ALLIED HEALTH PACKET

2015 Annual
Mandatory In-service
Self-Learning Packet
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MISSION....OUR REASON FOR BEING

MISSION
- Mission touches every piece of the organization; it is the task of all who are in our healing ministry to assume responsibility for it.
- It is the goal to provide the same excellence in care to all persons from deep spiritual and professional motivation and
- To be profoundly responsive to those most in need and challenging to serve.

CATHOLIC HEALTH SPONSORS
- Daughters of Charity founded in France in 1633 to serve poor, sick and those who had no one to care for them. Established Sisters of Charity Hospital in 1848.
- Diocese of Buffalo was established in 1847 by Bishop John Timon, CM. The Diocese comprises the eight counties of Western New York.
- Sisters of Mercy founded in Dublin Ireland in 1831 to serve the poor, sick and uneducated. Established Mercy Hospital in 1904 and Kenmore Mercy Hospital in 1951.

CATHOLIC HEALTH MISSION STATEMENT (Why we exist)
We are called to reveal the healing love of Jesus to those in need.

OUR 2020 VISION (What we are striving to do)
Inspired by faith and committed to excellence, we will lead the transformation of health care in our communities.

CATHOLIC HEALTH VALUES (What we believe in)
- Reverence
- Compassion
- Justice
- Excellence

VALUES CONTINUUM
All associates and staff are interviewed, oriented, educated, evaluated, and mentored within the framework of our values.

BEHAVIORS
We know who we are and we act accordingly.

REVERENCE
We honor the value of each individual we encounter at Catholic Health.
- Be an exceptional example of our Mission
- Show courtesy to everyone through warm, welcoming words and gestures
- Collaborate to foster our Mission and Values
- Care for and strengthen our healing ministry and all the resources entrusted to us
- Look for the face of God in everyone you meet

COMPASSION
We commit to walking with others through both joy and suffering.
- Be a transforming, healing presence in the communities we serve
- Extend a welcoming hand to all patients, residents, families and associates
- Reach out unconditionally in the spirit of the Good Samaritan
• Show kindness when you help others
• Offer empathy, tenderness and respect to those in need

JUSTICE
We dedicate ourselves to treat all people with respect, dignity and fairness.
• Advocate for persons who are poor and vulnerable
• Be accepting and understanding of people who need our help
• Recognize and affirm each individual’s contributions
• Be honest and ethical in all dealings
• Honor the uniqueness of each individual and maintain an inclusive environment
• Use resources wisely and increase environmental awareness by making lifestyle changes to reduce our “footprint” on the environment

EXCELLENCE
We commit to exceed the expectations of our patients, residents, their families, and all the people we meet at Catholic Health.
• Envision a future filled with hope
• Foster a high quality workplace
• Seek opportunities for professional and personal growth
• Be faithful to our Mission and Values
• Provide the highest quality of care and service

Mission and Values Are Expressed In All Aspects Of Care….Especially In The Care Of The Dying
We show:
• Compassion for those who are dying
• Reverence for all of life
• Presence & Healing as we care for families
  o Of chronically ill patients and in palliative care
  o When death is near

It is your responsibility to Enhance the Patient Experience by meeting our eight Pursuing Excellence Expectations.
1. Interact respectfully and compassionately
2. Demonstrate a positive attitude
3. Demonstrate accountability
4. Follow the rules
5. Communicate clearly and directly and perform effective hand-offs communication
6. Have a questioning attitude
7. Work together with your team
8. Pay attention to detail

You are Catholic Health

Yours is the voice people hear when you answer the telephone
Yours are the eyes they look into when they’re frightened and lonely
Yours are the voices people hear when they ride the elevators, when they try to sleep, and when they try to forget their problems.
You are what they hear on their way to their appointments that could affect their destinies and what they hear after they leave those appointments.
Yours are the comments people hear when you think they can’t.
Yours is the intelligence and caring that people hope they’ll find here.
When you’re considerate, so is Catholic Health.
When you’re helpful, so is Catholic Health
And when you’re compassionate and respectful, so is Catholic Health.
Visitors, patients, residents and co-workers will never know the real you unless you let them see it.
All they will know is what they see and hear and experience.
We are all judged by your performance.
All of us are the care you give, the attention you pay, the courtesies you extend.

QUESTIONS OR COMMENTS
Catholic Health Mission Leadership

Kenmore Mercy Hospital Mary Pat Barth (716) 447-6360
Mercy Hospital Buffalo John Kalinowski (716) 828-2190
Sisters of Charity Hospital /St. Joseph Campus Paula Moscato (716) 862-1905
Home & Community Based Care/LIFE Vacant (716) 706-2301

Bart Rodrigues, SVP, Chief Mission Officer (716) 862-2436
Sister Nancy Hoff, Ministry Formation (716) 923-9668
Deb Prautzsch, Administrative Assistant (716) 862-2435

CULTURAL COMPETENCE

Cultural competence is a set of attitudes, behaviors and skills that enable staff to work effectively in cross-cultural situations. It reflects the ability to gain and use knowledge of health related beliefs, attitudes, practices and communication.

It should be understood that there is no one way to treat any racial and ethnic group. As health care providers, we must provide evidence based care that is appropriately tailored to meet the needs of our patients, their families and the community.

Cultural competence begins with an honest desire not to allow biases to keep us from providing care and treating each patient with respect.

Cultural Diversity covers many obvious and less-obvious manifestations to include:

- Religion
- Ethnicity (Race)
- National Origin
- Gender
- Age
- Education
- Mobility (including handicaps)
Culture is defined as the sum total of the way of living to include values, beliefs, standards, language, thinking patterns, behavioral norms and communication styles. Culture guides decisions and actions.

Culture related to health belief systems:

- Define and categorize health and illness
- Offer explanatory models for illness
- Based upon theories of the relationships between cause and the nature of illness and treatments
- Defines the specific “scope” of practice for healers

Acquiring cultural competence starts with awareness of differences. Diverse groups are handled with specific skills which are refined through cross-cultural encounters. In caring for culturally diverse populations:

- Listen to the patient’s perception of the problem
- Explain your understanding of the problem
- Discuss differences and similarities
- Recommend a treatment plan and negotiate the plan

Culturally diverse populations have varying belief preferences, nutritional preferences, communication preferences and varying beliefs on patient care and dealing with death. To assist you with the care of culturally diverse populations, the Catholic Health Culture Tool can be accessed by going to the S: drive and reading the document in:

S:\Public\StaffDevelopment\Mandatory\CultureTool.pdf

**PATIENTS’ BILL OF RIGHTS**

As a patient in a hospital in New York State, you have the right, consistent with law, to:

1) Understand and use these rights. If for any reason you do not understand or you need help, the hospital must provide assistance, including an interpreter.
2) Receive treatment without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation, source of payment or age.
3) Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.
4) Receive emergency care if you need it.
5) Be informed of the name and position of the doctor who will be in charge of your care in the hospital.
6) Know the names, positions, and functions of any hospital staff involved in your care and refuse their treatment, examination or observation.
7) A non-smoking room.
8) Receive complete information about your diagnosis, treatment and prognosis.
9) Receive all the information that you need to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.
10) Receive all the information you need to give informed consent for an order not to resuscitate. You also have the right to designate an individual to give this consent for you if you are too ill to do so. If you would like additional information, please ask for a copy of the pamphlet "Do Not Resuscitate Orders - A Guide for Patients and Families."
11) Refuse treatment and be told what effect this may have on your health.
12) Refuse to take part in research. In deciding whether or not to participate, you have the right to a full explanation.
13) Privacy while in the hospital and confidentiality of all information and records regarding your care.
14) Participate in all decisions about your treatment and discharge from the hospital. The hospital must provide you with a written discharge plan and written description of how you can appeal your discharge.
15) Review your medical record without charge. Obtain a copy of your medical record for which the hospital can charge a reasonable fee. You cannot be denied a copy solely because you cannot afford to pay.
16) Receive an itemized bill and explanation of all charges.
17) Complain without fear of reprisals about the care and services you are receiving and to have the hospital respond to you and if you request it, a written response. If you are not satisfied with the hospital's response, you can complain to the New York State Health Department. The hospital must provide you with the Health Department telephone number.
18) Authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors.
19) Make known your wishes in regard to anatomical gifts. You may document your wishes in your health care proxy or on a donor card, available from the hospital.

**PATIENTS’ RESPONSIBILITIES**

As partners in health care, we ask that you review the following:

1) **Give Full Information:** Tell the staff responsible for your care everything you can about your condition, including all symptoms, medication you are taking, previous illnesses and hospitalizations.
2) **Report Any Changes:** Inform the staff immediately about perceived risks in care provided and changes in symptoms, medications or general condition.
3) **Follow Your Instructions:** Take all medication as prescribed. Listen carefully to instructions about diet, exercise, etc. Tell the staff if you are having trouble following the instructions. Ask questions if you need additional information.
4) **Keep All Appointments:** Plan carefully and schedule all tests and optional treatments in advance. If you must cancel an appointment, try to give at least 24 hours’ notice. Be on time for your appointments.
5) **Accepting the Results of Your Actions:** All patients have the right to refuse treatment, but be aware what effect this may have on your health.
6) **Fulfill Your Financial Obligations:** Late payments increase overall hospital expenses. Paying your bill on time helps keep medical costs down.
7) **Respect Others:** Be considerate of the rights of other patients and hospital personnel. The patient is responsible for being respectful of the property of other persons and the hospital.

**HEALTHCARE ASSISTANCE PROGRAM**

**General Policy:**

It is the policy of Catholic Health to ensure a socially accountable practice for expecting payment from all patients receiving care at one of our facilities. Patients served by Catholic Health are expected to pay for services provided based on non-medically necessary elective service rates, uninsured rates, rates negotiated by a third party payer or regulated by a governmental agency. The **Uninsured Expected Payment and Healthcare Assistance Policy** is specifically designed to address those patients who are uninsured or underinsured and require care from one of the facilities within Catholic Health.

The policy is divided into three distinct sections that grant different rights to patients based on the following Catholic Health ministries:
Acute Care:
All uninsured patients of Catholic Health receiving treatment at one of the Catholic Health’s acute care facilities who are residents of New York State, a contiguous State or the state of Ohio, excluding the following services:
- Non-Medically Necessary Elective Services (e.g. cosmetic surgery),
- Long term level of care services (Sub-Acute or Skilled Nursing),
- Physician services other than Catholic Health primary care physician services, and
- Medical equipment and supplies.

Continuing Care:
All residents of Catholic Health receiving treatment at one of the Catholic Health’s Long Term Care facilities (Hospital and Non Hospital Based) that are subject to insurance co-payments or deductibles and Adult Home residents may be eligible for charity care.

Home Healthcare:
All patients that receive services within the Catholic Health Home Care division (Certified Agencies, Licensed Agencies, and Infusion Pharmacy) may be eligible for Charity Care.

Acute Care Section Policy and Procedures:
All patients registered as uninsured (i.e., those without insurance, also often referred to as self-pay) will automatically be enrolled in the Healthcare Assistance Program. An optional application form will be offered at time of registration, but failure to complete the application will not exclude enrollment. As such, uninsured patients presenting for care at a Catholic Healthcare acute care facility need do nothing to apply for healthcare assistance.

The Healthcare Assistance Program (HAP) is the part of Catholic Health’s charity care program established for the provision of a Healthcare Assistance Program Allowance for uninsured patients who lack the financial resources necessary to obtain healthcare, granted based on need beyond the normal Uninsured Allowance issued for all uninsured including those patients that do not qualify for the HAP. The program is established and performed in a compassionate and professional manner consistent with all New York State and federal laws and regulations.

Healthcare Assistance Program (HAP) Allowances are the potential set of allowances that are available to uninsured patient for uninsured accounts, based on each such patient guarantor's financial resources and ability to pay for healthcare services. The allowances will be available to all uninsured patients with household incomes estimated to be less than 501% of the applicable Federal Poverty Guideline amount and who have a PARO score of less than 695.

Balances after insurance payment due from the patient or patient guarantor are referred to as After Insurance Balances. These balances include, but are not limited to, co-pays, deductibles and co-insurance. For insured patients without the financial ability to pay After Insurance Balances, After Insurance Balance Allowances are available based on a sliding scale. A different set of procedures must be followed in order to be the eligible for this allowance.

Applicants Right to Appeal:
An appeal procedure has been established which will cover disagreement and/or objection on the part of the applicant to healthcare assistance denials and/or healthcare assistance approvals which may be for less than the total healthcare assistance or less than expected. This “Appeal of Healthcare Assistance Denial Process” includes the following notice:
If you disagree with, or object to the Catholic Health decision regarding your application for healthcare assistance, then you may request that the decision be reviewed. A review may be requested in person or via the telephone with the Catholic Health Financial Clearance Manager. For telephone requests, please contact the Catholic Health Customer Service Office at 716-601-3600.

There is no time limit on the right to appeal.

UNDERSTANDING, AWARENESS AND SENSITIVITY FOR BARIATRIC PATIENT

Obesity is a complex disease where there is an excess of total body fat and weight is 20% or more above normal body weight. More than 35% of U.S. men and women were obese in 2009-2010 and 17% of U.S. children were obese in 2009-2012 (www.cdc.gov). The terminology for care of the obese patient population is called bariatric care. Obesity not only causes poor health for those people suffering from it, it also causes negative self-image, discrimination, depression and difficulty performing self-hygiene. Studies have shown that society has a low respect for people with obesity. People with obesity may experience social isolation, and have poor quality relationships.

Unfortunately, health care workers have been shown to have weight bias because it is thought that a lack of self-discipline and will power have caused this disease. When caring for people with obesity, ask yourself the following:

- What assumptions do I make based only on a person’s weight about their character, intelligence, success, and health status or lifestyle behaviors?
- Could my assumptions impact how I care for this person?
- Do I only look at their weight problem and not the other health problems they may have?

Challenge the weight bias in healthcare by leading by example and demonstrate sensitivity and compassion to our patients, residents, and visitors. Recognize that this individual is very aware of their weight problem and has probably tried to lose weight in the past. Acknowledge the difficulty this person may have with their health, activities of daily living and in their personal life. In addition, maintain their dignity by providing the right equipment, hospital gowns and privacy that will accommodate their size. As healthcare workers, whether clinical or non-clinical, our role is to provide care for the physical and social needs of the community. Good communication skills accompanied with compassion, empathy, support and a smile make a positive difference to people with obesity.

RECOGNITION OF ABUSE

Types of Abuse:
- Physical Assault
- Rape
- Sexual Molestation
- Domestic Abuse
- Elder Neglect or Abuse
- Child Neglect or Abuse

Domestic Violence: Physical, Sexual, Emotional Abuse
• Ninety eight percent of victims are women, but males can also be victims.
• A woman is beaten every nine seconds in the US, over 4000 are killed each year.
• Pregnant women who are abused have twice as many miscarriages.
• Sexual assault inflicts emotional as well as physical trauma on its victims.

**Signs/Symptoms:**
• Multiple injuries in various stages of healing.
• Unexplained injuries inconsistent with story.
• Distinct patterns (belt, cord, bite marks).
• Depression, anxiety, eating disorder.
• Fear of returning home.

**Elder Abuse:**
• National Center on Elder Abuse defines six major types of elder abuse (physical, sexual, emotional, neglect, abandonment and financial)

**Signs/Symptoms:**
• Bruises, broken bones, elder reports being hit, change in behavior.
• Unexplained bleeding or infection (genital)
• Bed sores, poor hygiene, unsafe living conditions

**Child Abuse/ Neglect**
An abused child is a child less than 18yr of age whose parent or guardian allows to be inflicted upon the child, physical injury, risk of injury or commits a sexual offense.

**Signs/Symptoms:**
• Bruises, pattern marks, grab marks, tattoos, cuts, burns, broken bones.
• Withdrawal, fear of parents or adults, nails biting, attempted suicide, mood swings.

**What to Report**
New York State Public Health Law (PHL) Section 2803-d requires the reporting of abuse, mistreatment or neglect immediately to the Department upon having “reasonable cause” to believe that abuse, neglect, or mistreatment has occurred.

*Anyone may report alleged abuse, mistreatment, or neglect.*

**New York State Hotlines:**
Adult Domestic Violence: 24 hours, 7 days a week
• English 1-800-942-6906
• Spanish 1-800-942-6908

National Committee to Prevent Child Abuse
• 1 800-342-7472

Reporting Child Abuse
• 1-800-342-3720

Erie County Department of Senior Services Adult Protection Unit
ORGAN DONATION

In 1998 the Federal government implemented a law that all hospitals must have an agreement with an organ procurement organization (OPO). The law requires hospitals to maintain written protocols and policies pertaining to the reporting of ALL DEATHS, ALL IMMINENT DEATHS, and ALL patients meeting “clinical triggers” to the OPO. The purpose of the law is to ensure that all families are informed of their options, if they have any, for organ, tissue, and eye donation.

The process of dying is looked at in two ways. The first is cardiac death – irreversible cessation of circulatory and respiratory functions – heart stops beating – no vital signs. All cardiac deaths need to be reported to the OPO within one hour of death. These patients may be able to donate tissue or eyes. The second is brain death – the irreversible cessation of all functions of the entire brain, including the brain stem. This is the legal definition of death. These patients may be able to donate organs as well as tissue and eyes. Clinical triggers of imminent death which would require notification to the OPO include: unresponsive or a Glasgow Coma Scale of 5 or less, loss of one neurologic response, brain death testing has been started or consulted, any discussion of withdrawal of life support, or anytime a family inquires about donation.

INTEGRATED HEALTHCARE DELIVERY SYSTEM - OUR JOURNEY

With the passage of the Affordable Care Act of 2010 healthcare providers across the country have been faced with interpreting and planning for changes required in healthcare delivery and in reimbursement. These changes are intended to expand access, improve quality, and control the rising costs of healthcare. In support of this, Catholic Health has begun the journey of becoming a High Performing Health System (HPHS). A HPHS is an integrated healthcare delivery system where the right care is provided, at the right time, in the right place, at the right time, and at the right cost. This is accomplished through many activities to include the implementation of labor and operational efficiencies, improvements in quality and safety through the use of medical and information technology, and enhancement of the patient experience by providing exceptional care and service.

The goal is to deliver patient centered care – where care is coordinated across the continuum as opposed to the provision of episodic care. Catholic Health is working closely with our Catholic Medical Partner physicians to integrate patient centered care throughout the continuum which will result in the provision of better care transition and coordination, supporting health maintenance and preventing unnecessary hospital readmissions. As this journey continues you will hear a number of terms used in association with High Performing Health Systems. The following definitions are provided so that you may become familiar with the language of health care reform:

- **Accountable Care Organizations** – a network of physicians and hospitals that share responsibility for caring for a select group of patients for a set fee
- **Care Coordination & Care Transition** – care is integrated and coordinated across all elements of the healthcare system and the community, using IT and other means to ensure patients get the care they need, when and where they need it
- **Patient Centered Medical Home** – an approach to providing comprehensive primary care that facilitates partnerships between patients, their physician, and the patients family
- **The Triple Aim** – the simultaneous pursuit of improving the patient experience, improving the health of populations, and reducing the cost of care
- **Disease State Management** – focus on treating the whole patient and the entire disease, not just specific episodes, with an emphasis on prevention and health maintenance

**CORPORATE COMPLIANCE**

New York State requires Catholic Health to annually certify that they have an effective compliance program in place.

CH Compliance Program protects the financial interests of the federal and state governments (taxpayer dollars), health insurance payers (premiums paid) and extends into ensuring implementation of sound business practices with those who interact with the organization.

Health care costs in the United States are continually rising. Catholic Health in its drive to become a high-performing health system embraces the Institute for Healthcare Improvement’s approach to optimize our health system’s performance. This Triple Aim pursues the following dimensions:

1. Improving the patient experience of care (including quality and satisfaction)
2. Improving the health of populations and
3. Reducing the per capita cost of health care.

Medicare and Medicaid combined constitute the largest single purchaser of healthcare in the U.S. and the outlays also continue to rise annually. Today’s policymakers are searching for ways to decrease the current levels of growth without reducing access to needed health care services or creating undue burdens for providers. Payment from government funded health plans will be affected by quality markers.

Medicare and Medicaid programs are vulnerable to fraud, abuse and waste by virtue of their sheer size, as well as their complex reimbursement rules, and decentralized operations. The focus of government investigations of healthcare organizations has resulted in monetary settlements that total into billions of dollars. The Government Accountability Office (GAO) cites the following reasons for causing improper payments: inadequate documentation, medically unnecessary services, coding errors, and payment calculation errors, including overpayments and underpayments.

The government in recognition of this issue signed in 2010 The Patient Protection and **Affordable Care Act** (PPACA), commonly called **Obamacare** which addresses a series of health care reform proposals. It has been and will be reforming the health care system in the United States until at least 2022. The **ObamaCare Health Care for America Plan** is focused on health care funding, reducing the cost of healthcare for Americans, increasing coverage and removing the burden that health care has become on the average American.

**WHY SHOULD I CARE ABOUT COMPLIANCE?**

The implementation of an effective corporate compliance program is a commitment by the organization to foresee potential problems. All directors, officers, managers, associates, medical staff, house staff, contractors, volunteer, students and others (hereafter referred to as constituents) from each Catholic Health System (CH) organization or affiliate have corporate responsibilities and duties.

It takes every individual doing his/her job well to make the Catholic Health System run efficiently. It is important that you know pertinent state, federal regulations and CH policies and apply them to your job.
Our compliance efforts will not work without your full support. One mistake or even a perception of wrongdoing could mean that we risk tarnishing our reputation of integrity and could trigger a government investigation that could result in severe financial and other penalties, loss of tax exemption, and a decline in business. The cost of these penalties affects the ability of the organization to bring needed healthcare services to our community. In certain circumstances, penalties for wrongdoings can be directly applied to the individual.

Enhancing the patient care experience involves upholding patient rights, having a questioning attitude, paying attention to details, following the rules, and accountability for your actions. These expectations create a Culture of Service which enhances the patient care experience and supports the Compliance Program.

CORPORATE COMPLIANCE PROGRAM
The CH compliance program plan presents guidelines designed to promote the prevention, detection and resolution of instances of conduct that do not conform to federal and state law, and private payer health care requirements as well as sound business policies. It helps us to better understand the ethical, professional and legal obligations we have as health care providers and the individual role we each play in meeting these important obligations.

An effective compliance program puts an organization in a position to function with integrity and “do the right thing” which ultimately provides better healthcare. Compliance is the responsibility of all associates. Associates have a duty to uphold compliance measures and to report items of concern. An associate’s Corporate Compliance responsibilities may include: development, implementation and enforcement of compliance related policies/procedures; education of constituents; investigation of reported concerns and ongoing auditing and monitoring of compliance related matters. Leonardo Sette-Camara is the CH Compliance & Privacy Officer with oversight responsibility for the compliance status and activities in all CH organizations.

POLICIES/PROCEDURES AND STANDARD OF CONDUCT
The first step in combating fraud, abuse and waste is to prevent it from happening in the first place through implementation of policies/procedures, standards of conduct, and training and education. The CH Corporate Compliance Program policies are available electronically to CH constituents on Compliance 360 under Legal Services. If you would like to review these documents and do not have access, contact your supervisor/manager for assistance or call the Compliance Office directly.

It is our responsibility to maintain the highest standards with respect to our delivery of care and to conduct our business affairs with integrity, based on sound ethical and moral standards.

- We recognize our responsibility to treat the people we serve with the same standards of care, regardless of payer source and in accordance with applicable rules, regulations and laws.
- We are intolerant of fraud, waste and abuse throughout the Catholic Health System and strive to always deliver medically necessary services in the most efficient and prudent manner.
- We also hold those we conduct business with to the same standards. An effective compliance program supports quality healthcare.

CH CODE OF CONDUCT
All associates and other agents are expected to understand and commit to:

1. Legal and Regulatory Compliance
   - Adhere to both the spirit and letter of applicable federal, state and local laws and regulations.
   - Refuse offers, solicitations and payments to induce referrals of the people we serve for an item or service reimbursable by a third party payor.
   - Complete, protect and retain records and documents as required by professional standards, governmental regulations and organizational policies.

2. Business Ethics
• Deal openly and honestly with fellow associates, customers, contractors, government entities and others.
• Maintain high standards of business and ethical conduct in accordance with the Catholic Health System Mission, directives of the Catholic Church and applicable federal, state and local laws and regulations
• Practice good faith in transactions occurring during the course of business.
• Conduct business dealings with the best interests of the Catholic Health System in view.
• Ensure compliance requirements regarding billing are monitored and enforced.
• Exercise discretion in the billing of services, regardless of payor source.

3. Conflict of Interest
• Disclose financial interests and/or affiliations or secondary employment with outside entities as required by the Conflict of Interest Statement.

4. Appropriate Use of Resources
• Use supplies and services in a manner that avoids waste.

5. Confidentiality
• Preserve patient confidentiality within the requirements of the law.
• Maintain confidentiality of proprietary information

6. Professional Conduct
• Hold vendors to this same Code of Conduct as part of their dealings with the Catholic Health System.

7. Responsibility
• Notify the Compliance Officer of instances of suspected non-compliance in a timely manner.
• Ensure appropriate corrective action is taken in a timely manner.
• Uphold the Non-Retaliation Policy for associates who report concerns in good faith.

CH Human Resources policies also reflect these standards of conduct and expectations.

ETHICAL DECISION MAKING
We, in the Catholic Health System, are called on to promote the standards of integrity and ethics. Essentially this means that we say what we mean and do what we say we will do. We treat others as we expect to be treated, and demand the best of ourselves. We each represent the Catholic Health System and accept shared responsibility for our programs, actions and decisions.

EDUCATION AND TRAINING
For all CH associates, volunteers and students, compliance program education takes place at time of hire, annually and on-the-job for specific identified compliance risk areas. Web-based compliance education and CH University classes are also available.

Promotion of and adherence to Corporate Compliance policies and other requirements is incorporated into each job description and is a factor in the performance evaluations of all associates including supervisors and managers. All managers and supervisors will be held accountable for and subject to disciplinary action for failure to uphold their compliance responsibilities.

CH compliance program policies are communicated to CH Physicians, Residents, Vendors and Contractors at the time of engagement and on a regular basis.

Through participation in the various educational opportunities, it is expected that associates will be familiar with accepted rules, regulations and policies and be able to recognize and question any deviation from these expectations.
GOVERNMENT AGENCIES AND POLICIES
Rules, regulations and laws governing healthcare organizations are found within numerous government agencies. These agencies are continually on the lookout for non-compliance because billions of dollars are involved in healthcare, the fund is limited and there is fear that there are multiple occurrences of deliberate fraud, waste and abuse.

THE FALSE CLAIMS ACT
One such law governing fraud, waste and abuse is the federal False Claims Act (FCA). The federal False Claims Act (31 USC 3729-33) makes it a crime for any person or organization to knowingly make a false record, file or submit a false claim with the government for payment.

Under certain circumstances, an inaccurate Medicare, Medicaid, or VA claim could become a false claim. Examples of possible False Claims include someone knowingly billing Medicare for services that were not provided, or for services that were not ordered by a physician, or for services that were provided at sub-standard quality where the government would not pay. Violations of the Federal False Claims Act will result in severe penalties.

New York State has also enacted a NYS False Claims Act (State Finance Law §§ 187-194) on April 1, 2007. It mirrors the federal False Claims Act with the focus being on state and local government rather than the federal government. Penalties are higher than the federal penalties.

The Deficit Reduction Act of 2005 significantly strengthens funding for government oversight agencies with emphasis on investigation and enforcement regarding Medicaid fraud and abuse.

The Fraud Enforcement and Recovery Act of 2009 (FERA) expands the FCA by adding liability for improper retention of government overpayment. Therefore, CH expects that our colleagues who are involved with submitting claims for provided services will only use true, complete and accurate information.

Under the 2010 Patient Protection and Affordable Care Act (PPACA), violations of the Anti-Kickback Statute (AKS) may trigger “False” claims and states that overpayments are to be returned within 60 days of discovery.

Under the False Claims Act, a person who knows a false claim was submitted for payment can file a lawsuit (Qui Tam action) in Federal Court on behalf of the government and, in some cases, receive a reward for bringing original information about a violation to the government’s attention. The New York State False Claims Act allows a similar lawsuit in State court if a false claim is filed with the State for payment, such as under Medicaid.

CH is committed to helping all constituents resolve conflicts, questions or concerns that arise in the workplace. Likewise, constituents have the responsibility to raise concerns with appropriate CH personnel.

GOVERNMENT INVESTIGATIONS
Government investigations are a fact of life in today’s business environment. CH has procedures for cooperating in these complex matters. You may be approached at work or outside of work, by a person who claims to be an investigator, with an inquiry for CH related information, or you may be presented with a subpoena or written request for information. You are not obligated to respond to the inquiry until after you have spoken with your supervisor or the Corporate Compliance Officer. If you have been approached by or have spoken with an investigator, you must report this to your supervisor or the Corporate Compliance Officer. The Corporate Compliance Officer will verify the investigator’s credentials, determine the investigation’s legitimacy, and assist you in following proper procedure for cooperating with the investigation.
CONFLICT OF INTEREST

All constituents have the responsibility to act in the best interest of Catholic Health and be fair in making business decisions. To maintain professional judgment, situations must be avoided that lead to actual or perceived conflicts of interest. A conflict of interest exists when an outside activity or relationship appears to influence a constituent’s decision-making process. Conflicts of interest could arise in areas of:

- Secondary employment
- Acceptance of gifts, payments or services of more than a nominal amount, directly or indirectly, from patients, families, sponsors, or vendors to influence care, referrals or the Catholic Health System business decisions.
- Directing business to a company in which a constituent or his/her family has a financial interest.
- Owning or holding a financial interest in a company that is a vendor, contractor, or supplier of the Catholic Health System.
- Performing consultative services for a customer, vendor or supplier of the Catholic Health System.

Anything that you believe based on these definitions to be a potential conflict of interest, must be disclosed as the initial step to assuring an actual conflict of interest does not occur. Consult your supervisor or the Corporate Compliance Officer (Leonardo Sette-Camara) for clarification.

CH constituents in key positions where there is increased potential to encounter conflict of interest situations are required, on a regular basis, to sign a Conflict of Interest Disclosure Statement. Disclosures are reviewed by the Compliance Officer, kept confidential and on file in the compliance office.

REPORTING

The second step in combating fraud, abuse and waste can be achieved through ongoing reporting, auditing process improvement and continued monitoring of identified compliance risk areas.

One of the most important ways to ensure that everyone in the organization lives out the Standards of Conduct is to report questionable behaviors. All individuals associated with CH have an obligation to report, in good faith, concerns about actual or potential wrong-doing related to governmental rules, laws and regulations, organizational policies/procedures and the CH Code of Conduct. Associates are not permitted to overlook such situations. CH has adopted an open door policy allowing associates to report a discrepancy/concern with assurance that it will be addressed at the appropriate level. We are firmly committed to a policy that encourages timely disclosure of such concerns.

It is understood that you may not wish to report concerns if you feel you will be subjected to retaliation or harassment for doing so. Catholic Health, federal and state policies prohibit any retaliation or retribution against persons who report in good faith suspected violations of laws and policies. Anyone who engages in such retribution is subject to discipline, up to and including dismissal on the first offense.

CH will investigate any allegation of retaliation against a colleague for speaking up, and will protect and/or restore rights to anyone who raised a genuine concern. It is the responsibility of any associate who believes he or she has been subjected to any such retribution or retaliation, or has knowledge or information of such actions, to bring this to the attention of the Compliance office either by calling the Compliance Officer directly (821-4469) or the Compliance Line (1-888-200-5380).

ISSUES REQUIRING REPORTING

Violations may occur intentionally or unintentionally. These behaviors must be reported because of the potential consequences for our organization:

- Discrimination and harassment
• Dishonest communication
• Violations of confidentiality
• Conflicts of interest
• Inappropriate gifts
• Stealing / misuse of assets
• Fraud, abuse or false claims
• Environmental / safety issues
• Improper lobbying/ politics
• Proprietary information – misuse
• Inadequate (inaccurate/incomplete) documentation

If you have questions or concerns about a specific behavior or situation related to compliance, seek guidance. Questions and concerns should be directed through the…

THREE STEP PROCESS

1. Report the activity to your immediate supervisor.
2. If your concern is not resolved, report the concern to a higher level manager.
3. If the manager does not bring closure to the matter, report the issue to the Corporate Compliance Officer or phone Compliance Line.

Associate grievance issues regarding disciplinary actions, benefits, compensation, and other personnel matters should be brought to the attention of a Human Resources representative.

Compliance concerns can be reported to the Corporate Compliance Officer, Leonardo Sette-Camara., directly (821-4469) or through the CH Compliance Line 1- 888-200–5380: 24 hours a day, 7 days a week.

 Calls to Compliance Line are not taped or traced, and callers do not have to provide their name or any other identifying information. An investigation can be limited by the information provided if the caller chooses to remain anonymous. Should a caller choose to reveal his/her name, it will be held in confidence to the fullest extent practical or allowed by law.

CH is obligated to also extend the same confidentiality to any individual who may be named in the call; therefore, the caller may not be able to be informed of specific actions taken to investigate or address the caller’s concerns regarding a fellow associate. However, they will receive a response. It is the investigator’s responsibility to maintain anonymity and confidentiality of reported matters and the reporting individual.

AUDITING AND MONITORING

An effective compliance program consists of ongoing auditing and monitoring. The compliance office works in conjunction with the organization’s management and department personnel to ensure continuing compliance improvement. The compliance department will monitor the findings of the regularly scheduled department reviews as well as establish specific audits/reviews based on internal or external input, new rules and regulations or governmental focus.

Department managers and supervisors are responsible to adequately monitor departments for detection of violations and/or non-compliance with applicable policies and legal requirements which, with reasonable diligence, would have led to the discovery of any problem or violation and to take corrective action upon discovery of a violation. It is the responsibility of all constituents to implement solutions and continually evaluate the situation.
DOCUMENTATION AND BILLING
It is important that all those associated with CH maintain high personal and professional standards in regard to all documentation and reimbursement areas. It is CH policy to bill all payers in compliance with all federal, state and third party payer laws, rules and regulations. It is fraudulent to either document services that were not performed or to provide services without appropriately documenting those services. Reimbursement can only be sought for services or items that have been provided, appropriately documented and determined to be medically necessary.

All individuals associated with CH must be committed to the integrity, accuracy and confidentiality of information for the benefit of those we serve. In the normal course of our business, medical records and claims are created and maintained to comply with legal, regulatory and accreditation requirements. They must be legible, accurate, complete, secured, and maintained for the required length of time.

COMMITMENT
Everyone plays a significant role in the success or failure of our compliance efforts. Through your participation in the CH Corporate Compliance Program, your actions set in place the standards of conduct, unify our compliance initiative within CH and assist in providing quality care and services to those we serve throughout our community.

Do the right thing, and if you are uncertain….Always Seek Knowledge (A.S.K.).
Act with integrity.

COMMUNICATION ASSISTANCE POLICY
Communication is fundamental in attaining high quality health care for CH patients. To facilitate communication addressing health care needs, all CH facilities will identify patients of limited English proficiency or who are hearing impaired and offer interpretation and translation services. This means that any limited English speaking or hearing impaired patient who presents at our facilities for care will have access to interpretive services 24 hours a day, 7 days a week. Language assistance will be offered at registration or at the beginning of the provision of services. Patients are informed that the service is provided free-of-charge.

Agencies such as NYS Department of Health (NYSDOH), the federal government and Joint Commission have regulations and standards regarding the delivery of health care to persons with limited English proficiency (LEP) and the documentation of such. In order that we comply with laws, standards and regulations, CH has implemented a Communication Assistance Program.

Information on accessing LEP services is provided in the Communication Assistance Policy available in Compliance 360. A one-page summary sheet is also available as a quick resource. The Nursing Supervisor or patient representative is available if further assistance or information is needed.

Blind or Visually Impaired Patient
The hospital must “offer” pre-admission information or a patient discharge plan in enlarged print to the visually impaired patient. If a blind patient requests an audio of the above documents, follow policy or check with your manager. The visually impaired patient’s rights are a part of NYS Public Health Law as well as Joint Commission Communication Standard.

HIPAA PRIVACY & SECURITY REGULATIONS
Health Insurance Portability Accountability Act, “HIPAA” was signed into law in 1996. The intent of HIPAA is to set standards and guarantee security and privacy to protect the healthcare information. In 2009, the HITECH
Act, part of the Stimulus Bill, added modifications to patient privacy rights, required mandatory investigations with risk assessments resulting in breach notification requirements, increased penalties for failure to adhere to HIPAA standards, and increased government enforcement. Again in 2013 HIPAA regulations were strengthened with the Omnibus Rule which resulted in many CH Privacy policy revisions.

THE LAW APPLIES TO COVERED ENTITIES AND BUSINESS ASSOCIATES

Covered Entities are:

- **Health Care Providers** - Conducting HIPAA Transactions
  - Physicians
  - Hospitals
  - Long term care facilities

  *Home Care facilities*

  *Ambulatory surgery centers*
  - Managed care organizations
  - Government health care programs

- **Health Plans**
  - Insurers
  - HMOs
  - Self-insured employers

- **Health Care Clearinghouses**

Business Associates are individuals or companies (billing services, collection agencies, contract coders, IT vendors) that have been given access to the Covered Entity’s PHI in order to perform a service on behalf of the Covered Entity. They are required to report breaches to the Covered Entity and are accountable under the HITECH ACT of 2009. This requirement has been reinforced by the Omnibus Rule

WHAT IS PROTECTED?

Individually Identifiable Health Information (Protected Health Information - PHI)

“Health Information” is any past, present and future information (oral or recorded) in any form or medium that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school, university, or health care clearinghouse and includes payment information.

SPECIFIED IDENTIFIERS:

<table>
<thead>
<tr>
<th>Name</th>
<th>E-mail and web site addresses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security Numbers</td>
<td>Telephone and fax numbers</td>
</tr>
<tr>
<td>Account numbers</td>
<td>Health plan beneficiary numbers</td>
</tr>
<tr>
<td>Certificate/license numbers</td>
<td>Full face photographic images</td>
</tr>
<tr>
<td>Vehicle identifiers and serial numbers</td>
<td>Medical Device numbers</td>
</tr>
<tr>
<td>Geographic subdivisions smaller than a state</td>
<td></td>
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<tr>
<td>Biometric identifiers (finger prints and voiceprints)</td>
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</tbody>
</table>

All elements of dates directly relating to the individual’s: birth date, admission date, discharge date, date of death, and all ages over 89.

Any other unique identifying number, characteristic or code
CONSENT FOR TREATMENT, PAYMENT, & HEALTH CARE OPERATIONS:
Consent (Consent and Financial Agreement) is obtained from the patient upon presenting for treatment and allows disclosure of PHI for treatment, payment & healthcare operations.

Authorization Requirement:
Authorization is needed for all uses and disclosures other than for treatment, payment or health care operations. An authorization must be completely and accurately filled out.

PRIVACY NOTICE:
A Covered Entity must provide a Notice of Privacy Practices to each individual from whom it will receive Protected Health Information.

The Notice of Privacy Practices titled CH Privacy Notice:
- Describes how medical information may be used and disclosed.
- Notifies the individual of his or her rights.

MINIMUM NECESSARY USE & DISCLOSURE:
Access, acquisition, use or disclosure of PHI is only on a need to know basis and based on treatment, payment, healthcare operations or pertaining to other purpose as it relates to job function. This information is to be held confidential and not shared with or disclosed to others who are not providing care of the patient and/or are not covered as a need to know entity.

WHAT INFORMATION CAN PROVIDERS SHARE?
- CH providers can discuss PHI (other than sharing medical records or films) with a patient’s family member, friend, or caregiver without authorization, so long as patient, who is able to, doesn’t object. If the patient is alert and oriented, the patient should be given the opportunity to object prior to sharing information. (If the information is being shared in the patient’s presence, it may be inferred that patient is not objecting).
- If the patient is not present or incapacitated, a health care provider may share patient information with a patient’s family and friends as long as it is determined, based on professional judgment, that is in the best interest of the patient.
- Health care providers can share patients’ information to provide continuity of care.
- Providers can share necessary health information with licensing and credentialing agencies.

PERSONAL REPRESENTATIVES
CH must provide a patient’s “personal representative” with all of the rights and privileges that are possessed by the patient with respect to PHI that is relevant to the individual’s representation.

Examples of Personal Representatives in NY:
- A Health Care Agent, as named in a Health Care Proxy. If in effect, the agent can review medical records, films, etc. if that will assist to make health care decisions for the patient.
- A guardian of an adult patient, as authorized by a judge, such as an Article 81 Guardian.
- An executor, administrator or person who has legal authority to act on behalf of a deceased individual or their estate.
- A parent, guardian, or person who has legal authority to make health care decisions on behalf of a minor-except for prenatal care, mental health treatment, substance abuse treatment, and treatment of sexually transmitted diseases.

PHYSICAL SAFEGUARDS FOR MAINTAINING PRIVACY OF INFORMATION:
- Be aware of your surrounding, lower your voice.
- Be conscious of who is in the immediate area when discussing sensitive patient information
- Be careful when on the phone discussing patient information
Secure your area when not attended
Log off of computer screens containing PHI before leaving the area. If you are returning shortly use Ctrl/Alt/Delete then simply enter your password to return to the screen.
Close medical records when not in use and store them in a secure area
Do not allow other associates to utilize your ID and computer password
Do not leave papers with PHI in plain view
Secure fax machines in areas away from public access
Pick up faxed or printed PHI immediately and correctly identify and verify transmissions
Destroy and dispose of documents containing PHI so that the information cannot be retrieved
Report immediately potential or actual HIPAA concerns

SENDING EMAILS WITH PHI INTERALLY AND EXTERNALLY
All emails sent internally within CH are secure. Emails sent externally, outside the system, need to be encrypted. You can locate the instructions for sending external encrypted emails by typing “encryption” in the search box of Compliance 360.

USES AND DISCLOSURES OF MEDICAL INFORMATION WITHOUT PATIENT AUTHORIZATION FOR FUNDRAISING
CH may use PHI (name, address and date of service) for purposes of fundraising activities. The patient has the right to opt out of receiving fundraising solicitations by sending a written request to the Privacy Officer.

UNAUTHORIZED ACCESSING AND DISCLOSURE OF PATIENT INFORMATION
An associate may access PHI that has been assigned and needed to carry out their duties. Curiosity can be a normal human trait. However, accessing health information on self, family members, friends, co-workers, persons of public interest or any others that is not work related and that you are not involved in the care of is a VIOLATION of HIPAA.

All patients utilizing CH services, including co-workers are entitled to privacy of their health information. Disclosing PHI through careless safeguards or to those outside of the need to know for treatment, payment or health care operations is also a VIOLATION of HIPAA.

VIOLATIONS OF PRIVACY POLICY & PROCEDURE MAY RESULT IN:
- corrective action against the associate with possible termination of employment
- monetary fines for CH and the individual
- civil and criminal penalties (jail time) for the individual violator.

Associate duties:
1. Safeguard protected health information
2. Keep communication of PHI limited to the minimum amount necessary
3. Only access PHI necessary to perform your job function
4. Only disclose PHI necessary for treatment, payment or healthcare operation to those who need to know.
5. CH associates have an obligation to report any potential or actual HIPAA incident immediately to the Privacy Officer for investigation and implementation of appropriate corrective measures.
6. Reasonable steps must be taken to mitigate any harmful effect of the violation.

Examples of incidents that require immediate reporting:
- Lost laptop
- Lost PDA (Personal Digital Assistant)
- PHI left in the cafeteria
- Cell phone pictures of patients or patient information
Faxes containing PHI sent to the wrong number/person
Unauthorized access of patient PHI
Unauthorized disclosure of patient PHI
Theft or loss of passwords, computer equipment or any other devices/information that compromise the safety of protected health information.

CH considers violations of HIPAA a serious breach of patient confidentiality and represents a direct opposition of our commitment for respect and dignity of our patients. The CH computer system is able to track when associates view records of patients. Associates computer use can be monitored and CH is required by law to conduct security audits.

**COMPLAINTS:**
Patient complaints regarding CH compliance with patient privacy are directed to the Privacy Officer, Leonardo Sette-Camara. All complaints will be thoroughly investigated.

HIPAA privacy and security policies are located in Compliance 360. Additional HIPAA educational information is available to all CH associates in NetLearning and at CH University classes.

The CH Privacy Officer is Leonardo Sette-Camara
For Privacy breaches or questions, please call Leonardo Sette-Camara at 821-4469, the HIPAA Line 862-1790 or the Corporate Compliance Line at 1-888-200-5380

The CH Security Officer is Pete Capelli.
For Security breaches, loss of computer laptops, flash drives, discs etc or for security questions, please call Sally O'Brien, 862-1938, HIPAA Line 862-1790, CH HelpDesk 828-3600 or the Corporate Compliance Line at 1-888-200-5380
All calls are confidential.

**SOCIAL MEDIA POSTINGS**
Catholic Health recognizes social media as an avenue for self-expression, however, CH Associates must remember that they are personally responsible for the content they contribute and should use social media responsibly. Catholic Health’s human resources policies – including its equal employment opportunity and sexual harassment/non harassment policies – and its policies on patient confidentiality/HIPAA, apply to associates’ on line conduct.

Social Media includes, but is not limited to social networking sites such as Facebook, LinkedIn, Flickr and Twitter, personal websites, news forums and chat rooms.

The following rules must be followed by all individuals covered by this policy.
1. Follow Catholic Health values, Code of Conduct and policies in all social media usage.
2. Carefully consider what you post.
3. Representation of Catholic Health on any social media site is subject to approval
4. Affiliation with Catholic Health must be disclosed.
5. Identify your opinions as your own and not those of Catholic Health.
6. Do not disclose private, confidential or proprietary information.
7. Abide by federal and state laws.
8. Be respectful.
9. Be professional.
10. Do not engage in solicitation.
11. Associates may not use any Catholic Health social media site to gain access to contact lists or names to be used for any purpose that would violate federal or state laws or any Catholic Health policy.
12. Do not post photographs taken on Catholic Health property.
14. Think twice before “connecting.”
15. Use of Catholic Health e-mail address.

Conduct that violates other policies would also be prohibited through social media. Catholic Health may monitor any social media activity of individuals covered by this policy if there is reason to believe that a policy or legal violation has occurred as well as in connection with Human Resource investigations. Catholic Health reserves the right to edit or remove posts that violate this policy.

**HUMAN RESOURCES**

**Discrimination and Harassment**

**PURPOSE:**
Catholic Health’s objective is to ensure individuals are treated with respect and dignity in addition to complying with Federal and State Laws prohibiting discrimination and harassment.

**APPLIES TO:**
This policy applies to associates, medical staff, volunteers, vendors and any other persons in contact with Catholic Health.

**I. POLICY STATEMENT**
Catholic Health (CH) is committed to a work environment in which all individuals are treated with respect and dignity.

Each individual has the right to work in a professional atmosphere that promotes equal employment opportunities and prohibits discriminating practices including harassment. Therefore, CH expects that all relationships among persons at work will be business-like and free of bias, prejudice or harassment. CH encourages all staff to report all perceived incidents of discrimination and harassment. CH will promptly investigate such reports and will take appropriate corrective action.

Any associate who is found violating this policy is subject to disciplinary action up to and including termination of employment.

**A. EQUAL EMPLOYMENT OPPORTUNITY**
It is the policy of CH to ensure equal employment opportunity on the basis of race, color, religion, gender, sexual orientation, age, disability, marital status, veteran status, citizenship, or any other characteristic protected by law. CH prohibits any such discrimination.

**B. HARASSMENT**
It is the policy of CH that harassment is defined as offensive or intimidating conduct of a verbal or physical nature, which has the purpose or effect of unreasonably interfering with an associate’s working condition or performance, creates a hostile, intimidating, or offensive work environment or otherwise affects employment opportunities.

Examples of harassment include:
• Jokes, derogatory expressions or comments involving race, color, religion, gender, national origin, marital status, mental or physical disability, veteran status, sexual preference, alternate lifestyle, or physical appearance.
• The display of degrading graphics, cartoons, or objects involving race, color, religion, gender, national origin, marital status, mental or physical disability, veteran status, sexual preference, alternate lifestyle or physical appearance.
• Physical contact which could be construed as aggressive or intimidating, such as grabbing an associate by the arm, poking, etc.
• A pattern of intimidating body language (words or actions) which the alleged victim has identified as such to the alleged harasser.

Sexual harassment is defined as any unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature. For example:
1. Submission to such conduct is made either explicitly or implicitly a term or condition of an individual’s employment;
2. Submission to a rejection of such conduct by an individual is used as a basis for employment decisions affecting such individual;
3. Such conduct has the purpose or effect of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile, or offensive working environment.

Sexual harassment may include a range of subtle and not so subtle behaviors and may involve individuals of the same or different genders. These behaviors may include but are not limited to:
• unwanted sexual advances or requests for sexual favors;
• sexual jokes and innuendo;
• verbal abuse of a sexual nature;
• commentary about one’s body;
• sexual prowess or sexual deficiencies;
• leering, whistling or touching;
• insulting or obscene comments or gestures;
• display in the workplace of sexually suggestive objects or pictures;
• any other physical, verbal or visual conduct of a sexual nature.

II. INDIVIDUALS & CONDUCT COVERED
The policies apply to all associates, whether related to conduct engaged by fellow associates or someone not directly connected to CH (e.g. affiliated health care providers, patient, patient visitor, volunteer, vendor or consultant).

III. DISCRIMINATION/HARASSMENT COMPLAINT PROCESS
Any person electing to utilize this process will be treated courteously, the problem handled swiftly and as confidentially feasible in the light of the need to take appropriate corrective action. Associates are strongly urged to utilize this process. The filing of malicious complaints is an abuse of this policy and is prohibited and will lead to corrective action.

A. RESPONSIBILITIES:
1. All Catholic Health associates must share the responsibility of understanding and preventing discrimination and harassment. Individuals who believe they have been discriminated against or harassed or have witnessed such behavior have the primary obligation to inform Management.
2. Executives, Managers and Supervisors have a special responsibility as agents of the System to act promptly to eliminate discrimination and harassment.
B. COMPLAINT PROCEDURE
Any possible victim or observer of discrimination or harassment has an obligation to notify his or her supervisor, or the organization’s respective Human Resources Director and any other officer of the organization immediately.

The complainant is expected to provide information that the organization requests, including a detailed account of the complaint including witnesses (if any dates and other information considered relevant by the organization). A formal investigation of the complaint will be initiated by the Human Resources Department as soon as possible. All associates whether complainant, witness, or accused are required to be truthful, accurate and cooperative during the investigation.

Anyone who is found to have engaged in prohibited discrimination or harassment will be subject to appropriate disciplinary action which may include termination.

C. RETALIATION
No hardship, loss of benefit, and penalty may be imposed on an associate as punishment for:

1. Filing or responding to a bona fide complaint of discrimination or harassment;
2. Appearing as a witness in the investigation of a complaint; or
3. Serving as an investigator.

This policy is available in the Human Resources Policy Manual - No. HR-016-PC, which is located on Compliance 360

BULLYING
Nearly half of all American workers (49%) have been affected by workplace bullying, either being a target themselves or having witnessed abusive behavior against a co-worker. Some co-worker behaviors include sabotaging work, having resources or information withheld, being excluded from conversations or activities at work, being accused of errors by co-workers, and being yelled or screamed at by co-workers. You may feel that potential interaction with co-workers makes you anxious before coming to work or you might avoid an individual because of past interpersonal interactions. The offense under our Conduct Principle and Corrective Action Policy HR-011 deal with creating conflict, unprofessional behavior toward co-workers, verbal abuse, interfering with the work of a co-worker, and spreading malicious rumors which are connected to bullying.

First recognize the behaviors as bullying and take action by:

- Prepare to address the individual and make it known the behavior will not be tolerated and will be dealt with each time it occurs.
- Plan what you will say and say it with an even tone to your voice.
- Be prepared to tell the co-worker to stop and specifically name what you want the co-worker to stop doing.
- If addressing the individual does not work, report the behaviors to your manager as soon as possible.
- Be very aware of the policies in your facility to address workplace conflict and interaction.

BREASTFEEDING AT CATHOLIC HEALTH: WHAT MANAGERS AND ASSOCIATES NEED TO KNOW
Support of Breastfeeding is a Priority Public Health Case
Breastfeeding is the standard for infant feeding and protects infants and children from many significant infectious and chronic diseases. The direct benefits to baby/future adult include:
  - Lower obesity rates, less ear and respiratory infections as well as reduction in asthma, gastrointestinal infections and dermatitis. Also lower Type 1 and Type 2 diabetes and leukemia.

$13 billion of direct pediatric health-care costs and more than 900 lives would be saved annually if 90% of women were able to breastfeed exclusively for six months as recommended.\(^2\)

Women who breastfeed have a reduced risk of breast and ovarian cancer, type 2 diabetes, postpartum depression, and cardiovascular disease.\(^3-5\)

**Work Remains a Barrier to Breastfeeding** \(^6-10\)

- Full-time employment decreases breastfeeding duration by an average of more than eight weeks.
- Mothers are most likely to wean their infants within the first month after returning to work.
- Only 10% of full-time working women exclusively breastfeed for six months.
- Catholic Health is a leader in supporting breastfeeding moms in the workplace.

If a mother chooses to breastfeed, she needs to pump breast milk during the workday in order to maintain her milk supply. Missing even one needed pumping session can lead to decreased milk production and other undesirable consequences.

**Women Need Worksite Lactation Support** \(^11\)

- Breaks for lactation are similar to other work breaks for attending to physical needs:
  - Time to eat/drink, restroom breaks, accommodation for health needs (e.g., diabetes)
  - When mother and child are separated for more than a few hours, the woman must express milk.
  - Missing even one needed pumping session can have undesirable consequences:
    - Discomfort – Leaking – Inflammation
    - Infection – Decreased Milk Production
    - Breastfeeding Cessation

**How to Support Breastfeeding Employees**

- In general, women need 30 minutes (15 to 20 minutes for milk expression, plus time to get to and from a private space and to wash hands and equipment) approximately every 2 to 3 hours to express breast milk or to breastfeed.
- Needs may vary from woman to woman and over the course of the breastfeeding period.
- It is the law to give women time to express breast milk (see CHS Policy HR-096-BE)

**Business Case** \(^11\)

- Lactation programs are cost-effective, showing a $3 return for every $1 invested.
- By supporting lactation at work, employers can reduce turnover, lower recruitment and training costs, cut rates of absenteeism, boost morale and productivity, and reduce health-care costs.
- Lactation accommodation is not one-size-fits-all. Flexible programs can be designed to meet the needs of both the employer and employee. Be flexible and proactive!
- Breastfeeding support in workplace helps families meet their personal goals to breastfeed and raise their children without the added guilt of working part and full time. If work makes it easier to breastfeed, associates report higher levels of job satisfaction, increased loyalty, and increased focus on job duties.
- In the long run, breastfeeding prevents chronic diseases which ultimately contributes to a healthier future workforce through reduction of obesity, cancers, etc.

**Legal Basis**

Under the Fair Labor Standards Act employers are require to provide ‘reasonable break time for an associate to express breast milk for her nursing child for one year after the child is born and for each time the employee has
a need to express breast milk’. Employers are required to provide ‘a place other than a bathroom, that is
shielded from view and free from intrusion from coworkers and the public, that may be used by an associate to
express breast milk’. This could be an office or exam room or private space that is designated as needed by a
manager.

Resources
What resources are available for managers?
• Catholic Health Policy on Lactation (Compliance 360; HR-096-BE)
• Identify location within your department for your associate who may want to breastfeed her child and express
(pump) breast milk. Be proactive and supportive.
• Direct associates with specific breastfeeding/personal advice regarding lactation that they can call 862-1939.

What resources are available for employees?
• Baby Café at Sisters
• Mercy and Sisters Hospital Lactation Department
• Educational materials, professional support.
• See the Catholic Health System website for more information and guidance

References
Practice Center). Breastfeeding and maternal and infant health outcomes in developed countries. Evidence Report/Technology
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5. Gunderson EP, Jacobs DR, Chiang V, et al. Duration of lactation and incidence of the metabolic syndrome in women of
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RISK MANAGEMENT

What is Risk Management?
Risk Management is the systematic review of events that have caused harm or present a potential for harm and
could result in loss for the hospital system.
OCCURRENCES

What is an Occurrence Report?
Occurrences are events that are unplanned, unexpected and unrelated to the natural course of a patient’s disease process or routine care and treatment.

What is the purpose of an Occurrence Report?
- Enhance quality of patient care
- Assist in providing a safe environment
- Quick notice of potential liability

Sources of Occurrences:
- Patients
- Visitors
- Security Reports
- Patient Complaints
- Equipment related (Safe Medical Device Act)

Occurrences can happen in any department. Any associate or physician who discovers, witnesses or to whom an occurrence is reported is responsible for documenting the event immediately via Occurrence Report. Any associate who requires assistance should contact his/her manager. It is important to document the facts only – who, what, when, where and why.

DO NOT:
- Document in the medical record that an “occurrence report” was completed
- Give your opinion in the medical record or on the occurrence report
- Make copies of an occurrence report

PATIENT COMPLAINTS
Complaints are another opportunity for improvement. The patient bill of rights provides for the patient to bring concerns to our attention without fear of reprisal.

What happens when a Complaint is filed?
- When appropriate, an employee may handle a complaint on his/her own. Employees are empowered to resolve issues within the scope of their job (or report to manager). Employees are free to seek assistance if required. It is part of the quality improvement process to complete the form. DO NOT ask the complainant to fill out the form. Remember that they also have the right to take concerns to the Department of Health.
- A complaint may be referred to the Patient Representative
- A complaint may be referred to Risk Management

RISK MANAGEMENT PROCESS
Patient and visitor safety are assessed from both clinical and environmental perspectives.
- Following an occurrence, assure patient/visitor safety, then complete Occurrence Report
- Notify Quality and Patient Safety Department of patient occurrences
- Notify Security of visitor or property occurrences
- Risk Management will be notified of occurrence and will investigate and collect information
- Risk Management participates on the team to evaluate the occurrence and help improve safety
Risk Management reports events to insurance carriers in case of potential liability

**SYSTEM RISK MANAGEMENT OFFICE RESPONSIBILITIES**
- Identify potential risk and collaborate in reduction of potentially compensable events throughout the system
- Manage claims and assist in the management of suits. Employees will be supported throughout the entire litigation process (interviews/deposition/trials)
- Respond to or assist in response to subpoenas or Summons with Complaints.

*Please Note:* The Administration Office of any facility is the only department authorized to accept Summons with Complaints. Administration, Health Information, Business Office and Primary Care Centers are able to accept Subpoenas. Be cautious – service may come by mail. Carefully document the date and time of service as well as who accepted the documents.

**** Notify Risk Management immediately upon receipt of a work related Summons or Subpoena. If you are uncertain about accepting documents, please contact Risk Management before accepting service.

- Maintain insurance for the hospitals, long term care and home care (including all employees)
- A system resource for medical-legal-risk concerns
- Provide Risk Management education programs

**IDENTITY THEFT RED FLAG RULES**
- Identity theft is fraud committed or attempted by using identifying information of another person without that person’s authority.
- Identifying information is a name or number that may be used to identify a specific person, for example: name, address, telephone number, social security number, date of birth, driver’s license, or insurance number.
- The Federal Trade Commission (FTC) issued regulations known as the “Red Flag Rules” in 2007 which stemmed from The Fair and Accurate Credit Transactions Act (FACTA) of 2003 which is intended to protect consumers from identity theft.
- “Red Flag Rules” apply to health care facilities that maintain “covered accounts” or extend credit to consumers. These facilities must have written policies and procedures to identify, detect, prevent and mitigate identity theft.
- Catholic Health has an “Identity Theft Prevention and Mitigation” policy that can be found on the Compliance 360 policy management system. This can be accessed via the internet under Favorites/CH Enterprise Link/policy search.
- Contact Risk Management when an occurrence of Identity Theft is suspected or reported.

**EMTALA REGULATIONS**
EMTALA is the Emergency Medical Treatment and Active Labor Act, a.k.a. COBRA. EMTALA provides a guideline for safely and appropriately transferring patients in accordance with Federal regulations. The law provides for a medical screening exam (MSE) to all individuals seeking emergency services on hospital property. Hospital property includes the driveway, parking lot, lobby, waiting rooms and areas within 250 yards of the facility. If an emergency medical condition is found, it will be stabilized within the hospital’s ability to do so, prior to the patient’s transfer or discharge. If a patient does not have an emergency medical condition, EMTALA does not apply.

***Important Reminder: Never suggest that a patient go elsewhere for treatment.***
QUALITY AND PATIENT SAFETY

At CH we believe that the patients and associates safety are our main concern. As a result we have focused our efforts to strengthen our Culture of Safety with the ultimate goal of eliminating medical errors to our patients and injuries to our associates. How? – by raising our expectations of our Board, Leaders, Physicians and Associates.

Through education and implementation of proven tools that will help us all communicate better, help each other and prevent harm to our patients and associates. Below are some proven tools that are currently being implemented to help us achieve our goals.

Every Associate and Member of the Medical Staff is Expected to Practice

“Pursuing Excellence Expectations for Patient Experience and Patient Safety”

- Pay Attention To Detail
- Communicate Clearly and Directly & Perform Effective Handoffs
- Have a Questioning Attitude
- Work Together With Your Team
- Follow the Rules
- Interact Respectfully and Compassionately
- Demonstrate a Positive Attitude
- Demonstrate Accountability for your Actions

Every Associate will be held accountable through the evaluation process for how the expectations are being met.

PAY ATTENTION TO DETAIL

STAR – S top, T hink, A ct, R eview – when you are busy.
This review only takes a few seconds and helps to make sure you have not missed a critical step.

STOP: Stop and concentrate on the task you will be doing
THINK: Think about what is the right thing to do
ACT: Perform the task
REVIEW: Review your actions to make sure everything was completed

- STAR is a tool to utilize when you are on auto- pilot and it is easy to forget a step without knowing
- STAR can be utilized when you are multi-tasking and do not want to make an error

STANDARDIZED COMMUNICATION: SBAR

The Joint Commission has reported that communication failure is the root cause of 65% of the 2,840 sentinel events to them.

SBAR stands for the following:

1. Situation  What is going on with the patient / situation?
2. Background  What is the background or context?
3. Assessment  What do I think the problem is?
4. Recommendation  What would I do to correct it?
KEYS TO EFFECTIVE COMMUNICATION:

- Information included in the hand-off should be clear, concise, accurate and up-to-date
- The caregiver receiving the hand-off should have the opportunity to review relevant historical data contained in the patient’s medical record
- Repeat–back or read-back should be used to verify the information received, as appropriate
- Interruptions during hands-off should be limited to minimize the possibility that information might be forgotten or simply not conveyed.
- Interactive communication should occur allowing for clarifying questions between the giver and receiver of patient information
- Phonetic and numeric clarifications should be utilized when appropriate

NOTE: In both Soarian and Med Host there is a SBAR hand-off form that should be utilized.

Information to be communicated during TEMPORARY HAND-OFFS:

Examples of TEMPORARY hand-offs:

- Transfers between inpatient units and diagnostic imaging
- Transfers between inpatient units and cardiology for stress testing
- Transfers between inpatient units and dialysis units

<table>
<thead>
<tr>
<th>S - Situation</th>
<th>Patient Name</th>
<th>Date of Birth</th>
<th>Current Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>B - Background</td>
<td>Diagnosis</td>
<td>Allergies</td>
<td>Code Status</td>
</tr>
<tr>
<td></td>
<td>Fall Precautions</td>
<td>Isolation status</td>
<td>Assistive device use</td>
</tr>
<tr>
<td></td>
<td>IV infusing, if any</td>
<td>O2 therapy</td>
<td>Telemetry</td>
</tr>
<tr>
<td></td>
<td>Language assistance needs</td>
<td>Skin status</td>
<td></td>
</tr>
<tr>
<td>A - Assessment</td>
<td>Recent changes in condition</td>
<td>Pain level and location</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medications (list – needs to be sent if medications will be given in the receiving department)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>R - Recommendation</td>
<td>Potential changes to watch for</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Information to be communicated during PERMANENT HAND-OFFS:

Examples of PERMANENT hand-offs:

- Transfers between inpatient units and operating room / GI unit
- Transfers between Operating Room and PACU
- Transfers between PACU and inpatient units
- Transfers from inpatient unit to inpatient unit

- Transfers from the Emergency Room to inpatient unit
**HAVE A QUESTIONING ATTITUDE:**
If something doesn’t seem right, it probably isn’t. Stop and ask a question

**Advocacy and Assertion**
Advocate for the patient
- Invoked when team members’ viewpoints don’t coincide with that of the decision maker

Assert a corrective action in a *firm* and *respectful* manner
- Make an opening
- State the concern
- Offer a solution
- Obtain an agreement

**Two-Challenge Rule**
When an initial assertion is ignored:
- It is your responsibility to assertively voice concern at least *two times* to ensure it has been heard.
- The team member challenged must acknowledge,
- If the outcome is still not acceptable:
  - Take a stronger course of action
  - Utilize supervisor or chain of command

Empowers all team members to “*Stop the Line*” if they sense or discover an essential safety breach.

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<table>
<thead>
<tr>
<th><strong>S - Situation</strong></th>
<th><strong>B - Background</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Patient Name</td>
</tr>
<tr>
<td></td>
<td>Date of Birth</td>
</tr>
<tr>
<td></td>
<td>Current Unit</td>
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</table>

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Allergies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Status</td>
<td>Fall Precautions</td>
</tr>
<tr>
<td></td>
<td>Isolation status</td>
</tr>
<tr>
<td></td>
<td>Assistive device use</td>
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<tr>
<td></td>
<td>IV infusing, if any</td>
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<td></td>
<td>02 therapy</td>
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<td></td>
<td>Telemetry</td>
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<tr>
<td></td>
<td>Language assistance needs</td>
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<tr>
<td></td>
<td>Skin status</td>
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</table>

<table>
<thead>
<tr>
<th><strong>A - Assessment</strong></th>
<th><strong>R - Recommendation</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Recent Vital Signs</td>
<td>Potential changes to watch for</td>
</tr>
<tr>
<td></td>
<td>Vital signs that are due</td>
</tr>
<tr>
<td></td>
<td>Medications that are due</td>
</tr>
<tr>
<td></td>
<td>Labs/tests that are pending</td>
</tr>
</tbody>
</table>

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```
I am CONCERNED!
I am UNCOMFORTABLE!
This is a SAFETY ISSUE!

"Stop the Line"

Meet goals without compromising relationships.

"True collaboration is a process, not an event"
```
SPEAK UP FOR PATIENT SAFETY

➢ We all have a responsibility to say something when patient safety is at risk
  Use a “Gentle Nudge”
  • Get the person’s attention utilizing their name (Example: Debbie)
  • Relay the information expressing that YOU have a CONCERN (Example: I think the policy is to label bloods at the bedside.)
  • Propose a solution (utilize words like check/verify). (Example: Debbie, can I get you the labels so you can verify the patient’s name and DOB and label the tubes when they are drawn)
  • Let the person know that YOU are UNCOMFORTABLE with the situation
➢ If the response to direct communication with the attending physician, nurse and/or team members is inadequate to restore safety
➢ You have the authority to Stop the Process and get Management Involved.
➢ The appropriate member of management should be contacted. The chain of command should be followed.
➢ Escalate your concerns

Work Together With Your Team:
We need to help each other. This means if you see someone not following a rule, you need to tell them and if they tell you, you should thank them. Offer each other assistance. Put the patient first. Remember if you do not directly care for patients what you do impacts the care of our patient’s.

Follow the Rules:
Know the policies and procedures that apply your department and that impact your safety and the safety of our patient’s. Follow those policies. Examples include: Patient Identification, Invasive Procedure Protocol (Time-Out), Falls Prevention, Verbal Orders, Hand-Hygiene, etc……..

Interact Respectfully and Compassionately:
Remember to make eye contact, say hello and utilize a patient and/ or co-workers name. Put yourself in the place of the other person. Conversations are conducted in appropriate settings with discretion to protect confidentiality.

Demonstrate a Positive Attitude:
Exceed the expectations of our patients and your co-workers. Attempt to directly influence others through your behavior. Do not engage in or listen to negativity or gossip. Stop the gossip rather than participate in it.

Demonstrate Accountability for Your Actions:
It is everyone’s responsibility to take action when you notice something that needs to be changed or improved. The action could include notification to management, notifying another department of a problem, completing occurrence report, or cleaning up a spill. Do not wait until an error occurs or there is a patient complaint before something is said or done.

WHAT IS QUALITY IMPROVEMENT?
It is a Focused approach to identify, evaluate and improve strategic clinical processes to realize our overall goals of improving patient safety and clinical outcomes.

WHAT IS CATHOLIC HEALTH’s FOCUS?
• Improving the Patient Experience
• Preventing Falls
• Preventing Pressure Ulcers
• Reducing Medication Errors related to insulin, anticoagulants and narcotics
• Preventing Associate Injuries
• Reducing Hospital Infections – (Central Line Infections, Urinary Tract Infections from Catheters, MRSA, Surgical Site and Ventilator Associated Pneumonia)
• Disease Specific Measures (Heart Failure, Pneumonia, Acute MI, Stroke)
• Reducing Readmissions

HOW DO WE MAKE IMPROVEMENTS?
• Utilize Plan Do Check Act
• Establish Multi-disciplinary Teams at site and /or system level (Associates are often asked to participate) (Plan)
• Set Target / Goals that are reported up to the Board (Plan)
• Collect and Analyze Data (Check)
• Utilize National Best Practices (Do)
• Standardize Practices / Policies (Do)
• Provide Education (Do)
• Monitor the changes and obtain feedback from end users. Modify the processes based on monitoring, data and feedback (Act)

REDUCING PATIENT FALLS
• All patients are assessed for falls risk on admission
• A falls risk assessment is completed daily on all patients
• The Morse Falls Risk Assessment is Utilized

<table>
<thead>
<tr>
<th>Assessment Variable</th>
<th>Assessment</th>
<th>Score</th>
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<tbody>
<tr>
<td>History of Falling</td>
<td>Yes</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>Secondary diagnosis</td>
<td>Yes</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>Ambulatory aid</td>
<td>Furniture</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>Cane/walker</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>None</td>
<td>0</td>
</tr>
<tr>
<td>IV or W access</td>
<td>Yes</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>Gait</td>
<td>Impaired</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Weak</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Normal</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Immobile</td>
<td>0</td>
</tr>
<tr>
<td>Patients ability to understand instructions</td>
<td>Patient understands instructions – will follow instructions</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Patient consistently does not call for assistance – will not follow instructions</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inpatient Fall During this Hospital Stay</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
</table>

If answer is Y implement Fall Risk Interventions for high risk patients

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>MFS Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low risk</td>
<td>0-34</td>
</tr>
<tr>
<td>Moderate risk</td>
<td>35-99</td>
</tr>
<tr>
<td>High risk</td>
<td>60+</td>
</tr>
</tbody>
</table>
FALL RISK REDUCTION STRATEGIES:
- Patients who are at a high risk for falls are identified by yellow socks and a yellow blanket.
- Utilize Bed and Chair Alarms as appropriate. These alarms are often indicated for patients who are unaware of their own limitations (will get out of bed without asking for help when told to ask for help).
- If a bed alarm is in use and the alarm needs to be turned off for any reason – “FLIP THE FLAP” – keep the flap of the alarm panel up until the alarm is turned back on.
- Do not leave high risk patients alone in the bathroom or on the commode. If you need to walk the patient to the bathroom, they should not be left alone.
- Make sure call lights and other personal items are within reach of the patient.

IF A PATIENT FALLS:
- Patient must be assessed by a physician, NP, PA
- Attending Physician must be notified
- Family must be notified
- An occurrence report must be completed
- Complete a POST FALL HUDDLE with your team.
- The fall must be documented in the medical record – If the patient is an in-patient utilize the post fall documentation form in Soarian
- Complete a new fall risk assessment
- If patient is on anticoagulation and hit their head or you are unable to determine if they hit their head during a fall, the provider should assess the patient’s potential need for a CT of the head and neuro checks.

RESTRAINT USE
What is a Restraint?
- Any manual method that immobilizes or reduces the ability of the patient to move his or her arms, legs, body or head freely

Catholic Health approach to restraints is:
- One that protects the patient’s health and safety
- Preserves the patient’s rights and well-being.

The Catholic System is committed to reducing restraint use for patients.

Restraint use reduction:
- Alternatives must be attempted
- Least restrictive method must be utilized
- Physician must order and must reorder daily
- Patient must be monitored on a routine basis
- Documentation must include patient’s response and rationale for continued use
- CMS requires reporting / tracking of all deaths while a pt. is in restraints or within 24hrs after removal of a restraint. The QPS department is responsible to report/track. Patient care services is responsible to notify the QPS department.

- Mitts are not considered a restraint. A provider order is not required. The patient is free to move their hand. If a restraint is used is combination this would be a restraint.
- If restraints are discontinued based on patient assessment, a NEW order is required to place the patient back in restraints. If restraints are removed as a trial a NEW order is also required to place the patient back in restraints.
Restraints can be DANGEROUS!! Use as a last resort!

**Negative Effects:**
- Death
- More serious injuries from falls
- Injury from entrapment
- Prolonged hospitalization
- Skin breakdown
- Depression

If you need to apply restraints and have not been trained or have any concerns on how to apply a restraint always ask prior to using.

**WHAT ABOUT SIDERAILS?**
Joint Commission Sentinel Event Alert: “Both split and full rails have the potential to cause injuries as well as entrapment…” Catholic Health supports limited side rail use to no more than 2 whenever possible.

**PATIENT IDENTIFICATION:**
Patient identity should be verified:
A. Prior to starting any procedure including blood draws.
B. Prior to medication administration.
C. Prior to performing an assessment.
D. Prior to transport off a unit/department.
E. Upon arriving to unit/department.
F. When obtaining a consent.
G. Whenever an arm band is placed on a patient.
H. When documenting in the medical record including but not limited to placing orders, documenting notes or placing documents into the record.
I. Prior to administration of a blood product
J. Feeding of breast milk
K. Delivery of patient meals.
L. Any clinical interaction with a patient.

**Process for Patient Identification:**
- Patient Identification requires two unique identifiers which are: Date of Birth and Patient Name as found on the Patient ID band
- The information on the ID band will be compared to another source of documentation (i.e.: MAR, blood product label, transport slip, outpatient registration slip).
- Whenever possible the patient should be involved and requested to state information which is compared to another source.
- The use of bar-coding technology to verify patient identification does not exclude involving the patient; whenever possible the patient should be involved in the process.
- When using the EMR always verify patient identification to insure you are entering information into the correct medical record.
- **ROOM NUMBER SHOULD NEVER BE UTILIZED AS A PATIENT IDENTIFIER.**

**NOTE:** In the newborn nursery/NICU - Name and Medical Record are utilized as the 2 patient identifiers.

“**Time Out**” Immediately before starting procedure
The “time-out” includes the following:
- Correct patient confirmed by team
- Agreement by team on procedure to be performed
- Correct side/site marked - agreement on site/side by team
- Correct patient position
- Equipment/implants appropriately prepared
- Prophylactic Antibiotics started within 60 minutes prior to incision (exception - 2 hrs Vancomycin if > 60 minutes or 2 hrs re-dose then proceed)
- Confirmation of Images
- Safety Concerns Addressed

The process needs to be completed for **ALL** procedures requiring **CONSENT**

- This form is utilized for all time-outs whether in the OR or at the Bedside. The RN or Clinical Person responsible for the procedure should lead the “time-out”

**Note:** If a **central line is inserted** complete the additional check list on the back of the form. This is the Central Line Insertion Bundle. This should be completed even if the central line is inserted in the OR.
Preventing Central Line Infections: When inserting a Central Line refer to the back of the time-out form.
The documentation insures that the team is compliant with the insertion bundle prior to proceeding. The goal is to reduce Hospital Acquired Central Line Infections.

![Central Line Insertion Check List]

**CRITICAL VALUES**

*What is a critical value?*
A Critical Value is a test result that when action is not taken immediately can cause patient harm

*What are examples of a critical value?*

**Radiology Results**
- Pneumothorax
- Intra-Cranial Bleeds
- Retained Foreign Body

**Cardiology Results**
- Acute MI on EKG
- Echo that notes Aortic Dissection

**Lab Results**
- Positive Blood Culture
- White Blood Cell Count > 50
- Potassium > 6

*Who needs to be notified?*

The Physician/Provider ALWAYS needs to be notified/aware within 60 minutes:
- The person who obtains the result is responsible to notify a RN on the nursing unit for in-patients or the physician for out-patients.
- The RN on the nursing unit is responsible to call the physician. The Physician needs to return the call within a reasonable time generally not to exceed 60 minutes.

*What should be documented?*
- Document the time that you called the provider or nursing unit.
- Document the time the provider returned the call.
- Document the conversation and/or orders received

*What should you do if the provider does not call back?*
- When the provider does not return the call follow the chain of command (Notify your Supervisor – who can notify the Department Chair of that physician)
- A Rapid Response Team can always be called if the patient requires immediate care
- Report the delay of care on an occurrence report
What if you feel the value is not addressed?

- There is the Speak up for Safety policy
- First offer your suggestion to the provider, if this is ignored get your supervisor / manager involved

**ANTICOAGULATION SAFETY**

Anticoagulants, such as Unfractionated Heparin, Low Molecular Heparins, and Warfarin are considered high risk drugs. What can be done to reduce or prevent these adverse events related to these medications?

- Provide your patient education – all patients receiving anticoagulation should receive education regarding the medication they are receiving. This education should be documented in the medical record. Patient education tools regarding these medications are available on the nursing units. Within Soarian there is the ability to print the Warfarin administration record.
- Insure your patient is properly monitored – patient’s receiving anticoagulation need to be carefully monitored. The medical staff, pharmacy, nursing and the lab need to work together to insure this is accomplished according to policy. When critical values are obtained they need to be called to the physician and the medication may need to be adjusted.
- Medications need to be administered carefully – IV heparin always needs to be administered via an IV pump; it should not be free flowing. Utilize the Guardrails on the IV pumps. Medication doses should be carefully checked, careful attention should be paid to detail to insure errors are not made with look-alike sound alike medications. The Heparin protocol should be utilized for IV Heparin orders.
- Patients receiving anticoagulants tend to bleed for longer periods of time so this may require additional time of holding a site following a blood draw. If a patient on an anticoagulant experiences a fall they are at greater risk for a serious injury. Additional monitoring is often required.
- Patients taking Coumadin need to watch their intake of vitamin K – green leafy vegetables are a high source of vitamin K.

**MEDICATION RECONCILIATION:**

*Medication Reconciliation is Required on Admission*

1. Obtain an accurate list of medications the patient is taking prior to admission. This information is recorded in Soarian for all in-patients. The home medication list is recorded in Med-Host for emergency room patients. Certain out-patient procedures require that a medication list is obtained (examples: CT Scans, GI procedures, OP surgeries)
2. For all in-patient / observations admissions the physician is responsible to insure that patient’s home medications are addressed on admission. This is accomplished within Soarian.
3. If a patient reports they are not receiving a home medication communicate this to the physician.

**During the Hospital Stay:**

1. If medications are administered via MAK verify orders by comparing the new order in MAK to the physician order
2. If the patient is on a non- MAK unit complete the MAR discrepancy process
3. Reconcile meds at time of transfer
   - From unit to unit by insuring all new orders have been taken off
   - Post procedure by obtaining reorders for medications

**At Discharge:**

1. The patient must be given a complete list of medications they are to take at discharge (includes nursing home patients) – the list should be reviewed with the patient and/or family.
2. The physician can reconcile medications within Soarian and the patient can be provided an electronic list at discharge.
3. Out – patients always need clear instructions with regards to any changes in medications
## DO NOT USE ABBREVIATION LIST

<table>
<thead>
<tr>
<th>Abbreviation/ Dose Expression</th>
<th>Intended Meaning</th>
<th>Misinterpretation</th>
<th>Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>U or u</td>
<td>Unit</td>
<td>Mistaken as a zero (0) e.g. 4U seen as “40”</td>
<td>“Unit” has no acceptable abbreviation. Use “unit”.</td>
</tr>
<tr>
<td>IU</td>
<td>International unit</td>
<td>Mistaken as IV (intravenous) or 10 (ten)</td>
<td>Use “units”</td>
</tr>
<tr>
<td>Trailing zero after decimal point (1.0 mg)</td>
<td>1 mg</td>
<td>Mistaken as 10 mg if the decimal point is not seen</td>
<td>Do not use trailing zeros for doses expressed in whole numbers</td>
</tr>
<tr>
<td>No leading zero before a decimal dose (.5 mg)</td>
<td>0.5 mg</td>
<td>Mistaken as 5 mg if the decimal point is not seen</td>
<td>Always use zero before a decimal when the dose is less than a whole unit</td>
</tr>
<tr>
<td>MgSO4</td>
<td>Magnesium sulfate</td>
<td>Mistaken as morphine sulfate</td>
<td>Spell out “magnesium sulfate”</td>
</tr>
<tr>
<td>MSO4, MS, Morphi sulfate</td>
<td>Morphine sulfate</td>
<td>Mistaken as magnesium sulfate</td>
<td>Spell out “morphine sulfate”</td>
</tr>
<tr>
<td>qd, QD, q.d.</td>
<td>Every day</td>
<td>Mistaken as q.i.d.</td>
<td>Use “daily”</td>
</tr>
<tr>
<td>qod, QOD, q.o.d.</td>
<td>Every other day</td>
<td>Mistaken as q.d. (daily) or q.i.d. (four times daily)</td>
<td>Use “every other day”</td>
</tr>
</tbody>
</table>

These abbreviations should never be utilized anywhere in the medical record. If a “Not to Use Abbreviation” is utilized it should be clarified before action is taken.

## RAPID RESPONSE TEAM (RRT)
The goal of the RRT is to:
- Identify any problems early on and prevent complications by treating problems before they become life threatening.
- Prevent “Failure to Rescue”
- Decrease hospital mortality and morbidity

### When to call the RRT
- Acute change in vital signs
- Acute drop in blood oxygen level
- Altered mental function
- Acute respiratory distress
- Any staff member concern about the patient

### To call the RRT Dial 55555

## PRESSURE ULCER PREVENTION

### How to Prevent Pressure Ulcers:
- Position the patient off of Bony Prominences
- Turn and reposition every Two Hours
- Suspend (Float) the Heels
- Use pillows and wedges to position the patient
- Keep the patient dry
  - Moist skin opens easier
  - Use Perineal Spray to Remove Urine & Feces
  - Use Moisture Barrier after each Incontinent Episode
• Manage the patient’s nutrition status
  o Assist with Meals and Drinks
  o Document Amount Patient Eats and Drinks
  o Let the Nurse know if Patient Doesn’t Eat or has Trouble Eating

Assess the patient daily for risk of pressure ulcers using the Braden Scale

<table>
<thead>
<tr>
<th>Braden Skin Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date: __________________ Time ____________</td>
</tr>
<tr>
<td>Signature________________________</td>
</tr>
</tbody>
</table>

**Sensory Perception**: 1 – Completely Limited  2 - Very Limited  3- Slightly Limited  4- No Impairment

**Moisture**: 1 – Constantly Moist  2- Moist  3- Occasionally Moist  4- Rarely Moist

**Activity**: 1 – Bedfast  2- Chairfast  3- Walks Occasionally  4- Walks Frequently

**Mobility**: 1 – Completely Immobile  2 - Very Limited  3- Slightly Limited  4- No limitations

**Nutrition**: 1 – Very Poor  2- Probably Inadequate  3- Adequate  4- Excellent

**Friction & Shear**: 1 – Problem  2- Potential Problem  3- No Apparent Problem

**Documentation**:
- Clear documentation of skin status on admission is essential. Document any pressure ulcer that may be present on admission. Complete a full assessment of the patient’s skin on admission.
- Weekly measure the pressure ulcer and document.
- Use the pressure ulcer documentation in Soarian document assessment of the ulcer.

**ALARM SAFETY**
- Follow established policy guidelines for alarm settings on alarm-equipped medical devices.
- Follow established policy guidelines for tailoring alarm settings and limits for individual patients.
- Respond to patient alarms timely and evaluate patient for change in condition.
- Assure the volume on alarms is audible to staff at all times.

**SCREENING FOR ABUSE, NEGLECT, or MALTREATMENT**
- The purpose is to provide consistent and appropriate screening, identification, and management of patients who are victims of child abuse, adult/elder abuse or domestic violence.
- It is the policy of the Catholic Health System to provide patients with an environment which is free from neglect and abuse.
- All patients seen in the emergency room, admitted to the hospital in an observation or inpatient status are screened for potential abuse, neglect, maltreatment as part of a nursing assessment.
- Screening assessments and observations include but are not limited to: a skin assessment, behavior assessment including fear, anxiety and withdrawal, and also appearance and hygiene.
- Screening questions include but are not limited to: Do you feel safe at home? or Is anyone hitting, hurting or causing you fear?
• When a patient seen in an outpatient or ancillary departments is identified as having been a potential and/or actual victim of abuse, neglect, or maltreatment, the department manager and/or nursing supervisor will assist with further evaluation and management of the patient.

• When a patient in the emergency room or admitted to the hospital in an observation, or Inpatient status is identified as having been a potential and/or actual victim of abuse the patient will be evaluated and managed by the physician and members of the interdisciplinary care team as appropriate.

INDICATORS OF CARE:
These indicators are evidenced based and proven to improve the quality of care provided to our patients. Some of the data is reported to the public by CMS (Center for Medicare Services) and/or the Joint Commission. Compliance with the indicators can impact reimbursement by Medicare. The data is also utilized to maintain stroke center certification.

**Surgical Care Improvement Project (SCIP)**

In-Patient Measures
- Prophylatic Antibiotic within 1 hr of Surgery
- Select the Appropriate Antibiotic
- D/C Antibiotic within 24 hrs Post-op
- Perform Appropriate Hair Removal
- Glucose Control
- Peri-operative Beta-Blockers
- Discontinue Urinary Catheters by Day 1 or Day 2

Out-Patient Measures:
- Prophylactic Antibiotic within 1 hr of Surgery
- Select the Appropriate Antibiotic

**Acute Myocardial Infarction Care (AMI)**

In-Patient Measures
- ASA on Arrival and at Discharge
- Beta-Blockers at Discharge
- ACEI or ARB when Indicated by Reduced LVF
- Thrombolytic Timing
- PCI Timing

Out-Patient Measures:
- Fibrinolysis within 30 min
- Time to Transfer to Acute Coronary Intervention
- Aspirin at Arrival
- Mean Time to ECG

**Heart Failure Care (HF)**

- Assessment of LVF
- ACEI or ARB when Indicated by Reduced LVF

**Pneumonia**
- Blood Cultures for patients that are admitted to the Critical Care Unit
- Appropriate Antibiotics

**Immunization:**
- Influenza vaccine is screened for and or received

**Emergency Department:**
- Decision to Departure
• Arrival to Departure

**Venous Thromboembolism:**
- Venous Thromboembolism Prophylaxis
- Venous Thromboembolism Patients with Anticoagulation Overlap Therapy
- Venous Thromboembolism Patients Receiving Unfractionated Heparin with Dosages/Platelet Count Monitoring by Protocol
- Patients discharged on Warfarin that receive complete discharge instructions

**Stroke:**
- Timely administration of rt-PA
- Patient receives VTE Prophylaxis
- Patient receives Anticoagulation if there is a diagnosis of Afib/Aflutter
- Patient receives stroke education
- NIHSS scale is reported initially and at discharge
- Door to imaging and door to imaging read

**SIGNIFICANT EVENTS & ROOT CAUSE ANALYSIS**

**Stroke:**
- Timely administration of rt-PA
- Patient receives VTE Prophylaxis
- Patient receives Anticoagulation if there is a diagnosis of Afib/Aflutter
- Patient receives stroke education
- NIHSS scale is reported initially and at discharge
- Door to imaging and door to imaging read

**SIGNIFICANT EVENTS & ROOT CAUSE ANALYSIS**

Are a set of defined events that have caused or have the potential to cause harm to a patient.

**Root Cause Analysis:**
A team of administration, medical staff and associates that analyze a Significant Event to determine the **Causes** and find **Solutions** to prevent a future occurrence of a similar event.

The events include:

**ADDITIONAL PATIENT SAFETY INITIATIVES:**

<table>
<thead>
<tr>
<th>SURGICAL OR INVASIVE PROCEDURE EVENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery or other invasive procedure performed on the wrong site</td>
</tr>
<tr>
<td>Surgery or other invasive procedure performed on the wrong patient</td>
</tr>
<tr>
<td>Wrong surgical or other invasive procedure performed on a patient</td>
</tr>
<tr>
<td>Unintended retention of a foreign object in a patient after surgery or other invasive procedure</td>
</tr>
<tr>
<td>Intraoperative or immediate postoperative/post procedure death in an ASA Class 1 patient</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PRODUCT OR DEVICE EVENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient death or serious injury associated with the use of contaminated materials, devices, or biologics provided by the healthcare setting</td>
</tr>
<tr>
<td>Patient death or serious injury associated with the use of a device or in a patient care, in which the device is used or functions normally</td>
</tr>
<tr>
<td>Patient death or serious injury associated with intravascular hemoglobin that occurs while being cared for in a healthcare setting</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PATIENT PROTECTION EVENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person</td>
</tr>
<tr>
<td>Patient death or serious injury associated with patient elopement (disappearance)</td>
</tr>
<tr>
<td>Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CARE MANAGEMENT EVENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient death or serious injury associated with medication error (e.g., error involving the wrong drug, wrong dose, wrong patient, wrong line, wrong rate, wrong preparation, or wrong route of administration)</td>
</tr>
<tr>
<td>Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting</td>
</tr>
<tr>
<td>Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy</td>
</tr>
<tr>
<td>Patient death or serious injury associated with a fall while being cared for in a healthcare setting</td>
</tr>
<tr>
<td>Any Stage 3, Stage 4, and unacceptably pressure ulcers acquired after admission/presentation to a healthcare setting</td>
</tr>
<tr>
<td>Artificial insemination with the wrong donor sperm or wrong egg</td>
</tr>
<tr>
<td>Patient death or serious injury resulting from the irretrievable loss of an irrepealable biological specimen</td>
</tr>
<tr>
<td>Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ENVIRONMENTAL EVENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting</td>
</tr>
<tr>
<td>Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or is contaminated by toxic substances</td>
</tr>
<tr>
<td>Patient or staff death or serious injury associated with a burn from or in the course of a patient care process in a healthcare setting</td>
</tr>
<tr>
<td>Patient death or serious injury associated with the use of physical restraints or bed rails while being cared for in a healthcare setting</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RADIOLOGIC EVENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>POTENTIAL CRIMINAL EVENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider</td>
</tr>
<tr>
<td>Abduction of a patient/resident of any age</td>
</tr>
<tr>
<td>Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting</td>
</tr>
<tr>
<td>Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting</td>
</tr>
</tbody>
</table>

**Manifestations of Poor Glycemic Control**
- Diabetic Ketoacidosis
- Diabetic Hyperosmolar Coma
- Hypoglycemic Coma
- Secondary Diabetes with Ketoacidosis
- Secondary Diabetes with Hyperosmolality

**Catheter-Associated Urinary Tract Infection (CAUTI)**

**Surgical Site Infection Following**
- Coronary Artery Bypass Graft (CABG) - Mediastinitis
- Bariatric Surgery
- Laparoscopic Gastric Bypass
- Gastroenterostomy
- Laparoscopic Gastric Restrictive Surgery
- Orthopedic Procedures
  - Spine
  - Neck
  - Shoulder
  - Elbow

**Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE)**
- Total Knee Replacement
- Hip Replacement

**Ventilator Associated Pneumonia**
- **Reduce Hospital Acquired Infections** – Wash hands before and after patient contact – follow standard precautions, **ASK** – Is this central line needed?, Does this patient need to have a urinary catheter?
- Follow the prevention bundles
- **Encouraging Patients to include Family/Support Persons in their care** - A patient is allowed to have a family member/support person stay with them around the clock. Involving the patient in their care is important to enhancing patient safety.

- **Purposeful Rounding** – Rounding on patients at regular intervals to insure that their needs are met. This includes all belongings are close by, the patient toileting needs have been met, the patient has been repositioned and pain has been addressed. Purposeful rounding has been proven to **reduce** falls and pressure ulcers and **improve** the patient experience.

**OCCURRENCES**
Occurrences are events that are unplanned, unexpected, and unrelated to the natural course of a patient’s disease process or routine care and treatment. Situations which are not consistent with:

- The accepted standard care of a patient.
- The routine operation of a facility that has the potential or has already had an untoward effect on patient care.

Remember, when an event occurs please document the facts only (Do not use subjective opinions) - who, what, when, where and why on the CH Occurrence report form and make sure your supervisor receives the completed occurrence as soon as possible. The Quality and Patient Safety Department should be notified by telephone of any serious occurrence.

**Remember reporting a “Near Miss” is as important as reporting an actual event. Reporting of near misses may assist in preventing actual events**

**Examples of occurrences are:**
Visitor or patient falls, patient identification errors (wrong information in a medical record, x-ray on wrong patient, specimen labeled wrong, delays in care (orders not followed, incorrect test performed) medication errors, equipment failures and lost or stolen items.

Catholic Health fully endorses and supports the Joint Commission (JC) standards wherein any employee who has concerns about the safety or quality of care provided in the hospital may report these concerns to the JC. Furthermore, CH demonstrates it’s commitment by taking no disciplinary action against any associate who reports a safety or quality of care concern to the JC.

**PATIENT EXPERIENCE:**
Monthly a sample of patients are mailed a survey to complete.
Sample Questions

**Overall Satisfaction**
How would you rate this hospital overall on a scale of 0-10?

**Willingness to Recommend**
Would you recommend this Hospital to your friends and family?

**Physical Comfort**
Do you think that the hospital staff did everything they could to help control your pain?
Did you have help, if needed, getting to the bathroom?
Patient Experience Scoring:
THE HIGHEST SCORE IS THE ONLY SCORE THAT IS “NOT” CONSIDERED A PROBLEM – i.e. Definitely Yes or “9 or 10”
- Specific questions help us understand the perceptions of our patients.
- Measures are compared to hospitals nationally
- **CH Goal: To have the best scores nationally**

😊 Improving the patient experience is the responsibility of every associate at Catholic Health. Whether you interact with patients or the associates that care for patients what you do every day impacts the patient experience.

The in-patient data is reported to the Public on the CMS (Center for Medicare) web site.

Involving the Patient and Family:
Encourage Patient & Family Involvement as Part of Patient Safety Strategy:
Catholic Health believes in partnering with our patient and families to provide a safe environment
- Provide patients with education, insure this education is in the patient’s primary language.
- Include patient’s family / support person in the education
- Family / support person is encouraged to be with the person. CH visitor hours allow for the family/support person to stay with the patient.
- If patient and / or support person voices a potential safety concern – listen, investigate and follow-up.

Examples of involving the patient/family include; use of white boards, bed-side report, discussions on end-of-life care, discharge education

**HEALTH, SAFETY, SECURITY AND ENVIRONMENT**

This information is provided to give you an overview of some of the key areas of the Catholic Health - Health, Safety, and Environment Management Program.

Detailed telephone numbers, points of contact, etc., are found in your enclosed facility specific information sheets.

**GOALS**
The goal of the CH Health, Safety, and Environment Management Program is to provide an environment free of risk to the safety and health of associates, patients and visitors. It includes the prevention of injury, the prevention of low impact injury or illness, the protection of the community from contamination (environmental damage), and the protection of associates, patients and visitors from harm due to criminal events.

**PREVENTION**
Prevention is the key to successful programs
- Anticipate and recognize potential hazards
- Evaluate the likelihood that the hazard may cause an injury or illness
- Control the risk associated with the hazard

*Prevention is everyone’s responsibility!*

1. RESPONSIBILITIES

*LET’S ENHANCE OUR HIGH REGARD FOR THE WORTH OF EACH OTHER BY ENSURING OUR WORK AREA IS SAFE.*
ASSOCIATES
Associates have the greatest opportunity to anticipate and recognize hazards since they are exposed most often. They are responsible for:
- Following all policies and procedures.
- Using the specific equipment the job calls for and using it properly.
- Wearing the required Personal Protective Equipment (PPE).
- Ask for assistance if you need help—especially for lifting or carrying.
- Communicate with fellow associates when performing tasks together.
- Think things through; pause a second to plan the job to eliminate potential hazards.
- Identify hazards before you start the job.
- Respect all precautions—do not take chances.
- Obey warnings/warning signs—they are posted for a reason.
- Ask your Supervisor when in doubt about a task.
- Know in advance what could go wrong, and what to do about it.
- Know how and where to get help.
- Special training or equipment may be needed.
- Keep your mind on what you are doing—concentrate.
- Report any unsafe act or condition immediately to your supervisor, Safety Manager, and/or the Director of Health, Safety, and Environment.
- Report any unsafe act or condition immediately on the safety tip line at 447-6585.
- Use good body mechanics in all activities.
- Be aware of and use overhead silver mirrors/domes. When used, they can prevent collisions from oncoming traffic.
- Do not be tempted to wedge doors open.
- Know your responsibilities during an Emergency or Emergency Code.
- Do not block corridors, egress paths, exits, smoke / fire doors, fire alarm pull stations, fire extinguishers, eyewash stations, medical gas cutout valves, or electrical panels.

SUPERVISORS
- Responsible for ensuring procedures, equipment and protective equipment relevant to their department’s activities are available and implemented.
- Be sure all incidents are investigated and that the Incident Report Form (HR 27) is sent to IDM within 24 hours of the incident.
- Complete department rounds to ensure the environment of care is safe for patient, visitors, and associates.

SAFETY COMMITTEES
- The Committee members represent associates and management of departments from multiple disciplines.
- Responsible for ensuring the programs address the hazards and concerns of the departments and that the control measures developed to address specific hazards are effective, practical and in compliance with the Safety Program.

SAFETY/SECURITY PERSONNEL (See Facility specific sheets for the names of personnel)
- Responsible for planning and coordinating the design, implementation, evaluation, and improvement of the Programs.

HOSPITAL ADMINISTRATION
- Assure the appropriate level of responsibility and accountability is assigned at all levels of the organization.
II. SAFETY MANAGEMENT PROGRAMS

GENERAL SAFETY MANAGEMENT
The goal of General Safety Management is to provide a physical environment free of hazards and manage the use of control measures to reduce the risk of injuries.

Associate Injury/Incident Program
What do you do when you have an Incident?

- Make sure you are all right.
- Report all incidents immediately to your Supervisor. **And complete an incident report as soon as possible or the latest by end of shift.**
- If injured, obtain medical attention from the nearest CH Emergency Department or own provider.
- If lost or restricted time from work and/or medical treatment, notify the IDM dept.

As soon as possible or the latest by the end of the shift, the associate should complete an Incident Report (HRF 27), the Supervisor should complete the Incident Investigation (back page of report) with the associate, and forward to the IDM dept. First, it ensures that you are treated for any immediate concerns. Second, it establishes the time and date of the incident so that if you have any long-term effects, your rights to compensation are established. Third, the information gathered at the time of reporting helps us analyze the causes of incidents for safety initiatives and improvement.

Personal Protective Equipment (PPE)
This program ensures that proper PPE is utilized whenever it is likely to reduce the risk of exposure to a hazard. Examples include: gloves, face shields, gowns and respirators. Proper selection, availability, use, storage, maintenance, limitations, and training are all addressed.

Electrical Safety Program
1. Be aware of hazards:
   - Leakage current
   - Electrical fires
   - Electrical shock
2. Immediately report defective equipment, tag it, take it out of service, and/or secure it.
3. All electrical equipment must be inspected prior to use.
4. Inspect the power cord and plug before each use. The ground prong should be intact and unbent. The power cord insulation should be unbroken and uniform throughout its length. Special attention should be given to the insulation at the point where the cord and plug join as well as the place where the cord enters the device.
5. Do not use equipment on which liquids have been spilled.
6. Do not use equipment which has been immersed in liquids.
7. Never stack things on or behind electrical equipment that might interfere with proper ventilation of the device. Unplug the power cord, and then report any burning or unusual odors that come from the device. If the device does not sound, feel or act right, then report it immediately to your supervisor and facilities department.
8. Unplug electrical equipment by pulling on the plug not the cord.
9. Three wire to two wire adaptors should never be used.
10. Extension cords should only be used on a temporary basis and should be tested and approved by the maintenance department.
11. The use of cellular telephones is prohibited in patient care areas.
Lock-out / Tag-out (LOTO)
Designed to protect associates working on hazardous energy sources, e.g. electric greater than 30V. Never remove a lock-out or tag-out device.

Smoking Control
Smoking (including E-cigarettes) on CH grounds is strictly restricted in accordance with The Joint Commission and NYS Department of Health guidelines.

Ergonomics
Ergonomic (Musculoskeletal) injuries/disorders are injuries or disorders of the muscles, nerves, tendons, ligaments, joints, cartilage and spinal discs generally caused or exacerbated by excessive repetition or overuse.
1. Ergonomic risk factors may include:
   - Awkward positions/posture
   - Force
   - Task duration
   - Task frequency
   - Vibration
   - Mechanical stress
   - Low temperature or other environmental stresses
2. Body Mechanics:
   Body Mechanics are the application of proper or natural body movement to daily activities, to prevent and correct problems associated with posture. Good body mechanics can significantly reduce the potential for ergonomic injury. Therefore, good body mechanics in combination with proper lifting techniques must be used when transferring or repositioning materials and patients.
3. Proper Lifting Techniques:
   - Bend knees (maintain low back curves)
   - Maintain a wide base of support with feet while standing and lifting.
   - Keep patient close and use transfer / gait belt
   - Utilize appropriate safe patient handling and movement equipment for lift, transfers, and bed mobility (e.g. mechanical lifts, friction reducing sheets, transfer belts, etc.)
   - Plan your movements ahead of time. Replace quick/jerky movements with smooth ones.
   - Communicate all moves with your patient and assisting associate
   - Ask for assistance when appropriate
   - Get as much help from the patient as possible and allow patient time to perform movements.
   - Pivot your feet, DO NOT twist your back.
   - Minimize reaching and bending

III. SECURITY MANAGEMENT
The goal of Security Management is to protect staff, patients, and visitors from harm due to criminal events.

Security Program
1. Four Goals of Hospital Security:
   - Personal Protection of patients, visitors, associates and staff members.
   - Property Protection of CH materials or associate, patient, visitor, and staff belongings.
   - Facility Protections from vandalism, improper access, and improper use of grounds.
   - Parking and Traffic Control; clear emergency lanes and parking security.

2. The Associate’s Responsibilities:
• Understand and follow hospital rules and regulations.
• Be alert for irregularities or suspicious activities.
• Wear your identification badge on upper half of chest.
• Associates are responsible for enforcing hospital visitor rules.
• Safeguard your valuables.
• Park in designated associate parking areas and lock your vehicle.

3. Workplace Violence Prevention:
   • Prevention Measures:
     • Provide comfortable waiting area
     • Keep customers informed regarding delays, changes
     • Address customers in a friendly manner, in person/on telephone
     • Empathize with a problem
     • Use pleasant/sympathetic tone of voice
     • LISTEN
     • Be courteous to patient
   • Signs To Be Alert To:
     • Suspicious acting person
     • Person acting inappropriately
     • Surroundings
     • Body Language
     • Verbal threats/actions
   • Actions To Take:
     • Alert others
     • Follow “CODE SILVER” Procedures

   • Direct Threat Response:
     • Try to remain calm
     • Try to move toward an escape route
     • Keep eye contact
     • Speak clearly
     • Follow instructions
     • Don’t be a hero
     • If able, stall for time

IV. HAZARDOUS MATERIALS AND WASTE MANAGEMENT

The goal of Hazardous Materials Management is to control exposures or discharges to hazardous materials and waste with identified physical, health or environmental effects.

Hazard Communication / Associate “Right to Know”

CH facilities are supported by a written Hazard Communication Program. This program provides guidance on information gathering and communication with associates. It also addresses mandatory requirements for labeling hazardous materials, management of Safety Data Sheets (SDSs), and training. The written program is available on the CH shared drive or from the Health, Safety, and Environment Department.

Labeling
   The program requires all hazardous materials containers to have a label on the outside of the container that includes:
New OSHA Requirements

- OSHA has adopted new hazardous chemical labeling requirements bringing it into alignment with the United Nations’ Globally Harmonized System of Classification and Labeling of Chemicals (GHS).
- These changes will help ensure improved quality and consistency in the classification and labeling of all chemicals and will also enhance worker comprehension.
- As a result, workers will have better information available on the safe handling and use of hazardous chemicals, thereby allowing them to avoid injuries and illnesses related to exposures to hazardous chemicals.
- The label will provide information to the workers on the specific hazardous chemical.
- Safety Data Sheets (SDSs) – previously known as Material Safety Data Sheets (MSDSs), must accompany hazardous chemicals.
- All hazardous chemicals shipped after June 1, 2015, must be labeled with specified elements including pictograms, signal words and hazard and precautionary statements.

Labels

There are six Main Elements that need to be included on each label. They are as follows:

a. Product/Chemical Identifier
b. Supplier Identifier
c. Hazard Pictogram(s) – standardized under GHS
d. Signal Word – standardized under GHS
e. Hazard Statement(s) – standardized under GHS
f. Precautionary Information – Standardized under HCS

Pictogram

- “Pictogram” means a composition that may include a symbol plus other graphic elements, such as a border, background pattern, or color, that is intended to convey specific information about the hazards of a chemical.
Eight pictograms are designated under this standard for application to a hazard category.

<table>
<thead>
<tr>
<th>Health Hazard</th>
<th>Flame</th>
<th>Exclamation Mark</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Carcinogen</td>
<td>- Flammables</td>
<td>- Irritant (skin and eye)</td>
</tr>
<tr>
<td>- Mutagenicity</td>
<td>- Pyrophorics</td>
<td>- Skin Sensitizer</td>
</tr>
<tr>
<td>- Reproductive Toxicity</td>
<td>- Self-Hoarding</td>
<td>- Acute Toxicity (harmful)</td>
</tr>
<tr>
<td>- Respiratory Sensitizer</td>
<td>- Emits Flammable Gas</td>
<td>- Narcotic Effects</td>
</tr>
<tr>
<td>- Target Organ Toxicity</td>
<td>- Self-Reactives</td>
<td>- Respiratory Tract</td>
</tr>
<tr>
<td>- Aspiration Toxicity</td>
<td>- Organic Peroxides</td>
<td>- Irritant</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Hazardous to Ozone Layer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Non-Mandatory)</td>
</tr>
</tbody>
</table>

- Gases Under Pressure
- Skin Corrosion/ Burns
- Eye Damage
- Corrosive to Metals

- Oxidizers
- Aquatic Toxicity
- Acute Toxicity (fatal or toxic)

Signal Word
- “Signal word” means a word used to indicate the relative level of severity of hazard and alert the reader to a potential hazard on the label.
- The signal words used in this section are “danger” and “warning”. “Danger” is used for the more severe hazards, while “warning” is used for the less severe.

Hazard Statement
- “Hazard statement” means a statement assigned to a hazard class and category that describes the nature of the hazard(s) of a chemical, including, where appropriate, the degree of hazard.
  a. Example: Fatal if swallowed (Acute Oral Toxicity)

Precautionary Statement
- “Precautionary statement” means a phrase that describes recommended measures that should be taken to minimize or prevent adverse effects resulting from exposure to a hazardous chemical, or improper storage or handling.
  a. Example: Do not eat, drink, or smoke when using this product
  b. Example: keep container tightly closed
- The statements assigned to a chemical address the following four areas:
  a. Prevention
  b. Response
  c. Storage
  d. Disposal

Safety Data Sheets (SDS)
- Safety Data Sheets (SDSs), previously known as Material Safety Data Sheets (MSDSs) must accompany hazardous chemicals and are the more complete resource for details regarding hazardous chemicals.
- The information contained in the SDS is largely the same as the MSDS, except now the SDSs are required to be presented in a consistent user-friendly, 16-section format.

Associates, What Can You Do?
• Ensure you are trained properly on any chemicals that you may use.
• Review the SDS on all chemicals used.
• Ensure you are trained on and know where Personal Protective Equipment (PPE) is that is required.
• Review SDS annually for the chemicals you use.
• Talk to your Supervisor/Manager if you are unsure of procedures.
• Ensure that the containers with chemicals are properly labeled.

Safety Data Sheets (SDSs)
The collection and maintenance of a Safety Data Sheet (SDS) file for the chemicals used or stored onsite is also required. This file is readily available to you through our MSDS Online service 24 hours-a-day. To access MSDS Online follow these steps:
• Locate a computer with internet access.
• Double click on the “Internet Explorer” Icon (Blue E).
• If prompted to do so, Do Not Log On.**
• At the top of the page, type “MSDS” in the address line and hit ENTER.
• Once the CH MSDS Online web page appears you can begin your search
• When you have identified the most recent file for the product you are looking for double click the icon in the “View MSDS” column to read or print (need printer available) the manufacturers SDS.
• If you are unable to find the SDS you need, there are several options:
  1) Contact your Supervisor
  2) Contact the House Supervisor
  3) Contact the Manufacturer (If phone # is available.)
  4) Contact the Director of Health, Safety, & Environment

**Note: An individual does not need internet access authorization to use MSDS Online.

Training
It is imperative that before you begin to use a chemical, you receive training on its specific hazards and proper conditions of use. For example: the need for special ventilation, Personnel Protective Equipment (PPE), or should emergency equipment such as an eyewash be nearby. Almost any product can become hazardous given the right circumstances. Therefore, it is important to understand the properties of the products used in your work area. The best sources of information are:
• The Label
• Your Supervisor
• The Safety Data Sheet (SDS)
• Department of Health, Safety, and Environment

Disposal
Hazardous materials (chemicals) need to be disposed of in accordance with accepted CH practices to comply with applicable laws and regulations. At no time shall hazardous chemicals be disposed of down the drain. If you or your department does not know how to properly dispose of a hazardous material, contact the Health, Safety and Environment Department. Consent for special disposal procedures must be reviewed and approved by the Department of Health, Safety, and Engineering.

Spills
If you have or encounter a hazardous material spill, attempt to contain the spill and then:
• Get away from the area
• Keep others away
• Follow the facility’s procedure for a “CODE ORANGE”
• Get the SDS for the chemical spilled
• Notify the Health, Safety & Environment Department Immediately

Asbestos Program
Designed to prevent associate exposure to asbestos in facilities with asbestos containing materials (ACM). Protection is ensured through a thorough ACM inventory, access control, and education.

Chemical Hygiene Program
A written Chemical Hygiene Plan defines special protective measures for laboratory personnel and operations.

Ionizing Radiation Safety Program
A written safety program that defines special protective measures to keep exposures to ionizing radiation at levels that are As Low As Reasonably Achievable (ALARA). Operations usually covered include x-ray, nuclear medicine, and oncology.

Formaldehyde Exposure Control Program
A written safety program that defines special protective measures for operations, which use Formaldehyde describing processes for exposure monitoring, emergency procedures, work practices and associate training. Usually encountered in the labs.

Community Sharps Collection Program
Community generated medical sharps including needles and lancets are collected for safe disposal at all CH Emergency Departments. Participants are not asked to register or pay any fees, and they can use the service anytime day or night. We ask that sharps be presented in a sturdy, leak proof, plastic container, such as a bleach bottle.

V. EMERGENCY MANAGEMENT
The goal of Emergency Management is to ensure an effective, timely response to disasters or emergencies affecting the environment of care.

Emergency Response Program
It is extremely difficult to anticipate all of the complications that an emergency will bring. Simply stated, disastrous events are unpredictable.

For the hospital, this means we must always be ready for an unknown number of victims with unknown types of injuries. When the victims arrive, an incredible number of things must be done ———FAST!
The Comprehensive Emergency Management Plan “CEMP” is designed to provide clear guidelines for a time when many unusual demands will be made on the hospital. It is also the plan by which we maintain normal levels of care for those patients already here, who are not victims of the emergency. Every associate shares the responsibility to keep the hospital functioning smoothly during a crisis.

Hospitals have flexibility in creating either a single CEMP that accurately reflects all sites of the hospital, or multiple Emergency Management Plans. Some remote sites (LTC Clinics, Home Care, etc) may be significantly different from the main site (for example, in terms of hazards, location, and population served); in such situations a separate Emergency Management Plan is appropriate.

The immediate responsibility, to receive and treat victims, falls more heavily on a particular group of associates who have the specialized knowledge needed. They depend on the rest of us to carry out a large number of support activities and to provide willing, cooperative assistance, wherever, whenever needed.

Each facility has plans in place to respond to a wide range of situations. Some facilities have adopted specialized codes that are not listed below. It is your responsibility to be aware of all the emergency codes for your facility. A standardized “Code” system for all facilities has been adopted as follows:

**CODE RED** Fire
**CODE WHITE** Evacuation
**CODE YELLOW** Mass Casualty
CODE ORANGE  Hazardous Materials/Bioterrorism  
CODE PURPLE  Bomb Threat  
CODE SILVER  Security  
CODE BLUE  Medical Gas Failure  
CODE GREEN  Natural Disaster  
CODE BROWN  Utilities Failure  
CODE PINK  Imminent delivery  
CODE “A”  Infant/Child Abduction  
CODE “E”  Elopement  
CODE 10  Cardiac/Pulmonary Arrest  

**Copies of the General Emergency Response Action Table are posted throughout every work area at Department Meeting Points. Refer to this for guidance prior to an emergency. This contains detailed steps to be taken.**

**VI. LIFE (FIRE) SAFETY MANAGEMENT**

The goal of Life (Fire) Safety Management is to provide a fire-safe environment that protects patients, visitors, associates, staff members, and property from fire and the products of combustion.

**Life (Fire) Safety Program**

1. Chemistry of Fire

   When fuel, oxygen, and heat are combined in the right proportions fire results. There are very few processes that can compete with fire’s tenacity and ability to expand geometrically. Prevention is critical.

2. Fire Safety System

   Should, in spite of our best efforts, a fire start, our actions must be careful, deliberate, and planned. We are not charged with holding back the forces of the fire single-handedly. We are charged with coordinating the many resources at our disposal. Our response is an integrated part of a larger fire control plan which includes:
   - Early Detection: As soon as a fire begins emitting heat and smoke, our detection systems are designed to automatically alert us.
   - Mobility: Our ability to transfer affected persons out of an area of danger is preserved through the maintenance of clear aisle ways, exit stairwells, and hallways.
   - Support: Through the use of our communication and the Department Meeting Point Systems, extra hands can be summoned immediately.
   - Compartmentalization: Through the use of fire resistive construction (rooms, smoke compartments, floors, buildings and exits) we can effectively slow the growth of a fire simply by closing doors, buying valuable time.
   - Mitigation: Oxygen and medical gas line shutoffs are located in every area and can be used to stop the flow of accelerants immediately.
   - Horizontal Evacuation: Should a unit need to be evacuated the process can be expedited quickly through the use of multiple fire zones on each level of our buildings.

3. RACE (Code Red Response)

   The RACE model has been specifically designed to take advantage of these features and prioritize your actions. In the event you identify a fire emergency follow this action plan:

   **Rescue:** Remove people from the immediate area of danger and close the door.
   **Announce:** Call out Code Red & Location when you discover a fire.
   - Pull the closest fire alarm
   - Call the switchboard (or fire department) using the facility emergency number 55555 (911) and state Code Red & Location
Confine: Contain the fire and smoke by closing all doors and windows.
Evacuate: The unit or surrounding area as directed. Once the decision to evacuate is made the medical gases are to be shut off when not required.

Fire Extinguishers
Ordinarily, associates are not expected to use fire extinguishers. Our primary response to fire and smoke is isolation using the compartmentalization provided by our building structures, and horizontal evacuation. Should a condition arise where fire extinguisher use is deemed appropriate and you are not putting yourself in danger, follow the PASS technique.

Pull the pin securing the handle
Aim at the base of the fire
Squeeze the handle
Sweep side to side.
It is important to remember to keep the extinguisher upright, and to extinguish the fire completely as you go to prevent re-ignition.

4. ILSM Program (Interim Life Safety Measures)
From time to time, our fire prevention systems, detection systems, suppression system, or means of egress (exit) may be compromised. During those times we implement special procedures known as Interim Life Safety Measures (ILSM) to protect associates and patients.

VII. MEDICAL EQUIPMENT MANAGEMENT
The goal of Medical Equipment Management is to promote the safe and effective use of medical equipment.

Medical Equipment Safety Program
All medical equipment must be inspected by the Biomedical Engineering Department for electrical and operational safety before they are used or put into circulation. Do not use cheater plugs for any medical equipment. Do not use damaged, broken, or malfunctioning equipment. If you encounter damaged, broken, or malfunctioning equipment follow these steps to assure safe patient care.

1. Immediately remove the equipment from use. This is a patient safety requirement.
2. Ensure the patient is safe, replace equipment if needed.
3. Quarantine the medical equipment and all associated supplies (tubes, leads, etc)
4. Place a “Defective Equipment” tag on the device (CH# FC 01262).
5. List descriptive information on the tag (What is the problem, what happened, etc.?).
6. Complete an Occurrence Report if a failure or malfunction occurred during patient care.
7. Call to have the equipment picked up by Biomedical Engineering.

VIII. UTILITIES MANAGEMENT
The goal of Utility Services Management is to ensure a safe, controlled, and comfortable environment, minimize utility failures, and ensure operational reliability of utility systems.

Utility Systems Safety Program
All major utility systems such as electric, water, heat, medical gas, elevators, ventilation, etc. are maintained by the Facility and Engineering Departments at each site. Communication utility systems (telephone & computer) are maintained by the Telecommunications and Information Systems Departments. Utility systems are periodically tested for functionality and/or placed on a preventive maintenance program to keep them in good working order. Utility system back-ups and contingency plans have been established because there is always the potential for a utility system failure. If you experience a utility failure emergency in your area call the switchboard using the facility emergency number and let the operator know you are experiencing a CODE
BROWN. Provide the operator with your location and the type of utility system failure that you are experiencing. Contingency plans for hospital associated facilities may differ as needed.

VIII. ASSOCIATE HEALTH

For the well-being of all patients, associates, and visitors, all associates and affiliates with suspected or proven communicable disease must be restricted from work.

Always use respiratory etiquette. Cover your cough, use tissues and wash your hands!

Do not come to work if you have the following:

- Fever of 100 or greater
- Conjunctivitis (pink eye): ok to return to work after 24hrs on antibiotics
- Strep Throat: you need to be on antibiotics for at least 24 hours.
- Upper respiratory infection (this does not mean a runny nose or being “stuffed up” or allergy symptoms) generally, you would have a fever. If you have a cough, practice Respiratory Etiquette.
- Diarrhea
- Active Tuberculosis (TB) (this is not a positive PPD) - If you have been diagnosed with Active TB you need to be cleared by an appropriate physician before returning to work.
- Chicken pox, measles or mumps.
- A draining lesion. Please consult Associate Health.
- Shingles and herpes simplex. Please consult Associate Health.
- Other potentially communicable illness or condition

Always check with your manager or Associate Health for conditions which may impact your ability to work.

Annual Assessment & PPD

You also need an annual health assessment and PPD test. The PPD is the test to determine exposure to Tuberculosis. All associates are required to have one every year at the time of your annual reassessment. The only exception to this is if you already have a history of a positive PPD and then Associate Health will review the signs & symptoms with you at your annual reassessment. Pregnancy is NOT a contraindication for PPD testing.

Note: Failure to have your Annual Assessment & PPD may result in suspension.

Influenza Vaccine

Remember the flu vaccine! The flu vaccine is offered every year to associates. The flu vaccination program usually begins in October/November and is recommended yearly.

Note: You must complete a declination if you decline the flu vaccine or receive the flu vaccine elsewhere.

Hepatitis B Vaccine

This vaccine is available through the Associate Health office to all staff who may have exposure to blood or body fluids.

VIX. OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (OSHA) BLOODBORNE PATHOGEN ACT

THIS REFRESHER TRAINING IS NOT A SUBSTITUTE FOR INITIAL BLOODBORNE PATHOGENS TRAINING PROVIDED IN NEW ASSOCIATE GENERAL ORIENTATION
In 1991 OSHA developed the Occupational Exposure to Blood borne Pathogen Act to protect health care professionals against the health hazards related to the more serious blood borne diseases, namely Acquired Immunodeficiency Syndrome (AIDS), Hepatitis B (HBV) and Hepatitis C (HCV). A copy of the OSHA standard 29 CFR 1910.1030 is available from Associate Health or on the internet at www.osha.gov. If you have any questions regarding the information in this training contact your supervisor to have your questions answered before continuing.

Health care facilities are required by OSHA to have a written exposure control plan for Blood borne Pathogens. Catholic Health has a written plan for exposure to blood and other potentially infectious materials. The plan is located on the Infection Control Web site. Be sure that you can locate the plan at your facility.

**Bloodborne pathogens** are microorganisms, which can transmit infection through direct or indirect contact with blood and some body fluids. There are three blood borne pathogens, which are of special concern to the health care worker. They are:

- **Hepatitis B (HBV)**
- **Hepatitis C (HCV)**
- **HIV (causes AIDS)**

**Hepatitis B**

Hepatitis B is a virus that attacks the liver. It can be transmitted from infected blood and body fluid, items contaminated with infected blood, through sexual contact and from mother to child during pregnancy & birth (if the mother is infected). The symptoms of hepatitis B include fatigue, poor appetite, stomach pain, fever, nausea, vomiting and occasionally joint pain, hives or rash. Urine may become darker in color, and then jaundice (a yellowing of the skin and whites of the eyes) may appear.

You can minimize the risks of developing Hepatitis B from an accidental exposure by receiving the **Hepatitis B vaccine**. If you have not received the vaccine you can receive it at no cost to you through Associate Health. Remember the vaccine is....

- Synthetic (not a live vaccine)
- A series of three (3) shots at specific time intervals
- Always given in the deltoid (arm)
- You need all three doses to develop immunity!!!

If you have not received the vaccine call the Associate Health Office in your facility to make arrangements.

**Hepatitis C**

Hepatitis C is a virus that attacks the liver. It is primarily transmitted through infected blood. It is the number one reason for liver transplants in the U.S. About 85 % of individuals who become infected stay infected. There is no vaccine available for preventing Hepatitis C.

Approximately 20 percent of persons exposed to the virus develop symptoms which may include jaundice (yellowing of the skin and whites of the eyes), fatigue, dark-colored urine, stomach pain, loss of appetite and nausea. After the initial infection, 15-25 percent will recover and 75-85 percent will become chronically infected (lifelong infection). Approximately 70 percent of persons chronically infected will develop liver disease, sometimes decades after initial infection.
**HIV**

HIV is a virus that causes AIDS. It affects the immune system directly. There is no vaccine and no cure. However with the advances in medical treatment individuals can live a long life with AIDS. Once someone is infected with the HIV virus he/she is infectious to others who have direct contact with blood, certain body fluids or through sexual contact. The HIV virus is not transmitted through touching, feeding or caring for HIV infected individuals; nor is it transmitted in all body fluids. Urine, stool, sputum, tears and sweat have not been proven to transmit the virus (unless there is visible blood in these body fluids).

The first symptoms of HIV infection can resemble symptoms of common cold or flu viruses. Some people who contract HIV experience very strong symptoms, but others experience none at all. Those who do have symptoms generally experience fever, fatigue, and, often, rash. Other common symptoms can include headache, swollen lymph nodes, and sore throat. Because of the nonspecific symptoms associated with primary or acute HIV infection, symptoms are not a reliable way to diagnose HIV infection. All HIV related information is confidential. All HIV testing is voluntary, confidential and education needs to be provided to the patient prior to testing.

**Measures to Minimize exposure Risk**

Regard all contact with blood, body fluid, mucous membrane and non-intact skin as infectious. This is Standard Precautions. It applies to every patient, every time.

Wear the correct Personal Protective Equipment to minimize that direct contact.

Types of Personnel Protective Equipment:

- **Gloves:** are worn whenever you have contact with blood, body fluid, non intact skin or mucous membrane or whenever you handle equipment contaminated. There are non-sterile, non-latex gloves available in every patient care area.

- **Eye Protection & Masks:** are worn whenever splashing or sprayng into your face, particularly eyes and mouth, is likely. There are fluid resistant masks and eye shields available. These items are single use and must be removed when leaving the patient care area. Single issue re-useable goggles are available in certain situations.

- **Gowns:** are worn when splashing or spraying onto your clothing is possible. There does not have to be a large volume of fluid anticipated to wear a gown. Be sure that you tie the neck at the back to provide the best protection. These gowns are single use. Also, remember that scrub suits, lab coats or patient gowns do not provide any fluid resistance and are not considered protective.

**Do Not Eat or Drink** in any work areas where blood or body fluid is located. This includes specimen storage areas, nurses’ stations, housekeeping carts, lab work areas or areas where contaminated equipment is kept.

**Sharps** are to be handled carefully. Do not bend or manipulate any sharps unnecessarily.

**Do Not Recap!!** Needles should be disposed of immediately after use in an appropriate sharps container. If you must recap because of a special circumstance be sure to use a one- handed scooping method. Be careful to pick up sharps that have dropped with a forceps, hemostat or mechanical device. If a sharp object is falling allow it to fall. Do not try to grab it.

**Sharps do not belong in the trash!!!** Sharps containers must be changed when they are three quarters full. Do not overfill sharps containers!! Also be sure to use the right sharps container for the equipment. There are small sharps containers on IV start trays or blood draw trays. There are larger sharps containers in the patient care areas and there are very large containers on wheels that can be moved into an area where a large sharp is being used. The point is you want the sharp to fit and not be sticking out the top. Make sure to only put the appropriate item into the container- do not put gauze, tape, EKG electrodes, plastic eating utensils or gloves into these containers.
There are several devices that are designed to prevent injury by inactivating the needle after use or by utilizing a needle-less system. If your job requires blood draws or starting IV lines, be sure you know how to use these products. Also be aware that new products are introduced. Be sure to use the safety feature of every safety device. All safety devices should be activated with your hand or finger behind the needle or blade. If you are responsible for obtaining specimens from a Foley catheter be sure to use the needle less device and not a needle!

Remember these measures to prevent unnecessary percutaneous exposure:
1. Proper equipment set up and disposal of angiocaths.
2. Proper use of needle stick prevention devices.
3. Constant visualization and communication of sharps on the surgical field.

Preventing needle stick injuries is the best way to protect yourself from accidental exposure to potentially infectious material.

Blood Spills
Remember to clean up blood spills promptly. Blood spill kits are available on clean supply carts on each unit. Clean with the disinfectant. Spray on and wipe up any gross soil then spray again and allow to dry. Always wear gloves. You may need to wear a gown and/or mask/eye shield if splashing in the face is anticipated. Dispose of everything in a red bag. This is regulated medical waste.
For large blood spills initiate containment with paper towels and contact Environmental Services.

Biohazard Labels indicates infectious material. Be aware.

Red bags or red containers means regulated medical waste (RMW).

These **DO** go in the red bag:

**Contaminated:**
- Visibly Bloody Gloves
- Visibly Bloody Plastic Tubing
- Visibly Contaminated PPE
- Saturated Gauze
- Saturated Bandages
- Blood Saturated Items
- Blood & Body Fluids
- Closed SharpsDisposable Containers

These **DON’T** go in the red bag:
- Medication
- Compressed Gas Cylinders
- Loose Sharps
- Hazardous and Chemical Waste
- Radioactive Waste
- Garbage
- Fixatives and Preservatives

**MEASURES TO TAKE IF AN ACCIDENTAL BLOOD/BODY EXPOSURE OCCURS**
If an exposure occurs (e.g. contaminated sharp, blood or body fluid splashed to non-intact skin or mucous membranes) the following measures should be implemented:
1. Wash area with soap and water. If mucous membrane exposure flush with water only.
2. Report to supervisor and obtain packet (red folder)
3. Call the Associate Health nurse during regular business hours
4. Complete the Risk Assessment and Associate Incident. The Associate Health nurse can assist you.
5. Report to the Emergency Department with the packet.
6. Remind the Healthcare provider that this is a time sensitive issue. You want to take care of this as soon as possible after the injury – that means within 15-20 minutes you should be reporting to the Emergency Department. **Do not wait!**
7. Follow up with Associate Health as soon as possible.

### INFECTION CONTROL

**Objectives:**

After this presentation the associate will be able to:
1. Define his/her role in infection prevention.
2. Reinforce good hand washing technique.
3. Understand standard and isolation precautions
4. Be familiar with focus areas for prevention
5. Identify infections that would prevent an associate from working
6. Understand viral respiratory infection
7. Understand the Biological Incident Plan

Infection Control may be contacted at the numbers listed below:

<table>
<thead>
<tr>
<th>Facility</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kenmore Mercy Hospital</td>
<td>447-6369</td>
</tr>
<tr>
<td>Mercy Hospital of Buffalo</td>
<td>828-3895</td>
</tr>
<tr>
<td>Sisters of Charity Hospital</td>
<td>862-1282</td>
</tr>
<tr>
<td>Sisters of Charity Hospital St Joseph’s Campus</td>
<td>891-2705</td>
</tr>
</tbody>
</table>

### Infection Control Program 2015

Infection Control performance improvement activities are intended to monitor, document, and improve the quality of Infection Control practice through ongoing surveillance.

*Preventing infection is the responsibility of everyone working at Catholic Health.*

Infections can put everyone at risk. We know that infections can be prevented if **everyone is committed to doing his/her part to prevent infections from developing and spreading.**

### Hand Hygiene

One of the best ways to prevent the spread of infection is **Hand Hygiene (IC Policy #110)**

**Hand hygiene** is the single most important measure to reduce the risks of transmitting micro-organisms from one person to another or from one site to another on the same patient. Hands should be washed between patient contacts (even when gloves are worn) and after contact with blood, body fluid, secretions, excretions and equipment contaminated by them.
Good Hand Hygiene Techniques:

Traditional Hand Washing
- Use running water and soap. Remember to keep the water temperature comfortable.
- 15-20 seconds is needed for effective Hand washing. Sing “Happy Birthday”!!
- Apply friction to all surfaces.
- Rinse and dry; turn off faucets with a paper towel.
- THAT’S IT!!

Waterless Hand Sanitizer
Is available and is just as effective as soap and water in most circumstances. Waterless Hand sanitizer dispensers are conveniently located throughout the building. Waterless Hand sanitizer should NOT be used when your hands are visibly soiled because you need the mechanics of handwashing.

Artificial fingernails of any sort are not to be worn if you work in any clinical setting.

General principles of the Infection Control program: (IC Policy #102)
Hand hygiene before and after every patient contact, and after handling any contaminated items.

Food/Beverage
In accordance with Blood Borne Pathogens Standard, food and beverage are prohibited for consumption or storage in areas where blood or body fluid exposure can be reasonably anticipated. Food and beverage are prohibited in clinical areas.
Food and beverage may be consumed in:
- Designated break rooms
- Conference rooms
- Non-clinical areas
- Non-patient care areas

Other measures
- Hair is to be neat and clean. Long hair must be so styled and/or restrained so as not to interfere with work performance, safety and infection control. Hair may not obscure vision or come in contact with patient or other surfaces.
- Regulated Medical Waste must be disposed of in red bags
- Keep your work area clean.
- Remove empty pop cans and bottles
- Equipment shared by patients is cleaned between each patients use
- Be sure your refrigerators are clean. Do not store staff and patient food together
- Food and beverages should not be placed on carts with patient items. – linen carts, medication carts, etc.
- Do not place equipment that is used from patient to patient on a patient’s bed. i.e. –IV start tray etc.
- For large blood or body fluid spills, consult environmental services.

Surveillance (IC policy#100)
The infection control program conducts surveillance on key focus areas. In addition, there is a continuous monitoring for trends or clusters of illness in all settings. The goal is to prevent transmission of infection for our patients, staff, physicians, visitors and anyone affiliated at our facilities.
Priority focus areas for patient safety include:
- Ventilator associated pneumonia
- Catheter associated Urinary infections
- Vascular access device - IV, Central lines
- Clostridium difficile
- Surgical site infection prevention
- Multidrug resistant organisms – MRSA, VRE

The prevention strategies are evidence based, and when used correctly and consistently, can prevent healthcare associated infections. Prevention measures are based on the Center for Disease Control, NYS Health Department and other regulatory agencies.

The following “bundles” of prevention measures are currently in place for infection prevention. Please adhere to protocols for patient safety.

VAP- ventilator associated pneumonia prevention:
- Hand hygiene
- Head of bed elevated 30 degrees unless contraindicated
- Oral care at prescribed intervals
- Sedation ‘vacation’
- Weaning protocols
- Deep vein thrombosis prevention
- Peptic ulcer prevention

CLABSI- central line infection prevention:
- Hand hygiene
- Maximum barriers for insertion
- Aseptic technique
- Appropriate line selection for intended use
- Appropriate site of insertion
- Correct skin prep using chlorhexidine gluconate
- Avoid use of femoral lines
- Scrupulous care and maintenance of the line
- Prompt removal when no longer indicated

SSI- Surgical Site infection prevention:
- Hand hygiene
- Hair removal with clippers when indicated
- Appropriate skin antisepsis
- Appropriate antibiotic selection
- Antibiotic timely administered
- Avoid contamination of the wound

CAUTI- Catheter associated urinary tract infection prevention:
- Hand hygiene
- Foley insertion using aseptic technique
- Appropriate use of a foley catheter
- Routine peri-care
• Excellent care and maintenance of the foley
• Prompt removal of the foley catheter when no longer indicated

**Clostridium Difficile**
• Hand Hygiene
• Environmental cleaning and disinfection is critical
• Appropriate use of antibiotics
• Isolation precautions until symptoms have been treated and are resolved

**Standard and isolation precautions (policy #106 and #103)**
The purpose of isolation precautions is to prevent the transmission of a communicable disease by direct or indirect contact to patients, personnel, volunteers, visitors and others.

**Standard Precautions**
Designed to reduce the risk of transmission of micro-organisms for both recognized and unrecognized sources of infection. Standard precautions apply to all contact with blood, all body fluids, secretions and excretions (regardless of whether or not they contain visible blood), non-intact skin and mucous membranes.

*Standard precautions apply to all patients at all times.* Healthcare workers should avoid contamination of clothing and the transfer of microorganisms to other patients, surfaces and environments. Standard precautions are thought to be the most effective way to accomplish this and they protect against health care associated infections.

**If the patient is coughing productively and the health care worker is in close contact with secretions, a mask with shield is worn to prevent splashing to the face.**

**Transmission based precautions require additional specific control measures to prevent the transmission of infectious agents or communicable disease.** The precautions are based on the way an illness may be transferred from one person to another.

There are three types of precautions we utilize based on CDC criteria. They are Contact, Droplet, and Airborne described below.

**Contact Precautions**
Designed to reduce the risk of transmission of infectious agents which are spread by *direct or indirect* contact. **Direct** contact transmission involves skin-to-skin contact and physical transfer of organisms. **Indirect** contact transmission involves contact with a contaminated object. Contact precautions apply to specified patients known or suspected to be infected or colonized with epidemiologically important pathogens that can be transmitted by direct or indirect contact including Multi Drug Resistant Organisms (MDROs), clostridium difficile and skin rashes. Please note; there are two different colored signs for contact precautions. The second sign is for clostridium difficile to identify the use of soap and water for hand hygiene.

**Droplet Precautions**
Designed to reduce the risk of transmission of infectious agents spread through close respiratory or mucous membrane contact with respiratory secretions. Droplet precautions apply to any patient known or suspected to be infected with epidemiologically important pathogens that can be transmitted by infectious droplets.

**Airborne Precautions**
Designed to reduce the risk of transmission of infectious agents that remain infectious over long distances when suspended in the air. Airborne Isolation applies to patients with known or suspected infections that can be transmitted by the airborne route.

Respiratory protection:

- **Wear an N95 respirator.** Perform appropriate “fit check” each time mask is worn.
- Susceptible persons should not enter the room if measles (rubella) or varicella (chicken pox) is known or suspected and if immune caregivers are available.
- If susceptible persons must enter the room, wear an N-95 respirator.
- No mask is required for the person(s) handling transport as long as the patient is wearing a mask.

**Viral Respiratory Infection & Biological Incidents**

Flu (Influenza) refers to illnesses caused by a number of different influenza viruses. Flu can cause a range of symptoms and effects, from mild to lethal. Influenza is transmitted by large droplets that travel through the air when talking, coughing, or sneezing.

Flu symptoms may include fever, coughing, sore throat, runny or stuffy nose, headaches, body aches, chills and fatigue.

Most healthy people recover from the flu without problems, but certain people are at high risk for serious complications.

Annual outbreaks of the seasonal flu usually occur during the late fall through early spring. A yearly seasonal flu vaccine is available.

Flu vaccine is recommended for all healthcare workers. Declination is required this year.

**Respiratory infection prevention includes the following steps:**

- Wash your hands often with soap and water. When hand washing is not possible, use antibacterial hand sanitizers.
- Practice good “respiratory etiquette” by covering your mouth and nose when coughing and sneezing, use and throw out the tissue and wash your hands.
- Cough or sneeze into the “crook” of your arm to prevent contaminating your hands.
- Stay at least three feet from people who are coughing or sneezing.
- Consider obtaining the “seasonal” flu vaccine and other vaccines as available or required.
- Stay at home when you are sick.
- Keep your children home from school or daycare when they are sick.
- If you go to the doctor’s office or emergency department when you are sick, ask for a mask.

**In the Healthcare Setting**

The goal is early detection, isolation and treatment of persons with suspect or probable flu to prevent additional transmission.

Surveillance and triage are critical to early detection. This is mainly accomplished by assessment of patients being seen in the emergency departments and primary care centers. Additionally, an assessment is conducted to monitor associate illness during an increased volume of illness.

Control measures for flu include isolation (usually droplet precautions -follow most current guidelines issued from the Infection Control Department) appropriate use of personal protective equipment, hand hygiene, special separation and possible special ventilation requirements.
Education is needed annually and “just in time” training may also be implemented as the need arises.

The situations involving influenza change rapidly and during this time it is very important that all staff stay updated and well informed.

**Biological incident preparedness (policy# 0553 CEMP)**

Bioterrorism is the deliberate release of pathogenic microorganisms/bacteria, viruses, fungi or toxins into a community. According to the CDC, the most likely diseases would be:

- Smallpox
- Anthrax
- Botulism
- Plague
- Tularemia
- Viral Hemorrhagic Fever

**Why Are Biological Incidents Different?**

Biological events are different from all other types of incidents.

- The onset of the incident may remain unknown for several days before symptoms appear;
- Even when symptoms appear, they may be distributed throughout the community’s health system and not be recognized immediately by any one provider or practitioner;
- Once identified, the initial symptoms are likely to mirror those of the flu or the common cold so that the health system will have to care for both those infected and the “worried well;”
- Having gone undetected for several days or a week, some infectious agents may already be in their “second wave” before the first wave of casualties is identified;
- Health care authorities and hospitals may want to restrict those infected to a limited number of hospitals, but the public may seek care from a wide range of practitioners and institutions.

High Risk areas for exposure to Biological agents are:

- Emergency Department
- Primary care centers
- Physician offices
- Critical Care Units
- During aerosol generating procedures
- General public access
- Mailroom

**Recognizing a Biological Incident:**

Infection Control Plan is part of the Emergency Preparedness Protocols

The key to rapid intervention and prevention is to maintain a high level of vigilance. The early clinical symptoms of infection for most bioterrorism agents and emerging infectious diseases may be similar to common diseases seen by health care professionals every day. The principles of epidemiology should be used to distinguish cases of a disease currently circulating in the community from those representing an unusual event.

Most of the potential pathogens that could be used as a biologic weapon (e.g., anthrax, plague, and smallpox) would present initially as a non-specific influenza-like illness. Therefore, an unusual pattern of respiratory or influenza-like illness (i.e., occurring out of season or large numbers of previously healthy patients presenting simultaneously) should result in a notification to the Erie County Department of Health. These disease patterns might represent an early start to the influenza season, the introduction of a new pandemic strain, or could be the
initial warning of a bioterrorist event. This communication would be facilitated through the Infection Control Department.

Some features of an outbreak caused by a bioterrorist agent or emerging infectious disease may include:
- An unusual clinical presentation or cluster of illness.
- A single case of an uncommon respiratory illness.
- A confirmed or suspected lab result of a biological agent
- An increase in reports of dead animals
- A symptom or cluster of symptoms associated with a particular disease or biological agent

Catholic Health participates in syndrome surveillance with the New York State Department of Health.

This syndrome surveillance allows for rapid identification of clusters of similar symptoms of illness.

If a cluster or trend of infection or illness is identified, then the Infection Control department would institute enhanced surveillance measures.

Catholic Health would work collaboratively with the local and state health departments to address any potential biological incident.

Each Biological agent requires specific identification, intervention and treatment. This information is part of the CEMP Biological Annex and would be implemented as soon as possible.

**Assessment and monitoring for respiratory illness:**
With both the Influenza and Biological Incident, several areas will be assessed and carefully monitored under the Comprehensive Emergency Management Plan (CEMP).

- Infection Control Surveillance – Protocols would be specific to address the identified concern
- Respiratory Protection Program
- Equipment and Supply Inventories
- Pharmaceutical - Supplies for antiviral medications and antibiotics among other medications
- Surge Capacity Issues – (Large influx of patients into the facility) Both for the emergency department and the hospital’s total patient capacity
- Staffing/Human Resource Protocols
- Communication Issues – internal to the facilities and to external agencies, including all physicians and staff
- Associate Health – Protocols would be utilized dependent on the current situation

Any Hazard mitigation (e.g. decontamination following a potential exposure) would be conducted as necessary.

Continuous assessment, reassessment and education would be conducted.

The information in this training is intended to be a summary of key factors regarding infection control and the infection control program. It is not all inclusive. Many policies exist within individual departments regarding infection control activities. It is the associate’s responsibility to be familiar with the policies and procedures within the department where they work. Infection control staff should be contacted for questions, concerns, or for appropriate information or intervention.

**Specific infection control information such as policies, newsletters, updates, please go to the Infection Control Web Site - “click on the bug” from main CHS web page.**

[Catholic Health - Compliance360 Policy Search] - Policies & Procedures for Catholic Health
Thank you for providing safe care and preventing the spread of infection!

Please contact Infection Prevention and Control for any additional questions or concerns.

ICD-10 TRANSITION

ICD-10 Overview

1. What Is Driving the Change?
   - The World Health Organization (WHO) publishes the International Classifications of Diseases (ICD) code set, which defines diseases, signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or disease.
   - As part of the Health Insurance Portability and Accountability Act of 1996, all “covered entities” will be required to adopt ICD 10 codes for use in all HIPAA transactions with dates of service on or after October 2013*
     Implementation has been delayed to October 1, 2015
   - ICD-9, the current methodology is over 30 years old, contains outdated terminology, and is inconsistent with current medical practice. In addition, the codes lack specificity and detailed support

2. Why Change to ICD-10?
   - ICD-10 is used internationally, converting will enable global diagnosis comparison.
   - ICD-9 is 30 years old and does not contain enough detail for meaningful analysis and disease reporting.
   - ICD-10 is expected to result in better medical necessity justification, fewer claim errors and reduced opportunity for fraud.
   - Specific reporting of diagnosis codes is key to many health insurance coverage policies and are used in pay-for-performance initiatives.
   - Better quality data collection for research, improved measures for severity, risk and outcomes, and disease tracking affecting public health.
   - Practice management and electronic health records will be improved with more effective use of diagnosis and procedure codes.

3. Who Is Impacted By ICD – 10?
   - All Covered Entities
     - Physicians
     - Hospitals
     - Home Health Care
     - Long Term Care
     - Rehab, Lab, Imaging
   - Teams Impacted
     - Physicians
     - Health Information Management – Coding
     - Patient Financial Services
     - Clinical Documentation Improvement
     - Care Management/Utilization Review
     - Quality
     - Financial Reporting

4. ICD-10 Overview
   - ICD International Classification of Diseases is used on virtually 100% of patients and visits within CH – all ministries
ICD CODES are used to describe and catalog the patients’ conditions (Diagnosis) and the Acute Inpatient Procedures
ICD directly influences 90% plus of all of CH Revenue Streams
The WORDS and Clinical VALUES (a tumor size measurement) present in the clinical record are used to assign the CODES
Physicians must document with the correct specificity in order to code ICD-10
ICD-10 is federally mandated change from ICD-9, due Oct 2015
ICD-10 directly impacts all Software Applications that process/contain ICD-9 codes and their interfaces – all will need to be upgraded
ICD-10 is a major Financial risk and significant Clinical impact

5. Introduction to ICD-10-CM/PCS

- The implementation date for ICD-10-CM is October 1, 2015.
- Physicians are responsible for ensuring that their documentation supports the services provided to the patient in order for appropriate code assignment to be completed.
- Due to ICD-10 code specificity, documentation is more crucial than ever.
- Coders are responsible for translating the documentation into the ICD-10 codes per the coding guidelines to populate claims for billing; however, this cannot be done appropriately without the correct specificity documented.
- If documentation is not present to support the codes needed for billing, we will be at significant financial risk.

6. Basic Facts about the Change from ICD-9 to ICD-10

- ICD-10-CM is Diagnosis coding used by all providers in every healthcare setting
- ICD-10-PCS will be used for inpatient hospital procedures. It will not be used on physician claims of any kind.
- CPT and HCPCS codes used for outpatient procedure coding are not affected
- Use of ICD-10-CM and ICD-10-PCS will start with visits or discharges that occur on or after October 1, 2015.
- All IT software that houses, uses or generates ICD-9 codes will need to be updated to an ICD-10 compatible version by the go-live date.
- Practice tools such as charge capture forms, problem lists or superbills will need to be converted to ICD-10 codes.

7. Diagnosis Codes:
   Comparison of ICD-9 to ICD-10-CM

<table>
<thead>
<tr>
<th>ICD-10-CM (NEW)</th>
<th>ICD-9 (OLD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 – 7 Characters in Length</td>
<td>3 – 5 Characters in Length</td>
</tr>
<tr>
<td>Approximately 68,000 codes</td>
<td>Approximately 13,000 codes</td>
</tr>
<tr>
<td>Digit 1 is alpha; digits 2 and 3 are numeric; digits 4-7 are alpha or numeric</td>
<td>First digit may be alpha (E or V) or numeric; digits 2-5 are numeric</td>
</tr>
<tr>
<td>Flexible for adding new codes</td>
<td>Limited space for adding new codes</td>
</tr>
<tr>
<td>Very specific</td>
<td>Lacks detail</td>
</tr>
<tr>
<td>Has laterality (codes identify right vs. left)</td>
<td>Lacks laterality</td>
</tr>
</tbody>
</table>
Example:
K21.0 – Gastro-esophageal reflux disease with esophagitis

Example:
540.9 – Acute appendicitis

## Comparison of ICD-10-CM to ICD-9 Specificity

<table>
<thead>
<tr>
<th>ICD-10-CM</th>
<th>ICD-9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple codes differentiating unique types of mechanical complications and grafts and devices</td>
<td>One code for a mechanical complication of a vascular device, implant or graft</td>
</tr>
<tr>
<td>T82.41XA – Breakdown (mechanical) of vascular dialysis catheter, initial encounter</td>
<td>T82.511A – Breakdown (mechanical) of vascular created arteriovenous shunt, initial encounter</td>
</tr>
<tr>
<td>T82.513A – Breakdown (mechanical) of balloon (counterpulsation) device, initial encounter</td>
<td>T82.515A – Breakdown (mechanical) of umbrella device, initial encounter</td>
</tr>
<tr>
<td>996.1 – Mechanical complication of other vascular device, implant, and graft</td>
<td></td>
</tr>
</tbody>
</table>

## Comparison of ICD-9 to ICD-10-PCS

<table>
<thead>
<tr>
<th>ICD-10-PCS (NEW)</th>
<th>ICD-9 (OLD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 alpha-numeric characters in length</td>
<td>3 – 4 Numbers in length</td>
</tr>
<tr>
<td>Approximately 87,000 codes</td>
<td>Approximately 3,000 codes</td>
</tr>
<tr>
<td>Reflects current usage of medical terminology and devices</td>
<td>Based on outdated technology</td>
</tr>
<tr>
<td>Flexible for adding new codes</td>
<td>Limited space for adding new codes</td>
</tr>
<tr>
<td>Very specific</td>
<td>Lacks detail</td>
</tr>
<tr>
<td>Has laterality</td>
<td>Lacks laterality</td>
</tr>
<tr>
<td>Detailed descriptions for body parts</td>
<td>Generic terms for body parts</td>
</tr>
<tr>
<td>Provides detailed descriptions of methodology and approach for procedures</td>
<td>Lacks descriptions of methodology and approach for procedures</td>
</tr>
<tr>
<td>Precisely defines procedures with detail regarding body part, approach, any devices used, and qualifying information</td>
<td>Lacks precision to adequately define procedures</td>
</tr>
</tbody>
</table>
ICD-10 PCS Character Meanings

<table>
<thead>
<tr>
<th>Character</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition</td>
<td>Name of Section</td>
<td>Body System</td>
<td>Root Operation</td>
<td>Body Part</td>
<td>Approach</td>
<td>Device</td>
<td>Qualifier</td>
</tr>
</tbody>
</table>

*When documenting procedures, these documentation elements must be specified in order for coding to occur*

Right Knee Joint Replacement = 0SRD0JZ

|   |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|
| 0 | Medical and Surgical Section |
| S | Lower Joints |
| R | Replacement |
| D | Knee Joint, Right |
| 0 | Open |
| J | Synthetic Substitute |
| Z | No Qualifier |

8. **Clinician Impacts**
   - Documentation practices must change to specify as required by codes
   - Encounter forms, charge capture forms, scripts for tests such as lab work and super bills must be modified to use ICD-10 codes
   - The number of documentation queries to physicians to provide more detailed diagnosis information may increase
   - Potential delays in reimbursement if coding cannot be completed due to lack of documentation or denials due to incorrect coding on claims.

9. **Patient Financial Services and Patient Registration/Scheduling Impacts**
   - Potential risk for increase of denials due to coding/claim issues related to ICD-10
   - Scripts for tests such as lab work must use ICD-10 codes, if the code on the script is not an ICD-10 code follow up will need to be done to get the correct code for processes such as medical necessity checking, etc.
   - Any registration tip sheets that used ICD-9 codes will need to be updated and/or new tools will need to be used to look up ICD-10 codes
   - The individuals should become familiar with ICD-10-CM and ICD-10-PCS codes in order to better understand when issues arise and/or identify issues with registrations, claim creation, or payer remittances.
   - Scheduling systems must accommodate ICD-10 codes.

10. **Reporting Impacts**
    - Code structure is changing, so all reports using ICD-9 codes will need to be updated with applicable ICD-10 codes.
    - Codes are changing from being numeric to alpha-numeric
- No one-to-one match exists between ICD-9-CM and ICD-10, so manual intervention will be required to map information and develop comparable reports
- ICD-10-CM and ICD-10-PCS may use more or fewer codes to identify procedures or conditions.
- Reporting in both ICD-9-CM and ICD-10-CM/PCS may be necessary for a period of time during the transition
- Increased specificity of ICD-10 codes will require more documentation and change the definitions of what is reported

11. Coding/Clinical Documentation Impacts
- Coders and Clinical Documentation specialists must have in depth education in order to learn the new coding system and how to code in ICD-10 format
- Coders must learn documentation and coding guidelines in order to identify when physician queries are needed to complete coding

12. CHS Education and Training Resources:
Catholic Health Intranet
1.CHIS Intranet → Education & Training → ICD-10
https://my.chsbuffalo.org/edu/icd-10

13. CHS Resources:
1.Elsevier Online Training
Elsevier/MC Strategies Performance Manager – ICD-10 eLearning Page
www.webinservice.com/CatholicCoreLearning
All CHS employees and CMP physicians/office managers have access to ICD-10 education modules via Elsevier. Default username and password prompts are on the Elsevier homepage linked above.
14. CMS Resources:
1. Implementation Guide & Timeline
   CMS ICD-10 Implementation Guide for Small and Medium Practices
   CMS ICD-10 Small Providers Timeline
   CMS ICD-10 Myths and Facts

AMA Resources
AMA ICD-10 Resource Page:
http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-
insurance/hipaahhealth-insurance-portability-accountability-act/transaction-code-set-standards/icd10-code-
set.page
See AMA Educational Resources → Fact Sheets #4 & #5 for Implementation
ICD-10 Code Set to Replace ICD-9

HHS Continues Moving Forward with Oct. 1, 2014 Requirement

The Department of Health and Human Services announced a one year delay of ICD-10 implementation which is now scheduled for October 1, 2015. AMA Board Chair Steven J. Stack, MD, commented, "The AMA appreciates the administration's decision to provide a one year delay in response to AMA advocacy, but we have urged CMS to do more to reduce the regulatory burdens on physician practices so physicians can spend more time with patients."

"This is not the final action on this issue. In the rule, the administration stated its commitment to engage stakeholders on a wide variety of ICD-10 implementation issues, including reduction of burden on physician practices."

The AMA looks forward to working with the administration to address physician concerns with ICD-10 and the multiple reporting programs and burdens associated with them, in greater depth.

Background

ICD-9 and ICD-10 Code Freeze

ICD-10 FAQs

ICD-10 Implementation Planning

AMA Advocacy on ICD-10

AMA Educational Resources

Additional Resources