St. Luke's Roosevelt

Continuum Health Partners, Inc.

VOLUNTEER
CORE COMPETENCY
HANDBOOK

2009

Continuum Health Partners, Inc.

Beth Israel | **Roosevelt Hospital** | **St. Luke's Hospital** | **Long Island College Hospital** | **NY Eye & Ear Infirmary**

Dear Volunteer:

St. Luke's – Roosevelt Hospital Center is committed to assuring that all staff
members and Volunteers are highly competent and consistently provide quality
services to our patients and our community. This booklet has been designed as a
resource to help staff develop and maintain their competence. Topics have
been selected because of their importance to our patients and our institution.

It is essential that you carefully review the Core Competency Handbook at
the time of your application and during each calendar year thereafter. This is an
institutional requirement that will help us to meet the mandates of regulatory
agencies such as The Joint Commission, the Occupational Safety and Health
Administration (OSHA) and the New York State Department of Health
(NYSDOH).

After reviewing the handbook, please complete the test related to the content.
Of course, you may refer to the handbook to check for the accuracy of your answers.
Give your completed test to the volunteer administrator for him/her to review with you.

Please remember to continue to incorporate the information that you have reviewed
into your everyday practice. The Volunteer Services Department as well as the patients,
their families and the St. Luke's-Roosevelt staff thank you for the time you give or are
about to give to St. Luke's-Roosevelt.

You are very special to us, thank you for joining our volunteer team.

Sincerely,

Kathleen Dalton
Director Volunteer Services
St. Luke's - Roosevelt Hospital Center

TABLE OF CONTENTS

Section V Performance Improvement/Risk Mgmt.

Section VI Patient Safety

Section VII Customer Service

Section VIII Population Specific Care

Section IX Corporate Compliance

Revised: February 2009

Section I

Mission/Vision/Goals

MISSION STATEMENT

The mission of St. Luke's-Roosevelt Hospital Center (SLRHC) is threefold:

♦ Provide **outstanding health care**

♦ Provide the **highest quality education** to health care professionals

♦ Further **research medical knowledge** and develop **excellence in health care delivery**

Everyday you are a part of this mission when you help a patient, participate in educational activities, or are a part of research activities.

VISION STATEMENT

St. Luke's-Roosevelt Hospital Center will build on our recognized clinical strengths in serving Manhattan's West Side communities and our other areas by becoming the provider of choice. We will transform ourselves into a health care system capable of managing a wide range of ambulatory, inpatient and sub-acute care.

GOALS

For 2009, SLRHC has the following goals:

1. To redefine how we do business to ensure the best quality, customer service, and financial performance and to monitor and sustain that performance on an ongoing basis.

2. To manage the delivery of the most efficient and effective quality care to our patients through careful clinical organization, use of resources, and monitoring of outcomes.

3. To identify opportunities to change the ways we use our campuses to optimize clinical and operational efficiency.

4. To identify opportunities to expand or improve the operating performance of our ambulatory care business.

Section II

Environment of Care

SECURITY*

Refer to the Security Management Plan in your Environmental Care Manual for additional information.

"SECURITY IS EVERYONE'S BUSINESS"

MINIMIZE SECURITY RISKS:
- ✓ Wear and conspicuously display, your hospital Identification (ID) badge at all times while on premises
- ✓ Challenge anyone not wearing a Hospital Center ID badge- call security if needed
- ✓ Secure your work space and vulnerable areas at all times
- ✓ Safeguard patient, hospital, personal property
- ✓ Utilize security escort services while traveling on or between the Hospital Center campus and adjacent hospital properties

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EMERGENCY PROCEDURES
(For immediate security response due to threatening, aggressive or violent behavior)

For Security Emergencies at St. Luke's and Roosevelt-

Dial 4444
Inform the operator of a security emergency

REPORTING "NON-EMERGENCY" SECURITY INCIDENTS:
(such as a suspicious person in the hallways)
- ✓ Security representatives are available 24 hours/day:

St. Luke's	212-523-1000
Roosevelt	212-523-7512

- ✓ Provide your name and location of the incident
- ✓ Describe the nature of the incident
- ✓ Provide information and description

SECURITY TIPS

Always

- Stay Alert – observe who is in front of you and who is behind you. Don't be distracted by diversions.
- Remain Calm
- Without being obvious, take notice of details: clothing, behavior, means of escape, unique features of persons
- Exhibit confidence
- When possible, let someone know where you are going and when you expect to return.
- Remember any one can be a victim of crime at any time. This can happen to you.
- TRUST YOUR INSTINCTS – If you feel uncomfortable, walk away, consider your options and notify security or seek other help.
- Roosevelt 212-523-7512
  St. Luke's 212-523-1000

Do Not

- Panic
- Try to be a hero
- Travel alone
- Approach vehicles for any reason
- Fail to report a crime or suspicious activity

FIRE SAFETY

***Refer to the Fire Risk Plan in   your Environment of Care Manual for additional information,
EC 02.03.01, and EC 02.03.035.**

You Can Prevent a Fire	## *Follow the <u>NO Smoking Policy:</u>* *1. Never smoke in the hospital.* Be an example to others and never smoke in the hospital. For everyone's health and safety, leave the hospital building when you smoke. Please remember not to smoke in front of any hospital entrance. *2. Inform patients of the <u>No Smoking Policy.</u>* If you see patients or visitors smoking - ask them to stop. A polite explanation usually works. Call the security department for help only after all your efforts fail. **Maintaining a smoke-free environment is everyone's job.**

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7 Tips for Hospital Fire Safety

1. **Elevators -** Never use elevators during a fire alarm situation. Use elevators only when directed by the Fire Department.
2. **Smoke / Fire Barrier Doors -**   Designated cross corridor hallway doors close automatically when there is a fire alarm activation. All room doors are closed by staff. Please provide a quick reassuring word of explanation to patients when closing their room doors.
3. **Fire Alarms -** When fire alarms are sounded, remember to check the fire station chart to find the location of the fire.
4. **"Fire Code Word" -** Never yell "fire" - it can cause fear and panic. *Use the phrase "Code Red" at St. Luke's-Roosevelt Hospital Center when discovering a fire or smoke situation.*.
5. **Horizontal Evacuation or Area of Refuge -** The first mode of evacuation is moving patients horizontally, to the other side of smoke-barrier doors or a designated area of refuge on the same floor.
6. **Vertical Evacuation -** Moving patients vertically can be dangerous and should only be considered as a last resort. This type of evacuation will be completed only when ordered by Fire Department personnel or the hospital administration. Evacuate personnel at least two floors below the fire/smoke affected area.
7. **Storage –** Do not store anything within 18 inches of the top of a sprinkler head.

In the Event of a Fire: Ambulatory patients are evacuated first.

RESPONSE LEVELS

Four (4) Response levels are applied any time the fire alarm system is activated. The response levels are based on the unit or area in which staff are located in relation to the origin of fire. It utilizes the "Define In Place" healthcare design concept.

AWARENESS LEVEL - An alarm in any part of the hospital building requires an awareness level response from all staff. This means that all personnel not within the origin of fire floor must be aware of the location of the fire affected area, and they should be aware and prepare themselves for the evacuation of personnel from other areas of the building to their unit. In addition, if the fire affected floor is located on a floor or area below them, smoke could possibly travel up and might require evacuation of the area. Be alert for what is happening on your floor, and your surrounding areas. Report any problems to EH&S by calling the emergency response number x 4444.

ACTION LEVEL – The unit adjacent to the fire of origin area requires that all staff in this area prepare for the possible horizontal evacuation of patients and visitors to their unit. Staff in this area will check any rooms to ensure they are not affected by smoke. In addition, staff in the area will clear corridors and close room doors to patient care rooms to minimize the transmission of smoke. (Remember to check on patients on a regular basis to reassure them that they are not in any danger.)

RESPONSE LEVEL – If the fire is on your floor, activate the **RACE** procedure immediately. Activate the fire alarm by pulling the nearest manual pull station and call emergency number x 4444. Remove all affected personnel by moving them horizontally across smoke/fire barrier doors. Close all room doors and windows. If possible, extinguish the fire at its source utilizing the appropriate extinguisher. **NOTE**: Using a fire extinguisher on a fire has the potential to put yourself at risk! **DO NOT** attempt to use an extinguisher if you feel that your safety is in jeopardy. Staff should only try to extinguish small incipient fires, i.e., trash cans. **PLEASE** make sure the fire alarm system has been activated by pulling the nearest manual pull station prior to trying to extinguish a fire situation.

FIRE RESPONSE TEAM LEVEL - Fire Response Team (FRT) members are staff who are not part of the unit who respond to the fire alarm activation area. FRT members may be from building services, engineering, security, and safety. They help area staff implement the RACE process as directed by the unit's clinical manager or department head. They will also report the severity of the situation to security staff who will meet the fire department upon entry to the hospital.

The NYC Fire Department is an integral part of the hospital's fire response. Fire fighters are trained in the advanced techniques of suppression and containment, and St. Luke's/Roosevelt Hospital's staff will work with them to coordinate a fire response and the hospital's resources once they arrive on-site.

Whenever a fire alarm is activated, remember to implement:

R -	**RESCUE persons in danger**
A -	**ALARM; yell out CODE RED, pull the alarm, dial 4444**
C -	**CONTAIN fire by closing doors**
E -	**EXTINGUISH fire if possible with an extinguisher**

Please ask your manager/supervisor to explain or provide information on your department's specific fire response.
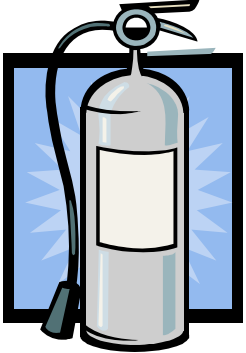
When you are located on your unit or department, please walk around and become familiar with the location of important fire prevention items:

1. Stairwells
2. Manual fire alarm pull stations
3. Fire alarm code charts (know your area's fire alarm code and the general building codes)
4. Portable fire extinguishers (determine the type of extinguisher for your area, and read the directions on the side of the extinguisher)
5. Smoke and fire barrier doors
6. Medical gas shut off valves and note the area or room(s) they control (remember medical valves can only be shut upon the direction of unit's nurse-in-charge)

IT IS EVERYONE'S RESPONSIBILITY TO LISTEN AND RESPOND APPROPRIATELY TO FIRE ALARM ACTIVATION. YOU MUST ALSO PARTICIPATE IN ALL FIRE DRILLS.

Fire drills are conducted once per quarter per shift in healthcare and ambulatory surgery buildings or locations. Off-site clinic areas participate in one fire drill per year.

Portable Fire Extinguishers are conveniently located throughout the hospital in cabinets along the corridors. The location of extinguishers are noted by signs adhered to the wall. The extinguisher or cabinet must be clearly seen from the corridor.

Water Extinguisher – Use on Class A fires • Contained in the shiny, silver-colored container. • Used for **Class A fires only –** ordinary combustibles such as wood, paper, linen, clothing, mattresses, plastic, furniture, and waste containers. • Do **not** use on electrical equipment, Class C, or flammable liquid, Class B fires.	
Carbon dioxide extinguisher – Use on Class B and C fires • Contained in a red metal container which has a large cone shaped nozzle. • Used for **Class B fires** which involve flammable liquids such as oils, greases, chemicals, flammable gases, xylene, alcohol, and plastics. • Used for **Class C fires** which involve electrical equipment, medical equipment, electrical wiring, fuse box, or circuit breakers. • It can be used on electrical equipment without receiving an electrical shock.	
Wet chemical extinguisher – Use on Class K - cooking fires • Contained in the shiny, silver-colored container. This container is shorter, and slightly wider than the water extinguishers. • These extinguishers are marked for use on grease, hot oil, or cooking fires. • These extinguisher are located only in kitchen areas within 15 feet of the cooking equipment. • Used for **Class K fires only** – Cooking fire, grease, hot oil, deep fat fryers, etc.	

Dry chemical extinguisher – The all purpose extinguisher and it can be used on Class A, B, or C fires

- Contained in a red container marked "dry chemical".
- Used for **Class A fires –** ordinary combustibles such as wood, paper, linen, clothing, mattresses, plastic, furniture, and waste containers.
- Used for **Class B fires** which involve flammable liquids such as oils, greases, chemicals, flammable gases, xylene, alcohol, and plastics.
- Used for **Class C fires** which involve electrical equipment, medical equipment, electrical wiring, fuse box, or circuit breaker.
- It can be used on electrical equipment without receiving an electrical shock.
- Can be used on ALL TYPES OF FIRES.
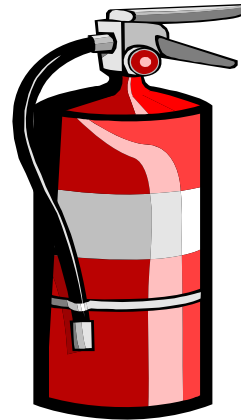
To use a fire extinguisher you - PASS.

P *Pull the pin.* The pin is in place to prevent the accidental discharge of the fire extinguisher. Check its location on the extinguisher.

A *Aim the nozzle.* The nozzle is usually clipped to the side of the extinguisher. In the event of a fire, aim the nozzle at the base of the fire.

S *Squeeze the handle.* Use firm pressure and squeeze the two handles located on top of the extinguisher.

S *Sweep the extinguisher nozzle from side to side.* Holding the nozzle and pointing at the base of the fire, the person activating the fire extinguisher should try to move nozzle in a sweeping motion.

EMERGENCY MANAGEMENT

DISASTER PLAN

The plan can be found in the Environment of Care Manual - Section 6

Definition: A disaster is a natural or man-made event that results in a major disruption in our ability to maintain a SAFE ENVIRONMENT OF CARE for the patients and staff. Any event that threatens that ability can trigger St.Luke's - Roosevelt to activate our emergency response plans (Code D Plan.) A Safe Environment of Care means the physical environment in which care is delivered is free from hazards and is safe to care for patients and the hospital has sufficient resources to assure that patient care is not compromised.

Types of Emergencies

- **Internal** - those events occurring within the hospital: for example, a fire inside the hospital, loss of internal communications, union strike

- **External** - those events occurring outside the hospital but affecting the way the hospital functions: for example, a pandemic influenza resulting in a surge of patients into the hospital, a blizzard that hampers staff's ability to report to work

Hotline - Continuum has established an emergency hotline for employees and volunteers to obtain updated information. In the event that Code D is activated, the hotline will provide specific information and direction by hospital site. The hotline number is **1-877-518-1878**. This number is also operational during normal hospital operations to provide updates on Continuum efforts to advance emergency readiness.

Activating the Emergency Response Plan - Code D

A Code D is activated by the senior most administrator on duty. The staff on duty are notified in the following ways:

-A series of four single fire alarm bells will sound

-The Medical Center telephone operator will make the following announcement on the overhead page system:

Code D - report to your supervisor for instructions
-Key staff will be text paged

Disaster Team members are designated as such by Department Heads. Everyone else should remain at usual post until called for by Disaster Command Team

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A Volunteer's role when a (Code D) is activated:
All volunteers on duty shall:

1. Report to the volunteer office for direction
2. End all non-emergent phone calls
3. Wear Hospital ID conspicuously on outermost garment clearly
4. Follow instructions of the volunteer office supervisor
5. Avoid going to disaster treatment area unless requested to by supervisor

No one will be allowed in the disaster treatment area (Emergency Department) without the proper vest. This vest can only be obtained in the labor pool.

All volunteers at home shall:
1. Call the Continuum Prepares Hotline: 1-877-518-1878 to find out what you need to do
2. Call the Volunteer Office for further instruction: 1-212-523-7155

Hospital Emergency Incident Command System (HEICS)
Once a Code D is activated, HEICS goes into effect. HEICS is a standardized structure of organizing administrators and other key personnel within the hospital to lead and direct the hospital during a response to an emergency event. HEICS ensures that the disaster response is coordinated, effective and efficient.

Incident Commander - The Incident commander is in charge of the event and is assisted by other officers and chiefs each assigned to specific responsibilities and duties. The Incident commander is the senior most administrator on duty at the time of the event. During evenings, nights and weekends, this role is assumed by the Nursing Administrator on site. The event is coordinated from a Command Center, which is equipped with all the tools necessary to effectively run the event.

Command Center:

St. Luke's	Roosevelt
Nursing Administration	Administrative Office
Travers 4	Conference Room

Personal Preparedness- Knowing that you and your family are prepared for an emergency can help ease your mind.
1. Establish a phone contact outside of your immediate region. Each family member should be instructed to call the contact who can relay information back and forth among your family.
2. Select two places to meet your family in an emergency, make sure all family members know how to get there.
3. Gather an emergency supply kit for your home: a three day supply of food and bottled water, first aid kit, batteries, flashlight, candles and matches.
4. For additional information visit, www.ready.gov

INFANT ABDUCTION: PREVENTION and RESPONSE

What You Should Do to Prevent Infant Abductions:

- Always wear your hospital ID badge at all times while on hospital premises. Look for special hospital IDs that identify staff who work in units providing care to infants.

- Do not let "**tailgaters**" or "**piggy backers**" in or out of the locked units with you unless they have been cleared by a unit secretary or member of the nursing staff on the maternal infant care or pediatric units. Tailgaters are people who attempt to gain access to an MCH unit by following employees or permitted visitors through access doors.

- Question suspicious visitors, asking if they need help, or asking whom they are here to see. Abductors target hospitals where they don't feel threatened.

- Actively participate in **Code Pink** drills (*see section below on how to respond to an infant abduction*).

How to Respond to an Infant Abduction:

- In the event that a newborn, infant, or child is discovered missing from the maternal infant care or pediatric unit, a **Code Pink** will be activated. The following announcement will be made over the public address system 3 times:

> "**Code Pink, (state location), all personnel must report to their assigned locations.**"

- When a **Code Pink** is announced, all staff in the hospital should go "on alert" and notify Security immediately of anyone acting suspiciously. Be especially aware of persons carrying large bags or transporting an infant in arms instead of in a bassinet.

- Depending on where you work, you may be assigned to check bathrooms or rooms or monitor an egress. Check with your supervisor about what your role is when a **Code Pink** alert is announced. It is important to remember that **all employees are the eyes and ears for the Security staff.** Notify Security if you see anyone or anything suspicious.
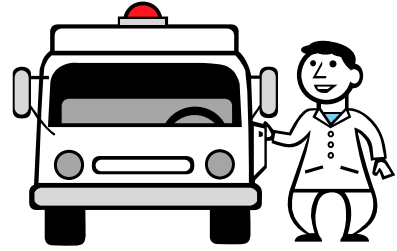
CODE GREEN

Q: What is Code Green?

A: Code green is a response to **Non–Life Threatening Medical Emergencies.** Code Green assures that non life-threatening medical emergencies that occur on and off Hospital campus will be responded to in an appropriate manner, without placing the patient in danger.

What to do in the event of a Non-Life Threatening emergency on campus:

♦ Once you have identified that another person, (a patient, staff member or visitor) requires emergency medical assistance but is still alert, **pick up the nearest phone and dial 4444**.

♦ Inform the operator that this is a **Code Green**, indicating that medical intervention is required but that the person needing assistance appears alert.

♦ The **operator calls a Code Green on the overhead paging system** to the identified location.

♦ Someone should **remain with the patient** at all times, providing support and comfort.

♦ The respective **Emergency Department responds**.

♦ The **Department of Transportation responds** to the site with a stretcher.

♦ Once the patient is transported, **complete an occurrence report** and forward it to Hospital Administration.

TELEPHONE BYPASS SYSTEM

The telephone bypass system allows the Hospital Center to maintain essential communications in the event of a telephone outage. It is a backup system. The telephone bypass system is able to respond to limited outage or site outage.

In telephone bypass the following should occur:

- An overhead page will identify the affected areas. Pay close attention to this notification so you will know the areas affected.

- Let your co-workers know what areas are affected.

- If you are in an affected area, you should only use the bypass phones. **Bypass phones are those with red cords on the handset.**

- If you are calling an affected area, you should use the bypass number listed in your SLRHC telephone directory or on the yellow or white laminated cards attached to the "red cord" phones.

REMEMBER: In the event of a telephone bypass, only essential calls and pages are permitted.

MEDICAL EQUIPMENT SAFETY

1. Most of the patient related medical equipment (electrical, mechanical, etc.) used at SLRHC sites is periodically checked for proper performance and safety by the Biomedical Engineering Department as indicated by the stickers affixed to the equipment items. **ALL NEW EQUIPMENT, INCLUDING EQUIPMENT BROUGHT IN FOR EVALUATION OR TEMPORARY USE, MUST BE CHECKED BY BIOMED PRIOR TO USE, and INVENTORIED IN OUR HOSPITAL SYSTEM.**

2. If the calendar date is past the next inspection due date indicated on the sticker, do not use the equipment and call Biomedical Engineering.

3. Visually check physical conditions of the equipment for signs of abuse, broke/frayed/loose patient cables, power cables, power plug pins, etc. and report abnormalities to Biomed, immediately.

4. In case of abnormal noise, burning odor, electrical shock or other unusual signs proceed with the following steps:
   Step 1: Disconnect patient wires from the patient.
   Step 2: Turn off the power switch of the device involved.
   Step 3: Unplug the power cord.
   Step 4: Remove faulty device from patient room and apply a **"DEFECTIVE, DO NOT USE"** tag and call Biomed, immediately.

5. Avoid use of extension cords whenever possible.

6. Patient owned medical equipment brought to the hospital is to be cleared by the treating physician and then Biomedical Engineering. Non-medical personal electrical/electronic equipment is not permitted except battery operated devices.

7. Cell phones and/or other hand-held communication devices are prohibited from use within patient rooms in Critical/Post critical areas, the OR/Recovery Room, the ED, Radiology, and Catheterization labs, etc. All of the restricted areas are site specific and subject of review by sites' clinical/Biomed leadership. The use of cell phones is allowed outside of designated restricted areas, preferably at the entrances to those areas, lobbies, elevators, waiting areas, etc. as per posted signs.

8. All vital or life support equipment should be plugged into red (emergency) electrical outlets at all times.

9. All questions regarding medical equipment, its performance, safety, in-service, etc. are to be referred to the **Biomedical Engineering Department**.
   St. Luke's 212-523-3118   Roosevelt 212-523-7020

MRI (Magnetic Resonance Imaging) SAFETY

Introduction to MRI	• MRI is an exam performed in the Radiology Department that obtains detailed images of organs and tissues throughout the body without the use of x-rays. Instead, it uses a powerful static magnetic field, a changing magnetic field, radio waves, and a complex computer to generate pictures. For this procedure, the patient is placed within the scanner, typically a large tunnel or doughnut-shaped magnet that is open at both ends. • The static magnet is **never shut down**, even when the scanner is not active and is not scanning a patient. It is "ON" 24 hours a day, 7 days a week. For that reason, safety precautions must always be taken no matter what time of day or night one is in the vicinity of the unit.
MRI Safety Issues	• Magnets attract many types of metals, and the magnet in the MRI scanner is no exception. Remember that this is a large, powerful magnet. • Objects brought into the magnet room, or even to the **doorway** may be propelled into the magnet. These items can be of any size, **from bobby pins and jewelry, to floor buffers and stretchers**. The large items will be yanked out of the bearer's hands. Clearly, this is a hazard to any individual already in the room. • If a large object becomes lodged into the scanner, the magnet must be turned off so the object can be removed, and then the magnetic field must be re-generated. This is a long and expensive process. • Some people, staff, visitors, and patients, may have metallic devices, wires, or metal fragments in their body that could be affected by the magnetic field. This could result in malfunction of the device and/or direct injury to the person.

Restrictions and Precautions	• Do not enter the MRI area without the knowledge and permission of a Radiologist, MRI Technologist, or Radiology Administrator. Never remain in the MRI area alone.
	• When in the MRI area, you are under the strict supervision of the MRI personnel and you are required to follow any and all directions they give you. You may be directed to empty your pockets and remove any jewelry, watches, cell phone, beeper, etc, and must do so.
	• Most metal items must not be brought into the MRI area unless they are specifically OK'ed by a Radiologist or MRI Technologist. This includes but is not limited to:
	    ◘ *tools* ◘ *carts* ◘ *cleaning equipment* ◘ *oxygen tanks* ◘ *IV poles & pumps* ◘ *stretchers* ◘ *wheelchairs* ◘ *respiratory and monitoring equipment* ◘ *chairs*
	    WHEN IN DOUBT, ASK BEFORE ENTERING!!!

What can happen if MRI safety precautions are ignored?	*Death or serious injury to you, the patient, their visitors, or other hospital employees.*

HAZARD COMMUNICATION

The **Occupational Safety and Health Administration** and the **New York State Right to Know Law** state that employers are responsible for informing employees of the hazards and the identities of workplace chemicals to which they are exposed.

Under Occupational Safety and Health Administration regulation, an Employer is required to provide the following information:
1. Identify and list hazardous chemicals in their workplace.
2. Obtain Material Safety Data Sheets and labels for each hazardous chemical.
3. Train employees before they use known hazardous chemicals
4. Train employees on how to identify hazardous chemicals used in their work areas.

Q. What should you do if you are worried about chemicals or other hazards in the workplace?

A. The first action is to read the label on the bottle. All manufacturers are required by federal law to indicate hazards on the label of any chemical bottle, which contains a hazardous material. Labels are required to be legible, in English, and prominently displayed on the container. If you want more detailed information on the hazard, then you need to go to the MSDS (MSDS are located on the SLR intranet). All MSDS copies are provided via MSDS online service.
USER NAME: rooseveltuser
PASSWORD: msdsonline

Or go directly to MSDSonline's full database on the internet:
www.msdsonline.com
USER NAME: lukeroosevelt
PASSWORD: msds

Call the **Safety Department** for assistance.

St. Luke's and Roosevelt Hospitals - 212-523-6636, or 2050

If you want to learn more information about the Hazardous Communication Standard, go to www.OSHA.gov/

If you are employed and work in our clinical or research laboratories, please make sure that your supervisor informs you of our Chemical Hygiene Plan.

MATERIAL SAFETY DATA SHEETS

What is a MSDS?
MSDS stands for Material Safety Data Sheet. It provides detailed information prepared by the manufacturer or importer of a chemical that describes the physical and chemical properties, physical and health hazards, routes of exposure, precautions for safe handling and use, emergency and first-aid procedures, and control measures. (MSDSs have no prescribed format.) It will list known acute and chronic health effects, material exposure limits, and it will also inform personnel if the material is a known carcinogen.

MSDS are found on every floor in bright yellow binders with the word MSDS on it. There is also a full inventory of all known MSDS in the security offices at SL and RH sites. MSDS are located in areas in which staff have access 24/7. Ask your supervisor where your unit's MSDS binder is located.

The following categories are typically found on a MSDS:

1. Chemical Product and Company Identification
2. Composition, Information on Ingredients
3. Hazards Identification
4. First-Aid Measures
5. Fire Fighting Measures
6. Accidental Release Measures
7. Handling and Storage
8. Exposure Controls, Personal Protection
9. Physical and Chemical Properties
10. Stability and Reactivity
11. Toxicological Information
12. Ecological Information
13. Disposal Considerations
14. Transport Information
15. Regulatory Information
16. Any Additional Information

Q. How can you find out more about proper safety precautions when using a chemical?
A. In most cases, all the safety details that you would need are available on the appropriate Material Safety Data Sheet (MSDS).

Remember, do not throw away any chemical hazardous material container that is not empty in a regular trash container. All hazardous materials and aerosols must be discarded through our hazardous waste vendor, Triumvirate Environmental.

Contact the Safety Department for more information.
St. Luke's and Roosevelt Hospitals - 212-523-2050, 2051

Update your dept's chemical inventory list when purchasing new chemicals.

WASTE MANAGEMENT

Wherever you work, in whatever position, you are responsible for proper disposal of the waste you generate. The following is a brief overview of what you need to know.

What goes in red bags?	Red bag waste (Regulated Medical Waste) disposal is expensive. They are used for: • Blood and blood products • Anything soaked, caked or dripping in blood (not blood-tainted) • Cultures and stocks of infectious agents • Serums and vaccines • Suction canisters, hemovac and pleurovac drainage containing any waste • Waste generated from patients with <u>highly</u> communicable diseases (examples: Smallpox, Ebola) • Pathological Waste such as animal carcasses, placenta and surgery and autopsy waste
What goes in Sharps Containers?	Anything that can cut or puncture the skin must be discarded in a sharps' container. Do not overfill sharps' container. • Needles and syringes (even syringes without needles) • Scalpels • Slides, pipettes • Razor blades • Test tubes
What goes in Recycling Receptacles?	In the **blue** recycling receptacles deposit: • Papers, newspapers, magazines • Junk mail • Post-its • File folders – except Pendaflex folders, they contain plastic • Brochures, pamphlets
What goes in Yellow Chemotherapy Waste Containers?	In the **yellow**, rigid chemotherapy waste containers deposit all items labeled "Cytotoxic Drugs": • IV bags and tubing used with these drugs • Bottles • Needles and syringes used in preparation and/or administration • Spill cleanup materials

UTILITY SYSTEMS

Employees must have a basic knowledge of operation for all utility systems in their work area. Utility systems in the hospital include:

1. Electrical (normal and emergency power)
2. Elevators
3. Heating/ventilation/air conditioning (HVAC)
4. Medical gas and vacuum (suction)
5. Steam, Water, Gas and Sewer
6. Telephone and data systems
7. Plumbing
8. Nurse Call systems
9. Fire Alarm system

The Hospital Center has a back-up plan for each of the essential utility systems in the event of an interruption of service. These plans can be found in the *Environment of Care Manual*, located on the intranet.

Emergency power is available throughout the hospital in the event of a power failure. It is provided by emergency generators that start automatically upon the loss of power from the local utility.

Red electrical outlets are connected to the emergency generator power system.

Remember:
*   Emergency power availability varies depending on location.
*   Details on emergency power for your work location can be obtained from your supervisor.

Safe Lifting Checklist

FOLLOW SAFE LIFTING PRINCIPLES TO AVOID BACK STRAIN.
- Let your legs, not your back, do the work.
- Try to avoid leaning, bending, reaching, and stooping.
- Stand at bedside with one knee bent or resting on a stool.
- Don't twist to reach or change positions. Turn your feet or swivel your hips, keeping your back straight.
- Wear sturdy shoes with nonskid soles.
- Keep feet spread a bit to provide support.
- Work at a height that doesn't require much bending.
- Change positions frequently.
- Take short breaks to stretch or move around.
- Don't overexert yourself. Learn your own limits.

PLAN BEFORE YOU LIFT OR MOVE A PATIENT.
- Decide if you need help from another person or mechanical aid.
- Assemble the equipment or help you need.
- Check that you have a clear route; remove any obstacles.
- Explain the procedure to the patient.

PLAN AND COORDINATE TWO-PERSON LIFTS.
- Have one person in charge, giving the count.

POSITION AND COMPLETE LIFTS PROPERLY.
- Make sure the bed and other surfaces are level, close, and locked in place.
- Move the patient to the transfer side of the bed.
- Stand close to the patient, with your feet shoulder-width apart.
- Bend at the hips and knees with your back straight.
- Grip the patient firmly and hold him or her close to your body.
- Lift slowly with your legs, keeping knees bent.
- Use lifting boards or mechanical lifts where possible.
- Have two or more persons help on the move if the patient is heavy, immobile, or attached to tubes and wires.

GET HELP WHEN IN DOUBT ---- SOLO MOVES ARE VERY RISKY!!!

BODY MECHANICS

The basic lifting rule - *think things through before you start !*

General Rules for Lifting Things Safely!

1. Stand close to the object with wide stand and firm footing
2. Squat down and keep back straight and bend knees
3. Grasp object firmly so it won't slip
4. Breathe in – inflated lungs help support the spine
5. Lift with legs – straighten and knees
6. Hold object close to body

Be aware of awkward positioning, which can include,

- Twisting while lifting
- Bending over to lift
- Lateral or side bending
- Back hyperextension or flexion
- Forces on the spine increase when lifting, lowering or handling objects
- Reaching forward or twisting to support a patient from behind to assist them in walking.

CHRONIC STRAIN ON BACK MUSCLES

If your job requires you to sit or stand partly bent over for long periods of time, it can cause chronic strain on your back muscles.

To prevent or relieve the fatigue and strain you can do the following at work:

- **Change Position** as often as possible. Shift your weight by alternating feet on a footrest during standing jobs.

- **Stretch.** Clasp hands behind head; bring elbows back. Then bend forward until back is horizontal.

- **Adjust Working Heights** to prevent slumping or excess reaching.

- **Relax.** Let shoulders and neck muscles go limp; swivel head and let it droop all the way forward.

Muscle pulls are due to microtrauma from repetitive activity over time, or it can be the product of a single traumatic event. Many times, symptoms are ignored until the condition becomes acute. Please report muscular injuries to your manager, and get help when they occur. Use the Employee Accident Report form to report these injuries so the hospital can track and trend injuries. You are not required to see a physician if you fill out this form.

Section III

Infection Control

INFECTION CONTROL PROGRAM

Who can be contacted for information about infection control?	Contact the Nurse Epidemiologist about any infection control questions: **Eloisa Santos** **beeper 39235** **Barbara Smith** **beeper 37485** **Angela Gabasan** **beeper 35484**
How can health care workers prevent the spread of infection?	Hand hygiene remains the single most important way to prevent the spread of infection for both patients and associates. The Hand Hygiene Guidelines developed by the Centers for Disease Control and Prevention (CDC) recommend that healthcare workers use an alcohol-based hand wash to routinely clean their hands between patient contacts, as long as their hands are not visibly soiled. Understanding and practicing the principles and guidelines of Standard Precautions are essential for all healthcare workers.
What are the indications for hand washing with soap and water or alcohol-based hand wash? 	When hands are visibly contaminated or soiled with blood or body fluids or when caring for a patient with *C. difficile*, wash with soap and water. • For general patient care, a non-microbial soap is recommended. • Handwashing with soap and water is most effective if it's done for at least 10-15 seconds. If hands are not visibly soiled, use an alcohol–based hand wash for routine decontamination of the hands. • For invasive procedure (e.g., placing an IV) an antimicrobial soap or alcohol-based hand wash should be used before performing the procedure. For procedures that require a surgical scrub, nails should be kept short (nails flush with the fingertips).
Are artificial fingernails and long nails allowed in the clinical area? 	• No, associates with direct patient contact may not wear artificial fingernails or extenders since they are proven risk factors for colonization of organisms of the hand. • Nail length is important because even after careful hand washing, healthcare workers often harbor substantial numbers of potential pathogens under their nail and fingertips. As per SLRHC dress code policy nail length should be short enough to allow for thorough cleaning underneath the nails and not cause gloves to tear.

What are Standard Precautions?
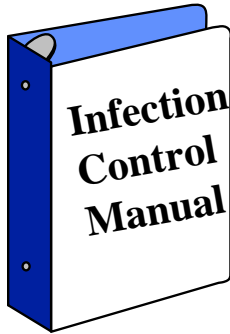 	
Infection Control Manual
	Standard Precautions refer to the way that we handle:
	
	• Blood
	• All body fluids, secretions and excretions, except sweat regardless of whether or not they contain visible blood
	• Non-intact skin
	• Mucous membranes
	
	You follow Standard Precautions when you:
	
	• Wear personal protective equipment (gloves, gown, mask, eyewear) when there is the possibility of contact with blood, body fluids, excretions, secretions, non-intact skin or mucous membranes.
	• Wash your hands with soap and water or use alcohol-based hand wash
	  ➢ between patient care procedures or activities (even with the same patient)
	  ➢ after each patient contact
	  ➢ after removing gloves
	• Prevent needle stick and sharps injuries by using and disposing of equipment properly.
	• Use appropriate hospital disinfectants to clean up and decontaminate spills of blood and body fluids.

What are Transmission Based Precautions?	Transmission Based Precautions are designed for patients who have or who are suspected to have a transmittable illness that requires extra precautions *in addition to Standard Precautions*. These precautions are needed to prevent the transmission of the organism to others. There are three categories of transmission based precautions: • Airborne • Contact • Droplet Standard precautions and these 3 Categories of transmission precautions replace the use of Universal Precautions. The *Infection Control Manual*, which is available on the Hospital Intranet, has a Disease Index with the necessary isolation/precautions category.
How are blood borne pathogens transmitted?	Common ways of blood exposure: • Injection of blood, blood component, or blood containing fluid by a needle stick or cut from a sharp instrument contaminated with blood or blood product • Splash of blood, blood component or blood-containing fluid onto exposed skin which has severe dermatitis, acne, open cuts, wounds or scrapes • Splash of blood, blood component or blood-containing fluid onto mucous membranes such as mouth, eyes, nostrils.

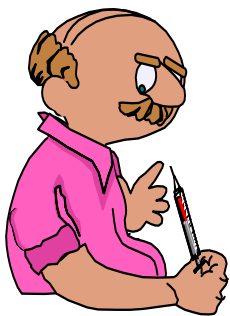|	
What items are considered Personal Protective Equipment (PPE)?	PPE is primarily described as items worn to protect the associate from contracting blood borne pathogens as part of Standard Precautions. PPE to be worn when caring for all patients include: • **Gloves** - to protect hands if there is a chance of exposure to blood or body fluids. • **Mask** - to protect the mouth if there is a chance of blood splatter into the mouth. • **Eyewear** - to protect eyes if there is a chance of blood splatter into the eyes. • **Gown** - to protect clothes if soiling by blood or body fluid is possible.
How can needle sticks be prevented?	Preventing needle stick injuries is every associate's responsibility. Nobody wants to cause an accidental needle stick to himself or anyone else**.** You can prevent needle stick injuries by: • Using safety devices as much as possible. • Discarding needles in the Sharps' Container. • Never overfilling or forcing a needle into the Sharps' Container. • Being aware of "at-risk" situations. (Example: an agitated patient resisting blood drawing.)
What do you do if you experience a needle stick or blood exposure?	If you experience a needle stick or blood exposure: 1. Wash the affected site. 2. Contact your supervisor. 3. During the week, Employee Health Services provides the post needle stick (HBV/HIV) protocol. Late hours, weekend, and holiday exposure incidents as well as needle stick or blood exposure occurring at the RH site will be directed to the Emergency Department (ED). The ***Blood/Body Fluid Exposure Category Worksheet*** is used to manage the exposure incident. 4. Exposure evaluation includes a review of hepatitis B vaccine status, serologic testing or prophylaxis as indicated, and hepatitis C screening. 5. If the source is positive or at high risk for HIV infection, a decision regarding antiviral prophylaxis should be made immediately. **If prophylaxis is elected it should be started as soon as possible, within an hour if possible.** 6. When initial management is done in the ED, an evaluation will follow at Employee Health Service at the SL site on the next business day to review blood tests and provide continuity of care. 7. The number at Employee Health Service is 212-523-2342. If you call this number, you will be told what to do in case of a needle stick.

Latex Allergy

Reports of reactions to latex have risen in recent years, especially among health care workers where latex gloves are widely used to prevent exposure to HIV, Hepatitis B and other bloodborne pathogens. The increase is also the result of more and more latex-containing products and medical equipment in health care facilities and the environment in general. The amount of exposure needed to cause a reaction is not known. Reactions can begin within minutes of exposure, or they can occur hours later. Associates using latex gloves or latex products should be aware of the types of latex reactions both for themselves and their patients.

Allergic Contact Dermatitis	• Caused by exposure to latex and chemicals added to products, such as gloves, during manufacture. • It causes skin reactions similar to poison ivy. • Rash occurs 24-48 hours after contact and may progress to blisters.
Latex Allergy	• A more serious reaction. Begins within minutes but can occur 1 - 2 hours later. It can progress from skin redness, hives or itching to respiratory symptoms including sneezing, running nose, asthma and anaphylactic shock and possible death (rare).
Who is at risk for latex sensitivity/allergy?	Individuals with history of: • general allergies • latex exposure at work • food allergies, especially banana, kiwi, avocado • previous surgical procedures • allergic reactions during anesthesia, surgery, dental work, catheterization, rectal or vaginal exams • congenital abnormalities such as spina bifida which require frequent bladder catheterizations
What items in the healthcare environment contain latex?	Many products contain latex: medical supplies, personal protective equipment, office supplies. Here are a few examples: **Emergency Equipment** **Hospital supplies** **Office supplies** Blood pressure cuffs Catheters Rubber bands Stethoscopes Wound drains Erasers Gloves Injection ports Tourniquets Multidose vials IV tubing Anesthesia masks Electrode pads Endotracheal tubes

EMPLOYEE HEALTH SERVICE

What are Employee Health Service infection control issues?	Employee Health Service provides the following related to infection control: • Annual testing of all volunteers for tuberculosis. • Treatment and follow-up for post needle-stick exposure. • Treatment and follow-up for communicable disease exposure. • Latex allergies. You are responsible for: • Keeping your immunizations up to date. • Obtaining your TB test (PPD). • Reporting if you experience an accidental needle-stick. • Reporting your exposure to communicable diseases.(i.e.: TB, hepatitis A, meningitis).

Employee Health Services provides the volunteer with:
- **assistance with on-the-job injury or illness**
- **PPD testing**
- **return-to-work clearance**
- **regulatory agency compliance requirement services**
- **flu shots**
- **bloodborne pathogen exposure treatment and follow-up**
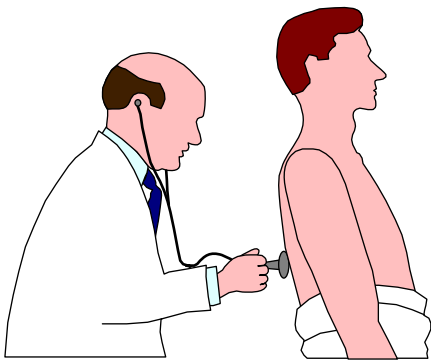
**Employee Health Service
212-523-2342**

Section IV

Patients' Rights

PATIENTS' BILL OF RIGHTS

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

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

Public Health Law (PHL) 2803 (l) (g) Patients' Rights, 10NYCRR, 405.7, 405.7 (a) (l), 405.7 (a) (2)

CULTURAL COMPETENCY

The workforce of St. Luke's-Roosevelt Hospital and the patient population we serve represent many nationalities, races, religious and cultural beliefs. These differences can impact the quality of our communication, the quality of our work environment and the quality of patient care.

Every associate is expected to develop a basic level of cultural competency, enabling him or her to work effectively in cross-cultural situations.

Valuing Workplace Diversity

Workplace diversity refers not only to the different characteristics of associates such as life experience, age, gender, sexual orientation and physical abilities but also work experience, job title, union affiliation, seniority and other workplace related differences. To create an inclusive work environment, one which enables all associates to make a full contribution to the success of St. Luke's-Roosevelt Hospital, all associates are encouraged to:

- ✓ Show respect for one another
- ✓ Engage in open discussions about cultural, racial or other differences
- ✓ Constructively address misunderstandings and conflict.

Associates are encouraged to respectfully address negative behaviors that may occur in the workplace such as:

- ✘ Remarks perceived as offensive or demeaning
- ✘ Unresolved cultural misunderstanding or disagreements
- ✘ Judging cultural beliefs of others
- ✘ Active exclusion of others.

Diversity Charter:
Create a multicultural environment that works for everyone
-
Value and respect each other's contributions to the workplace

Caring for Patients and Families

Providing Culturally Competent Care	
Challenges	Solutions
Patients have different religious and cultural beliefs about health care Patients are at greater risk to some diseases than other ethnic groups Patients are at risk of diseases specific to their ethnic group	Develop skills to better hear what people from different cultures want to communicate to you Learn about the cultures you serve and use that knowledge to provide individualized care to each patient
Patients may be more receptive to care if the environment is familiar and respectful of their culture	Conduct a cultural audit to assess the cultures served by your area. Take actions such as using posters and magazines in waiting areas that reflect the population served, offer appropriate pastoral services, meet dietary requests when possible and hang appropriate signage.
Deaf patients and patients with Limited English Proficiency (LEP) must have access to medical information in their preferred language	Utilize interpreter services properly and provide translated documents when available.

Keep in mind that while it is helpful to learn about different cultures, we do not treat cultures; we treat individuals.
Our Diversity Mission:

To treat each patient as an individual within their own cultural context.

The Human Resource Department has a Diversity Office located at 555 W. 57th St. For more information please contact Pamela Abner, AVP HR at 212-523-3204.

35

PATIENT REPRESENTATIVES

Patients' Bill of Rights	Each patient in a hospital in New York State has rights under the law; they are described in the *Patients' Bill of Rights.* Basically, a patient is viewed as an equal partner in the healthcare process. These are some highlights from the *Patients' Bill of Rights* stating each patient has the right to: • a complete understanding of the diagnosis and treatment; • a foreign language or sign language interpreter; • refuse treatment and know the consequences; • considerate and respectful care, without discrimination; • privacy and confidentiality; • complain about care without fear, and receive a response; • get the telephone number for **NYS Health Department, 800-804-5447,** to register a complaint.
A copy of the Patients' Bill of Rights can be found:	• On every Inpatient Unit. • In the Outpatient/Ambulatory Department. • In the Emergency Department. • In the Admitting Office.
Patient Representative Department	The Patient Representative Department is here to: • assist patients and their families obtain information, understand hospital policies and procedures, exercise their rights under the law, and resolve problems and concerns; • be a vehicle by which patients may voice their grievances and recommend changes in hospital policy. **St. Luke's 212-523-3700** **Roosevelt 212-523-7225**
How can you demonstrate respect for patients' rights?	• Identify yourself to the patient by name and position. • Explain your role in the care of the patient to the patient. • Listen to patients and answer their questions. • Identify problems early and refer them to your supervisor or to a Patient Representative. • Respect a patient's need for privacy and confidentiality. • Assess each patient for possible special needs, and do what you can to meet them. • Obtain interpreter assistance if the patient has special communication needs (see page 42).

ETHICS COMMITTEE

When difficult treatment decisions must be made, patients, families, physicians and any member of the health care team may seek the advice of the Hospital Ethics Committee.

To contact the Ethics Committee for an issue at St. Luke's-Roosevelt Hospital Center call: 212-523-3700 to leave a message.

ADVANCE DIRECTIVES

Important questions may arise about the type and duration of treatment of a patient who becomes too ill to speak for him/herself. Under the law, patients can make known their wishes for future treatment by means of **advance directives**. These can be in writing, such as a **Health Care Proxy,** a **Living Will**, or **Do Not Resuscitate (DNR) orders**, or they can be expressed orally.

Written advance directives are far preferable and provide legally acceptable proof of the patient's wishes.

New York State Law requires that all hospitalized patients be given the opportunity to complete an advance directive. The *Health Care Proxy* is given to each patient on admission. The Nurse, Patient Representative or Social Worker can provide a patient with information regarding the *Health Care Proxy* or any other advance directive.

CONFIDENTIALITY

The Patients' Bill of Rights and the HIPAA laws both ensure patient confidentiality. Also, New York State passed a law guaranteeing confidentiality to all persons related to **HIV status** and **HIV testing**. If HIV information is released without proper authorization, the individual can be charged with a misdemeanor and fined up to $5000.

Do not share computer passwords.

Do not discuss any patient information in public areas such as elevators, hallways, cafeterias, or hospital jitneys, or with:

- one patient about another.
- relatives and friends of the patient (*unless officially authorized*).
- visitors to the hospital.
- representatives of the news media.
- other staff except when in a conference.
- your own relatives, friends and/or neighbors.

RECYCLING CONFIDENTIAL INFORMATION

Continuum Recycles Protected Health Information (PHI)

The Health Insurance Portability and Accountability Act (HIPAA) of The Federal Office of Civil Rights requires health care facilities to establish written policies and procedures for implementation of privacy and security measures. In other words, our patients have a right to the privacy of their health information. So if we throw away any office paper that contains protected health information (PHI), we have to ensure its security and ultimate destruction.

Locked versus unlocked bins

Unlocked recycling bins are used for paper recycling in those areas that are **inaccessible** to patients and public. Whether paper waste is newspaper, magazines, junk mail or Protected Health Information (PHI), all paper recyclables go into a blue recycling bin. Locked bins are for the same exact material, that is, both Personal Health Information and regular paper recyclables, but the locked bins are in final storage areas and in areas that are **accessible** to patients/visitors.

For More Information…

The HIPAA-compliant recycling policy is found in the *Environment of Care Manual* under Section 5 – Hazardous Materials and Waste Management.

What is Protected Health Information (PHI)?

What is the definition of confidential waste?

Protected Health Information is anything that contains:

- Patient Name and/or address
- Names of relatives
- Names of employer(s)
- Birth date
- Telephone number
- Fax number
- Email address
- Social security number
- Medical record number
- Health plan beneficiary number
- Account number
- Certificate and/or license number
- Any vehicle or device serial number
- Web URL
- Internet protocol address
- Finger or voice print
- Photographic images
- Any other unique identifying number, characteristic or code (whether generally available in the public realm or not.)

For pick-up requests, in-service information or for additional bins contact Environmental Services:

- **St. Luke's – 212-523-2489**
- **Roosevelt Hospital – 212-523-7001**

FINANCIAL ASSISTANCE

All Continuum hospitals help the uninsured or the underinsured through our financial assistance policy. Those patients who lack health insurance or the financial resources to pay for quality health care services have the opportunity to apply for financial assistance.

The Financial Assistance Policy:

- Patients will have access to information regarding charges for hospital services.

- Our associates will first assist in determining eligibility for government sponsored programs.

- Patients who do not qualify for government sponsored programs may apply for the programs that are offered through our hospitals.

- *The Policy applies to hospital charges for medically necessary in-patient elective/emergent/urgent care, ambulatory surgery, out-patient emergency, clinic, and referred ambulatory services within our coverage areas. All patients are eligible to apply for Emergent/Urgent care. In addition, all patients living in the 5 boroughs of NYC are eligible to apply for Elective services.*

- *The Policy excludes deductibles, co-payments and co-insurance imposed by third party payors on hospital claims.*

- Our Policy gives all patients the opportunity to apply for a full or partial discount on *their hospital bills.*

- The Department of Financial Counseling will determine eligibility based on a patient's family size, income and resources.

- Patients who have completed the Financial Assistance Policy application process will qualify for a prompt-pay discount or an extended payment plan, based on a patient's ability to pay.

Patients inquiring about financial assistance for In-patient services should be directed to **the Department of Financial Counseling**. *Patients inquiring about financial assistance for out-patient services should be directed to* **the HEAL Center**. *Eligibility for discounts, and/or payment plans will be made by DFC or HC.*

If a patient needs access or information about any of our Financial Assistance Programs, please direct them to one of the following location.

Roosevelt Hospital:
1000 Tenth Avenue at 58th Street
New York, NY 10019
Phone: (212) 523-7816
Fax: (212) 523-8143

St. Luke's Hospital:
1111 Amsterdam Avenue at 114th Street
New York, NY 10025
Phone: (212) 523-2552
Fax: (212) 523-5620

HEAL Program:
1111 Amsterdam Avenue
Room Clark 10B
New York, NY 10025
Phone: (212) 523-3900
Fax: (212) 523-3955

1000 Tenth Avenue
Room 1M
New York, NY 10019
Phone: (212) 523-5632

LANGUAGE ASSISTANCE

It is Continuum's policy to provide our patients with free, trained medical interpreters to eliminate language as a barrier to quality health care. Aside from this policy being part of our mission to provide excellent medical care for the communities we serve, it keeps us compliant with the Executive Order 13166 "Improving Access to Services for Persons with Limited English Proficiency".

Each institution has been developing their own Language Assistance initiatives. These resources may include:

- Staff interpreters
- Volunteer interpreters
- Independent contractors
- The Language Line (telephone interpretations)
- Language cards and posters
- ASL Videoconference rovers

How do I know if a patient needs an interpreter?
Appropriate phrasing to determine patient's needs should be utilized at all times. Statements such as: " in which language do you prefer to communicate" are correct.
DO NOT ASK: "Do you speak English?"

What is the procedure to get an interpreter?

Monday through Friday between 9:00 AM and 5:00 PM at SL call:
- For Spanish Interpreters only page 3-3853
- For other languages call extension 23-2187

Monday through Friday between 9:00 AM and 5:00 PM at RH call:
- For Spanish Interpreters only page 3-7155
- For other languages call extension 23-2187

At all other times or if the interpreter is not available
- Call the Language Line at extension 36-5096 and give SLRHC ID # 202266

What services are available for hearing impaired patients?

- **Monday-Friday 9:00 AM to 5:00 PM,** to schedule an ASL interpreter (at least 24 hrs. in advance) or for emergency and walk –in requests call 23-2187.
- **All other times call 23-5678**

The ASL Videoconference rovers are located at the ED and at the Admitting Department.

PATIENT EDUCATION

Every associate has a responsibility to teach or explain things to patients. SLRHC has many resources to help you with this important job. They include:

1. Printed Material
- Over 250 Health Guides in English and Spanish
  These cover diagnostic tests, health problems, and treatments
- *A Patient's Guide to Surgery at St. Luke's –Roosevelt Hospital Center*
  21-page booklet in English and Spanish
- Health Information Resource Directory
  List of community resources for many types of health problems
- *Speak Up!*
  A booklet to encourage patients to ask questions and Speak Up!

2. Hospital Intranet:
- **All Health Guides posted for entire hospital center to use.** To access Intranet: (You will need Internet access and Adobe Acrobat Reader) Click on Internet Explorer and type in http://intranet.chpnet.org. This will open the Continuum home page. Click on "Clinical" bar and then "Health Guides". You will find an alphabetical list of Health Guides.
- **Lexi comp online for medication information**. Type in Medication Name; click search

3. Closed Circuit TV for patients/ families: All are free
- Channel 71 – English programs - 15 hours/day
- Channel 72 – Spanish programs - 15 hours/day
- Newborn Network for new parents (channel 65 English and 66 Spanish)
- On-demand TV- Patient education programs available on TV in patient rooms. First TV screen explains how to use it. Free service. Programs in English and Spanish

4. Continuum Health Partners Internet web site (www.wehealny.org)
- General information about hospital departments/ services
- Physician directory
- General health information

5. Parent-Family Education classes
  Over 27 different classes for expectant and new parents. For more information call 212-523-6222.

For more information contact: Judith Nierenberg (212-523-8595), Patient Education Manager or Grace Phelan (212-523-8575), Patient Education Coordinator, Department of Nursing.

HEALTH LITERACY AND PATIENT SAFETY

A recent government study estimates that over 89 million American adults have limited health literacy skills. Other research shows that nearly 50% of American adults have difficulty understanding and using health–related information.

What Exactly is Health Literacy?

Health literacy is more than a buzzword in health care today. *It is the ability to read, understand and act upon health-related information.* Health literacy is important to ensure patient safety. It includes writing, listening, speaking, arithmetic and conceptual knowledge. Even well educated people with strong reading and writing skills may have trouble understanding a medical form or instructions regarding a drug or procedure.

Costs of Low Health Literacy

Poor health literacy is associated with higher rates of hospitalization, more medication errors, less ability to comply with treatments and a higher mortality rate. Studies also show that people from all ages, races, income and education levels are challenged by this problem. Additional risk factors that may impact the rate of poor health literacy include:

- ✓ Advanced age
- ✓ Low educational level
- ✓ Poverty
- ✓ Inability to read
- ✓ Learning disabilities
- ✓ Lack of English proficiency

How Health Care Professionals Can Help

To know how to educate patients one needs to have a grasp of the patient's health literacy skills and this is not always obvious. Patients are hesitant to let it be known that they cannot read or understand questions or written communications.

SLR has adopted a "universal precautions" approach which requires associates to use language that is easy to understand and free of jargon and/or abbreviations when communicating with patients.

The "universal precautions" approach requires the following:

1. Making effective communication an organizational priority to protect the safety of patients

- Train all staff to recognize and respond appropriately to patients with literacy and language needs.

- Use well trained medical interpreters for patients with low English proficiency.

2. Addressing patients' communication needs across the continuum of care

- Use plain language. Examples of plain language would be to use words such as "sore" instead of lesion or "bad" instead of "adverse". Simplify documents by using conversational language to get the point across without jargon.

- Use "teach back", asking the patient to explain to you what you just taught him in his own words.

- Position yourself to face the patient when talking with him. Establish eye contact.

- Limit information to two or three important points at a time. What is my main problem? what do I need to do? and why is it important for me to do it?

- Keep it simple and slow down.

- Use drawings, models or devices to demonstrate points.

- Repeat information often. Reinforce with print material.

- Encourage patients to ask questions. You can get feedback that way.

- Regularly place outreach calls to patients to ensure understanding of, and adherence to, the self-management regimen.

- Redesign the informed consent process to include forms written in simple sentences and in the language of the patient.

Be creative and innovative when providing your patients with health information and keep it simple. And, be sure that they understand.

PAIN

Many of our patients who come to our facilities have pain. **ALL** associates, not just patient care providers, have a role to play in effective pain management.

WHAT IS PAIN?

- Pain is whatever the person experiencing the pain says it is. It is important to remember that we all experience pain differently.
- Pain may be expressed differently within different cultures.
- Pain is personal and can vary in intensity and severity.
- Pain can be acute (e.g., after an operation, fracture, or with an infection) or chronic (e.g., long term pain associated with cancer or persistent back pain).
- Pain can be expressed in different ways such as verbally (saying "It hurts!" or moaning) and non-verbally (crying or grimacing).

PAIN IS MORE THAN HURT. IT MAY LEAD TO:

- Depression, fear, and anxiety
- Weakness, fatigue, or confusion
- Loss of self-esteem
- Strained interpersonal relationships
- Disrupted sleep-wake cycles
- Decreased ability to work and enjoy social activities and family

SOME TIPS FOR ASSISTING OUR PATIENTS IN PAIN

- All associates can promote a healing environment for our patients by limiting noise, clutter, and disruption.
- If you see or hear someone in pain, alert the patient care providers.
- Patient care providers may use various pain rating scales to help the patient assess his/her pain. There are scales available for children and patients who do not speak English. Documents with pictures of faces indicating how much pain a patient is in are available to use.
- All patient care providers should always be aware of pain and what is being done for it for all patients.

VICTIMS OF ABUSE, NEGLECT, OR EXPLOITATION

As associates in a healthcare institution, we are all responsible for recognizing and taking care of possible victims of abuse, neglect, or exploitation.

The following are some indicators for identifying victims:

Signs of Physical Abuse
- Multiple injuries such as bruises, welts, and bite marks, in various stages of healing
- Repeated visits to the ER and/or injuries that cannot be accounted for claimed as accidental, and suspicious in nature
- Burns, resulting from scalding water, irons, ropes, or cigarettes
- Victim appears fearful of guardian or caretaker

Signs of Emotional Abuse
- Sudden changes in self-confidence
- Anxiety which can be mild or severe
- Abnormal fears, increased nightmares

Signs of Sexual Abuse
- Difficulty in walking or sitting
- Abdominal pain, bedwetting, urinary tract infection, genital pain or bleeding, and sexually transmitted disease especially for preteens and the elderly
- Finding foreign objects in vagina or rectum

Signs of Neglect
- Chronic health problems both physical and mental
- Signs of malnourishment (e.g. sunken eyes, loss of weight)
- Consistent hunger and poor hygiene

Signs of Exploitation
- Inability to pay bills for basic needs despite adequate income and resources
- Bills for expensive items not likely to be used by the victim
- Anxiety or lack of knowledge about own financial affairs
- Workplace injury obtained by an under age minor

If you suspect that a patient may be a victim of abuse, neglect, or exploitation, what should you do?

If the patient is an adult patient (over the age of 18):

- If the patient is on a patient care unit, notify the Nurse Manager and then he/she will notify a Social Worker.
- If the patient is in an ambulatory or an off site clinic, notify the Supervisor. The Supervisor will then notify the designated Social Worker or the Department of Social Work.
- If the patient is in the Emergency Department, notify supervisory staff who will contact the social worker for the area. After 5:00 PM, call the page operator who will contact the social work manager on call.
- Currently, there are no mandatory reporting laws for family mistreatment of the elderly (age 65 and above).
- NYS does have mandatory reporting for abuse occurring in a nursing home, hospital, or other institutional setting, i.e., DOH.
- Cases of suspected abuse (for persons 18 years of age or older), including elder abuse, occurring in the community are referred to Adult Protective Services (NYC HRA office).
- SLR Crime Victims Treatment Center (212-523-4728) is a resource for referral and/or consultation.

If the patient is a child (up to age 18):

- New York State law requires a mandated reporter (see box below) that suspects or has reason to suspect that a child up to age 18 is being abused and/or maltreated report his/her suspicions, **personally**, to the New York State Central Register.
- Prior notification to supervisory/social work staff is not required of mandated reporters.

SLRHC POLICY ON
CHILD ABUSE/NEGLECT/SEXUAL ABUSE

New York State enacted significant revisions to the requirements for reporting child abuse in 10/07. Among other changes, mandated individual reporters (i.e., physicians, house staff, nurses, social workers, health care professionals, including hospital personnel engaged in the admission, examination, care or treatment of children up to age 18, etc.) must now report suspected child abuse, *personally*, to the Statewide Central Register (SCR) at 1-800-635-1522.

Typically, hospital staff communicated their suspicions of child abuse to social work, who in turn reported the case to the SCR. However, the recent revisions to state law requires hospital staff who are individual mandated reporters and who have direct knowledge of any allegations of child abuse, to now *personally* make a report to the SCR and then notify supervisory staff/social work that a report has been made.

Social work staff is then responsible for subsequent internal administration necessitated by the report. Employees and medical staff are no longer relieved of reporting by informing the "hospital".

Additionally, the hospital is prohibited from imposing any conditions (i.e., including prior notification) upon a member of the staff mandated to report suspected child abuse.

The complete procedure concerning child abuse and maltreatment can be found in the Administrative and Social Work Manuals.

END OF LIFE CARE

EVERY patient who enters the St. Luke's-Roosevelt Health Care System must receive information and counseling, if needed, concerning use of ADVANCE DIRECTIVES.

As part of the admission process, the patient is given a packet containing the booklet, *Your Rights as a Hospitalized Patient,* which contains the NY State Healthcare Proxy (This is available on every patient care unit). Out-patients receive a packet with the Patients' Bill of Rights and the Health Care Proxy. The information in this booklet is reviewed with the patient and the patient is then given an opportunity to discuss their questions and concerns with a staff member.

When we ask patients if they have an Advance Directive, what exactly do we mean?

An advance directive is a mechanism through which patients can articulate their treatment preferences in the event they lose the capacity to make decisions. Patients can select an authorized surrogate decision-maker in advance of a time when they may no longer be able to make their wishes known. Advance directives can be used to clarify what treatments patients do want as well as what treatment they do not want.

Examples of Advance Directives include:

- *Health Care Proxy: A document in which a patient appoints a legally authorized surrogate decision-maker, called the health care agent, in the event the patient loses the ability to make his/her wishes known.*

- *Living Will: A document patients can use to express their treatment preferences to be followed when they have lost their ability to be involved in the treatment decision-making process.*

- *Oral Advance Directive: A spoken statement made by the patient, prior to loss of decision-making capacity, which clearly reflects the patient's preferences about specific treatment options. Any oral statements made by a patient during their hospitalization must be fully documented in the medical record.*

- *Do Not Resuscitate (DNR) Order: Patients and their surrogate decision makers also have the right to ask for a DNR order if they would not want cardiopulmonary resuscitation attempted in the event they experience a cardiac or pulmonary arrest. Consent for a DNR order is given by the patient, health care proxy agent, or next of kin when a patient has lost decision-making capacity. This consent for the DNR order is obtained by the attending physician, and must be reassessed every 7 days while a patient is hospitalized. A non-hospital DNR can be obtained for discharged patients.*

Section V

Performance Improvement

Risk Management

QUALITY IMPROVEMENT

Continuous Quality Improvement (CQI) is a system in which individuals or teams in the health care system look for ways to do things better.

Why is a Quality Improvement (QI) program needed?	A QI Program is needed because: • it defines a systematic mechanism and organization-wide program to measure, improve, and deliver quality patient care and services; • it promotes a multidisciplinary/comprehensive approach in which data are used to monitor and evaluate patient care, improve communication between health care providers and patients, improve patient safety, and reduce medical/health care errors/adverse outcomes • it allows for open discussions about how things work in the hospital and how the functioning of these areas affect patient care and views; • it provides a method of how to measure the care we deliver to our patients and the outcome of the services; • it helps to improve the overall performance of the hospital; and • it helps to assess and evaluate any new or changed processes that are designed to meet the needs and expectations of the patients.
What is quality and how can it be measured?	Quality is determined by meeting or exceeding the patient's needs and expectations. Quality can be measured by evaluating outcomes such as: • patient satisfaction, and • how well the patient did during and after his/her hospital stay. Remember, a hospital would not exist without patients. Quality standards are also determined by various regulatory agencies, such as: The Joint Commission, New York State Department of Health (DOH), Occupational Safety and Health Administration (OSHA), Centers for Medicare and Medicaid Services (CMS) etc.

How are QI activities to be monitored selected?	Activities to be monitored are selected in various ways, such as: • according to the mission, vision and values of the hospital; • community needs; • patient safety • needs and expectations of patients and families; • input from medical staff and employees; • whenever there is a change in operational policy or procedure; • high volume and high risk diagnoses/procedures/processes; In addition we monitor care of the patients with ***Acute Myocardial Infarction, Congestive Heart Failure and Pneumonia.*** The data on care of these patients are publicly released for comparison with other hospitals at: www.hospitalcompare.hhs.gov.

What is the QI process at SLRHC?	At SLRHC **ACES** is the framework for QI:
	    Assess the process
	    Collect and analyze data
	    Evaluate and implement solutions
	    Sustain improvement
	
	• An activity to be monitored is identified.
	• Designated associates collect the data in the unit or department.
	• Appropriate departmental associates or committee analyze and track data. An improvement plan is developed if the data do not meet the set goal(s)
	• This information is aggregated and reported in the monthly or quarterly departmental QI report. The report is forwarded to the Department of Quality Initiatives.
	• The QI Department reports the outcomes of selected QI activities to the Quality and Performance Improvement Committee (QPIC).
	• QPIC reports the results to the Medical Board and Board of Trustees.

How can staff find out the results of QI activities?	The way results are communicated to the associate may vary from unit or department. In general, the results can be discussed during staff meetings; posted in the staff lounge area; or placed in a binder/book and made available in the unit or department. Each associate should ask his/her immediate supervisor about the QI activities in his/her area **and be familiar with the QI program in his/her department/area.** If an associate is involved in a QI Team/Committee, he/she should bring back the information to his/her unit or department.

LET'S STAY ON TARGET FOR QUALITY PATIENT CARE!

CORE MEASURES

There is an increased demand by the public for accountability in health care delivery. Therefore the federal government and other regulatory agencies have developed performance measures to see how well a hospital is caring for its patients.

The Joint Commission and the Center for Medicare Services (CMS) have started the ORYX Core Measure Initiative to help hospitals measure their performance and ultimately, to improve the care they provide. As part of the ORYX Initiative, The Joint Commission accredited hospitals, such as St. Luke's-Roosevelt, must collect and report data on specific performance measures. These performance measures are based on treatments that are evidence based.

The ORYX Core Measure Initiative allows The Joint Commission and CMS to review data trends and to work with hospitals as they use the information to improve patient care.

Currently, accredited hospitals collect and submit performance data on the following:

1. Acute MI (heart attack)
2. Heart Failure
3. Community Acquired Pneumonia
4. Surgical Care Improvement Project
5. Outpatient Surgery (as of April 2008)

The performance of SLRHC is measured and compared to all other institutions in the above four areas. In the future, our funding will be related to our performance in these areas (Pay for Performance).

Results of data collected are publicly reported and may be reviewed by healthcare consumers on two web sites:

www.jointcommission.org (click on Quality Check)

www.hospitalcompare.hhs.gov

PROFESSIONAL MISCONDUCT & IMPAIRED HEALTH PROFESSIONAL

Some of the main examples of professional misconduct include:
- Engaging in substance abuse or practicing the profession while impaired by alcohol, drugs, physical disability or mental disability
- Verbally or physically harassing, or abusing or intimidating a patient or employee
- Refusing to care for a person because of race, color, religion, national origin, sexual orientation, or ability to pay
- Breaching confidentiality
- Failing to tell the patient who will be involved in their non-emergency procedure or surgery
- Performing services which have not been authorized
- Failing to respond to the Department of Health
- Abandoning or neglecting a patient
- Failure to maintain proper patient records
- Engaging in fraudulent activity in obtaining a license or in practice
- Permitting or aiding an unlicensed professional to perform activities that only a licensed professional can do
- Making false reports or failing to file reports
- Failing to give patients copies of documents which they request or failing to help them fill out insurance forms.

The decision about whether professional misconduct has occurred should be made by the Legal Department in consultation with hospital administration. If any associate observes or suspects professional misconduct on the part of any professional, that associate must immediately report the circumstance and the facts upon which it is based to any of the following:
- His/her supervisor
- Risk Management
- Legal Department
- Department Chair of the provider (physicians, dentists, podiatrists, house staff)
- Corporate Compliance Hotline (1-800-692-2353)

Any supervisor who receives a report of professional misconduct or provider impairment must promptly relay it to Legal Department or the Chief Medical Officer.

OCCURRENCE REPORTING

New York State Public Health Law requires all hospitals to have an incident reporting system.

SLRHC has an occurrence reporting system which requires us to document and report any activity or condition within the Hospital Center that is not consistent with safe practice or safe environment and which compromises or has the potential to compromise the welfare of patients, visitors and/or associates.

The responsibilities of the person witnessing or discovering an occurrence are:

>   1. Call the physician or nurse immediately.
>   2. Remain with the patient, but do not move the patient.
>   3. Report what happened.

A few examples of when an occurrence report should be completed are: falls, medication errors, elopement, spills and burns.

The healthcare professional will evaluate the situation and proceed as indicated. An occurrence reporting form must be completed and submitted to Risk Management in a timely manner, preferably within 24 hours.

VOLUNTEER ACCIDENT REPORTING

If you are injured while on duty or you contract an illness as a result of your assignment, you should do the following:

- Report the incident immediately to your supervisor (This includes sharps or needle stick injuries, and TB conversions.)
- With your supervisor, complete the "Employee Accident Report" form (#30010)
- Remember to print hard and write legibly (this is a multi-part form)
- Remember to request a copy of this form and keep for your own records
- Submit the form within 48 hours to Human Resources for prompt response and evaluation

Make sure all boxes in the form are filled out, especially:
Age or Date of Birth
Social Security Number
Time of your Start of Shift
Date Hired
(This information is required by OSHA.)

On the employee form, the bottom half contains a section that should be completed by the volunteer, and returned to safety. It is very important that the volunteer submit to Safety information on any time lost, medical attention received, and if any prescription dose medications were prescribed due to this incident. This helps us report accurate data to OSHA, and track and trend issues effectively.

If you are seriously injured on the job, report directly to the Emergency Department. It is your responsibility to call, or have someone call on your behalf, your direct supervisor to inform them of your accident

Any worker compensation claims are handled through the HR department. Contact them if you need assistance or want information, 212-523-3033.

TEAMWORK

Using a TEAMWORK approach is one of the best ways we can all improve performance.

Elements of effective teamwork are commitment, common purpose, organization, interdependence, and strong leadership.

WHAT ARE SOME EXAMPLES OF HOW WE WORK AS A TEAM?

- When we care for our patients, each member of the patient care team (physician, nurse, nursing assistant, physical therapist, dietitian, etc.) contributes to the overall care. All of the members of the patient care team communicate with each other (in person or in writing) so that all know what each member is doing. This contributes to the most efficient care for the patient.

- When we respond to emergencies, we respond as a team and each member has specific tasks to perform.

- When a department has been assigned a large job to complete, the work is divided up among the members of the department so that the job can be finished quickly and accurately.

- When we work together on Quality Improvement Initiatives – for example, increasing patient satisfaction or decreasing medication errors.

THERE ARE MANY ADVANTAGES TO WORKING AS A TEAM:

- Teamwork uses everyone's skills and expertise

- Work is accomplished more efficiently

- Teams offer the opportunity to learn from each other

WHEN DO WE TRAIN AS A TEAM?

- Mock codes
- Fire drills
- Infant abduction drills
- Other _____(think of an example from your department)

Section VI

Patient Safety

PATIENT SAFETY

SLRHC is committed to providing safe, high quality patient care. Maintaining an environment that ensures safety for patients, families, visitors and associates is critical if SLRHC is to be recognized as the provider of choice on Manhattan's West Side. To accomplish this, SLRHC not only has to have safety systems in place, but also needs the participation of all associates in recognizing and reporting risks and concerns to patient and associates safety and medical/healthcare errors. This reporting hopefully will effect changes that raise the bar for patient and associates safety at SLRHC.

WHAT IS ALREADY IN PLACE AT SLRHC TO ENSURE PATIENT AND VOLUNTEERS' SAFETY?

- Policies and Procedures : Administrative, Departmental, Environment of Care, Human Resources, Attendings and House Staff
- Competency Assurance Programs
- Hospital wide and department specific training programs
- Corporate Compliance Program (see Section IX)
- Risk Management Programs (see Section V)
- Quality Improvement Programs (see p. 52)
- Employee Health Service Programs (see p. 31)
- Facilities Management Programs:
  Security, Engineering, Biomedical, Engineering, Safety, Waste Management (see Section II)
- Emergency Preparedness Programs (see p. 12- 13)
- Infection Control Programs (see Section III)
- Patient Relations Program (see p. 36)
- Medication Use Safety Improvement Committee (MUSIC)
- Safe Babies/Safe Haven Program

IF A VOLUNTEER HAS A SUGGESTION RELATED TO REDUCING OR ELIMINATING A POTENTIAL UNSAFE CONDITION OR PRACTICE, WHAT CAN BE DONE?

- Speak with his/her manager.
- Call the Quality Improvement Department 212-523-2158.
- Submit ideas in writing related to reducing blood exposures to Dr. Bruce Polsky, Chairman, Infection Control Committee.
- For unsafe condition, contact Environment of Care Committee (Yvonne Guariglia, Director of Safety, 212-523-2050).

IF A VOLUNTEER CAUSES OR WITNESSES HARM, POTENTIAL RISK, OR HAS ANY CONCERNS ABOUT THE SAFETY OR QUALITY OF THE CARE PROVIDED, WHAT CAN BE DONE?

- Speak with his/her manager.
- Call the QI Department 212-523-2158.
- Contact Risk Management 212-523-5663.
- Contact the Corporate Compliance Officer (Lou Schenkel, 212-523-2162) or Corporate Compliance Hotline (1-800-692-2353).
- Call the Quality Improvement Department 212-523-2158.

> - **Concerns may be reported directly to the**
>   **<u>Joint Commission</u>**
>   **by calling 1-800-994-6610 or**
>   **by sending an e-mail to**
>   **complaint@jointcommission.org**

WHAT ROLE DO ALL VOLUNTEERS PLAY IN PROMOTING PATIENT AND STAFF SAFETY?

- Strict adherence to **ALL** SLRHC policies and procedures
- Case finding and reporting of potential or actual unsafe conditions or practices
- Completing and forwarding occurrence reports to Risk Management

> **NO DISCIPLINARY ACTION WILL BE TAKEN FOR ANY REPORT MADE IN GOOD FAITH.**

2009 NATIONAL PATIENT SAFETY GOALS

Medical errors are one of the nation's leading causes of death and injury. A report by the Institute of Medicine estimates that as many as 44,000 to 98,000 people die each year as the result of medical errors. Beginning in 2003, The Joint Commission has enforced national patient safety goals for healthcare organizations to strive for in order to increase patient safety.

The following are the **nine** national patient safety goals and one universal protocol for 2009. New Requirements are indicated in **bold and underlined.**

1. IMPROVE THE ACCURACY OF PATIENT IDENTIFICATION
- Use at least two patient identifiers (neither to be the patient's room number) whenever administering medications or blood products; taking blood samples and other specimens for clinical testing, or providing any other treatments or procedures. **Containers used for blood and other specimens are labeled in the presence of the patient.**
- **Eliminate transfusion errors related to patient misidentification.**

HOW DOES SLRHC ACCOMPLISH THIS GOAL?
- We use patient **name** and **date of birth** to confirm the correct patient.
- Administrative Policy, *A2-107: Patient Identification* requires that all patients are properly identified prior to any care, treatment, or services. In the event of an emergency, patients that are unable to provide identifying information will receive treatment prior to identification, if such care is necessary to stabilize the patient's condition.
- Blood Bank and Transfusion Service Policy, *Requirements for Patient Samples and Requests* and Patient Care Services Policy, *Blood Product Administration* require that patients are properly identified prior to dispensing and administering blood and blood products.

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2. IMPROVE THE EFFECTIVENESS OF COMMUNICATION AMONG CAREGIVERS
- Implement a read-back policy when taking verbal/telephone orders or critical test results.
- Standardize abbreviations, acronyms and symbols used. Prohibited abbreviations may not be used.
- Improve the timeliness of reporting and timeliness of receipt by the caregiver of critical test results/values.
- Implement a standardized approach to "hand-off" communications, including an opportunity to ask and respond to questions.

HOW DOES SLRHC ACCOMPLISH THIS GOAL?

- Clinical staff with authority to take verbal or telephone orders or critical test results are required to read orders back to the practitioners, and the critical test

results back to the department reporting the results.
- ▪ Refer to Administrative Policy, *A2-121: Reporting of Alert Values* and Patient Care Services Policy: *Verbal and Telephone Orders*.
- ▪ SLRHC has a list of unapproved abbreviations, which is in the front of every patient's medical record and is posted on all patient care units.
  Read more about unapproved abbreviations on page 68.
- ▪ Administrative Policy, *A2-126: Standardizing "Hand Off" Communications Between Healthcare Providers* requires that there be communication (verbal or written) between staff about a patient's care, treatment, service needs, and current condition when responsibilities are "handed off" from one provider to another.

3. IMPROVE THE SAFETY OF USING MEDICATIONS

- • Identify, and at a minimum, annually review a list of look-alike/sound-alike drugs, and take action to prevent errors involving the interchange of these drugs.
- • Label all medications, medication containers (e.g. syringes, medicine cups, basins), or other solutions on or off the sterile field in perioperative and other procedural settings.
- • Reduce the likelihood of patient harm associated with the use of anticoagulation therapy.

HOW DOES SLRHC ACCOMPLISH THIS GOAL?
- ▪ The Pharmacy and Therapeutics Committee has established standard concentrations of drugs that are available to patient care units.
- ▪ Pharmacy has developed a list of look-alike/sound-alike drugs. Pharmacy has re-organized the way these drugs are stored.
- ▪ Staff in the perioperative and procedural settings label all medications containers used on the sterile field.
- ▪ Refer to Perioperative Services Policy: *Medication on the Sterile Field*.
- ▪ Evidence-based guidelines on anticoagulation therapy are currently being developed. Revised guidelines will be disseminated to all clinical practitioners in the near future.

4. REDUCE THE RISK OF HEALTH CARE-ASSOCIATED INFECTIONS

- • Comply with current World Health Organization (WHO) Hand Hygiene Guidelines or CDC hand hygiene guidelines.
- • Manage as sentinel events all identified cases of unanticipated death or major loss of function associated with a nosocomial infection.
- • **Implement evidence-based practices to prevent health care-associated infections due to multidrug-resistant organisms.**
- • **Implement best practices or evidence-based guidelines to prevent central line-associated bloodstream infections.**
- • **Implement best practices for preventing surgical site infections.**

HOW DOES SLRHC ACCOMPLISH THIS GOAL?
- The Infection Control Dept. has placed alcohol-based hand cleansing solutions in designated patient care service areas.
- Signs are posted as a reminder to wash hands, and literature on the importance of hand hygiene is distributed to patients.
- The Hand Hygiene Team monitors compliance with hand washing and provides feedback to staff.
    - Refer to Infection Control Policy: *Hand Washing.*
- All nosocomial infections that result in death or permanent loss of function are reported to Risk Management and Quality Initiatives Depts.
- The Medical Board Committee on the Prevention and Control of Infection provides oversight and assures adherence to evidence-based practices for prevention of health-care associated infections.

Read more about our Infection Control Program on page 27.

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5. ACCURATELY AND COMPLETELY RECONCILE MEDICATIONS ACROSS THE CONTINUUM OF CARE

- There is a process for comparing the patient's current medications with those ordered for the patient while under the care of the organization.
- The patient's most current reconciled medication list is communicated to the next provider of service, either within or outside the hospital. Note: When the next provider of service is unknown or when no know formal relationship is planned with a next provider, giving the patient or family the list of reconciled medications is sufficient.
- **Upon discharge, a complete and reconciled list of the patient's medications is provided to the patient and, as needed, the family, and the list is explained to the patient and/or family.**
- **In settings where medications are used minimally, or prescribed for a short duration (i.e, in the ED, outpatient Radiology, Ambulatory Care), modified medication reconciliation processes are performed.**

HOW DOES SLRHC ACCOMPLISH THIS GOAL?
- Licensed Independent Practitioners (LIPs) are required to reconcile patients' current medications, at a minimum - on admission, on transfer between services, and upon discharge.
- A complete list of the medications to take at home is given to patients on discharge.
- Refer to Administrative Policy, A2-137: *Medication Reconciliation.*

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6. REDUCE THE RISK OF PATIENT HARM RESULTING FROM FALLS

- Implement a fall reduction program including an evaluation of the effectiveness of the program.

HOW DOES SLRHC ACCOMPLISH THIS GOAL?
- On admission and at regular intervals during the hospital stay, nurses identify patients at risk for falling using a Fall Risk Assessment tool.
- ALL patients are instructed to use the call light for assistance and to wear non-slip footwear.
- The Nursing Dept. collects and analyzes data on patient falls and subsequent injuries in order to evaluate the effectiveness of the program.
- An interdisciplinary Falls Task Force develops action plans based on these findings.
  - Refer to Patient Care Services Policy: *Fall Prevention*.
  Read more about our Fall Prevention Program on page 69.

7. ENCOURAGE PATIENTS' ACTIVE INVOLVEMENT IN THEIR OWN CARE AS A PATIENT SAFETY STRATEGY

- Identify the ways in which the patient and his or her family can report concerns about safety and encourage them to do so.

HOW DOES SLRHC ACCOMPLISH THIS GOAL?
- On admission to the hospital, patients are provided with the *Speak Up!* brochure which encourages patients to get involved in their own health care by speaking up if they have questions or concerns. *Speak Up!* posters, in English and Spanish, have been placed throughout the hospital.
- The patient safety video *Teaming Up for Patient Safety* is available on the hospital TV channel. The video, available in English and Spanish, encourages patients to be aware of their own safety needs while hospitalized.
- Patient Representatives are available to assist patients resolve problems and concerns and serve as vehicles by which patients may voice their grievances.
  Read more about our Patient Representatives on page 36.

8. THE ORGANIZATION IDENTIFIES SAFETY RISKS INHERENT IN ITS PATIENT POPULATION

- The organization identifies patients at risk for suicide. (Applicable to patients being treated for emotional or behavioral disorders only.)

HOW DOES SLRHC ACCOMPLISH THIS GOAL?
- All patients admitted for emotional or behavioral disorders (on behavioral units) are assessed throughout their hospital stay for suicide risk. Interventions are implemented based on risk criteria.
- Patients on the general inpatient (non-behavioral) unit are assessed on admission and regularly thereafter for suicidal history or ideation.

9. IMPROVE RECOGNITION AND RESPONSE TO CHANGES IN A PATIENT'S CONDITION.

- The organization 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.

HOW DOES SLRHC ACCOMPLISH THIS GOAL?
- Our Rapid Response Team is comprised of a team of clinicians who bring critical care expertise to the patient bedside.
- The RRT can be initiated 24 hours a day by a patient care provider for a patient outside of the Operating Room, Emergency Department or Intensive Care Unit by calling 234444 and stating that a Rapid Response Team is needed.
- SLRHC joined the GNYHA-UHF Rapid Response System Collaborative in 2006. The goals of the Collaborative are to identify and disseminate effective models and best practices throughout the region; share lessons learned from implementation experiences; and, provide technical assistance and education to hospitals with RRTs.
- Patient/family information (in English and Spanish) about our RRT Team are posted on inpatient areas.
- Refer to Administrative Policy, A2-142: *Rapid Response Team (RRT).*

This is a Universal Protocol:
ELIMINATE WRONG-SITE, WRONG-PROCEDURE AND WRONG-PATIENT PROCEDURES
- Conduct a pre-procedure verification process.
- Mark the procedure site. For procedures involving right/left distinction, multiple structures, or multiple levels, the intended site must be marked such that the mark is visible after the patient has been prepped and draped.
- Implement **Time-Out** immediately before starting the procedure to confirm:
    Correct patient
    Correct side / site
    Accurate procedure consent form
    Agreement on the procedure to be done
    Correct patient position
    Relevant images and results are properly labeled and displayed
    The need to administer antibiotics or fluids for irrigation purposes
    Safety precautions based on patient history or medication use

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HOW DOES SLRHC ACCOMPLISH THIS GOAL?
- Prior to the start of any procedure, an on-going process of information gathering and verification is conducted by involved team members.
- A "time-out" is used prior to start of the procedure to confirm correct patient, procedure, and site.
- Site is marked with the word '**YES**' for all procedures involving laterality (Right, Left), level (e.g.: Spine) and multiple structures (e.g.: Finger).
- Refer to Administrative Policy, *A2-107: Patient Identification – Principles of Time Out.*

UNAPPROVED ABBREVIATIONS

All prescribers are required to print or write legibly. In addition, the following abbreviations are unacceptable, effective January 1, 2006:

Practice to Discontinue	Example	Rationale	Accepted Practice	Example
OD or QD for daily	Digoxin 0.25mg QD	OD or QD mistaken for QID, resulting in a four-fold overdose	Spell out the word, "daily"	Digoxin 0.25mg daily
QOD for every other day	Warfarin 2.5mg QOD	Mistaken for QD or QID, resulting in overdose	Spell out the words, "every other day"	Warfarin 2.5mg every other day
"u" for units or "IU" for international units	Regular insulin 10u QAM Bicillin 600,000 IU	"u" often taken as a zero, resulting in a 10-fold overdose "IU has been mistaken as "IV"	Spell out the word, "units"	Regular insulin 10 units QAM Bicillin 600,000 units
No leading zero	Digoxin .25mg	Decimal point easily missed, resulting in a 10-fold overdose	Leading zero	Digoxin 0.25mg
Trailing zero	Valium 2.0mg	Decimal point easily missed, resulting in a 10-fold overdose	No trailing zero	Valium 2mg
MS, MSO_4 or $MgSO_4$	MSO_4 2mg IV once	Confused for one another. Can mean morphine sulfate OR magnesium sulfate	Spell out the words, "morphine sulfate" or "magnesium sulfate"	Morphine sulfate 2mg IV once

Pharmacists and nurses will question and validate all medication orders containing an unapproved appreviation or illegible writing. Please expedite care by complying with these important policies.

PATIENT FALL PREVENTION PROGRAM

All patients are at risk for falling. In order to create an environment of safety for our patients, ALL HOSPITAL ASSOCIATES, not just patient care providers, have a role in preventing patient falls.

WHY IS THIS IMPORTANT?

Adverse events associated with falls may include cuts or bruises, bone fractures, head injuries, and fear of falling again. Injuries resulting from a fall may lead to a longer hospital stay.

One of the 2009 National Patient Safety Goals is to reduce the risk of patient harm resulting from falls.

WHAT IS THE HOSPITAL'S FALL PREVENTION PROGRAM?

- On admission and at regular intervals during the hospital stay, nurses identify patients at risk for falling using a Fall Risk Assessment tool.
- Patients and family are provided with education to prevent falls.
- All patients are instructed to use the call light for assistance.
- All patients are instructed to wear non-slip footwear.
- Increased monitoring of patients who are identified at <u>moderate or high risk</u> for falling. These patients will be identified with the following:
  - **Yellow** armband placed on wrist
  - **Yellow** non-skid socks
  - **Yellow** name tag at room door
  - **Yellow** "Fall Risk" sign placed over patient's bed or on room door
  - **Yellow** "Fall Risk" sticker placed on front of chart
- Educate ALL HOSPITAL STAFF to increase awareness of patients who are at risk for falling.

WHAT IS MY RESPONSIBILITY IN PREVENTING PATIENT FALLS?

ALL HOSPITAL ASSOCIATES are to be aware of their responsibility in preventing patient falls from occurring. REMEMBER:
- If patient is at risk for falling or needs help, request assistance for the patient and stay with them until help arrives.
- Communicate unsafe situations (e.g., liquid on floor, broken equipment, furniture blocking pathway to the bathroom) to the charge nurse or Nurse Manager/Supervisor.

RAPID RESPONSE TEAM

St. Luke's-Roosevelt Hospital Center, in an effort to make health care safer and more effective, joined the Institute for Healthcare Improvement's *100,000 Lives Campaign* in 2005. One of the interventions, proven to decrease hospital mortality rates, is the implementation of a **Rapid Response Team**. (Rapid Response Teams are included in the IHI's *5 Million Lives Campaign* also).

The Rapid Response Team (RRT) — known by some as the Medical Emergency Team — is a team of clinicians who bring critical care expertise to the bedside. Simply put, the purpose of the Rapid Response Team is to bring critical care expertise to the patient bedside (or wherever it's needed).

Our RRT was activated in December 2005. Team members include a Pulmonary / Critical Care Fellow, Hospitalist, or a Dept. of Medicine house staff, a Nurse Manager / Administrator, and a Respiratory Therapist.

The Rapid Response Team (RRT) can be initiated 24 hours a day by a patient care provider for a patient outside of the Operating Room, Emergency Department or Intensive Care Unit by calling 234444 and stating that a Rapid Response Team is needed. The RRT does not replace the patient's primary care team, but can be called if assistance is needed or more than 1 stat page is needed to assemble a team to respond to a crisis.

We also encourage patients and families to notify associates when they have concerns about a patient's condition.

If a patient lacks pulse or respiration, a Medical Code should be called.

Suggested criteria for initiating the RRT:
1. Respiratory:
    *   Rate < 8 per minute or > 36 per minute
    *   New or worsening hypoxemia or pulse oximetry < 90% with the patient on oxygen
    *   New requirement for > 50% oxygen to keep saturation above 90%
    *   Cyanosis
2. Cardiac:
    *   Severe acute chest pain unresponsive to nitroglycerin
    *   Heart Rate: < 40 per minute or > 140 per minute with new symptoms or hypotension
    *   Blood Pressure: < 80 systolic (with signs of shock) or > 200 systolic or 120 diastolic with chest pain or dyspnea
3. Neurological:
    *   Abrupt loss of consciousness
    *   Sudden loss of body movement, weakness or suspected stroke
    *   Seizure
    *   Sustained, new onset of agitation or confusion
4. Other:
    *   In-hospital accidental injury
    *   Acute, severe bleeding
    *   Suicide attempt
    *   Deterioration post procedure

THE COLORS OF SAFETY
Color-Coded Patient Alert Condition ID Bands

As part of a national effort to enhance patient safety, St. Luke's-Roosevelt Hospital Center is using pre-printed, color-coded patient wristbands that alert associates to certain patient conditions.

Color-coded wristbands allow us to quickly communicate important information among associates regarding these patient alert conditions:

- **RED** means **Allergy Alert**. Red alerts us to stop and look in the medical record to find out information on the patient's allergies, so we can provide safe care.
- **YELLOW** means **Fall Risk**. Yellow alerts us that the patient may need extra assistance when walking or transferring to prevent falls. Patients assessed at risk for falls may also be wearing yellow slipper socks and have yellow Fall Risk Stickers on the medical record and on the room name tag outside the patient's door.
- **PINK** means **Limb Alert.** Pink alerts us not to take Blood Pressures, start IV's, or draw blood specimens in the arm with the pink Limb Alert band. (Used in patients with mastectomies, dialysis shunts, etc.)
- **GREEN** means **No Blood Transfusion.** Green alerts us that the patient requested no blood transfusions and signed a consent defining what blood or blood products are permitted in his or her care.

WHAT IS THE HOSPITAL'S POLICY ABOUT USING PATIENT ALERT ID BANDS?

- Patients will wear patient alert ID bands from the time of admission, or from the time the alert condition is identified, until discharge.
- If a patient is being transferred to another Continuum hospital, please DO NOT remove patient alert ID bands before transfer.
- We **ARE NOT using DNR bands at SLRHC** but you may see them on patients transferred from another facility. The national color of safety for DNR is purple.

IS IT THE PATIENT'S RIGHT TO REFUSE TO WEAR AN ALERT ID BAND?

A competent patient may decide, as with all other treatment decisions, not to wear patient alert ID bands. Please remember to document your discussion with the patient, and his/her decision against wearing the band(s) in the medical record.

HOW CAN WE KEEP THE PATIENT SAFE IF THEY REFUSE TO WEAR AN ALERT ID BAND?

All of the information on a patient alert ID band is also found in the medical record and should be part of handoff communication from nurse to nurse and to other caregivers:

- <u>Allergies</u> can be found in the provider's History and Physical, the nursing admission assessment in PRISM or in EMSTAT or Healthmatics.
- <u>DNR</u> requires an MD order and patient consent.
- <u>Fall Risk</u> can be found in daily nursing documentation in PRISM
- <u>Limb alert</u> is usually an MD order, but may also be identified by nursing assessment
- <u>No blood transfusion</u> requires the patient's written consent.

CAN I EXPECT TO SEE SIMILAR PATIENT ALERT ID BANDS ON PATIENTS WHO ARE TRANSFERRED TO SLRHC FROM ANOTHER HOSPITAL OR NURSING HOME?

As more and more hospitals and nursing homes begin to participate in the Colors of Safety Program, we can expect to see patient alert ID bands in the same colors we are using.

It is important to support and educate other staff members, patients and family members by carefully explaining the color-coding system.

Section VII

Customer Service

HCAHPS
(Hospital Consumer Assessment of Healthcare Providers and Systems)

CMS, or Medicare, has developed the Hospital CAHPS (HCAHPS) survey, to provide a standardized instrument and data collection methodology for measuring patient satisfaction with hospital care. While many hospitals collect information on patient satisfaction, there is no national standard for collecting or publicly reporting this information that would enable valid comparisons to be made across all hospitals. Therefore, CMS has required all hospitals who receive Medicare reimbursement to participate in the HCAHPS survey and to have their scores reported publicly on the Internet.
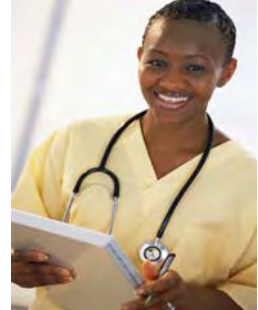
There are three broad goals that have shaped the HCAHPS survey.

1. The survey is designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between hospitals on domains that are important to consumers.

2. Public reporting of the survey results is designed to create incentives for hospitals to improve their quality of care.

3. Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of hospital care provided in return for the public investment.

There are 7 areas that will be measured:

- Nurse Communication
- Doctor Communication
- Cleanliness and quiet of the hospital environment
- Responsiveness of hospital staff
- Pain Management
- Communication about medicines
- Discharge Information

SLRHC is committed to having the highest scores possible on the HCAHPS survey so that patients will choose to come to our facilities. Therefore it is important for all associates to familiarize themselves with the questions and the areas in which we can improve our scores.

Results of data collected are publicly reported and may be reviewed by healthcare consumers at the following web site:

www.hospitalcompare.hhs.gov

STANDARDS OF CUSTOMER CARE

Standard #1: We will make our patients and their families feel welcomed.
- Introduce ourselves using name and title, and explain to the patient our role in his/her care
- Wear our hospital ID badge with name and picture visible
- Greet patients and families with a smile
- Respond promptly to inquiries or problems
- Offer assistance to individuals who are disabled or may be confused with the surroundings

Standard #2: Whenever we have a patient or associate interaction, we will act in a professional manner and we will dress professionally to communicate that visibly.
- Greet a patient using his/her formal name, unless invited to call him/her differently
- Interview a patient in private by closing the door, the curtain, or by finding a private place
- Always knock before entering a room and asking permission to enter
- Ask patient if he/she wants others present when discussing private medical matters
- Welcome, assist and orient new associates
- Identify ourselves to callers by name and department
- Ask permission to place a caller on hold and wait for an answer

Standard #3: We will maintain a peaceful, calm and healing environment.
- Speak in a quiet tone of voice
- Respect the privacy of our patients by closing doors and curtains during exams and treatments
- Provide a proper gown/robe/blanket to ensure a patient's modesty
- Offer assistance when needed and possible
- Ask "Is there anything else I can do for you?" when leaving a patient room

Standard #4: We will keep our personal frustrations separate.
- Keep staff gossip and personal matters out of a patient's hearing
- Disagree with colleagues in private
- Help others with our "know how" and ask for help when we need it
- Always link problem identification with problem solving suggestions

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Section VIII

Population Specific Care

POPULATION SPECIFIC CARE

Patients who come for care at SLRHC represent a great variety of populations. Therefore, our associates must be able to take care of the many different populations. But what does population really mean? Population can be defined many ways. The Joint Commission states that population can be defined by the following:

- **Age** (e.g., pediatrics, adult, elderly)
- **Health status/disease process** (e.g., diabetics, cardiac patients, surgical patients)
- **Cultural/Spiritual** (e.g., Christian, Jewish, Muslim, Hispanic, Chinese)
- **Functional Status** (e.g. limited mobility, deaf, visually impaired, developmentally disabled)
- **Equipment used in treating the population** (e.g. Fetal monitor, telemetry, ventilator)

All associates with direct patient contact should identify the populations whom they care for. Just as importantly, associates must be able to identify the skills they need to care for these populations. It may be easier to answer these three questions:

- What do you do?
- Whom do you care for?
- What are the qualifications of the associates who work in the department?

What makes you qualified (or competent) to work with your particular population? This will vary depending on your position and where you work. For example, if you are an RN working with a pediatric population, you need to know pediatric lab values and how to calculate medication dosages for children. However, an RN working on a telemetry unit must be able to identify cardiac rhythms.

Every associate with direct patient contact should be able to identify the populations they care for and the skills or competencies needed. This will vary by department and by position.

Section IX

Corporate Compliance Handbook

Dear Continuum Health Partners, Inc. Colleague:

Continuum Health Partners, Inc. ("Continuum"), through its member hospitals, St. Luke's-Roosevelt Hospital Center, Beth Israel Medical Center, the Long Island College Hospital and the New York Eye and Ear Infirmary, is committed to providing and supporting health care excellence in the communities it serves throughout the New York City metropolitan area. As part of this commitment, it is critical that we furnish the highest quality health care services in a lawful and ethical manner.

This Handbook has been designed to serve as an essential resource for all associates to be informed about the various aspects and components of our Corporate Compliance Program. In addition, this Handbook is intended to serve as a training guide in regard to the Corporate Integrity Agreement that was entered into between Beth Israel Medical Center and the Office of Inspector General of the federal Department of Health & Human Services.

It is essential that you carefully read and review this Corporate Compliance Handbook. It will provide you with both an overview, as well as specific information, regarding the many facets of our Corporate Compliance Program.

After reading the contents of this handbook, you will be required to answer some questions testing your knowledge. If you have any questions about the content contained in the handbook, and how it applies to you and your Continuum position, do not hesitate to discuss any issues with your supervisor or manager. I am available, as well as members of my staff, to answer your questions as well.

After reading this handbook and taking the post-test, please return the post-test answer sheet to your supervisor or manager. Additionally, you should record your completion on your *Record of Individual Participation in Staff Development Activities.*

In closing, I wish to thank all of you for your commitment for conducting your responsibilities at Continuum with integrity and in accordance with the highest ethical standards.

Sincerely,

Louis I. Schenkel
Corporate Compliance Officer

Eff: 01/07

What is Corporate Compliance?

There are many definitions as to what constitutes a Corporate Compliance Program. On a basic level it is about the commitment of the Continuum hospitals ("Continuum") to operate and assure compliance with and conform to all applicable federal, state and local laws, rules and regulations, as well as policies and standards set by the government, insurance programs and other payers (i.e. Medicare and Medicaid). Additionally, Continuum, as a provider of health care, is an organization that promotes integrity and ethical behavior through all levels of the organization.

Corporate Compliance - Introduction

Continuum has voluntarily established a Corporate Compliance Program in accordance with guidance set forth by the Office of Inspector General of the United States Department of Health & Human Services.

The purpose of the Corporate Compliance Program is to prevent, detect and investigate violations of law. This also includes fraudulent and unethical behavior, as well. Continuum is committed to educating and training staff to comply with the laws as well as encouraging staff to ask questions or seek advice to ensure that they conduct Continuum business in a lawful and ethical manner.

Corporate Compliance - Health Care Origins

In the 1970s and early 1980s the Department of Defense was paying exorbitantly high prices for supplies. (You may remember the news stories about $200 hammers and $500 toilet seats, at taxpayers' expense.) The Department of Defense and its suppliers developed and implemented self-regulatory guidelines to help eliminate such fraud and abuse. This was an early example of a compliance program.

Health care, as a component of the United States federal budget exceeds well over $1.5 trillion, mostly through the Medicare and Medicaid programs. In the mid 1990's, government estimates regarding the extent of health care fraud amounted to approximately 10% of the total U.S. health care expenditures- more than $100 billion annually. At this time the U.S. government made combating health care fraud a high priority.

In February 1998, the Office of Inspector General declared a zero tolerance for fraud and issued voluntary guidance for hospitals that encouraged hospitals to establish their own internal corporate compliance programs. The guidance encouraged hospitals, among other things, to draft organizational Codes of Conduct, provide compliance orientation and training to its associates and to conduct auditing and monitoring activities.

Continuum's Corporate Compliance Program - History

Prior to 1998, each of the Continuum hospitals had their own separate and distinct Corporate Compliance program, and their own Corporate Compliance Officer. In the fall of 1999, it was decided to create a Continuum-wide Corporate Compliance Program. Louis I. Schenkel was appointed Continuum's Corporate Compliance Officer.

In January 2000, a Continuum-wide Code of Conduct was developed and distributed to all associates. The Code of Conduct's credo is **"One Way…the Right Way"**. During the spring of 2000, all staff received training regarding the newly developed Code of Conduct. Newly hired associates received Code of Conduct training at the time of their orientation.

Other Corporate Compliance Program milestones achieved include:

- The establishment of a Continuum-wide anonymous and confidential Corporate Compliance Hotline
- The establishment of a Corporate Compliance Committee
- Written compliance manuals for the areas of:
    - Physician Billing
    - Hospital Billing
    - Hospice
    - Laboratory
- The establishment of a comprehensive Continuum-wide Conflict of Interest Policy
- The drafting of additional Corporate Compliance and HIPAA policies and procedures

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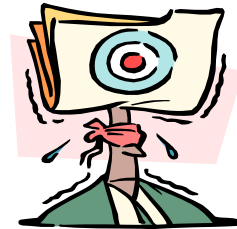
The Risks of Non-Compliance

Healthcare organizations that are not in compliance with government laws and regulations face severe penalties that could result in monetary settlements, mandated compliance programs (through corporate integrity agreements), exclusion from government healthcare programs (i.e. Medicare, Medicaid), and possible criminal prosecution and incarceration for intentional and egregious acts.

Organizations suspected of fraud and abuse must deal with extensive government audits and reviews. These investigations usually result in costly civil monetary settlements and can disrupt routine hospital operations.

Fraud and Abuse

The terms fraud and abuse are often used in regard to Corporate Compliance Programs. The following are their definitions together with examples:

Fraud - is an intentional deception or misrepresentation which the individual or entity knows to be false or does not believe to be true and results in some unauthorized benefit. The most frequent kind of fraud arises from a false statement or misrepresentation that relates to payment from a health care program (i.e. Medicare, Medicaid, Empire Blue Cross, etc.) Fraud also includes reckless disregard for compliance with laws, rules and regulations. Examples of healthcare fraud may include the following:

- Incorrect reporting of diagnoses or procedures to maximize reimbursements
- Billing for services, supplies or equipment that were not rendered
- Disguising non-covered or non-chargeable services/supplies/equipment as covered items
- Deliberate double billing of payors and/or patients

Abuse - is used to describe incidents or practices of providers, physicians, or suppliers of services which, although not usually considered fraudulent, are inconsistent with accepted sound medical, business or fiscal practices, that directly or indirectly result in unnecessary costs to the government heath care programs, improper reimbursement, or payment for services that fail to meet professionally recognized standards of care or which are medically unnecessary. One type of abuse to which healthcare payors are particularly vulnerable is overutilization of medical and healthcare services. Abuse may include the following:

- Excessive charges for services or supplies
- Claims for services not medically necessary
- Improper billing practices (i.e. billing Medicare instead of another third party payer)

Corporate Compliance - Related Laws and Regulations

Below are a few of the significant laws and regulations that apply to healthcare organizations participating in federal health programs:

Medicare Regulations - delineates standards of patient care and billing and reimbursement procedures for participation in the federal Medicare program.

False Claims Act - this federal law imposes civil and, in some cases, criminal liability on organizations (and individuals such as physicians, pharmacists, etc.) that makes or causes to be made false or fraudulent claims to the government. A False Claims Act violation can result in penalties of up to $11,000 per false claim, plus triple damages for

the billed amount. In addition, the government can exclude violators from participating in Medicare, Medicaid or other government healthcare programs.

The Anti-Kickback Statute – prohibits individuals from soliciting or receiving any form of payment, direct or indirect (money or non-monetary payment), in return for referrals of patients. Violators are subject to civil and/or criminal penalties up to $35,000 per violation, as well as imprisonment and exclusion from federal program participation.

Stark Laws - also known as Physician Self-Referral Laws, prohibits physicians from referring patients to facilities (i.e. laboratories, imaging centers, rehabilitation centers) in which they or family members have a financial or ownership interest for which payment may be made under Medicare, unless they meet certain statutory/regulatory exceptions. Violators are subject to civil and punitive penalties of up to $100,000 as well as exclusion from federal program participation.
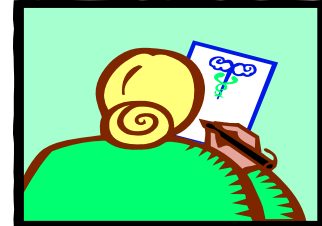
Federal Deficit Reduction Act – as a participant in the Medicaid Program, this federal law mandates that hospitals adopt written policies and procedures for all associates that provide detailed information about the federal and New York State False Claims Acts, the rights of associates to be protected as whistleblowers and Continuum's policies and procedures for detecting and preventing fraud, abuse and waste. The law also requires that these policies and procedures be provided to our contractors and vendors as well.

Fraudulent or Abusive Billing Practices

Government agencies, along with fiscal intermediaries, are watchful for billing practices that could indicate fraud or abuse. A high-risk area for hospitals is the preparation and submission of claims or other requests for payment to the federal healthcare programs. The following list is a representative sampling of billing practices that could result in government scrutiny:

Upcoding – the practice of using a billing code that provides higher reimbursement than the billing code that actually reflects the services furnished to the patient. In a hospital setting, the focus is on code pairs (known as diagnosis related groups {DRG}) for similar medical conditions, with one pair resulting in a higher reimbursement depending on the condition of the patient and the level of services rendered.

Unbundling – the practice of submitting bills piecemeal or in fragmented form to maximize the reimbursement for various tests or procedures that are required to be billed together at a reduced cost. As a case in point, hospital-based laboratories are required to bill for multiple tests performed simultaneously on a patient at a lower rate than the individual tests.

Billing for Medically Unnecessary Services – claims that intentionally seek reimbursement for services not warranted by the patient's current and documented medical condition. Hospitals and physicians should only bill for services that meet Medicare's "reasonable and necessary" standard.

Billing for Services not Rendered – submitting a claim representing that the provider performed a service when the provider did not actually perform all or part of the service. For example, billing for services after the date of death.

Duplicate Billing – submitting more than one claim for the same service or submitting bills to more than one primary payor at the same time.
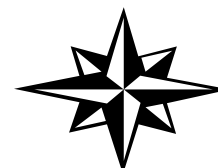
The Seven (7) Elements of a Corporate Compliance Program

The Office of Inspector General's ("OIG") compliance guidance for the hospital industry recommends that Corporate Compliance programs contain the following seven (7) elements for every Corporate Compliance Program:

1-Establishment of Standards of Conduct
This element represents the Code of Conduct that demonstrates Continuum's commitment to abiding to the relevant laws and regulations of federal and state government and federal healthcare program requirements. Further, to provide additional guidance, Corporate Compliance specific policies and procedures have been developed which are available to all staff, and which address certain identified risk areas. These Policies and Procedures, as well as the Code of Conduct, are contained in the Corporate Compliance section on the Continuum Intranet web site.

2-Designation of Corporate Compliance Officer and Compliance Committee
Louis I. Schenkel is the Continuum Corporate Compliance Officer. The Corporate Compliance Officer is responsible for the development, operation and oversight of the Corporate Compliance Program.   Mr. Schenkel was appointed to this position by the President & Chief Executive Officer. He has a dual reporting relationship to both the President, as well as the Board of Trustees. His office telephone number is (212) 523-2162.

The Board's Audit Committee serves as the Corporate Compliance Committee, and is comprised of members of executive management as well as the Board of Trustees. This multidisciplinary committee assists in the design, implementation and operation of the Corporate Compliance Program and serves in an advisory role to the Corporate Compliance Officer.

3- Training and Education
All newly hired staff receive a copy of the Code of Conduct and Corporate Compliance education and training at new associates orientation. The training includes an

explanation of the structure and operation of the Corporate Compliance Program and discussion of the risk areas. Topics include the seven (7) elements, the Code of Conduct, the Compliance Hotline and an overview of applicable laws and regulations and policies. Incumbent staff receives specific training on a periodic basis on issues such as federal and state laws, regulations and guidelines, as well as refresher training through the Annual Core Competency.

4- Reporting Channels- Effective Lines of Communication
Open and effective communication enhances an organization's ability to identify and respond to compliance concerns and issues.

All staff have a duty to report suspected or actual violations of federal, state or local laws, rules, regulations policies and procedures or the Continuum Code of Conduct to their supervisor, either in writing, by telephone or in person. All associates are encouraged to make reports through their administrative chain of command. Associates may contact the Office of Corporate Compliance directly at (212) 523-2162. **Anonymous reporting of violations may be made via the toll-free Corporate Compliance Hotline: 1-800-692-2353**. **There will be no reprisals or any retaliation against associates for good faith reporting.**

5-Enforcement of Disciplinary Standards
All staff are accountable for complying with the standards of the Corporate Compliance Program. By enforcing disciplinary standards, Continuum helps to create an organizational culture that emphasizes ethical behavior.

Disciplinary actions may be taken for:
- Violating the Code of Conduct or other laws and regulations
- Failing to report a violation of the Code of Conduct or cooperate in an investigation
- Retaliation against an individual for reporting a violation or possible violation of the Code of Conduct
- Deliberately making a false report of a violation of the Code of Conduct

The extent of disciplinary action utilized will depend on the nature, severity and frequency of the violation. The Corporate Compliance Officer is authorized to recommend, in consultation with appropriate management staff, as necessary, appropriate discipline, up to and including termination.

6-Auditing and Monitoring
Continuum is committed to an ongoing evaluation process. Monitoring and auditing activities are conducted under the auspices of the Corporate Compliance Officer. Audits are designed to address compliance with laws, regulations and policies governing, among other things, coding, reimbursement, documentation, medical necessity and other areas that may be deemed as high-risk areas. Issues for audit are also based on publications such as OIG Special Fraud Alerts and the annual OIG Work Plan. Reports of audits are made to the Board Audit/Compliance Committee.

7-Responding to Detected Offenses and Implementing Corrective Action Initiatives

All reported violations will be promptly, thoroughly and confidentially investigated by the Corporate Compliance Officer. Associates are required to cooperate with any investigation conducted in response to a report concerning compliance issues. Appropriate follow-up will be made to correct the issue and prevent recurrence.

Corporate Integrity Agreement

On November 30, 2005, Beth Israel Medical Center entered into an amicable settlement with the U.S. Attorney's Office for the Southern District of New York, to settle a review of the hospital's Medicare claims for the period of 1992-2001. The U.S. Attorney's Office found that Beth Israel's complex Medicare Cost Reports contained errors that resulted in overpayments to Beth Israel during this ten-year period. Beth Israel representatives fully cooperated with the U.S. Attorney's Office during the course of a three-year review period.
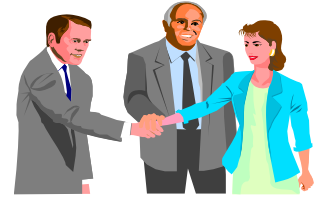
As a result of the settlement, Beth Israel Medical Center entered into a Corporate Integrity Agreement with the Office of Inspector General of the Department of Health & Human Services. All Beth Israel Medical Center associates are required to comply with the requirements of the Corporate Integrity Agreement and all applicable federal healthcare program requirements. The term of the settlement is five and one-half (5.5) years.

The Corporate Integrity Agreement requires us, among other things, to:

- Ensure the effective operation of the Corporate Compliance Program through its Compliance Committee and Corporate Compliance Officer
- Maintain and distribute our Corporate Compliance Code of Conduct to all associates
- Implement and disseminate written policies and procedures relating to the Corporate Compliance Program
- Provide Compliance training to all associates
- Conduct periodic reviews to assess and evaluate cost reporting processes
- Maintain the present Disclosure Program which emphasizes a nonretribution, nonretaliation policy and mechanism for anonymous and appropriate reporting
- Maintain present screening of associates to ensure that they are not ineligible persons on the OIG Sanction List
- Provide various other reports to the OIG (i.e. Annual Reports)

Failure to comply with the requirements of the Corporate Integrity Agreement or federal healthcare programs, or to report violations or suspected violations, could pose a serious risk to Beth Israel Medical Center. Violations or suspected violations of the Corporate Integrity Agreement or applicable federal healthcare program requirements

must be reported in accordance with our Code of Conduct and relevant Corporate Compliance policies & procedures.

If you have any questions about the Corporate Integrity Agreement, please contact the Office of Corporate Compliance at (212) 523-2162.

The Office of Corporate Compliance

The Office of Corporate Compliance's mission is to promote adherence to appropriate standards of business conduct and to ensure conformance to applicable federal, state and local laws and regulations, as well promoting integrity and ethical behavior throughout the organization. The Office of Corporate Compliance strives to ensure organizational compliance with the seven elements of an effective Corporate Compliance Program.

The Office of Corporate Compliance is headed by **Louis I. Schenkel**, Corporate Compliance Officer. Other members of the staff include **Kathleen Gallichio**, Director of Professional Billing Compliance and **Norman Werner**, Director of Hospital Compliance.

Background and Sanction Screening

A background screening is conducted on all individuals to whom employment is offered as well as to individuals applying for membership to the medical staff. The federal Department of Health & Human Services guidelines require that healthcare providers conduct appropriate screening of its associates, physicians, and other healthcare providers, vendors and business partners to ensure that they have been not sanctioned or otherwise excluded from providing services in a federal healthcare program. Such screening consists of making inquiry against the Office of Inspector General ("OIG") List of Excluded Individuals and Entities and, the federal General Services Administration ("GSA") Excluded Parties List Service. These inquiries are made to ensure that individuals have not been convicted of a criminal offense related to healthcare and/or listed by the aforementioned federal agencies as excluded, debarred, or otherwise ineligible for federal program participation. More information about sanction screening can be found in the Office of Corporate Compliance policy and procedure and in the Code of Conduct.

Code of Conduct
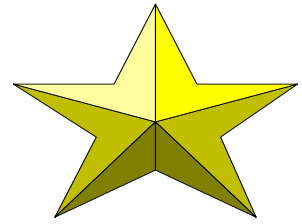
Continuum's Corporate Compliance Code of Conduct has been adopted by the Continuum Board of Trustees to provide standards by which trustees, associates, physicians, volunteers and other affiliated entities will conduct themselves in order to protect and promote organization-wide integrity and to enhance Continuum's ability to achieve its mission. The Code of Conduct is an encompassing foundation document based on the principles outlined in the Mission Statements of the Continuum hospitals and in accordance with organizational values based on integrity and trust. It also contains resources to help resolve any questions about appropriate conduct in the workplace. The Code of Conduct applies to all Continuum staff, including board members, physicians and vendors and sets forth Continuum's commitment to comply with all federal and state laws and regulations, inclusive of an emphasis on preventing fraud and abuse.

All staff receive the **Code of Conduct** upon hire and are required to sign an acknowledgement that they will abide by it during their employment at Continuum.

The Code of Conduct addresses many issues relating to lawful and ethical behavior. Some of these issues include:
- Patients' Rights
- Workplace Practices
- Conflict of Interest
- Billing/Reimbursement
- Confidentiality

Further, other fundamental provisions contained in the Code of Conduct, as well as requirements stipulated in the Corporate Integrity Agreement, include:

- Continuum's commitment to full compliance with all federal healthcare program requirements, including its commitment to prepare and submit accurate claims consistent with such requirements.
- The requirement that all staff are expected to report suspected or actual violations of any federal healthcare program requirements or of applicable laws and regulations or the Code of Conduct, through the respective associate's's administrative chain of command or directly to the Corporate Compliance Officer.
- The right of all associates to make confidential and/or anonymous disclosures of any identified issues or questions associated with Continuum's policies, practices, applicable laws and regulations or the Code of Conduct, through their respective administrative chain of command, to the Corporate Compliance Officer or to the toll-free Corporate Compliance Hotline. All such reports will be in accordance with Continuum's non-retaliation policy.
- The possible disciplinary consequences to both Continuum and associates of failure to comply with federal healthcare program requirements as well as the failure to report such non-compliance.

Non-Retaliation

It is the policy of Continuum that all staff have a duty and responsibility to report suspected or actual violations of laws, regulations, policies, procedures and the Code of Conduct, without fear of retaliation. Continuum does not tolerate or condone retaliation against staff for good faith reporting of concerns or violations. Any associate who commits or condones any form of retaliation or retribution will be subject to disciplinary action, up to and including termination.

Corporate Compliance Hotline

As stated in the Corporate Compliance Code of Conduct, all staff are obligated to report actual or suspected violations of laws or to report fraud, abuse or waste to their supervisor or to others within their administrative chain of command.
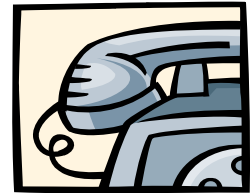
Another form of reporting mechanism is calling the Corporate Compliance Hotline. This is a toll-free telephone number-**1-800-692-2353** - that may be accessed seven (7) days per week, twenty-four (24) hours per day. Calls may be anonymous to the extent permitted by law, and will be handled in strict confidence. All allegations will be investigated. No attempt will be made to identify the caller or trace the call. No reprisals or retaliation will be taken against staff for good faith reporting of suspected allegations.

Leaders' and Managers' Responsibility

While adherence to the Corporate Compliance Code of Conduct is the responsibility of all Continuum associates, it is expected that Continuum's leaders will set ethical and lawful examples and to be in all respects models of such behavior.

All Continuum leaders are expected to:

- Explain to their staff the importance of complying with ethical and lawful standards
- Create an environment to encourage discussion and dialogue of issues contained in the Code of Conduct
- Respond promptly and properly to concerns raised by their staff
- Ensure that appropriate issues are communicated to the Corporate Compliance Officer

Employee Performance Appraisals

Managers need to include a discussion of corporate compliance matters including adherence to laws and regulations and abiding to the Code of Conduct during the time of associates' performance appraisals. The appraisal forms include corporate compliance issues as a component of the appraisal.

Exit Interviews

Prior to leaving employment from Continuum, associates are asked to participate in an exit interview. The Department of Human Resources is responsible for conducting this exit interview. As part of this process, the associate is asked to complete an exit interview questionnaire that asks them to rate Continuum on a number of factors. The questionnaire requests their reason for leaving Continuum and provides an opportunity to give feedback on their experience at Continuum.

ETHICS

Conflict of Interest
Upon hire, all associates receive a copy of the Conflict of Interest Policy and are required to complete a Conflict of Interest Disclosure Statement. Certain designated associates and members of the Board of Trustees must complete the Conflict of Interest Disclosure Statement on an annual basis. These statements are subject to internal review by the Corporate Compliance Officer and review by the Board of Trustees.

Dual Employment
You may not engage in other business activities that may be in conflict with your Continuum position.

Gifts and Business Travel
Receiving gifts (including money, travel, tickets, etc.) from vendors, patients or others who you may be in contact with as part of your Continuum duties is prohibited.

You may, however, receive certain perishable or consumable gifts given to a group or a department (i.e. flowers, candy), which are considered items of nominal value. Under no circumstances may you solicit gifts. If you are unsure whether a gift is nominal in value or is otherwise acceptable, discuss it with your supervisor or the Corporate Compliance Officer.

Use of Confidential Information
You are not permitted to disclose confidential Continuum information or use it for your personal interests.

EMTALA

EMTALA is an acronym for the Emergency Medical Treatment & Active Labor Act. It is a federal law that became effective in 1986 and is sometimes referred to as the "Anti-Dumping Law". Its primary purpose is to ensure emergency care for anyone who requires it regardless of his/her ability to pay or insurance coverage.

What is Continuum's Commitment?

Continuum is committed to providing quality emergency medical services to all patients who present at any of Continuum's Emergency Departments (or in the case of a pregnant woman presenting at the labor/delivery area) regardless of their payor status.

Basic EMTALA Obligations

1- Provide an appropriate **Medical Screening Examination** ("MSE") (an MSE is more than just triaging a patient) to determine whether an emergency condition exists

2- Provide any necessary **stabilizing treatment**, including treatment for pregnant women and their unborn child

3- Provide an appropriate **transfer** to another facility, if necessary, regardless of the patient's ability to pay

Other Key Points

- It is a violation of EMTALA to delay a Medical Screening Examination to inquire about a patient's payor or insurance status. After an MSE has been conducted by qualified medical personnel (i.e. physician) to determine if an emergency condition exists, insurance and other payment information may then be obtained from a patient

- Hospitals that violate EMTALA can be fined up to $50,000 per violation

- All Continuum hospitals and labor/delivery suites have required signage which states that patients have the right to a Medical Screening Examination, Stabilizing Treatment and a Transfer, if necessary

If you have any questions about EMTALA, speak to your supervisor, the Patient Relations Department or the Office of Corporate Compliance.

91

Your Role in Corporate Compliance

- **Become familiar with and abide by the Code of Conduct** - You are expected to read and understand and abide by the Code of Conduct. If you have any questions about the Code of Conduct ask your supervisor or the Corporate Compliance Officer.

- **Know and comply with applicable laws and regulations** - You are expected to be familiar with laws that apply to your specific job function and level of responsibility. If you are not sure about whether a law or standard applies, ask your supervisor.

- **Assume and take individual responsibility** - Corporate Compliance is everyone's business. Don't assume someone else is doing or not doing something about an issue. Step forward and tell someone about a concern or issue you may know of.

- **Report in good faith suspected or actual violations of laws, regulations or the Code of Conduct using the administrative chain of command.**

- **Understand the consequences of non-compliance** – failure to comply with laws and regulations, the Code of Conduct or the Corporate Integrity Agreement could pose serious risks to associates as well as to Continuum.

- **Ask questions** - If you don't know something or want answers to your questions, just ask; if you have doubts about the legal or ethical implications of a situation, ask your supervisor or the Corporate Compliance Officer.

- **Lead by example** - be a leader and role model of lawful and ethical behavior…"One Way…the Right Way"

Compliance is Everyone's Responsibility!

Corporate Compliance Case Scenarios

Compliance Issue # 1
You are a nurse caring for a nine (9) year old pediatrics patient. The parents of the patient ask you to "go the extra mile and give their baby a little more attention and TLC". When the child is preparing for discharge a few days later, the father thanks you profusely and gives you a $100 gift certificate to Banana Republic as a token of their appreciation.

Is there a problem with you receiving this gift certificate?

Answer: Yes, in a couple of ways. From a quality point of view, all patients should be afforded the same excellent quality of care that Continuum clinicians are known for. Additionally, accepting the gift certificate is against the Continuum Gifts & Entertainment policy. We do not accept "tips" from patients or their families for doing our job. The nurse should have thanked the father for his generosity and declined the gift certificate. If he insisted, the nurse should then suggest that any gifts or donations be made to the Continuum Department of Development.

Compliance Issue # 2
A patient arrives at the outpatient department with a physician's prescription order for a couple of laboratory tests—a urinalysis and a CBC (complete blood count) to rule out an infection. The patient, who knows he has high cholesterol, asks the registrar to add a cholesterol test (HDL and LDL) to the order because he wants to know how high his count really is. The registrar tries to call the physician to confirm if she wants to add these tests but is unsuccessful since the physician is currently in the O.R. doing surgery. The patient offers the registrar two box seats for a New York Yankees game if she will add the tests.   Problem?

Answer: Yes. This also is a violation of the Continuum Gifts and Entertainment policy similar to scenario #1. The registrar did the right thing by calling to confirm with the physician whether she wanted the additional tests added to the order. If the registrar had added the lab tests to the order, the registrar would have broken the law, committed fraud and been unethical.

- Only qualified medical personnel such as physicians, nurse practitioners or physician assistants are permitted by law to order tests (i.e. lab tests, x-rays, etc.) for patients; the registrar would have been breaking the law;

- There was no apparent medical necessity to having the patient's cholesterol levels checked since it had nothing to do with his symptoms related to infection; the subsequent bill that would be submitted would then be considered a false claim and expose the hospital to a fraud claim;

- Generally speaking, the registrar would be committing an unethical and unlawful act by knowingly doing something illegal outside the scope of his job description.

Compliance Issue # 3
Your supervisor makes you and other members of your department uncomfortable with his rude and sexually oriented jokes. What should you do?

Answer: This type of behavior may be considered harassment, which is a form of discrimination. Talk to your supervisor about how you feel. If you are uncomfortable talking directly to your supervisor, talk to another manager, Human Resources or call the Corporate Compliance Officer. If you wish to remain anonymous, you may call the toll-free Corporate Compliance Hotline. Continuum does not tolerate harassment or a hostile work environment. Staff will not be retaliated against for making a good faith report.

Compliance Issue # 4
Your brother owns a small company that sells medical supplies like stethoscopes and tongue depressors to Beth Israel Medical Center. You are an electrician in the Department of Facilities Management and have nothing to do with his products. Should you tell anyone about this relationship?

Answer: Yes. You should discuss this issue with your manager who should refer to the Continuum Conflict of Interest Policy, as well as contact the Corporate Compliance Officer to make sure that no conflict exists.

Compliance Issue # 5
You are a nurse in Labor/Delivery and your co-worker, who just returned to work from maternity leave after she had her baby, is stealing baby formula and pampers from the unit. She is a friend of yours but you don't like the fact that she is stealing. What should you do?

Answer: While this may pose a difficult personal situation for you, in accordance with the Code of Conduct you owe it to yourself and to Continuum to let management or Human Resources or the Corporate Compliance Officer know what is happening. If you want to remain anonymous, you could call the Corporate Compliance Hotline as well.

Compliance Issue # 6
You support a particular political candidate in your community and would like to send some E-mails at work on your Continuum PC to fellow associates and friends to encourage their support. Is this okay?

Answer: It is admirable that you are involved in the political process. However, unless your job requires you to do so, you are not permitted to utilize Continuum's resources (your time, funds, equipment, or materials) to support a particular candidate, and you should not engage in political activities while on the job.

HIPAA

General

HIPAA stands for a federal law called the Health Insurance Portability and Accountability Act. This law, among other purposes, was created to protect the privacy and security of patient healthcare information, which is considered Protected Health Information ("PHI"). It also established uniform standards for electronic billing and the computerized transfer of healthcare information.

Protected Health Information

PHI includes any information (i.e. oral, recorded on paper, or sent electronically) that is unique to a patient and by itself can identify that person in regard to their physical or mental health, services rendered or payment for those services, including personal information connecting the patient to the records. Some examples of PHI include:

- Name
- Address
- Social security number
- Telephone number
- Medical record number
- E-mail address
- Hospital admission date
- Discharge date, etc.

Generally, PHI cannot be used or disclosed by staff without a patient's consent or authorization, unless it is for "TPO". TPO stands for Treatment, Payment and Operations.

Treatment- refers to how Continuum and its health care providers manage, coordinate or provide health care. This includes consulting with other health care providers or patient referrals.

Payment*-* refers to the activities necessary for Continuum and its health care providers to obtain payment for rendered services.

Operations- refers to the administrative, financial, legal and quality improvement activities necessary to support Continuum functions relating to treatment and payment.

Notice of Privacy Practices

The HIPAA law requires that all patients be provided with the written Continuum Notice of Privacy Practices ("NPP") when utilizing Continuum health services for the first time. The NPP informs patients of their rights regarding the use and disclosure of PHI as well as Continuum's legal obligations to safeguard the PHI. Patients are asked to sign an acknowledgement form noting their receipt of the NPP.

Minimum Necessary Rule

The HIPAA regulations require Continuum to take reasonable steps to limit the use and disclosure of PHI. The least amount of PHI required for you to do your job effectively is considered "minimum necessary". Staff need to be careful in terms of how they use and share PHI. Basically, disclosure of PHI must be limited to the least amount needed to get the job done right.

Business Associates

Under HIPAA, when Continuum shares patient information with contracted vendors such as transcription services or billing companies, they become "business associates" and must also follow HIPAA rules. Continuum's **"business associate agreements"** (contracts) with these vendors must include an acknowledgement of HIPAA compliance.

Privacy Officer

Continuum has appointed a Privacy Officer who has overall responsibility for ensuring compliance to the HIPAA regulations. Louis I. Schenkel, the Corporate Compliance Officer, also serves as the Continuum Privacy Officer. Among his HIPAA duties are the drafting of policies and procedures. These policies are posted on the Continuum Intranet web site.

The Privacy Officer is also responsible for investigating and acting upon privacy complaints. Similar to Corporate Compliance issues, associates and others may not be retaliated against for making good faith reports of privacy violations.

If you have any questions or concerns about compliance with the HIPAA Privacy Rule, speak to your supervisor or the Privacy Officer, who can be contacted at (212) 523-2162.

Your Role in HIPAA

- Ensure that PHI is not disclosed improperly

- Do not discuss PHI in elevators or in public areas such as cafeterias where your conversations may be overheard

- Protect and do not share computer passwords

- Make good faith reports of HIPAA violations to the Privacy Officer

HIPAA Case Scenario # 1

You work in the Medical Records Department and a certain physician requests medical records of patients that she is not involved with. Is he allowed to do this?

Answer:
No. Only the attending, covering or consulting physicians may have access to patient medical records. "PHI"- Protected Health Information, can only be released for the purposes of "TPO"- Treatment, Payment or Operations. Patients are entitled to expect confidentiality, the protection of their privacy and the release of PHI only to authorized parties. This physician should be reported to your supervisor or to the Corporate Compliance Officer.

HIPAA Case Scenario # 2

You are a physical therapist who just found out that your favorite teacher from high school is in the Emergency Department arriving via ambulance after a car accident. She had X-rays taken and her husband has asked you to get the results since you know the radiology supervisor and the Emergency Department physician is busy with another patient. Should you do this?

Answer:
No. Even though you have the ability to get the X-ray results, this patient's PHI has nothing to do with your job, nor is it related to TPO. If you obtain the results from the radiology supervisor, both of you will be violating HIPAA, the Code of Conduct, and subjecting the hospital to the risk of liability for breaching the patient's right to confidentiality and privacy.