
Fall Prevention for Patients
The following are basic actions that should be done for every patient to assist in identifying and preventing falls:
Click each box to learn more
Fall Risk Assessment
Medications
Educate Patient and Family
Rounding
Identify
Interventions
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Fall Prevention for Patients
Fall Risk Assessment
• Appropriate fall risk assessment should be chosen based on care area. Please see NMH Fall Prevention Policy and Procedure.
• Conduct a fall risk assessment upon arrival, during admission, once every shift and with any change in condition.
• Nurses may implement fall prevention interventions for any patient, including those who are not considered at high risk of falling.
• If a patient has fallen during hospitalization, they are considered at high risk for falls for the remainder of their hospitalization. A history of falls is considered a risk factor for future falls.
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Fall Prevention for Patients
Medications
• Assess patient's medication to determine risk for dizziness, lightheadedness, or postural hypotension.
• Consult pharmacy if you have any concerns.
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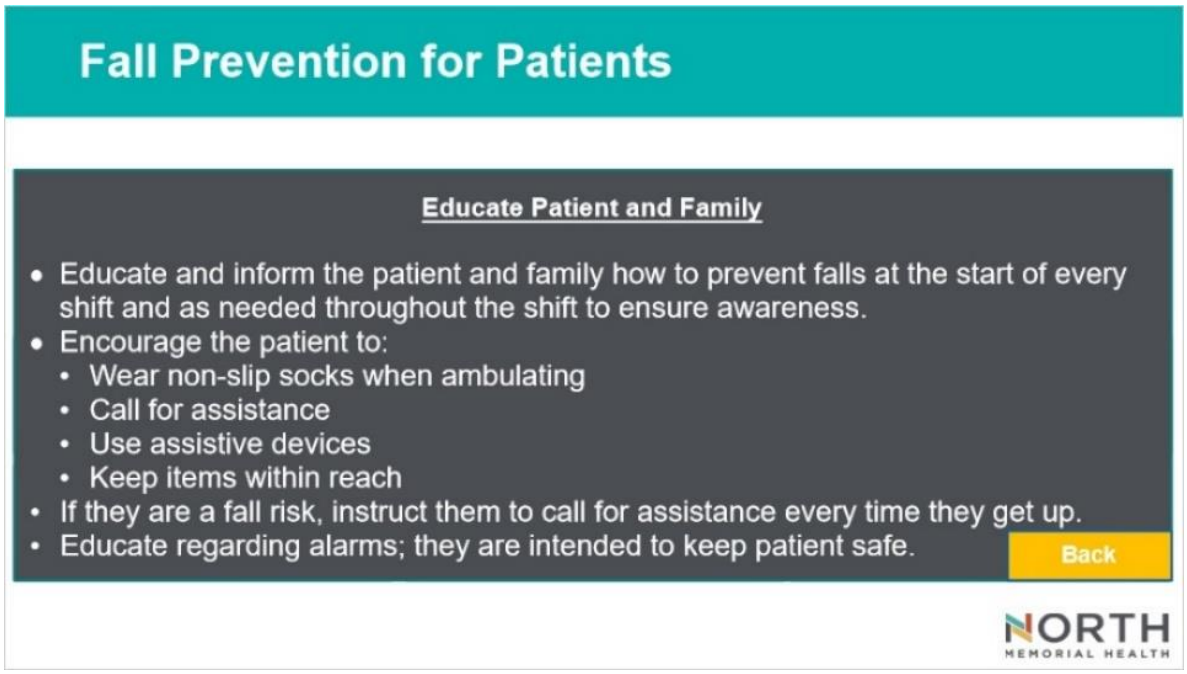
Fall Prevention for Patients
Educate Patient and Family
• Educate and inform the patient and family how to prevent falls at the start of every shift and as needed throughout the shift to ensure awareness.
• Encourage the patient to:
• Wear non-slip socks when ambulating
• Call for assistance
• Use assistive devices
• Keep items within reach
• If they are a fall risk, instruct them to call for assistance every time they get up.
• Educate regarding alarms; they are intended to keep patient safe.
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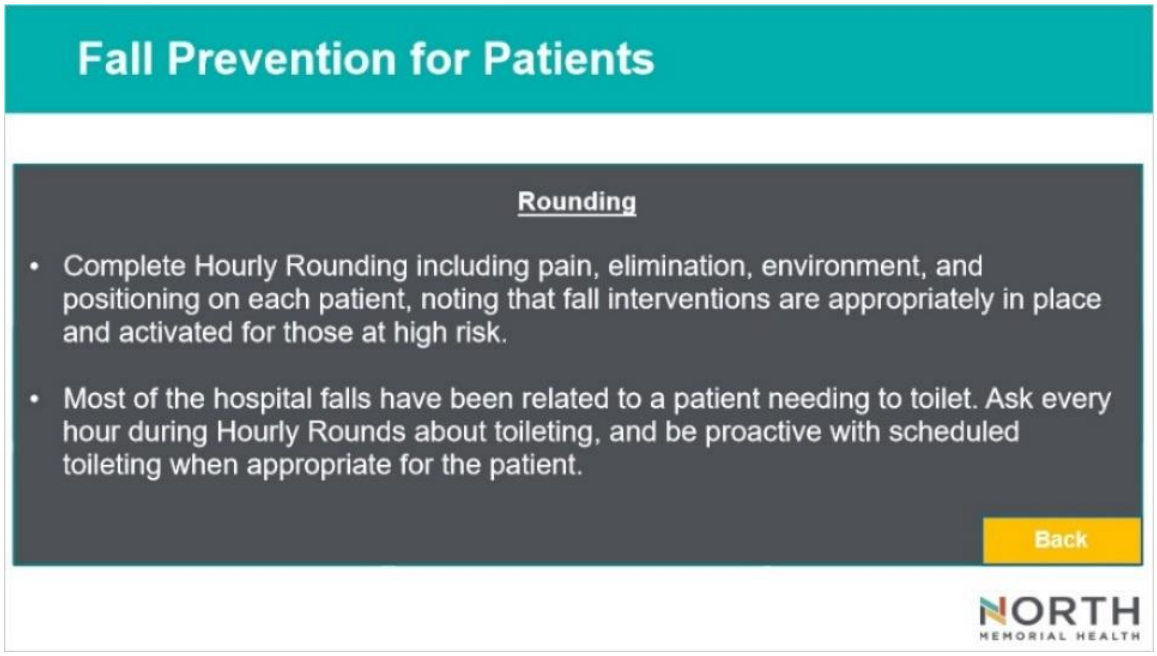
Fall Prevention for Patients
Rounding
• Complete Hourly Rounding including pain, elimination, environment, and positioning on each patient, noting that fall interventions are appropriately in place and activated for those at high risk.
• Most of the hospital falls have been related to a patient needing to toilet. Ask every hour during Hourly Rounds about toileting, and be proactive with scheduled toileting when appropriate for the patient.
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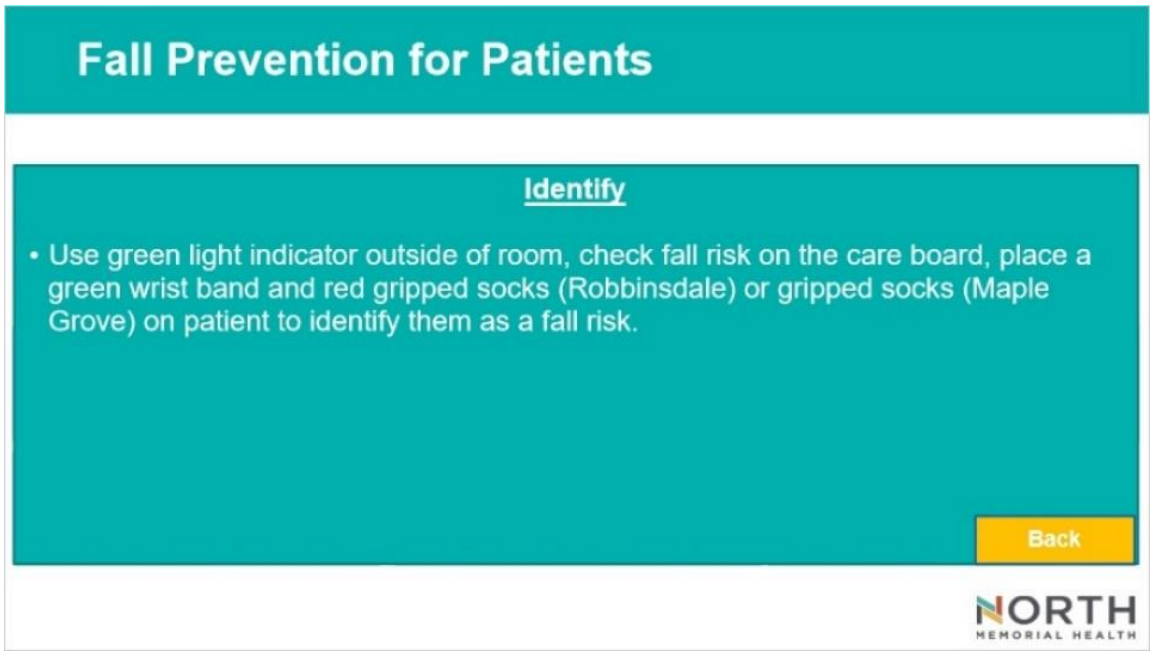
Fall Prevention for Patients
Identify
• Use green light indicator outside of room, check fall risk on the care board, place a green wrist band and red gripped socks (Robbinsdale) or gripped socks (Maple Grove) on patient to identify them as a fall risk.
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## Fall Prevention for Patients

**Interventions**

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

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## Pressure Injury Prevention

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

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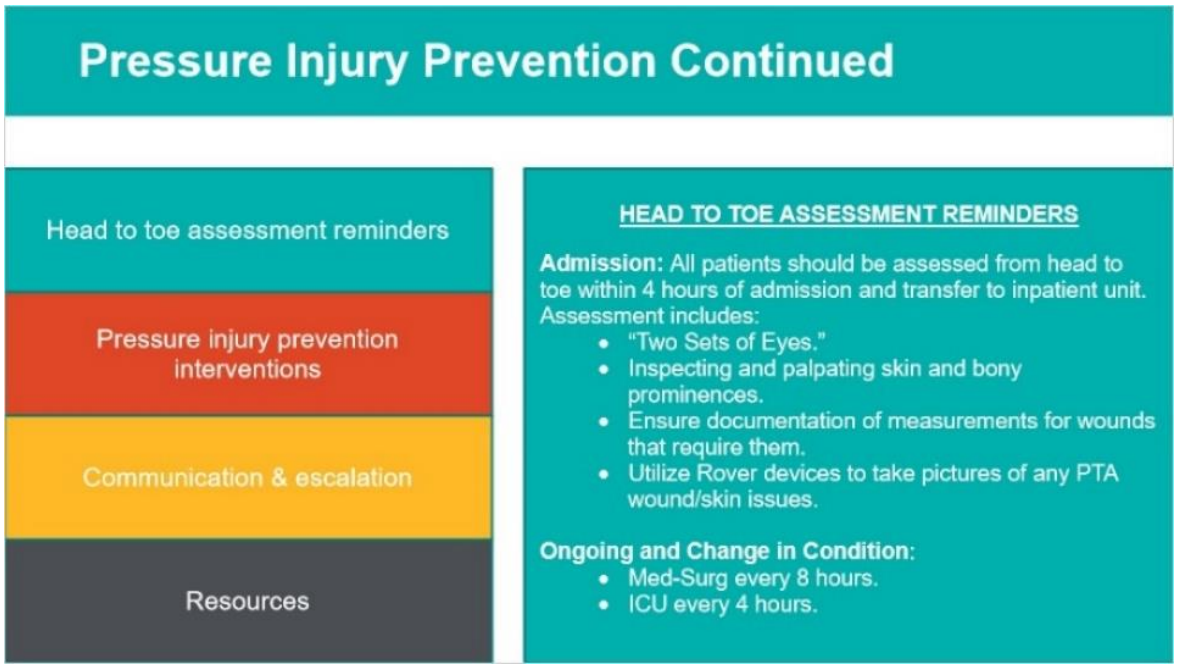
Pressure Injury Prevention Continued
Head to toe assessment reminders
Pressure injury prevention interventions
Communication & escalation
Resources
Click the buttons to the left for more information on each topic.


Pressure Injury Prevention Continued
Head to toe assessment reminders
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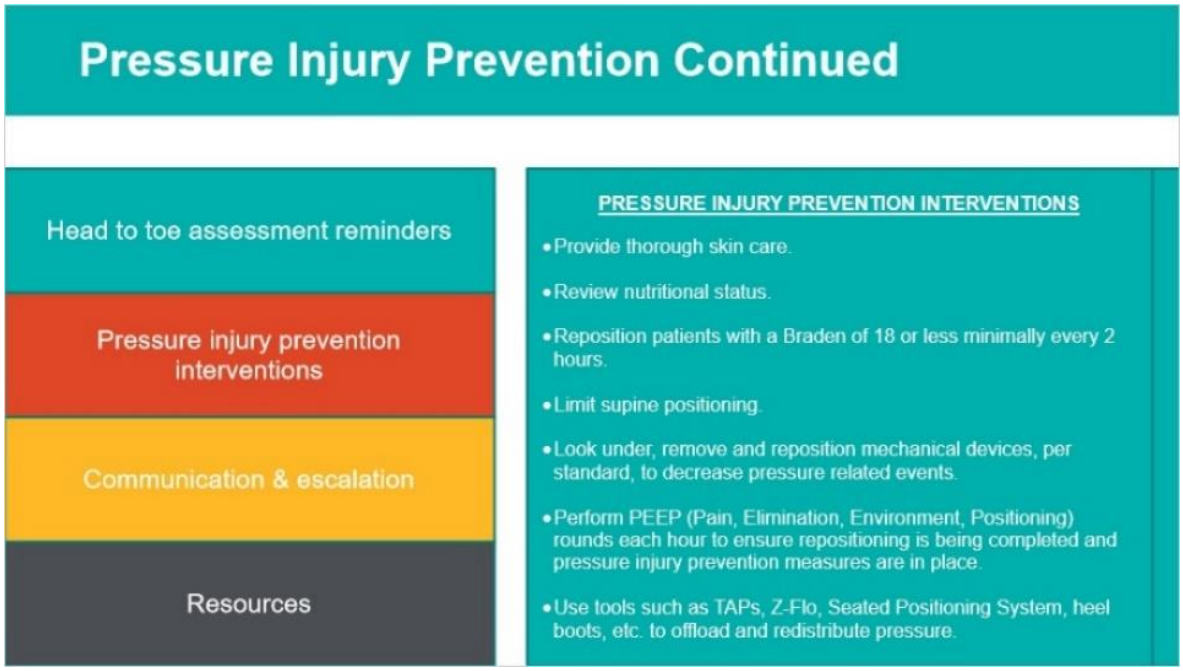
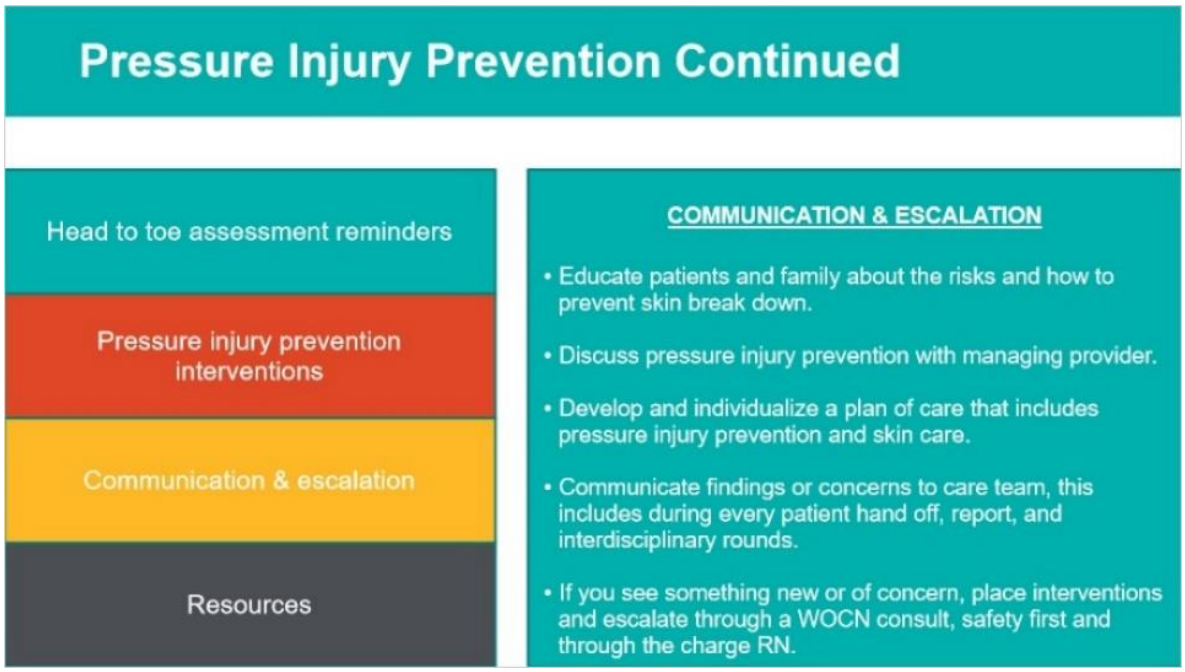
Resources
HEAD TO TOE ASSESSMENT REMINDERS
Admission: All patients should be assessed from head to toe within 4 hours of admission and transfer to inpatient unit.
Assessment includes:
• "Two Sets of Eyes."
• Inspecting and palpating skin and bony prominences.
• Ensure documentation of measurements for wounds that require them.
• Utilize Rover devices to take pictures of any PTA wound/skin issues.
Ongoing and Change in Condition:
• Med-Surg every 8 hours.
• ICU every 4 hours.


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


Pressure Injury Prevention Continued
Head to toe assessment reminders
Pressure injury prevention interventions
Communication & escalation
Resources
COMMUNICATION & ESCALATION
• Educate patients and family about the risks and how to prevent skin break down.
• Discuss pressure injury prevention with managing provider.
• Develop and individualize a plan of care that includes pressure injury prevention and skin care.
• Communicate findings or concerns to care team, this includes during every patient hand off, report, and interdisciplinary rounds.
• If you see something new or of concern, place interventions and escalate through a WOCN consult, safety first and through the charge RN.

## Pressure Injury Prevention Continued

Head to toe assessment reminders

Pressure injury prevention interventions

Communication & escalation

Resources

**RESOURCES**

- Utilize support tools in the electronic health record such as the Skin Accordion to synthesize information related to skin.
- See the Pressure Injury Prevention policy for specific standards and expectations.
- See the Skin care page to see tip sheets and tools available for all team members for pressure injury prevention.
- See Pressure Injury Prevention Refusal and Escalation Algorithm policy in C360.

## Lift Equipment Objectives

The learner will be able to:

- Identify lifting equipment that is available at Robbinsdale Hospital and Maple Grove Hospital.
- Review case studies regarding which piece of equipment to use.

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## We Know That Bedrest is Bad!

Prolonged immobility is correlated with:

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

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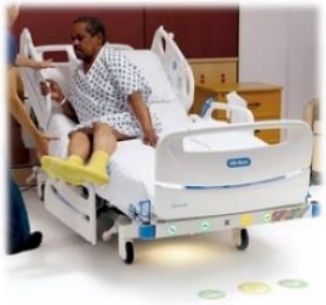
## Tips for Mobilizing Patients

Progressing mobility:

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



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

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## Equipment Available at NMHH and MGH

Stand Aid

EZ Stand

Mechanical Lift


Lateral Transfer Assist Device

Click on each piece of equipment to learn more.

**Who?**

- Patient must have the strength and stability to lift and support themselves, but who have difficulty walking

**How to Use:**

- Assist of 1. **(Recommended to use with assist of 2**: remember if patient loses consciousness, they will let go of equipment and fall).
- Prior to transfer, raise the two split seat units up.
- Position Stand Aid in front of patient and place feet onto the foot tray lining up shins/knees to the pads.
- **Lock both rear casters.**
- Have patient grab cross bar using their own strength to stand.
- Lower both split seat units behind patient, then patient can lower themselves down to seat.
- Unlock wheels, transfer patient to new surface. Align patient with new surface **and lock wheels**.
- Have patient pull up to standing position.
- Raise the two split seat units up.
- Stand by patient as they lower onto the new surface.
- Ensure patient is safely positioned, then unlock the casters.

Back

**Who?**

- Patients who can sit with supervision, follow commands well and are a heavy assist of two to transfer to a chair or commode. They also must be able to bear 50% of their weight.

**How to use:**

- **Requires 2 team members** (not family or visitors).
- Weight max is labeled on a sticker on the lift.
- Ensure you know the location of the emergency lever or button.
- Safety check should include assessing for holes/rips in sling and ensuring the battery is charged.
- Identify sling/belt size by looking at the tag on the sling.
- **Apply belt 2 inches above the waistline and tighten.**
- Lock wheels.
- Position **patient's feet onto foot tray**, positioning knees into knee pad and Velcro behind legs.
- Hook shortest loops of sling/belt onto the stand arm hooks.
- **Raise patient slightly and re-tighten belt if needed.**
- Transfer with one team member standing with patient and the other controlling the lift.
- When lowering, lock the wheels and guide the patient down to a proper position using the sling/belt.

Back

**Who?**

- Patients who can follow directions, non combative and are a heavy assist of 2 or more. This can be used to transfer from chair, bed or even the floor in certain cases.

**How to use:**

- **Requires 2 team members** (not family or visitors).
- Weight max is labeled on a sticker on the lift.
- Ensure you know the location of the **emergency lever or button.**
- Safety check should include assessing for holes/rips in sling and ensuring the battery is charged.
- Identify sling size by looking at the tag on the sling.
- Apply sling:
  - Hook shorter loops by patient's shoulders and longer loops by patient's legs.
  - The **color of hoops should match at each level**.
  - Criss cross the leg loops and loop into each other.
- **Lock the wheels** when raising patient from the floor.
- One team members should stand with patient and other should be using remote and controlling the lift.
- Transfer patient to appropriate position and ensure patient safety prior to removing sling.

Back

**Who?**

- To be used to transfer any patient from a flat surface to another flat surface, uses appropriate ergonomics for staff and is most comfortable for patients.

**How to use:**

- **Requires assist of 4 team members.**
- 1200 pound weight limit.
- **Lock wheels of bed and stretcher** prior to use.
- Center patient on transfer device prior to inflation.
- Attach safety buckles loosely around patient to **ensure patient is in the center of the transfer device.**
- Attach hose of transfer device to the mat and then power on an inflate mat.
- After transfer, ensure transfer device is centered on desired location before deflating.
- Lateral transfer assist device is not designed to stay underneath patient and is **not skin friendly**. Remove transfer device as soon as patient is back into their bed.


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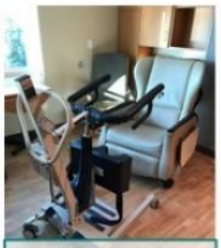
## Scenario #1

Susan is a 75 year old woman who presents after a fall resulting in a hip fracture. Patient underwent surgery and is now weight bearing as tolerated to her left leg. You were able to assist the patient into a standing position, though once standing she is having trouble with pivoting to the recliner chair. ***What piece of equipment could you utilize to assist in this transfer?***

Stand Aid



EZ Stand

Mechanical Lift


Lateral Transfer Assist Device

## Scenario #1

Correct, it's a Stand aid.

Susan is able to stand and bear weight but is having difficulty pivoting. The stand aid is great for patients who can stand and have the strength to hold themselves up.

## Scenario #2

Ray is a 60 year old male who presented to the hospital initially with a lower leg wound. After a prolonged hospital stay, he is now status post below the knee amputation. Overall, Ray is very deconditioned and weak. You attempt to help him sit up at edge of bed, though he has poor sitting balance and requires assist of 2+ people for safety. ***What piece of equipment could you use to assist Ray with getting into the wheelchair to come to his therapy appointment?***


Stand Aid


EZ Stand


Mechanical Lift

Lateral Transfer Assist Device

## Scenario #2

Correct, the safest way to transfer Ray would be to use the Mechanical lift (also known as a Hoyer or Floor lift).

## Scenario #3

Esther is a 75 year old female who presents with urinary tract infection and generalized weakness. During report, you were told Ester was a heavy assist of 3 to get up to the chair during day shift. She is now requesting to use the commode. She is not combative, can follow commands well and has no weight bearing restrictions. You were able to assist her into sitting at edge of bed where she is able to sit with supervision. ***How would you complete this transfer to the commode?***

Stand Aid

EZ Stand

Mechanical Lift

Lateral Transfer Assist Device

## Scenario #3

Correct, The EZ stand. Esther meets all the qualifications to be able to use the EZ stand.

**Who?**

- Patients who can sit with supervision, follow commands well and are a heavy assist of two to transfer to a chair or commode.

## Scenario #4

Bobby is a 42 year old who has been complaining of pain in his leg and his arm. He is going to get some x-rays and needs to be transferred from his bed to a stretcher. ***What is the safest, most comfortable way to transfer him to a stretcher?***


Stand Aid


EZ Stand


Mechanical Lift

Lateral Transfer Assist Device

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## Scenario #4


Correct, the lateral transfer assist device. This is the most comfortable way to transfer him.

## Critical Results and Communications

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

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## Critical Results and Communications

- Critical tests and critical results are reported and documented as a priority and are timely.
- Results must be communicated to or received by the responsible licensed caregiver (RN or MD) who may take action on behalf of the patient. CMA and LPNs cannot acknowledge or take action on critical results.
- Verification of patient identification and the reported critical value must always be confirmed with a "read back" of the information by the qualified recipient.
- Please see Critical Communications, Results and Findings policy for more information.

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## Surgical & Procedural Site Marking

- Surgical and procedural site marking occurs to ensure the correct procedure is completed on the correct patient and on the correct site.
- Patient site marking occurs before procedures, regardless of where the procedure will be performed, e.g. Operating Room (OR), Patient Care Center (PCC), Post Anesthesia Care Unit (PACU), Interventional Radiology (IR), or the patient's room.
- Verification occurs at multiple points in the care of the patient and requires coordination between the privileged provider performing the procedure, the patient or legal guardian, and all members of the surgical/procedural team.

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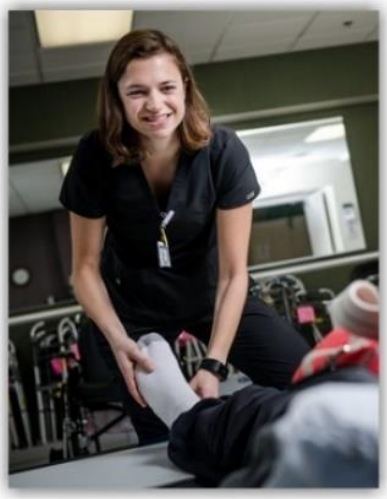
## Surgical & Procedural Site Marking



- The privileged provider performing the procedure marks the correct surgical or procedure site. With the patient awake and aware, if possible, the privileged provider will mark the procedure or operative site with their initials.
- The site will be marked with a permanent marker that will be visible when any draping or prepping of the site occurs.
- When unable to mark the site, this is documented on the Alternate Site Marking Tool.

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## Surgical & Procedural Site Marking

- For anesthesia procedures, such as regional blocks, the anesthesiologist will mark the site with an "A" and circle the "A".
- For procedures involving the spine and ribs, intra-procedure imaging with opaque instruments marking the specific bony landmarks will be taken and are compared with the pre-procedure imaging.
- Final verification is the comparison of pre- and intra-procedure imaging by the privileged provider performing the procedure.


Associated Policy: Time Out

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## Time Out

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

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## Time Out

All team members will stop their routine duties and focus their attention on the final verification of:

| | |
|---|---|
| Patient identity using two identifiers; | Informed consent form/source documents; |
| Correct operative or invasive procedure; | Correct procedure side or site (and level if appropriate); |
| Necessary imaging, equipment, implants, or other special requirements available, as appropriate; | Correct patient position; |
| Visualization of the marked site(s), if applicable; | Pre-procedural antibiotic administered, if appropriate |
| Medication and dosage on field | Allergies |

- Associated Policy: Time Out

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## Time Out

All team members will stop their routine duties and focus their attention on the final verification of:

| | |
|---|---|
| Patient identity using two identifiers; | Informed consent form/source documents; |
| Correct operative or invasive procedure; | Correct procedure side or site (and level if appropriate); |
| Necessary imaging, equipment, implants, or other special requirements available, as appropriate; | Correct patient position; |
| Visualization of the marked site(s), if applicable; | Pre-procedural antibiotic administered, if appropriate |
| Fire Risk Assessment is conducted for all procedures in the Operating Room and as applicable for procedures outside the Operating Room, e.g. Cardiac Catheterization Lab, Interventional Radiology, Emergency Department and at the bedside. The Fire Risk Assessment is completed by the Anesthesia Provider, when present. | |
| Medication and dosage on field | Allergies |

- Associated Policy: Time Out

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## Stop the Line

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

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

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


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## Stop the Line

**Examples of care situations of concern might be:**

- A patient is being prepared for a surgical procedure, when you notice missing elements on the informed consent and another team member is present to transport the patient to the OR.

- A team member enters a patient's room to transport them to another unit for testing and when checking the patient identification, the arm band is missing and you observe the patient transferred to the wheelchair in preparation to leave the room.


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## Stop the Line

**Examples of care situations of concern might be:**

- Wrong site injection being performed.
- Wrong immunization going to be administered.


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## Stop the Line

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

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

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## Stop the Line Non-Compliance or Retaliation

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

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

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

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## Stop the Line

All team members have the responsibility and authority to immediately intervene to protect the safety of a patient.

Any team member providing patient care will immediately stop and respond to the request to stop for clarification to reassess the patient's safety.

Leadership will support all personnel to speak up and advocate for patient safety.

Any team member who observes or becomes aware of an imminently harmful action in patient care has the authority and responsibility to speak up against the request, so the process can be stopped in order to clarify the patient safety situation.

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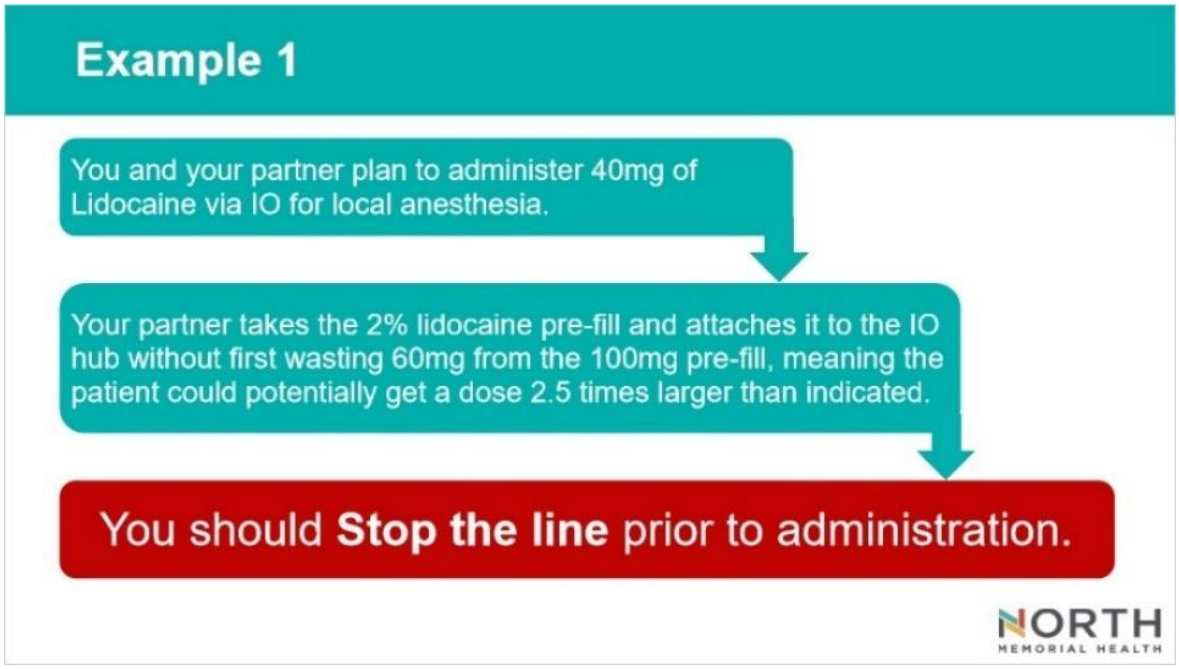
Example 1
You and your partner plan to administer 40mg of Lidocaine via IO for local anesthesia.
Your partner takes the 2% lidocaine pre-fill and attaches it to the IO hub without first wasting 60mg from the 100mg pre-fill, meaning the patient could potentially get a dose 2.5 times larger than indicated.
You should Stop the line prior to administration.
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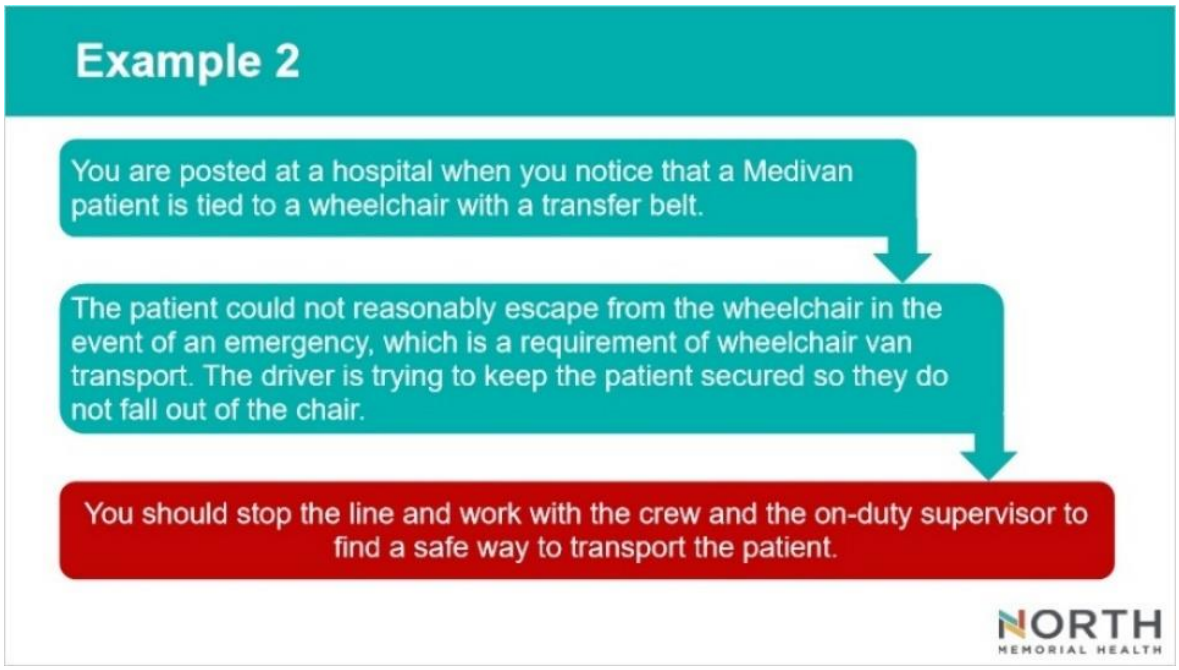
Example 2
You are posted at a hospital when you notice that a Medivan patient is tied to a wheelchair with a transfer belt.
The patient could not reasonably escape from the wheelchair in the event of an emergency, which is a requirement of wheelchair van transport. The driver is trying to keep the patient secured so they do not fall out of the chair.
You should stop the line and work with the crew and the on-duty supervisor to find a safe way to transport the patient.
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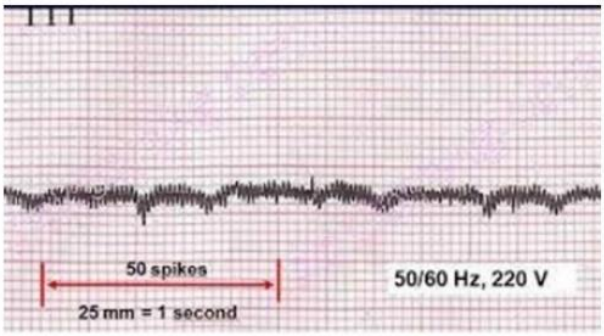
## Example 3

- You are caring for an unconscious patient with your partner. At the rhythm check, your partner calls out "V-fib" and begins the process of charging the monitor. You note the rhythm below, which you believe is due to a loose electrical outlet nearby.
  - **You should stop the line and consider changing leads or moving the patient prior to checking the rhythm again.**

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## Example 4

You and your partner are in the process of performing a MAAM. After executing the pre-oxygenation process, the team member performing the laryngoscopy is still in the airway at 31 seconds on their second attempt.

You should **stop the line** and place an iGel.

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## Plan of Care

- An individualized plan of care and patient education is developed and documented within 24 hours of admission and includes goals and interventions, including nursing diagnosis and comorbidities.
- The patient and/or patient representative has the right to be involved in the development and implementation of the plan of care.
- The care plan is reassessed and individualized to the patient every shift and with condition changes, and includes the following:
  - Goals which are consistent with the provider's plan for medical care.
  - Nursing interventions.
  - Evaluation of patient's progress towards the goals.
  - Reflection of findings on assessments, both physiological and psychosocial factors.
  - Discharge planning.
  - Interdisciplinary assessments (as applicable).

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## Plan of Care

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

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

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## Information for Vocera Users


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

Every attempt should be made to achieve appropriate communication practices to limit disruption to the patient and care teams within NMH and to protect patient information. Inappropriate or vulgar language shall not be used. Be aware of the volume of your device settings and your voice when using Vocera.

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## Maintaining Confidentiality During Calls

Team members must always be aware of their surroundings and protect patient information as outlined by HIPAA. The following options will help maintain confidentiality during calls:

- Walk to a private area to take the call.
- Place the call "on hold" and walk to a private area to take the call.
- Transfer the call to a nearby phone and resume the call.
- Return the call at another time.
- Do not leave messages that include patient identifiable data.
- Do not leave messages that include medical verbal orders. Vocera messaging shall not be used to give or receive medical verbal orders.


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## Reminders for Vocera Use

- Be courteous and respectful when answering a call on Vocera.
- Set the stage for a caller "Hi this is -----, I am with a patient, how can I help you?"
- If calling someone on Vocera, be mindful that they may not know who is calling and may be busy, say "Hi this is----, is this a good time?" or "Hi this is ---, can you please call me when you are finished?"

**More detail about communicating via Vocera can be found in the policy "Appropriate Use of Vocera Communication System" found in C360.**


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## Verbal and Telephone Order Safety

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

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## Do I call the On-Line Medical Control ED Physician, or do I call system On-Call Medical Director?

**If needing immediate assistance, radio ED physician**

- Termination of resuscitation (always call North ED)
- Medication/treatment orders on 911 calls

**If needing assistance, but less emergent, have dispatch page on-call medical director**

- Medication/treatment orders on interfacility transports(IFTs)
- Decisions related to IFT appropriateness or care levels
- Sending/receiving facility asking to speak with medical director
- Conflicting messages or things that don't "feel right"

NORTH MEMORIAL HEALTH

## How to Contact On-Line Medical Control ED Physician "Radio the ER"

**For North Memorial ED:**

- In Metro area: Use MRCC-W Talkgroup and ask for med control at NMHH
- Move to North Talkgroup in B bank of radio
- In Outstate: Call MRCC-W (612) 347-2123 and ask for med control at NMHH
- They will patch you through by phone
- When calling medical control, ensure you have a succinct question or request.

**For receiving facility, if asking specific questions prior to patient arrival to ED:**

- Follow local protocols

NORTH MEMORIAL HEALTH


How to Contact On-Call Medical Director
Call dispatch: 763-581-2897
Ask to have the system on-call medical director paged
• You may be asked to stay on the line, or they may take your number and either Dr. Tanghe, Dr. Finn, or Dr. Lilja will call you
• May take 5-10 minutes
• Notify dispatch if no response within 10 minutes
• Radio contact will not be reliable
NORTH
MEMORIAL HEALTH

# Patient Safety 2023


## The Patient's Bill of Rights Includes:

Information about rights
Courteous treatment
Appropriate healthcare
Physician's identity
Relationship with other health services
Information about treatment
Participation in planning treatment
Continuity of care
Right to refuse care
Experimental research and right to associate
Freedom from maltreatment
Pain management
Treatment privacy
Confidentiality of records
Disclosure of services available
Responsive service
Personal privacy
Grievances
Communication privacy
Personal property
Services of the facility
Protection and advocacy services
Right to communication disclosure
Seclusion and restraint

NORTH MEMORIAL HEALTH

## Patients' Bill of Rights

- All patients receive a copy of the Patients' Bill of Rights. This includes:
  - Hospital
  - Mental Health (Inpatient & Outpatient Clinic Services)
  - Hospice

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

NORTH MEMORIAL HEALTH

## Visitation Rights

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

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

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## Patient Responsibilities

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

Provide information about health status

Keep appointments

Be honest

Know their medications

Understand their health problems

Know their caregivers

Follow the treatment plan

Be considerate of others

Accept consequences of not following treatment plan

Be tolerant/accepting of those who are different from them

Click here for more info

NORTH MEMORIAL HEALTH

## Patient Responsibilities

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

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

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

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## Suspected Abuse, Neglect or Financial Exploitation

Patient-facing team members are defined by Minnesota Law as mandated reporters. Minnesota law requires mandated reporters to report suspected maltreatment of vulnerable adults including suspected abuse, neglect or financial exploitation. North Memorial Health has an internal reporting structure through *Safety First*.

NORTH MEMORIAL HEALTH

## Vulnerable Adult

Mandated reporters are required to report to the Minnesota Adult Abuse Reporting Center (MAARC) if they have reason to believe that a vulnerable adult is being neglected, mistreated, or exploited or have knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained.

Who is a vulnerable adult?

- A person 18 years or older
- Who is a resident or inpatient of a facility
- Who receives home care services
- Who possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction - that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision - and because of the dysfunction or infirmity and the need for care or services, the individual has an impaired ability to protect the individual's self from maltreatment.

NORTH MEMORIAL HEALTH

## What is Maltreatment?

Click on each box below for more information.

| Abuse | Neglect | Financial Exploitation |
|---|---|---|

Reporting

If you have reason to believe that a vulnerable adult is experiencing abuse, neglect, or financial exploitation, report internally through *Safety First* or to the MAARC at 844-880-1574.

NORTH MEMORIAL HEALTH

## Child Abuse

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

NORTH MEMORIAL HEALTH

## Indicators of Child Abuse & Maltreatment

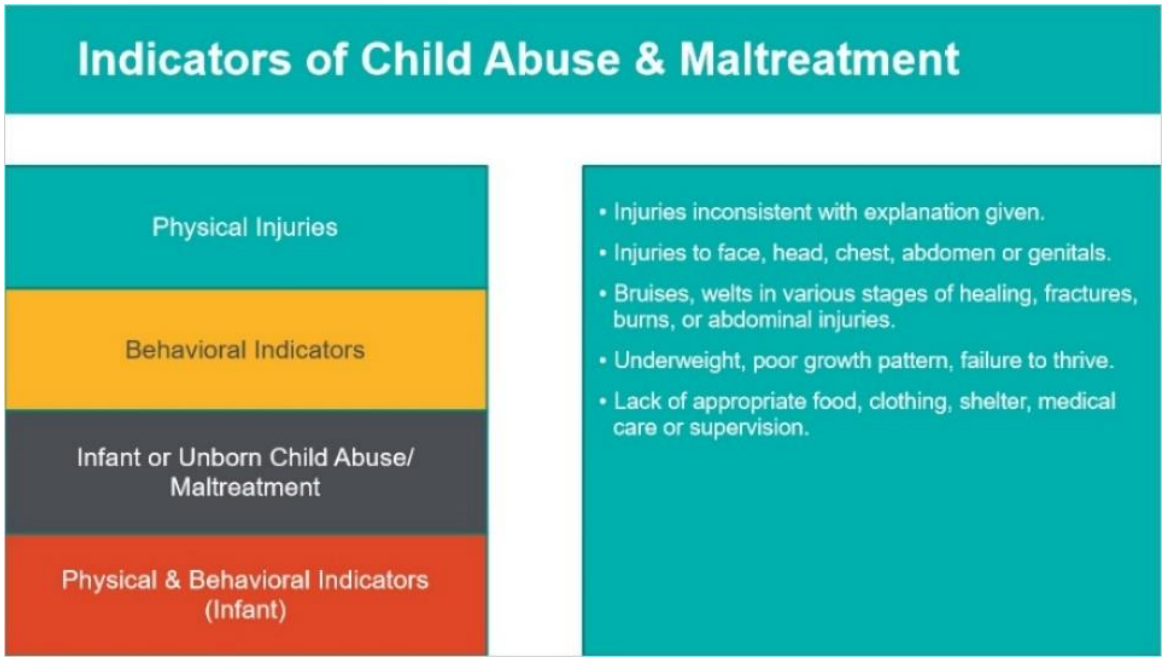
Physical Injuries

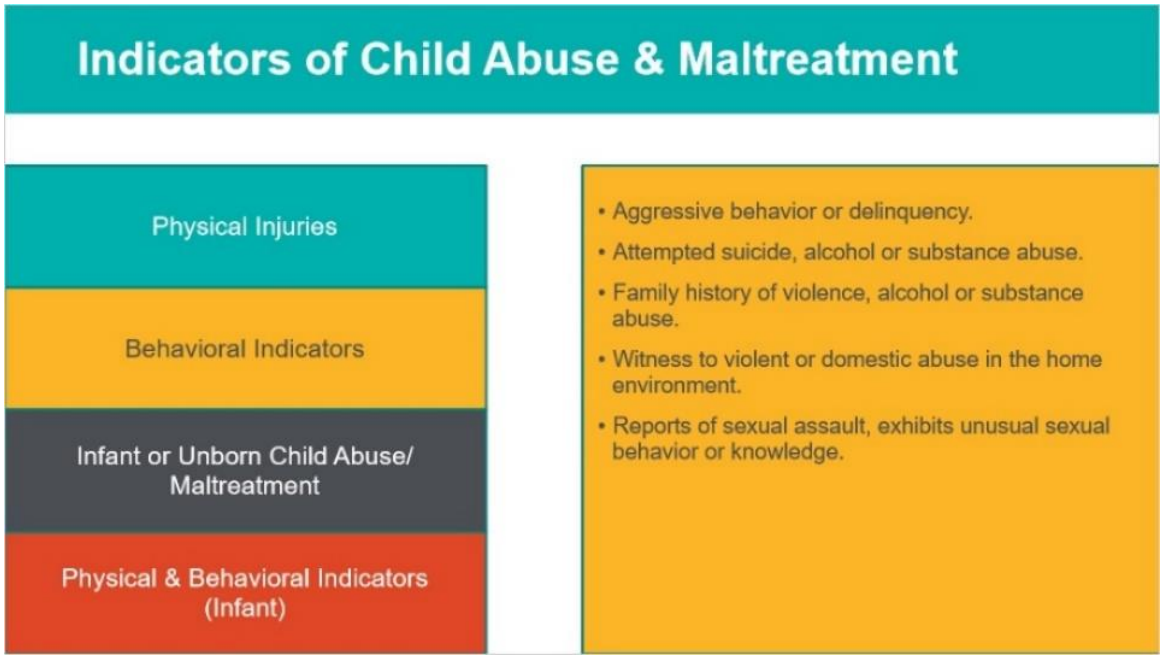
Behavioral Indicators

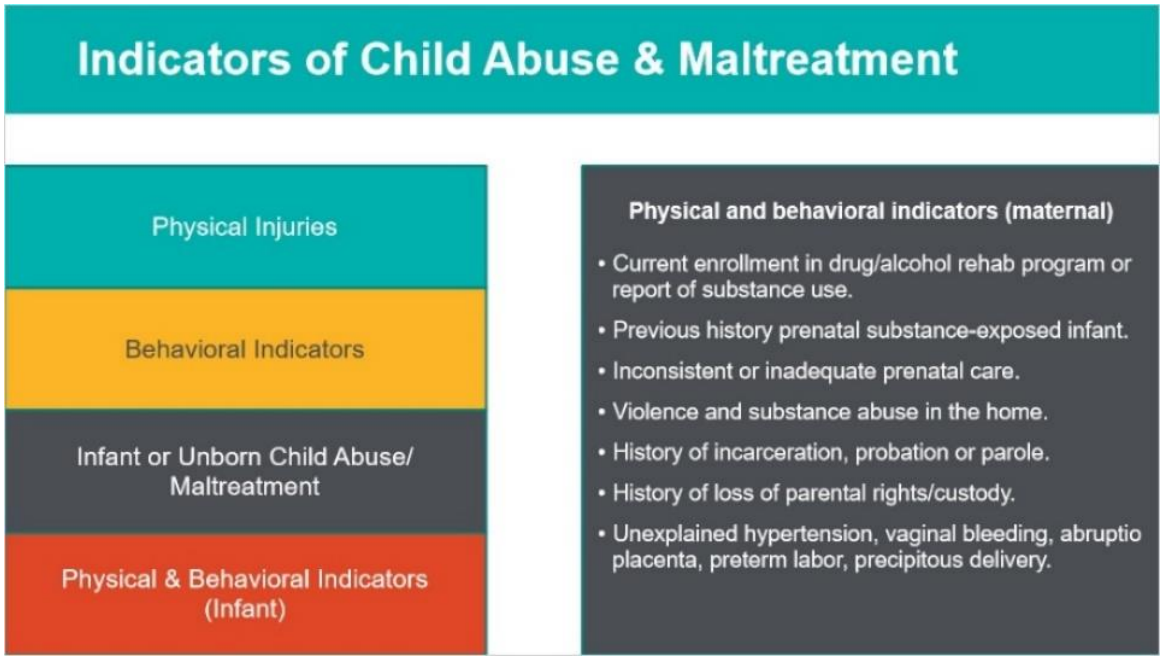
Infant or Unborn Child Abuse/ Maltreatment

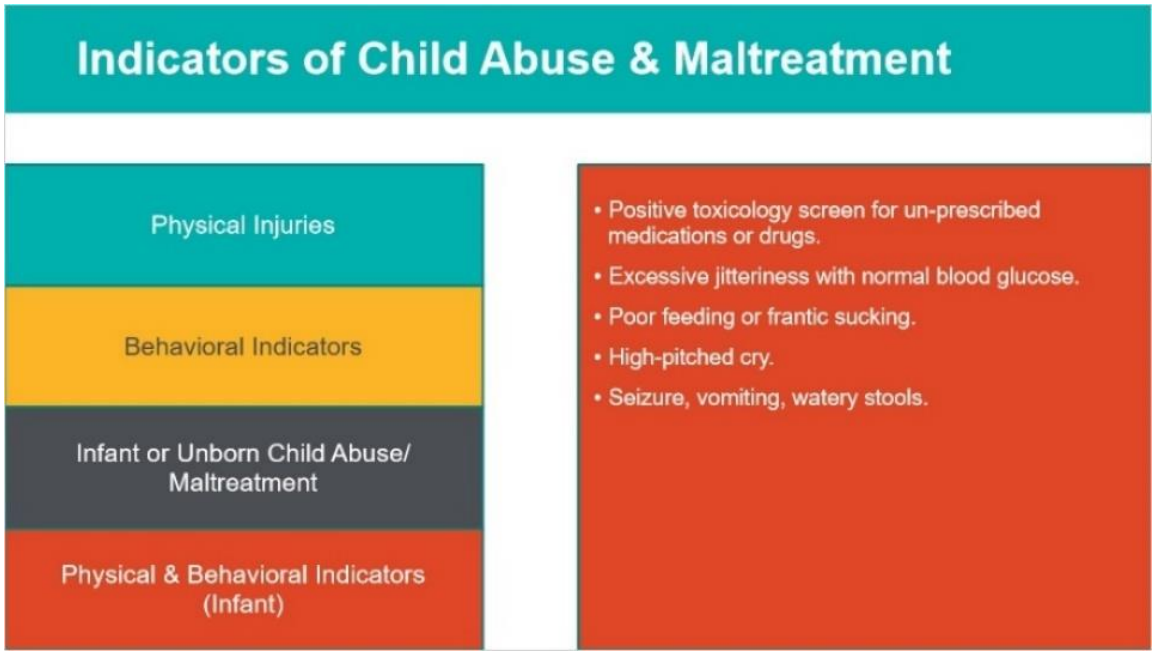
Physical & Behavioral Indicators (Infant)

Click the buttons to the left for more information on each topic.


Indicators of Child Abuse & Maltreatment
Physical Injuries
Behavioral Indicators
Infant or Unborn Child Abuse/ Maltreatment
Physical & Behavioral Indicators (Infant)
• Injuries inconsistent with explanation given.
• Injuries to face, head, chest, abdomen or genitals.
• Bruises, welts in various stages of healing, fractures, burns, or abdominal injuries.
• Underweight, poor growth pattern, failure to thrive.
• Lack of appropriate food, clothing, shelter, medical care or supervision.


Indicators of Child Abuse & Maltreatment
Physical Injuries
Behavioral Indicators
Infant or Unborn Child Abuse/ Maltreatment
Physical & Behavioral Indicators (Infant)
• Aggressive behavior or delinquency.
• Attempted suicide, alcohol or substance abuse.
• Family history of violence, alcohol or substance abuse.
• Witness to violent or domestic abuse in the home environment.
• Reports of sexual assault, exhibits unusual sexual behavior or knowledge.


Indicators of Child Abuse & Maltreatment
Physical Injuries
Behavioral Indicators
Infant or Unborn Child Abuse/ Maltreatment
Physical & Behavioral Indicators (Infant)
Physical and behavioral indicators (maternal)
• Current enrollment in drug/alcohol rehab program or report of substance use.
• Previous history prenatal substance-exposed infant.
• Inconsistent or inadequate prenatal care.
• Violence and substance abuse in the home.
• History of incarceration, probation or parole.
• History of loss of parental rights/custody.
• Unexplained hypertension, vaginal bleeding, abruptio placenta, preterm labor, precipitous delivery.


Indicators of Child Abuse & Maltreatment
Physical Injuries
Behavioral Indicators
Infant or Unborn Child Abuse/ Maltreatment
Physical & Behavioral Indicators (Infant)
• Positive toxicology screen for un-prescribed medications or drugs.
• Excessive jitteriness with normal blood glucose.
• Poor feeding or frantic sucking.
• High-pitched cry.
• Seizure, vomiting, watery stools.

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

## Informed Consent

Healthcare providers must discuss all treatment options with their patients. This includes the option of ***no treatment***.

For ***each treatment*** option, the patient needs to know:

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

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

NORTH MEMORIAL HEALTH

## Informed Consent - Minors

- Any patient under the age of 18 is considered a minor. In general, a parent or legal guardian must provide consent on behalf of the minor.
- MN state laws allows minors to consent to certain types of services without parent or guardian permission (Minnesota Statutes Sections 144.341 - 144.344). These laws help young people seek confidential health care for sensitive issues such as pregnancy or pregnancy prevention, sexually transmitted infections, and substance use or abuse. Minnesota Statute 253B.04 subd.1 allows youth who are 16 years of age or older to consent for inpatient mental health services.
- Parents and guardians have access to their minor children's medical records, unless the minor legally consents for services specifically listed under the Consent of Minors for Health Services statutes (Minn. Stat. §§ 144.341 to 144.347). In that case, parents or guardians do not have access to the minor's health care records without the minor's authorization (Minn. Stat. § 144.291, subd. 2, para. (g)).
- However, a health professional may inform a minor's parent or guardian of treatment if, in the professional's judgement, failure to inform the parent or guardian would seriously jeopardize the minor's health (Minn. Stat. § 144.346).

NORTH MEMORIAL HEALTH

## Informed Consent - Minors

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

The following ***exceptions*** are specifically provided under Minnesota law:

1

2

3

Click on each
of the numbered boxes to the left.

NORTH MEMORIAL HEALTH


Informed Consent - Minors
Any patient under the age of 18 is considered a minor. In general, a parent or legal guardian must provide consent on behalf of the minor.
The following exceptions are specifically provided under Minnesota law:
1
2
3
Any minor may give consent to their own medical, dental, mental and other health services treatment provided that the minor is living separate from their parents or legal guardian, with or without their consent regardless of the duration, and further provided that the minor manages their affairs regardless of the source or extent of any income.
NORTH
MEMORIAL HEALTH


Informed Consent - Minors
Any patient under the age of 18 is considered a minor. In general, a parent or legal guardian must provide consent on behalf of the minor.
The following exceptions are specifically provided under Minnesota law:
1
2
3
Any minor may give consent for medical, mental, or other health services to determine the presence of, or to treat pregnancy and other associated conditions, venereal disease, and alcohol or other chemical dependency. This provision does not allow a minor to consent to admission for inpatient treatment for alcohol or other chemical dependency.
NORTH
MEMORIAL HEALTH

## Informed Consent - Minors

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

The following ***exceptions*** are specifically provided under Minnesota law:

1

2

3

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

NORTH MEMORIAL HEALTH

## Complaints & Grievances

What is a Complaint?
Click here to learn more

What is a Grievance?
Click here to learn more

NORTH MEMORIAL HEALTH

## Complaints & Grievances

- Most concerns can be addressed quickly.
  - If a team member cannot resolve a concern at the point of care, it should be referred to management.
  - If management cannot resolve the concern, refer to the Patient Representative Office (After hours M-F, weekends and holidays, contact the Nursing Administrative Manager).
- Grievances (formal complaints) may be filed with state agencies whether or not the patient has used North Memorial's internal grievance process. Instructions for filing a grievance can be found in the Patient Welcome Book and the Patient's Bill of Rights booklet.

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## Restraint Use

- Restraints pose a risk to the physical safety and psychological well-being of the patient and team members.
- Restraints are used only in an emergency and only after alternative strategies have been tried.
- Physically holding patients, which restricts movements against their will, is also considered restraint use. This does not include holding patients for purpose of conducting a routine physical examination or tests.


**All restraint documentation should be reviewed at the end of every shift for completeness.**

NORTH MEMORIAL HEALTH


Restraint Use Continued
Nonviolent or Nonself-destructive Restraint Use
Click here for more info.
Violent or Self-destructive Restraint Use
Click here for more info.
NORTH MEMORIAL HEALTH


When to Restrain
01
When verbal de-escalation techniques do not work, it is important to not engage in the behavior the agitated patient has exhibited.
02
Do not be afraid to restrain patients exhibiting any objective sign(s) of aggression with family, first responders, or EMS.
03
Most crew assaults come from patients who showed signs of aggression on scene, yet were never restrained.
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## When to Restrain Continued

Pay attention to your instincts

Use tools at your disposal to protect you, your partner and the patient

All seatbelts | Buckle Guard | Spit Hood | Physical restraints | Pharmacological restraints

If you feel unsafe, please contact law enforcement for assistance.

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## Buckle Guard

- Buckle guards should be placed on all stretcher seatbelts that are on a transport or 72 hour psychiatric hold.
- Please see Restraint CIG for additional information in your guidelines.

NORTH MEMORIAL HEALTH
AMBULANCE & AIR CARE
Clinical Care Manual

Step by Step:
Buckle Guards:

1. Remove the white cap from the buckle guard by pressing down and turning (just like a "child safe cap" on a pill bottle from a pharmacy).
2. Open the buckle guard along the hinge point.
3. Locate the narrow slot on the buckle guard. This is the slot the buckle "blade" will pass through.

Narrow slot (buckle blade side) | Wide slot (buckle strap side)

4. Place the buckle guard around the seat belt buckle on the stretcher so the blade of the buckle passes through the narrow slot on the buckle guard and the opening in the buckle guard is over the release button on the stretcher buckle.

YES — Buckle guard has been placed so the blade of the buckle passes through the narrow slot of the buckle guard

NO — Buckle guard has been placed backwards, with the narrow slot of the buckle guard surrounding the strap side of the buckle

NO — Buckle guard has been placed on the outside of the stretcher buckle, with the narrow slot of the buckle guard surrounding the strap side of the buckle

5. Place the white cap back on the buckle guard and turn it until it is secured.
6. To release the stretcher buckle, remove the white cap as directed in step 1 and then depress the buckle release button on the stretcher strap

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CIG Restraints APR 2019.docx

# Limb Restraint

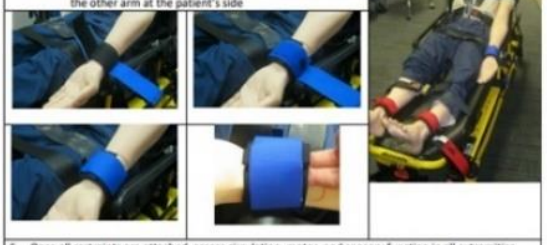
NORTH MEMORIAL HEALTH
AMBULANCE & AIR CARE
Clinical Care Manual

Refer to your guidelines for more information.

**Limb Restraints:**

1. Ensure you have enough providers to safely restrain the patient. This is not a two-person procedure.
2. Gather restraints. The blue restraints will be used for the upper extremities and the red restraints for the lower extremities.
3. Attached the unpadded side of the restraint to the stretcher. Attach these to non-moving parts only. *Wrist restraints must be attached to "winged" stretchers before placing the patient on the stretcher.*


4. One extremity at a time, place the distal joint of the patient in the padded portion of the restraint, looping the Velcro portion back on to itself once. Ensure two fingers can be slid between the restraint and the patient's limb
   a. One arm should be secured above the patient's head with the other arm at the patient's side



5. Once all restraints are attached, assess circulation, motor, and sensory function in all extremities and document findings
6. Apply buckle guards (see above) to all EMS gurney "seatbelt" buckles/straps used secure the patient to the gurney prior to transport
7. Re-check CMS in each extremity every 15 minutes and document your assessment findings. If safe to do so, consider switching the position of the arms (one limb at a time) every 15 minutes to maintain CMS and comfort
8. On arrival at the ED, ensure enough help is present to safely and securely move the patient

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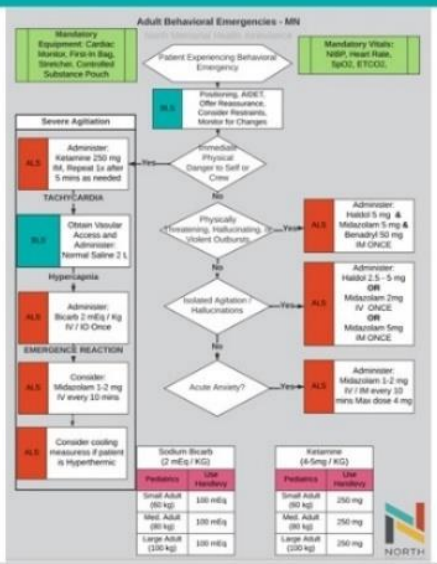
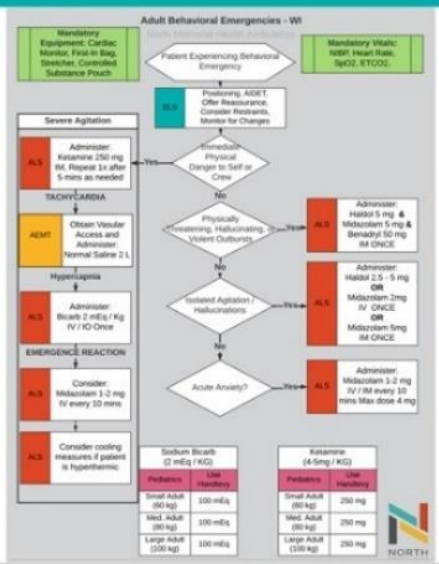
# Adult Behavioral Emergencies

Refer to your guidelines for more information.

Minnesota




Wisconsin

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# Adult Behavioral Emergencies Continued

| Bedside Report<br>No Specific Care Conversations Identified | | |
|---|---|---|
| Agitation Level | Title | Descriptor |
| 1 | Confused | Obviously Confused or Disoriented |
| 2 | Irritable | Easily Annoyed or Angered |
| 3 | Boisterous | Behavior Overtly Loud or Noisy |
| 4 | Verbally Threatening | A Verbal Outburst With Intent to Intimidate or Threaten |
| 5 | Physically Threatening | Definite Intent to Physically Threaten |
| 6 | Attacking Objects | An Attack Directed at an Object |
| 7 | Attacking People | Any Physical Assault on Another Person |

NORTH MEMORIAL HEALTH

# Emergency Medical Treatment & Active Labor Act

## EMTALA

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

NORTH MEMORIAL HEALTH

## EMTALA Applies When…

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

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## Pregnant Patients and Patients in Labor

- A pregnant patient has an Emergency Medical Condition (EMC) if the Medical Screening Exam (MSE) reveals they are in labor. If after a reasonable period of observation, it is determined that they are in false labor, the patient does not have an EMC.
- A pregnant patient may also seek emergency treatment for conditions related to their pregnancy although they are not in labor and/or for conditions unrelated to the pregnancy.

When EMTALA applies definitive criteria must be met.

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

## Infant/Fetal Loss

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

- Social Services — Both hospitals
- Chaplains — Both hospitals
- Perinatal Nurse Navigator — MGH
- Guest Services — MGH

NORTH MEMORIAL HEALTH

## Butterfly – Symbol for Loss

**At Maple Grove, a butterfly is shown on the Epic electronic greaseboard next to the patient's name. Additionally, a butterfly is placed on the door to the patient room for awareness.**

**At Robbinsdale, a butterfly is shown on the EPIC electronic greaseboard next to the patient's name and in the generic EPIC unit greaseboard next to it for awareness. The butterfly magnet will be placed on the patient's doorframe.**

NORTH MEMORIAL HEALTH

## Emotional Support

- Note any patients with a butterfly.
- Compassionately acknowledge the loss.
- Chaplains, RNs and Perinatal Nurse Navigators (MGH only) are available to provide additional support. They can be contacted through Vocera.
- See Compliance 360 for complete policies related to infant/fetal loss.

NORTH MEMORIAL HEALTH

## Purpose of the Medical Interpreter

The primary task of the interpreter is to interpret, that is, to convert a message uttered in a source language into an equivalent message in the target language so that the intended recipient of the message responds to it as if he or she had heard it in the original. The primary test of a competent interpreter, therefore, is the accuracy and completeness of the interpretation, per the International Medical Interpreters Association (IMIA).


NORTH MEMORIAL HEALTH

## Language Services

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

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

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## Working With Medical Interpreters

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

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