saying, "You need to lose weight."
7. Acknowledge the difficulty of lifestyle changes
8. Recognize that small weight losses can result in significant health gains

9. Create a supportive health care environment with large, armless chairs in waiting rooms, appropriately-sized medical equipment and patient gowns, and friendly patient reading material.

It is also useful to identify one's own bias. Asking the following questions can be helpful in this regard:

1. Do I make assumptions based only on weight regarding a person's character, intelligence, professional success, health status, or lifestyle behaviors?
2. Am I comfortable working with people of all shapes and sizes?
3. Do I give appropriate feedback to encourage healthful behavior change?
4. Am I sensitive to the needs and concerns of obese individuals?
5. Do I treat the individual or only the condition?

For additional resources on weight stigma, including academic articles, PowerPoint presentations, and measures to assess weight bias, please visit www.yaleruddcenter.org/what_we_do.aspx?id=10

FALL PREVENTION

Patient falls are among the most common occurrences reported in hospitals. The morbidity, mortality and financial burdens attributed to patient falls in hospitals are among the most serious risk management issues. Of those who fall, as many as half may suffer moderate to severe injuries that reduce mobility and independence, and increase the risk of premature death. For the patient, consequences include, but are not limited to, fracture, soft tissue or head injury, fear of falling, anxiety, and depression.

The Joint Commission began adding National Patient Safety Goals (NPSG) and Requirements for hospitals and other settings that touched on preventing falls. In 2005, the NPSG stated: "Reduce the risk of patient harm resulting from falls and the specific requirement: Assess and periodically reassess each patient's risk for falling, including the potential risk associated with the patient's medication regimen, and take action to address any identified risks." National Patient Safety Goals included reducing falls and prevention of harm from falls. At Bellevue, a falling star alerts staff that the patient is at risk for falling.

BLOOD BANK AND TRANSFUSION MEDICINE

Requirements for blood bank samples:

- Label must be placed immediately after drawing blood while still at the patient's bedside. Label must include at least two identifiers.
 - **These could be the name of patient; MR#; assigned name, if the patient's name is unknown; complete date of birth.**
- Patient ID wrist band (bracelet) must correspond to the label on the blood sample.
- Patient related data on the blood requisition slip must correspond to that of patient ID band and the sample label.
- Drawn blood must be collected in pink top tube and the label, after proper completion.
- Sample must be signed or initialed by the practitioner who drew the blood.
- Blood sample must be transported directly to the Blood Bank either by pneumatic tube or personally and handed to the Blood Bank technologist.

Requirements for Blood Unit Pick-Up:

- Anyone who is trained may pick-up blood from the Blood Bank.
- A transporter can not pick-up blood for multiple patients.
- Blood will only be issued to a given transporter for one patient at a time.
- For the OR multiple units can be picked-up for the same patient as long as they are transfused within 30 minutes of pick-up time
- Pick-up slip must be presented to the Blood Bank.
 - The contents of this slip should include the same patient data as that on the T&S sample.
- No blood may be released if above conditions are not satisfied
- All blood picked-up must be directly transported to the site intended for transfusion
- Any blood unit that is kept outside Blood Bank or Blood Bank monitored refrigerator for longer than 30 minutes cannot be returned to Blood Bank for use in another case
- Transfusion must be completed within 4 hours of issuance from Blood Bank
- Blood transfusion should start within 30 minutes of issuance

What to do if you suspect a transfusion reaction?

- Stop the transfusion!
 - Do not restart the transfusion
 - Only with urticaria may the unit be restarted after the symptoms have resolved
- Report ALL suspected reactions!
- Monitor and assess the patient
- Notify the Blood Bank
- Check to verify that the name and MRN on the blood unit matches the patient's wrist band
- Return the blood unit to the Blood Bank
- Draw a post-transfusion specimen and send to Blood Bank for work-up
- Provide supportive care to the patient if necessary

RESTRAINTS

Restraint is any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs and body freely.

Types of restraint:

A. Non-Violent or Non-Self Destructive Behavior:

- Used in situation when the patient's behavior is not violent, not aggressive but
- Presents a serious danger to the patient's physical safety or jeopardizes medical healing and
- When all possible less restrictive measures were ineffective.

B. Violent or Self-Destructive Patient:

- Used in situations when the patient's behavior is violent, aggressive
- Presents an imminent and serious danger to the safety of the patient, staff and others and
- When all possible less restrictive measures were ineffective.

Least restrictive measures may include the following:

- Allow for personal space
- Diversion or ask the patient to stay calm, develop eye contact to help redirect patient, direct patient away from focus of anger or giving patient simple task to perform or exercise
- Companionship / family sitter
- Ensuring tubes, lines and drains are not in the way during ambulation / explain the importance of not pulling out medical devices
- Environmental modification: subdued lighting / quiet room / soothing sounds

The number of restraint episodes is tracked and trended. Restraint data are reported at Quality and Patient Safety Council.

CLINICIAN WELLNESS PROGRAM

A GUIDE TO CONSTRUCTIVE ACTIONS WHEN YOU BELIEVE A MEDICAL STAFF MEMBER IS IMPAIRED

MEDICAL STAFF IMPAIRMENT

Bellevue Hospital Center believes that, in most instances, the conditions related to medical staff member impairment are treatable illnesses. The focus of the Clinician Wellness Program is to help the impaired medical staff member recognize any impairing condition that might exist, receive rehabilitative services, and return to, or remain in active work status with appropriate monitoring in place.

WHAT IS PHYSICIAN IMPAIRMENT?

The Federation of State Licensing Boards defines an “impaired physician” as one who is unable to practice medicine with reasonable skill and safety by reason of:

- Mental illness; or
- Physical illness or condition, including but not limited to those illnesses or conditions that would adversely affect cognitive, motor or perceptual skills; or
- Habitual or excessive use of substances which impair your ability to Function.

In general, medical staff members become impaired because of three major problems:

- Substance Abuse: Alcohol abuse is the most common problem. Abuse of narcotics, sedatives, and other depressants as well as stimulants, including cocaine, or any other substance which may impair your ability, may also occur. According to current estimates, 8 to 10 percent of medical staff members abuse alcohol and 2 percent abuse narcotics.
- Psychological Problems: Excessive stress, depression, anxiety and divorce are the most common issues.
- Physical Illness: Physical ailments, either temporary or long-term, can lead to incapacity.

Of these three groups of illnesses, substance abuse is the problem for which medical staff members are least likely to seek help.

WHAT ARE THE WARNING SIGNS?

- Irritability, depression, mood swings
- Difficult to contact; won't answer phone or return calls
- Rounds at irregular times
- Argumentative, bizarre behavior
- Complaints by patient and nurses

- Neglect of patients, incomplete charting, or neglect of other medical staff duties
- Inappropriate treatment or dangerous orders
- Excessive prescription writing
- Unusually high doses or wastage noted in drug logs
- Loss of interest in professional activities, social or community affairs
- Irresponsibility, poor memory, poor concentration
- Unexplained accidents or injuries to self
- Neglect of family, isolation from friends
- DWI arrest or DWI violations
- Intoxication at social events or odor of alcohol on breath while on duty
- Noticeable dependency on alcohol or drugs to relieve stress
- Financial and/or legal problems
- Bloodshot
- Unkempt appearance, poor hygiene
- Trembling, slurred speech

If you believe a medical staff member has an impairment problem, encourage him or her to seek help through the Clinician Wellness Program.

The purpose of the Clinician Wellness Program is to ensure the well-being of the medical staff and to strive to improve the quality of care for patients by helping to resolve matters relating to a medical staff member's health, well-being or impairment before they evolve into significant patient care problems.

To this end, the Clinician Wellness Program serves as a free and *confidential source* of information and assistance by providing individual medical staff members advice, counseling or referrals, as appropriate. The Clinician Wellness Program has a site on the Bellvue Hospital Intranet. The site provides contact information for clinicians who are available for confidential evaluation and information about additional resources that a clinician can access for assistance.

Internal Reporting:

The Clinician Wellness Program encourages all facility personnel to refer such issues to their superiors, who then in turn will report to the Chief of Service, or the President of the Medical Staff, or any medical staff member of the MEC when a situation suggests that a medical staff member's ability to perform his or her duties may be impaired. Allegations will be appropriately investigated and needed action will be taken if indicated according to the By-laws of the Medical Board. Confidentiality of the individual reporting will be maintained.

External Reporting:

Additionally, any medical staff member may self refer to the Clinician Wellness Program or any of the resources listed on the hospital intranet.

WHY GET HELP?

If you suspect that a medical staff member has an impairment problem, it is essential to realize that the problem will not go away on its own. Nor are you, no matter how well-meaning and concerned, able to offer all the assistance needed.

Sometimes a friend's well-intended attempts to help may actually have the effect of enabling the medical staff member to persist with the very behaviors that are causing the problem.

Generally, impaired medical staff members do not seek help on their own. In fact, like other impaired persons, they usually deny that there is a problem.

Early intervention is critical. When left alone, problems caused by impairment tend to worsen – they can lead to divorce, financial disaster, and loss of employment or suicide. Severely impaired medical staff members may be endangering the safety of patients, and others as well as themselves.

Fortunately, impairment can be helped if approached properly. Whether the problem stems from substance abuse or emotional or physical factors, there has been a great deal of experience in working with impaired medical staff members. Experts are readily available to assist the impaired medical staff member in recovery.

It is important to remember that help is available. Because denial is so common in situations of impairment, it is important that you, the concerned colleague, take some action to assist the medical staff member who needs help. Remember that a failure to act on your part may have the effect of enabling that problem to continue.

OUTSIDE RESOURCES

The following programs and services are voluntary and confidential:

- Committee for Physician's Health.....800-338-1833
(A program of the Medical Society of the State of New York founded to help physicians affected by substance abuse/addiction, mental health problems and cognitive disorders.)
- American Dental Association Well-Being Assistance program.....312-440-2622
- Council on Chemical Dependency Hotline (for Dentists).....800-225-2100

NEW YORK CITY PROGRAMS:

- Al-Anon.....212-254-7230
- Alcohol Council of Greater NY212-979-1010
- Alcoholics Anonymous.....212-647-1680
- Cocaine Anonymous.....212-496-4266
- Cocaine Hotline.....1-800-COCAINE
- Narcotics Anonymous.....212-929-6262
- New York State Drug Information.....800-522-5353
- Samaritans 24 Hour Suicide Prevention Hotline.....212-673-3000

PREVENTION OF WORKPLACE INJURIES

Ergonomics & Back Injuries

What is Ergonomics ?

Ergonomics (er'go nom'iks) – n. is the study of the relationship between individuals and their work or working environment, especially with regard to fitting jobs to physiology and abilities of workers.

Poor Ergonomics can lead to Injuries

Job Risk Factors

- Lifting Heavy Weights
- Lifting Awkward Weights
- Awkward movements/Posture:
 - Torso Flexion
 - Twisting
 - Arms extended

Types of Injuries:

- Muscle pain.
- Joint pain.
- Repetitive motion injury.
- Cumulative trauma disorder.
- Musculoskeletal disorder.
- Numbness.
- Swelling.
- Restricted motion.

Cumulative Trauma Disorders

A class of musculoskeletal disorders arising from repeated biomechanical stress due to ergonomic hazards. Common names for these disorders

- Carpal Tunnel Syndrome
- Tendonitis
- Tennis Elbow
- Bursitis

Computer Ergonomics

Ergonomic Risks associated with computers include:

- Cumulative Trauma Disorders
- Repetitive motion/stress injury
- Restricted motion
- Eyestrain
- Headaches
- Fatigue

Ergonomic Controls

Methods used to lessen the impact of the work environment on the worker are called Ergonomic Controls.

3 Types of Ergonomic Controls:

- Engineering
- Administrative
- Work Practices

Engineering Controls

- Work Station Design
- Room Lighting
- Ergonomic Chairs
- Wrists and arm supports
- Ergonomic Keyboards
- Glare resistant monitors.

Administrative Controls

- Physical conditioning/exercise
- Rest-pause – take breaks from repetitive tasks.
- Task rotation- switch task as possible (i.e from typing to filing)
- Medical management- see doctor immediately after symptoms of ergonomic illness appears.

Work Practices

Training on:

- Proper lifting techniques
- Proper posture
- Use of ergonomic tools
- Proper procedures for safely doing job.

Preventing Back Injuries

Back Facts:

- 1 in 5 workplace injuries are back injuries.
- 80% occur to the lower back.
- 8 out of 10 are related to manual materials handling tasks.
 - Lifting objects
 - Turning objects
 - Pushing objects

Injury Risk Factors

- The 5 leading causes of Back Injuries are:
- Poor Posture
- Poor physical condition
- Improper body mechanics
- Incorrect lifting
- Jobs that require high energy.

Lifting

✓ DO...

- ✓ Plant your feet firmly - get a stable base.
- ✓ Bend at your knees - not your waist.
- ✓ Tighten your abdominal muscles to support your spine.
- ✓ Get a good grip - use both hands.
- ✓ Keep the load close to your body.
- ✓ Use your leg muscles as you lift.
- ✓ Keep your back upright, keep it in its natural posture.
- ✓ Lift steadily and smoothly without jerking.
- ✓ Breathe - If you must hold your breath to lift it, it is too heavy.

Do Not....

- ✗ Lift from the floor.
- ✗ Twist and lift.
- ✗ Lift with one hand (unbalanced)
- ✗ Lift loads across obstacles.
- ✗ Lift while reaching or stretching.
- ✗ Lift from an uncomfortable posture.
- ✗ Don't fight to recover a dropped object.
- ✗ Don't hold your breath while lifting - GET HELP.

SUICIDE PREVENTION

Suicide Facts and Statistics

- ONLY HUMANS COMMIT SUICIDE
- Each year, over 30,000 Americans die by suicide and over 70,000 make a suicide attempt.
- Suicide is not about wanting to die, but about a powerful need for pain to end. People choose suicide because they feel unable to cope with feelings of pain, hopelessness, helplessness, isolation and uncertainties.
- According to the APA, four out of five people who attempt suicide have given clear warnings. The strongest warning sign is verbal.
- Common remarks are: “I can’t go on,” “Nothing matters anymore” or even “I’m thinking of ending it all.” Take these comments seriously.
- Research has shown that more than 90 percent of people who die by suicide have a mental illness and/or substance abuse disorder.
- Suicide deaths consistently outnumber homicide deaths by a margin of three to two.
- In 2003, twice as many Americans died from suicide than from HIV/AIDS.

USA Suicide: 2003 Official Statistics

- In 2003 (the latest year for which we have national statistics), there were 31,484 suicides in the U.S. This translates to an annual suicide rate of 10.8 per 100,000.
- Suicide is the eleventh leading cause of death.
- Suicide ranks third as a cause of death among young (15-24) Americans; only accidents and homicides occur more frequently.
- Relative to those younger, rates of completed suicide are highest among the elderly (age 80 and over).
- Firearms remain the most common utilized method of completing suicide.
- The most common method of suicide for all females was poisoning. In fact, poisoning has surpassed firearms for female suicides since 2001.

Some Research Findings

- Although there are no official national statistics on attempted suicide (e.g. non-fatal actions) it is generally estimated that there are 25 attempts for each death by suicide.
- Those with the following diagnoses are at particular risk: bipolar disorder, depression, schizophrenia, drug and/or chemical dependency, personality and conduct disorders (the latter in adolescence).
- There is a positive relationship between alcoholism and suicide.
- The vast majority of individuals who are suicidal often display cues and warning signs.

Risk Factors

The first step in preventing suicide is to identify and understand the risk factors. A risk factor is anything that increases the likelihood that persons will harm themselves. However, risk factors are not necessarily causes. Research has identified the following risk factors for suicide (DHHS 1999):

- Previous suicide attempt(s)
- History of mental disorders, particularly depression
- History of alcohol and substance abuse
- Family history of suicide
- Family history of child maltreatment
- Feelings of hopelessness
- Impulsive or aggressive tendencies
- Barriers to accessing mental health treatment
- Loss (relational, social, work, or financial)
- Physical illness
- Easy access to lethal methods
- Unwillingness to seek help because of the stigma attached to mental health and substance abuse disorders or suicidal thoughts
- Cultural and religious beliefs—for instance, the belief that suicide is a noble resolution of a personal dilemma
- Local epidemics of suicide
- Isolation, a feeling of being cut off from other people

Protective Factors

Protective factors buffer people from the risks associated with suicide. A number of protective factors have been identified (DHHS 1999):

- Effective clinical care for mental, physical, and substance abuse disorders
- Easy access to a variety of clinical interventions and support for help seeking
- Family and community support
- Support from ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution, and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation instincts

Fiction and Fact

Fiction

- People who talk about suicide do not commit suicide.
- Suicidal people are absolutely intent on dying.
- Suicide happens without warning.
- Improvement after a crisis means that the suicide risk is over.
- Once a person is suicidal he/she is always suicidal.

Fact

- Most people who kill themselves have given warnings of their intentions.
- Many are ambivalent.
- Suicidal people often give ample indication.
- Suicides can occur in a period of improvement when the person has the energy and the will to turn despairing thoughts into destructive action.
- Suicidal thoughts may return but they are not necessarily permanent and in some people they may never return.

Understanding and Helping the Suicidal Individual

Be Aware of the Facts

- Suicide is preventable. Most suicidal individuals want to live; they are just unable to see alternatives to their problems.
- Most suicidal individuals give warnings of their suicidal intentions, but others are either unaware of the significance of these warnings or do not know how to respond to them.
- Talking about suicide does not cause someone to be suicidal.

Warning Signs of Suicide

The mnemonic ***IS PATH WARM?*** can be used to remember the warning signs of suicide:

- Ideation :Expressed or communicated ideation
 - Threatening to hurt or kill him/herself, or talking of wanting to hurt or kill him/herself; and/or
 - Looking for ways to kill him/herself by seeking access to firearms, available pills, or other means; and/or
 - Talking or writing about death, dying or suicide, when these actions are out of the ordinary.
- Substance Abuse :Increased substance (alcohol or drug) use
- Purposelessness: No reason for living; no sense of purpose in life
- Anxiety: Anxiety, agitation, unable to sleep or sleeping all the time
- Trapped: Feeling trapped (like there's no way out)
- Hopelessness: Hopelessness
- Withdrawal: Withdrawal from friends, family and society
- Anger: Rage, uncontrolled anger, seeking revenge
- Recklessness: Acting reckless or engaging in risk activities, seemingly without thinking
- Mood Change: Dramatic mood changes

Ways to be Helpful to Someone Who is Threatening Suicide

- Be aware. Learn the warning signs.
- Get involved. Become available. Show interest and support.
- Ask if he/she is thinking about suicide.
- Be direct. Talk openly and freely about suicide.
- Be willing to listen. Allow for expression of feelings. Accept the feelings.

- Be non-judgmental. Don't debate whether suicide is right or wrong, or if feelings are good or bad. Don't lecture on the value of life.
- Don't dare him/her to do it.
- Don't give advice by making decisions for someone else to tell them to behave differently.
- Don't ask 'why'. This encourages defensiveness.
- Offer empathy, not sympathy.
- Don't act shocked. This creates distance.
- Don't be sworn to secrecy. Seek support.
- Offer hope that alternatives are available, do not offer glib reassurance; it only proves you don't understand.
- Take action! Remove means! Get help from individuals or agencies specializing in crisis intervention and suicide prevention.

People at risk for suicide can be encouraged to contact their primary care doctor for an initial assessment and appropriate referral or to call their local emergency room. Family members and others can also call on their behalf.

Organizations such as the National Association for Mental Illness (www.nami.org) can also be a useful source of referrals.

Be Aware of Feelings, Thoughts, and Behaviors

- Can't stop the pain
- Can't think clearly
- Can't make decisions
- Can't see any way out
- Can't sleep, eat or work

- Can't get out of the depression
- Can't make the sadness go away
- Can't see the possibility of change
- Can't see themselves as worthwhile
- Can't get someone's attention
- Can't see to get control

Get Help & Call National **Suicide** Prevention **Hotline**
1-800-273 TALK www.suicidepreventionlifeline.org/

[The Samaritans of New York](http://www.samaritans.org)
24 hours / 7 days Suicide Prevention
Hotline (212) 673-3000

Being able to talk to someone anonymously is often a powerful helpline. Give this number to all who present with any risk factor for suicide.

UNAUTHORIZED CAPTURING OF PATIENT IMAGES

HHC Policy

- Under HHC Policy, it is strictly prohibited to capture images or *partial* images of our patients/residents with staff members' personal devices.

→ Failure to follow this policy and applicable laws protecting patient confidentiality may result in disciplinary action, including but not limited to termination or dismissal and licensure sanctions.

What's Included?

- HHC prohibits staff from capturing patient images using the following personal devices:
 - Smart phones
 - Photo-capable cell phones
 - Video recorders
 - Point-and-shoot cameras
- Further, sharing photos of patients/residents via e-mail, text message, Facebook, or other social platforms is a deep violation of privacy and is strictly prohibited

When is photographing patients allowed?

- Only in the most limited circumstances, and even then, subject to applicable laws and HIPAA regulations.
- Recording of patient images should only be undertaken with HHC-furnished image recording devices.

Protect patient privacy!

- Remember that even capturing partial images of patients on personal devices is prohibited.
- Unauthorized recording of patient images on such devices subjects those devices – and all the personal information stored on them – to inspection and disclosure in the event of governmental investigations or litigation.

PATIENT-CENTERED MEDICAL HOME

The patient-centered medical home (PCMH) is a model of primary care that places patients at the center of the health care system. It combines traditional concepts of primary care (a personal physician providing first-contact, continuous and comprehensive care) with newer responsibilities to systematically improve the health of the medical home's patient population (e.g. through the use of chronic disease registries, information technology and new opportunities for communication between patients and the practice). It is based upon seven joint principles:

- ☐ **Personal physician** - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care
- ☐ **Physician directed medical practice** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients
- ☐ **Whole person orientation** – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care
- ☐ **Care is coordinated and/or integrated** across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner
- ☐ **Quality and safety** are hallmarks of the medical home. It emphasizes evidence-based medicine, clinical decision-support tools and performance measurement and improvement
- ☐ **Enhanced access** to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff
- ☐ **Payment** appropriately recognizes the added value provided to patients who have a patient-centered medical home.

In February, 2011, The Adult Primary Care Center (APCC) at Bellevue Hospital received recognition as a Level III (highest level) PCMH by the National Committee for Quality Assurance (NCQA). In our ongoing efforts to transform primary care, the APCC is focusing on: conversion from a visit-based model to a panel-based model of care; transitioning from physician-led care to team-led care (TLC); establishing care management; and, enhancing our information technology to improve the health of our patients. Our goals are to provide 'open access' scheduling, prevent disease, reduce ED visits and avoidable hospitalizations and ensure care team accountability.

HOSPITAL CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (HCAHPS)

The HCAHPS survey is a national, standardized, publicly reported survey of patients' perspectives of hospital care. The survey has three broad goals:

- Produce data about patients' perspectives of care that allow objective and meaningful comparisons of hospital on topics that are important to consumers.
- Public reporting of the survey results creates new incentives for hospitals to improve quality of care.
- Public reporting serves to enhance accountability in health care by increasing transparency of the quality of hospital care provided in return for the public investment.

The HCAHPS survey asks discharged patients 27 questions about their recent hospital stay. The survey contains 18 core questions about critical aspects of patients' hospital experiences (communication with nurses and doctors, the responsiveness of hospital staff, the cleanliness and quietness of the hospital environment, pain management, communication about medicines, discharge information, overall rating of the hospital and would they recommend the hospital).

The survey is administered to a random sample of adult patients across medical conditions between 48 hours and 6 weeks after discharge. Hospitals must survey patients throughout each month of the year. The survey is available in English, Spanish, Chinese, Russian and Vietnamese versions. It can be found on the HCAHPS website www.hcahpsonline.org.

For each participating hospital, ten HCAHPS measures (six summary measures, 2 individual items and 2 global items) are publicly reported on the Hospital Compares website www.hospitalcompare.hhs.gov. As of 2013, CMS the Center of Medicaid/Medicare, will be using the HCAHPS scores to rank hospitals and the hospitals with low rankings will receive less reimbursement dollars. This is called Value Based Purchasing.