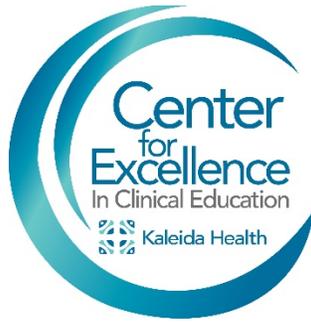# Kaleida Health

2018

ORIENTATION

FOR

STUDENTS AND FACULTY AFFILIATIONS

PREPARED BY:
NURSING EDUCATION AND PROFESSIONAL PRACTICE
And
THE CORPORATE COMPLIANCE OFFICE

Everyone at Kaleida Health is glad to welcome you to our facilities. Please review all sections of the enclosed information prior to beginning your experience with us to protect your safety and the well being of our patients.

Table of Contents

The Center for Excellence in Clinical Education supports Kaleida Health corporate orientation for professional and unlicensed nursing staff, Critical Care Nurse Core, Oncology Nurse Core, Preceptor Class, Charge Nurse Class, Clinical Trainer Competency, the AHA Training Center, Simulation, Introduction to the Electronic Medical Record (Cerner), The Triumph Program for new hire RNs, and corporate education initiatives by delivering excellence in nursing education, American Heart Association certifications, and quality engagement with newly hired nurses, unlicensed staff, and students. The Center for Excellence in Clinical Education collaborates with academic partners, Department leadership and educators across Kaleida. The Center for Excellence in Clinical Education is an integral part of the Kaleida Health mission and vision for success.

Welcome to Kaleida Health

We fully support your clinical experience!

Vice President Clinical Education and Professional Practice: Dr. Mary Alice Hall
Manager Clinical Education: Julie Pollino-Tanner, RN, MSN
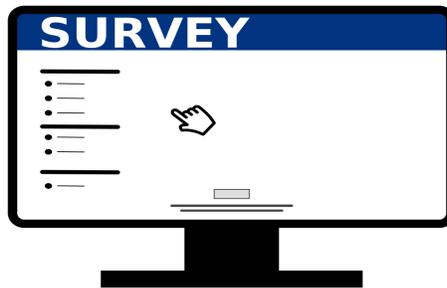Executive Secretary: Elizabeth Geraci
(716) 859-5515

Clinical Student Experience Survey

At the completion of your experience at Kaleida Health, we invite you to complete a brief 10 question survey at:
https://www.surveymonkey.com/s/FC8V7QH

The survey is also available under the Resources tab at
http://www.kaleidahealth.org/clinicalaffiliations

HIPAA Privacy Rule

Dear Student and Faculty,

As you are aware, the Standards for Privacy of Individually Identifiable Health Information (Privacy Rule) of the Health Insurance Portability and Accountability Act (HIPAA) require that Kaleida Health train its workforce so they understand the privacy procedures that are required by this Rule.

Since, under this Rule, students are considered part of the workforce, we require that students and faculty from your institution complete the online learning self-study course on HIPAA, fire and safety, infection control, and Leading with Care on the following web site on an annual basis: http://www.kaleidahealth.org/clinicalaffiliations/ . Toward the bottom of the screen they will see a button entitled "View – Clinical Student Orientation". They should click that button to begin the learning. The clinical coordinator must verify completion of the learning for all clinical students and faculty that will be listed on the spreadsheet submitted to Kaleida Health's Nursing Education and Professional Practice department.

In order for Kaleida Health to be in compliance with regulations, students may start their clinical experience only after documented completion of this training.

HIPAA Security Rule

(Supplement to HIPAA Privacy Rule Training)

If you have any questions regarding the material contained in this section, or any other HIPAA-related questions, please contact one of the following:

Your Clinical Instructor or Clinical Coordinator
Kaleida Health's Security Officer: Kevin Gilbert
Kaleida Health's compliance reporting methods:

- Confidential Reporting Hotline
- www.lighthouse-services.com/kaleidahealth
- or Toll-Free Telephone:
  - English speaking USA and Canada: 833-990-0040
  - Spanish speaking USA and Canada: 800-216-1288
    - All calls are confidential and the identity of the caller will remain anonymous.

    - E-mail: reports@lighthouse-services.com (must include company name with report)
    - Fax: (215) 689-3885 (must include company name with report)

    - *Please note: Regular business issues and matters not requiring anonymity should be directed to the*
      - *employee's supervisor or Human Resources Department*

HIPAA Security Rule

There are three components to the Health Insurance Portability and Accountability Act (HIPAA):
1. Standards for the Privacy of Individually Identifiable Health Information
2. Standards for Electronic Security
3. Standards for Electronic Transactions and Code Sets

This module focuses on the Standards for Electronic Security – the "Security Rule."

Under the Security Rule, covered entities are required to:
- Protect the integrity, confidentiality and availability of electronic protected health information (PHI) that they collect, maintain, use or transmit
- Put security measures in place to:
  - control access to electronic PHI, and
  - protect electronic PHI from alteration, destruction, loss or disclosure to unauthorized persons

What is covered under the Security Rule?

The Security Rule includes electronic PHI that is received, created, transmitted or maintained by a covered entity and covers the storage as well as transmission of electronic PHI.

It covers all electronic media:
- Computer networks, desktop computers, laptop computers, personal digital assistants and handheld computers are all considered "electronic media"
- Electronic media also includes magnetic tapes, disks, compact disks, and other means of storing electronic data
- Paper-to-paper, person-to-person telephone calls, video teleconferencing or messages left on voice mail are **not** covered by the Security Rule

Health care organizations must:

- Assess potential risks to the electronic PHI in their possession
- Develop, implement and maintain appropriate security measures
- Document security measures
- Designate a responsible person – the Security Officer – to oversee security implementation and enforcement of the Security Rule

HIPAA Security Standards

The Security Rule is made up of three categories of standards
1. Administrative Safeguards
2. Physical Safeguards, and
3. Technical Safeguards

1. Administrative Safeguards

Administrative Safeguards require written documentation of the security measures, policies and procedures implemented by the covered entity with respect to:

- Security management processes
- Assignment of security responsibilities
- Workforce security
- Management of access to information
- Security awareness and training
- Security incident procedures
- Contingency planning
- Evaluation
- Business associate contracts or other arrangements

Policies and procedures must ensure prevention, detection, containment and correction of security violations.

The organization must have policies and procedures in place to make sure that all members of the workforce have appropriate access to electronic PHI in order to perform their jobs.

Inappropriate access prevention must also be ensured and policies and procedures implemented to make sure that security incidents are reported internally and handled promptly.

Organizations should establish policies and procedures for responding to computer system emergencies. Planning in advance for an emergency must include data back-up, a disaster recovery plan, and an emergency mode operations plan.

2. Physical Safeguards

Physical Safeguards are security measures that protect a covered entity's electronic information system hardware and related buildings and equipment.

Physical Safeguards require written documentation of the security measures, policies and procedures implemented by the covered entity with respect to:
- Facility Access Controls
- Workstation Use
- Workstation Security
- Device and Media Controls

Organizations should implement policies and procedures to limit, when appropriate, physical access to their electronic information systems and the facility or facilities where the information systems are kept

Access to computers or computer systems containing electronic PHI must be restricted to authorized users.

3. Technical Safeguards

Technical Safeguards include the use of computer technology solutions to protect the integrity, confidentiality and availability of electronic PHI

Technical Safeguards require written documentation of the security measures, policies and procedures implemented by the covered entity with respect to:

- Access Control
- Audit Control
- Integrity
- Person and Entity Authentication
- Transmission Security

Policies and procedures are required to allow access only to those people or software programs with access rights under the administrative safeguard standards.

A procedure should be implemented to verify that a person or entity seeking access to electronic PHI is the one he, she, or it is claiming to be.

When electronic PHI is sent from one point to another electronically, it must be secured to avoid theft, damage or destruction of the information.

HIPAA and HITECH

1. The federal Health Information Technology for Economic and Clinical Health Act ("HITECH Act") imposes significant new obligations for compliance with HIPAA.

   - The HITECH Act **requires** covered entities to notify patients of unauthorized access, acquisition, use or disclosure of protected health information ("PHI") that compromises the privacy or security of their protected health information and poses a significant risk of financial, reputational, or other harm.
   - Covered entities have a limited amount of time to notify each individual whose information may have bene comprised.
   - It is important to report a suspected or potential unauthorized access, acquisition or **use or disclosure** of PHI.

2. The HITECH Act has greatly increased fines and penalties for violations of HIPAA. Civil (monetary) penalties (up to $250,000) and criminal penalties (up to 10 years in prison) may be imposed on any **individual or entity** that wrongly obtains or discloses protected health information maintained by a covered entity.

3. To reduce the risk of potential loss of patient trust in Kaleida Health as well as the potential for lawsuits, a privacy surveillance solution has been purchased by Kaleida Health which will identify users who are engaging in risky behaviors such as:

   - VIP record snooping
   - Executive record snooping
   - Co-worker record snooping
   - Examination of medical records of family members and self
   - Examination of medical records of neighbors
   - Identity theft
   - Medical identity theft

4. Protect yourself!

   - **Do not access any patient information, in either electronic or paper format, that you do not need to do your Kaleida Health job function!**
   - Do not access the protected health information of your co-workers, your children, your family members, your friends, your neighbors, **or yourself** unless you need it to do your Kaleida Health job function.

5. Kaleida Health has strengthened discipline for HIPAA violations in light of the HITECH Act.

   - Employees who violate the confidentiality of a patient's protected health information will be subject to disciplinary action up to and including termination of employment.
   - Anyone who knows or has reason to believe that another person has violated the confidentiality of a patient's PHI should report the matter promptly to his/her supervisor or the Kaleida Health Privacy Officer or call the Compliance Hotline. Reports can be made anonymously.
   - **The Privacy Officer for Kaleida Health is Timothy Cleary; 859-8053**.

The Compliance Hotline numbers are:

> English speaking USA and Canada: 833-990-0040
>
> Spanish speaking USA and Canada: 800-216-1288

- Additional information regarding the accessing of patient information may be found in Kaleida Health policy MR.14, *Release of Patient Protected Health Information.*

HIPAA

For review purposes
<u>Post-Test Questions/Answers</u>

Please answer all questions True or False:

1.	Under HITECH, individual employees can be fined and criminally prosecuted for violating the confidentiality of patient information.	True
2.	An employee can call the Kaleida Health Privacy Officer to report a possible violation of confidential patient information.	True
3.	An employee can use the Kaleida Health patient information systems to look up the results of his lab tests.	False
4.	An employee can use the Kaleida Health patient information systems to look up the birth date of a co-worker in order to send her a birthday card.	False
5.	Employees should only look at the protected health information that they need to carry out their Kaleida Health job function.	True

INFECTION CONTROL
AND PREVENTION

If you have any questions regarding the material contained in this section, or related to Infection Control, please contact the IC practitioner(s) at your site.

Buffalo General Medical Center Gates Vascular Institute

Tracie Arnold 859-1703
Suzanne Bradley 859-7414
Robin McLaughlin 859-7108
Donna Wirth 859-2528
Lisa Hoyt 859-1519

Oishei Children's Hospital

Christina Ostwald 323-1755
Tracy Meyer 323-1756

DeGraff Memorial Hospital

Heather Nugent 690-2123

Millard Fillmore Suburban Hospital

Doreen Grobe 568-3996
Debby Ohayon 568-3999

HighPointe on Michigan

Lorraine McLaughlin 748-3105

Healthcare Associated Infections

Healthcare associated infections (HAIs) have become front-page news. In 2007, hospitals began mandatory reporting of some infections, including Central-line Associated Bloodstream Infections (CLABSI) and certain surgical site infections (SSIs). That information will be publicly reported, allowing patients to compare infection rates among hospitals.

Additionally, October 1, 2008 marked the beginning of the Center for Medicare and Medicaid Services (CMS) regulations that will no longer reimburse hospitals for some healthcare acquired conditions, including CLABSIs, some SSIs, indwelling catheter-associated urinary tract infections (CA-UTI), and c-difficile infection. This list is expected to grow longer each year.

Now, more than ever, it's essential that every health care worker understands how to prevent the spread of infection and follows those practices carefully.

In American hospitals alone, healthcare-associated infections account for an estimated 1.7 million infections and 99,000 associated deaths each year. Of these infections:

- 32 percent of all healthcare-associated infection are urinary tract infections
- 22 percent are surgical site infections
- 15 percent are pneumonia (lung infections)
- 14 percent are bloodstream infections

Most pneumonias, urinary tract, surgical site, and bloodstream infections are preventable when we *ALL <u>CONSISTENTLY</u> DO OUR PART* in maintaining good Infection Control practices.

Healthcare Worker Medical Glove Checklist

When to wear gloves

☐ When touching patient mucous membranes or nonintact skin.

☐ While performing phlebotomy and other vascular access procedures.

☐ When processing body fluid specimens.

☐ When performing finger sticks or heel sticks.

☐ When touching items contaminated with blood or body fluids.

☐ While treating lacerations, abrasions, and compound fractures.

☐ During patient care when the healthcare worker has hangnails, chapped hands, or other abrasions on the hands.

☐ When performing environmental service duties.

☐ Sterile gloves required when performing invasive procedures.

How to wear gloves

☐ Wear gloves that fit properly.

☐ Before putting on gloves, check for tiny punctures, discoloration, and other physical defects.

☐ Do not use defective gloves.

☐ Remove gloves before handling non contaminated items such as telephones and when leaving the area.

☐ Change gloves and wash hands between patient contacts. Never wash or disinfect latex or vinyl gloves for reuse.

How to remove gloves without contamination

☐ Grasp the outside of the glove with opposite hand; peel off.

☐ Hold removed glove in glove hand.

☐ Slide fingers of ungloved hand under remaining glove at wrist.

☐ Peel gloves over first hand.

☐ Discard gloves in a waste container.

☐ Perform hand hygiene immediately after removing gloves.

Kaleida Health

Infection Control

Purpose:
To provide a review of basic infection control principles to meet the requirements of OSHA, NYSDOH & DNV

Standard Precautions:
Standard Precautions is a basic approach to patient care, which recognizes that all body fluids or substances may contain potentially infectious organisms.

- <u>Wear gloves where potential exists for contact with blood or body fluid</u>

- <u>Wear gowns when splashing is likely</u>

- <u>Wear a mask and eye protection when eyes, nose or mouth may be splashed</u>

- <u>Remove barriers and perform hand hygiene prior to leaving the room</u>

- **<u>Use Good Hand Hygiene!</u>**

Hand Hygiene

Remember gloves are not a substitute for hand hygiene. Hands must be washed for a minimum of 15 seconds when beginning or ending work, before and after eating, smoking or using the washroom and whenever visibly soiled. Only use soap and water for patients with c-diff.

Hands may be cleaned with an alcohol-based hand rub when not visibly soiled with a minimum of effort and skin irritation. These can be found in all patient care areas. **Hand hygiene <u>MUST</u> be done before and after <u>every</u> patient encounter.**

OSHA has mandated that no food or beverages be consumed in an area where the potential exists for contamination with blood or other potentially infectious material. Therefore, **eating and drinking in patient care areas is prohibited and is only permitted in the break room and cafeteria.**

Transmission Based Precautions:

In addition to Standard Precautions, Transmission Based Precautions are followed to reduce the spread of communicable diseases in patient care settings. The four types of precaution are described as follows:

1. Contact Precautions

2. Enteric Precautions

3. Droplet Precautions

4. Airborne Precautions

1. CONTACT PRECAUTIONS

When a patient has known or suspected culture-positive or self-identified multi-drug resistant organism (MDRO) such as Methcillin-resistant staphylococcus aureus (MRSA) or Vancomycin-resistant enterococcus (VRE).

- Private Room
- Gloves and Gown
- Hand hygiene before and after patient care, glove use

2. ENTERIC PRECATUIONS:

For patients with known or suspected c-difficile infection or diarrheal illness

- Gown and gloves prior to entering patient room
- Hand hygiene with soap and water
- Clorox wipes to disinfect high-touch surfaces or reusable equipment

3. DROPLET PRECAUTIONS:

- Private room
- Hand hygiene
- Surgical mask when within 6 feet of patient for visitors/staff

4. AIRBORNE PRECAUTIONS

Patient with known or suspected Mycobacterium tuberculosis, varicella, disseminated herpes zoster (shingles)

- Negative pressure room
- Hand hygiene
- Appropriate respirator mask or PAPR hood

NOTE: Prior to admitting a patient to a negative air room, the room must be smoke-tested by Facilities Management to assure negative air flow in the room. Smoke testing must also be performed daily until Airborne Precautions are discontinued.

TUBERCULOSIS

Active infection with tuberculosis should be considered when a patient is seen with "classic" signs and symptoms. These include:

- History of prolonged cough, (more than three weeks)
- History of night sweats
- History of weight loss
- Bloody sputum
- Cavitary lesion on chest X-ray
- History of exposure to known active TB case

When active pulmonary TB is considered in the differential diagnosis, the patient must be placed on **Airborne Isolation** in a negative pressure room as soon as possible.

To reduce the risk of exposure, until isolation can be established, the patient should be given a mask to wear, asked to cover his/her mouth when coughing or people in the immediate area should wear a respirator (PFR N95).

The patient will remain on isolation until the risk of transmission is eliminated or TB is ruled out.

The risk of transmission is reduced or eliminated when the patient's sputum no longer contains acid fast bacilli (AFB). This can be demonstrated by collecting and testing early morning sputum samples on three consecutive days. If the sputum does not contain AFB, the patient is not considered infectious. If the sputum does contain AFB, then he/she must remain in isolation until specific criteria are met (refer to the Kaleida TB Control Plan).

Annual TB skin testing (PPD) is mandatory for all employees with a negative PPD status. Comply with your annual health assessment to receive the screening.

Remember TB control is best achieved when all these measures are used in combination, early identification, isolation in negative pressure rooms, use of personal protective equipment (PFR N95 respirator) and annual TB screening.

> Refer to the Kaleida TB Control Plan located online for more information and details regarding control of TB.

Occupational Exposure:

Exposure can occur through a needle stick or sharps injury with blood contaminated instrument or broken glass, or blood fluid exposure to non-intact skin or blood or body fluid splash to mucous membranes.

- In the event of an exposure, immediately cleanse the wound with soap and water. If eyes, nose or mouth are exposed, flush with cold water for several minutes.

- Notify your supervisor of the exposure and report immediately to the Emergency Department for medical evaluation.
  The physician will advise you regarding testing and/or prophylaxis (medications) which you may elect to take to reduce your chances of becoming infected.

- Maintain strictest confidentiality for you and the source patient, and keep appointments with Employee Health.

- Report all exposures, regardless of how insignificant you think they are.

You can reduce your risk of being infected with hepatitis B by being immunized if you haven't already. You can reduce your risk of infection with other bloodborne pathogens by handling sharps in a safe manner.

- Do not recap used needles
- Do not remove used needles from syringes
- Do not bend, break or otherwise manipulate needles
- Dispose of needles in an approved sharps container
- Do not overfill sharp containers (change when ¾ full)
- Do not walk long distances with sharps. Place them in a basin or similar device for transport
- Be mindful of those around you when handling sharps
- Be sure to activate and use safety sharps where available

__Safety__

If you have any questions regarding the material contained in this section, please contact the Safety Officer at your site.

Each department has a Corporate Environment of Care Manual where all corporate-wide safety policies are located. You can also access the Corporate Environment of Care Manual on Kaleidascope. If you need assistance finding information, contact your manager or safety representative.

SAFETY

It is everyone's responsibility to maintain a safe workplace.

For safety concerns, call 878-SFTY (878-7389) to leave an anonymous message or request a call back.

Call **7911** for any security, safety, or medical emergencies at any of our Kaleida Health hospitals. For other sites such as outpatient Clinics, use 911 for emergency calls.

Security escorts to your vehicle are available upon request.

Become familiar with your clinical site! <u>Day 1, know:</u>
- Location of fire exits/stairwells
- Location of Fire extinguishers and Fire alarm pull boxes
- General layout of unit – location of rooms with doors that lock
- Take time to review intranet, KalediaScope, for additional policies and resources

HAZARD COMMUNICATION

You have a right to know about any chemicals and hazardous materials you work with and how to protect yourself. This is the basis for the Occupation Safety and Health Administration's (OSHA) Hazard Communication Standard. Your primary sources of information will be the chemical container label and the **material safety data sheet (MSDS).** MSDS may be located in the Security Department at each facility and on some units

<u>**Hazardous Chemical Spills**</u> --

Incidental spills are those spills that occur within your work area with an amount that you work with on daily basis. If you know the hazards of a spill, have the proper personal protective equipment and spill absorbent, you should attempt to clean up a spill within your department. If a spill poses hazards to patients, visitors or staff or you do not have the proper materials, Kaleida policy is to contact Security, Safety and Plant Operations. For spills outside of our resources, we will contact outside Emergency Responders. In these circumstances, it may be necessary to isolate the area of the spill and/or evacuate the area.

Green Z is the spill absorbent used by Kaleida Health. **Approximately 1 Tablespoon of Green Z per 1 liter of liquid is poured over the spill area.** Mercury spills require an addition of water with the Green Z and special disposal. Mercury waste should be collected and saved for proper disposal by your safety representative. Environmental Services can assist with cleaning mercury spills, if you do not feel comfortable cleaning it yourself. For all hazardous material spills, contact Safety to assist in determining proper disposal procedures.

COMPRESSED GAS CYLINDER SAFETY

Did you know that, if a cylinder falls over and the valve breaks off, it can become a missile or torpedo? It can be powerful enough to go through a wall! By following simple safety precautions, you can easily prevent this type of accident.

E-Cylinders: Generally, these are small green cylinders that contain oxygen and are used during patient transport. These cylinders must be secured at all times to prevent them from falling over. There are holders available throughout Kaleida Health and are designed specifically to secure E-cylinders.

H-Cylinders: These are large cylinders that contain many different types of gases. They come in various colors according to the type of gas they contain. These cylinders must be secured at all times. Because of their size, they are generally secured by chaining or strapping to a wall or cart. When in storage, a valve protection cap must be in place.

Other precautions:

- Never use cylinders as doorstops
- Follow the same safety precaution with "empty" cylinders as you would with full ones. There is usually residual gas that remains in "empty" cylinders, so they can still become torpedoes.
- Keep cylinders upright and avoid banging them together or dropping them.
- Store cylinder away from heat and flammable materials.
- Notify your manager or safety representative of unsafe conditions.
- Always check the label for cylinder content.
- Empty cylinders should be separated from full cylinders and different gas types should be separated.

ELECTRICAL SAFETY

Any electrical items for personal employee or patient use that do not appear to be safe should be immediately reported to Clinical Engineering. The Clinical Engineering staff will do a quick safety inspection of the equipment. Be particularly cautious of items with heating elements, such as toaster ovens, toasters, coffee makers, etc…

If an electrical power failure occurs, electricity will be restored to specific areas by emergency generators. Generally, red outlets or outlets with red dots will receive emergency power. Ask your manager where your emergency outlets are. Only plug critical equipment, such as ventilators, into red outlets. The generators should restore power within 10 seconds. If a power failure occurs and more than 10 seconds passes, you must consider back-up alternatives, such as hand bagging patients who are on ventilators.

FIRE SAFETY

When responding to a fire, remember the word "**RACE**":

R – **Rescue** those in danger.
A – **Alarm** Pull the nearest red fire pull box and notify the switchboard. Call 7911 except off site locations call 9911, for police, fire, and ambulance.
C – **Contain** the fire by closing doors and windows
E – **Extinguish** the fire if possible. **Evacuate** if necessary.

Work as a team. One person may pull the alarm, while another calls the switchboard. If you must rescue a patient in immediate danger, call out "**FIRE ALARM**" so that other staff members can begin sounding the alarm.

The overhead announcement for a fire is "**FIRE ALARM ACTIVATION**".

The need to shut off piped oxygen is considered on a case-by-case basis depending on the circumstances of the fire. The decision to do so can be made by anyone in charge of the department. Oxygen cabinets are labeled with the area(s) that they control. Be sure that you are shutting off oxygen to the correct location.

You are responsible for knowing the location of the fire extinguishers, oxygen cabinets, pull boxes and exits in your department. Always make sure that exits and hallways are unobstructed, and never block fire extinguishers, fire hoses, pull boxes and oxygen cabinets.

When using a fire extinguisher, remember the work "PASS":

P – **Pull** the pin.
A – **Aim** at the base of the fire.
S – **Squeeze** the handle.
S – **Sweep** across the base of the fire.

Throughout Kaleida Health, you will mainly find "ABC" type extinguishers, which can be used on all fire types, but please check first to assure that you're using the correct extinguisher type. If you use the wrong type of extinguisher, you can make the fire worse! Portable fire extinguishers generally last less than 60 seconds! Use extinguishers only for incipient stage (small, early stage) fires.

FIRE EXTINGUISHER TYPE	USED FOR
Type A	Ordinary combustibles, such as paper, wood or plastics.
Type B	Flammable liquids
Type C	Electrical equipment

When the fire alarms sound, fire doors throughout the facility will automatically close. When these doors close, they divide the facility into smoke compartments so that the fire and smoke remain in the fire area without spreading to other areas of the facility. Never prop open a fire door and always report missing ceiling tiles. If a fire door is propped open or ceiling tiles are missing, the fire and smoke may spread to other areas of the facility.

It may be necessary to evacuate your department. If evacuation is necessary, always evacuate horizontally first, past the fire doors. Any person in charge of your department can make the decision to evacuate horizontally. In rare circumstances, you may be required to evacuate vertically, using the stairwells. This decision is generally made by the fire department or Administration.

If smoke is in your area, stay low to the ground. Smoke and heat rise to the ceiling. In fires, it is typically the smoke and heat, not the fire that causes death.

- If you smell smoke coming from behind a close door, feel the door with the back of your hand. If it's too hot to touch, don't open it. If it's touchable, open it slowly.
- During fires, use the stairwells, not the elevators.
- In most Kaleida Health facilities, a fire response team represented by various staff members, is present and will respond to the fire scene very quickly. In most cases, they will be there before the fire department.
- Refer to the Corporate Fire Procedures for instructions on how to evacuate patients.
- In the event of an evacuation, mark each door with an "X" after the room has been searched. This assures that time isn't wasted searching rooms that have already been checked and prevents fresh air from being introduced into a fire room that has been closed. You can use tape, marker or other device to accomplish this.
- If a fire is located in a trashcan or other container, you can generally smother the fire by placing a wet towel or sheet over the container.
- Fire extinguishers are meant for small, controllable fires. Don't put yourself in danger by attempting to extinguish a large, uncontrollable fire.
- You must always pull the fire alarm and notify the switchboard, even if the fire has quickly been extinguished. An investigation must be done and, many times, fires have re-ignited after staff thought they were extinguished.

EMERGENCY PREPAREDNESS

A disaster or emergency is any event that disrupts the normal function of our facility(s). An external emergency involves an event outside of the facility that generates victims that enter your facility. Examples of such events include: major traffic accidents, plane crashes, train derailments, etc. Examples of an internal emergency involve an event that affects the internal operation of the facility. Examples of internal emergencies include: infant abductions, major fires, bomb threats, utility failures, etc.

Departmental response actions vary based on the type of emergency. To handle these emergencies, each facility has a Site Emergency Plan that outlines how staff is to respond once the plan is activated. All sites have a Command Center for overseeing the Emergency and taking necessary actions in the specific situation. Some departments have very specific jobs according to the plan, while others may continue to do their normal jobs or may be sent to a Labor pool.

<u>Confidentiality</u>

Patient Confidentiality

Purpose:
To provide an annual review of Patient Rights and Confidentiality consistent with New York State Law.

At the completion of this section of the packet you will be able to:

- Discuss patient confidentiality and what is included under the law.
- State who is responsible for maintaining patient confidentiality.
- Relate what acceptable information may be written on a whiteboard

The New York State Patient Bill of Rights states that all patients have the right to privacy while the hospital and confidentiality of all information and records regarding their care. The HIPAA Privacy Rule provides Federal privacy protection.

What is Confidentiality?

- A conscious effort by everyone to keep private all personal information regarding a patient while they are receiving health care.
- Privacy is a basic right. Safeguarding that right is your obligation if you work within a health care system.

Confidentiality Includes Patient's:

- Identity
- Physical or psychological condition
- Emotional Status
- Financial situation

WHO is responsible for protecting patient's rights?

- **EVERYONE!!!!!!**
  - Anyone who cares for and consults with patients
  - Anyone who hears conversation about patients
  - Anyone who has access to patient information

All confidential information regarding medical treatment of patients is privileged and should be held in the strictest confidence.

Confidential information cannot be:

- ❖ Used for personal gain
- ❖ Passed on to any person, including family or friends or other employees unless the information is necessary to carry out duties

  Only authorized individuals may have access to any portion of the medical record or any information originating from that record.

  Discussions about the medical care of any patient or prohibited in any public place including elevators, corridors, cafeteria, or anywhere persons can overhear. A person found responsible for divulging patient information or allowing another unauthorized employee or person to access such information, written, spoken or by electronic means, is subject to corrective action up to an including termination of employment.

Information Access:

- **ONLY** share information with co-workers on a "need to know" basis
- **NEVER** share written or spoken patient information with strangers or anyone else (insurance companies) without prior written consent from the patient
- If approached by an attorney, insurance representatives, private investigators seeking answers regarding patient care, do **NOT** give any information. **CONTACT YOUR MANAGER**. This also applies to individuals seeking information about any hospital procedures, equipment, or purchasing practices.
- Even a patient's family members may **NOT** have access to patient information.
- **NEVER** discuss patient information where others can overhear your conversation! (e.g. hallways, elevators, cafeteria)
- **NEVER** discuss patient information after work hours with anyone.
- **REPORT** breaches of confidentiality to your manager.
- **NEVER** assure visitors and patients who have fallen or lost something that the hospital will pay for the treatment or the lost item(s).
- If an accident occurs or there are claims of lost or destroyed articles, complete an incident report. If needed, discuss the circumstances with Risk Management.

Use of Whiteboards a means of communication

It is Kaleida Health's legal and ethical obligation to protect the confidentiality of patient information. Whiteboards are recognized as an effective tool in the provision of safe and efficient care. Whiteboards, chalkboards and other such communication tools are to be used in a manner that protects the privacy of confidential patient information.

Acceptable information:

❖ Last name
❖ Generic patient activities that do not imply diagnosis. e.g. "Labs pending", "to x-ray"
❖ Nurse assigned to the patient
❖ Physician's name if their practice is not associated with a specialty that may infer a diagnosis
❖ Physician initials may be used if the physician has a known specialty.

Information NOT permitted on whiteboards:

❖ Diagnosis, including official or unofficial diagnosis abbreviations
❖ Procedures that can imply a diagnosis. e.g. "gone to dialysis"
❖ Any other data that can be used to infer a diagnosis along with the identity of a patient

Safeguarding Records:

▪ **KEEP** medical records in a secure location
▪ **DO NOT** expose patient's name in any way – this is a direct breech of confidentiality
▪ **DO NOT** allow family members, friends, or visitors to read any patient information without permission from the patient or the patient's authorized representative (i.e. health care agent, guardian etc.).
▪ **DO NOT** leave patient information on isolation carts or clipboards in the hallways.
▪ **LOG OFF** computer before walking away
▪ **CLOSE** patient chart when done accessing

Red Flag Regulations

IDENTITY THEFT – THE PROBLEM

- Serious problem for businesses, consumers, and law enforcement in the U.S.
- Causes consumers to lose time and money
- Businesses incur millions of dollars in losses

FACT Act (Fair and Accurate Credit Transactions Act)

- Enacted by US Congress in 2003
- Requires creditors to adopt a written Identity Theft Prevention Program containing reasonable policies and procedures for detecting, preventing, and decreasing potential identity theft.

Red Flags at Kaleida Health:
Fall into one of the following general categories:
- Suspicious documents
- Suspicious personal identifying information
- Suspicious or unusual use of covered accounts; and
- Alerts from others (for example, a patient/client/resident or his/her representative; an identity theft victim; law enforcement; etc.)

Kaleida Health is committed to monitoring for the potential that patients may be victims of identity theft, and to maintaining a process to address this risk.

Kaleida Health requests photo identification to help minimize medical identity theft,

Kaleida Health employees are educated to "Do the Right Thing" and report any irregularities in information and/or documents submitted by patients.

Anti-discrimination Laws

Kaleida Health follows all regulations regarding non-discriminatory practices in patient care, employment practices and a harassment-free workplace. Policy HR 100 (Equal Opportunity Employment) defines Kaleida Health employment practices. Policy HR003 addresses the harassment investigation and remediation process. No form of harassment or discrimination of any sort is permitted. Our harassment-free and discrimination-free policies extend to business associates such as vendors, professionals and other providers of good and services to Kaleida Health. Employees should promptly report discrimination and harassment concerns to their site Human Resources department.

Examples of behavior that may be considered harassment:
1. Behavior of an offensive nature related to an individual's race, color, religion or belief, national origin, ancestry, age, sex, sexual orientation, marital status, veterans status, occupation, physical disability, mental disability, medical condition, or other personal characteristics.
2. Any behavior that may cause distress, such as name-calling, ridicule, insults, jokes, graffiti, physical abuse, display of pornographic images, etc.
3. Sending inappropriate jokes or comments through e-mail, text, websites or other electronic media.

Use of Abbreviations
In Medical Records

In order to promote standardization of documentation in medical records, to assure patient safety and maintain compliance with DNV and the CMS Conditions of Participation, Kaleida Health will allow the following types of abbreviations in the medical record.

1. Universally accepted terms usually relating to units, organisms, phenomena, and found in ordinary, scientific or medical dictionaries, (e.g. Rh, pH, cm, IV, NPH insulin, K. E. Coli).

2. Contractions that are readily explainable without confusion, (e.g. sed. Rate, strep., staph).

3. Established chemical formulas and chemical symbols.

4. Established abbreviations listed to signify metric measurements except as noted below.

5. Those found on the attached list.

6. Abbreviations are allowable as either upper or lower case unless specified as upper and lower case on attached listing.

7. Any new forms used in the Medical Record should be compliant with these lists of acceptable abbreviations.

Medication documentation in the medical record requires special consideration to lessen the potential for medication errors to occur. The following table lists the Problematic abbreviations, which should NEVER be used to document medication orders, MAR transcription or a patient history of medication use.

Keynote: Medication names should always be written out completely. No abbreviations should ever be used for medication name.

Keynote: All entries in the medical record must be dated, timed, signed with legal professional credentials (MD, RN etc.) and be legible.

Keynote: All new medication orders must contain date, time of order, drug name, dose, indication, route and frequency of administration. The provider must sign the order. If the order is verbal, the order must be co-signed within 48 hours by a LIP.

	Title: Use of Abbreviations	**# MR.4**
Kaleida Health **POLICY**	**Owner:** Health Information	**Issued:** 9/98
Keywords: abbreviations		

I.   Statement of Purpose
This policy has been developed to maintain consistency in medical record documentation within the Kaleida Health Organization.

II.   Audience
Anyone documenting in the medical record, Health Information

III.   Instructions
A.   The following types of abbreviations are acceptable in the paper or electronic medical record:
1.   Universally accepted terms usually relating to units, organisms, phenomena, and found in ordinary, scientific or medical dictionaries, (e.g. Rh, pH, cm, IV, NPH insulin, K. E. Coli, *APAP, ASA, ECASA,NTG etc.).*
2.   Contractions that are readily explainable without confusion, (e.g. sed. Rate, strep., staph).
3.   Established chemical formulas and chemical symbols except when ordering medications. (eg: these are unacceptable: NaCl, MagSul)
4.   Established abbreviations listed to signify metric measurements except as noted below.
5.   Abbreviations are allowable as either upper or lower case unless specified as upper and lower case on the attached listing.
6.   Any new forms used in the Medical Record should be compliant with these acceptable abbreviations.
7.   Abbreviations that may be specific to our demographic region (see Appendix A)

B.   Medication documentation in the medical record requires special consideration to lessen the potential for medication errors to occur. The following table lists the unacceptable abbreviations, which should NEVER be used to document medication orders, MAR transcription, patient history of medication use, or any area in the medical record that addresses the patient's medications.
**Keypoint: Practitioners are strongly encouraged to write out all medication names to avoid potential confusion.

**Keypoint: Use of problematic abbreviation in ANY hand written or electronic documentation of the medical record is strongly discouraged due to potential safety concerns.

C.   UNACCEPTABLE ABBREVIATIONS

Abbreviation	Intended Meaning	Error	Recommendation
U	**Units**	**Misread as 0, 4, or cc (e.g. An order for 10 U of insulin can be misread as 100)**	**Write out "units"**
IU	**International unit**	**Mistaken as IV (intravenous) or 10(ten)**	**Write "unit"**
QD, QOD	**Once daily, or once every other day**	**Mistaken for each other. The period after the Q can be mistaken for an "I" and the**	**Write "daily" or "every other day"**

		"O" can be mistaken for an "I"	
Trailing zero (e.g. 1.0 mg)	**1 mg**	**Misread as 10 mg**	**DO NOT USE trailing zeros after a decimal point**
Lack of leading zero	**0.1 mg (e.g. .1 mg)**	**Misread as 1 mg or 11 mg**	**Always use a zero before a decimal point**
MS, MSO4, MgSO4	**Morphine Sulfate or Magnesium Sulfate**	**Misread as the other**	**Write out drug name**

D. **The following abbreviations are strongly recommended not to be used in medication documentation**

BIW TIW	Two times per week Three times per week	Misread as two or three times a day	Specifically write out "two" or "three times per week"; or write out specific days medication is to be administered (e.g.Q Mon, Wed, Sat)
Ug	***Mcg***	Misread as mg, or u misread as 0 units read as grams	***Use "mcg" instead***
AU, AS, AD	Both ears, left ear, right ear	Misread as OU, OS, OD	Specifically write out intended route of administration
OU, OS, OD	Both eyes, left eye, right eye	Misread as AU, AS, AD	Specifically write out intended route of administration
X3d	***For 3 days***	Misread as for three doses	Write out "for 3 days"

IV. **Approved by - (Include date)**
Quality Improvement and Patient Safety   10/08, 8/13
Adult Med Surg Standards Committee   9/08
Nurse Policy Council   10/08
Nurse Executive Committee   8/13

V. **References**
Attachment A – Institution Name Abbreviations

Version History:

Effective Date:	Reviewed/ Revised
7/5/16	Reviewed no changes
7/13	Revised
10/08	Revised
7/05	Revised
12/04	Revised

Patient Safety Goals

Kaleida Health believes that the well-being of our patients is of prime importance and has established policies that protect the safety and well being of our patients. Listed below are some of the Patient Safety Goals and the requirements under each goal. All employees and individuals who utilize our facilities in the course of their studies are expected to be aware of these Goals and how they apply to patient care.

Patient Safety Goals

- *Improve the accuracy of patient identification.*

- *It is required that at least two patient identifiers (neither to be the patient's room number) are used whenever administering medications or blood products, taking blood samples and other specimens for clinical testing, or providing any other treatments or procedures*

- *Improve the effectiveness of communication among caregivers.*

- *For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the information record and "read-back" the complete order or test result.*

- *Standardize a list of abbreviations, acronyms and symbols that are not to be used throughout the organization.*

- *Measure, assess and, if appropriate, take action to improve the timeliness of reporting, and the timelines of receipt by the responsible licensed caregiver, of critical test results and values.*

- *Implement a standardized approach to "hand off" communications, including an opportunity to ask and respond to questions.*

Keynote: Ask our staff about SBAR Communication

- *Improve the safety of using medications.*

- *Standardize and limit the number of drug concentrations available in the organization.*

- *Identify and, at a minimum, annually review a list-alike/sound-alike drugs used in the organization, and take action to prevent errors involving the interchange of these drugs.*

- *Label all medications, medication containers (for example, syringes, medicine cups, basins), or other solutions on and off the sterile field.*

Keynote: Ask our staff about BRIDGE MED Administration

- *Reduce the risk of health care-associated infections*
- *Comply with current Centers for Disease Control and Prevention (CDC) hand Hygiene guidelines.*
- *Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection.*
- *Reduce central line infections, ventilation pneumonia and c-difficile infections.*
- *Accurately and completely reconcile medications across the continuum of care.*
- *Implement a process to obtaining and documenting a complex list of the patient's current medications upon the patient's admission to the organization and with the involvement of the patient. The process includes a comparison to the medications the organization provides to those on the list.*
- *A complete list of the patient's medications is communicated to the next provider of service when a patient is referred to another setting, service, practitioner or level of care within or outside the organization.* **The complete list of medications is also provided to the patient on discharge from the facility**
- *Reduce Patient Harm*
- *Minimize skin breakdown on pressure points*
- *Prevent development of DVT*

- *Prevent foley catheter associated urinary tract infections*

- *Reduce the risk of patient harm resulting from falls.*

  o *Implement a fall reduction program and evaluate the effectiveness of the program.*

- *Encourage patient active involvement in their own care as a patient safety strategy.*

  o *Define and communicate the means for patients and their families to report concerns about safety and encourage them to do so.*

- *The organization identifies safety risks inherent in its patient population.*

  o *The organization identifies patients at risk for suicide. [Applicable to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.]*

- **Every patient is to have an individualized nursing care plan. All disciplines should contribute as appropriate to the patient's care.**

- **Every patient has the right to expect best standard of care as per evidence-based quality metrics for heart attack care, heart failure, pneumonia, surgical care and pediatric care.**

Quality and Patient Safety Overview

Mission

The Quality team will lead the organization in best practice through a culture of patient centeredness, always.

Vision

Kaleida Health will exceed national benchmarks in quality outcomes by ensuring that every patient always receives safe, exceptional and compassionate care.

Values

- Patient and family-centered
- Safety
- Excellence
- Compassionate care
- Innovation
- Transparency
- Integrity and accountability

Quality and Safety Plan

Kaleida Health adopted a new Quality Improvement and Patient Safety Plan to improve patient safety, promote quality and foster an environment in which patients, residents, their families, staff and leadership can identify and manage safety risks. The plan is the foundational document on how Kaleida Health will address quality moving forward.

Three tenets will drive interactions with patients and residents and shape the behaviors of staff and providers:

1. Every provider and staff member at Kaleida Health will behave and act with the patient at the center of their concerns. All will have a working understanding of the implications of this approach.
2. Every provider and staff member at Kaleida Health will have a working knowledge of continuous quality improvement based upon the rapid cycle process of PDCA: Plan, Do, Check and Act.

Every provider and staff member will understand that the approach to patient care and interactions at Kaleida Health is based upon best practice, best evidence, and the reduction of unexplained variation.

Safe Patient Handling

Kaleida Health has a commitment to workplace safety and is implementing a Safe Patient Handling (SPH) Program for mechanical lifting, transferring, and repositioning patients/residents. The basic objectives of the SPH program are to:

Increase the quality of care for patients

Perform a safe and comfortable mechanical lift and/or transfer for patients

Create a safe working environment for the staff by reducing the frequency of manual lifting, transferring and repositioning

Reduce and prevent work related injuries to staff

Kaleida Health	Title: Proper Use of Safe Patient Handling (SPH) Equipment	# CL.72
POLICY	**Owner:** Director Safe Patient Handling	Issued: 3/17/15
Keywords: SPH Equipment, No-Lift, Zero Lift		

I. **Statement of Purpose**

Knowing how to use the safe patient handling (SPH) equipment properly is the responsibility of all employees. Proper use of SPH equipment is outlined in this document. Employees gain skill, and further knowledge on proper SPH equipment use through live hands-on demonstration by the SPH Team, on Talent Management by viewing SPH videos and through annual completion of required SPH curriculum. Competence and confidence with SPH equipment use comes with practice, viewing the SPH videos as a refresher and reference as well regular frequent use. For the purpose of this document, the term "patient" shall include acute hospital patients as well as long term care (LTC) residents.
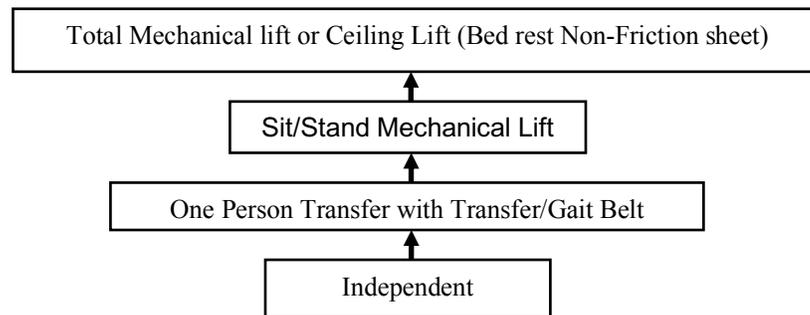
II. **Audience**

All employees caring for or transferring patients

III. **Instructions –** (Outline necessary steps for consistent completion of process/ procedure)

A. **Patient Assessment**

1. An initial lift/transfer needs assessment will be completed by the licensed professional on the day of admission or at the time of a change in the patient status. Additionally a quarterly assessment shall be done for long-term residents.

2. Select the appropriate lift/transfer status of the patient by referring to the *Lift/Transfer Protocol* (CL.73a) for assessment of patient criteria, contraindications, sling criteria and required staff.

   **Keypoint: A patient status may differ based on the time of day or other patient factors. This may require two different levels of transfer during a single day. A secondary lift shall be identified when appropriate.

3. The caregiver shall consider his/her own ability, the environment and the patient current status prior to any lifts or transfers. When the caregiver feels that the current patient handling technique cannot be performed safely it is acceptable to move to the next higher level of transfer (i.e. sit/stand mechanical lift to a total mechanical lift, independent to a one person transfer with transfer/gait belt).

   a. The caregiver shall not move to the next lower level of transfer without first having a licensed professional reassess the patient's transfer lift status.

   b. Long term care unlicensed personnel must notify the licensed caregiver immediately prior to the lift/transfer so that a reevaluation can be done.

4.   Refer to the decision tree when changing the patient lift status.

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┌─────────────────────────────────────────────────────────────┐
│  Total Mechanical lift or Ceiling Lift (Bed rest Non-Friction sheet)  │
└─────────────────────────────────────────────────────────────┘
                              ▲
            ┌──────────────────────────────────┐
            │     Sit/Stand Mechanical Lift     │
            └──────────────────────────────────┘
                              ▲
        ┌──────────────────────────────────────────┐
        │  One Person Transfer with Transfer/Gait Belt  │
        └──────────────────────────────────────────┘
                              ▲
                ┌──────────────────────────┐
                │         Independent        │
                └──────────────────────────┘
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5.   The patient lift/transfer shall be performed as determined by the lift/transfer assessment.
Exception: The licensed professional caregiver shall determine the appropriate method of lift/transfer on the patient in the event of a medical emergency or fire.

B.   **Lift/Transfer Equipment**
1.   **Mechanical Lifts** - All mechanical lifts shall be maintained in the designated area and plugged in for recharging when not in use. Do not block exits, fire alarms, and fire extinguishers with the lifts. Note: some mechanical lifts have a removable battery that requires recharging. The battery charger should be kept in a designated area and the unit should have a minimum of two batteries per lift.
2.   **Slings -** Place all soiled slings in designated laundry bag/hamper.
3.   **Safety**
      a.   Assess integrity and function of all lift equipment prior to use. Any broken or malfunctioning equipment shall be removed from use and tagged with a "Do Not Use" label. See SS-F.1 - Medical Equipment Management Plan. Non-functioning equipment shall be reported by calling TAC at 859-7776
      b.   Inspect all slings prior to use for signs of wear and tear or signs of compromised integrity including loose stitching, tears, or fraying straps. Remove damaged slings and tag "DO NOT USE" and return to unit manager.
            Keypoint: Damaged slings shall be replaced never repaired. The repositioning slings must be left under the patient however never utilized as a transfer sling.

      c.   Do not leave repositioning non-friction device under the patient after move/transfer is completed.
      d.   Always close the legs of the lift when moving the lift.
      e.   The brakes are to be on when the lift is parked, being charged and during the initial set up of the sit/stand lift or total mechanical lift.
            Keypoint: Whenever you are operating the lift or lowering the lift the brakes **must** be off. The lift has an Emergency Stop button when engaged shuts the power off to the motor. The Emergency Stop button needs to be reset to operate the lift.

C.   **Infection Control**
1.   Barriers shall be used between the patient's skin and the sling. (E.g. underwear, incontinent pad)
2.   All SPH soft goods (which include slings, non-friction sheets, gait belts, air matts etc.) with minor soilage may be spot cleaned using hospital approved disinfectant wipes. See IC.21 – Non Commercial Washing Machine Use.
3.   A single dedicated sling will be used for a patient on isolation/or a LTC patient known to have a multi resistant organism or communicable illness and laundered after discontinuation of isolation or discharge, whichever comes first.
4.   All framework/hardware will be wiped down with hospital approved disinfectant wipes after each patient use.

D.   **Total Mechanical Lift**
A total mechanical lift provides a safe transfer for patients from a supine to seated position or seated to seated transfer. A total mechanical lift will be used by those patients who have no weight bearing abilities or who have been assessed to need a total mechanical lift for transfer.
1.   **Equipment/Personnel**
    a.   Total mechanical lift
    b.   Two (2) or more caregivers

2.   **Procedure**
    a.   There must be two caregivers interfacing with their hands on the patient & the total mechanical lift.
    b.   Adjust bed to a height that promotes good body mechanics.
    c.   Visually inspect sling for signs of wear and tear. Do not use any sling that is visibly damaged.
    d.   Position patient on the appropriate sling.
    e.   Position lift with the base open so that the spreader bar is perpendicular to the patient's shoulders and hovering above the chest.
    f.   Attach the sling straps without pulling or tugging, to the desired
setting.
    g.   Verbally prepare patient for transfer.
    h.   Gently raise patient minimally from surface.
    i.   **Be sure to close the legs of the lift while moving the lift; keeping the patient's body on the inside of the lift legs. Not swinging to the outside of the lift legs.**
    j.   Gently lower patient into chair. (The staff should limit the distance and time the patient is in the mechanical lift by arranging the environment. This practice is known as the zero air space procedure when transferring the individual).
    k.   Remove sling from under patient (if appropriate).
    l.   **Before** a patient that is on the floor is moved, touched or mechanically lifted, a licensed professional **must** assess the patient. In order to promote safe patient handling, **use** a total mechanical lift (floor or ceiling model) when getting a patient off the floor.
    m.   The two methods for the hammock sling applications are the cross through method and the cradle method.
        a.   The cross-through is the recommended method for a total hip patient. The cross through method is the safer method that anchors the patient.

> b. The cradle method is used on a patient with an amputee of their lower extremity(ies), and for a patient who experiences discomfort in the cross through method (i.e., patient with increased girth at their thigh).

> n. The universal sling may be utilized to transfer a bariatric patient. The lower limb straps are crossed between the thighs of the patient.
> o. The staff may choose to utilize a limb strap or the easy glide boards to assist in placing a sling behind a patient.

E. **Ceiling Lift** - when available
A ceiling lift provides a safe transfer for a patient similar to the total mechanical lift. Floor space challenges are not an issue with a ceiling lift therefore there is reduced injury risk for patient and healthcare worker. With the use of the repositioning slings the ceiling lift reduces the exertion and injury risk related to positioning tasks in bed.

1. **Equipment/Personnel**
   a. Ceiling lift
   b. Two (2) or more caregivers

2. **Procedure**
   a. There must be two caregivers present to operate the ceiling lift
   b. Adjust the height of the bed to promote good body mechanics.
   c. Visually inspect sling for signs of wear and tear. Do not use any sling that is visibly damaged.
   d. Position the patient on the appropriate sling. The two methods of sling attachment for the hammock sling are cross through and cradle method.
   e. The universal sling may be utilized to transfer a bariatric patient. The lower limb straps are crossed between the thighs of the patient.
   f. Position the motor so the carry bar is perpendicular to the patient's shoulders. If utilizing two motors position the second carry bar perpendicular to the hips.
   g. Lower the carry bar(s) attaching the sling straps to the desired setting.
   h. Verbally prepare the patient for transfer.
   i. Gently raise the patient clearing the surface they are on; guide the patient by grasping the sling and moving toward the desired transfer surface. Gently lower and position the patient to the chair or desired transfer surface. (The staff should limit the distance and time the patient is in the mechanical lift by arranging the environment. This practice is known as the zero air space procedure when transferring the individual).
   j. When performing a positioning task on a dependent patient, the staff should utilize a repositioning sling. The repositioning sling can be used with the ceiling or floor mechanical lift. The different style slings are: the tri-turner, full body and split sheet sling. The sling loops/strap buckle is attached to the carry bar by the staff without pulling or tugging.
   k. When positioning the dependent patient on their side the sling attachment loops/buckle strap is fastened to the lift carry bar(s) on one side. (Note the tri-turner and split sheet sling is only utilized to turn the patient in bed)

l.   When repositioning the patient up in bed align the carry bar parallel to the patient's trunk. The full body sling attachment loops are connected on both sides of the carry bar.

m.   When repositioning the patient with 2 ceiling lift motors both carry bars should be aligned perpendicular to the patient's trunk. The attachment loops on the full body sling will be connected on both sides of the carry bars. The full body sling is only utilized to turn, reposition and laterally transfer a patient from bed to gurney. Never utilize any of the repositioning slings to transfer a patient to a chair.

n.   The staff may choose to utilize a limb strap or the easy glide boards to

assist in placing a sling behind the patient.

o.   To maintain charge the ceiling lift motor must be returned to the docking station. The amber light will indicate the motor is accepting the charge. Please note, some fixed ceiling motors have a continuous charging track. The amber light will appear when the lift is stationary awaiting use.

p.   The ceiling lift motor has an emergency (red) pull cord to lower the carry bar. The emergency pull cord needs to be reset once disengaged to operate the motor.

F.   **Sit/Stand Mechanical Lift**
A sit/ stand mechanical lift provides a safe seat-to-seat transfer for the patient who has partial weight bearing capabilities in one or both legs and has good cognition. With assist, the patient must be able to move from a supine position to sitting position and balance in a sitting position on the edge of the bed. The assist handle/rail or head of bed can assist with sitting balance. Prepare for transfer before patient sits bedside, including the use of 2-assist. Never leave a patient alone sitting bedside, maintain hands on.

1.   **Equipment/Personnel**
    a.   Sit/stand mechanical Lift
    b.   Two (2) or more caregivers

2.   **Procedure**
    a.   Apply proper harness so that the bulk of the harness rests in the patient's

    lower back region. Tighten the inner belts so that they fit snug to the patient. Apply leg straps if applicable. Never tighten the legs straps on the TT Harness.

    b.   Position the sit/stand mechanical lift with the base of the lift open and lift is facing patient.

    c.   Instruct/assist patient to place feet on the footplate of the lift. Patient's legs must be against the black calf pad at all times during the transfer.

    d.   Attach the strap of the harness to the lift without pulling or tugging.

    e.   Instruct/assist patient to grasp handles on lift with arms on the outside of the harness.

    f.   Close the legs of on the lift during movement of the lift with patient in it. **Do not** move the lift with the legs open.

    g.   Verbally prepare patient for transfer.

    h.   Instruct/ assist patient to lean back into the harness as they are gently lifted minimally from the surface.

    i.   Transfer patient to new surface.
    There must be two caregivers present with their hands on the mechanical lift

**Keypoint: The patient's patella should be above the shin pad when performing a transfer with their feet stationary on the footplate. The patient's patella should be in the middle of the shin pad when ambulating with the footplate removed. The patient may be transferred with one leg resting on the shin pad. i.e. total knee patient.

G. **Transfer/Gait Belt**

A transfer/gait belt provides a firm, grasping surface for the caregiver, protects the patient from accidental trauma to the skin, provides a sense of security to the patient, and protects the caregiver from injury while transferring or ambulating a patient. Transfer/gait belts are used on a patient who is not independent in rising or during ambulation. The patient must be able to move their feet in the desired direction during a transfer. Also, the patient should not require lifting or need to be held up. If a patient is at risk for collapsing or falling, the transfer/gait belt is not the safest mode of transfer. A reassessment is indicated. The sit/stand lift with the TT harness and leg straps may be indicated or a full mechanical lift.

1. **Equipment/Personnel**
   a. Transfer/gait belt
   b. One caregiver – second caregiver assistance used only to manage medical equipment or a wheelchair.

2. **Procedure**
   a. Explain purpose of the transfer/gait belt and the procedure of its use to the patient.
   b. Put the transfer/gait belt on over the patient's clothing and around the waist and make sure the belt is snugly in place.
   c. Assist patient to a standing position by grasping the handles on the transfer/gait belt.
   Keypoint: **Caregiver should be able to insert two fingers between the belt and the patient's clothing.

   d. Before assisting patient in transfer or ambulation, make sure that the belt is properly positioned and that the buckles are securely fastened.
   e. Do not allow patient to place hands or arms around the caregiver's

neck

   f. If a patient begins to slide while getting up, lock the patient's knees against the caregiver's knees.
   g. If the patient begins to fall during transfer/ambulation, pull the patient close to the caregiver's body using the transfer/gait belt, call out for help and lower patient as far as your arms will extend to the floor.
   h. Use the total mechanical lift or ceiling lift to lift patient from floor.

H. **Non-Friction Device**

A non-friction device helps to reduce the push pull forces associated with repositioning and laterally transferring patients. The device is utilized for a patient who is dependent requiring assistance for bed mobility or lateral transfers.

1. **Equipment/Personnel**:
   a. Non-friction device
   b. Two (2) or more caregivers

2. **Procedure for use of Non-Friction Device to reposition in Bed:**

a. Adjust bed to a height that promotes good body mechanics and place the bed in the flat position.

b. Have the patient roll to one side. Position the non-friction device underneath the patient. Place a sheet between the patient and the non-friction device.

Keypoint: Do not pull the non-friction device. Utilize the sheet that is between the patient and the non-friction device. The non-friction device may be applied by tucking the device under a sheet or incontinent pad. Multiple non-friction sheets maybe utilized for a bariatric patient tucking the device half way underneath the individual. The non-friction device may be utilized when performing a portable X-ray slipping the film between sheet layers.

c. With at least one caregiver on either side of the bed, grasp the sheet with the caregiver's palms down and maintain wrists flat on the bed while transferring.

d. Using proper body mechanics, caregivers will shift their weight sliding patient into proper position on the bed.

e. Roll patient until the non-friction device can be removed. The non-friction device may be removed by tucking the device under the sheet or incontinent pad with the second caregiver walking and grasping the device.

3. **Procedure for use of Non-Friction Device to Laterally Transfer**

a. Roll the patient until he/she is positioned on the non-friction device. A sheet should be positioned between the patient and the non-friction device. Note: the non-friction sheet may be tucked underneath the patient if they are dependent requiring assist to roll.

b. Adjust bed so that it is at the same height as the stretcher and so that bed is in the flat position.

c. **Be sure to bridge the gap between the 2 surfaces with a slide board.**

d. The caregivers should be positioned: one on the side of the supporting surface (example: bed, stretcher, procedure table) and the other caregiver on the opposite side of the second supporting surface.

e. The caregiver will grasp the sheet with their palms down and maintain their wrists flat on the supporting surface.

f. Using proper body mechanics, the first caregiver shall push the patient towards the stretcher while the second caregiver receives patient and pulls the patient the rest of the distance.

g. Roll patient until the non-friction device can be removed. The non-friction device may be removed by tucking the device under the sheet or incontinent pad with the second caregiver walking and grasping the device.

Keypoint: The non-friction device cannot be left under the patient after use.

I.   **Air Matt**
An air matt technology increases employee and patient safety by reducing friction, push-pull forces and load during all positioning, repositioning, turning and lateral transfer acts conducted.

1.   **Equipment/Personnel**:
   a.   Air matt
   b.   Two (2) or more caregivers

2.   **Use of the Air Matt to reposition in bed:**
   a.   Adjust bed to a height that promotes good body mechanics.
   b.   Air matt is placed on top of the mattress under the bedding.
   c.   Air matt stays under the patient for as long as needed.
   d.   Air matt is always deflated under the patient.
          Keypoint: Air matt is only inflated when caregivers are standing next to the patient and next to the bed and **prepared to conduct the following tasks: turning, repositioning and performing a lateral transfer.

   e.   Air matt use requires two side rails to be up before turning on the air supply and it requires the patient to be centered on the air matt.

3.   **Use of the Air Matt to laterally transfer:**
   a.   Adjust bed so that it is at the same height as the stretcher and so that bed is in the flat position.
   b.   Make sure patient is centered on the air matt.
   c.   The caregivers should be positioned: one on the side of the supporting surface (example: bed, stretcher, procedure table) and the other caregiver positioned close to the side of the other supporting surface (side rails positioned up if available on surface).
   d.   Using proper body mechanics, the first caregiver should push the patient diagonally (feet first) towards the supporting surface while the second caregiver pulls and receives the patient (feet). Same procedure is performed when the patient torso is diagonally transferred to the supporting surface.
   e.   Once patient is safely transferred to supporting surface, deflate the air matt.

4.   **Use of Air Matt to position patients:**
   a.   Adjust bed to a height that promotes good body mechanics.
   b.   Make sure patient is centered on the air matt.
   c.   Make sure bed rails are in the up position. A pillow should cover the bed rails in the direction the patient is rolling.
   d.   The caregivers should be positioned on both sides of the bed working as a team.
   e.   Using proper body mechanics, one caregiver will push the patient towards the second caregiver, while the second caregiver pushes down on the inflated air matt and pulls the straps towards them.
          **Keypoint: This will cause the patient to begin to roll easily on their side, so the caregivers should not over exert or use excessive force.

   f.   Once the patient is safely positioned on their side, the air matt should be deflated.

5.   **Applying portable x-ray cassette for diagnostic procedure:**
   a.   Adjust bed to a height that promotes good body mechanics.
   b.   Make sure patient is centered on the air matt.

    c.   Inflate air matt and slide x-ray cassette under air matt.
    d.   Deflate air matt and perform procedure/diagnostic test.
    e.   Inflate air matt and remove the x-ray cassette.
    f.   Deflate air matt making sure patient is properly positioned in bed.

J.   **Complications and Reportable Incidents**

1.   All damaged slings should be reported to the nurse manager or nurse supervisor.

2.   Employee injury during lifts or transfers should be reported to employee health and manager. Complete incident report on STARS.

3.   Patient injury during lift or transfer will be reported to the unit manager and physician. A complete incident report will be completed on STARS.
**Keypoint: Report all of the above to the Safe Patient Handling (SPH) Director and SPH Coordinator.

IV.   **Approved by -** (Include date)

Infection Control Committee	8/14
Nurse Policy Council	2/11/15, 3/9/16
Nurse Executive Committee	2/15, 3/16/16

V.   **References**

CL.73 - Safe Patient Handling (SPH)
CL.73a - Safe Patient Handling Assessment Tool
IC.21 - Noncommercial Washing Machine Use
SS-F.1 - Medical Equipment Management Plan

American Association for Safe Patient Handling & Movement

Centers for Disease Control and Prevention – Safe Patient Handling

NYS Assembly Subcommittee on Workplace Safety. Safe Patient Handling in New York: Short Term Costs Yield Long Term Results (2011).
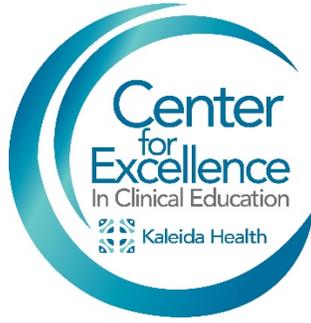
OSHA – Safe Patient Handling

Version History:

Effective Date:	Reviewed/ Revised
4/11/16	Revised

Lift Type	Patient /Resident Criteria	Contraindications	Sling Criteria/Devices	Staff
Total Mechanical Lift or Ceiling Lift	• Non weight bearing • Not able to sit/balance on edge of bed • Non weight bearing patient needing repositioning in a non-reclining chair	• **Cross through attachment method for Split Leg Hammock sling is standard; UNLESS** • **Cradle Method of sling attachment is required for Bilateral Amputees or high residual limb amputations. This attachment may also be more comfortable for Bariatric patients.**	**Use - Hygiene sling if patient has:** • Good upper body control • Cognitive • Able to assist • Transfer is for toileting/access to perineal area.	2 – 2+ Hands on patient/res. for duration of transfer.
			Hammock Split Leg style sling provides universal fit with 2 attachment methods **Sizing: Body morphology also considered** S – 45 – 100 lbs. M – 100 – 210 lbs. L – 210 – 440 lbs. XL – 440 – 800 lbs.	2 – 2+ Hands on patient/res. for duration of transfer.
Sit/Stand Mechanical Lift	• Partial weight bearing in one or both legs • Can hold on with one or both hands • Cooperative • Able to move supine to sit and be able to sit/balance on edge of bed with 1-assist and/or use of assist rail/head of bed. • Partial weight bearing patient needing repositioning in a non-reclining chair	• Abdominal, chest or back surgery (if the area of surgery would be compromised resulting in harm to the patient/resident) • Spinal or pelvic fracture (if the fracture site would be compromised resulting in harm to the patient/resident) • Poor skin integrity in area of belt	**Use - Band Harness if patient:** • **CAN** bear weight continuously	2 – 2+
			Use -TT Harness if patient: • **CANNOT** bear weight continuously • **Band sling is not large enough** • **If leg straps are needed** • **Never tighten the TT Harness leg straps**	2 – 2+ Once patient/res is seated bedside for transfer do not leave their side. Contact Guard
Transfer/Gait Belt	• Full weight bearing and able to ambulate with guidance or hands on cueing • Partial weight bearing if they can take steps and move feet • Steady • Sound cognition • Cooperative	• Abdominal, chest or back surgery (if the area of the surgery would be compromised resulting in harm to the patient/resident) • Spinal or pelvic fracture (if the fracture site would be comprised resulting in harm to the patient/resident) • Poor skin integrity in area of belt	Ambulation devices	1 + another to handle medical equipment
Slide sheets, Air Matt or Repositioning slings	• Bedrest • Unable to assist with lateral transfer • Needs repositioning in bed or reclining chair		• Tri-Turner- size based on bed size • Full Body Positioning Sling- size based on bed size • Split Sheet-size based on bed size • Limb Straps-1 or 2 based on task	Use of SPH Tools and… More than 300 lbs-3 assist may be needed 2-2+
No Lift Device	• Full weight bearing bilaterally • Steady • Or patient ≤ 30 LBS		None	0 – 1

3/17

Thank you for reviewing the orientation materials.

The entire clinical education team wishes you much success!

Please contact our department with any questions or concerns.

I'm not telling you it's going to be easy – I'm telling you it's going to be worth it.

― Art Williams

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