AND THE ENVIRONMENT OF CARE
BROADLAWN MANOR
SOUTH OAKS HOSPITAL

2015 ANNUAL MANDATORY COMPETENCY PROGRAM ON SAFETY, QUALITY CARE AND INFECTION PREVENTION AND CONTROL

Enclosed you will find the Annual Competency Education for 2015. The topics and information included have been identified as essential for all employees to learn.

You will find a copy of the health system Mission, Vision and Values, along with other relevant topics in an effort to continue to get all of our employees familiar with information and expectations.

As we believe you will see, our objectives and mission of Caring for People falls right in line with the health system expectation of always putting our patients first.
Program Objectives

After reviewing the content of this program, the learner will be able to:

1. State the mission, vision, and values and expectations of both the facility and health system.
2. State responsibilities in upholding the core values of the organization.
3. Identify ways to prevent or minimize workplace injuries or illness.
4. Describe their role in relation to general safety in the workplace including patient & resident safety goals, fire safety and security.
5. Verbalize value of teamwork and collaboration.
6. Follow and enforce hand hygiene procedures.
7. Demonstrate behaviors that illustrate cultural competence.
8. Identify at least two patient or resident safety goals related to areas of responsibility.

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Mission, Vision, and Values and Expectations

Mission
To improve the health and quality of life for the people and the communities we serve by providing world-class service and patient-centered care.

Vision
To be a national healthcare leader, committed to excellence, compassion and improving the health of the community.

Values and Expectations
The health system's core values are Excellence, Integrity, Teamwork, Innovation and Caring. By putting these core values into action, we ensure that our customers have the best possible experience at our facilities and when receiving our services. We always put our patients first. Each team member always demonstrates our values by making them a part of your daily routine: Always putting our customers first, working as a team, promoting quality and pursuing excellence are just some of the expectations we have of our team members.

North Shore LIJ

CUSTOMER EXPERIENCE
Patients First
Deliver exceptional and personalized care and service to exceed our customers' expectations.

INTEGRITY
Act honestly and enthusiastically promote excellence at all levels.

EXCELLENCE
Promote quality to reach performance to achieve best-in-class outcomes.

TEAMWORK
Always strive to work together to address organizational goals.

CARING
Innovate empathy to understand and enhance our environment of care.

INNOVATION
Generate unique solutions to positively impact business goals.

October 2015
Teamwork

Teamwork is coming together, working together, and succeeding together.

Effective teamwork:

- Allows for getting more done in less time — and with less cost.
- Is driven by a clear purpose and a stated goal.
- Functions through clearly defined goals.
- Promotes a sense of connection and belonging.
- Emphasizes the value of diversity.
- Allows different preferences to lead to useful and effective problem solving.

- Improves communication.
- Reduces conflict and stress.
- Values the strengths of others.
- Equals total team participation.
- Leads to increased cooperation.
- Leads to increased conflict management.
- Assists with change management.

TeamSTEPPS

Keep on Track with Team STEPPS: Improve Safety and Enhance Communication!

Brief: a short planning session before care and work begins.

Debrief: a brief review at the end of the day or after an event to see how things went and suggest ways to make solutions better.

Huddle: a short meeting to solve problems. Each team member can call a huddle.

CUS: “I’m Concerned, I’m Uncomfortable, This is a Safety issue.”

DESC: Describe, Express, Suggest Consequences. A constructive way to resolve conflict.
Service Excellence

Our Health system embodies a culture of C.A.R.E. By pledging to C.A.R.E. you are committed to upholding the values and mission, while remaining committed to the wants and needs of our patients and customers. We have two additional frameworks for which we deliver care; our communications framework C.O.N.N.E.C.T. and our service recovery model L.A.S.T.

**Patient Satisfaction**

*Our #1 Priority*

- Employee Name
- Wear ID badges at all times
- Make eye contact with other employees, patients, visitors and share a greeting such as, "Hello, how are you, etc..."
- Hand prior to entering a patient's room
- Introduce yourself to the patient and tell them who you are and explain why you are there
- Before leaving a patient's room, always ask, "Is there anything else I can help you with?"
- Keep patients and families informed of what is going on: labs, new medications, treatments, etc...
- Improve communication among caregivers
- Assist in answering call bells

**Contact:** Smile, make eye contact, shake hands, touch on shoulder (as culturally appropriate)

**Opening Greeting:** Say good morning/good afternoon

**Name/Title:** Introduce yourself by name and title

**Needs:** Assess and address customer needs

**Explanation:** Set expectation of role and time together

**Close:** Close by asking if there is anything else you can do

**Thank:** Thank the customer

**Listen:** Pay attention, make eye contact and listen to the patient/resident/client

**Apologize:** "I apologize." "I'm sorry that happened to you."

**Solve:** Propose a solution, or find an alternative

**Thank:** "Thank you bringing this to my attention."

October 2015
Quality Management *(Formerly Performance Improvement)*

The health systems' vision is to be the most trusted name in healthcare. Providing high quality, safe patient care and services supports the health system in achieving this vision. Our goal is to eliminate unintended patient harm and to have the safest facilities with the lowest mortality rates. Providing the best value to the communities we serve is also a quality priority.

**Our guiding principles are:**

- Putting patients first and at the center of everything we do – patient engagement and empowerment.
- Building teamwork based on collegiality and mutual respect/physician alignment
- Promoting clinical excellence and patient safety.
- Supporting two-way, barrier free communication leading to a culture of safety and building trust.
- Adopting best practices and adhering to evidence-based guidelines.
- Transparency - measuring and publicly reporting our progress in terms of quality and patient safety on our website: www.northshorelij.com

**Your role in providing quality/safe care is to:**

- Maintain the highest standards of quality care and patient safety.
- Be a good team player – assist others.
- Observe the patient; assist as needed and/or ask for help.
- Involve patients and families in their care.
- Always seek assistance and ask questions when you are uncertain or unclear about something.
- Provide/promote different aspects of care such as infection prevention/hand hygiene, medication safety, and surgical safety.
- Document clearly and accurately in the patient’s medical record.

*If you have ideas about improving quality or safety, inform your manager or department head.*
The Joint Commission National Patient Safety Goals (NPSGs)

Each year, the Joint Commission issues National Patient Safety Goals (NPSGs), the purpose of which is to improve patient safety and assist organizations to focus efforts on urgent safety issues. All team members should be familiar with these goals and the requirements as they pertain to his/her position. The current National Patient Safety Goals focus on:

➢ Identifying a patient correctly. Use at least two (2) Patient Identifiers.

➢ Improving staff and physician communication, especially surrounding the reporting of abnormal test results that are critical to the patient’s care. E.g. CRRB

➢ Recording and passing along correct information about a patient’s medications, using medications safely, especially related to labeling of medications used during procedures and for those medications that are used to thin a patient’s blood.

➢ Preventing infection by always practicing proper hand washing and using proven guidelines to prevent infections that are difficult to treat or those that may be acquired while in a health care facility.

➢ Identifying patient safety risks, such as which patients are most likely to be at risk for suicide. Complete suicide assessment on admission, discharge, or any time as warranted by patient’s condition.

Reporting safety/quality concerns

Any employee who has a concern about the quality of safety of care provided in the organization may report these concerns to the Joint Commission or any regulatory agency. No disciplinary action will be taken as a result.

Online: www.jointcommission.org

Email: patientsafetyreport@jointcommission.org

Phone: 1 (800) 994-6610

Fax: (630) 792-5636

Mail: Office of Quality and Patient Safety
The Joint Commission
One Renaissance Blvd
Oakbrook Terrace, Il 60181.
The Joint Commissions National Patient Safety Goals for
Long Term Care

Goals that relate specifically to long term care:

Goal #1: Improve the accuracy of resident identification by using two resident identifiers when providing care, treatment or services, and labeling containers used for blood and other specimens in the presence of the resident.

Goal #3: Improve the safety of using medications by reducing harm from anticoagulation therapy and maintaining and communicating accurate resident medication information.

Goal #7: Reduce the risk of health care-associated infections by practicing proper hand washing and implementing evidence-based procedure guidelines to prevent central line-associated bloodstream infections.

Goal #9: Reduce the risk of resident harm resulting from falls.

Goal #14: Prevent health care-associated pressure ulcers (Decubitus ulcers).

The Joint Commission conducts an unannounced survey in the South Oaks Hospital every three years. If you have unresolved issues regarding patient safety and/or quality of care, you may contact the Joint Commission on Accreditation of Healthcare Organizations at the following address:

Division of Accreditation Operations
Hospital Service Team
The Joint Commission
One Renaissance Blvd.
Oakbrook Terrace, IL 60181
www.jcaho.com
Phone: 1 (800) 994-6610

We suggest you address concerns for resolution to your direct supervisor before utilizing TJC. We are interested in your ideas and suggestions for any improvement to patient care.
Safety/Risk Awareness

Staff awareness about safety risks within the Environment of Care begins with an overview during the initial orientation process conducted by both Human Resources and your department, and on an annual basis. Our goal is to continually foster a culture of safety. The topics have been identified through various methods (e.g. Quality/PI Committee, TJC Patient Safety Goals, DOH Alerts, Regulations, response to drills/events and completion of an annual hazard vulnerability analysis) so that you will know what to do to identify hazards, safeguard those hazards and report them for corrective action; and so that you will know how to respond to emergencies or urgent situations.

All employees are required to complete this safety competency education on an annual basis which includes all mandatory topics and a competency quiz. Department specific education is conducted on an as needed basis.

To promote an ongoing culture of safety, environment of care safety rounds are conducted on a regular basis throughout the facility. These rounds involve all staff working in the area(s) surveyed and also include safety education, follow up on prior recommendations/corrective actions, and staff feedback and suggestions on improvements needed. Awareness of environmental risks is also highlighted in various bulletins and newsletters.

Safety Management

Safety is everyone’s business! No matter what your job, you share the responsibility for maintaining safe conditions to protect yourself, other hospital staff, residents/patients and visitors. This team effort will create a safe and healthy environment for all.

➢ Report all injuries, however slight, to your supervisor and get immediate first aid. All injuries and incidents involving staff, patients and visitors require filing of an incident report.

➢ Report any unsafe conditions (i.e., damaged equipment) immediately to the appropriate department.

➢ Obey the “Tobacco-Free Environment” policy.

Reporting processes for common problems:
All Emergencies are reported using the 222 color code system which will be described under the Emergency Preparedness section of this packet.

Security Incidents: To report a non-emergency security incident contact the security department by dialing the operator, or by calling the security department directly at Extension 5492.

Employee Injuries: When an employee is injured he/she will report the incident to a Supervisor/Dept. Head as soon as possible. The supervisor will enter the accident report into the Meditech system. The Safety Officer and Human Resources Coordinator monitor these reports on a day-to-day basis in order to detect any trends, patterns or system failures.
Visitor Incidents: All Visitor incidents are reported to the Security Department directly or via the switchboard operator. The Security Director or Supervisor will conduct an investigation and complete an incident report using the Meditech system. Administration is notified and provided a copy of all visitor/security incidents.

Reporting methods for other issues include:
- Equipment failure/hazards
- General repair
- Carpet/Flooring repairs
- Safety hazards for non-emergency

Prepare "work order" for Engineering Dept.
Prepare "work order" for Engineering Dept.
Contact Environmental Services x 5401/5402
Call Safety Hotline x 5499

Safety Competencies

While we cannot completely eliminate the threat of an accident, we can improve the odds through teamwork. Safety is everyone’s responsibility!

Administration sets the tone for facility safety by implementing policies and procedures, and providing personal protective equipment. Administration also ensures that employees acquire an understanding of these procedures and the knowledge of how to use equipment properly.

Employee Responsibilities
1. Recognize hazards, correct conditions if possible, and safeguard the area.

2. Report hazards immediately to a Supervisor, Department Head or the Safety Officer.

3. Communicate via the SAFETY HOTLINE — extension 5499.

4. Take responsibility for keeping your work area safe and free of obstructions. 
   If it's broken, safeguard it and make the proper notification!

5. Understand and follow the guidelines for policies and procedures and learn the proper use of personal protective equipment.

6. Use proper BODY MECHANICS. Rearrange your workspace to avoid your need to strain your muscles or lift heavy objects. Do warm up exercises and be aware of proper lifting techniques to prevent injuries.

Safety and Security start with you. BE AWARE (Don’t be afraid to ask)

1. Report any incidents of potential harassment or workplace violence to a supervisor.
2. Familiarize yourself with the Wellness Program and Proper Body Mechanics.
3. Report all injuries sustained on the job to a supervisor immediately.
4. The Patient Safety Officer is Vincent Pozzolano
5. The Director of facility Security and Safety is Vincent Pozzolano.
Security Competencies

The Security Department strives to provide a safe and secure environment for all patients/residents, staff and visitors. The Security Department will take appropriate actions in order to prevent injury, theft and damage to equipment, buildings or personal property. It is also responsible for regulating traffic control and parking restrictions. Security serves to protect patients/residents, staff and visitors whenever and wherever possible.

Security “Codes”

222 Code Gray – If an employee witnesses or become aware of an incident involving a situation or confrontation that is or has the potential to become violent, he/she will dial 222, state “Code Gray” and give the location and a brief description of the incident. This will prompt an immediate security response to the location.

222 Code Green Active – In the event that the facility must be locked down internally due to a serious emergency such as a bomb threat, fire, chemical spill, child abduction or terrorist threats, the Security Department will implement the Code Green Active procedure. Code Green Active is the designation of a building or specific area as a “Frozen Area” off limits to all patients, visitors and non-essential staff until the emergency is over.

222 Code Green- refers to hostage situation and/or an incident where there is violence with a weapon.

Traffic/Parking Regulations

1 – Campus speed limit is 10 MPH

2 – Employees cannot park in the following designated spaces:
   a – “Physicians Only” in the Doctor’s Lot
   b – Visitor (green) spaces during visiting hours
   c – Fire (yellow) lanes or zones
   d – Handicap (blue) spaces.

3 – All Employees are required to have a L.H Parking Permit on all vehicles that they park on grounds. Contact Security at Ext. 5492 for more info.

Employee/Vendor Identification

All employees, vendors and outside contractors must display an identification card while on campus, at all times. All visitors must sign in at the receptionist. All visitors to Valentine Hall must acquire a visitor’s pass from the receptionist.

NOTE: If an employee sees any suspicious person in his/her work area, security should be notified immediately.
Diversity Awareness & Cultural Competency

The Long Island Home supports a work environment where all individuals are respected and valued regardless of age, ethnicity, gender, race, sexual orientation, physical/mental abilities, religion, socio-economic status or education. We recognize the value of a diverse workforce and how individual uniqueness can have a positive impact on our growth and change as an organization as we learn from each other.

Promoting a culture of safety and respect for all employees, patients/residents and their families is the responsibility of every staff member. By creating a warm and nurturing environment and by appreciating each and every person's characteristics we can improve teamwork, morale, the quality of care, patient/resident outcomes and assure the future success of The Long Island Home.

Cultural Competence is the ability of health care providers and organizations to understand and respond effectively to the cultural and language needs brought by the patient/resident to the health care encounter. We recognize that every person that enters the facility has a unique set of needs - clinical symptoms that require medical attention and issues specific to the individual that can affect his or her care.

Remember, we block communication when we lack cultural awareness and sensitivity.

Diversity and Inclusion

All employees should uphold the following:

- Deliver "culturally sensitive" care to patients and encounters with co-workers.
- Be culturally sensitive and possess the knowledge, skills and an accepting attitude towards those who differ.
- Be aware, understand and attend to the total context of each patient situation.
- Treat all patients and their families, colleagues, costumers and business partners with dignity and respect.
Diversity and Inclusion

What is Diversity and Inclusion?

➤ A mosaic of people who bring a variety of backgrounds, styles, perspectives, values and beliefs as assets to the workplace. It is a collection of different life experiences and genetics that differentiates groups and people from one another.

➤ Being inclusive creates an environment where all individuals feel supported, valued, appreciated and welcomed.

Why is Diversity and Inclusion Important to Health Care?

➤ Inclusive workplaces are fertile environments for new ideas and innovation.

➤ Diverse groups:

➤ Have better decision making and problem-solving skills.

➤ Are more creative.

➤ Deal more effectively with complex challenges.

By developing cultural competency and appreciating diversity we can:

- Improve Teamwork
- Improve Employee Morale
- Improve the Quality of Care
- Assure LIH's Future Success

Sample Checklist to improve Effective Communication, Cultural Competence, and Patient- and Family-Centered Care:

✓ Identify and address the person’s communication needs. Monitor changes in the person’s communication status throughout care and/or treatment.
✓ Identify and address the individual’s mobility needs.
✓ Identify the person’s cultural, religious, or spiritual beliefs or practices that influence care. Accommodate those needs and practices.
✓ Identify and address the person’s dietary needs or restrictions that affect care.
✓ Involve patient/resident families in the care process.
Non-Verbal Communication and Positive Approaches

The following guidelines should be kept in mind when interacting with patients, visitors and co-workers who may have different cultural beliefs or practices:

Non-Verbal Communication:

➢ Facial expression – may give many messages, positive and negative.
➢ Gestures – may be invasive, offensive or unpleasant.
➢ Contact – the individual may or may not want to be touched by others.
➢ Use of space – may be too close when speaking.

Positive approaches to Diversity in Culture:

➢ Seek and praise the uniqueness of others.
➢ Be willing to listen with an open mind.
➢ Remain open to ideas and people whose values are different.

➢ Maintain continued awareness of The LIH mission to Care for People; to provide quality care with dignity and compassion.

➢ Maintain continued awareness of The LIH Values of: compassion, dignity, diversity, efficiency, excellence, integrity, learning, respect, and teamwork.

➢ Being culturally competent doesn’t mean knowing everything about every culture. However, we do need to be open to learning about different cultures and to understand how culture may impact communication so it does not negatively impact healthcare outcomes.

It All Comes Down to Dignity and Respect – Cultural and language differences may create misunderstandings which may negatively impact clinical situations and working relationships among individuals.
Limited English Proficiency (LEP)

Some of our patients, their family members and visitors may speak a language other than English, or in addition to English, or have some Limited English Proficiency (LEP).

An LEP individual is a person who is unable to speak, read, write or understand the English language at a level that permits him or her to interact effectively with health and social agencies and providers.

Communicating with LEP Patients

The following are methods for communicating with LEP patients:

Medical Qualified Interpretation Services

➢ Qualified telephonic interpretation services available at all facilities. The Long Island Home uses CYRACOM phone system.

Non Medical Interpretation Services Language Bank – Administrative Interpreters

What Can We Do To Enhance Effective Communication?

Use “plain language”

➢ Have a conversation with everyday words and without medical jargon.

Use the “Teach-Back” method

➢ It is an excellent way to be sure your patient understands what you have explained to them.

➢ “I want to be sure I explained that clearly. Can you please tell me how you would explain what I’ve just told you to your wife when you get home?”

➢ If they can’t describe the information accurately, try explaining again, using different terms. Then ask your patient again to explain what you’ve told them in their own words. Repeat this process until they fully understand.

➢ Encourage your patients to ask questions by using an open ended approach

➢ Ask…What questions do you have?
Applicants and Employees with Disabilities

The Americans with Disabilities Act and New York State Law:

➢ Protect qualified individuals with disabilities from discrimination in employment, such as in hiring, advancement, discharge, compensation, job training and other terms, conditions, and privileges of employment.

The health system is required to:

➢ Employ qualified individuals with disabilities.

➢ Make reasonable accommodations for qualified individuals.

➢ Maintain the confidentiality of medical information.

Requests for Accommodations:

➢ Accommodation requests/reasonable accommodations may take many forms:
  - Granting a leave of absence or extending a leave beyond periods in law or policy
  - Making facilities more accessible
  - Restructuring jobs
  - Modifying work schedules
  - Reassignment to vacant positions
  - Acquiring or modifying equipment

➢ If you need to make a request for a reasonable accommodation, please speak with your supervisor or department head, or contact the Human Resources department (608-5506) or via email to HR Disability Manager group name.

The Interactive Process:

➢ Employee must generally request accommodation(s) unless the disability and need are obvious

➢ The LIH will engage in an interactive process to seek an appropriate accommodation

➢ The process involves a review of essential job functions and exploring requests for accommodation

➢ The LIH is responsible for maintaining an interactive communication process.
Emergency Management

All employees must be familiar with the system's emergency management procedures. The Emergency Operations Plan (EOP) describes how the organization will respond to any emergency, which may affect the environment of care or the organization's ability to provide essential services to patient, residents, employees or the community.

KNOW WHERE TO FIND THE PLAN! Each department has a green binder with a copy of the Emergency Plan. The EOP is also available on the LIH (I) Drive under Emergency Preparedness. For updates on facility response to events or unusual situations contact the Emergency Information Line: (631) 608-5520

Each department has a specific function outlined in the Emergency Preparedness Plan and will follow this plan:

- Your department will execute a phone call chain (refer to your department manual).
- Your supervisor will assign responsibilities for individual team members.
- Always carry and display your hospital identification badge.
- Personnel not needed in their own department may be asked to report to the labor pool to assist in other areas.

Hospital Incident Command System (HICS)

The health system uses the Hospital Incident Command System (HICS) response method during an emergency. The following are the 4 levels of HICS:

- LEVEL I: Activated when there is a potential for impact on hospital operations such as an event that may produce casualties, or an impending weather event.
- LEVEL II: Activated for an incident with minor impact on hospital operations.
- LEVEL III: Activated for an incident with moderate impact on operations (i.e. physical plant or utility disruption affecting a major area or general operations).
- LEVEL IV: Activated for an incident with significant impact on operations during potential for long-term duration.
Disaster-Emergency Preparedness

The Long Island Home has an Emergency Management Committee that meets regularly. It is a multidisciplinary team of administrative, clinical, and non-clinical personnel responsible to coordinate preparedness activities in the facility.

To report an emergency DIAL: "222" state the color code + location and stay on the line until you verify your message was received. Any employee may initiate a Code.

- Code RED = Fire
- Code BLUE = Cardiac Arrest
- Rapid Response = Medical Emergency (individual is alert)
- Code GREEN = Violence with Weapon
- Code GREEN ACTIVE = Lockdown
- Code = Missing resident/patient
- Code GRAY = Security needed
- Code RADIO = An emergency/event and we need staff to begin using radios
- Code ESCORT = Outpatient escort to Valentine Hall (SOH only)
- Code FLIGHT = Active Elopement
- Support Team = Psychiatric Emergency

To report an elopement of a patient (from SOH) dial 222 code yellow, then state location last seen.
Broadlawn Manor Nursing & Rehabilitation Center
Emergency Preparedness
Nursing Home Evacuation Plan

In the event of a weather emergency or other scenario that would require the evacuation of all or part of the facility, Broadlawn Manor has developed an evacuation plan in conjunction with the New York State Department of Health. The plan sets forth policy, procedures and guidelines for mitigation of, preparedness for, response to and recovery from the relocation or evacuation of residents and staff from the facility.

**Broadlawn Manor Evacuation Plan:**

- Utilizes the Incident Command System to organize and manage the evacuation response.
- The highest ranking person in the facility at the time of the evacuation is the Incident Commander.
- The decision to evacuate will come in the form of an order from the Suffolk County Supervisor.
- The authority to evacuate and activation of the plan is held in the following order:
  - Administrator
  - Director of Nursing
  - Nurse Manager
  - Nursing Supervisor
- Broadlawn Manor has agreements with other nursing homes that are located away from the coastline to evacuate to.
- Residents, their personal belongings, medications and all equipment needed to care for the resident will be evacuated to the new location.
- At a minimum, there should be enough supplies, medication and food transported to last 72 hours away from the facility.
- Residents should be evacuated in an orderly fashion using transportation levels designated by the NYSDOH. The levels are – Ambulatory, Wheelchair and Stretcher.
- The facility has med sleds on every nursing unit to utilize to transport non-ambulatory residents down the stairs if elevators are not functional.
- Broadlawn Manor will use our facility buses, Transcare vans and NSLIJ ambulances to transport residents to the evacuation location.
- A complete walkthrough will be completed by the Incident Commander/Designate before the building is vacated and the residents and staff leave for the evacuation site.
- Once the weather emergency is over, the Administrator will designate a team to return to the facility to evaluate the structure and determine if it is safe for residents to return.
- Once the facility is deemed to be safe, the residents and staff will return.

**Rapid Response Team:** To request a team to immediately assess/treat a patient with a worsening medical condition (SOH charge nurses only) **dial 222 Rapid Response Team** and state the location.
➢ The person in charge during an emergency is called the INCIDENT COMMANDER. The "IC" is the highest-ranking administrator or supervisor on-site at the time of the emergency until relieved by a more senior manager/administrator.

➢ The EMERGENCY OPERATION CENTER "EOC" is located in Carone Hall 3rd floor boardroom room 304 extension # 6053/6054. The "IC" and other leaders meet in the "EOC" to direct and plan the organization’s response.

Prepare your family for emergencies and disasters. Make a Plan! When your family is ready, you are ready.
Material Safety Data Sheets (MSDS)

MSDS provides information about the hazards of materials you work with so you can protect yourself and respond to emergencies. Information found on MSDS includes:

➤ Material’s Physical Properties
➤ Materials Toxicity
➤ Level of Protective Equipment Needed
➤ First Aid
➤ Response To Spills, Releases and Emergencies
➤ Disposal
➤ Name, Contact of Product Company
➤ Regulator Information

NOTE: MSDS must be readily available to staff at all times.

Hazardous Materials, Waste and Chemicals

HAZMAT & HAZMAT Subcommittee Manager: Jim Gravina, Director of Support Services – EXT. 5410

Hazardous Materials: Any biological (i.e., infectious material, sharps, etc.), chemical (toxic, corrosive, flammable, etc.) or radioactive substance that has negative health and/or environmental implications.

Hazardous Wastes includes hazardous chemicals, drugs or other materials deemed hazardous by the U.S. Environmental Protection Agency (EPA) and NYS Department of Environmental Conservation (DEC). They must be stored and disposed of in accordance with applicable Federal and State Regulations. Hazardous Chemicals include toxic, corrosive, flammable and reactive agents.

Precautions for handling all of the above:

➤ Ensure that all containers have labels indicating contents and associated hazards/warnings.
➤ Do NOT open/use any containers that do not have the appropriate label and associated warnings.
Use Personal Protective Equipment (PPE) to protect self and others from unnecessary exposures or contamination. PPE includes: gloves, mask, goggles, respirator, etc.

Know hazards associated with materials you work with.

Before you handle any chemical product:
- Read the container label
- Read the Material Safety Data Sheet (MSDS)
- Always follow proper procedures
- Take part in all chemical safety training

MSDS's describe how to use chemicals safely, provide information related to personal protective equipment and emergency first aid measures.

Understand and follow the guidelines for policies and procedures, and learn how to use Personal Protective Equipment (PPE). I.e. eye protection, hearing protection, a mask, gloves, protective footwear, etc.

There are several sets of comprehensive MSDS manuals, which have complete inventory listings of all chemicals used at the facility. These manuals are located in the Safety Director’s office (Valentine Hall), Environmental Services, Supervisor’s office in BLM and in the Employee Health/Medical Dept. office (lower level of Valentine Hall). In addition, each department has an inventory list and MSDS's for all chemicals used.

Safety is a two part responsibility. It is the employer’s responsibility to provide the information and equipment necessary to use chemicals safely. It is the employee’s responsibility to follow all safety procedures, to wear or use personal protective equipment as instructed, to report any hazardous conditions and any job-related injury or illness to the supervisor immediately and to exercise the rights provided under the Act, in a responsible manner.

Please note that we have classified chemical spills into two categories, INCIDENTAL and EMERGENCY. Incidental chemical spills are those most likely encountered by employees in patient care areas. These types of chemical spills should be handled in the usual manner. All chemical spills are NOT emergencies and Do Not require members of the “hazmat” or spill response team.

A list of spill response team members is located in the Safety Director’s office, the Environmental Services Dept., and both SOH and BLM departments.

In addition, the personal protective equipment and absorbent material needed to contain and clean the “emergency” chemical spills are located in the yellow cabinets in Valentine basement tunnel, just outside the lab.

**Globally Harmonized System**

OSHA modified the Hazard Communication Standard in 2012 to conform with the United Nation’s Globally Harmonized System (GHS), an international approach to Hazard Communication. GHS provides consistent information and definitions for hazardous chemicals by using:
Standardized 16-section Safety Data Sheets (SDS), which are replacing Material Safety Data Sheets (MSDS).

Standardized labels for chemical containers that include product name, manufacturer’s identification, pictograms, signal words, hazard statements, and precautionary statements.

The implementation dates for the new Hazard Communication Standard provisions are as follows:

- December 1, 2013; employers must train all employees on new labels and SDS format.
- June 1, 2015; chemical manufacturers, importers, and employees must comply with all modified provisions of the law.
- June 1, 2016; employers must update alternative workplace labeling and Hazard Communication Programs as needed, and provide additional training to employees for newly identified health or physical hazards.

**Safe Medical Devices**

The Safe Medical Devices Act (1990) was established so the FDA (Food and Drug Administration) would be notified of any suspected deaths or serious injuries resulting from a medical device, so the defect/problem could be detected and corrected quickly. As a hospital and nursing home, we have investigation and reporting requirements to comply with the regulations.

The Federal Government defines a medical device as anything used to diagnose, assess, treat, or provide care with the exception of drugs.

Examples of medical devices include:
- Thermometers,
- Hoyer-type lifts (any mechanical lifting devices)
- Syringes and catheters

In the event a patient, visitor, or worker is injured our first priority is always the injured person. Then,

- Notify the supervisor immediately,
- Remove the medical device from service and safeguarded it so there are no additional injuries, and
- Tag the device noting that it may have possibly injured someone

The device should not be disposed of, cleaned, or disassembled before an investigation of the incident has taken place.

Some incidents involving medical devices injuring patients, workers, or others will have to be reported to the Federal Government following investigation.
Lock-Out / Tag-Out Procedure

1. The Lock-Out or Tag-Out Procedure is used to protect workers from "HAZARDOUS ENERGY" when they do service on maintenance work on machines or equipment.

2. LOCK-OUT DEVICE
   a. It is the locking mechanism that isolates an energy source from a worker.
   b. A Lock-Out Device secures the energy isolating device in a safe position.
   c. When an isolating device is locked out, the equipment it controls will not work until the lock is removed.

3. TAG-OUT DEVICE
   a. Is when a warning tag "TAG OUT DEVICE" is secured to energy isolating device.
   b. The tag "TAG-OUT DEVICE" must be securely fastened to the energy isolating device and will state the equipment being serviced or maintained can't be operated until the tag is removed.

WHAT IS AN AFFECTED AND AUTHORIZED EMPLOYEE
1. Affected Employee - An employee who works in the area in which the energy control device is being used. An affected employee "DOES NOT" perform servicing or maintenance on the equipment.

2. Authorized Employee - An employee who performs servicing or maintenance on machines or equipment. The Lock-Out/Tag-Out device is installed by the authorized employee on the equipment being serviced.

REMOVAL OF THE LOCK-OUT/TAG-OUT DEVICE

The Authorized employee that installed the Lock-Out/Tag-Out device must remove it when all work is completed and it is safe to be removed.

Utility Management - Emergency Generators

The hospital / nursing home has five emergency generators for a total of 770 KW of emergency power.

Each emergency generator is inspected and tested under actual load and operating temperature conditions for at least 30 minutes, once per month, and under no load at all other times. A record of the test is maintained in the Main Power Plant. The emergency generators are tested under load of at least 30% or more of the rated KW.

Each generator has an adequate supply of fuel to insure 24 hours of continuous operation.
The emergency generators provide power for the following:

1. Emergency Lighting
   a) Exit signs
   b) Corridor lighting and means of egress
   c) Dining room
   d) Lounges
   e) Medication rooms
2. All Fire Alarm systems
3. Nurses call system
4. One elevator per building
5. Emergency communication systems
6. Heating and hot water systems
7. Medication and food storage refrigerators
8. Main kitchen and food preparation areas
9. Laboratory
10. Pharmacy
11. Electric switch gear room
12. Emergency Electric Outlets (RED PLATE)

**Impairment in Health Care Professionals**

The abuse of prescription drugs—especially controlled substances—is a serious social and health problem in the United States today. People addicted to prescription medication come from all walks of life. However, the last people we would suspect of drug addiction are health care professionals—those people trusted with our well-being. Yet health care workers are as likely as anyone else to abuse drugs or suffer from other emotional illnesses.

Even though the vast majority of DEA registered practitioners comply with the controlled substances law and regulations in a responsible and law-abiding manner, you should be cognizant of the fact that drug-impaired health professionals are one source of controlled substances diversion.

Valuable team members need to be retained and behavioral issues from drugs, alcohol, emotional distress and cognitive impairment can all be helped.

**What are My Responsibilities?**

You have a legal and ethical responsibility to uphold the law and to help protect society from drug abuse.

You have a personal responsibility to protect your practice from becoming an easy target for drug diversion and healthcare errors.
How Do I Recognize a Drug Impaired Co-Worker?

Drug abusers often exhibit similar aberrant behavior. Certain signs and symptoms may indicate a drug addiction problem in a health care professional.

Have you observed some of the following signs?

- Work absenteeism - absences without notification and an excessive number of sick days used;
- Frequent disappearances from the work site, having long unexplained absences, making improbable excuses and taking frequent or long trips to the bathroom or to the stockroom where drugs are kept;
- Excessive amounts of time spent near a drug supply. They volunteer for overtime and are at work when not scheduled to be there;
- Unreliability in keeping appointments and meeting deadlines;
- Work performance which alternates between periods of high and low productivity and may suffer from mistakes made due to inattention, poor judgment and bad decisions;
- Confusion, memory loss, and difficulty concentrating or recalling details and instructions. Ordinary tasks require greater effort and consume more time;
- Interpersonal relations with colleagues, staff and patients suffer. Rarely admits errors or accepts blame for errors or oversights;
- Heavy "wastage" of drugs;
- Sloppy recordkeeping, suspect ledger entries and drug shortages;
- Inappropriate prescriptions for large narcotic doses;
- Insistence on personal administration of injected narcotics to patients;
- Progressive deterioration in personal appearance and hygiene;
- Uncharacteristic deterioration of handwriting and charting;
- Wearing long sleeves when inappropriate;
- Personality change - mood swings, anxiety, depression, lack of impulse control, suicidal thoughts or gestures;
• Patient and staff complaints about health care provider's changing attitude/behavior;

• Increasing personal and professional isolation.

**Should I Become Involved? YES!**

If you recognize the aforementioned signs or symptoms in a co-worker, it's time to demonstrate concern. You may jeopardize a person's future if you cover up or don't report your concerns.

By becoming involved, you can not only help someone who may be doing something illegal, but more importantly, your action could affect the safety and welfare of your addicted employee or coworker AND those patients or the public who may come in contact with him or her. Contact your direct supervisor to report your concern.
Infection Prevention and Control

Infection Prevention and Control Coordinator SOH /BLM
Susan Bayh Martino, RN - Ext. 5643

Infection Control: Chain of Infection

Infection control is an important part of maintaining a safe and secure work environment. Understanding the chain of infection (below) will prepare you, should there be a threat of infection. Since the agent and the host are difficult to control, the focus of infection control is directed toward breaking the chain.

Breaking the chain of infection involves ALL healthcare workers!

- Infectious diseases are a major risk to patients, visitors and staff. Diseases are most commonly spread on the hands of caregivers, or environmental surfaces.

- Hand hygiene is the most effective way to prevent the spread of infection. As a minimum, hand hygiene must be performed before the start of the shift; after removal of gloves; before and after patient/resident contact; before and after using the toilet/toileting someone else; before eating, or feeding someone else; and after picking anything up off the floor.

- Standard precautions require the use of Personal Protective Equipment (PPE) whenever any contact with blood, body fluids (which may contain blood), mucous membranes or non-
intact skin is anticipated. PPE most commonly means gloves but in certain situations would also include masks, goggles and or gowns.

Every unit has a PPE box to store these items. In order to prevent the spread of microorganisms, Personal Protective Equipment must be removed, and hand hygiene performed, as soon as the task that required it is completed

**FOLLOW THESE GENERAL UNIVERSAL PRECAUTION GUIDELINES:**

**PREVENT INJURIES FROM SHARPS:**

- Dispose of used sharps promptly after use in designated containers only. **NEVER** reach into the container. Sharps include needles, razors and broken glass
- Utilize needle -- protective systems properly, at all times
- Call to have sharps containers removed and replaced when ¾ full. **NEVER** reach into a used sharps container. Environmental Services is in charge of sharps removal

**ACCIDENTAL SHARPS EXPOSURE:**

- High-risk exposure can occur from a needle stick with a used needle; from a used razor or other sharp objects; or from a human bite that punctures the skin.
- If accidental exposure occurs, don’t panic! Take immediate action to decrease the likelihood of disease transmission. Immediately wash the exposed area; call your supervisor and employee health; fill out an incident report.

**ASK FOR INFORMATION ABOUT:**

- Pneumococcal vaccine which provides protection against one of the more serious forms of pneumonia, is indicated for everyone age 65 and over, age 50 and over with medical conditions, and for asthmatics and smokers.
- The Hepatitis B vaccine – getting vaccinated is the most effective way to prevent this disease. Vaccine provided here free of charge.
- Flu Vaccine – The most effective way to protect your patients / residents, your family and yourself is to be vaccinated every Flu season. Vaccines are provided here free of charge (mid October → April). Flu vaccine is available as a shot or nasal spray.
- Getting the Flu shot will NOT give you the Flu, as the Virus in the shot is dead.
- Varicella, Pneumococcal, Tetanus, Diphtheria, Pertussis Measles, Mumps, Hepatitis B, Shingles and Rubella Vaccines are provided to those who need them, free of charge

**Contact Employee Health @ Ext 5313**
Tuberculosis (TB) is a bacterial infection that can be dormant (latent) or active (spread to others through respiratory secretions). While most commonly found in the lungs, TB can be found in many parts of the body (brain, kidneys, bones and joints). All health care workers must be tested or screened annually for TB either via the PPD skin test or a review of signs and symptoms of active TB disease.

Infection Control breaks the chain of transmission between the germ reservoir and the susceptible host.

Infection control precautions require some judgment for each situation. Changing conditions can change your potential exposure. Keep alert.

Per OSHA the blood and certain body fluids of all patients/residents are considered potentially infectious for HIV, Hepatitis B, Hepatitis C, and other blood borne pathogens. Since we do not routinely test all patients/residents, it is always possible that someone is infected and we don’t know it. Use standard precautions for all patient/resident care.

A “Stop” sign outside a patient or resident room indicates that some sort of Protective Precautions are in place, either contact or droplet. Check with the Nurse in Charge to see what Precautions are required.

Hand washing – Use proper hand washing technique!! Minimum time needed to wash hands properly is 15 seconds. If you cannot determine how long the minimum amount of time is, sing a song (such as the “ABC” song or the “Happy Birthday” song twice) in your head, and before you know it, you are done. Dry hands and turn off faucets with clean paper towels.

Alcohol based Hand Sanitizer gels: such as “Purell” are a good substitute for hand washing most circumstances (Exception: When hands are visibly or noticeably soiled or if caring for a patient or resident with GI illness, such as, C-Diff, or vomiting/diarrhea, hands must be washed with soap and water). Alcohol is effective at killing germs but must also be completely dry before going near an open flame or plugging in any electrical equipment. Purell is also not allowed in food-prep areas.
**Respiratory Hygiene/Cough Etiquette**

The following measures to contain respiratory secretions are recommended for all individuals with signs and symptoms of a respiratory infection.

- Cover your mouth and nose with a tissue when coughing or sneezing; PREFERRED: to cough or sneeze into your arm/elbow as this is less likely to transmit organisms
- Use in the nearest waste receptacle to dispose of tissues after use;
- Perform hand hygiene (e.g., hand washing with soap and water, or alcohol-based hand rub) after having contact with respiratory secretions and contaminated objects/materials.
- When possible, encourage patients/residents to do the same

**Masking & Separation of Persons with Respiratory Symptoms**

During periods of increased respiratory infection activity, masks can be worn by persons who are coughing, or by the staff providing care to them. Either procedure masks (i.e., with ear loops) or surgical masks (i.e., with ties) may be used to contain respiratory secretions. When space and chair availability permit, encourage coughing persons to sit at least three feet away from others in common areas.

**Droplet Precaution**

Advise healthcare personnel to observe Droplet Precautions (i.e., wearing a surgical or procedure mask for close contact), in addition to Standard Precautions, when examining or caring for a patient with symptoms of a respiratory infection, particularly if fever is present. These precautions should be maintained until it is determined that the cause of symptoms is not an infectious agent, or the person no longer shows signs/symptoms.
Suicide Awareness and Prevention

Depression is the major cause of suicide.

**Major risk factors in suicide are:**
- A family history of suicide
- A history of past attempts
- Look at discoverability, rehearsal, lethality
- A history of physical/childhood sexual abuse
- Repeated failures at sobriety from drugs/alcohol
- Affect is one of desperation, fear of life unraveling
- No sense of hope or relief, making death preferable

**Examples of Behaviors and risk factors to be aware of by population:**

- Giving away possessions, sudden peacefulness/calmness

**Adolescent/Young Adult Population-Behaviors**
- Restlessness and irritability
- Drop in school performance
- Involvement with drugs and alcohol
- Preoccupation with themes of death and violence
- Disturbed sleep/appetite
- Revenge suicide

**Middle Adult/ Senior Adult-Behaviors**
- Persistent, sad, anxious mood
- Constant fatigue
- Persistent physical symptoms that do not respond to treatment
- Delusion that one is dying or seriously ill
- Repeated verbalizations of hopelessness, self worthlessness

**Risk Factors- Mid-Senior Adult**
- Major loss
- Lack of family/community support
- Recent diagnosis of illness with dire prognosis
- For chemically dependent pt: social stressors-debts, fraud, estranged family and friends, job loss, fear of withdrawal and behavior under the influence
- Religious/Cultural beliefs that see suicide as an accepted action for shame and failure

**Protective - Preventive factors that reduce the risk of suicide:**
- Support network
- Reason to live
- Religious/Cultural beliefs that prohibit suicide
- Having a pet to care for
- Having a hobby

✓ **Staff Interventions – Suicide Prevention** Some important steps to take to prevent suicide include: Take the concern seriously; Do not provoke the person, Listen and try to be understanding; and Communicate with members of the treatment team or the supervisor.
✓ If you see something suspicious, please report it immediately to the appropriate clinician, charge nurse or supervisor.
✓ Remove access to means of suicide through a thorough Body Assessment, Environmental Safety Checks, Contraband searches and room searches.
✓ Keep the environment free of any potential means that a patient may use to harm himself or herself

Psychiatric Hospitalization itself is protective by providing an environment of safety and by offering treatment for patient’s mental illness or chemical dependency.

**Non-Discrimination Non-Harassment**

"It is the policy of The Long Island Home to provide a work place free from harassment on the basis of sex or gender of any employee by a supervisor, employee, client/customer, visitor, or the representatives of businesses with whom the employee interacts as part of his or her job. Sexual harassment is a form of misconduct which undermines the integrity of the employment relationship and will not be tolerated by The Long Island Home.

“Just as sexual harassment is strictly prohibited, so is harassment on the basis of race, color, ethnicity, disability, religion, national origin, age, veteran status, sexual preference, citizenship, marital status, or any other category protected by law.”

- **Harassment is a form of unacceptable conduct that negatively affects:**
  - Employee satisfaction and performance
  - Other employees
  - Patients/residents/clients, and
  - The organization as a whole.

- **Harassment is also illegal and will not be tolerated.**

**Sexual Harassment in the Workplace**

- **Sexual harassment includes repeated, unwanted behaviors such as:**
  - Unwelcome sexual advances
  - Sexually offensive pictures/images
  - Sexually offensive jokes
  - Teasing about a person's sex/gender
  - Requests for sexual favors
  - Suggestive comments; Sexual innuendos
  - Sexually oriented “kidding”, “teasing”, “practical jokes”

- All employees should be careful about their actions and sensitive to the possible effects of their behavior on those around them. A good rule to follow is: treat fellow employees with courtesy and respect, and you can be sure that you are not harassing anyone.

- Report any incidents of sexual harassment that you experience or witness to your supervisor or the person’s supervisor, or site human resources.
COMPLAINTS OF HARASSMENT

- Complaints of harassment must be reported to one of the following:
  - Immediate Supervisor
  - Department Head
  - The Director of Human Resources / Ext. 5500
  - The Director of Safety and Security / Ext 5490

- Employees have a right to a work place free of harassment, and a right to be free of retaliation for making a complaint of harassment or participating in the investigation of such a complaint.

- Possible corrective actions in the case of a substantiated complaint may include discharge of any employee who violates the policy on harassment.

Violence Prevention

We support a Trauma-Informed Coercion-Free Environment of Care.

Prevention of injury to patients, residents and employees is a primary goal of the LIH.

- Recognize early stages of escalating behaviors which might lead to violence and seek assistance

- “Step Back” and call for help, or initiate either a Code 13 or a Code Green, when possible to prevent injuries

- Involve patients in communicating what works best for them in order to prevent violence

- Adhere to policies and procedures RE: safe intervention

- Avoid physical intervention without help, unless there is an imminent threat to safety

- Wear long sleeve shirts / lab coats to protect against scratches and bites.

- Monitor yourself and co-workers to ensure optimal communication skills and avoid precipitating patient acting out, power struggles, etc.
Patient’s Bill of Rights

New York State mandates that the Patient’s Bill of Rights is distributed to all patients admitted to a hospital. Each admitted patient is provided a booklet titled, “Your Rights as a Hospital Patient in New York State,” which contains the Patient’s Bill of Rights along with other key information pertinent to their rights and regulations. The Patient’s Bill of Rights is available in other languages and can be generally obtained through the facility’s language assistance coordinator. It is each team member’s responsibility to ensure that the 19 patient’s rights are observed and respected at all times. Some examples of patients’ rights are listed below:

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

- 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.

- Receive treatment without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation, source of payment or age.

- Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.

- Receive emergency care if you need it.

- Be informed of the name and position of the doctor who will be in charge of your care in the hospital.

- Know the names, positions and functions of any hospital staff involved in your care and refuse their treatment, examination, or observation.

- Privacy while in the hospital and confidentiality of all information and records regarding your care.

- Receive complete information about your diagnosis, treatment and prognosis.

- 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.
Patient Rights

New standards have been implemented to enhance patient rights. Patients must be provided information regarding their right to have and to identify the following individuals:

Health Care Agent - a support person who has the legal authority to make health care decisions for the patient if the patient is unable to make his/her own decisions.

Patient Representative - participant in patient care and helps make patient’s healthcare decisions and carry out patient rights.

Support Person - makes decisions about visitation and provides emotional support and comfort during their stay.

Patients may choose to have one person to serve in all of these roles or choose different people for each role, or may refuse to identify anyone. It is their choice. These new roles do not override prior rules regarding advance directive or health care proxy.

In addition, patients must be asked if they have a physician who they want notified of their admission to the hospital.

The new standards promote visitation by family and friends while the patient is in the hospital. We are expected to accommodate patients’ requests for visitation to the greatest extent possible.
BLM Patient/Resident Rights and Abuse/Neglect

Patient/Resident Rights

- The LIH is committed to embracing and promoting patient/resident rights in all areas of the operation.
- All patients/resident will be treated with dignity and respect.
- All residents/patients have the right to voice grievances without the fear of reprisal.
- Patient/Resident rights to confidentiality and informed consent to treatment services will be protected under Federal and State regulations.
- Patients/Resident will be informed of their rights and responsibilities and of the procedure to register complaints and suggestions on admission.
- Patients/Residents will be informed about "unanticipated outcomes" both positive and negative by the attending physician.
- The LIH maintains a zero tolerance for violations of a patient/resident's right to be free from abuse, neglect, mistreatment and misappropriation of property.

All patients/residents must be informed of their rights:

Ensure Informed Consent
- Provide each patient/resident and family with the opportunity for informed participation in all decisions involving their treatment plan.
- Inform each patient/resident of their diagnosis and provide information when requested.
- Inform patient/resident of risk and benefits of all medications.

Ensure Confidentiality and Privacy
- Prepare and manage all communications and records pertaining to each patient/resident's care or personal information in a confidential and discreet manner.

Ensure Right to Refuse Treatment
- Respect any competent refusal of treatment. Patient/residents who object to any proposed medical treatment or procedure may not be treated over their objection except in cases that necessitate emergency treatment as outlined in regulation.

Ensure Advanced Directives are carried out
- Respect written instructions that describe a patient/resident's wishes regarding future treatment in the event they become incapacitated. Advance directives include Do-Not-Resuscitate orders and Health Care Proxy which appoints an agent to make healthcare decisions in the event they are unable to do so at a later time.

Abuse and Neglect
- All patients/residents have the right to be free from verbal, sexual, physical and mental abuse, neglect, corporal punishment, involuntary seclusion and misappropriation of property.
- Abuse is defined as the willful infliction of physical or mental harm to a patient/resident.
- Neglect is defined as the failure to provide services necessary to avoid physical or mental harm. You do not have to have willful intent for neglect to occur.
• All staff working in health care facilities are required by law to report abuse when they have reasonable cause to suspect it has occurred.
• All allegations of abuse must be reported by the facility to the New York State Department of Health.

What is your role in preventing abuse and neglect:
• If you witness abuse, stop it (if able) and get assistance from coworkers, security or your supervisor.
• Report any allegations of abuse whether witnessed or not to your supervisor.
• Report any injuries to resident/patients to the head nurse on the unit.
• Observe and report any signs of aggressive behaviors amongst patients/residents. Resident/patient to resident/patient abuse is also considered reportable to the State Department of Health.
• Observe yourself and your coworkers for warning signs that could lead to abuse or neglect including stress, burnout, fatigue and frustration.

BLM WANDERING/ELOPEMENT PREVENTION

Definitions:
Unsafe Wandering – resident wandering that is disruptive to other residents or places the wandering resident or others in danger.
Elopedent – when a resident successfully leaves the facility unsupervised and undetected.

Causes of Unsafe Wandering/Elopment Behaviors:
- Boredom
- Disorientation
- Stress/Anxiety
- Past Life Experiences

Behaviors/Actions that can lead to elopement:
• Stating that they want to go home
• Putting on a coat or other item that signifies their desire to leave
• Stating/actual packing for a trip
• Restlessness
• Calling out for family members or others who are not present
• Pacing
• Attempts to go to the elevators, doors or exits unaccompanied by staff, family or volunteers.
• History of elopement/unsafe wandering either in the community or in the facility.

All Staff Responsibilities:
• Everyone is responsible to be aware of behaviors that contribute to unsafe wandering/elopement.
• If you see these behaviors/actions, you MUST report them to the charge nurse immediately.
• Do not assume everyone knows the behavior.
Residents who are identified to be a HIGH RISK to wander/elope wear a Roam Alert Bracelet; have an orange triangle alert on the ID bracelet and orange tape on the back of the wheelchair.

**Roam Alert System:**

Broadlawn Manor is equipped with the Roam Alert system for elopement prevention. This is an electrical and computerized system that sounds an alarm when a resident who is wearing a special bracelet passes the sensor panel. In addition, it will indicate the resident’s location of the alarm on the computer at the nursing stations. Once the alarm sounds, ALL staff are responsible to take action to either redirect the resident and/or delay the system for the resident to pass the area. In addition, the alarm must be cleared on the computer at the nursing stations.

The Roam Alert alarms and keypads are located in the following areas:

- All Elevators
- Adult Day Care Entrance
- Main Entrance
- Employee Entrance
- MDR Door leading to the Main Patio
- Stairwell opposite PT Gym
- Adult Day Health Center

Roam Alert listings of residents who have alarm bracelets are located at the above locations and on every nursing unit. The elevators are not equipped with keypads that display the bracelet number. Staff should be able to identify the resident since the elevator cannot move until the alarm is cleared.

When a resident is in the area but has not crossed the alarm zone, the alarm will “chirp”. This means the system “senses” the resident in the area. No action needs to be taken at this time. When the resident crosses into the alarm zone, the alarm will ring in a continuous tone non-stop. At this point you must take action. ALL staff are responsible to respond to a Roam Alert alarm to ensure that the resident is safe and accounted for.

Please see Broadlawn Manor’s policies and procedures manual for additional details regarding your responsibilities and rights under the federal law.
Advance Directives

Advance Directives are declarations made by a competent person of their choices about treatment. They serve to protect the residents/patient's right to make his or her own choices/legally valid decisions concerning future medical care and treatment. Examples are:

Medical Orders for Life-Sustaining Treatment (MOLST)

➤ Do Not Resuscitate (DNR) and other Life-Sustaining Treatments (LST) - Written instruction to facility personnel concerning what actions to take if a terminally ill resident suffers a cardiopulmonary arrest (heart and breathing stops). Residents with a DNR have a red dot on their wristband, on their chart binder and in the HMR.

Living Will

➤ Written instructions that explain one's health care wishes, especially about end-of-life care.

Health Care Proxy

➤ Appointment of a health care representative to make healthcare decisions when unable to do so for oneself.

Ethical Issues

Difficult situations can arise when healthcare decisions must be made. For help with ethical problems or questions, notify your supervisor immediately so that issues may be referred to the facility Ethics Committee.

Refer to the facility's Administrative Policy and Procedure Manual which contains policies to guide ethical decisions relative to Health Care Agents and Proxies, Do Not Resuscitate Orders, Forgoing Life Extending Treatment, etc.
NOTICE

REPORTING REASONABLE SUSPICION OF A CRIME

All employees of Broadlawn Manor Nursing and Rehabilitation Center have the following responsibilities and rights under Federal law:

If you reasonably suspect that a crime has occurred against a resident or person receiving care in Broadlawn Manor, you must report that suspicion to the police and State Survey Agency:

AMITYVILLE POLICE DEPARTMENT
631-264-0400

NEW YORK STATE DEPARTMENT OF HEALTH
888-201-4563

You must make the report within two (2) hours after you first suspect that a crime has occurred if the suspected crime involves serious bodily injury to the individual, or within 24 hours if there is no serious bodily injury involved.

WARNING: If you fail to report your reasonable suspicion of a crime, you may be subject to a civil monetary penalty of up to $300,000 and/or you may be excluded from participation in any Federal health care program.

NO RETALIATION

Broadlawn Manor cannot punish you or otherwise retaliate against you for reporting your reasonable suspicion of a crime against a resident or person receiving care from this facility.

RIGHT TO MAKE A COMPLAINT

You have the right to make a complaint to the State Survey Agency (888-201-4563) if Broadlawn Manor punishes you or otherwise retaliates against you for reporting your reasonable suspicion of a crime against a resident or person receiving care from this facility.
The Long Island Home Compliance Office

The Long Island Home has a Privacy official to make sure no one breaks the privacy rule. The Compliance Office is responsible for coming up with the organization's privacy policies and enforcing them. If you see that someone is breaking the rules, report them to your supervisor, or anonymously by leaving a voice mail message on EXT. 5080. However, do not fear any retaliation if you report a privacy violation in good faith.

Passwords

Passwords and other security features that restrict access to the computer system protect patient information. If you have a password access to Meditech, NEVER share passwords or log in to the system using borrowed credentials. Letting someone else use your password, or logging on and letting him or her use the system in your session without you there is a violation against the Long Island Home's Policy. It is essential that the Long Island Home be able to tell who gains access to what records. DO NOT write your password down, post it, or keep it where others can find it.

Remember, "Loose Lips Sink Ships"

Personal cell phones & other electronic devices are only permitted in authorized break areas i.e. Cafeteria (Oak Room) or BLM Staff Lounge (across from the pharmacy) and may only be used when off duty. Personal cell phones and devices are not permitted in patient/resident care areas.

Deficit Reduction Act – False Claims Act

False Claims Act Reporting and Whistleblower Protections

To assist the health system in meeting its legal and ethical obligations, any employee who is aware of or reasonably suspects the preparation or submission of a false claim or report, or any other potential fraud, waste or abuse related to a health care program that receives federal or state funds is required to report such information to:

1. his/her manager;
2. the Compliance Director of the facility where he/she is employed;
   - LIH- Corporate Compliance Hotline at Extension 5080
3. the Chief Corporate Compliance Officer by calling (516) 465-8097; or
4. the Compliance Help Line by calling (800) 894-3226 or by visiting www.northshore-lij.ethicspoint.com

Individuals using the Compliance Help Line may choose to remain anonymous if they wish. It is the responsibility of all employees to understand the federal and state false claims statutes and the role of such laws in preventing and detecting fraud, waste and abuse in federal and state healthcare programs.

One of the primary purposes of the False Claims Act is to combat fraud and
abuse in government healthcare programs. The False Claims Act seeks to accomplish the goal by making it possible for the government to bring civil actions to recover damages and penalties when healthcare providers submit false claims for payment to the government.

The Federal False Claims Act (FCA) provides that any person or entity that knowingly submits a false or fraudulent claim for payment of United States government funds is liable for significant penalties and fines. The fines include a penalty of up to three times the amount recovered by the Government, civil penalties ranging from $5,500 to $11,000 per false claim, and the costs of the civil action against the entity that submitted the false claims. The FCA applies to all federally funded programs, including Medicaid and Medicare.

The FCA also contains a whistleblower provision. This allows a private person with knowledge of a false claim to bring a civil suit on behalf of the United States government to recover the funds paid by the government as a result of the false claims. If the suit ultimately is successful, the whistleblower who initiated the suit may be awarded a percentage of the funds recovered. The FCA also protects a whistleblower from retaliation by his/her employer. Employers may not discharge, demote, suspend, threaten, harass or discriminate against an employee as a result of the employee's lawful acts in furtherance of a false claims action.

The New York False Claims Act permits the New York Attorney General and local governments to bring lawsuits against any person or entity that knowingly presents a false or fraudulent claim for payment to the State or a local government. This statute also allows individuals to bring suits on behalf of the State for violations of the Act. In certain circumstances where the suit is successful, individuals may receive a portion of the funds recovered by the State.

Like the FCA, the New York False Claims Act prohibits all forms of retaliation by an employer against any employee who brings a lawsuit concerning false or fraudulent claims or who otherwise assists in the prosecution of a suit. Any employee who is retaliated against may be entitled to reinstatement, back pay and other compensation.

New York Labor Law §§ 740 and 741 also prohibit retaliation against employees who disclose information to regulatory, law enforcement or other similar agencies or public officials about employer policies, practices or activities that violate the law and create substantial and specific danger to the public health, that constitute healthcare fraud under Penal Law § 177 or that constitute improper patient care. The employee’s disclosure is protected only if it is asserted in good faith and if the information disclosed constitutes a violation of law or improper patient care. Labor Law § 740 also requires that the employee first raise the matter with a manager and give the employer a reasonable opportunity to correct the alleged violation.

Other New York statutes provide for fines and criminal penalties for making false statements for the purpose of obtaining services provided under programs such as Medicaid and Medicare. A detailed description of the federal and New York False Claims Acts and the other New York statutes and the specific rules
and procedures relating to fraud and abuse detection and prevention, including reporting rights and processes, are set forth in the Corporate Compliance policy #800.09 entitled "Detecting and Preventing Fraud, Waste and Abuse." A copy of this policy is provided to every employee and is also available on HealthPort and the North Shore-LIJ website. A summary of these laws also is available online at the Website for the Office of the New York Medicaid Inspector General at: www.omig.state.ny.us.

**HIV Testing / Records Keeping / Confidentiality**

**Important Points:**

- HIV is the virus that causes AIDS. It is spread through contact between human blood and other body fluids through sexual intercourse, the sharing of infected needles, transfusion or tissue transplantation or contact between infected body fluid and broken skin.

- The Hospital / Nursing Home admission policy does not discriminate against persons who are HIV positive.

- No Hospital / Nursing Home employee is permitted access to information about any individual's HIV status unless he/she is a designated member of the patient's treatment team.

- No staff member may reveal information about the HIV testing or status of a patient.

- Violation of confidentiality regulations may also violate state law and lead to arrest and criminal prosecution.

- All patients who may be at risk are educated about safe living procedures to avoid HIV infections.
FIRE SAFETY AND EVACUATION PLAN

ANNOUNCE: 222 CODE RED

➢ Rescue
➢ Alarm
➢ Contain
➢ Extinguish

1. ANNOUNCE / YELL! 222 CODE RED to all personnel in FIRE AREA.

2. RESCUE / EVACUATE patients from immediate danger.

3. ALARM / PULL FIRE ALARM BOX - Alarm box can be pulled by the person finding the fire or other personnel when they hear "222 CODE RED."

4. IMMEDIATELY DIAL EXTENSION - "222" - give the operator the building and location of the "FIRE." The operator will call the Fire Department to confirm the alarm.

5. CONTAIN / CLOSE ROOM DOOR - Hang towel over doorknob or place in front of door.

6. EXTINGUISH FIRE (IF POSSIBLE) - Use Fire Extinguisher from immediate area.

7. REPORT TO LOCATION OF ALARM - All designated personnel are to report to the Location of the alarm and seek direction from the Incident Commander. Fire Extinguishers from the floor/immediate area are brought to Fire Location.

8. FIRE AREA / UNIT EVACUATION - Under the direction of the Incident Commander (IC), evacuate all patients from the fire area through fire doors or down fire escapes.
   
   A. ROOM EVACUATION - look under beds, behind doors, inside closets, inside bathrooms and shower/tub areas.

   B. "CLOSE DOOR" - Hang towel over doorknob.

9. IF NO EVACUATION IS NECESSARY - Have all patients remain in their rooms, Day Area, Dining Room, etc. and close doors, as necessary, throughout the facility.

10. If the building Fire Alarm System MALFUNCTIONS, do the following:

    A. ANNOUNCE / YELL! "222" CODE RED - to notify staff on the floor/unit.

    B. DIAL "222" - State "CODE RED + Location" to the operator, who will notify Fire Department and Security Department.

    C. USE BUILDING PA SYSTEM - Announce "222/CODE RED" and location of the Fire.
FIRE DRILL PROCEDURE

✓ A "RED FLASHING STROBE LIGHT" will be placed in front of a room.

✓ The first person to see the RED STROBE LIGHT will follow the R. A. C. E. procedure (as noted earlier).

➢ Upon hearing Code Red the highest ranking supervisor in the area will put on the Incident Commander Vest.

➢ The IC is in charge of the drill/event and will direct staff and patients/residents to safety.

➢ All designated personnel are to report to the location of the fire drill and seek direction from the Incident Commander.

➢ The IC will remain in a designated area to oversee the drill and to direct staff and patients/residents.

➢ All staff involved will participate in a debriefing session at the conclusion of the drill.

Remember the THREE basic steps to Evacuate:
1. Move horizontally away from danger, behind fire doors. If necessary;
2. Move vertically, downstairs to the first floor. If directed then
3. Move outside the building according to your unit's evacuation plan.

FIRE FIGHTING EQUIPMENT

Fire extinguishers are located in all buildings and patient units as per the class of fire most likely to occur.

TYPE A FIRE - ordinary combustible materials such as: wood, cloth, paper, etc.

TYPE B FIRE - flammable liquids, oils, greases, oil base paints, lacquers, gasoline

TYPE C FIRE - involves energized electrical equipment where the electrical non-conductivity of the extinguishing media is of most importance (when electrical equipment is de-energized (unplugged) a Class A fire extinguisher may be used.)
FIRE EXTINGUISHERS

TYPE A  2½ Gallon Water Fire Extinguisher; use on ordinary combustibles

TYPE B, C  Carbon Dioxide and Dry Chemical Fire Extinguisher: use on flammable liquids or electric

TYPE A, B, C  Dry Chemical Extinguisher: flammable liquids and electrical fires

TYPE K--  Foam: Extinguishers located in Kitchen for use on Grease Fires

FIRE EXTINGUISHER USE

To use a Fire Extinguisher – Remember “P. A. S. S.”

P  Pull the Locking Pin.
A  Aim the Nozzle at the base of the fire.
S  Squeeze the handle.
S  Sweep the nozzle back and forth to extinguish the fire.

Then return the quiz to Employee Health Services in Valentine Hall. Thank you for your participation!
Thank you for taking the time to review this material.

To provide excellent patient care in an environment that is open, honest and fair, we must know the rules and play by them at all times. This is not only a financial issue. It is a matter of protecting the Health System. By ethically participating in the Medicare and Medicaid programs, we are more important than ever that everyone associated with the Health System knows the rules and follows them at all times.

The number of government audits has skyrocketed and will continue to grow. The fines and penalties for violations have been increased.

We welcome the North Shore-IL Health System's 2015 Compliance Training Program. Every year ethical and federal government increases.
Thank you,

[Paragraph discussing the Health System's compliance program and emphasizing the importance of reporting any violations.]

Vice President and Chief Corporate Compliance Officer, North Shore-LIJ Health System

A Message from Greg Radinsky,
The Code of Ethical Conduct

Objective

To establish the ethical and professional standards of conduct for all employees and contractors of the organization, as well as to promote a culture of integrity and compliance with laws, regulations, and company policies.

Scope

This code applies to all employees, contractors, and agents of the organization, and is effective upon adoption.

Definitions

(Provide definitions for key terms used in the code)

Responsibilities

Employees and contractors are responsible for:

1. Adhering to the ethical principles outlined in this code.
2. Reporting any violations or potential violations to the appropriate authority.

Violations

Any violation of the code may result in disciplinary action, including but not limited to:

1. Counseling
2. Warning
3. Suspension
4. Termination

Compliance

This code is intended to guide the actions of employees and contractors in their daily work. It is designed to be simple, clear, and easy to understand.

The Code of Ethical Conduct (The Code) emphasizes our commitment to compliance, which is demonstrated by our policies and procedures.
The Health System’s policy on gifts and interactions with industry which includes health care vendors such as pharmaceutical and medical.

The Health System’s policy on gifts and interactions with industry.

Please consult Health System policy #800.04, “Gifts and Interactions with Industry” for additional information. You can call the Office of Compliance at (516) 465-8087 if you have questions about the policy or its application to you. Please note that these arrangements with industry may be permissible but must be approved before services are provided pursuant to an agreement.
The Office of Corporate Compliance.

I would like to thank...the Office of Corporate Compliance.

The Anti-Kickback Statute.

The Anti-Kickback Statute prohibits payments by the Health System to any referral source for the purpose of receiving referrals of patients, providers, we do not pay for referrals, and we do not accept payment of any kind for making or receiving patient referrals from other health care providers or services that are reimbursed by Medicaid, Medicare, or any other federal or state health care program. Here at the Health System.
Important Federal and State Compliance-Related Laws: Deficit Reduction Act and
Payment Card Industry (PCI)
Health System policy #800.10, "Business Conduct is Essential to Your Health System," states that you must consult and follow the Stark Law. The Stark Law is a federal law that prohibits physicians from referring patients to certain healthcare providers in exchange for financial benefits. If you or your employer engages in any non-monetary compensation to influence referrals, you must comply with the Stark Law.

In particular, please note that the Health System cannot provide more than $392 per year in non-monetary compensation to certain entities, and those who receive such compensation may be subject to penalties. This is the reason why all Health System employees who interact with physicians must know and understand the legal requirements for these arrangements.

Recently, the Detroit Medical Center paid a $30 million penalty for failing to follow the Stark Law by engaging in prohibited activities.

Individuals who violate the Stark Law may be subject to significant penalties, including fines and possible exclusion from Medicare and Medicaid programs. Violations of the Stark Law are considered illegal, and serious violations can result in criminal charges.

Another important federal law is the Anti-Kickback Statute, which prohibits physicians from referring patients to certain healthcare providers in exchange for financial benefits. If you or your employer engages in any non-monetary compensation to influence referrals, you must comply with the Anti-Kickback Statute.

Health System policy #800.10, "Business Conduct is Essential to Your Health System," states that you must consult and follow the Stark Law. The Stark Law is a federal law that prohibits physicians from referring patients to certain healthcare providers in exchange for financial benefits. If you or your employer engages in any non-monetary compensation to influence referrals, you must comply with the Stark Law.

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Individuals who violate the Stark Law may be subject to significant penalties, including fines and possible exclusion from Medicare and Medicaid programs. Violations of the Stark Law are considered illegal, and serious violations can result in criminal charges.
The Emergency Medical Treatment and Active Labor Act (EMTALA)
the credit card handling policy—If you're not sure, ask.

Provide customer receipts showing more than the last four digits of the credit card number. Preferably, do not make assumptions about

Ask for or store credit card CSC/CVD or PIN code which is the three or four digits on back of card.

Permit

Store credit card information digitally in any format. For example, do not store the information in billing systems or in any other place of

You should never:

Send or receive credit card information over email, instant messaging, fax or any other medium that is not explicitly permitted by NSLI

You should never:

Summarized:
Think about your own job. What types of PHI do you work with? What steps do you take to safeguard our patients? PHI?

Identification

- Unless otherwise permitted by the Privacy Rule for RE.
  - 18. Any other unique identifying number, characteristic, or code.

PHI includes: Acquired or derived directly or indirectly from PHI.

- 17. Personal Health Information.
  - 16. Personal identifiers.
    - 15. Internet Protocol (IP) address numbers.
    - 12. Vehicle identifiers and serial numbers, including license plate numbers.

Age 60 or older.

- 11. Certified identification numbers.
  - 10. Account numbers.
    - 7. Social security numbers.
    - 5. Government-issued numbers.
    - 4. Telephone numbers.

Geographic units containing 20,000 or fewer people are

- 3. All combinations of digits (except year) for dates directly related to
  an individual, including birth date, admission date, discharge date, and
  death date.

A geographic unit formed by combining all ZIP Codes for all such

- 2. All geographic subdivisions smaller than a state, including street
  addresses, city, county, precinct, ZIP Code, and their equivalents.

Names.

There are 18 Elements of PHI:

- Only written and electronic. Any communication of PHI is covered by HIPAA.

Identifiable information about a patient’s health care services or payment for those services.

PHI is all individually

The HIPAA Privacy Rule puts restrictions on the use and disclosure of protected health information (PHI). PHI is all individually
Appropriate purposes by authorized individuals.

At the Health System we have to re-strat our efforts to ensure that all patient information is kept confidential and is used only for services such as outpatient care or legal assistance – sometimes while patients were still in the HR 
emergency room, patients’ medical records and personal identification information, and other related information are gathered with HIPAA policies.

In March of last year, two employees of Thomas Hospital Medical Center were charged with HIPAA violations for stealing and setting information about another patient on an individual’s computer, who used the data to solicit low cost and Deterrent is to be sentenced to 12 months in federal prison for improperly accessing 760,000 electronic health records and then

The medical community publishes warnings where patient data is lost, stolen or otherwise improperly acquired. A Patient Breach

per violation

This is a much higher standard than in years past. The fines and penalties for violations of HIPAA are now enormous — up to $1.5 million. Improperly accessing the health care provider can demonstrate that there is a low probability the provider health information was acknowledged. All health care providers are required to notify the federal government when confidential patient information is accessed, used or disclosed, result in serious fines and employers can be sent to jail for improperly handling a medical record, they were not authorized to view.

The Health Insurance Portability and Accountability Act, HIPAA.

The Health Insurance Portability and Accountability Act 40
Before I write my name on the board, I'll need to know how you're planning to use that data."

HIPAA - The "Minimum Necessary" Rule

Patient's entire medical record does not need to be disclosed.

Regarding a patient's bill from an insurance carrier, you only need to disclose the patient's PHI that relates directly to the inquiry. The minimum amount necessary to achieve the purpose of disclosure. For example, if you receive an inquiry or disclose only the minimum amount necessary to achieve the purpose of disclosure, you must use the "Minimum Necessary" rule. This rule states that when you are using or disclosing a patient's PHI, you must use the minimum amount necessary to achieve the purpose of disclosure. The HIPAA has a "Minimum Necessary" rule regarding PHI.
The right to be notified if the privacy of your protected health information has been breached, as defined by HIPAA.

The right to file a complaint with the Office for Civil Rights of the U.S. Department of Health and Human Services if HIPAA is violated.

The right to request and receive confidential communications concerning their PHI by alternative means.

The right to request a Notice of Privacy Practices at the first reasonable opportunity or by request.

The right to request an amendment of their medical records and to receive a response to this request within 60 days.

The right to request an accounting of the disclosures made of the patient's medical records to outside entities.

The right to opt-out of the patient directory while in the hospital.

The right to request restrictions on the release of a patient's medical records, including disclosures restricted to a health insurer when a record is maintained electronically by the health system.

The right to access, inspect, and copy a patient's own medical records, including the right to obtain an electronic copy of the medical record.

The Privacy Rule also gives patients certain rights with respect to their PHI. These rights are:

- The right to be notified if the privacy of your protected health information has been breached, as defined by HIPAA.
- The right to file a complaint with the Office for Civil Rights of the U.S. Department of Health and Human Services if HIPAA is violated.
- The right to request and receive confidential communications concerning their PHI by alternative means.
- The right to request a Notice of Privacy Practices at the first reasonable opportunity or by request.
- The right to request an amendment of their medical records and to receive a response to this request within 60 days.
- The right to request an accounting of the disclosures made of the patient's medical records to outside entities.
- The right to opt-out of the patient directory while in the hospital.
- The right to request restrictions on the release of a patient's medical records, including disclosures restricted to a health insurer when a record is maintained electronically by the health system.
- The right to access, inspect, and copy a patient's own medical records, including the right to obtain an electronic copy of the medical record.
marketing of a patient's PHI.

Under the regulations, patients have the right to receive a copy of their health information within a specified time frame. If the patient requests a copy of their PHI, the provider must provide the information in a portable format. If the patient requests to review their PHI, the provider must schedule a time for the patient to review their information.

In addition, the regulations require that providers limit the use and disclosure of PHI to the extent necessary to accomplish the intended purpose. This includes limiting the use and disclosure of PHI for purposes other than those related to the treatment, payment, or operations of the provider. Providers must also obtain patient consent before using or disclosing PHI for marketing purposes.

Finally, the 2013 HIPAA regulations included several changes that affect the use and disclosure of PHI. For example, the regulations clarified the definition of PHI and provided additional protection for individually identifiable health information. The regulations also included provisions for the protection of patient privacy and the security of electronic health information.
If you follow these steps, you will help to keep our patient's PHI safe.

Confidential Health System Information.

Paper containing PHI is regular waste basket or dumpsters. Please see policy 800.47 Disposal Policy for disposal of PHI properly. This means shredding it and disposing of it in locked bins. Do not drop or let a more private location before disposing it.

Remember that the rules about PHI include verbal, written, or spoken PHI. Don't discuss PHI where you can be overheard by others.

Office of Comptroller of Corporate Compliance, if you have any questions.

In general, PHI also can be used to obtain payment for health care services rendered to the patient, for health care operations, when permitted disclosure of PHI is to an individual who is involved in the patient's care, so long as the patient does not object to this disclosure.

It is important to note that PHI may always be used for treatment of a patient. No authorization or consent by the patient is required for

Confidentiality of Protected Health Information.

HIPAA - Use and Disclosure of PHI

HIPAA - Use and Disclosure of PHI
Don't be a victim of Cybercrime – Protect your personal data. Never give your password to anyone over the phone or through email.

Always check the email address of the sender. Here the name "Helpdesk" does not match the correct email address.

Cybercriminals attempt to use email to obtain your personal information. Take a look at one such attempt we received via email. The email was disguised to look legitimate. Click on the link to reveal the real destination. It's different if it looks suspicious or not.

Be suspicious of emails that require immediate action or create a sense of urgency. This is a common technique to rush people into making a mistake.

Be suspicious of emails that require personal information, especially financial information.

Cybercriminals attempt to gain access by using fake websites and phony calls designed to steal information. Take a look at one such attempt we received via email.

We also all need to be aware of the most current issues with phishing attacks and make sure we don't fall victim. A phishing attack is when...
Health System is working hard to ensure the security of our data through these safeguards and others.

- Encryption in transit – data is encrypted while being transmitted.
- Encryption at rest – data is encrypted while stored where appropriate and reasonable.
- Person or entity authentication – you are who you say you are (password, token, or both).
- Integrity – system checks to ensure no data has been manipulated other than intentional or by an unauthorized source.
- Audit controls – the ability to see who has accessed the patient’s record.
- Automatic logoff – after a certain period of inactivity, system should force a logoff.
- Emergency access – electronic records must be accessible at all times.
- Access control – everyone must have a unique ID and password and should never share it.

Technical safeguards – it is important that we all have a basic understanding of the technical safeguards as they help reduce the risk to electronic protected health information of PHI.

The technical safeguards include software to monitor for viruses, the encryption of data and system非凡的 of log on attempts.

- The Security Rule also requires device and media content to track hardwear.
- The physical safeguards required by the Security Rule include bodily access controls such as ID badges, which must be worn at all times.
- Security breaches and other violations and misuse of computer systems can be serious.

Types of safeguards:

- The HIPAA Security Rule protects electronic PHI and sets standards for the electronic transmission of PHI. The Security Rule provides three...
For more information about Identity Theft, please see Policy 990.11 to review our Identity Theft policy. If you suspect someone committed or contributed to financial or medical identity theft, contact Corporate Security right away.

North Shore-LIJ has a no-tolerance policy for misappropriation or misappropriation of confidential information. Violating this policy will result in disciplinary action, up to and including termination of employment.

According to the Identity Theft Resource Center, identity theft accounts for 43% of all identity thefts in the United States last year. That is much higher than any other category of identity theft, including banking.
CLOUD COMPUTING

As you can see, there are many situations that can result in a loss of a patient's privacy. In fact, equipment such as CDs, old workstations or laptops and USB drives need to be discarded properly when you're ready to dispose of them. You should call the IS helpdesk to set up an appointment for pick up of these types of items. Never throw them in the trash.

Another very important topic is Cloud based storage.

Cloud storage vendors that do not meet the health system's information security requirements cannot be used to store confidential information, including PHI and sensitive health system documents. Cloud-based storage refers to information residing on remote systems maintained by a third-party vendor, and accessed from the internet. Examples of cloud storage vendors that are currently unapproved to store confidential information include Google Drive, Dropbox and HighTail, among others. As an alternative to cloud-based storage, please use existing, secure systems such as your shared drive on the health system's servers.
If you are not sure how to encrypt emails at your location, please call the help desk. Please refer to Information System Policy.

The special rules for email communication with patients, such as patient consent and encryption, must be followed at all times.

- A patient's PHI should never be included in the subject line, as that does not get encrypted.

- Emails that contain a patient's PHI must have the word "secure" or the term "PHI" in the subject line, as the subject line will not be encrypted.

- Email communication with patients or about patients must be treated with the same confidentiality as the written or electronic medical record.

- Make sure that your emails are professional in all respects.

- Do not forward Health System email to a personal email account.

- Use the Health System email for Health System business only.

The basic principles for using the Health System email are:

- Extreme care should be taken when using email in the workplace, or when representing your workplace.

- Email, social media networks, and programs like instant messaging can be a lot of fun and they are also useful. However, you have to be

Email and Social Networks Health System Email
All computers and mobile devices must be password-protected and use a screen saver whenever possible in accordance with Health System policy. You should store all of your documents containing PHI on network drives, not on your computer’s hard drive.

Never leave a computer or any device containing PHI — or paper PHI — in a car overnight. You should even remove the computer, device or and screen devices. Lock your computer wherever you are not using it.

Computer users must actively protect Health System computers from loss or theft. It is very important that you keep track of your equipment and report any loss or theft.

Regulating the use of portable devices containing PHI. Policies help us to do this by informing us about the safeguards and procedures that must be utilized to secure PHI. For example, there is a policy within our document stored on a portable device or a computer, or spoken about between employees in an appropriate context. Health System employees who are responsible for protecting PHI. We are all responsible for protecting PHI.
The Compliance Helpline:

There are a number of ways that you can report violations. You can report to your supervisor, to the Office of Corporate Compliance or to the Health System’s policies and procedures.

EMTALA Violations, theft of company assets, shrink and anti-kickback violations, gift issues and violations of the Code of Business Conduct.

All Health System employees have a duty to report compliance-related violations. These include: HIPAA, coding and billing issues.

Duty to Report Compliance Violations

"Federal and State Breach Notifications" issues, along with any other applicable department, will handle the rest of the matter. Please refer to Health System Policy #001.7

Your responsibility is to notify Corporate Compliance as soon as you become aware of the potential breach. Compliance and Legal

No other than Compliance and Legal Affairs should attempt to make this determination or conduct an investigation into the alleged breach.

Breaches must be reported to the government and whether the affected patients need to be notified.

Compliance immediately, the Office of Legal Affairs will take the lead in making the determination as to whether the breach, if any, is HIPAA-related. This is not an investigation of an alleged HIPAA violation. Implementation of the Privacy Rule and corresponding the scope of the policy of PHI, an immediate use of disclosure of protected health information, which is detailed in, "An Unauthorized Acquisition, Access, use or disclose of unsecured, unencrypted protected health information which is included in "my covered entities or business associate, if applicable, demonstrates that there is a law.

HIPAA - Breach Notification
Health System Business Information and Employee Data

System Information for personal use or for any other unapproved reason is confidential at all times. You should only use this information when you are required to do so for your job. You should never share or use Health System information for any other reason.

In addition to PHI, please remember that all Health System business information which includes employee personal data should be treated as confidential at all times. You should only use this information when you are required to do so for your job. You should never share or use Health System business information for any other reason.

System Human Resources Policy: "Social Media Acceptable Use." Thinks before you act. Protect patient privacy and protect the Health System's confidential business information. Please refer to Health System's Human Resources Policy for more information on your personal Facebook or Twitter page.

Abolishing all Health System information should be posted on your personal Facebook account or other similar social media sites. This policy and the HIPAA Privacy Rules apply equally to anything posted on Facebook or Twitter that is patient Health Information or confidential business information.

Facebook and Twitter
THANK YOU.

ФАРВАРНІНГ® IS ACTIVELY MONITORING OUR ELECTRONIC MEDICAL RECORD SYSTEMS TO DETECT INAPPROPRIATE ACCESS. DO NOT RISK IT.

OFFENSES AND NOT ACCEPTABLE UNDER ANY CASE.

ФАРВАРНІНГ® IS OUR PRIVACY DESTRUCTION SYSTEM AND IT ALLOWS US TO MONITOR EACH EMPLOYEE'S ACCESS TO PATIENTS IN OUR ELECTRONIC MEDICAL RECORD SYSTEM.

ФАРВАРНІНГ®
The Compliance Helpline

Report of any issue, however, please be aware that making a false report could result in discipline and on the Helpline are investigated and resolved as appropriate. You can make a report by calling the Helpline at 800-894-3226 or by going online to www.northshore.nlitextension.com. The service is available 24 hours a day, seven days a week. You can make an anonymous report or you can use your name or other contact information. All reports received are investigated and resolved as appropriate. You cannot be retaliated against for making the Helpline to make a good faith report of any issue.
The contact information for the Office of Corporate Compliance is:

Kathy Abney, Corporate Privacy Officer
KathyAbney@uhs.com
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Jennifer Remmick, Corporate Director of Privacy Officer
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The Health System is committed to ensuring the confidentiality of your health information. Please read the Office of Corporate Compliance's Privacy Policy to find out how information about your health will be protected.

The Office of Corporate Compliance is committed to providing the highest level of care and integrity in all aspects of our business. If you have any concerns, please contact our Compliance Officer at (647) 331-4717.