Dear Volunteer:

Welcome to Mount Sinai Roosevelt and Mount Sinai St. Luke’s Hospitals. We are delighted to have you apply to become a volunteer. Our hard-working and dedicated volunteers play an important role at the Hospitals and enrich the lives of our patients. Whether it is helping an office worker or spending time with patients, each volunteer makes a valuable contribution.

Opportunities for volunteers exist throughout Roosevelt and St. Luke’s Hospitals. Some of the assignments involve patient contact, while others entail office support. We will try to place you in a position that will reflect a combination of your skills and interests with the needs of the Hospitals. Remember – whatever service you perform is vital to the total care received by our patients. We hope that you find your volunteer experience personally fulfilling and derive satisfaction from helping the Hospitals provide the highest quality care to its patients.

Roosevelt and St. Luke’s Hospitals is committed to assuring that all staff members and volunteers are highly competent and consistently provide quality services to our patients and our community. This handbook has been designed as a resource to help volunteers develop and maintain their competence. Topics have been selected because of their importance to our patients and our institution. It is essential that you carefully review the handbook at the time of your application and during each calendar year thereafter. This is an institutional requirement that will help us to meet the mandates of regulatory agencies such as The Joint Commission, the Occupational Safety and Health Administration (OSHA) and the New York State Department of Health (NYSDOH). If you have any questions about the content of the handbook and how it applies to you and your assignment, be sure to discuss these issues with the volunteer administrator for him/her to review with you.

After reviewing the handbook, please complete the test related to the content. Of course, you may refer to the handbook to check for the accuracy of your answers. Give your completed test to the volunteer administrator for him/her to review with you. Please remember to continue to incorporate the information that you have reviewed into your everyday practice.

You are very special to us. Thank you for your time and interest in joining the St. Luke’s-Roosevelt Hospital volunteer team.

Kathleen Dalton, Director of Volunteer Services
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Section 1

Environment of Care

- Security
- Emergency Management
  - Fire Safety
  - Body Mechanics
Environment of Care

Various departments are responsible for the Environment of Care (EOC). The EOC standards, policies, plans, and procedures can be found in the Environment of Care Manual.

Security

The security team is responsible for ensuring a safe environment for everyone who enters Mount Sinai St. Luke's and Mount Sinai Roosevelt.

EMERGENCY PROCEDURES:

CODE BLUE IS A SECURITY EMERGENCY
(For immediate security response due to threatening, aggressive or violent behavior)
For Security Emergencies at Mount Sinai St. Luke's and Mount Sinai Roosevelt
Dial 4444

Inform the operator of a security emergency

REPORTING “NON-EMERGENCY” SECURITY INCIDENTS:
(Such as a suspicious person in the hallways)
Security representatives are available 24 hours/day:
Mount Sinai St. Luke's 212-523-1000
Mount Sinai Roosevelt 212-523-7512

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

Security is Everybody’s Business - Minimizing Security Risks
The following are security measures that have been established to eliminate or reduce risk to patients, visitors, employees, volunteers and physical assets.

ID Badges
Identification badges should be worn at all times while on hospital premises. All employees (including physicians, volunteers, temps, etc.) must wear their badge at chest height with the photo clearly visible. An associate who loses their ID badge must report the loss to the Security Department and his/her supervisor.

Personal Property
Secure your workspace and vulnerable areas at all times.

Security Tips
• Stay Alert – observe who is in front of you and who is behind you. Don’t be distracted by diversions.
• If you are involved in a security incident, without being obvious, take notice of details: clothing, behavior, means of escape, unique features of persons.
• When possible, let someone know where you are going and when you expect to return.
• Remember anyone can be a victim of crime at any time. This can happen to you.
• **TRUST YOUR INSTINCTS** – If you feel uncomfortable, walk away, consider your options and notify security or seek other help.
• **Security #s - Mount Sinai Roosevelt** 212-523-7512 / **Mount Sinai St. Luke's** 212-523-1000
• **Do Not**
  - Panic
  - Try to be a hero
  - Travel alone
  - Approach vehicles for any reason
  - Fail to report a crime or suspicious activity

---

**Code Silver/Active Shooter Policy**

**Code Silver/Active Shooter Policy** is a coordinated response to minimize personal risk of injury/harm and loss of life in the event of an **Active Shooter** incident. Code Silver is activated if an active shooter is on the premises, actively engaging a firearm. You will be notified via an overhead announcement **Code Silver** and location.

**An employee or volunteer should:**
- Seek Cover and Evacuate if possible
- Shelter in Place (cover and conceal)
- Clear out hallways
- Dial 911
  - Give location
  - Give number of assailants
  - Give physical description of assailant(s)
  - Give number and type of weapons
  - Give number of potential victims and location

**Once police arrive:**
- Remain calm and follow officers command
- Put anything in your hands down
- Raise your hands and spread your fingers
- No screaming, yelling, or pointing
- Avoid quick motions
- 

**In addition:**
- Have an escape route
- Plan ahead for the “what-if’s”
- Recognize and report any workplace violence
The term **Code Pink** is used to denote infant/child abduction. All hospital employees and volunteers must be aware of the CODE PINK policy and their responsibility to exercise their role in response and awareness.

**Know how to respond…..**

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

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

- When a **Code Pink** is announced, all staff and volunteers in the hospital must be “on alert” and notify security immediately of anyone acting suspiciously. Be especially aware of persons carrying large bags or transporting an infant in arms instead of a bassinet.

- It is important to remember that **all employees and volunteers are the eyes and ears for the security staff**. Notify security if you see anyone or anything suspicious.

**Your Role During A Code Pink**

Understand what **CODE PINK** means and actively participate in drills. The following are the appropriate general responses for all MSSL&MSR employees and volunteers during a CODE PINK alert:

1. All employees and volunteers play an important role during a CODE PINK alert.
   - Be aware – look around-hallways/elevator banks/fire stairs. The abductor can appear anywhere in the building in an effort to leave!
   - Call Security Emergency line at 4444 and/or security for any suspicious activity you observe.
   - All employees and volunteers should make every effort to be aware of anyone behaving suspiciously - especially those who may be concealing a child in a bag or large coat, etc.
   - Provide a detailed description to Security: Height/weight/race/age/hair/clothing.
   - If the abductor is encountered, attempt to maintain a visual of the abductor, alert Security and other employees in the area, then wait for Security.
   - Always wear your Hospital ID. Maternal Child Health employees have a special access ID which contains an image of a blue bear.
   - Watch for “tailgaters” or “piggybackers” as you travel in or out of any locked unit that has newborns, infants or children.
Fire Prevention

The Fire Safety Plan familiarizes employees and volunteers with procedures to follow in the event of a fire. When procedures are followed, employees and volunteers will minimize injuries and loss of life among patients, visitors and personnel. *(Refer to the Fire Risk Plan in your Environment of Care Manual for additional information, EC 02.03.01, and EC 02.03.035.)*

It is the policy of MSSL&MSR to provide a healthy and smoke-free environment for all who enter our facilities. Smoking is prohibited in all areas of MSSL&MSR including but not limited to:

New York State Clean Indoor Air Act and New York City Local Law 47 bans smoking by hospital entrance doors

Smoking is *permitted only* away from all buildings in areas specifically designated and posted as smoking areas. All tobacco residues must be placed in an appropriate ash can or other waste receptacle located outside of non-smoking areas.

Fire Safety

Fire hazards arise from unsafe conditions and practices. Every and volunteer has a responsibility and vested interest in maintaining a safe hospital environment.

7 Tips for Hospital Fire Safety

1. Never yell “Fire!” - It can cause fear and panic. Use the phrase “Code Red” to alert other employees and volunteers in the area.

2. Smoke Barrier Doors - The hallway doors should close automatically when there is a fire alarm. Ensure there are no equipment, instruments or other items blocking the doors that would prevent them from closing. All patient room doors should also be closed by employees and volunteers with a quick word of explanation to the patients. (Note: doors are not considered closed until you hear the latch click in place.)
3. **Horizontal Evacuation to Area of Refuge** - The first phase of evacuation is moving patients to the other side of the smoke barrier doors or the area of the refuge on the same floor.

4. **Vertical Evacuation** - Moving patients to a lower floor can be dangerous. It should be done only when ordered by Fire Department personnel or the hospital safety designee.

5. **Elevators** - Never use elevators during a fire alarm situation. Use elevators only when directed by the Fire Department.

6. **Oxygen Shut Off** - The oxygen shut off valve should only be turned off when directed by the Nurse Manager or designee on the floor.

7. **Storage** - Do not store anything within 18 inches of the height of a sprinkler head.
Your Role In Fire Safety

It is important that you and all staff are prepared to respond to fires and other emergencies.

Everyone has a role and responsibility in the event of a fire emergency which may involve the removing of patients and others, sounding the alarm, or extinguishing a fire. All employees and volunteers should know the following:

- MSSL&MSR Fire Emergency Plan/Evacuation procedures
- The location of alarm pull/call boxes
- The location of and how to use a fire extinguisher

Please ask your manager/supervisor to explain or provide information on your department’s specific fire response.

When you are on your unit or department, please walk around and become familiar with the location of important fire prevention items:

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

**IT IS EVERYONE’S RESPONSIBILITY TO LISTEN AND RESPOND APPROPRIATELY TO FIRE ALARM ACTIVATION.**

**In the event of a fire: Ambulatory patients are evacuated first. Whenever a fire alarm is activated, remember to implement RACE.**

**R.A.C.E.**

This easy to remember acronym is our procedure in the case of a fire. Every employee is trained to recognize and respond appropriately in the case of a fire using this acronym.

- **R** - RESCUE / REMOVE persons in danger
- **A** - ALARM pull the alarm and then dial: 4444
- **C** - CONTAIN / CONFINE fire and close doors
- **E** - EXTINGUISH if possible and/or EVACUATE
Fire Extinguishers

A **fire extinguisher** is an active fire protection device used to extinguish or control small fires, often in emergency situations. It is not intended for use on an out-of-control fire, such as one which has reached the ceiling, endangers the user (i.e., no escape route, smoke, explosion hazard, etc.), or otherwise requires the expertise of the fire department. Portable fire extinguishers are conveniently located throughout the hospital in cabinets along the corridors. The location of extinguishers are noted by signs adhered to the wall. The extinguisher or cabinet must be clearly seen from the corridor.

<table>
<thead>
<tr>
<th><strong>Water Extinguisher – Use on Class A fires</strong></th>
<th><img src="image" alt="Water Extinguisher" /></th>
</tr>
</thead>
<tbody>
<tr>
<td>Contained in the shiny, silver-colored container.</td>
<td></td>
</tr>
<tr>
<td>Used for <strong>Class A fires only</strong> – ordinary combustibles such as wood, paper, linen, clothing, mattresses, plastic, furniture, and waste containers.</td>
<td></td>
</tr>
<tr>
<td>Do <strong>not</strong> use on electrical equipment, Class C, or flammable liquid, Class B fires.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Carbon dioxide extinguisher – Use on Class B and C fires</strong></th>
<th><img src="image" alt="Carbon Dioxide Extinguisher" /></th>
</tr>
</thead>
<tbody>
<tr>
<td>Contained in a red metal container which has a large cone shaped nozzle.</td>
<td></td>
</tr>
<tr>
<td>Used for <strong>Class B fires</strong> which involve flammable liquids such as oils, greases, chemicals, flammable gases, xylene, alcohol, and plastics.</td>
<td></td>
</tr>
<tr>
<td>Used for <strong>Class C fires</strong> which involve electrical equipment, medical equipment, electrical wiring, fuse box, or circuit breakers.</td>
<td></td>
</tr>
<tr>
<td>It can be used on electrical equipment without receiving an electrical shock.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Wet chemical extinguisher – Use on Class K - cooking fires</strong></th>
<th><img src="image" alt="Wet Chemical Extinguisher" /></th>
</tr>
</thead>
<tbody>
<tr>
<td>Contained in the shiny, silver-colored container. This container is shorter, and slightly wider than the water extinguishers.</td>
<td></td>
</tr>
<tr>
<td>These extinguishers are marked for use on grease, hot oil, or cooking fires.</td>
<td></td>
</tr>
<tr>
<td>These extinguishers are located only in kitchen areas within 15 feet of the cooking equipment.</td>
<td></td>
</tr>
<tr>
<td>Used for <strong>Class K fires only</strong> – Cooking fire, grease, hot oil, deep fat fryers, etc.</td>
<td></td>
</tr>
</tbody>
</table>
Dry chemical extinguisher – This all-purpose extinguisher can be used on Class A, B, or C fires

- Contained in a red container marked “dry chemical”.
- Can be used on ALL TYPES OF FIRES.

To use a fire extinguisher- we use the acronym P.A.S.S.

**P**: Pull the pin. The pin is in place to prevent the accidental discharge of the fire extinguisher.

**A**: Aim the nozzle at the base of the fire. The nozzle is usually clipped to the side of the extinguisher.

**S**: Squeeze the handle. Use firm pressure when squeezing the two handles located on top of the extinguisher.

**S**: Spray onto the fire using the nozzle. Spray at the base of the fire in a sweeping motion.

Note: Do not pull the pin until you intend to use the extinguisher. All fire extinguishers have a seal to keep the pin place. When pulling the pin give a twist to break the seal. This will allow the pin to be removed. Squeeze the handle to release the extinguishing agent.
Emergency Management

Emergency Management ensures an effective response to disasters or emergencies affecting the environment of care. Emergency Management has coordinated resources and responsibilities for dealing with all aspects of emergencies, both on and off-site.

**EMERGENCY PLAN: CODE D**

An event is determined a disaster if the event has an effect on St. Luke's - Roosevelt Hospital Center’s ability to maintain a ‘safe environment of care’ for patients and staff. Any event that threatens that ability can trigger SLRHC to activate our emergency response plans (Code D plan.)

SLRHC categorizes a disaster/emergency in one of two ways: Internal (fire inside the hospital) or external (a blizzard that hampers staff’s ability to report to work; or a pandemic influenza outbreak.)

The Code D is activated by senior administration on duty and the staff and volunteers are notified by:

- a series of four fire alarm bells followed by,
- an overhead announcement: ‘Code D is activated’

**If VOLUNTEERS are on assignment** when a Code D is activated:

- Report to your supervisor for direction
- End all telephone calls that are not an emergency

**If VOLUNTEERS are home**, and hear about the event on the media call the Continuum Prepares Hotline: 1-877-518-1878 and call the Volunteer Office for further instruction
Body Mechanics

Body mechanics refers to the way we move during every day activities. Good body mechanics may be able to prevent or correct problems with posture (the way you stand, sit, or lie). Good body mechanics may also protect your body, especially your back, from pain and injury. Using good body mechanics is important for everyone.

Why Do I Need To Have Good Body Mechanics?

Having your body in the right position helps protect your back and allows you to use your body in a safe way.

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

1. Look the object over and decide how you can best hold/grasp it.
2. Clear a path so there are no obstacles.
3. Know where and how you will put the object down.
4. Get help if you have any doubts about lifting the object.

General Rules for Lifting Things Safely!

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

Be aware of awkward positioning, which can include,

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

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

Plan Before You Lift Or Move A Patient.
- Decide if you need help from another person or mechanical aid.
- Assemble the equipment or help you need.
- Check that you have a clear route; remove any obstacles.
- Explain the procedure to the patient.

Plan and Coordinate Two-Person Lifts.
- Have one person in charge, giving the count.

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

GET HELP WHEN IN DOUBT ---- SOLO MOVES ARE VERY RISKY!!!
Section 2

Infection Control

- Infection Control Program
- Employee Health Service
Infection Control Program

The Department of Infection Control is responsible for conducting surveillance of hospital-acquired infections; investigating and controlling outbreaks or infection clusters among patients and health care employees and volunteers; and evaluating new and existing infection control products and devices.

What are Standard Precautions?

Using Standard Precautions reduces the risk of transmission of microorganisms from both recognized and unrecognized sources of infection. In hospitals Standard Precautions apply to:

- Blood
- All body fluids, secretions and excretions, except sweat, regardless of whether or not they contain visible blood
- Non-intact skin
- Mucous membranes

All hospital employees must use Standard Precautions when caring for all patients. You follow Standard Precautions when you:

- Practice hand hygiene after touching blood, body fluids, secretions, excretions, non-intact skin mucous membranes and contaminated items whether or not gloves are worn.
- Use protective barriers to reduce the risk of exposure.
- Prevent injuries by needles, scalpels and other sharps by handling and disposing of them properly.
- Report all needle injuries and mucous membrane exposures as an incident.
- Obtain the Hepatitis B vaccine if your work puts you at risk to come into contact with blood and body fluids
- Use approved hospital disinfectants to clean up and decontaminate spills of blood and body fluids.

Hand Hygiene/Hand Washing

Hand hygiene remains the single most important way to prevent the spread of an infection for both patients and employees and volunteers. The Hand Hygiene Guidelines developed by the Centers for Disease (CDC) recommend that healthcare workers wash their hands or use an alcohol-based hand wash (as long as their hands are not visibly soiled) to routinely clean their hands between patient contact. Understanding and practicing the principles and guidelines of Standard Precautions are essential for all healthcare workers.

You should always wash your hands:

- After caring for a patient with Clostridium difficile (C. difficile) - You must wash your hands; do not use alcohol based products as they are not effective against this organism.
- After touching patient care equipment or environmental surfaces.
Hand hygiene/ Hand washing cont’d

You should always wash your hands:

- If hands are visibly soiled
- At start of shift
- Before and after every patient contact
- After leaving a patient’s room
- After removing gloves
- After blowing your nose
- After handling garbage
- If hands are contaminated with blood/body fluids
- Before and after eating
- Before performing invasive procedures
- If hands are sticky from repeated Purell use
- After coughing or sneezing into your hands
- After using public restrooms

The proper way to wash your hands is as follows:

- Wet your hands with clean running water and apply soap. Use warm water if it is available.

- Rub hands together to make lather and scrub all surfaces, making sure to clean between fingers and under fingernails. Point fingers downward when washing. Continue rubbing hands for 20 seconds, or about the time it takes to sing the “ABC’s” or Happy Birthday song.

- Pointing fingers downward rinse hands well under running water.

- Dry your hands using a paper towel or air dryer. If possible, use a paper towel to turn off the faucet and open door if exiting a room.

If soap and clean water are not available, use an alcohol-based hand sanitizer to clean your hands.

- Apply product to the palm of one hand.
- Rub hands together.
- Rub the product over all surfaces of hands and fingers until hands are dry.
- Do not dry or wipe hands with paper towel.
REMEMBER: Alcohol based hand rubs can only be used up to 6 times in a row without washing one’s hands. After the sixth usage you must wash your hands.

Artificial Fingernails
Employees and volunteers with direct patient contact may not wear artificial fingernails or extenders since they are proven risk factors for colonization of organisms of the hand. Nail length is important because even after careful hand washing, healthcare workers often harbor substantial numbers of potential pathogens under their nails and fingertips. As per MSSL&MSR dress code policy, nail length should be short enough to allow for thorough cleaning underneath the nails and not cause gloves to tear.

Respiratory Etiquette
Cover your nose or mouth when sneezing or coughing with a tissue or into upper sleeve.

Personal Protective Equipment (PPE)
PPE is primarily described as items worn to protect the skin, eyes, nose, and throat of the employee and volunteer from pathogens, blood, and other bodily fluids. Remember PPE is one time use only (Except N95 particulate respirators/masks used for Airborne Precautions). PPE must be removed if penetrated with any blood or body fluids!

PPE to be worn when caring for all patients include:
- **Gloves** - to protect hands if there is a chance of exposure to blood or body fluids. Always remove after use, discard, and wash hands immediately.
- **Mask** - to protect the mouth if there is a chance of airborne exposure or blood splatter into the mouth.
- **Eyewear** - to protect eyes if there is a chance of blood splatter into the eyes.
- **Gown** - to protect clothes from soiling from blood or bodily fluids. *These gowns are not to be worn outside of a patient’s room.*
  - PPE must be removed before leaving a patient’s room.
  - Lab coats should be used to protect scrubs.

Vaccination-Get the Flu shot
Vaccination is generally considered to be the most effective and cost-effective method of preventing infectious diseases. The vaccine can either be live but weakened forms of pathogens (bacteria or viruses) or killed or inactivated forms of these pathogens. The common virus Influenza (‘flu’) is a contagious disease. It is easily spread from one person to another. The flu vaccine is recommended for everyone six months and older. It is especially recommended for anyone who lives with or cares for people at risk for influenza-related complications, such as health care providers. Unvaccinated healthcare workers have been sources
of healthcare–associated outbreaks. Employees and volunteers need to get this year’s flu vaccine to protect against this year’s flu. The flu is not acquired through the flu shot - it is an inactivated (dead) vaccine.

Employee Health Service provides the following vaccinations related to Infection Prevention:
- Hepatitis B
- Mumps
- Rubella
- Pertussis
- Varicella
- Tetanus
- Influenza

### Transmission Based Precautions

Transmission Based Precautions are designed for patients documented or suspected to be infected with a highly transmissible or epidemiologically important pathogen for which additional precautions beyond Standard Precautions are needed to interrupt the spread of the infection.

1. **Airborne Precautions** (e.g. TB, measles)
2. **Droplet Precautions** – (e.g. rubella, influenza, adenovirus)
3. **Contact Precautions** - (e.g. multi-drug resistant organisms, draining wounds, diarrhea)

The Intranet, which is accessible on each patient care unit, has in the Policy and Procedure Section, a document “Care of a Patient with a Communicable Disease in the In-patient and Outpatient Setting”. This document contains a disease index with the necessary isolation/precautions category for commonly identified (and some not so common) communicable diseases.

Properly identify the type of isolation/precaution the patient should be on and place a sign on the door to alert all employees and volunteers and visitors.

When patients are on precautions, the precautions should remain in place until the patient is discharged or the physician discontinues the precautions. When in doubt, contact Infection Control.

When a patient who is on precautions is transported to another department for a procedure or test, it is the sending unit’s responsibility to inform the receiving department of the type of precautions the patient is on.
What do you do if you experience a needle stick or blood exposure?

If you experience a needle stick or blood exposure:

1. Wash the affected site.
2. Contact your supervisor.
3. During the week, Employee Health Services provides the post needle stick (HBV/HIV) protocol. Late hours, weekend, and holiday exposure incidents, as well as needle stick or blood exposure occurring at the RH site, will be directed to the Emergency Department (ED). The *Blood/Body Fluid Exposure Category Worksheet* is used to manage the exposure incident.
4. Exposure evaluation includes a review of hepatitis B vaccine status, serologic testing or prophylaxis as indicated, and hepatitis C screening.
5. If the source is positive or at high risk for HIV infection, a decision regarding antiviral prophylaxis should be made immediately. If prophylaxis is elected it should be started as soon as possible, preferably within one hour.
6. When initial management is done in the ED, an evaluation will follow at Employee Health Service at the SL site on the next business day to review blood tests and provide continuity of care.
7. The number at Employee Health Service is 212 523-2342. If you call this number, you will be told what to do in case of a needle stick.
The Employee Health/Occupational Medicine Division provides the following services related to infection control:

- Annual testing of all employees and volunteers for tuberculosis (PPD). Testing may be done more frequently in certain areas depending upon risk of transmission of TB.
- Treatment and follow-up of bloodborne pathogen exposure (e.g. needle stick).
Section 3

Patients’ Rights

- Patients’ Bill of Rights
- Financial Assistance
- Pain
  - Cultural Competency
  - Advance Directives
  - Language Assistance
Cultural Competency

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

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

Valuing Workplace Diversity

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

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

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

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

Diversity Vision:
To create an inclusive environment where everyone values and respects each other’s contributions to the workplace.

Caring for Patients and Families

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients have different religious and cultural beliefs about health care.</td>
<td>Develop skills to better hear what people from different cultures want to communicate to you.</td>
</tr>
<tr>
<td>Patients in some ethnic groups can be at greater risk to some diseases than other ethnic groups.</td>
<td>Learn about the cultures you serve and use that knowledge to provide individualized care to each patient.</td>
</tr>
<tr>
<td>Patients can be at risk of diseases specific to their ethnic group.</td>
<td></td>
</tr>
</tbody>
</table>
## Providing Culturally Competent Care

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients may be more receptive to care if the environment is familiar and respectful of their culture.</td>
<td>Conduct a cultural audit to assess the cultures served by your area. Take actions such as using posters and magazines in waiting areas that reflect the population served, offer appropriate pastoral services, meet dietary requests when possible and hang appropriate signage.</td>
</tr>
<tr>
<td>Deaf patients and patients with Limited English Proficiency (LEP) must have access to medical information in their preferred language.</td>
<td>Utilize interpreter services properly and provide translated documents when available.</td>
</tr>
</tbody>
</table>

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

**Our Diversity Mission:**

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

For more information, please contact Pamela Abner, Chief Administrative Officer, Office of Diversity and Inclusion, at 212-523-3204, or Shana Dacon, Diversity Program Manager at 212-636-8980.
Hospital Financial Assistance

Mount Sinai St. Luke's and Mount Sinai Roosevelt help the uninsured or the underinsured through our financial assistance policy. Those patients who lack health insurance or the financial resources to pay for quality health care services have the opportunity to apply for financial assistance.

Patients inquiring about Hospital Financial Assistance for in-patient services should be directed to the Department of Financial Counseling (DFC). Patients inquiring about Hospital Financial Assistance for out-patient services should be directed to the HEAL Center. Eligibility for discounts, and/or payment plans will be made by DFC. If a patient needs access or information about any of our Financial Assistance Programs, please direct them to one of the following locations:

<table>
<thead>
<tr>
<th>Mount Sinai Roosevelt HEAL Program</th>
<th>Mount Sinai St. Luke's HEAL Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>1000 Tenth Avenue at 59th Street</td>
<td>1111 Amsterdam Avenue</td>
</tr>
<tr>
<td>Room 1M12</td>
<td>Room Clark 108</td>
</tr>
<tr>
<td>New York, NY 10019</td>
<td>New York, NY 10025</td>
</tr>
<tr>
<td>Phone: (212) 523-3900</td>
<td>Phone: (212) 523-3900</td>
</tr>
<tr>
<td>Fax: (212) 636-3806</td>
<td>Fax: (212) 523-3955</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mount Sinai Roosevelt DFC Program</th>
<th>Mount Sinai St. Luke's DFC Division</th>
</tr>
</thead>
<tbody>
<tr>
<td>1000 Tenth Avenue at 58th Street</td>
<td>1111 Amsterdam Avenue</td>
</tr>
<tr>
<td>Room 2J</td>
<td>Room B150</td>
</tr>
<tr>
<td>New York, NY 10019</td>
<td>New York, NY 10025</td>
</tr>
<tr>
<td>Phone: (212) 523-7816</td>
<td>Phone: (212) 523-2552</td>
</tr>
<tr>
<td>Fax: (212) 523-8143</td>
<td>Fax: (212) 523-5620</td>
</tr>
</tbody>
</table>
New York State Patients’ Bill of Rights

These regulations exist to help ensure the quality and safety of a patient’s hospital care. Patients receive a copy of the Patients’ Bill of Rights upon admission to the hospital. They are posted in

- Patients’ waiting room areas
- Admitting Office
- Inpatient Units
- Outpatient/Ambulatory Departments
- Emergency Departments
- Other public locations throughout the hospital

PATIENTS’ BILL OF RIGHTS

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

1. Understand and use these rights. If for any reason you do not understand or you need help, the hospital MUST provide assistance, including an interpreter.
2. Receive treatment without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation, source of payment or age.
3. Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.
4. Receive emergency care if you need it.
5. Be informed of the name and position of the doctor who will be in charge of your care in the hospital.
6. Know the names, positions and functions of any hospital staff involved in your care and refuse their treatment, examination or observation.
7. A no smoking room.
8. Receive complete information about your diagnosis, treatment and prognosis.
9. Receive all the information that you need to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.
10. Receive all the information you need to give informed consent for an order not to resuscitate. You also have the right to designate an individual to give this consent for you if you are too ill to do so. If you would like additional information, please ask for a copy of the pamphlet “Do Not Resuscitate Orders - A Guide for Patients and Families.”
11. Refuse treatment and be told what effect this may have on your health.
12. Refuse to take part in research. In deciding whether or not to participate, you have the right to a full explanation.
13. Privacy while in the hospital and confidentiality of all information and records regarding your care.
14. Participate in all decisions about your treatment and discharge from the hospital. The hospital must provide you with a written discharge plan and written description of how you can appeal your discharge.
15. Review your medical record without charge. Obtain a copy of your medical record for which the hospital can charge a reasonable fee. You cannot be denied a copy solely because you cannot afford to pay.
16. Receive an itemized bill and explanation of all charges.
17. Complain without fear of reprisals about the care and services you are receiving and to have the hospital respond to you and if you request it, a written response. If you are not satisfied with the hospital’s response, you can complain to the New York State Health Department. The hospital must provide you with the Health Department telephone number.
18. Authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors.
19. Make known your wishes in regard to anatomical gifts. You may document your wishes in your health care proxy or on a donor card, available from the hospital.

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

The Patient Representative Department is the liaison between patients, their families, and hospital employees. They assist patients and their families in obtaining information, understanding hospital policies and procedures, exercising their rights under the law, and resolving problems and concerns. They are the vehicle by which patients may voice their grievances and recommend changes in hospital policy.

Mount Sinai St. Luke’s 212-523-3700
Mount Sinai Roosevelt 212-253-7225

Patients’ Bill of Rights

Each patient in a hospital in New York State has rights under the law; they are described in the Patients’ Bill of Rights on the previous page. A patient is viewed as an equal partner in the healthcare process. There are eight categories in the Patients’ Bill of Rights:

1. Access to Medical Care
   - EMTALA - Emergency Medical Treatment & Active Labor Act - To ensure public access to emergency services regardless of ability to pay.
   - The Joint Commission - (formerly known as JCAHO) - Its mission is “To continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations”.
   - ADA - The Americans with Disabilities Act gives civil rights protections to individuals with disabilities similar to those provided to individuals on the basis of race, color, sex, national origin, age, and religion. It guarantees equal opportunity for individuals with disabilities in public accommodations, access to healthcare, employment, transportation, state and local government services, and telecommunications.

2. Patient Autonomy
   Patients have the right to make decisions about their medical care without their health care provider trying to influence their decision. Patient autonomy does allow for health care providers to educate patients but does not allow the health care provider to make the decision for the patient. Patients also have the right to:
   - a complete understanding of the diagnosis and treatment
   - refuse treatment and know the consequences
   - considerate and respectful care, without discrimination
   Patients in return are encouraged to:
   - Provide accurate information about their past and current medical history.
   - Ask for an explanation if they do not understand what is being told to them.
   - Provide feedback to the hospital on services provided.

3. Right to know with whom they are Interacting during their Health Care
   Patients have the right to know the name, title, and position of members of their care team and name of physician in charge of care – All staff must wear their ID in a manner that shows their name and photograph.
4. Access to a Safe Environment of Care

Patients have the right to a secure, smoke-free setting, and policies and procedures that support patient care.

5. Privacy and Confidentiality

All hospital personnel and volunteers have the responsibility to protect patients’ confidentiality at all times. The Patients’ Bill of Rights ensures patient confidentiality.

- Do not discuss any patient information with other patients, relatives and friends of the patient (unless officially authorized), visitors to the hospital, representatives of the news media, your own relatives, friends, and or neighbors.
- Do not discuss any patient information in public areas such as elevators, cafeteria, hallways, or on the jitneys.
- Speak in a low voice in private/appropriate areas.
- Do not share computer access codes or passwords with anyone.
- Patients’ records are released only with their written authorization or as otherwise required by law. Release forms are available in Medical Records.
- Medical records must be secured on the patient care units to prevent unauthorized access. Do not leave records unattended.
- Do not face computer terminals in direction where there is public access.
- Do not write medical information on white boards that can be seen by the public.
- Discard paper with patient information in locked receptacles.

*New York State has passed a law guaranteeing confidentiality to all persons related to HIV status and HIV testing. If HIV information is released without proper authorization, the individual can be charged with a misdemeanor and fined up to $5000.

6. Grievance Process

The Grievance Process exists to respond to, investigate, and resolve concerns expressed by hospital patients, visitors and community members. Patients should be able to complain about care without fear, and receive a response. Patients can file a complaint with the NYS Health Department, 800-804-5447.

7. Advance Directives

An Advance Directive is a legally recognized document that expresses a person’s wishes regarding medical treatment that he/she would or would not want in the event that he/she loses the ability or capacity to make or communicate those decisions. Patients can make their wishes known in advance through a legal form known as an advance directive. Every patient who enters MSSL&MSR must receive information and counseling, if needed, concerning use of ADVANCE DIRECTIVES.

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

Examples of Advance Directives include:

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

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

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

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

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

The Patient Representative is also a resource for Hospital Center staff who have questions about specific advance directives brought in by patients or about advance directives in general.

**Key points regarding advance directives:**

- Adults in New York State have the right to accept or refuse medical treatment, including life-sustaining treatment.

- The New York State Health Care Proxy Law enables a competent adult to designate another person to make health care decisions for that adult should he/she lose the ability to do so.

- Oral directives are spoken statements a patient may make regarding health care wishes. These statements, if made to a clinician, should be documented in the medical record.

- Under New York State law, adult patients can request a “Do Not Resuscitate” order (DNR). The DNR order instructs the medical staff not to try to revive the patient if breathing or the heartbeat has stopped.

- Completed forms must be appropriately witnessed, signed and dated. The patient has the right to change or revoke an advance directive at any time.

- Advance directives become a permanent part of the medical record. The hospital must ensure that the patient’s wishes are carried out to the extent permitted by law.
**Ethics Committee**

The Ethics Committee advises and offers support and consultation for patients, families and staff when any of these individuals feel there is an ethical dilemma related to patient care. Committee members include doctors, nurses, social workers, an attorney, a chaplain, a medical ethics professional, and a member of the community. The scope of the Ethics Committee involvement includes:

- Adherence to advance directives
- Dispute resolution in implementing Do Not Resuscitate Orders
- Recommending policies and procedures regarding the resolution of ethical issues
- Providing feedback to the hospital on services provided
- Information and education on ethical issues

To contact the *Ethics Committee* for an issue at Mount Sinai St. Luke's and Mount Sinai Roosevelt:

*Contact the Social Worker assigned to that nursing unit.*
The Family Health Care Decisions Act

On June 1, 2010, the New York Family Health Care Decisions Act (“FHCDA”) went into effect. This law empowers family members and close friends to make treatment decisions for patients who no longer have the capacity to decide for themselves, and provides a way for physicians to make treatment decisions for patients who have no one to speak for them. The FHCDA:

1. Applies to patients in hospitals and nursing homes in New York State.
2. Does not apply if the patient has a health care proxy.
3. Does not apply if the patient has a mental illness and is in an Office of Mental Health licensed facility and in some cases if the patient has mental retardation or a developmental disability.
4. Repeals New York’s DNR law (except to Non Hospital DNR Orders). DNR Orders will now be written under the same standards as any other order to withhold or withdraw life sustaining treatment.
5. Provides that all health care decisions be made on the basis of the patient’s known wishes, and if they are not known, in the patient’s best interests.
6. Repeals the “clear and convincing evidence” standard for end of life decisions.
7. Permits artificial nutrition and hydration to be withheld or withdrawn whether or not the patient has discussed his/her wishes with the surrogate (differs from the Health Care Proxy Law).
8. Allows a surrogate to consent to HIV testing and HIV care unless the patient has requested otherwise.
9. Requires that Advance Directives must be honored including “prior decisions” made by the patient to consent to or to withhold or withdraw life sustaining treatment.
10. Identifies a list of surrogates in order of priority to make health care decisions for the incapacitated patient. The list is similar to the old DNR list except that it includes “domestic partner” on the same level of priority as a spouse:
   (a) Guardian authorized to decide about health care pursuant to Mental Hygiene Law Article 81
   (b) Spouse (if not legally separated from the patient) or domestic partner
   (c) Son or daughter 18 years of age or older
   (d) Parent
   (e) Brother or sister eighteen years of age or older
   (f) Close friend.
11. Provides a process for physicians to make health care decisions for a patient without a surrogate.
12. Mandates that an Ethics Review Committee review cases which cannot be otherwise resolved; in a few rare circumstances, the Committee’s decision is required and is binding.
13. Mandates that all patients and Surrogates receive the DOH publications summarizing the patient’s and surrogate’s rights and obligations under the FHCDA.
To eliminate language as a barrier to quality health care, the Language Assistance Program provides free trained interpreters for limited English proficiency and deaf patients. Aside from this being part of our policy and mission to provide excellent medical care for the communities we serve, it keeps us compliant with the Executive Order 13166, “Improving Access to Services for Persons with Limited English Proficiency.” When interpreting vital information, accuracy is crucial to ensuring that patients are fully informed and able to make decisions about their healthcare. Family members or minors may be able to have a conversation in foreign language, but may not be able to interpret medical information.

**Our resources in providing medical interpretation may include:**

- Staff/volunteer interpreters
- Sign Language Interpreter
- Language cards and posters
- Over the phone interpretations
- American Sign Language (ASL) Videoconference rovers
- Easy Listeners and amplifiers
- Written Translations
- Telecommunications Device for the Deaf (TDD/TTY)

**How Do I Know if a Patient Needs an Interpreter?**

Upon admission, staff will assess the patient’s language needs. Appropriate phrasing to determine a patient’s needs should be utilized at all times. The following examples of statements are considered appropriate and respectful:

“What language do you feel most comfortable speaking?”

“Do you need a medical interpreter?” and “In what language?”

You may also use **Language Identification cards** to ask the patient to identify the language spoken. These are located at the front desks, ER, Admitting and all nursing units.

**DO NOT ASK! - “Do you speak English?” or “Do you understand English?”**

**What is the procedure to get an interpreter?**

**Monday through Friday between 9:00 AM and 5:00 PM at Mount Sinai St. Luke’s call:**
- For Spanish Interpreters only page 3-3853
- For other languages call extension 23-2187

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

**At all other times or if the interpreter is not available**
- Call the over-the-phone interpretation service at extension 36-5096

**What services are available for deaf and hard of hearing patients?**

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

ASL Videoconference rovers and sound amplifiers are located at the ED and at the Admitting Department.
8. Language Assistance for Persons with Limited English Proficiency (LEP) cont’d

**Refusing Hospital Interpreter**

By federal law, all non-English speaking patients MUST be offered a free interpreter. If the patient chooses to use a family member, the medical record MUST contain documentation that an interpreter was offered and the patient has chosen to use a family member.

Under no circumstances is anyone under the age of 16 to be used as an interpreter except in an emergency. This must be documented in the medical record.

**Documentation of Interpreter Use**

Whenever Medical Information is provided to an LEP patient, it should be recorded in the patient’s medical record.

When an interpreter is used (live or over-the-phone) document in the medical record:

- Type of interpretation (live or over-the-phone)
- Start and end time of the interpretation
- ID number (language line) or name of interpreter

**Note:** When a hospital employee or volunteer is fluent in the patient’s primary language the employee and volunteer may communicate non-medical information to the patient with limited English proficiency. However, all medical information is to be communicated to the patient using multilingual clinical staff such as MD, RN and NP or trained and certified staff in medical interpretation.
## Recycling Confidential Information

### How Mount Sinai St. Luke's and Mount Sinai Roosevelt Recycle Protected Health Information (PHI) Securely

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

### Locked versus unlocked bins

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

### What is Protected Health Information (PHI)?

What is the definition of confidential waste?

Protected Health Information is anything that contains:

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

### For More Information...

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

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

- Mount Sinai Roosevelt – 212-523-7001

Locked recycling containers cannot be opened to retrieve items accidently placed inside!
Many of our patients who come to our facilities have pain. **ALL** employees and volunteers, not just patient care providers, have a role to play in effective pain management.

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

**Pain Is More Than Hurt; It May Lead To:**
- Depression, fear, and anxiety
- Weakness, fatigue, or confusion
- Loss of self-esteem
- Strained interpersonal relationships
- Disrupted sleep-wake cycles
- Decreased ability to work and enjoy social activities and family

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

- Core Measures
- Employee Accident Reporting
Core Measures

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

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

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

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

1. Acute MI (heart attack)
2. Heart Failure
3. Community Acquired Pneumonia
4. Surgical Care Improvement Project
5. Immunization
6. ED arrival to Admission time
7. ED arrival to Discharge time

The performance of MSSL&MSR is measured and compared to all other institutions in the above seven areas. It is important to note that our funding will be related to our performance in these areas (Pay-for-Performance).

Starting in 2013, CMS and The Joint Commission required data on several psychiatric indicators, patients admitted with stroke, patients who develop deep vein thrombosis or a pulmonary embolism while in the hospital, and perinatal care, like elective c-sections prior to 39 weeks. In addition to the above, tracking of hospital acquired infections, readmission of patients and several patient safety indicators are reported.

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

The Joint Commission:  
www.thejointcommission.org (click on Quality Check)

U.S. Department of Health & Human Services:  
www.hospitalcompare.hhs.gov
Professional Misconduct & Impaired Health Professional

Professional misconduct is behavior by physicians, nurses or other health care professionals which violates professional standards of conduct and puts patients at risk. Any employee and volunteer who believes he or she has observed professional misconduct must report it to the persons listed below.

Some of the main examples of professional misconduct include:

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

The decision about whether professional misconduct has occurred is made by the Legal Department in consultation with hospital administration. If any employee or volunteer observes or suspects professional misconduct on the part of any professional, that employee or volunteer must immediately report the circumstance and the facts upon which it is based to any of the following:

- His/her supervisor
- Risk Management Department
- Legal Department
- Department Chair of the provider (physicians, dentists, podiatrists, house staff)
- Corporate Compliance Hotline (1-800-692-2353)

Any supervisor who receives a report of professional misconduct or provider impairment must promptly relay it to anyone mentioned above.
Volunteer Accident Reporting

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

- Report the incident immediately to your supervisor (including sharps or needle stick injuries, and TB conversions).
- With your supervisor, complete the “Employee Accident Report” form (#30010).
- Print hard and write legibly (this is a multi-part form).
- Request a copy of this form and keep for your own records.
- The supervisor will submit the form within 48 hours to Human Resources for prompt response and evaluation.
Section 5

Patient Safety

- Patient Safety
  - Rapid Response Team
  - 2014 National Patient Safety Goals
  - Colors Of Safety
  - Fall Prevention Program
Patient Safety

MSSL&MSR are committed to providing safe, high quality patient care. Maintaining an environment that ensures safety for patients, families, visitors and employees is critical if MSSL&MSR are to be recognized as the provider of choice on Manhattan’s West Side. To accomplish this, MSSL&MSR not only have to have safety systems in place, but also need the participation of all employees and volunteers in recognizing and reporting risks and concerns related to patient and employee or volunteer safety, and medical/healthcare errors. This reporting hopefully will effect changes that raise the bar for patient and employee or volunteer safety at MSSL&MSR.

What is already in place at MSSL&MSR to ensure patient and employee and volunteer safety?

- Policies and Procedures: Administrative, Departmental, Environment of Care, Human Resources, Attending and House Staff
- Competency Assurance Programs
- Hospital wide and department specific training programs
- Corporate Compliance Program
- Risk Management Programs
- Quality Improvement Programs
- Employee Health Service Programs
- Facilities Management Programs
- Security, Engineering, Biomedical, Engineering, Safety, Waste Management
- Emergency Preparedness Programs
- Infection Control Programs
- Patient Relations Program
- Medication Use Safety Improvement Committee (MUSIC)
- Safe Babies/Safe Haven Program

If an employee or volunteer has a suggestion related to reducing or eliminating a potential unsafe condition or practice, what can be done?

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

If an employee or volunteer causes or witnesses an event that causes harm or has a potential to cause harm or has any concerns about the safety or quality of the care provided, what can be done?

- Speak with his/her manager.
- Contact the Risk Management Department (212-523-5663).
- Contact the Corporate Compliance Office or the Corporate Compliance Helpline.
- Contact the Quality Improvement Department (212-523-2158).
WHAT ROLE DO ALL EMPLOYEES, VOLUNTEERS AND PHYSICIANS PLAY IN PROMOTING PATIENT AND STAFF SAFETY?

- Strict adherence to ALL MSSL&MSR policies and procedures
- Case finding and reporting of potential or actual unsafe conditions or practices
- Completing and forwarding Occurrence Reporting Forms to Risk Management and Quality Improvement Departments.
2014 National Patient Safety Goals

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

The following are the six national patient safety goals and one universal protocol for 2014.

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

   **HOW DO MSSL&MSR ACCOMPLISH THIS GOAL?**
   - We use patient **name** and **date of birth** to confirm the correct patient.

2. Improve the Effectiveness of Communication among Caregivers
   - Report critical results of tests and diagnostic procedures on a timely basis.

   **HOW DO MSSL&MSR ACCOMPLISH THIS GOAL?**
   Administrative Policy, A2-121: Critical Test Results requires that all results of critical tests or values are to be reported to the appropriate provider as soon as possible but no longer than one hour from the time it is received.

3. Improve the Safety of Using Medications
   - Label all medications, medication containers (e.g. syringes, medicine cups, basins), or other solutions on or off the sterile field in perioperative and other procedural settings.
   - Maintain and communicate accurate patient medication information.

   **HOW DO MSSL&MSR ACCOMPLISH THIS GOAL?**
   - Staff in the perioperative and procedural settings labels all medications containers used on the sterile field.
   - Refer to Perioperative Services Policy: *Medication on the Sterile Field*.
   - Administrative Policy, A2-130: *Medication Reconciliation* requires that patients’ current medications are reviewed upon admission and compared to those ordered while under the care of the organization to identify and resolve any discrepancies. A list of medications that the patient should be taking is provided at time of discharge.
4. Reduce the Risk of Health Care-Associated Infections

- Comply with current World Health Organization (WHO) Hand Hygiene Guidelines or CDC hand hygiene guidelines.

**HOW DO MSSL&MSR ACCOMPLISH THIS GOAL?**

- The Infection Control Dept. has placed alcohol-based hand cleansing solutions in designated patient care service areas.
- Signs are posted as a reminder to wash hands, and literature on the importance of hand hygiene is distributed to patients.
- The Hand Hygiene Team monitors compliance with hand washing and provides feedback to staff.

5. The Organization Identifies Safety Risks Inherent In its Patient Population

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

**HOW DO MSSL&MSR ACCOMPLISH THIS GOAL?**

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

6. Improve the Safety of Clinical Alarm Systems

- The organization establishes alarm system safety as a priority.
- Identify the most important alarm signals to manage.

**HOW DO MSSL&MSR ACCOMPLISH THIS GOAL?**

- The Department of Patient Care Services has developed guidelines for Alarm Management which are integrated into device and equipment-specific policies (e.g., CC-C06, P-5, RT-9001).
2014 National Patient Safety Goals cont’d

This is a Universal Protocol:

ELIMINATE WRONG-SITE, WRONG-PROCEDURE AND WRONG-PATIENT PROCEDURES

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

HOW DO MSSL&MSR ACCOMPLISH THIS GOAL?

- Prior to the start of any procedure, an on-going process of information gathering and verification is conducted by involved team members.
- A “time-out” is used prior to start of the procedure to confirm correct patient, procedure, and site.
- Site is marked with the procedural’s INITIALS for all procedures involving laterality (Right, Left), level (e.g.: Spine) and multiple structures (e.g.: Finger).
- Refer to Administrative Policy, A2-133: Universal Protocol.
Rapid Response Team

Mount Sinai St. Luke's and Mount Sinai Roosevelt, in an effort to make health care safer and more effective, joined the Institute for Healthcare Improvement's *100,000 Lives Campaign* in 2005. One of the interventions, proven to decrease hospital mortality rates, is the implementation of a **Rapid Response Team**.

The Rapid Response Team (RRT) — known by some as the Medical Emergency Team — is a team of clinicians who bring critical care expertise to the bedside. Team members include a Pulmonary/Critical Care Fellow, Hospitalist, or a Dept. of Medicine house staff, a Nurse Manager/Administrator, and a Respiratory Therapist.

**The RRT can be initiated 24 hours a day by a patient care provider** by calling 234444 and stating that a Rapid Response Team is needed. The RRT does not replace the patient’s primary care team, but can be called if assistance is needed or more than 1 stat page is needed to assemble a team to respond to a crisis.

**Other criteria for initiating the RRT:**
- A fall, injury, or illness for non-inpatients or staff in any area of the hospital that requires medical assistance. If staff determines that a non-inpatient can be transported to the ED without the need for a RRT page, the unit staff will contact the ED in advance. A Registered Nurse, NA or provider (MD/PA/NP) may accompany the person.
Patient Fall Prevention Program

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

What Is the Hospital’s Fall Prevention Program?

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

Educate **ALL HOSPITAL STAFF** to increase awareness of patients who are at risk for falling.

Why Is This Important?

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

What Is My Responsibility In Preventing Patient Falls?

**ALL HOSPITAL EMPLOYEES AND VOLUNTEERS** are to be aware of their responsibility in preventing patient falls from occurring. **REMEMBER:**

- If patient is at risk for falling or needs help, request assistance for the patient and stay with them until help arrives.
- Communicate unsafe situations (e.g., liquid on floor, broken equipment, furniture blocking pathway to the bathroom) to the charge nurse or Nurse Manager/Supervisor.
Colors of Safety

Color-Coded Patient Alert Condition ID Bands

As part of a national effort to enhance patient safety, Mount Sinai St. Luke's and Mount Sinai Roosevelt are using pre-printed, color-coded patient wristbands that alert staff members to certain patient conditions.

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

- **RED** means **Allergy Alert**. Red alerts us to stop and look in the medical record to find out information on the patient’s allergies, so we can provide safe care.
- **YELLOW** means **Fall Risk**. Yellow alerts us that the patient may need extra assistance when walking or transferring to prevent falls. Patients assessed at risk for falls may also be wearing yellow slipper socks and have yellow Fall Risk Stickers on the medical record and on the room name tag outside the patient’s door.
- **PURPLE** means **Do Not Resuscitate**. Some patients have expressed an end-of-life wish and we want to honor that request.
- **PINK** means **Limb Alert**. Pink alerts us not to take blood pressures, start IV’s, or draw blood specimens in the arm with the pink Limb Alert band. (Used in patients with mastectomies, dialysis shunts, etc.)
- **GREEN** means **No Blood Transfusion**. Green alerts us that the patient requested no blood transfusions and signed a consent defining what blood or blood products are permitted in his or her care.
Section 6

Customer Service

AIDET

HCAHPS

Standards of Customer Care
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

There is now a national survey for collecting and publicly reporting patient satisfaction which is called HCAHPS.

CMS requires all hospitals who receive Medicare reimbursement to participate in the HCAHPS survey. The outside agency that distributes the surveys to patients, collects, and organizes the scores is NRC Picker. SLR managers and administrators can keep track of our scores through EReports at NRC Picker.

There are 7 areas that are measured:

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

The Language of Caring is a hospital-wide program that promotes caring communication between caregivers and patients and among co-workers. Below are the Language of Caring communication skills that are expected to be practiced by MSSL&MSR employees:

Heart-Head-Heart Communication
The Practice of Presence
Acknowledging Feelings
Showing Caring Non-verbally
Positive Intent
The Blameless Apology
The Gift of Positive Regard
The Caring Broken Record

All staff should attend a Language of Caring training session to learn these communication skills. Ask your supervisor for a list of sessions.

Mount Sinai St. Luke's and Mount Sinai Roosevelt are committed to having the highest scores on the HCAHPS survey so that patients will choose to come to our facilities. Therefore it is important for all staff to familiarize themselves with questions and the areas in which we can improve our scores. For further information about MSSL&MSR initiatives for improving scores, please speak with your manager.
Standards of Customer Care

Standard #1: We will make our patients and their families feel welcomed.
- Welcome patients and visitors and inquire how we can help
- Introduce ourselves using name and title
- We will explain to the patient our role in his/her care during individual encounters
- Wear our hospital ID badge at chest height with name and picture visible
- Establish eye contact and smile when speaking to patients, visitors, and colleagues
- Respond promptly to inquiries or problems
- Offer assistance to individuals who are disabled or may be confused with the surroundings

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

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

Standard #4: We will keep our personal frustrations separate.
- We will speak positively of MSSL&MSR and of our colleagues when speaking to patients, visitors, and colleagues
- Keep staff gossip and personal matters out of a patient’s hearing
- Disagree with colleagues in private
- Help others with our “know how” and ask for help when we need it
- Always link problem identification with problem solving suggestions
Standards of Customer Care cont’d

Standard #5: We will relieve the fears and anxieties of our patients by listening, answering questions and explaining procedures.
- Repeat a patient’s request or concern so he/she knows we understand
- Communicate in a clear, easy to understand manner
- Inform a patient of the time of a test or procedure
- Give honest reasons for any delay without causing unnecessary anxiety
- Maintain eye contact when talking and listening
- Always try to go that “extra step”

Standard #6: We will acknowledge when we have failed to meet their expectations and apologize sincerely for inconveniences.
- Apologize for all delays – even though we may not be responsible for them
- Recognize and stay calm when a patient is upset and ask what we can do to help
- Assume ownership of a problem, regardless of fault
- Remain calm with an angry caller; the most important thing we can do is listen

Standard #7: We will ask colleagues how we can help.
- We will welcome and assist new employees and volunteers
- We will assist our colleagues whenever possible
- We will help others with our “know-how” and ask for help when we need it

### AIDET for Admissions and change of shift

<table>
<thead>
<tr>
<th>A</th>
<th>Acknowledge your patient by naming them (e.g., “Hello Mrs. Jones, welcome to Mount Sinai St. Luke’s Hospital or Mount Sinai Roosevelt Hospital.”)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Introduce yourself with your name and telling the patient what you do and how many years of experience you have. Introducing your coworkers and doctors will help transition care to another staff member. For example, you could say, “You are in good hands with Miss Jones, your PCA. She has been here for 15 years and she always gives excellent patient care.”</td>
</tr>
<tr>
<td>D</td>
<td>Duration How long will the procedure take? How long will the patient wait? How long till results arrive? Discuss the patient’s expectations of a great hospital stay and put on the white board. Discuss the estimated time of discharge and put on the white board. Make sure you give a time frame that will surely be met.</td>
</tr>
<tr>
<td>E</td>
<td>Explanation and write on white boards: Educate patients to our goals for them that include their white board concerns. Ask “Is there anything else I can do for you?” before leaving the patient’s room.</td>
</tr>
<tr>
<td>T</td>
<td>Thank you Thank family for their assistance. Thank them for choosing our hospital.</td>
</tr>
</tbody>
</table>
Hourly Rounding with the 5 “T’s”

For each of the 5 T’s, here are some possible questions to ask your patient:

**PAIN**
“Mrs. Johnson I just want to check to see how you are feeling.”
“Are you in pain today?” If so, explore and treat.

**POTTY**
“Do you have any toileting issues?”
“Do you need assistance getting to the toilet?”

**POSITIONING**
“Do you need a pillow?”
“Oh, are you sore on that side? I can put a pillow under that side to make you more comfortable.”

**PERSONAL INFORMATION**
“Do you like watching TV? What is your favorite show?”

**PERSONAL ITEMS – placed nearby**
“Here is your water and I am moving your TV button close so you can reach it. Is there anything else you need that I can get for you now?”

**PRESCRIPTIONS** When a patient changes meds, review them together.
Section 7

Population Specific Care
**Population Specific Care**

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

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

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

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

**What makes you qualified (or competent) to work with your particular population(s)?**

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

Every employee or volunteer with direct patient contact should be able to identify the populations they care for and the skills or competencies needed. This will vary by department and by position.
Section 8

Corporate Compliance

- HIPAA
- Code of Conduct
- Non-Retaliation
- Office of Corporate Compliance

- Eight Elements of Corporate Compliance Program
- Fraud and Abuse
- EMTALA
Corporate Compliance

What Is Corporate Compliance?

There are many definitions as to what constitutes a Corporate Compliance Program. On a basic level it is about the commitment of Mount Sinai Beth Israel, Mount Sinai Beth Israel Brooklyn, Mount Sinai St. Luke's and Mount Sinai Roosevelt (collectively, “Hospitals”) to operate and assure compliance with and conform to all applicable federal, state and local laws, rules and regulations, as well as policies and standards set by the government, insurance programs and other payers (i.e. Medicare and Medicaid). Additionally, the Hospitals, as providers of health care, are part of an organization that promotes integrity and ethical behavior through all levels of the organization.

Corporate Compliance - Introduction

We have established a Corporate Compliance Program in accordance with guidance set forth by the Office of Inspector General of the United States Department of Health & Human Services, as well as by legislation enacted by the state of New York.

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

Corporate Compliance - Health Care Origins

Federal Government

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

Health care, as a component of the United States federal budget exceeds well over $2.7 trillion, mostly through the Medicare and Medicaid programs. In the mid 1990s, government estimates regarding the extent of health care fraud amounted to approximately 10% of the total U.S. health care expenditures - more than $100 billion annually. At this time the U.S. government made combating health care fraud a high priority. That $100 billion has risen proportionately in relation to healthcare expenditures.

In February 1998, the Office of Inspector General declared a zero tolerance for fraud and issued voluntary guidance for hospitals that encouraged hospitals to establish their own internal corporate compliance programs. The guidance encouraged hospitals, among other things, to draft organizational Codes of Conduct, provide compliance orientation and training to its employees and to conduct auditing and monitoring activities.
Corporate Compliance - Health Care Origins con’t

New York State

In addition to the guidance promulgated by the federal Department of Health & Human Services Office of the Inspector General (OIG), New York State, through its Office of the Medicaid Inspector General (OMIG), requires that its hospitals implement corporate compliance programs as well. Essentially, the requirements of the New York and the federal OIG are very similar in scope with certain variations. The OIG and the OMIG require that hospital compliance programs contain certain essential elements (see below – the Eight (8) elements of a Corporate Compliance Program). The OMIG regulations also list certain specific risk areas that a compliance program must address. They include billing, payments, medical necessity and quality of care, governance, mandatory reporting, credentialing and having certain policies and procedures, inclusive of a policy addressing non-intimidation and non-retaliation. Additionally, the OMIG requires that hospitals certify on an annual basis that they have established and implemented an effective compliance program that meets the OMIG’s standards.

The Risks of Non-Compliance

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

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

Fraud and Abuse

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

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

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

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

- Excessive charges for services or supplies
The Eight (8) Elements of a Corporate Compliance Program

The Office of Inspector General’s (“OIG”) compliance guidance for the hospital industry and the New York State Office of the Medicaid Inspector General, recommend that Corporate Compliance programs contain the following eight (8) elements for every Corporate Compliance Program:

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

2- Designation of Corporate Compliance Officer and Compliance Committee
Frank Cino, Senior Vice President, serves as the Chief Compliance Officer. Louis I. Schenkel is the Vice President for Compliance. They are responsible for the development, operation and oversight of the Corporate Compliance Program. Mr. Schenkel’s office telephone number is (212) 523-2162.

The Hospitals Compliance Oversight Committee, which is a multi-disciplinary committee comprised of senior leadership assists in the design, implementation and operation of the Corporate Compliance Program.

3- Training and Education
All newly hired staff and volunteers receive a copy of the Code of Conduct and Corporate Compliance education and training at orientation.

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

All staff and volunteers have a duty to report suspected or actual violations of federal, state or local laws, rules, regulations policies and procedures or the Code of Conduct to their supervisor, either in writing, by telephone or in person. All employees and volunteers are encouraged to make reports through their administrative chain of command. Employees may contact the Office of Corporate Compliance directly at (212) 241-9391. Anonymous reporting of violations may be made via the toll-free Corporate Compliance Helpline: 1-800-853-9212. There will be no reprisals or any retaliation against employees and volunteers for good faith reporting.

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

Disciplinary actions may be taken for:

- Claims for services not medically necessary
- Improper billing practices (i.e. billing Medicare instead of another third party payor)
• Violating the Code of Conduct or other laws and regulations
• Failing to report a violation of the Code of Conduct or cooperate in an investigation
• Retaliation against an individual for reporting a violation or possible violation of the Code of Conduct
• Deliberately making a false report of a violation of the Code of Conduct

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

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

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

8- Non-Retaliation
All Hospital employees and volunteers have a duty and responsibility to report suspected or actual violations of laws, regulations, policies and procedures and the Corporate Compliance Program Code of Conduct, without fear of retaliation, retribution or intimidation. Retaliation against any associate, who seeks advice, raises a concern or reports an ethical or corporate compliance issue in good faith will not be tolerated.

The Office of Corporate Compliance

The Office of Corporate Compliance’s mission is to promote adherence to appropriate standards of business conduct and to ensure conformance to applicable federal, state and local laws and regulations, as well promoting integrity and ethical behavior throughout the organization. The Office of Corporate Compliance strives to ensure organizational compliance with the eight (8) elements of an effective Corporate Compliance Program.

Code of Conduct

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

All staff and volunteers receive the **Code of Conduct** and are required to sign an acknowledgement that they will abide by it during their service.

The Code of Conduct addresses many issues relating to lawful and ethical behavior. Some of these issues include:

- Patients’ Rights
- Workplace Practices
- Conflict of Interest
- Billing/Reimbursement
- Confidentiality

Further, other fundamental provisions contained in the Code of Conduct include:

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

**Non-Retaliation**

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

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

What is Our Commitment?

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

Basic EMTALA Obligations

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

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

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

Other Key Points

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

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

- Our Hospitals’ Emergency Departments and labor/delivery suites have required signage which states that patients have the right to a Medical Screening Examination, Stabilizing Treatment and a Transfer, if necessary

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

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

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

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

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

- **Understand the consequences of non-compliance** – failure to comply with laws and regulations or the Code of Conduct could pose serious risks to employees as well as to our Hospitals.

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

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

**Compliance is Everyone’s Responsibility!**

**HIPAA**

**General**

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

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

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

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

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

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

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

**Notice of Privacy Practices**

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

**Minimum Necessary Rule**

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

**Business Associates**

Under HIPAA, when we share patient information with contracted vendors such as transcription services or billing companies, they become “business associates” and must also follow HIPAA rules. Our “business associate agreements” (contracts) with these vendors must include an acknowledgement of HIPAA compliance.
Privacy Officer/HIPAA Security

The Hospital has appointed a Privacy Officer, Louis Schenkel, who has overall responsibility for ensuring compliance to the HIPAA regulations. Among the Privacy Officer’s HIPAA duties are the drafting of policies and procedures. These policies are posted on the Hospital Intranet web site.

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

If you have any questions or concerns about compliance with the HIPAA Privacy Rule, speak to your supervisor or the Privacy Officer, who can be contacted at (212) 523-2162 or (212) 241-4669.

For questions or issues relating to the security component of HIPAA, please contact Raymond Shelton, who can be reached at (212) 523-7019.

Your Role in HIPAA

- Ensure that PHI is not disclosed improperly
- Do not discuss PHI in elevators or in public areas such as cafeterias where your conversations may be overheard
- Protect and do not share computer passwords
- Make good faith reports of HIPAA violations to the Privacy Officer

HIPAA Case Scenario # 1

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

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

HIPAA Case Scenario # 2

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

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