Morris Hospital & Healthcare Centers

2026 STUDENT ORIENTATION

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Morris Hospital & Healthcare Centers Mission Statement:

To improve the health of area residents

Vision: Transforming Healthcare to Support Healthier Living

Morris Hospital & Healthcare Centers strives to provide an environment where customers (internal and external) are treated with respect and dignity. All employees, contractors, volunteers, board members, medical staff members, and suppliers (collectively, "Morris Hospital Associates") must adhere to the highest standard of customer service to promote the principles, ideals and mission of the hospital.

Values

The values to which employees, medical staff, and board members of Morris Hospital & Healthcare Centers subscribe are as follows:

CARE

C = Compassion

A = Accountability

R = Respect

E = Excellence

Customer Interaction

The Huron principle of AIDET is used when interacting with our patients and customers.

AIDET

- **A**cknowledge
- **I**ntroduce
- **D**uration
- **E**xplanation
- **T**hank
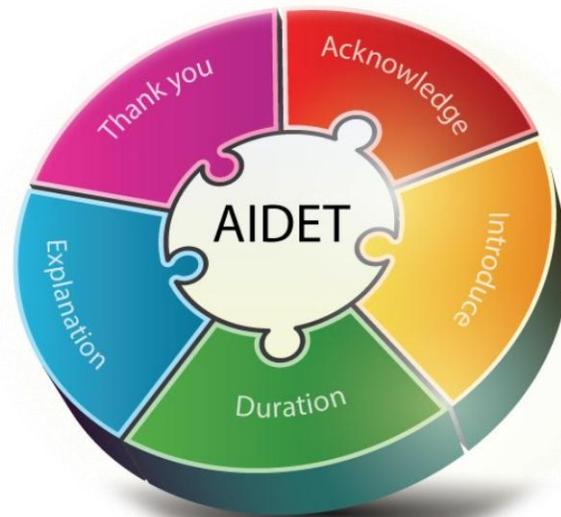
AIDET Framework of Communication

Acknowledge

- In person, with your body:
  - Smile
  - Make eye contact
  - Use open body language
- On the telephone, with your voice:
  - Smile
  - Give the person your undivided attention

Introduce

- First Generation
  - Name
  - Department
- Next Generation
  - Self, Skill Set, Experience & Certification
  - Co-Workers
  - Other Departments
  - Providers

AIDET Framework of Communication

Duration

- How long will the test, procedure, appointment or admission take?
- How long will the patient need to wait before they can go home, return to work…?
- When should they expect results or a returned phone call from you?

Explanation

- Why are we doing this?
- What will happen and what should you expect?
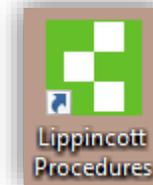- What questions do you have?
- Use understandable language

Thank
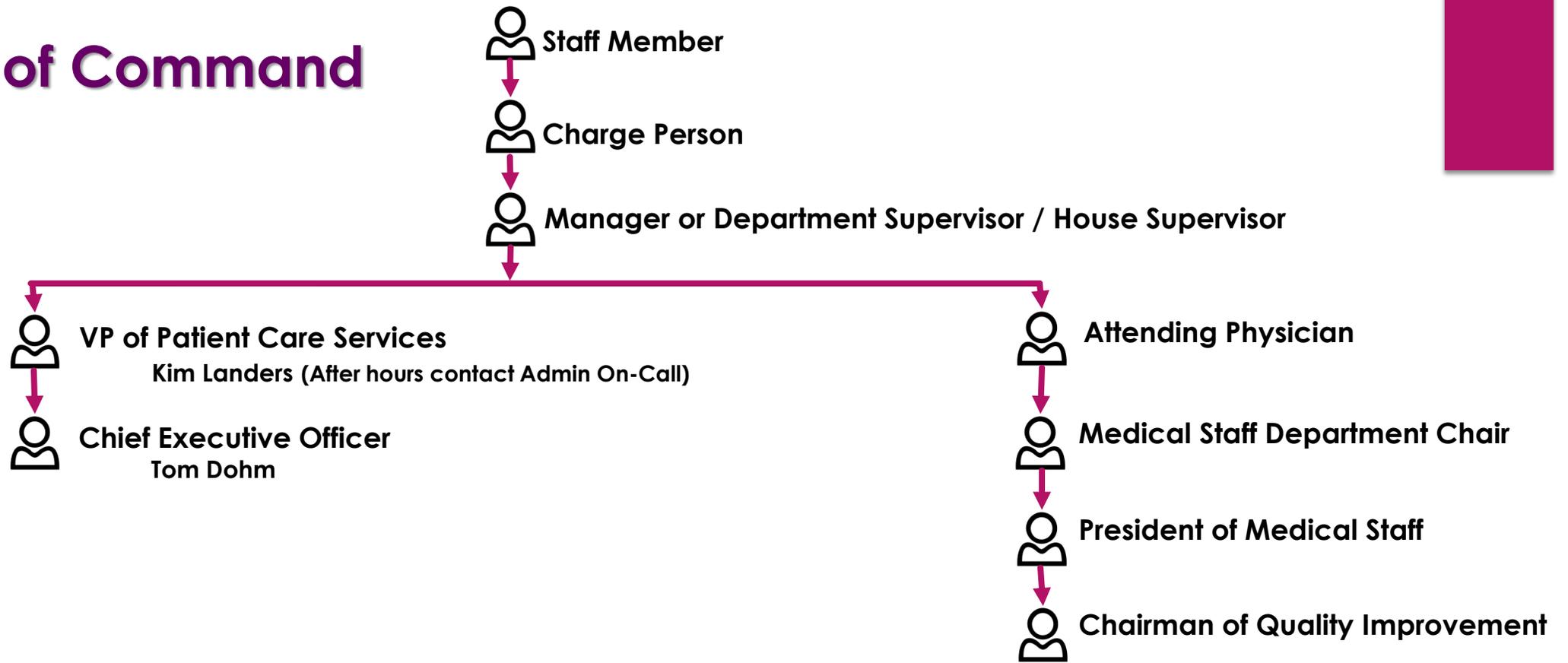
Thank them for choosing YOU!

Additional AIDET Measures

- Discuss hand hygiene with patients
- Close door/curtain for privacy (inform patients of this)
- Bedside Shift Report / Hand Off Communication
- Managing Up
- Call Backs
- Writing thank you notes
- What is your ONE thing?

- White communication boards in patient rooms
- Discuss new medications and their side effects with patients
- Immediate response to call lights
- Rounding
  - Inpatient – Hourly
  - ED – Every 30 minutes
  - OP & Clinics – Every 15 minutes

Accessing Policies / Forms / iShare

- iShare is the Morris Hospital home page for the intranet

- iShare is a communication hub where the following can be accessed:

  - Policies & Procedures

  - Standing Orders

  - MH Forms

- If the computers are not working and internet access in unavailable, hard copies of Policies & Procedures are kept in Administration & the House Supervisor's Office

- iShare can be accessed from any hospital computer simply by accessing the internet

- Pages - iShare (morrishospital.org)

- If you do not have computer access, please ask a MH employee to assist you with accessing the information needed

- Lippincott Procedures icon on desktop

Chain of Command

Staff Member

↓

Charge Person

↓

Manager or Department Supervisor / House Supervisor

↓

VP of Patient Care Services
Kim Landers (After hours contact Admin On-Call)

↓

Chief Executive Officer
Tom Dohm

Attending Physician

↓

Medical Staff Department Chair

↓

President of Medical Staff

↓

Chairman of Quality Improvement

Please Note: *When calling, let the person know you have instituted the Chain of Command. If an employee feels their concern is not addressed at any level they may go on to the next level*

Morris Hospital Guidelines

Facility Responsibility

- Patient care is the responsibility of the hospital and is under the Director/Manager/designee's control and supervision.

- The clinical faculty maintains a cooperative relationship with each Director/Manager/designee and recognizes the Director/Manager's accountability/responsibility for quality patient care at Morris Hospital.

- Students are to adhere to the policies/procedures, standards and practices of the hospital, and their assigned department, and follow all directives concerning patient care.

Paramedic Students

► The Morris Hospital Paramedic Program is accredited by the Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions (CoAEMSP) and the Commission on Accreditation of Allied Health Education Programs (CAAHEP). The Morris Hospital Paramedic Program has a Memorandum of Understanding (MOU) with Joliet Junior College. Morris Hospital paramedic students follow the CoAEMSP accredited student orientation and clinical rotation guidelines that are outlined in this policy as well as our Paramedic Handbook.

► Morris Hospital clinical sites have full access to our Paramedic Handbook, which is updated annually, along with the paramedic student phases of education, student exposure plan, and disciplinary action. All clinical staff that are in contact with our students are required to complete a specific paramedic preceptor training as a requirement of CoAEMSP.

Patient Care

▶ Students will participate in a structured orientation that includes hospital policies and procedures, infection control practices, confidentiality, Health Insurance Portability and Accountability Act (HIPAA), and the individual's responsibilities in maintaining a safe work environment. Students are expected to adhere to all hospital/department policies and procedures.

▶ Clinical faculty should collaborate with the Director/Manager/designee of the appropriate department to discuss clinical objectives and appropriate student assignments. Student clinical experiences are scheduled to promote or facilitate both the highest quality level of patient care possible as well as the efficient operations of the department.

▶ Starting time for students active in patient care assignments will be mutually agreed upon by the Manager of Education or designee and may include chairperson/director of affiliating school/college, based on patient care needs of the individual department.

▶ When applicable, pre and post conferences will be in assigned areas only. No conferences are allowed in the lobby, cafeteria, or unassigned rooms.

▶ Documentation of patient care will comply with policies and procedures of Morris Hospital.

Students

▶ The affiliating school/college will provide identification/name badge for the students.

▶ Students must adhere to the Morris Hospital dress code while on Morris Hospital premises.

▶ The student name badge should be worn above the waist and facing forward at all times.

▶ The student is to report their presence to the Director/Manager/appropriate department designee prior to beginning research.

▶ Students are to review only the chart(s) of their assigned patient(s), or those suggested by their instructor to review, as it relates to their course objectives.

▶ If the student is going to be absent, notification must be made to Director/Manager/appropriate department designee prior to the beginning of the hospital shift, or as soon as possible thereafter.

▶ If a session is cancelled because of instructor illness or school/college closure, it is the responsibility of the faculty member to contact the appropriate department designee.

Students

Students are **not** to use electronic devices (i.e. cellular phones) for personal use while on the clinical unit unless in case of emergency. Electronic devices used for personal use are only permitted during break/meal times.

Removal of Students

The facility may immediately remove any student from Morris Hospital premises for behavior that the hospital deems to be an immediate threat to the health or welfare of the hospital's patients, staff members, visitors, or operations. In such event, the hospital will notify the school/college in writing of its actions and the reasons as soon as possible. If the hospital desires to remove a student for any other reason, Morris Hospital will notify the school/college in writing of the reasons for the removal and will consult with the school/college before removing the student.

Confidentiality

- Students and/or faculty will have access to medical records of patients to complete their assignments. Students who receive access to the electronic medical record will keep their password in a secure place and follow all HIPAA regulations.

- Any information or written reports by the student should identify the patient by initials only, rather than full name or any other patient identifiers.

- Students and clinical faculty must exercise confidentiality with regard to all patient/staff information gained through the clinical experience and will respect the confidentiality of individual information as provided under HIPAA and ethics of health care professionals.

- When students leave the clinical unit, discussion of patients will be limited to clinical conferences, theory courses, and student/instructor interaction.

Health Insurance Portability & Accountability Act (HIPAA)

HIPAA Privacy & Security

Federal Regulations – Privacy Regulations effective April 2003; Security Regulations effective April 2005

Office of Civil Rights (OCR) – Federal Agency oversees and enforces Federal Privacy Regulations

Privacy Regulation

Protects the security and privacy of all Medical Records and other health information that is used or shared in any form, whether on paper, electronically or verbally by healthcare facilities, employees and their business associates

Notice of Privacy Practice (NOPP) – Morris Hospital provides each new patient with a Notice of Privacy Practice regarding how their health information will be used

Security Regulation

Safeguards the confidentiality, integrity and availability of Electronic Protected Health Information (ePHI)

Minimum Necessary / Need to Know – Each employee is responsible to access **ONLY** the health information that is required for them to complete their job

Privacy & Confidentiality

- Privacy and confidentiality are important patient rights
- Each patient has the right to:
    - Expect privacy and freedom from intrusions or disturbances regarding his or her personal affairs
    - Expect that all communications and records concerning his or her care will be treated as confidential. Information will only be shared with those who need to know the information to perform their duties on behalf of the patient
    - Review the records pertaining to his or her medical care

Maintaining Patient Confidentiality

► Maintaining patient confidentiality means keeping information about a patient's healthcare private

► Only people who need to know information should receive it and only to the extent needed to perform duties for the patient

► Maintaining patient confidentiality requires that any information about a patient cannot be repeated to anyone who is not directly involved with the care of that patient

► One of the greatest forms of communication and connectivity in the twenty first century is social media

► You should never post any information regarding patient care on any form of social media

Maintaining Patient Confidentiality

Healthcare staff have an obligation to safeguard patient information.

Measures that safeguard this information include:

- Shredding transitory documents containing PHI
- Leaving phone messages or sending mail reminders for appointments
  - Only the date and time should be given, never the reason
- Keeping fax machines in secure locations
  - The use of preprogrammed fax numbers will help eliminate sending information to incorrect sources
- Verifying the identities of all involved in the care of each patient
- Secure storage of permanent records containing PHI

Safeguarding Electronic Records

Healthcare staff has access to confidential information via electronic records.

The confidentiality of these electronic records must be safeguarded through the following actions:

▶ Computer workstations should be secured at all times

▶ Passwords should **NOT** be shared

▶ Access to electronic information should be limited to those who have a need to know the information

▶ Computer workstations should always be logged off at the end of each session

Security/Safety

- Students and instructors are required to sign in and out using the Rep Trax kiosk in the main lobby if the clinical rotation is at the main hospital. Instructions will be provided to the students prior to first clinical.

- Students assigned for greater than three months in some cases will require access to specific areas of the hospital and be given a Morris Hospital picture identification (ID) badge with the appropriate access. Managers/Directors will be responsible for retrieving those badges at the end of the student's rotation. These students will not be required to utilize the Rep Trax system when entering and leaving the building.

- Students are required to park in the visitor's parking lot. Students that are assigned Morris Hospital ID badges with access will be required to park in the designated employee parking.

- Lockers are not provided; students are encouraged to bring in only items needed for their rotation.

- Instructor identification badges will provide access to the necessary areas required to fulfill clinical rotation expectations.

Medication Administration

- Students and instructors will follow Morris Hospital policies when administering medications or intravenous solutions.

- Students will administer medications under the direct supervision of their instructor for clinical rotations where the instructor is onsite.

- Students will administer medications under the direct supervision of the preceptor for clinical rotations where the instructor is not onsite.

- Prior to administration, the student will check each medication or intravenous solution with the instructor or preceptor.

- All instructors/preceptors are responsible for obtaining medications out of the automated medication dispensing system (Pyxis). Training and access will be provided for the instructors during their orientation by the Pharmacy Department.

Medication Administration

- All instructors administering medications will complete Electronic Medication Administration Records and Bedside Medication Verification (EMAR/BMV) training for those areas scanning medications. Instructors are responsible for the documentation.

- Instructor or the preceptor will check all medications prior to student administration.

- Medications requiring specialized training will not be administered by the students or the instructor (cardiac drips, insulin drip, heparin, etc.)

- Students will not administer blood, plasma, or any blood products.

- Students are permitted to participate in intravenous (IV) procedures after the student has completed the theoretical and laboratory component of IV therapy during their didactic training.

  - The students' activities in starting IVs, regulating, priming, and administering IV solutions, flushing IV locks, administering IV medication, or discontinuing IVs will be supervised by the clinical instructor or the preceptor.

Dress Code

Professional Appearance

- All students are expected to be clean, groomed, and free of body odor.

- Beards and mustaches must be neat, clean, and trimmed at all times.

- Students report to clinical in a clean, neat, properly fitting uniform, and wear appropriate undergarments. Sheer clothing or undergarments should not be visible through or outside of clothing. Midriffs must be covered at all times.

- Students may be required to cover tattoos or remove piercings that management deems inappropriate or that may present a safety threat in areas such as direct patient care.

Safety and Hygiene

- Keep hands and nails clean and free from visible dirt at all times.

- Hair that is longer than collar length must be tied back or netted while working in any clinical/patient care area, sterile work rooms, EVS, or food handling area as a way to prevent spread of micro-organisms.

- Appropriate footwear that is safe, clean, and comfortable must be worn.

- Long sleeve shirts may be worn in clinical areas as long as they do not inhibit proper handwashing. Short or ¾ sleeves are preferred.

- Stethoscope covers are not allowed.

Clinical/Patient Care Areas

- Clinical/patient care areas, sterile work rooms, or Environmental Services (EVS) area employees may wear nail polish in good repair with no chipping. Nail polish must be removable with regular nail polish remover (non-acetone). No artificial nails are allowed. This is defined as any substance or device applied or added to the natural nails to augment or enhance the nail, including bonding, extensions, tips, wraps, gel or acrylic overlays, and tapes.

- Fingernails shall not extend beyond the distal end of the finger.

- For infection prevention and safety purposes, jewelry worn should be minimal such as one pair of stud earrings, ring, and watch. Necklace/chains must be concealed inside the uniform. A small stud nose piercing or nose ring may be allowed.

- Family Birthing Suites (FBS), SPD, Cath Lab, Surgery, Post-Anesthesia Care Unit (PACU), and Endoscopy Lab - Jewelry, including earrings, necklaces, watches and bracelets that cannot be contained or confined within the surgical attire shall not be worn.

Plain Language Codes

Plain Language Codes

Medical Alert		Facility Alert		Security Alert	
Adult Code Blue	MEDICAL ALERT + ADULT CODE BLUE + LOCATION	**Fire Alarm**	FACILITY ALERT+ FIRE ALARM+ LOCATION	**Armed Intruder**	SECURITY ALERT + ARMED INTRUDER + LOCATION
Pediatric Code Blue	MEDICAL ALERT + PEDIATRIC CODE BLUE + LOCATION	**Evacuation**	FACILITY ALERT+ EVACUATION+ LOCATION	**Assistance Needed**	SECURITY ALERT + ASSISTANCE NEEDED+ LOCATION
Stroke	MEDICAL ALERT + STROKE+ LOCATION	**Nuclear**	FACILITY ALERT+ NUCLEAR	**Missing Person**	SECURITY ALERT + MISSING PERSON + DESCRIPTION + LOCATION LAST SEEN
Trauma	MEDICAL ALERT + TRAUMA + LOCATION	**Network Failure**	FACILITY ALERT+ NETWORK FAILURE + DESCRIPTION	**Lockdown**	SECURITY ALERT + LOCKDOWN
Stemi	MEDICAL ALERT + STEMI + LOCATION	**Disaster Plan**	FACILITY ALERT+ DISASTER PLAN+ DESCRIPTION	Weather Alert	
Rapid Response	MEDICAL ALERT + RAPID RESPONSE TEAM + LOCATION	**Management Team**	FACILITY ALERT+ MANAGEMENT TEAM + LOCATION	**Severe Thunderstorm Warning /Tornado Warning**	WEATHER ALERT + SEVERE THUNDERSTORM WARNING/ TORNADO WARNING+ INSTRUCTIONS
Infusion	MEDICAL ALERT+ MASSIVE TRANSFUSION +LOCATION	**Utility Failure**	FACILITY ALERT+ UTILITY FAILURE + LOCATION	All Clear	
Decon Team	MEDICAL ALERT + DECON TEAM + LOCATION			**All Clear**	ALERT TYPE+ ALL CLEAR

Medical Alert: Adult Code Blue
Cardiac Arrest Procedure

▶ Call for help and/or pull the 'Code' lever in the room

▶ Page overhead by dialing 3515, announce "Medical Alert + Adult Code Blue + Location" at least twice

▶ In the areas that have the computer icon, page the 'Code Blue Team' or in areas that do not have the computer icon, call the Operator at ext. 0), and ask them to page the 'Code Blue Team' on the computer

▶ Access the "Codes" icon found on computer desktop in addition to calling overhead page.

▶ Begin CPR

▶ In the event the internet can not be accessed:

　▶ Page the 'Code Blue Team' by telephone (815) 851-7777 and include the department extension where the code is taking place and 7777 followed by the # sign to send the message (Example: 11597777#)

Medical Alert: Pediatric Code Blue

- 'Medical Alert: Pediatric Code Blue' is the term used for a pediatric resuscitative emergency at Morris Hospital & Healthcare Centers

- The staff member identifying the emergency will immediately call a 'Medical Alert + Pediatric Code Blue + Location' overhead   (ext. 3515) and initiate the appropriate Basic Life Support (BLS)

- Please refer to the Cardio-Pulmonary Resuscitation Policy on iShare for detailed information specific to your work area

Medical Alert: Stroke or STEMI

- **Purpose:** To ensure a person experiencing stroke symptoms is recognized as a medical emergency, receiving medical/nursing care in a prompt and appropriate manner

- Establishes the process that the team will use when responding to an acute stroke emergency

- 'Medical Alert + Stroke + Location' will be called by the Nurse or the Provider

- Medical Alert: Stroke will be utilized for Inpatient and Emergency Department Stroke patients

- Medical Alert: STEMI is utilized for Inpatient and Emergency Department Heart Attack patients

Medical Alert: Rapid Response Team

Adult Emergencies include:
(this list is not all inclusive)

- Staff member or licensed provider concerned about a subtle change

- New onset chest pain

- New neurological findings
  - If a patient presents as a possible stroke, dial 3515 and announce "Medical Alert + Stroke + Location" without calling a Rapid Response

- Symptomatic bradycardia

- Symptomatic hypotension

- Acute respiratory distress

- Acute change in mental status or seizures

- Acute significant bleeding

- Acute change in blood oxygen saturation

- Failure to respond to treatment for an acute problem/symptom

- A MEWS Score of 5 or greater

Medical Alert: Pediatric Rapid Response Team

- The Rapid Response Pediatric Team is a team of experienced clinicians who bring their expertise by rapidly responding to pediatric emergencies to rescue the patient with a change in status

- A pediatric rapid response may be initiated by a licensed provider, employee, patient, visitor, or family member

- Pediatric patients are anyone less than 17 years of age (excluding newborns in the Family Birthing Suites)

- Pediatric emergencies include:
  - Acute changes in heart rate, blood pressure or respiratory rate
  - Hypoxia
  - Mental status changes/seizures
  - Staff and/or family concerns

Facility Alert: Fire Alarm

Facility Alert + Fire Alarm + Location

R = Rescue anyone in immediate danger
A = Activate the fire alarm
C = Contain the fire (close all doors and windows)
E = Extinguish the fire

It is the responsibility of everyone to know:

► Fire prevention and fire safety in their areas

► What to do if a fire is discovered

  ► In the hospital

  ► In their department specifically

  ► What to do if a fire alarm is sounded

► How to evacuate patients, visitors, and employees with disabilities

Fire Extinguisher

P = Pull the pin
A = Aim the nozzle at the base of the fire
S = Squeeze the handle
S = Sweep side to side at the base of the fire

Fire Extinguisher ABCs

► **Class A:** Paper, Wood, Cloth

► **Class B:** Flammable liquids or gasses

► **Class C:** Electrical

► **HALON:** For Class ABC fires and will not harm computer equipment

► **Class K:** Cooking appliances using combustibles

► **ABC:** General Purpose

Fire Response

- Do not respond to the announced area
  - Security, EVS, & Facilities Only
- Clear corridors of obstructions
- Close file cabinets and desk drawers
- Do not use elevators
- Do not enter fire zone, be cautious moving through the building
- Follow any specific department plans that are in place

Fire Watch: Not an Overhead Announcement

To watch the building for fires when the fire alarm system is down

Implementation:

- Fire Watch will only be sent via email when the fire alarm system is down either for repairs or testing

- When the 'Fire Watch' is emailed all departments must watch for fires in an around their area

- The Maintenance Department will notify via email when the fire alarm system is back up and running using "Fire Watch, All Clear"

- If a fire occurs in your area, notify the operator immediately

  - The operator will turn in the call to the fire department

  - The operator will announce overhead "Facility Alert + Fire Alarm + Location"

  - We will follow our normal fire procedures

    - R.A.C.E.

    - P.A.S.S.

Severe Weather: (such as Tornado or Thunderstorm)

When severe weather is imminent in the hospital's location, the operator or designee will announce "Weather Alert + Severe Thunderstorm Warning/Tornado Warning + Instructions

IMMEDIATELY RESPOND TO THIS PROCEDURE

- Hospital is in imminent danger. Tornado is in immediate area and headed for the hospital
- Every effort should be made to physically protect the patients, visitors and yourself the best that you can

Patient Care Areas

- Move all ambulatory patients to inner utility rooms, etc., that do not have windows. Instruct them to shield self from flying debris
- Move as many non-ambulatory patients' beds as possible into the inner corridor. If unable to fit all the beds into the inner corridor, push beds as far away from windows as possible, pull curtain between beds, position patient facing away from window and shield head with pillow
- Clear visitors from waiting rooms with windows to inner corridors or waiting rooms without windows
- Close doors to rooms

Severe Weather: (such as Tornado or Thunderstorm)

Family Birthing Suites
Nurse must stay with labor patient
Move to inner corridor if possible

Nursery
All babies are to be taken to inner corridor
Give baby to mother if possible
Nurse to stay with mothers and babies

ICU
Pull drapes between beds
If patient's condition permits, move patient to the hallway

Surgery
Remain in surgery suite unless patients can be moved to inner corridor

ED
Move patients to inner corridor
If patient can not be moved, close door to room and remain with patient

Non-Patient Care Area – Ancillary Departments
All patients, visitors, and employees should move into the inner corridor or rooms without windows
Close all doors to hallways
Operator stays at switchboard – shield self under desk

ED staff will notify Administration when the watch/warning has been cancelled, and the switchboard will be notified to announce "Weather Alert, All Clear"

Facility Alert: Disaster Plan + Description

- Provide definitive medical treatment to a large number of casualties with minimum delay
- Utilize existing hospital facilities to minimize the disruption of regular hospital activities
- Announce overhead

   "Facility Alert: Disaster Plan + Description"
- Initiate plan as per policy in your work area
- Refer to Emergency Operations Plan on iShare

Medical Alert: Decon Team + Location

- Chemical/biological Event:
  - Interior: Evacuate immediate area; close all doors
  - Exterior: Prepare for patient decontamination and triage

Contact the House Supervisor (ext.7490) who will page out accordingly

Facility Alert: Evacuation + Location

- Evacuation Procedure
    - A designated person will keep the department schedules and log employees out
    - Evacuation of ambulatory patients will be given first priority
    - Non-ambulatory patients will be evacuated next followed by critical patients
    - Employees will be evacuated after patients
    - Destination of the evacuees will be determined by the situation

Security Alert: Armed Intruder + Location

- Indicates there is a person on hospital or healthcare center campuses in possession of a weapon and threatening to use it
- Please refer to the Armed Intruder policy for department and personnel response required for this type of event

Facility Alert: Nuclear

- Nuclear Disaster Procedure:
  - The hospital will be notified by Emergency Services and Disaster Agency (ESDA)
  - At the time of notification, follow the guidelines specific to your area
  - Status of the situation will be communicated at all times
  - Depending on information communicated from ESDA, Morris Hospital will either be used as a shelter or be evacuated

Security Alert: Assistance Needed + Location

- Violent Situation Procedure:
  - When an employee or physician perceives a situation may be or has become threatening, verbally or physically, they should call the hospital operator
  - State "Security Alert: Assistance Needed and Location"
  - All available personnel will respond to the location on a 'stat' basis (immediately)
  - Activate the emergency response alarm if indicated in your work area

Security Alert: Missing Person + Description + Location Last Seen

- Abduction Procedure:
  - If 'Security Alert: Missing Person + Description + Location Last Seen' is overhead paged:
    - All personnel will immediately secure all exits and stairwells
    - No person should leave the building unless the police have authorized them to leave or a 'Security Alert: Missing Person ALL CLEAR' has sounded

Facility Alert: Network Failure + Description

- This overhead page indicates an unscheduled downtime of the computer system
  - Immediately initiate your department computer downtime procedures
  - When the computer system is back up 'Network Failure: ALL CLEAR' will be overhead announced

Medical Alert: Trauma + Location

- Trauma Team Activation:
  - If this is overhead paged, the trauma team automatically responds to the announced location
  - Trauma team responds 'stat' upon arrival of a walk-in trauma patient who meets criteria

Medical Alert: Massive Transfusion + Location

- Physician determines need for Massive Transfusion Protocol
  - Patient requires urgent transfusion for the treatment of life threatening hemorrhage
  - Massive Transfusion Protocol (MTP) initiated
  - Protocol available on iShare

Security Alert: Lockdown

- Total Site Lockdown
  - This is the highest level of facility and perimeter security
  - During a total lockdown, all perimeter doors and exterior barriers are secured and no one is allowed to enter or exit the facility
  - Security or designees will be deployed to key entry/exit point areas
- Partial Lockdown
  - During a partial lockdown, all perimeter doors are secured and Security or designees are deployed to all public entrances and exits
  - Each person attempting to enter/exit would be screened and escorted as needed

The House Supervisor or the Administrator On-Call is the only one authorized to call a total or partial lockdown

Facility Alert: Management Team + Location

- If this alert is overhead paged, the Management Team is to respond to the location given

Combative Patients/Visitors

- Announced as "Security Alert + Assistance Needed + Location" x2

- This is called when any employee or physician perceives that the situation may, or has, become verbally or physically threating

  - Be sure to maintain a good Reactionary Distance

- Security, Maintenance, House Supervisors, and other trained personal then respond to the location on a "stat" basis

- Be aware of your surroundings: call the alert BEFORE the situation gets out of control if possible

Alert Type: ALL CLEAR

- This alert will be overhead paged whenever any alert has been mitigated and threat has been resolved

Infection Prevention & Control

Hand Hygiene is the #1 way to prevent the spread of infections

Why? You can take action by practicing hand hygiene regularly and by asking those around you to practice it as well.

When? You and your loved ones should clean your hands very often, especially after touching objects or surfaces in the hospital room, before eating, and after using the restroom. Your healthcare provider should practice hand hygiene every time they enter your room.

How? It only takes 15 seconds of using either soap and water or an alcohol-based hand rub to kill the germs that cause infections.

Which? Use soap and water when your hands look dirty; otherwise, you can use an alcohol-based hand rub.

Who? You, your loved ones, and your healthcare providers should practice hand hygiene.

For more information, please visit www.cdc.gov/handhygiene or call 1-800-CDC-INFO

A Patient's Guide

Hand Hygiene Saves Lives

hand hygiene
- Washing hands with soap and water.
- Cleansing hands using an alcohol-based hand rub.
- Preventing the spread of germs and infections.

CDC

hand
hygiene
saves lives

Why?

To prevent hospital infections.

- In the United States, hospital patients get nearly 2 million infections each year. That's about 1 infection per 20 patients!
- Infections you get in the hospital can be life-threatening and hard to treat.
- All patients are at risk for hospital infections.
- You can take action by asking both your healthcare providers and visitors to wash their hands.

Remember: Hand hygiene saves lives.

To make a difference in your own health.

- Hand hygiene is one of the most important ways to prevent the spread of infections, including the common cold, flu, and even hard-to-treat infections, such as methicillin-resistant *Staphylococcus aureus*, or MRSA.

When?

You should practice hand hygiene:

- Before preparing or eating food.
- Before touching your eyes, nose, or mouth.
- Before and after changing wound dressings or bandages.
- After using the restroom.
- After blowing your nose, coughing, or sneezing.
- After touching hospital surfaces such as bed rails, bedside tables, doorknobs, remote controls, or the phone.

Healthcare providers should practice hand hygiene:

- Every time they enter your room.*
- Before putting on gloves. Wearing gloves alone is not enough to prevent the spread of infection.
- After removing gloves.

Remember: Ask your doctors and nurses to clean their hands before they examine you.

* If you already have an infection, your healthcare providers may take special measures (isolation precautions) to prevent the spread of your infection to others. They might enter your room wearing protective equipment (e.g., gloves, gown, mask). You do not need to ask them to clean their hands because they should have done so before they put on gloves.

How?

With soap and water:

1. Wet your hands with warm water. Use liquid soap if possible. Apply a nickel- or quarter-sized amount of soap to your hands.
2. Rub your hands together until soap forms a lather and then rub all over the top of your hands, in between your fingers and the area around and under the fingernails.
3. Continue rubbing your hands for 15 seconds. Need a timer? Imagine singing the "Happy Birthday" song twice.
4. Rinse your hands well under running water.
5. Dry your hands using a paper towel if possible. Then use your paper towel to turn off the faucet and to open the door if needed.

Remember: It only takes 15 seconds to protect yourself and others.

With an alcohol-based hand rub:

1. Follow directions on the bottle for how much of the product to use.
2. Rub hands together and then rub product all over the top of your hands, in between your fingers and the area around and under the fingernails.
3. Continue rubbing until your hands are dry. If enough rub was used to kill germs, it should take at least 15 seconds of rubbing before your hands feel dry. You should not rinse your hands with water or dry them with a towel.

Which?

Use soap and water:

- When your hands look dirty.
- After you use the bathroom.
- Before you eat or prepare food.

Use an alcohol-based hand rub:

- When your hands do not look dirty.
- If soap and water are not available.
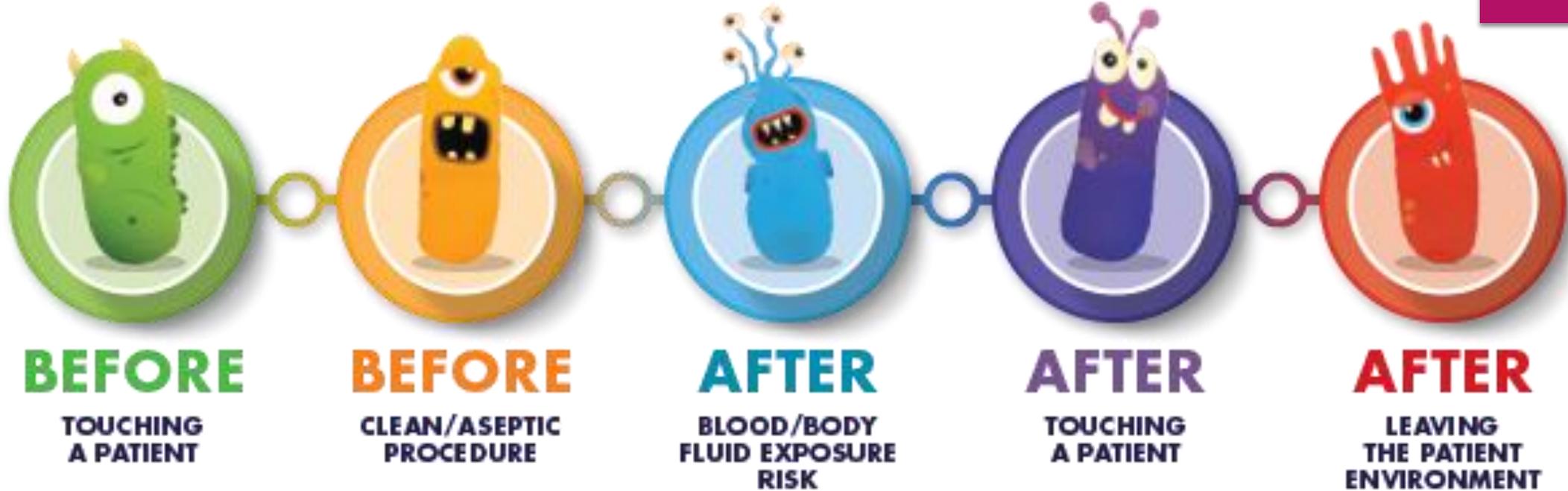
Alcohol based hand rubs

- Products that kill germs on the hands.
- Should contain 60% to 95% ethanol or isopropanol (types of alcohol).
- Are fast-acting and convenient.

Who?

You can make a difference in your own health:

- Healthcare providers know they should practice hand hygiene, but they sometimes forget. Most welcome your friendly reminder.
- Ask healthcare providers to practice hand hygiene in a polite way — tell them that you know how easy it is for people to get infections in the hospital and that you don't want it to happen to you.

Remember: Take control of your health, practice hand hygiene.

MH# 1439 6/2016

BEFORE
TOUCHING
A PATIENT

BEFORE
CLEAN/ASEPTIC
PROCEDURE

AFTER
BLOOD/BODY
FLUID EXPOSURE
RISK

AFTER
TOUCHING
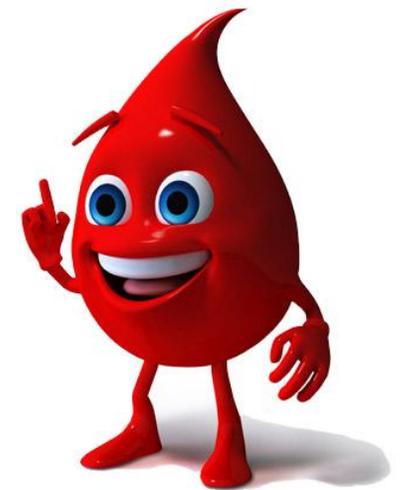A PATIENT

AFTER
LEAVING
THE PATIENT
ENVIRONMENT

5 Moments of Hand Hygiene

It takes just 5 Moments to change the world

Clean your hands, stop the spread of drug-resistant germs!

Blood Borne Pathogens

Occupation Safety & Health Administration (OSHA) Blood Borne Pathogen Standard

Blood borne pathogens are infectious microorganisms present in blood that can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV), the virus that causes AIDS. Workers exposed to blood borne pathogens are at risk for serious or life-threatening illnesses.

OSHA's Bloodborne Pathogens Standard

Bloodborne pathogens are infectious microorganisms present in blood that can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV), the virus that causes AIDS. Workers exposed to bloodborne pathogens are at risk for serious or life-threatening illnesses.

Protections Provided by OSHA's Bloodborne Pathogens Standard

All of the requirements of OSHA's Bloodborne Pathogens standard can be found in Title 29 of the Code of Federal Regulations at 29 CFR 1910.1030. The standard's requirements state what employers must do to protect workers who are occupationally exposed to blood or other potentially infectious materials (OPIM), as defined in the standard. That is, the standard protects workers who can reasonably be anticipated to come into contact with blood or OPIM as a result of doing their job duties.

In general, the standard requires employers to:

- **Establish an exposure control plan.** This is a written plan to eliminate or minimize occupational exposures. The employer must prepare an exposure determination that contains a list of job classifications in which all workers have occupational exposure and a list of job classifications in which some workers have occupational exposure, along with a list of the tasks and procedures performed by those workers that result in their exposure.

- **Employers must update the plan annually** to reflect changes in tasks, procedures, and positions that affect occupational exposure, and also technological changes that eliminate or reduce occupational exposure. In addition, employers must annually document in the plan that they have considered and begun using appropriate, commercially-available effective safer medical devices designed to eliminate or minimize occupational exposure. Employers must also document that they have solicited input from frontline workers in identifying, evaluating, and selecting effective engineering and work practice controls.

- **Implement the use of universal precautions** (treating all human blood and OPIM as if known to be infectious for bloodborne pathogens).

- **Identify and use engineering controls.** These are devices that isolate or remove the bloodborne pathogens hazard from the workplace. They include sharps disposal containers, self-sheathing needles, and safer medical devices, such as sharps with engineered sharps-injury protection and needleless systems.

- **Identify and ensure the use of work practice controls.** These are practices that reduce the possibility of exposure by changing the way a task is performed, such as appropriate practices for handling and disposing of contaminated sharps, handling specimens, handling laundry, and cleaning contaminated surfaces and items.

- **Provide personal protective equipment (PPE), such as gloves, gowns, eye protection, and masks.** Employers must clean, repair, and replace this equipment as needed. Provision, maintenance, repair and replacement are at no cost to the worker.

- **Make available hepatitis B vaccinations to all workers with occupational exposure.** This vaccination must be offered after the worker has received the required bloodborne pathogens training and within 10 days of initial assignment to a job with occupational exposure.

- **Make available post-exposure evaluation and follow-up to any occupationally exposed worker who experiences an exposure incident.** An exposure incident is a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or OPIM. This evaluation and follow-up must be at no cost to the worker and includes documenting the route(s) of exposure and the circumstances under which the exposure incident occurred; identifying and testing the source individual for HBV and HIV infectivity, if the source individual consents or the law does not require consent; collecting and testing the exposed worker's blood, if the worker consents; offering post-exposure prophylaxis; offering counseling; and evaluating reported illnesses. The healthcare professional will provide a limited written opinion to the employer and all diagnoses must remain confidential.

- **Use labels and signs to communicate hazards.** Warning labels must be affixed to containers of regulated waste; containers of contaminated reusable sharps; refrigerators and freezers containing blood or OPIM; other containers used to store, transport, or ship blood or OPIM; contaminated equipment that is being shipped or serviced; and bags or containers of contaminated laundry, except as provided in the standard. Facilities may use red bags or red containers instead of labels. In HIV and HBV research laboratories and production facilities, signs must be posted at all access doors when OPIM or infected animals are present in the work area or containment module.

- **Provide information and training to workers.** Employers must ensure that their workers receive regular training that covers all elements of the standard including, but not limited to: information on bloodborne pathogens and diseases, methods used to control occupational exposure, hepatitis B vaccine, and medical evaluation and post-exposure follow-up procedures. Employers must offer this training on initial assignment, at least annually thereafter, and when new or modified tasks or procedures affect a worker's occupational exposure. Also, HIV and HBV laboratory and production facility workers must receive specialized initial training, in addition to the training provided to all workers with occupational exposure. Workers must have the opportunity to ask the trainer questions. Also, training must be presented at an educational level and in a language that workers understand.

- **Maintain worker medical and training records.** The employer also must maintain a sharps injury log, unless it is exempt under Part 1904 -- Recording and Reporting Occupational Injuries and Illnesses, in Title 29 of the Code of Federal Regulations.

Additional Information

For more information, go to OSHA's Bloodborne Pathogens and Needlestick Prevention Safety and Health Topics web page at: https://www.osha.gov/SLTC/bloodbornepathogens/index.html.

To file a complaint by phone, report an emergency, or get OSHA advice, assistance, or products, contact your nearest OSHA office under the "U.S. Department of Labor" listing in your phone book, or call us toll-free at **(800) 321-OSHA (6742)**.

OSHA® Occupational Safety and Health Administration
www.osha.gov 1-800-321-6742

Standard Precautions

▶ To provide an effective means to prevent and control the transmission of infection among patients and personnel.

▶ Standard Precautions are to be observed for contact with all patients, blood and body fluids, and equipment that is potentially contaminated. (OSHA, 2012).

▶ Transmission-based precautions are implemented for patients diagnosed with, or suspected of having, infections with highly transmissible or epidemiologically important pathogens. (Centers for Disease Control (CDC, 2007)).

Standard Precautions

Use when caring for **all** patients in all healthcare settings, regardless of the suspected or confirmed presence of an infectious agent.

- **All** blood, body fluids, excretions, and secretions (except sweat) regardless of whether they contain visible blood.

- Non-intact skin

- Mucous membranes: prevent transmission of microorganisms from both recognized and unrecognized sources of infections.

- Wear Personal Protective Equipment (PPE) to prevent exposure to potentially contaminated body fluids
    - Gloves
    - Gowns
    - Masks
    - Protective Eyewear / Face shield

- Visitors shall be instructed on the location and use of PPE and instructed on hand hygiene practices by nursing staff.

Donning & Doffing PPE

SEQUENCE FOR PUTTING ON PERSONAL PROTECTIVE EQUIPMENT (PPE)

The type of PPE used will vary based on the level of precautions required, such as standard and contact, droplet or airborne infection isolation precautions. The procedure for putting on and removing PPE should be tailored to the specific type of PPE.

1. GOWN
- Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
- Fasten in back of neck and waist
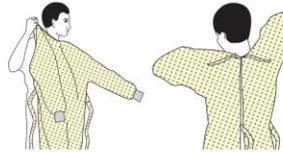
2. MASK OR RESPIRATOR
- Secure ties or elastic bands at middle of head and neck
- Fit flexible band to nose bridge
- Fit snug to face and below chin
- Fit-check respirator

3. GOGGLES OR FACE SHIELD
- Place over face and eyes and adjust to fit

4. GLOVES
- Extend to cover wrist of isolation gown

USE SAFE WORK PRACTICES TO PROTECT YOURSELF AND LIMIT THE SPREAD OF CONTAMINATION
- Keep hands away from face
- Limit surfaces touched
- Change gloves when torn or heavily contaminated
- Perform hand hygiene

CDC

HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 2

Here is another way to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. **Remove all PPE before exiting the patient room** except a respirator, if worn. Remove the respirator **after** leaving the patient room and closing the door. Remove PPE in the following sequence:

1. GOWN AND GLOVES
- Gown front and sleeves and the outside of gloves are contaminated!
- If your hands get contaminated during gown or glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp the gown in the front and pull away from your body so that the ties break, touching outside of gown only with gloved hands
- While removing the gown, fold or roll the gown inside-out into a bundle
- As you are removing the gown, peel off your gloves at the same time, only touching the inside of the gloves and gown with your bare hands. Place the gown and gloves into a waste container

2. GOGGLES OR FACE SHIELD
- Outside of goggles or face shield are contaminated!
- If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Remove goggles or face shield from the back by lifting head band and without touching the front of the goggles or face shield
- If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container

3. MASK OR RESPIRATOR
- Front of mask/respirator is contaminated — DO NOT TOUCH!
- If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
- Discard in a waste container
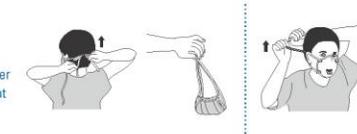
4. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE

OR
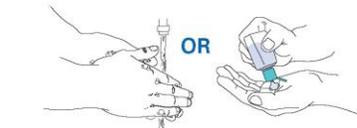
PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE

CDC

In addition to Standard Precautions we use **Transmission Based Precautions** to prevent the spread of other infections

Airborne Isolation Precautions
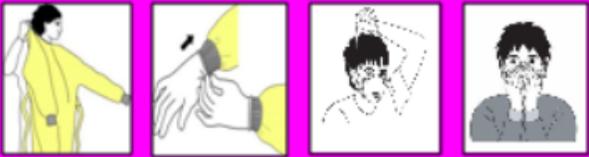

Airborne precautions are used for patients with known or suspected infections spread by airborne transmission **such as those with known or suspected tuberculosis, measles, and varicella (chicken pox and disseminated zoster).** Airborne transmission occurs by dissemination of airborne droplet nuclei (very tiny particle residue of evaporated droplets that may remain suspended in the air for long periods of time or dust particles containing the infectious agent) which can be dispersed widely by air currents within a room.

- Required Personal Protective Equipment (PPE)
    - Gown
    - Gloves
    - N95 Respirator Mask or Powered Air Purifying Respirator (PAPR) Hood.
        - Staff must receive annual fit testing in order to use an N95 Respirator Mask. Annual training is also required for PAPR hood use.
- Patient Transport : If transport or movement is necessary, place a surgical / procedure mask on the patient and follow Respiratory Hygiene/Cough Etiquette.

Droplet Isolation Precautions

DROPLET PRECAUTIONS

In addition to Standard & Contact Precautions

HAND HYGIENE:
EVERY TIME you Enter and Exit the Room,
REGARDLESS if you intend to cross the BLUE LINE.

Gown   Gloves   Simple Mask

USE PROPER PPE:
EVERY TIME you cross the BLUE LINE into the room.

VISITORS MUST STOP AT NURSE'S STATION
FOR INSTRUCTIONS ON HOW YOU CAN PROTECT YOURSELF
& YOUR FAMILY / FRIEND IN ISOLATION.

Droplet Isolation Precautions are used for patients known or suspected of having infections spread through close respiratory or mucous membrane contact with respiratory secretions. Droplet precautions are used for infections such as **influenza**, **whooping cough (Pertussis),** and **bacterial meningitis**.

- Required Personal Protective Equipment (PPE)
  - Gown
  - Gloves
  - N95 respirator masks are used when performing an aerosol generating procedure. PAPR hoods can be worn if staff unable to pass fit-testing. A procedural mask should be worn over N95 to assure cleanliness of N95
  - Wear a regular surgical/procedural mask when working within three - six feet of the patient.
  - Remove mask when greater than six feet from the patient and before leaving the patient's room and wash/decontaminate hands.
  - Protective eyewear or face shield (if performing an aerosol generating procedure, such as suctioning or intubation/extubation)
- Patient Transport: If transport or movement is necessary, place a surgical / procedure mask on the patient and follow Respiratory Hygiene/Cough Etiquette.

Special Droplet Isolation Precautions

For patients known to have or suspected to be infected or colonized with an infection spread through respiratory droplets for which enhanced precautions are needed at certain times during patient care activities. **Special Droplet precautions are used for infection such as COVID-19 or Suspected COVID Patients (PUIs).**

- Required Personal Protective Equipment (PPE)
  - Gown
  - Gloves
  - N95 respirator masks or PAPR hoods can be worn if staff unable to pass fit-testing
  - Mask – procedural mask should be worn over N95 to assure cleanliness of N95
  - Protective eyewear or face shield
  - For patients with COVID-19, patients are placed in a negative-pressure inpatient room if undergoing aerosol generating procedures.
- Patient Transport: If transport or movement is necessary, place a surgical / procedural mask on the patient and follow Respiratory Hygiene/Cough Etiquette.

DON'T FORGET…
► Disinfectant: Clorox wipes

Contact Isolation Precautions

For patients known to have or suspected of being infected or colonized with epidemiologically important microorganisms that can be transmitted by **direct contact** with the patient (hand or skin-to-skin contact that occurs when performing patient activities that require touching the patient) or **indirect contact** (touching environmental surfaces or patient care items such as electronic thermometers and glucose monitoring machines) in the patient's environment. **Contact Precautions would be used for infections such as patients with methicillin-resistant Staphylococcus aureus (MRSA), extended-spectrum beta-lactamase (ESBL), vancomycin-resistant Enterococcus (VRE), or patients with respiratory syncytial virus (RSV).**

- Required Personal Protective Equipment (PPE)
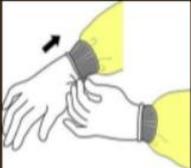
    - Gown

    - Gloves

Enteric Contact Isolation Precautions

For patients with diarrheal illness, including C. diff and Norovirus. Patient will remain in Enteric Contact Precautions for the duration of their hospital stay if they have a positive test for enteric pathogen, such as C. diff or Norovirus. A flag is not placed in the multidrug-resisting organism (MDRO) banner in the electronic medical record for C. diff. Upon readmission a patient with a history of C. diff does not require isolation unless they are symptomatic (i.e. having diarrhea type stools) or have not yet completed treatment.

USED TO ISOLATE PATIENTS WITH LOOSE OR LIQUID STOOLS (3 or more within a 24 hour period)

- Required Personal Protective Equipment (PPE)
  - Gown
  - Gloves
    - Place red stop sign signage on alcohol based hand rub dispenser in the room to discourage use. Hand Hygiene is to be performed using soap and running water. Alcohol-based hand rubs should not be used for patients in Enteric Contact Precautions.
    - If transport is required and patient is incontinent of stool, place adult diaper on patient to contain the stool.

PATIENTS REMAIN IN ISOLATION FOR THE DURATION OF THE ILLNESS:

► Until they have completed treatment **AND** Are free of diarrhea or loose stools

DON'T FORGET...

- ✓ **Hand Hygiene:** Soap & water Only during care and on exit

- ✓ **Disinfectant:** Clorox wipes.

- ✓ **Nurse Driven Protocol for C diff testing**

- ✓ **Stools must be Type 6 or 7 meaning the sample must confirm to the contain. If it does not, lab will reject the specimen.**

Protective Isolation Precautions

PROTECTIVE PRECAUTIONS

In addition to Standard Precautions

VISITORS MUST STOP AT NURSE'S STATION BEFORE ENTERING!

- Perform Hand hygiene **EVERY TIME** you enter and exit the room
- Please do not visit if you are sick!
- Keep the door closed.
- No fresh flowers or potted plants.

Gown, gloves and masks are NOT required unless otherwise posted.

For patients who are severely immune compromised and at high risk for infections.

- All persons must perform hand hygiene before entering and after leaving the rooms of neutropenic patients.
- Standard precautions should be followed for these patients and Transmission Based Precautions should be implemented as indicated.
- The patient will be placed in a private room.
- Plants and dried or fresh flowers should not be allowed in the patient room.
- No AIIR isolation rooms should be used for patients in Protective / Neutropenic Precautions due to the direction of airflow . The air pressure required in protective / neutropenic precautions patient rooms should be positive compared with adjoining areas, such as hallways, toilets, and anteroom.
- Door must remained closed.
- All persons entering the room must be free of communicable diseases.
- Patient must wear a surgical mask when leaving the room or transported out of the room.
- Visitors shall be instructed on the location and use of PPE and instruct on hand hygiene practices by nursing staff.

Know Your Disinfectant Wet Contact Time!

1 Minute

Wet Contact Time

3 Minute

Wet Contact Time

Exposure Control Plan

Blood Borne Pathogens

Morris Hospital & Healthcare Centers (MHHC) shall evaluate and provide prophylaxis treatment per Centers for Disease Control and Prevention (CDC) and Occupational Safety and Health Administration (OSHA) for an employee who has sustained a parenteral, percutaneous, or mucous membrane exposure to blood, tissue, or other potentially infectious body fluids such as semen, cerebrospinal fluid, amniotic fluid, vaginal secretions, synovial fluid, pleural fluid, peritoneal fluid, or pericardial fluid. Feces, nasal secretions, sputum, sweat, tears, urine, and vomit are not considered potentially infectious unless they are visibly bloody.

Types of Sources

► Individual Source: any individual, living or dead, whose blood or potentially infectious body fluid exposes or contaminates another person.

► Exposed Employee: employee whose blood (through breaking of the skin with a needle or sharp object) or mucosa (inner layer of mouth, nose, and eyelid) gets contaminated with another person's blood or body fluid as above.

► Unknown Source: person who is the source of contaminated instrument, needle, body fluids as above, or blood that cannot be identified, i.e. exposure from biohazard bag.

► Known Source: person who is the source of contaminated instrument, needle, or blood that can be identified.

► Responder to Hepatitis B Vaccine (HBV): person who, after receiving three doses of the Hepatitis B vaccine, tests reactive for the Hepatitis B surface antibody.

► Non-responder to Hepatitis B Vaccine: person who, after receiving three doses of the Hepatitis B vaccine, does not develop antibodies to the Hepatitis B virus. The Hepatitis B surface antibody is non-reactive and the Anti-HBc also reads non-reactive.

► Exposure: needle stick with needle contaminated with blood or body fluids, oral or ocular mucosa or non-intact skin contaminated by blood/body fluids, or an accidental cut with contaminated instrument (knife, scissors, etc.)

The Procedure

- Clean wound or contaminated area thoroughly with soap and water as soon as possible or flush with copious amounts of water for eye exposure.
- Employee notifies Security and their manager/supervisor/director.
- (ONSITE) Security notifies House Supervisor and brings the packet to accident site. Security has employee fill out Section I on form 680 and sign the Illinois Compensation Trust Release of Information Authorization Form. A copy of the Injured Employee Memo is given to the employee.
- House Supervisor:
  - Completes Section II on Form 680 (page 2 of packet). This form stays with the packet.
  - Explains the needs for possible blood draw to the patient. Writes the source DD#, and unit/department of injury on the Employee Exposure/Needle Stick Source Patient Standing Order Form (page 5 of packet). Dates, times, and signs the form and tubes it to Lab. The House Supervisor will call lab to draw source patient and notify Lab of paper order being sent to them.
  - Writes employee's name and source patient's DD# on the Blood Borne Pathogen Exposure Form (page 6 of packet). This form stays with packet. If source is unknown, advises employee to clock out of unit, fill out blue time sheet, and go to Emergency Department(ED) immediately.
  - Instructs employee they should not leave the hospital until HIV results have been called to them.

Procedure

- The employee will keep the packet until House Supervisor notifies them of source patient's results.
- The Lab will receive order for source patient draw from House Supervisor and check for source patient's blood in Lab before draw. If no blood is in Lab, Lab will draw source patient. They will register source as referred account utilizing the client registration. Choose Morris Hospital Client with mnemonic of: CLIMORHOSPWC. Lab will call House Supervisor with Rapid HIV results and if source is positive, they will notify ED Physician. Lab will fax results to EHN.
- The House Supervisor will call employee with source patient's rapid result. If source is positive, employee will go to ED immediately and notify ED that it is urgent. If source is negative or employee is declining medications, employee should go to the ED as soon as possible but no later than the end of shift.
- The House Supervisor will call employee with source patient's rapid result. If source is positive, employee will go to ED immediately and notify ED that it is urgent. If source is negative or employee is declining medications, employee should go to the ED as soon as possible but no later than the end of shift.
- The ED will order Employee Needle Stick Panel per Form 614. The ED physician will provide education on HIV/Hepatitis and medication to employee. The Post Exposure Prophylaxis Hotline (PEP Line) may be contacted at 1-888-448-4911 to provide current and prompt treatment regimen. If employee consents to HIV prophylaxis, give the 1st dose of the medications ordered in the ED. Medications are to be given within 1 to 2 hours of occurrence.

Procedure

▶ If the employee is prescribed medication, they will receive a prescription for a 7 day supply of medication from the hospital pharmacy.

▶ The ED will instruct employee to follow-up with EHN, and notify Security to retrieve packet.

▶ The employee will take prescription to the hospital pharmacy for fulfillment of medications. They will complete Remote Data Entry general risk form on iShare, and follow- up post exposure with EHN.

▶ The EHN will evaluate any additional follow-up needed and provide additional education.

▶ Offsite Facilities: If the employee declines HIV prophylaxis, blood may be drawn at clinic and sent to lab. If they are requesting prophylactic medication, they must report to ED immediately. Refer to the Reporting Employee Injuries Policy for further instruction.

Test Panels for Exposure

- Health Care Workers Panels:

  - On-site employee exposure panel/vaccinated (H EEP/V) includes: Hepatitis B Surface Antibody, Hepatitis B Core Antibody Immunoglobulin M (IGM), Hepatitis C vaccine (HCV), HIV. Offsite includes: H EEP/V

  - On-site employee exposure/not vaccinated (H EEP/NP) includes: Hepatitis B Surface Antigen, Hepatitis B Core Antibody IGM, HCV, HIV. Offsite includes: H EEP/NP.

- Source Panel: (HEPS) includes: Hepatitis B Surface Antigen, Hepatitis B. Core Antibody IGM, HCV, RAPID HIV.

Employee Post-Testing Follow-up

- Lab will send results of tests (employee and source) to OHP and EHN.

- EHN will contact employee to discuss test results and schedule follow-up appointments. See Attachment A.

- Any problems with follow-up or compliance will be reported to Employee Health, Infection Preventionist and department manager/director.

- In the event employee testing shows active disease of HIV, HBV, or HCV, the employee's ability to remain in their current job description will be confidentially evaluated by Infectious Disease physician and Infection Preventionist and discussed with Medical Staff President if indicated.

Medication Precautions

- Hepatitis B immune globulin (HBIG) should be used cautiously in patients with a history of human immune globulin hypersensitivity. Do not administer HBIG to patients with known severe, potentially life-threatening reaction to human immune globulin.

- Do not give HBIG to patient with Immune globulin A (IgA) deficiency.

- Live vaccinations should be delayed until 3 months after HBIG administration and it may be necessary to revaccinate persons who received HBIG shortly after live virus vaccination.

- Use HBIG cautiously in patients with severe thrombocytopenia or any coagulation disorder that would potentially contraindicate intramuscular administration use only if the expected benefits outweigh the risks of HBIG.

- Consult current CDC and American College of Obstetrician and Gynecology guidelines prior to HBIG use in pregnant patients. Administer HBIG cautiously with breast feeding patients as the excretion of HBIG into breast milk in unknown.

Patient Safety

Identification Bands/Clips for Patient Safety

- **White Band** - Patient Identification Band
- **Red Alert Clip** - Allergy Band
- **Yellow Alert Clip** - Fall Risk
- **Purple Alert Clip** - Do not Resuscitate (DNR)
- **Green Band** - Blood Unit Band
  - Do not remove – call Lab for removal
- **Pink Alert Clip** - Limb Alert
- Security Tags - Security tags are placed on ALL pediatric patients (0 to 17 years of age) and newborns

Quality

Regulatory Readiness

Patient Safety

Quality Department

Medical Staff Quality

Continuous Improvement

Accreditation & Certification Surveys

What is Quality & Patient Safety?

Quality

- Quality is what is done and how well it is done to provide care and services to customers

- It ensures safe, effective, patient-centered, timely, and efficient, equitable (IOM)

Patient Safety

- Patient Safety refers to reducing risk from harm and injury
  - Medication Errors
  - HOSPITAL Acquired Infections (HAI)
  - Hospital Acquired Conditions (HAC)
    - Falls
    - VTE
    - Pressure Injuries

What if We Don't Measure Up?

Patients
- Errors/defects
- Lower quality care/poor patient outcomes

Employees
- Re-work
- Morale

Financial (bottom line)
- Medicare reimbursement based on our performance
- Increase costs associated with re-work

Reputation
- Healthcare is consumer driven.
- Almost all of our data is publically reported

Improvement Requires a Team Approach

Coming Together is a Beginning

Keeping Together is Progress

Working Together is Success

- Henry Ford

Culture of Patient Safety

- Healthcare is a **high-risk** and **error prone** environment
- All employees share responsibility for risk reduction and patient safety
- We must be vigilant and **proactive**

Improvement Requires a Team Approach

No role in healthcare is too small to either positively or negatively impact the patient!

Teamwork is **ESSENTIAL**!!

Three Guiding Principles for Improvement:

Standardize

Create Independent Checks

Learn From Deficits

Now how do we fix the problem?...

PCDA

Act
► Any Adjustments?
► Begin Next Cycle

Plan
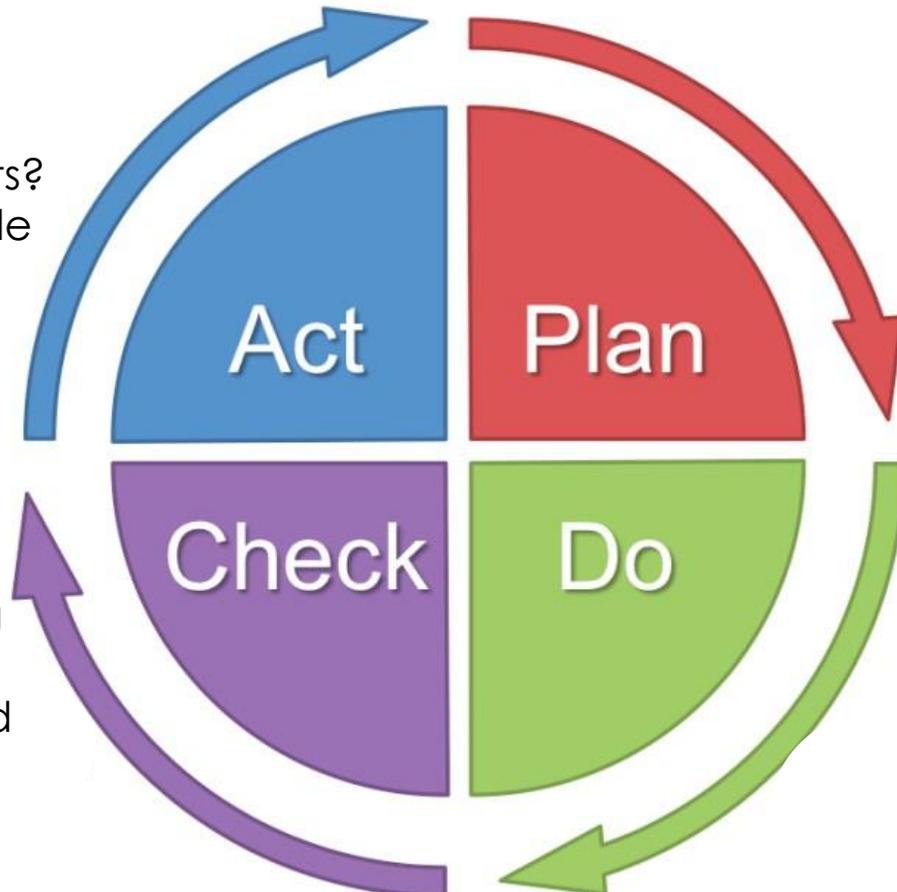► For a Team
► Define Objectives
► Develop Plan
► Collect Baseline Data

Check
► Analyze Data
► Is Data Meeting Objectives?
► Lessons Learned

Do
► Implement Plan
► Collect Data

Act | Plan
Check | Do

Rapid Cycle for Improvement

Reporting is part of a Patient Safety Culture…

Each error or near miss is an opportunity for us to improve

- Errors and near misses (an event that did not reach the patient, but could have harmed them if it did)

- Reporting these are critical to ensure patient safety

We report only to find ways to continuously improve, not for punitive reasons!

Things You Would Report in an RDE

- All Falls
- Medication issues
  - Additional doses or omissions
  - Monitoring errors
  - Wrong med/strength/frequency
  - Duplicate meds on chart
  - Wrong patient
  - Wrong IV rate
  - Adverse drug reactions
- Communication issues
- Delays in patient care
- Any issue effecting patient safety

Risk/Patient Safety Reporting

To report an event or near miss go to iShare and click RDE smiley face - this opens up the Midas Remote Data Entry forms - select event type

Risk/Patient Safety Reporting

Mandatory fields are in bold print. Squares indicate drop down selections available.
State FACTS of event (not opinions or judgements) in comment fields.
Events can be entered anonymously.
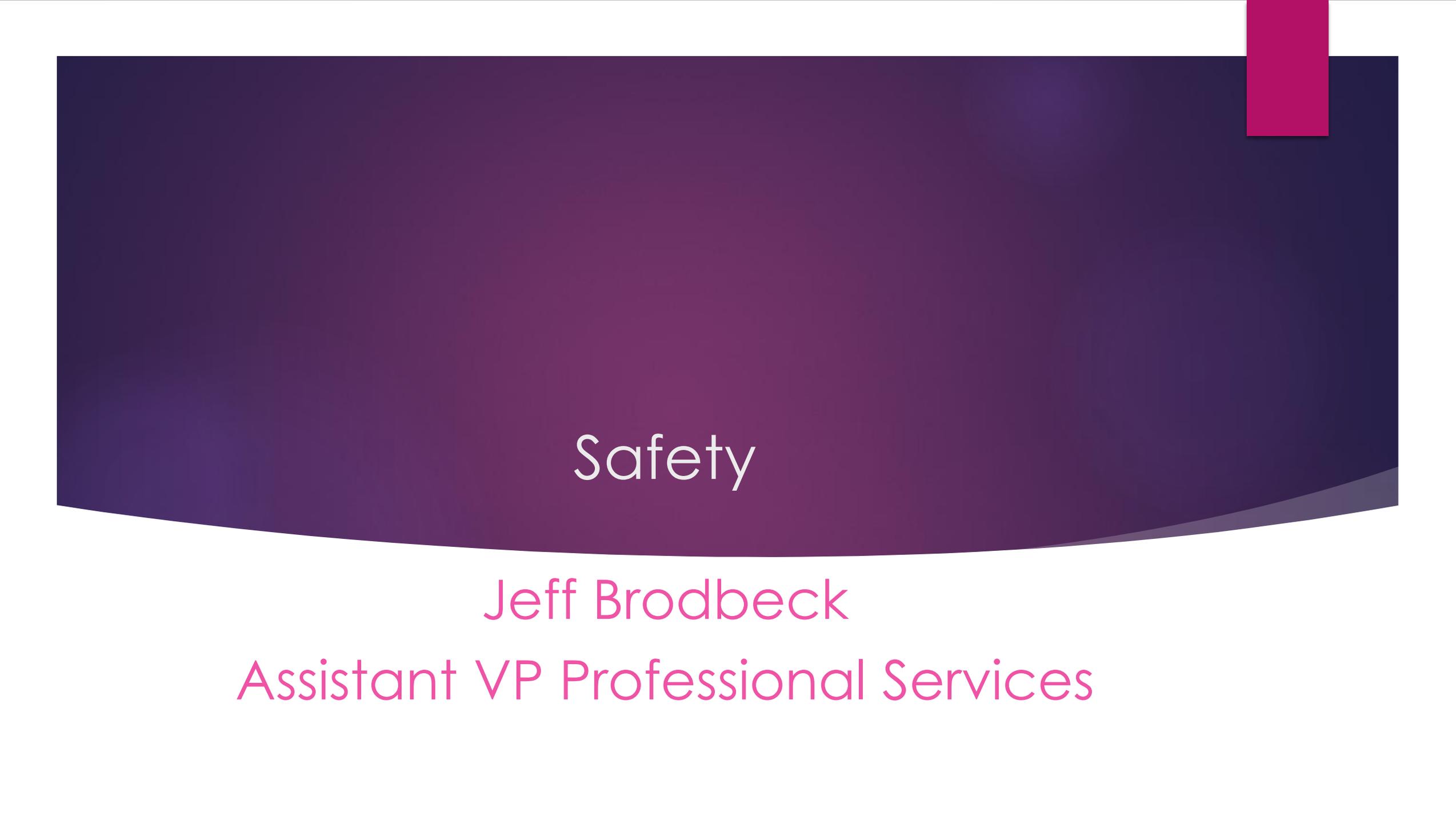
Safety

Jeff Brodbeck

Assistant VP Professional Services

Safety Standards

Morris Hospital follows ACHC, which identifies six compliance areas for the Environment of Care or Physical Environment:

1. Safety
2. Security
3. Hazardous Materials/Waste
4. Fire/Life Safety
5. Medical Equipment
6. Utilities

Doing a job safely is the responsibility of each staff member.

Safety

1. Staying Safe as an Organization:

   ▶ Safety Committee/Safety Officer

   ▶ Environment Rounds

   ▶ Smoking Policy

   ▶ Recall Management

   ▶ Annual review of program

2. Staying Safe as an Employee:

   ▶ Use common sense, listen to your gut, and don't take chances!

   ▶ Wear appropriate clothing and shoes

   ▶ Use PPE as required

   ▶ Get assistance for lifting heavy objects; use assistive devices for lifting/transferring patients

   ▶ Follow policies and procedures

   ▶ Assist with smoking policy compliance

   ▶ If in doubt, ask questions

Safety

3. Reporting Safety Issues:

   ▶ Report department safety concerns to your manager or supervisor

   ▶ Report building maintenance problems to Facilities or enter a Work Request

   ▶ Contact the Safety Officer (Jeff Brodbeck at ext. 1253) for general hospital concerns or to discuss a previously reported issue further

4. Anonymous Reporting:

   ▶ Issues reported to the Safety Officer will remain anonymous if requested

   ▶ Alertline compliance hotline:

      ▶ 1-844-621-0574

Helicopter Safety

- Do not approach without the pilot's acknowledgement and the rotors have stopped

- Keep in the pilot's field of vision at all times

- Ensure no people are closer than 100 – 200 feet of the pad

- Driveways adjacent to the pad are blocked off until the helicopter rotor blades have stopped

- Traffic movement is stopped until the helicopter is secured

Helicopter Safety Zones
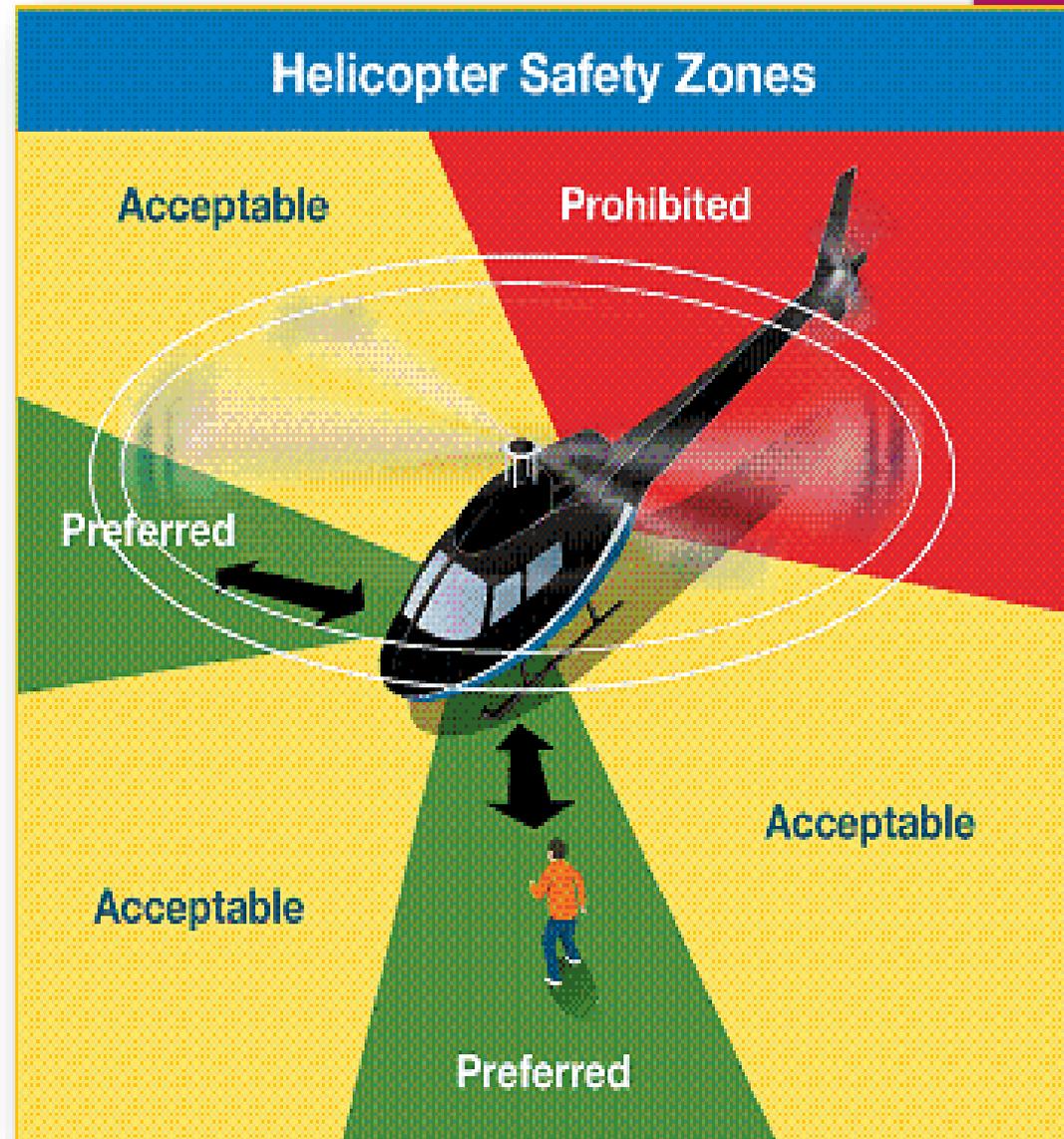
Security

1. Staying Safe as an Organization:
   - Security-sensitive areas identified/secured
   - 24-hour video surveillance
   - Security Officer 24/7/365
   - Electronic access control system
   - Panic buttons
   - Workplace Violence/Threat Management Plan
2. Staying Safe as an Employee:
   - Be aware of your surroundings **SCAN**:
     - **S**ee: Notice unusual scenarios
     - **C**ontact: Contact the individual in a casual manner
     - **A**sk: Can I be of assistance/
     - **N**otify: Let your Supervisor and Security know about suspicious activity
   - Wear your ID badge and look for proper identification on others
   - Don't let unauthorized people wander. Assist people who appear to be lost
   - Be vigilant with access control. Don't allow "tailgating"
   - Contact Security (ext. 1250) when needed
     - Security provides escorts in/out of building as requested. They also fill tires, jump start cars (waiver required), and mange lost and found.

Utilities

- Staying Safe as an Organization:
- Inspections, testing, and preventive maintenance
- Backup electrical feed and emergency generators
- Air filtration and pressure relationships
- Emergency controls
- Emergency Clinical Interventions
- Staying Safe as an Employee:
- Follow policies and procedures (ex: red plugs for critical equipment)
- Understand utility failure procedures (ex: medical gases, emergency power)
- Report failures immediately to Facilities (x7590)
- Don't block electrical panels or medical gas valves

Utility Failure Alerts

▶ Follow Quick Response Guides for any announced utility or network failures

▶ Use Red Phones in departments for emergency communication when regular phone system is down. Phone list is in Quick Response Guides.

Medical Equipment

1. Staying Safe as an Organization:
   - Inspections, testing, and preventive maintenance
   - Repair program
   - Recall management
   - Trialing equipment before purchase
   - Staff training on equipment use

2. Staying Safe as an Employee:
   - Make sure you're trained on the equipment
   - Check the date on the inspection sticker
   - Check the cord for cuts/frays
   - Pull on the plug housing, not the cord, to unplug equipment
   - Be careful of the cord during transport
   - Don't use liquids around equipment
   - Don't use equipment around liquids
   - Remove defective equipment immediately and tag it "Out of Service"
   - Notify Clinical Engineering (x7546) for all equipment failures

Fire/Life Safety

1. Staying Safe as an Organization:
   - Inspections, testing, and preventive maintenance
   - Fire alarm and sprinkler systems
   - Building features (compartmentalization)
   - Fire extinguishers, automatic systems
   - Fire response and evacuation plans
   - Alternate Life Safety Measures

2. Staying Safe as an Employee:
   - Know the fire response plan (RACE and PASS)
   - Know where your nearest pull box and fire extinguisher are
   - Know where your nearest smoke compartment doors are
   - Understand fire extinguisher types
   - Don't block fire extinguishers and pull boxes
   - Keep hallways clear
   - Don't wedge doors open
   - Notify the Safety Officer immediately for any identified fire risks

Hospital are designed to keep people in during a fire **COMPARTMENTALIZATION** (Fire Compartments)
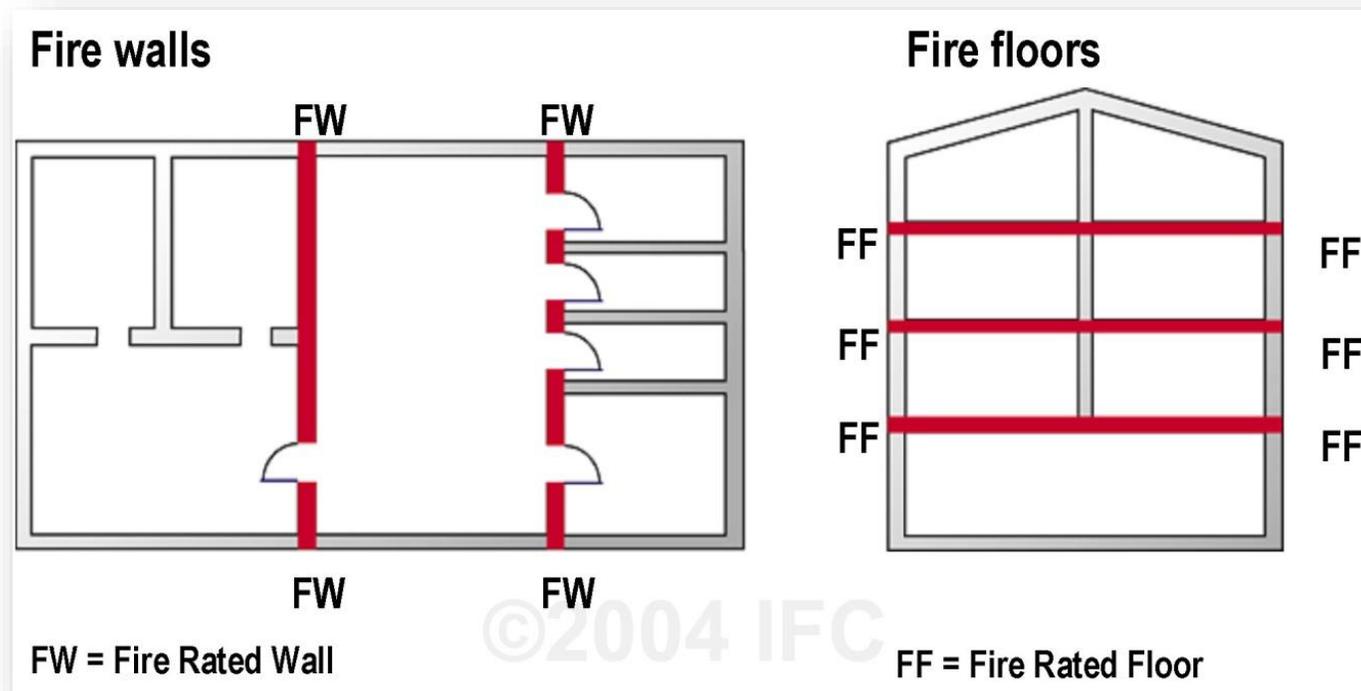
The spread of fire can be restricted by dividing a building into separate compartments with fire-resisting walls and floors creating areas of safety during fire.

White Tag Program

- The White Tag Program was started to help maintain our Fire & Smoke walls. Each year thousands of dollars of damage was caused by workers working above the ceiling.

- This damage was not only costly it endangered the safety of our patients, visitors, and staff.

- The first person to call ext. 7602 and report someone working above the ceiling without a white tag on their ladder will receive a **Free Lunch**

Code of Conduct

Morris Hospital & Healthcare Centers

CODE OF CONDUCT

MORRIS
HOSPITAL
& HEALTHCARE CENTERS

Message from our President & CEO:

Dear Team Members:

Every day, thousands of area residents rely on Morris Hospital and Healthcare Centers for quality, compassionate healthcare, including our neighbors, friends, and even our own family members. We accept this enormous responsibility with great pride and a commitment to delivering clinical excellence and outstanding patient experiences.

Yet it takes even more to earn the confidence of our patients and respect of our community, and that is the ethical conduct of our actions. To assure that Morris Hospital and Healthcare Centers always stands for honesty and integrity at the highest level, we have a written Code of Conduct -- a clear set of ethical principles and standards that guides all employees, providers, volunteers, and stakeholders in their interactions with each other, with patients and their families, and with our community.

The Morris Hospital and Healthcare Centers Code of Conduct provides us with the resources and information we need to operate our organization responsibly, to make ethical decisions, and to maintain trust. It's how we ensure that responsible behavior is aligned with our values and our culture of honesty, integrity, accountability and professionalism in all aspects of our work as we strive to provide the highest quality patient care, protect patient privacy, and work honestly and fairly with our business partners and government regulators.

No matter your role in our organization, each one of us is accountable to uphold the mission and values of Morris Hospital and Healthcare Centers and to act in accordance with the highest standards of conduct.

As you review the Code of Conduct, keep in mind that this is your guide to making the right choices while always placing the needs of our patients first.

Let's make sure our actions and decisions always reflect the spirit of code of conduct and align with our mission. Thank you to your continued dedication to Morris Hospital and Healthcare Centers and for your commitment to improving the health of our community.

Sincerely,

Thomas J Dohm

President and CEO

Introduction:

Code of Conduct
At Morris Hospital and Healthcare Centers (MHHC), we are driven by our mission, vision, values and culture commitments to uphold our ethical-and legal- responsibility to act in ways that protect the best interests of our area residents, including following health care laws, rules and regulations. Adhering to our Code of Conduct is critical to our commitment to operational excellence and exceptional patient care.

Mission: To improve the health of area residents.

Vision: Transforming Healthcare to Support Healthier Living.

Values: The values to which MHHC subscribe are as follows:
- Compassion
- Accountability
- Respect
- Excellence

This Code of Conduct ("Code") establishes standards of integrity for all board members, medical staff members, employees, contractors, vendors, consultants, students, volunteers and others who do business with us (collectively referred to throughout as "Workforce"). The Code is meant to be used in conjunction with and complement MHHC policies, procedures and guidelines. Its purpose is to provide our Workforce with clear expectations and the resources needed to build an ethical culture of compliance and integrity at MHHC.

Compliance Centered Hierarchy of Objectives

Compliance Plan

MHHC has adopted a comprehensive Compliance Plan overseen by the Board of Directors. The main objectives of the Plan are to prevent, detect and correct any violations of this Code, organizational policies, or applicable law and regulations. The Compliance Plan designates a Compliance Committee and a Compliance Officer to implement the Plan. It is the responsibility of the whole Workforce to make sure our choices are in the best interest of our patients. The decisions we make can positively or negatively impact people's lives in direct and indirect ways. By choosing actions that are in the best interests of our patients, we remain true to our mission and values.

Responsibilities

Workforce members are responsible for:

- Building and maintaining the trust of others by acting with integrity.
- Reviewing and following the Code, and paying attention to those areas that apply to your daily work.
- Asking questions and seeking guidance when you're uncertain about what to do.
- Speaking up and reporting concerns about actions or behaviors you encounter at MHHC that may be inconsistent with the Code.
- Participating in mandatory annual training to further our understanding of our responsibilities.

Leadership responsibilities

Workforce members must follow the terms of the Code, leaders are expected to set the example and be role models of integrity. They are expected to foster a culture that promotes the highest standards of ethics and compliance while maintaining an environment in which all Workforce members feel free to raise concerns and propose ideas for improvement. Finally, we expect our leaders to ensure they, as well as those Workforce members they are responsible for, have the necessary information to do the right thing.

Leaders set a good example by:

- Showing what it means to act with integrity.
- Earning and fostering the trust of the Workforce, patients and community.
- Operating in an honest and candid manner.
- Soliciting ideas and feedback of Workforce.
- Creating an open and psychologically safe environment that encourages Workforce engagement. Creating an open and psychologically safe environment that encourages Workforce members to express ideas and concerns without embarrassment or fear.
- Ensuring the Workforce members in their area understand the Code and related policies.
- Holding Workforce members accountable for acting in compliance with the Code.
- Being knowledgeable about available resources.
- Supporting Workforce members who, in good faith, ask questions or raise concerns.
- Reporting suspected instances of non-compliance.

Reporting concerns

Step up! Speak up!

MHHC expects a commitment from its Workforce to do the right thing. This includes reporting any activity or conduct that we believe in good faith violates this Code or related policies, applicable laws, or regulations. If you become aware of an activity or behavior that you believe may be a problem, step up and speak up. It is always the right thing to do, even if you're not entirely sure if misconduct or a violation has occurred.

What to Report:

- Anti-Kickback
  - Offering items of value to groups who may refer patients to the hospital
    - Gift basket to private physician office
  - Giving or receiving free items or discounts
    - Vendor offering sports tickets in return for purchasing product
- Claims/Billing Process
  - Duplicate billing
  - Billing for services not medically necessary
  - Inaccurate coding or billing
- Conflict of Interest
  - Any situation where job performance or decision making is influenced by anything other than patient needs or hospital interests
- Copyright
  - Copying of print or electronic books, journals, or other publications
- Documentation
  - Incomplete documentation
    - Missing consents or notes
  - Inaccurate documentation
- Human Resources
  - Discrimination
  - Harassment
  - Inappropriate workplace behavior
  - Labor law violations
- Identity Theft
  - Patient registering under false name
- Inducement
  - Offering items of value to influence a Medicare/Medicaid beneficiary to choose the hospital
    - Routine waivers of co-pays and deductibles
- Medical Staff/Stark
  - Provider financial/compensation arrangements
  - Non-monetary compensation
    - Dinners or gifts for physicians provided by the hospital
- Privacy/Security
  - HIPAA violations/breaches-even incidental-any wrongful access/disclosure
  - Fax sent to incorrect number
  - Paperwork given to wrong patient
  - Test results sent to incorrect physician
  - Social media posts regarding patients or patient care
  - Documents that are scanned into wrong patient medical record

Reporting concerns continued

At MHHC, psychological safety is a shared belief that it is safe to speak up, propose new ideas, and learn from mistakes which fosters our culture by creating a sense of belonging for all.

How to speak up

Discuss your concern with your leader. If you're uncomfortable doing so or unsatisfied with your leader's response, other options include:

- Continue to raise the issue through the leadership reporting hierarchy.
- Discuss your concern with the Compliance Officer (815-705-7120).
- Report your concern using the Compliance Hotline. If desired, you may remain anonymous. The hotline is answered 24 hours a day, 7 days a week, by an unbiased third party. (844-621-0574)

Non-retaliation

MHHC prohibits retaliation for reporting, in good faith, a suspected compliance violation. Good faith means you actually believe the information you are reporting is true.

Forms of retaliation could include being terminated, demoted, suspended, reprimanded, harassed or discriminated against because you reported a concern. If you believe retaliation has occurred, contact the Compliance Officer (815-705-7120) or Compliance Hotline (844-621-0574).

Adhering to the Code of Conduct demonstrates MHHC Workforce's commitments:

Adhering to the Code of Conduct demonstrates MHHC Workforce's commitments:

- To our patients and communities
- Compliance with laws and regulations
- Ethical business relationships
- To our employees
- To protecting our assets

Our commitment to our patients & communities:

Patient Rights
Each patient has certain rights, including the right to be treated with dignity and respect at all times. Patients also have the right to participate in, and make decisions about, their health care, including the right to refuse medical treatment to the extent permitted by law.

- We provide treatment without discrimination and without regard to gender identity, race, color, religion, national origin, ancestry, sex, political belief or affiliation, marital status, age, sexual orientation, physical or mental disability or association with a person with a disability, order of protection status, military status, or pregnancy.
- We inform patients and their families and others, when permission is given, about care, treatment and service options, as well as therapeutic alternatives and the risks associated with the care they are receiving.
- We involve patients and families in decisions regarding care to the extent practicable, including discharge planning, advance directives and end-of-life decisions.
- We inform patients of the availability of financial assistance.
- We provide language interpretation services free of charge to assist all patients in understanding and participating in their care.
- We comply with laws that govern how we care for patients including the Emergency Medical Treatment and Labor Act (EMTALA).

Privacy of patient information
Patient information has privacy protections under state and federal laws, including the Health Insurance Portability and Accountability Act (HIPAA), and we all have a duty to protect the confidentiality and security of that patient information. Our Notices of Privacy Practices describe how we use, access and disclose the Protected Health Information (PHI) of our patients. To safeguard PHI, we must adhere to the following requirements:

- Only access and use PHI that you need for the task at hand in the course of your official job duties: never share PHI with anyone that is not authorized to see or use it. Never post PHI or stories about patients on social media.
- Always get a patient's permission before sharing PHI or speaking about it in the presence of others, including the patient's family or friends.
- Never leave PHI out in the open where unauthorized people can see it, whether on paper, a computer screen, a whiteboard, or any other media.
- Be aware of your surroundings when discussing PHI with another authorized party so as to limit the chances of others overhearing. Avoid having such conversations in public areas such as elevators or the cafeteria.
- PHI should never be saved to unauthorized, personal electronic devices. Never remove PHI from your facility without prior approval.
- Immediately report the loss, misplacement, or theft of PHI to the Privacy Officer (815-705-7702)

Safe environment for care

MHHC is a high reliability organization and recognized a Just Culture will improve patient safety and the delivery of quality care. Our Just Culture encourages all who work in our organization to report patient safety issues, incidents and near misses so they can be addressed timely through changes to systems and processes without fear or blame.

We recognize human error is inevitable, and we learn from our mistakes. To promote a safe and reliable work environment, all workforce members should:

- Complete required safety training.
- Comply with all laws, regulations, accreditation standards, Occupational Safety and Health Administration (OSHA) requirements.
- Know how health and safety policies apply to our specific job responsibilities.
- Inform a leader if we find our team using shortcuts to complete a work process.
- Inform a leader if we find it difficult to comply with a policy or standard of work.
- Notify a leader about safety hazards, broken pieces of equipment, any workplace injury or any situation presenting a danger of injury so timely corrective action may be taken.
- Report any safety issues, incidents and near misses through Remote Data Entry (RDE).

Leaders have the responsibility to:

- Address our concerns and process issues that impact our work.
- Create an atmosphere of psychological safety in which all are encouraged to address essential safety, compliance and job performance-related issues in a fair and just manner.
- Take situational factors into consideration when determining disciplinary or corrective action.

Professional licensure & credentials

MHHC requires that its workforce maintain licensure, certification and registration as required by law to provide services applicable to their roles in the organization. Workforce members must:

- Maintain appropriate licenses and credentials required to perform their job.
- Not provide care to patients when their credentials are lapsed or revoked.
- Understand the scope of practice that their licensure or credentials permit them to perform and stay within those boundaries.
- Provide a copy of their current license, certification or other required credentials to the Human Resources department upon hire and when requested thereafter.

Ineligible persons

Upon hire and monthly thereafter, MHHC screens all Workforce members against federal and state databases to ensure all are qualified to participate in providing services to a federal health care program. MHHC does not hire, contract with, or bill for services rendered by an individual or entity that:

- Has been convicted of a criminal offense related to their position or that disqualifies the individual from employment.
- Is excluded from participating in federally funded health care programs.
- Is a suspected terrorist, as determined by the federal government.

Our commitment to comply with laws & regulations

We are committed to providing health care services in a manner that complies with applicable laws and regulations and satisfies the highest standards of business and professional ethics. We also are committed to being honest and communication truthfully in all business interactions.

We are committed to billing for care and services that are properly authorized and documented as medically necessary. We take reasonable precautions to produce billing and coding that is accurate, timely, relevant and in compliance with our policies as well as federal and state laws and regulations. Certain government regulations and many insurance payer contracts require patients to pay co-insurance, copayments and deductibles. We comply with these requirements. Those working in areas impacting billing or coding are expected to understand and comply with all billing and coding policies, procedures and documentation requirements established by MHHC and third-party payers.

Fraud, waste & abuse

We comply with the Federal False Claims Act and state laws that prohibit us from knowingly submitting, presenting or causing another person or entity to submit or present false or fraudulent claims for payment of government funds.

"Knowingly" means:

- Actually knowing a claim is false.
- Deliberately ignoring whether a claim is true or false.
- Recklessly disregarding whether a claim is true or false.

False claims include:

- Submitting a claim for services that were never rendered or were worthless.
- Misrepresenting a diagnosis to justify services or increase reimbursement.
- Filing a claim for services that were not medically necessary.
- Billing for a single service multiple times (double billing).
- Making a false statement (e.g., forging a physician signature or using a physician's computer signature) to obtain payment for a service rendered.
- Misrepresenting data or other information on federal grant applications or progress reports.
- Unbundling charges to enhance reimbursement.
- Filing a claim for a service that was the result of a payment for a patient referral.

To ensure the accuracy of our claims we:

- Document diagnosis, treatment and all other components of the patient's record in a timely and accurate manner.
- Bill only for medically necessary services that were actually provided.
- Follow current coding procedures and standards
- Generate accurate and truthful bills.
- Correct any billing errors or refund money received in error (e.g., overpayments) in a timely manner.
- Submit accurate cost reports as defined by applicable laws and regulations.
- Submit accurate research grant proposals and progress reports.

Accurate record keeping & document retention

Our records are prepared accurately, reliably, honestly and in accordance with established finance, accounting and medical record-keeping requirements.

Accurate record keeping helps MHHC protect our patients, manage our business, and comply with legal and regulatory requirements. Records include financial statements, billing claims, expense reports, invoices, payroll records, benefit claims, and medical charts and records. It is against MHHC policy to falsify or alter records. If you suspect or know that a record has been tampered with or is intentionally incorrect, tell your supervisor or the Compliance Officer immediately.

There are various state and federal laws that require we retain all records for specific periods of time. Never destroy a record without first verifying the appropriate time period has expired. Records and documents are not to be destroyed or altered in anticipation of, or in response to, a request for those documents by any government agency or court.

Interactions with government agencies & officials

MHHC is committed to cooperating with government representatives, officials or law enforcement officers and agents. MHHC will respond to requests for information from government agencies and officials under the direction of Risk Management. We will be truthful in our statements, and we will comply with our legal obligations.
Government officials and law enforcement may make announced and unannounced visits to a MHHC facility. It is very important that you let your supervisor, and Risk Management know immediately if you are contacted by a government official or law enforcement in connection with an investigation or request for documents, or receive a subpoena, demand or other official request related to your role or MHHC.

It is our policy that we:

- Treat government officials and law enforcement with courtesy and respect.
- Find a private area or room for the government officials and law enforcement when at a MHHC facility, and contact the Risk Management Department for direction.
- Do not volunteer any information, answer any questions or hand over any documents or requested items without first contacting the Risk Management Department.
- If you are approached outside of a MHHC facility about something related to MHHC, immediately notify the Risk Management Department. As individuals, we have the legal right not to speak to an investigator.

Anti-trust

We are committed to complying with anti-trust laws. These laws protect individuals and organizations from unfair trade practices, promote competition and preserve the free enterprise system. To comply, we do not:

- Enter into agreements with competitors to fix wages, prices, rig bids or divide markets.
- Enter into "no-poach" or "non-solicit" agreements with other health systems that are not reasonably necessary to any separate, legitimate business collaboration.
- Conduct boycotts.
- Make price discrimination agreements.
- Steal trade secrets.
- Offer bribes or use deceit, intimidation, or other similar practices.

Except when approved by executive leadership- and to protect our competitive, financial, ethical and reputational interests, in accordance with parameters provided by the Risk Management Department- we do not communicate with a competitor, directly or indirectly, about prices charged or costs of goods, supplies, equipment or services, including physician services. All contracts negotiated with a competitor, contractor or supplier must be competitive and at fair market value. Contracts must be based primarily on price, quality and service.

Questions regarding anti-trust matters should be directed to the Risk Management Department.

Our commitment to ethical business relationships

The Stark Law (or the Physician Self-Referral Law) prohibits physicians from referring patients to receive designated health services payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies

The Anti-Kickback Statute prohibits payment of anything of value to induce or reward referrals or the generation of business involving any items or service payable by Medicare, Medicaid or other federal health care programs.

Physician relationships

MHHC is committed to ensuring all its interactions with physicians are ethical and comply with the Stark Law and the Anti-Kickback Statute. We adhere to the following principles in our interactions with physicians:

- We will not pay for referrals. We will accept patient referrals and admissions based on the patient's medical needs and our ability to render the needed services. We will not offer to pay or reward anyone for the referral of patients.
- We will refrain from offering any gifts or business courtesies to any physician or healthcare provider to induce or encourage the referral of business to MHHC. Reasonable meals and gifts of nominal value may be offered under certain circumstances but must satisfy Stark requirements and be tracked.
- We will not accept payments for referrals we make. No Workforce member acting on behalf of MHHC is permitted to solicit or receive anything of value, directly or indirectly, in exchange for the referral of patients. When making patient referrals to another health care provider, we will not take into account the volume or value of referrals the provider has made, or may make in the future, to our organization.
- We will appropriately document our financial relationships with physicians in accordance with the law and standard business practice. MHHC will not make payments to physicians unless an appropriately documented employment arrangement or contractual agreement is in place.

Vendor relationships & interactions

Relationships with external parties are an important aspect of daily business operations. It is our policy to select suppliers based on impartial factors such as price, quality, diversity, performance, customer service, patient safety and reputation. All Workforce members have a responsibility to make decisions and maintain vendor relationships that affect MHHC based on our health care mission and in the best interests of our patients, not personal gain. We also are committed to complying with the Anti-Kickback Statute in all interactions and to eliminating situations where inappropriate vendor influence would result in increased costs, unfair competition, or treatment decisions that are not based solely on patient care interests. Our selection of consultants, contractors, suppliers and vendors will be made on the basis of objective criteria, including but not limited to quality, technical experience, price, delivery, service and maintenance of adequate supply sources.

- We do not offer or accept kickbacks in exchange for doing business.
- Any solicitation on behalf of MHHC must be done by or in conjunction with the MHHC Foundation.
- Employees may attend a vendor sponsored free educational event that relates to their job but must pay for any associated travel, lodging and entertainment, unless otherwise approved by the Compliance Officer.
- Regardless of where they are located, we expect our vendors and contractors to have the same sense of integrity and compliance we do. They are expected to comply with our standards and policies, federal requirements and the law.
- Employees may not accept free meals from vendors unless it's a business-related meal or provided during an educational event that provides continuing education credit to attendees. Vendors are otherwise prohibited from bringing free food into MHHC facilities.

Conflict of interest refers to a situation in which financial or other personal interests may compromise, or have the appearance of compromising, an individual's ability to make objective decisions in the course of performing one's job responsibilities. Outside or secondary employment could qualify as a potential conflict of interest, depending on the circumstances.

MHHC employees, board members and medical staff members are prohibited from:

- Gaining personal enrichment through access to confidential information from MHHC including but not limited to buying or selling stock or other securities based on information obtained as a result of employment with MHHC.
- Misusing their position in a way that results in personal gain.
- If employed by MHHC, engaging in an activity that competes with or compromises the interests of MHHC.

Disclosure of conflicts of interest

MHHC employees, board members and medical staff members (!) must exercise good judgment and engage in ethical behavior to protect themselves and the organization form inappropriate actions resulting from conflicts of interest, and (2) may not use their positions to obtain benefits directly or indirectly for themselves, immediate family members or any other person with whom they have a personal relationship.

Sometimes, conflicts may arise despite best efforts to avoid them. If that happens at any point during the year, promptly and fully disclose it to your supervisor or the Compliance Officer so they can help you figure out what to do. Remember, having a conflict is not necessarily a problem; not reporting it is. You should not wait for the annual disclosure to report a relationship or ask a question about a relationship.

Patient relationships

Gifts & free items for patients

The Beneficiary Inducement Statute prohibits offering gifts, free or discounted services and anything else of value to patients or potential patients to influence an individual to seek services at your facility or entity.

- We will not offer any item of value or service, even if nominal, to patients if the intent is to steer them to use MHHC services.
- We may offer select, free preventive services. Contact the Compliance Officer to determine what is permissible.
- Donations to MHHC Foundation is permissible, as these benefit our mission to serve.
- Discounts provided as part of the formal patient financial assistance program are permissible.

There may be circumstances when a MHHC Workforce member would like to provide a gift to a patient as part of a service recovery effort or in recognition of a patient's volunteer efforts. This is permitted, as long as:

- The value of the gift does not exceed $15 per item.
- The aggregate value of all gifts given to a patient does not exceed $75 per calendar year.
- The gift is not cash or a cash equivalent (such as a gift card or certificate) except as specifically approved by the Compliance Officer in advance.
- The gift is an approved stipend to offset basic costs incurred by a research participant.

Gifts from patients

We are committed to providing high quality care and service to all our patients and we do not expect tips, gratuities or personal gifts from patients. Whenever feasible, patients wishing to show their appreciation should be directed to donate to the MHHC Foundation. At times, however, it can be difficult to refuse a well-intended gift from a patient. A gift may be accepted when:

- It is reasonable token of appreciation (valued at $50 or less) not intended to influence behavior.
- It is not cash or cash equivalent like a gift card or certificate.
- The circumstances are such that refusal of the gift could be counterproductive to the patient-caretaker relationship.

Our commitment to our employees

MHHC is committed to providing equal employment opportunities to qualified individuals in accordance with federal and state laws, and maintaining a work environment that respects the rights, dignity and cultural differences of employees and others with whom we interact. We expect employees to maintain professionalism and treat each other with mutual respect, courtesy and fairness. We build transparency and trust through frequent and direct communications with employees. We encourage collaboration and teamwork by sharing best practices and supporting each other. We encourage employees to exhibit courage and adopt innovative practices. Discrimination, retaliation, harassment, incivility, bullying, threat, violence or abuse of any form (e.g., physical, mental or verbal) and at any level are inappropriate and will not be tolerated.

Equal employment opportunity
MHHC does not discriminate with regard to race, color, religion, sex, sexual orientation, gender-related identity, genetic information, pregnancy, marital status, age, national origin, ethnicity, disability, military service or any other characteristic prohibited by law.

General & sexual harassment
MHHC prohibits harassment of its employees by another employee or leader, and prohibits any conduct that creates an intimidating hostile or offensive work environment.
Examples of prohibited verbal, physical, auditory and visual conduct include, but are not limited to:

- Derogatory comments
- Sexual advances
- Threats or intimidating remarks
- Racial or ethnic jokes or slurs
- Uninvited touching
- Cyber harassment

If an employee feels they are the target of these prohibited behaviors, and feels comfortable doing so, the employee should inform the offending person the behavior is unwelcome and offensive. The employee also should promptly report any such incident to their leader or to the Human Resources Department.

Employee confidentiality
MHHC values the privacy of its employees' information. Access to employee records is permitted for legitimate business purposes, such as payroll, benefits administration and other employment-related activities. Information is not disclosed to third parties except as specifically permitted by our policies, with employee consent, or as required by law. Employee information obtained during or as a result of one's work duties must not be shared with anyone not authorized by MHHC to receive such private information.

Email messages are considered company records, and MHHC reserves the right to monitor its email system for proper business conduct and possible inappropriate behavior. Employees have no expectation of privacy relative to the use of MHHC email system. Similarly, access to the internet is a privilege; thus, MHHC reserves the right to monitor internet activities on its business devices.

Workplace safety

MHHC is committed to providing a safe and secure environment for Workforce members and visitors.

Workforce members have the responsibility to maintain a safe workplace by:

- Refraining from violent behavior, neither tolerating nor making threats, and immediately reporting all violence or threats of violence.
- Not possessing weapons or ammunition while on the premises of MHHC facility except secured in a locked personal vehicle.
- Not willfully destroying MHHC property or the property of others.
- Refraining from the use of alcohol or any illicit or prescription drugs that may impair the ability to perform one's job duties.
- Promptly reporting any incident, practice, or condition that may pose a safety threat or any violation of our safety policies.

Tax-exemption status

As a tax-exempt organization, MHHC operates for the benefit of the communities we serve. Surplus funds are typically reinvested to further our charitable and social welfare endeavors. In exchange for these charitable activities, MHHC is exempted from paying many federal, state and local taxes. To retain the tax exemptions, we must satisfy rigorous standards established by the government. As an organization, we do not:

- Pay more than fair market value for goods, services or in compensation arrangements.
- Re-sell supplies purchased using MHHC tax-exempt status.
- Use MHHC assets for the private benefit of an individual, such as meeting space, preparation of mailings, etc.

Political Activities

Our employees have many passions and interests, and we support your right as private citizens to participate in the political process and serve as advocates for religious and charitable organizations, provided that your participation is kept separate from MHHC responsibilities.

- Our charitable work for outside organizations and political activities may not interfere with our work schedule or responsibilities.
- We do not use MHHC name, logo or resources, such as computers, phones or printers, to support our own charitable or political activities.
- We do not distribute political literature at work.
- We do not contribute or direct the contribution of MHHC funds to any political candidate, political party or political campaign.
- We do not campaign directly or indirectly, for or against the election of any candidate for public office during any MHHC function or at MHHC facilities.
- If we, as individuals, decide to volunteer for a political or charitable cause, we do not make any statements or take any action in the name of MHHC.

You should not express your political or religious views in the workplace in a way that conflicts with your ability to do your job. Your personal beliefs and activities should be conducted on your own time and in a way that makes clear you do not represent MHHC views in those activities or statements.

Our commitment to protecting our systems & assets

We take the security of our systems and the confidentiality of information seriously, and it is important that our assets, property and technology be safeguarded from threats, including cyberattacks. MHHC assets that are assigned or made available to employees may be used only for authorized business purposes and not for personal gain or enrichment. You must safeguard all assets, follow applicable policies, and comply with copyright and software licensing laws.

You must return all assets, equipment, credentials, records, confidential information and technology upon request or at the end of your tenure with MHHC. If you still have any of these after you leave, we have the right to ask you to return them in person or to ship them to us.

Examples of assets include, but are not limited to:
- Equipment
- Supplies and inventory
- Funds
- Confidential and proprietary information
- Our reputation

To ensure MHHC assets are protected, we will:
- Maintain accurate business records, free of any false or misleading information.
- Not use MHHC funds or assets for personal use, unapproved business expenses or for any improper or illegal use.
- Handle business transactions transparently, price them at fair market value and structure them to comply with applicable federal and state laws.

Interaction with the media
Only the MHHC Marketing department is authorized to speak to the media on behalf of MHHC. "Media" includes reporters, editors, photographers, producers or any other representatives of newspapers, magazines, trade publications, radio, televisions, internet periodicals, websites and blogs.
Marketing department will:
- Respond to inquiries and requests from the media.
- Contact the media about a story or news item regarding MHHC.
- Conduct interviews with members of the media where the subject matter relates to MHHC.
- Not reveal to a member of the media an individual's PHI, which includes whether or not a person has sought or is seeking care at MHHC facility (unless authorized to do so).

Refer all requests and inquiries from the media to the Marketing department.

Confidential & proprietary information
All MHHC Workforce members are responsible for safeguarding our confidential data and information. This includes information that is not generally available to the public or information that would be useful to a competitor.

Confidential and proprietary information includes, but is not limited to:

- Clinical, quality and patient information.
- Financial data, including reports and projections.
- Personnel files, wage and salary data and Human Resources files (except your own wage data).
- Billing and pricing figures, cost data and projected earnings and losses.
- Strategic business plans and marketing strategies.
- Intellectual property (for example, patents, trademarks, copyrights, as well as work created using MHHC resources while a MHHC employee),
- Legal advice and opinions and information regarding legal actions involving MHHC.
- Technology and system credential such as logins and passwords.
- Vendor information.

Workforce members should not discuss confidential information outside the scope of their duties at MHHC. Informatio should be discussed with others on a need-to-know basis, even in social or business relationships. We are prohibited from posting MHHC confidential or proprietary information on any social media platform or website. This includes posting on **any** social network, discussion blog, forum or news group as well as traditional forms of mass media.

Are you still unsure of what action(s) to take? Talk to a Morris Hospital & Healthcare Centers' leader (your supervisor or another member of the management team) or contact the Compliance Officer.

Code of Conduct Acknowledgment

All Morris Hospital & Healthcare Center Workforce members are required to acknowledge understanding of this Code by signing the annual Attestation.

If you have concerns or questions, use the following resources:

- Ask the department supervisor/manager/director
- Contact the Compliance Officer, Kelly VanFleet ext. 7701
- Utilize Alertline 1-844-621-0574

Hazardous Waste & Material Safety

Hazardous Waste & Materials Safety

Hazard Classification

▶ Identifying and evaluating available scientific evidence to determine if a chemical is hazardous and the degree of the hazard is called hazard classification

▶ It involves the following three steps:

  ▶ 1. Identification of relevant data regarding the hazards of a substance or mixture

  ▶ 2. Subsequent review of those data to ascertain the hazards associated with the substance or mixture

  ▶ 3. A decision on whether the substance or mixture will be classified as a hazardous substance or mixture, and the degree of hazard, where appropriate, by comparison of the data with agreed hazard classification criteria

Hazard Communication Standard Labels

▶ All labels are required to have:

  ▶ A signal word

  ▶ Pictograms

  ▶ Hazard and precautionary statements

  ▶ Supplier identification

  ▶ Product identifier

Hazardous Waste & Materials Safety

- Hazard communication programs help reduce the risk of workers being exposed to chemicals because employees may work with chemicals as part of their jobs
- The hazard communication program requires healthcare facilities to:
  - Keep a list of chemicals stored by workers
  - Train employees about these chemicals
  - Use labels, signs, and detailed chemical information provided on the SDSs
- Healthcare facilities must comply with the hazard communication programs as required by ACHC, CMS, and OSHA

- OSHA's revised Hazard Communication Standard reduces confusion in the workplace, facilitates safety training, and improves understanding of hazards
- The Globally Harmonized System of Classification and Labeling of Chemicals (GHS) provides a single set of harmonized criteria for classifying chemicals according to their health and physical hazards and specifies hazard communication elements for labeling and safety data sheets
- Knowing these criteria will help chemical manufacturers determine hazardous chemicals and explain how to prepare labels or safety data sheets

Hazardous Waste & Materials Safety

- Chemical manufacturers and importers are required to evaluate the hazards of the chemicals they produce or import, and to provide information about them through labels on shipped containers and more detailed information sheets called safety data sheets (SDSs)

- The Globally Harmonized System requires that all SDSs follow the same format and contain 16 standard pieces of information

Figure 3. Safety Data Sheet (SDS)—required information

1.	Identification of the substance or mixture and of the supplier
2.	Hazards identification
3.	Composition/information on ingredients
4.	First aid measures
5.	Firefighting measures
6.	Accidental release measures
7.	Handling and storage
8.	Exposure controls/personal protection
9.	Physical and chemical properties
10.	Stability and reactivity
11.	Toxicological information
12.	Ecological information
13.	Disposal considerations
14.	Transport information
15.	Regulatory information
16.	Other information including information on preparation and revision of the SDS

Source: U.S. Department of Labor, Occupational Safety & Health Administration

Chemical Labeling

- All hazardous chemical containers must have labels so that the content can easily be identified and to let employees know about any hazard warnings

- The labels must include pictograms

GHS Pictograms

Skull and Crossbone Acute Toxicity (fatal or toxic)	**Exclamation Mark** Irritant (skin and eye) Skin Sensitizer Acute Toxicity (harmful) Narcotic Effects Respiratory Tract Irritant	**Health Hazard** Carcinogen Mutagenicity Reproductive Toxicity Respiratory Sensitizer Target Organ Toxicity Aspiration Toxicity
Corrosion Skin Corrosion Eye Damage Corrosive to Metals	**Flame** Flammables Pyrophorics Self-Reactives Organic Peroxides Emits Flammable Gas	**Explosive Material** Explosives Self-Reactives Organic Peroxides
Flame Over Circle Oxidizers	**Gas Cylinder** Gases Under Pressure	**Enviromental** Aquatic Toxicity

- Chemicals currently must be labeled with:
  - Common name
  - Chemical name
  - Fire, spill, and leak instructions
  - Handling and storage instructions
  - Hazard statement explaining the physical and health hazards of the chemical
  - Instructions in case of exposure
  - Name, address, and phone number of the manufacturer
  - Precautions to be taken when working with the chemical
  - Signal word (such as warning, caution, or danger)

Hazardous Material Placard System

▶ A hazardous material placard system is used to assist in identifying a hazardous chemical during use, storage, shipping, and transport

▶ The external labeling placard system requires that symbols be posted in visible locations to warn and assist emergency responders in case an accident occurs

▶ The labeling on the different placards is as follows:

  ▶ Fire hazards are signified with a red diamond

  ▶ Reactivity hazards are indicated by a yellow diamond

  ▶ Specified chemical hazards are signified with a white diamond

  ▶ Health hazards are indicated by a blue diamond

Hazardous Materials & Waste

GHS Label Elements

1. Signal Word: Indicates relative level of hazard. "Danger" is used for most severe instances, while "Warning" is less severe.

4. Hazard Statements: Phrases that describe the nature of hazardous products and oftentimes the degree of hazard.

5. Precautionary Statements: Phrases associated with each hazard statement, that describe general preventative, response, storage or disposal precautions.

Carbon Monoxide

DANGER

Extremely flammable gas. Toxic if inhaled. May damage the unborn child. Causes damage to organs through prolonged or repeated exposure

Keep container tightly closed. Avoid breathing vapours. If inhaled: Remove victim to fresh air and keep at rest in a position comfortable for breathing. Call a Poison Center or doctor. Store in a well-ventilated place.

Company ABC | 1234 Long Road | Sydney, NSW | 1800 000 000   Refer to the SDS before use.

3. Product Name or Identifiers

2. Symbols (Hazard Pictograms): Convey health, physical and environmental hazard information with red diamond pictograms. May use a combination of one to five symbols.

6. Manufacturer Information: Manufacturer name, address, telephone number and local emergency number.

MORRIS HOSPITAL WASTE STREAM MANAGEMENT

MORRIS HOSPITAL & HEALTHCARE CENTERS

HAZARDOUS PHARMACEUTICAL WASTE	NON-HAZARDOUS PHARMACEUTICAL WASTE	INCOMPATIBLE HAZARDOUS PHARMA WASTE	CONTROLLED SUBSTANCES	MAINTENANCE IV SOLUTIONS & FEEDINGS	TRACE CHEMOTHERAPY WASTE	SHARPS CONTAINERS	BIOMEDICAL WASTE	GENERAL TRASH NO MEDICATIONS

HAZARDOUS PHARMACEUTICAL WASTE

All partially used or unadministered drugs and non-empty drug containers that are indicated as a hazardous substance.

EXAMPLES:
- Insulins
- Bulk chemotherapy medications
- All medication spill clean-up
- Barium contrasts
- Warfarin

NON-HAZARDOUS PHARMACEUTICAL WASTE

All partially used or unadministered drugs and non-empty drug containers that are not indicated as a hazardous or controlled substance.

- Non-empty containers of medication
- Unused medications: pills, tablets, powders, ointments and vials
- Non-empty IV bags and tubing containing residual medication
- Full or partial syringes of medication, with or without needles
- Oral and IV contrast
- Propofol and non-empty propofol containers
- TPN Lipids
- MVI

INCOMPATIBLE HAZARDOUS PHARMA WASTE

Incompatible wastes require segregation to ensure safety and satisfy EPA and DOT requirements.

Place in clear zip-lock bag.

Return to Pharmacy.

- **Aerosols examples:**
  - Inhalers
  - Dermoplast Aerosol
  - Hurricaine Aerosol
  - Gebauer's Pain Ease
  - Proctofoam
- **Corrosives examples:**
  - Astringyn
  - Econazole Nitrate Cream
  - Elcys Solution
  - Sporanox Oral Solution
- **Oxidizers examples:**
  - Used and unused silver nitrate sticks

CONTROLLED SUBSTANCES

Substances that are regulated and controlled under the Controlled Substances Act (CSA) in the United States. Liquids, Tablets, and Patches accepted

To be disposed of into the Rx Destroyer container.

Empty bottles/vials should be placed in trash.

MAINTENANCE IV SOLUTIONS & FEEDINGS

NO MEDICATIONS ALLOWED

Open and pour down the drain.

Place empty plastic bag in trash.

- Feedings
- Maintenance IV Solutions Containing:
  - Potassium Chloride
  - Potassium Phosphate
  - Sodium Phosphate
  - Calcium
  - Sodium Bicarbonate
  - Dextrose
  - Saline
  - Magnesium
  - Lactated ringers
  - Electrolytes

When medicines are mixed with maintenance solutions, the entire solution must be discarded into a pharmaceutical waste container: hazardous or non-hazardous.

TRACE CHEMOTHERAPY WASTE

Waste that is contaminated through contact with chemotherapeutic agents.

Containers deemed "RCRA Empty" with no more than 3% by weight of the container remaining.

- Tubing and empty bags
- Contaminated gloves, masks and gowns
- Needles and syringes

Containers containing over 3% by weight should be disposed of as hazardous.

SHARPS CONTAINERS

NO MEDICATIONS ALLOWED

- Scalpel blades
- Syringes with or without a needle
- Opened empty ampules
- Empty carpuject syringes
- Broken glass
- Other sharp objects
- Trocars
- Scissors
- Single-use instruments
- Glassware contaminated with blood or body fluids

BIOMEDICAL WASTE

Red container and/or a container with a red liner labeled with the words "biohazardous waste" or with the international biohazard symbol.

- Disposable items saturated with blood or Other Potentially Infectious Material (OPIM)
  - Soaked
  - Saturated
  - Caked
  - Flakeable
- Blood tubing/bags/ hemovacs/pleuravacs
- Suction canisters or liners with bloody fluid or OPIM
- Liquid or semi-liquid blood or OPIM
- Dressings
- Gauze
- Sponges

NOTE:
Feces, urine, sputum, vomit, sweat, and tears are not biohazardous unless there is visible blood.

GENERAL TRASH NO MEDICATIONS

NO MEDICATIONS ALLOWED

- All empty
  - IVs
  - Tubing
- Wrappers and packaging
- Gloves
- Stained gauzes/ dressings
- Empty glassware that is free of blood or body fluids
- OTC nicotine replacement therapies

NOTE:
Feces, urine, sputum, vomit, sweat, and tears with no visible blood should be placed into the sewer and the containers disposed of as regular trash.

For service, please call environmental services.

Daniels

Patient Rights

Patient Rights & Organizational Ethics

▶ The Morris Hospital & Healthcare Centers (MHHC) presents a statement on the patient's rights and responsibilities with the expectation patients have a fundamental right to considerate and respectful care that safeguards their personal dignity and respects their cultural, psychosocial, and spiritual values.

▶ Understanding and respecting these values guide the Physician/Advanced Practice Professional (APP) in meeting the patients' care needs and preferences and will contribute to more effective patient care and greater satisfaction for the patient, their Physician/APP, and the hospital organization.

▶ MHHC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age disability or sex, sexual orientation, gender identity or gender expression.

Patient Rights & Organizational Ethics

▶ A copy of Patient's Rights is given to all patients (inpatients, outpatients, and clinic patients)

▶ The complete Statement of Patient Rights & Responsibilities is available on iShare (Form #208)

Patient's Right to respect, privacy & safety:

▶ Please knock before entering the patient's room

▶ Identify yourself and your department

▶ Address patient by the name they wish to be addressed by

▶ State your reason for being there

▶ Maintain a safe environment and report any safety issues

Patient Rights In Hospital

Patient Rights & Organizational Ethics

- It is recognized that the basic rights of human beings for independence of expression, decision and action take on a new dimension during sickness, and especially in an organizational structure

- It is in recognition of these concerns that MHHC affirms its responsibility to endeavor to assure that these rights are preserved for patients

- MHHC respects a patient's right to delegate their right to make informed decisions to another person (as allowed under State Law)

Patient or Their Representative's Rights

- To participate in the development and implementation of their plan of care
- To make informed decisions regarding their care. The patient's rights include being informed of their health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right is not a mechanism to demand treatment or services deemed medically unnecessary or inappropriate.
- To personal privacy
- To receive care in a safe setting
- For being considerate of the rights and safety of other patients and hospital personnel, and helping control of noise and disturbances, following smoking policies and limiting the number of visitors.

- To formulate advanced directives and to have hospital staff and Physician/APP who provide care in the hospital comply with these directives
- To have a family member or representative of their choice and their own Physician notified promptly of their admission to the hospital. MHHC will make reasonable efforts that the system sends notifications to all applicable post acute care service providers identified by the patient as their Physician/APP
- To the confidentiality of their clinical records
- The patient is responsible for being respectful of the property of other persons and of the hospital
- For outcomes if they do not follow the care, service or treatment plan

Patient or Their Representative's Rights

- To be free from all abuse or harassment, including those based on gender identity or gender expression
- To access information contained in their clinical records within a reasonable time frame
- To be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation by staff
- To know the relationship(s) of the hospital to other persons or organizations participating in the provision of their care
- For assuring that the financial obligations of his/her healthcare are fulfilled as promptly as possible
- For following hospital rules and regulations concerning patient care and conduct

- To be fully informed of and consent or refuse to participate in any unusual, experimental or research project without compromising his/her access to services
- To know the professional status of any person providing their care/services
- To know the reason for any proposed change in the professional staff responsible for their care
- To know the reasons for their transfer either within or outside the hospital
- Of access to the cost, itemized when possible, of services rendered within a reasonable period of time
- For notifying healthcare providers of the patient's Durable Power of Attorney for Healthcare or Living Will and its amendment or revocation. This document must be presented

Patient or Their Representative's Rights

- To be informed of the policies and procedures of the hospital regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the hospital may need to place on such rights and the reason for the clinical restriction or limitation

- To be informed of the source of the hospital's reimbursement for their services, and of any limitations which may be placed upon his/her care

- To be informed of the right to have pain treated as effectively as possible

- Of informed consent for donation of organs and tissues

- To inform the patient (or support person), where appropriate, of the right, subject to their consent, to receive the visitors whom they designate, including, but not limited to, a spouse, a domestic partner (including same sex domestic partner), and other family member, friend, and their right to withdraw or deny such consent at any time

- Not restrict, limit or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability

- To ensure that all visitors enjoy full and equal visitation privileges consistent with patient preference

Patient or Their Representative's Rights

The safety of healthcare is enhanced by the involvement of the patient as a partner in the healthcare process. A patient has the responsibility to provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to their health. They have the responsibility for reporting perceived risks in their care and unexpected changes in his/her condition to the responsible Physician/APP. A patient is responsible for making it known whether they clearly comprehend a contemplated course of action and what is expected of them. The patient and family help the hospital improve its understanding of the patient's environment by providing feedback about service needs, expectations and safety issues.

For following the care, service or treatment plan recommended by the Physician/APP primarily responsible for their care. This may include following the instructions of nurses and allied health personnel as they carry out the coordinated plan of care and implement the responsible Physician/APP's orders, and as they enforce the applicable hospital rules and regulations. The patient is responsible for asking questions when they do not understand what they have been told about their care or what they are expected to do. The patient should express any concerns they have about their ability to follow and comply with the proposed care plan or course of treatment. The patient is responsible for keeping appointments and when they are unable to do so for any reason, for notifying the responsible Physician/APP or the hospital.

The parents or legal guardians of neonatal, pediatric and adolescent patients shall assume the aforementioned rights and responsibilities on their behalf

Patients will be made aware of their right to voice concerns and complaints in the following manner via the Patient Rights and Responsibilities handout including:

The hospital takes quality of care very seriously and encourages patients or patient representatives to contact hospital management with any concerns as soon as they arise. Please feel free to contact the manager of the department, or the Director of Risk Management, Compliance Officer at 815-705-7701 if you have any concerns about safety or quality of care issues. The House Supervisor can assist you during the evening and midnight shifts.

If concerns cannot be resolved through the hospital, contact may be made to the Illinois Department of Public Health, Central Complaint Registry, at 1-800-252-4343, (for hearing impaired use TTY 1-800-547-0466) or write to the Illinois Department of Public Health, Division of Healthcare Facilities, 525 W. Jefferson St., Springfield, IL 62761-0001 or fax 217-782-0382.

A Medicare beneficiary may call the Medicare Quality Improvement Organization at 1-888-524-9900 (for hearing impaired use TTY 1-888-985-8775).

Patient or patient representatives can also file a civil rights complaint with the U.S. Department of Health and Human Services, office for Civil Rights electronically at https://orcportal.hhs.gov/ocr/portal/lobby.jsf by mail at 200 Independence Avenue, SW Room 509F, HHH Building, Washington, DE.C. 2021 or by email at OCRComplaint@hhs.gov

For DME concerns related to Orthopedics and Sports Medicine Product, that have not been resolved by your provider office, you may contact ACHC directly at 1-855-937-2242 or refer to their website at www.achc.org

Interpretive Services

- Morris Hospital & Healthcare Centers provides language interpretation 24 hours a day at no cost to the patient

- These services are available upon request or as identified by a healthcare provider

- If you need these services, contact any staff member, or call 1-815-705-7490 for the MHHC House Supervisor for assistance

Restraint Use

Patients in Restraints for Non-Nursing Staff

- At times, patients will be put into physical restraints to keep them from pulling out tubes or wires or to keep them from harming themselves or others

- Restraints are **NOT** to be removed by non-clinical staff

- Restraints can ONLY be released by the patient care team members: PCT, CNA, RN

  - PT & OT can remove medical non-violent restraints only

- If a patient in restraints appears to be in any distress, notify the RN/Charge RN immediately

THE END
Please Complete Your Written Test