STUDENT PACKET: For Your Information

Thank you for your interest in Kootenai Health as a clinical site. In this packet you will find several important policies to review. They include:

- Professional Appearance Policy
- Hospital Access Control Badges
- Confidentiality Agreement
- Kootenai Health Main Campus Parking Policy
- Infection Prevention Education
- Smoke Free & Tobacco Free Environment
- Patient Bill of Rights and Responsibility
- Event Notification Report
- Safety Orientation
- Notice of Non Discrimination
- Language Translation
- Restraint and Seclusion
- Clinical Communication ISBARD

You will be fully eligible to complete a Kootenai student experience by:

1) Completing a Kootenai Student Application online
2) Reading through this packet
3) Filling out the *Student Packet: To Complete*
4) Receiving a Kootenai student badge

If you have any questions about the material in this packet, they may be directed to Kootenai Student Services at 208-625-6078 or at studentservices@kh.org

Thank you

12/2015

KootenaiHealth

POLICY

Title: Professional Appearance

Effective Date: 07/10/2015

Policy:

Our commitment to the Kootenai Health Way is demonstrated through the professional appearance of Kootenai Health employees both in the workplace and at functions representing Kootenai Health. Our patients and families experience Kootenai Health in many ways including our day-to-day appearance. Our patients and patient families should walk away remembering our care/service not our appearance. The following guidelines are minimum expectations for appearance and address differences for direct patient care and non-patient care

Each department may develop additional appearance expectations. Please ask your supervisor/manager for specific additional requirements in your location. Supervisors, Managers and Department Directors are responsible for enforcing this policy and ensuring that each employee's attire is appropriate.

Special Instructions:

A. Intent of Kootenai Health's Professional Appearance Policy

Words are often inadequate to clearly define professional appearance for all employees in all situations. All managers and employees must meet the following appearance standards in order to:

- Present a positive professional image to patients, guests, visitors, physicians and fellow employees.
- Be identifiable by our customers based on our roles. Each employee will embrace role identity through consistency in uniform/clothing selection.
- Present an appearance that promotes confidence from others and pride in Kootenai Health staff.

B. Who Is Affected By This Policy

This policy applies to all Kootenai Health/Kootenai Clinic employees including temporary, introductory and regular status personnel. In addition, all temporary, contracting employees and vendors working on-site directly with patients and visitors must adhere to this policy at all times.

C. General Appearance Guidelines

In preparing for each day, please keep in mind that your daily appearance and cleanliness reflect on your commitment to good health and the professional image of both yourself and Kootenai Health. Outlined below are expectations for selected items. There may be positions at the hospital that must wear attire that is compatible with the working conditions of the job and are outlined below.

1. **Identification Badge** – Your identification badge communicates that you are a Kootenai Health employee, with your name, your title, your department, and assures patient/guests that you are here to care for their needs. Your identification badge must be worn at all times when you are at work and will be worn above the mid-chest level. Please refrain from placing anything on your photo ID badge. ID badges must be attached to a badge clip. In addition, lanyards (a cord worn around the neck for carrying something) are not allowed for both safety reasons and because they do not allow for correct badge positioning. For security purposes if an ID badge is lost, please report the loss to Security as soon as possible. You will be issued a replacement at that time.

2. **Jewelry and Tattoo** – *Jewelry* - is to be tasteful, limited in amount and safe for our patients and yourself. "Safe" may be determined at the department level. Acceptable piercings are limited to the ears. *Tattoos* - Visible tattoos must be in good taste and covered at all times if related to sexual, political or of a religious nature.

3. **Hair** – Hair (including facial hair) must be neat, clean, well-groomed and of a natural occurring hair color. Hair must not interfere with the safe delivery of patient care or the completion of work duties. Long hair in patient care areas must be tied back away from the face.

4. **Personal Hygiene** – Employees are expected to be clean and free of offensive body odors.

5. **Finger Nails/Toe Nails** – Nails must be clean and of moderate length. Polish, if worn, must be of good repair without cracks or chips.

   Direct Patient Care – (refer to the Surgical Attire Policy) Employees/staff who provide direct patient care, handle or reprocess medical equipment, clean patient or procedure rooms, prepare IV admixtures, or handle food – Artificial enhancements are **not** to be worn. Nail polish is permitted (must be intact), but anything applied to natural nails other than polish is considered an enhancement. This includes, but is not limited to artificial nails, tips, wraps, appliqués, acrylics, gels and any additional items applied to the nail surface.

6. **Scents -** Tobacco, perfume, after-shave and cologne can be harmful as well as inconsiderate to both patients and peers and will not be worn. Water based or unscented lotions or lotions supplied by the hospital are acceptable.

7. **General Dress** - Professional clothing and uniforms must be modest, conservative, neat, clean, pressed, and appropriate for your department at all times. Appropriate underclothing must be worn and be inconspicuous. Hats are not to be worn unless part of the required uniform.

8. **Shoes**– Shoes must be clean, safe, quiet with soft and/or rubber soles, well fitted and professional in appearance. All shoes should be designed to provide stability and be slip resistant. Shoes protect employees from exposure to hazards that might injure the foot.

   Direct Patient Care: Employees providing direct patient care or non-clinical employees serving primarily in patient care areas are required to wear close-toed shoes.
   Non-Patient Care: Professional, open-toe shoes are acceptable. Flip-flops commonly seen at the beach and/or swimming pools are not permitted in any area.

9. **Hose/Socks** –
   Direct Patient Care: Hosiery/socks are to be worn at all times.
   Non-Patient Care: Not required.

10. **Pants** – No jeans or jean-like material pants of any kind may be worn during paid time.
    Pants must touch mid-calf (crop pant) and/or extend to the ankle/foot and be pressed and professional in presentation. Examples of pants that do not present a professional image include the following: low-cut pants, stretch pants, stirrup pants, leggings, cargo pants, sweat pants, shorts, pants with rivets, bib overalls and any other comfort/lounge wear.
    Outpatient clinics – Black is the required color for all bottoms.

10. **Shirts/Tops** – Kootenai Health polo shirts may be worn as part of a uniform, unless otherwise stated in a department policy. Refrain from wearing shirts/tops that do not represent a professional image. Denim shirts, tops or vests are considered inappropriate at Kootenai Health. Employees working directly with patients may not wear sleeveless tops unless covered by a jacket or lab coat. Sleeveless shirts must cover from the base of the neck to the end of shoulder. Examples of inappropriate shirts/top may include but are not limited to the following: low-cut necklines, low-cut backs, narrow and/or spaghetti straps, shirts/tops that bare skin in the midriff area or can be seen through, and sweatshirts.

Outpatient clinics – Royal/medium blue is the required color for all tops. Clerical staff may select a professional style of their own choice but it must be within the royal/medium blue color. Logo wear is optional. A white or black shirt may be worn under royal/medium blue top, if desired.

11. **Skirts/Dresses** – Skirt and dress length should not be shorter than 2 inches above the knee. Examples of what not to wear include skorts, mini-skirts, and all denim clothing.

Outpatient clinics – Black is the required color for all bottoms.

12. **Uniforms/scrubs** – Professional uniforms or scrub uniforms are required for all patient care providers. Our goal is to enable patients, visitors and other hospital employees to easily identify the departmental affiliation of nurses and other staff based on the color of their scrubs.

- Scrub pants must extend to the ankle/foot, mid-calf length not acceptable.
- Cargo pockets on uniforms/scrubs are acceptable.
- Specific colors are defined by departments; please see Human Resources for current list.
- No Print scrub tops are to be worn
- If a shirt is to be worn under a scrub top it must be white or the same color as the designated scrub.
- Scrub jackets matching the color of the scrub top may be worn externally.

MA/CNA
Scrub Top: **Ciel blue** is the required color for MA/CNA scrub top.
Scrub Bottom: **Solid Navy blue** is the required color for MA/CNA scrub bottom.

RN/LPN
Scrub Top: **Solid Navy blue** is the required color for RN/LPN scrub top.
Scrub Bottom: **Solid Navy blue** is the required color for RN/LPN scrub bottom.
Scrub Dress: **Solid Navy blue**

Other departments may be issued industrial clothing that is appropriate to their work demands or may have a dress code expectation that includes specific colored scrubs. Refer to the Department management for specific departmental dress code expectation.
Scrubs are not to be worn if your department is not identified as a required department and/or position.

D. General Considerations for "On –stage and Off- stage" appearance

All Kootenai Health employees will be considerate to patients and guests by paying close attention to their behavior and actions. When you are on "On Stage" you are representing Kootenai Health and your profession and you will follow the Professional Appearance policy.
Definitions for on stage and off stage are as follows:

ON STAGE: Working in an area where you have direct or potential for direct interface with patients or customers. "On Stage" behavior is also expected when you are in the community representing Kootenai Health in a professional way. You must wear your name badge during these times.
OFF STAGE: Working behind the scenes, attending meetings or workshops, or out of sight and hearing of customers, e.g., in the staff lounge. Casual attire may be worn during these times.
Your name badge must not be worn in public areas while off stage.

E. Exceptions

Exceptions to this policy include infrequent activities or situations that warrant more casual dress.
For example, work parties, work accomplished outside of regular department hours, off duty time, and clean up days. With your manager's approval, festive wear may be worn during holiday periods.

F. Responsibility and Accountability

Title: Professional Appearance

Effective Date: 07/10/2015

Each employee is accountable for his or her behavior and professional appearance. The lead staff member or any member of management is responsible for the professional image of his or her department. It is expected that employees discuss any concerns and observations regarding a breach of professional appearance with his/her manager. It is the expectation of Kootenai Health that the manager will follow up on all breaches of professional appearance. If a manager becomes aware of a breach of appearance with an employee who does not report to them, they will contact the appropriate manager to initiate follow up. If an employee has three (3) or more occurrences within a 12-month rolling period it will trigger the implementation of the Improving Employee Performance policy, which could result in disciplinary action to include suspension and/or termination.

References: N/A

KootenaiHealth

POLICY

Title: Hospital Access Control Badges

Approver: Jeff Ewing, Director of Security Services Date: 02/17/2015

Keywords: badges, id badge, name badge, photo id, name tag, hospital access control badges, name tag

Policy:

In accordance with hospital policy, all Kootenai Health employees, physicians, volunteers, vendors, contracted workers, students and travelers, or anyone working in and around direct patient care areas are required to clearly display their Access badge with the photo showing at all times while on duty.

Special Instructions:

A. Access Control Badges are provided to all Kootenai Health employees at no charge. Name badges should be worn at chest level with name, title, department and picture showing in easy view of public and patients while performing duties at Kootenai Health (no lanyards).

B. Badges are intended to:

1. Properly identify the wearer to co-worker, patients, visitors, medical staff and all persons within Kootenai Health.

2. Provide authorized access to enter Kootenai Health buildings and parking garage.

3. Authorize payroll deductions for meals, coffee stand and gift shop expenses.

C. Issued badges may **NOT** be modified in any fashion including but not limited to attaching stickers, pins, magnets, or anything else that may alter the look or function of the badge.

D. Access Badge must be worn at all times while on duty; name, department, and picture must be visible at all times.

E. Access Badge format will follow Kootenai Health Graphic Standards – The purpose of the access badge is to identify each employee by photo, name, title, and department.

- The design standard for the Kootenai Access badge applies to all departments. Modifications to this design are not allowed.

F. The Picture on the access control badge should be regularly updated and not be more than three years old. Security Services may require that a picture be updated at any time.

G. Badge holder is responsible for the condition of the Access Control Badge, and its proper use and care at all times.

1. **If an Access Control Badge is lost or misplaced**, report it immediately to the Security Department at 625-6201. Leave your full name, employee ID number, and brief message.

2. **Lost, stolen badges** need to be reported to Security Operations Center 625-6200 immediately upon discovery to avoid breach of security to facility. Once reported as missing the access badge will be disabled until either found or replaced.

3. **Damaged badges** are not to be altered with additional holes, tape etc. contact security for a replacement.

4. **Improper use -** any of the above including (sharing, loaning, door access to unauthorized individuals etc.) excessive loss and defacing of access control badge could result in corrective action.

H. To obtain a new Access Control Badge, an employee or supervisor must call or email ahead to set an appointment for badge replacement.

1. Office Hours M - F 7:30am – 11:30am by appointment.

2. After Hours leave detailed message with FULL Name, Employee Number, Return Phone Number, and Access Control Badge number (found on the back of badge) if available.

I. A replacement fee of $10 *per badge* will apply if any of the following are applicable:

1. Lost, stolen, or damaged – other than normal wear and tear.

2. New photo requested by employee.

3. For employees, these charges will be paid via payroll deduction.

4. Department(s) request reprint of entire staff due to department name change or other applicable change may be billed accordingly.

J. Termination of Employment, volunteer, contractor status, access badge use.

3. Upon voluntary/involuntary termination of employment with Kootenai Health – Access Badge must be returned to Human Resources on last day or $50 fee will be deducted from employee's last paycheck.

4. Volunteers, Contractors, Students and all non-employees' must return their access control badge on last day.

- Original Authorizing department is responsible for ensuring the access badge is turned in and may be charged for unreturned badges.

KootenaiHealth

POLICY

Title: Confidentiality

Approver: Christine M. Curtis, Manager Medical Records Date: 11/14/2013

Keywords: confidential, health information, HIPAA, PHI, privacy, confidentiality statement, confidentiality

Policy:

Kootenai Health staff, physicians (and their office staff), students, contract employees, vendors and volunteers will maintain confidentiality and security of patient and hospital information.

Purpose:

To maintain patient and employee confidentiality.

Special Instructions:

A. Definition of Confidentiality:

Confidential information is intimate and private information (either written, electronic, or spoken) that the unauthorized or careless disclosure of would be embarrassing, discriminating, cause undo hardship for the person whose information was shared without their permission or knowledge, or is in violation of the Health Insurance Portability and Accountability Act of 1996 regulations and the HITECH Act.

B. Expectation of All Kootenai Health Staff, Physicians, Volunteers:

1. Kootenai Health has a legal and an ethical responsibility to protect the privacy rights of patients and employees. Every person must take full responsibility to follow appropriate release and disclosure procedures of all information gained through their service at Kootenai Health.

2. It is expected that all health care providers who come in contact with confidential information know, practice and enforce confidentiality with customers, patients and each other. When a breach of confidentiality is identified, it is expected that steps be taken to stop it. This may be done through immediate discussion with those involved or reporting/discussing options with their supervisor, and/or department director, or facility primary officer. Incidents may also be reported in the QM/RM module.

3. Kootenai Health is committed to taking action when a violation of this policy is identified. For example, if an employee breaches this policy, they may be subject to disciplinary action. A student would be subject to the contract the school has with the hospital.

C. Information Classified as Confidential:

1. Confidential information includes written, electronic, and verbal information. All patient and employee records, financial data, or other clinical data is the property of Kootenai Health. This information is confidential and should not be discussed or released other than as allowed in this policy (or by more stringent policies as determined by individual Kootenai Health departments). Patient information can only be discussed with the patient care team as needed for optimum care and with those people identified by the patient.

2. Information of a patient admitted to Kootenai Behavioral Health is confidential and must follow the Federal Regulations regarding release of information.

D. Information Usually Not Classified As Confidential:

1. When a patient enters Kootenai Health (excluding Kootenai Behavioral Health admissions), public information about that patient's hospitalization can be released without written authorization. This includes: patient's name, date of admission/discharge, hometown or city of residence, and general condition – fair, serious, guarded, etc. Patients may request that public information be secured from general distribution. Patients admitted under the category of "confidential" should not have any information released without their permission.

2. General information can also be released regarding an employee without a written release: employee's names, job title, job status, and date of hire. All other information in the personnel record is considered confidential and requires a written authorization for release.

E. Appropriate Settings to Discuss Confidential Information:

Information about a patient, including clinical or financial information, should only be discussed in a private setting. Inappropriate areas would include the cafeteria, hallways, elevators, stairwells, open office settings, patient waiting rooms, or outside the hospital. Discussion should be limited to the interests of the patient and only on a need-to-know basis. Employees are expected to enforce this by seeking appropriate areas and by requesting that those who may be discussing confidential information in an inappropriate setting seek a private place for a confidential conversation.

F. Definition of Need-To-Know:

1. Information about patients, customers, and employees should be shared only with those who have a need-to-know that information in order to perform their job functions. If an employee is not directly involved, the person does not need-to-know the information.

2. If employees are involved, every precaution must be taken to give out information only to others whose jobs are also directly impacted by the information. Family members do not have an automatic right to an adult patient's confidential information. Employees must have a patient's approval before sharing information with anyone.

3. If in doubt about someone's right-to-know, get the patient's or effected person's permission.

G. Releasing Confidential Information:

See Releasing Protected Health Information from the Medical Record.

H. Ways to Ensure Confidentiality Is Maintained:

1. Ask patients what information they want others to know. (Review page two (2); Definition of Need-To-Know) If the patient is unable to participate in the discussion, ,ask those involved in the following hierarchy (per Idaho Code) guardian; person with power of attorney; spouse; parent; appropriate relative; other person responsible for patient's care.

2. If you hear others discussing confidential information, remind them about confidentiality.

3. Refer questions to the patient -- do not assume that you know what the patient would want shared.

4. Always ask yourself, "Do I have a need-to-know this information, or am I just curious?"

5. It is your responsibility to report a breach of confidentiality. Remember, confidentiality is the patient's right.

6. Protect visible information (i.e. reports lying on desks, computer screens, etc.

7. Look for opportunities to improve and protect confidentiality in your work setting and communicate these to your supervisor.

8. Take responsibility for verifying the identity of people accessing patient information in your work environment and take action to secure the confidentiality of the patient's record. Anyone wanting to see a record should be wearing a nametag.

9. Take responsibility to protect individual computer passwords. Log off of computer when done using them.

I. Confidentiality Statement:

1. Each individual who obtains access to Personal Health Information (PHI) / Employment information will be asked to sign the Confidentiality Statement. This will be housed in their personnel file.

2. *These are considered the minimum standards to assist in maintaining patient confidentiality. Policies cannot tell what to do in every situation. Protecting confidentiality is everyone's responsibility, which requires an understanding of the issues and sound judgment. (See Confidentiality Agreement.)*

J. Health Insurance Portability and Accountability Act Exemption for Direct Healthcare Provider:

All persons who are defined, as direct health care providers by their institutions are considered exempt from the minimum necessary regulations in Health Insurance Portability and Accountability Act of 1996 when providing direct patient care (for treatment purposes.) Being "exempt" from the minimum necessary disclosure portion of Health Insurance Portability and Accountability Act of 1996 does not mean employees are exempt from keeping information received confidential. The use of the information received is for treatment purposes only!

Special Instructions:

1. If you are a "health care provider" for Kootenai Health and are involved in the "treatment of patients", then you are considered by Health Insurance Portability and Accountability Act of 1996 to be part of the "exempted" group. It also exempts all requests by health care providers for information, that is reasonably necessary, to be used for treatment purposes.

   Provisions in the regulation that require special justification for disclosing the entire medical record do not apply to treatment-related disclosures because they are not subject to the minimum necessary standard in the first place.

2. Health Insurance Portability and Accountability Act Regulations of 1996 respect the important role that "covered entities" play in the training of medical, nursing and Allied Health students. Training programs are covered under the definition of "health care operations" in the regulations. Therefore, when a provider obtains consent, an individual's health information can be used not only for treating the patient, but also for training students. Under the definition of "health care operations," students in accredited health based training programs are considered to be "health care providers". Exception: Research, see separate policy.

3. Health Care Providers include all health professionals involved in the treatment of patients at Kootenai Medical Center. For example:

   a. Medical and Dental staff
   b. Nursing staff
   c. Allied Health staff (i.e. therapists, counselors, pastoral care providers)
   d. Nurse-Practitioners, Physician's Assistant, Certified Registered Nursing-Anesthetist, or Certified Nurse-Midwives
   e. Health Unit Coordinators
   f. Directors
   g. Other staff acting on behalf of the patient in providing continuing care and or treatment options.

KootenaiHealth

POLICY

Title: Parking – Kootenai Health main campus

Approver: Debbie Kerns, Director of Human Resources Date: 7/21/2014

Policy:

Kootenai Health's parking lots are meant to provide access to services for our patients and their family members. Therefore, this policy is meant to clearly outline options for employees and students that will ensure convenient access for our visitors and patients. Employees leaving at odd hours are encouraged to contact security for an escort to their car. Security Services has the responsibility for parking, planning and enforcement.

Kootenai Health provides parking to all employees, providers, vendors and students in designated areas only. It is the employee's responsibility to recognize and adhere to authorized parking locations. 2015-Parking_Map-Fall

Kootenai Health parking regulations require a parking decal to be affixed in the lower left corner, or either the back driver's side windshield or bumper, of the vehicle it is registered to.

A. Exceptions to this policy may include:
   1. Handicap employees will utilize the handicapped parking spaces in the designated employee parking areas.
   2. Employee of the Month parking passes.
   3. Kootenai Health parking passes (issued by employee health or special applications approved by security services).

B. Those employees who work in the Interlake Medical Building complex are required to park in either the main KH campus, or in the northwest employee designated parking lot of the Interlake Building. 2015-Parking_Map-Fall

C. Trailer and RV parking is available to patrons and guests, located in the west gravel lot behind 2251 West Ironwood Center Drive (Transportation & Transcription occupancy). Registration / check in with Security Services is required within 24 hours of arriving.

D. Department directors are responsible for ensuring that employees are informed of the policy. All violations will be reported to the department director so that they can communicate directly with the employee and discipline if necessary. Employees who choose not to follow this policy will be subject to disciplinary action.

   Enforcement:

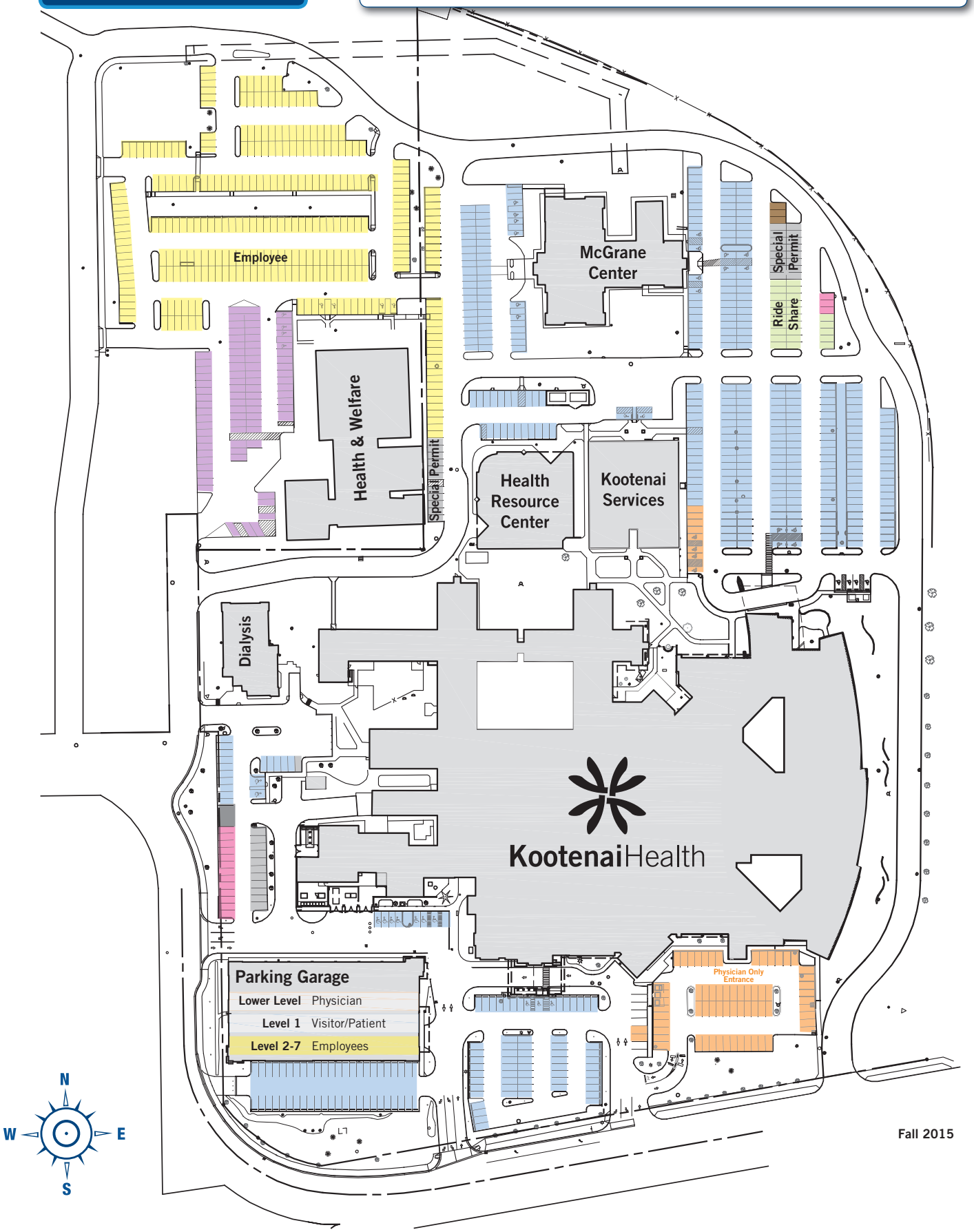
   Security may issue parking citations to individuals / vehicles that violate parking policies or present safety concerns. Multiple citations will result in notification to appropriate department head and/or Human Resources for counseling. Habitual offender vehicles may be towed and/or a "Parking Boot" may be placed on the vehicle. This will be accomplished at the owner's expense and liability. Additionally, anyone who disregards the direct parking instructions by a department manager, vice president or Security Officer, or is disrespectful to same, is subject to disciplinary actions up to and including termination.

   During situations such as construction, the parking policy may be superseded by temporary instructions; all employees will follow the instructions for parking as they occur.

Parking Map

Parking Map Legend and Construction Timeline

- Employee
- Ride Share
- Health & Welfare
- Vendor
- Physician
- Special Permit
- Patient/Visitor
- Vanpool



Fall 2015

KootenaiHealth

POLICY

Title: Infection Prevention Education

Approver: Audra Dawson, Infection Prevention Supervisor Date: 09/02/2014

Keywords: infection prevention, exposure, infection control education

Policy:

All KH employees will receive instruction and training in infection Prevention issues. These include, but are not limited to: hand hygiene, prevention and transmission of pathogenic (disease producing) organisms, exposure prevention and post exposure protocols.

Purpose:

To assure that the essential elements for protecting health care workers and patients from the transmission of disease is reviewed at initial orientation, continuing education programs, and annual review.

Special Instructions:

A. Educational activities will be the combined responsibility of Infection Prevention, Employee Health, and Organizational Development.

B. Program content shall reflect the common recommendation of the Infection Prevention Committee and Quality Council Committee.

C. Content shall include but not be limited to: (*Specific policies)

1. Bloodborne pathogens (HIV, Hepatitis B, Hepatitis C).

2. Exposure to Bloodborne pathogens protocol, including post exposure follow up. *

3. TB exposure testing recommendations. *

4. Vaccines available to prevent diseases. *
   a. Influenza prevention
   b. Measles, Mumps, and Rubella
   c. Chickenpox
   d. Tetanus-diphtheria-pertussis
   d. Hepatitis A and Hepatitis B vaccines

5. Employee illness guidelines relating to contagious illnesses/conditions.

6. Workplace practice to decrease the risk of transmission of diseases.
   a. Standard and Isolation Precautions
   b. Personal Protective Equipment (PPE)
   c. Engineered Safety Devices
   d. Hand Hygiene
   e. Environmental Cleaning
   f. Respiratory Hygiene and Cough Etiquette
   g. Injection Safety
   h. Reprocessing of Reusable Medical Devices

Title: Smoke Free and Tobacco Free Environment

Effective Date: 09/28/2015

Policy:

The health hazards of tobacco use, including being subjected to secondary passive smoke, are well recognized. As a healthcare organization, Kootenai Health is dedicated to providing a healthy, safe and professional environment. Consistent with our mission to meet the healthcare needs of the regional service area, all use of tobacco products and electronic simulated smoking devices are prohibited by employees, visitors, medical staff and patients within any Kootenai Health campus. This includes but is not limited to the main campus; all off-campus clinics (Kootenai Cancer Centers, Kootenai Physician Clinics, Kootenai Behavioral Health, Kootenai Diabetes and Endocrinology Center) and any other Kootenai Health owned or leased buildings or properties and any Kootenai owned vehicles. Furthermore Effective September 1, 2014 Kootenai Health Will adopt a Nicotine free Hiring Policy. (See policy “Kootenai Health Nicotine-Free Hiring Policy”)

It is the responsibility of management and all employees to professionally reinforce this policy with visitors, patients and employees within Kootenai Health Facilities and properties.

Special Instructions:

A. Tobacco Use by Visitors:
   1. Anyone observed smoking or using tobacco products will be reminded in a courteous and professional manner of the organization’s policy.
   2. Visitors that continue to be non-compliant will be asked to leave campus. If necessary, additional assistance should be sought through supervisory or administrative staff or Security Services.

B. Tobacco Use by Patients:
   1. Upon admission, patients will be reminded of the tobacco use policy.
   2. Patients who are identified as tobacco users will be asked to sign the tobacco free environment form.
   3. In the event a patient requests to leave the unit/department to smoke and all other alternatives have been attempted to no avail or patient refuses, the patient will be discharged AMA. The attending physician is to be contacted to explain circumstances. Physician will uphold AMA order or directly discuss options with patient before final determination.
   4. Nicotine replacement options may be ordered by physicians to help patients who have difficulty abstaining from tobacco products while at Kootenai Health.
   5. A referral for tobacco cessation counseling will be made for all patients who use tobacco products.
   6. Every attempt to make the patients more comfortable with appropriate substitutions should be made.

C. Tobacco Use by Employees Hired prior to September 1,2014:

1. It is the intent of Kootenai Health that all employees observe a smoke free/tobacco free workday. It is every employee's responsibility to support and enforce this policy.
2. Employees will be considered in violation of this policy if they are observed using tobacco in any Kootenai Health building, on any part of the grounds, sidewalks, parking lots, driveways, or in any vehicle on the premises at any time.
3. Employees are expected to remain tobacco free from the time they arrive to work until the time they depart. Employee tobacco use is not permitted in any Kootenai Health location at any time.
4. Employees are expected to be free of tobacco odors on their breath or clothing while on hospital property.
5. Employees may not use tobacco on any adjacent public or private properties, nearby residential neighborhood or sidewalks.
6. Employees found to be in violation of this policy will be referred to their manager for counseling, coaching and/or corrective disciplinary action.
7. Tobacco cessation assistance is available to all employees and their benefited adult dependents, contact Employee Health for more information.

D. Tobacco Use by Employees Hired After September 1, 2014:

1. Kootenai Health Will no longer employ individuals who use nicotine of any kind.
2. Applicants who state on the application that they use tobacco will not be eligible for a job. They are free to apply for open positions if they quit using tobacco.
3. All new Kootenai Health employees will be tested for nicotine use as part of their post offer, pre-employment drug screen.
4. Applicants who test positive for nicotine use during their drug screen, but, state on the application that they do not use tobacco, will be considered to have falsified their application and will be treated according to Kootenai Health's policies for falsified employment applications.
5. Other than applicants who have falsified their applications, applicants who test positive for nicotine during their drug screen may reapply after 60 days. (See policy "Kootenai Health Nicotine-Free Hiring Policy").

E. Tobacco Use by Medical Staff:

1. Our medical staff is also expected to follow the same tobacco/smoke free restrictions as described above for employees. Violations of this policy will be referred to the Medical Staff Services Office for appropriate follow-up through the medical staff bylaws structure (i.e. Chief of Staff, Med Exec Committee, etc…).
2. The medical staff will also support this policy with their patients including providing an explanation to the patient that they will not be able to use tobacco at Kootenai Health at any time during their care or stay, an assessment of the need for nicotine replacement therapy (NRT), and referral to tobacco cessation programs if appropriate.

KootenaiHealth

POLICY

Title: Patient Bill of Rights & Responsibilities

Effective Date: 10/01/2015

Purpose:

At Kootenai Health, our primary commitment is to provide professional care at the highest standard in collaboration with the families we serve. Each patient will receive a written statement of his/her rights and responsibilities. Our patients may exercise these rights without regard to race, sex, culture, economic, educational or religious backgrounds, gender identity, sexual orientation, disability or their source of payment for their care.

Special Instructions:

1. A Patient Rights and Responsibilities Brochure will be offered to every inpatient and to every outpatient prior to providing care and upon discontinuation of care.

   A Patient Rights and Responsibilities Brochure will be offered during the first visit and will be offered at each follow-up visit.

2. The Patient Bill of Rights brochure will contain information regarding how to communicate a grievance.

Title: Event Notification Report Policy

Effective Date: 09/30/2015

Policy:

An electronic mechanism for reporting and tracking incidents/events that impact patient, non-patient, and employee safety.

Purpose:

To provide computerized incident reporting that produces valuable data that will lead to performance improvement initiatives. This allows the hospital to track all patient and non-patient incidents, perform data reporting and trending, and to help minimize the hospital's risk of legal liability and financial loss.

A. Confidentiality

1. This ***Event Notification Software*** is confidential data and the Risk Manager controls access to the report information. The information is secure and is not shared unless specifically authorized by the Risk Manager.

2. As a Kootenai Health employee, you have a legal and ethical responsibility to protect the privacy rights of patients and employees.
   a. Do not make photocopies of notifications (downtime notification forms) for any reason.
   b. If a downtime hard copy report is completed, please enter the notification into the software as soon as the system is active and destroy the original.
   c. A hard copy report must never be made part of the medical record.
   d. Do document a description of the event/incident in the medical record, but not the fact that an event notification was completed.

B. Definitions:

Event is any happening that is not consistent with the routine care of a particular patient whether or not it resulted in harm. Any event that is not consistent with the normal operations of a particular organization (such as criminal acts, physical disasters, behavioral issues, accidental exposures, falls, etc.)

An **adverse event** is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. Such events are called 'adverse' because they signal the need for immediate investigation and response.

The term 'adverse event' and 'medical error' are not synonymous; not all adverse events occur because of an error and not all errors result in adverse events.

'Need to know': Information about patients, customers, and employees should only be shared with those who ***need to know*** the information in order to perform their job.

A "**just culture**" is doing business through a set of standards by which regulators, employers, and employees can work together to create the best possible outcomes. It is about creating a reporting environment where staff can raise awareness and escalate the concern when they have seen a risk, or error. It is a culture that puts a high value on open communication, where risks are openly discussed between leadership and staff. A just culture also must recognize that while we as humans are fallible, we do generally have control of our behavioral choices, whether we are an executive, a manager, or a staff member. It is an organization that understands the concept of accountability, that good system design and good behavioral choices of staff together produce good results.

C. Expectations:

1. Notification of all events through electronic reporting is the responsibility of all staff.

2. The 'Notification' report needs to be a factual account of what happened, who, when, where, how, and why. The report exists to document what happened, to permit review of the event to determine its cause and to improve policies, procedures, and processes in a timely manner and to prevent reoccurrence.

3. Finger pointing or accusatory language is not appropriate; just include the facts.

4. Initial notification reports of all events are to be entered within 24 hours when known or at the time of discovery.

D. Special Instructions:

1. The involved staff member(s) who discover(s) or observe(s) the incident/event will complete the entry into the RM software in Midas which can be accessed by opening the Midas+RDE icon available on any Kootenai Health computer.

2. If a serious event occurs please refer to the Adverse Event policy and notify Administration, House Supervisor and/or the Risk Management Department.

3. All notifications will be reviewed by the department manager and those which reach the patient will be reviewed by the Risk Management Department.

4. *Managers are asked to review events within 24 hours of receipt of the initial notification report. It is this organization's expectation for all managers and directors to address, correct, and document actions taken in regards to each event. Reported events should be addressed to such a degree that a final disposition can be assigned within 7 working days from the day the event was reported. For all events that result in patient harm which reaches the level of minimal temporary or minimal permanent harm an Apparent Cause Analysis must be completed by the department manager. The Apparent Cause Analysis timeline for complication is 7 business days. (see attachment which includes the ACA investigation tool)*

5. *RM Notifications resulting from complaints are addressed and resolved in accordance to KH Patient Grievance Policy.*

6. During computer downtime, the hard copy downtime form Patient and Visitor Notification is available on the intranet. Staff members will be required to complete this form within 24 hours.

7. The good catch program provides early recognition of patterns and trends reflected through incident reporting can result in corrective action or preventive action.

8. *Event notifications which remain incomplete after 7 days will result in a report that is sent to location Director who will help identify any barriers which prevent the completion of the investigation. A monthly report showing deviations will be sent to the Vice President of the service line.*

9. *The managers response to the event nonfiction is considered complete when the following criterion is met:*
   a. *What level of investigation was completed*
   b. *What follow-up was done*
   c. *What corrective or preventive action was taken*
   d. *Completion of an Apparent Cause Analysis must be completed by the department manager when events that result in patient harm which reaches the level of minimal temporary or minimal permanent harm. The Apparent Cause Analysis timeline for complication is 7 business days.*

Note: *For examples of events, refer to the same downtime report form linked to this policy.*

E. Individual Access:

1. As an employee, you are responsible and liable for everything that is charted under your login. ***Your electronic password is considered your electronic signature!***

2. **Do not leave your computer unattended while you are logged on!**

3. For added security the Midas system will close your session after 20 minutes if you are not actively using the screen.

4. **Clarification for Completing a Notification Report** (Review this before you begin to enter notification):

   Patient – anything related to a patient, includes family complaints about care provided, lost or stolen patient items, etc.

   Non-Patient – anything not related to a patient's stay and not an employee, i.e. visitor incidents, resident/student/physician injuries/illnesses, security issues, etc. (exceptions – lost stolen patient items or professional practice issues).

   Employee – for KH employees with work related injuries or illnesses.

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208.625.4000 **tel**
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SAFETY ORIENTATION

Safety is a core value at Kootenai Health, and this information is to help you be safe while you are working and to provide safety for our patients.

Hazardous Chemicals are those that pose significant physical or health risks.
Chemical physical hazard characteristics include substances which are:

- combustible,
- compressed gases,
- explosive,
- flammable,
- organic peroxides,
- oxidizers.
- pyrophoric, and
- unstable (reactive) or water reactive

Examples of located on Kootenai Health property are:

- Compressed air in a pressurized cylinder
- Fire extinguishers (all types)
- Oxygen in portable cylinder tanks

Chemical health hazard includes substances which are:

- toxic,
- irritants,
- sensitizers,
- carcinogens, and those with
- target organ effect

Examples of a health hazard located on Kootenai Health property are:

- Bleach
- Chemotherapy medications
- Mercury
- Ether
- Radium implants

It is important to know which chemicals are kept in your work area:

- Read the label on every container you move, handle, or open. Know what the label information means.
- Know how to access the Material Safety Data Sheets (MSDS) located on the Kloud.net.
- Know in advance what could go wrong and what to do about it.
- Know in advance what to do in case of a spill.
- Wear appropriate protective equipment when working with any hazardous chemical.

<u>Symbols for Hazardous Materials</u>
When patients are receiving chemotherapy, a symbol denoting "chemotherapy precautions" is posted outside the patient's room to alert all staff. The symbol is a circle of green with a white swirl in the center. This is the universal symbol for chemotherapy precautions. Chemotherapy precautions designate that all contaminated disposables, unused drugs, syringes and needles will be placed in a leak-proof, puncture-proof container, appropriately labeled: "BIO-HAZARD WASTE".

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If a cytotoxic intravenous chemotherapy agent spill should occur, there are special procedures to be followed. If you work in the following areas, familiarize yourself with this policy.

- Pharmacy
- All nursing units
- Kootenai Clinic: Cancer Services
- Laboratory
- Housekeeping
- Surgical Services

When you see the "Stop Sign" outside a patient's room, DO NOT ENTER those rooms until you have checked with the patient's nurse.

Disaster Response

When a Disaster Alert is announced employees will check in with their respective departments for further instructions. Keep your phone with you. To assure as much telephone capacity as possible for official business during a disaster period, all routine patient and personal calls should be delayed. Limit cell phone use as much as possible.

1. EXTERNAL TRIAGE means there is an external disaster.
    - Mass casualties
    - Severe weather
    - Massive power outage
    - Nuclear, biological and chemical accidents
2. INTERNAL TRIAGE means there is an internal emergency affecting multiple departments. Information about the disaster and other instructions will be provided.
    - Bomb or bomb threat
    - Computer network is down
    - Major plumbing problems
    - Power or telephone outage

Patient evacuation equipment to be used in an evacuation (information on how to use this equipment can be found on the Kloud: Online Learning Center)

1. Stryker Evacuation Chairs are located in the main staircases between 2nd and 3rd floors in the hospital building.
2. Med Sleds are located in the clean equipment storage rooms on the 2nd and 3rd floors of the main hospital.

Disaster Duties of Personnel Off Duty during a Disaster Alert:

1. Department directors or their designee will be among the first personnel to be notified or called back to duty for an "Internal Triage" or "External Triage".
2. Each director will then determine their department's need for personnel and will authorize the calling back of employees.
3. If a specific point of entry is appropriate you will be notified of that location.
4. Once inside the building: returning personnel will report to their department or assigned disaster work location.
5. Employees, who are forced to bring their children to the hospital so that they can report for duty, may utilize baby-sitting services available in the Day Care Center. This will be at the hospitals expense.
6. Do not self-report unless you are scheduled to report for your normal shift.

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Electrical Safety

If you come across any electrical equipment that does not work properly take it out of use immediately. Complete a work order on the Kloud.net under Resources, and then select Facility Work Request.

- Do Not attempt to repair it yourself
- Do Not place it out of the way
- Do Not send it back without flagging it

A large percentage of equipment in the healthcare setting is electric. This means there is risk of electric shock. Electric shock can cause:

- Burns
- Muscle Spasms
- Ventricular fibrillation
- Respiratory arrest
- Death

Use the following safety measures to protect patients from electrical hazards:

- Maintain patient areas, keep floors dry at all times
- Place electrical equipment at a distance from patients
- Do not touch patients and electrical equipment at the same time

Kootenai Health has a power generator that supplies emergency power during a power outage. During a power outage use the outlets with a red cover:

- These are the only electrical outlets that will supply power.
- Emergency outlets have normal power and can be used for routine purposes, just like any other outlet.

Patient safety is a priority at Kootenai Health.

- All new equipment needs to have an incoming inspection completed by the clinical engineering department if it's clinical or the engineering department for non-clinical equipment. The equipment is not to be used until these departments have had a chance to inspect it and declare it safe for use, including all extension cords.
- Report tripped circuit breakers or blown fuses to Facility Services. Misuse of power strips and extension cords can result in overloaded circuits.
- Check all electrical cords regularly, and report immediately any frayed, splitting or broken electrical cords. If any cord or switch feels hot immediately report it to Facility Services.

During a power outage **do not** call Engineering. They are aware of any power outages, and have many duties to perform at these times. Kootenai Health's staff service elevator is the only one of our elevators that will operate during a power outage. This elevator is to be used for transport of patients and equipment only.

Fire Safety

The first person who discovers the fire or flame-board (the flame-board is the method of initiating a fire drill at Kootenai Health) will **RACE** for Fire Safety using these steps:

R –Rescue anyone in immediate danger from fire or smoke by removing them from the actual fire area.
A –Activate the nearest alarm and call 3333 for the main hospital. Other Kootenai Health properties dial 911. Report "CODE RED" and the location of the fire.
C –Contain the fire by closing all doors. Leave any of the automatic fire doors closed.
E –Extinguish the fire with an extinguisher only if you are sure you can safely put it out.

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Fire Drill Measures

- Return to your area when a fire alarm is sounded or CODE RED is announced. Carry out your specific departmental fire assignment.
- Reassure patients and visitors that all appropriate fire safety measures are being taken. Keep calm and do not shout "fire"
- Escort visitors to a waiting area or ask them to remain in the patient's room with the door closed.
- Account for patients according to your departments procedures.
- Clear corridors and exits of all equipment. Corridors and exits need to be clear of obstacles to prevent injury to staff and firefighters and allow for evacuation. If the area becomes filled with smoke, obstacles will be difficult to see and injury is more likely to occur.
- Avoid using elevators during fire or drill. Report to your assigned area using stairwells.
- Restrict telephone calls to the switchboard operator while a Code Red is in progress. Restrict all incoming and outgoing phone calls to emergencies only.
- Restrict travel between departments.
- Know the facility's evacuation plan. An entire building is rarely evacuated.

At Kootenai Health, most extinguishers are RED (ABC) multi-purpose, which can be used for:

- Paper
- Wood
- Cloth
- Electrical equipment
- Flammable liquids

In certain locations such as Nuclear Medicine, Central Supply, and the main computer room they are RED HALON EXTINGUISHERS (BC) which is used on delicate electrical equipment such as computers, since they do not leave a residue that will damage the equipment. Halon is colorless, tasteless and non-toxic and dispenses O2 just like CO2.

Steps to operate a fire extinguisher:

P –Pull the locking pin after breaking the seal
A –Aim the nozzle at the base of the fire
S –Squeeze the handles together, hold firmly
S –Sweep the nozzle from side to side at the base of the fire staying 8 to 10 feet from the fire. Use a side to side sweeping motion, starting at the base of the fire. When the fire appears to be out, prevent it from starting again by soaking it with the rest of the extinguisher contents. Always keep in mind that the fire may again spread to where you can't see it and that it may suddenly reignite.

Fire Alarm Systems

Pull stations are located throughout the facility as per Code and Regulations. A central alarm system alerts people working in all areas of the facility. Pulling the handle down inside the red alarm box activates the alarm system.
During a drill, false alarm, or real fire Engineering may shut off the sound of the alarm. This may be done while they are identifying or correcting the problem that initiated the alarm. When the alarm sound is turned off, the light will continue to flash which means the CODE RED is still in effect. A CODE RED is over only when the operator announces "code red all clear".

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Building Fire Safety Features

- Automatic Alarms can be set off by various factors other than a real fire, and is treated as a REAL fire until Engineering can evaluate the situation and give direction to the operator
- Smoke Detectors are placed in various locations throughout the facility
- Sprinkler Systems have proven to be extremely effective in putting out fires before they cause extensive damage
- Fire Doors are fire resistant
- Automatic Fire Door Closures are activated when the fire alarm starts ringing
- Fire Exits can be stairwells or other escape routes from the building
- Hospital Walls are built to withstand a fire for several hours before they burn through
- Elevators are unsafe during fires
- Fire Management is important in maintaining the safety of Kootenai Health patients and employees.

Evacuation

Evacuations should not proceed until someone in charge authorizes it. Limited evacuation of patients may be necessary in the actual fire area. An evacuation route map is posted in every department. Memorize the map in our department and know the evacuation route you might need to use it. Hospital evacuations are done in three (3) stages:

1. Horizontal
2. Vertical
3. Out of the building-a last resort!

Move patients beyond the fire doors on the same floor where the actual fire is. If there is time and enough personnel, someone should also remove the patients' charts from the fire area. When all patients and staff have been accounted for, make sure the Fire Doors are closed tightly. You may wish to place wet towels at the bottom of the doors to help seal in the smoke.

Title: Notice of Non-Discrimination

Approver: Debbie Kerns, Director of Human Resources Date: 12/23/2013

Keywords: notice of non discrimination, civil rights

Policy:

Kootenai Medical Center does not discriminate against persons in its admission, services or employment practices on the basis of race, color, national origin, handicap or age.

Special Instructions:

Kootenai Medical Center operates its program in compliance with ADA/Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Discrimination Act of 1975, and the Regulations of the Department of Health and Human Services implementing these laws.

For more information about this policy, if you believe that discrimination has occurred, or if you have any questions about the accessibility of our programs or facility, you may contact the Director of Human Resources, at telephone number 208-625-4636 or 208-625-4620. You may also contact the United States Department of Health and Human Services with any questions.

United States Department of Health and Human Services
Office for Civil Rights
2201 Sixth Avenue
M/S Rx - 11
Seattle, Washington 98121
206-615-2290
TTY/TDD 615-2296 or 1-800-362-1710

KootenaiHealth

POLICY

Title: Language Translation (OPI)/Deaf and Hard of Hearing

Approver: Pam Thompson, Director of Social Services Date: 08/11/2014

Purpose:

It is the policy of Kootenai Health to provide interpreters as well as Auxiliary Aids for individuals with communication needs because the ability of patients to interact with hospital staff, and with persons outside the hospital, is a critical part of receiving full medical treatment. This policy is to ensure that the Deaf and Hard of Hearing have equal access to all medical services and that non-English speaking or limited English speaking patients have equal access to all medical services. Kootenai Health is committed to serving all patients according to their needs and recognizes that persons who are deaf or hard of hearing have special needs. Kootenai Health has a commitment and an obligation to meet those needs. Kootenai Health will make reasonable efforts to provide service without cost to individuals who may have language and/or hearing needs in order that our patients and their families may fully participate in all programs or benefits administered by Kootenai Health. If hospital personnel recognize or have any reason to believe a patient, relative, or companion of a patient is deaf or hard of hearing, said personnel must advise the person that appropriate auxiliary aids and services including interpreters will be provided free of charge when necessary for effective communication. The responsible health care provider will ensure that such aids and services including interpreters are offered, utilized, and documented.

Definitions:

Auxiliary Aids: Any effective method of making orally and visually delivered material and other similar services and actions, available but not limited to hearing impaired and limited English proficient (LEP), individuals. Video remote interpreting (VRI) service means an interpreting service that uses video conference technology over dedicated lines or wireless technology offering high-speed video connection that delivers high-quality video images. Qualified interpreter means an interpreter who, via video remote interpreting (VRI) services or an on-site appearance, is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary.

Limited English Proficient (LEP): shall mean any patient, family member, or other person, who is unable to speak, read, write or understand English at a level that permits meaningful access to and full participation in Kootenai Health's services, activities or other benefits.

Special Instructions:

A. The deaf and hard of hearing may need special provisions for adequate communication to occur. Kootenai Health maintains special assistive equipment, such as VRI (Video Remote Interpreting), TTY machines, closed caption television and amplification devices through PETS (625-4526).
   1. When hospital staff becomes aware that provisions for the deaf or hard of hearing are required, the necessary equipment will be promptly obtained.
   2. All departments have access to a list of auxiliary aid equipment. This list is maintained in the PETS department (625-4526).
   3. Nursing or Social Services staff can order the equipment from PETS. The equipment is serviced and maintained through the PETS department.
   4. Social Services is available to assist staff in accessing an interpreter if needed Monday through Friday, 8:00 a.m. to 4:30 p.m., and on weekends by paging the weekend social worker. After hours contact the house supervisor.
   5. Send any bill for interpreters to Social Services for payment.

B. Individuals whose primary language is not English will be provided with an interpreter thru OPI (Optimal Phone Interpreting) to assist them in communication. This allows the patient to communicate their choices and needs regarding their medical care at Kootenai Health.
   1. All staff has access to the OPI thru telephone interpreting (877-746-4674).

2. Social Services is available to assist staff in accessing an interpreter if needed Monday through Friday, 8:00 a.m. to 4:30 p.m., and on weekends by paging the weekend social worker. After hours, contact the house supervisor.

C. Social Services at Kootenai Health oversee the operation of interpretation services and are available to assist staff in interpreting policy and procedures relevant to interpreter access.

D. During scheduling, pre-admission or admission, Patient Registration assesses the patient/family's need for interpretation services.

E. Kootenai Health makes reasonable efforts to provide communications/education in the language most readily understood by the patient/family.

F. Staff communicates the availability of interpretation services at no cost to patient/family.

G. Patient/family is informed of the availability of auxiliary aids and that Kootenai Health provides reasonable accommodations upon request.

H. Acceptable methods for the provision of interpreter services include, but are not limited to the following:
1. Face-to-face interpretation (in person); and the VRI (Video Remote Interpreting) for sign language.
2. Over the phone interpretation (OPI); this method is used for limited English-speaking patients or customer needs when language is a barrier to communication.

I. A staff member needs to be present at all times during an interpretation session, (e.g., registration, education, discharge instructions, sight translation of a consent form, etc.). The interpreter should never be alone with patient/family while information/education is given.

J. Kootenai Health discourages the use of family members to interpret for LEP or deaf patients/family/legal guardian. Minor children and young adults (under the age of 18) are not used as interpreters. The following circumstances may occur:
1. An adult family member or friend may be used to interpret in an emergency situation, pending the arrival of VRI equipment or a qualified interpreter if requested, or if the patient declines the use of Kootenai Health professional services.
2. If the patient/family/legal guardian declines Kootenai Health's professional services after being advised that the qualified interpreter/VRI is available at no cost; staff should document this on the patient's chart.
3. Patient/family/legal guardian shall be informed that they have the right to change their mind and request Kootenai Health to provide an interpreter/VRI at any subsequent time.
4. When Kootenai Health has reasons to believe that a patient/family's preferred interpreter is hampering effective communication, or there is a conflict of interest, Kootenai Health shall provide interpreter services.
5. In emergency situations, care is provided in accordance with standard medical practice, interpreters are sought promptly. However, emergency care is not delayed pending the arrival of an interpreter.

DEAF PATIENT INFORMATION

ITEM	AVAILABLE FROM	INSTALLATION BY
VRI (Video Remote)	PETS	PETS
Closed Caption TV	Hospital	PETS
TTY Phone (Keyboard Phone)	PETS	PETS
Pocket Talker Ultra	PETS	PETS

INTERPRETERS AVAILABLE:

These people are "qualified" to interpret in health care issues / discussions / consents.

1. Deborah Berzins Cell (208) 440-4044

2. Donna Helmer Cell (509) 999-3665

3. Cartrine Stoddard Home (208) 667-6863

4. T Ford Interpreting: Teresa Ford 208-755-0278 Cell
208-712-3047 Office

PHONE INTERPRETING SERVICES

OPTIMAL PHONE INTERPRETERS (OPI)

Please review prior to initiating the conference call.

How to assist with meeting your limited English-speaking patient or customer needs when language is a barrier to communication:

Before I Call:

- Know the language that is needed.
- Be prepared to brief the interpreter about the nature of the call before he/she speaks to your limited English speaker.

How Do I Make a Call to OPI:

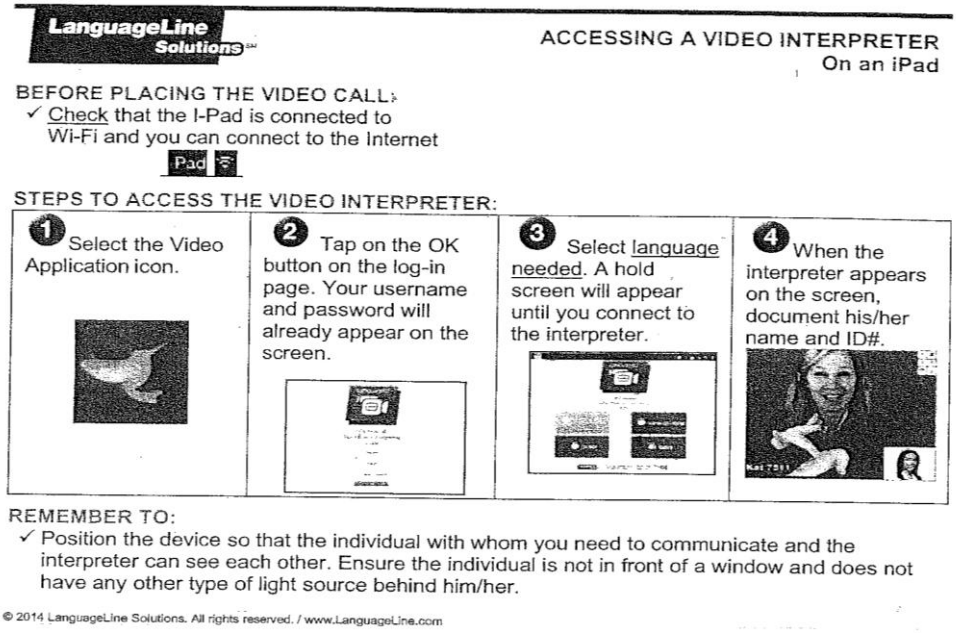
- Dial 1-877-746-4674, you will be asked:
  - What language you need.
  - Where you are calling from: Kootenai Health.
  - What department are you calling from?

During the Call:

- Speak in short phrases or sentences.
- Avoid slang, jargon, and technical terms.
- Check for understanding from your limited English speaker throughout the call. If needed, rephrase the questions or statements until understood.
- When speaking to the interpreter, do not give and/or ask too much information at one time. Although the interpreter will not have difficulty translating the information, your limited English speaker may have difficulty understanding all at once.
- Ask questions in the first person. Avoid asking questions to the interpreter such as “Can you find out when he arrived?” Instead, ask the interpreter to ask the limited English speaker, “When did you arrive?”
- Make sure to pause to allow the interpreter time to translate and the limited English speaker time to respond.

Ending the Call:

Before ending the conversation, ensure that both your limited English speaker and the interpreter knows that the session is about to end.



OPTIMAL
phone interpreters

Languages Available

Acholi	Farsi (Persian)	Latvian	Sesotho
Afrikaans	Fijian	Liberian	Shanghaiese
Akan	Filipino	Lithuanian	Shona
Arabic	Finnish	Lkale	Sicilian
Amharic	Flemish	Llahe	Sindhi
Albanian	French	Llocano	Sinhalese
Apoi	Fukienese	Macedonian	Slovak
Armenian	Fuzhou	Madura	Slovenian
Assamese	Fulani	Makua	Somali
Ashanti	Gaelic	Malay	Soninke
Assyrian	Galician	Malagasy	Spanish
Azerbaijani / Azeri	Gbandi	Malayalam	Sranang
Bahasa	Georgian	Maltese	Sudanese
Balinese	German	Mam	Swahili
Bambara	Ga	Mandarin	Swedish
Bassa	Gikuyu	Mandinka	Szechuan
Batak	Guarani	Marathi	Tagalog
Belarusian	Gujarathi	Marshallese	Taiwanese
Bengali	Greek	Mende	Tamil
Berber	Hainanese	Mien	Tanga
Balochi	Haitian Creole	Minangkabau	Telugu
Basque	Hausa	Mixteco	Thai
Bhili	Hebrew	Moldovian	Tibetan
Bicol	Hiligaynon	Mongolian	Tigre
Boholano	Hindi	Moore	Tigrinyan
Borana	Hmong	Nahuatl	Toisanese
Bosnian	Hungarian	Navajo	Tongan
Bulgarian	Ilocano	Nepali	Turkish
Burmese	Ilonggo	Nigerian	Turkmen
Cachi	Indonesian	Nuer	Tshiluba
Cambodian	Ibo	Norwegian	Tsonga
Canjobal	Igbo	Oriya	Tswana
Cantonese	Italian	Oromo	Ukranian
Cape Verde Creole	Japanese	Pampango	Umbundu
Catalan	Javanese	Pangasinan	Urdu
Cebuano	Kannada	Papiamento	Uyghur
Chaozhou	Kanuri	Pashto	Uzbek
Chavacano	Kashmiri	Persian	Vietnamese
Cherokee	Kazakh	Polish	Visayan
Chichewa	Khmer	Portuguese	Waray
Chuukese	Khmu	Punjabi	Welsh
Creole	Kinyarwanda	Quiche	Wolof
Croatian	Kirundi	Quechua	Xhosa
Czechoslovakian	Kongo	Romani	Yoruba
Danish	Korean	Romanian	Yiddish
Dari	Krahn	Russian	Yoruba
Dinka	Kurdish	Samoan	Yi
Dutch	Kyrgyz	Santali	Yugoslavian
Estonian	Lao / Laotian	Serahule	Zapoteco
Ethiopian	Lakota	Serbian	Zhuang
Ewe	Latin	Serbo-Croatian	Zulu

1-877-746-4674 (RING-OPI)

KootenaiHealth

GUIDELINE

Title: Restraint and Seclusion

Approver: Jon Scallan, Regulatory Compliance Manager Date: 09/04/2014

Keywords: restraints, seclusion, behavioral restraints, medical restraints, violent and self-destructive restraint, non-violent and self-destructive restraint, violent restraint, physical hold, chemical restraint, combative patient

Introduction:

At Kootenai Health all patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be used to ensure the immediate physical safety of the patient, staff members, or others. Restraint or seclusion will be considered as a last-resort intervention following documented attempts to use less restrictive alternatives. Restraint or seclusion will be discontinued at the earliest possible time.

Purpose:

To communicate Kootenai Health's policy on the appropriate use of restraint and seclusion within all patient care areas.

Table of Contents:

See Also: Treatment of Restrained Patients in Procedural Areas

I. Definitions:

Non-violent/ self- destructive restraint (Medical) - A restraint applied in order to directly support a patient's medical healing.

Violent/ self- destructive restraint (Behavioral) - a restraint applied due to a patient's actions constituting a danger to self or others.

Restraint-

1) *Physical*- Any manual method, physical, or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely.
2) *Chemical*- A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition. Thereby, drugs that are part of a patient's therapeutic plan of care, although they have mood or behavior altering effects (including as needed (PRNs) will not be considered restraints. The same drug given to another patient solely to control behavior and with no long-term therapeutic expectations would be considered a restraint.
3) *Not Included*- A restraint does not include (see Table 1):
    - Methods of holding a patient for the purpose of conducting a physical exam or test
    - Protecting the patient from falling out of bed (patient must be able to lower side rails),
    - Narrow carts and their use of side rails is not a restraint,
    - Adaptive Support/Protective Devices intended to permit a patient to achieve maximum normative bodily functioning, including orthopedic appliances, brace, wheelchairs, or other devices used for postural support. This could include tabletop chairs or helmets. The top two (2) side rails on patient's bed may be utilized by the patient to assist with repositioning and enhance access to bed controls.

Physical Escort - Physical escort includes a light grasp to escort the patient to a desired location. If the patient can easily remove or escape the grasp, this would not be considered a physical restraint. *If the patient cannot easily remove or escape the grasp, this would be considered physical restraint.*

Physical Hold – Physical holding of a patient for the purpose of conducting routine physical examinations or tests is permitted. However, patients have the right to refuse treatment. *Holding a patient that restricts the patient's movement against the patient's will is considered a restraint.* This includes "therapeutic holds." Physically holding a patient during a forced psychotropic medication procedure is considered a restraint.

Seclusion - Seclusion is involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving.

- Seclusion may only be used for the management of violent or self-destructive behavior.
- Confinement on a locked unit where the patient is with others does not constitute seclusion.
- If a patient willingly remains in a room, even when on a police hold or physician hold, it does not constitute seclusion.
- Simultaneous restraint and seclusion use is only permitted if the patient is continually monitored.

Voluntary Restraint- It is not authorized to place a patient in restraints if they, or a family member, voluntarily requests a restraint. A patient may only be placed in restraints if alternative options have been evaluated as insufficient and restraint use is evaluated by nursing staff and the attending physician as being necessary.

II. Policy Exclusions:

Contraindications - Contraindications to the use of restraints may include any medical condition that could be exacerbated by its use, i.e., broken or burned extremities or claustrophobia. The benefits as compared to the risks must be evaluated.

Forensic (law enforcement purposes)* - Direct application by law enforcement agents. Medical record documentation should reflect that the restraint was applied by forensic staff.

Shackled Inmates - All prisoners from the jail are shackled (ankle to wrist) prior to being transported to the hospital. When in bed, one (1) extremity may be shackled to the bed. During the time the patient is hospitalized, the extremities are shackled and observed for injury. A guard must be furnished by the law enforcement agency.

***Note:** The use of handcuffs, manacles, shackles, other chain-type restraint devices, or other restrictive devices applied by law enforcement officials for custody, detention, and public safety reasons are considered law enforcement restraints. The use of such devices would not be considered safe, appropriate health care restraint interventions for use by hospital staff to restrain patients. The law enforcement officers who maintain custody and direct supervision of their prisoner (the hospitals patient) are responsible for the use, application, and monitoring of these restrictive devices in accordance with Federal and State law. However, the hospital is still responsible for an appropriate patient assessment and the provision of safe, appropriate care to its patient (the law enforcement officer's prisoner).*

III. Prevention of Restraints:

In the event a patient is pre-identified as a behavioral or medical risk that may warrant an escalation to restraint or seclusion, alternatives or less restrictive interventions will be evaluated, attempted if possible, and clearly documented. These include, but are not limited to, the following:

Companionship or Supervision:

- Education/ explanation to the patient
- Intentional rounding on the patient
- Sit with patient (staff or family)
- Position near nurses' station
- Utilize safe room/area

Diversion & Physical Activities:

- Use music, movies, television
- Allow pacing
- Exercise when appropriate
- Reading
- Simple games
- Other alternative coping (journaling, drawing, etc.)

Reality Orientation and Psychosocial Interventions:

- Involve patient in conversation (don't talk over them!)
- Ask them what would help
- Convey a sense of calm to help reduce fears
- Relaxation techniques
- Use clear simple language
- Give the individual time to think
- *Give them space*

IV. Restraint Application:

A. All patients receive a comprehensive assessment to identify medical reasons that could be causing behavioral changes. The assessment will be documented in the medical record. The comprehensive assessment is the clinical justification for the restraint or seclusion and must include:

1. Physical assessment to identify medical problems that may be causing behavior changes.
2. Neurological and cognitive status.
3. Evaluation of appropriate alternatives.
4. Evaluation of medical equipment and tubes for managing medical condition.
5. Circumstances under which the restraint can be discontinued.

B. When less restrictive alternatives to restraint have been unsuccessful, restraint use may be initiated. The staff present for the event will make the determination whether restraint or seclusion is administered to facilitate medical healing (non-violent) or to manage assaultive/ self-harming behavior (violent).

C. In determining whether a restraint is violent vs. non-violent the patient's current behaviors must be the determining factor and not the diagnosis. For example, in the case of a dementia patient that is striking out at staff members and no other medical intervention is being attempted, the patient's diagnosis is not the determining factor for classification of restraint type. It is a medical diagnosis, but a violent behavior, that is prompting the restraint.

D. Patient restrained in a mechanical restraint, **will not** be restrained in a prone (face down) position

E. The Registered Nurse immediately notifies a physician or LIP (licensed Independent Practitioner) for an order. To ensure immediate physical safety, in the absence of a physician, or LIP, a staff member who has completed KH's applicable Restraint and Seclusion Competencies may initiate restraints or seclusion. But a physician's order must be obtained ASAP (within minutes) following application of a restraint.

F. The attending physician does the following **either in person or by phone**:

1. Review with staff the physical and psychological status of the patient.
2. Determines whether restraint or seclusion should be continued.
3. Supplies an order that:
   a. Outlines reason for restraint.
   b. Measurable criteria for release from restraint.

G. A development, or acceleration, of new symptoms that may represent a physiological change in the condition of the patient is considered a significant change. A significant change requires that the Registered Nurse immediately notifies the physician or Licensed Independent Practitioner.

H. Restraints must be discontinued at the earliest possible time, regardless of the time identified in the order. If the restraint or seclusion is discontinued and the behavior re-occurs, a new order must be obtained prior to, or shortly following, re-application of restraints. **Trial releases are not allowed. PRN orders are not allowed.**

I. If the restraint is discontinued to utilize a different restraint, a new order is required for the new restraint, even if less restrictive.

V. Notifications:

A. As soon as possible (within minutes) after the initiation of seclusion or restraint, in the absence of a physician order, the RN must notify the attending physician of the use of restraint or seclusion and obtain a written or verbal order.

B. If the MD did not conduct the evaluation they must be notified of the results of the Initial **RN/MD evaluation** within 1 hour of initiation of restraint. Prior to the expiration of the restraint/seclusion, the RN or LIP/MD must repeat this assessment, and report the findings to the attending physician and obtain a new order if necessary.

C. The Hospital Supervisor must be notified for every initiation, change, or discontinuation of restraint/seclusion (includes chemical restraint).

D. The Hospital Supervisor must be notified by end of shift for holds/escorts which meet restraint criteria.

E. In cases in which the patient has consented to having the family informed about his or her care, treatment or services and the family has agreed to be notified, or if patient is a minor, staff will make earnest attempts to notify family/custodian/legal guardian promptly of the restraint or seclusion episode by the end of the shift.

F. Prolonged Use**-** In the event that a non-violent restraint is applied for greater than a 24 hour period or a violent restraint is applied for greater than a 12 hour period the hospital supervisor and unit manager will be verbally notified. A documented review of the case will take place.

VI. RN/MD Evaluation Requirements for Violent Restraints

An RN must perform an **in person** evaluation within **one hour** of a violent restraint or seclusion on all patients. The evaluation must include:

- The patient's immediate situation
- The patient's reaction to the intervention
- The patient's medical and behavioral condition to include vital signs, O2 sats, medical history, current mental status
- The need to continue or terminate the restraint or seclusion.

This information must be conveyed to the attending physician **as soon as possible** after the evaluation (document on assessment form).

VII. Patient Evaluation by Attending Physician:

1. The attending physician must evaluate the patient **in person** within **24 hours** of the initiation of restraint or seclusion, even if the patient has been released from restraint or seclusion.

2. At the time of the in- person evaluation the attending physician does the following:
   a. Works with the patient and staff to identify ways to help the client regain control/meet criteria for restraint release.
   b. Revises the patient's plan for care, treatment, and services as needed.
   c. If necessary, a physician provides a new written order.

VIII. Physician Order Requirements:

A. *Nonviolent*- Restraint orders must be renewed daily.

B. *Violent*- The attending physician does the following **either in person or by phone**:
   a. Review with staff the physical and psychological status of the patient.
   b. Determines whether restraint or seclusion should be continued.
   c. Supplies staff with guidance in identifying ways to help the patient regain control so that restraint or seclusion can be discontinued.
   d. Supplies an order that outlines:
      1) Reason for restraint.
      2) Time limit for restraint
         a) 4 hours for patients ages 18 and older
         b) 2 hours for children and youth ages 9 to 17
         c) 1 hour for children under age 9
         (*Time limited orders do not mean that the restraint or seclusion must be applied for the entire length of time for which the order is written.*)
      3) Measurable behavioral criteria for release from restraint.

C. *Violent*- When the original order is about to expire, An RN must complete another **RN evaluation** of the patient, contact the physician, report the results of the assessment, and request that the original order be renewed. Symptoms must be documented that necessitate the continued use of restraint or seclusion. Criteria for release should be re-evaluated at this time.

D. *Violent*- Whether or not an onsite MD assessment is necessary prior to renewing the order is left to the discretion of the attending physician or other LIP in conjunction with a discussion with the RN who is over-seeing the care of the patient. Another 1 hour face-to- face patient evaluation, by the RN, is not required when the original order is renewed.

IX. Monitoring and Reassessment:

A. Observation

1. **Violent (Behavioral):** Continuous in-person observation by a staff member who has had applicable training. Monitoring will include: level of distress/discomfort and agitation, nutrition, hydration, and elimination needs, readiness for discontinuation of restraint or seclusion.

2. **Non-Violent (Medical):** Direct observation must be performed at **a minimum of every one-hour**. Direct observation of patients each hour is a minimal care standard. The frequency of monitoring will vary according to the type and design of the device or intervention as well as the emotional, psychological and physical condition, needs, and symptoms of the patient.

3. **Chemical Restraint:** Patients that have received a chemical restraint do not require continuous in person monitoring.

B. Assessment

1. **Violent (Behavioral):**
   - **RN/MD evaluation** within one hour after initiation of restraint (including physical and chemical) or seclusion. Prior to the renewal of the restraint /seclusion, the RN or LIP/MD must repeat this assessment, and report the findings to the attending physician and obtain a new order.
   - For **Restraint--** at a minimum of once every fifteen (15) minutes and documented by a qualified staff member
   - For **Seclusion—**at a minimum of once every sixty (60) minutes, but based on acuity, and documented by a qualified staff member.

2. **Non-Violent (Medical):** Assessment will occur every 2 hours at a minimum. The assessment will include, positioning, range of motion, and CMS of involved extremities. This is to be documented by a qualified staff member.

Behavioral and Medical restraint or seclusion assessments will contain the following elements:

- Signs of any injury associated with applying restraint or seclusion.
- Circulation and sensation to restrained extremities.
- Nutrition and hydration needs.
- Hygiene, elimination, and general care needs.
- Physical and psychological/mental status and comfort.
- Readiness for discontinuation of restraint or seclusion.
- Educate patient of behaviors that need to be met for restraint or seclusion, to be discontinued and rationale.
- Assess the patient's response to the seclusion or restraint. For example, does the patient exhibit the ability to discuss a plan for safety? Is the patient oriented to the environment? Is there a cessation of verbal threats?
- Readiness for discontinuation of restraint or seclusion
- Skin integrity and range of motion in the extremities every two hours for patients in mechanical restraints.

C. Vital Signs and Oxygen Saturation

1. **Violent (Behavioral):**
   - Taken every 15 minutes unless clinically contra-indicated, such as intervention would further escalate the patient or cause harm to the patient and/or staff. In such cases, staff will document their rationale.
   - For patients in seclusion, Vital signs and Oxygen Saturation will be completed upon release.

2. **Non-Violent (Medical):** Taken as per physician order or documentation as to why staff was unable to obtain.

3. **Chemical restraint:**
   - VS and O2 saturation monitoring must be completed at 15 minutes, 30 minutes, 60 minutes, 90 minutes, and 120 minutes.
   - Thereafter, VS frequency will be according to department specific policy.
   - Documentation must be completed, along with VS and O2 saturation, at the following intervals: 15 minutes, 30 minutes, 60 minutes, 90 minutes, and 120 minutes.

X. Discontinuation of Restraint or Seclusion:

A. Restraint must be discontinued at the earliest possible time, regardless of the time identified in the order. **A trial release is not permitted.** An RN shall assess for appropriateness of release on an ongoing basis. Release is directed by the RN based on assessment of one (1) or more of the following but not limited to:
   1. Improved mental status
   2. Patient agrees to comply with safe behavior

B. Temporary release is permitted for the following but not limited to:
   1. Toileting
   2. Range of Motion
   3. Positioning
   4. Hydration/Feeding
   5. Assisted ambulation

C. An RN shall assess and document the presence or absence of physical complaints at time of release.

XI. Documentation Requirements:

The clinical record contains the following documentation:

- Written or verbal orders: for use of intervention and continued use, including the rationale for the type of intervention used, and behavioral criteria for discontinuing the intervention.
- Documentation of alternatives: or other less-restrictive interventions attempted/considered and patient's response. If no alternatives were considered documentation must be present to justify why alternatives were not appropriate.
- The patient's behaviors/ symptom(s): that warranted the use of the restraint or seclusion that led to restraint or seclusion.
- The intervention used: and rationale for each episode of restraint or seclusion.
- The time of initiation: and time of release for all restraint /seclusion episodes.
- The initial face-to-face evaluation: (within one hour of initiation) if restraint or seclusion is used to manage violent or self-destructive behavior, and each in person evaluation or reevaluation of the patient by RN or MD/ LIP prior to renewal of order.
- The patient's response: to the intervention(s) used, including the rationale for continued use of the intervention.
- Ongoing monitoring: and assessment of the patient's status. This will documented in the medical record every 15 minutes for violent restraints/ every two hours for nonviolent restraints/ every hour for seclusions/ and at 15-30-60-90-120 minutes following administration of a chemical restraint.
- Vital Signs and oxygen saturation
- Evidence of actions to Inform/educate: and assist the client to meet the behavioral criteria for discontinuing restraint or seclusion.

- Significant changes: in patient's condition
- Any injuries: and treatment for the injuries.
- RN assessment: of patient condition on release.
- Event Notification: of the patient's family, as appropriate.
- Plan of Care: note any modification to the treatment plan as a result of the seclusion or restraint.

XII. Staff Competence and Training:

All direct care nursing staff receive training before working with a patient who is in restraint or seclusion. Training occurs during the orientation period and on an ongoing basis thereafter.

A. Physicians and other LIP's that order restraints or seclusions will be educated about Kootenai Health's restraint and seclusion policy.

B. All nursing staff as appropriate for their role will have ongoing education and training in the proper and safe use of restraints and will have completed Kootenai Health's Restraint Competency before initiating restraints, or performing assessments on a restrained person.

C. Only staff members who have completed the education and training may initiate and monitor patients in restraints.

D. Evidence of competencies will be kept in staff members working file.

E. Training consists of, but is not limited to:

- Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint
- The use of non-physical intervention skills
- Choosing the least restrictive intervention
- Safe application of restraints used in the hospital, including training in how to recognize how to respond to signs of physical and psychological distress
- Clinical identification that restraint is no longer necessary
- Monitoring the physical and psychological well-being of the patient who is restrained, including, but not limited to respiratory and circulatory status, skin integrity, vital signs
- The use of first aid techniques and certification in the use of CPR

XIII. Performance Improvement Activities Governing Restraint and Seclusion:

The use of restraints and seclusion will be routinely examined as part of on-going performance improvement efforts. Data is collected and analyzed to assure adherence to this policy and in order to reduce restraints and seclusions.

Data on all restraints and seclusions will be collected from and classified for all units by the following:

- Shift
- Setting or Department
- Staff who initiated the process
- Length of each episode
- Date and time each episode was initiated
- Date and time of order
- Day of the week each episode was initiated

- The type of restraint used
- Whether injuries were sustained to the patient or staff
- Age of the patient
- Gender of the patient

XIV. Death Reporting Requirements:

A. Kootenai Health must report the following information to CMS:
   1. Each death that occurs while a patient is in restraint or seclusion.
   2. Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.
   3. Each death known to the hospital that occurs within one week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing, or asphyxiation.

B. Each death referenced in this paragraph must be reported to CMS by telephone no later than the close of business the next business day following knowledge of the patient's death, with the following exception:

C. ***Patient death involving the use of soft cloth-like wrist restraints and no seclusions while a patient is in the restraints or within 24 hours of being removed from such restraints must be reported within 7 days in an internal log or other system made available to CMS immediately upon request.***

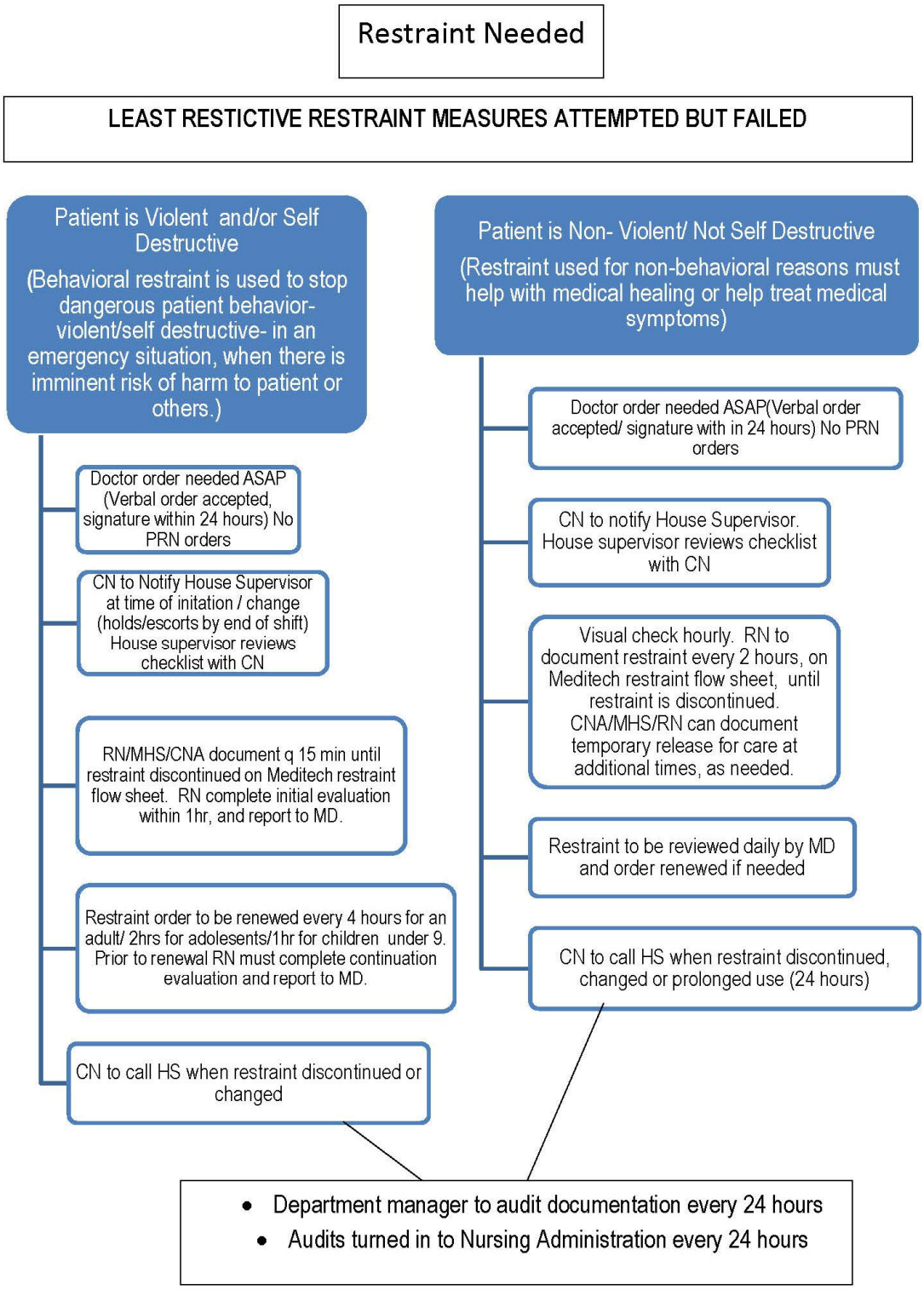
D. Staff must complete an RM notification and notify the Hospital Supervisor or the manager or director.

E. Documentation will include the date and time the death was reported to CMS.

Types of Restraints Used at Kootenai:

Device	Restraint	Not A Restraint
Arm restraints, leather wrist cuffs, soft wrist restraints, ankle restraints, restraint board	Yes	If used in postanesthesia care/ procedural area but becomes a restraint if maintained after transfer to another unit
Geri Chair/ Recliner	only if patient cannot easily remove the restraint appliance and get out of the chair on his or her own	
Hand mitts	- If pinned or attached to bedding or using in conjunction with wrist restraints - If applied so tightly that patient's hands or fingers are immobilized - If they are so bulky as to significantly reduce the use of the patient's hands - If applied to both hands	If patient has one functional hand not in a mitt.
IV arm board	If arm is tied down and the board itself is attached to a device preventing patient access to the arm	
Orthopedically prescribed devices, surgical dressings, bandages, protective helmets	No	
Net bed/ enclosed bed	Yes	If used for a toddler in a crib
Side rails	- If used to restrict a patient's freedom to exit the bed. - If all four side rails are raised and patient cannot lower them.	- When used as a prudent safety measure, it is not a restraint. Such as a patient that is on a ventilator and sedated. - If a patient is not able to physically get out of bed regardless of the position of the side rails it does not impact the patient's freedom of movement and would not be a restraint even with all four side-rails up. Such as a patient that is comatose. - When used as a safety precaution on a bed that constantly moves it is not a restraint. - When four side rails are raised due to seizure precautions it is not a restraint.
Tucked sheets	If tucked in a manner that immobilizes patient.	
Lap Belts/Bed Belts	If used to restrain a patient to the bed.	If used as a safety precaution to prevent a fall and if patient can remove the belt themselves.

Restraint Algorithm:



KootenaiHealth

POLICY

Title: Clinical Communication Using ISBARD

Approver: Jan Moseley, Director of Nursing System/Innovation/Operations Date: 06/09/11

Keywords: communications, isbard, hand off communications, patient hand off, clinical communication using isbard

Purpose:

To improve the effectiveness of communications among caregivers by defining the structure on how, when and what information is exchanged during a patient hand-off using a standardized format called ISBARD.

Definitions:

Hand-off: The exchange of verbal or written information between healthcare providers in order to accurately communicate a patient's pertinent care, treatment, and service needs as well as the patient's current condition and any recent or anticipated changes. This exchange of patient information provides an opportunity for questions and answers to be exchanged between the giver and receiver of information.

ISBARD:

Introduction: *Of self by name and role in the patient's care & patient's name (Asking if the person receiving the information/report knows the patient is helpful in determining the appropriate amount of information to convey).*

Situation: What are your concerns, patient's needs/problem? How **urgent** is the situation?

Background: *Significant medical history, briefly explain the current objective data (VS, lab results, 02 sat., medications etc.).*

Assessment: *Summary of patient's condition or assessment of the situation.*

Recommendations/Request/Read Back Verbal/Telephone Order: *What is recommended by the current caregiver or verifies the plan of care/order?*

Document: *Document what has transpired: Physician's Contact screen; Transfer screen; Patient Notes.*

Special Instructions:

Clinical patient communication using ISBARD is expected of all licensed and unlicensed direct health care providers caring for patients at Kootenai Health (Kootenai Medical Center, Kootenai Cancer Center, Kootenai Behavioral Health, Kootenai Heart Center, etc.).

The ISBARD format shall be used during patient clinical communication including but not limited to the following situations:

- Shift changes.
- Patient report at the time of transfer to a different unit .
- Temporary transfer of patient care responsibility from one care provider to another
- RN to Physician .
- Nursing and physician patient hand-off reports for patient being transferred to other facilities.
- Physicians transferring complete responsibility for a patient.
- Physicians/LIP's transferring on-call responsibility.
- Anesthesiology report to post-anesthesia nurse.

Protocol:

- ISBARD format will be used in all patient hand-offs.
- The pertinent information contained in each element of ISBARD may vary depending on the purpose and circumstances of the patient hand-off.
- Interruptions during patient hand-offs should be limited to minimize the possibility of forgetting or misinterpreting information..
- A read-back process will be used to verify the appropriate information. (i.e. Critical values, orders, etc.)

References:

1. Hartford Hospital Policy Manual; *"Hand-Off Communication Guideline for Using ISBAR*" document 30809, Sept 2006; Hartford Hospital: The Institute of Living Hartford, CN

2. Joint Commission on Accreditation of Healthcare Organizations; *2006 Critical Access and Hospital National Patient Safety Goals*; National Patient Safety Goal 2E, Jan 24, 2006.

3. Arizona Hospital and Healthcare Assoc.*; "SBAR Communication Standardization in AZ: Implementation Toolkit"*; April 2007