Team Member Annual Required Learning Packet

Required Learning 2022-2023

***In the context of this learning packet, “Team Member” refers to employees of North Memorial Health as well as any person working in the facilities including providers, contracted agency personnel, and students. Assignment of this packet and signing the Required Learning Receipt does not constitute an employment agreement. ***

Required Education 2022-2023

This packet is for NMH employees and others. It presents fundamental and important information that helps us create a safe and caring environment for our patients, clients, customers, coworkers and ourselves.

We call this a “Required Education” because it contains information about the requirements our accrediting agencies identify as needing to be reviewed each year. These agencies include, for example, the Center for Medicare & Medicaid Services (CMS), Occupational Safety and Health Administration (OSHA) and the Minnesota Department of Health (MDH).

We review information not merely as a requirement, but as a process to continually improve our skills and knowledge.

Directions

1. Review this Education Packet.
2. Submit the Required Education Attestation

Paid Employees: The expected time to complete this learning activity is 45 minutes. If you are unable to complete it during scheduled work time, it may be completed outside of work with prior approval from your manager/supervisor. Any overtime must be approved in advance by your manager/supervisor.

If you have questions or any special learning needs, please contact your site leader

Throughout the learning modules you will note references to Policies and Procedures. All policies can be found in the electronic document management system – Compliance 360 (C360)

If you have any issues with the electronic document management system, contact IT 763-581-2580

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OUR MISSION

Empowering our customers to achieve their best health.

OUR VISION

Together, health care the way it ought to be.

OUR VALUES

Accountability, Inventiveness and Relationships.

1. Annual Compliance Training

1.1 Overview

The North Memorial Health (NMH) Compliance Program is an organization wide set of activities that:

- Helps MGH team members follow federal and state laws
- Demonstrate MGH's commitment to ethical business practices
- Encourages team members report compliance concerns

- Facilitates timely response to identified concerns
- Reduces the risk of adverse government/regulatory actions

The Compliance Program helps MGH identify compliance issues and reduce compliance risks.
Compliance Department Staff work with team members to implement changes that correct identified non-compliance and prevent the problem from happening again.

1.2 Program Activities

THE COMPLIANCE PROGRAM INCLUDES:

- MGH Code of Conduct
- Written policies and procedures
- Training and education for team members
- Monitoring and auditing activities that identify areas of non-compliance
- Investigation of reported concerns
- Corrective action plans to correct non-compliance

1.3 Reporting Concerns

All NMH Team members are expected to report any known or potential concerns of non-compliance.

- Team members can report concerns in several different ways.
- All reported compliance concerns are investigated by the Compliance department. Investigations are handled confidentially.

HOW TO REPORT A COMPLIANCE CONCERN

- You can speak to your supervisor and your supervisor will report the concern to compliance
- Email: compliance@northmemorial.com
- Call the Compliance Hotline
    - This number is printed on the back of your team member badge
    - You may leave an anonymous message on the Hotline

1.4 Retaliation

NMH prohibits anyone from retaliating against a team member who asks compliance-related questions or makes a compliance report in good faith.

However, if you do not feel comfortable identifying yourself, you may leave an anonymous message on the Compliance Hotline.

Please be aware that anonymous reports do not allow Compliance Staff to gather more details from you to assist with completing a thorough investigation. You are encouraged to leave contact information when making a report.

1.5 NMH Code of Conflict

- The NMH Code of Conduct is available on the Compliance Department intranet webpage and with our policies on C360.
- The Code of Conduct is a set of principles that ensure MGH business is conducted in a safe, respectful, and ethical way.
- All team members must follow the Code of Conduct when conducting their job duties.

1.6 Policies and Procedures

All NMH policies and procedures are maintained in the document management system. Our system is called Compliance 360 or C360.

Team Members have access to the Document Management System. It can be accessed through the NMH Citrix Portal. Non-employed team members who do not have access to NMH Citrix portal should contact their onsite NMH leader to review documents/policies as needed.

All revised Policies and Procedures must be approved according to NMH policy management process. You can learn more about this process on the C360 Document Development and Approval Process.

1.7 Patient Nondiscrimination

North Memorial Health is committed to providing customer care to all communities.

Discrimination against customer or visitors based on age, ancestry, color, disability, gender, gender identity, marital status, parental or familial status, race, religion, creed, national origin, sexual orientation, status with regard to public assistance, membership or activity in a local commission, or veteran's status is **prohibited.**

For more information, please refer to the Patient Nondiscrimination policy in C360.

1.8 Conflict of Interest

A conflict of interest exists when your own personal interests influence or appear to influence your actions while performing NMH duties.

NMH has a conflict-of-interest policy that all staff must follow. Any potential conflicts of interest must be reported.

Team members must maintain professional relationships with customers.

- NMH prohibits team members from accepting cash or cash equivalents like gift cards or vouchers from customers. Non-monetary gifts (flowers, candy, cookies, pizza) from a grateful customer may be accepted if the item is reasonable and is shared among team members.
    - Team members must not serve as a personal representative for a customer or be named in a customer's will.
    - Clinical team members may not provide care to his/her own family members

Business relationships may create conflicts of interests.

- NMH prohibits team members from accepting gifts or reimbursement from vendors. Please see the Gift Policy for more information.
- NMH prohibits team members from conducting personal business at work, as well as using MGH equipment or property for conducting personal business.
- Medical staff are prohibited from engaging in inappropriate self-referral arrangements.
- No NMH team member may offer gifts or payments of any kind to a physician who refers customers to NMH.

1.9 Expectations

Expectations of Compliance

- Compliance is an expectation of your employment.
- Compliance violations are subject to disciplinary action, up to and including termination
- All disciplinary actions taken for non-compliance are consistent with MGH Human Resources policies.

When in doubt, ask questions and report concerns!

COMPLIANCE CONTACT - Chief Compliance Officer: Compliance@northmemorial.com

2 Covid-19 Essential Information

2.1 COVID-19 Transmission

Covid-19(SARS-CoV-2 virus) spreads when an infected person breaths out droplets and particles that contain the virus. People who are closer than 6 feet from the infected person are most likely to get infected.

COVID-19 is spread in three main ways:

- Breathing in air when close to an infected person who is exhaling particles that contain the virus.
- Having these small droplets land on the eyes, nose, or mouth especially through spray that occurs when coughing and sneezing.
- Touching eyes, nose, or mouth with hands that have the virus on them.

Pre-Symptomatic

- A person who has not yet developed symptoms but goes on to develop symptoms later.

Asymptomatic

- An infected person who never developed symptoms.

Transmission of COVID-19 can occur whether the infected individual is asymptomatic, pre-symptomatic or showing symptoms of the illness.

2.2 When to Seek medical Attention

What to do if you are sick with COVID-19

- Most people with COVID-19 have mild illness and can recover at home without medical care
- Take care of yourself. Get rest and stay hydrated.
- Stay home except in the event you need medical care
- if you are showing any of these signs seek emergency medical care immediately:
    - trouble breathing
    - persistent pain or pressure in the chest
    - new confusion
    - inability to wake or stay
    - pale, gray, blue colored skin, lips, or nail beds depending on the skin tone

Call 911 or call ahead to your local emergency facility. Let them know you are seeking care for someone who has or may have COVID-19.

2.3 Employer- Specific Policies and Procedures on Patient Screening and Management

Early identification of illness helps control the spread of COVID-19. NMH has protocols in place to identify customers displaying signs or symptoms of COVID-19 across multiple settings.

- Outpatient customers are screened through Care Access at time of check-in.
- Hospital nurses screened for risk factors as part of the triage process.
- Admitted customers are tested for COVID-19 regardless of symptoms.

Mask Use

- All team members are required to use a medical grade mask in customer-facing spaces per current public health guidance for COVID-19.
- This provides source control from potentially infectious particles, even if the individual is asymptomatic.
- There may be instances when a customer's acute medical condition does not allow them to tolerate the use of a mask.

Standard Precautions

- All team members are required to use a medical grade mask in all customer-facing spaces per current public health guidance for COVID-19.
    - Wear a mask that fits snuggly and covers both the nose and the mouth, avoiding frequent touching of the exterior of the map when in use.
    - When removing, grasp by ear loops. Do not remove it by touching the front of the mask.
    - Obtain a fresh mask daily and whenever you have is wet, damaged, or soiled.

- Eye protection is also required for team members when performing bedside/direct patient care tasks.
    - Note: personal eyeglasses alone are not considered eye protection.

Full Barrier Precautions

- Customers identified as COVID-19 person under investigation (PUI) are managed with a higher level of PPE protection, known as full barrier precautions.
- Refer to infection prevention policies and procedures for full barrier precaution details.

Patient Clinical Management

Patient clinical management protocols are available on the COVID-19 Intranet resource page for specific clinical areas.

2.4 Tasks/Situations that Result in COVID-19 Exposure

- Team members can be exposed to COVID-19 by either a customer or another team member
- Data provided from the Minnesota Department of Health shows that household/social exposures (outside of work) is the most likely source for a healthcare worker to acquire COVID-19.
    - ≤ 2% of healthcare workers acquire COVID-19 after a known high-risk exposure in the workplace

Team Member to Team Member Exposure Risks

Situation	Risk Level	Example
TM was in the same indoor environment **without a mask** on, but >6 feet away and <15 minutes	Low ✓	Break room, cafeteria (where a mask would be removed for eating)
TM was in the same indoor environment **with a mask** on, with close contact (<6 feet for >15 minutes)	Low ✓	Team members attended a meeting together in a conference room
TM was in the same indoor environment **without a mask** on, with close contact (<6 feet for >15 minutes)	High ✕	Team members ate lunch together at the same table
TM had direct contact with infectious secretions of the infected TM, **with or without a mask***	High ✕	Team member was coughed on or touched a used tissue with bare hand

*Refer to HCW exposure grids on COVID-19 intranet page for detailed exposure information

Team Member to Patient Exposure Risks

Situation	Risk Level	Example
TM **and** patient wore a mask during close contact. No aerosol-generating procedures were performed.	Low ✓	Team member roomed a customer and performed vitals.
TM wore a mask and eye protection during close contact with an **unmasked** patient. No aerosol-generating procedures were performed.	Low ✓	Team member provided routine care to an unmasked patient (toileting, positioning, wound care, etc.).
TM wore a respirator* but did not have on eye protection during close contact with an **unmasked** patient. No aerosol-generating procedures were performed.	High ⚠	Team member provided routine care to an unmasked patient, but lacked a critical PPE element (eye protection).
TM wore a mask while performing/present for an aerosol-generating procedure instead of wearing the following: respirator*, eye protection, gown and gloves. The patient was **not masked.**	High ⚠	The team member emergently intubated the patient, but lacked one or multiple PPE elements.

*Respirator = N95, PAPR or elastomeric devices

2.5 COVID-19 Medical Removal from the Workplace

Team Member must notify the Team fine if you can get it yeah Member Service Center if they:

- Have experienced high risk exposure with an individual with confirmed positive for COVID-19
- Have tested positive for COVID-19 or have been diagnosed with COVID-19 by a licensed healthcare provider
- Have been told by a licensed healthcare provider that they are suspected to have COVID-19
- Are experiencing a fever of ≥ 100.4 degrees Fahrenheit and new unexplained cough associated with shortness of breath or
- Are experiencing two or more of the following symptoms
    - Cough, sore throat, headache, shortness of breath, body aches, loss of taste or smell, nausea or vomiting, diarrhea, congestion or runny nose.

The Team Member Service Center must be contacted through a ServiceNow Request or phone call.

- Team Members will be removed from the workplace and will need to complete an acceptable COVID-19 test indicating a positive result for work exclusion. In addition to the Abbot and QuickVue, the CDC has approved the acceptance of all home antigen tests indicating positive results.
- Team Members receiving a negative result:
    - Team members with symptoms and a negative antigen test must complete a PCR test.
    - Team members receiving a negative result from a PCR test are expected to return to work immediately. You do not need to receive clearance for return to work from the TMSC prior to reporting back to work with a PCR negative test result
    - If the Team Member is still ill or shows signs of a fever, even if the PCR test is negative, team member should not return to work and may need to seek further clinical evaluation.
- Team members receiving a positive test result:
    - Team Member receives a positive result from an accepted antigen and/or PCR test must meet the return-to-work guidelines and be cleared to return to the workplace.
- Team members who refuse or cannot take a test
    - If a team member refuses to test for COVID-19, the team member will be medically removed from work consistent with the CDC and OSHA COVID-19 ETS
    - Team members that refuse to take a COVID-19 test will not be eligible for medical removal benefits

- Team members who cannot take the test for religious or disability-related medical reasons consistent with the Americans Disability Act (ADA) must request an accommodation through Team Member Health

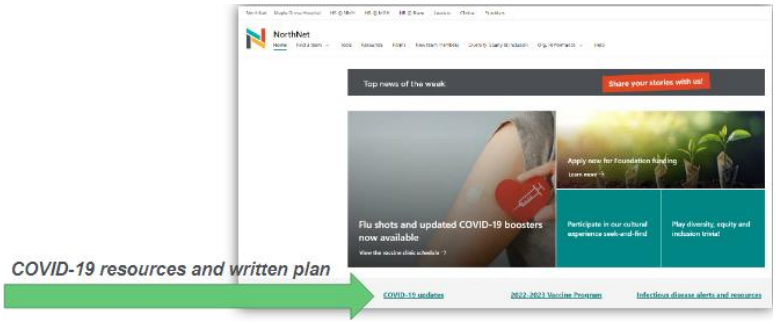
2.6 Covid-19 Medical Benefits

Team members will be provided job protected leave while medically removed from the workplace due to COVID-19 when remote work is not available.

- Team Members are required to use their available paid time away (sick, vacation, paid time off, medical leave bank, and/or sick and safety leave) while absent from work.
  - If available paid time away is exhausted, team members will be allowed to go negative up to 40 hours with vacation or paid time off
  - Once available pay time off is exhausted (including a negative balance of 40 hours), team members who meet the medical renewal requirements will be eligible for company paid leave up to, but not to exceed, their biweekly hours held within the HR system (FT E)
    - Medical removal benefits will be reduced by the amount of compensation received through any other source, such as publicly or employer funded compensation program (i.e., Worker's Compensation benefits, Short-term Disability Benefits, etc.)
  - Team Members will be provided paid time for a reasonable amount leave during a scheduled shift to receive a COVID-19 vaccination.
    - Team Members must work with their leader to take time to receive each dose of the COVID-19 vaccination or booster.
    - Team Members who experienced side effects of the COVID-19 vaccination will be provided absence forgiveness for up to two calendar days immediately following vaccination.
      - Team members are required to use their own pay time away for absences related to COVID-19 vaccination side effects

2.7 COVID-19 Policies and Procedures

Current COVID-19 protocols and procedures can be found on the NMH Intranet under 'COVID-19 Updates'



3 Customer Care Team Members

3.1 Patient Identification

How Many patient identifiers are required for administering medications, collecting blood samples, and other specimens for clinical testing (not including Blood Bank samples), and providing treatments or procedures or services? (Services include transporting patients within North Memorial Health Hospital and transferring patients to other healthcare facilities) **TWO** – Patient identification includes active

involvement of the patient, if able, and /or family. If possible, always ask the patient to state their name and DOB.

- The patient identification (ID bracelet must be on the patient at all times. It cannot be taped to the bed.
- The patient's room number or physical location is NEVER used as an identifier.
- If the patient's identity is unknown, refer to the section: Patients that Present with Unknown Identifying Information in the Patient Identification policy.

3.2 Specimen Labeling for Lab Testing

- The correct labeling of laboratory specimens is critical to customer care and customer safety.
- Print specimen labels only when you are ready to collect the sample from the customer.
- If any part of the patient (customer) identification is missing and/or "cut off" from the label, you must hand write it or print a new label that is accurate. Call IT for any label printer problems.
- Collect all blood samples according to established "Order of Draw" and mix well immediately after collection.
- Label all samples at the customer's bedside, verifying that the patient (customer) identification band matches the sample labels before you leave the room.
- Apply the label STRAIGHT with the tube cap on your left.
- Place label over the original label on the tube, with tube cap on the LEFT (not over the clear opening-sample must be visible to ensure specimen integrity)
- Write your initials and the date and time of collection on the bottom, lower right corner of the barcoded label, with ink (Yes, we know it is a small space)
- DO NOT WRITE ANYTHING NEXT TO THE BARCODE
- No black pen, sharpie marker, or pencil. You can use a red pen – this does not interfere with the instrument barcode.
- Never label "the lid" of a sample. The identification must be on the body of the container.
- The laboratory will test only those samples that have complete and accurate identifying information affixed to the specimen container. Specimens that are not adequately labeled must be recollected per laboratory policy.

Order of Draw for Common Laboratory Tests

Order of Draw for Common Laboratory Tests

1  ***Blue -*** Sodium Citrate anticoagulant – tube MUST be filled to minimum fill line. (e.g., PT/INR, PTT, Heparin, D-dimer, Fibrinogen)

2  ***Red -*** No anticoagulant in tube (e.g., drug levels, miscellaneous tests)

3  ***Yellow -*** No anticoagulant in tube (e.g., Hepatitis, HIV, SARS - this sample type produces serum vs. plasma)

4  ***Green (Plasma Separator Tube) –*** Lithium Heparin anticoagulant (most chemistry testing – e.g., BMP, Lipids, Troponin, Liver enzymes, Kidney function testing)

5  ***Purple-*** EDTA anticoagulant (e.g., CBC, CBC w/diff, Hgb, Platelet, Sed rate)

6  ***Pink-*** EDTA anticoagulant – mostly Blood Bank testing - which requires a 3rd unique Customer Identifier***

ALWAYS USE 2 UNIQUE CUSTOMER IDENTIFIERS
LABEL ALL TUBES AT THE PATIENT BEDSIDE
Place specimen labels directly over original label, reading from left to right with cap of tube on left. Date, time and your initials.

Refer to test generated Label for all tube type requirements, *examples listed are not all-inclusive.*

***** Tubes shown in order of draw starting from top**
*****If Blood cultures are ordered they become the 1st to draw**
Call the Laboratory if you have questions

3.3 Point of care Lab Testing

Patient (customer) identification is the first and most important step in performing bedside testing on our customers. All Point of Care testing requires the HAR (encounter) number for the patient (customer) ID. The team member performing the testing must accept the responsibility toward assuring the accuracy of every single result. Following the individual testing procedures in C360 and adhering to all the test requirements are mandatory.

North Memorial Clinical Laboratory supports Point of Care testing in the hospital:

- Whole blood glucose testing
- *EPOC blood gas and chemistry reporting in the ED (ECC), NICU, ICUs and OR*
- *Activated clotting time (ACT) in OR, Cath lab, and A4*
- *Urinalysis and hCG in the ED (ECC)*
- *AmniSure ROM (rupture of fetal membranes) in Labor and Delivery.*

There is required initial and annual competency for all waived testing (WBG, urinalysis, Clinitek, and hCG), and an additional 6 month AND annual competency for "moderate complexity" testing (EPOC, Hemochron and AmniSure).

3.4 Patient (Customer) Hand Off

Customer hand offs have been identified as a vital opportunity to pass on information from team member/provider to team member/provider to keep a customer safe.

NMH procedure for customer hand off is as follows:

- Use SBAR (Situation, Background, Assessment and Recommendation) framework to pass on critical information about the customer and their care.
- Read-back to verify important information
- SBAR is to be used in the customer's medical record notes as well as in verbal communications between health care professionals.

3.5 Pain Management

We take a holistic approach to pain management and focus especially on making sure our customers are comfortable during their hospitalization. In addition to medications and non-pharmacologic treatments (such as aromatherapy and heat/cold compresses), comfort enhancing techniques including a quiet environment conductive to healing, a warm smile and conversations, and attention to details (for example making sure the call light is within reach, watching for non-verbal signs of discomfort). We believe everyone has a role in helping our customers.

Improve Recognition & Response to Changes in a Customer's Condition

All customers will receive the best level of pain control that can safely be provided in order to prevent unrelieved pain. See Policy and Procedure: Pain Management. Pain management includes regular pain assessments that include level of pain, location, intervention, reassessment and appropriate customer/family interventions/education.

- Providing customers/family with verbal and written information about pain management, including pharmacologic and non-pharmacologic interventions
- Teaching customers/families to use pain rating scale that is age appropriate for reporting pain intensity and that the goal of pain management is prevention (Example pain scales: Numeric, Verbal, N-Pass, FLACC, Faces, Behavior)
- Developing an individual pain management plan which includes the customer's goal for pain management, customer preferences for treatment, age, type of pain, risk for cognitive impairment, history of chemical dependency, chronic pain and cultural beliefs and practices.
- Perform hourly rounding using PEEP (Pain, Elimination, Environment, Positioning) as a tool each hour to ensure pain is being managed and reassessed.
- Using the Careboards for communicating comfort goals, plans, and interventions to team members and customer/family.

- An INTIAL assessment is required prior to pain intervention. Best practice shows to do this within 30 minutes.
- A pain REASSESSMENT must be completed within 60 minutes following an intervention.

3.6 Fall Prevention for Customers

The following are basic actions that should be done for every customer to assist in identifying and preventing falls:

Fall Risk Assessment:

- Appropriate fall risk assessment should be chosen based on care area. See Fall Prevention Policy and Procedure.
- Conduct a fall risk assessment upon arrival, during admission, once every shift and with any change in condition.
- Nurses may implement fall prevention interventions for any customer, including those who are not considered at high risk of falling.
- If a customer has fallen during hospitalization, they are considered at high risk for falls for the remainder of their hospitalization. A hisotry of falls is considered a risk factor for future falls.\

Medications

- Assess customer's medication to determine risk for dizziness, leightheadedness, or postural hypotension.
- Consult pharmcy if you have any concerns.

Educate Customer and Family

- Educate and inform the customer and family how to prevent falls at the start of every shift and as needed throughout the shift to ensure awareness.
- Encourage the customer to:
    - Wear non-slip socks when ambulating
    - Call for assistance
    - Use assistive devices
    - Keep items within reach
- If they are a fall risk, instruct them to call for assistance every time they get up.
- Educate regarding alarms: they are intended to keep customer safe.

Rounding

- Complete hourly rounding including the components of PEEP (Pain, Elimination, Environment, Positioning) on each customer, noting that fall interventions are appropriately in place and activated for those at high risk. Most of the hospital falls have been related to a customer needing to use the toilet. Ask every hour during Hourly Rounds about toileting and be proactive with scheduled toileting with appropriate for the customer.

Identify

- Use green light indicator outside of room, check fall risk on the care board, place a green wrist band and red socks (NMHH) or gripped socks (MGH) to identify them as a fall risk.

Interventions

- Always stay within arm's reach when a high fall risk customer is ambulating, transferring, or when on the toilet or commode.
- Use bed alarms and chair alarms – ensure they are on and working during Hourly Rounds and after ambulating or transferring
- Keep beds at the lowest level and keep wheels locked. Use the Seated Positioning System for customers at risk of sliding out of the chair.
- Keep items within reach. A large number of falls occur because customers are reaching for something. Ensure the trash basket, water, personal items, and call light are within reach before leaving the room.
- Gait belts should be used consistently and sent with patients to ancillary departments to assist in transfers. Utilize assistive devices and wheelchairs as appropriate based on customer conditions.
- **Consistent use of interventions is KEY in preventing falls!**

3.7 Pressure Injury Prevention

NMH continues to have reportable pressure injuries. **Specifically, device related, and bony prominence pressure injuries are of concern.**
Preventing hospital acquired pressure injuries is imperative for customer safety at North Memorial Health. Pressure injury prevention requires a team approach. Identifying customers at risk for skin breakdown is the initial step. Once an at-risk customer has been identified, it is imperative for the whole team to implement prevention measures immediately and remain consistent until the risks have been removed.

Head to toe assessment reminders:

- Admission: all customers should be assessed from head to toe within 4 hours of admission and transfer to inpatient unit. Assessment includes:
    - "Two sets of eyes" (NMHH Only)
    - Inspecting and palpating skin and bony prominences
    - Ensure documentation of measurements for wounds that require them
    - Utilize Rover devices to take pictures of any PTA wound/skin issues
- Ongoing and Change in Condition:
    - Med-surg every 8 hours
    - ICU every 4 hours

Pressure Injury Prevention Interventions:

- Provide thorough skin care
- Review nutritional status
- Reposition patients with a Braden of 18 or less minimally every 2 hours
- Limit supine positioning
- Look under, remove and reposition mechanical devices, per standard, to decrease pressure and related events
- Perform PEEP (Pain, Elimination, Environment, Positioning) rounds each hour to ensure repositioning is being completed and pressure injury prevention measures are in place.
- Use tools such as TAPs, Z-Flo, Seated Positioning System, heel boots, etc. to offload and redistribute pressure.

Communication and Education:

- Educate customers and family about the risks and how to prevent skin break down.
- Discuss pressure injury prevention with managing provider
- Develop and individualize a plan of care that includes pressure injury prevention and skin care.
- Communicate findings or concerns to care team, this includes during every customer hand off, report, and interdisciplinary rounds.
- If you see something new or of concern, place interventions and escalate through a WOCN consult, safety first and through the Charge RN (NMHH) or PCF (MGH)

Resources

Utilize support tools in the electronic health record such as the Skin Accordion to synthesize information related to skin.

- See the Pressure Injury Prevention and Management-Adult policy for specific standards and expectations

3.8 Lift Equipment

Objectives:

The learner will be able to:

- Identify lifting equipment that is available at the NMHH and MGH
- Review case studies regarding which piece of equipment to use

We Know That Bedrest is Bad!

Prolonged immobility is correlated with:

- Increased length of stay
- Increased admission to nursing homes
- Falls during and after hospitalization
- Loss of independence after discharge
- Increased cost of hospitalization

Progressing mobility:

- Begin with bed mobility (have patient help to roll, boost, etc.)
- Sit at edge of bed
- Standing at bedside
- Transfer to chair (for meals)
- Walk to the bathroom vs. use of commode
- Walk in the halls

At any point, if these activities require a heavy assist of 2 or more people, consider using lift equipment.

3.9 Critical Results and Communications

- Critical tests and critical results are reported and documented as a priority and are timely.
- Results must be communicated to or received by the responsible licensed caregiver (RN or MD) who may act on behalf of the customer
- Verification of customer identification and the reported critical value must always be confirmed with a "read back" of the information by the qualified recipient.
- Please see *Critical Communications, Results and Findings* policy for more information.

3.10 Surgical & Procedural Site Marking

- Surgical and procedural site marking occurs to ensure the correct procedure is completed on the correct customer. Customer site marking occurs before procedures, regardless of where the procedure will be performed, e.g., Operating Room (OR), Patient Care Center (PCC), Post Anesthesia Care Unit (PACU), Interventional Radiology (IR), or the customer's room. Verification occurs at multiple points in the care of the customer and requires coordination between the privileged provider performing the procedure, the customer or legal guardian, and all members of the surgical/procedural team.
- The privileged provider performing the procedure marks the correct surgical or procedure site. With the customer awake and aware, if possible, the privileged provider will mark the procedure or operative site with their initials. The site will be marked with a permanent marker that will be visible when any draping or prepping of the site occurs. When unable to mark the site, this is documented on the Alternate Site Marking Tool.
- For anesthesia procedures, such as regional blocks, the anesthesiologist will mark the site with an "A" and circle the "A". For procedures involving the spine and ribs, intraprocedural imaging with opaque instruments marking the specific boney landmarks will be taken and are compared with the pre-procedure imaging. Final verification is the comparison of pre- and intra-procedure imaging by the privileged provider performing the procedure.
- Associated Policy: Time out

3.11 Time Out

Just prior to the incision, injection, or procedure start, a final verification process "Time Out" is performed. Through active verbal participation, the privileged provider performing the procedure and surgical or bedside procedure will initiate the "Time Out" by stating "Let's do the Time Out."

- *All team members will stop their routine duties and focus their attention on the final verification of:*
    - Customer identity using two identifiers
    - Informed consent form/source documents
    - Correct operative or invasive procedure
    - Correct procedure side or site (and level if appropriate)

- Necessary imaging, equipment, implants, or other special requirements available, as appropriate
- Correct customer position
- Visualization of the marked site(s), if applicable
- Pre-procedural antibiotic administered, if appropriate
- Fire Risk Assessment is conducted for all procedures in the Operating Room. The Fire Risk Assessment is completed by the Anesthesia Provider when present
- Medication on field
- Allergies

- Associated Policy: Time out

3.12 Stop the line

All team members, medical staff, students, and volunteers have the responsibility and authority to immediately intervene to protect the safety of a customer, to prevent a customer safety event and subsequent customer harm.

Any team member providing customer care will immediately stop and respond to the request to stop for clarification to reassess the customer's safety. This is a proactive practice to speak up in advocating for all our customers receiving care. North Memorial Health leadership supports all personnel to speak up and advocate for customer safety.

Any team member who observes or becomes aware of an imminently harmful situation in customer care has the authority and responsibility to speak up and request the process be stopped to clarify the customer safety situation.

Examples of care situations of concern might be:

- A customer is being prepared for a surgical procedure, when you notice missing elements on the informed consent and another team member is present to transport the customer to the OR.
- A team member enters a customer's room to transport them to another unit for testing and when checking the patient (customer) identification, the arm band is missing, and you observe the customer transferred to the wheelchair in preparation to leave the room.

Team member is to verbalize "Stop the Line, I have a customer safety concern," at least two times to ensure that the request has been heard by all parties involved.

A "STOP THE LINE" situation takes priority over any provider and/or licensed independent practitioner order or intervention. Care is resumed when all of the involved parties are in agreement that the concern(s) have been resolved, explained and/or reconciled.

When there is non-compliance in responding to the "Stop the Line" request, the chain of command (Administrative Consult) policy process is followed.

Care situations in which a "Stop the Line" request was verbalized and not honored are reported, reviewed, and followed up by clinical leadership.

Retaliation by any individual against a team member making a good-faith request to "Stop the Line" will not be tolerated. Medical Staff leaders and/or Human resources are to be consulted if retaliation occurs or is perceived to occur.

3.13 Care Plans

An individualized plan of care and customer education is developed and documented within 24 hours of admission and includes goals and interventions.

The care plan is reassessed and individualized to the customer every shift and with condition changes, and includes the following:

- Goals which are consistent with the provider's plan for medical care

- Nursing interventions
- Evaluation of customer's progress towards the goals
- Reflection of findings on assessments, both physiological and psychosocial factors
- Discharge planning
- Interdisciplinary assessments (as applicable)

The care team member documents the customer's progress towards meeting the plan of care goals which have been the focus of care.

The care plan and customer education are resolved when goals are met, teaching completed, or customer is discharged or transferred.

3.14 Vocera use

The Vocera badge is to be used primarily for internal business to relay information that pertains to active customer care and to assist staff in being responsive to customers' needs.

- Every attempt should be made to achieve appropriate communication practices to limit disruption to the customer and care teams and to protect customer information. Inappropriate or vulgar language shall not be used. Be aware of the volume of your device settings and your voice when using Vocera.
- Team members must always be aware of their surroundings and protect patient information as outlined by HIPAA. The following options will help maintain confidentiality during calls:
    - Walk to a private area to take the call
    - Place the call "on hold" and walk to a private area to take the call
    - Transfer the call to a nearby phone and resume the call
    - Return the call at another time
    - Do not leave messages that include customer identifiable data
    - Do not leave messages that include medical verbal orders. Vocera messaging shall not be used to give or receive medical verbal orders

Reminders:

- Be courteous and respective when answering a call on Vocera.
- Set the stage for a caller "Hi this is -----, I am with a customer, how can I help you?"
- If calling someone on Vocera, be mindful that they may not know who is calling and may be busy, say "Hi this is----, is this a good time?" or "Hi this is ---, can you please call me when you are finished?"
- More details about communicating via Vocera can be found in the policy "Appropriate Use of Vocera Communication System" found in C360.

3.15 Verbal and Telephone Order Safety

- Verbal and Telephone orders are given directly from the ordering physician to the approved care team member taking the order. No third party should be involved.
- Ordering physician will clearly state the order, spelling out any "Sound alike" words. No abbreviations should be used
- The approved care team member who receives the order will repeat it back and the individual that gave the order then must confirm that the read back is correct.

4 Customer Safety

4.1 Patients' Bill of Rights

Each of us must ensure a health care ethic that respects the patient. Staff must be sensitive to cultural, racial, linguistic, religious, age, gender, sexual orientation, and other differences including the needs of persons with disabilities.

Federal and state government law exists around a "Patients' Bill of Rights". The intent of the Patients' Bill of Rights is to ensure that all regional activities be conducted with an overriding concern for the values and dignity of patients. Centers for Medicare and Medicaid Services and our accrediting agency (DNV) survey compliance to ensure we are meeting the Patients' Bill of rights.

The Patients' Bill of Rights Includes:

1) Information about rights
2) Courteous treatment
3) Appropriate healthcare
4) Physician's identity
5) Relationship with other health services
6) Information about treatment
7) Participation in planning treatment
8) Continuity of care
9) Right to refuse care
10) Experimental research and right to associate
11) Freedom from maltreatment
13) Pain Management
13) Treatment Privacy
14) Confidentiality of Records
15) Disclosure of Services Available
16) Responsive Service
17) Patient Privacy
18) Grievances
19) Communication Privacy
20) Personal Property
21) Services of the Facility
22) Protection and advocacy Services
23) Right to communication Disclosure
24) Seclusion and restraint

All patients receive a copy of the Patients' Bill of Rights. This includes:

- Clinic/Emergency services
- Same Day Surgery
- Hospital admission
- Ambulatory services

Patient Rights information is posted at key entrances. The patient Bill of Rights is available in large print and different languages from Minnesota Department of Health website at https://www.health.state.mn.us/facilities/regualtion/billofrights/index.html

4.2 Visitation Rights

- North Memorial Health (NMH) is committed to providing a safe, healthy, and healing environment for all customers, families, visitors and team members.
- NMH welcomes customer's choice of visitors including but not limited to a spouse, a domestic partner including a same sex partner, another family member or friend.
- NMH does not restrict, limit or otherwise deny visitation privileges based on race, color, national origin, religion, sex, gender identity and expression, sexual orientation, or disability.

For more information, please refer to the Visitation Rights policy in C360

4.3 Patient Responsibilities

To have the best possible treatment experience while someone is a patient, they are asked to take on some responsibilities, such as:

Provide information about health status
Keep appointments
Be honest
Know their medications
Understand their health problems
Know their caregivers
Follow the treatment plan
Be considerate of others
Accept consequences of not following treatment plan
Be tolerant/accepting of those who are different from them

Along with these patient responsibilities, patients are being asked to participate in:

- Assessment and management of their pain
- Creation of a safe environment for their health care like asking questions when they don't understand what they have been told or need clarification on procedures or medication usage.
- Communication with caregivers to accurately inform them of medical conditions, medications or other health-related matters.

4.4 Suspected Abuse, Neglect or Financial Exploitation

Health care providers are defied by Minnesota Law as mandated reporters. Minnesota Law requires mandated reporters to report suspected maltreatment of vulnerable adults including suspected abuse, neglect or financial exploitation. North Memorial Health has a internal reporting structure through RL solutions.

If you are unsure, it's better to report than not report.

Vulnerable Adults

All health care professionals are required to report to a county CEP/Adult Protection agency if/when they believe that a vulnerable adult is being or has been maltreated or has sustained an injury that's not reasonably explained.

What is a vulnerable adult?

- 18 years of age or older
- Lives in a licensed facility where he/she receives care of supervision
- Receives home care services, clinic or hospital care
- Has a physical or mental infirmity or an emotional dysfunction which limits his or her ability to meet their basic needs or impairs the ability to protect him/herself from maltreatment

What is maltreatment?

- ***Abuse – Includes but is not limited to:***
  - Assault, criminal sexual conduct, verbal abuse, hitting, slapping, kicking, involuntary confinement, deprivation, etc.
  - Use of drugs to injure or facilitate a crime
  - Staff to patient sexual conduct
- **Neglect – Includes but is not limited to:**
  - Failure to provide for basic needs of food, shelter, health care and sleep
- **Financial exploitation- includes but is not limited to:**
  - Misuse of funds, especially for benefit other than to patient, unauthorized expenditures

Reporting

If you have a concern that a patient is being abused or mistreated, call the MN Adult Abuse Reporting Center at 844-880-1574

If you are unsure, it's better to report than not report.

For more information see the Vulnerable Adults-Mandated Reporting and Child Abuse/Maltreatment Assessment and Reporting policies and procedures

<u>Child Abuse</u>

Child abuse/maltreatment can be inflicted by anyone caring for children, and it can occur in all types of families and settings. It is important to remember that children of all ages may be abused. Health care workers must always be alert to the possibility that abuse/maltreatment may be occurring. The child may not say anything or may say that he/she has never been hurt. Children frequently do not complain about abuse. All health care providers and other staff are legally required to report suspected neglect, physical or sexual abuse of a child to County Child Protection Services.

<u>Some indicators of child abuse and maltreatment are:</u>

Physical injuries

- Injuries inconsistent with explanation given

- Injuries to face, head, chest, abdomen, or genitals
- Bruises, welts in various stages of healing, fractures, burns, or abdominal injuries
- Underweight, poor growth pattern, failure to thrive
- Lack of appropriate food, clothing, shelter, medical care, or supervision

Behavioral Indicators

- Aggressive behavior or delinquency
- Attempted suicide, alcohol or substance abuse
- Family history of violence, alcohol or substance abuse
- Witness to violent or domestic abuse in the home environment
- Reports of sexual assault, exhibits unusual sexual behavior or knowledge

Infant or unborn child abuse/maltreatment Physical and behavioral indicators (maternal)

- Current enrollment in drug/alcohol rehab program or report of substance use
- Previous history prenatal substance-exposed infant
- Inconsistent or inadequate prenatal care
- Violence and substance abuse in the home
- History of incarceration, probation or parole
- History of loss of parental rights/custody
- Unexplained hypertension, vaginal bleeding, abruptio placenta, preterm labor, precipitous delivery

Physical and behavioral indicators (infant)

- Positive toxicology screen for un-prescribed medications or drugs
- Excessive jitteriness with normal blood glucose
- Poor feeding or frantic sucking
- High-pitched cry
- Seizure, vomiting, watery stools

To report suspected cases of child physical abuse and neglect (up to 17 years of age), call the Suspected Child Abuse and Neglect (SCAN) Team at ext. 1-4357 or 763-581-4357. A member of SCAN team will assist in identifying, reporting, and collecting information

Domestic Abuse

Maple Grove Hospital's policy is that all patients, men as well as women, will be assessed for domestic abuse. The patient's response to the assessment questions must be documented in the medical record. It is important for the patient to know that this is a safe place to discuss issues of physical, emotional, or sexual abuse whether current or past. The medical setting provides a unique opportunity to meet with patients in private, so the patient can feel safe to disclose concerns about abuse.

A few indicators of abuse:

Emotional abuse

- Depression, suicide attempts, panic attacks
- Chemical use
- Threats to harm victim, family members, pets

Sexual / Physical abuse

- Statements of forced sexual contact, rape
- Presence of a sexually transmitted disease
- Injury to vaginal and/or rectal tissue
- Marks to areas commonly covered by clothing
- Strangulation marks on neck

Presenting symptoms

- Injuries inconsistent with explanation of injury
- Frequent medical visits with vague complaints or symptoms (may be a cry for help)
- Partner answers all questions, overly solicitous, does not want to leave patient alone with hospital staff
- Little or no prenatal care
- Considerable delay in seeking medical treatment

Documentation

- Objective, factual reporting of injuries and statements made by patient may be invaluable to patient in possible legal proceedings and should be documented
- Photographs of injuries
- Inform patient that medical records are available for them if needed as proof

Positive assessment:
If an assessment is positive, ask patient if she/he would like to talk with a Safe Journey Advocate who can assist with safety planning, support and resources. If the patient agrees, make referral by calling Safe Journey, extension 13940 or 763-581-3940.

4.5 Informed Consent

Healthcare providers must discuss all treatment options with their patients. This includes the option of no treatment. For each treatment option, the patient needs to know:

- Risks, benefits
- Potential medical consequences
- Alternatives including no treatment

Clinical team members and the patient or authorized representative review and confirm agreement with the proposed procedure or treatment as written on the Informed consent form and verify the signatures of the patient or authorized representative on the form.

Informed Consent - Minors

Any Patient under the age of 18 is considered a minor. In general, a parent or legal guardian must provide consent on behalf of the minor.

MN State laws allow minors to consent to certain types of services without parent or guardian permission (Minnesota Statutes Sections 144.341 – 144.344) These laws help young people seek confidential health care for sensitive issues such as pregnancy or pregnancy prevention, sexually transmitted infections, and substance abuse. Minnesota Statute 253B.04 subd.1 allows youth who are 16 years of age or older to consent for inpatient mental health services.

Parents and guardians have access to their minor children's medical records, unless the minor legally consents for services specifically listed under the Consent of Minors for Health Services statutes (Minn. Sts. 144.341 – 144.347). In that case, parents or guardians do not have access to the minor's health care records without the minor's authorization (Minn. Stat 144.291, subd. 2, para.(g)). However, a health professional may inform a minor's parent or guardian of treatment if, in the professional's judgement, failure to inform the parent or guardian would seriously jeopardize the minor's health (Minn. Stat. 144.346).

The following exceptions to a parent/guardian giving consent on behalf of a minor are specifically provided under Minnesota law:

- Any minor may give consent to his or her own medical, dental, mental, and other health services treatment provided that the minor is living separate from his or her parents or legal guardian, with or without their consent regardless of the duration, and further provided that the minor manages his or her financial affairs regardless of the source or extent of any income.

- Any minor may give consent for medical, mental, or other health services to determine the presence of, or to treat pregnancy and other associated conditions, venereal disease, and alcohol or other chemical dependency. This provision does not allow a minor to consent to admission for inpatient treatment for alcohol or other chemical dependency.

- Because of the complexity of some situations, refer to the Informed Decision-Making Authority policy and procedure found in C360

4.6 Grievances

A complaint is a concern or request that can be addressed and resolved by team members present at the time the concern is raised, or the request is made. **A Grievance** is a concern that cannot be resolved at the point of care by team members and is postponed for later resolution due to the need for further investigation by leadership. Patients have the right to file a formal grievance and they are informed of this right through the Patients' Bill of Rights, documents, and signage.
Most concerns can be addressed quickly.

- If a team member cannot resolve a concern/grievance at the point of care, it should be referred to management.
- If management cannot resolve the concern, refer to the Patient Representative Office at 763-581-1025. (After hours M-F, weekends, and holidays, contact the Nursing Administrative Manager). Please place issues in the Safety-First Reporting system.

Grievances (formal complaints) may be filed with state agencies whether or not the customer has used MGH's internal grievance process. Instructions for filing a grievance can be found in the Customer Welcome Book and the Patient's Bill of Rights booklet.

4.7 Restraint Use

- Restraints pose a risk to the physical safety and psychological well-being of the customer and team members.
- Restraints are used only in an emergency and only after alternative strategies have been tried.
- Physically holding customers, which restricts movements against their will, is also considered restraint use. This does not include holding customers for the purpose of conducting a routine physical examination or tests.
- Restraints are ordered by a Licensed Independent Provider and are time limited.
- Team members applying restraints must have completed training and have shown competency in restraint use.
- All required documentation, including efforts to remove restraints, must be included in the EMR

ALL restraint documentation should be reviewed at the end of every shift for completeness

Non-Violent Use: Restraint used to manage behaviors which interfere with medical/surgical healing.

Violent Use: Restraint used to manage behaviors which are unanticipated, severely aggressive or destructive behavior placing the customer or others in imminent risk of harming themselves or others, and non-physical intervention has not been effective.

See Policy and Procedure for Restraint or Seclusion in C360 for additional information.

4.8 Guardianship

Guardianship: A legal arrangement under which one person, a guardian who is appointed by a court, has the legal right and duty to care for another person

Guardian: Appointed by the court to make a set of decisions on behalf of another person and MUST be contacted when a customer comes to the Hospital. Guardians may have to consent for procedures (Order for Guardianship includes details). This can include consent for procedures or any type of care at all.

Person Subject to Guardianship: Person(customer) subject to guardianship (August 2020 statute language change)

4.9 EMTALA

EMTALA is the Emergency Medical Treatment & Active Labor Act

MGH shall provide emergency medical services in accordance with the requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA) and applicable regulations. MGH shall provide a medical screening exam performed by some qualified medical personnel to any individual who comes to the hospital campus property to determine if the patient has an emergency medical condition (EMC). If an emergency exists, the individual's condition must be stabilized prior to discharge. Any transfer must be made in accordance with the procedures outlined in the Emergency Medical Treatment & Active Labor Act (EMTALA) policy.

EMTALA Applies When

- An individual comes to a dedicated Emergency Department and requests examination or treatment of a medical condition or has such a request made on his or her behalf. In the absence of a request, a request will be considered to exist if a prudent layperson observer would believe, based on the individual's appearance or behavior, that they need examination or treatment for a medical condition
- An individual on the Hospital Campus requests examination or treatment of an emergent medical condition or has such a request made on their behalf. In the absence of a request, a request will be considered to exist if it is apparent to a prudent layperson that there is a need for emergency medical treatment and the individual is unable to communicate a request for examination or treatment
- An individual is in a North Memorial Health owned ambulance
- An individual is in a non-North Memorial Health ambulance once it is on Hospital Campus, even if the hospital's instructions to divert the ambulance were disregarded.
- Individuals in the custody of law enforcement brought to a dedicated Emergency Department are entitled to the protections of EMTALA

Pregnant Women and Women in Labor:

- A pregnant patient has an EMC if the MSE reveals she is in labor. If after a reasonable period of observation, it is determined that she is in false labor, the patient does not have an EMC.
- A pregnant patient may also seek emergency treatment for conditions related to her pregnancy although she is not in labor and/or for conditions unrelated to the pregnancy

When EMTALA applies, definitive criteria must be met.

****Please refer to the Emergency Medical Treatment & Active Labor Act (EMTALA) Policy"**

4.10 Infant/ Fetal loss.

We recognize the life changing event of baby or fetal loss and importance of taking meticulous care of the family during this intense time. We have many team members devoted to understanding grief and loss and helping through the process. When an infant or fetal law occurs, the following departments are notified:

- Social services.
- Chaplain.
- Guest services.
- Perinatal nurse navigator.
- Customer service center.
- Volunteers.
- Gift shop.

When the patient's name it added to the White Board, a purple butterfly magnet is placed next to it for awareness.

- Note any customers the purple butterfly.
- I compassionately acknowledged the loss.

- Chaplains, RN and perinatal nurse navigators are available to provide additional support. They can be contacted through Vocera.
- See compliance 60 or competencies related to infant and fetal loss.

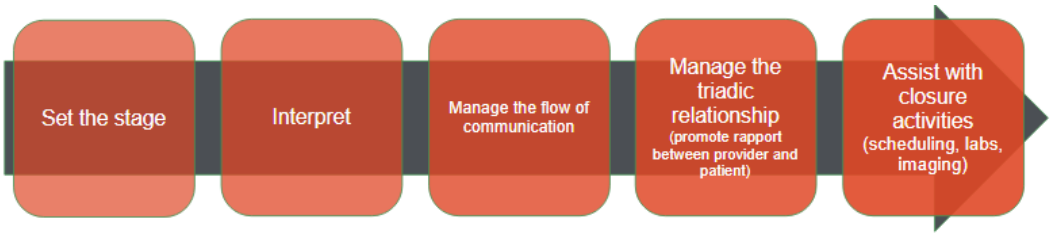
4.11 Language Services

Purpose of the Medical Interpreter:

The primary task of the interpreter is to interpret, that is, to convert a message uttered in a source language into an equivalent message in the target language so that the intended recipient of the message responds to it as if they had heard it in the original. The primary test of a competent interpreter, therefore, is the accuracy and completeness of the interpretation.

As of July 2016, the Office of Civil Rights issued a final ruling on Section 1557 of the Affordable Care Act that explicitly states that:

- Providers must use a qualified interpreter (as defined by federal guidelines)
- Bilingual minors, adult family members, friends and staff are prohibited from interpreting
- It is illegal to require a limited English Proficiency (LEP) patient to supply an interpreter
- Providers may be held individually liable for miscommunication that occurs because a **professional** interpreter was not used when the need was known



Working with Medical Interpreters

• The interpreter must interpret everything spoken or signed in her/his presence. If there is something you do not want the patient to hear, do not say it while the interpreter is present.
• Allow enough time; include time needed for registration, labs, x-rays, waiting time, and checkout.
• Provide the interpreter with background information or written materials before going into the patient's room.
• Look at the customer, not at the interpreter.
• Speak naturally at a reasonable, modest pace. Avoid terms such as "ask her" or "tell him"; it can be confusing
• For American Sign Language (ASL), slowing at names can be helpful, since they are finger-spelled and can take time.
• It is typical for them to be behind a sentence or two. They must listen and understand a complete thought before interpreting it.

Should professional interpreters provide information about the culture and belief system to facilitate communication? YES
Should professional interpreters use family members to interpret medical information? NO
Should professional interpreters sit in the room with a customer alone? NO
Should professional interpreters omit offensive messages to clean up and make them nice? NO

Language Access Laws:

The Americans with Disabilities Act (ADA) prohibits discrimination on the basis of disability in employment, state and local government, public accommodations, commercial facilities, transportation, and telecommunications.

Complaints of Title III violations may be filed with the Department of Justice. The Department is authorized to bring a lawsuit where there is a pattern or practice of discrimination in violation of title III, or where an act of discrimination raises an issue of public importance. Title III may also be enforced through private lawsuits. It is not necessary to file a complaint with the Department of Justice (or any Federal agency), or to receive a "right-to-sue" letter, before going to court.

Example: Following a three week trial in Hudson County, New Jersey, a jury awarded a deaf patient $400,000, including $200,000 in punitive damages, against a Jersey City rheumatologist who failed to provide a sign language interpreter at the patient's request (the communication was done through family members). The physician also may be personally liable because his malpractice carrier denied coverage as well as a defense.

Title VI

Title VI protects people of every race, color, or national origin from discrimination in programs and activities that receive federal financial assistance from HSS

Affordable Care Act

Section 1557 of the Affordable Care Act (ACA) also prohibits discrimination on the ground of race, color, or national origin, under "any health program or activity, any part of which is receiving Federal financial assistance… or under any program or activity that is administered by an Executive agency, or any entity established under (Tile 1 of ACA)… **Also clarifies what a qualified interpreter is, and that family and friends cannot interpret.** It also gives LEP persons expanded power to sue.

Guidelines for Requesting Interpreters

- Please use professional medical interpreters for: admits, provider encounters, family meetings, therapies and discharge and consent forms.
- If interpreter services are needed, call or page Interpreter Services during business hours first to see if an in-house interpreter is available. If one is not available, please use MARTTI or CLI (connected to your Vocera, say "Call CLI", the code is "NMHC").
- Using interpreters only for as long as they are needed makes them available to help other customers.

Language Services Resources:

The hours in-house interpreters are available in person, over the phone, or by video: M-F, 7am-9pm; Saturday-Sunday 7am-3:30pm. Call extension 10850 24/7. Page only during business hours.

To contact NMIS, please call ext. 10850

- Please include as much information as possible regarding your request in the page in order to dispatch an interpreter as quickly as possible.

Information about interpreter services for a given inpatient customer can be found in two places:

- Staff-to-staff communication on the RN snapchat
- "Dear Doctor"

Please check these if you are wondering whether a customer has an interpreter scheduled.

For outpatient appointments, you will see 'NMRINT' added under 'DEPT' on the appointment desk when an interpreter has been assigned. For outpatient telehealth visits, you will see a note added on the appointment desk when an interpreter has been assigned.

Request an in-person interpreter for: admits, MD rounds, family meetings, and discharge.

- If interpreter services are needed for less than 15 min in a given hour, use MARTTI or a phone interpreter.
- Using interpreters only for as long as they will be needed makes them available to help other customers
- **Limited English Proficiency (LEP) Patients**

Maple Grove Hospital provides auxiliary aids or services to assure accurate and complete communication to deaf, hard-of-hearing, and Limited English Proficiency (LEP) patients and their companions.

MARTTI (My Accessible Real-Time Trusted Interpreter)

An on-demand video interpretation system available for many languages, including American Sign Language (ASL) for the deaf. MARTTI units are stored and available on every floor where patient care is delivered.

CLI)

Certified Languages International, or CLI, is our contracted phone interpreter service, available at any time of day or night. To communicate with an LEP customer over the phone, call 1-844-209-4472, or use Vocera 'Call CLI'. Instructions for using CLI are available on the Intranet Language Services/Interpreters.

• Pocket Talker

Used for people with hearing deficits but who are not deaf. It is also used with people who have difficulties making their voice heard. Order by Customer Service, or by ordering in EPIC. After 2330, the Administrative Managers will help obtain the equipment.

• TTY for the Deaf

An electronic device for text communication used with a telephone to communicate with people who are deaf or hard-of-hearing by typing and reading communications. Order by calling Customer Service -12321, or by ordering in EPIC. After 2330, the Administration Managers will help obtain the equipment.

• Printed Materials

Printed materials in various languages available via the Multilingual Exchange on NMH Intranet on the Interpreter Services page.

Guidelines for Police, Child Services, and/or SANE Exams

North Memorial Interpreters, both in-house and contracted agency interpreters, are qualified **medical** interpreters. If an interpreter is needed, the police, child services, or SANE nurses **MUST** call someone **their agency contracts with**. Our medical interpreters **cannot** interpret for anyone if the police are in the room; if police enter the room, our interpreters will have to leave.

- Our phone/video interpreters also cannot be used by the police. Again, they must contact someone they contract with.
- Police must get an interpreter from an agency they contract with, even if MGH or NMH also contracts with that same agency. Police must contact/request themselves

- Interpreter Services and contracted agencies CANNOT 'just help out' on an ad hoc basis. Legal liability for providing a qualified interpreter rests with the police and must remain with the police, so our department/contracted agency partners will not be willing or able to help.

- This is a community standard. Even if some police officers, RNs, or other professionals have used hospital staff interpreters or agency medical interpreters in this capacity in the past, it does not change the law or the community standard.

4.12 Non-Clinical Support - Ligature Risk

It is now our responsibility to keep all customers safe while in our care. This includes a duty to reduce environmental factors that contribute to inpatient suicides, suicide attempts, and other self- injurious behaviors for our at-risk customers.

- Anticipate things that customers could use as weapons or use to hurt themselves.
- This may include, but is not limited to:
- assessing any areas/ things that a patient can wrap or loop something around, causing potential harm (i.e., choking or hanging.)
- Harmful substances.
- Plastic bags (Suffocation) that could be on the cleaning/tray/tool cart

For those working in EVS.:

- Retain only the absolute necessary equipment and devices in the cleaning cart and consider all items as potentially dangerous objects. On an ongoing basis, evaluate the need to remove or secure the following items from the cleaning cart:
    - Unneeded cables, cords and tubing (i.e.: oxygen tubing and telephone cords)
    - Items in team member pockets (such as scissors, extra pens or pencils, hemostats)
    - Plastic liner bags.
    - Extra equipment and cleaning solutions should be locked in a closed cabinet.
    - Anything that the customer could potentially use as a weapon or cause harm.

For Dietary Workers:

- Ensure meals are served with plastic utensils for safety. Metal utensils should be substituted with plastic.
- Do not let customer or visitors through the secured entrances/exits in customer care areas with you. Please help them to find a team member who can assist them.

For Contract Workers:

- Ensure tools are kept in line of sight at all times.
- Do not let customer or visitors through secured entrances in customer care areas with you. Please help them to find a team member to assist them.
- Temporary construction doors should remain locked at all times within the emergency areas *and 2W and 2E at North Memorial Hospital.*
- Retain only the absolute necessary equipment and devices on any cart you utilize in the area and consider all items as potentially dangerous objects. On an ongoing basis, evaluate the need to remove or secure the following items from your cart or work area.
    - Tools.
    - Unneeded cables, cords and tubing (i.e., oxygen tubing and telephone cords)
    - Items in team member pockets such as scissors, extra pens or pencils and hemostats.
    - Plastic liner bags.
    - Extra equipment- anything that the customer could potentially use as a weapon or cause harm.

All Team members: If you see something, say something. Please trust your gut instinct and let a leader know if something doesn't feel, look, or just seem quite right. We value your input in helping to keep our customers safe.

4.13 Safe Place for Newborns

North Memorial premises will accept infants presented to the hospital within 7 days of birth.

North Memorial will not notify the police to report any person for abandonment if the infant is in unharmed condition and:

- Presented to a hospital or clinic staff member on the North Memorial's premises and during its hours of operation, either by the mother or a person with the mother's permission to relinquish the newborn;
- Presented to an ambulance dispatched in response to a 911 telephone call from a mother or a person with the mother's permission to relinquish the newborn; and
- Presented within seven days of birth as determined within a reasonable degree of medical certainty

Refer to "Safe Place for Newborns (Give Life a Chance)' Policy and Procedure in C360

4.14 Bariatric Sensitivity

Obesity is a complex multifactorial chronic disease that develops from an interaction of genotype and the environment. Our understanding of how and why obesity develops is incomplete but involves the integration of social, behavioral, cultural, physiological, metabolic and genetic factors.

41.9% of adults in the U.S. age 20 or older have obesity (BMI> 30) (2017 - March 2020 data).
73.6% of adults in the US A 20 and over are overweight (BMI>25) or obese (BMI >30).

A person who chooses weight loss surgery is:

- someone who has struggled with their weight loss most of their life.
- Someone who has tried it after diet and has been unable to get the weight off or keep it off.
- Someone who may have been teased about their weight.
- Someone who is motivated to get healthy and live a long and happy life!

We must educate ourselves and each other about the stigma of obesity. Weight bias in the medical setting adversely affects patients and they are less likely to receive preventative care, interventions and cancer screenings.

We must hold ourselves accountable and accountable to treat everyone equally.

Point out inappropriate comments to others and challenge negative attitudes. Nobody deserves unkind remarks.

Furniture seating options are available for customers with a weight capacity of 500 pounds or more. These are covered in bariatric gold fabric, whenever possible, for easy recognition for customers and their families. Our mission is to make every customer feel safe.

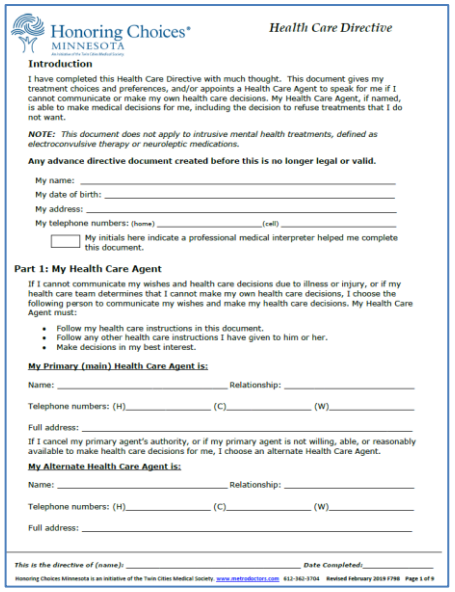
4.15 Advance Care Planning - ACP

Advance Care Planning (A C P) is a process of multiple discussions in advance of a medical crisis with Customers, their families and people they trust and/or Healthcare providers resulting in a set of preferences, wishes or choices which express the health care values of the person. Documenting discussions with customers in EPIC can help with continuity of care and ensure the care aligns with the values of the customer.

Viewing ACP Documents:

- North Memorial recommends customers provide a copy of their own Health Care Directive so it can be easily accessed in Epic – but it is their choice to do so, or not.
- If a Health Care Directive has been provided by the customer, it is accessible in Epic
- A POLST is a medical order and should be scanned into the customer's medical record/Epic
- It is easy for customers to give a copy of their ACP documents:
    - Mail or fax – Free postage paid envelopes are available through SmartWorks.
    - Drop it off – to primary care clinic
    - MyChart – uploaded using the "What's in my Record" – "End of Life Planning" option.

A Health Care Directive (HCD) is a legal document created by the customer. The customer stores the HCD and gives permission to MGH to store this document in EPIC. Blank HCD can be found in electronic document management systems and on each unit and are available in multiple languages.



Honoring Choices® MINNESOTA

Health Care Directive

Introduction

I have completed this Health Care Directive with much thought. This document gives my treatment choices and preferences, and/or appoints a Health Care Agent to speak for me if I cannot communicate or make my own health care decisions. My Health Care Agent, if named, is able to make medical decisions for me, including the decision to refuse treatments that I do not want.

NOTE: *This document does not apply to intrusive mental health treatments, defined as electroconvulsive therapy or neuroleptic medications.*

Any advance directive document created before this is no longer legal or valid.

My name: _____

My date of birth: _____

My address: _____

My telephone numbers: (home) _____ (cell) _____

☐ My initials here indicate a professional medical interpreter helped me complete this document.

Part 1: My Health Care Agent

If I cannot communicate my wishes and health care decisions due to illness or injury, or if my health care team determines that I cannot make my own health care decisions, I choose the following person to communicate my wishes and make my health care decisions. My Health Care Agent must:

- Follow my health care instructions in this document.
- Follow any other health care instructions I have given to him or her.
- Make decisions in my best interest.

My Primary (main) Health Care Agent is:

Name: _____ Relationship: _____

Telephone numbers: (H)_____ (C)_____ (W)_____

Full address: _____

If I cancel my primary agent's authority, or if my primary agent is not willing, able, or reasonably available to make health care decisions for me, I choose an alternate Health Care Agent.

My Alternate Health Care Agent is:

Name: _____ Relationship: _____

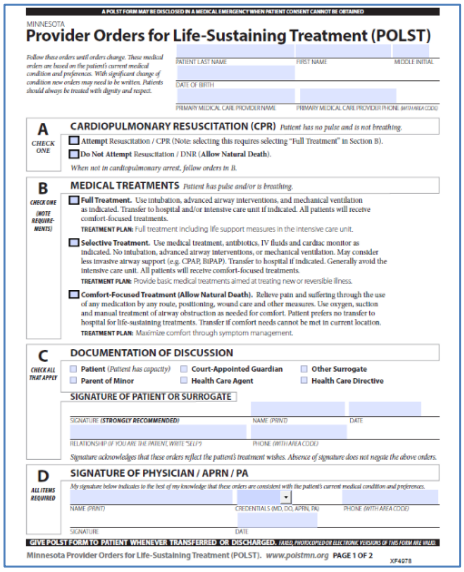
Telephone numbers: (H)_____ (C)_____ (W)_____

Full address: _____

This is the directive of (name): _____ *Date Completed:* _____

Honoring Choices Minnesota is an initiative of the Twin Cities Medical Society. www.metrodoctors.com 612-362-3704 Revised February 2019 F798 Page 1 of 9

Provider Orders for Life Sustaining Treatment (POLST) - is a medical order created by provider, stored with customer/residence and accessible in EPIC. Yellow in color; Available on each unit. Blank forms (POLST) are available on each unit.



A POLST FORM MAY BE DISCLOSED IN A MEDICAL EMERGENCY WHEN PATIENT CONSENT CANNOT BE OBTAINED.

MINNESOTA

Provider Orders for Life-Sustaining Treatment (POLST)

Follow these orders until orders change. These medical orders are based on the patient's current medical condition and preferences. With significant change of condition new orders may need to be written. Patients should always be treated with dignity and respect.

PATIENT LAST NAME | FIRST NAME | MIDDLE INITIAL

DATE OF BIRTH

PRIMARY MEDICAL CARE PROVIDER NAME | PRIMARY MEDICAL CARE PROVIDER PHONE (WITH AREA CODE)

A CHECK ONE — **CARDIOPULMONARY RESUSCITATION (CPR)** *Patient has no pulse and is not breathing.*

☐ **Attempt** Resuscitation / CPR (Note: selecting this requires selecting "Full Treatment" in Section B).

☐ **Do Not Attempt** Resuscitation / DNR (**Allow Natural Death**).

When not in cardiopulmonary arrest, follow orders in B.

B CHECK ONE (NOTE REQUIREMENTS) — **MEDICAL TREATMENTS** *Patient has pulse and/or is breathing.*

☐ **Full Treatment.** Use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated. All patients will receive comfort-focused treatments.
TREATMENT PLAN: Full treatment including life support measures in the intensive care unit.

☐ **Selective Treatment.** Use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). Transfer to hospital if indicated. Generally avoid the intensive care unit. All patients will receive comfort-focused treatments.
TREATMENT PLAN: Provide basic medical treatments aimed at treating new or reversible illness.

☐ **Comfort-Focused Treatment (Allow Natural Death).** Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.
TREATMENT PLAN: Maximize comfort through symptom management.

C CHECK ALL THAT APPLY — **DOCUMENTATION OF DISCUSSION**

☐ **Patient** (*Patient has capacity*) ☐ **Court-Appointed Guardian** ☐ **Other Surrogate**
☐ **Parent of Minor** ☐ **Health Care Agent** ☐ **Health Care Directive**

SIGNATURE OF PATIENT OR SURROGATE

SIGNATURE (**STRONGLY RECOMMENDED**) | NAME (PRINT) | DATE

RELATIONSHIP IF YOU ARE THE PATIENT, WRITE "SELF" | PHONE (WITH AREA CODE)

Signature acknowledges that these orders reflect the patient's treatment wishes. Absence of signature does not negate the above orders.

D ALL ITEMS REQUIRED — **SIGNATURE OF PHYSICIAN / APRN / PA**

My signature below indicates to the best of my knowledge that these orders are consistent with the patient's current medical condition and preferences.

NAME (PRINT) | CREDENTIALS (MD, DO, APRN, PA) | PHONE (WITH AREA CODE)

SIGNATURE | DATE

GIVE POLST FORM TO PATIENT WHENEVER TRANSFERRED OR DISCHARGED. (Make photocopy for medical home. Original or this form are valid.)

Minnesota Provider Orders for Life-Sustaining Treatment (POLST). www.polstmn.org **PAGE 1 OF 2** XF4275

North Memorial recommends customers provide a copy of their own Health Care Directive so it can be easily accessed in EPIC – but it is their choice to do so, or not.

If a Health Care Directive has been provided by the customer, it is accessible in EPIC.

- It is easy for customers to give a copy of their ACP documents:
- Mail or fax (free postage paid envelopes are available through Smartworks
- Drop it off – to primary care clinic
- MyChart - upload using the "What's in My Record" – "End of Life Planning" option

4.16 End of Life

Palliative Care

- Palliative care (pronounced pal-lee-uh-tiv) is specialized medical care for people living with a serious illness. This type of care is focused and provides relief from symptoms and stress of a serious illness. The soul is to improve quality of life or both the patient and the family.
- Palliative care is not hospice care. It does not replace the patient's primary treatment. Palliative care works together with the primary treatment being received. It focuses on the pain, symptoms and stress of serious illness most often as an adjunct to curative care modalities. It Is not time limited, allowing individual who are 'upstream' of a six month or less terminal prognosis to receive services aligned with palliative care principles. Additionally, individuals who qualify for Hospice services, and who are not emotionally ready to elect Hospice care could benefit from these services (Center to Advance Palliative Care. 2019.)
- Hospice care focuses on the pain, symptoms, and stress of serious illness during the terminal phase. The terminal phase. It is defined by Medicare as an individual with a life expectancy of six months or less if the disease runs its course. This care is provided by an interdisciplinary team who provides care encompassing the individual, patient and their families' holistic needs. (National Hospice and Palliative Care Organization. 2019.)

- North Memorial Health offers palliative care when customers are in North Memorial Health Hospital and Maple Grove Hospital, and where there is a diagnosis of cancer through the NMH Cancer Center.
- North Memorial Health Hospice also offers Hospice care for customers living in the community with a terminal illness, with a life expectancy of six months or less. This could include customers living in private residences, assisted living and skilled nursing facilities.

Hospice provides death and bereavement care procedures that demonstrate our commitment to customers and family members. Key steps include providing emotional and spiritual support as family and friends prepare for a death. This includes spiritual support provided by chaplains and the additional support of bereavement specialists. Nursing/medical support and multidisciplinary teams are available for support during this time. Full details are in Death and Bereavement Care, Adult, Non-Infant policy and procedure located in C360.

Team members may understand the dying process and what is normal and what is not, but family/friends may not.

Take time to walk family through what to expect with each phase of dying.

Talk about why we are giving certain medications or doing certain cares.

> Example: "We will give morphine to help with their breathing and pain. It seems like a high dose, which is needed in someone who is at this stage because their body can't process or metabolize the medication as it normally would."

Talk about the goals of symptom management and that the goal of end-of-life care is to relieve suffering of a dying patient, not to hasten death.

4.17 Organ, Tissue and Eye Donation

Did you know one person can save and heal up to 75 lives through organ, tissue and eye donation?

- North Memorial Health is committed to advocating for organ donation to benefit those waiting for a transplant. Our hospital has an organ, tissue and eye donation policy that explains the hospital care team's role in the donation process.
- In 2002, a MN law clarified that if a person designates that he or she is a donor via will, Advance Directive, driver's license, or MN identification, the designation serves as intent to donate after death and cannot be overridden.
- Every customer and customer's family are given the same opportunity, and all are treated with the same discretion and sensitivity. All customer deaths from ages 36 weeks in gestation or older must be referred to the donor referral line for an organ, eye, and tissue donation assessment.
- Donor family care comes from OPO (Organ Procurement Organization) and support continues indefinitely or for as long as the family wishes.
- If customer meets the trigger for donation, they are referred to 1-800-24-SHARE within one hour

To preserve potential for donation, all patients meeting triggers must be referred within ONE HOUR. Triggers to call LifeSource include:

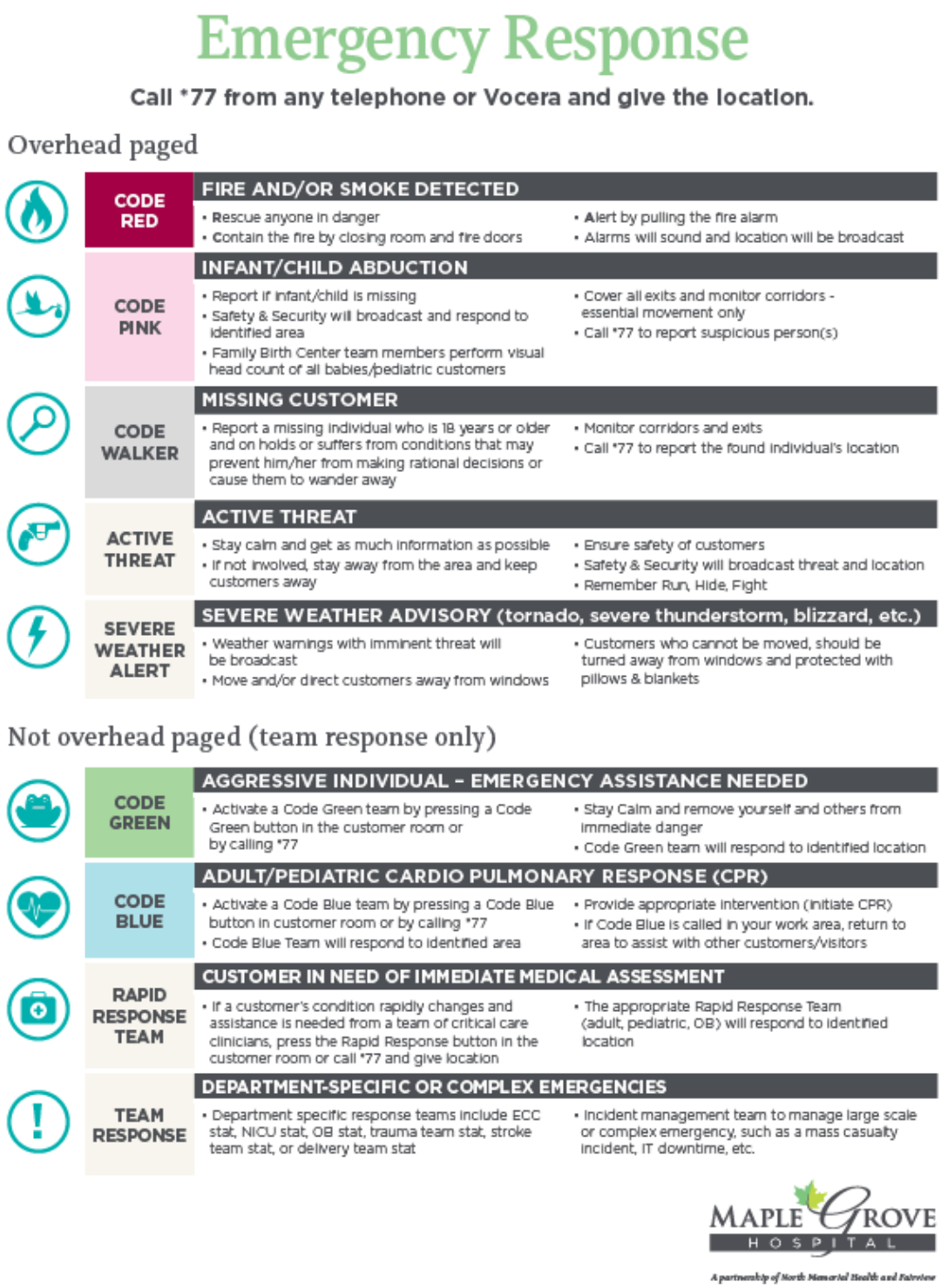
- Ventilator dependent patients with a neurological injury (GCS<5) or non-survivable illness AND any of the following:
    - Loss of two or more brain stem reflexes
    - Prior to any end-of-life conversation
    - Anticipated withdraw of life sustaining support
- **All** patients who experience cardiac death (asystole) or loss of two or more brain stem reflexes
- If the family mentions or has questions about donation or if you have questions.

Key Points:

- Donor family comes from OPO (Organ Procurement Organization), and support continues indefinitely or for as long as family wishes.
- If customer meets the trigger for donation, they are referred to 1-800-24-SHARE within one hour.

- ONLY the Donor Coordinator can determine donor suitability and discuss donation options with the potential donor families.
- Specifically trained personnel, always from the donation agency, will discuss donation with the customer's family.
- Organ, tissue and eye recovery is performed by the donation agencies as soon as possible after the time of death.
- Contact LifeSource at 1-800-247-SHARE. You can serve as an advocate for the customer/family by making the call within one hour.

5 Emergency Response and Equipment Safety



Emergency Response

Call *77 from any telephone or Vocera and give the location.

Overhead paged

CODE RED	**FIRE AND/OR SMOKE DETECTED**	• Rescue anyone in danger • Contain the fire by closing room and fire doors • Alert by pulling the fire alarm • Alarms will sound and location will be broadcast
CODE PINK	**INFANT/CHILD ABDUCTION**	• Report if infant/child is missing • Safety & Security will broadcast and respond to identified area • Family Birth Center team members perform visual head count of all babies/pediatric customers • Cover all exits and monitor corridors - essential movement only • Call *77 to report suspicious person(s)
CODE WALKER	**MISSING CUSTOMER**	• Report a missing individual who is 18 years or older and on holds or suffers from conditions that may prevent him/her from making rational decisions or cause them to wander away • Monitor corridors and exits • Call *77 to report the found individual's location
ACTIVE THREAT	**ACTIVE THREAT**	• Stay calm and get as much information as possible • If not involved, stay away from the area and keep customers away • Ensure safety of customers • Safety & Security will broadcast threat and location • Remember Run, Hide, Fight
SEVERE WEATHER ALERT	**SEVERE WEATHER ADVISORY (tornado, severe thunderstorm, blizzard, etc.)**	• Weather warnings with imminent threat will be broadcast • Move and/or direct customers away from windows • Customers who cannot be moved, should be turned away from windows and protected with pillows & blankets

Not overhead paged (team response only)

CODE GREEN	**AGGRESSIVE INDIVIDUAL – EMERGENCY ASSISTANCE NEEDED**	• Activate a Code Green team by pressing a Code Green button in the customer room or by calling *77 • Stay Calm and remove yourself and others from immediate danger • Code Green team will respond to identified location
CODE BLUE	**ADULT/PEDIATRIC CARDIO PULMONARY RESPONSE (CPR)**	• Activate a Code Blue team by pressing a Code Blue button in customer room or by calling *77 • Code Blue Team will respond to identified area • Provide appropriate intervention (initiate CPR) • If Code Blue is called in your work area, return to area to assist with other customers/visitors
RAPID RESPONSE TEAM	**CUSTOMER IN NEED OF IMMEDIATE MEDICAL ASSESSMENT**	• If a customer's condition rapidly changes and assistance is needed from a team of critical care clinicians, press the Rapid Response button in the customer room or call *77 and give location • The appropriate Rapid Response Team (adult, pediatric, OB) will respond to identified location
TEAM RESPONSE	**DEPARTMENT-SPECIFIC OR COMPLEX EMERGENCIES**	• Department specific response teams include ECC stat, NICU stat, OB stat, trauma team stat, stroke team stat, or delivery team stat • Incident management team to manage large scale or complex emergency, such as a mass casualty incident, IT downtime, etc.

MAPLE GROVE HOSPITAL

A partnership of North Memorial Health and Fairview

5.1 Activate Emergency Response & Codes

- On Campus:
    - Dial *99 if at NMHH on campus
    - Dial *77 on any campus phone
    - Designated button in patient care room

Off Campus:

Dial emergency number (911, 9-911)

5.2 Code Red

Fire or Smoke

What types of fires must be reported?

- Visible Flame
- Visible Smoke
- Smoke Odor
- "Out fires" (Fires that have been extinguished)

Rescue anyone in danger

Confine by closing doors. Only go through the fire doors to evacuate or move people to an adjacent safe place (area of refuge). Do not use elevators.

- Close all doors and windows
- Turn on all lights
- Remove all items from the corridor on the floor of the alarm
- Secure the area! Stop pedestrian traffic from entering the area. Assure that no one enters except fire response personnel

Alert by pulling alarm or dialing *77 (MGH) and giving your location

- Activating a fire alarm pull station on your way to the nearest safe telephone
- Calling *77
    - Provide the following information:
        - Who you are
        - Where the fire is located (be very specific, e.g. Four Seasons Cafe, lower level, Maple Grove Hospital)
        - How large is the fire?
        - What type of fire is burning?
        - If people are in danger
    - Stay on the line until you:
        - Are released by the call center
        - Determine it is unsafe for you to remain at your location, or
        - Hear the "All Clear" announced on the public-address system

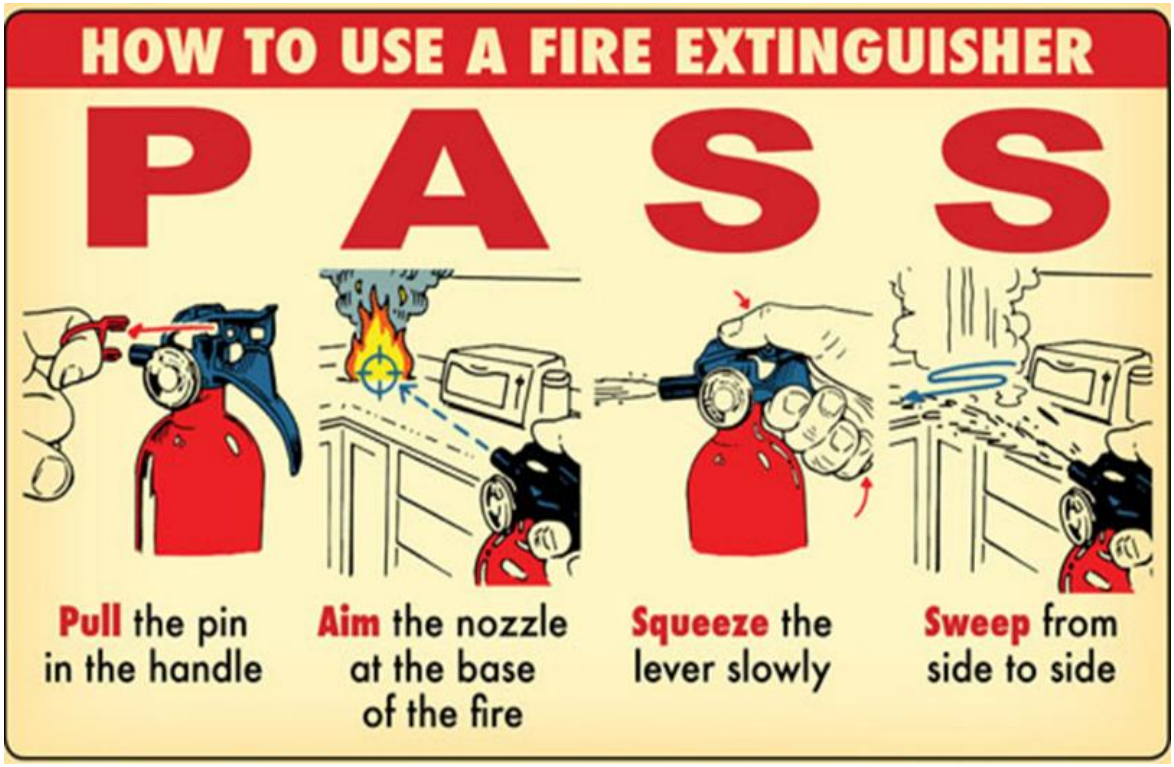
What if I hear the Code Red announcement indicating a fire in my building, but NOT in my area?

- All pedestrian traffic within the building in which the alert is given is to be stopped. Passage through smoke doors is prohibited unless staff are needed for immediate patient care.
- Persons are not permitted to remain in stairwells and elevator lobbies.
- Hospital telephones are to be restricted to emergency use.
- Report any adverse conditions to the Emergency Operator.

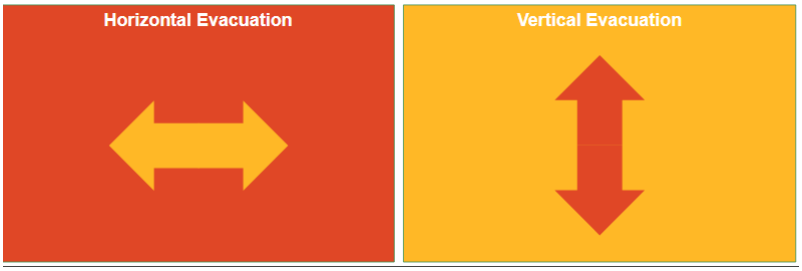
Operating Rooms:

Operating rooms follow the Maple Grove Hospital policy regarding fires in the OR.

5.3 PASS



5.4 Evacuation Process/Stryker/MedSled



What is the Fire Evacuation Plan?

- Fire doors will close with activation of fire alarm
- Fire doors should only be opened to allow for movement to the next compartment – do not wedge doors open
- There is a 2-hour fire rated separation between the compartments
- Each compartment has a stairwell for movement to the next level of the building if necessary.

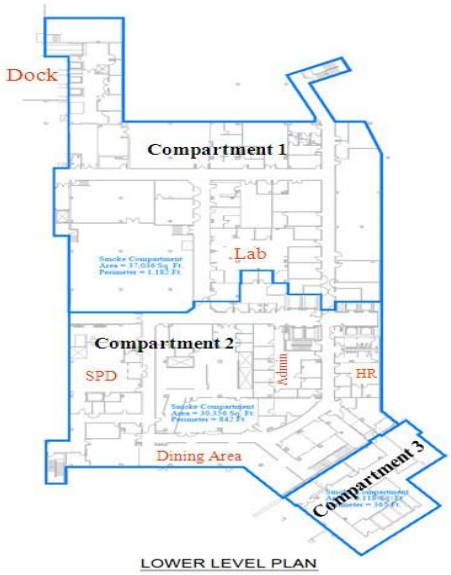
If fire/smoke is in:

-Compartment 1: Move to Compartment 2

-Compartment 2: Move to Compartment 1

-Compartment 3: Move to Compartment 2

If there are no smoke compartments left that are safe to move into, move up to the 1st Floor



LOWER LEVEL PLAN

Lower Level Plan

If fire/smoke is in:

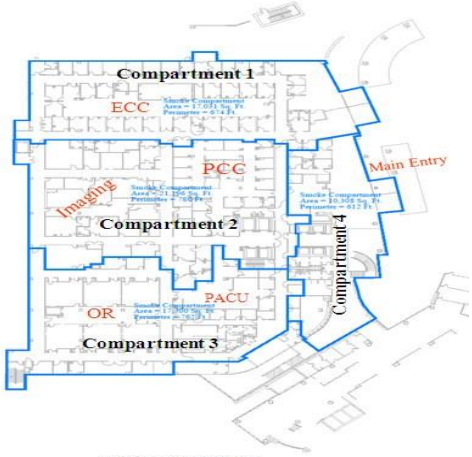
-Compartment 1: Move to Compartment 2

-Compartment 2: Move to Compartment 3 (PACU)

-Compartment 3: Move to Compartment 2 (PCC)

-Compartment 4: Move to Compartment 1

Surgical area has their own customized fire plan to follow



FIRST LEVEL PLAN

1st Floor Plan

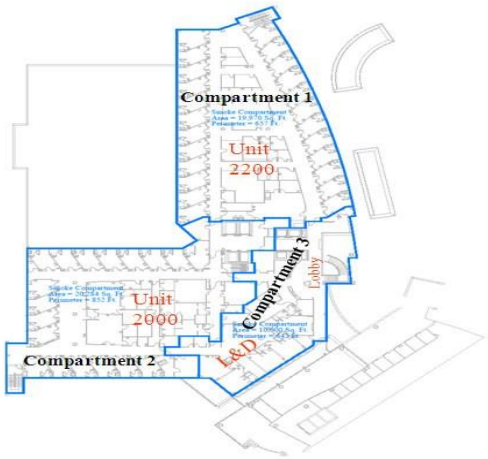
If fire/smoke is in:

-Compartment 1: Move to Compartment 2

-Compartment 2: Move to Compartment 1

-Compartment 3: Move to Compartment 2

If there are no smoke compartments left that are safe to move into, move down to the 1st Floor



SECOND LEVEL PLAN

2nd Floor Plan

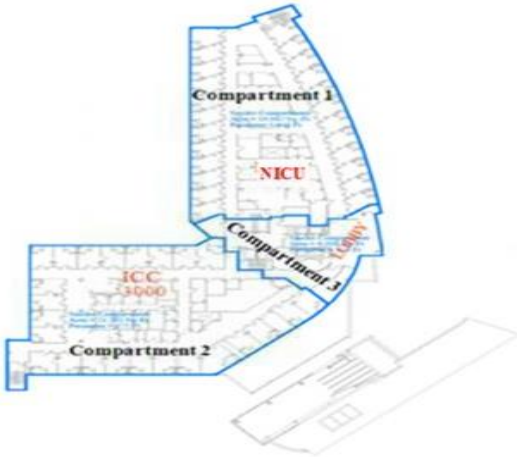
If fire/smoke is in:

-Compartment 1: Move to Compartment 2

-Compartment 2: Move to Compartment 1

-Compartment 3: Move to Compartment 1

If there are no smoke compartments left that are safe to move into, move down to the **2nd** Floor



THIRD LEVEL PLAN

3rd Floor Plan

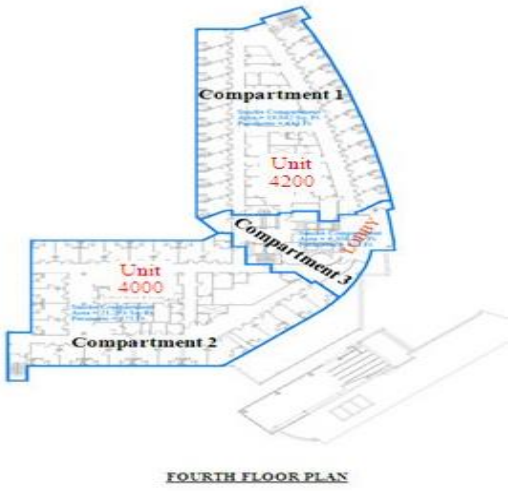
If fire/smoke is in:

-Compartment 1: Move to Compartment 2

-Compartment 2: Move to Compartment 1

-Compartment 3: Move to Compartment 1

If there are no smoke compartments left that are safe to move into, move down to the 3rd Floor



FOURTH FLOOR PLAN

4th Floor Plan

***Please note that if there was a fire on Unit 3200, NICU patients would evacuate down to the 2000 NICU. If there was a fire on Unit 2000 NICU patients would be evacuated up to 3200, to allow patient care to continue. ***

MGH has the following evacuation equipment:

- **Medsleds**: Standard and Bariatric
  - Both rated to hold 1000 pounds
  - Bariatric sled is 12 inches wider than standard sled to accommodate larger girth
  - 1 regular and 1 bariatric stored on each unit (stored in equipment rooms)

Standard Adult Sled

Bariatric Sled

- **Stair Chairs:**
  - Rated to hold 500 pounds
  - Stored in cabinet near north stairwell on:
  - 4200 (1)
  - 3200 (1)
  - 2200 (1)

- **NICU Evacuation Baskets**
  Stored at:
  - Cabinet near North Stairwell on 3200 (9)
  - Cabinet to the left of the NICU nursery entrance on 2000 (9)

Hands-Free

5.5 Code Green

A code Green alerts a trained team to assist with a situation involving an aggressive individual or an individual who has the potential to become aggressive.
A Code Green response is not overhead paged. Only a trained Code Green Team is alerted when this code is activated.

Activate the Code Green Team by:

- Pressing a Code Green button in the customer room
- Or by calling *77

Stay calm and remove yourself from immediate danger. Provide information to the code green team members as they arrive.

5.6 Code Blue

Adult/Pediatric Cardiopulmonary Response (CPR)

Code Blue Alerts a trained team when an adult or pediatric customer is in need of Cardiopulmonary Response (CPR).

- A Code Blue Response is not overhead paged. Only a trained Code Blue Team is alerted when this code is activated.
- Activate the Code Blue Team by:
    - Pressing a Code Blue Button in a Customer room
    - Or by calling *77

5.7 Code Pink

Infant Child Abduction

Notification/Activation:

- Upon realization that an infant/child is missing or upon suspicion of actual or attempted infant/child abduction. Team Members are to call Security or *77 to activate Code Pink. Give location where the infant/child was last seen.
- Safety and Security will activate Code Pink when needed, giving location by overhead paging system. Safety and Security will re=broadcast every 5 minutes until the Code Pink status is resolved.

Alarm/Event	Definition	Audio/Visual Strobes	Timing of Initiation	Clearing Alarm (FBC)	Exit Control	Security Response	FBC Response	Vocera Notification
Door Ajar	Exit door is being held open	Flash Only	1 Minutes	Manual	None	Awareness	Close affected door	No
Loiter	A tagged patient is standing near a closed exit	Flash Only	Immediate	Automatic	Door where event is happening Locks/Disable Push Plate	Awareness	Move tag/infant away from exit	No
Exit	A tag is detected at an exit with an open door	Flash & Sound	Immediate	Manual	None	Locate infant	"Eyes on Baby"	Yes (all MGH)
Tag Tamper	A tag's strap has been cut or pulled on	Flash & Sound	2 Seconds	Manual	All Doors Lock/Disable Push Plate & elevators lock	Awareness	"Eyes on Baby" & Replace strap	Yes (Safety and Security and FBC)
Supervision Timeout	The Hugs System cannot see the tag	Flash & Sound	3 min	Manual	Door Lock/Disable Push Plate & elevators lock	Awareness	"Eyes on Baby"	Yes
Check Tag Tightness (CTT)	Tag has lost physical contact with the infant skin	Flash Only	25 Seconds	Automatic	None	Awareness	Bedside RN address specific baby & tighten strap	Yes (staff assignment)
Tag Loose	CTT has not been resolved	Flash & Sound	2 Minutes	Manual	Door Lock/Disable Push Plate &	Awareness	"Eyes on Baby" & tighten strap	Yes (Security and FBC)
Improperly Applied Strap	Strap applied then immediately detached or damaged	Flash Only	5 Minutes	Manual	None	Awareness	Bedside RN address specific baby	No
Strap/Band Detached	Strap has not been applied correctly	Flash Only	3 Minutes	Manual	Door Lock/Disable Push Plate & elevators lock	Awareness	Bedside RN address specific baby	Yes (Security and FBC)
Transport Expired	Tag transport time has run out	Flash Only	End of Transport Event	Manual	None	Awareness	Bedside RN address specific baby	No

When a Code Pink is activated:

- **ALL TEAM MEMBERS** are expected to move to cover entrances, exits and corridors that they find themselves in until an All Clear is called.

- NO ONE should be allowed to enter or leave the hospital until the “All Clear” is called. This excludes law enforcement and patients presenting with an emergency medical condition.
- Limit movement unless moving for urgent/emergency patient care needs. This excludes law enforcement, security personnel, and responding medical code teams.
- Limit movement within facility but know that some movement of Team Members may be necessary for urgent/emergent care. This excludes law enforcement, security personnel, and responding medical code team.

5.8 Rapid Response Team

Customer in Need of immediate Medical Assessment

Rapid Response Teams are a group of clinicians who will partner with the bedside nurse to administer diagnostic assessments and tests through protocol driven care for customers showing signs of clinical deterioration.

- A Rapid Response is not overhead paged. Only a trained Rapid Response team is alerted when this code is activated.
- The appropriate Rapid Response team (adult, pediatric, newborn, OB) will respond to the identified location within **10 minutes**.
- Activate the Rapid Response Team by:
    - Pressing a Rapid Response button in a customer room
    - Or by calling *77

5.9 Severe Weather Alert 4

Severe Weather Advisory (tornado, severe thunderstorm, blizzard, etc.)

- Weather warnings with imminent threat will be broadcast
- Move and/or direct visitors and customers away from windows
- Customers who cannot be moved should be turned away from window and protected with pillows and blankets

If Maple Grove Hospital is within the Severe Weather Warning area, Safety and Security will:

- Overhead page: “May I have your attention please. The National Weather Service has issued a severe weather warning for Maple Grove.” X 3.
- Vocera page team members the type of Severe Weather Warning:
    - “Severe Thunderstorm Warning in effect until further notice” or
    - “Tornado Warning in effect until further notice”

All Team Members upon hearing the Severe Weather Warning:

- Remain calm but alert customers of the warning and advise them to move away from exterior windows and exits. This includes ALL exterior windows and exit areas (lobby areas, conference rooms, halls, café and patient rooms, ambulance entrance, etc.).
- Close shades where available.
- Close doors of empty patient rooms to prevent glass from flying into the hallways.
- Once your area is secure, assist other areas (especially customer care areas). Nonclinical team members take direction from clinical team members.
- In customer rooms:
    - Turn beds so they are out of direct line of an exterior window.
    - Use pillows and blankets to protect the customer from flying glass and debris.
    - Close door to bathroom

IN THE EVENT OF A TORNADO WARNING BY THE WEATHER SERVICE, THE FOLLOWING PROTOCOLS WILL BE INVOKED. The call center will page “Activate Weather Alert” three times which is proceeded by a siren tone alert

- Close and lock all outside windows. Remove all objects from windowsills.
- Pull shades and drapes on all outside windows.
- Lower all patient’s beds to minimum height.
- Turn corridor lights on.
- Reassure patients as you proceed. Leave lights on in the rooms.
- “Patient room” doors may be left open at the discretion of the nursing personnel (close all other doors).
- Do not panic; do not shout; do not run. Keep all people away from outside windows.
- Do not restrict the use of elevators.

- Employees shall return to their workstation or department and remain there until “all clear:” is announced.
- Notify the Call Center by dialing *99 at NMHH and *77 at MGH if there is damage or a problem in your area.
- Files and drawe3rs shall be closed.
- Visitors in classrooms, boardrooms, cafeteria, etc., will be told of warning by Food and Nutrition Services or dietary.
- Persons in areas with exterior glass will be directed to leave the area and report to an inner hallway.
- Persons in the atrium area at NMH will be advised by the information desk to report to the lower level of the Atrium

5.10 Code Walker

Missing Customer (Elopement) who is 18 years or older on holds or suffers from conditions that may prevent them from making rational decisions or cause them to wander away.

- *Call *77 at MGH to report a missing individual*
- *Monitor corridors and exits*
- *Safety and security will broadcast and respond*
- Upon realization that a patient is missing, the team member who is first aware will immediately enlist all available team members to assist:
    - Call *77 and advise Security, “Code Walker”, location and a brief physical description to include approximate age, race, male/female, clothing, etc.
    - Safety & Security staff will announce, “Code Walker” via overhead paging system and Vocera to alert all hospital staff.
    - The PCF of the unit the patient is missing from will remain in their unit to coordinate and delegate: Securing exits/elevators in the area; Search of the area; Provide necessary information to responders.
    - Unit/Department team members from the area of the activation will report immediately to their unit/department to assist in response efforts, if appropriate.
- All Team Members:
    - Be alert to elopement linens which are specially marked and Spice Red colored. Any patient in elopement linens unaccompanied by a staff person is considered an elopement risk.
    - If present at exits or stairwells at the time a “Code Walker” is announced, hospital staff are directed to observe and report only any unusual activity by calling *77. Team members should not attempt to apprehend a missing/eloping patient. Such action could endanger the team member and/or the patient. If the team member is comfortable and believes he/she can maintain personal safety, the team member may decide to follow the patient at a discreet distance to note elopement route, physical characteristics and clothing to aid in identification.
    - Departments will deploy team members to observe the nearest exit or stairwell and report only by calling *77 as described above. The team member(s) should remain in the location until the “Code Walker all clear” is paged overhead and on Vocera, or until given further instructions by a Safety & Security Officer.
    - Team members involved in non-essential non-patient care activities are requested to avoid the area of the activation until the “Code Walker all clear” is paged.

5.11 Incident Management Response Team

Department Specific or Complex Emergencies

- Department specific response teams include OB stat, trauma team stat, stroke team stat, or delivery team stat
- Incident management team to manage large scale or complex emergencies, such as a mass casualty incident, IT downtime, etc.

EMERGENCY MANAGEMENT

Emergencies regardless of size, cause or complexity need to be managed efficiently. Our System Emergency Operations Plan (EOP) is designed to establish a scalable, flexible framework within which MGH will accomplish the comprehensive emergency management activities of mitigation, preparedness, response and recovery for a variety of

emergency situations that could affect the safety of customers, team members, and the physical environment while meeting applicable codes and regulations.

Leadership will determine the need and size of an incident Management Team and will set up an Incident Command System as necessary. This team may meet in person or virtually over the phone depending on the emergency.

In an emergency, be flexible. You may be asked to do a different job or report to the Labor Pool (location given at time of event) for reassignment. If you are away from work and are needed, you will be notified through Everbridge and will be asked to reply with your availability and then will be given specific instructions on where and when you are needed.

5.12 Stoke Emergency

Stroke has decreased to the 5th leading cause of death but remains the leading cause of disability in Minnesota and the United States.

North Memorial Health, as a Comprehensive Stroke Center, is at the forefront of that change to improve the quality of stroke care throughout our region. In 2019, the American Stroke Association (ASA) has again awarded us it's highest award: *Gold Plus Target Honor Role* Elite for the quality care we deliver to our patients

What is a stroke?
A stroke occurs when a clot blocks the blood supply to the brain (ischemic or when a blood vessel in the brain bursts (hemorrhagic). A CT scan is used to determine the type of stroke and the appropriate treatment.

Signs and Symptoms of Stroke:
Early recognition is essential since some treatments are time dependent. All staff should recognize the warning signs of stroke. The acronym now used to assess a customer for a stroke is B.E. F.A.S.T.
B= Balance: a person may have difficulty walking and may even appear drunk
E= Eyesight or vision: any change in vision, double vision, inability to see on one side – all of these can be signs of stroke
F=Facial Droop; Facial droop, or facial weakness, may be apparent when you ask the person to smile.
A= Arm Weakness: ask the person to hold up their arms in front of them. Does one drop down from its position?
S=Slurred Speech: Is the person's speech clear? Ask them to speak to you.
T=Time, call 911: Call a Stoke Team stat if in house. Outside hospital, always call 911. The EMS crews can begin stroke identification in the ambulance and alert the hospital.

Approximately 80% of stroke patients have at least one of the symptoms of B.E. F.A.S.T. Additional, signs and symptoms of a stroke include visual changes in one or both eyes; sudden trouble walking or dizziness; loss of balance or coordination; sudden severe headache (no cause) or sudden confusion.

Immediate interventions include:

- Call for help
- Use the stroke team button on the touch screen in the patient's room to activate the code. If no touch screen is available, call *77, state "Stroke Team", give the patient location and your name.
- Ensure breathing and pulse is intact
- Reassure patient that help is on the way
- Avoid giving anything to eat or drink
- Collaborate with Stroke Team when they arrive

5.13 Communication System Failure

Telephone system Failure: Essential areas have the 511E Intercom system to communicate between departments and/or Emergency Power Failure Phone, which are either all RED or have a RED handset cord, to make outgoing calls and take incoming calls.
Team members may also use:

- Computerized tube system
- Portable walkie-talkies
- Vocera
- Runners/Messengers

5.14 Downtime

- In the event there is a downtime involving IT systems (EPIC, Internet, etc.) you should be familiar with your department's DOWNTIME BOX and procedures
- Downtime procedures should be followed until IT has given the "all clear" message.
- Team members are responsible for understanding how to use the paper forms in their department's downtime box.

5.15 Personal and Family Emergency Preparedness

Be informed! Know what to do before, during and after an emergency that could impact you, your family, your workplace, or community. For example, external emergencies may be weather-related such as tornadoes, severe thunderstorms, ice storms or blizzards. External emergencies may also be mass casualty incidents or communitywide outbreaks (like influenza) where many people show up at the hospital for care. Emergencies may also be internal, such as IT or communication failure, a utility failure, or a security type incident.

MN Homeland Security Management

- **Know Your Role:** Know your role when there are emergencies at work (see NMMC Emergency Codes). Review the policies and procedures BEFORE you need to use them and contact your manager/supervisor or NMMC Emergency Management Coordinator if you have questions.
- **Get Involved!** Participate in drills
- **Build a Kit!** Good examples can be found at www.ready.gov. Make it a family activity!
- **Make a Plan!** Based on the types of emergencies you expect, build a plan for your family including childcare, elder care, pet care and any specific care for family members with special needs.

5.16 Backup Generators

- Electrical outlets connected to back up generators have **RED outlets** and/or plates.
- Think ahead about how you would deal with a power failure and work with only emergency power. What would your environment look like with only emergency power? How would patient care be different?
- Know which equipment has battery operated back up. Make sure emergency equipment is plugged into a **RED outlet**. Extension cords can be used temporarily.
- Emergency generators are tested monthly.

5.17 Utility Management and Reporting

Notify Maintenance for the following utility failures or problems:

- Electricity
- HVAC (heating, ventilation and air conditioning)
- Water and sewer
- Elevators
- Medical gases including:
  - Medical air
  - Clinical vacuum
- Computerized tube system
- Intercoms

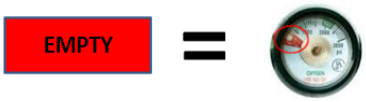
Notify IT at x12580 for other communication system problems or failures, such as telephones and pagers. There are back up systems in place for most utility failures.

5.18 Storing Compressed Gas

Cylinder Storage

Compressed gas cylinders should always be secured. Appropriate securing devices include chains attached to the wall or holding racks as pictured below. If you encounter a cylinder that is not correctly secured; immediately return it to a securing device or alert someone who can.

- Gas cylinders are to be used for patient transport or activity and then promptly returned to an appropriate holding rack. Cylinders should not remain in patient rooms.
- Tanks must be placed into a secure holding rack or cart
- Cylinders in storage must be easily identified as empty or full. At MGH, EMPTY = Red zone on Guage (Less than 500psi)

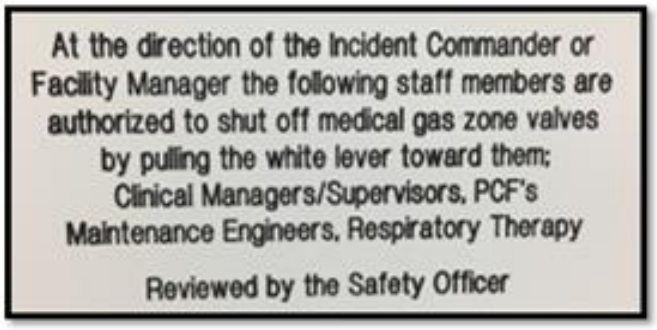


Approved tank storage areas will include information about the number of tanks that can be stored per fire zone at a given time. Please refer to your department for this information.

5.19 Shutting off Oxygen Valves

- All patient care providers authorized to use oxygen may turn off local oxygen meters, regulators, or valves located in patient care/treatment rooms.
- Zone valves may only be turned off by authorized staff (Facilities, Respiratory Care practitioners, managers/supervisors and other named designees). A label next to each zone value lists persons authorized to turn off a zone. Each zone valve is labeled with the rooms/area it supplies.
- Signage available from the Respiratory Therapy Department must be posted on zone valves out of service, or whenever the oxygen system needs to be taken down for either elective or emergent reasons.

Medical gas shut off



When advised by the authorized team member (as posted on the plaque next to the gas panel), a PCF/Leader may be asked to turn off a gas valve.

5.20 Hallway Clutter

Corridor clutter is any item that creates an obstruction in a corridor or exit path. The Life Safety Code requires that "all exit paths must remain free of obstructions, including unattended items that are not considered in use by staff members. In other words, any item not in use or unattended for more than 30 minutes- or blocking the egress- can be considered clutter. The exceptions to this rule allow crash carts and patient isolation supply carts (provided the cart is serving a patient on contact precaution isolation) to be left unattended longer than 30 min.

Why is this so important?
In fire and other emergency scenarios, it may become necessary to relocate or evacuate customers, often in reduced visibility. On first appearance, corridors seem to have ample space for many items that help support patient care: equipment, supply carts, food carts, empty beds, etc.

What you can do to keep hospital corridors free of obstructions:

- Items in a hallway waiting for direct patient use within 30 minutes should all be placed on one side of the corridor, against the wall.
- Do not allow items to block stair tower doors, extinguisher cabinets or cross automatic smoke or fire doors.
- In the event of an emergency requiring evacuation, move items out of the corridors and into unoccupied rooms or behind the nurse stations to allow unobstructed egress.

5.21 Safe Medical Devices

It is the policy to prevent or minimize medical device-related patient incidents, to ensure patient safety, and to improve the quality of patient care. Physicians, nurses, or other healthcare personnel who use or maintain the products often discover medical product defects. It is essential that all personnel understand the importance of immediately reporting all product defects and device-related adverse patient events.

Safety testing of medical equipment: customer care and some non-clinical equipment that requires preventative maintenance will have a preventative maintenance (PM) sticker on it. If you see a sticker with an overdue date, call the appropriate engineering department indicated on the label. If the sticker is overdue for preventative maintenance, please remove the item from service and call the appropriate department.

The Safe Medical Device Act of 1990

Was enacted to ensure:

- That prompt and appropriate actions are taken when defective medical devices are identified

- Timely regulatory reporting (within 14 days of the event) of a device-related patient incident that caused a death, serious injury or illness
- Is enforced by the Food and Drug Administration (21 CFR 803)

Definitions

Medical Device: Broadly defined as anything used in treatment or diagnosis that is not a drug (e.g., implants, disposables, machines, instruments, etc.)

Serious Illness and Serious Injury: An illness or injury that:

- Is life threatening
- Results in permanent or serious impairment or damage to the body
- Requires medical or surgical intervention to prevent permanent or serious harm to the body

Safe Medical Devices – Test Prior to Use and Routine
Equipment Failure Incidents

- Safety testing of medical equipment: Customer care and some non-clinical equipment that requires preventative maintenance will have a preventative maintenance (PM) sticker on it. If you see a sticker with an overdue date, call the appropriate Department:
    - **a.** North Memorial Hospital: Engineering department indicated on the label; BioMed, ext. 1-2440 (763-581-2440) or Maintenance, ext. 1-2390 (763-581-2390)
    - **b.** Maple Grove Hospital: 1-2321

What if equipment fails/breaks?

- Remove from service
- Put on a defective sticker
- Call the appropriate engineering department

What is a safe medical device related incident?

- If medical device (anything used in customer care that is not a drug) may have contributed to the serious illness, injury or death of a patient or a user, it may be a Safe Medical Device reportable incident. In this event:
    - Attend to the medical needs of the customer/user
    - Remove the equipment from service
    - Put on a defective sticker, noting it was involved in an incident
    - Tell the area's manager/supervisor
    - Save the disposables for evaluation during the investigation of the incident
    - Complete a Safety First Report
    - Call BioMed, ext. 12440 and Risk Management, ext. 12390 or 763-581-2390

HOW DO I KNOW THE EQUIPMENT IS SAFE/READY FOR USE?

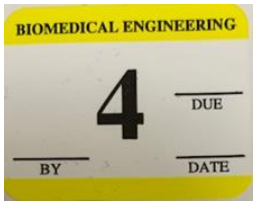
Your Responsibility to our patients:

- Look for the GREEN serviced tags or the WHITE medical equipment tag. If not found, take the equipment out of service, fill out a defective sticker, and call 1-2321.
- Check the DUE line – if the date is past, take the equipment out of service, fill out a DEFECTIVE stick and call 1-12321

"Equipment Was Safety Checked"

sticker tells you:

- Equipment was inventoried and safety checked prior to its initial use
- Equipment is assessed individually for ongoing testing



MGH Biomed uses color coded stickers to indicate when preventative maintenance is next due. Each sticker will have information about when the inspection was last performed (bottom right line), when it is due next (top right line), and who performed it (bottom left line). There are different colors for each month.

DEFECTIVE DO NOT USE

What do I do with defective equipment?

- Remove from service
- Tag and label (labels found in utility rooms)
- Report it to Biomed/Maintenance by calling the Customer Service Center 1-12321 or, after hours, the Patient Care Facilitator

5.22 Slips, Trips and Falls

Most falls occurring from slips and trips are due to slipping on an icy surface or tripping over an object. A fraction of the falls occurs when people fall off ladders or steps. It is also a fact that falls at the workplace can be prevented.

- Ensure that all spills and wet surfaces are immediately cleaned up from the floor
- See to it that all walking pathways in the workplace are clutter free
- In case you need to reach something that is high, always use a safe stepladder. Never use chairs or desks to climb to access things above your head
- Make sure that you only carry loads that you can safely handle. While carrying objects, make sure your line of vision is not affected and do not carry a load that is too heavy.
- Always have good illumination around the office space. Indoors or near to the exteriors, ensure that lighting is adequate, and visibility is not affected.
- Always wear good footwear. We may not have control over the condition of the surface that we walk on, but we do have control over what we choose to wear on our feet.

5.23 Electrical Safety

Most equipment in the healthcare setting is electric so there is a risk of electric shock. Electric shock can cause burns, muscle spasms, ventricular fibrillation, respiratory arrest, and death.
To help prevent electrical accidents, remove, and report electrical hazards, use electrical equipment properly, maintain, test, and inspect equipment and use power cords and outlets properly.

Safety Inspections

- Look for a Safety Inspection sticker on patient care devices, products and equipment, e.g., IV pump, chair, bed, lift. If there is no sticker or the sticker has a past due inspection date, remove the product from patient use and contact Facilities or Bio-Medical Engineering.
- If your department is purchasing new equipment, contact Facilities or Bio-Medical Engineering for a safety check and inspection.

Electrical Outlets

- Cover outlets in pediatric areas to prevent little fingers from getting big shocks. \
- Do not overload outlets. Overloaded circuits can cause fire or shorted circuits.
- Think ahead about how you would deal with a power failure and work with only emergency power. *What would your environment look like with only emergency power? How would customer care be different?*

- Know which emergency equipment battery has operated back up. Make sure emergency equipment is plugged into a RED outlet. Extension cords can be used temporarily

Emergency Electrical Outlets

- Provide generator supplied power in ten seconds or less.
- Plug all life support and critical patient care equipment into specially marked emergency electrical outlets (red), this includes downtime computers and printers.

Moisture/Fluids

- Any type of moisture is an electrical hazard. This includes wet or sweaty hands, standing on a wet floor, liquid spills on the floor, etc. Keep your hands dry. Wipe up small, non-hazardous spills immediately.

Cords and Plugs

- Never break off the third prong on a grounded plug to adapt it to a two-slot outlet!
- Use three-pronged instead of two-pronged plugs. Only double-insulated appliances shall be permitted to have two-pronged plugs.
- To remove a plug from an outlet, pull on the plug, not the cord.
- Never pull the cord from a device and leave the cord dangling from an outlet!
- Approved extension cords should be used in emergency situations only.
- Keep cords away from heat and water. Don't run cords under rugs or through doorways.
- Cords that are damaged or that feel warm/hot to touch must be taken out of use immediately and reported to Bio-Medical Engineering. Call x12321 to report.

6 Fraud, Waste and Abuse Prevention

6.1 Overview

Your role at MGH is critical to preventing Fraud, Waste and Abuse (FWA)

- Both federal and state governments establish many complex regulations and guidelines to help health care organizations detect, prevent, and respond to fraud.
- Following these regulations and guidelines, as well as MGH internal policies, is critical to maintaining patient safety, demonstrating business integrity, being good stewards of our financial resources, and maintaining MGH's reputation in the community.

6.2 FWA Detection and Prevention

Detecting and preventing FWA is a responsibility of all MGH team members

The Compliance department serves as a resource to the organization providing tools and processes to identify and prevent FWA

- Prevention requires collaboration between:
  - NMH team members and vendors
  - Vendors and affiliated health care providers
  - State and federal agencies
  - Customers (patients)

6.3 Fraud, Waste, and Abuse Defined

To meet the fraud control expectations established by government agencies, we must be able to identify FWA in our health care environment.

Fraud is when someone intentionally executes or attempts to execute a scheme to inappropriately obtain money or property from a government health care program (such as Medicare).

Waste means incurring unnecessary costs under a government health care program because of deficient management, practices, systems, or controls.

Abuse occurs when health care providers or suppliers perform actions that directly or indirectly result in unnecessary costs to any government health care program. **Abuse includes any practice that:**

- Is inconsistent with providing medically necessary services.

- Provides services that do not meet professionally recognized standards; or
- Provides services that are not fairly priced.

EXAMPLES OF FWA

It is impossible to list all types of potential fraud, but the following list provides examples of activities that have been found to be FWA in other organizations:

- Billing for goods and services that were never provided to a customer
- Conducting excessive office visits or writing excessive prescriptions
- Misrepresenting the service that was provided to a customer
- Billing for a higher level for the service than was delivered
- Incorrectly billing non-covered services or prescriptions as covered items
- Using multiple billing codes instead of one billing code for a drug panel test to increase reimbursement ("unbundling")

6.4 The Fraud Continuum

Because fraud, waste and abuse are so broadly defined, errors and mistakes can be violations of the law. Therefore, you need to pay close attention to your duties to avoid errors that could be considered fraud.

The Centers for Medicare and Medicaid (CMS) investigates all causes of improper payments – from unintentional errors to intentional fraud.

Not all improper payments are fraud (i.e., intentional misuse of funds). In fact, the vast majority of improper payments are due to unintentional errors. The most common error is lack of clinical documentation.

Unintentional Error: A mistake caused by poor reasoning, carelessness, or insufficient knowledge and is made without the intent to deceive

Poor Control Environment: When a workplace fails to prevent undesirable acts from occurring, it is called a poor control environment. This means that standard processes and checks are not followed to be sure work is done in a consistent and compliant manner. Examples include lack of separation of duties, proper authorization, or adequate documentation for transactions.

Intentional Fraud: Occurs when someone Commits an act knowingly and with the intention to deceive.

6.5 What is Intent?

The seriousness of the fraud is determined by the intent behind the fraud

- Was the mistake an unintentional error? Or was it the result of intentional fraudulent behavior?
- If the mistake was an unintentional error, could it have been prevented with environmental controls (e.g., better policies directing documentation, better delineation of duties to ensure appropriate decision making)?

6.6 FWA Laws

The federal and state governments have a long history of regulating health care practices to prevent fraud, waste and abuse. These include

- False Claims Act

- Anti-Kickback Statute
- Physician Self-Referral Statute (Stark)
- Exclusion Statue
- Civil Monetary Penalties Law

You do not need to know all the details of these laws to do your part in preventing FWA. However, you should have a general understanding of how these laws impact your role at MGH.

6.7 False Claims Act

This law makes it illegal for any person to knowingly make a fraudulent claim for payment to the federal or state government.

- You do not have to intend to defraud the government to violate this law. You can be liable for violating this law if you act with deliberate ignorance or reckless disregard of the law.
- The False Claims Act generally applies to any type of government claim for payment, but the federal government aggressively pursues False Claims Act enforcement within the health care industry.

False Claims Act violations can be fined up to three times the amount of the false claim, plus $21,916 per claim. Fines can add up quickly because each separate claim submitted to the government can be separate grounds for liability.

6.8 The Anti-Kickback Statute

makes it a crime to knowingly and willfully offer, pay, solicit, or receive, directly or indirectly, anything of value to induce or reward referrals of items or services reimbursable by a government health care program (such as Medicare or Medicaid).

- Remember that both the "giver" and the "receiver" of an inappropriate inducement or reward are liable under the Anti-kickback statute. This is why all NMH business must be conducted in a fair and transparent manner.

Anti-kickback violations can result in prison sentences and fines and penalties of up to $100,000 per kickback plus three times the amount of the underlying transaction.

6.9 Stark Law

The Self-Referral Prohibition Statute is also commonly known as the **Stark Law**.

- This law prohibits physicians from referring Medicare or Medicaid patients to an entity with which the physician or a physician's immediate family member has a financial relationship — unless an exception applies.
- This is a complex law with severe penalties for non-compliance, so every contractual arrangement between MGH and a physician must be reviewed by Provider Services and Compliance/Legal. All relationships must be appropriately documented.

Penalties for physicians who violate the Stark Law may include fines of up to $24,253 for each service performed in violation of the law, repayment of claims, and potential exclusion from all Federal Health Care Programs.

6.10 Exclusion Statute

Under the Exclusion Statue, the federal Health and Human Services Office of the Inspector General must exclude providers and suppliers convicted of any of fraud, waste or abuse from participation in federal health care programs (such as Medicare and Medicaid).

- As a Medicare/Medicaid provider, MGH must not employ, contract, or otherwise do business with any excluded individual or entity.
- The federal government maintains exclusion lists, and NMH is obligated to routinely screen these lists to ensure it does not do business with any excluded individual or entity.

6.11 The Civil Monetary Penalties Law

The Civil Monetary Penalties Law authorizes penalties for a variety of health care fraud violations. Violations that may justify penalties include:

- Presenting a claim that you know, or should know, is for an item or service not provided as claimed or that is false or fraudulent.
- Presenting a claim you know, or should know, is for an item or service that Medicare will not pay.
- Violating the Anti-kickback Statute.

Penalties may be assessed up to three times the amount claimed for each item or service, or up to three times the amount of payment offered, paid, solicited, or received.

6.12 FWA Committed by Customers

In addition to the types of errors or intentional bad acts that may constitute FWA committed by health care providers, Medicare/ Medicaid beneficiaries may also commit FWA. If you see any of these situations occur, report the activity to the compliance department.

- **Drug diversion** occurs when someone uses drugs, medications, and other pharmacy supplies for reasons other than their original or intended purpose.
- **Member fraud** occurs when a member carries out a fraudulent activity by falsifying member enrollment data or identity theft.
- **Identity fraud** occurs when someone pretends to be someone else by assuming that person's identity; often, this is done to access resources, obtain credit, or obtain other benefits in that person's name.

6.13 FWA Prevention

WHAT ARE YOUR FWA PREVENTION RESPONSIBILITIES

You play a vital part in preventing, detecting, and reporting potential FWA, as well as Medicare/Medicaid non-compliance.

- You must comply with all applicable regulatory requirements, including participating in compliance program activities.
- You have a duty to report any suspected or actual non-compliance that you may know of.
- You have a duty to follow MGH's Code of Conduct. The Code of Conduct can be found on the Compliance intranet webpage.
- When in doubt, ask questions. The Compliance Department is a resource for all NMH team members.
- **All NMH Team Members are expected to report any known or potential concerns of FWA.**
- **All reported compliance concerns are investigated by the Compliance Department. Investigations are handled confidentially.**
- **NMH prohibits any form of retaliation against a team member who reports a FWA concern in good faith.**

6.14 Reporting

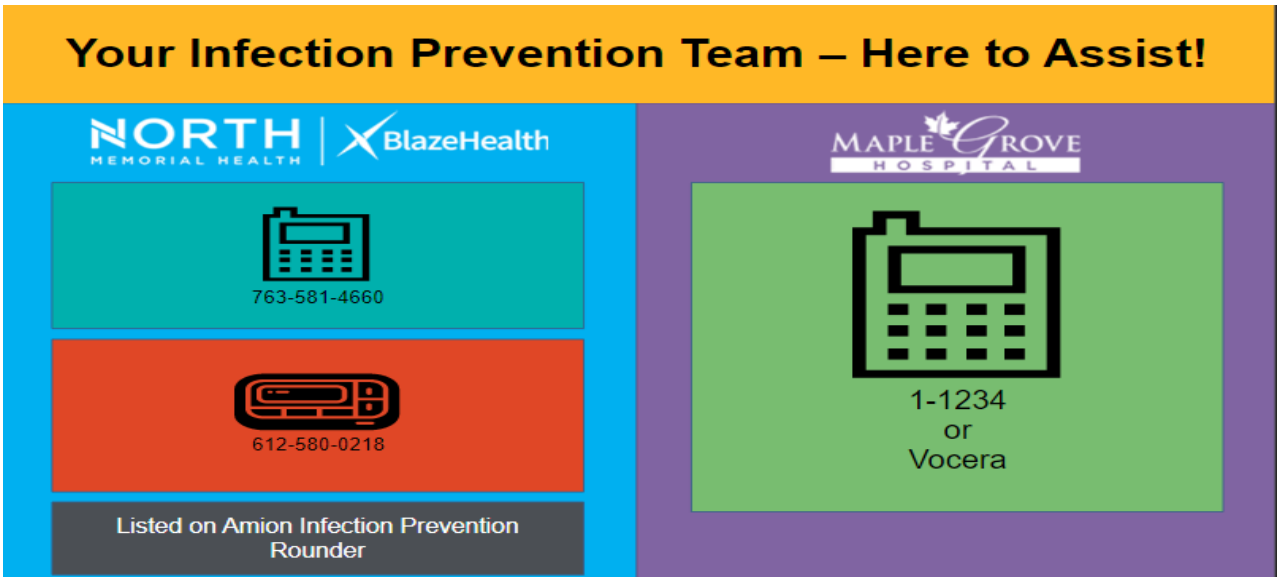
HOW TO REPORT A FWA CONCERN

1. You can speak to your supervisor, and your supervisor will report the concern to Compliance.
2. You can call or email any Compliance Department team member.
3. You can contact the Compliance Hotline (763.581.1575).
   (This number is printed on the back of your Team Member badge)
4. You may leave an anonymous message on the Hotline.

The Compliance Program helps NMH identify concerns and reduce compliance risks. Compliance Department staff work with team members to implement changes to correct identified non-compliance and prevent the problem from happening again.

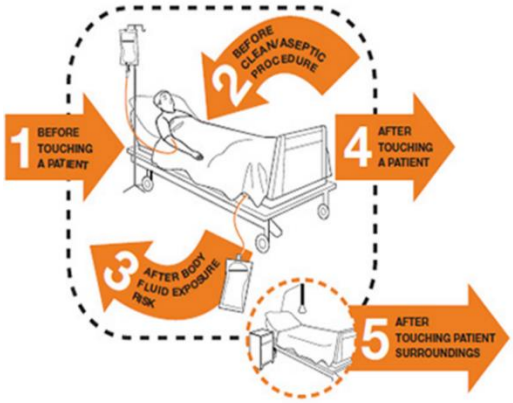
Chief Compliance Officer: compliance@northmemorial.com

7 Infection Prevention



Best practice policies and procedures are in place to reduce opportunity for these infections

Center for Disease Control:
"Hand washing is the single most important procedure for preventing healthcare acquired infections"



The World Health Organization (WHO) guideline recommend you perform hand hygiene at these five (5) specific moments:

1. Before touching a patient
2. Before a clean/aseptic procedure
3. After a body fluid exposure/risk
4. After touching a patient
5. After touching a patient surroundings

Waterless Hand Rub

- Apply enough product to keep hands wet for 15 seconds
- Rub all surfaces, including nails
- Don't use after caring for patients with diarrhea or when hands are soiled – use soap and water

Soap and Water Hand washing

- Moisten with water
- Mechanically wash surfaces for 20 seconds
- Thoroughly rinse
- Pat hands dry
- Use paper towel to turn off faucet

Hand Hygiene Step 2: Moisturize

Take care of your hands – the most commonly used medical instrument

- Use moisturizing lotion or cream in your work shift to keep skin neutral
- See Team Member Health if you are having skin difficulties or product concerns

Jewelry and Nails

A Patient Safety concern!

- Artificial nails and jewelry are a source for harmful pathogen transmission to patients.

- Nails and jewelry are kept in accordance with organizational professional appearance standards
- Direct customer care team members must keep their nails clean and short (<1/4 in). Artificial nails, chipped nail polish, or nail enhancements must not be worn by those who provide direct customer care. Nail polish is completely prohibited for the following: anyone performing patient care in the NICU, in the OR sterile field, or in the pharmacy.
- Know your department specific policies for additional requirements

7.1 Standard Precautions

ARE USED FOR ALL PATIENTS, ALL THE TIME
Treat ALL blood or body fluids as infectious.

- Use personal protective equipment (PPE) based on anticipated exposure
- Practice sharps safety
- Use respiratory etiquette (cover your cough)
- Practice hand hygiene
- Clean and disinfect equipment immediately after use

7.2 PPE

Gowns: Are worn when anticipating contamination; for specific isolation; managing blood and body fluids and excretions

- Gowns are generally worn in combination with other PPE
- Put on before you go in the room
- Take off before you exit

A new gown is necessary with each encounter with the patient
Perform hand hygiene after removal.

Gloves: Wear gloves when touching abnormal skin, non-intact skin, rashes, blood, body fluids, mucous membranes, contaminated items, and environmental cleaning products.

- Additional indications for sterile vs. clean glove use can be found in the Standard Precautions Policy.
- Hand hygiene is required before and after donning/doffing gloves.

Face Shields: Worn to protect eyes when there is a risk of droplet dispersal, splashing of blood and or body fluids.

- Full face Shields are the preferred choice for eye protection, which provides protection for eyes, nose, and face.
- Alternative eye protection options are also acceptable when worn with a mask, including safety goggles and safety glasses with minimal gap between the glasses and forehead.
- Personal eyeglasses alone are not adequate protection.
- NOTE: eye protection is RECOMMENDED for all direct care activities per current COVID-19 public health guidance

Standard Masks: Masks are used in health care facilities:

- Project team members from infectious respiratory particles from patients.
- To protect patients from exposure to infectious organisms during a procedure requiring sterile technique.
- As the source control to limit potential spread of infectious respiratory particles during community outbreaks (e.g., COVID-19)

NOTE: Universal masking (source control) is currently required for all individuals who enter North Memorial Hospital, Maple Grove Hospital or clinic COVID-19 public health guidance.

Respirators: filtering-facepiece masks that you may see being used as well. See the respirator protection section of this document.

N95

PAPR

The above are filtering-facepiece masks that you may see being used as well. There is a separate module that goes in detail about these masks if your role requires them.

DONNING AND DOFFING PPE

The type of PPE used will vary based on the level of precautions required, such as standard and contact or airborne infection or isolation professions. The procedure for putting on and removing PPE should be tailored to the specific type of PPE.

DONNING

Step 1: Donning a gown

- Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back.
- There are re-useable and disposable gowns. While doffing is different, donning is the same
- Fasten in back of neck and waist

Step 2: Donning a Mask or Respirator

- Secure ties or elastic bands at middle of head and neck
- Some masks have ear loops
- Fit flexible band to nose bridge
- Fit snug to face and below chin
- Fit-check respirator

Step 3: Donning Goggles or Face Shield

- Place over face and eyes and adjust to fit

Step 4: Donning Gloves

- Extend to cover wrist of isolation gown. There are a variety of ways to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials

DOFFING

Step 1: Doffing Gloves

- Using gloved hand, grasp the palm area of the other gloved hand and peel off the first glove.
- Hold removed glove in gloved hand.
- Slide fingers of ungloved hand under remaining glove at wrist and peel off second glove over first glove.
- Discard gloved in waste container

Step 2: Doffing a gown

Determine if gown is re-usable or disposable
For Re-useable Gowns:

- Unfasten gown ties, taking care that sleeves don't come in contact with body when reaching for ties.
- Pull down from the shoulders, touching inside of down only.
- Fold or roll into a bundle and discard into laundry bin (fabric/laundered gown)

For Disposable Gowns:

- Grasp the gown in front and pull away from your body so that the ties break, touching the outside of gown only with gloved hands.
- While removing the gown, fold or roll the gown inside out into a bundle.
- As you remove the gown, peel off your gloves at the same time, only touching the inside of the gloves and the gown with your bare hands.
- Place the gloves into a waste container. Fold or roll down into a bundle and discard into a waste container.

Step 3: Doffing Goggles or Face shield

- After leaving patients room, remove eye protection without touching the front (contaminated) area
- Some types of eye protection are reusable (goggles, face shield). If reusable, decontaminate after removing, otherwise discard in regular trash. Referred to PPE policies and guidelines for reuse instructions.

Step 4: Doffing Mask or Respirator

- The front of mask/respirator is contaminated – DO NOT TOUCH!
- Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
- Discard in a waste container

Step 5: Perform hand hygiene.

- Perform hand hygiene between steps if hands become contaminated and immediately after removing all PPE

7.3 Transmission Based Precautions

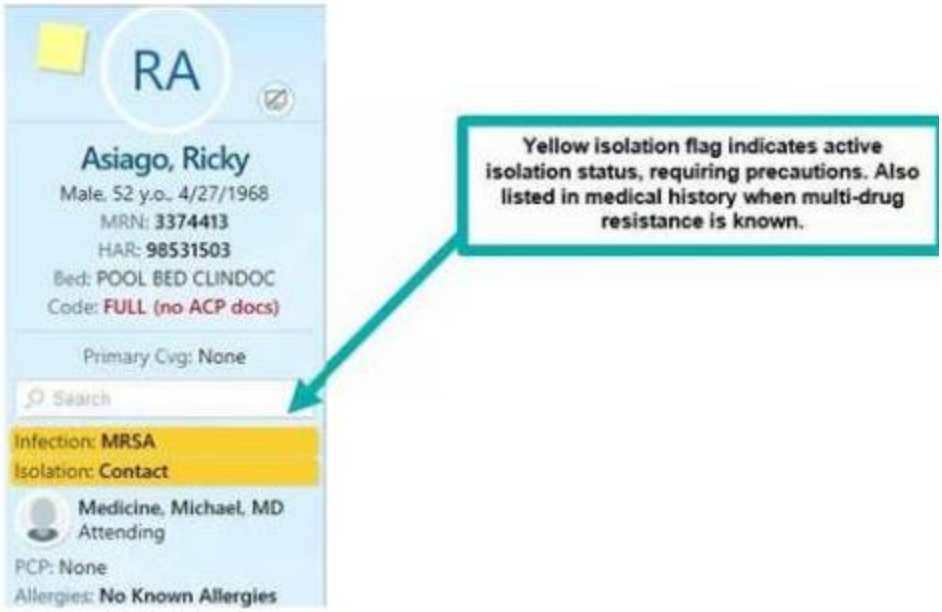
Contact, Droplet, Airborne, Enteric, and Full Barrier

The need for precautions can be guided by the patient's symptom presentation (e.g., cough, rash), known disease (e.g., multi-drug resistant organism history), or lab diagnostics (e.g., new positive result).

Transmission Based Precautions Flag

Providers, RN's, Infection Prevention may order transmission-based precaution.

- Outside the EMR, team members are alerted to precautions by a visual door sign. Door signs should be placed immediately upon identification of isolation need.
- Electronic medical record infection flag or new isolation order will indicate the need for precautions.
- The yellow isolation flag in EMR indicates active isolation status, requiring precautions. Also listed in medical history when multi-drug resistance is known.




isolation cart @ North


isolation bag @ MGH

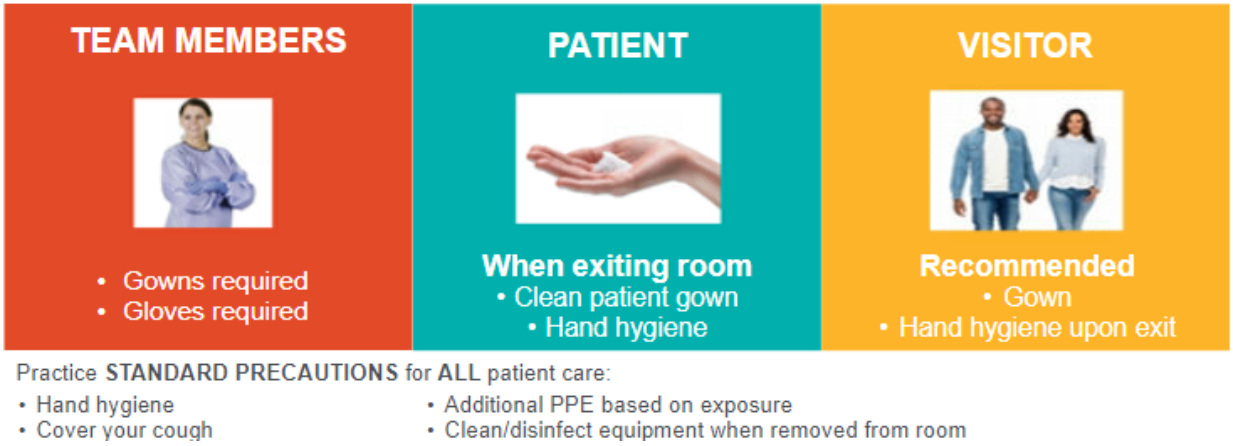
Where to obtain PPE supplies:
Refer to infection prevention isolation policies and procedures for further precaution and PPE guidelines.

7.4 Contact Precautions

Prevent transmission of pathogens of infectious agents, including epidemiologically important multi-drug resistant organism(s) (MDRO), which spread by direct or indirect contact with the patient or the patient's environment.

- Carriers (colonized): persons who can transmit an infectious disease to others but do not have active signs or symptoms of illness
- Infected (symptomatic): persons who have active signs and symptoms of an infectious illness and could transmit the illness to others
- Common MDRO
  - Methicillin-resistant Staph Aureus (MRSA)
  - Extended-Spectrum Beta Lactamase organism (ESBL)
  - Carbapenem-Resistant Pseudomonas (CRPA)
  - Vancomycin-Resistant Enterococcus (VRE)

Example for a patient on contact precautions



7.5 Droplet Precautions

Droplets are propelled through the air up to 3-6 feet
Some disease examples include:

- Pertussis
- Influenza
- RSV

- Door must be closed during aerosol generating procedures (AGP)
- Patient should stay in room whenever possible and must wear a procedure mask when outside room
- Provide respiratory etiquette supplies (tissues, hand hygiene product)
- Required PPE
    - Standard procedure mask
    - Eye protection

REMINDER: Team members should wear a respirator, instead of a procedure mask when performing an aerosol-generating procedure such as:

- Endotracheal tube (ETT) intubation, extubation or exchange
- CPAP and BiPAP – non-invasive positive pressure ventilation (NIPPV)
- Bag mask valve (BVM) ventilation (ambu bag ventilation)
- Cardiopulmonary resuscitation (CPR) with chest compressions
- Bronchoscopy
- Open suctioning of airways
- Sputum induction
- Nebulizer treatment (use CPAP and BiPAP mask if possible)
- Upper endoscopy (including PEG tube placement
- Transesophageal echocardiography (TEE)
- High flow oxygen by nasal route or face mask >6L/min

- Droplets are propelled through the air 3-6 feet
- Some disease examples that require Droplet Precautions are Pertussis, Influenza, RSV

7.6 Airborne Precautions

Precautions required:

- Airborne organisms can stay suspended in the air for an extended period of time and travel with circulating airflow
- Required for patients suspected or known to have:
    - Laryngeal/pulmonary Tuberculosis
    - Chicken Pox
    - Measles
- Can be expelled by coughing, sneezing, talking, breathing, or when performing aerosol generating procedures.

7.7 Negative Airflow Rooms

Customer is placed in a negative air flow environment as soon as possible.

- Air flows from the corridor into the patient room.
- The air is exhausted to outdoors.
- The door must remain closed.
- Negative air flow room locations can be found in the Infection Prevention Airborne Isolation Policy in the electronic management system.

In addition:

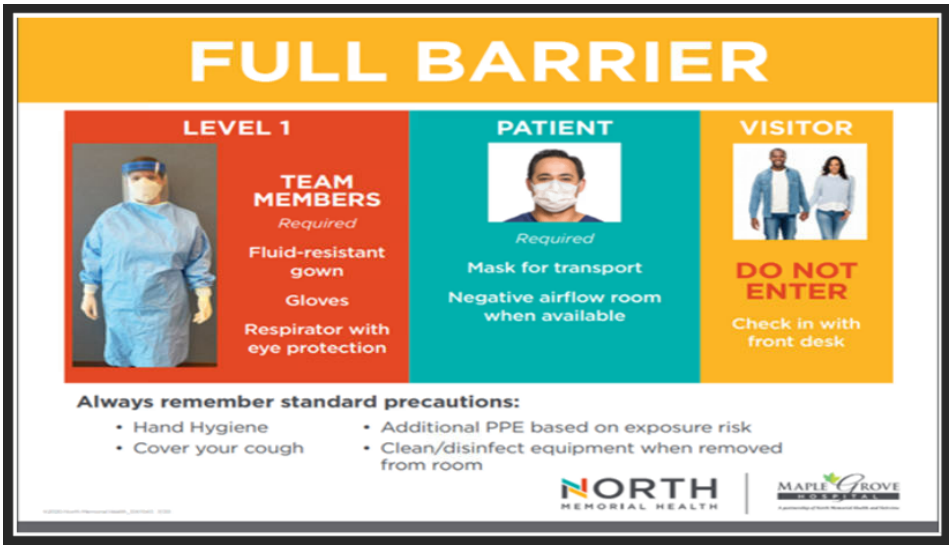
- Call Maintenance to verify room is negative, monitoring is required until isolation is discontinued.
- Order airborne isolation in EPIC
- Place isolation signage on the door.
- Keep the door closed.

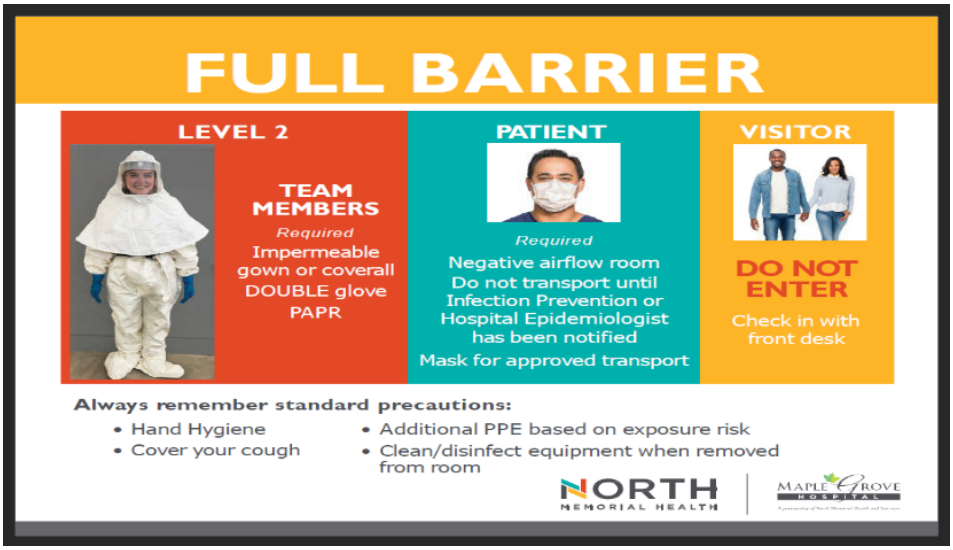
7.8 Full Barrier

Full Barrier precautions are used for infectious pathogens where a combination of PPE is required. It can also sometimes be used for a new/evolving pathogen where transmission is not yet well understood

There are two types of Full Barrier Precautions used:
Full Barrier Level 1: Used for respiratory illnesses such as COVID-19, Middle eastern Respiratory Syndrome (MERS) and severe acute respiratory syndrome (SARS) – Gown, gloves, eye protection and N95 required.
Full Barrier Level 2: Typically includes gastrointestinal or hemorrhagic disease presentations such as Ebola or Lassa Fever – Impermeable gown or coverall, Double glove and PAPR required.

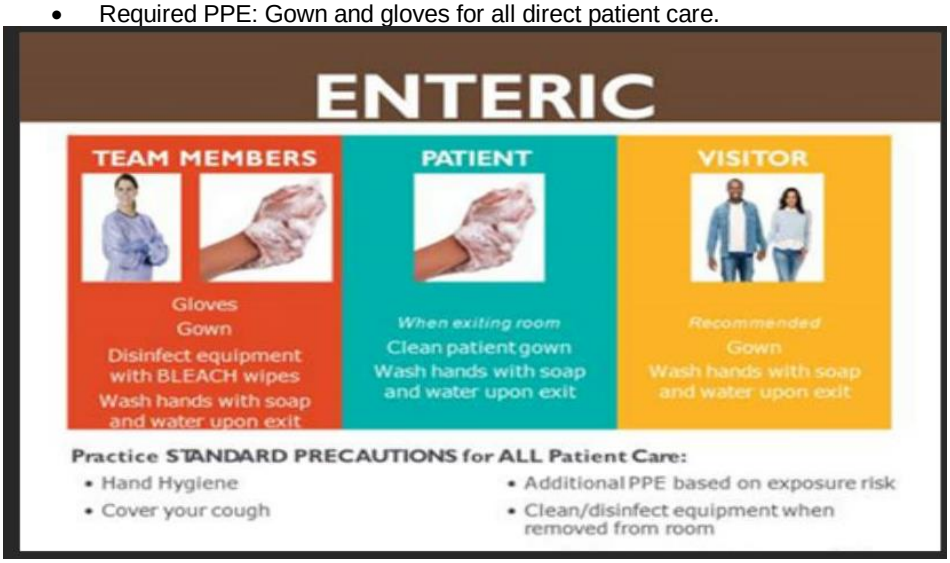
A private room and bathroom are required for patient placement. A negative airflow room may be preferred – refer to organism specific protocols (i.e., COVID-19 protocols).





7.9 Enteric

- Patients with diarrhea or vomiting are proactively isolated when enteric tests are ordered (C-difficile, Norovirus).
- Isolation practices include hand washing rather than foam after encounters and using bleach wipes for environmental cleaning.
- Terminal cleaning is required after enteric precautions are used. A sporicidal disinfectant is used.
- In settings where UV equipment is available, the room is ultraviolet light disinfected after terminal cleaning is complete.
- Required PPE: Gown and gloves for all direct patient care.



7.10 Blood and Body Fluid Exposure

NMH maintains an Exposure Control Plan to mitigate exposure opportunity to bloodborne pathogens (BBP). The plan is reviewed annually, and the policy is available to team members in the electronic management system.
Blood pathogens include:

- Hepatitis B (HBV): a virus that causes acute or chronic liver infection, which can lead to permanent liver damage, failure or cancer.

        - Symptoms include fever, fatigue, loss of appetite, nausea, vomiting, pain, and jaundice
        - Transmission occurs through activity that involves puncture through the skin, mucosal contact with infectious blood/body fluid
        - Incidence of HBV is declining in the United States due to vaccination efforts. The vaccine is 95% effective
        - EXPOSURE RISK: without the vaccine, the risk of acquiring HBV after exposure is 6-30%
            - NMH offers vaccination to susceptible team members at no cost
            - The vaccine is highly effective, with 95% efficacy.
    - Hepatitis C (HCV) is a varus that causes acute or chronic liver infection, which can lead to permanent liver damage, failure, or cancer
        - Symptoms include fever, fatigue, loss of appetite, nausea, vomiting, pain, and jaundice.
        - May show no symptoms at all
        - Transmission occurs through activity that involves puncture through the skin, mucosal contact with infectious blood/body fluid
        - An estimated 2.7-3.9 million people have chronic HCV in the U.S.
        - EXPOSURE RISK: The risk for acquiring HCV after exposure is 1.8%. Up to 85% of those infected will develop chronic infection
            - There is no vaccine to prevent HCV
            - After exposure, ongoing follow-up/monitoring may be required with clinician.
    - Human Immunodeficiency Virus (HIV) is a virus that attacks the immune system and can lead to a more severe phase called AIDS
        - Initial symptoms include fever, chills, fatigue, muscle aches, sore throat, and swollen lymph nodes
        - Transmission occurs through activity that involves puncture through the skin, sexual contact with infectious blood/body fluid
        - While new infections are declining in the U.S., 1.1 million people in the U.S. live with HIV
        - EXPOSURE RISK: Healthcare worker risk for HIV is considered low. The likelihood of infection after exposure through a contaminated needle is <1%. There is no vaccine to prevent HIV

A bloodborne pathogen (BBP) exposure is defined as an event in which personnel come into contact with blood or other potentially infectious material through direct contact, contaminated instruments or by other indirect means (e.g., needle stick).

BBF exposures should be reported as soon as possible to a supervisor so counseling and medical evaluation can be done timely before entering event in Safety First Reporting.

Blood/Body fluid exposures – What should you do?

Robbinsdale: North Memorial Team Members report to the Team Member Health Center when exposure occurs during normal business hours. At all other times, report to the NMHH Emergency Department.

Maple Grove Hospital: go to MGH Emergency Care Center when exposure occurs

Contractors or non-employed individuals working in an NMH facility who experience exposure should report to ED or ECC.

For **customer exposures**, Infection Prevention should be alerted ASAP.

Patients can also experience BBP exposure.
Examples: Breast milk given to wrong infant, insulin pen of one patient used by another, use of contaminated surgical instrument

7.11 Environment of Care

Food and drink storage

Hospitals and health care facilities must maintain a clean inventory. Safety practices to help achieve this include:

- Store personal food and beverages only in a designated location in your department. Food and drink may not be stored on any surface where there is a potential for cross contamination with blood/body fluid, specimen handling or storage, patient equipment reprocessing, or supply storage.

Linen

- Soiled/used linen is contaminated and should be handled wearing gloves.
  - Dispose at point-of-use in designated container
  - When moving to a collection area, hold away from your uniform

Supply management

- Perform hand hygiene before accessing clean supply storage areas. Do not store any patient care equipment or supplies in proximity to water sources (<3 ft of the splash zone)

7.12 Disinfection Wipes and Equipment Cleaning

- Always consult manufacturer's instructions for cleaning and disinfection to prevent damage
- Cleaning and decontaminating patient care equipment and the environment is a shared responsibility all team members
- Reusable patient equipment must be decontaminated after use.

Effective cleaning and decontaminating require a two-step process.

1. Clean this approved disinfectant wipe to remove organic material.
2. Decontaminate disinfect surface by applying wipe for the recommended contact time specific on the label.

8 Information Privacy

8.1 Overview

- The federal Health Information Privacy and Accountability Act ("HIPAA") and state laws require us to protect customer privacy.
- As an NMH team member, you are responsible for protecting the privacy and security of customer information.

NMH must protect these three main classifications of information

- PCI -Payment Card Industry: This includes any credit card information we may have in our system and must be protected by data security standards (DSS)
- PII- Personally Identifiable Information: MN Statutes require notification to individuals whose information is acquired by an unauthorized person. Personal information includes name in combination with any one or more of the following:
    - Social Security number
    - Driver's license or MN ID card number, or
    - Account number or credit or debit card number in combination with any required security code, access code, or password that would permit access to an individual's financial account
- PHI- Protected Health Information: information that
    - Identifies or could reasonably be used to identify the customer
    - Relates to the customer's health, health services received, or payment for those services

8.2 PHI

Disclosure of PHI
Most disclosures that are for purposes other than treatment, payment or health care operations require customer authorization

- NMH privacy polies explain when disclosures may be made without authorization. Examples include:
    - Reporting child abuse/neglect to child protective services
    - Responding to inquiries from health oversight agencies, such as the Centers for Medicare and Medicaid Services (CMS) or the MN Department of Health
- NMH privacy policies provide additional information about appropriate disclosures. When in doubt, do not disclose PHI outside of NMH without consulting the Privacy Department.
- When in doubt, do not disclose PHI outside NMH without consulting the Privacy Department

8.3 Minimum Necessary

When doing your job, you may only access the minimum amount of PHI necessary to accomplish your work. This is known as the "Minimum Necessary Rule"

1. NMH privacy policies prohibit you from viewing any information that is not required for you to complete your job tasks
2. Disclosures of information outside of the organization should be limited to the minimum amount of PHI necessary to fulfill the request.

8.4 Disclosing PHI

You must take the following steps to protect PHI:

- Double check patient identifiers on all paperwork, such as discharge summaries and after visit summaries before handling paper to customers. This will prevent PHI from being given to the wrong customer.
- All paper containing PHI must be disposed of in confidential destruction bins (Shred-it). Keeping discarded PHI in a box near your workstation is prohibited.

A secured communication is one that is sent on an approved NMH communication tool and is encrypted, isolated, protected (not in a public domain), requires single user known access credentials (log-in and password), and is auditable.

- Use approved-electronic health record (HER) systems, such as EPIC, for communicating PHI. Use tools within the electric health record as appropriate to support communication (e.g., InBasket, Secure Chat).

- If an email must be sent, you may send PHI to an internal NMH Outlook email address; internal email is already secure (no need to encrypt). Do not include PHI (e.g., customer name or medical record number) in the subject line of the email.
- Assure that communications are:
    - Being sent to an appropriate recipient
    - Meet minimum necessary standards
    - Are sent as a Secure Communication

EMAILING PHI:
If there is a business need to send an email with PHI outside of our NMH Outlook system, it must be encrypted to assure security during transmission. To encrypt an email, include the work "encrypt" in the subject line of the email.

There are new Information Blocking rules that prohibit us from keeping information from customers and caregivers. As a result, much information is available to customers without delay on MyChart. This includes all Epic notes, lab results, appointments,

8.5 Cell phones and social media

- NEVER take customer photos or transmit PHI over personal cell phones/devices
- NEVER post MGH business or PHI online

8.6 Access to PPI

HIPPA PRIVACY AND EPIC USE

HIPAA 

Curiosity is NEVER an appropriate reason to look at customer PHI

- You must have a business purpose for accessing any patient record
- Only access the minimum necessary PHI needed to complete your work

8.7 Privacy Policies

- NMH privacy policies prohibit you from viewing
    - Census reports/customer records from units where you are not assigned
    - Records of family members, friends, co-workers, etc. unless required for your job
    - Records of customers that you hear about in the news
    - Pages or portions of the Epic record that you do not need to access to complete your work

EPIC "Break the Glass:

- NMH uses Break the Glass functions in Epic as an added level of information security to certain health records that require additional privacy protections
- If you get a Break the Glass notice, complete the prompts within EPIC to access the record and do your job
- If you get a Break the Glass notice, and you do not have a job-related reason for viewing the record, close the record immediately
- Privacy Department staff routinely monitor Break the Glass access

EPIC access to your own health record

- MyChart is the Epic Portal designed for use by all customers, including NMH/MGH employees who are also customers of NMH/MGH

You are strongly encouraged to use MyChart to access your records.

In Epic, Team members are prohibited from:

- Documenting in or modifying their own health records in any way
- Viewing the Epic records of their children (regardless of age), spouse, or other family members.

- Employees who access the Epic records of family members are subject to investigation and disciplinary action

8.8 Privacy Audits

All team members are subject to random and focused privacy audits.

- If privacy identifies Epic access that was not for a business purpose or was not limited to the minimum necessary, Privacy will contact the team member's manager and request follow-up.
- Privacy policy violations are subject to disciplinary action in accordance with HR policies.

NMH must report all confirmed privacy breaches to the Office for Civil Rights, which oversees HIPAA enforcement

Privacy Investigations

- All reports of privacy non-compliance are investigated by the Privacy Department.
- Reports may be made by any team member, customer, or family member.
- Reports may be made to the Privacy Officer.

If you suspect that patient confidentiality may have been compromised, please let us know immediately of the concern so that appropriate action can be taken.

8.9 Business Associates

- MGH has contracts with many vendors and business partners that perform functions or activities on behalf of MGH that involve the use or disclosure of PHI
- These partners are known as Business Associates under HIPAA
- Prior to disclosing any PHI to a Business Associate, MGH must have a signed contract and a business associate agreement

All questions regarding Business associate Agreements should be referred to the Privacy Officer, privacy@northmemorial.com, or the Chief Compliance Officer.

8.10 Customer Privacy Rights

Customers have the right to:

- Access their own health records
- Request confidential communications and restrictions on their health records
- Request amendments to their records
- Request a list of certain disclosures of their health records

Release of information requests and other requests related to health records should be directed to the Health Information Management department.

IF YOU SUSPECT THAT PATIENT CONFIDENTIALITY MAY HAVE BEEN COMPROMISED. PLEASE LET US KNOW IMMEDIATELY SO APPROPRIATE ACTION CAN BE TAKEN

8.11 Reporting Privacy Concerns

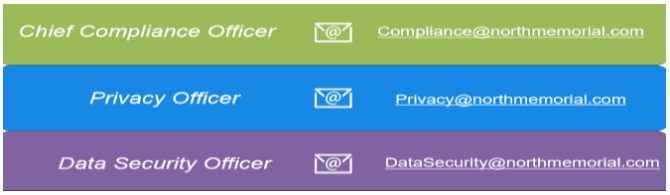
You may notify:

- Your manager
- The Privacy Officer
- privacy@northmemorial.com
- Compliance officer

- Compliance Hotline (on the back of your ID badge
- compliance@norhtmemorial.com

Privacy Considerations for Remote Workers

- Requires a private area to be used only for work purposes
- Do not leave your computer unattended. Do not allow viewing of NMH work or allow others to use your computer while logged in to North Memorial.
- Do not forward NMH emails to your personal email
- Do not move or save any content to your home computer
- Do not print unless you have been granted special approval
- Minimize PHI written on paper
- Assure two levels of physical safeguards in place storing PHI (notebook, folder, locked cabinet, safe, closed door)
- Destroy paper PHI in an authorized, secure manner (cross-cut shredder, Shred-it bin)



9 Information Security Training

9.1 Data Security

- As an NMH team member, you are responsible for protecting customer information and business data.
- In addition to following the Privacy Policies, you must also do your part to help

IT Role:

- Performs annual audits and risk assessments to identify security risks
- Complete risk management plans to respond to identified risks
- Maintains appropriate IT policies, processes, technologies, and workflows to manage and secure the IT systems
- Responds to Data Security Incidents

The Data Security Program is managed by the Director of IT Infrastructure

Your Role:

- Every team member must follow NMH IT and Data Security policies to ensure the privacy and security of customer's protected health information (PHI) and the confidentiality of business data. You must know and understand the "IT – Computer, Network and Internet Usage Policy". This policy is available in C36

9.2 Access to NMH Computer Systems

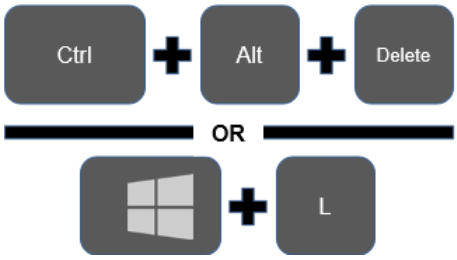
Your job role will determine the type of access you have to the NMH computer system.

- All team members need a password to log into the IT system
- You must always keep your password private. Do not post or share your password.
- If you suspect your password has been used by someone else, change it immediately and contact IT support desk at 763-581/2580

If you are using a shared computer, you must always log out when you walk away from the computer. This ensures the privacy of any customer information you are accessing. It also prevents other team members from using the computer under your user account. If you have a dedicated workstation, you must lock or log out of your computer when you are away from your chair.

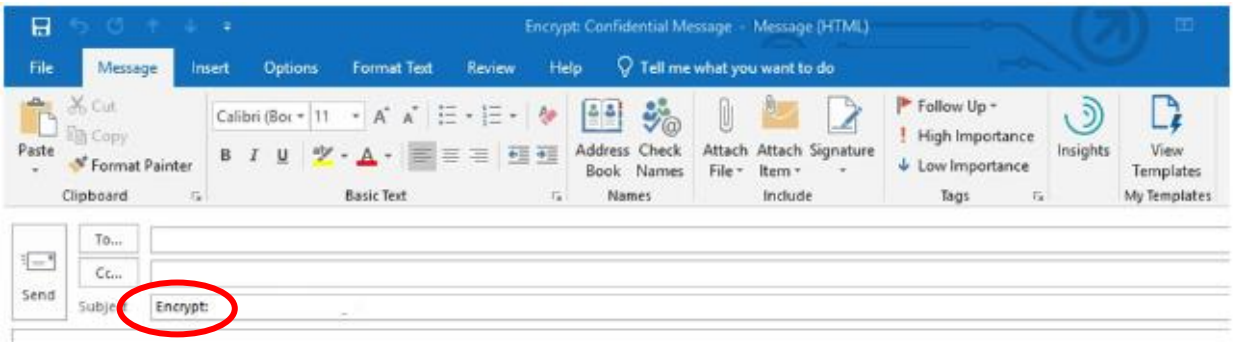
You may lock your computer quickly by pressing Control/Alt/Delete or the "Window" and "L" keys at the same time.

You must always secure your computer when you are away from it.



9.3 Emailing PHI

Ensure you establish minimum but necessary guidelines for emailing PHI. Encrypt any externally sent email containing PHI or confidential business information



In the subject line, type Encrypt: and then the subject. PHI must only be sent via the secure email system to external recipients

9.4 Phishing Awareness

Data Phishing is an attempt to gather sensitive information such as usernames and passwords, often for malicious reasons, by pretending to be a trustworthy entity.

The most common phishing attempts are email and text messages.

NEVER open emails or attachments if you do not recognize the sender.

CAUTION: This email originated from outside of North Memorial. **DO NOT CLICK** links or open attachments unless you recognize the sender and know the content is safe.
◊ Be sure to look at the email address itself in addition to the sender's name to ensure that it is as expected and not a phishing attempt.
◊ If the email is "pretending" to be from a fellow team member it is likely not valid since it will be coming from an external source.
◊ If the email was not expected or does not look legitimate to you, do not open it or click anything and delete it.
◊ If you have any questions about how to handle a received email, please call the IT Service Desk at X12580 for assistance.

The above banner appears on ANY email originated outside of NMH. When this banner appears, you know it is from outside of NMH and to only opens if you know it is from a safe source and that it is not a spoofed email.

9.5 Malicious Software

Malicious Software (a virus) is often embedded or disguised to look innocent or non-obtrusive and is a risk to the NMH computer system.

NMH requires that all software be installed by IT. Do not open or "click" anything that seems suspicious, or you do not know what it is. This may be an attempt by a hacker to compromise our computer systems.

If you think something unexpected was installed on your computer, contact IT immediately so appropriate steps can be taken.

9.6 Video conferencing

Microsoft Teams (MS Teams) is the organizational standard for meeting collaboration. The Zoom app is available upon request but is primarily used for telehealth needs and providers only.

- In all virtual meetings, any shared info should be minimum but necessary. No PHI should be shared unless approved for an exception from Privacy.
- If you are working from home, there are a few apps that allow you to connect via video. If you are using

9.7 Always report concerns

Contact the IT Service Desk when something is not working properly, or you notice any suspicious behavior or system malfunctions.

NMH promptly investigates all data security incidents and concerns made by customers, team members, and medical staff members.

Concerns or complaints about data security -report to the Data Security Officer

10 Medication Safety

10.1 Pharmacy Services

The Department of Pharmacy Services is committed to providing pharmaceutical care that focuses on ensuring appropriate, effective, and safe drug therapy for our customers

The Pharmacy Department supports this mission by assuring optimal use of medications focusing on safe and effective patient care.

If you have any questions or issues related to medication management, please call Pharmacy for assistance. We are here to help!

10.2 Medication Safety

Look Alike/ Sound Alike medications require extra precautions to prevent dangerous mix-ups. NMH has implemented TALL MAN letters for Look-alike, Sound-alike (LASA) meds (ex. ALPRAZolam and LORazepam)

- A full list can be found at https://www.ismp.org/tools/confuseddrugnames.pdf

Medication Removed from Original Package

When a medication is removed from the original package and is not going to be administered immediately and completely, it must be labeled.

- Examples include solution containers, syringes and basins
- **If a medication is not labeled, discard it.**

- Example of the information that should be on the label:

High risk medications are those that bear a heightened risk of causing significant patient harm when used.
To decrease risk, we employ *the Independent Double Check*. The second check should come to their own answer WITHOUT discussing the first check.

Medications that require an independent double check include:

- Intravenous anti-thrombotic (e.g., [Heparin, bivalirudin)]
- Non-oral chemotherapy
- Epidural administration by nursing
- IV and SQ insulin that are not prepared by the pharmacy for the patient and the dose
  - e.g., insulin pens or stock insulin vials
- Patient Controlled Analgesia [PCA] and Intravenous opioid infusions
- Intravenous epoprostenol
- Intravenous magnesium sulfate 4g and 40g infusions

More Information: *High Risk Medication Policy* in Compliance 360

10.3 Medication Security

- Home medication use is restricted except under specific circumstances. Medications brought in from home should be **sent home** if possible OR inventoried into secure medication bag and **sent to pharmacy.**
  - All medications sent through the tube system will be sent using a code
  - Medications need to be secured at all times. Only take what you need at the time. If a medication is removed from Omnicell and not opened/used, return the medication immediately. Unsecured storage in patient rooms is not allowed.
- For more information, see:
  - Control of Patient's Own Medications Policy
  - At NMHH: Medication Selection, Procurement, Storage, and Control Policy and Procedure
  - At MGH: Medication Security and Storage Policy

10.4 Medication Range and Titratable Orders

Range orders are only allowed for the dose field (e.g., morphine 2-4 mg IV every 2 hours prn pain)

- Dose ranges SHOULD be limited so that the maximum dose should be no more than 4 times the minimum (e.g., hydromorphone 0.2 mg to 0.8 mg).
- Exclusions: Infusions, insulin, contrast, intra-procedure medications, non-systemic routes of administration, comfort/palliative care.

- Frequency ranges (e.g., 2 – 4 hours prn, 4-6 hours prn) will NOT be used.

The prescribed medication does, and interval should be based on the assessment of the customer (i.e., pain, nausea, sedation level), his/her goal, anticipated reduction in symptoms, and the least potential for side effects.

- Start with the lowest dose in the range. Future doses should be based on customer response.
- Generally, the response for oral and IM medications is 60 minutes and 30 minutes for IV.

Titratable infusion should follow the order parameters and the administration instructions.

- Components of a titratable infusion order
  - Starting rate (initiate at)
  - Infusion rate (dose range)
  - Frequency of titration
  - Incremental unit of rate increase or decrease

- Goal parameter

10.5 Time Critical Medication

Most medication doses are to be given within 1 hour before or after the scheduled due time. Medication doses that must be given as close to the due time as possible include:

- STAT doses
- Doses specifically timed for procedures
- Doses timed with serum drug levels

Time critical medications must be given within 30 min before or after the due time. These include:

Fluoroquinolone oral antibiotics	**Itraconazole**
Pancrelipase	Oral tacrolimus
Nimodipine	Oral cyclosporine
Oral pyridostigmine and neostigmine	Prandial insulin aspart

10.6 Drug Diversion

Diversion is the transfer of a controlled substance from a lawful to an unlawful channel of distribution or use.

North Memorial Hospital monitors the movement of controlled substances throughout the facility and provides effective controls to guard against theft and/or diversion.

- It is **everyone's responsibility** to recognize, and report suspected diversion.
- Drug diversion is a serious crime
  - Average jail time is 11.2 years
  - Average fine is $201,776

Diversion by health care professionals can lead to potential customer harm.

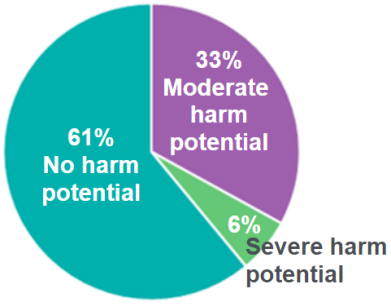
- Between 2004 and 2014
- 118 patients were infected nationally with gram-negative bacteria or hepatitis C because of hospital workers contaminating supplies while diverting drugs.

10.7 Medication History and Reconciliation

Medication History and Reconciliation is the process of creating the most accurate list possible of all medications a patient is taking – including drug name, dosage, frequency, and route – and comparing that list against the physician's admission, transfer, and/or discharge orders.

- *The customer's medication list must be reviewed and corrected for every patient encounter*
- *The list needs to be reconciled when the customer is referred or transferred to another setting, service, practitioner, or level of care within or outside the organization*
- *The complete and reconciled list of medications is provided to the customer and explained on discharge.*
- *Medication Reconciliation is everyone's responsibility. Pharmacy completed >80% of inpatient medication reconciliation, but if it is not done prior to bed placement, it is the expectation that the admitting RN complete it.*

More than half of patients have > 1 unintended medication discrepancy at hospital admission



More information See Medication Reconciliation policy in Compliance 360

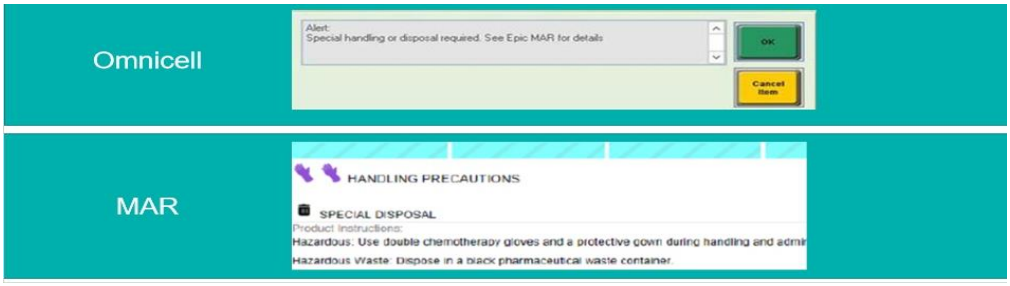
10.8 Antibiotic Stewardship

- Centers for Disease Control (CDC) 2013 report, "Antibiotic Resistance Threats in the United States," estimates at least 2 million illnesses and 23,000 deaths annually are caused by antibiotic resistance.
- Just using antibiotics can create resistance and need to only be used for infections
  - Antibiotics are among the most commonly prescribed drugs in human medicine and can be lifesaving
  - However, up to 50% of the time antibiotics are not optimally prescribed (either not needed, incorrect dosing, or duration)
- Antimicrobial Stewardship is the effort to measure and improve how antimicrobials (including antibiotics) are used, improve patient outcomes, and decrease resistance to antibiotics.
- Our Antibiotic Stewardship Program (ASP)started at NMH in 2010
  - contacts are:
    - Dr. Leslie Baken (Infectious Disease)
    - Emily Herstine, PharmD, BCPS (clinical specialist)

10.9 Hazardous Drug Handling & Disposal

As shown in the Waste Stream Management Grid, many medications require special disposal in many instances, these medications also require special handling.

To inform front line users of hazardous drug handling requirements, there is an alert in Omnicell AND more detailed information in the MAR



11 Respiratory Protection

Required only for those using an N95, PAPR, or Elastomeric Face Mask

11.1 Introduction

A respiratory protection program has been developed that establishes the safe use of respirators within our system. It is available for your review in C360 – “Infection Prevention: Respiratory Protection Program”

11.2 Respirators

Why use a respirator?

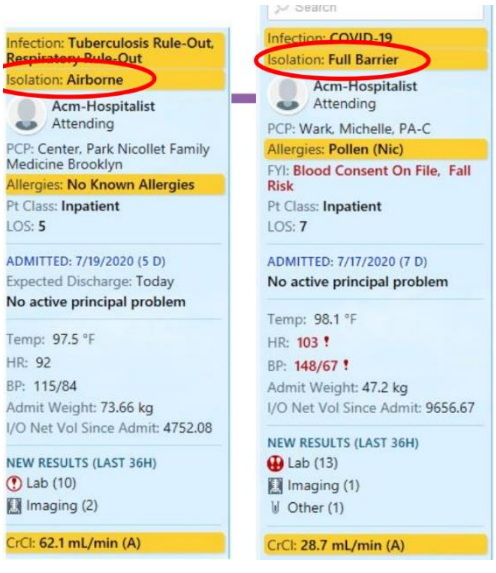
Respirators in healthcare are used to filter out tiny infectious particles and prevent them from coming in contact with your respiratory system and transmitting disease

The type you use will depend on:

- Your clinical setting
- Your unique medical issues based on the medical clearance you have completed
- Your ability to obtain adequate seals during a fit test

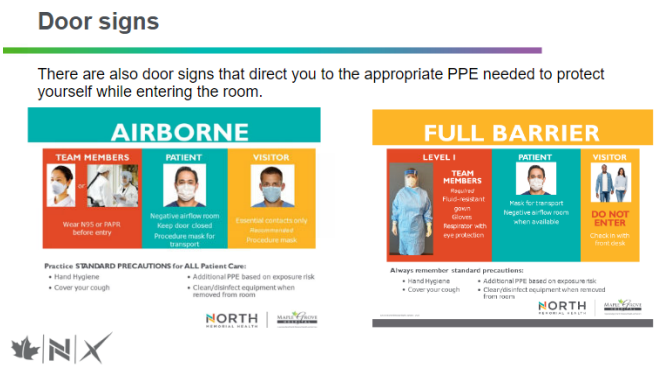
Communicable disease screening questions or a lab result within the EMR may prompt you to begin precautions using a respirator. Refer to the *Infection Prevention: Isolations Precautions Master Grid* for precautions specific to the pathogen.

How do I know when to use a respirator? When precautions are indicated, the patients EMR will be flagged on the storyboard to alert you.



How do I know when to use a respirator? When precautions are indicated, the patients EMR will be flagged on the storyboard to alert you.

There are also door signs that direct you to the appropriate PPE needed to protect yourself when entering the room. See infection prevention section.



Limitations:

Unless specifically approved for another hazard defined by the Respiratory protection program, the healthcare respirators primary intent is filter particles. Do not assume they will protect you from air that is unsafe to breathe due to vapors, gases or insufficient oxygen.

11.3 Fit Testing

- Tight fitting respirators (Filtering facepiece, elastomeric, etc.) rely on a seal between your face and the respirator to be effective.
- Fit testing ensures the seal is adequate for you as all faces are unique. It and either be a qualitative test or a quantitative test.
- Fit testing does not take the place of seal checks, which are safety checks that you should do anytime you don a tight-fitting respirator.
- Fit testing is done annually, when there are any significant changes in your facial structures, and anytime you are using a new model of respirator.

11.4 Medical Limitations

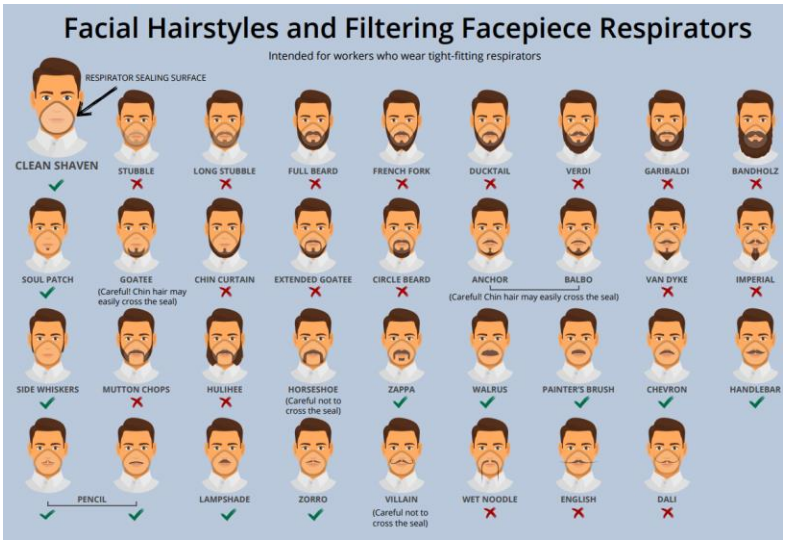
And initial medical clearance is performed before you start wearing a respirator, and periodically after to ensure you are safe when wearing the respirator. However, if you have any of the following occurs since your last fit test, consult Team Member Health:

- Weight gain or loss over 20 pounds
- Facial structure changes (significant dental work, facial surgery, or fractures)
- Any intolerance to the respirator, including skin rashes, difficulty breathing, any symptom you note worsen, or occur only with respirator use.

For clinical team members, supervisors perform fit testing. Update supervisor of any of the changes listed above.

Other Limitations

Facial hair that is present under a tight-fitting respirators seal makes the respirator ineffective.



Improper use can limit effectiveness.

Use of a respirator inappropriately can put you at increased risk of infection. Key practices that help protect you are.

- Only use the model that you have been successfully fit tested for (other than the PAPR)
- Inspect the respirator for how to Don, Doff or operate the respirator.

- Perform a seal check every time you don your respirator.
- Ensure your face is free of facial hair for any tight-fitting respirator.
- Perform hand hygiene prior to donning the respirator and following its removal

Emergency Situations

- In the event of malfunctions, remove yourself from the room or hazardous area as soon as possible and report the defect via Safety First or to your supervisor.

11.5 N95

A filtering facepiece respirator, commonly known as an N95 in healthcare, is a tight-fitting device that functions by collecting tiny infectious particles and preventing inhalation. N95 refers to the level of filtration (N-not resistant to oil and 95=filters at least 95% of airborne particles). There are numerous manufacturers and models, so it is vital you only utilize ones that have been successfully fit tested.

Component	Check for
Head Straps	Loss of elasticity, torn, cut
Facepiece	Cracked, torn, distorted, dirty
Inhalation/Exhalation Diaphragms (only on some models)	Missing, torn, improperly seated.

Donning and Seal Check

- Team members will be instructed on donning at the time of fit testing and varies slightly by model.
- A seal check is done by covering your mask with a clean hand and exhaling sharply to create pressure. If a leak is detected, readjust or discard respirator if unable to obtain it after repeated attempts.

Donning:

- Perform hand hygiene.
- Open new N95, don and perform seal check (Seal check should be performed each time a new N95 is donned

Doffing:

- In room, remove soiled gloves and gowns. Perform hand hygiene.
- Step outside of room; don clean gloves. Prepare to remove eye protection.
- Don't touch the outer shield, remove it with straps.
- Inspect for damage or gross soiling
- If reusable eye protection is used, disinfect with Sani wipes.
- If disposable eye protection is used, discard it in trash.
- Take off gloves. Do hand hygiene.
- Remove N95 by strap without touching the inside of N95.
- Discard N95 in trash.

- Perform hand hygiene.

Conventional vs Crisis PPE use

NMH is currently practicing Conventional PPE use, which means N95s are intended to be used one time before discarded.

During global pandemic situations (i.e., COVID-19) that influence supply chain, the facility may adopt crisis strategies for optimizing supply of N95 respirators under the guidance of the Centers for Disease Control and Prevention, CDC.

Do not practice reuse of N95s unless further directed by your leader. This is not in effect at this time.

11.6 PAPR

A PAPR uses a blower to pass contaminated air through a HEPA filter, which removes the contaminant and supplies purified air to a facepiece.

The PAPR hood is not designed to fit tightly so does not require a fit test prior to use. However, you will need medical clearance to ensure you have no medical contraindications to its use.

PAPRs Are utilized when facial hair precludes the use of a tight-fitting respirator. It is also used for those that are not medically cleared to wear other respirator models, as the physiologic burden of this respirator type is less for most people. It is also used for some team members that have infrequent need for respirator protection due to their role.

Inspection prior to use of PAPR.

Note below the grid; it is vital you understand how to do air flow checks and how to disinfect the PAPR in order to ensure its safe use.

Component	Check for
Hood	Cracks, damage, soiled, defects
Tubing	Cracks , damage, defects
Blower unit	Charged and blowing sufficiently to float tester.

Versaflo PAPR Instruction Guide

Step 1:

Obtain battery from charger.
Press the test button on the battery to confirm that the battery is charged. Inspect battery for damage. If damaged, do not use it.

Step 2:

Attach battery to blow unit. Inspect blower unit and filter for damage. If damaged, do not use it.

Step 3:

Air flow check:

- Insert the air flow indicator into the outlet of the blower unit.
- Hold blower unit so air flow indicator is vertical.
- Turn the blower unit on by pushing and holding the small blue power button until you hear a beep. When the blower is up to speed, the unit will either vibrate or the lights will stop blinking.
- Run the PAPR for one minute to allow air flow to stabilize.
- Ensure indicator ball rises above the H level.
- Remove air flow indicator.

Low Air flow alarm

- After removing the air flow indicator, tightly cover the outlet of the blower unit with the palm of your hand. The motor will speed up attempting to compensate for the low air flow condition.
- Hold your palm tightly around the outlet, making a tight seal. After 30 seconds, the blower unit will sound an audible alarm and a fan shaped LED will flash.
- Remove your hand. The flashing LED and alarm will stop and the motor returns to a lower speed.

Required: Air flow verification to protect yourself. Failure to do so may result in inadequate air flow, which may cause serious bodily injury or death.

If the PAPR does not pass the air flow check, **do not use the device**. Send it to BioMed for service.

Step 4:

Attach breathing tube to blower.

a. Inspect breathing tube for damage. Replace before use if damaged.
b. Attached by lining up notches on end of breathing tube. Press in and rotate right to secure.

Step 5:

Attach a breathing tube to appropriate fitting and correct size hood

Appropriate fit

- The sweatband and elastic encircle your head with sweatband against your forehead.
- The face Shield is pulled as far as possible under your chin and is hugging your face.
- The hood fits just above your ears.
- The hood does not shift on your head.

Step 6:

Don the PAPR

a. Secure belt to waist. Place the blower unit (breathing tube pointing up towards head) against your lower back along spine.
b. Fasten the buckle in the front and make sure the unit rests comfortably and securely.
c. Remove the protective covering of the visor. Put the hood on. Make sure it fits properly and air flows to the front of the hood.

PAPR Removal:

- **Only** remove once outside of patient room. Remove the hood first, followed by the belt and turn off the blower unit by pressing and holding the blue power button.
- Wipe down breathing tube, battery and blower unit (avoid the blower pins and battery pads) with bleach wipes.
- Remove battery and store on charger.
- Do not throw out the breathing tube. It is reusable.
- If the PAPR is broken, call BioMed.
- If you need a PAPR to use temporarily, call the hospital medical equipment company.
- For further assistance, contact infection prevention NMHH: 1-4660; MGH 1-1234

To Re-use PAPR Hood

- Gather PAPR motor blower unit, hood, and tubing.
- If anticipating more than one, use during the course of your shift (i.e.: repeated encounters with patients on full barrier precautions) wright name on clean PAPR hood.
- Follow instructions located in C360.
- After removal:
- Disinfect all equipment with Sani wipes and allow it to dry. (blower unit, tubing and hood)
- It's expected to reuse during the course of your shift, lace hood in a paper bag labeled with your name until next use.
- Disinfected hoods can be used for contact with multiple patients but discarded at the end of the shift.
- At the end of the shift, discard Hood in regular trash.

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11.7 Elastomeric

Half face, also known as elastomeric respirators, are durable respirators that are used in some areas of our organization. As they have an exhalation valve that discharges the user's unfiltered exhaled respiratory droplets, they are not to be used in a sterile setting. Face Shields are also worn off the respirator to provide source control. Filters are used in conjunction with the respirator mask and filtration is equal to or greater than a filtered facepiece, N95. Fit testing and specific donning and doffing training is required for this respirator.

Inspection Prior to use of Elastomeric Respirator

Component	Check for
Head Straps	Loss of elasticity, torn, cut
Buckles/head cradle	Damaged or broken
Facepiece	Cracked, torn, distorted, dirty
Inhalation/Exhalation Diaphragms	Missing, torn, improperly seated.
Filter Cartridge	Cracked, damaged, not properly seated.

Donning and Seal Check

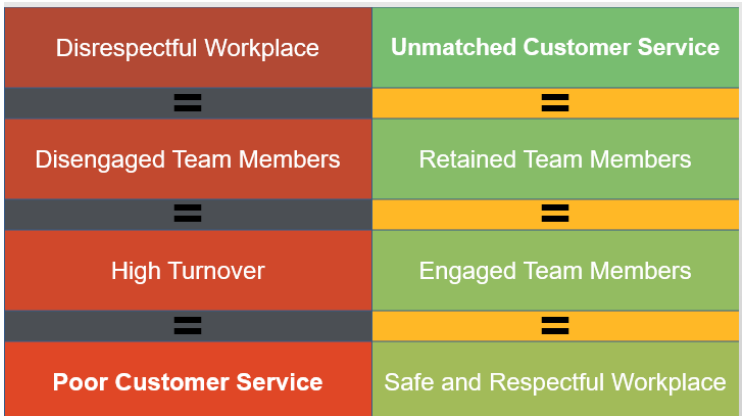
- Team members will be taught donning and doffing for their particular respirator model at the time of fit testing. Seal checks are required to ensure the mask is adjusted properly.
- Seal check: Perform a negative pressure and positive seal check after donning and prior to entering a contaminated area.
- **Positive pressure:** Cover exhalation valve and exhale gently to create pressure. Readjust if leak is detected.
- **Negative pressure:** Cover both cartridges and inhale and hold your breath. Space peace should slightly collapse. If it leaks, adjust.

Disinfecting after use:

- Each time the elastomeric respirator is doffed and after an aerosolizing procedure or overt splash, wipe external services with a hospital approved disinfectant wipe. Wait for the appropriate contact time. Follow up by wiping the external surface with a water dampened paper towel or saline wipe. Allow to dry and place on a hook away from contaminated areas or in a labeled paper bag for storage.
- Filters (except for unprotected disc type, i.e., pancake style) may be used for an extended period if the filter housing of cartridge is disinfected after each patient interaction, provided the disinfectant or cleaning agent does not come contact with the filter media.
- Between uses, team members store their elastomeric respirator in a paper bag labeled with their name or hung on a hook (labeled) in a clean area free from contaminants.
- Filters should be replaced if filter media becomes grossly soiled, clogged or damaged. Filters will be replaced no later than 12 months after initiation of use at the annual fit test

12 Respectful Workplace

NMH promotes a respectful work environment where people treat each other with respect, courtesy and professionalism and where individual differences are valued.



OBJECTIVES:

- Explain the components of a respectful workplace and why it's important.
- Outline what unlawful harassment and discrimination is and is not.
- Describe steps to navigate inappropriate behaviors as it relates to potentially discriminatory or harassing behavior.
- Outline what you can do for a great work environment.

12.1 Inappropriate Customer Behavior

NMH will not tolerate, reinforce or encourage inappropriate behavior directed toward any team member by patients or customers because of the team member's race, color, creed, religion, national origin, gender, disability, genetic information, age, sexual/affectional orientation, marital/familial status, status with regard to public assistance, veteran/military status, or any other legally protected status.

12.2 Prohibited Behavior

Prohibited behavior by customers or visitors is behavior which is objectively inappropriate towards a team member including behavior motivated by protected class status.
Examples of prohibited behavior:

- Deliberate/Carless jokes
- Derogatory remarks/gestors
- Offensive language
- Threats to safety or job

When Verbal Abuse Occurs
Lead with Empathy

- Be sure the customer knows SAFE CARE is your priority

Set Boundaries

- In a not threatening way, state the next steps if the customer is unable to stop their use of abusive language

Example Phrases

- "I recognize this must be challenging, but your language is not Okay"
- "I want to provide the care you need. If you are able to change your words, I will not be able to stay in the room."
- "In this hospital, abusive words are not tolerated. Please change your words and I can provide the care you came here for."

Politely and safely exit the situation if you feel uncomfortable, threatened, or unsafe for any reason. If patient care needs prohibit you from leaving the room, call for help.

12.3 Getting your leader involved

Immediately report the situation to your leader, the Administrative Manager, Unit Manager, or clinic manager. The Administrative Manager or Unit manager will meet with the team member and, if appropriate, the customer to assess de-escalate the situation and redirect the behavior.

- The treating provider should be consulted regarding any questions involving the patient's behavior/appropriateness that may be related to medical or behavioral diagnoses.
- The person leading the assessment may request additional assistance from the Patient Representative, Risk Management, Chaplain, or other resources to resolve the conflict.

After getting the manager involved, the team member may choose to voluntarily withdraw from caring for the patient. Care assignments will not be changed without the consent of the team member. If the affected team member chooses to continue providing care to the customer, the Administrative Manager or Unit/Clinic Manager will communicate to the customer/family and affected care team members that there will be no change in team assignments. Care assignments will not be changed without the consent of the team member.

12.4 Safe and Therapeutic Environment

The care team will develop a plan of care moving forward. If applicable, the team will utilize a Unique Treatment Plan (UTP) to ensure a safe and therapeutic environment for all involved parties. We want you to feel safe and comfortable at work. We will take action by investigating any complaint if you do not feel it is a respectful workplace.

12.5 Protected Classes

Discrimination is prohibited by State, Federal, and Local Laws

- Cannot treat team members differently because of a protected class status
- Protected classes include:

Federal	State (adds)
• Race	• Marital Status
• Color	• Status with regard to public assistance
• Religion	• Sexual Orientation/Affectional Orientation
• Creed	• Membership on a local civil rights commission
• Sex	• Familial Status
• Sexual Orientation	
• National Origin	
• Veteran/Military Status	
• Disability	
• Age	
• Genetic Information	
• Gender/Gender identity	

12.6 EEO Statement and Affirmative Action Overview

EEO STATEMENT AND AFFIRMATIVE ACTION OVERVIEW

NMH is an Equal Employment Opportunity Employer and is committed to equal employment opportunity. That means that all individuals are welcome to work at NMH. In addition, NMH prohibits discrimination against any team member based on a protected class basis.

NMH is committed to providing a working environment in which all individuals are treated with dignity and respect. Every individual has the right to work in a professional atmosphere that promotes equal employment opportunity and prohibits unlawful discriminatory practices, including illegal harassment based on any protected class status. Therefore, NMH requires that all work-related conduct and behavior be free of bias, prejudice and harassment based on any protected class status.

12.7 What is Illegal and Unlawful Harassment?

Harassment is a form of discrimination

- Harassment is unwelcome behavior and is a form of discrimination
- Harassment becomes illegal when enduring the offensive conduct becomes a condition of continued employment or the conduct is sufficiently severe or pervasive to create a work environment that a reasonable person would consider intimidating, hostile, or abusive.

Harassment based on any protected class unlawful

Q: If you constantly tease someone about their age, is it harassment?
A: Yes. Age is a protected class.
Q: If you constantly tease someone about listening to Taylor Swift music, is it harassment?
A: No. Taste in music is not a protected class.

NMH follows all federal, state, and local laws that prohibit discrimination and harassment based on a protected class status. This includes words or actions that are offensive to another based on any protected class under applicable federal, state or local laws. Harassment based on a protected class status will not be tolerated.

12.8 Sexual Harassment

Sexual harassment can include unwelcome sexual advances, requests for sexual favors, sexually motivated physical conduct or other verbal or physical conduct or communication of a sexual nature when:

1. Submission to that conduct or communication is made a term or condition, either explicitly or implicitly, of employment
2. Submission to or rejection of that conduct or communication is used as a factor in decisions affecting that individual's employment; or
3. That conduct or communication has the purpose or effect of substantially interfering with an individual's employment.

Quid Pro Quo

Unwelcome sexual advances or requests for sexual favors or other verbal or physical conduct of a sexual nature where acceptance is made a term or condition of employment

- This for that
- If you go with me, I'll give you a promotion

Hostile Work Environment

The creation of an intimidating, hostile, or offensive working environment through unwelcome verbal or physical conduct or communication of a sexual nature which has the purpose or effect of unreasonably interfering with an individual's employment.

IF YOU SEE OR EXPERIENCE INAPPROPRIATE BEHAVIOR, REPORT IT! You can report it to any leader, human resources or the Compliance Hotline

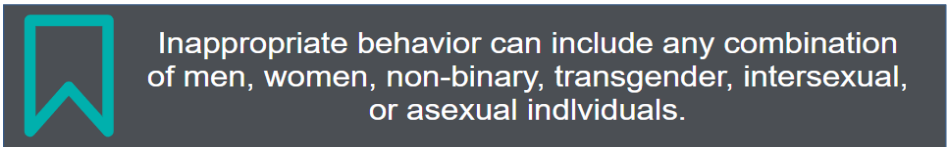
Scenario:

Dr. Jones, who has hospital privileges, but is not employed by MGH, yells at the receptionist and RN who regularly works with Dr. Jones.

1. Is it quid pro quo harassment?
   No. Dr. Jones is not asking for something in return. And while it isn't pro quo harassment, it would be a violation of our respectful workplace policy.

12.9 Behaviors that Create a Hostile Environment

- Lewd jokes.
- Sexual innuendos.
- Making sexual comments about someone's appearance, clothing, or body parts.
- Ogling or leering or whistling (staring in a sexually suggestive or offensive manner);
- Inappropriate touching
- Making sexual comments about appearance, clothing, body parts
- Sexually suggestive sounds;
- Displays of pictures, calendars, cartoons, or other materials with sexually explicit or graphic content



Additional Examples of Inappropriate Behavior

- **Repeated unwelcome attention about someone's protected class** (race, color, religion, sex, age, national origin, disability, etc.) that a reasonable person would believe has created a hostile or intimidating working environment.
- Mimicking an accent.
- Using racist slang, phrases, or nicknames.
- Making remarks about an individual's religious beliefs
- Displaying racist drawings, or posters, bumper stickers, or signs
- Making offensive reference to an individual's mental or physical disability
- Repeatedly using the incorrect pronoun

12.10 Reporting Harassing Behavior

WHAT TO DO IF YOU HEAR OR SEE HARASSING BEHAVIOR? REPORT IT!

- If a team member believes that he/she has been subject to behavior that violates the policy, they must report the behavior so the employer can investigate and stop the behavior if it is occurring.

WHO SHOULD YOU REPORT IT TO?

- Human Resources
- Your supervisor
- Your Supervisor's Supervisor
- Any leader
- Compliance Hotline: see the number on the back of your ID
- NMHH/BLAZE: 763-581-6947
- MGH 763-581-1580

12.11 Employer Responsibilities

- If an employer receives a report of inappropriate behavior or the employer is aware or becomes aware of potentially inappropriate behavior, the company will review the issue, respond in a timely manner, and enforce the Respectful Workplace Policy.

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12.12 Retaliation

NMH Prohibits all forms of retaliation against team members including good faith reports of inappropriate conduct or participation in a company investigation

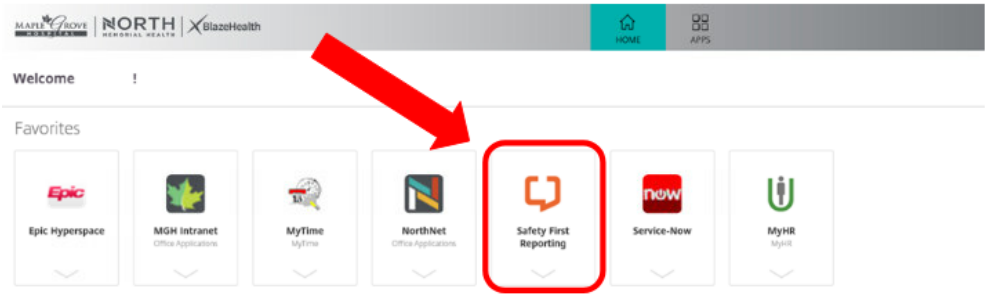
13 Team Member Right to Know and Safety

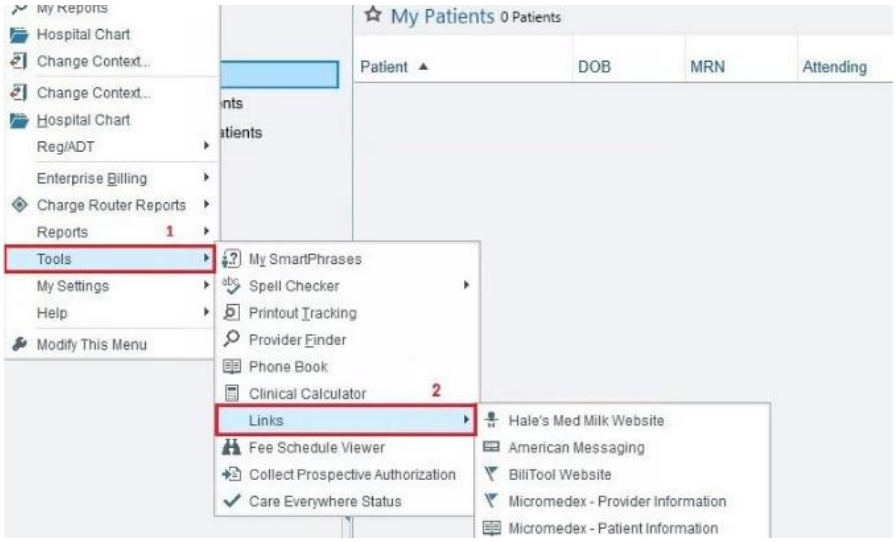
13.1 Safety First Reporting

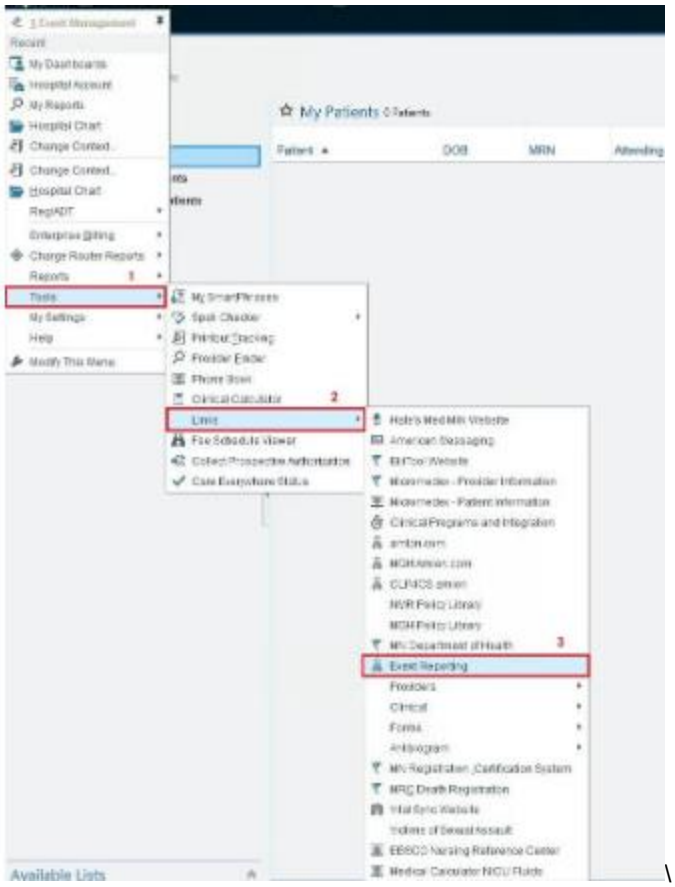
Safety first reporting is the electronic system we use to internally track team members, customers and visitor safety events, near misses or good catches, including significant events.

When an event near miss or good catch occurs that may not be consistent with the appropriate care of customer or the routine operation of a North Memorial Health department or care site, complete a Safety-First Report.

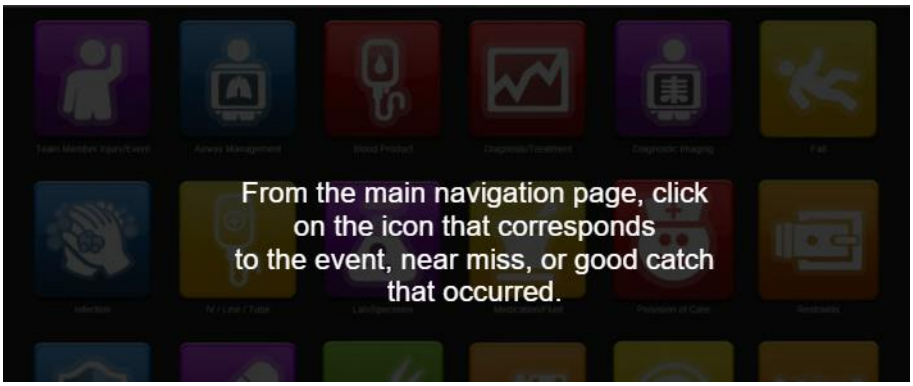
Safety First reports are peer protected and are handled in a confidential manner and are not disclosed to anyone except to the extent necessary to carry out quality improvement review and risk management functions.

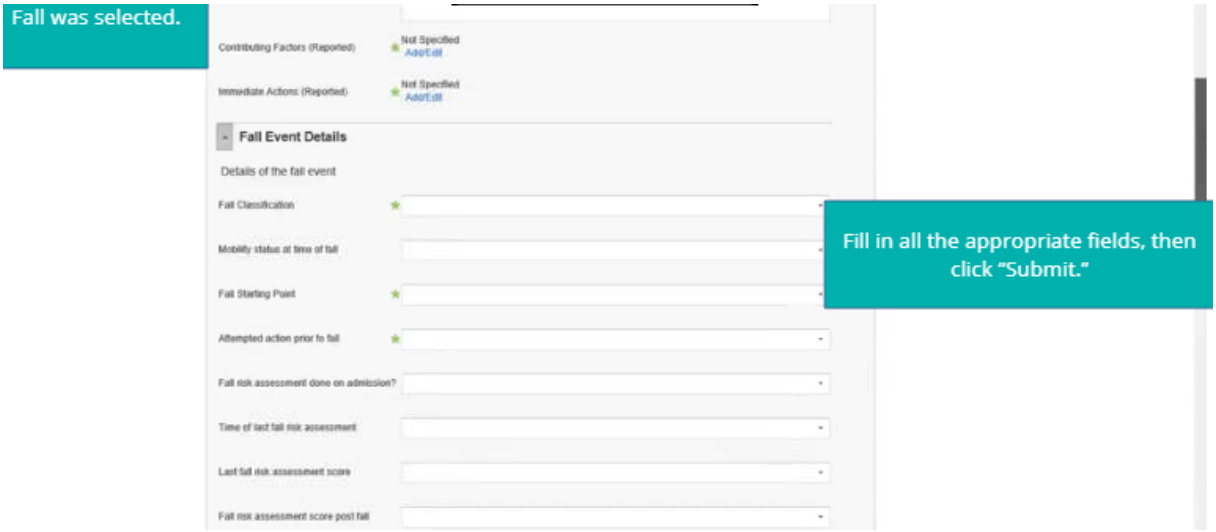

NORTH
BlazeHealth
HOME
APPS
Welcome !
Favorites
Epic Hyperspace
MGH Intranet
MyTime
NorthNet
Safety First Reporting
Service-Now
MyHR


My Reports
Hospital Chart
Change Context...
Change Context...
Hospital Chart
Reg/ADT
Enterprise Billing
Charge Router Reports
Reports
1
Tools
My Settings
Help
Modify This Menu
My Patients 0 Patients
Patient
DOB
MRN
Attending
My SmartPhrases
Spell Checker
Printout Tracking
Provider Finder
Phone Book
Clinical Calculator
2
Links
Fee Schedule Viewer
Collect Prospective Authorization
Care Everywhere Status
Hale's Med Milk Website
American Messaging
BiliTool Website
Micromedex - Provider Information
Micromedex - Patient Information


My Patients
Patient
DOB
MRN
Attending
Tools
Links
Event Reporting
Available Lists


1. Enter your Team Member Number, e.g., E00000, M000000, etc.
2. Enter your portal Password
3. Click "Login"
NORTH
MAPLE GROVE
Login
Powered by
RLDatix





All events are reviewed and followed up on by appropriate leadership. A review of the event is conducted to identify the underlying reasons or the cause of the event and to implement appropriate actions to prevent recurrence.

An adverse health event review may be conducted when significant adverse health events occur. (For example, medication error fall with injury, wrong surgical Procedure, Hospital acquired pressure Injury, Hospital acquired condition.)

The review is conducted by a multidisciplinary team with a focus on identifying the root cause and contributing factors to the event and creating corrective and preventative actions to prevent recurrence.

Disclosing an Adverse Event

The customer has the right to a prompt and truthful conversation. The following steps should take place to assist the process after their immediate needs have been addressed.
1). Complete the safety-first reporting.
2). Connect with your unit supervisor or administrative manager to develop a plan for communication.
3). Connect with risk management as needed.

13.2 Adverse Events

Recognize, respond to, and Disclose Adverse Events

When an adverse event or Good Catch (“near miss”) occurs, healthcare workers must respond quickly and effectively to prevent or reduce harm. Adverse events and Good Catches must be reported promptly. Disclosing the facts of an event to the patient according to MGH’s policies and procedures and discussing a plan of care should occur as soon as appropriate.

A review of the event is conducted to identify the underlying reasons and to implement appropriate actions for preventing a recurrence. Adverse events and close calls are learning opportunities to reduce system issues and to improve work performance.

Key Work Expectations or Competencies

- Recognize the occurrence of an adverse event or good catch.
- Lessen harm and address immediate risks for patients and others affected by adverse events and good catches.
- Disclose the occurrence of an adverse event in accordance with policies.

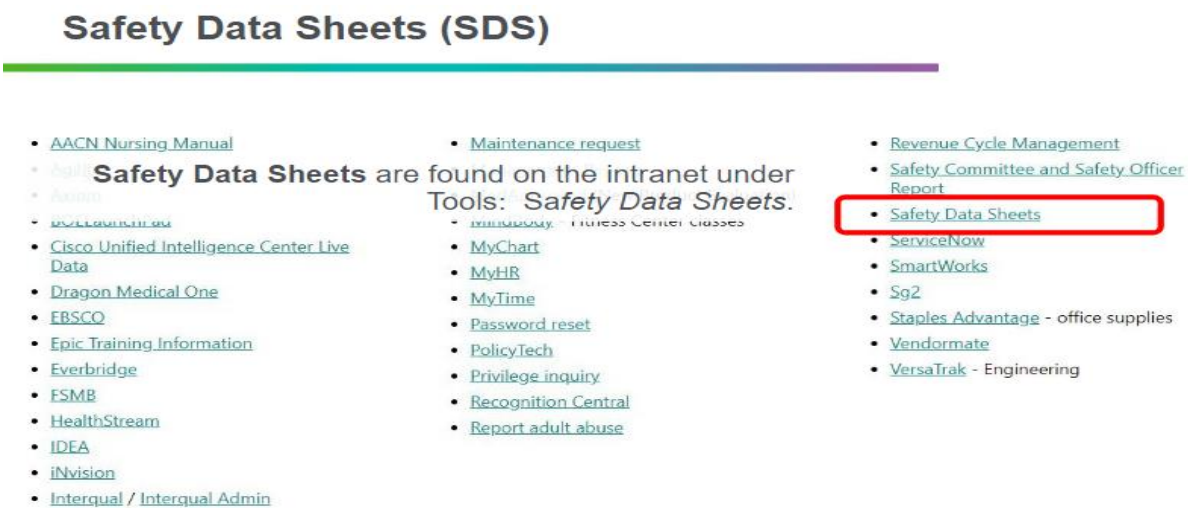
Example of appropriate recognition, response, and disclosure when a patient falls in the hospital:

- A patient care assessment is conducted immediately, the patient’s physician is informed, and appropriate care is provided.
- The fall prevention plan is updated, and new interventions are identified and put into place.
- The facts surrounding the fall and the care provided are documented in the electronic health record and the fall is discussed with the patient and family.
- A Safety-First Report submitted and reviewed by the manager/supervisor of the area, so that system related factors associated with the fall can be identified and addressed.

Team members need to:

- Know and understand Maple Grove Hospital’s Safety-First Report policy.
- Share concerns about occurrences and events with immediate manager/supervisor.
- Document occurrences for review by manager/supervisor.

13.3 Safety Data Sheets



Safety Data Sheets (SDS) give detailed information about a chemical so that you can work safely with it. Read the SDS before using a chemical. If you have questions about a chemical, see your manager or supervisor. Information found on SDS:

- Chemical Identification

- Hazardous Ingredients/Identification Information
- Physical Data/Characteristics
- Fire and explosion Hazard Data or physical Data
- Reactivity Data
- Precautions for Safe Handling and Use or Spill or Leak Precautions
- Special Protection Information or Control Measures.

13.4 MN Employee Right to Know

The Minnesota Employee Right to Know Act is a combination of State and Federal laws that ensure team members are told about the dangers associated in working with hazardous substances, infectious agents, and harmful physical agents.

Hazardous Substances: Include chemicals or substances that are toxic, corrosive, irritants, flammables, highly reactive explosives, strong oxidizers nuclear materials or by-products, sanitizers or pressurized containers. It is a substance that may produce short-term or chronic long-term health effects.

Infectious Agents: Include communicable bacteria, viruses, fungi or parasites that can cause illness as a result of exposure to the agent. Exposure may occur by inhalation (breathing in, Ingestion (eating or drinking), Injection or absorption through the skin.

Harmful Physical Agents: Include laser, noise, extreme heat or cold, dust, or non-ionizing radiation such as from an x-ray machine.

Team Member's Role:

- Learn about the hazards of your job
- Learn how to work safely
- Know where to find information about these hazards
- Report any unsafe situation to your manager/supervisor or the Safety and Security Department
- Know how to access the SDS database on the NMHH Intranet

North Memorial Health's Role:

- Tell team members about hazards they may encounter at their jobs
- Discuss what team members need to know to work safely
- Show team members where they can find information about hazards
- Evaluate all substances entering and exiting in the workplace that may present hazards.
- Provide team member training at orientation and annually thereafter in SDS database access, use and purpose
- Have information about job hazards accessible to employees and maintain a current SDS database

Team Member's Right:

- Refuse to work in an unsafe situation
- Refuse to work if they have not been trained
- Receive information about the hazards of their job

Individual Factors that can affect performance

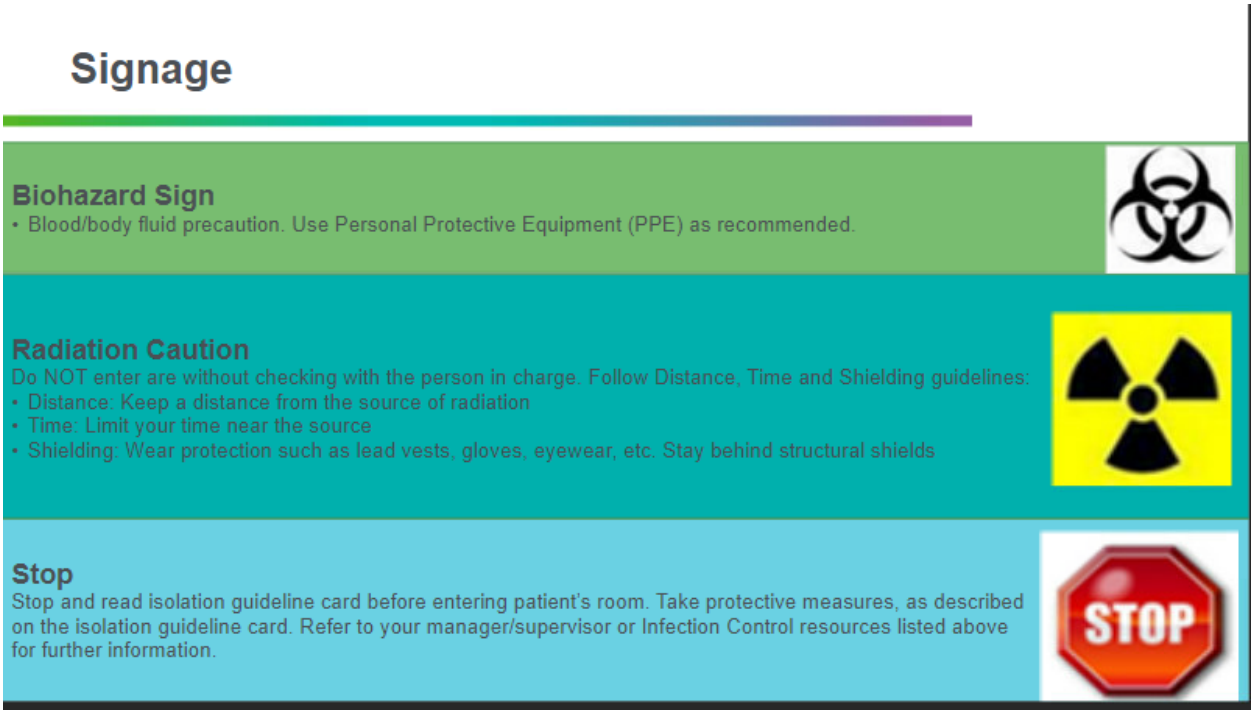
A variety of factors contribute to safety. Attention to managing the human and environmental factors associated with adverse events can optimize customer, co-worker, and organizational safety.

- Human Factors include fatigue, illness, stress, rushing through an assigned task, non-compliance to required safety education or not using critical thinking skill
- Environmental factors can include things like poor lighting, disorganized work areas or improperly maintained equipment.

Leaders and healthcare workers share responsibility for creating a safe environment to work and practice. It is important that all of us assess our work environment for safety, understand our own work performance and the performance of others, and obtain the training needed to operate equipment and technology. The goal is to work together for continuous improvement.

A few ideas on what you can do:

- Appreciate the safety challenges that come with operating equipment and technology.
- Apply critical thinking skills to perform work assignments safely.
- Address human factors such as getting enough rest prior to coming to work, staying home when ill, exercising to improve health and reduce stress levels, and maintaining a healthy diet.
- Addressed environmental factors such as organizing and standardizing customer supply rooms so equipment can be stored safely while ensuring easy access to essential patient care and work supplies.



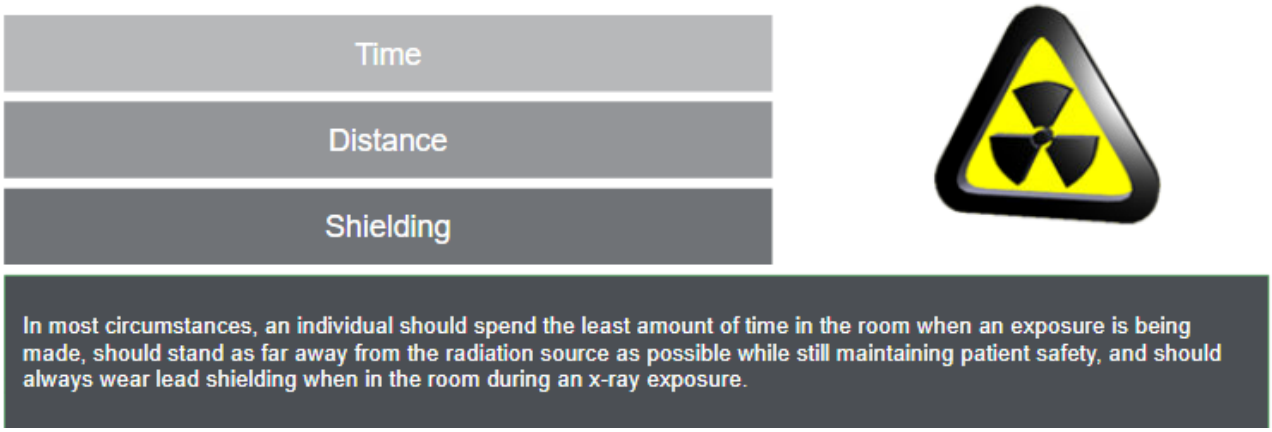
13.5 Radiation Safety

There are two primary sources of ionizing radiation within the healthcare setting: equipment and radioactive materials.

Equipment gives off radiation only during the time of an X-ray exposure. Some examples of equipment that emit radiation are general radiology, C arms, O arms, CT, interventional radiology. fluoroscopy and mammography.

Radioactive materials are utilized in the nuclear medicine and Positron Emission Tomography (PET) departments. This involves administering a radiopharmaceutical to the patient so internal structures can be imaged.

Radiation protection involves effective measures employed by radiation workers to safeguard customers, team members, and the general public from unnecessary exposure to ionizing radiation. The three basic precautions involved in radiation protection are:



Radiation is a harmful physical agent. Radiation exposures can occur by unprotected exposer to radioactive materials or an x-ray machine. Radioactive materials are used for both diagnosis and treatment. For example, temporary or permanent patient implants of sealed radioactive sources are placed in surgery. All rooms where radioactive materials are stored and/or used are posted with a “Radioactive Materials” sign.

Precautions:

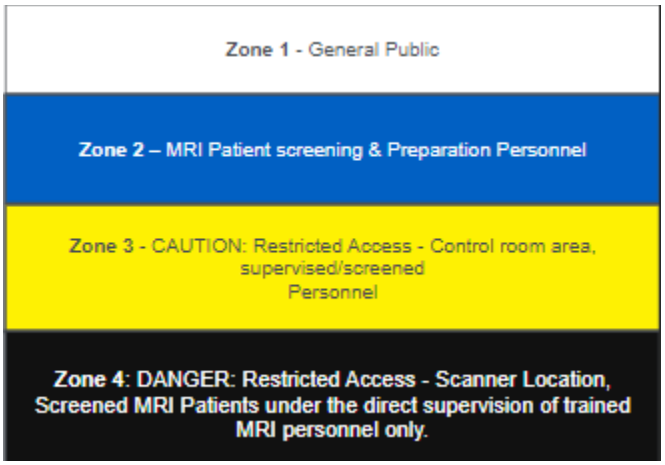
- When entering rooms, look for signs indicating where radioactive materials are stored. Any cabinet, refrigerator, package, bottle or other container marked with a yellow and magenta Caution Radioactive Material” sign is a potential source of radiation exposure.
- When cleaning the area, work quickly and take only the materials you need with you. Do not empty trash containers marked “Radioactive Material”. If you notice leaks or damage to any object labeled “Radioactive”, do not attempt to clean. Close and lock the door. Call Safety and Security.
- Radioactive materials may be used in restricted patient rooms. DO NOT ENTER THESE ROOMS; check with the Patient Care Facilitator. These rooms will be posted with a yellow and magenta radiation caution sign. The radiation caution sign may be removed only by the Radiologist.

13.6 Magnetic Resonance Imaging (MRI)

- Magnetic Resonance imaging (MRI) Is not ionizing radiation. Instead, it utilizes a very strong magnet and radiofrequency waves to image internal structures.
- Safety reminders:
- All individuals near the MRI need to be screened to determine if they are safe to be in the area.
- MRI has secured zones that cannot be accessed without clearance by MRI personnel.
- All objects must be evaluated and deemed to be MRI safe before they are brought into the MRI area.

- The magnet is always on, whether a customer is being scanned or not.

4 Safety Zones are posted and described to control access to the MRI environment. MRI safety trained individuals monitor the area.



13.7 Indoor Air Quality (IAQ)

The quality of indoor air depends on many factors, including structure, building material, outdoor environment, and occupants. Indoor contaminants that have been shown to have health consequences come from indoor and outdoor sources, as well as from occupant related activities. The main contaminants include:

- Bioaerosols which include pathogens and allergens
- Volatile organic compounds, such as alcohol and acetone
- Formalin products
- Cleaning products
- Particulates, e.g., lead dust, asbestos
- Combustion products such as carbon monoxide, or tobacco smoke

Examples of common concerns identified by team members include exhaust fumes by the loading dock areas, cigarette smoke and mold growth.

- Maintenance/Facilities Departments maintain various types of air handling systems to assist in control of all known contaminants
- Additionally, many processes are in place to test for and identify the source and abate as necessary
- If you have concerns with indoor air quality contact:
    - Customer Service Center at 1-2321 at Maple Grove Hospital
    - Maintenance at 1-2390 or 763-581-2390 at North Memorial Health Hospital

NMH facilities are Fragrance-Free

Perfume, cologne, scented soap, hair products and lotions are **NOT** to be worn by hospital Team Members within the hospital (scented deodorant is permissible). Recognizing that sensitivity to fragrance is not limited to patient care areas; this policy applies to all Team members, including employees, volunteers, physicians, students, and contracted patient care providers

13.8 Latex Balloons

In an effort to reduce unneeded exposure to latex, latex balloons are not allowed in any facility owed or operated by North Memorial or at any North memorial sponsored events.

- **Signs are posted at entrances to alert visitors**
- **Visitors with balloons may return the balloons to their vehicle, or leave them at the information desk (NMH) or Security Desk (MGH), to be put into a plastic trash bag and sealed, to be picked up later**

13.9 Hazardous Material Handling

Hazardous substances are any chemicals that can harm you (health hazard) or can create a dangerous situation (physical hazard) such a fire or explosion.

- Before handling any chemical container for the first time, read the label. Warnings may be in words, pictures or symbols. Report any torn or illegible label to your manager/supervisor. Always carry and store chemicals in approved, properly labeled containers.
- A Safety Data Sheet (SDS) gives information about ingredients, what protective equipment to use, how it can enter your body, and signs of over exposure. SDS information is found on MGH Intranet. If needed, ask your manager/supervisor for help.

- **Hazardous Material Spills/Leaks**: People in the area are the first line of defense. If they have been trained to clean it up, they should take care of it
    - Remove people to a safe area as needed (e.g., overcoming fumes)
    - Secure the area to prevent persons from coming in contact with the spill
    - Tell your manager/supervisor
    - Call Security *77
    - Give Safety and Security a copy of the chemical's SDS

Hazardous Substances: Purpose and Storage

Hazardous substances (Chemicals) help you perform many tasks. When used correctly, chemicals are safe. When used or stored incorrectly, they can harm you. Be informed about the chemicals that you use. A chemical that can potentially harm or injure you is classified as hazardous. A chemical can be either a physical and/or aa health hazard. Hazardous substances are stored in:

- Original containers: Some chemicals are used right from the manufacturer's original container. The manufacturer has already properly labeled these containers.
- Transfer Containers: Some chemicals used within the organization are removed from their original container and transferred into another container. These containers are called transfer containers. Transfer containers must be labeled with a National Fire Protection Association (NFPA) 704 label or equivalent.

Hazardous Waste Disposal

- **Batteries:** Place used battery containers in your area. Contact Environmental Services via the Customer Service Center at 1-2321 for pick up when your bucket needs to be emptied.
- **Toner cartridges** (copier, fax, printer): Return empty cartridges to Materials Management for recycling.
- **Aerosol Cans:** If empty, place in regular waste/trash. If unable to use/get all of product out because of a damaged or expired container, call Environmental Services via the Customer Service Center at 1-2321 to pick up for disposal.
- **Pharmaceutical Waste:** Put non-hazardous in the BLUE container in your area. Hazardous pharmaceutical waste, designated by a BLACK "Special Handling Required" label and/or an Omnicell "Special Handling Required" message, should be put in a BLACK container. Blood and sharps should not be placed in these containers.
- **Laboratory and Other Waste**: Follow established guidelines for disposal, labeling, and manifest management as appropriate.

Labeling Containers

Anytime a chemical is transferred from one container/bottle to a different one, the secondary bottle/container must be labeled with the following:

- Identify the chemical or product in the bottle
- Appropriate hazard warnings
- Expiration date

Labeling Containers: Example
For example taking a cleaning solution and putting it into another spray bottle. The spray bottle must be labeled with the name and any appropriate warnings

Failure to follow waste disposal regulations will result in county, state and federal fines

13.10 Pharmaceutical Waste

- Put nonhazardous pharmaceutical waste in the BLUE container in your area, if available.
- Put Hazardous pharmaceutical waste, designated by a BLACK "Special Handling Required label and/or "Special Handling Required" message, should be put in a BLACK container. NO SHARPS OR BIOHAZARDOUS MATERIAL

- Bottles of contrast media containing iodine are utilized in the Imaging Department. Iodine containing contrast bottles needs to be disposed of in a BLACK container.

Exception: **Controlled substances** should *NEVER* be put into the BLUE or **BLACK** pharmaceutical waste or RED Sharps containers.

Controlled substances should be disposed of as follows:

- Injectable controlled substances should be wasted in the sink or flushed down the toilet.
- Patches containing controlled substances (i.e., Fentanyl) should have the sticky sides folded together and then flushed.
- Controlled substance tablets should be wasted by flushing down the toilet or washed down the sink.

13.11 Chemical Hazards/Risks

Physical Hazard: A chemical is a physical hazard if it can cause a dangerous situation (e.g., explosion, fire, toxic fumes) when it is exposed to another chemical or certain environmental conditions (heat, light, vibration [shock] and moisture). Chemicals that represent a physical hazard include combustible liquids, compressed gases, organic peroxide, explosives, oxidizers, flammables, pyrophoric, unstable-reactive, or water-reactive.
Health Hazards: A chemical is a health hazard if its ingredients can cause health problems. Some of these effects will show up right away (for example, within 24 hours)– Acute health effect); some effects show up later -chronic health affect. These chemicals can make you sick; they can cause vomiting, a fever or headache; they can irritate or burn the lungs, eyes, skin or mucous membranes or can poison internal organs such as the liver, kidneys, or brain; they can cause cancer, damage the reproductive or central nervous system, damage bone marrow and lymph nodes, and cause death.

Three common ways a chemical can enter your body:

- Contact: splashing a chemical on your skin or in your eyes
- Inhalation: breathing in a chemical's fumes, vapors, mists, or dust particles
- Ingestion: swallowing a chemical or food/drinks contaminated by a chemical.

If a chemical can't get in, you win protect yourself. Know how to safely handle, use, store and dispose of the chemicals you use.

Signs of overexposure to a chemical include nausea, headache, fever, dizziness, burns, irritation of the eyes, nose, throat or lungs, skin rash, blurred vision, fatigue, and vomiting. If you think you have had an overexposure to a chemical, tell your manager and get medical assistance according to procedure.

13.12 Clean up

Cleaning up an identified chemical spill

- If you know the chemical that has spilled, have the proper spill cleanup equipment, and have been trained, you can clean up a chemical.
- Tell your manager/supervisor

Unknown/Unidentified Chemical Spills:

- Remove people to a safe area as needed (e.g., vapors/gases are overcoming). Clean up the spill, following directions on the container, SDS, and/or emergency spill kits. Use personal protective equipment per instruction
    - If a chemical splashes on you, wash the area. Use eyewash stations and showers if available
    - Tell you manager/supervisor and call Safety and Security
    - If spill is giving off vapors/gases, Security will dial 911

- Fill out an appropriate Safety-First Report
- Get medical help.

13.13 Blood and Body Fluid Spills

Small Spills of Blood and Body Fluids

- Block area to prevent access to contaminated area
- Don clean gloves and protective equipment
- Use disposable towels to absorb excess infectious material and discard into red waste bag
- Disinfect surface with a facility-approved disinfectant following product instructions for contact time
- Follow up by cleaning the surface with a facility-approved disinfectant to remove any remaining soil
- Discard all contaminated supplies into red waste bag
- Perform hand hygiene after glove removal

Large Spills of Blood and Body Fluids

Larger spills that cannot be contained

- Block affected space to prevent access to contaminated surface
- Contact Environmental Service for assistance

13.14 Infectious/Chemo/Pathological Waste Handling Disposal

- Trace chemo waste goes into designated **YELLOW** containers, bulk chemo is placed in **BLACK** containers.
- Pathological waste is placed into red containers or gray containers labeled for “incineration”
- Sharps are discarded into designated, rigid red containers

Place blood or other potentially infectious material contaminated items in red biohazard bag.

- May require double bag if large volume
- Sharps – discard in ridged containers

Failure to follow waste disposal regulations will result in county, state and federal fines.


These DO go in the red bag:
Contaminated:
• Visibly Bloody Gloves
• Visibly Bloody Plastic Tubing
• Visibly Contaminated PPE
• Saturated Gauze
• Saturated Bandages
• Blood Saturated Items
• Blood & Body Fluids
• Closed Sharps Disposable Containers
Special handling and marking may be required:
• Certain Pathological Waste*
• Trace-Chemotherapy
These DON'T go in the red bag:
Medication
Compressed Gas Cylinders
Loose Sharps
Hazardous and Chemical Waste
Radioactive Waste
Garbage
Fixatives and Preservatives
Stericycle

Sewer System

Place into SINK

- Plain IV Solutions
- Solutions with additives – "food like" substances

Examples:

- NS, D5, LR
- Starter TPN
- Electrolytes (KCL, KPhos, Mag, Calcium, etc.)

Stericycle CxRx Waste Container

ALL Controlled substances (must be witness waste)

Examples:

- Morphine, Hydromorphone, Fentanyl, etc.

Hazardous Rx Waste

Place into BLACK CONTAINER

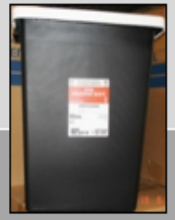
Identified with an alert in Omnicell and Epic

"Special Disposal Required"

Any partially used injectable, multi-used items, tablets that were opened, but not given to pt.

Examples:

- Insulin
- Boostrix and Hepatitis B Vaccines
- Pitocin vial and IV bags
- Diazepam
- Neo-Synephrine
- Contrast
- Methylprednisolone (Solu-medrol)
- Dexamethasone oral syringe
- Oxytocin vial & IV bags
- Fluconazole Infusion
- Metronidazole Infusion
- Ziprasidone (Geodon)



Incompatible Rx Waste

Place into Plastic Bag and RETURN to PHARMACY

Identified with an alert in Omnicell and Epic

"Send BACK to PHARMACY for disposal"

Any empty or partially used drug containers *and wrappers/packaging*.

Examples:

- Selected Inhalers
- Used/Unused Silver Nitrate sticks
- Cetacaine, Hurricaine
- Dermoplast
- Doxycycline Infusion Bags
- Warfarin
- Nicotine
- Physostigmine

Non-Hazardous Rx Waste

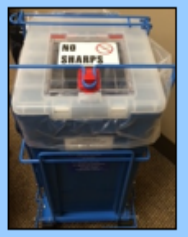
Place into BLUE CONTAINER

Any item from pharmacy that is not "food-like" and does not have a "Special Disposal Required" alert in Epic and Omnicell.

REMOVE/SHRED PATIENT NAME LABELS!!

Examples:

- Most antibiotics
- Lidocaine
- Marcaine
- Heparin
- TPN with Additives



Bio Hazardous Waste

Place into RED BAGS/BINS

Infectious Waste (i.e. blood objects that are drippable, pourable, or squeezable)

Examples:

- Saturated Bloody Gauze
- Body Fluids
- Tubing with blood in it

REGULAR TRASH (REMOVE/SHRED PATIENT LABEL!)

- Outside packaging and overwrap that did not contact Rx
- Regular Trash/Shipping Packaging
- Examples: Empty IVPB, empty epidural cartridge

SHARPS

Examples:

- Needles
- Empty syringes with needles
- Opened Ampules (empty or partially used)

13.15 Sharps Safety

Defined as: Needles, scalpel blades, and other sharp objects that can penetrate the skin

- Use only the approved safety mechanism to cover a used needle. Never use the disposable needle cover.
- Activate safety sheath before disposal, utilizing one handed technique of the hand used to perform the injection.
- Dispose of them in puncture-resistant container immediately after use.
- Use a no-pass technique for handling sharps during surgical procedures.
- Use mechanical devices (forceps) for removal of reusable sharps.

Additional information on infectious waste or sharps management may be obtained from Infection Prevention Policies or by contacting Infection Prevention or Environmental Services

13.16 Safe Patient handling

NMH is committed to providing customers with the safest care possible. Customers who require assistance to move will be handled in accordance with the Safe Patient Handling policy. Mechanical lifting equipment and/or other approved customer moving aids will be used in all circumstances when lifting/moving customers except when absolutely necessary, such as in a medical emergency. This policy complies with regulatory requirements in regard to the health and safety of both customers and team members.

North Memorial will use Safety First Reporting as well as the Team Member Injury Report to track patient and caregiver injury trends that occur when lifting, positioning or transferring. Those tasks identified as having caused or likely to cause an injury will be assessed by the Safe Patient Handling Committee to determine equipment or education needs. Further action will be taken to prevent future occurrences.

Use lift equipment whenever possible such as stands, mobile lifts, celling lifts, transfer devices, etc. Your decision to use lift equipment is the most effective factor in improving the patient and your safety.

- Lack of time is never a reason to take shortcuts for patients and your safety
- You can stop the line anytime you feel unsafe with any patient handling task and equipment not being used.
- If you get resistance from anyone regarding using the equipment, you can be assured that you are supported by leadership and can discuss your concerns at any time.
- Customers are at risk of being injured (such as falling or pulling on their arms) during a transfer, and if necessary, equipment is not used.
- Research shows that team members should not lift more than 35 lbs. of a customer's weight during any transfer or repositioning task.
- If a customer requires more than minimal assistance (i.e., assist of 1), the appropriate stand assist or lift equipment should be used.

13.17 Ergonomics/Back injury Prevention

STEP 1: Your Chair: Sit as far back in the chair as possible.

- Adjust the seat height so your shoulders are down and relaxed and your elbows and forearms are at a 90-degree position with your wrists and hands straight.
- Adjust the armrests so your shoulders and arms are relaxed and supported. Consider removing the armrests if they do not adjust or are in the way.
- Adjust the seat back (lumbar) height so the inward curve of your lower back is comfortably supported by the chair's lumbar support.
- Adjust the seat back tilt so that your upper and lower back is comfortably supported in a slightly reclined position.

- Ensure that your feet are resting flat on the floor and your thighs are level or parallel to the floor while sitting back in the chair. A footrest should be used if your feet are not comfortably resting on the floor.
- TIP: Frequent positional changes and stretching can significantly help to minimize fatigue.

STEP 2: Your Keyboard

- Pull up close to your keyboard so there is a comfortable 100 -110-degree angle bend in your elbow.
- Keep the mouse as close as possible to the keyboard on the same work level. Don't reach!
- Maintain a level or neutral wrist position. If you rest your wrists on the work surface, you may want to use a wrist rest for keyboard and mouse.
- Maintain the keyboard tray in slightly negative tilted position (-5 to -10-degree angle).
- TIP: Incorporating short cut keys will help minimize strenuous moussing.

STEP 3: Your Monitor

- Center the monitor directly in front of you.
- Position the top of the monitor at eye level. (If you wear bifocals, lower the monitor to a comfortable reading level.)
- Position the monitor at a distance for easy viewing while sitting back in your chair. This is typically an arm's length away.

OTHER CONSIDERATIONS:

- Use a headset if on the phone more than 25% of the workday.
- Position frequently used items within easy reach (e.g., phone, stapler, etc.).
- Use a document holder and position it close to or in-line with the monitor.

Want more information? Contact Team Member Health Center at 1-2194.
Useful web links:
http://www.osha.gov/SLTC/etools/computerworkstations/components_keyboards.html#placement
http://www.healthycomputing.com/office/setup

Use Proper Lifting Techniques

- Test the weight of the load before lifting
- Keep the load close. Assume a wide base of support and bend your knees
- Pivot your feet. Don't twist!
- Use smooth, controlled movements. Avoid rapid or jerking motions!
- Keep your head up and tighten your stomach muscles as you lift!
- Keep items within a safe lifting zone-between shoulders and waist.

13.18 Tips to Maintaining a Healthy Back

TEN EASY TIPS TO MAINTAINING A HEALTHY BACK

1. **Use proper lifting techniques**
   Test the weight of the load before lifting
   Keep the load close
   Assume a wide base of support and bend your knees
   Pivot your feet – don't twist
   Use smooth, controlled movements. Avoid rapid or jerking motions
   Keep your head up and tighten your stomach muscles as you lift
   Keep items within a safe lifting zone-between shoulders and waist
2. **Use equipment when possible** – Patient lifting devices (EZ stand, mobile lifts, HoverMatts, etc.), carts, etc.

3. **Ask for assistance when lifting heavy objects**

4. **Maintain Good Posture** – Keep the natural curve of the spine. Don't slouch!

5. **Avoid prolonged postures**. Change positions frequently throughout the day.

   STANDING
   - Stand on an anti-fatigue mat
   - Wear comfortable footwear
   - Prop your foot up on a stool or elevated surface
   - Keep a slight bend in your knees – don't lock your knees
     SITTING
   - Sit as far back in the chair as possible
   - Adjust the chair for proper posture and comfort
   - Ensure that your feet are comfortably resting on the floor and your thighs are level or parallel to the floor while sitting back in the chair. A footrest should be used if your feet are not comfortably resting on the floor.
   - Adjust the seat height so your shoulders are down and relaxed and your elbows are at a comfortable right-angle position with your wrists and hands straight
   - Keep work close – don't reach

6. **Stretch frequently throughout the day**
7. **Maintain a healthy diet**
8. **Maintain an adequate level of physical fitness/exercise**
9. **Maintain good sleeping posture.** Sleep on a firm mattress on your back or side rather than your stomach whenever possible
10. **Maintain a healthy lifestyle**

Want more information? Contact Team Member Health Center at 1-2194.

Useful web link: http://ergonomics.ucla.edu/Back_Lifting.html

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NMH will use Safety First Reporting as well as the Team Member Injury Report to track patient and caregiver injury trends that occur when lifting, positioning, or transferring. Those tasks identified as having caused or likely to cause and injury will be assessed by the Safe patient Handling committee to determine equipment or educational needs. Further action will be taken to prevent future occurrences.

Remember:

Ask for assistance when lifting heavy objects

Maintain good posture

Avoid prolonged postures

Stretch frequently throughout the day

Maintain an adequate level of physical flexibility/exercise

13.19 Work Related Injury Reporting

The safety and health of team members is of primary importance. It is North Memorial's desire that no team member has an injury or illness because of a work situation. Sometimes injuries or illnesses do occur and are work related. Work-related injuries or illness must be documented in accordance with state and federal regulations. The team member, the manager/supervisor, and the Team member health center (TMHC) all have responsibilities for this process.

What should you do if you have an injury or illness due to work?
Team member Responsibilities:

- *Immediately report the work-related injury/illness (including blood/body fluid exposures) to your manager/supervisor or designee.*
- *Report your injury via Safety First and contact TMHC or Emergency Department if medical triage or care is required.*
- *Attend all follow-up appointments with TMHC and maintain communication with all appropriate parties*

Manger/Supervisor Responsibilities:

- Direct the injured team member to TMHC or Emergency department as appropriate
- Review circumstances related to the injury or illness for measures that would prevent this type of incident from occurring again to this or other team members.
- Review restrictions to determine if the team member can work in the assigned department; discuss with Team Member health Center possible work options
- Maintain ongoing communication with the team member and the Team Member Health center.
- For injuries that involve loss of life, hospitalization, loss of eye or amputation, immediate escalation is required as OSHA reporting mandated within 8-24 hours.

Team Member Health Center Responsibilities

- TMHC handles all required MN OSHA documentation
- Coordinate monitor medical care
- Communicate work limitations to manager/supervisor
- Initiate First Report of Injury as required by law
- Review incidents to identify trends and to correct possible unsafe working conditions.

13.20 AWAIR – A Workplace Accident Injury Reduction plan

What are the Team Members' responsibilities?

All Team Members of Maple Grove play an important role in the safety of your hospital and are responsible for keeping the work environment safe. Responsibilities of the Team Member include:

1. Always report any injuries or accidents to your immediate manager/supervisor.
2. Report unsafe work practices or hazards immediately to your manager/supervisor.
3. Complete safety training as required and participate in safety activities.
4. Be familiar with the proper use of required personal protective equipment, limitations and maintenance. Most importantly, wear or use the PPE when performing activities that require such protection.
5. Footwear appropriate for the job is required per hospital policy.
6. Do not remove safety guards from any equipment. Do not operate any equipment if a safety guard is missing.
7. When entering hallways from offices look both ways

8. Notice mirrors at “T” intersections and check for people around the corner
9. Practical jokes and horseplay can lead to accidents and will not be tolerated. Never distract the attention of another Team Member.
10. Obey all warning signs posted throughout the facility or affixed to equipment.
11. Complete timely health protection, training or testing (e.g., FIT test, Mantoux).

AWAIR Plan and Corrective Action

Corrective action procedures are established to address any disregard of Maple Grove Hospital’s policies, procedures, and safety rules, or who is repeatedly negligent in their duties. Corrective action is set up to first counsel, however Maple Grove Hospital cannot and will not permit negligent team members to repeatedly injure themselves and/or put their fellow team members at risk.

Remember, you are the key to a safe work environment!

13.21 Care Conflicts

Participating in care that conflicts with cultural values, ethics, or religious beliefs

Talk to your manager/supervisor if you are unable to participate in care that you feel is in conflict with your cultural values, ethics, or religious beliefs. Every effort will be made to meet the needs of team members without jeopardizing customer care.

13.22 Resolving Ethical Questions or Concerns

NMH Ethics Committee are here as a consult service to review ethical situations while using the principles of medical ethics

- A request for a consult can be made by any team member, customer/surrogate decision maker
- A Biomedical Ethics consult can be done:
  - Through Epic/Amion
  - Phone the hospital operator “0” and ask to page the Ethics Coordinator for you

Common issues include:

- Determining a family decision maker when the customer is unable to participate
- Expected harm versus benefit of available treatment options

HOW TO ARRANGE AN ETHICS CONSULT:

- Contact the Administrative Manager and explain the patient situation as well as the need and urgency of the ethics consultation.
- Administrative Manager will discuss the case with the Ethics Facilitator to determine if an ethics consultation is appropriate. Ethics Facilitators are available during business hours Monday through Friday.
- If an ethics consult is needed and appropriate, the Ethics Facilitator will (in coordination with requester, care team, and patient/family as appropriate) arrange a date, time, and location for the ethics consult. Refer to “Ethical Issues in Patient Care” attachments A and B for additional details, tools, and procedures.
- Contact the Medical Staff Coordinator at North Memorial, who will send out an Everbridge message to all MGH Ethics Committee members, notifying them of the ethics consult and meeting details.

13.23 Vendor Certification Program

Vendor representatives are the people that enter Maple Grove Hospital to sell their products and services. The business partner is the company they work for. All vendor representatives and business partners must complete the Vendor Certification Program before selling products and providing services inside our hospital. Please complete Certification program at https://northmemorial.vendormate.com.

We have many reasons for the vendor representatives to complete the Vendor Certification Program:

- The program helps us meet regulatory requirements
- Promote the safest environment of care for our patients
- Attain the best business practice to control cost and maintain contracts\
- Products purchased meet patient needs as specified by clinicians
- So, they can obtain a visible ID badge

It is important for the vendors to complete certification, so they have a better understanding of Maple Grove Hospital's expectations. The program is easy for the vendor to complete online. Appointments must be made prior to a vendor showing up at Maple Grove Hospital. If a vendor representative does not have an appointment, he or she is not allowed to stay on Maple Grove Hospital property. **The vendor representative must wear a Maple Grove Hospital issued ID badge**. If the vendor is not wearing a badge, he or she must return to the designated check-in site to receive an ID badge.

As a system, we want to send a clear message to the vendor:

- Vendors will complete the form for New Product and Equipment Introduction for all new products (FDA, 510k and/or new to Maple Grove Hospital)
- Vendors complete Vendor Certification Program on-line
- Vendors always wear Maple Grove Hospital ID badge
- Vendors comply with Research Expectations
- If you see a vendor without a Maple Grove Hospital issued ID badge, let someone know! The vendor is not following Maple Grove Hospital policy! Please ask that vendor to return to the Safety and Security desk by the ECC entrance door to check in and pick up a badge. The staff at the Security desk will check to see if the vendor has completed the certification program before handing out a badge.

13.24 Quality Standards and Regulation

- NMHH, MGH, our Specialty Clinics and our Comprehensive Stroke Program are accredited by DNV
- DNV, the Joint Commission and others are granted federal authority for hospital survey and accreditation
- The National Integrated Accreditation for Healthcare Organizations (NIAHO) standards are developed by DNV to incorporate the CMS conditions of Participation requirements and for hospitals to use for accreditation
    - CMS COP+ISO=NIAHO
- CMS Conditions of Participation are standards for health care services that all healthcare organizations must be surveyed against for compliance to care for most patients under federal and state programs.
- ISO 9001:2015 Quality management System standards or clauses are internationally recognized standards for quality, process design, management and improvement, integrated with the NIAHO standards for our accreditation program.
- The Quality Management System (QMS) is the framework by which we monitor and continually improve our processes within the organization.
- QMS is comprised of the CMS Conditions of Participation/NIAHO Standards, the ISO 9001:2015 Standards and our mission, vision and values
- At a department or unit level, you will see your QMS reflected in your quality board.

Team members:

- Know where your quality board is located
- Understand the work you are focused on to improve the care you give to our customers
- Know how this work reflects the overall QMS of the organization (Strategic priorities)
    - For example: a lower Hand Hygiene rate of 80% at a department level affects the overall Hand Hygiene rate of the hospital – 89%. Therefore, an incremental improvement in Hand Hygiene will help to improve the overall hospital rate.

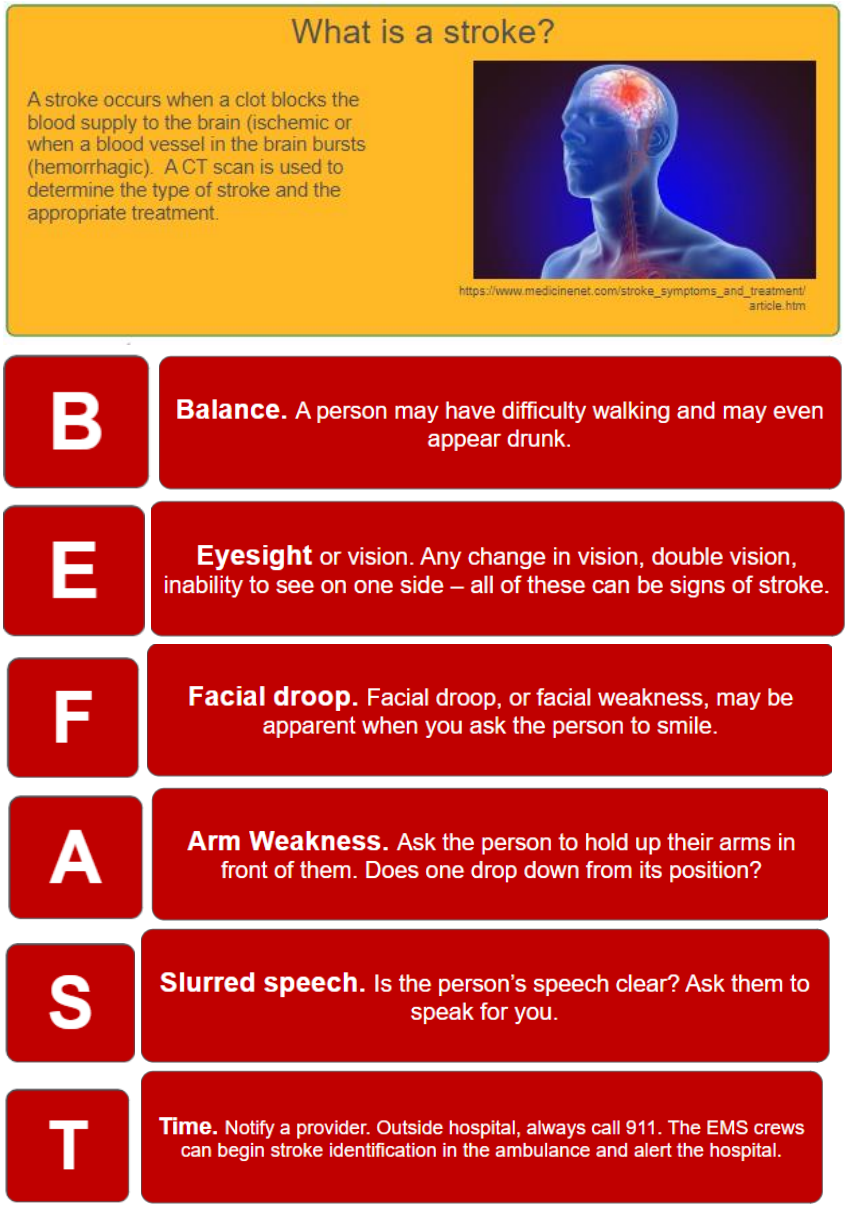
We perform internal audits to assess the strength and compliance of our quality system. This is another way to say that we are "doing what we say we are doing" as reflected in our policies and procedures.

Specially trained internal auditors focus on high-risk processes in each department as a way to proactively identify areas of vulnerability within our organization. This allows us the time to fix our process so that it matches policy/procedure.

13.25 Stroke Awareness

Stroke has decreased to the 5th leading cause of death but remains the leading cause of disability in Minnesota and the United States.
North Memorial Health is a Comprehensive Stoke Center and is at the forefront of that change to improve the quality of stroke care throughout our region.

- In 2020, the American Stroke Association (ASA) and American Heart Association has again awarded NMH its highest award*: Gold Plus Target Honor Roll Elite* for the quality care we deliver to our patients.
- Maple Grove Hospital is an Acute Stroke Ready Hospital
    - In 2022, MGH re-certified as an Acute Stroke Ready Hospital through the MN Department of Health. This means that they can evaluate, stabilize, and provide emergency treatment to customers with stroke symptoms.



13.26 Make it OK

Mental illness touches all of us every day; one in four people will experience a mental illness at some point in their life. Mental illness touches individuals of every race, age, ethnicity, and occupation. It disrupts a person's thinking, feelings, mood, ability to relate to others, and daily functioning. Mental illness is biological in nature and can be treated effectively.

Stereotypes surround mental illness and create a sigma around this medical illness.

- Stigma impacts how each of us think about, talk about, and even treat those experiencing a mental illness.
- Media often portrays mental illness in a negative light-usually as associated with violence. Only 5% of violent crimes are committed by an individual suffering from mental illness.
- Stigma can be very harmful and often leads people to be ashamed of their or their family member's illness. It causes most people to wait an average of 10 years to seek treatment. The impact of this waiting will result in high school dropout rates (highest rates are youth with mental illness), suicide, job loss, and isolation, to name a few.

The Make It OK campaign exists to equip people to better understand mental illness and to encourage people to start talking more openly about it; their tagline "Stop the silence: Make It OK" reflects this mission. They highlight that it is OK, mental illness is a medical illness, not a character flaw, and they seek to equip people with tips to stop the silence and start talking.

NAMI National Alliance on Mental Illness MINNESOTA

NMH Mental Health Resources:

Employee Assistance program: free and confidential access to assistance with whatever life throws at you
Learn to Live: Online therapy programs. Enter code: NMH
Resilience Coaching: Resilience strategizes/practices help manage the emotions which are fueling stress reactions and influences how to "see/experience" the world
Hearth Math: practices to self-regulate emotions and behaviors help regulate stress and increase resilience.

Visit NAMIhelps.org for more information and resources for mental illnesses.
Visit MakeItOK.org for more tips on talking about mental illness
Visit NAMIhelps.org for more information and resources for mental illnesses.

Suicide Prevention

- It is the policy at MGH to take reasonable and prudent actions to appropriately assess an individual who expresses suicidal ideation, exhibits self-harm or suicidal behaviors.
- Customers are assessed for suicide risk in the ED, on admission to the inpatient unit and in PCC.
- If identified to be at risk, nursing team members have a set procedure to create an environment that is safe for the customer.
- Nursing also provides ongoing assessments for customers deemed at risk for further interventions as needed.
- If a customer is deemed a suicide risk, the nurse should be consulted prior to bringing new items into the room.

Our Suicide Risk Assessment and Prevention policy and procedure provides more information on the above information and describes our risk assessment tools.

14 Workplace Fitness for Duty & Accommodations

14.1 Safety is OUR priority

We are committed to maintaining a safe work environment that is free from impairment and/or the influence of alcohol and/or illegal drugs to protect health, safety, and well-being of our customers, team members, providers and visitors.

It is imperative that we engage in supporting a safe workplace by assessing any type of impairment or other inability to safely and effectively perform job functions.

We are focused on overall health and safety that includes creating safety in the moment intervention.

- It is imperative that we “stop the line” should safety be jeopardized
- When in doubt or if you have questions, do not hesitate, immediately reach out within your leadership escalation.
- We use the following policies, procedures and tools to guide us in leading this work
    - Drug and Alcohol Testing for Team Members and Providers Policy
    - Fitness for Duty (C360)

14.2 Impairment

Drug and Alcohol Testing for Team Members & Providers Policy Highlights

- We prohibit the use, possession, transfer, manufacture, dispensation, distribution, and sale of alcohol and/or illegal drugs while working, while on all premises owned or operated by the North Memorial System, and while operating any of our vehicle, machinery, or equipment
- It also prohibits reporting for work, and working anywhere on behalf of North Memorial System, under the influence of alcohol and/or illegal drugs. “Illegal Drugs” means-controlled substances and includes prescription medications that contain a controlled substance, and which are used for a purpose or by a person for which they are not prescribed or intended.

Voluntary Disclosure: Any team member with a drug and alcohol problem or concern is encouraged to contact EAP for assistance. They will be supported by existing employee benefits as applicable without fear of discrimination because of the disclosure. A voluntary disclosure does not excuse or exclude team members from potential disciplinary action when there are violations to the above policy statement

Grounds for Testing: Reasonable suspicion testing for alcohol and/or drugs (meaning a controlled substance as defined by applicable law) will be requested or required when there are objective behaviors identified that would lead one to believe the individual may be under the influence of alcohol and/or illegal drugs. Testing will be performed by an independent lab in accordance with state law. TMHC will be notified of the results of the testing.

A team member/ provider may be requested or required to undergo drug and/or alcohol testing if a leader or TMHC has referred the team member/provider.

A team member/ provider may be requested or required to undergo drug and/or alcohol testing without prior notice during the evaluation or treatment period and for a period of up to two years following completion of a prescribed treatment program.

Notification: Before requesting or requiring a team member/provider to undergo drug and/or alcohol testing. Leadership will provide the team member/provider with a copy of the Drug and Alcohol Testing Policy and provide the team member/provider with an opportunity to read and acknowledge the policy in writing.

Refusal to Undergo Testing: a team member may refuse to undergo drug and/or alcohol testing. An employed team member /provider who refuses to be tested or whose behavior prevents meaningful completion of drug and/or alcohol

testing will be subject to discipline up to and including termination. If a team member/provider refuses to undergo drug and/or alcohol testing, no test will be administered.

Pending the results of a test, a team member/provider will be placed on administrative leave.

Team members and providers have certain rights to explain a positive test result and request re-testing of the sample within specified timeframes.

A negative test result means they have satisfactorily completed the test. Fitness for duty assessments or another follow-up may still apply.

Confidentiality: Test result reports and other information acquired in the alcohol and/or drug testing process shall be treated as private, confidential information. This information will not be communicated by Employer or TMHC to individuals inside or outside the organization without the team member's/provider's consent except to those who need to know this information to perform their job functions and as permitted or required by law or regulation.

If there is suspicion of theft of narcotics, escalate to leadership immediately. Additional investigation and measures will be taken which could result in disciplinary action.

14.3 Fitness for Duty

We are committed to a safe and healthy environment for our customers. Team members, providers, and visitors.

Such an environment is only possible when each team member/provider is able to perform their job duties. In a safe, secure, and effective manner throughout their entire shift.

Team members and providers who are not fit for duty may present a safety risk to themselves and to others.

- "Fit for Duty" means that a team member or provider is physically, mentally, and medically fit to perform their assigned duties, sufficiently rested and unimpaired by drugs or alcohol. We are committed to team member and provider fitness for duty by providing adequate rest opportunities between duty periods, the opportunity for team members and providers to report fitness issues via a positive and confidential TMHC process and encouragement for team members and providers to seek treatment for substance abuse or any physical and mental health issues that they might face.

No team member or provider should commence work if not fit for duty and should stop such work if they become unfit. Any team member or provider observing a potentially unfit coworker should seek a leader to assist. Because this policy does not protect actions contrary to company policy or regulation, reporting an unfit condition before commencing work is always preferred and provides the best protection for all involved.

To ensure that our team members and providers are fit for duty and have the support necessary requires a shared responsibility between North Memorial Health leaders and team members and providers.

NORTH MEMORIAL HEALTH WILL:

- Provide an EAP that allows anonymity for team members and providers seeking help.
- Provide training and education on the importance of reporting, assistance programs, and recognition of symptoms of unfitness in themselves and others.
- Encourage self-reporting by team members and providers when they are not fit for duty.
- Encourage coworkers to watch for signs of unfitness and provide an avenue to report concerns free of retribution, while maintaining the confidentiality of that reporting.

EACH TEAM MEMBER/PROVIDER IS RESPONSIBLE FOR:

- Not reporting for duty is unfit or removing oneself from duty upon becoming unfit.

- Report and safe events or concerns with fitness for duty immediately to management.
- Participating actively in training and educational opportunities.
- Escalate or stop the line if you feel safety is jeopardized.

A team member or provider may be required to participate in a fitness for duty evaluation when there is objective evidence that the team member or provider is unable to perform the essential functions of their job due to a medical or psychological condition or pose a direct threat to themselves or others. Fitness for duty may be completed by their own treating providers. However, we may require an independent medical exam as directed by TMHC.

This policy does not limit your employer's ability to take employment action under normal disciplinary policies. Team members/ employed providers who fail to perform their job functions or engage in misconduct may face disciplinary action, up to and including termination, despite the need for a fitness for duty evaluation.

To the extent allowed by law, we will protect the confidentiality of our team member/provider medical information.

Safety is OUR Priority

Example: You overhear your coworkers talking about another patient care staff who was out of it and acting funny while working yesterday. The coworkers states that they were worried about whether the person was going to get home safely and share what they witnessed the day before. The team member is working today and seems fine.

What should have been done?

- The member is witnessed being potentially impaired.
- Team member escalates to the leader their concerns right away. If you become aware after the fact, please report and confirm it has been escalated.
- The following are all things that are possible that could happen under these circumstances.
    - Errors in medication ordering and administration.
    - Patients fall during great repositioning or transferring
    - Missed medical crisis for the team member.
    - Team member or coworker injury due to impaired communication or physical ability.

We are all responsible for safety!

It is imperative that we stop the line at any time. Safety could be jeopardized.

Each of us can set the tone on safety in our environment. These policies are intended to support you in maintaining safety.

14.4 Accommodations

North Memorial Health believes in providing team members and applicants with reasonable accommodations to enable them to enjoy Equal Employment opportunities, in accordance with applicable law and internal policies.

If a team member is identified as a qualified individual with a disability or a person with a sincerely held religious belief. NMH will provide them with reasonable accommodation in accordance with applicable law, rules, and regulations. This policy applies to both active team members and applicants.

Medical Accommodations

The objective of the occupation is to allow a qualified individual to perform the essential functions of the position and enable them to enjoy equal benefits and privileges of employment, unless such accommodation is unreasonable, poses an undue hardship to the organization or is it health or safety risks to others.

Reasonable accommodation will be made in accordance with the requirements of the Americans with Disabilities Act, ADA, the ADA Amendment Act of 2008, Minnesota Human Rights Act and state and local human rights laws as applicable.

Religious Belief Accommodations

If a team member has a sincerely held religious belief that conflicts with any job requirement, the objective of any accommodation is to resolve the conflict between the belief and the applicable employment requirement and enable the team member to enjoy equal benefits and privileges of employment unless such accommodation is unreasonable or poses an undue hardship to the organization.

Reasonable accommodation will be made in accordance with the requirements of Title VII of the Civil Rights Act. The Minnesota Human Rights Act and state and local human rights laws, as applicable.

Definitions:

A qualified individual with a disability is an individual with a disability who, with or without reasonable accommodation, can perform the essential functions of the employment position in question.

Religious Belief: A sincerely held religious or moral observance, practice, or belief. This includes moral or ethical beliefs as to what is right and wrong and that our sincerely held with the strength of traditional religious views. Social, political, or economic philosophies, as well as mere personal preferences, are not religious beliefs protected by law or this policy.

Reasonable Accommodation: Accommodations are based on a case by case assessment of the facts and circumstances of the applicant or team members job, job, duties, customer and department need, and other business factors. Examples of accommodations may include, but are not limited to, changes to the work environment, making existing facilities readily accessible to and usable, job restructuring, temporary periods of telecommuting or work from home reassignment to a vacant position, acquisition or modification of equipment or devices.

A team member or applicant may request medical or religious accommodation to current public health recommendations for personal protective equipment. As part of the interactive process, infection control concerns the team members role and responsibilities and the risk to safety of other team members, visitors and patients will be considered in evaluating the ability to provide an accommodation such as a face shield or other mask alternatives or alternate hand sanitizers.

Accommodations Request Process

The interactive process will be used if the team member requests an accommodation.

Accommodation is reviewed on a periodic basis and may be modified or withdrawn based on changing conditions of either the individual or the organization.

Details regarding the interactive process and any resulting accommodation will be treated as confidential team member information.

Step one: Requesting an accommodation.

- A-Team Member may request an accommodation in writing by submitting a medical or religious accommodation request form or a verbal request to the team member, service center or their manager. However, in all cases, written or verbal, the team member will be asked to complete the applicable accommodation request form. You should not specify the nature of the religious belief or the medical condition to your manager if the team member is unable to make the accommodation request themselves, a family member or a friend may do so on their behalf.

- If an applicant would like to request a change in the interviewing or hiring process, they would contact the applicable talent acquisition partner or notify the hiring manager. Applicants follow the same process as team members.

Step Two: Forms and Documentation

- A team member may make their request verbally by calling the team member service center. However, they will be required to complete the applicable accommodation request form within service now.
- The team member will be requested to provide religious or medical documentation to substantiate the need for accommodation. This information will not be reviewed by their leader, but instead will be reviewed and maintained confidentially during the review process.

Please contact the team member service Center for more information on accommodations. 763-581-6947 (MYHR)

15 Workplace Violence and Situational Awareness for Team Members

15.1 Introduction

What is workplace violence?

Workplace violence is any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. It ranges from threats and verbal abuse to physical assaults and even homicide. It can affect and involve Team Members, clients, customers, and visitors. - https://www.osha.gov/SLTC/workplaceviolence/

There are four types of workplace violence: criminal intent, customer/client violence, worker-on-worker violence, and personal relationship violence (CDC, 2014).

Type 1: Criminal Intent

- An example of violence with criminal intent would be a robbery or being assaulted in the parking garage at your place of employment (CDC, 2014).
- Though this type of violence is possible in the hospital setting, it is typically more prominent in locations that carry cash on site.

Type II: Customer/client-on-worker

- This type of violence includes patients, their family members, and visitors (CDC, 2014).
- Often referred to as client-on-worker violence, this can range from verbal abuse, threats, or physical abuse in the healthcare setting against providers (CDC, 2014).
- Most commonly experienced in the healthcare setting, this is the focus of workplace violence prevention.
- An example would be a patient becoming physically combative against a nurse or nursing assistant.
- Another would be a patient being verbally abusive in the waiting area.
- Unfortunately, no area of healthcare is immune to this type of violence.

Type III: Worker-on-worker

- This type of violence occurs between coworkers, or from someone in a supervisory position.
- Emotional and/or verbal abuse such as intimidation, humiliation, or bullying is included in this type of violence

Type IV: Personal Relationship

- A current or former personally related or intimate person that is threatening, and/or assaulting a staff member (CDC, 2014).
- An example is when a domestic abuser follows the healthcare worker to their workplace, or shows up during their shift (CDC, 2014).
- This is not only dangerous for the healthcare worker, but could possibly endanger other staff members, patients, or visitors (CDC, 2014).

NMH's Policy Regarding Workplace Violence

NMH recognizes that it is in the best interest of the community, team members, customers and the organization as a whole to maintain an environment which is free from violence and harassment, misuse of power and authority,

threats, harassment, aggression or violent behavior by Team members, customers, visitors, relatives, acquaintances, strangers, vendors or others will not be tolerated.

DID YOU KNOW?...

- NMH has a Workplace Violence Prevention committee that meets monthly to review recent events from Safety First Reporting and trends.
- The committee also makes recommendations to senior leadership based on trends and events reviewed or things such as education recommendations, equipment ideas, and more.
- Comprised of a multidisciplinary team, the committee includes frontline team members, leaders, security and enforcement.

15.2 Awareness

In your everyday life, as well as at work, it is important to be aware of your surroundings.

Situational awareness; the perception of environmental elements with respect to time or space and the comprehension of their meaning

- Be in touch with nursing staff if you have any questions or concerns regarding a customer.
- Please Be aware of customers who may attempt to leave secure areas when doors are open or join in elevators without badge access.
- Always be aware of exits and avoid allowing the customers to come between yourself and the door or exit. Request help from team members if you feel you need it.
- Hospital doors are open to the public so it should be a best practice for all team members on campus to keep an eye out for suspicious behavior

If something doesn't feel right, it probably isn't.

Prevent Injury to Yourself

- Dress for safety by removing anything from your person that can be used as a weapon or grabbed by someone.
- long hair should be tucked away so that it can't be grabbed
- avoid earrings or necklaces which can be pulled
- overly tight clothing can restrict movement
- overly loose clothing or scarves can be caught
- glasses, keys, or name tags dangling from cord or chains can be hazardous; make sure to use breakaway safety cords or lanyards

The main objective is **your safety**.

- Maple Grove Hospital has adopted the **"FROG"** magnet shown here as a visual for all Team Members upon entering a room with a Customer to do the following if appropriate
- Ask Team Members that are Providing Care for the Customer if there is anything you should know for your safety and the Customers safety before your interaction with the Customer

- Be aware of your surroundings when you enter a room or begin interacting with a Customer.
- Be vigilant throughout the encounter.
- Watch for signs of escalating behavior or violence
- Maintain behavior that helps defuse anger
- Have an escape plan, discuss with Team Members ahead of time
- If it part of the plan for the Customer, call Security ahead of time and have them wait outside the customer door or come in with you.

Three kinds of awareness:

- Self: hair tucked away, no jewelry, clothing not overly loose or tight, break away safety cords
- Others: in restricted areas
  - Do they have a visible badge?
  - Are they in a restricted area?
  - Do they need help finding their destination?
  - Are they displaying comfortable or uncomfortable behavior?
- Surroundings:
  - Identify entry and exit points.

- Stay vigilant.
- Identify objects around you.

Two Asks of Every Encounter

Did you know there are two simple things that can help portray a safer and more aware workplace?

1. Make Eye Contact: You can't identify someone you never looked up to see. Their eye contact, or lack thereof, will help determine your gut instinct
2. Verbal Acknowledge: This will enhance your gut instinct and help further the confidence you portray. "Good morning" "What can I help you find?"

15.3 Prohibited Behavior

Prohibited behavior by customers or visitors is behavior, which is objectively inappropriate towards a team member, including behavior motivated by protected class status.

Examples of prohibited behavior:

- Deliberate/Careless jokes
- Derogatory remarks/gestures
- Offensive language
- Threats to safety or job

When Verbal Abuse Occurs:

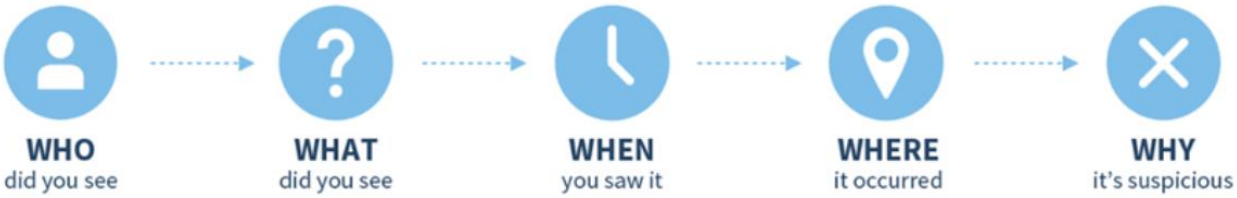
- Lead with empathy
  - Be sure the customer knows SAFE CARE is your priority
- Set Boundaries
  - You may need to state what is "okay" and what is not. Don't assume the customer knows.
- Set Clear expectations
  - In a non-threatening way, state the next steps if the customer is unable to stop their use of abusive language
  - Example Phrases:
    - I recognize this must be challenging, but your language is not okay.
    - I want to provide the care you need. If you are unable to change your words, I will not be able to stay in the room
    - In this hospital, abusive words are not tolerated. Please change your words and I can provide the care you came here for.

Responses to Prohibited Behavior:

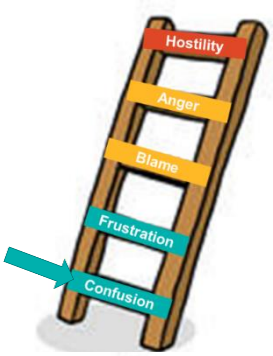
- Politely and safely exit the situation if you feel uncomfortable, threatened, or unsafe for any reason. If patient care needs prohibit you from leaving the room, call for help.

How to Report it:

- NMHH and MGH: Call security to report or call 911 for imminent threats
- Off campus, call 911
- Remember to document the events in Safety First Reporting after you've notified security and/or law enforcement.

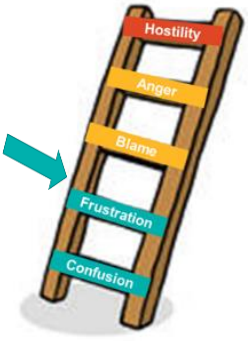


- **Five Warning Signs of Escalating Behavior:** There are 5 warning signs people tend to progressively display as they get upset. Each behavior tends to be one step closer to a potential violent incident.
    1. **Confusion**
    2. **Frustration**
    3. **Blame**
    4. **Anger**
    5. **Hostility**



15.4 Confusion

Warning Signs of Confusion	Responses to Confusion
The person appears bewildered or distracted.	Listen Attentively to the person
They are unsure or uncertain of the next course of action.	Ask clarifying questions
	Give factual Information



15.5 Frustration

Warning Signs of Frustration	Responses to Frustration
The person is impatient and reactive	Move the person to a quiet location
The person resists information you are giving them	Reassure them, talk to them in a calm voice
The person may try to bait you	Attempt to clarify their concerns

De-Escalation in Person

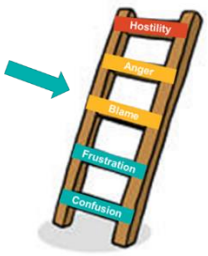
- Listen and acknowledge (e.g., head nods, paraphrase back)
- Speak in a calm and even voice
- Identify their values and respond in kind
- Demonstrate empathy – do not get defensive
- Keep positive
- Do not get emotionally involved – know your own triggers
- Apologize if appropriate
- Offer to let the person speak to another team member instead of you
- Make sure you are understanding them correctly and vice versa
- Reassure them you will keep them safe
- Give them space – for their comfort and your safety!
- Don't turn your back to them

De-escalation over the phone

- Listen and do not cut them off
- Acknowledge by repeating back to them
- Speak in a calm and even voice
- Avoid putting them on hold
- Identify their values and respond in kind to build trust
- Do not argue
- Don't tell someone, "There is nothing I can do"
- Demonstrate empathy – do not get defensive
- Keep positive
- Do not get emotionally involved
- Apologize if appropriate
- Offer to let the person speak to someone else instead of you
- Make sure you are understanding them correctly and vice versa

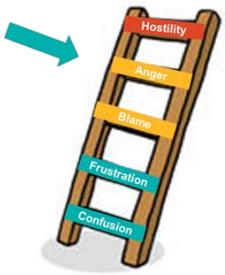
15.6 Blame

Warning Signs of Blame	Responses to Blame
The person places responsibility on everyone else	Disengage with the person and bring a second party into the discussion
They may accuse you or hold you responsible	Use a teamwork approach
	Show concern and respect
They may find fault with others	Draw the person back to the facts
They may place blame on you	Focus on areas of agreement to help resolve the situation



15.7 Anger

Warning Signs of Anger	Responses to Anger
The person may show visible change in body posture	Don't argue with the person
Actions may include pounding fists, pointing fingers, shouting or screaming	Don't offer solutions
This signals **VERY RISKY BEHAVIOR**	Prepare to evacuate the area or isolate the person
	CONTACT YOUR SUPERVISOR AND CODE GREEN TEAM



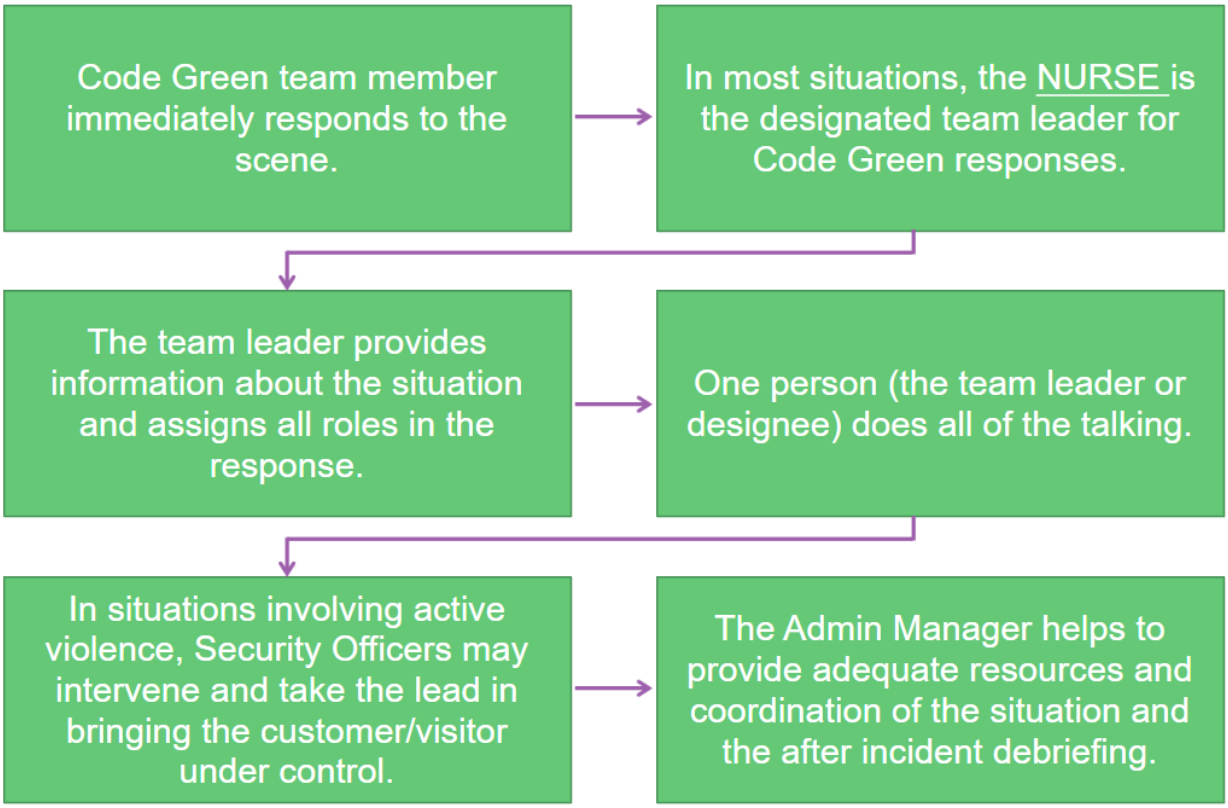
CODE GREEN:

If you called for a Code Green;

- Make sure you are safe

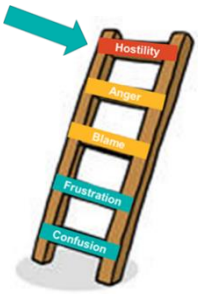
- Continue to monitor the situation
- Provide information to the Code Green Team Members as they arrive so a safe plan of action can be determined

CODE GREEN TACTICS

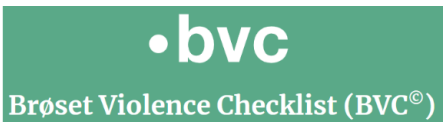


15.8 Hostility

Warning Signs of Hostility	Responses to Hostility
Physical actions or threats appear imminent	Don't argue with the person
There is immediate danger of physical harm or property damage	Don't offer solutions
Out-of-control behavior signals the person has crossed the line	Prepare to evacuate the area or isolate the person
	CONTACT YOUR SUPERVISOR AND CODE GREEN TEAM



15.9 Broset tool (for those with Epic Access)

Most often customers indicate increased anxiety, stress, distress through various behaviors. An established routine screening can assist in identifying customers who are demonstrating early signs of high-risk behaviors.
The Broset (Broset Violence Checklist) tool is an evidenced based tool that is used each shift in various organizations to identify customers who are high risk for violence 

The Broset tool is a licensed tool created to help identify customers who have risk factors for violence. This tool has been built into EPIC.

Screening questions in EPIC: Two or more risk factors equals high risk; screens out low risk patients

Risk factors that contribute to a positive screening:

- Verbal aggression in past 24 hours
- Past episode of violence/aggression
- Alcohol or drug influence
- Dementia or delirium
- Psychotic symptoms
- Hostility
- Impulsivity

Screening questions in EPIC:

- 2 risk factors = High Risk
- Screens out low risk patients

Violence Risk Assessment

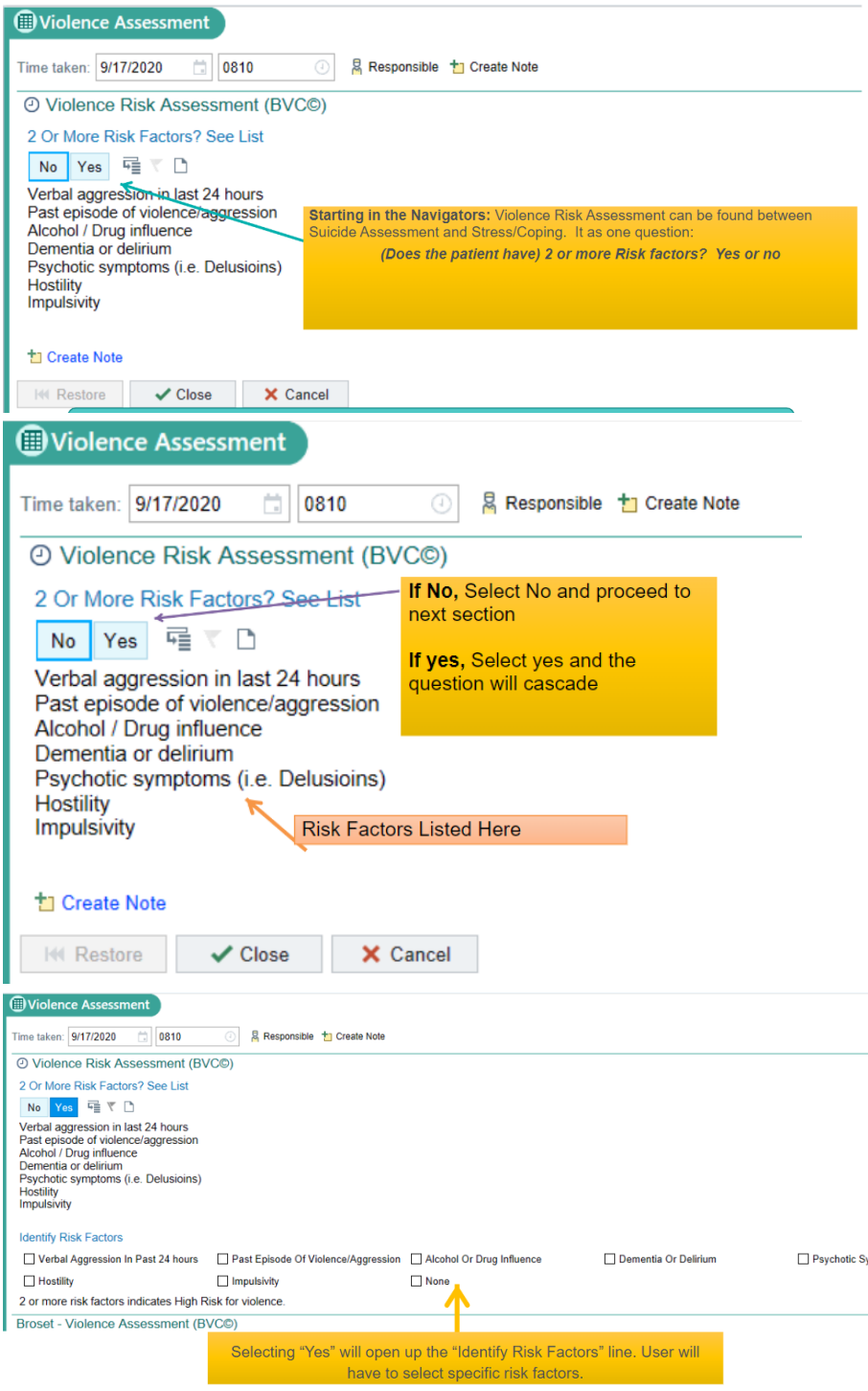
To access the Broset tool, an initial assessment called the "Violence Risk Assessment" is used. This tool will be found in the:

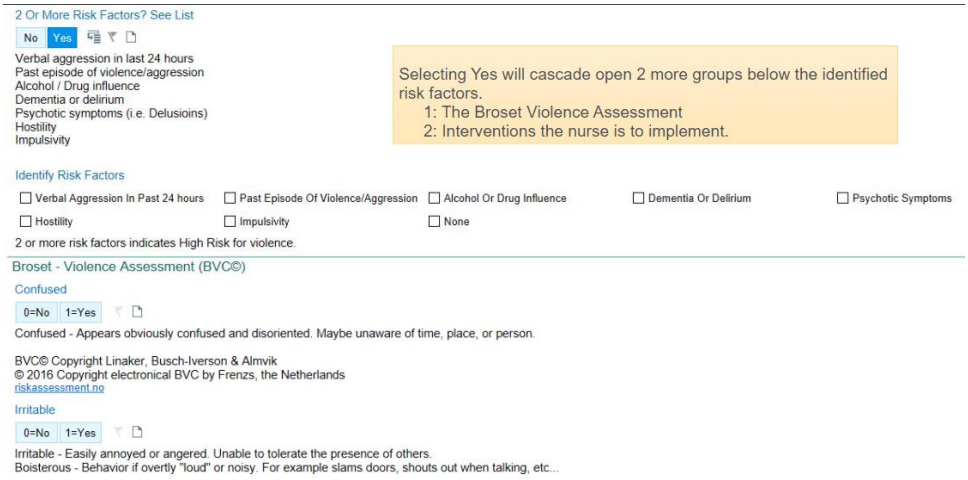
- Cares and safety flowsheet (previously known as the Patient cares/ADL flow sheet)
- Admission navigators
- Area specific navigators (ED/ECC, PCC PACU, Etc.)

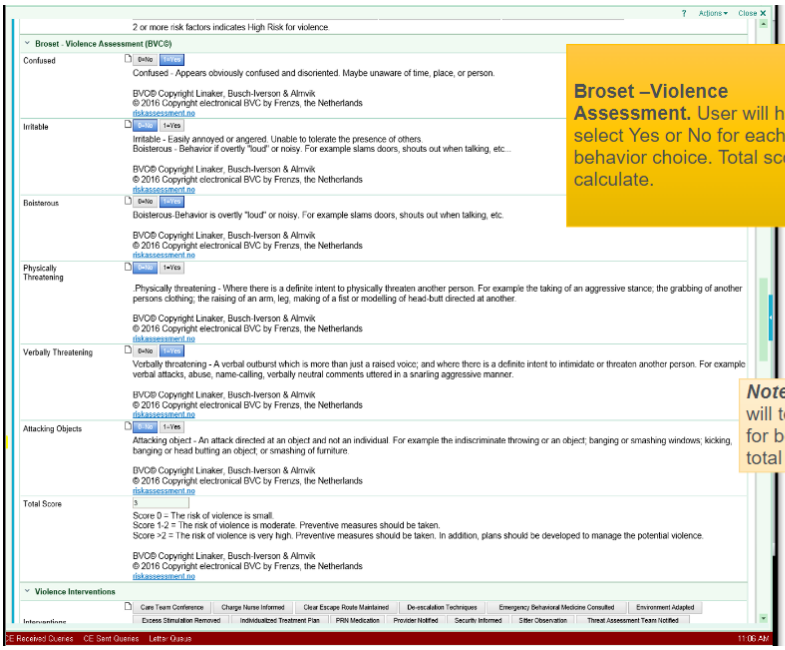
Interventions for Customers at Risk of Violence:

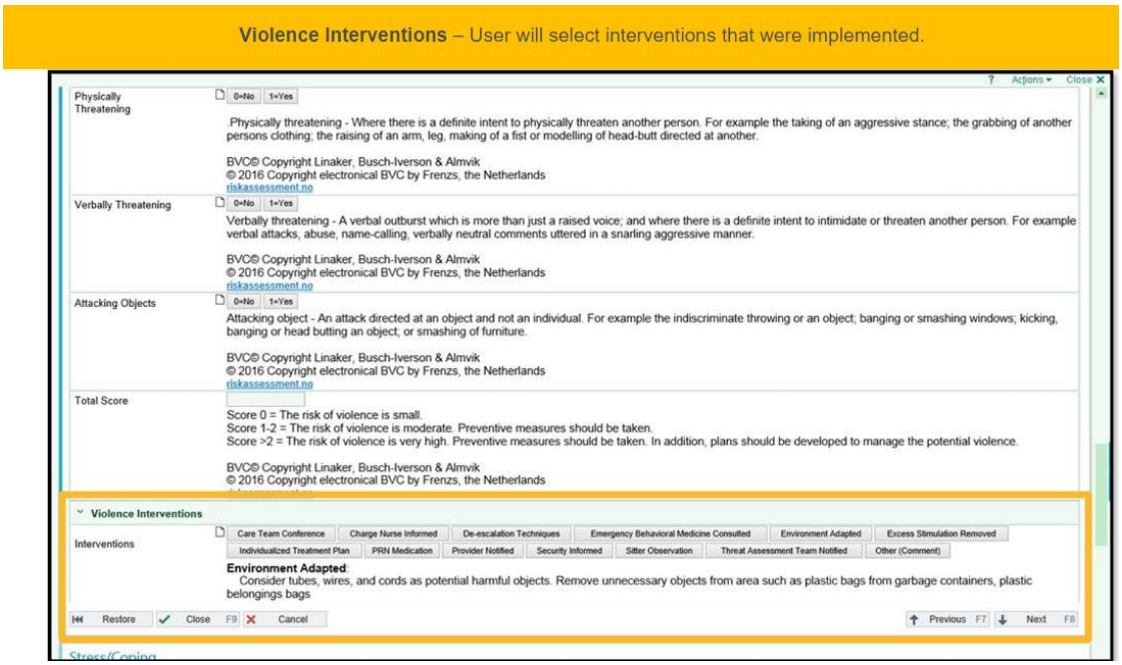
- Care team conference
- Patient Care Facilitator informed
- De-escalation techniques
- Emergency behavioral medicine consulted
- Environment adapted
- Excess stimulation removed
- Individualized treatment plan
- PRN medication
- Provider notified
- Security informed
- Sitter observation
- Threat assessment Team Notified via administrative manager
  Unique treatment plan

15.10 Broset Example


Violence Assessment
Time taken: 9/17/2020 0810 Responsible Create Note
Violence Risk Assessment (BVC©)
2 Or More Risk Factors? See List
No Yes
Verbal aggression in last 24 hours
Past episode of violence/aggression
Alcohol / Drug influence
Dementia or delirium
Psychotic symptoms (i.e. Delusioins)
Hostility
Impulsivity
Starting in the Navigators: Violence Risk Assessment can be found between Suicide Assessment and Stress/Coping. It as one question:
(Does the patient have) 2 or more Risk factors? Yes or no
Create Note
Restore Close Cancel
Violence Assessment
Time taken: 9/17/2020 0810 Responsible Create Note
Violence Risk Assessment (BVC©)
2 Or More Risk Factors? See List
No Yes
Verbal aggression in last 24 hours
Past episode of violence/aggression
Alcohol / Drug influence
Dementia or delirium
Psychotic symptoms (i.e. Delusioins)
Hostility
Impulsivity
If No, Select No and proceed to next section
If yes, Select yes and the question will cascade
Risk Factors Listed Here
Create Note
Restore Close Cancel
Violence Assessment
Time taken: 9/17/2020 0810 Responsible Create Note
Violence Risk Assessment (BVC©)
2 Or More Risk Factors? See List
No Yes
Verbal aggression in last 24 hours
Past episode of violence/aggression
Alcohol / Drug influence
Dementia or delirium
Psychotic symptoms (i.e. Delusioins)
Hostility
Impulsivity
Identify Risk Factors
Verbal Aggression In Past 24 hours
Past Episode Of Violence/Aggression
Alcohol Or Drug Influence
Dementia Or Delirium
Psychotic Symptoms
Hostility
Impulsivity
None
2 or more risk factors indicates High Risk for violence.
Broset - Violence Assessment (BVC©)
Selecting "Yes" will open up the "Identify Risk Factors" line. User will have to select specific risk factors.


2 Or More Risk Factors? See List
No
Yes
Verbal aggression in last 24 hours
Past episode of violence/aggression
Alcohol / Drug influence
Dementia or delirium
Psychotic symptoms (i.e. Delusioins)
Hostility
Impulsivity
Selecting Yes will cascade open 2 more groups below the identified risk factors.
1: The Broset Violence Assessment
2: Interventions the nurse is to implement.
Identify Risk Factors
Verbal Aggression In Past 24 hours
Past Episode Of Violence/Aggression
Alcohol Or Drug Influence
Dementia Or Delirium
Psychotic Symptoms
Hostility
Impulsivity
None
2 or more risk factors indicates High Risk for violence.
Broset - Violence Assessment (BVC©)
Confused
0=No
1=Yes
Confused - Appears obviously confused and disoriented. Maybe unaware of time, place, or person.
BVC© Copyright Linaker, Busch-Iverson & Almvik
© 2016 Copyright electronical BVC by Frenzs, the Netherlands
riskassessment.no
Irritable
0=No
1=Yes
Irritable - Easily annoyed or angered. Unable to tolerate the presence of others.
Boisterous - Behavior if overtly "loud" or noisy. For example slams doors, shouts out when talking, etc...


Broset - Violence Assessment (BVC©)
Confused
Irritable
Boisterous
Physically Threatening
Verbally Threatening
Attacking Objects
Total Score
Violence Interventions
Broset –Violence Assessment. User will have to select Yes or No for each behavior choice. Total score will calculate.
Note: that the row details will tell you what to look for behavior and what the total score means.

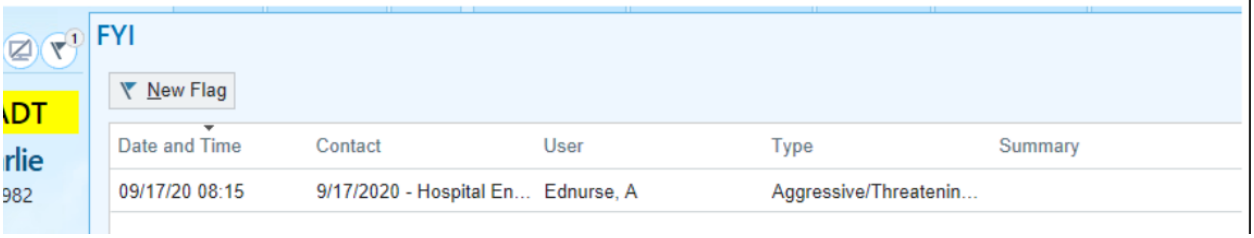


This assessment:

- Is to be completed in all areas on admission (excludes NICU)
- Is located in the Safety Care Flowsheet
- Needs to be completed during each shift

If a customer has active interventions and is high risk, this assessment should be completed more frequently to capture changes and effectiveness of interventions.

FYI Flag



- Selecting “Yes” will automatically add an FYI to the customer’s chart. You will have to close the chart and then re-enter Epic to see the new FYI flag
- If at a later time the customer no longer exhibits risk factors and the nurse now documents “No”, the FYI is removed
- The comment section should be used to identify known triggers or specific information that will assist team members in keeping the customer safe.
- NICU, Pediatrics, and other areas – the FYI can also be used for family or caregiver behaviors.

AFTER THE BROSET

- Depending on their Broset score, a threat assessment may be suggested and can be requested by contacting the unit leader or admin manager.
- The Broset is meant to help determine next steps to keep our team and our customers safe

- Complete the interventions suggested and let your leaders or the Admin Manager know if you need additional support.

15.11 Threat Assessment Team

A Threat Assessment Team may be utilized NMH system wide in order to pre-plan, prevent, or respond to any actions, intentions, threats or other information that indicates harm to NMH Customers, Team members, NMH property or facilities.

NOTE: If there is an active emergency, activate your emergency response procedures (Call 911)

Possible Triggers:

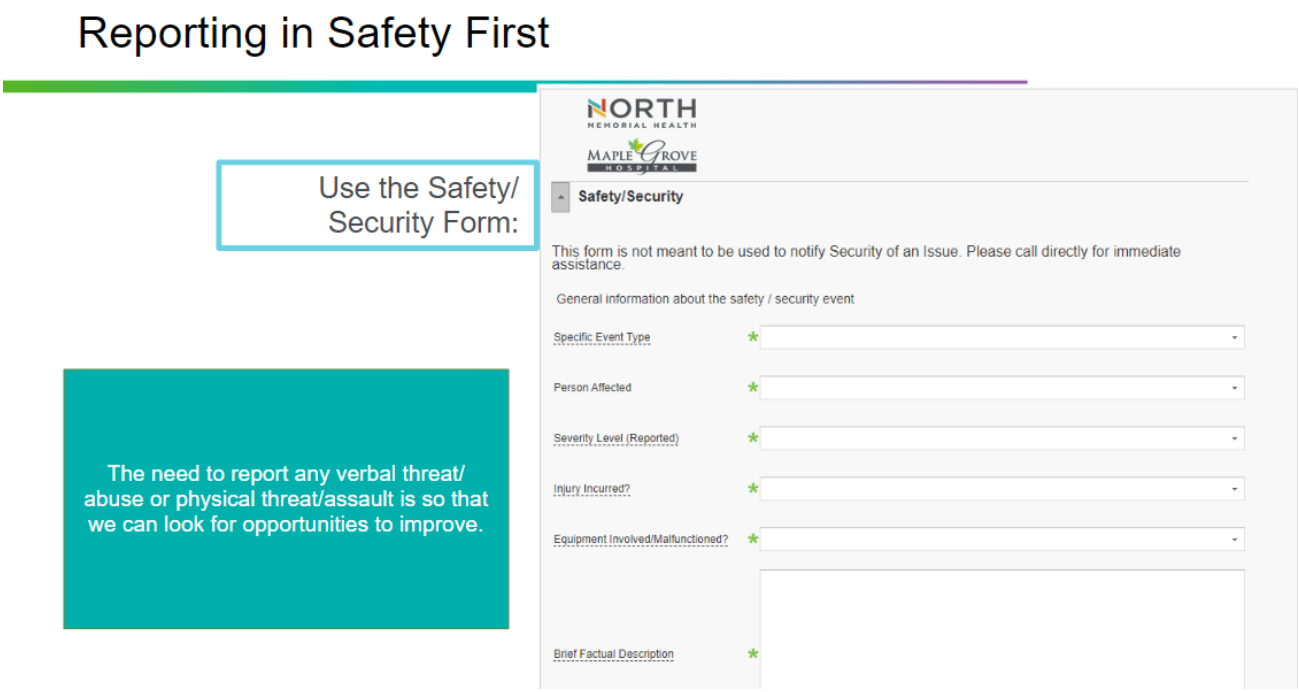
- Results or key indicators from a Broset Tool
- Threat to Team members, customer or NMH facility/property
- Potential for a threat (civil unrest)
- Incident/event that is close in proximity of NMH facilities
- Code Green
- Customer (Patient and/or visitor) behavior
- Nature of admission
- To maintain situational awareness of potential threats that present themselves.

CHALLENGE YOUR THINKING!
This is NOT part of your job!

- One of the biggest reasons why the data on violence experienced by healthcare workers is so inconsistent is that it is often underreported (CDC, 2014)
- This occurs because healthcare staff fell that this is 'just part of the job' (CDC, 2014)
- If it's not reported, organizations do not realize the magnitude of the problem.

WHEN IS THE THREAT ASSESSMENT TEAM CALLED?
When you **feel threated** or receive a verbal or written threat (or witness someone else being threatened)
Notify your immediate supervisor/manager: the supervisor/manager will contact the Admin Manager or on-call Administrator who will page the site-specific Threat Assessment Team.

NOTE: If there is an emergency, activate your emergency response procedures – call 911



15.12 Active Threat

An Active Threat is anything that is a threat to the safety of NMH team members, customers, or property.

Immediate Threat:

- Aggressive individual with object or weapon
- Something that can cause bodily harm injury or death
- Hostage situations

Potential Threat: If you see something, say something

- Suspicious items - backpack, package, unattended weapon, etc.
- Verbal or written threat of violence via phone call in person or e-mail
- civil unrest – protest, demonstration, upset family members or customers,

If the immediate threat is a person, use any of the following response actions based on your ability and circumstances in the moment.

- Run: Run away from the threat if possible.
- Hide: If running is not possible and not safely get away from the threat, hide and protect yourself.
- Fight: If you cannot escape, counter the human threat.

Report it!

Take note of what or who you saw and heard, when you saw it, where it occurred, why it is.

Call 911 or DIAL 9-911. “Active Threat” and the location will be broadcast. Plain language ensures that both team members and visitors know the danger and how to respond and reduces confusion. Examples include, but are not limited to persons with weapons, bomb threats, terrorist activities, civil disturbances, suspicious packages and suspicious activity.

How do I identify an Active Threat?

- An active shooter is an individual aggressively engaged in killing or attempting to kill in a confined and populated area.
- The situation occurs rapidly and without warning. The shooter's objective may be a specific target such as an estranged spouse or former boss or may just be all persons present. In either case, anyone within weapon range is a probable victim.
- Most end in less than 15 minutes so the arrival of law enforcement may have little effect on the outcome. The shooter often commits suicide or is looking for "suicide by cop."
- Individuals need to prepare physically and mentally to respond to an active shooter incident.

Recognize:

- Potential threat: if you **see something, say something**
- Immediate threat: someone or something that can cause immediate injury or death – requires immediate action

Report:

- Report suspicious activity to Security immediately *77 MGH
- Notify your supervisor
- Get to safety, then take note of what or who you saw/heard, when you saw/heard it, and where it occurred
- Describe specifically what you observed, including:
    - Who or **what** you saw
    - **When** you saw it
    - **Where** it occurred; and
    - **Why** is it suspicious?
    - If there is an emergency, call 9–1–1.

15.13 Lockdown procedure

Security will issue a lockdown mode through overhead paging when a situation has the immediate potential to jeopardize the safety of customers, visitors, team members or property. (Maple Grove Hospital is initiating lockdown procedures due to "Issue" and "location")

During a lock down mode, the emergency entrance will serve as the only hospital entrance point unless an alternate entrance is deemed necessary by security and Administrative Mangers. This entrance will be continuously monitored by Safety and Security.

"Hospital Lock Down All Clear" will be announced through overhead page when the lock down mode is canceled. If the situation is an active threat within the hospital. Refer to the Active Threat Policy.

15.14 Active Shooter

Statistical Breakdown of the location categories where 250 active shooter incidents took place in the U.S. from 2000-2017:

- Areas of commerce: 105 incidents 42%
- Educational environments: 52 incidents, 21%
- Government property: 25 incidents, 10%
- Open spaces: 35 incidents, 14%
- Residences: 12 incidents, 5%
- House of worship: 10 incidents, 4%
- Health care facilities: 10 incidents, 4%

Prepare for an Active Shooter

- An active shooter is an individual aggressively engaged in killing or attempting to kill in a confined and populated area.
- The situation occurs rapidly and without warning. The shooter's objective may be a specific target such as an estranged spouse or former boss or may just be all persons present. In either case, anyone within weapon range is a probable victim.

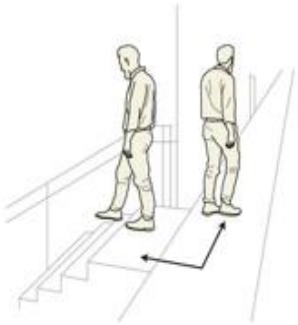
- Most end in less than 15 min so the arrival of Law Enforcement may have little effect on the outcome. The shooter often commits suicide or is looking for “suicide by cop”
- Individuals need to prepare physically and mentally to respond to an active shooter incident.

15.15 RUN, HIDE, FIGHT

Run

RUN

The first — and best — option is to get out if you possibly can. People have been shot while they froze in place a few steps from an exit door, said Scott Zimmerman of K17 Security. Encourage others to leave with you, but don't let their indecision keep you from going.



Choose a route carefully

Don't run willy-nilly or blindly follow a crowd. Pause to look before you enter choke points such as stairwells, lobbies and exits to make sure you can move through them quickly and not get stuck out in the open.

Think unconventionally

Doors are not the only exits. Open a window; if you have to break it, aim for a corner. See if the drop ceiling conceals a stable hiding place or a way to enter another room. You may even be able to punch through thin drywall between rooms.

Look down

If you're trapped on the second floor, consider dropping from a window, feet first, ideally onto a soft landing area. (But if you're higher than the second floor, the drop itself could be fatal.)

Be quiet and stealthy

Try not to attract a shooter's attention. Remember that edges of stairs are less likely to creak than the centers. Stay low and duck when you pass windows both inside and outside the building.

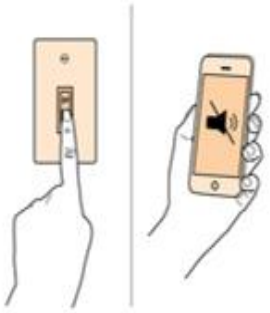
HIDE

HIDE

If you can't immediately leave a building or room, you want to buy time — time to plan another way out, time to prepare in case the shooter forces his way in, time for the police to arrive.

Block doors

Don't just lock them, barricade them with desks, chairs, bookcases — anything big and heavy. Wedge objects under them at the farthest points from the hinges. Prop or wedge something under door handles to keep them from turning all the way. Tie hinges and knobs with belts or purse straps. A shooter doesn't want to work hard to enter a room.



Turn off lights, silence phones

Make sure someone has alerted 911 with as many details as you can about your location and anything you know about the shooter's whereabouts. Cover windows if you have time; if not, make sure you can't be seen through the glass.

Choose a hiding place

If you know you will hide and stay hidden, don't count on particle-board furniture to stop bullets. Get behind something made of thick wood or thick metal if you can, or stack several layers of thinner material. Make yourself as small a target as possible, either curling into a ball or lying flat on the ground.

Make a plan

Don't just get under a desk and wait. Plan how you will get out or what you and the other people who are with you will do if the shooter gets into the room.

FIGHT

FIGHT

This is the last resort, a dangerous option to be used only if your life is at risk and you are trapped with a gunman. Different situations call for different strategies, but all of these turn the element of surprise against the shooter.

Create chaos

Throw books, coffee mugs — anything you can grab. Make noise. Keep moving. A moving target is much harder to hit than a stationary one. Greg Crane, founder of the ALICE Training Institute, which has worked with nearly 3,000 schools, said that even children can be taught to move, make noise and distract so they can buy time to get away.

Swarm

Some experts teach a Secret Service-style technique in which people wait beside the door and grab the shooter as he enters. At least one person goes for the arm that holds the gun, one wraps his legs and others push him down. Using their body weight, a group of smaller people can bring a large man to the ground and hold him there.

Move the weapon away

Once the gun is separated from the shooter, cover it with something such as a coat or a trash can. Don't hold the weapon, because if police storm in, they may think you are the shooter.

Attack

This is last even among last-resort options. The ALICE program doesn't even suggest this for adults, and none recommend it for children. But if you try to fight, choose a weapon and aim for vital areas such as the head, eyes, throat and midsection. Don't quit.

What about Customers?

The key thing to remember is that you cannot help others if you are injured or dead. Do not delay getting yourself to safety in order to help someone else.

Thinks you can do:

- Encourage others to run with you if they are ambulatory
- Hide: shut doors and turn out the lights in patient areas that may not be able to evacuate
- If your best option is to hide in a customer's room, barricade the door and plan how you will defend yourself and the customer if the assailant manages to enter

After an Event of WPV

- Huddle for safety
  - Anyone injured should be evaluated
  - Assess for necessary resources
- Document and notify
  - Violence Risk Assessment/Broset
  - Notify provider or leaders as needed
  - Safety First Reporting
- Request a defusing from your unit leader or the Administrative Manager
  - An opportunity for team members to self-assess their own psychological well-being and to determine the need for other immediate interventions.

Closing Thoughts

- It is everyone's responsibility to keep our workplace safe
- If you see something, say something
- Remember to RUN, HIDE, FIGHT
- Report to Security, your supervisor, or any leader
- If something does occur that you are a part of, utilize Safety First and report it after the incident
- Team Member Health Services has great resources if you need them
- For mor information on Workplace Violence and efforts to improve safety, see the NMH and MGH Intranet

16 Unmatched Customer Service

In 2017, we made a bold move to differentiate ourselves in Twin Cities Healthcare. We rebranded and let our customers know we agreed with them – healthcare is broken – and made a promise to do better. To keep that

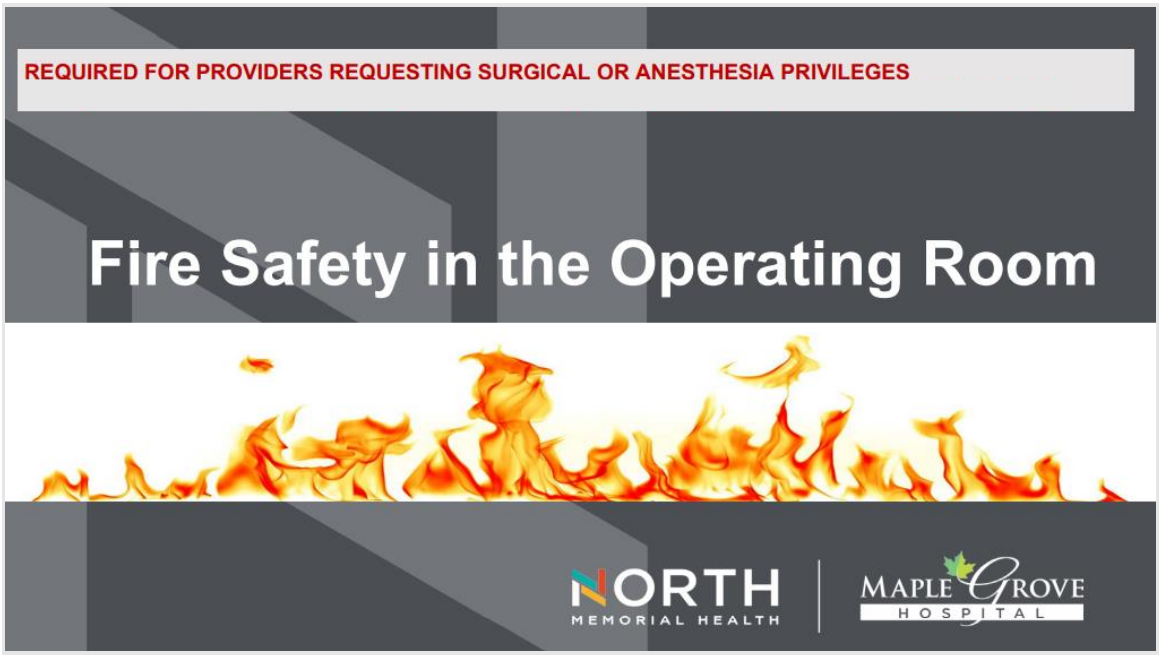
promise, we aligned our values of accountability, inventiveness, and relationships to meet our mission of empowering our customers to achieve their best health.

Building on our foundation of clinical and operational excellence, we continue to follow our guiding principle of Unmatched Customer Service.

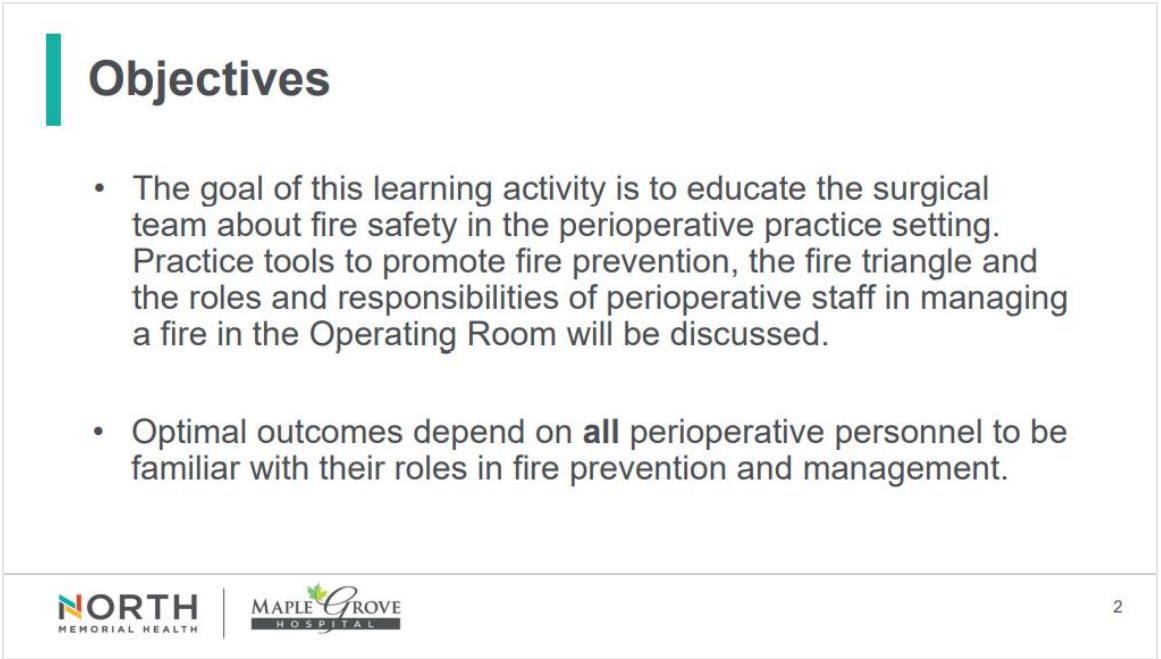
Experience Drivers are 10 evidence-based behaviors that improve the customer experience. They are simple practices that make a hug impact.

Explain things in a way they can understand	We ensure that others hear and understand what we are sharing with them
Show Courtesy and Respect	We treat others the way we want our own special people to be treated
Listen Carefully	We let others speak without interruption and make sure they feel we've truly heard them
Demonstrate Empathy	We show we genuinely understand other's feelings and concerns
Narrate Care and Service	We explain what we're doing and why to relieve anxiety and build trust
Exceed Expectations	We look for ways to go above and beyond to care for others
Empower our customers	We create an environment where others feel more in control of their healthcare journey
Use Preferred Names	We use preferred names – pronounced correctly – in conversations with others
Make a Personal Connection	We find ways to connect personally with those we care for and work alongside
Be a Team Player	We show others that we are a member of a team they can trust

Fire Safety in the Operating Room



Other providers not requesting surgical, or anesthesia privileges may skip to the last page and complete the attestation.



Fact or Fiction?

- Fires no longer happen in modern surgical suites due to advances in technology.

FICTION: According to The Emergency Care Research Institute (ECRI) (2017), surgical fires are estimated to occur about 250 times each year in the United States making them nearly as common as wrong site surgeries. This number has decreased from 550-650 occurrences in recent years due to increased awareness and training despite advances in technology.

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Fact or Fiction?

- Fires only occur in inferior facilities. If a fire does occur, it was not preventable.

FICTION: Fires occur in every location where the 3 sides of the fire triangle come together. This includes hospitals, physician offices, and ambulatory surgery centers. The key to fire prevention is altering one or more of components of the fire triangle so combustion is not possible. This is accomplished by active participation in fire prevention strategies and awareness of fire risks. This will be discussed further in the module.

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Fire Facts:

- Of the 200-240 OR fires per year in the US:
  - 44% occur on the Head, Neck or Upper Chest
  - 26% elsewhere **on** the body
  - 21% in the airway
  - 8% elsewhere **in** the body (within the body cavity)
    - 20-30 are serious and result in disfiguring or disabling injuries
    - 2-3 are fatal and typically occur in the customer's airway.
    - The Emergency Care Research Institute (2018)

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The Fire Triangle

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The Fire Triangle

- For a fire to occur, three components need to be present: **Fuel**, **Ignition Source,** and an **Oxidizer.**
- Whenever these 3 components are in close contact under the appropriate conditions and proportions, a fire **will** occur.
- Fire is a risk in the Operating Room since all 3 sides of the triangle are usually present during the procedure and can be under the influence of 3 different people.

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The Fire Triangle – Ignition Source

- Usually controlled by the Surgeon
  - Cautery (responsible for 70% of all fires)
  - Fiber optic light source
  - Lasers
  - Defibrillator
  - Argon beam coagulator
  - Power tools (drills, burrs)

Anything that provides enough energy to start a fire.

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The Fire Triangle - Oxidizer

- Present in every perioperative setting
- Usually controlled by Anesthesia
  - Oxygen
  - Oxygen-Enriched environment (O2 % is greater than 21%)
  - Nitrous Oxide

Defined as gases that can support combustion.

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The Fire Triangle - Fuel

- Present in every perioperative setting
- Usually controlled by Nurses/CST
  - Drapes
  - Gowns
  - Towels
  - Sponges
  - Dressings
  - Alcohol-based skin prep
  - Human hair
  - Humans
  - Endotracheal tubes

Defined as anything that will burn.

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The Fire Triangle

- The key to fire prevention is altering one or more of components of the fire triangle so combustion is not possible thus mitigating the risk.

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What is a Fire Risk Assessment?

- Before beginning any procedure, an assessment must be completed to identify each aspect of the fire triangle and communicated to the entire surgical team in conjunction with the Time Out.
- The Fire Risk Assessment is collaboratively completed by Anesthesia providers and the Circulating Nurse with prevention protocols put in place prior to incision.
- All member of the team must participate to ensure they are prepared should an emergency occur.

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What is a Fire Risk Assessment?

- The Fire Risk Assessment should identify
  - Fuel that is present
  - Ignition source
  - Oxidizer or potential for oxygen-enriched environment
  - Additional preventative measures that are required based on the components of the fire triangle.

FIRE RISK ASSESSMENT		
Procedure site or incision above the xyphoid	1 (Yes)	0 (No)
Open oxygen source (face mask/nasal cannula)	1 (Yes)	0 (No)
Ignition source (Cautery, laser, fiberoptic light source)	1 (Yes)	0 (No)
SCORE 1 or 2: Initiate Routine Protocol SCORE 3: Initiate High Risk Fire Protocol	Total Score:	

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What is the Fire Score?

The customer is having a left carotid endarterectomy under general anesthesia. The RN has prepped the surgical skin site using chlorohexidine gluconate with alcohol (Chloraprep). The surgeon is planning on using cautery. What is the Fire Risk Score? What Protocol should be initiated?

FIRE RISK ASSESSMENT		
Procedure site or incision above the xyphoid	1 (Yes)	0 (No)
Open oxygen source (face mask/nasal cannula)	1 (Yes)	0 (No)
Ignition source (Cautery, laser, fiberoptic light source)	1 (Yes)	0 (No)
SCORE 1 or 2: Initiate Routine Protocol SCORE 3: Initiate High Risk Fire Protocol	Total Score: 2	

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What is the Fire Score?

The customer is having a mole removed from their lower abdomen under local anesthesia. The RN has prepped the surgical skin site using povidone (betadine). The surgeon is planning on using a scalpel. What is the Fire Risk Score? What Protocol should be initiated?

FIRE RISK ASSESSMENT		
Procedure site or incision above the xyphoid	1 (Yes)	0 (No)
Open oxygen source (face mask/nasal cannula)	1 (Yes)	0 (No)
Ignition source (Cautery, laser, fiberoptic light source)	1 (Yes)	0 (No)
SCORE 1 or 2: Initiate Routine Protocol SCORE 3: Initiate High Risk Fire Protocol	Total Score: 0	

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What is the Fire Score?

The customer is having a right total knee arthroplasty with spinal anesthesia. Supplemental oxygen is being utilized at 50%. The RN has prepped the surgical skin site using chlorhexidine gluconate with alcohol (Chloraprep). The surgeon is planning on using cautery and powered equipment (drills and saws). What is the Fire Risk Score? What Protocol should be initiated?

FIRE RISK ASSESSMENT		
Procedure site or incision above the xyphoid	1 (Yes)	0 (No)
Open oxygen source (face mask/nasal cannula)	1 (Yes)	0 (No)
Ignition source (Cautery, laser, fiberoptic light source)	1 (Yes)	0 (No)
SCORE 1 or 2: Initiate Routine Protocol SCORE 3: Initiate High Risk Fire Protocol	Total Score: 2	

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16

What is the Fire Score?

The customer is having a right port placement under Monitored Anesthesia Care (MAC). Supplemental oxygen is being utilized at 50%. The RN has prepped the surgical skin site using chlorhexidine gluconate with alcohol (Chloraprep). The surgeon is planning on using cautery. What is the Fire Risk Score? What Protocol should be initiated?

FIRE RISK ASSESSMENT		
Procedure site or incision above the xyphoid	1 (Yes)	0 (No)
Open oxygen source (face mask/nasal cannula)	1 (Yes)	0 (No)
Ignition source (Cautery, laser, fiberoptic light source)	1 (Yes)	0 (No)
SCORE 1 or 2: Initiate Routine Protocol SCORE 3: Initiate High Risk Fire Protocol	Total Score: 3	

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What is Routine Protocol?

A Fire Risk Assessment score of a 0, 1, or 2 would initiate Routine Protocol Fire Prevention. This includes:

- Controlling Ignition sources
- Controlling Fuel Sources
- Controlling Oxidizers

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Routine Protocol: Controlling Ignition

- Cautery and Laser safety precautions are followed
- A holster will be attached to the sterile field on every case that requires cautery. This includes the long cautery holster for laparoscopic cautery.
- The cautery will be placed in the holster when not in active use. Keep electrode cords from coiling. The only exception is if there is an urgent/emergent situation within the sterile field (e.g. active bleeding) or an instrument pad is being used.
- Keep surgical drape or linen away from activated ESU.
- Keep active electrode tip clean.
- Cautery will only be activated when at the surgical site and by the individual controlling the ESU.
- Use the lowest power setting possible for desire results.
- In endoscopic cases, the light source is to be off until connected to the scope, and care is taken that the light source is not in contact with the surgical drapes.
- Do not use an ignition source to enter the bowel when it is distended with gas.
- Inspect electrode for impaired insulation.

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Routine Protocol: Controlling Ignition

- Defibrillator safety precautions are to be followed by selecting paddles that are the correct size for the customer and placing paddles correctly to allow optimal skin contact.
- The Laser shall be in stand-by mode when not in use.
- A basin of water or saline containing a towel submerged in liquid should be available for all laser procedures.
- Wet towels should be used to “square off” the surgical site for laser procedures used to treat external pathology.
- All flammable or combustible items should be removed from the treatment site while the laser is in use. All towels and sponges should be soaked with water or saline to prevent ignition.
- The use of drying agents, prep solutions, or ointments that contain alcohol or other flammable products in the presence of the laser beam is strongly discouraged. There is always a fire potential with these products.
- Only the person controlling the laser beam should activate the laser.
- Place the light source in standby mode when not in use.
- Inspect electrical cords and plugs for integrity prior to use. Remove if broken.
- Do not bypass or disable equipment safety features.

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Routine Protocol: Controlling Fuel

- Prevent pooling of surgical skin preparation solutions
- Remove prep-soaked linen and disposable prepping drapes prior to incision
- Allow skin-prep agents to dry and fumes to dissipate prior to draping.
- Dry time is based on manufacturer's recommendations. This can vary from no time (povidone) to greater than 1 hour (Alcohol based preps used in/on hair).
  - Chloraprep/Duraprep minimum 3 minute dry time on hairless skin, up to 1 hour in hair.
    - Wet hair is flammable. May take up to 1 hour to dry.
- Sterile water and/or sterile saline is opened on every surgical procedure. Irrigation connected to a delivery device (e.g. Interpulse) is acceptable
- A towel should be available near the operative site to assist to smother/pat out a fire, if needed

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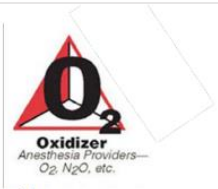
Routine Protocol: Controlling Oxidizers



Interventions to control oxidizers all attempt to decrease the potential for an oxygen-enriched environment to be created.

- Check anesthesia circuits for possible leaks.
- Turn off O2 at the end of each procedure
- Draping will be done in a manner to enable venting of gases to flow down to the floor and minimize the tenting effect.
- Evacuate surgical smoke to prevent accumulation in small or enclosed spaces as smoke is flammable.

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High Risk Protocol

A Fire Assessment score of 3 would initiate High Risk Protocol Fire Prevention. In addition to Routine Protocol Interventions, utilize the following interventions when applicable:

- Use of an incise drape is recommended to minimize oxygen from entering the surgical site through the surgical towel/drapes.
- Utilize a scalpel or surgical scissors first. Minimize use of cautery when possible.
- When cautery in use, use lowest setting possible.
- Encourage use of wet sponges. Use saline to cool.

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High Risk: Controlling Oxidizers

For any procedure on the head, neck, and upper chest, when the patient is receiving supplemental oxygen via a nasal cannula or face mask:

- Use of a non-alcohol based prep is recommended
- Use of an incise drape is recommended to minimize oxygen from entering the surgical site through the surgical towel/drapes
- Draping will be done in a manner to enable venting of gases to flow down to the floor and minimize the tenting effect
- Moistened sponges are to be utilized when possible
- Use of surgical scissors or scalpel is recommended versus use of cautery, when possible
- For coagulation, the use of bipolar not monopolar is recommended
- It is recommended to lubricate the facial hair (e.g. eyebrows, beard, mustache) within the sterile field with a water-soluble surgical lubricating jelly to decrease flammability

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High Risk: Controlling Oxidizers

Shared Airway Procedures

- Cautery
  - Anesthesia will not utilize nitrous oxide
  - Anesthesia will maintain patients SaO2 above 90% with delivery of oxygen and air at or below a FiO2 of 33%
  - Anesthesia will notify the surgeon if higher oxygen levels are required to maintain an adequate SaO2 level
- Laser
  - Laser safe endotracheal (ET) tube rated for the laser's wavelength should be utilized
    - The ET tube cuff shall be inflated with saline and methylene blue to serve as a visual indicator if the cuff becomes damaged
    - Sponges soaked with water should be used to help shield the ET tube from the laser
    - The FIO2 level shall be reduced to below 30% for at least 1 minute prior to the laser's activation and shall remain below 30% during the lasers use
    - Nitrous Oxide shall not be used
    - Evacuate surgical smoke from enclosed spaces as smoke can be flammable.

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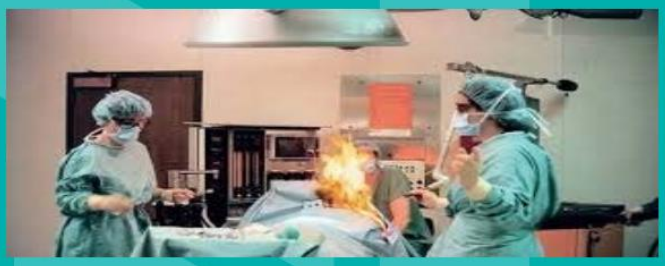

What do I do if there is a Fire?

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What do I do if there is a Fire in the OR?

- Anyone in the immediate area: (ex: Surgeon, CST, PA, NP, RN)
  - Pat out the fire. Water or saline may be used when appropriate.
  - If the fire is fueled by an alcohol solution, **DO NOT** use water or saline, since this may spread the flames.
  - DO NOT use water or saline on electrical equipment. If drapes are burning, remove them from the patient and smother them, if possible.
- Anesthesia provider:
  - Turn off oxygen and nitrous oxide on the anesthesia gas machine when the fire is in the immediate area or an oxygen enriched atmosphere is contributing to the fire.
  - Ventilate patient with air and use IV agents to maintain anesthesia.
- Circulating RN:
  - At Maple Grove, initiate a Code Red by calling *77 on vocera or phone, and call OR control to activate the fire pull station.
  - At North Memorial, initiate a Code Red by activating the fire pull station or by calling *99 on a phone or vocera. Then contact the OR control desk.

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What do I do if there is a Fire in the OR?

- OR Team:
  - Upon hearing the alarms in the hallway indicating a Code Red, update/notify the staff in the other OR rooms as necessary until Code Red All Clear is announced.
- PCC/PIR Team:
  - Upon hearing Code Red, hold all patients going to surgery until the All Clear is sounded.
- PACU team:
  - Upon hearing Code Red, prepare to receive patient from the affected OR suites, as necessary.

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What do I do if the fire is *NOT* controlled?

- OR Control Desk/Additional OR and Anesthesia Staff:
  - Document the time the fire started.
  - Determine how many people are in the department and account for everyone.
  - Set up a communication point (inside of affected core) and identify two staff to communicate personally to the ORs affected.
  - Determine the state of surgical cases in each area.
  - Consult with Anesthesia care provider in charge and surgeon on how to handle each patient.
  - Assign personnel to assist with transport of patients to evacuation site.
  - Direct and control traffic as necessary.
  - Notify surrounding rooms for possible evacuation. Because of the air flow from the rooms, evacuation to the halls should be done only in extreme situations.
- Anesthesia Provider:
  - Give direction for the shut off of the supply of oxygen and nitrous oxide to the affected OR room, if not already done. Because all rooms function independently with shut off valves located outside each room
  - Give a re-dose of antibiotics to the patient as soon as possible.
  - Maintain patient's anesthetic state, take ambu and collect anesthetic drugs to carry on during transport. Disconnect leads, take IVs off poles and place on OR table with patient.

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What do I do if the fire is *NOT* controlled?

- Surgical Support Staff:
  - Assist in securing necessary equipment and supplies for continuation of the surgery.
  - Secure equipment for transporting the patient as directed by the staff in the affected OR suite.
  - Follow instructions for evacuating the patient if needed.
  - Assist as directed and hold doors open.
  - Check to see that all Fire Exits are free from obstructions.
  - See that all hall lights are on.
- Surgical Team:
  - Disconnect any cords, leads, etc. On the field, assist anesthesia.
  - Communicate to the OR control desk.
  - Gather minimal instruments in basin or towel, and place with patient.
  - Meet in evacuation site and assist anesthesia and surgeon in proceeding with patient care.

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What do I do if the fire is *NOT* controlled?

- Surgeon:
  - Control and maintain surgical wound and give final instructions for evacuation to surgical team.

- Everyone:
  - Move patient on OR table from the OR room to the evacuation site.
  - Close all room doors and place saturated wet blankets at the base of the OR door. This will indicate to the First Responders that the room has been evacuated.
  - Assist with the evacuation of adjoining areas as necessary.
  - Prepare to evacuate patients and families, as necessary.

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What do I do if the fire is *NOT* controlled?

What is the immediate response to an uncontrolled surgical fire within the sterile field?

Follow RCA

- Rescue the individual involved in the fire
- Confine the fire
- Alarm sounded as soon as possible
  - Initiate a Code Red by calling *77 at Maple Grove and *99 at North Memorial on Vocera or phone, or call the OR Control Desk, Labor and Delivery Desk, or team member in your area to pull the nearest fire alarm

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How do I use a fire extinguisher?

PASS is an acronym to aid staff when operating a fire extinguisher.

P: Pull the pin
A: Aim the nozzle at the base of the fire
S: Squeeze the handle
S: Sweep at the base of the fire from side to side

What happens when the fire is out?

Pat yourself on the back!! ☺

- All Staff:
  - If evacuation was required, leave everything in the room in place for fire investigators.
  - If fire was contained and the surgical procedure is able to be completed in the room, remove any involved electrical equipment from use; tag equipment per Biomed policy.
  - Save all articles involved in the fire, and any related packaging or labeling, such as drapes, towels, skin preps or other solutions/ointments, cautery hand pieces, ground pad, airways, tubing, cords, etc.
- Circulating RN:
  - Notify Nurse Manager, Hospital Safety Officer, and Risk Management.
  - Turn over involved articles.
  - Complete a Safety First report.

Anesthesia Patient Safety Foundation Video

- Interested in watching how to prevent and manage fire in the OR in live action???
- This video, *Prevention and Management of Operating Room Fires*, which was released in February 2010, is intended for everyone who works in the OR during surgery.

APSF Operating Room Fire Safety - YouTube

https://www.youtube.com/watch?v=oxjF4ctFD

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Summary

- In summary, to be able to effectively prevent surgical fires, perioperative team members should be aware of the components of the fire triangle and how they interact to generate a fire.
- The second portion of fire prevention is communication and active participation in mitigating risk.
- If a fire were to start, it is essential that the perioperative team understand their roles and responsibilities during this emergency situation to minimize harm to both the customer and surgical team members.

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References:

Please review the following for complete procedure for Fire Safety in the Surgical Setting:

MGH Policy and Procedures:

- Fire Prevention and Plan for Surgical Services
- Code Red- Att. F- Evacuation Procedure
- Laser Safety

NMH Policy and Procedures:

- Fire Prevention and Plan for Surgical Services
- Emergency Evacuation Procedure
- Laser Safety
- Fire Plan

AORN Standards, Recommended Practices and Guidelines.

- Current edition located on Surgical Services Intranet Page.

The Emergency Care Research Institute (2018)

Rothrock, J.C. (2018) Alexander's Care of the Patient in Surgery. Elsevier Inc. New York, NY.

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