<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTRODUCTION</td>
<td>3</td>
</tr>
<tr>
<td>MISSION STATEMENT</td>
<td>3</td>
</tr>
<tr>
<td>VISION STATEMENT</td>
<td>4</td>
</tr>
<tr>
<td>VALUES STATEMENT</td>
<td>4</td>
</tr>
<tr>
<td>THE SIZE AND SCOPE OF OUR MEDICAL CENTER</td>
<td>4</td>
</tr>
<tr>
<td>EMPLOYEE HEALTH SERVICES</td>
<td>6</td>
</tr>
<tr>
<td>QUALITY ASSURANCE / PERFORMANCE IMPROVEMENT</td>
<td>8</td>
</tr>
<tr>
<td>Sentinel Events</td>
<td>10</td>
</tr>
<tr>
<td>Root Cause Analysis</td>
<td>10</td>
</tr>
<tr>
<td>Failure Mode and Effect Analysis (FEMA)</td>
<td>12</td>
</tr>
<tr>
<td>Value Based Purchasing</td>
<td>13</td>
</tr>
<tr>
<td>Core Measures</td>
<td>13</td>
</tr>
<tr>
<td>National Patient Safety Goals</td>
<td>16</td>
</tr>
<tr>
<td>Universal Protocol</td>
<td>18</td>
</tr>
<tr>
<td>Pre-Procedure Verification Process</td>
<td>18</td>
</tr>
<tr>
<td>Marking the Procedure Site</td>
<td>18</td>
</tr>
<tr>
<td>“Time Out” Immediately Before Starting the Procedure</td>
<td>18</td>
</tr>
<tr>
<td>THE EMERGENCY MEDICAL TREATMENT AND LABOR ACT</td>
<td>18</td>
</tr>
<tr>
<td>ABBREVIATIONS, ACROYNMS AND SYMBOLS</td>
<td>20</td>
</tr>
<tr>
<td>“Do Not use” Abbreviation List</td>
<td>20</td>
</tr>
<tr>
<td>REPORTING OF MEDICATION ERRORS</td>
<td>21</td>
</tr>
<tr>
<td>Procedure for Self-Reporting of Medical Errors</td>
<td>21</td>
</tr>
<tr>
<td>Examples of Medication Errors</td>
<td>22</td>
</tr>
<tr>
<td>What to Look at in Medication Errors</td>
<td>22</td>
</tr>
<tr>
<td>INFECTION CONTROL</td>
<td>22</td>
</tr>
<tr>
<td>Some Guidelines used in Infection Control to Prevent and Control Infections</td>
<td>22</td>
</tr>
<tr>
<td>Standard Precautions</td>
<td>22</td>
</tr>
<tr>
<td>Transmission-Based Precautions</td>
<td>23</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>24</td>
</tr>
<tr>
<td>RISK MANAGEMENT</td>
<td>25</td>
</tr>
<tr>
<td>Notifications</td>
<td>25</td>
</tr>
<tr>
<td>Documentation</td>
<td>27</td>
</tr>
<tr>
<td>Informed Consent</td>
<td>27</td>
</tr>
<tr>
<td>Professional Misconduct</td>
<td>29</td>
</tr>
<tr>
<td>Legal Documents</td>
<td>30</td>
</tr>
<tr>
<td>ENVIRONMENT OF CARE</td>
<td>30</td>
</tr>
<tr>
<td>General Safety Awareness</td>
<td>30</td>
</tr>
<tr>
<td>HAZARDOUS MATERIALS AND WASTE MANAGEMENT</td>
<td>33</td>
</tr>
<tr>
<td>Hazardous Material Spill</td>
<td>33</td>
</tr>
<tr>
<td>MATERIAL SAFETY DATA SHEETS</td>
<td>36</td>
</tr>
<tr>
<td>OSHA “Right to know” Hazardous Communications</td>
<td>38</td>
</tr>
<tr>
<td>Topic</td>
<td>Page</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>FIRE SAFETY</td>
<td></td>
</tr>
<tr>
<td>Fire Prevention in the Work Place</td>
<td>39</td>
</tr>
<tr>
<td>In Case of a Fire</td>
<td>39</td>
</tr>
<tr>
<td>Fire Extinguishers</td>
<td>40</td>
</tr>
<tr>
<td>INTERIM LIFE SAFETY MEASURES</td>
<td></td>
</tr>
<tr>
<td>EMERGENCY MANAGEMENT</td>
<td>40</td>
</tr>
<tr>
<td>BIO-TERRORISM</td>
<td>42</td>
</tr>
<tr>
<td>ERGONOMICS</td>
<td></td>
</tr>
<tr>
<td>Computer use Ergonomics</td>
<td>44</td>
</tr>
<tr>
<td>SECURITY MANAGEMENT</td>
<td></td>
</tr>
<tr>
<td>The “Doctor Armstrong” Code</td>
<td>46</td>
</tr>
<tr>
<td>PATIENT RELATIONS / CUSTOMER SERVICE</td>
<td></td>
</tr>
<tr>
<td>Benefits of Exceptional Customer Service</td>
<td>47</td>
</tr>
<tr>
<td>The Five “R’s” of Customer Service Skills</td>
<td>47</td>
</tr>
<tr>
<td>Handling Difficult Situations</td>
<td>48</td>
</tr>
<tr>
<td>Mishandling Difficult Situations</td>
<td>48</td>
</tr>
<tr>
<td>Telephone Etiquette</td>
<td>48</td>
</tr>
<tr>
<td>Ten Commandments of Customer Relations</td>
<td>50</td>
</tr>
<tr>
<td>CULTURAL COMPETENCY</td>
<td></td>
</tr>
<tr>
<td>PATIENT RIGHTS</td>
<td></td>
</tr>
<tr>
<td>Advance Directive</td>
<td>55</td>
</tr>
<tr>
<td>Patients Who Do Not Speak English</td>
<td>56</td>
</tr>
<tr>
<td>BIO ETHICS – ETHICS CONSULTATION PROCESS</td>
<td></td>
</tr>
<tr>
<td>ABUSE AND NEGLECT</td>
<td>58</td>
</tr>
<tr>
<td>PRIVACY AND CONFIDENTIALITY: HIPAA</td>
<td></td>
</tr>
<tr>
<td>Health Information Management</td>
<td>59</td>
</tr>
<tr>
<td>Acceptable use of Computer Resources</td>
<td>61</td>
</tr>
<tr>
<td>CORPORATE COMPLIANCE</td>
<td></td>
</tr>
<tr>
<td>FRAUD AND ABUSE</td>
<td>62</td>
</tr>
<tr>
<td>RESTRAINTS</td>
<td></td>
</tr>
<tr>
<td>PAIN ASSESSMENT AND MANAGEMENT</td>
<td>63</td>
</tr>
<tr>
<td>ENSURING STAFF COMPETENCY</td>
<td></td>
</tr>
<tr>
<td>STAFF RIGHTS ON CULTURAL, ETHICAL AND RELIGIOUS BELIEFS</td>
<td>64</td>
</tr>
<tr>
<td>SEXUAL HARRASSMENT</td>
<td></td>
</tr>
<tr>
<td>RECOGNIZING THE IMPAIRED EMPLOYEE</td>
<td>65</td>
</tr>
<tr>
<td>DRESS CODE</td>
<td></td>
</tr>
<tr>
<td>RULES OF CONDUCT</td>
<td>66</td>
</tr>
</tbody>
</table>
INTRODUCTION:
Here is the Interfaith Medical Center 2013 edition of the Employee Reference Guide. This Guide was developed to provide you with answers regarding Interfaith Medical Center’s policies and practices. Inside, you will find information that will guide you in becoming familiar with our Mission, Vision and Values and such areas as Infection Control, Safety in the Workplace and our Corporate Compliance Program.

Interfaith Medical Center’s Policies and Procedures may change during the course of a year, with notifications distributed through normal channels. Employees are expected to keep current.

This Guide also serves as a reference point to employees as they complete the Annual Education Program and required test.

If you have any questions about any of the material contained in this guide, do not hesitate to contact: Denise McLellan, Director of Human Resources at extension 6560.

MISSION STATEMENT:
Interfaith Medical Center is a voluntary, community teaching hospital dedicated to providing high quality health care services to the residents of Bedford-Styvesant, Crown Heights and surrounding Brooklyn communities. Care will be rendered without regard to race, color, creed or national origin and with sensitivity to patient’s spiritual, cultural, social, language and clinical needs, in a safe, caring and compassionate environment.

Interfaith offers a continuum of care which includes acute medical, surgical, gynecological, pediatric and psychiatric in-patient, outpatient care and emergency services, and patient-focused education and prevention services in the inpatient and ambulatory settings.

Interfaith is committed to providing the appropriate patient resources on-site through the use of technological and scientific advances enhancing quality clinical programs, the retention of qualified providers, and by affiliations with other hospitals, long-term care facilities, health care agencies and physician groups.

Interfaith is dedicated to supporting residency and fellowship programs, which will train practitioners of excellence. It subscribes to the requirements and standards of programmatic and hospital accrediting agencies and organizations.
VISION STATEMENT:

Interfaith Medical Center’s vision is focused on the development of a highly effective community, teaching hospital and ambulatory care system. This system will offer needed levels of patient service provided through internal program development and enhancement as well as networking with external resources. The foundation on which Interfaith Medical Center's system will be built consist of four basic elements; automated and integrated record keeping, case management to integrate services and interdisciplinary teamwork.

The patient is the principal focus of Interfaith Medical Center's system. Essential patient service needs will be identified by the medical and management staff in conjunction with local and State officials. This vision has been conceptually framed by the epidemiology of our community and is reflective of the population served by Interfaith.

The system will plan, implement and manage a seamless continuum of care for both health and ancillary services. Outcome measures will be community oriented and disease based. Improving the health status of our patients is the objective of this patient centered health care system.

VALUES STATEMENT:

Interfaith Medical Center believes it can best provide high quality healthcare services for our community through a commitment to a patient centered focus, commitment to fiscal responsibility and a commitment to quality and performance improvement.

THE SIZE AND SCOPE OF OUR MEDICAL CENTER

Interfaith Medical Center (IMC) is a multi-site community teaching health care system which provides a wide range of medical, surgical, gynecological, dental, psychiatric, pediatric, and other services throughout Central Brooklyn, New York. Interfaith Medical Center is a newly modernized hospital with over 1700 employees and 287 inpatient beds including 120 psychiatric beds, 20 detox, 20 rehabilitation beds, and 127 acute care beds. IMC has an extensive ambulatory network with 16 clinics and five shelter programs stretching across the Central Brooklyn communities of Crown Heights and Bedford-Stuyvesant.

Additionally, Interfaith Medical Center provides Emergency care delivery for pediatric, adult, and psychiatric patients through the various Emergency Departments. In 2006, an expanded ED Fast-Track module delivery was implemented to expedite the non-urgent patient care needs. Extension inpatient and outpatient testing procedures are available in the Cardiac Testing Laboratory, Cardiac Catheterization Unit, and Radiology Departments. Ambulatory surgery procedures are facilitated
through Pre-admission Testing and the Ambulatory Surgery Unit. Interfaith Medical Center offers a variety of medical specialties including Residency Training Programs in Internal Medicine, Podiatry, Ophthalmology, and Dentistry.

The following specialties/services are available at Interfaith Medical Center:

**MEDICINE:** Cardiology/hypertension; Cardiac Catheterization; Endocrinology; Gastroenterology/GI/Endoscopy; Geriatrics; HIV AIDS; Hematology and Oncology; Hepatology/Liver diseases; Infectious Diseases; Nephrology/Acute Dialysis; Neurology; Neurophysiology Laboratory; Primary Care; Pulmonary Diseases/Asthma/Bronchosopy; Rheumatology/Arthritis; Adult Sickle Cell Program

**SURGERY:** Adult and Pediatric General Surgery; Breast Surgery; Colorectal Surgery; Head and Neck Surgery; Laparoscopic and Arthroscopic Surgery; Ophthalmology; Oral Surgery; Orthopedics; Otolaryngology and Audiology (ear, nose and throat) Plastic Surgery; Podiatry; Thoracic Surgery; Urology; Vascular Surgery

**GYNECOLOGY:** Colposcopy; Comprehensive Family Planning; Genetic Counseling; Gynecologic Surgery; HIV Counseling and Testing; PCAP; Women’s Health

**PEDIATRICS:** Adolescent Medicine; General Pediatrics; Pediatric Allergy; Pediatric Cardiology; Pediatric Critical Care; Pediatric Endocrinology; Pediatric Gastroenterology; Pediatric Hematology and Oncology; Pediatric Infectious Diseases; Pediatric HIV Counseling and Testing; Pediatric Nephrology; Pediatric Neurology; Pediatric Pulmonology/Asthma/Bronchoscopy; Pediatric Sickle Cell Program; Pediatric Urology

**PSYCHIATRY:** Alcohol Detoxification; Community Mental Health (CMH); Drug Detoxification; HIV Counseling and Testing; Intensive Psychiatric Rehabilitation Therapy (IPRT); Mentally Impaired Chemical Treatment Program (MICA); Methadone Maintenance Treatment Program (MMTP); Mobile Crisis Intervention; Partial Hospitalization; Substance Abuse

**DENTISTRY:** General Adult and Pediatric Dentistry; Dental Anesthesia; Facial Pain; Oral Maxillofacial Surgery; Implants; Orthodontics

**PHYSICAL MEDICINE:** Physical Therapy; Rehabilitation

**RADIOLOGY:** Brachytherapy Program; Diagnostic and Therapeutic CT Scan; Diagnostic and Therapeutic Radiology; High Voltage Linear Accelerator; Interventional Radiology; Intra-operative Program; Mammography; Nuclear Medicine; Ultrasonography; MRI
EMPLOYEE HEALTH SERVICES

The function of Employee Health Services is to ensure all employees who enter the Medical Center are within the health codes as set by the State Department of Health (DOH), Occupational Safety and Health Administration (OSHA), Joint Commission and policies set by the Medical Center.

Hours of Operation
Employee Health Services is open Monday to Friday (no weekends or holidays).

Phone/Fax (718) 613-4014 (718) 613-4879

Pre-Employment Physical
This is a physical examination performed by the Employee Health medical practitioner to ensure that the applicant is healthy, free of contagion and physically capable of performing the job for which he or she was hired. Blood tests are done to establish immunities and to have a baseline on record of chemistries and other blood levels. Applicants may be asked to have a chest x-ray or EKG, depending on their health history and job category.

Annual Health Assessment
The Annual Health Assessment is a requirement of the Department of Health, Joint Commission on Accreditation of Healthcare Organization and Occupational Safety and Health Administration. This is not a physical but an update of your health status. Depending upon which area you are assigned, an assessment may be required of you every six months. During this assessment, your TB status will be evaluated as well as any test which may be missing or in need of updating. The Annual Health Assessment will be done by the Employee Health medical practitioner.

PPD, Hepatitis Vaccine and Other Vaccines
PPD testing is required at pre-employment and annually/semiannually as appropriate for individuals with a negative response to previous Mantoux tests. Reading of the PPD must be done in 48 to 72 hours. Failure to comply requires a repeat of the PPD. Individuals testing positive with prior negative test results will be offered a chest x-ray and possible treatment modalities.

Prophylactic vaccination for Hepatitis B is available to ALL employees of the Medical Center. Although it is not required, it is highly recommended and encouraged.

Anyone who is not immune to rubella (German measles), measles, mumps and chicken pox will be offered the appropriate vaccine. Flu vaccine is available to anyone who requests it during flu season.
On Duty Injury
Should you be injured while on duty, an Employee Injury Report is to be completed by you and your supervisor, and you may be seen in Employee Occupational Health Services during operating hours. During EHS non-operating hours, go to the Emergency Department (ED). When reporting to Employee Health Services for an on-duty injury, you must present with the completed Employee Injury Report. Whether seeking care for an on duty injury or not, an injury report must be completed and submitted to the Human Resources Department within 48 hours of the occurrence.

Needle Stick/Sharps Injury Body Fluid Exposure
If you receive a needle stick/sharp injury or body fluid exposure, you should report to Employee Health Services for initial screening and follow up testing. Follow up testing may include HIV, Hepatitis B and C, and STD testing. You may be offered anti-retroviral drugs if the patient or source is known to be HIV positive, has AIDS or is strongly suspected to be infected. Whether you accept testing or not, an Employee Injury Report must be completed and submitted to the Human Resources Department within 48 hours of the occurrence.

On Duty Illness
Should you become ill (sick) while on duty, you may be seen in Employee Health Services for assessment. When reporting to Employee Health Services for an on-duty illness, you must present a referral slip. The referral slip is to be obtained from your supervisor/manager/department head. No one will be seen without a referral slip. If you become ill at home, you are not to come to Employee Health Services for treatment.

Return to Duty
After being out sick for a minimum of three (3) days, you are required to be cleared by Employee Health Services before returning to work. The request for clearance must be accompanied by a note from your physician indicating the date your illness began, the date you can work at full duty (partial/light duty is not accepted). When reporting to Employee Health Services for clearance to return to work, you must present a referral slip. The referral slip is to be obtained from your supervisor/manager/department head. No one will be seen without a referral slip.

Request for Employee Health Record
You are entitled to copies of your Employee Health Record. However, it is asked that your request be reasonable. By law we are allowed fifteen (15) working days to comply with requests for copies, and you must sign authorization consent for copies. Please keep this in mind when requesting copies of your Employee Health Record.
QUALITY ASSURANCE/PERFORMANCE IMPROVEMENT

What is Performance Improvement (PI)?
Performance Improvement is a systematic process by which IMC assesses the services provided to customers with the goal of improving patient outcomes. The process is interdisciplinary and collaborative. All employees look to identify opportunities to improve patient care and service.

What are the key processes of PI? At Interfaith, we use...

Improvement Planning – Involves getting the right people together, across departments, to look at the planning of systems.

Process Design – Looks at the services provided by a hospital area and ways of improving that service. For example, the Emergency Department provides a valuable service that must be given in a timely manner. Staff in the ER is constantly looking at ways to improve the timely delivery of care.

Performance Measurement – Looks at indicators or measurements that tell us how a particular service or department is performing. For example, is the quality of patient care appropriate, is a department practicing efficient infection control, safety, risk management and utilization?

Performance Assessment – Once data has been compiled, it is analyzed and interpreted. For example, if data shows an increase in infections, one may want to look at the relationship to poor hand washing hygiene practices of the staff.

How Do We Ensure Quality and Patient Satisfaction?
Interfaith Medical Center has adopted the FOCUS-PDCA process as its model for improvement. The process is summarized as:

F Find a process to improve
O Organize a Team
C Clarify what is known about the process
U Understand the causes for variation
S Select a strategy for improving the process

P Plan
D Do
S Study
A Act

How is Performance Improvement measures used?
- to improve patient care processes/outcomes
- to identify staff educational needs
- to reduce costs
What is your involvement in PI?

- Introduced to PI during orientation
- Participate at PI meetings (unit based/departmental)
- Collect data for performance measures/indicators
- Participate in patient satisfaction surveys
- Participate in implementing change

What tools are employed throughout the PI process at IMC?

- **Brainstorming**: group gives ideas on problems/solutions
- **Flowchart**: the steps/path of a process are defined to identify areas for improvement
- **Cause and Effect**: causes of a specific problem are discussed. (Fishbone Diagram)
- **Pareto Chart or Graphs**: graphics that help determine which problems to solve and in what order.

Why is Quality Important?

- Quality is meeting or exceeding our customers/patients expectations – Doing the right thing and doing it well – Service with minimum effort, rework and waste.
  - Our patients demand quality
  - It costs less to do the right thing the first time
  - Quality results in patient/family satisfaction – a better image “reputation” for the facility
  - Develops teamwork between coworkers and departments to improve patient care outcomes
  - Avoids waste and rework
  - Makes us feel good about the work we do
  - Results in employee satisfaction – retention of “talented staff”

What is JOINT COMMISSION?

The Joint Commission evaluates and accredits nearly 17,000 health care organizations, including Interfaith. Joint Commission sets the standards for patient care. Their focus includes improving patient care and outcomes, support and enhancement of patient safety, quality improvement efforts, and the reduction of sentinel events. Any quality or safety issues can be reported directly to Joint Commission without fear of retaliation (see below for means of contacting Joint Commission directly.)
Sentinel Events

A sentinel event is an unexpected occurrence involving death, serious injury or risk to a patient. Examples of Sentinel Events are:

- Fatal falls
- deaths related to restraints, or to hospital acquired infections
- significant medication errors
- wrong-side surgeries
- infant/child abduction
- blood transfusion error
- ventilator related death and injuries
- assault/homicide
- medical gas mix-ups
- infusion pump errors
- suicide

Reporting Sentinel Events

Sentinel events must be immediately reported to the supervisor of the department where the event occurred and the Risk Management Department. In addition, the Joint Commission can be contacted directly.

Events can be reported to Joint Commission without fear of retaliation by several means:

- Email: complaint@jointcommission.org
- Telephone: 1-800-994-6600 (8.30 am to 5 pm Central Time)
- The incident report can be obtained on line at www.jointcommission.org, and sent by:
  - fax to the Office of Quality Monitoring at (630) 792-5636, or by
  - mail to Office of Quality Monitoring, Joint Commission, One Renaissance Boulevard, Oakbrook Terrace, IL 60187

Root Cause Analysis

The goal of a Root Cause Analysis is to find out

- What happened
- Why did it happen
- What to do to prevent it from happening again.

Root Cause Analysis is a tool for identifying prevention strategies. It is a process that is part of the effort to build a culture of safety and move beyond a culture of blame. It is believed that problems are best solved by attempting to correct or eliminate root causes, as opposed to merely addressing the immediately obvious symptoms. By directing corrective measures at root causes, it is hoped that the likelihood of problem recurrence will be minimized.
In Root Cause Analysis, basic and contributing causes are discovered in a process similar to diagnosis of disease - with the goal always in mind of preventing recurrence.

Root Cause Analysis is:
- Inter-disciplinary, involving experts from the frontline services
- Involving of those who are the most familiar with the situation
- Continually digging deeper by asking why, why, why at each level of cause and effect.
- A process that identifies changes that need to be made to systems
- A process that is as impartial as possible

To be thorough, a Root Cause Analysis must include:
- Determination of human and other factors
- Determination of related processes and systems
- Analysis of underlying cause and effect systems through a series of why questions
- Identification of risks & their potential contributions
- Determination of potential improvement in processes or systems

To be credible, a Root Cause Analysis must:
- Include participation by the leadership of the organization & those most closely involved in the processes & systems
- Be internally consistent
- Include consideration of relevant literature

General Principles of Root Cause Analysis
- Aiming corrective measures at root causes is more effective than merely treating the symptoms of a problem.
- To be effective, RCA must be performed systematically, and conclusions must be backed up by evidence.
- There is usually more than one Root Cause for any given problem.

General Process for Performing Root Cause Analysis
- Define the problem.
- Gather data/evidence.
- Identify problems that contributed to the problem (causal factors).
- Find root causes for each Causal Factor.
- Develop solution recommendations.
- Implement the solutions.
- Measure the effectiveness of the implemented solutions.
An interdisciplinary team conducts a thorough Root Cause Analysis (RCA), develops and implements remedies, and monitors the gains within 45 days of the incident.

**Failure Mode and Effect Analysis (FMEA)**

Similar to the Root Cause Analysis in theory, a FMEA is conducted prior to incidents occurring in order to reduce the possibility of harm.

- A systematic method to identify possible failures that pose the greatest overall risk.
- Changes are made in processes to make them safer.
- Near misses are analyzed to determine how processes fail, possible cause of the failure, and consequences of the failure. Risk is analyzed to see the frequency, severity and consequences of the failure.

---

**Performance Improvement**

- Was the process designed to ensure patient safety and quality care?

- Conduct a FMEA to identify potential failures to the process.

- Conduct an RCA to identify what went wrong and to make changes in the process.

ENSURES PATIENT SAFETY AND QUALITY OF CARE

---

**Dimensions of Performance:**

- Efficacy
- Appropriateness
- Availability
- Timeliness
- Continuity
- Safety
- Efficiency
- Respect and Caring
Value Based Purchasing

HOW DOES HOSPITAL VALUE-BASED PURCHASING WORK?

Starting in October 2012, Medicare rewards hospitals that provide high quality care for their patients through the new Hospital Value-Based Purchasing (VBP) Program. For the first time, hospitals across the country will be paid for inpatient acute care services based on care quality, not just quantity of service they provide.

This Hospital VBP Program, established by the Affordable Care Act, will implement a pay-for-performance approach to the payment system that accounts for the largest share of Medicare spending, affecting payment for inpatient stays in over 3,500 hospitals across the country.

Under the Hospital VBP Program, Medicare will make incentive payments to hospitals beginning in Fiscal Year (FY) 2013 based on either:

- How well they perform on each measure, or
- How much they improve their performance on each measure compared to their performance during a baseline period.

The Hospital VBP Program is designed to promote better clinical outcomes for hospital patients as well as improve their experience of care during hospital stays.

Under Medicare’s Hospital VBP Program, hospitals will receive incentive payments based on how well they perform on 12 Clinical Process of Care Measures (CORE Measures) as well as 8 patient Experience of Care Measures (HCAHPS Scores) or on how much their performance improves relative to a baseline performance.

Core Measures

A Core Measure is a specific item that can easily be measured in many hospitals. Joint Commission uses this method in order to make valid comparisons between hospitals.

Core Measures use standardized sets of valid, reliable, evidence-based ‘core’ measures that can be used to track progress in making hospitals safer for everyone. Core measures relate to a disease or process of care.

The Joint Commission requires accredited hospitals to collect and submit performance data on the following measure sets:

- Acute Myocardial Infarction (Heart Attack) (AMI)
- Congestive Heart Failure (CHF)
- Community Acquired Pneumonia (CAP)
- Surgical Care Improvement Project (SCIP)
- VTE Prophylaxis (Venous Thromboembolism)
- Hospital Based Inpatient Psychiatric Services (HBIPS)
- Stroke
- Immunization
- ED Throughput
- Outpatient measures

This requirement was established to improve the safety and quality of care and to support performance improvement in hospitals.
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS Survey—also known as Patient Perception Survey.)

What is the HCAHPS Survey?

The HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Survey, also known as the HCAPS Hospital Survey or Hospital CAHPS, is a standardized survey instrument and data collection methodology that has been in use since 2006 to measure patients’ perspective of hospital care. While many hospitals collect information on patient satisfaction, HCAHPS (pronounced “H-Caps”) created a national standard for collecting and public reporting information that enables valid comparisons to be made across all hospitals to support consumer choice. The HCAHPS sampling protocol is designed to capture uniform information on hospital care from the patient’s perspective.

Three broad goals shape the HCAPS Survey. First, the survey is designed to produce comparable data on patients’ perspective of care that allows objective and meaningful comparison among hospitals on topics that are important to consumers. Second, public reporting of the survey results is designed to create incentives for hospitals to improve quality of care. Third, public reporting serves to enhance public accountability in health care by increasing transparency. With these goals in mind, the HCAHPS project has taken substantial steps to assure that the survey is credible, useful, and practical. This methodology and the information it generates are available to the public.

What are the survey questions?

1. How often did nurses treat you with courtesy and respect?
2. How often did nurses listen carefully to you?
3. How often did nurses explain things in a way you could understand?
4. After you pressed the call button, how often did you get help as soon as you wanted it?
5. How often did doctors treat you with courtesy and respect?
6. How often did doctors listen carefully to you?
7. How often did doctors explain things in a way you could understand?
8. How often were your room and bathroom kept clean?
9. How often was the area around your room quiet at night?
10. Did you need help from nurses or other hospital staff in getting to the bathroom or in using a bedpan?
11. How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?

12. Did you need medicine for pain?

13. How often was your pain well controlled?

14. How often did the hospital staff do everything they could to help you with your pain?

15. Were you given any medicine that you had not taken before?

16. Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?

17. Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?

18. During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?

19. During this hospital stay did you get information in writing about what symptoms or health problems to look out for after you left the hospital?

20. Using any number from 0 to 10 where 0 is the worst hospital possible, what number would you use to rate this hospital during your stay?

Remember to use AIDET methodology when caring for or addressing patients

These Five Fundamentals of Consistent Communication lead to:

Safety      Decrease Anxiety    Increase Compliance    Quality      Patient Loyalty

A- Acknowledge
Key message: you are important, make eye contact, make the patient feel that you expected them, connect with the patient, be polite and respectful

I-Introduce
Name, Role, (Take to the next level), Education, Experience, Skill Set, Certifications

D-Duration
Manages patient expectations about time, How long will the registration process take?, Are there any delays?, How long will the test, procedure, appointment or admission actually take?

E- Explanation
We want to keep you informed, Why are we doing this?, What will happen and what you should expect?, What questions do you have? (About medications, instructions for follow up care)
National Patient Safety goals:

The purpose of the Joint Commission’s National Patient Safety Goals is to promote specific improvements in patient safety. The goals highlight problematic areas in health care and describe evidence and expert-based solutions to these problems. Recognizing that sound system design is intrinsic to the delivery of safe, high quality health care, the goals focus on system-wide solutions, wherever possible.

As with other Joint Commission standards, accredited organizations are evaluated for continuous compliance with the specific requirements associated with the National Patient Safety Goals. Although these requirements are generally more prescriptive than Joint Commission standards requirements, organizations are permitted to design alternative approaches to meeting goal requirements and to request Joint Commission consideration and approval of such alternatives. The Joint Commission also provides guidance on how to achieve effective compliance with each goal’s requirements.

The National Patient Safety Goals are derived primarily from informal recommendations made in the Joint Commission’s safety newsletter, Sentinel Event Alert. The Sentinel Event database, which contains de-identified aggregate information on sentinel events reported to the Joint Commission, is the primary, but not the sole, source of information from which the Alerts, as well as the National Patient Safety Goals, are derived.

The Current patient safety goals are:

NPSG.01.01.01: Use at least two patient identifiers when providing care, treatment, and services.
- At Interfaith, these two identifiers are the patient’s name and either the medical record number or date of birth.
- Label containers used for blood and other specimens in the presence of the patient

NPSG.01.03.01: Eliminate transfusion errors related to patient misidentification.
- Prior to administering blood products two (2) employees one of which is the transfusionist, must verify the patient’s identity at the bedside.

NPSG.02.03.01: Report critical results of tests and diagnostic procedures on a timely basis

NPSG.03.04.01: Label all medications, medication containers (for example, syringes, medicine cups, basins), or other solutions on and off the sterile field.
NPSG.03.05.01: Reduce the likelihood of patient harm associated with the use of anticoagulant therapy.

NPSG.03.06.01: Maintain and communicate accurate patient medication information
- Medication reconciliation is to occur on admission, transfer and discharge of patients
- Medication reconciliation should also be conducted in the outpatient settings, i.e. Emergency Department, Ambulatory Surgery/GI and outpatient clinics
- Next provider is to be provided a medication list

NPSG.07.01.01: Comply with current World Health Organization (WHO) hand hygiene guidelines or Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.
- Hand sanitizers are available throughout IMC
- Wash hands with soap and water if visibly soiled

NPSG.07.02.01: Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function related to a health care–associated infection

NPSG.07.03.01: Implement evidence-based practices to prevent health care–associated infections due to multidrug-resistant organisms in acute care hospitals

NPSG.07.04.01: Implement best practices or evidence-based guidelines to prevent central line–associated bloodstream infections.

NPSG.07.05.01: Implement best practices for preventing surgical site infections.

NPSG.07.06.0: Implement evidence based practices to prevent indwelling catheter associated urinary tract infections (CAUTI)
- Limit use and duration of indwelling catheters

NPSG.15.01.01: The hospital identifies patients at risk for suicide.

NPSG.16.01.01: The hospital selects a suitable method that enables health care staff members to directly request additional assistance from a specially trained individual(s) when the patient’s condition appears to be worsening.
- IMC created a Rapid Response Team (RRT) in 2007. The team consists of a medical resident, critical care nurse and respiratory therapist. Nursing staff can call a “code 77” to activate the team whenever there is a change in their patient’s condition.
UNIVERSAL PROTOCOL

The following steps, taken together, comprise the Universal Protocol for eliminating wrong site, wrong procedure, or wrong person surgery:

UP.01.01.01 Pre-procedure verification process
- Purpose: To ensure that all of the relevant documents and studies are available prior to the start of the procedure and that they have been reviewed and are consistent with each other and with the patient’s expectations and with the team’s understanding of the intended patient, procedure, site and, as applicable, any implants. Missing information or discrepancies must be addressed before starting the procedure.
- Process: An ongoing process of information gathering and verification, beginning with the determination to do the procedure, continuing through all settings and interventions involved in the preoperative preparation of the patient, up to and including the “time out” just before the start of the procedure.

UP.01.02.01 Marking the procedure site
- Purpose: to identify unambiguously the intended site of incision or insertion.
- Process: For procedures involving right/left distinction, multiple structures (such as fingers and toes), or multiple levels (as in spinal procedures), the intended site must be marked such that the mark will be visible after the patient has been prepped and draped.

UP.01.03.01 “Time Out” immediately before starting the procedure
- Purpose: To conduct a final verification of the correct patient, procedure, site and, as applicable, implants.
- Process: Active communication among all members of the surgical/procedure team, consistently initiated by a designated member of the team, conducted in a “fail-safe” mode, i.e., the procedure is not started until any questions or concerns are resolved.

EMTALA – Emergency Medical Treatment and Labor Act

The Emergency Medical Treatment and Labor Act, was enacted by Congress in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985. The act became the de facto national healthcare policy for dealing with the uninsured and made emergency departments America’s most important health care safety net.

Before transferring a patient to another facility, the Emergency Department must:
- Stabilize a patient’s emergency condition
- Inform the patient of the reasons for transfer
• Receive the patient’s written consent
• Notify the receiving facility

EMTALA applies to:
• All hospitals that participate in the Medicare program and offer emergency services
• Patients in those facilities, whether or not they receive Medicare benefits

A dedicated Emergency Department can be any one of the following:
• Is licensed by the state
• Is held out to the public as providing emergency medical care for emergency medical conditions
• Provides at least one-third of its outpatient visits for the treatment of emergency medical conditions on an unscheduled basis

EMTALA does not apply to:
• Individuals who come to off-campus outpatient clinics that do not routinely provide emergency services
• Individuals who have begun to receive scheduled, non-emergency outpatient services, such as lab tests, at the main campus

An ER physician, as well as any non-physician practitioner involved in emergency treatment, may contact a patient’s regular physician at any time for relevant information, as long as the call does not inappropriately delay services.

Hospitals may have a reasonable registration process, including asking whether the patient is insured, as long as it doesn’t delay the medical screening exam and stabilizing treatment.

Even if the insurer or personal physician denies authorization, the hospital is still obligated to provide the necessary stabilizing treatment, if it can. Transfers should only occur:
• If the hospital does not have the necessary resources
• For reasons in the best interest and with the consent of the patient.
• Other definitions:
  • MSE – Medical Screening Examination includes, but is not limited to Triage.

EMC – Emergency Medical Condition: a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the individual’s health [or the health of an unborn child] in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs
ABBREVIATIONS, ACRONYMS, AND SYMBOLS

To help reduce the numbers of errors related to incorrect use of terminology, the Joint Commission issued a list of abbreviations, acronyms and symbols that should no longer be used. The action supports one of Joint Commission's national patient safety goals: to improve the effectiveness of communications among caregivers. In support of this, during the new employee’s Departmental Orientation, Interfaith Medical Center requires that all clinical staff read and sign a memorandum indicating that they have reviewed the list of “do not use” abbreviations, and that they agree to refrain from the use of these abbreviations.

Interfaith Medical Center issued Policy Number VIII-IM-04 entitled “Abbreviations and Symbols in the Medical Record” in July 2003, in order to improve the effectiveness of communication among caregivers, and to maintain consistency in the interpretation of documentation. It stipulates that only standardized abbreviations, acronyms, and symbols approved by Interfaith Medical Center shall be used to document information in the medical record. The policy contains a list of approved abbreviations, acronyms and symbols, and a list of those that are unacceptable.

“Do Not Use” Abbreviation List

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Potential Problem</th>
<th>Acceptable Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>U (unit)</td>
<td>Mistaken for “0” (zero), the number “4” (four), or “cc”</td>
<td>Write “Unit”</td>
</tr>
<tr>
<td>IU (international unit)</td>
<td>Mistaken for IV (intravenous) or the number 20 (ten)</td>
<td>Write out the term “International Unit”</td>
</tr>
<tr>
<td>aD., aD, q.d., qd (daily) Q.O.D., QOD, q.o.d., qod (every other day)</td>
<td>Mistaken for each other. The period after the O can be mistaken for an “I” and the “O” can be mistaken for “I”</td>
<td>Write “daily” Write “every other day”</td>
</tr>
<tr>
<td>Trailing zero (X.0 mg)*</td>
<td>Decimal point is missed</td>
<td>Write X rig</td>
</tr>
<tr>
<td>Lacking of leading zero (.X mg)</td>
<td>Write 0.X mg</td>
<td></td>
</tr>
<tr>
<td>MS</td>
<td>Can mean morphine sulfate or magnesium sulfate</td>
<td>Write “morphine sulfate” Write “magnesium sulfate”</td>
</tr>
<tr>
<td>MSO₄ and MgSO₄</td>
<td>Confused for one another</td>
<td></td>
</tr>
</tbody>
</table>

Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

* Exception: A “trailing zero” may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report
REPORTING OF MEDICATION ERRORS

Interfaith Medical Center’s policy is to provide a mechanism by which the clinical staff will have direction as it relates to self-reporting of medical errors which will assure accountability in communication of outcomes in patient care.

Medication errors have been identified as the fourth most common cause of patient deaths in the United States. Between 44,000 and 96,000 deaths each year may be attributed to medical errors, giving rise to systematic efforts throughout the healthcare industry to address the issues and better protect patient safety.

A Medication Error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the patient is in the care of the health care professional. Such events may be related to professional practice, health care products, procedure and systems, including prescribing; order communications; product labeling, packaging, and nomenclature; compounding; dispensing distribution; administration education, monitoring, and use.

An Adverse Drug Reaction is any undesirable and/or intentional consequences of drug administration occurring at doses normally used which necessitate discontinuation or decrease of the drug or extends patients hospitalization.

Procedure for Self-Reporting of Medical Errors

- Individual practitioner must have self-awareness or identify that a Medical Error has occurred.
- The individual must contact/notify his/her supervisor and self-report the incident.
- The attending Physician must be notified to evaluate and ensure that the patient is stable.
  - Should the patient display signs of distress, prompt medical attention is required.
  - An occurrence report is to be entered into the Risk Management Notification module of the Meditech System
- The supervisor and practitioner will conduct a review of how the incident occurred and what could have been done to prevent the error.
  - If an employee self-reports a medical error, there will be no disciplinary action involved.
  - Should an employee not self-report a medical error, there will be disciplinary action involved.
All incidents are to be referred to the Risk Management Department for review.

**Examples of Medication Errors**
- Prescribing
- Wrong Patient
- Improper dose/quantity
- Extra Dose
- Wrong drug preparation
- Wrong administration technique
- Omission
- Wrong time
- Wrong treatment
- Wrong dosage form
- Unauthorized drug
- Wrong side

**What to Look At in Medication Errors:**
- Type of error
- Cause of error
- Factors contributing to the error
- Location of error
- Level of staff
- Action taken to prevent future errors
- Direct result of the error on the patient

If an employee self-reports a medication error, there will be no disciplinary action involved. Should an employee not self-report a medical error, there will be disciplinary action involved.

**INFECTION CONTROL**

Infection Control is a process in which a health care facility seeks to identify and reduce the risks of infections from developing or spreading. Infection Control benefits everyone, including patients, visitors, students, volunteers and health-care workers.

The key to Infection Control is summarized as Surveillance, Prevention, and Control of healthcare associated infections.

Everyone in the Hospital must be actively involved in the Infection Control process. Infection Control involves everyone, no matter which department you work for. As long as you are in the Hospital you are part of the Infection Control plan.

**Some Guidelines Used in Infection Control to Prevent and Control Infections**

**Standard Precautions**

Standard precautions require everyone to assume that anyone’s blood and body fluids may carry hepatitis viruses, HIV, or other blood-borne infections. Infectious substances include blood and all body fluids, secretions and excretions, except sweat, even if they do not contain any visible blood. Standard precautions are guidelines issued for the care of patients in hospitals but should be used to prevent disease transmission in all walks of life. They require you to always have a barrier between any infectious substance and your skin, eyes, inside of your mouth, or the inside of your nose. Mask and eye protection or a face shield should be worn during procedures and patient-care activities that are likely to generate
splashes or sprays of blood, bloody fluids, secretions or excretions. The use of standard precautions constitutes the primary strategy for successful control of health-care associated infections, and reduces the risk of transmission from both recognized and unrecognized sources of infection. These guidelines should be utilized at all times, and with every patient, no matter the clinical condition, age, race, medical diagnosis, etc.

**Standard precautions refer to:**

- Hand hygiene
- Environmental controls
- The use of gloves
- Linen handling and transport
- The use of mask and eye protection of face shields
- Occupational health and blood-borne pathogens
- The use of gowns
- Care of patient care equipment
- Patient placement

**Transmission-Based Precautions**

This strategy must be used in addition to *Standard Precautions*, and it is designated to be instituted for those patients whose diseases/infections require additional precautions beyond *Standard Precautions* to interrupt hospital transmission.

There are three categories of transmission-based precautions. Color coded signs need to be posted on the patient’s room door to alert visitors and staff of the precautions to be taken when entering the room:

a) **Contact Precautions**: *Orange sign* used with epidemiologically important pathogens that can be spread by direct or indirect contact.
   - Wash your hands and put on gloves before entering the room.
   - Wear a gown if soiling is likely.
   - Remove personal protective equipment (PPE) when leaving the room first and then wash your hands.

b) **Droplet Precautions**: *Green sign* used with epidemiologically important pathogens that can be spread through the air in large particles, droplets (more than 5 microns in size), to conjunctive or mucous membranes of a susceptible person.
   - Wash your hands before you enter the room.
   - A regular standard surgical mask must be worn within three feet of the patient.
   - Patients can be chorded in the same room if they have the same microorganism or are separated more than three feet.
   - Dispose of surgical mask then wash your hands upon leaving the room.

c) **Airborne Precautions**: *Blue sign* used with patients known or suspected to have infectious agents that can be spread through the air in small airborne particles (less than 5 microns in size) to the respiratory tract.
• Wash your hands before you enter the room.
• A HEPA or N-95 mask needs to be worn before you enter the room at all times, and at all distances from the patient (Fit testing is required).
• Negative pressure room or HEPA filter system needs to be initiated immediately.
• The door(s) need(s) to be closed at all times.
• Patients can never be cohorted. Each one must be in a room by himself or herself.
• Patient must wear a mask when leaving the room.
• Dispose of surgical mask then wash your hands upon leaving the room.

Hand Hygiene

Hand hygiene is the single most important Infection Control practice to control the spread of microorganisms via the hands. A new recommendation from the CDC on the use of alcohol-based hand sanitizer has also been implemented in the Hospital in areas where soap and water are not readily available.

Hands must be washed:

- When coming on duty.
- When hands are obviously soiled.
- Between handling of individual patients, before and after procedure.
- Before and after personal use of the toilet.
- After blowing or wiping nose.
- After handling used dressings, urinals, bedpans, specimen containers, and indwelling catheters, or soiled equipment/supplies.
- Before and after eating and/or feeding patients.
- After removing gloves.
- Before entering and after leaving any isolation room.
- On the completion of duty.

Procedure for effective hand hygiene using soap and water:

- Stand away from the sink, turn on water and adjust the temperature.
- Wet hands and wrists thoroughly, holding hands downwards.
- Take a generous portion of soap from the dispenser.
- Make friction, paying attention to the front, back, under the nail, the cuticles, and web spaces of the hand.
- Rub hands together for at least 15 seconds.
- Rinse thoroughly under running water keeping arms and hands downwards.
- Dry hands completely with a paper towel.
- Turn off the faucet with the paper towel.
- Discard the paper towel in the container provided for that purpose.

This entire process should last about 30 seconds or the length of time it takes to sing the ‘Happy Birthday’ song three (3) times.
Effective Procedure for Hand Hygiene with the Alcohol-Based Hand Sanitizer:

- Dispense the product to the palm of one hand.
- Spread over both hands up to one half inch above the wrists.
- Rub vigorously paying attention to the front, back, between the fingers and under the nails on both hands.
- Continue rubbing until dry.

RISK MANAGEMENT

Risk management means making the healthcare facility as safe as possible for patients, visitors, and staff. It means preventing problems and taking action to report and solve any that do occur.

An effective risk management program requires a team effort from all staff and its success depends on understanding and effort. The more each staff member knows about performing his or her job safely and efficiently, the better the facility will run.

Patient satisfaction helps eliminate risk management problems. To ensure patient satisfaction, remember that many people feel frightened and vulnerable when they are ill and in need of medical care. They are afraid of equipment, upset about being poked, prodded and tested, uncertain about their future, and hesitant to ask questions. The best approach is to be courteous, do your job well, and inform the patient what to expect regarding procedures and answer questions clearly. It is important that people know your name and what your job is when you introduce yourself for the first time. Some people may need to be reminded on subsequent visits.

Remember that patients depend upon staff to provide a safe, secure environment. It is necessary to know and follow all applicable policies and procedures and always to think about safety. If an adverse event occurs, take immediate action to manage the situation and answer questions clearly.

Notifications

All adverse occurrences involving a patient, visitor, or other (any person not employed and paid directly by Interfaith Medical Center) must immediately be reported to the Clinical Nurse Manager (or during evenings, nights, or weekends, the Nursing Supervisor), and the Administrator-On-Call, as appropriate. The Risk Management office is to also be notified in a timely manner. This includes accidents and facility issues as well as clinical events. Occurrences are reported via the Risk Management Module of the Meditech System.

Please note the following:

1. Notifications are to be entered into the system as soon as the patient’s safety
has been assured.

2. Notifications are not part of the medical record.

3. The obligation to complete an online Notification belongs to the staff member who witnesses, discovers and/or to whom the occurrence was reported, and the physician responsible for assessing, evaluating and treating the patient, visitor or other.

In cases in which a patient or individual report an event, the staff member who receives the report for the patient/visitor is responsible for entering the Notification and, if necessary, contacting the Risk Management office at Extension 4374.

1. In cases in which an individual presents to the ER, stating that he/she was injured on hospital grounds, staff is to complete either a Non-Patient Notification or a Patient Notification and contact the Risk Management office.

2. Limit the written comments on the Notification to an accurate description of the actual event and follow-up measures taken. All notification must be objective.

3. Objective documentation of the occurrence in the medical record by the nurse and the physician is required.

4. If a physician fails to evaluate the patient, the nurse will notify the appropriate administrative staff member.

5. All visitors or others are to be referred to the Emergency Department for treatment.

6. When any type of equipment is involved in an occurrence, it must immediately be sequestered and held for evaluation by the Bio-Medical Department. The equipment screen in the Notification is to be completed. Disposables should also be sequestered and maintained in a safe place for testing. A reasonable attempt should be made to secure the packaging that the disposables came in.

7. Do not refer to Notifications, Risk Management, Quality Assurance or Peer Review activities or meetings in the patient’s medical record.

8. Do not record premature conclusions in the patient’s medical record. (i.e. “Patient fell out of bed” instead of “Patient noted on floor”). The patient’s medical record must only reflect what was observed and known to be a fact.

The following are examples of incidents that are to be reported by completing a Notification:

- Unexpected patient death
- Medication error
- Medication count discrepancy
- Blood reaction/error
Interfaith Medical Center

- Patient self-extubates
- Treatment with disregard to DNR
- Patient or Visitor slip/fall
- Missing patient / Patient Elopement
- Patient to Patient Altercation / with peer or staff
- Loss / Missing Patient Property
- Malfunction of Equipment
- Burns
- Unsanitary environment – i.e. ceiling leak; water puddle, broken doors
- Destruction of Hospital property
- Telephone system down for any period of time
- Fire

**Documentation**

Documentation in the medical record serves several purposes:

1. Ensures continuity of care among shifts and disciplines.
2. Justifies the care provided to third-party payers and regulatory agencies.
3. Can help defend the quality of the care given in the event of legal action.

If an error is made while making an entry into the automated medical records adhere to hospital policy for updating information in Meditech.

A patient’s medical record is not the place to vent frustration about any administrative problems or policies. Nor is it appropriate to use it to point fingers at other health care providers, physicians or departments. Clear, objective, timely, and legible documentation is the best protection for the patient, the staff, and the hospital.

**Informed Consent**

Informed consent must be obtained for all non-emergent, invasive procedures performed on patients. There is a hospital policy in the Hospital Administrative Manual (HAM) delineating procedures requiring consent.

**Elements of Informed Consent:** The patient/next of kin must be told the purpose of the procedure and how it will be performed in language understandable to the patient (this includes providing an adult interpreter, if necessary). The patient/next of kin must be given a description of the risks, benefits and alternatives, including no treatment, and all information that might affect the patient’s/next of kin’s decision regarding the procedure.

**Who May Give Consent?**

1. Conscious, competent adults, 18 years of age and older, may give consent for themselves and their minor children, or any minor for whom they are legally appointed guardian. For foster children, consent must be obtained from the legally appointed guardian or natural parent.

2. Emancipated minors, defined as self-supporting minors living away from
parents or minors who are married or have a child, may give consent for themselves and their children.

3. Incompetent Adults: when the patient is unable to sign the consent; it may be signed by the patient’s health care agent/proxy as defined in the New York State Health Proxy Law; a legally appointed guardian or the immediate next of kin. Immediate next of kin is defined as any of the following, in the order listed: spouse (even if legally separated), parent, adult child, adult sibling, aunt, uncle or close friend.

4. For abortion procedures to be performed on a patient less than 18 years of age consent must be obtained from the patient, and parental knowledge and consent is advised.

5. For sterilization procedures, patients must be 21 years of age. Federal form DSS3134 must be signed at least 30 days and not more than 180 days prior to the performance of a tubal ligation or vasectomy. The white copy of this form must be placed in the patient’s medical record. The patient must reaffirm her/his consent by signing the form for the second time within 72 hours of the procedure.

Role of the Physician in Obtaining Consent
It is the attending physician’s responsibility to explain the elements of Informed Consent, as described above. Consent must be obtained before performing a procedure.

Role of Administration
Although an Administrator cannot give “administrative consent,” the Nursing Supervisor and/or the Administrator-on-Call must be informed when unusual problems arise and in situations in which there is no one available to provide consent on behalf of the patient.

Telephone Consent
When telephone consent is to be obtained, the physician and a witness (on an extension phone) must confirm the identity of the person giving consent, that the person is at least 18 years of age, and he or she is the appropriate person to be giving consent. An explanation of the procedure to be performed, and the risks, benefits and alternative procedures, including no treatment, must be provided. Both the physician and the witness must document this information in a progress note in the patient’s medical record and indicate on a consent form that telephone consent was obtained and from whom the consent was obtained. The person giving consent should then sign the actual consent form when he or she comes in person to IMC.

Emergency Situations
In an emergency, the physician may provide appropriate treatment, with or without a signed consent. Documentation of the emergency situation and the need for intervention must be recorded in the medical record by two attending physicians.

Expiration of Consent
Informed consent must be obtained for each invasive procedure performed. This consent is valid for thirty (30) days unless there is a change in the patient’s clinical or mental status.

Consent for routine non-invasive treatment and examination obtained at the initial visit or on admission does not require periodic renewal. However, if there is a change in the patient’s clinical
or mental status that renders the patient incompetent, the consent must be re-signed by the appropriate person.

Consent for sterilization procedures expire within 180 days of the initial signature.

Confidentiality

- A patient’s medical status can be discussed only with the patient, or, if the patient is not competent, only with the health care agent or next of kin.
- Discuss a patient’s medical information only in areas where privacy can be maintained.
- Medical records are only to be reviewed by those personnel who need to know about the patient’s medical status.
- Medical records may only be released with an appropriate HIPAA-compliant authorization.
- Employees may not view their own medical records nor request others to view them except in the course of performing your job functions, i.e. medical coder or biller.

- Even stricter rules apply to the release of information and records pertinent to drug and alcohol abuse, HIV, and psychiatric diagnoses.

HIV-Related Information

HIV-related information is confidential and is protected by city, state, and federal law. This encourages people who have been exposed to the risk of HIV infection to come forward and learn their HIV status so they can make informed decisions about their health care. They can also learn how to change behaviors, which may put themselves and others at risk and limit the risk of discrimination or harm caused an individual as a result of the inappropriate disclosure or misuse of HIV-related information.

Confidential HIV-related information is any information indicating that a person has AIDS or an HIV-related illness, is infected with the HIV virus, has had an HIV-related test, or has potentially been exposed to HIV.

Consent for HIV testing can only be given by a person who has the ability (without regard to age) to understand and appreciate the nature and consequences of a proposed health care service, treatment, or procedure, and to make an informed decision based on such understanding.

Professional Misconduct

A license to practice a profession in New York State is in effect for life unless surrendered by the holder or revoked by the Board of Regents upon a finding of professional misconduct. It is the responsibility of every professional to be aware of the laws and regulations governing his or her profession.

Professional misconduct includes practicing beyond the authorized scope of practice, practicing fraudulently, practicing with gross negligence or gross incompetence, habitually
using drugs, being convicted of a crime, fee splitting, delegating professional duties to an unauthorized person, physically or sexually abusing a patient, filing false reports, failing to maintain proper records, ordering excessive or unnecessary tests, practicing while the ability to practice is impaired by alcohol, drugs, or mental disability and other serious matters.

Anyone who suspects or knows of any professional misconduct must contact the Risk Management Department.

Legal Documents

Subpoenas, summons and complaints for Interfaith Medical Center are accepted in the Risk Management office from 9 am to 5 pm, Monday through Friday (718-613-4374). The Health Information Management Department accepts subpoenas for medical records. The Human Resources Department accepts subpoenas for employment related requests.

Legal documents to be served on medical staff members or employees of Interfaith Medical Center must be personally served on the named person or the unrelated entity.

Employees are to notify Risk Management, Extension 4374 that a legal document was served and to bring all legal documents received pertinent to their employment. Do not discuss a patient’s health care information with any attorney, District Attorney or police officer before consulting Risk Management or the Administrator on Call.

ENVIRONMENT OF CARE

General Safety Awareness

Why do Occupational Hazards Occur?
- Use of faulty equipment/machinery
- Failure to use Personal Protective Equipment (PPE) or inaccessibility of PPE
- Unsafe environment conditions
- Inadequate orientation prior to employees performing job functions or using certain equipment
- Unsafe work practices

How can I minimize the risk of accidents/injuries at work?
If you following these safety tips, you will avoid most accidents/injuries/illnesses that occur on the job:

- Identify all potential hazards before you start a job (read warning labels, signs, etc.)
- Know how to access the Material Safety Data Sheets (MSDS) on the IMC portal (they contain important product information such as manufacturer’s name and telephone number
- Know how to store flammables and combustibles
- Wear the correct Personal Protective Equipment when necessary
- Protect your back by lifting, bending, reaching and standing correctly
- Prevent slips, trips and falls
- Ask your supervisor when in doubt; Remember, giving SAFETY top priority can save your life!
- Plug all life sustaining equipment into RED outlets
- Know how to locate and shut off medical gas shut-off valves in a fire emergency

## OCCUPATIONAL HAZARDS LOCATION TABLE

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>HAZARD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiology</td>
<td>Radiation, infectious diseases, chemical lifting, pushing, pulling</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Pharmaceuticals, Antineoplastic agents</td>
</tr>
<tr>
<td>Pathology</td>
<td>Infectious diseases formaldehyde, phenols, flammables, solvents, carcinogens, disinfectants</td>
</tr>
<tr>
<td>Operating Rooms</td>
<td>Anesthetics, disinfectants, compressed gases, sharps, glutaraldehyde, formaldehyde, infection, electrical hazards, lifting, pushing, pulling, slips/trips/falls</td>
</tr>
<tr>
<td>Nuclear Medicine</td>
<td>Radio nuclides, X-rays, Infection</td>
</tr>
<tr>
<td>Maintenance/Engineering</td>
<td>Asbestos, noise, electrical hazards, welding fumes, solvents, flammables, carbon monoxide, paints, mercury, sewage, adhesives, heat/cold, stress, slips/trips/falls, lifting, pushing, pulling, pesticides</td>
</tr>
<tr>
<td>Patient Care</td>
<td>Needle sticks, formaldehyde, glutaraldehyde, electrical hazards, infection chemicals, solvents, radiation, chemotherapeutic agents, mercury, slips/trips/falls,</td>
</tr>
<tr>
<td>Department</td>
<td>Hazards</td>
</tr>
<tr>
<td>------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Housekeeping</td>
<td>Detergents, disinfectants, cleaners, solvents, infection, sharps, electrical hazards, waste, slips/trips/falls, lifting, pushing, pulling, pesticides</td>
</tr>
<tr>
<td>Laboratories</td>
<td>Chemicals, carcinogens, teratogens, mutagens, flammables, explosive agents, radiation, infections, chemical waste, cryogenic hazards</td>
</tr>
<tr>
<td>Food Services</td>
<td>Disinfectants, wet floors, detergents, cleaners, pesticides, hot plates, heat, noise, electrical hazards, sharp equipment, steam lines, lifting, pushing, pulling</td>
</tr>
<tr>
<td>Dental Services</td>
<td>X-rays, anesthetic gases, sharps, needle sticks, disinfectants, infection</td>
</tr>
<tr>
<td>Dialysis</td>
<td>Formaldehyde, cleaners, disinfectants, infection</td>
</tr>
<tr>
<td>Laundry</td>
<td>Wet floors, lifting, needle sticks, detergents, bleaches, solvents, heat, noise, biological waste, infection</td>
</tr>
<tr>
<td>Office Areas and Data</td>
<td>Video display terminals, air quality, ozone, chemicals, ergonomics</td>
</tr>
<tr>
<td>Central Supply</td>
<td>Ethylene Oxide (ETO), soaps, detergents, steam, infection, sharps, disinfectants, noise, lifting</td>
</tr>
</tbody>
</table>
There are serious health risks in handling hazardous materials. Hazardous materials can enter the body through:

- inhalation
- ingestion
- absorption
- injection

Hazardous Material Spill

Staff must be aware of procedures for cleaning up spills of hazardous materials.

- Notify immediate supervisor immediately.
- Notify Environmental Services at 4269. Environmental Services has spill kits and is to be notified when there is a spill.
- Environmental Services Managers and some staff have been trained to clean up spills.
- Employees who have not been trained should not clean up any spills.
- Use appropriate personal protective equipment.
- Contain the spill.
- Clean up the spill using specific clean-up materials appropriate for the chemical(s) spilled.
- Dispose of the contaminated spill material by using the appropriate hazards disposal protocol

Hazard Communications

The Occupational Safety and Hazardous Act require:

- Hospitals to maintain a written plan
- Manufacturers to properly label hazardous substances
- Employees to properly label potentially hazardous substances
- Hospitals to train all employees regarding hazardous materials management

Types of Hazards

- **Flammables** are combustible explosive materials
- **Corrosives** are materials such as acids, caustics and irritants
- **Toxins** are poisons to the body’s internal organs
- **Reactives** are unstable materials - when mixed they produce heat/gas/explode. Examples are bleach and ammonia
- **Carcinogens** have been found to cause cancer
- **Sensitizers** may cause allergic reaction after one or more exposures
Recognizing Hazardous Substances

**Signs**
Picture of fire, cross bones, exploding ball, lightning bolt (see below)

**Colors**
Red and yellow are most common colors that mean danger

**Labels**
Warning label such as CORROSIVE, POISON, etc.

**NFPA Hazard Rating System**

The NFPA system uses a diamond-shaped diagram of symbols and numbers to indicate the degree of hazard associated with a particular chemical or material. These diamond-shaped symbols are placed on containers of chemicals or materials to identify the degree of hazard associated with the chemical or material.

Below are the three color-coded categories of hazard for each material:

The degrees of hazard in each of these categories are given as follows:

1. **Health – Blue** - The degree of health hazard of a chemical or material is based on the form or condition of the material, as well as its inherent properties (NFPA ratings). The degree of health hazard of a material should indicate the degree of personal protective equipment required for working safety with the material:

   a. **A rating of 1** is for slightly hazardous (toxic) material which require only minimal protection (for example, safety glasses and gloves) in addition to normal work clothing to work with safely

   b. **A rating of 2** is for moderately toxic or hazardous material which requires additional PPE or equipment (e.g. chemical goggles, lab/work smock, and local ventilation) in addition to that required for less toxic material. Consult the MSDS for specific health hazard and proper PPE to use with this material.

   c. **A rating of 3 or 4** is for highly to extremely toxic (deadly) material (and any carcinogen, mutagen, or teratogen). These materials will require specialized equipment (e.g. respirator (or exhaust hood), full face shield, rubber apron, specialized glove, handling tongs, etc) beyond that required for moderately toxic material. You must consult the MSDS and/or other safety information to determine the hazard (acute or chronic) and the proper PPE and engineering controls to safely use of this material.

2. **Flammability - Red** - The flammability hazards deal with the degree of susceptibility of the material to ignite and burn. The form or condition of the materials, as well as their properties, affects the extent of the hazard. Many hazardous materials, such as
acetone and gasoline, have a flash point (ignition temperature) far below freezing and will readily ignite with a spark if the vapor concentration is sufficient. A low rating of 1 is for material with a flash point above 200°F while more hazardous ratings of 2, 3, and 4 are for materials with respective flash point below 200, 100 and 73 F. (NFPA ratings)

3. **Reactivity - Yellow** - The reactivity hazards deal with the potential of a material or chemical to release energy. Some materials are capable of rapid release of energy without any catalyst, while others can undergo violent eruptive or explosive reactions if they come in contact with water or other materials. Generally this rating is used to indicate the potential to reactive if the material is heated, jarred, or shocked... A low rating of 1 indicates a material that is normally stable but may be reactive if heated. The more hazardous ratings of 2, 3, and 4 indicate a material is capable of violent reaction, shock/rapid heating and detonation respectively (NFPA ratings)

4. **Other Hazard Information** - An open space at the bottom of the NFPA diagram can be used to indicate additional information about the chemical or material. This information may include the chemical or material's radioactivity, proper fire extinguishing agent, skin hazard, and its use in pressurized containers, protective equipment required, or unusual reactivity with water. For example, the usual signal to indicate unusual reactivity with water is the letter "W" with a long line through the center. Similarly, the words ACID, COR (corrosive), RAD (radiation), OXY (oxidizer), Rad (radioactive), CARC (carcinogen) or other abbreviations may be used.

**Poisonous & Infectious Materials – Bio-hazardous infectious material**

Materials which contain harmful microorganisms, which may cause a serious disease resulting in illness or death.

When handling, you should:
- Take every measure to avoid contamination
- Handle the material only when fully protected by the proper, designated equipment
- Handle the material in designated areas where engineering controls are in place to prevent exposure

Examples: cultures or diagnostic specimens containing salmonella bacteria or the hepatitis B virus.

**Poisonous & Infectious Materials - Other Toxic Effects**

This includes materials causing immediate eye and/or skin irritation as well as those which can cause long-term effects in a person repeatedly exposed to small amounts.
These materials:

- Are poisonous substances that are not immediately dangerous to health
- May cause death or permanent damage as a result of repeated exposures over time
- May be skin or eye irritant
- May be a sensitizer, which produces a chemical allergy
- May cause cancer, birth defects or sterility when handling, you should:
  - Avoid contact with the skin or eyes by wearing the proper protective equipment, including eye, face and hand protection and protective clothing.
  - Avoid inhaling by working in well-ventilated areas and/or wearing respiratory equipment.
  - Store the containers in designated areas
    Examples: acetone (irritant), asbestos (carcinogen), toluene diisocyanate (sensitizer).

MATERIAL SAFETY DATA SHEETS

It is the policy of Interfaith Medical Center to provide a safe environment for its employees, patients and visitors. Employees have the right to know what hazardous chemicals they work with or could be exposed to, and what they can do to avoid injury or illness when working with these chemicals. Interfaith Medical Center provides information to reduce the possibility of accidental exposure and to comply with the Occupational Safety and Health Administration Hazard Communication Standard (HCS).

Hazardous Materials Inventory & Material Safety Data Sheets (MSDS)

- Know the location of department/division MSDS binder(s). Be familiar with the MSDS and the potentially hazardous materials inventory contained in the binder(s).
- Before handling any potentially hazardous material, read and understand the MSDS and product label, and follow special handling instructions to prevent chemical exposure and accidents.
- Material Safety Data Sheets are also available online at [www.imcintranet.com](http://www.imcintranet.com)

What is a Material Safety Data Sheet (MSDS)?

A Material Safety Data Sheet (MSDS) is designed to provide both workers and emergency personnel with the proper procedures for handling or working with a particular substance. MSDS include information such as physical data (melting point, boiling point, flash point etc.), toxicity, health effects, first aid, reactivity, storage, disposal, protective equipment, and spill/leak procedures. These are of particular use if a spill or other accident occurs.
Who are MSDS for?

MSDS are meant for:
- Employees who may be occupationally exposed to a hazard at work.
- Employers who need to know the proper methods for storage etc.
- Emergency responders such as fire fighters, hazardous material crews, emergency medical technicians, and emergency room personnel.

MSDS are not meant for consumers. An MSDS reflects the hazards of working with the material in an occupational fashion. For example, an MSDS for paint is not highly pertinent to someone who uses a can of paint once a year, but is extremely important to someone who does this in a confined space 40 hours a week.

Where can I get MSDS?

- Your workplace should have a collection of MSDS that came with the hazardous chemicals you have ordered (don't throw them away!)
- You can get them from the distributor that sold you the material. If you can't find them then contact the manufacturer's customer service department
- MSDS are available online at Interfaith Medical Center at www.imcintranet.com
- The Internet has a wide range of free resources
- Books such as the Merck Index and Prudent Practices in the Laboratory are not acceptable substitutes for MSDS, but these can give practical information on toxicity, physical properties and incompatibles.

Agency Requirements
a. OSHA enforces Hazard Communication standards
b. All containers must be labeled, especially when pouring in a secondary container
c. MSDS are required for all chemicals

Product Labels
All product labels should contain
a. Precautionary statements
b. Hazards/Cautions/Warnings
c. Explanation of how to handle safely
d. Medical treatment required
e. How to store and dispose of product

Color coding on labels
a. Blue - represents health hazards
b. Red - represents flammability
c. Yellow - represents reactivity (The higher the #, the more hazardous the material)
d. Oxidizers - can make other materials more flammable
e. Corrosive - eat away skin/weaken steel
f. Carcinogenic - increases the risk of cancer
g. W - dangerous if comes in contact with water

MSDS contents - not all MSDA will look the same
a. Section 1 - Name of the produce, name and address of company, how to reach in case of emergency
b. Section 2 - Lists hazardous ingredients
c. Section 3 - Lists physical and chemical characteristics - color and odor under regular conditions
d. Section 4 - Reactivity - Whether product is stable and what to avoid mixing with it
e. Hazardous Data section - signs/symptoms of over exposure, how chemical can enter body, 1st aid steps listed
f. Special protection section - lists special equipment/clothing necessary to use product
g. Special precautions - lists safe handling and storage

Important Tips
a. Special precautions - lists safe handling and storage
b. Read all labels
c. Don't mix chemicals
d. Thoroughly rinse buckets, etc, after using chemical
e. Don't inhale
f. Flush drains before and after dumping chemical

OSHA "Right to Know" Hazardous Communications

Our goal is to ensure employees are aware of the dangers associated with hazardous substances, harmful physical agents or infectious agents they may be exposed to in the workplaces.

To comply with the Employee Right-to-Know standard, employers must identify the hazardous substances, harmful physical agents and infectious agents that are present in the workplace and provide information and training to employees who are "routinely exposed" to those substances or agents. "Routinely exposed" means that a reasonable potential exists for exposure to hazardous substances, harmful physical agents or infectious agents during the normal course of the employees' work assignments. Routinely exposed includes working in areas where hazardous substances have been spilled and assignment to cleaning up leaks and spills. It does not include a simple walk-through of an area where a substance or agent is present and no significant exposure occurs.
FIRE SAFETY

Fire Prevention in the Work Place

- Smoking is the number one cause of fires. All staff members and patients are required to obey the NO-SMOKING policy of the facility. Interfaith Medical Center is a SMOKE FREE facility.

- Trash can start a fire. Therefore, precaution should be taken to properly discard all trash to avoid unnecessary and unsafe accumulation. Trash build-ups should be reported to the Environmental Services Department.

- Linen should be stored properly in storage areas or carts. Soiled linen must be properly bagged and safeguarded until deposited in the linen chute. Chute doors must be kept closed to prevent the spread of fire.

- Electrical equipment and appliances may pose a hazard. Inspect any electrical equipment you use for hazards (faulty wiring, dirt, grease, noise, odors, extreme heat, etc.). Contact Biomedical Engineering for repairs.

Fire Prevention & Safety

<table>
<thead>
<tr>
<th>DO</th>
<th>DON'T</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observe the No-smoking policy</td>
<td>Do not block corridors with equipment</td>
</tr>
<tr>
<td>Check fire doors frequently</td>
<td>Do not use wedges to keep doors open</td>
</tr>
<tr>
<td>Store chemicals in closed containers</td>
<td>Do not use multiple plug adapters</td>
</tr>
<tr>
<td>Store flammables properly</td>
<td>Do not overload electrical circuits</td>
</tr>
<tr>
<td>Report faulty electrical appliances</td>
<td>Do not discard empty flammable containers with combustible items</td>
</tr>
<tr>
<td>Check electrical appliances regularly</td>
<td>Maintain a clean and safe work area</td>
</tr>
</tbody>
</table>

In case of a Fire:

- **R**-Rescue anyone in immediate danger from the room or area
- **A**-Pull the nearest fire alarm, which is located at each exit stairway, Dial**46
- **C**-Confine the fire or smoke by closing all doors and windows
- **E**-Extinguish the fire with the appropriate extinguisher or evacuate
  
  (shout CODE RED to warn others of the fire)
Fire Alarm Codes

Become aware of the fire alarm codes for your department and for those areas directly horizontal and vertical to your work area.

Fire Evacuation

- Close the door where fire is located
- When evacuating horizontally, move to an adjacent safe compartment
- When evacuating vertically, leave the area/floor using the nearest/safest stairway
- Ambulatory Care Site – staff should evacuate the building immediately when necessary
- DO NOT USE ELEVATORS during a fire
- Use common sense!

What are the Fire Extinguisher techniques to use during a fire?

- Pull the pin
- Aim the nozzle at the base of the fire
- Squeeze the handle
- Sweep from side-to-side

What are the Fire Extinguisher types I should know about?

- Type A used for fires caused by wood, paper, cloth, or rubber
- Type B used for fires caused by liquid, grease or oil
- Type C used for fires caused by electrical items
- Type ABC this is a multipurpose extinguisher which can be used for all of the above types of fires

INTERIM LIFE SAFETY MEASURES

The purpose of Interim Life Safety (ILS) Measures is to maintain a safe and fire free environment, protect life and property, facilitate egress during a fire emergency and provide prompt notification to the Fire Department in times of emergency.

At Interfaith Medical Center, we will document the interim life safety measures used during times that the Fire Plan is affected due to construction, repair or other events that limit the ability to protect life during a fire emergency. Interim life safety measures should be implemented when:

- There are penetrations to fire and smoke barriers
Fire exits are blocked or restricted

Access to the Emergency Department is blocked or restricted

The fire alarm system is disabled or there is limited use of the system

Use of hazardous substances during construction

When ILS measures are implemented the following procedures must be adhered to:

- When the Fire Alarm System is taken out of service, plans will be implemented to compensate for this loss and a fire watch will be instituted

- All personnel in areas affected by reduced fire safety will be instructed if alternative emergency exits are being used

- All new egress and evacuation routes will be inspected daily

- All fire exits must be unobstructed

- When normal access routes are affected, there shall be an alternative route provided for public access

- Access to the Emergency Department will remain open to emergency vehicles

When construction is in progress, the following procedures will be complied with:

- Penetrations in fire barriers will be inspected daily

- Additional fire extinguishers will be placed in the construction area

- Fire drills will be increased to 1 per shift per month

- Construction areas will be kept clean and free of debris blocking exits

- The Hospital's Infection Control Officer, Director of Engineering and the Director of Security and Safety will inspect construction sites daily for hazardous conditions

- Employees will receive additional instruction in Interim Life Safety Measures.
Disasters can impact seriously on the Hospital's ability to operate. Therefore, it is important that all staff be aware of how to manage during a disaster.

**What is a Disaster?**

A disaster is a natural or man-made event that significantly disrupts the environment of care. For example,
- severe storms
- hurricanes
- earthquakes
- power, water or telephone loss

Disasters can be:
- **Internal:** any incident within the Hospital that is disruptive to the environment of care
- **External:** any incident that occurs outside the facility that produces deaths/injuries that would exceed our normal ability to operate

**Is the Hospital prepared for a disaster?**

Yes, the hospital has set up the Hospital Incident Command System (HICS) which is activated when there is an internal or external disaster.

- **CODE BLUE** will alert us that there is an external disaster occurring
- **RED ALERT** will alert us that there is an internal disaster occurring
- **CODE RED** fire/smoke condition
- **CODE PINK** infant/child abduction
- **SITUATION AMBER** fire alarm system not working
- **4-4-4** when sounded as alarm bells indicates that a disaster exits.

The Hospital's Chief Executive Officer or his designee is the only person who can declare either an internal or external disaster.
Bio-terrorism

All employees should understand clinical information on bio-terrorism diseases. In addition, it is essential that we all comprehend the clinical practitioner’s role in the public health surveillance of exposure to Bacillus Anthracis and other agents of bioterrorism.

We should be able to:

- To recognize the pathogens for the five major Category A bioterrorism-related diseases.
  - Anthrax
  - Smallpox
  - Botulism
  - Plague
  - Tularemia
- To identify the clinical manifestations and diagnosis of infection with these agents.
- To identify the appropriate specimen selection, handling, transport, and assay for each of the agents.
- To describe the vaccine availability and effectiveness for these agents.
- To describe the mass casualty management of exposure to the above agents, including the appropriate post-exposure prophylaxis.

Anthrax Prevention
Anthrax prevention includes:
- Vaccination
- Infection Control
- Post exposure prophylaxis
- Early recognition and reporting

Anthrax Infection Control
In treating patients with exposure to anthrax, it is necessary to:
- Use standard precautions
- Know that no masks are necessary
- Know that you do not have to isolate the patient
- Wash exposed skin with soap and water

Smallpox
Smallpox is very contagious. Person-to-person transmission occurs. There are several means of contacting smallpox:
Smallpox Respiratory and Contact precautions
- Patient must be placed in a separate room with negative airflow
- The room must contain HEPA filtration to outside
- Patient should be placed on home isolation when possible

Smallpox Infection Control
- Use transmission-based precautions
- Use hand hygiene protocol

Botulism Infection Control
- Use standard precautions

Secondary transmission from infected patients is not a hazard; Toxin is inactivated by heat, sunlight, chlorine

Plague Infection Control
The pulmonary form is highly contagious and requires isolation
- Use transmission-based precautions
- Use hand hygiene protocol

The bubonic form is not as contagious
- Use standard precautions

Tularemia Infection Control
- Use standard precautions

ERGONOMICS
Ergonomics are “work laws or principles” which are based on fitting the worker to the job. Studies have shown that at least 80% of us will experience low back pain or work related injury at some point during our lifetime. Such injuries are the result of months/years of poor posture/working habits. These studies have also shown that we have spent over $4.6 billion annually on work related injuries.

Causes of Injuries
- Poor posture
- Poor lifting techniques
- Lack of general fitness
- Stress
Preventing Injuries

**Sitting Posture/Standing Posture**
- Line up ears, shoulders and hips
- Use towel roll or pillow when sitting
- Keep abdominal muscles tightened

**Bending & Lifting Technique**
- Avoid lifting when you can
- Use mechanical help or get help if load is heavy
- Use handles and lifting straps when you can
- Bend your knees – let your legs do the work

**Pushing & Pulling**
- Push an object rather than pull it
- Avoid leaning over object you are moving
- Move with the object
- Use your whole body to push, not just your arms
- Get help if you need it

**Computer Use Ergonomics**
- Place the computer screen directly in front of you
- Keep head balanced over shoulders – looking forward
- Maintain comfortable eye/monitor distance (24 inches)
- Position top of screen at or just below eye level
- Move mouse close to centerline of your body
- Place hard copy holders next to the screen
- Place keyboard at approximately seated elbow height
- Work with wrists straight
- Use adjustable furniture with padded wrist rest and/or arms on chair
Look at a far object every 15-30 minutes

Close blinds to decrease glare on the screen

Stretch

- Roll shoulders – Turn head from side to side
- Pull hands/wrists back slowly
- Hold each stretch for 5-10 seconds

Change position often

- Position feet flat on the floor or on adjustable footrest

SECURITY MANAGEMENT

Staff Identification Program

- As a security precaution, everyone entering IMC’s facility must be identified by an I.D. Badge. All employees must wear their I.D. badges at all times.
- If the card is lost, notify the Security Office immediately at extension 4043.
- To obtain a replacement card, employees should go to Human Resources for an authorization form. There may be a charge associated with the replacement of an I.D. badge.

<table>
<thead>
<tr>
<th>IMC’s identification program includes:</th>
<th>IMC’s Security Systems include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Employees</td>
<td>o Access Control</td>
</tr>
<tr>
<td>o Patients</td>
<td>o Card Access</td>
</tr>
<tr>
<td>o Visitors</td>
<td>o Panic Alarms</td>
</tr>
<tr>
<td>o Clergy</td>
<td>o Door Locks</td>
</tr>
<tr>
<td>o Vendors</td>
<td>o Escort Service</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IMC’s Sensitive Areas include:</th>
<th>As an IMC employee, your responsibilities include:</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Detox/Rehab</td>
<td>o Wearing your Identification Badge</td>
</tr>
<tr>
<td>o Pharmacy</td>
<td>o Ensuring Patient Confidentiality</td>
</tr>
<tr>
<td>o Morgue</td>
<td>o Securing Patient Valuables</td>
</tr>
<tr>
<td>o Emergency Room</td>
<td>o Securing your own Person Valuables</td>
</tr>
</tbody>
</table>
The “Doctor Armstrong” Code

Situation: You need security to come to your office because there is an irate or dangerous patient or visitor, and the situation is such that you cannot openly call the Security Office for assistance.

Action: Call the Security Office (4280 at Site A, 6689 at Site B) and ask whoever answers to send Doctor Armstrong to your location.

Result: Security Officers will quietly enter your work area as if they were simply on a routine patrol of the area. If the situation requires their intervention, they will take appropriate action.

PATIENT RELATIONS/CUSTOMER SERVICE

Health care is a service industry. The service and care we render to our patients is our particular product. Unlike other products that are manufactured and checked for quality before reaching the customer, our product is manufactured at the instance of delivery.

You are the best public relations agent Interfaith has. Every time a patient, visitor, family member comes in contact with an employee, there is opportunity to project a positive image and develop trust.

The customer service we render must be right the first time. If we fail, there is no second chance. We must recognize that each patient is a unique and important human being and, as health care providers, we are obligated to act as partners with him/her in the care we provide.

Benefits of exceptional Customer Service

To Self:

◆ High degree of personal satisfaction
◆ Recognition by institution
◆ Good reputation
◆ More professional opportunities
◆ Continued employment

To Interfaith Medical Center:

◆ Satisfied patients
◆ People recommend your institution
The Five “R’s” of Customer Service Skills

Recognition: The ability to make people feel special (Giving positive acknowledgement)

Reading: The ability to assess a person’s needs

Reaching: The ability to reduce anxiety in yourself and others

Responding: The ability to take appropriate action (Keeping your commitment)

Relating: The ability to deal with all types of customers (Keeping your professionalism)

Handling Difficult Patient Situations

Listen and avoid defensiveness
Listen (really and truly). Give the patient the opportunity to express his/her feelings.
Maintain eye contact. Often just nodding one’s head indicates “I hear what you’re saying.”

Check for understanding
Use methods to identify the patient’s problem/concern. Avoid jumping to conclusions.
Strive to seek out the facts surrounding the situation. Use open-ended questions. These are questions which cannot be answered with a mere “yes” or “no”. Examples:
✓ “Why do you feel you should not pay this bill?”
✓ “What would you like me to do for you?”
✓ “What can we do to resolve this problem?”

Mishandling Difficult Situations

Patient anger and hostility in a difficult situation is often made worse by the following:

Becoming defensive
Comments such as “I only work here” or “It is not my fault” usually make the situation worse.

Poor Listening
Failure to listen intently to a patient’s complaint, interrupting, acting unconcerned, or minimizing the complaint will almost always increase the patient’s hostility.

The run-around
Giving the patient the impression that you are ‘passing the buck’. “There’s nothing I can do about it” or “I am too busy right now to look into it” are other ways to further increase the patient’s hostility.

Arguing
Arguing with patients never works.

Non-Verbal Behavior
Appearing rushed, looking at your watch, looking away from the patient, becoming preoccupied by reading, writing, conducting other paper transactions, or turning your back.

Telephone Etiquette

Because the telephone is such an important instrument in our daily work, here are some helpful hints, and proven phone techniques, that will help to make your conversations more effective.

Create a Good First Impression
✓ Try to answer the phone on the second ring. Answering a phone too fast can catch the caller off guard and waiting too long can make the caller angry.
✓ Answer with a friendly greeting. (Example - “Good Afternoon, Outpatient Clinic, Sherrie speaking. How may I help you?”).
✓ Smile - it shows, even through the phone lines.
✓ Ask the caller for their name, even if their name is not necessary for the call. This shows you have taken an interest in them. Make sure that if you ask for their name, that you use it.
✓ Speak clearly and slowly. Never talk with anything in your mouth, this includes gum.
✓ Lower your voice if you normally speak loud.
✓ Keep the phone two-finger widths away from your mouth.

Putting Callers on Hold
When putting a caller on hold, always ask permission. If the caller asks why, provide the answer. For example: "Would you mind holding while I get your file?" or "Can you hold briefly while I see if Mr. Jones is available?"

When taking a caller off of hold, always thank him or her for holding.

Transferring a Caller
✓ If the caller needs to speak to another person or department, transfer the caller directly to the desired person's extension, not to the operator. This will save the caller having to explain his/her requests another time, and it will cut the number of times the caller needs to be transferred.
✓ When transferring a call, let the caller know to whom you are transferring him/her, and announce the caller to the person you are transferring them to.
Taking Phone Messages
When taking a phone message always include the following information:
- Caller's name and company name if applicable,
- Time and date of call,
- What the call is regarding,
- If the caller wants a return phone call, and if so,
- Obtain a phone number that is best to return the call.

Last Impressions
- Before hanging up, be sure that you have answered all the caller's questions.
- Always end with a pleasantry: "Have a nice day" or "It was nice speaking with you."
- Let the caller hang up first. This shows the caller that you weren't in a hurry to get off the phone with them.

Ten Commandments of Customer Relations
1. Thou shall treat every patient courteously.
2. Thou shall not make any value judgment on any patient.
3. Thou shall not put ethnic groups into specific “clusters.”
4. Thou shall never use racial slurs.
5. In a sensitive situation, Thou shall not compare thy country of origin.
6. Thou shall stick to English at the patient's bedside.
7. Thou shall respect thy coworkers.
8. Thou shall use the telephone judiciously.
9. Thou art an IMC ambassador.
10. Do unto others, as you would like for them to do unto you.

CULTURAL COMPETENCY
What Is Cultural Competency?!
Cultural and linguistic competence is a set of harmonious behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.

And why is it important?
Quite simply, health care services should be respectful of and responsive to the health beliefs and practices, and cultural and linguistic needs of diverse patient
Culture and language may influence:

- health, healing, and wellness belief systems
- how illness, disease, and their causes are perceived by the patient/consumer
- the behaviors of patients/consumers who are seeking health care and their attitudes toward health care providers
- the delivery of services by the provider who looks at the world through his or her own set of values, which can compromise access for patients from other cultures

The increasing population growth of racial and ethnic communities and linguistic groups, each with its own cultural traits and health profiles, presents a challenge to the health care delivery service industry in this country. The provider and the patient each bring their individual learned patterns of language and culture to the health care experience which must be transcended to achieve equal access and quality health care.

Glossary of Terms

**CLAS standards** - the collective set of culturally and linguistically appropriate services (CLAS) mandates, guidelines, and recommendations issued by the United States Department of Health and Human Services Office of Minority Health intended to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate health services (National Standards for Culturally and Linguistically Appropriate Services in Health Care Final Report, OMH, 2001).

**Culture** - the thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. Culture defines:

- how health care information is received
- how rights and protections are exercised
- what is considered to be a health problem
- how symptoms and concerns about the problem are expressed
- who should provide treatment for the problem
- what type of treatment that should be given

**Cultural and linguistic competence in health** - a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.

**Culturally and linguistically appropriate services** - health care services that are respectful of and responsive to cultural and linguistic needs.

**Health care organizations** - any public or private institution involved in any aspect of delivering health care.

**Limited-English proficiency** - persons who have difficulty speaking, reading, writing, or understanding the English language because they are individuals who:
were not born in the United States or whose native language is a language other than English
◆ come from environments where a language other than English is dominant
◆ are American Indian and Alaskan Natives and who come from environments where a language other than English has had a significant impact on their level of English language proficiency
◆ are denied the opportunity to learn successfully in classrooms where the language of instruction is English or to participate fully in our society

Patients/consumers - individuals, including accompanying family members, guardians, or companions, seeking physical or mental health care services, or other health-related services.
Staff - individuals employed directly by a health care organization, as well as those subcontracted or affiliated with the organization.

National Standards on Culturally and Linguistically Appropriate Services (CLAS)

The CLAS standards are primarily directed at health care organizations; however, individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible. The principles and activities of culturally and linguistically appropriate services should be integrated throughout an organization and undertaken in partnership with the communities being served.

The 14 standards are organized by themes: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14). Within this framework, there are three types of standards of varying stringency: mandates, guidelines, and recommendations as follows:

◆ CLAS mandates are current Federal requirements for all recipients of Federal funds (Standards 4, 5, 6, and 7).

◆ CLAS guidelines are activities recommended by OMH for adoption as mandates by Federal, State, and national accrediting agencies (Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13).

◆ CLAS recommendations are suggested by OMH for voluntary adoption by health care organizations (Standard 14).

Standard 1
Health care organizations should ensure that patients/consumers receive from all staff member’s effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
Standard 2
Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Standard 3
Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Standard 4
Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5
Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6
Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Standard 7
Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Standard 8
Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Standard 9
Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

Standard 10
Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected
in health records, integrated into the organization's management information systems, and periodically updated.

**Standard 11**
Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

**Standard 12**
Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

**Standard 13**
Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

**Standard 14**
Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

**SELF ASSESSMENT CHECKLIST FOR COMMUNICATING ACROSS CULTURES**

- I speak slowly, audibly and distinctly.
- I allow extra time to communicate with someone whose first language is not mine.
- I consider the effect of cultural differences on messages being transmitted and I check my assumptions.
- I adapt myself to the demands of a situation.
- I do not judge people on their nationalities, religions, accents or languages.
- I never make ethnic jokes.
- I try to be open and direct in giving feedback.
- I never make remarks that are “Hot Buttons” for specific groups.

**EXPLORING YOUR OWN CULTURAL ATTITUDES**

1) “I do not feel obligated to provide quality care to a drug addicted patient. He is a low life who should have known better anyway.”

   _____agree _____somewhat agree  _____disagree  _____strongly disagree

54
2) “I do not have to respect the average IMC patient. He never had anything in life and should be grateful for a clean bed and three meals a day.”

_____ agree _____ somewhat agree  _____ disagree  _____ strongly disagree

3) “The average patient never worked a day in his life. My taxes are paying for his stay here. He should respect me.”

_____ agree _____ somewhat agree  _____ disagree  _____ strongly disagree

4) “A thirteen year old has no business having a baby. I will ensure that her delivery is a nightmare. She'll never do that again.”

_____ agree _____ somewhat agree  _____ disagree  _____ strongly disagree

5) “The government should really tighten its immigration policy. The foreigners have taken over this place.”

_____ agree _____ somewhat agree  _____ disagree  _____ strongly disagree

PATIENT RIGHTS

The Patient’s Bill of Rights is:

◆ Posted in inpatient rooms and public places of the Medical Center.
◆ Described in the "Patient Information Booklet" found in the bedside stand.
◆ Available in Spanish and Arabic.
◆ Rights include: medical care information, pain management, discharge planning, cost of hospital care, medical records, personal needs, transfers, freedom from abuse and restraints, privacy and confidentiality and more.

Advance Directive

An advance directive is a document where a person states choices for medical treatment and/or designates a health representative who should make treatment choices if he/she loses decision-making capability. Do Not Resuscitate form, Living Will and Health Care Proxy are examples of advance directive instruments.

◆ Nurse asks on admission about existing Advance Directive and documents. S/he may request family members to bring it in for the medical record.
◆ Nurse asks if patient wants further information about completing one.
◆ Pastoral Care available to assist patients in completing the advance directive.

Pastoral Care

Pastoral Care personnel are available 24/7 to meet the spiritual needs of patients, their families and staff and ministers to members of all religious faiths. Call extension 4773.
Hearing Impaired Patients

◆ Contact the Patient Relations Department with requests for video relay service, TTY, doorknockers, amplified telephones, closed-caption televisions, and all other special requests for hearing impaired patients. During off hours, contact the Assistant Director of Nursing/Nurse Manager.

◆ Hospital personnel with patient responsibility must promptly identify the communications needs and preferences of persons who are deaf or hard of hearing. Qualified interpreter services, audio-video interpreting service equipment, flashcards and pictographs will be available to augment the effectiveness of communication.

◆ All complaints, whether written or non-written, concerning the need for a communication aid or auxiliary aid, will be forwarded to the Patient Relations Department.

Meeting Special Needs

◆ Interfaith Medical Center is barrier free for the physically impaired.

◆ Seeing Eye and hearing ear dogs have access.

◆ Admissions and surgical consents are available in large print.

◆ TTY and TDD machines are available through the Patient Relations Department. During off hours, contact the Assistant Director of Nursing/Nurse Manager.

Patients Who Do Not Speak English

◆ Family members of the patient or other patients should not be asked to translate medical information.

◆ Clinical personnel (physicians and nurses) may be asked to translate medical information.

◆ AT&T Language Line Services. Information for access is posted on each nursing unit.

Concerns, Problems, Complaints

If a patient has a concern, problem, or complaint related to any aspect of care during a hospital stay, the patient should speak to the physician, nurse, or hospital staff member. If hospital staff does not resolve the problem, the patient may contact the New York State Department of Health by mail or by phone.

◆ Phone: 1-800-804-5774

◆ Mail: New York State Department of Health, Centralized Hospital Intake Program, 433 River Street, Sixth Floor, Troy, New York 12180

◆ Further information, questions or comments: hospinfo@health.state.ny.us

◆ The complaint form is available on line at
http://www.health.state.ny.us/nysdoh/hospital/docs/hospital complaint form.pdf
Patient Bill of Rights

Employees of Interfaith Medical Center should be as familiar with the Patient’s Bill of Rights as the patients themselves.

The following is a synopsis of the rights as outlined in the document:

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 or source of payment.

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 no 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 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
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.

New York State Department of Health Complaints and Concerns
Toll Free: 1-800-804-5447
Local calls: 1-212-417-5990

BIOETHICS ~ ETHICS CONSULTATION PROCESS

Interfaith Medical Center’s Bioethics Committee can be reached through the office of Sr. Vice President of Medical Affairs at 718-613-4356. The Committee is charged with the design, implementation, and coordination of the Ethics Consultation Process for the medical center.

The committee will:
- Meet quarterly to conduct routine business and as needed for review of special issues regarding patients.
- Establish a forum for the discussion of ethical issues that occur within the medical center.
- Serve as the body who will provide consultation and consideration of individual patient care ethical dilemmas upon request.
- Establish policies and procedures related to patient rights, bioethics, and organizational ethics.
- Assist in the education of the medical staff and hospital employees regarding patient rights, bioethics, and organizational ethics.
- Review all hospital wide policies that relate to bioethics, patient rights and organizational ethics.
- Recommend appropriate changes to policies and the development of new policies as required or desired.

Membership in the Bioethics Committee includes the Sr. Vice President for Medical Affairs, the Asst. V.P. Medical Affairs, the Vice President of Patient Care Services, and the Chairs of Medicine, Surgery, Gynecology, and Psychiatry, the Director of Social Work or designee as well as representatives from the departments of Risk Management and Quality Assurance. Membership will include at least one member of the clergy and at least one member of the community who is not a health care professional. Ad hoc members may be added to discuss individual cases at the discretion of the Chair.

Individual cases:
- The Bioethics Committee establishes an on-call schedule to be available 24 hours a day, 7 days a week, for consultation in individual cases. An off-hours contact with the members of the Bioethics Committee is made through the Hospital operator.
- The member on-call will determine if individual consultation or the committee are appropriate for review of a specific case.
- The member on-call will schedule a meeting to discuss the case, facilitate communication among interested parties, and provide a forum for dispute mediation and advice regarding legal ramification of recommended decision and the potential consequences of actions.
- The committee will convene at a time and place appropriate to the necessary action pending in each individual case.
- The committee will convene at the request of a patient, family member, guardian or a member of staff.

ABUSE AND NEGLECT

Health care providers are required to report suspected cases of abuse.

Child Abuse
- New York State mandates the reporting of Child Abuse. The law provides
Immunity from civil/criminal liability and enforces a penalty for failure to report.

- Physical and behavioral indicators are used to identify physical abuse or neglect, sexual abuse, or emotional maltreatment.
- Hotline Number: 1-800-342-3720
- Web site address: http://www.ocfs.state.ny.us/main/cps/
- New York State Child Abuse and Neglect Prevention Information Line 1-800-342-7472

The Child Protective Services Act of 1973 encourages more complete reporting of child abuse and maltreatment. Each Child Protective Service is required to investigate child abuse and maltreatment reports, to protect children (under 18 years old) from further abuse or maltreatment, and to provide rehabilitative services to children, parents, and other family members involved.

The New York State Office of Children and Family Services (OCFS) maintain a statewide Central Register of Child Abuse and Maltreatment for reports made pursuant to the Social Services Law. The Central Register, also known as the "Hotline", receives telephone calls alleging child abuse or maltreatment within New York State. The Central Register relays information from the calls to the local Child Protective Service for investigation, monitors their prompt response, and identifies if there are prior child abuse or maltreatment reports.

The Hotline receives calls 24 hours a day, seven days a week from two sources: persons who are required by law, or mandated, to report suspected cases of child abuse and maltreatment; and calls from non-mandated reporters, including the public.

**Elder Abuse**

Elder Abuse is a term referring to any knowing, intentional, or negligent act that causes harm or a serious risk of harm to a vulnerable adult.

- Bruises, abrasions, sudden changes in financial situation, or changes in personality may indicate abuse or neglect.
- Report elder abuse to Adult Prevention Services.
- New York State Elder Abuse Hotline 1-800-342-9871

**Domestic Violence and Abuse**

Services for victims of domestic violence and abuse are free and available in New York. Referrals can be made to Domestic Violence Shelters and Domestic Violence Counseling Centers.

- 24/7 NY Domestic Violence Hotline - (800) 799-SAFE. New York State hotline 1-800-942-6906
In New York City, the Mayor's Office to Combat Domestic Violence (OCDV) formulates policies and programs; monitors the citywide delivery of domestic violence services; and works with diverse communities to increase awareness of domestic violence. OCDV works closely with community leaders, health care providers, City agencies and representatives from the criminal justice system to hold batterers accountable and to create solutions that are critical to preventing domestic violence in New York City.

If you are a victim of domestic violence, call the New York City Domestic Violence Hotline at (800) 621-HOPE (4673), TDD (800) 810-7444 OR 311

24-Hour Hotlines

✓ New York City Domestic Violence Bilingual Hotline 1-800-621-HOPE
✓ Hearing Impaired 1-800-810-7444
✓ Victim Services Agency (212) 577-7777
✓ Violence Intervention Program Bilingual Hotline 1-800-664-5880

Legal Services are also available and provide free advice and services for victims of domestic violence:

City-Wide

✓ Sanctuary for Families Center for Battered Women's Legal Services (212) 349-6009
✓ Main Street Legal Services, Battered Women's Rights Clinic, CUNY Law School 1-800 621-HOPE
✓ Victim Services West Side Legal Project 1-800-621-HOPE
✓ In Motion (formerly Network for Women's Services) - Legal assistance for battered women seeking divorces. (212) 695-3800

Brooklyn

Brooklyn Legal Services, Corporation B (718) 237-5500

PRIVACY AND CONFIDENTIALITY: HIPAA

Confidentiality

◆ All employees sign a confidentiality agreement when hired.
◆ Passwords are not shared.
◆ Patient information is not discussed in elevators or other areas where it may be overheard.
◆ Curtains are closed and quiet voices are used in semi-private rooms.
◆ Medical records are stored where visitors do not have access.
◆ When an employee becomes a patient, privacy is maintained.

Health Insurance Portability and Accountability Act

In order to be in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA):

61
IMC makes every reasonable effort to safeguard information from unauthorized use, access, modification, destruction or disclosure. Patients are given "Notice of Privacy Practices." Policies are in place to protect patients’ personal health information (PHI). Staff is trained about these procedures. The Hospital’s HIPAA/Privacy Officer is the Chief Information Officer. He can be reached at ext. 6501.

What is HIPAA?

HIPAA is the single most significant Federal legislation affecting the health care industry since the creation of the Medicare and Medicaid programs in 1965. Title I of HIPAA improves the portability and continuity of health insurance coverage for American workers and their families.

Title II provides for administrative simplification, requiring the development of standards for the electronic exchange of health care information including standard identifiers. HIPAA administrative simplification also requires the protection of the privacy of personal health information and the establishment of security requirements to protect that information.

More specifically, HIPAA Administrative Simplification calls for:

1. Standardization of electronic patient health, administrative and financial data
2. Unique health identifiers for individuals, employers, health plans and health care providers
3. Privacy and Security standards protecting the confidentiality and integrity of "individually identifiable health information," past, present or future.

Who is affected?

HIPAA ‘covered entities’ include health care providers (who submit electronic transactions today), health plans, and clearing houses. This also includes the health care-related functions in organizations such as group health plans established by employers, county governments, local public health units, and universities.

Are There Penalties?

HIPAA calls for severe penalties for noncompliance, including: civil fines up to $25,000 for violations per standard in a calendar year, and criminal fines up to $250,000 and/or imprisonment up to 10 years for knowingly misusing individually identifiable health information.
a. **Electronic Health Transactions Standards**

The term "Electronic Health Transactions" includes health claims, health plan eligibility, enrollment and disenrollment, payments for care and health plan premiums, claim status, first injury reports, coordination of benefits, and related transactions.

Today, health providers and plans use many different electronic formats. Implementing a national standard will mean we will all use one format, thereby "simplifying" and improving transaction efficiency nationwide. The rule requires use of specific electronic formats developed by ANSI, the American National Standards Institute, for most transactions except claims attachments and first reports of injury. Proposed regulations for these exceptions are not yet out.

Health organizations also must adopt STANDARD CODE SETS to be used in all health transactions. For example, coding systems that describe diseases, injuries, and other health problems, as well as their causes, symptoms and actions taken must become uniform. All parties to any transaction will have to use and accept the same coding. Again, in the long run, this is intended to reduce mistakes, duplication of effort and costs. Fortunately, the code sets proposed as HIPAA standards are already used by many health plans, clearinghouses and providers, which should ease the transition.

**Unique Identifiers for Providers, Employers, Health Plans and Patients**

The current system allows us to have multiple ID numbers when dealing with each other, which HIPAA sees as confusing, conducive to error and costly. It is expected that standard identifiers will reduce these problems.

b. **Security of Health Information & Electronic Signature Standards**

The new Security Standard will provide a uniform level of protection of all health information that is:

1. Housed or transmitted electronically and that
2. Pertains to an individual.

The Security standard mandates safeguards for physical storage and maintenance, transmission, and access to individual health information. It applies not only to the transactions adopted under HIPAA, but to all individual health information that is maintained or transmitted. However, the Electronic Signature standard applies only to the transactions adopted under HIPAA.

The Security Standard does not require specific technologies to be used; solutions will vary from business to business, depending on the needs and technologies in place. Also, no transactions adopted under HIPAA currently require an electronic signature.
Privacy and Confidentiality

In general, privacy is about who has the right to access personally identifiable health information. The rule covers all individually identifiable health information in the hands of covered entities, regardless of whether the information is or has been in electronic form.

c. The Privacy Standards

◆ Limit the unauthorized use and disclosure of private protected health information (PHI);
◆ Give patients new rights to access their medical records and to know who else has accessed them;
◆ Restrict most disclosure of health information to the minimum needed for the intended purpose;
◆ Establish new criminal and civil sanctions for improper use or disclosure;
◆ Establish new requirements for access to records by researchers and others.

Acknowledgement
This HIPAA overview was substantially based on content from HIPAA Help Now at http://www.hipaahelpnow.com

Health Information Management

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatments, and a plan for future care or treatment. The medical record, in manual or automated form, houses an individual's medical history and information, information that describes all aspects of patient care and serves for several purposes. Your record serves as a:

● basis for planning your care and treatment
● means of communicating between the many health professionals who contribute to your care
● legal document describing the care you received
● verification of services for which you or a third-party payer were billed
● source of data for health research and planning

The purpose of the Health Information Management department is to collect, maintain, and make available to authorized users, timely, accurate, and complete patient health information. These functions are performed in a way that maintains the privacy of each patient's health information.

Health Information Management covers issues related to:

○ Patient Confidentiality
○ Medical Records
○ Computers
Release of Information

Patient Confidentiality

- Safeguarding patient information is your ethical and moral obligation.
- The hospital owns the medical record but the patient owns the information.
- Don't discuss patients in public areas.

Medical Records

- Keep medical records at the nursing station.
- Never leave medical records in patients’ rooms.
- Ensure each patient that only authorized personnel have access to their health information.
- Authorization to view the medical record must be signed by patient.

Computers

- Never give out your password
- Close the file completely
- Don’t leave patient information on the screen
- Position screen so that the information is not in view of the public

Release of information is permissible under proper circumstances:

- Patient’s written consent
- Subpoena
- Court Order

Faxing used in an emergency and only with patient's consent

Acceptable Use of Computer Resources

Acceptable use of Interfaith Medical Center’s computer resources is governed by policy number HAM::VIII:IM:03, revised on April 19, 2006.

POLICY #1:
IMC’s computing resources are provided for the use of the IMC staff solely for the provision of health care services or the administration of health care services at the Medical Center and its owned or affiliated entities. Access to and use of these resources are contingent upon compliance with the policies and procedures described herein as well as other applicable Medical Center rules.

Information Technology Systems (ITS) provides IMC staff, including authorized contractors and consultants, (IMC Systems User) with access to software through computer workstations deployed throughout the Medical Center and its affiliated entities. Unlicensed or unauthorized software is not permitted on the Medical Center’s computers.
IMC Systems Users will receive user accounts and passwords for the computer systems according to their job functions. Terminated IMC Systems Users will have their passwords removed from the system. Only currently employed staff members as well as authorized contractors and consultants are permitted to access the information systems at IMC. IMC Systems Users are expected to report unauthorized access or known abuse of computing resources to ITS or to Medical Center administration. Questions about policies for correct use of IMC computers should be directed to ITS.

POLICY #2:  
Any IMC Systems User who has the authority to access IMC computer resources from a remote location (e.g., home, private office, etc.) must abide by these policies and procedures when connected to any IMC computer systems. IMC computer systems access from a remote location is considered use of IMC computer resources until the remote connection is terminated and all IMC data is cleared from the computer screen and memory.

POLICY #3  
Any IMC Systems User who violates the policy is subject to disciplinary action by Interfaith Medical Center (IMC), and possible legal action under the laws of the state of New York, the Federal Electronic Communications Privacy Act, the HIPAA guidelines, Joint Commission requirements and/or other prevailing authorities.

POLICY #4:  
All new IMC Systems Users are required to read and sign a copy of this Policy and Procedure as part of their new employee orientation. The employee may maintain a copy of the signed document for their records.

PROCEDURE:

1.0 Appropriate and Ethical Use  
1.1 Appropriate use of IMC’s computing resources includes the productive use of resources for their intended purpose: the care of patients or the administration of healthcare services at IMC.
1.2 All IMC Systems Users should conduct their computer-based activities in an ethical and legal manner that does not interfere with the rights of others, violate patient or employee privacy and in conformance with all computer software and hardware licensing agreements. Examples of inappropriate use include but are not limited to:
   1.2.a Unlawful, improper or criminal purpose or activity
   1.2.b Posting or transmitting information or communications that are obscene, indecent or pornographic, or of a sexually explicit or graphic nature
   1.2.c Transmitting unsolicited commercial e-mails
   1.2.d Bombarding individuals or groups with uninvited communications, data or information, or other similar activities including but not limited to
“spamming” or “flaming”

1.2.e Intercepting, interfering or redirecting e-mail intended for third parties
1.2.f Introducing viruses, worms, harmful code and/or Trojan horses
1.2.g Interfering with another person’s legitimate use of IMC computer resources
1.2.h Posting or transmitting information or communications that are
defamatory, fraudulent or deceptive
1.2.i Damaging the name of IMC or its owned or affiliated entities
1.2.j Transmitting confidential or proprietary information except in
accordance with prevailing laws IMC policies and procedures
1.2.k Violating IMC’s or any third-party’s copyright, trademark, proprietary
or other intellectual property rights including trade secrets
1.2.l Attempting to subvert, or aid others to subvert the security of any
computer or computer facility

1.3 IMC Systems Users shall not impersonate any person or use a false name while
using IMC computer resources.
1.4 Only software licensed by IMC shall be utilized.
1.5 IMC Systems Users should exercise careful thought and good judgment when
crafting e-mail message text. Sent messages are often very difficult to recall;
inappropriate messages are subject to disciplinary action by the IMC Human
Resources Department as well as local, state and federal authorities.

2.0 Licensing

2.1 The use of software at IMC is governed by the terms of licensing agreements
between the Medical Center and the software licensors. IMC Systems Users shall
not delete any proprietary designations, legal notices or other identifiers
belonging to third parties from any information obtained or sent using IMC
computer resources.
2.2 IMC Systems Users must abide by the terms of those agreements.
2.3 The use of such proprietary software may also be subject to copyright or patent
restrictions as defined in the license agreements. IMC Systems Users may not
copy, disclose, transfer or remove from any IMC location any software of any type
including programs, applications, databases, codes, manuals or data residing on
any such media.

3.0 Sexual Harassment/Pornography

Any use of the computing resources for the creation, display, storage or transmittal of
sexually explicit, pornographic, harassing, abusive or other similar material or
communications shall be considered a violation of Medical Center employee conduct
guidelines.

4.0 Compliance with Legal Authorities

IMC may be ordered by a court of law or other authority to surrender communications
that have been transmitted over the IMC network. It should be assumed that IMC will
comply with any such requests.

5.0 Passwords
5.1 Sharing of computer passwords is prohibited.
5.2 Any IMC Systems User who shares his or her password is responsible for any actions taken by the person using his or her password.
5.3 IMC Systems Users who allow others to access IMC computer resources with their password will be referred to the Human Resources Department for appropriate action.
5.4 New passwords or replacements for forgotten passwords may only be provided by authorized representatives of ITS. Execution of the Medical Center’s privacy statement and positive identification may be required prior to issuing new or replacement passwords.

6.0 Internet Usage Guidelines
Commercial use of IMC’s computing resources are strictly forbidden. The Internet is not a secure network and should not be relied upon for transmitting confidential or sensitive information. Random electronic mailings (junk mail or “spam”, personal musings, political or religious statements, chain letters, unauthorized solicitations, repetitive mailings, etc.) are not allowed.

7.0 Computer Environment
Computers should be utilized in such a way that minimizes to the greatest extent possible the unauthorized viewing of confidential patient or employee information. Any concerns about computer location should be communicated immediately to ITS. No food or drink should be used in close proximity to the computer devices. Should this be unavoidable, ITS should be requested to install keyboard shields or similar protection.

8.0 Violations
IMC treats the abuse of computing resources including equipment, software, information, networks or privileges seriously. IMC Systems Users who violate the policies outlined in this document, and/or Rules of Conduct for Medical Center Employees, and/or HIPAA privacy or security rules, or other regulatory guidelines are subject to sanctions according to the nature, severity and number of offenses and will be referred immediately to the Human Resources Department. Such sanctions may include immediate termination of employment, violators may be identified by electronic means, direct observation or a formal complaint filed by an employee, patient or visitor.

CORPORATE COMPLIANCE
Interfaith Medical Center (Interfaith) is committed to providing services of highest ethical, business, and legal standards. Any form of unlawful or unethical behavior by anyone associated with Interfaith will not be tolerated. We expect and require all personnel to be law-abiding, honest, trustworthy, and fair in all of their business dealings. In this regard, all personnel must not only act in compliance with all applicable legal rules and regulations, but also strive to avoid the appearance of impropriety.
The Corporate Compliance Program serves as a positive integrated guide for Interfaith and its staff in prevention of submission of erroneous claims and engaging in unlawful or noncompliant conduct involving the Federal and State health care programs. Accordingly, the Compliance Program Code of Conduct Handbook is designed to be a resource to help all personnel ensure that their behavior is in compliance with all laws and regulations that affect their business dealings.

The standards of conduct set forth in the Compliance Program Code of Conduct Handbook are consistent with Interfaith’s commitment to uphold the highest standards of ethical conduct. The standards of conduct however, cannot cover every situation that employees might face. If you are unsure of what a proper course of conduct might be in a specific situation, or believe that the standards of conduct in the handbook have been violated, you are urged to contact the Compliance Officer, Sandra Dwyer at extension 4374. Employees are also urged to call the Compliance Hotline, 1-877-647-6723, to report complaints or concerns about practices or behavior that they feel may present a compliance risk to the organization.

Interfaith has a policy that prohibits retaliation or harassment of any kind against any employee for reporting a concern or issue.

Each employee is required to fully cooperate with the compliance program. The compliance program will work effectively only if everyone works together to ensure its success, understands what is required under the law and our own Code of Conduct, and works to ensure that those standards are being followed in all of our business dealings. Failure to comply with Interfaith’s standards of conduct can result in serious consequences both to the employee (such as being disciplined, being fired, or even being charged with a crime) and to the organization, (such as criminal prosecution, substantial monetary fines and, of primary importance, the loss of our reputation for honesty and integrity).

Next Steps
The foregoing brief summary is intended only to introduce some basic concepts, ideas and terminology. In order to prepare our employees to work in an environment where compliance with HIPAA legislation is critical, Interfaith Medical Center provides mandatory online e-learning for all staff members, tailored according to each individual’s job description. Annually, each employee is required to return to the web site, log on, and complete the update.

Each employee is required to complete the modules on HIPAA and on Professional & Corporate Compliance. Ideally, these should be completed during the initial introductory period.

FRAUD AND ABUSE
The Federal Deficit Reduction Act of 2005 mandates that entities receiving at least five million dollars in Medicare/Medicaid payments annually develop policies to educate employees about False Claim Laws and Whistleblower protection.
False Claim Laws

The law prohibits hospitals and their employees from knowingly presenting or causing a false or fraudulent claim to the Federal government.

Examples of the above include:

- Withholding information about other payers and submitting claims to Medicare and Medicaid
- Reporting incorrect diagnoses and procedures on claims
- Reporting incorrect dates of service
- HIM up-coding
- Billing Medicare/Medicaid for services deemed medically unnecessary by the payers

Whistleblower Protection

New York Law enforces protection of employees who may notice or report any of the inappropriate activities above. The law prevents the employer from taking any retaliatory action against the employee. No action may be taken against employees reporting fraud or false claims in good faith. The law also includes provisions for employee who produce claims without basis or fact, resulting in the employee being held liable to the employer for legal costs.

To report a false claim or suspected fraud, contact the Compliance Hotline at (877) 647-6723. You may also contact the Compliance Officer at (718) 613-4374.

RERAINTS

At Interfaith Medical Center, our philosophy is to:

- Prevent, reduce, and eliminate when possible the use of restraints and seclusion.
- Prevent emergencies that have potential to lead to use of restraints and seclusion.
- Use nonphysical interventions as preferred intervention.
- Limit restraint use to emergencies in which there is imminent risk of a patient physically harming her/himself or others, including staff.
- Discontinue use of restraints as soon as possible.
- Preserve patient's safety and dignity when restraints or seclusion are in use.

Types of Restraints

- **Physical restraints** refer to any method of physically restricting a person's freedom of movement, physical activity or normal access to his/her body. Restraints are only used when clinically necessary and are never coercive, disciplinary, retaliatory or for the convenience of staff.

- **Behavioral restraints** are primarily to protect the individual against injury to self
If a patient requires restraints, clinical staff is encouraged to:

- Use prevention strategies and alternatives: diversion companionship, mittens, etc.
- Ensure face-to-face Physician Evaluation and written order within 24 hours required.
- Remember that restraint orders are time-limited.

PAIN ASSESSMENT AND MANAGEMENT

**IMC Policy:** Assess and manage pain in all patients. Respect and support the patient’s rights to optional pain control. Address appropriateness and effectiveness of pain management. Believe the Patient’s report of pain!

- On admission, when patient answers yes to having pain, the RN will conduct a comprehensive pain assessment.
- Pain treatments are included in the patient’s plan of care.
- Patient is instructed about reporting pain and the role they play in enhancing care.
- Standardized, developmentally appropriate pain scales are used to assess pain.

**Pain Assessment Tools**

- Elderly patient
  - FACE measurement tool
- Person with language barrier
  - FACE measurement tool
- Patients over 10
  - Numeric Rating Pain Scale
- Pediatric Age 3 to 10:
  - FACE measurement tool
- Neonates Age 0-3:
  - FLACC Behavioral Pain Scale (face, legs, activity, cry, consolability)

**Pain Management**

- IMC Nursing Staff will believe, assess and treat patient reports of pain.
- Non-pharmacological aids to promote comfort are used and documented.
- Pain intervention, reassessment, and patient responses are documented on the Pain Reassessment Record.
- Reassessment is completed 30 minutes after a parenteral medication and within 1
(one)-hour for oral medication administration for all patients.

- Documentation includes:
  - Pain intensity (scale)
  - Pain character (sharp, dull, throbbing)
  - Pain frequency/pattern (continuous, intermittently subsides)
  - Pain location

ENSURING STAFF COMPETENCY

Staff Orientation

- The Medical Center Orientation is a mandatory full two-day program for all new employees, as well as volunteers, agency and contract personnel. The Orientation includes information about the Hospital’s mission and values, infection control, safety, security, HIPAA, Corporate Compliance, EMTALA, patient rights and relations, cultural awareness, emergency procedures, disaster preparedness, benefits, and career opportunities.
- In addition to a general orientation for new employees, all staff members receive Department-Specific and Job-Specific Orientation sessions with their immediate supervisor. These detailed orientation programs include an introduction to their working area, colleagues, policies and procedures, a careful review of the job description and the personnel evaluation system, issues associated with working with cultural and linguistic special needs and the hearing-impaired, and any special issues specific to the department or work area.
- Clinical staff is briefed on the “Do Not Use” Abbreviations List from the Hospital Policy VIIIIM-04 entitled “Compliance with Patient Safety Standards,” and they sign a written acknowledgement that they have received the list and will comply with Interfaith Medical Center’s policy. This Hospital Policy includes a list of acceptable abbreviations as well as a list of unacceptable abbreviations.

Competency Assessment

Interfaith Medical Center’s Performance Evaluation Program is governed by Policy Number HRVI-5. Department Heads are responsible for the evaluation of every employee in their respective departments, including supervisors who should evaluate each employee’s job performance on an ongoing basis throughout the year. The objectives of the performance evaluation process are to assess employees’ job performance and competence, determine learning and developmental needs, and provide feedback concerning these factors in order to improve the overall performance of their jobs at Interfaith Medical Center as a whole. A formal performance evaluation is completed on an annual basis, based on job specific criteria directly related to the appropriate job description.

The three general documentary components of the Annual Assessment process are the Annual Performance Evaluation Form, the Competency Assessment Form, and the Annual Employee In-service Module Quiz (which is based on the Employee Reference Guide).
Competency assessment begins as part of the new hire process and continues throughout orientation. Specific elements of competency are identified and published for each job description, so that employees and their supervisors can clearly focus on the skills, knowledge and abilities required in order to satisfactorily accomplish the tasks associated with a job position. An initial assessment of competency is accomplished when the new employee arrives and begins work, and is documented throughout the process by which a supervisor determines whether a new employee can be moved from probationary to regular status.

- Competency is continuously monitored by managers and is documented yearly in conjunction with the conduct of the employee’s annual performance appraisal.
- Unit-specific, age-specific, and pain management competencies are written for clinical staff, but every job description has a discrete set of specific competencies which detail the essential skills that an employee requires in order to effectively perform the requirements of the position.
  - The Competency Assessment Form shows what specific skills, including equipment specific skills, are necessary to perform a job.
  - The outcome of the individual and collective competencies will determine the educational needs of the individual and of the unit.
- Performance appraisals for non-management staff are conducted annually during the month in which the employee’s anniversary date occurs, and they are completed within thirty (30) days. For director-level personnel, all performance appraisals are conducted annually around November 30 and are submitted to the Human Resources Department within thirty (30) days.
- In addition to completing the task specific performance appraisal form, supervisors must meet with the employee to explain and discuss the evaluation. These sessions should be conducted in a private setting, free from distractions and interruptions.
  - The employee is expected to sign the performance appraisal, to acknowledge that they have participated in the process.
  - The employee is entitled to a copy of the completed form if requested.
  - If an employee refuses to sign, the supervisor/manager should sign and note the employee’s refusal to sign.
  - If an employee receives an unsatisfactory evaluation or low competency assessment, the employee must be provided with a plan of action, with specific time frames for the improvement of the job performance.
- Employees who are dissatisfied with their appraisals should put their comments in writing in the comment section of the form and submit copies to the supervisor or department head.
  - The supervisor or department head will review the employee’s issue(s), notify Human Resources, and determine what action is warranted
  - Employees must receive feedback.
Ongoing Education

- Ongoing in-services and learning fairs exist for annual training about abuse, PI, infection control, emergency preparedness, hazardous chemicals, medical gas safety, alarms, cultural competence, etc.
- Education about new equipment and procedures is ongoing.
- Grand rounds conferences and continuing education seminars are available.

STAFF RIGHTS ON CULTURAL, ETHICAL AND RELIGIOUS BELIEFS

It is Interfaith Medical Center's policy to ensure that employees whose personal, cultural values, ethics and/or religious beliefs conflict with the care/treatment provided to patients, reports such conflicts to their immediate supervisor.

Employees are expected to perform all of the essential functions of their positions based upon the job descriptions, standards of care and skills competencies. If a conflict should arise:

- The employee should immediately notify his/her manager.
- The manager will look at the particular job involved and determine its purpose and essential functions.
- The manager will consult with the individual employee to determine the specifics as to his or her cultural values, ethics or religious beliefs that are in conflict with the care or treatment to be delivered to a given patient.
- In consultation with Human Resources, the manager will identify potential accommodations and assess how effective each would be in enabling the individuals to perform the essential job functions.
- In consultation with Human Resources, the manager will determine whether a reasonable accommodation can be made without creating an undue hardship to the hospital or compromising patient care.
- At no time will patient care be jeopardized.

SEXUAL HARASSMENT

Overview:
“Employee decisions that are based upon your submission to, or refusal of, sexual requests are sexual harassment. A sexually offensive hostile environment, or intimidating environment that interferes with your work or academic performance is also sexual harassment. Retaliation for reporting sexual harassment is also against the law.”
Sexual harassment is a form of sex discrimination that violates Title VII of the Civil Rights Act of 1964.

The Equal Employment Opportunity Commission issued the following guidelines on sexual harassment.

Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature constitute sexual harassment when:

1. Submission to such conduct is made either explicitly or implicitly a term or condition of an individual’s employment.
2. Submission to or rejection of such conduct by an individual is used as the basis of employment decisions affecting such individual.
3. Such conduct has the purpose or effect of unreasonably interfering with individual work performance or creating an intimidating work environment.

Examples of Sexual Harassment:
Sexual Harassment may involve, but is not limited to:

- Making direct or indirect overtures of unwanted sexual activity.
- Making sexually oriented noises, remarks, or jokes.
- Making comments about a person’s sexuality or sexual experiences.
- Making derogatory comments of a sexual nature.
- Asking intrusive sexual questions.
- Touching a person intentionally by patting, pinching, stroking, squeezing, tickling, massaging, or brushing against a person without their consent.
- Impeding or blocking movements.
- Sending unwelcome notes, letters, invitations, gifts, telephone calls, voice mails, or e-mails messages of a sexual nature.
- Leering or gesturing of a sexual nature.
- Displaying sexually suggestive objects, pictures, posters, graffiti, or cartoons.

Key Points to Remember:

1. The EEOC’s definition sets forth two general criteria for sexual harassment: that the conduct in question whether physical or verbal, is both unwelcome and of a sexual nature.

2. The EEOC’s definition includes two types of conduct considered to be sexual harassment:

   - **Quid Pro Quo** (“this for that”) involves the exchange or denial of a job benefit or threat for express or implied sexual favors. Example: Manager states “I can do a lot for you if you'll travel with me to the business conference. If you don't have dinner with me I may have to rethink your annual raise.”
Hostile Work Environment occurs when unwelcome conduct of a sexual nature interferes with an individual’s performance on the job, or when unwelcome sexual behavior creates an intimidating, hostile, or offensive work environment. Example: This appears in the workplace when employees start calling in sick to avoid the hostile work environment; they can’t concentrate because they are upset by work environment. Employee takes a different route to avoid a co-worker. Doesn’t volunteer for projects if they have to work with offending co-worker; diminishes morale.

3. Keep in mind that the above-mentioned conduct also applies to other discriminatory actions, such as race, color, religion, or national origin.

4. In reviewing whether sexual misconduct has occurred, the facts will be assessed using the following criteria:

- Frequency of conduct
- Severity of conduct
- Whether conduct was physically threatening or intimidating
- Whether conduct was unwelcome and if communicated to Respondent
- Whether the conduct unreasonably interferes with an employee’s performance and or advancement.
- “Reasonable person” standard: Would a reasonable person have reacted to the alleged conduct in the same manner.
- Totality of the circumstances: Consider all the circumstances of the situation.

RECOGNIZING THE IMPAIRED EMPLOYEE

Federal law obligates the hospital to make a good faith effort to maintain a drug-free work place. In that context, we remind you of the Hospital rule prohibiting the illegal manufacture, distribution, possession or use of a controlled substance in the work place.

Recognizing the impaired employee/physician

- Slurred speech
- Unstable gait
- Bloodshot or watery eyes
- Mood swings

What should you do?

- Employees who notice suspicious behavior on the part of a co-worker or
physician should bring this to the attention of a supervisor or hospital administrator immediately as patient care may be jeopardized.

✓ Supervisors should observe and document the employee's behavior, attendance and job performance, taking note of common observable manifestations of substance abuse, alcoholism or other behavioral problems.

✓ Employees who are incapable of performing their job duties will be referred to the Employee Health Services or the Emergency Department for testing and/or possible treatment referrals.

**DRESS CODE**

Employees of Interfaith Medical Center must always present a professional dress and demeanor (including personal hygiene) as health care providers and/or representatives of the Medical Center. Appropriate attire on the job is essential to prevent infection, to promote safety and to improve the perception of the Medical Center by patients and visitors.

**General Dress Code**

- Each employee must always wear a valid identification badge with picture and name clearly visible, while at work as part of his/her dress.
- Employees whose jobs require a uniform as attire must maintain their uniform in a neat and clean manner, at all times.
- Even when the Medical Center supplies the uniforms, the employee remains responsible for changing uniforms as needed to adhere to this policy.
- Employees are responsible for the negligent loss or damage to their uniform.
- Any uniform provided by the Hospital must be returned upon termination of employment.

Non-management male employees who work in public areas or in office environments are required, at a minimum to wear dress slacks and a dress shirt with shoes. Non-management female employees must wear a dress, dress pants or a skirt and top with shoes.

The following items are not permitted to be worn at the Hospital:

- Beachwear
- Jeans
- Spandex stretch pants
- Sweatshirts or sweatpants
- Shorts
- Extremely short skirts
- T-shirts and/or tank tops
- See through and/or low cut shirts/blouses
- Bare backs or bare midriffs
- Clothing bearing provocative statements
Body piercing other than ear piercing
- Baseball caps and/or hats unless religiously indicated

Shoes
- Shoes are to be clean and are to be worn at all times.
- Shoes with rubber soles/heels must be worn by all those working in patient care areas.
- Loose sandals, thongs, clogs and sneakers (unless medically indicated) may not be worn.
- Employees (such as Patient Care Technicians, Patient-Support Associate or Patient Companions, Transporters, Dietary and Housekeeping Workers) and professional workers (such as Physical, Occupational and Respiratory Therapists) whose job descriptions require extensive walking will, however, be permitted to wear white sneakers.

Other
- Leg coverings must be worn at all times, e.g. stockings/nylons and socks.
- Head dress and hair must be in accordance with regulatory and/or department requirements.
- Fingernail art, length and jewelry must be in accordance with regulatory and/or departmental requirements.
- Style of shoes must be in accordance with departmental safety standards.
- Walkman type radios or similar electronic devices with or without headphones are not to be worn/or operated while working.
- Personal cell phones, beepers and similar type equipment for personal use are not to be used while working.

This list is not meant to be all-inclusive. There may be other requirements depending on the department, job category of the employee and/or the nature of certain jobs.

RULES OF CONDUCT
Overview

Interfaith Medical Center believes common sense, good judgment and regard for the rights and interest of both the Hospital and one’s co-workers shall ensure the well-being of the patients entrusted to our care. Accordingly, the Hospital expects employees to adhere to high standards of personal conduct at all times. It is impractical to spell out everything that is expected of employees by the Hospital and by co-workers in terms of honesty, courtesy and good conduct. However, some of the actions which cannot be condoned and shall lead to disciplinary action, up to and including discharge are spelled out in the rules that follow.

Since we are working as a team, it is necessary that we have certain requirements on position conduct for the guidance of all. Any necessary disciplinary steps are intended to correct serious violations of Hospital regulations and to insure good patient care.
In addition to performance expectations that relate specifically to employees’ individual positions, all employees are required to conduct themselves at all times in a courteous manner. Those expectations are defined in a positive fashion. The following is a partial list of conduct which constitutes unprofessional behavior on the job, violations of performance standards, hospital rules and standards of behavior. Employees who engage in such behavior will receive discipline, up to and including termination. This list is not meant to be complete, but merely a guideline for employees and supervisors in identifying unacceptable behavior.

Under the provisions of Policy Number HR VII-1, gross violations of conduct and Hospital rules are treated with immediate dismissal. The Hospital has the right to discharge, suspend or discipline any employee for reasons which include, but are not limited to:

- Excessive absenteeism or tardiness. This includes patterned absenteeism such as being absent the day preceding or following weekends, days off, holidays or vacation. Absenteeism and tardiness relate to the amount of time off from the job regardless of the reason. Failure to notify a supervisor prior to an absence is also violation of attendance standards.
- Unauthorized absence from work area during work time. Employees may be away from their workstations for breaks, meals and personal reasons, but only with the approval of their supervisor.
- Sleeping or loafing while on duty. Does not include authorized meal or rest periods in a non-work designated area.
- Insubordination. This includes refusal to follow a supervisor’s instructions, refusal to accept an assignment or disrespectful conduct towards a supervisor or any other managerial staff member.
- Failure to provide customer-driven responsiveness, including failure to perform assigned duties properly and promptly. The customer is defined by the job and the particular task, but includes patients, visitors, physicians, the general public, supervisors and fellow employees. Responsiveness applies to whatever task is involved in a particular job. All responses should be timely, professional, caring and respectful in accordance with the Behavioral Guidelines.
- Use of abusive, obscene or threatening language to customers on Medical Center grounds.
- Using, selling, processing, possession or being under the influence of illegal or unauthorized drugs or alcohol on Medical Center premises (HRI-5).
- Possession or use of a weapon on Medical Center premises.
- Soliciting, collecting funds, selling merchandise, tickets or services without specific authorization. This includes performing personal business on Medical Center’s time and/or property.
- Unauthorized possession, willful destruction or defacement of Medical Center property, or/another individual’s property, including fellow employees, patients, vendors and visitors.
- Violations of safety, security or fire prevention rules. This includes, but is not limited to failure to wear personal protective devices including gloves and goggles; failure to follow universal precautions and other infection control rules, and failure to report an on-the-job injury.
- Violation of the Medical Center’s dress code (HRVII-5), including maintaining appropriate personal hygiene.
- Violation of the Medical Center’s smoke free environment (HAM – EC-01)
- Unauthorized possession, use, copying, or reading of Medical Center records and e-mails, including misuse of computer access to confidential information or disclosure of such records or information to unauthorized persons.
- Misuse of computer access to information and/or improper disclosure of records or information obtained through computer access in either a written and verbal/oral manner.
- Disorderly conduct of any kind including fighting, provoking a fight, horseplay, intimidating, coercing or harassing fellow employees, visitors, vendors or patients on Medical Center premises.
- Soliciting or accepting tips or gifts from patients, visitors, or vendors.
- Unauthorized use of Medical Center telephone and paging system for personal use.
- Any act or conduct detrimental to patient care or Medical Center operations.
- Failure to wear hospital I.D., with picture clearly visible, while on Medical Center premises.
- Falsification of employment records (false statement on application), benefit claim forms or other Medical Center records. This includes failure to punch one’s own time card, punching another employee’s time card, or permitting another employee to punch one’s time card. This guideline applies to all forms of time records.
- Theft or possession without authorization of hospital property, the property of fellow employees, visitors, patients or vendors.
- Violation of Medical Center’s sexual harassment policy (HR1-4).
- Violation of Medical Center’s workplace violence policy (HRI-6).
- Engaging in any behavior, personal relationships or contact (physical, sexual, or otherwise) with a patient, not specifically justified by medical or legal requirements.
- Failure to maintain valid credentials (e.g. licenses, certifications, registration, etc.) required to perform the functions required by the job or job description.
- An employee who does not have a valid required license is not able to work until one is secured. Excessive abuse of this policy may lead to disciplinary action, up to, and including termination of employment.
- Unauthorized use of Medical Center provided e-mail and internet services, whether on Medical Center or personal time. Use of personal telephones (cellular phones) or other non-issued electronic equipment on medical center property during work time is prohibited.
- Bringing unauthorized individuals onto Medical Center premises.
- Recording of conversations, by video, audio or other methods, without the permission, knowledge and consent of the other party(s).
- Gambling while on Medical Center property.
- Unauthorized soliciting of any employees or distributing literature on Medical Center property. Soliciting other employees in immediate patient care areas, or in other areas where solicitation would interfere with patient care by disturbing patient or disrupting health care services, at any time. Immediate patient care areas are patient rooms; operating rooms; treatment rooms; corridors adjacent to patient rooms, operating rooms and treatment rooms; corridors adjacent to patient rooms, operating rooms and treatment
rooms; and sitting and waiting rooms on patient floors that are used by patients.

- No show, no call. This includes failure to call or come in to work without appropriate notification to supervisor for two (2) or more consecutive days.
- Unauthorized posting or removal of notices in the Hospital.

It is understood that circumstances often beyond the individual’s control shall occasionally cause tardiness. Occasional, isolated instances of tardiness shall not seriously affect the efficient operation of a department. However, excessive or chronic lateness can be a serious problem and shall be dealt with accordingly. The efficient operation of the Medical Center depends on the punctuality of every employee. Excessive lateness can seriously hamper the productivity of any department. Therefore all employees of Interfaith Medical Center are expected to arrive at their work station, ready to work, at their scheduled starting time.