ANNUAL TRAINING & ORIENTATION MANUAL

Welcome to Montefiore Nyack Hospital

The Center for Learning Development
at Montefiore Nyack Hospital

Revised November 2023

Montefiore | Nyack

Directions: This resource guide is the 2023 Mandatory Annual Education and Orientation Manual for MNH affiliates. Allied Health Students, Agency Nurses and Medical Staff must read Sections I-VIII. Contractors, Vendors, Volunteers must read Sections I-VII (Forensic/RPR are excluded). Read all required information, policies and related links. **Everyone must complete Section IX.** Send the completed Post-test and Attestation Statement to your Department Manager. Send the HIPAA Security/Confidentiality Form to MNHOnboarding@montefiorenyack.org to gain computer access. Thank you, Center for Learning Development.

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I. ORGANIZATION OVERVIEW

Mission Statement / Vision / Values

Mission Statement: "To provide competent, innovative and accessible emergency and acute care services for Rockland County. We are caring people operating an extraordinary community Hospital."

Vision: In its second century of service, Montefiore Nyack Hospital (MNH) will set the pace for sophisticated care in Rockland County. Getting better means all of us will be responsible for taking great care of our patients, each other, and our Hospital.

Values: Montefiore Nyack Hospital's values closely support its mission. The values represent guiding principles that are not independent criteria, but rather, are an integral part of every task or interaction.

Values:

Nyack Hospital's values closely support its mission. They represent guiding principles that are not independent criteria, but rather, are an integral part of every task or interaction.

- **SAFETY** - Safety means doing no harm to any person or property under our care. Safety is the absolute highest priority at Nyack Hospital.
- **COMPETENCE** - Competence means being highly skilled and expert at what we do.
- **COURTESY** - Courtesy means treating others in the same upbeat, respectful and professional way we want to be treated ourselves.
- **EFFICIENCY** - Efficiency means making the most of the Hospital's resources by offering relevant services, correctly charging for them and not wasting supplies.
- **INTEGRITY** - Integrity means following through on our commitments and complying with the Hospital's Code of Conduct without exception.

Just Culture

A Just Culture work environment provides a structured process to guide managers and investigators through the evaluation of an event, near miss, or the analysis of a risky behavior. There is a process for conducting an investigation of an event, for identifying system contributions, and for assessing accountability (whether remedial or punitive) for those involved in the event. While a Just Culture recognizes that individual practitioners are not held accountable for system failures over which they have no control, it also recognizes many individual or "active" errors represent predictable interactions between caregivers and the systems in which they work. Thus, in contrast to a "blameless culture", a Just Culture does not tolerate conscious disregard of clear risks to patients or gross misconduct. MNH promotes an organizational culture of quality and safety and a just culture. At this hospital:

- Safety is a top priority
- Actions are analyzed to insure individual accountability
- Appropriate actions are taken to correct system contributions and risky behaviors

We Care Standards

All employees and staff at MNH adhere to a strict code of conduct, known as WE CARE Standards. All employees, contractors, vendors and agency staff receive extensive training on these standards, and new employee orientation offers an overview of what is expected from each and every employee at MNH. Refer to Compliance-Code of Conduct Policy.

WORKING TOGETHER

"Commit to work together in a courteous, respectful manner. I will demonstrate a positive spirit of service with all employees with whom I interact."

I will:

- Place team success above individual recognition.
- Be receptive to new ideas and approaches within my workplace.
- Offer assistance generously without hesitation.

EMPOWERMENT

"Be accountable, responsible, and self-directed in all aspects of my work at all times."

I will:

- See projects through to ensure completion.
- Problem solve with patients, family members, and other employees.
- Follow up to ensure a resolution.

COMMUNICATION

"Demonstrate positive communication in a clear, courteous and appropriate manner at all times."

I will:

- Answer the phone within three rings if possible and identify myself, my department, and ask, "How may I help you"?
- Use effective verbal and written communication to patients, families, visitors, using the principles of AIDET (Acknowledge, Introduce, Duration, Explanation, Thank You)
- Use positive communication in my tone of voice, body language, and choice of words.
- Respond to e-mails in a courteous manner, with-in twenty-four hours.

APPEARANCE

"Dress in a manner that reflects a professional and positive image of the hospital at all times"

I will:

- Maintain a clean, neat, and professional appearance which adheres to the hospital dress code policy.
- Promote and adhere to Montefiore Nyack Hospital's guidelines regarding a safe and clean work environment for employees, patients, families and visitors.

RESPONSIVENESS

"Demonstrate the ability to provide timely feedback and communication to patients, visitors, and coworkers."

I will:

- Respond to patient call lights and ask if I can assist. (No Pass Zone).
- Respond empathetically.
- Apologize for delays and concerns.

EXCELLENCE IN SERVICE

"Strive to 'do my best everyday' in exceeding customer expectations."

I will:

- Anticipate and address my patients', families and visitors needs.
- Avoid negativity and exhibit a "can-do" attitude.
- "Manage up" fellow employees, physicians, departments, and the organization, to increase patient confidence both internally and in the community.
- Exit elevators to accommodate our patients' first.
- Acknowledge people in the hallway by smiling and making eye contact.
- Help lost guests and new employees by escorting them to their destination.

MNH Policies and Procedures

Policies and Procedures are located on the Shared Drive, Read_Only folder, labeled PoliciesProcedures. As of September 19, 2022, policies can be accessed from PolicyStat. Many policies are located in the "Administrative Policies & Procedures", a subfolder of the main folder referenced above. An icon on most desktops provides a shortcut to PolicyStat. You may search for policies using the search icon and key words in the root folder. If you are unable to locate a policy, please contact your supervisor for assistance. Please view key policies in this resource guide or on the shared drive. Policies are located on Shared Drive, read only: S:\Read_Only\PoliciesProcedures. Key HR policies for you to review are attached in Appendix IX in this resource guide.

Dress Code / Staff and Vendor Identification

All staff including vendors, students and contractors at MNH are expected to be dressed in a clean, neat and presentable manner that is appropriate in a hospital setting. Employees who are issued uniforms are to wear designated uniforms while on duty. Managers are expected to wear proper business attire. In order to provide a safe and secure environment, all persons while on MNH property are required to wear photo identification badges.

Security Department, in conjunction with HR, will issue photo ID badges to all employees, physicians, volunteers, contracted workers and Board members, as well as others deemed appropriate. Vendors will register with Vendormate utilizing the kiosk outside the Security Office on the ground floor. No person can enter the facility, or work, without a proper authorized hospital ID badge. See Appendix A – HR Attachments 1 & 2.

Electronic Communication

The hospital's electronic systems may NOT be used to transmit confidential patient or hospital information; to gamble; or to set up or run a personal business. MNH policy prohibiting harassment applies to the use of electronic communications systems. No one may use electronic communications in a manner to be construed by others as harassment or offensive based on race, national origin, sex, sexual orientation, age, disability, religious beliefs or any other protected class according to federal, state or local law. Unauthorized duplication of copyrighted computer software violates the law and is strictly prohibited. No one may access, or attempt to access, another's individual electronic communications, such as an e-mail account, without appropriate authorization. See Appendix A – HR Attachment 3.

Staff Competence/ Ongoing Training

Patients and families at MNH put their trust in hospital staff training and performance. All persons working at MNH must be competent to perform their assigned duties and maintain required certifications and licensure for their respective roles. Competency is defined as having the combination of observable and measurable knowledge, skills, abilities, and personal attributes that constitutes ones performance. Our expectation is that students/staff members, contractors, agencies and vendors remain competent to perform their duties and responsibilities to deliver safe, effective, and high quality care based on best practice standards. See Appendix A – HR Attachments 4 & 7.

II. COMPLIANCE/ HIPAA/ RISK MANAGEMENT

Compliance Program

A Compliance program is the active, ongoing process to ensure that legal, ethical and professional standards are met and communicated throughout the entire organization and that affected individuals who are impacted by Montefiore Nyack Hospital risk areas follow all laws, regulations, standards and ethical practices. Compliance is following Federal and NYS regulations, our hospital policies and our Code of Conduct. It is just doing the RIGHT things for the right reasons. (MNH PolicyStat ID 13723957 Compliance – Compliance Program)

Montefiore Nyack Hospital does a certain amount of business with NY Medicaid and Medicare so besides just good practice; we are required by the NYS Office of the Medicaid Inspector General (OMIG) and the Affordable Care Act (ACA) to have a Compliance Program.

MNH's compliance program is a set of internal policies and procedures that are put into place to help our organization comply with the law. Some of the benefits of an effective compliance program include: Helps to show that Montefiore Nyack Hospital is committed to honest and responsible corporate conduct. Increases the likelihood of preventing, identifying and correcting unlawful and unethical behavior at an early state. Encourages employees, volunteers, board members, vendors, students to report potential issues. Enhances Montefiore Nyack Hospital's operations, improves quality of care and reduces overall costs.

The compliance program applies to all MNH staff who are impacted by risk areas including: Employees, Senior Leadership, Board of Trustees, Contractors, Subcontractors, Vendors, and Students.

Where to Go to Help with Compliance Matters

Any concerns or violations of the Code of Conduct, operational policies, procedures or applicable laws or regulations should be reported following the established chain of command. All reports of suspected violations will be treated in a confidential manner to the extent allowable by law. Montefiore Nyack Hospital has a strict non-retaliation policy so you are protected when you report. No one will be disciplined or subjected to retaliatory actions because a report was made in good faith. The Compliance Office will ensure prompt and thorough investigation of all suspected violations and will coordinate appropriate follow-up action and resolution. (MNH PolicyStat ID 13765941 Compliance – Compliance Hotline).

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- The Compliance Office will ensure prompt and thorough investigation of all suspected violations and will coordinate appropriate follow-up action and resolution.

1. Supervisor

- Discuss concerns with your Supervisor or a delegate first if possible.

2. Human Resources

- Refer to Human Resources if a human resource issue.

3. Corporate Compliance

LuAnn Weis
Compliance Officer
(845) 348-2034

- If you feel uncomfortable reporting the concern to an immediate supervisor or manager.
- If you are not satisfied with the initial response you receive regarding a compliance issue.

4. Compliance Hotline

(888) 568-8548
https://montefiore.alertline.com

- If the compliance concern cannot be reported using the internal chain of command.
- The Hotline operates 24-hours, 7-days a week.
- **Provides a confidential and anonymous way to report concerns or violations.**

ISSUES THAT SHOULD BE REPORTED TO COMPLIANCE BUT NOT LIMITED TO:

We all have a duty to report any actual or suspected illegal, unethical, or improper conduct to the Compliance Department or the Compliance Hotline. Examples: Fraud, Waste and Abuse, Conflicts of Interest, Billing Concerns, HIPAA Privacy or Security Violations, and Patient Discrimination.

We are required to report potential non-compliance with any federal or state health care program requirements, MNH policies and procedures and MNH Code of Conduct. (MNH PolicyStat ID 13707389 Compliance – Code of Conduct Policy)

FEDERAL DEFICIT REDUCTION ACT OF 2005 - Montefiore Nyack Hospital is committed to complying with the requirements of Section 6032 of the Federal Deficit Reduction Act of 2005 and to preventing and detecting any fraud, waste or abuse in our organization. All employees, including management, Board of Trustees, vendors/agents who provide services, must comply with all applicable Federal and New York State false claims laws and regulations.

False Claims Act is a federal law, which allows people who are not affiliated with the government to file actions against federal contractors claiming fraud against the government. The act of filing such actions is informally called whistleblowing. If the action succeeds, the whistleblower is entitled to receive a percentage of the settlement, penalty or fine collected. Whistleblowers are also granted protection under the law from disciplinary actions taken by employers. NYS enacted its own FCA. (MNH PolicyStat ID 13723023 Deficit Reduction Act Fraud and Abuse and Whistleblower Provisions)

What constitutes a false claim? A false claim may be the result of billing for services that were not ordered by a physician, weren't medically necessary, weren't provided, or did not meet standards for quality care. In general, quality care means care that is safe, reliable, relevant and patient-centered. It also means that healthcare personnel providing that care are appropriately licensed, registered or certified in their respective fields of practice according to state law. Billing for services provided by an individual who does not possess the appropriate credentials is a false claim.

Anti-Kickback Statute (AKS)
The AKS makes it a crime to knowingly and willfully offer, pay, solicit, or receive any remuneration, directly or indirectly, to induce or reward referrals of items or services reimbursable by a Federal health care program if a safe-harbor exception is not met. Remuneration includes anything of value, such as cash, free rent, expensive hotel stays and meals, and excessive compensation for medical directorships or consultancies.

HIPAA is the acronym for the **Health Insurance Portability and Accountability Act of 1996** is a federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge. Any Protected Health Information (PHI) about the health status, provision of health care, or payment for health care that can be linked to a specific individual is a violation. Examples of identifiers: Name (full or partial), Address (street address, zip code, e-mail address) and Reference Numbers (SSN, health plan ID number, medical record number). Examples of patient health information: diagnosis, admission and discharge dates, laboratory results.

HIPAA Minimum Necessary Rule means only access the minimum necessary PHI to complete your workflow. EPIC users are role based; which means staff have access to patient information relevant to their work flow. We must use, disclose and/ or request the minimum amount of PHI needed to accomplish a necessary job/task based on the role/ task of the person involved in handling the PHI.

PROTECTING OUR PATIENTS PRIVACY RIGHTS – FairWarning™
Montefiore Nyack uses FairWarning™ an audit program that shows all accesses of our medical record systems. You are only accessing PHI necessary for treatment, payment, or other hospital operations. You have a business reason (part of your work flow). Not allowed to check on a family member; to schedule an appointment for yourself; to find someone's address or birth date. Accessing only Only accessing part of your workflow Scrolling through a list of patients or co-worker snooping will trigger an event action in Fairwarning™. Fairwarning™ collects and aggregates data 24/7. Sends alerts to Compliance about occurrences of possible inappropriate access to medical records.

WHAT IS A HIPAA BREACH? A HIPAA breach is defined as the acquisition, access, use or disclosure. Some examples of breaches: Impermissible disclosure of PHI. Lost or stolen devices containing PHI. Hacking incidents. Employee errors. Unauthorized access to PHI.

EMERGENCY MEDICAL TREATENT & LABOR ACT of 1986 (EMTALA) – to ensure public access to emergency services regardless of ability to pay. In an emergency condition, patients are provided with a medical screening examination (MSE) and emergency treatment, regardless of the patient's ability to pay or the source of payment. Patients are only transferred if need be, after the patient has been medically stabilized and an appropriate transfer has been arranged. (MNH PolicyStat ID 11521948 Transfer of Patients to Other Acute Care Facilities/EMATALA).

RISK MANAGEMENT

The Risk Management program at Montefiore Nyack Hospital is tasked with identifying actual or potential serious patient safety events from various referral sources, and mitigating risk. Based on reporting criteria from the Department of Health, certain events require a root cause analysis, which is a systematic and comprehensive review of the event, the identification of opportunities for improvement, and planning corrective actions to prevent future similar events.

State-reportable events include, but are not limited to:

- patients' deaths in circumstances other than those related to the natural course of illness, disease or proper treatment in accordance with generally accepted medical standards;
- injuries and impairments of bodily functions, in circumstances other than those related to the natural course of illness, disease or proper treatment in accordance with generally accepted medical standards that necessitate additional or more complicated treatment regimens or that result in a significant change in patient status;
- equipment malfunction or equipment user error during treatment or diagnosis of a patient which results in death or serious injury of a patient;
- patient elopements resulting in death or serious injury;
- abduction of a patient of any age;
- sexual abuse/sexual assault on a patient or staff member within or on the grounds of a general hospital;
- physical assault of a patient or staff member within or on the grounds of a general hospital, leading to death or serious harm;
- discharge or release of a patient of any age, who is unable to make decisions, to other than an authorized person;
- patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process;
- patient suicide, attempted suicide or self-harm resulting in serious injury;
- poisoning occurring within the hospital;
- fires or other internal disasters in the hospital which disrupt the provision of patient care services or cause harm to patients or staff members;
- disasters or other emergency situations external to the hospital environment which affect hospital operations;
- termination of any services vital to the continued safe operation of the hospital or to the health and safety of its patients and staff members, including but not limited to the termination of telephone, electric, gas, fuel, water, heat, air conditioning, rodent or pest control, laundry services, food, or contract services; and
- strikes by staff members

All staff are expected to escalate actual events and near-misses to their supervisor, as well as entering the event in the Verge incident reporting system, so that trends can be identified and reviewed.

The Risk Management Department also screens events for potential litigation risk and refers cases to the hospital's carrier. If staff are approached with legal papers, requests for information/ interviews and the like, they should contact their supervisor and the Risk Department.

DISCRIMINATION IS AGAINST THE LAW

Montefiore Nyack Hospital complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, religion, sex, national origin, disability, sexual orientation, gender identity or expression, physical appearance, or age. Montefiore Nyack Hospital does not exclude people or treat them differently because of race, color, religion, sex, national origin, disability, sexual orientation, gender identity or expression, physical appearance, or age.

Montefiore Nyack Hospital:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  -Qualified sign language interpreters
  -Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  -Qualified interpreters
  -Information written in other languages

If you need these services, contact Patient Experience at 845-348-6778.

If you believe that Montefiore Nyack Hospital has failed to provide these services or discriminated in another way of the basis of race, color, national origin, age, disability, gender identity or expression, or sex, you can file a grievance with:
Director of Patient Experience, Civil Rights Coordinator
Montefiore Nyack Hospital
160 North Midland Avenue
Nyack, New York 10960
845-348-6778 - Phone

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Director of Patient Experience is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

NEW YORK STATE | Division of Human Rights

New Yorkers are protected from gender identity discrimination by hospitals

Under the New York State Human Rights Law, discrimination based on gender identity or expression is prohibited in all places of public accommodation, including hospitals.

The New York State Division of Human Rights enforces the **Human Rights Law**. The Division investigates and decides complaints alleging discrimination on the basis of gender identity or expression.

What is Gender Identity or Expression?

Gender identity or expression means a person's actual or perceived gender-related identity, appearance, behavior, expression, or other gender-related characteristic regardless of the sex assigned to that person at birth, including, but not limited to, the status of being transgender.

A transgender person is an individual who has a gender identity different from the sex assigned to that individual at birth.

Gender dysphoria is a recognized medical condition related to an individual having a gender identity different from the sex assigned at birth.

Discrimination on the Basis of Gender Identity or Expression is Unlawful

In January 2019, the Human Rights Law was amended to add gender identity or expression as a protected category. For events occurring after February 23, 2019, discrimination on the basis of gender identity is explicitly covered by the Human Rights Law.

Also, pursuant to regulations issued by the Division in January 2016, gender identity discrimination has been, and continues to be recognized by the Division as sex and disability discrimination. Discrimination because of gender identity or expression is sex discrimination because the term “sex” when used in the Human Rights Law includes gender identity and the status of being transgender. Discrimination because of gender dysphoria or other conditions meeting the definition of disability under the Human Rights Law is disability discrimination.

Harassment on the Basis of Gender Identity or Expression is Unlawful

Harassment because of a person’s gender identity or expression, or the status of being transgender is explicitly unlawful. It also is recognized as sexual harassment. Harassment because of a person’s gender dysphoria, or other condition meeting the definition of disability, is harassment on the basis of disability.

Retaliation for Filing a Complaint or Opposing Discrimination is Unlawful

The Human Rights Law prohibits any place of public accommodation, including hospitals, from retaliating against an individual for filing a complaint of discrimination or otherwise opposing practices that are discriminatory.

Unlawful discrimination on the grounds of gender identity or expression by a hospital may include:

- denying equal access to a hospital because of gender identity or expression;
- indicating that transgender persons are unwelcome or objectionable;
- refusing to use a transgender person's legal name;
- refusing to refer to a transgender person by that person's preferred pronouns;
- denying the use of rest rooms or other facilities consistent with a person's gender identity;
- teasing, name-calling or bullying by staff because of a person's gender identity;
- refusing to treat a transgender person because that person has complained about discrimination.

These are just some of the ways gender identity or expression discrimination in a hospital may occur.

Contact the Division of Human Rights for further information about your rights.

For more information or to find the regional office nearest to you visit the Division's website WWW.DHR.NY.GOV. You can also call the Division's toll-free HOTLINE at 1(888)392-3644.

FILING A COMPLAINT at the DIVISION

If you believe that you have been discriminated against because of your gender identity or expression, you can file a complaint with the **New York State Division of Human Rights.** A complaint must be filed with the Division within one year of the alleged discriminatory act. To file a complaint:

- Visit the Division's website, at **WWW.DHR.NY.GOV**, and download a complaint form. Completed complaints should be signed before a notary public, and returned to the Division, by email, fax, mail or in person.
- Stop by a Division office in person.
- Contact one of the Division's offices, by telephone or by mail, to obtain a complaint form and/or other assistance in filing a complaint.

Your complaint will be investigated by the Division, and if the Division finds probable cause to believe discrimination has occurred, your case will be sent to a public hearing. There is no cost to you for the investigation or hearing, unless you choose to obtain private legal representation.

If the Commissioner of Human Rights finds in your favor following the hearing, the relief awarded to you may include such remedies as a cease and desist order, monetary compensation for the harm you suffered and civil fines and penalties.

Impaired Professional / Disruptive Behavior

The term "impaired" is used to describe a practitioner who is prevented, by reason of illness or other health problems from performing his/her professional duties at the expected level of skill and competency. Impairment also includes a decreased ability or unwillingness to acknowledge the problem or to seek help to recover. It places the practitioner at risk and creates a risk to public health and safety. Signs of impairment may include bur are not limited to deterioration of hygiene or appearance, personality or behavior changes, unpredictable behavior, unreliability, neglecting commitments, excessive ordering of drugs, lack of or inappropriate responses to pages/calls, decreasing quality of performance or pt care.

Disruptive conduct by a practitioner is behavior which adversely impacts the quality of patient care. It includes verbal or physical abuse of colleagues, hospital personnel or patients, sexual harassment and threatening or intimidating behavior exhibited during interactions with colleagues, hospital personnel or patients. Behaviors that do not promote a culture of safety are considered disruptive and are not in accordance with the values of this organization. This conduct will not be tolerated. Any Medical/MNH staff member, employee or agent of the hospital, or patient may file a complaint against a practitioner's disruptive conduct. No retaliation will be taken for reporting a concern in good faith. Complaints may be referred to the CEO (or designee), MEC Chair, applicable Department Chair, or the CMO. For reporting, refer to and follow the MNH Policy on titled Chain of Command policy PP-NH-C103. See Appendix A – Attachment 5.

Delineation of Privileges and Credentialing

Physician, Physician Assistants, and Nurse Practitioner privileges can be found on the hospital Read Only Drive, under a folder labeled DrPrivileges. S:\Read_Only\DrPrivileges

Health Insurance Portability and Accountability Act (HIPAA)

- Patients have the right to:
  - Request a restriction on certain uses and disclosures of their Protected Health Information
  - Request to opt-out of our Hospital Directory while they are a patient
  - Inspect and copy their Protected Health Information
  - Amend their health record
  - Obtain an accounting of disclosures of their health information
  - A patient request form can be obtained on the MNH website, "Connect with Us", select Medical Records, and then select the link for "Authorization for Release of Health Information Form"
- Privacy and Confidentiality
  - All information about, or relating to, a patient is treated as private and confidential
  - Any documentation with patient information such as charts, a computer, labels, log books, etc., should never be left unattended and should be kept out of public view
  - When finished using a computer workstation, log off so that pt information is not visible
  - When discussing information with a patient, voices should be kept low so that others may not hear the conversation. Do not discuss pt identifiable information in public areas, such as elevators, waiting areas, or the cafeteria, where the conversation might be overheard.
  - Patient information must be secured through encryption when transmitted. ALL release of information requests must be sent to Health Information Services.
  - All patient specific information being disposed of must be shredded or placed in a confidential shredding bin. This includes patient medication and other labels with patient information.
  - Sign in sheets must be designed in such a way to prevent PHI exposure when used for multiple patients
  - Refer to MNH policies on Protected Health Information (PHI) on Shared Drive, under "Read Only" folder, in "Policies/Procedures"

Medical Record Documentation and Downtime Process

Physicians and staff must maintain accurate and complete medical records and documentation of the services provided. Documentation must also support the claims we submit for payment. All entries in the medical record must be LEGIBLE and authenticated with the author's name, identity, and date and time.

"Downtime" means the electronic medical record (EMR) is not accessible due to a failure in the hospital information system. EMR's may have periodic scheduled downtime. IT will notify staff for planned downtime. Unscheduled downtime will be announced overhead as "Computer conference level one/two is now in session." Level One is used when some systems or users are affected. Level Two means major units and most users are affected.

Downtime tools available include:

- "Epic SRO (support read only)" which is available on all computers in a folder labeled Epic Downtime. It can be used to view and print patient information including Medication Administration Records during a planned downtime.
- If the entire network is down, specially marked BCA (Business Continuity Access) computers can be utilized to view and print limited clinical information.
- Staff will document on "Downtime Assessment" forms, located on the patient care unit with a patient identification label until an announcement is made overhead. Documentation paper forms, such as physician orders, and lab orders are located on the BCA devices, plastic buckets on the units and from the Repository (Access eForms Web Application). A note should be added to the patient record reflecting that there is downtime documentation.

Additional information such as policies and what information needs to be back-entered is located in the Downtime Resource folder on the BCA computers.

Corrections to the Medical Record

For corrections to the electronic medical record, a document titled Addendum may be completed for making corrections. Alternatively, if the entire document requires a correction, then you must "invalidate" the note within Epic and create a new note.

During downtime or on paper records, Errors in the paper medical record are corrected by drawing a single line through the incorrect entry, writing the word "error" or "incorrect" near the mistake, and dating, timing and initialing the correction. If an entry is made at a later date, it is entered as an addendum. An addendum is recorded on a separate piece of paper and is generally inserted at the end of the section to which it applies. "Addendum" should be recorded at the beginning of the document and it should be dated with the current date, timed and signed. Document a marginal note earlier in the record where applicable to alert the reader of the "addendum" note.

How to Add a Note or Addend a Note on a discharged patient:

1. Find recently discharge patient from either the 24 H IP Discharge list or the 4 Day IP Discharged list. Double Click on the patients name to open their Hospital Encounter.
2. If the Patient was discharged greater than 4 days, use "Patient Lookup".
3. Search using the patient's name or MRN.
4. The patient's chart opens up to the "Chart Review" tab. Click on "Encounters" tab under Chart Review and select the encounter you wish to addend a note or add a new note.
5. Right click on the encounter line and select "Edit or Addend Encounter".
6. The system will go to the selected encounter.
7. Select "Notes" tab
8. To addend your note, select your note and click on "Addendum" Button.
9. To add a new note, click on "New Note" or "Create in NoteWriter".
10. Complete your note.

Unapproved Abbreviations

In order to reduce error and foster clarity of written communication, unapproved abbreviations will NOT be used in writing physician orders and medication-related documentation in the patient's medical record and on pre-printed forms. Refer to Use of Abbreviations, Acronyms and Symbols in the Medical Record.

- **No trailing zeros:** It is mandatory that trailing zeros will not be used after a whole number. i.e., five milligrams should be written as 5 mg NOT 5.0 mg
- **The use of leading zeros** before a decimal point is mandatory: i.e. one-half milligram should be written as 0.5 mg NOT as .5mg.
- **QOD, Q.O.D, qod, q.o.d.** (Every other day): Write as "every other day."
- **QD, Q.D., q.d., qd, OD** (Daily): Write as "daily."
- **U, u** (Unit): Write out the word "unit."
- **IU** (International Unit) Write out "International Unit."
- **MS, MSO4** (morphine sulfate):Write out "Morphine (sulfate)."
- **MgSO4** (Magnesium sulfate): Write out "Magnesium sulfate."

Risk Management and Safety Event Reporting

How are unsafe conditions reported?

Notify your manager/director immediately and the Risk Manager @ 2139. Additional resources for addressing unsafe conditions are the Safety Officer @ 2056 and the Quality Director @ 2517.

What do you do if an unsafe condition causes a patient/visitor or employee event or incident?

Notify Administrative Supervisor and fill out a Verge Event Report with enough information to thoughtfully explain the condition. Any unexpected or unusual incident that is not part of the normal patient or visitor experience must be reported to the Risk Management office. Reports must be made before the end of the shift during which the incident took place. Clinical occurrences must also be documented in the patient's electronic medical record.

What can I expect after having reported an unsafe condition?

The Risk Manager or another member of the leadership team may need to contact you for more information to thoughtfully evaluate the circumstance and determine a safe and effective resolution. You should expect prompt response to your concerns. Sentinel Events and Near Miss Events require a Root Cause Analysis. A Root Cause Analysis is an investigative method to identify the underlying cause(s) of a serious event in order to determine corrective actions that will reduce the risk or prevent re-occurrence.

Sentinel Events

A sentinel event is an unexpected occurrence involving death, serious physical injury or major permanent loss of organ function. Some examples include wrong side/site surgery, wrong blood product, and falls with serious injuries. A near miss, also known as a good catch, is an event that occurred but did not result in death, serious physical injury or major permanent loss of organ function, but could result in these if there is a re-occurrence, or if it occurred in a different patient or setting. These should also be reported as an opportunity for the hospital to review systems that may have contributed to the event. *Sentinel Event Policy: S101 Sentinel Events (Serious Adverse June 2018)*

Daily Safety Huddle

A Daily Safety Huddle is conducted by Senior Leadership to highlight safety events or good catches that have occurred and departmental activities that might affect other departments, such as downtime, medical equipment or facilities maintenance. In addition, many departments conduct Safety Huddles each day to discuss topics relevant to the department.

Reporting to NYS DOH, The Joint Commission, OASAS, Justice Center

If an employee or medical staff member does not feel that their concerns about unsafe conditions are being addressed, they may report any concerns by contacting the Metropolitan Regional Offices of the NYS DOH New Rochelle Office 145 Huguenot Street, 6th floor New Rochelle, NY 10801-5291 or by calling weekdays during business hours, at (914) 654-7000; or the Joint Commission at The Joint Commission One Renaissance Blvd.Oakbrook Terrace, IL 60181, https://www.jointcommission.org/, or by calling 1-800-994-6610. These reports can be made without fear of disciplinary or punitive action.

Mandated reporters must submit reportable incidents of abuse or neglect of people with special needs to the NYS Justice Center. Reports can be submitted through the website at https://vpcr.justicecenter.ny.gov/WIRW/#/ or by calling 1-855-373-2122.

A person in a provider agency may be a "mandated reporter" for purposes of the SCR (see LSB 2014-03: https://

oasas.ny.gov/mis/bulletins/lsb2014-03.cfm) or a "mandated reporter" for purposes of the VPCR or both. Information on mandated reporters for the Justice Center may be found at: https://www.justicecenter.ny.gov/training/mandated-reporting.

III. LIFE SAFETY / EMERGENCY RESPONSE

Emergency Response

- Hospital Emergency Incident Command System (HICS) is a command structure that is activated to manage large scale emergencies.
- Emergency Command Center is located on 1st floor Administrative Conference Room (ACR).
- HICS manuals are located in every department and nursing unit
- All emergency phone numbers are located in the Red Emergency Preparedness manual and in the back of the phone directory.
- Top five potential emergencies for MNH and affiliated campuses:
  - Pandemic, Novel Coronavirus
  - Seasonal Influenza
  - Critical Supply Shortage
  - Patient Surge
  - Severe Winter Storm (heavy snow, blizzards, ice storms)
- Know and understand your role in the HICS plan.
- Be prepared for an emergency before it happens. Be familiar with your work/study environment including the locations of the nearest fire pull boxes and extinguishers; and follow the area- specific emergency procedures.
- You may want to keep emergency supplies in your vehicle including any medication you may require, a change of clothes, toiletries, etc. in the event of an unforeseen situation.
- Emergency Response: call the following extensions from any Hospital phone:
  Cardio-pulmonary arrest – Call 2222
  Medical Emergency other than arrest (Rapid Response Team) Call 2222

Montefiore Nyack Hospital Emergency Codes

Code Red - Fire/Smoke
Code Blue - Cardiac/Respiratory Arrest
Code White - Pediatric Cardiac/Respiratory Arrest
Code Pink - Child Abduction/Attempted Abduction
Code Orange - Hazardous Materials Spill
Code Grey - Security Emergency/Imminent Danger
Code Silver - Person With A Weapon/Hostage Situation
Code Yellow - Bomb Threat
Code Triage - Surge
Code HICS - Emergency Operations Center Activated
Code Obstetrics - Obstetrical Emergency
Code H - Promote Pt./Family Involvement in Pt. Care
Code Purple - Stroke Notification
Rapid Response - Rapid Response Team Activation

Rapid Response Team (RRT)

The Rapid Response Team (RRT) can be activated by dialing 2222 from any room phone to reach the operator and identify the patient's room number. The RRT is then paged overhead and on the hospitalist, management/MICU or SICU RN/lead Respiratory Therapist's beepers. The team responds to the patient's condition and collaborates with the primary RN in assessment and care. The nurse communicates with the attending physician utilizing the SBAR (situation, background, assessment, recommendation) methodology. Rapid Response Team calls may be initiated for acute changes in vital signs, neurological status, chest pain, change in urinary output, uncontrolled bleeding, RN concerns about patient for unexplained agitation for more than 10 minutes, color change, unrelieved pain. The team responding to Rapid Response Team calls is comprised of the Hospitalist, Critical Care RN and Respiratory Therapist. The Rapid Response Team's assessment and intervention are documented in the Medical Record. A debriefing tool is also completed, for performance improvement purposes, to evaluate the indications for the RRT, timeliness of response, availability of equipment and supplies, and the outcome of the response. This debriefing tool is submitted to the Code Blue/RRT Committee and is not included in the Medical Record. See policy "Rapid Response Team".

Active Shooter / Code Silver

An active shooter is ANY individual with ANY weapon using deadly force to harm, kill or threaten themselves or other victims, including a Hostage Situation. Active shooter situations are unpredictable and evolve quickly. Call 9-1-1 and tell them your name, location, building / room number. Call MNH Emergency line ext 2222 for "CODE SILVER" activation. Be aware of your environment and have an action plan: RUN, HIDE, FIGHT, or WAIT for arrival of law enforcement. Evacuate patients and visitors from area of threat.

Fire Prevention / RACE / PASS

Exit doors and hallways should remain unobstructed in order to expedite evacuation in the event of a fire or other emergency. Exit signs should be lit. Hospital aisles, corridors, and ramps required for exit access shall not be less than 8 feet in clearance must be unobstructed. This includes workstations on wheels (WOWs), chairs, and other medical devices excluding code carts and isolation carts. **30 Minute Rule:** Any item that has not been used in the past 30 minutes is considered stored and is not to be in hallway or on a ramp.

DO NOT block fire extinguishers, oxygen zone valves, and fire alarm boxes. Nothing should be parked in front of these that might impede access in an emergency. Fire extinguishers should have monthly inspection tags. Items in storage areas should not block sprinkler heads or their spray pattern. Do not attach decorative items to sprinkler heads. If a sprinkler head is dirty or dusty, notify facilities staff.

No cardboard shipping boxes should be stored in clean supply or medication rooms. This is an infection hazard and a fire hazard.Maximum of 2-32 gallon trash cans in a 10x10 room (unless fire rated).

Fire doors are not blocked or propped and when closed there must be positive latching.

Specialty Area Fire Prevention (OR, L&D, ER)

- **Control Ignition Sources:** place patient return electrode on a large muscle mass close to the surgical site, keeping active electrode cords from coiling, storing the ESU pencil in a safety holster when not in use, keeping surgical drapes or linens away from activated ESU, moistening drapes or place absorbent towels and sponges in close proximity to the ESU active electrode
- **Control Oxidizer:** tent drapes to allow for free air flow, keeping oxygen percentage as low as possible, using an adhesive incise drape
- **Control Fuel:** prevent pooling of skin prep solutions; remove prep-soaked linen and disposable prepping drapes; allow skin-prep agents and other chemicals (alcohol, collodion, tinctures, etc.) to dry and fumes to dissipate before draping.

RACE: Fire Alarm

In case of fire, R.A.C.E:

R – Rescue anyone in immediate danger

A – Alarm – pull the alarm box and call the operator ext 2222

C – Contain the fire by closing all doors and windows

E – Extinguish by using proper equipment

PASS: To use a fire extinguisher correctly, remember to P.A.S.S:

P – Pull the pin on the extinguisher. Twist the plastic tag to break the plastic and pull the pin.

A – Aim the hose at the base of the fire

S – Squeeze the handles together to release chemicals

S – Sweep the hose from side to side at the base of the fire until the fire is completely out.

Medical Waste

- Regulated medical waste is disposed of in red plastic bags labeled with a biohazard sign. Bags should be promptly placed in solid containers, and should not be stored on the floor.

- Sharps (needles, lancets, scalpels) are to be placed in a leak proof, puncture resistant needle box at the point of use. Container should be replaced when ¾ full. Contact Environmental Services for disposal. Call ext 6666 to replace waste containers.
- Comply with all regulated medical and pharmaceutical waste standards.
- Recycle paper, cardboard, newspapers, cans, plastic, and glass in proper receptacles.

Oxygen (O2) Safety

- Ensure there are not more than 12 full oxygen E-cylinders in a smoke compartment
- Segregate full, partial and empty O2 cylinders/tanks by physically separating and labeling them
- O2 cylinders are considered empty when in Red Zone on the gauge is less than 500 psi
- O2 and medical gas valves are shut OFF only by Nursing Supervisors, Designees, or Respiratory Therapy. In extreme emergencies, Fire Department or HVAC staff can turn off O2 valves.
- O2 tanks are stored in: Medical Gas Storage Rm, ER, OR, L/D, MRI, Transport, Respiratory Care
- O2 cylinders should be secured in a transport cart or chained to the wall; NEVER keep O2 tanks standing or laying alone
- Only Ambulation Cylinders and Code Cart O2 cylinders are on the Nursing Units.
- Ambulation cylinders are in single carriers and are changed by Respiratory Care.
- Code Cart O2 cylinders are checked by Nursing and changed by Respiratory Care.
- Transport is responsible for changing Transport cylinders, including O2cylinders in ER.
- Respiratory Care department personnel changes O2 cylinders for the OR, L&D and MRI
- Refer to MNH policies on Cylinder O2 E Chart and Cylinder Safety located on "Shared Drive" Read only, Environment of Care Policies, Environment of Care Manual, Medical Gas folder.

Magnetic Resonance Imaging Safety

MNH manages Magnetic Resonance Imaging (MRI) safety risks associated with the following:

- Patients who may experience claustrophobia, anxiety, or emotional distress
- Patients who may require urgent or emergent medical care
- Patients with medical implants, devices, or imbedded metallic foreign objects (such as shrapnel)
- Ferromagnetic objects entering the MRI environment
- Acoustic noise

MRI safety risks are managed by implementing the following practices:

- Restrict access of everyone not trained in MRI safety or screened by staff trained in MRI safety from the scanner room and area preceding the entrance to the MRI scanner room.
- Ensure restricted areas are controlled and under direct supervision of staff trained in MRI safety.
- Post signage at the entrance to MRI scanner room that conveys potentially dangerous magnetic fields are present in the room. Signage should also indicate that the magnet is always on except in cases where the MRI system can have its magnetic field turned ON and OFF by the operator.
- Refer to MNH policy Radiology – MRI Policies and Procedures.

Safety Data Sheets (SDS)

SDS are available on all products considered hazardous (cleaning chemicals, medications, etc.)
Access SDS by calling 1-800-451-8346 or www.3eonline.com, user name: Nyack, password: sds.

Minor Spill - A minor spill can be cleaned up by the person that discovers or causes the spill without any special equipment beyond what they normally use. These spills should be cleaned up promptly and no further action is needed. Example: A few drops of blood or a few drops of a normally used chemical.

Hazardous Material Spill – For hazardous materials such as chemotherapeutic medications or mercury, refer to specific policy on that content area. Refer to MNH Policies on Managing Chemotherapeutic Material and Waste; Infection Control or Pharmacy policy; or Policy on Mercury Spills.

Major Spill - Dial ext 2222 and request to activate CODE ORANGE paged overhead. Immediately evacuate the area while closing all of the doors. This will help contain the hazardous vapors.

IV. WORK PLACE SAFETY

Daily Safety Huddle

The "Daily Safety Huddle" is conducted by Senior Leadership to communicate MNH workplace safety events or good catches that have occurred and departmental activities that might affect other departments, such as downtime, medical equipment or facilities maintenance. In addition, many departments conduct Safety Huddles each day on patient care units to discuss PI topics relevant to the department.

Environment of Care Safety

- All staff, physicians, volunteers, vendors have badges easily visible, worn above the waist.
- Halls free of clutter; nothing plugged in; nothing in front of electrical panels, fire pulls or extinguishers, gas shutoff valves
- No doors propped open
- Unit clean, without visible dust
- Utility room:
  - Clear path to sink in soiled utility
  - Trash & linen carts not full
  - Surgical instruments handled per policy post procedure
  - Dirty utility room air flow functions appropriately – negative pressure
- Medication & Supply room:
  - No meds on counter tops (unsecured); pill crusher clean; only single patient use splitters
  - Insulin dated and other multi-dose vials dated per policy
  - All test strips and reagents dated, per policy
  - All logs complete with action taken if out of range
  - No outdated supplies; check any IV or other mobile carts. Supplies should be stocked using the First In – First Out technique. Supplies with the shortest expiration date are stocked in the front or top of the bin, to use prior to expiration
  - Splash guards on bottom shelves
  - Laminated Look Alike-Sound Alike med list is present
- Food / Drinks in Clinical Care Areas
  - Food and drink are only allowed in designated spaces on clinical care units (OSHA)
  - Food and drink consumed near pt records may render them illegible if spillage occurs.
- Refrigerators are clean and contain only those items designed for that refrigerator – specimens, medications, breast milk or patient food.
  - Ensure temperature logs are up to date and complete.
  - Any out of range temperatures must have actions taken documented on the log.
  - Any patient food in patient refrigerators is dated and labeled with patient name.
  - No open undated containers.
  - No outdated food or beverages.
  - Ice machine is clean, check the spout for dirt and residue
- Medical Equipment
  - Product/device maintenance are up to date; no tape or sticker residue
  - Broken equipment should be tagged with information about the problem identified, and transported off the unit for repair as soon as possible
  - Clean and dirty equipment is clearly identified
  - Crash cart: remove any extra log sheets, no outdated supplies, cart checked per policy
  - Upholstered furniture is intact, no cracks, tears. No cloth upholstery in pt care areas

- Do not store items under sinks due to risk of moisture and contamination.
- Housekeeping and maintenance carts and buckets should be either attended, or locked.
- All fluids on EVS carts are labeled AND never left unattended.
- Store housekeeping and maintenance carts in locked closets when not in use
- Utility and storage rooms remain locked
- Hazardous rooms are locked: EVS closets, supply closets, mechanical rooms, electrical panels
- Hazardous chemicals and flammable agents are labeled and stored properly
- Eyewash stations: Inspection tags are present and up to date with no missing dates
- Blanket, item warmers: Set to maintain temp of 130. Necessary logs are completed including actions taken for out of range temperature readings.
- Electrical safety: Use only hospital grade power strips, plugs and receptacles in good condition.
- Nurse call lights working in good order. Bathroom pull cords hang freely to 4" off floor.
- Air vents are clean

Workplace Violence and Harassment

Workplace violence ranges from offensive or threatening language to homicide. It includes violent acts, including physical assaults and threats of assaults directed toward persons at work, on duty, or on hospital premises. Domestic violence is also a workplace issue. It is your responsibility to understand the effects of domestic violence, ways to prevent and curtail violence, and methods to report such violence to authorities. Designated liaisons, persons who can assist with support and care at MNH are: Employee Assistance Program , HR - Benefits Department, and MNH Security Department.

Discrimination/Sexual Harassment - MNH seeks to retain a working atmosphere of cooperation and understanding free from discrimination and sexual harassment where each individual is to be respected for his/her contribution to the hospital mission. Infractions of discrimination violate Title VII of the Civil Rights Act of 1964, NYS Human Rights Law, Executive Order 9 and the policy of MNH. Individuals who experience or witness sexual harassment or other forms of discrimination should contact Human Resource Department to discuss options and may include filing a written complaint using the internal complaint procedure. See Appendix A – HR Attachment 6.

Effective Communication: AIDET, SBAR, Teach-Back

AIDET is a communication tool for healthcare professionals to communicate in a manner that would decrease patient anxiety, increase compliance and improve clinical outcomes.

Acknowledge (A)
- 10-5 Rule: Eye contact and smile at 10ft, verbal greeting at 5ft
- Acknowledge everyone in the room, greet in a pleasant manner and make patient/family your focus

Introduce (I)
- State your name, role, highlight your skill and expertise while managing up coworkers and departments

Duration (D)
- Keep patient and family informed, inform patient of expected wait times
- When this is not possible, give a time in which you will update patient on progress

Expectation (E)
- Explain all processes and procedures in a language, and manner the pt can understand
- Set clear and realistic expectations of what will be occurring
- Listen to what the patient is saying: allow for silence, be mindful of body language

Thank you (T)
- Thank pt/family for choosing MNH; express appreciation; ask if there is anything else we can do

SBAR is an internal communication tool used to provide a quick, concise explanation of the purpose of the conversation (**S**ituation), a **B**ackground and **A**ssessment of the patient's condition and a **R**ecommendation for the next step of care. SBAR is used to prevent communication gaps and medical errors; and to communicate effectively to the team by having our information organized in an accurate and concise format.

Teach-Back - Staff use the teach-back method to confirm whether a patient understands what is being explained to him/her. This closed feedback loop aids in communicating important information to ensure thorough and effective patient education and discharge instructions.

Safe Patient Handling and Injury Prevention

Locate equipment for safe patient handling and proper mobility devices. Use appropriate equipment and devices to take reduce the load and prevent injury. Proper transfer devices include gait belts, lifting devices, slide boards for safe patient care and prevent workplace injury to staff and clients. Report any injury to your supervisor immediately and complete the proper report forms including a description of the injury and the related event.

V. PATIENT SAFETY AND RIGHTS

Patient Ethics and Care Concerns

Patients have the right to be involved in their own care, and treatment decisions in a culturally sensitive, respectful, and informed manner. Patients also have the right to voice concerns related to their treatment plan. Questions and concerns about rights and responsibilities may be addressed to the MNH Patient Experience Department. Patients may also contact the NYS Department of Health, Centralized Hospital Intake Program, Mailstop: CA/DCS, Empire State Plaza, Albany, NY 12237; or by calling during business hours at 1-800-804-54447. Patient can also contact The Joint Commission, One Renaissance Blvd. Oakbrook Terrace, IL 60181, https://www.jointcommission.org/, or by calling 1-800-994-6610.

Disclosure of Unexpected Outcomes

If an event occurs that is unplanned or unexpected and results in temporary or permanent harm to a patient, or death, or significantly increases the planned length of hospitalization, it must be disclosed to the patient or his/her family and discussed. It is the physician's responsibility to conduct the discussion in a timely manner and to document the discussion in the medical record

Informed Consent

Obtaining informed consent presents an opportunity to establish a mutual understanding between the patient and the licensed independent practitioner or other licensed practitioners with privileges about the care, treatment, and services that the patient will receive. Informed consent is not merely a signed document. It is a process that considers patient needs and preferences, compliance with law and regulation, and patient education. Utilizing the informed consent process helps pt to participate fully in decisions about care, treatment, and services. Refer to MNH policy "Informed Consent", PP-NH-I112.

Language Assistance Program

Because communication is a cornerstone of patient safety and quality care, every patient has the right to receive information in a manner he or she understands. For communication to be effective, information provided must be complete, accurate, timely, unambiguous, and understood by the patient. Unfortunately, Limited English Proficiency (LEP) patients are at a higher risk for adverse events than English-speaking patients. Language barriers significantly impact safe and effective health care. MNH has a policy to ensure that patients who have hearing or language challenges receive appropriate care as described below. Refer to MNH policy on Language Assistance Program.

Propio Language Line Services

- Language translation is available to all pts and staff. Translation services are available throughout MNH. Staff members are trained in how to utilize the Propio phones and video remote interpreting devices.
- Notices about the availability of translation services are posted in the Patient Access Registration office, the ED Registration as well as other departments and elevators. These notices inform the pt that if they require translation services, they should inform staff. Staff must consult with the patient and document his/her preferred method of communication, as well as equipment needs.
- Propio phones (either corded or cordless) are available in all patient care areas. The Propio translation service is also available on all hospital phones by dialing #5.
- Video Remote Interpreting (VRI) is available for translation and interpretation of both spoken languages and American Sign Language.

- For non-English speaking, English as Second Language, and hearing impaired or deaf patients, an interpreter is provided at important times during care, to ensure effective communication during these encounters:
  - Obtaining the patient's medical history
  - Obtaining informed consent or permission for treatment
  - Diagnosis of the ailment or injury
  - Treatment or surgery if the patient is conscious, or to determine if the patient is conscious, or to determine if the patient is conscious
  - Explanations of medical procedures to be used
  - Those times the patient is in any of the Intensive Care Units or in the Post Anesthesia Care Unit
  - Assisting at the request of the doctor or other hospital staff
  - Discharge instructions and transition of care
- LIP's and staff utilizing Propie to communicate with a patient will document in the appropriate sections of the pt EMR that they used the Propio translation phone and translator's ID number.

Advance Directives

The NYS Health Care Proxy Law allows a person/patient to appoint someone s/he trusts to make healthcare decisions on his/her behalf when the capacity to make those decisions is lost. The person designated as having the health care proxy can agree to treatment, choose among different treatment options, and decide what treatments should not be provided, in accordance with knowledge of the wishes and interests of the person/patient.

A person/patient's wishes can be written on the Health Care Proxy form or in another document called the Living Will or on the Medical Orders for Life Sustaining Treatment (MOLST) form. Documentation of a person/patient's wishes is particularly important when decisions relating to end-of-life or artificial nutrition and hydration issues need to be made.

Following NYS law, the MOLST form should be completed on all chronically ill patients. This includes patients living in nursing facilities. A patient can be a full code, and wish to have all life saving measures performed if necessary, and have a MOLST. MOLST forms are pink, and can be found on every Nursing Unit. The original form should remain with the patient at discharge. MOLST forms are completed by the patient and LIP.

Conversations with patients/families regarding life saving measures should be documented in the medical record. If a patient/family member has decided that life saving measures should not be performed, an order stating "full" or "modified" Do Not Resuscitate (DNR) is placed in the medical record.

End of Life Care

Understanding the dying process, and knowing how to treat dying patients are critical to quality end of life care. The dying process gives us opportunities to make a difference in someone's life through aggressively managing pain and other symptoms. Compassionate care at the end of life focuses on providing pain management, symptom management, and emotional and spiritual support including:

- Pain management: Necessary for comfort and to reduce distress. Work with patient and family to identify pain and aggressively treat (medication, cold, heat, positioning, etc.).
- Symptom management: Treat symptoms such as nausea, weakness, bowel and bladder problems, mental confusion, fatigue, and difficulty breathing.
- Emotional and spiritual support is vital for patient and family in dealing with the stress of critical illness. Respect cultural and family rituals. Be with the patient and family, and respect the value of silence.
- Encourage family to participate in care if willing. Involve patient & family's spiritual support systems. Many times, just being with a dying patient is a comfort.
- Resources for end of life decisions: Palliative Care; Pastoral Care; Ethics Committee; Hospice.

Organ/Tissue Donation: "The Gift of Life"

Organ and tissue transplantation save or greatly improve the lives of thousands of men, women and children. Following are important facts about organ donation and transplantation:

- Hospitals are required to notify the LiveOnNY for ALL patient expirations within one hour of pronouncement, or who are progressing to brain death, or when withdrawal of life support is being discussed. The nurse caring for the patient or his/her designee (AA, Charge Nurse) will report all deaths within one (1) hour to LiveOnNY by calling LiveOnNY 1-800-443-8469.
- The quality of hospital treatment and efforts to save someone's life will not be lessened
- Donation will not disfigure the body
- The patient's estate does not pay for donation
- Race, color, creed and financial standing have nothing to do with who receives an organ or tissue
- A person of any age can donate
- Major religions support organ & tissue donation
- Eye Donation: families who do not wish to donate an organ have the option of eye donation
- Refer to policy "Organ and Tissue Donation, Including Donation following Cardiac Death" for more information.

Protection from Abuse, Neglect, Exploitation and Human Trafficking

All individuals have the right to safety and protection, and to be free of abuse, neglect, exploitation, or human trafficking. Follow policy for recognition, assessment, screening, tx and reporting.

Abuse - the willful infliction of physical pain, injury or mental anguish, unreasonable confinement, or the willful deprivation of services that are necessary to maintain a person's physical and mental health.

Neglect - an act or failure to act by an adult or caretaker towards a vulnerable person which results in the inadequate provision of care or services necessary to maintain the physical and mental health of the person, and which places him/her in serious injury or which is, or could be, life threatening.

Exploitation – the act or process of illegally or improperly using a person or his/her resources for another person's profit.

Human Trafficking – is a commercial sex act induced by force, fraud, or coercion, or in which the person induced to perform such an act has not attained 18 years of age; or the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery. LIP will assess for indications/red flags that the patient may be a victim of Human Trafficking in accordance with Public Health Law 2805-Y. Hospital social work will be notified and follow-up action taken to insure privacy and the protection of patient rights.

Safe Surrender – Safe Surrender or Safe Haven Law (NY) allows a parent/person to surrender an infant confidentially to a designated Safe Surrender site without fear of arrest or prosecution if the infant has not been abused or neglected. In the event of a "Safe Surrender" situation, it is advised to obtain as much medical background and history. Notify MNH Nursing Supervisor, NICU, ER and hospital security.

Cultural Preferences and Sensitivity Awareness - MNH mission is to ensure that care provided respects patients' rights, incorporates the patients' values and religious and cultural preferences when appropriate. Providers are sensitive to delivering holistic care without biased when caring for diverse populations including, bariatric patients, LGBTQ community members, and other religious sects.

Patient Satisfaction - Inpatients, Outpatients, Emergency Department and Ambulatory Surgery Patients all have the ability to receive a patient satisfaction survey in the mail upon discharge. Press Ganey is the vendor that MNH uses to compile our patient satisfaction data including information about patient's admission, room, meals, visitors/family, special services and personal issues. Hospital Consumer Assessment of Healthcare Providers and System (HCAHPS) is 32 question survey used for inpatients only that measures "patient satisfaction" of the care provided during their hospital admission. HCAHPS is publically reported data on the Hospital Compare government website www.hospitalcompare.gov.

No Pass Zone

Montefiore Nyack Hospital utilizes a **"No Pass Zone"**. Every staff member is responsible for responding to call bells.

VI. QUALITY / PERFORMANCE IMPROVEMENT

Performance Improvement (PI)

Montefiore Nyack Hospital utilizes Plan, Do, Study, Act (PDSA) for organization wide process improvement activity. Montefiore Nyack Hospital utilizes PDSA teams to design new processes, and to make improvements. The teams are interdisciplinary and include staff members from the involved departments, administration, and the Medical Staff as necessary. The teams identify processes or problems needing improvement and then study the process using the PDSA methodology to improve outcomes by indentifying root causes and implementing solutions. The Teams are initiated based on the priorities establised by the organization and its leadership. We use criteria aligned with our hospital and strategic goals to prioritize projects for improvement.

Analysis of the effectiveness of interventions will include "post testing/audits" to measure the impact of our transformational changes.

Failure Mode and Effects Analysis (FMEA)

- A Performance Improvement Tool used for proactive risk assessment of high risk processes.
- Actions to take to reduce the likelihood of failures.

Focus areas for Performance Improvement 2023

- Preventing HAC's and Patient Safety Indicators (PSI's) including HAPI, DVT and PE
- Falls (with and w/o injury)
- Infection Rate (CAUTI, CLABSI, MRSA, C DIFF, Surgical Site Infection, Hand Hygiene Compliance, etc.)
- Re-admission rate
- Sepsis (Severe Sepsis & Septic Shock)
- Stroke
- ED Throughput
- Maternal Child C-Section and Breastfeeding rates
- Patient Experience HCAHPS
- Culture of Safety Survey

CORE Measures Overview

INPATIENT MEASURES

ED Measures
- Median time of ED arrival to ED departure for admitted patients
- Admit decision time to ED departure time for admitted patients

Stroke
- Venous Thromboembolism Prophylaxis (VTE) (mechanical or pharmacological by day after admission)
- Discharged on antithrombotic therapy
- Antithrombotic therapy by end of hospital Day 2
- Assessed for Rehabilitation (Physical, Occupational or Speech Therapy)
- Statin prescribed at discharge
- Anticoagulation therapy prescribed on discharge for patients with Atrial Fibrillation/Flutter
- Stroke Education
- Dysphagia screening completed and documented prior to any oral intake
- NIH stroke scale completed and documented on admission
- Modified Rankin scale on discharge

Perinatal Care
- Elective Delivery – patients delivering newborns with >= 37 and < 39 weeks of gestation completed.
- Nulliparous patients with live term singleton in vertex presentation delivered by Cesarean section
- Exclusive breast milk feeding during newborn's entire hospitalization
- Unexpected complications in term newborns

Sepsis
- Initial and repeat lactate
- Blood cultures prior to starting antibiotic therapy
- Appropriate antibiotic therapy
- Crystalloid fluid administration
- Vasopressor administration
- Reassessment
- Mortality

Hospital Based Inpatient Psychiatric Service (HBIPS)
- Hours of physical restraint use
- Hours of seclusion use
- ETOH and tobacco screening including: medication in hospital, medication at discharge an follow up scheduled post discharge

OUTPATIENT MEASURES

ED Throughput
- Door to diagnostic evaluation by a qualified medical professional
- Patients who leave without being seen

Stroke
- Head CT or MRI scan results for Acute Ischemic Stroke or Hemorrhagic Stroke patients within 45 minutes of arrival
- Door in to door out time for stroke patients transferring to a higher lever of care

Endoscopy/Polyp Surveillance
- Appropriate follow up interval of 10 years for Normal Colonoscopy in average risk patients

HOSPITAL MEASURE

Healthcare Personnel Influenza Vaccination

VBP, CMS Star Rating, Leapfrog and Blue-Cross/Shield PI Initiatives

Improving the Patient's Experience

- Communication with Nurses
- Communication with Doctors
- Communication about medications
- Discharge information provided
- Responsiveness of hospital staff
- Care transitions
- Cleanliness & quietness
- Overall hospital rating

Imaging Efficiency

- MRI lumbar spine for low back pain
- Abdominal and Thorax CT use of contrast material
- Cardiac imaging for pre-op risk assessment for non-cardiac low risk surgery
- External beam radiotherapy for bone metastasis

Mortality Rates

- Heart Attacks
- Heart Failure
- Pneumonia
- COPD
- Sepsis
- Overall
- Stroke

Hospital Acquired Conditions

Infection Related

- Catheter associated urinary tract infections
- Central line associated blood stream infections
- Colon and abdominal hysterectomy surgical site infections
- MRSA bacteremia
- Clostridium difficile infections

Complications

- Pressure Injuries
- Falls with Injury
- Death in surgical patients with treatable conditions
  - Iatrogenic Pneumothorax
  - Postop hemorrhage/hematoma, or accidental abdominal puncture/laceration
  - Postop PE or DVT
  - Postop Wound Dehiscence
  - Postop Acute Kidney Injury requiring dialsysis
  - Postop Respiratory failure
  - Postop Sepsis
  - Birth trauma
  - OB Traumatic vaginal delivery with or without instrument

Readmissions/Unplanned Hospital Visits

- AMI
- Pneumonia
- Hip/Knee Replacement
- COPD
- Hip/Knee Replacement
- Unplanned admissions after outpatient chemotherapy
- Congestive Heart Failure (CHF)

2023 Hospital National Patient Safety Goals

The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in health care safety and how to solve them.

Identify patients correctly	
NPSG.01.01.01	Use at least two ways to identify patients. For example, use the patient's name *and* date of birth. This is done to make sure that each patient gets the correct medicine and treatment.
Improve staff communication	
NPSG.02.03.01	Get important test results to the right staff person on time.
Use medicines safely	
NPSG.03.04.01	Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.
NPSG.03.05.01	Take extra care with patients who take medicines to thin their blood.
NPSG.03.06.01	Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Give the patient written information about the medicines they need to take. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.
Use alarms safely	
NPSG.06.01.01	Make improvements to ensure that alarms on medical equipment are heard and responded to on time.
Prevent infection	
NPSG.07.01.01	Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.
Identify patient safety risks	
NPSG.15.01.01	Reduce the risk for suicide.
Prevent mistakes in surgery	
UP.01.01.01	Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.
UP.01.02.01	Mark the correct place on the patient's body where the surgery is to be done.
UP.01.03.01	Pause before the surgery to make sure that a mistake is not being made.

The Joint Commission

This is an easy-to-read document. It has been created for the public. The exact language of the goals can be found at www.jointcommission.org.

Clinical Alarm Safety

Ensure that alarms on medical equipment are heard and responded by clinical staff trained to address alarm issues.
High-risk alarms at MNH have been identified as:

- Cardiac/Telemetry monitors
- Fetal monitors
- Intracranial Pressure monitors
- Ventilators

All clinical alarm signals on medical systems must be "ON" when this equipment is used on a patient.
Be aware and know:

- The most important alarms and alarm signals in your department and how to manage them
- Clinically appropriate settings for alarms
- Surveyors will observe your response to clinical alarms and call lights
- Refer to MNH policy "Clinical (Critical) Alarm Management".

Restraint Use

Restraint and seclusion are only used to facilitate medical healing and to protect the immediate physical safety of the patient, staff, and others. Restraint and seclusion is used to prevent the patient from causing harm to him/herself or someone else, and should be released at the earliest possible time.

Restraint and seclusion are utilized only after appropriate alternative measures have been deemed unsuccessful, and the use of less intrusive measures poses a greater risk than the risk of using a restraint or seclusion. When restraint(s) are used, the least restrictive method that will protect the physical safety of the patient or others will be selected.

In an emergency situation, when care is compromised and less restrictive methods have failed, an RN may initiate restraint and seclusion. In the ED and Inpatient units, an LIP may order restraints and seclusion. A Face to Face is completed by the LIP within 1 hour of placing the patient in restraint(s). This may be documented by the RN.

MD Order

- Non-Violent/Non Self-Destructive Restraint: Ordered every 24 hours
- Violent/Self-Destructive restraint or seclusion: 17yo and above every 2 hours

Restraint and seclusion is discontinued when the RN or LIP/psychiatrist assesses that the behavior or condition, that was the basis for the order is resolved, even if less than the time limits set by the order and document discontinue in flowsheets. If the same behavior becomes evident again, a new order must be obtained.

Suicide and Risk Reduction in the Affected Population

Suicide is death caused by self-directed injurious behavior with any intent to die as a result of the behavior. All patients are screened for depression and suicide risk on admission. Patients at risk for suicide may include, but arenot limited to:

- Patients with a plan, act or preparation towards making a suicide attempt, but before potential for harm has begun
- Previous suicide attempt(s)
- Current stressors: recent loss of loved ones or property, financial difficulties
- Maladaptive substance use
- Highly impulse behavior
- Grossly disorganized mental status
- Pain, recently diagnosed/existing terminal/severe illness

Depression & Suicide Screenings are completed on admission. Clinical interventions will be instituted to alleviate imminent risk of self-harm for patients identified as at risk. This may include but is not limited to: Constant 1:1 observation and medication as needed. Suicide prevention interventions are incorporated into the plan of care or treatment plan. An environmental ligature risk assessment is completed prior to a patient being assigned to or placed in the room.

Ligature Risk

As of March 2017, the Joint Commission has placed added emphasis on the assessment of ligature, suicide and self-harm observations in psychiatric hospitals and inpatient psychiatric patient areas in general hospitals. In the Behavioral Health Setting (BHU and Psychiatric ED Area), all effort must can be geared towards making these environment ligature proof. Environment of Care 02.06.01 The hospital establishes and maintains a safe, functional environment. EP 1: Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided. BHU and Psychiatric ED Area must be ligature resistant in patient rooms, patient bathrooms, corridors, and common patient care areas. Nursing stations with an unobstructed view (so that a patient's attempt at self-harm at the nursing station would be easily seen and interrupted) and areas behind self-closing/self-locking doors do not need to be ligature resistant.

That said, the following must be performed in the BHU and Psychiatric ED Area:

- Ligature risk identified and addressed.
- Ligature resistant product must only be used in BHU and Psychiatric ED Area.
- If a risk is identified and cannot be removed, plans must be in place to mitigate the identified risk.
- Staffing patterns to support the mitigation plan (e.g. suicide risk patients place on constant monitoring outside of BHU and ED Psychiatric Area).
- Staff competencies on ligature identification and mitigation.

VII. INFECTION PREVENTION and CONTROL

HAND HYGIENE

Hand hygiene is the single most important procedure for preventing infections.

The **5 Moments for Hand Hygiene** (HH) defines key moments when health-care workers should perform hand hygiene. This evidence-based, field-tested, user-centered approach is designed to be easy to learn, logical and applicable in a wide range of settings.

  - BEFORE touching patients
  - BEFORE clean/aseptic procedures
  - AFTER body fluid exposure
  - AFTER touching any patient
  - AFTER touching patient surroundings
- **HH with soap and water** is indicated when hands are visibly dirty or are visibly soiled with blood or other body fluids (with or without glove use). **Scrub time of 15-20 seconds with soap.**
- **HH with soap and water** is indicated before eating and after using the bathroom.
- **HH with waterless sanitizer** (alcohol-based hand rub) can be utilized routinely for decontaminating hands if not visibly soiled.
- When C. difficile is suspected or confirmed, wash hands with soap and water after contact with patients or their specimens. **Do not use alcohol-based sanitizers.**
- **Wearing gloves is not a substitute for hand hygiene.** Hand hygiene should be performed prior to and after removing gloves
- **Nail length** ¼ inch or shorter, No artificial nails or tips; nail polish permitted without chips or raised design/ jewels. Additional Information: https://www.who.int/gpsc/5may/Hand_Hygiene_Why_How_and_When_Brochure.pdf

STANDARD PRECAUTIONS

Standard Precautions are used for all patients to protect healthcare providers from infection and prevent the spread of infection from patient to patient. In addition to performing Hand Hygiene, Standard Precautions includes the use of personal protective equipment (PPE) whenever there is an expectation of infectious material, following hygiene/

cough etiquette, disinfecting patient care equipment between patients, following safe injection practices; (including safe handling of needles/ sharps) and following transmission- based precautions when identified. When removing PPE remember the outer surface is contaminated: use great care with PPE not to contaminate yourself.

LOW LEVEL DISINFECTION USING HOSPITAL APPROVED GERMICIDAL WIPES

Clean, disinfect, and/or sterilize all reusable patient care equipment according to manufacturer's directions, including WOWs. WET time means the product being cleaned must remain wet for the necessary time.

Know the WET time for each product used.

1 MINUTE **WET**
contact time

4 MINUTES **WET**
contact time

TRANSMISSION-BASED PRECAUTIONS

Transmission-based Precautions are used in addition to Standard Precautions for patients who may be infected or colonized with certain infectious agents to prevent infection transmission.

CONTACT PRECAUTIONS

Contact Precautions are intended to prevent transmission of infectious agents that spread through contact such as **MRSA, VRE, CRE, ESBL**.

Healthcare personnel caring for patients on Contact Precautions must:

- Place patient in private room (door may be kept open).
- Adhere to strict hand hygiene on entry & exit and between tasks.
- Wear a gown & gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment.
- Limit the movement/transport of patients from room for essential purposes only.
- Dedicate the use of non-critical patient care equipment to single patient; use disposables when possible.
- Disinfect reusable care equipment between patients.

CONTACT PLUS PRECAUTIONS

Contact Plus Precautions are intended to prevent transmission of infectious agents that spread through contact such as ***Clostridium difficile, Norovirus and Candida Auris***.

Healthcare personnel caring for patients on Contact Plus Precautions must:

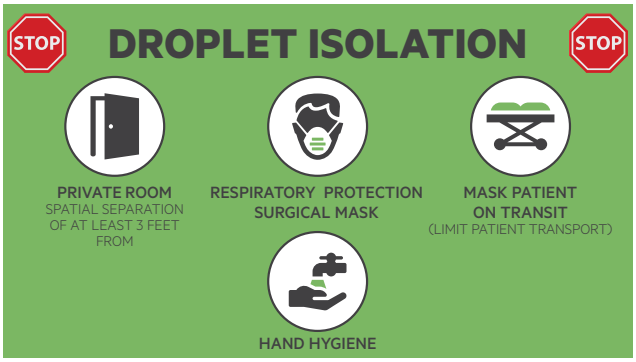
- Place patient in private room (door may be kept open).
- Adhere to strict hand hygiene on entry & hand washing

on exit and between tasks. . Hand washing is necessary after caring for a patient on Special Contact Precautions because alcohol will not remove or kill C. diff spores

- Wear a gown & gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment.
- Limit the movement/transport of patients from room for essential purposes only.
- Dedicate the use of non-critical patient care equipment to single patient, use disposables when possible.
- Disinfect reusable care equipment between patients with bleach wipes.

DROPLET PRECAUTIONS

Droplet Precautions are intended to prevent transmission of infectious agents that spread by respiratory droplets that are generated by a patient coughing, sneezing or talking. Examples include: Influenza, RSV, Pertussis, Diphtheria (pharyngeal), Mumps, Rubella & Meningitis.

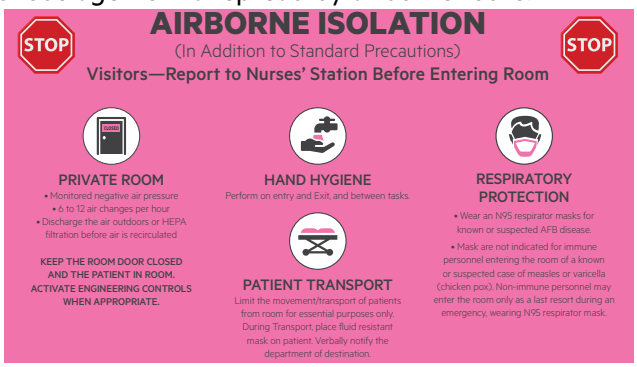


Healthcare personnel caring for patients on Droplet Precautions must:

- Place patient in private room (door may be kept open).
- Patient should wear a mask until private room placement or when patient transported.
- Adhere to strict hand hygiene on entry & exit and between tasks.
- Wear mask upon entering patient room. Additional PPE, as per Standard Precautions may be necessary.
- Limit the movement/transport of patients from room for essential purposes only.

AIRBORNE PRECAUTIONS

Airborne Precautions are intended to prevent transmission of infectious agents that spread by airborne route. Examples include: Tuberculosis, Measles, chickenpox, disseminated herpes zoster.



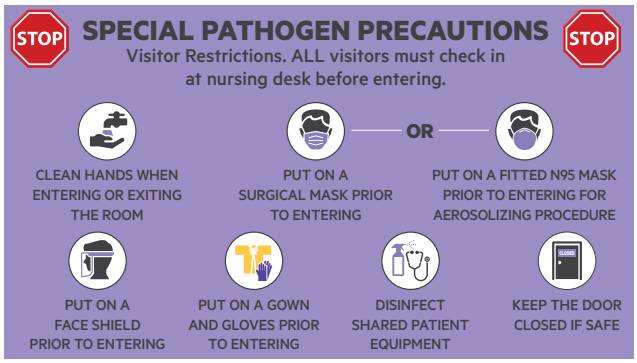
Healthcare personnel caring for patients on Airborne Precautions must:

- Place patient in negative pressure room, door must be kept closed. Notify engineering for daily negative pressure testing.
- Patient should wear a mask (surgical mask) until private room placement or when patient transported.
- Wear N95 respirator mask. Additional PPE, as per Standard Precautions may be necessary.
- Adhere to strict hand hygiene on entry & exit and between tasks.
- Limit the movement/transport of patients from room for essential purposes only.

SPECIAL PATHOGEN PRECAUTIONS

Droplet/Contact Precautions or Airborne/Contact Precautions

(The degree of Isolation Precautions are dependent on use of aerosolized generating procedures = Airborne/Contact Precautions)



Special Pathogen Precautions are intended to prevent transmission of infectious agents that spread by Contact and droplet/ or airborne route. Examples include: COVID-19 and Mpox

Airborne/Contact Isolation Precautions: Place patient in negative pressure room, door must be kept closed (notify engineering for daily negative pressure testing).

- Patient should wear a mask (surgical mask) until private room placement or when patient transported.
- Wear N95 respirator mask when caring for a COVID-19 patient or a "patient under investigation" (PUI). Yearly "fit-testing" for N95 respirator required.
- Adhere to strict hand hygiene on entry & exit and between tasks
- Limit the movement/transport of patients from room for essential purposes only.
- COVID-19 positive patient may co-hort in double patient rooms.
    - **Remember to change gloves and gowns between patient care (including hand hygiene).**

https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

https://www.cdc.gov/poxvirus/monkeypox/clinicians/infection-control-healthcare.html

EVIDENCED BASED PREVENTION STRATEGIES FOR:

- Prevent Central Line-associated Bloodstream Infections (CLABSI): includes insertion and maintenance bundles; daily need assessment.
  https://www.cdc.gov/hai/bsi/bsi.html and https://www.cdc.gov/hai/prevent/tap/clabsi.html
- Prevent Catheter Associated Urinary Tract Infections (CAUTI): includes criteria for insertion; daily need assessment.
  https://www.cdc.gov/hai/ca_uti/uti.html and https://www.cdc.gov/hai/prevent/tap/cauti.html
- Prevent Surgical Site Infections(SSI): includes pre-op antibiotic management, patient temperature control.
  https://www.cdc.gov/infectioncontrol/guidelines/ssi/index.html

RESPIRATORY ETIQUETTE

- Cover your mouth and nose with a tissue when coughing or sneezing;
- Use in the nearest waste receptacle to dispose of the tissue after use;
- Perform hand hygiene

SAFE INJECTION PRACTICES

The CDC and the New York State Health Department have defined Safe Injection Practice as described below in response to:

- National outbreaks of Hepatitis B virus and Hepatitis C Virus
- Investigation of post-myelography bacterial meningitis cases that concluded face masks were not worn by clinicians during the procedure and droplet transmission of oral pharyngeal flora was likely.
    - All licensed personnel must comply with these standards. This applies to: use of needles, cannula that replace needles, and intravenous delivery systems.

- One needle, one syringe, one time. No reuse of needles or syringes for more than one patient/no reuse to draw up additional medication
- Limit use of multi-dose vials and dedicate them to a single patient whenever possible
- Do not administer medications from a single dose vial or IV bag to multiple patients
- Wear a surgical mask when placing a catheter or injecting material into the spinal canal or subdural space (i.e.: myelograms, lumbar punctures, spinal or epidural anesthesia).

Prior to accessing an injection port "scrub the hub" for at least 5 seconds and allow to air dry unless an alcohol impregnated cap is on hub, then remove and scrub hub between multiple injections and replace with new alcohol impregnated cap when complete.
https://www.jointcommission.org/-/media/tjc/documents/resources/health-services-research/clabsi-toolkit/clabsi_toolkit_tool_3-21_scrub_the_hubpdf.pdf?db=web&hash=79BF0D29BD4AAF13DEC3C3DE5AB90494&hash=79BF0D29BD4AAF13DEC3C3DE5AB90494

See additional information: https://www.cdc.gov/injectionsafety/one-and-only.html

OCCUPATIONAL EXPOSURE TO BLOODBORNE PATHOGENS

(S:\Read_Only\ PoliciesProcedures\Employee Health Services\ Occupational Exposure to Bloodborne Pathogens (PP-MNH-EHS))

OSHA Blood Borne Pathogen Standard, considers the blood and body fluids of all patients potentially infectious without regard to their medical diagnosis (sharps safety; engineering controls; safety device use).

Additional Information: https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1030

FOOD AND DRINK AT WORKSTATIONS

Food and drink are only allowed in designated spaces on clinical care units. OSHA Bloodborne Pathogen Standard prohibits food and drink in areas where contamination is likely. For example, if laboratory specimens are handled in the area in question, the OSHA standard would prohibit food and drinks as contamination might occur. Also, food and drink consumed near medical records may render the record illegible if spillage occurs.

INFECTION PREVENTION KEY POINTS:

- Use Standard Precautions with All Patients
- Hand Hygiene
- Equipment Cleaning between patients
- PPE Use

HIGH LEVEL DISINFECTION/ STERILIZATION / PRE-CLEANING

Patient instruments that require High Level Disinfection (HLD) or Sterilization need to be pre-cleaned at the point of use. Cleaning items as soon as possible helps prevent the formation of biofilm and the drying of blood, tissue, and mucus on the items, which can increase the risk of corrosion and make cleaning even more difficult to perform.

VIII. MEDICATION SAFETY

The Pharmacy Department at MNH is responsible for the Medication Management Plan to support and deploy procedures to ensure a safe and effective medication use process across the enterprise. Refer to MNH Medication Management Use policies for more information.

Medication Formulary

The formulary identifies an appropriate selection of medications, including strength and dosage. These medications are available for prescribing, dispensing and administration. The medication formulary status is designated within the CPOE system. Medications that will be prescribed for outpatient use within the hospital (i.e. the Infusion Center) will follow the same formulary process as inpatient medications. A medication that has not been approved by the Pharmacy & Therapeutics Committee for inclusion in the hospital formulary is not stocked by the Department of Pharmacy but a separate process for reviewing non-formulary medication requests and obtaining the medication from the patient's own supply or from an outside source has been established. Many non-formulary medications can be obtained within 72 hours after an order from an LIP and approval by the Clinical Pharmacy Service. See Medication Furmulary policy.

Medication Reconciliation

The large number of people receiving health care who take multiple medications and the complexity of managing those medications make medication reconciliation an important safety issue. In medication reconciliation, a clinician compares the medications a patient should be using (and is actually using) to the new medications that are ordered for the patient and resolves any discrepancies. Medication reconciliation occurs upon admission, transfer to a different level of care, and discharge. Medication reconciliation consists of:

1. Obtaining information on the medications the patient is currently taking when he or she is admitted to the hospital or is seen in an outpatient setting. This information is documented in a list or other format that is useful to those who manage medications. At Montefiore Nyack Hospital, pharmacy technicians participate in the process of obtaining medication histories as part of the admission medication reconcilliation procedures.
2. Comparing the medication information the patient brought to the hospital with the medications ordered for the patient by the hospital in order to identify and resolve discrepancies. The comparison addresses duplications, omissions, and interactions, and the need to continue current medications. A qualified individual, identified by the hospital, does the comparison. At MNH, physicians and pharmacists are designated as qualified individuals.
3. Providing the patient (or family as needed) with written information on the medications the patient should be taking when he or she is discharged from the hospital or at the end of an outpatient encounter (for example, name, dose, route, frequency, purpose).
4. Explaining the importance of managing medication information to the patient when he or she is discharged from the hospital or at the end of an outpatient encounter.

Look-alike/Sound-alike Medications (LASA)

Medications that are easy to confuse (for example, Look-Alike and Sound-Alike drugs or reagents and chemicals that may be mistaken for medications) are segregated to deliver safe patient care.

- Pharmacy and Therapeutics committee approves a list of LASA medications for both inpatient and outpatient services.
- LASA medication list is reviewed annually by the Department of Pharmacy Services.
- Pharmacy Storage – Medication safety strategies in drug storage areas for LASA medications include labeling bins with caution stickers and segregating LASA medications from each other when feasible.
- Tallman lettering: Methods for differentiating the unique letter characters will be used to identify LASA medications on Computerized Physician Order Entry, pharmacy computer drug selection screens, computer-generated pharmacy labels, shelf labels, automated dispensing cabinet screens, and computer-generated medication administration records (MARs) whenever possible.

Refer to MNH policy on Medications, Look-Alike / Sound-Alike (LASA).

Medication Orders

A pharmacist reviews the appropriateness of all medication orders unless an LIP controls the ordering, preparation, and administration of the medication or when a delay would harm the patient in an urgent situation in accordance with law and regulation. All medications orders are reviewed for various things including allergies, drug interactions, and appropriateness of the medication. An LIP should be entering orders via the CPOE system wherever possible to ensure safety and avoid potential errors that may result from written or pre-printed prescriber order sheets.

The use of telephone/verbal orders should be limited to emergent situations, situations where the LIP does not have access to the CPOE system, or situations where a delay would lead to patient harm. Telephone/verbal orders must be cosigned by the prescriber. During emergent situations, medications may be removed without an order from the automated dispensing cabinet (ADC) under the override function. See policy MNH-PPM-136, "Removal of Medications from the ADC Using The Override Function".

Unapproved abbreviations must be avoided when sending a written order to the Pharmacy. Additionally, orders with dose ranges are not accepted unless they include a dose and frequency specific to a quantified monitoring parameter as the indication.

Examples

Acceptable: Morphine 2 mg IV every 4 hours PRN mild pain
Morphine 4 mg IV every 4 hours PRN moderate pain

Unacceptable: Morphine 2-4 mg IV q 4 hours PRN pain
Acetaminophen 650mg po q6h PRN pain or fever

PRN Orders: All orders are written with a specific dose, frequency, and indication for use. Orders with dose ranges are not accepted unless they include a dose and frequency specific to a quantified monitoring parameter as its indication (e.g. Morphine 2mg IV every 4 hours PRN mild pain; Morphine 4mg IV every 4 hours PRN moderate pain).

High Risk/High Alert Meds

High-risk or high-alert medications are those drugs involved in a high percentage of medication errors and/or sentinel events, and medications that carry a higher risk for abuse, errors, or other adverse outcomes. Refer to MNH policy PP-NH-M105 on "Medications, High Risk and High Alert Medications" in the Medication Use policy folder on the Shared drive.

High Risk Classes/Categories: **"IN CHECC"** Pneumonic

- **I**nsulin
- **N**euromuscular Blocking Agents
- **C**hemotherapy Agents (and Monoclonal Antibodies)
- **H**eparin (Intravenous)
- **E**lectrolytes (concentrated) and Intravenous potassium
- **C**oumadin
- **C**ontrolled Substances

Safeguard strategies include, but are not limited to:

- Standardized order sets and protocols
- Telephone orders and Verbal orders are not permitted unless it is an emergency
- Standardization of drug concentrations
- Segregation of high alert drugs
- "Smart" infusion pumps with programmable safeguard technology
- Staff training & testing for competency
- Independent double checks
- High alert auxiliary labeling and automated alerts
- Use of premixed parenteral solutions
- Elimination of unapproved abbreviations

- Improving access to information about these drugs
- Limiting access to high-alert medications

Pain Management / Assessment / Opioid Therapy

Unresolved pain can result in some of the following negative effects: inadequate sleep, exhaustion, confusion, agitation, increased heart rate, increased risk for blood clots, and a weakened immune system. Any of these effects could delay the healing process and negatively impact the patient's experience. Evidence based scales are used to assist the patient in communicating pain. Patients and families are educated about the scales as well as understanding the importance of pain management and the safe and effective use of medications. Examples include:

- Numeric Pain Intensity Scale (0-10) = Mild 1-3; Moderate 4-6; Severe 7-10
- Baker-Wong Faces Pain Scale (0-10) = Mild 1-3; Moderate 4-6; Severe 7-10
- FLACC Pain Scale (0-10) = Mild 1-3; Moderate 4-6; Severe 7-10
- CRIES Pain Scale (0-10) = Mild 1-3; Moderate 4-6; Severe 7-10
- Critical-Care Observation Tool (CPOT) (0-8) = Mild 1-3; Moderate 4-5; Severe 6-8

Interventions: Pain relief/ management may be pharmacological, non-pharm or combination of both.

- Pharmacological interventions are always ordered by the LIP.
- Whenever possible, pain management should include an around-the-clock, multi-modal approach individualized to the patient.
- A multimodal pain regimen which includes: non-opioids, adjuvant analgesics, opioids, and nonpharmacological interventions are recommended.
- Non-Pharmacological interventions can be implemented by the LIP or RN and do not require an LIP order. They include, but are not restricted to:
  - Application of hot or cold pack
  - Repositioning and/or ambulation
  - Distraction
  - Relaxation techniques (music, breathing, meditation)
  - Environmental modifications (darkened room, reducing noise)
  - Per developmental age (toy, game, parental touch, swaddling)

Pain Assessment and Re-assessment

- The patient is reassessed for pain, relief from pain, level of sedation, and response to treatment at regular intervals and at a minimum of once a shift.
- The frequency of pain reassessment is dictated by the pain assessment, level of sedation intensity of the patient's pain and the effectiveness of pain relief strategies.
- A re-assessment of pain intensity is performed after each pain management intervention (pharmacological and non-pharmacological)
- The post intervention (non-pharmacological or pharmacological) reassessment should be performed according to the intervention; once a sufficient time has elapsed; depend on the treatment modality and time needed for the intervention to reach peak effect.
- Follow hospital policy Pain Management, Assessment and Reassessment for timeliness of reassessment.

Opioid Management

- Monitoring for common side effects which may include over sedation, respiratory depression, nausea/vomiting, pruritus and acute confusion.
- Performing an adequate respiratory rate assessment for a full minute by a registered nurse.
- Pulse Oximetry is useful for assessing changes in oxygenation only • Pulse oximetry is a late indicator of ventilatory depression
- Utilization of the Pasero Opioid-induced Sedation Scale (POSS tool) for inpatient care units. See Appendix B.
- While patients are on opioid therapy, the physician may prescribe medications to control side effects. These medications may include: a stool softener/laxative combination (e.g. Senokot-S) to prevent constipation; an antiemetic [e.g., Ondansetron (Zofran)] for nausea/vomiting and an antihistamine [e.g., diphenhydramine (Benadryl)] for itching. A reversal agent for respiratory depression [e.g., Naloxone HCl (Narcan)] may be ordered for loss of consciousness, respiratory depression or other signs of overmedicating.
- For patients on PCA or epidural utilize orders for side effect management, Refer to MNH policy (PP-NH-NSG-P01).

Anticoagulation Therapy

Anticoagulation therapy can be used as therapeutic treatment for a number of conditions, the most common of which are atrial fibrillation, deep vein thrombosis, pulmonary embolism, and mechanical heart valve implant. However, it is important to note that anticoagulation medications are more likely than others to cause harm due to complex dosing, insufficient monitoring, and inconsistent patient compliance. To achieve better patient outcomes, patient education is a vital component of an anticoagulation therapy program. Effective anticoagulation patient education includes face-to-face interaction with a trained professional who works closely with patients to be sure that they understand the risks involved with anticoagulation therapy, the precautions they need to take, and possibly the need for regular International Normalized Ratio (INR) monitoring. The use of standardized practices for anticoagulation therapy that include patient involvement can reduce the risk of adverse drug events associated with heparins, thrombin inhibitors, factor Xa inhibitors, and warfarin. Refer to MNH policy NH-PP-A113“on Medication, Anticoagulation Management” in the Medication Use folder on Shared Drive.

Antimicrobial Stewardship

The purpose of the antimicrobial stewardship program is to ensure safe, effective, and appropriate use of antimicrobial agents, the results of which shall be monitored and reported to the Antimicrobial Stewardship (AMS) committee and Clinical Support Committee. The infectious disease pharmacist serves as the champion of the AMS Leadership Team, working with physician and infectious disease champions. This team coordinates educational initiatives for staff on antibiotic use as well as improving communication for symptoms and diagnostic testing. This team also assists pharmacists, prescribers, and nurses, in developing antibiotic use policies that ensure the appropriateness (drug, dose and duration of therapy) of any new antimicrobial agent ordered. When culture results become available, actions are taken to continue antibiotics, switch antibiotics, or discontinue antibiotics. MNH has implemented a bacteremia protocol to ensure timely administration of antibiotics for positive blood culture. MNH is committed to creating a culture, through education, and celebrating improvement, which promotes antimicrobial stewardship within the facility. Refer to policy “Medications, Antimicrobial Stewardship” NH-PP-M113.

Hazardous Medication Waste and Safe Handling

USP General Chapter 800 and OSHA’s Hazard Communication standard provide guidelines for the safe handling of hazardous medications. The National Institute for Occupational Safety and Health (NIOSH) maintains the list of medications deemed hazardous.

Hazardous medications, such as antineoplastic cytotoxic medications, seizure medications, anti-viral medications, and others may be:

- Genotoxicity- A chemical or agent that damages cellular DNA, resulting in mutations or cancer;
- Carcinogenicity- A cancer-causing substance or agent;
- Teratogenicity- Of, relating to, or causing malformations of an embryo or fetus or fertility impairment, or; serious organ or other toxic manifestation at low doses in experimental animals or treated patients.

MNH is committed to compliance of safe practice guidelines to prevent exposures and avoid adverse health effects.

For the most updated list of hazardous medications, refer to https://www.cdc.gov/niosh/docs/2016-161/default.html
For safe handling and disposal of hazardous medications, refer to the "Policy for Disposal of Hazardous Medications" in the Hazardous Materials folder on the Shared drive. A list of hazardous medications used at Montefiore Nyack Hospital is available on the Shared Drive at Shared Drive: Read Only: PoliciesProcedures: MedicationUsePolicies: USP 800: USP 800 Facility Med List. This list is updated at least annually.
As required by USP 800, the Safety Data Sheet (SDS) is available for each hazardous medication used at Montefiore Nyack Hospital. SDSs' are available at 1-800-451-8346 or at www.3eonline.com click on "3E Protect".

Automated Medication Dispensing Cabinets (ADC)
MNH uses Automated Medication Dispensing Cabinets (ADC) as the hospital automated medication dispensing system supporting decentralized medication management. The ADC helps clinicians safely and efficiently dispense medications to improve patient care and reduce potential adverse drug events.

IX. BLOOD ADMINISTRATION

Administration of blood components requires a physician/licensed independent practitioner order. Informed Consent is obtained by the LIP prior to administration of blood or blood components to the patient. Outpatient informed consent is valid for 30 days; Inpatient informed consent is valid for the duration of the current hospital admission. Pt may choose not to consent to the transfusion of blood/blood components. Refer to MNH policy on Administration of Blood/Blood Components PP-NH-B103 for indications for use.

Timeframes for Transfusion are noted:

a. Routine Request: The transfusion will be available within 4 hours of the receipt of the physician blood order in the Blood Bank.
b. STAT Request: Blood product will be available within 30 minutes.
c. Emergency Request: Uncross-matched blood will be released for the transfusion. LIP will sign Emergency Blood Request Form supplied by the Blood Bank.

Patients are assessed prior to transfusion for any pre-transfusion symptoms which could be confused with a transfusion reaction. If the patient has a temperature >100°F, the physician is notified before the transfusion is initiated and documented in the patient medical record. LIP approval is required for transfusing the patient with an elevated temperature. Physicians may choose to pre-medicate the patient with prophylactic medication (e.g., antihistamines, acetaminophen), if needed as per previous history of transfusion reaction. Blood is administered on a pump using special filter tubing from the Blood Bank.

Transfusions are started slowly while remaining with the patient for the first 15 minutes to observe for any transfusion reaction. If no transfusion reaction is noted, the infusion rate is regulated to the physician/licensed independent practitioner order. If a transfusion reaction occurs, the RN notifies the physician/LIP and the Blood Bank; both are notified immediately.

Note: If the patient has a newly elevated temperature, a telephone order to continue the transfusion is not accepted until the patient is examined by a physician/licensed independent practitioner.

Blood is administered on a pump within 4 hours from the time it is spiked/hung. Blood that has hung more than 4 hours is discarded and the physician is notified. Positive pressure is never applied when administering blood, except with a physician/licensed independent practitioner order. If a transfusion reaction occurs, the RN notifies the physician/LIP and the Blood Bank are notified immediately. Note: If the patient has a newly elevated temperature, a telephone order to continue the transfusion is not accepted until the patient is examined by a physician/licensed independent practitioner. Use of NovoSeven concentrate for any OFF LABEL use must be approved by Hematology or Transfusion Service Physician

X. APPENDICES

Appendix A – Human Resources Policies:

HR ATTACHMENT – 1: Employee Dress Code

HR ATTACHMENT – 2: Photo Identification Badge

HR ATTACHMENT - 3: Electronic Communications

HR ATTACHMENT - 4: Mandatory Education & Training – Annual

HR ATTACHMENT – 5: Code of Conduct – Disruptive Behavior

HR ATTACHMENT – 6: Discrimination Harassment/Sexual Harassment

HR ATTACHMENT – 7: Licenses

Status Active PolicyStat ID 11500399

Montefiore Nyack

Origination	07/2018
Last Approved	07/2021
Effective	07/2021
Last Revised	07/2018
Next Review	06/2024

Contact Linda Taff: Executive Assistant

Dress Code, Employee

POLICY:

Employees will dress in a manner that will communicate competence and promote a positive and professional image of the hospital at all times. Workplace attire and grooming must be neat, clean and appropriate for the work being performed and the setting in which the work is performed.

PURPOSE:

To have Montefiore Nyack Hospital employees dress in a manner that will enhance employee self-esteem, patient confidence, patient satisfaction and the public image and perception of Montefiore Nyack Hospital and its workforce. Employees contribute to the corporate culture and reputation of Montefiore Nyack Hospital in the way they present themselves. A professional appearance is essential to a favorable impression with customers, patients and the community.

PROCEDURES:

Staff is expected to present a professional, businesslike image to clients, visitors, customers and the public at all times. Acceptable personal and professional appearance is an ongoing requirement of employment with Montefiore Nyack Hospital.

Certain staff may be required to meet special dress, grooming and hygiene standards, such as wearing uniforms or protective clothing, depending on the nature of their job.

Natural and artificial scents may become a distraction from a well-functioning workplace, and are also a serious issue for patients with allergies. If a staff member's poor hygiene or use of too much perfume/ cologne is an issue, the supervisor should discuss the problem with the staff member in private and should point out the specific areas to be corrected.

During unusually hot or cold weather, employees are still expected to present a neat appearance and are not permitted to wear ripped, frayed or disheveled clothing, athletic wear, tight, revealing or otherwise inappropriate clothing.

Any staff member who does not meet the attire or grooming standards set by Montefiore Nyack Hospital Policy will be subject to corrective action such as having to leave the premises to change clothing. Employees will not be compensated for any work time missed because of failure to comply with designated workplace standards.

All staff must wear Montefiore Nyack Hospital's identification badge with photo displayed at all times.

While we respect our employees' rights to unique expression and body art, visible tattoos are not part of the Hospital's overall professional appearance. If hired with visible tattoos, employees will be required to cover them as much as possible unless covering creates a safety or infection control issue. Such exemptions must be approved by the Vice President, Human Resources.

No visible body or tongue piercings are allowed other than a maximum of two earrings per earlobe. Earrings must be professional in appearance.

Montefiore Nyack Hospital recognizes the importance of individually-held religious beliefs to persons within its workforce. Nyack Hospital will reasonably accommodate a staff member's religious beliefs in terms of workplace attire unless the accommodation creates an undue hardship on the Hospital. Such exemptions must be approved by the Vice President, Human Resources.

Business Attire:

All employees are expected to wear proper business attire; in a clean, neat and presentable manner that is appropriate in a hospital setting. The following guidelines apply to business attire:

Appropriate Examples: Khakis or corduroys, polo collar knit or golf shirts, short-sleeve blouses or shirts, shirts, turtlenecks, blazers or sport coats, jackets or sweaters and professional looking shoes.

Inappropriate Examples: Jeans, casual capri pants, exercise wear, novelty clothing and clothing that is worn out, faded or torn, sweatpants, leggings, t-shirts or sweatshirts, shorts, low rise pants, sandals, flip flops, tight and/or low cut clothing, visible shoulders or strapless outfits, hats and baseball caps.

Employees who are issued uniforms are to wear the designated uniform on duty as required. New employees must follow the dress code above until their complete uniform is available. Hospital scrubs are to be worn only in the areas that require them. Cover coats are to be worn over scrubs, as per CDC & NACOG regulations, when outside of their designated area (Operating Room staff is not required to wear cover coats when leaving the area). In patient-care areas, no logos, buttons, stickers or advertisements may be worn or displayed.

COMPLIANCE:

Department Managers are responsible for enforcing the Dress Code for all employees working within their department.

Non-compliant employees will be subject to the standard disciplinary process as per Montefiore Nyack Hospital policy. Departments may determine appropriate workplace attire and grooming for their area. Supervisors should communicate their department's workplace attire and grooming guidelines to staff during the orientation and evaluation period. Any questions about the department's guidelines for attire should be discussed with the immediate supervisor or Human Resources. Montefiore Nyack Hospital is confident each employee will use his/her best judgment in following this policy. Department Managers who are negligent or complacent in enforcing the dress code will be subject to disciplinary action.

All Revision Dates

07/2018

Approval Signatures

Step Description	Approver	Date

HR ATTACHMENT: 2

Status **Active** PolicyStat ID **11500094**

Montefiore Nyack

Origination	11/2021
Last Approved	06/2022
Effective	11/2021
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Next Review	10/2024

Contact: Linda Taff: Executive Assistant

Identification Badge, Photo

PURPOSE

Montefiore Nyack Hospital endeavors to provide a safe and secure environment for employees, patients, physicians, volunteers and visitors. All personnel while on Hospital property are required to wear photo identification badges.

PROCEDURE

I. At the start of employment, an employee will receive a color photo identification badge (ID) which should be worn with the photo facing forward and unobstructed by any items such as stickers, pins, etc. This badge serves two purposes, to identify Hospital personnel and to use in recording time worked.

1. Human Resources will authorize the issuance of an identification badge for all new employees
and for any employee who legally changes their name, or who completes a Preferred Name Form
in which the employee acknowledges that they prefer to use a name on their badge that aligns
with their gender identity rather than their given name.

II. The Security Department, in conjunction with the Human Resources Department, will issue photo identification badges to all employees, physicians, volunteers, contracted workers and Board members, as well as others deemed appropriate by Human Resources. Vendors will register with Vendormate utilizing the kiosk outside the Security Office on the ground floor. No person can enter the facility or work without an ID badge.

a. ID badges will be required to gain access to the Hospital and control movement within the Hospital.

b. ID badges will be required for access and identification during activation of the

Hospital's Disaster Plan.

III. An employee's ID badge is also used in conjunction with the Hospital's Time and Attendance System for timekeeping purposes. The information captured in the system is used for payroll purposes to generate an employee's paycheck. Depending upon the employee's job classification, exempt or non-exempt, the employee is required to swipe in, or in and out, daily at a time clock to record hours worked. Every employee of the Hospital will be enrolled in the Hospital's system and is required to swipe in daily.

IV. Any incidents of lost or stolen photo identification badges must be reported immediately to the Security Department. If a photo identification badge is damaged due to the normal performance of work or in cases of employee promotion or transfers to another department, the badge will be replaced by the Hospital at no charge to the employee, physician, volunteer, contractor, Board member or vendor.

V. Any employee terminating employment with the Hospital will be required to surrender the photo identification badge to the Department Manager at the completion of the employee's final day of employment. Department Managers will be required to ensure that employees submit their ID badges upon separation from the Hospital. The Manager will then forward the ID badge and the Terminating Access Form to the Human Resources Department who will forward the information on the termination to Security, Information Technology, Payroll and Health Information Services (if applicable).

VI. ID badges will be checked each day by Security and must be worn at all times while at the Hospital. The photo identification badges will, at all times, remain the property of Montefiore Nyack Hospital.

All Revision Dates

06/2022, 11/2021

Attachments

MNH_Preferred Name Form_Jun 2022.pdf

Approval Signatures

Step Description	Approver	Date

Montefiore | Nyack

PREFERRED NAME FORM

Requesting approval for my ID Badge to reflect my Preferred Name to be used in alignment with my gender identity.

EFFECTIVE DATE: _____ EEID #: _____

LEGAL NAME: _____

PREFERRED NAME: _____

DEPARTMENT: _____

TITLE: _____

EMPLOYEE SIGNATURE: _____

I understand this form will be maintained as part of my personnel file.

If I currently have or in the future obtain a professional license, I acknowledge that NYS Department of Education regulations require that an identification badge display a person's legal name as it appears on their license. In making this request for a preferred name on my identification badge, I solely assume all risks of enforcement actions by the Department of Education for any violation of NYS DOE regulations.

HR is authorizing the use of your Preferred Name on your Montefiore Nyack Hospital ID badge. If you legally change your name, you must complete the 'Employee Change Form' and provide required documentation in order for Montefiore Nyack Hospital to update its records.

_____	_____	_____
HR Authorization (Printed)	HR Authorization/Signature	Date

NOTE: This form should be maintained as part of the personnel file. If legal change of name documentation is provided, that form will supersede this form.

June 2022

Status Active PolicyStat ID 11499737

Montefiore Nyack

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Contact Linda Taff: Executive Assistant

Electronic Communications

PURPOSE

Montefiore Nyack Hospital supports a positive workplace environment that promotes optimum patient outcomes and prevents, decreases or eliminates actions that (a) negatively impact the operation of the Hospital, departments or units, (b) affects individuals in their ability to do their jobs, (c) interferes, disrupts or distracts an employee's ability to practice competently. The purpose of this policy is to establish guidelines and ensure that Hospital electronic communication resources are used for purposes appropriate to a patient care environment.

POLICY

Hospital equipment (including but not limited to computers, telephones, voicemail, fax machines and other means of electronic and telephonic communications) and the information stored in such systems, are the property of the Hospital and are to be used responsibly for business purposes. The Hospital may access electronic communications or any other computer files with or without notice to users. **Employees shall have no expectation of privacy with regard to their use of such equipment.** This policy applies to use of such systems both during and outside of working hours and on and off the Hospital's premises.

The Hospital's electronic systems may not be used to transmit confidential patient or Hospital information; to gamble; or to set up or run a personal business. The Hospital's policy prohibiting harassment applies to the use of electronic communications systems. No one may use electronic communications in a manner to be construed by others as harassment or offensive based on race, national origin, sex, sexual orientation, age, disability, religious beliefs or any other protected class according to federal, state or local law.

Unauthorized duplication of copyrighted computer software violates the law and is strictly prohibited. No one may access, or attempt to access, another's individual electronic communications, such as an e-mail

account, without appropriate authorization.

Telephone Calls and Electronic Devices - - Personal phone calls, including but not limited to the use of cell phones, are prohibited during work hours, except in cases of an emergency. Employees should discourage family, friends, and other non-employees from using the Hospital's communication systems for contacting them while at work except in cases of emergency. Use of electronic devices (iPhones, iPods, Mp3 Players and other portable devices) during working hours is not permitted. Only pocket pagers/beepers/cell phones or any other electronic equipment authorized by a Supervisor/Department Manager for Hospital business may be authorized for use on Hospital premises during an employee's working time..

Photographs and Electronic Devices - - Due to patient privacy and confidentiality and other related concerns, employees may not take photographs, digitally or otherwise, using any camera or other device (e.g., cell phone, tablet, personal digital assistant, etc.) anywhere inside the Hospital, unless authorized previously in writing.

This policy does not prohibit any lawful taping or recording engaged in by an employee on his or her own time, with his or her own equipment, away from the Hospital's place of business and which does not involve in any manner whatsoever, directly or indirectly, the business or activities of the Hospital, or any of its patients or of its employees.

Any violation of this policy may result in corrective action, up to and including termination of employment.

All Revision Dates

07/2021

Approval Signatures

Step Description	Approver	Date

Status Active PolicyStat ID 12560218

Montefiore Nyack

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Effective	02/2023
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Contact Linda Taff: Executive Assistant

Mandatory Education and Training

I. POLICY:

Montefiore Nyack Hospital (MNH) is dedicated to promoting a culture of safety by providing education and training to support best practices, and quality patient care services. MNH ensures that all employees and contracted individuals / entities are in compliance with receiving education and training required by regulatory agencies and accrediting organizations.

II. PURPOSE:

To outline the mandatory education and training requirements for all MNH employees, Agency staff, Contractors, Vendors, Students, Medical Staff, and Volunteers at MNH.

III. SCOPE:

All MNH employees, new hires, agency staff, contractors, vendors, allied health students, medical staff, and volunteers are required to comply with Annual Mandatory Education.

IV. EDUCATION AND TRAINING:

A. Mandatory Educational Requirements:

1. **New Hire** - All hospital employees, Agency, Contractors, Vendors, Medical staff, Students, and Volunteers must complete mandatory orientation education training upon hire as part of safe onboarding practice.
2. **Annual Mandatory Training** - All hospital employees, Agency staff, Contractors, Vendors, Medical Staff, Students/Instructors, and Volunteers must complete Annual Mandatory Education. Training methods may include:

a. **Online** - For hospital employees, MNH provides annual online courses through HealthStream, the hospital Learning Management System (LMS). Employees will be assigned specific annual online training modules that are to be completed by the specified due date and will serve as part of their education/training transcript portfolio. See Appendix Table 1. Mandatory Education and Training Crosswalk.

b. Annual Training and Orientation Manual – Agency staff, Contractors, Vendors, Medical Staff, Students/Instructors, and Volunteers receive a copy of the Annual Training and Orientation Manual that contains essential/regulatory education to be completed: prior to affiliation; as a new hire; and annually thereafter.

c. **Performance-Based Competency Assessment** - The Joint Commission defines competency as a combination of observable and measurable knowledge, skills, abilities, and personal attributes that constitute an employee's performance in order to deliver safe, quality care. Performance-based competency assessments are specific to the employee's role, unit, and job description. Mandatory competency-based assessment programs are offered for clinical and clinical support staff in an effort to provide safe and effective patient care at MNH including:

    - Disease Specific Joint Program - Training at defined intervals.
    - Department of Nursing - Staff attend mandatory Annual Skills Fair for RN's, Patient Care Associates (PCA), Patient Safety Attendants (PSA), TeleSitters, and OR/OB Technicians.

d. **Certifications** – Clinical and clinical support at MNH staff are also required to obtain advanced certifications (such as BLS, ACLS, PALS, NRP, TNCC, CPI, etc.) based on their role, staff responsibilities, and job descriptions. Certifications are offered through the Montefiore American Heart Association (AHA) Training Center. See American Heart Association Training Requirement and Certification policy PP-MNH-CLD-01 for additional information.

e. **Department Specific Training** – Specific departments have additional mandatory annual training requirements based on regulatory requirements (i.e. The Joint Commission, Centers for Medicare and Medicaid Services, Department of Health, Office of Civil Rights, etc.) and/ or job description. These additional educational requirements for staff include the Trauma Program, Joint Center Program, Stroke Program; and may include other department specific training as deemed necessary. See Table 1 below for additional information.

f. **Seminar/ In-Services** – Seminar/In-Service training includes continuing education programs, or clinically relevant conferences which are offered to a live audience, and may include contact hours (CEU, CE's).

    - Employees who are required to attend Seminars/ In-services during working hours are compensated for their training time.
    - If a non-exempt employee attends a mandatory in-service after regularly scheduled work hours, they will be paid.
    - Exempt employees do not receive additional compensation for seminar education, but may take the day as PTO or TRN with Manager/Director approval.

3. **Education Crosswalk –** It is the responsibility of all clinical staff at MNH to be familiar with the scope and standards of professional practice. Licensed professionals are responsible for ensuring they meet the competencies, knowledge, and practice standards in their respective discipline, service line, and/or specialty areas. See Appendix Table 1 for the MNH Mandatory Education and Training Crosswalk.

B. Mandatory Education Compliance/Documentation:

1. **Compliance** - Department Manager/Director are responsible to ensure 100% compliance by all employees and contracted staff to complete required mandatory annual training, skills, certifications, or unit/department specific training.
2. **Certificates** - Certificates of completion, eCards and/or education transcripts are submitted to Human Resources Department.
3. **Education Portfolio** - A completed education portfolio includes documentation of the following: the employees' relevant annual skill competencies; mandatory annual education; job specific AHA certification training (if applicable); department specific training/seminars; and the staff member's annual performance evaluation.
    - For MNH Employees - This completed education portfolio record is submitted to Human Resources Department and maintained in the employee's personnel file.
    - For Contracted staff – This completed education portfolio record is maintained by the Department Manager/Director in staff files on the respective units/departments.
4. **Non-Compliance Annual Training** - Any MNH employee or Contracted staff who has NOT completed annual mandatory required education (online modules, performance-based competencies, or unit specific certifications) by the **specified due date** will be put "off duty" and not permitted to work. Annual Mandatory Education and unit specific training/ certifications are offered throughout the year and are a condition of employment at MNH.
5. **Grace Period** - If a specific certification becomes a requirement for a particular position **after** the employee has been working on a designated unit, the employee shall be given a reasonable time frame to obtain such credentials (90 days). The grace period will be in effect as long as the granting of such does NOT place the hospital or the individual in violation of applicable laws, national or state boards, or other regulatory agencies. The grace period for compliance will be evaluated regularly by unit/department manager.

V. CROSS REFERENCE

This policy replaces the HR SEC II M 1/2019 policy American Heart Association Training Requirement

American Heart Association Training and Requirments for Certification

Stroke Center: Educational and Certification: Policy requirements for stroke team members

Vendor Credentialing and Access

VI. REFERENCES

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VII. APPENDIX:

Table 1. Mandatory Education and Training Crosswalk.

Appendix Table 1. MANDATORY EDUCATION & TRAINING CROSSWALK

Onboarding New Employees/Non-Employees	Description / Target Audience	Contact	Training Cycle
Orientation: MNH New Employees (Day1) • MNH Mission, Vision, Core Values • Policies & Procedures • Corporate Compliance • HIPAA • Risk Management • Infection Prevention • Environment Cleanliness & Safety • Service Excellence • Quality/ Performance Improvement	Essential onboarding training for Montefiore Nyack Hospital employees or Contractors. Attendance is required for all new employees.	Human Resources Department at 845.348.2155	Upon Hire
• Security, Codes, & Emergency Preparedness	Target Audience: All new hires to MNH.		
• Cultural Diversity & Pastoral Care • Employee Benefits • Employee Assistance Program (EAP) • Fall Prevention & Body Mechanics			

• WE CARE Standards • Payroll/ API			
Orientation: Department of Nursing	**RN , PCA , PSA** Clinical and Clinical Support staff attend nursing orientation which consists of classroom didactic education, computer based-training, and unit specific orientation depending on his/her job description.	Center for Learning Development (CLD) **at 845.348.7617**	Upon Hire
Orientation: Department Specific	Specific to the department and according to job title and responsibilities	Department Specific Hiring Manager	Upon Hire
Orientation: Non-Empioyees • Organizational Review • Compliance/ HIPAA/Risk Management • Code of Conduct	New hire education includes mandatory regulatory education information that includes new hire hospital orientation, and essential regulatory compliance trainings completed via the Annual Training & Orientation Manual distributed to staff, or is accessible online in MNH Shared Drive	Department Specific Hiring Manager	Upon Hire
• Compliance/ HIPAA/ Security/ Documentation • Life Safety/ Emergency Response • Work Place Safety • Patient Safety and Rights			

• Quality and Performance Improvement	*Completed by Clinical Staff one time only		
• Infection Prevention and Control • Behavioral Health/ Safety Restraints/ Ligature			
• Medication Safety*	Target Audience: All Agency RN's , Vendors, Contractors, Medical Staff, Students, and Affiliates.		
• Clinical Care Station * • Order Management* • Medication Administration*			
Annual Mandatory Education - Employees	**Description / Target Audience**	**Contact**	**Training Cycle**
Healthstream (LMS) includes online learning modules: • Code of Conduct • Compliance/ HIPAA/ Security/ Documentation • Life Safety/ Emergency Response	Annual mandatory regulatory education. Training is completed online via the hospital Learning Management System for TJC, DOH, CMS, etc.	Healthstream Administrator at **845.348.2730**	Annually
• Work Place Safety	*Completed by Clinical Staff only		

• Patient Safety and Rights • Quality and Performance Improvement			
• Infection Prevention	Target Audience: All MNH employees		
• Behavioral Health/ Safety Restraints/ Ligature • Medication Safety*			
Annual Mandatory Education - Non Employees	**Description/ Target Audience**	**Contact**	**Training Cycle**
• Code of Conduct • Compliance/ HIPAA/ Security/ Documentation • Life Safety/ Emergency Response • Work Place Safety • Patient Safety and Rights • Quality and Performance Improvement	Annual mandatory regulatory education. Training is completed via Annual Mandatory Education Manual on TJC, DOH, and CMS. Manual is distributed to staff or accessible online in MNH Shared Drive	Department Specific Hiring Manager	Annually
• Infection Prevention	*Completed by Clinical Staff only		
• Behavioral Health/ Safety Restraints/	Target Audience: Non Employees such as All Agency RN's, Vendors, Contractors, Medical Staff,		

Ligature	Students, and Affiliates		
• Medication Safety*			
Performance-Based Competency Assessment	**Description/ Target Audience**	**Contact**	**Training Cycle**
Skills Fair &/or Unit-Based Competency Assessments: • Restraints • Ligature Risk Assessment • Safe Patient Handling • Point of Care • Others*	Performance-Based Competency Assessment skills include: low volume-high risk, new equipment, problem/prone areas, new regulatory requirements in an effort to provide safe effective patient care. Targeted education and skills are specific to employee job title, job description, and pt care area.	CLD at 845.348.2617	New Hire, & Annually * Other skills every 3 years or more often based on QI data & safety events.
• Disease Specific Joint Program (see below)	Target Audience: Clinical and clinical support staff in the Department of Nursing including RN, PCA, PSA and Techs.		
Unit Department Specific Training	**Description/ Target Audience**	**Contact**	**Training Cycle**
Annual Stroke Education	8 hour CME/ CEU credits in the first year, with 8 credits annually in subsequent years Mandatory for ED and critical care staff. New hires have up to three (3) months to meet the educational requirements. If a new stroke team member was previously at another designated stroke center and met the requirements in the last	**MNH** Stoke Coordinator at 845.348.7622	Annually

	year at the other facility, this will meet the requirement. For support staff other than Stroke Team members, i.e. Occupational Therapy, Physical Therapy, Speech Therapy and Registered Nurses from other units, the requirement is for biannual in- service training related to the care of the patient with cerebrovascular disease		
Trauma Education	Programs in continuing education provided by trauma experts for trauma center staff, community nurses, physicians, and allied health personnel. ED and SICU RN staff complete Trauma Nurse Core Course Certification every 4 years. Target Audience: Designated Trauma Units including ED and SICU staff	MNH Trauma Program Manager 845.348-2854	Annually TNCC every 4 years
Total Joint Center: Disease Specific Program Education*	Joint specific educational training requirements are to be met by TJC Team members (other than the TJC Director) by the last day of the calendar year. • Joint eLearning modules on Healthstream and video • TJC Performance Checklist- Skills	MNH Joint Center Care Manager at **845.348.2580**	Annually

	Fair/ Performance-based Competency Assessment checklist **Target Audience:** Physicians/ Licensed Independent Practitioners; Navigator, Registered Nurses, Patient Care Associates, Pharmacists, Physical Therapist, Occupational Therapists who care for joint patients in the Total Joint Center that include the following areas: Pre-Admission Testing, Same Day Surgery, Intra-operative Area, PACU, and 5D Unit.		
Unit/Department Specific Training	Specific training to meet new regulatory requirements, new equipment, and/or best practice guideline recommendations.	Department Specific Unit Manager	As Needed
AHA Certifications	**Description / Target Audience**	**Contact**	**Training Cycle/ Renewal**
AHA Basic Life Support - Heart Code	Clinical and support staff including: *Physicians; Physician Assistants (PAs); Nurse Practitioners (NPs), Midwives; All Nurses (RNs, LPNs, including non-clinical) ; Patient Care Associates (PCAs) in ED, ICU, 3D (PCA Level 3 & 4); Pharmacist; Respiratory Therapist; Occupational Therapist; Physical Therapist; Speech Therapist; Surgical	AHA Training Center at Montefiore Medical Center- **cprtraining@montefiore.org** 718-920-2579	**Every 2 years**

	Technicians; Radiology Technologists ; Ultrasound Technologists; MRI Technologists; and Clinical Affiliates, Surge Sitters PSA; PCA (Level 1 & 2); Tele-Sitter; Patient Transporters; BHU and Recovery Center Counselors; Home Health Aide; and Security; Administrative Associates, and Registered Dieticians (optional). * BLS is not required for Board Certified Emergency Physicians		
Advanced Cardiovascular Life Support (ACLS)	ED-PA/NP's; ICU-PA/NP's; Sound Physician PA/NP's; Hospitalists; Intensivists; RNs who work in the ED, ECU, MICU, SICU, PACU, MRI, Radiology, Endoscopy, SDS, Labor & Delivery & OR area; Respiratory Therapists; Medical/ Surgical **RN's** and Pharmacists (optional), (**Board Certified ED Physicians are exempt) **Note: Board-Certified Emergency Medicine Physicians are required to complete a current course in advanced cardiac life support (ACLS) and pediatric advanced life support (PALS) or have had current training and experience equivalent to ACLS and PALS.	AHA Training Center at Montefiore Medical Center-**cprtraining@montefiore.org** 718-920-2579	**Every 2 years**

	Required for Administrative Nursing Supervisors		
Pediatric Advanced Life Support (PALS)	**Board Certified ED Physicians; ED PA/NP's; Pediatric Hospitalist; RNs-ED, Pediatrics, SICU, PACU, MRI, Radiology, Endo, and SOS. **Note: Board-Certified Emergency Medicine Physicians are required to complete a current course in advanced cardiac life support (ACLS) and pediatric advanced life support (PALS) or have had current training and experience equivalent to ACLS and PALS. Required for Administrative Nursing Supervisors	AHA Training Center at Montefiore Medical Center-**cprtraining@montefiore.org** 718-920-2579	**Every 2 years**
Neonatal Resuscitation Program (NRP) American Academy of Pediatrics	RNs- L&D, Mother/Baby, Obstetrics, NICU, Pediatric Hospitalists.	CLD at 845.348.7617	**Every 2 years**
Crisis Prevention Training*	PSA, PCA, Tele-Sitter, ED RN, Patient Transporters, Security; Behavioral Health & Recover Center Staff, Inpatient RNs *	CLD at 845.348 7617	**Every 1 year**

All Revision Dates

02/2023, 03/2022, 01/2019

Approval Signatures

Step Description	Approver	Date

VP HR	Mary Shinick: Vice President of Human Resources	02/2023
Policy Owner Approval	Linda Taff: Executive Assistant	01/2023

Status Active PolicyStat ID 11499789

Montefiore Nyack

Origination	03/2018
Last Approved	07/2021
Effective	07/2021
Last Revised	03/2018
Next Review	06/2024

Contact Linda Taff: Executive Assistant

Code Conduct – Disruptive Behavior

PURPOSE

Montefiore Nyack Hospital supports a positive workplace environment that promotes optimum patient outcomes and prevents, decreases or eliminates actions that a) negatively impact the operation(s) of the hospital, departments or units, b) affect individuals in their ability to do their jobs, c) create a "hostile work environment," d) interfere with other practitioners or professionals' ability to practice competently and e) impact the community's confidence in the hospital's ability to provide collaborative and cooperative quality patient care.

SCOPE

Montefiore Nyack Hospital believes in a collegial work environment in which all individuals within its facilities are treated with courtesy, respect, and dignity. To that end everyone associated with Montefiore Nyack Hospital – employees, physicians, board members, management, clinical staff, administrative staff, volunteers and contractors – must conduct themselves in a professional and cooperative manner in the hospital, so as not to impact patient care or the belief of those in the community that the hospital can appropriately and professionally address and accommodate the needs of its patients. Of course, nothing in this policy prohibits employees from collectively discussing the terms and conditions of their employment in accordance with applicable law, or from raising concerns with their managers or others.

Every person who works at the hospital has direct responsibility for giving our patients the competent, compassionate care they need and deserve. Our daily behaviors reflect the principles and values expressed in our **"We Care"** standards:

Working Together – Demonstrates courtesy and respect in all human interactions, a positive spirit of service and the ability to work together with employees inside and outside the department;

Empowerment – Demonstrates use of self-directed communication and decision-making, effective

problem solving skills, accountability for own words and actions at all times and the ability to complete work responsibilities/projects in a thorough and timely manner;

Communication – Demonstrates positive communication, professionalism and courtesy in all interactions when dealing with visitors, patients and others at the hospital;

Appearance – Demonstrates assistance in maintaining a clean, clutter-free environment as well as displaying personal pride in appearance in compliance with hospital dress code;

Responsiveness – Demonstrates ability to provide timely feedback/communication to patients, visitors or co-workers as well as effective problem-solving to point of resolution for customers;

Excellence in Service – Demonstrates ability and desire to exceed customer/patient (internal or external) expectations within job requirements while striving to achieve positive outcomes in all aspects of job requirements.

POLICY

Montefiore Nyack Hospital believes in a collegial work environment in which all individuals within its facilities are treated with courtesy, respect and dignity. **In that context, it is the Hospital's policy that everyone associated with the Hospital – employees, physicians, board members, management, clinical staff, administrative staff, volunteers and contractors – must conduct themselves in a professional and cooperative manner in the hospital.** Montefiore Nyack Hospital will not tolerate any form of inappropriate conduct. Again, nothing in this policy prohibits employees from collectively discussing the terms and conditions of their employment in accordance with applicable law, or from raising concerns with their managers or others.

All persons are encouraged to report violations of this policy. This policy also prohibits any form of retaliation against reporting individuals or any individual providing information about a violation of this policy. All reports of a violation of this policy or retaliation will be investigated. Penalties may be imposed against any individual violating this policy or taking any form of retaliation against a reporting individual.

This Code of Conduct – Disruptive Behavior policy has been developed and adopted to state clearly the behaviors we will each follow and look for in the conduct of others. It is grounded in our "We Care" standards of behavior – with the understanding that those who follow its guidelines will truly be living those standards in their activities at Montefiore Nyack Hospital.

OBJECTIVES:

The objective of this policy is to ensure optimum patient care by promoting a safe, cooperative, and professional health care environment and to preventing or eliminating, to the extent possible, conduct that:

a. Disrupts the operation of the Hospital
b. Affects the ability of others to do their jobs
c. Creates a "hostile work environment" for employees, physicians, board members, management, clinical staff, administrative staff, volunteers and contractors.

d. Interferes with an individual's ability to practice competently

e. Adversely affects or impacts the community's confidence in the hospital's ability to provide quality patient care.

f. Adversely affects or impacts patient care.

Inappropriate behavior/conduct:

May include, but is not limited to behavior such as:

a. Attacks, verbal or physical, leveled at other employees, physicians, board members, management, clinical staff, administrative staff, volunteers, contractors, patients or visitors, that are beyond the bounds of fair professional conduct;

b. Inappropriate comments made in person or in medical records or other official documents, impinging the quality of care in the Hospital, or attacking particular patients or visitors.

The following lists provide some examples of behavior that are inappropriate:

Inappropriate Words:

- Profane, insulting, demeaning or abusive language;
- Shaming others for negative outcomes;
- Demeaning comments or intimidation;
- Arguments with employees, physicians, board members, management, clinical staff, administrative staff, volunteers, contractors, patients or visitors that are unrelated to, or unnecessary in the course of, providing patient care;
- Boundary violations with employees, physicians, board members, management, clinical staff, administrative staff, volunteers, contractors, patients or visitors;
- Inappropriate negative comments about another individual's work or the care they provide to patients (orally or in writing), unless part of a bona fide complaint or concern raised in connection with hospital business;
- Passing severe judgment or censuring an employee, physician, board member, management, clinical staff, administrative staff, volunteer or contractor in front of patients, visitors or other staff;
- Outbursts of anger above/beyond the normal course of conduct;
- Behavior that others would describe as bullying;
- Insensitive comments about a patient's medical condition, appearance, situation etc. or the appearance, situation etc. of someone other than a patient;
- Jokes or non-clinical comments about race, ethnicity, religion, sexual orientation, age, physical appearance, socioeconomic or educational status, or any other category that is protected by applicable anti-discrimination law.

Inappropriate Actions/Inaction:

- Throwing or breaking things;

- Refusal to comply with known and generally accepted workplace or practice standards such that the refusal inhibits professional staff or employees from completing their work and/or from delivering quality care to patients;
- Use or threat of unwarranted physical force with patients, family members, staff or other care providers;
- Inappropriate physical touching or contact;
- Failure to respond to requests for assistance or direction or to pages or requests for information or persistent lateness in responding to requests for assistance when on-call or expected to be available;
- Not working collaboratively or cooperatively with others;
- Creating rigid or inflexible barriers to requests for assistance/cooperation.

PROCEDURE:

Any member of the Medical Staff, hospital employee, patient, visitor, physicians, board members, management, clinical staff, administrative staff, volunteers or contractors that has observed or been the victim of conduct that constitutes disruptive behavior may report the matter as listed below:

Step One: Use the attached form to report any incident of questionable behavior. Provide as much detail as possible including the following:

a. the date and time of the disruptive behavior;
b. the name of the person or patient if the disruptive behavior affected or involved a patient in any way;
c. the circumstances which precipitated the situation;
d. a description of the disruptive behavior limited to factual, objective language as much as possible;
e. the consequences, if any, of the disruptive behavior as it relates to patient care or hospital operations;
f. a description of any action taken to remedy the situation including date, time, place of action and name(s) of those intervening.
g. known witnesses to the event(s)

Step Two: All reports on physicians should be submitted to the Chief Medical Officer as per Bylaws of the Medical Staff - Section 15.3 - Manner of Reporting. All other incident reports should be submitted to the Vice President of Human Resources for investigation.

Step Three: In investigating the complaint, the following steps will be taken:

a. Meet with the complainant to discuss concerns outlined in the Code of Conduct Incident Form.
b. Meet with the accused and allow the opportunity to respond either verbally or in writing to the complaint.
c. Interview any relevant witnesses to the conduct/event that gave rise to the complaint.
d. Ensure that any prior complaints related to the accused are accessed through Human

Resources or the Chief Medical Officer as the case may be.

e. Prepare an investigation report detailing the nature of the investigation, the findings, the conclusions and the recommendations within thirty (30) days of receipt of the written complaint or as soon after as possible.

Step Four: If the report concludes that the complaint is unsubstantiated, all relevant parties are notified.

If the complaint is substantiated, either the Vice President of Human Resources or the Chief Medical Officer shall consider the findings of the report and determine the next course of action including corrective or disciplinary interventions, as may be appropriate.

Either the Vice President of Human Resources or the Chief Medical Officer will meet with the complainant and the accused to provide a summary of the report, but will only disclose to the complainant that the complaint has been investigated, the conclusions, and that they have met with the accused.

The Department Manager responsible for the accused shall communicate the corrective action steps required.

In the case of a physician, the Chief Medical Officer in consultation with the President of the Medical Staff and/or President & CEO will meet with the offending individual, as per the Bylaws of the Medical Staff. A letter will be sent to the physician stating the problem and instructing that the physician is required to behave professionally and cooperatively within the Hospital. The physician may submit a written rebuttal to the charge, which shall be maintained as a permanent part of the physician's file.

Step Five: Any further confirmed incidents of disruptive behavior shall result in the initiation of formal action in accordance with Montefiore Nyack Hospital's Medical Staff Bylaws or the Human Resources Disciplinary Policy.

All Revision Dates

03/2018

Attachments

Appendix A: Code of Conduct Incident Report

Approval Signatures

Step Description	Approver	Date

Montefiore
Nyack

CODE OF CONDUCT INCIDENT REPORT

POLICY: Montefiore Nyack Hospital believes in a collegial work environment in which all individuals within its facilities are treated with courtesy, respect and dignity. **In that context, it is the Hospital's policy that everyone associated with the Hospital - - employees, physicians, board members, management, clinical staff, administrative staff, volunteers and contractors - - must conduct themselves in a professional and cooperative manner in the hospital.**	Montefiore Nyack Hospital will not tolerate any form of inappropriate conduct. All persons are encouraged to report violations of this policy. This policy also prohibits any form of retaliation against reporting individuals or any individual providing information about a violation of this policy. All reports of a violation of this policy or retaliation will be investigated. Penalties may be imposed against any individual violating this policy or taking any form of retaliation against a reporting individual.

Instructions: Use this form to report all incidents of questionable behavior. Answer all questions in as much detail as possible. Attach additional sheets if necessary. All reports will be kept confidential. (Please Print)

Date of Report: _____ Date & Time of behavior: _____

Name of person committing the behavior: _____

Name of any person/patient(s) that the behavior affected or involved in any way: _____

_____

Describe the circumstances which precipitated the situation: _____

_____

_____

_____

Describe the behavior limited to factual, objective language as much as possible: _____

_____

_____

Describe the consequences, if any, of the behavior as it relates to patient care or hospital operations: _____

_____

_____

Provide the names of all witnesses to the behavior: _____

_____

Describe any action taken to remedy the situation including date, time place of action and name(s) of those intervening:

_____

_____

_____

Name of person submitting report: _____

The above statements are true to the best of my knowledge. _____
(Signature of person submitting report)

Submit completed Incident Report Forms to the Chief Medical Officer (for physician's incidents) or the Vice President, Human Resources (for all other incidents). (7/09)

HR ATTACHMENT: 6

Status **Active** PolicyStat ID **12863787**

Montefiore Nyack

Origination	01/2020
Last Approved	02/2023
Effective	02/2023
Last Revised	01/2020
Next Review	12/2024

Contact: Linda Taff: Executive Assistant

Discrimination Harassment/Sexual Harassment

POLICY

As a community hospital providing health care services to the residents of Rockland County and the surrounding vicinity, a significant strength of the Hospital is the diversity of its employees. Each day we must attend to the needs of young and old, male and female, individuals of all races, religions, colors and backgrounds. Our staff here at the Hospital, by reason of its own diversity, is better able to communicate with and understand the needs of those we serve.

It is of prime importance that Montefiore Nyack Hospital retains a working atmosphere of cooperation and understanding free from discrimination and harassment. Each individual is to be respected for their contributions to our mission of overall health care. It is the policy of Montefiore Nyack Hospital that all employees are responsible for insuring that the Hospital is free from discrimination and harassment. Each individual has the right to work in a professional atmosphere that promotes equal opportunities and prohibits discriminatory practices, including sexual harassment, harassment or discrimination because of sex, religion, race, color, citizenship, national origin, ancestry, citizenship status, disability, marital status, creed, sexual orientation, gender identity, genetic information, liability for service in the armed forces age or any other characteristics protected by applicable state or local law. Harassment or discrimination, whether verbal, physical or environmental and whether in the workplace itself or in outside work-sponsored settings, is unacceptable and will not be tolerated.

Discrimination should be brought to the attention of the Vice President of Human Resources, either directly, through a supervisor, union representative or other responsible person. The procedure for investigation of any allegation of harassment or discrimination will be that which is set forth in this policy.

Sexual Harassment

Sexual harassment constitutes discrimination and is illegal under federal and state laws. For purposes

of this policy, sexual harassment is defined as it is in the Equal Opportunity Guidelines of the Code of Federal Regulations as unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when (1) submission to such conduct is made explicitly or implicitly a term or condition of an individual's employment, (2) submission or rejection of such conduct by an individual is used as the basis of employment decisions affecting such individual or (3) such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile or offensive working environment. All employees must avoid action or conduct which may be viewed as sexual harassment. Sexual harassment may include a range of subtle or not so subtle behaviors. Depending on the circumstances, these behaviors may include but are not limited to: unwanted sexual advances; subtle or overt pressure for sexual favors; sexual jokes, flirtations, innuendoes, advances or propositions; verbal abuse of a sexual nature; graphic commentary about an individual's body, sexual prowess or sexual deficiencies; leering, whistling, touching, pinching, assault, or suggestive insulting, or obscene gestures; display in the workplace of sexual suggestive objects or pictures. Sexual harassment can include harassment between individuals of the same sex.

Based on New York State law, the employee handbook has been supplemented to include the State's model sexual harassment policy and complaint form as Appendices A and B. Employees are advised in the policy that they should review Appendix A and Appendix B for additional information regarding sexual harassment and Montefiore Nyack Hospital's sexual harassment complaint form.

Discrimination

Discrimination includes favoring or disfavoring individuals in the employment relationship because of sex, religion, race, color, citizenship, national origin, ancestry, citizenship status, disability, marital status, creed, sexual orientation, gender identity, genetic information, liability for service in the armed forces, age, or any other characteristics protected by applicable state or local law. Favoring or disfavoring includes influencing employment decisions such as promotion, salary or wages, work assignments, hours, shifts or other terms and conditions of employment because of one of the factors listed. This may include verbal abuse, racial, ethnic or age directed jokes, insults or jokes aimed at one's physical or mental capabilities or characteristics or other conduct of a demeaning, debasing or hostile nature.

This policy applies to all employees (officers, administrators, physicians, nursing staff, technical and professional services, dietary and food services, clerical, maintenance and support staff) whether related to conduct engaged in by fellow employees, supervisors or someone not directly connected to the Hospital such as patients, clients, vendors, consultants, visitors or others.

The Hospital encourages reporting of all perceived incidents of harassment or discrimination, regardless of who the offender may be. Individuals who believe they may have been the victim of sexual or other harassment or sexual or other discrimination or believe they have witnessed harassment or discrimination should discuss their concerns with a supervisor or with the Vice President of Human Resources.

The primary focus for investigation of possible harassment or discrimination will lie with Human Resources. Should you have any doubt respecting the person to whom you should report, report to the Vice President of Human Resources. Again, employees have been directed to review Appendix A and

Appendix B for additional information regarding sexual harassment and for Montefiore Nyack Hospital's sexual harassment complaint form.

COMPLAINT PROCEDURE

1. **Notification of Appropriate Staff:**

   As noted above, individuals who believe they have been the victims of sexual harassment or believe they have witnessed sexual harassment or believe they have been victims of discrimination, whether by harassment or otherwise, should discuss their concerns with a supervisor or Vice President of Human Resources. If the individual who has engaged in the conduct of which you complain is your supervisor, you need not talk to the supervisor, but may rather speak with the Vice President of Human Resources. If you receive information regarding harassment or discrimination in your capacity as a supervisor, you are obligated to report it to the Vice President of Human Resources.

   The Hospital encourages individuals who believe they are being harassed to promptly advise the offender that their behavior is unwelcomed - but only if they are comfortable doing so. The Hospital recognizes that it is not necessary to talk to an offender if this is uncomfortable. Nevertheless, none of us is perfect. It often occurs that an individual makes a remark, which they believe is totally innocent, and which is offensive to an individual hearing it. A statement from the offended person saying that they are offended by that type of remark, coupled with an apology from the individual who uttered the remark goes a long way to diffusing a situation.

   Employees are encouraged to use the sexual harassment complaint form included as Appendix B to the handbook.

2. **Timeliness in Reporting an Incident:**

   Prompt reporting of incidents is important so that action may be taken. However, due to the sensitivity of problems relating to sexual harassment or other forms of discrimination and because of the emotional toll such misconduct may have on the individual, there is no fixed period for reporting incidents. Report the incident as soon as you feel comfortable in doing so.

3. **Investigatory Process or Other Discrimination:**

   Any reported allegations of sexual harassment or other harassment or discrimination will be investigated promptly. The investigation may include interviews with the parties involved, and where necessary with individuals who may have observed the alleged conduct or may have relevant knowledge. In cases of claimed discrimination with regard to promotions, job assignments or the like, independent review of employee evaluations, qualifications and other data may also be undertaken. Any reported allegations will be investigated and will be handled in a sensitive and discreet manner.

   Additional information about the investigatory procedure in connection with sexual harassment complaints is included in Appendix A to the handbook.

4. **Confidentiality:**

Confidentiality will be maintained throughout the investigatory process to the extent practicable and appropriate under the circumstances to protect the privacy of the persons involved. It is not possible to maintain confidentiality throughout an investigation. In order to fairly investigate a claim by one individual that some other individual has either harassed or discriminated, the alleged offender must be given the opportunity to respond. Likewise, individuals who had the opportunity to observe alleged offensive conduct or may possess relevant information must be interviewed. However, the Hospital is well aware that each individual considers their personal affairs to be private matters. The Hospital will make efforts to restrict knowledge of the investigation to those who have a reasonable need to know and will caution those people that they are not to spread information to other individuals. The Hospital will reasonably attempt to restrict the information which it discloses to individuals with whom it must consult and must be interviewed during the investigatory process.

Again, additional information about the confidentiality of the investigatory process as that pertains to complaints of sexual harassment, can be found in Appendix A to the handbook.

5. **Protection Against Retaliation:**

Retaliation, against an individual who makes a report of alleged harassment or other discrimination or assists in providing information relevant to a claim, is a serious violation of this policy. The Hospital will not tolerate acts of retaliation and such acts should be promptly reported to the vice President of Human Resources. If you have been involved in an investigation of harassment or discrimination and believe that your job conditions have been unfavorably affected because of your participation, do not hesitate to report. Such reports will be handled expeditiously and appropriately.

Additional information about the protection against retaliation in connection with sexual harassment complaints can be found in Appendix A to the handbook.

6. **Responsive Action:**
Misconduct constituting sexual harassment or other forms of discrimination will be dealt with appropriately. Responsive action may include sensitivity training, referral counseling, and disciplinary action such as written warning, reprimand, withholding a promotion, withholding of pay increases, reassignment, temporary suspension without pay or termination of employment, depending upon the gravity of the offense and the work record of the individuals involved. Discrimination with respect to the terms and conditions of an individual's employment may be remedied by a pay increase, promotion, transfer or other action as may be appropriate to place the individual complainant in the position in which the employee would have occupied had discrimination not occurred. With respect to harassment, in the event the investigation should prove inconclusive, the Hospital may still recommend and impose sensitivity training or counseling. Should an investigation of discrimination reveal either that discrimination has not occurred or that it cannot be established that there has been any discrimination, the Hospital will take such action as it deems appropriate under the circumstance. In no event will retaliatory action be taken against an individual who has made a complaint of discrimination or harassment or has provided information respecting such a complaint. The result of the investigation shall be disclosed, at least to the complainant, and may be disclosed to the alleged offender at the conclusion of the investigation.

Additional information about responsive action to sexual harassment complaints can be found

in Appendix A to the handbook.

7. **Reconsideration:**
If any employee involved in a harassment or discrimination investigation wishes the matter to be reconsidered, that party may submit a written request within thirty days from the completion of the investigation and disclosure of the outcome to those individuals to whom the outcome is disclosed. The written request is to be submitted to the Vice President of Human Resources which shall meet and consider the request for reconsideration based upon the written information furnished to it as part of the investigation file and as part of the request for reconsideration.
Montefiore Nyack Hospital has developed this policy to ensure that all of its employees can work in an environment free from harassment and discrimination by reason of sex, religion, race, color, citizenship, national origin, ancestry, citizenship status, disability, marital status, creed, sexual orientation, genetic information, liability for service in the armed forces or age. In addition, the Hospital complies with applicable state and local laws governing non-discrimination in employment. The Hospital will make every reasonable effort to ensure that its entire employee population is familiar with the policy and is aware that any complaint received will be investigated and resolved appropriately. Any employee who has questions or concerns about this policy should speak with the Human Resources Department.

Employees are advised that they should review Appendix A and Appendix B for additional information regarding sexual harassment and Montefiore Nyack Hospital's sexual harassment complaint form. Appendix A and Appendix B 67 have also been appended to the end of this manual.

All Revision Dates

01/2020

Attachments

Appendix A: Montefiore Nyack Hospital Supplemental Sexual Harassment Policy

Approval Signatures

Step Description	Approver	Date
VP HR	Mary Shinick: Vice President of Human Resources	02/2023
Policy Owner Approval	Linda Taff: Executive Assistant	12/2022

APPENDIX A
Eff. October, 2018
Reviewed 7/2021

Montefiore Nyack Hospital Supplemental Sexual Harassment Policy

Introduction

Montefiore Nyack Hospital (the "Hospital") is committed to maintaining a workplace free from sexual harassment. Sexual harassment is a form of workplace discrimination. All employees are required to work in a manner that prevents sexual harassment in the workplace. This Policy is one component of the Hospital's commitment to a discrimination-free work environment. Sexual harassment is against the law[1] and all employees have a legal right to a workplace free from sexual harassment and employees are urged to report sexual harassment by filing a complaint internally with the Hospital. Employees can also file a complaint with a government agency or in court under federal, state or local antidiscrimination laws.

Policy:

1. The Hospital's policy applies to all employees, applicants for employment, interns, whether paid or unpaid, contractors and persons conducting business, regardless of immigration status, with the Hospital. In the remainder of this document, the term "employees" refers to this collective group.

2. Sexual harassment will not be tolerated. Any employee or individual covered by this policy who engages in sexual harassment or retaliation will be subject to remedial and/or disciplinary action (e.g., counseling, suspension, termination).

3. Retaliation Prohibition: No person covered by this Policy shall be subject to adverse action because the employee reports an incident of sexual harassment, provides information, or otherwise assists in any investigation of a sexual harassment complaint. The Hospital will not tolerate such retaliation against anyone who, in good faith, reports or provides information about suspected sexual harassment. Any employee of the Hospital who retaliates against anyone involved in a sexual harassment investigation will be subjected to disciplinary action, up to and including termination. All employees, paid or unpaid interns, or non-employees[2] working in the workplace who believe they have been subject to such retaliation should inform a supervisor, manager, or the Human Resources Department. All employees, paid or unpaid interns or non-employees who believe they have been a target of such retaliation may also seek relief in other available forums, as explained below in the section on Legal Protections.

[1] While this policy specifically addresses sexual harassment, harassment because of and discrimination against persons of all protected classes isprohibited. In New York State, such classes includeage, race, creed, color, national origin, sexual orientation, military status, sex, disability, marital status, domestic violence victim status, gender identity and criminal history.

[2] A non-employee is someone who is (or is employed by) a contractor, subcontractor, vendor, consultant, or anyone providing services in the workplace. Protected non-employees include persons commonly referred to as independent contractors, "gig" workers and temporary workers. Also included are persons providing equipment repair, cleaning services or any other services provided pursuant to a contract with the employer.

4. Sexual harassment is offensive, is a violation of our policies, is unlawful, and may subject the Hospital to liability for harm to targets of sexual harassment. Harassers may also be individually subject to liability. Employees of every level who engage in sexual harassment, including managers and supervisors who engage in sexual harassment or who allow such behavior to continue, will be penalized for such misconduct.

5. The Hospital will conduct a prompt and thorough investigation that ensures due process for all parties, whenever management receives a complaint about sexual harassment, or otherwise knows of possible sexual harassment occurring. The Hospital will keep the investigation confidential to the extent possible. Effective corrective action will be taken whenever sexual harassment is found to have occurred. All employees, including managers and supervisors, are required to cooperate with any internal investigation of sexual harassment.

6. All employees are encouraged to report any harassment or behaviors that violate this policy. The Hospital will provide all employees a complaint form for employees to report harassment and file complaints.

7. Managers and supervisors are **required** to report any complaint that they receive, or any harassment that they observe or become aware of, to the Human Resources Department.

8. This policy applies to all employees, paid or unpaid interns, and non-employees and all must follow and uphold this policy. This policy will be shared with all employees and provided to employees upon hiring.

What Is "Sexual Harassment"?

Sexual harassment is a form of sex discrimination and is unlawful under federal, state, and (where applicable) local law. Sexual harassment includes harassment on the basis of sex, sexual orientation, self-identified or perceived sex, gender expression, gender identity and the status of being transgender.

Sexual harassment includes unwelcome conduct which is either of a sexual nature, or which is directed at an individual because of that individual's sex when:

- Such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile or offensive work environment, even if the reporting individual is not the intended target of the sexual harassment;

- Such conduct is made either explicitly or implicitly a term or condition of employment; or

- Submission to or rejection of such conduct is used as the basis for employment decisions affecting an individual's employment.

A sexually harassing hostile work environment includes, but is not limited to, words, signs, jokes, pranks, intimidation or physical violence which are of a sexual nature, or which are directed at an individual because of that individual's sex. Sexual harassment also consists of any unwanted verbal or physical advances, sexually explicit derogatory statements or sexually discriminatory remarks made by someone which are offensive or objectionable to the recipient, which cause the recipient discomfort or humiliation, which interfere with the recipient's job performance.

Sexual harassment also occurs when a person in authority tries to trade job benefits for sexual favors. This can include hiring, promotion, continued employment or any other terms, conditions or privileges of employment. This is also called "quid pro quo" harassment.

Any employee who feels harassed should report so that any violation of this policy can be corrected promptly. Any harassing conduct, even a single incident, can be addressed under this policy.

Examples of sexual harassment

The following describes some of the types of acts that may be unlawful sexual harassment and that are strictly prohibited:

- Physical acts of a sexual nature, such as:
  - Touching, pinching, patting, kissing, hugging, grabbing, brushing against another employee's body or poking another employee's body;
  - Rape, sexual battery, molestation or attempts to commit these assaults.

- Unwanted sexual advances or propositions, such as:
  - Requests for sexual favors accompanied by implied or overt threats concerning the target's job performance evaluation, a promotion or other job benefits or detriments;
  - Subtle or obvious pressure for unwelcome sexual activities.

- Sexually oriented gestures, noises, remarks or jokes, or comments about a person's sexuality or sexual experience, which create a hostile work environment.

- Sex stereotyping occurs when conduct or personality traits are considered inappropriate simply because they may not conform to other people's ideas or perceptions about how individuals of a particular sex should act or look.

- Sexual or discriminatory displays or publications anywhere in the workplace, such as:
  - Displaying pictures, posters, calendars, graffiti, objects, promotional material, reading materials or other materials that are sexually demeaning or pornographic. This includes such sexual displays on workplace computers or cell phones and sharing such displays while in the workplace.

- Hostile actions taken against an individual because of that individual's sex, sexual orientation, gender identity and the status of being transgender, such as:
  - Interfering with, destroying or damaging a person's workstation, tools or equipment, or otherwise interfering with the individual's ability to perform the job;
  - Sabotaging an individual's work;

- Bullying, yelling, name-calling.

Who can be a target of sexual harassment?

Sexual harassment can occur between any individuals, regardless of their sex or gender. New York Law protects employees, paid or unpaid interns, and non-employees, including independent contractors, and those employed by companies contracting to provide services in the workplace. Harassers can be a superior, a subordinate, a coworker or anyone in the workplace including an independent contractor, contract worker, vendor, client, customer or visitor.

Where can sexual harassment occur?

Unlawful sexual harassment is not limited to the physical workplace itself. It can occur while employees are traveling for business or at employer sponsored events or parties. Calls, texts, emails, and social media usage by employees can constitute unlawful workplace harassment, even if they occur away from the workplace premises, on personal devices or during non-work hours.

Retaliation

Unlawful retaliation can be any action that could discourage a worker from coming forward to make or support a sexual harassment claim. Adverse action need not be job-related or occur in the workplace to constitute unlawful retaliation (e.g., threats of physical violence outside of work hours).

Such retaliation is unlawful under federal, state, and (where applicable) local law. The New York State Human Rights Law protects any individual who has engaged in "protected activity." Protected activity occurs when a person has:

- made a complaint of sexual harassment, either internally or with any anti-discrimination agency;
- testified or assisted in a proceeding involving sexual harassment under the Human Rights Law or other anti-discrimination law;
- opposed sexual harassment by making a verbal or informal complaint to management, or by simply informing a supervisor or manager of harassment;
- reported that another employee has been sexually harassed; or
- encouraged a fellow employee to report harassment.

Even if the alleged harassment does not turn out to rise to the level of a violation of law, the individual is protected from retaliation if the person had a good faith belief that the practices were unlawful. However, the retaliation provision is not intended to protect persons making intentionally false charges of harassment.

Reporting Sexual Harassment

Preventing sexual harassment is everyone's responsibility. The Hospital cannot prevent or remedy sexual harassment unless it knows about it. Any employee, paid or unpaid intern or non-employee who has been subjected to behavior that may constitute sexual harassment is encouraged to report such behavior to a supervisor, manager, or the Human Resources Department. Anyone who witnesses or becomes aware of potential instances of sexual harassment should report such behavior to a supervisor, manager, or the Human Resources Department.

Reports of sexual harassment may be made verbally or in writing. A form for submission of a written complaint is attached to this Policy, and all employees are encouraged to use this complaint form. Employees who are reporting sexual harassment on behalf of other employees should use the complaint form and note that it is on another employee's behalf.

Employees, paid or unpaid interns or non-employees who believe they have been a target of sexual harassment may also seek assistance in other available forums, as explained below in the section on Legal Protections.

Supervisory Responsibilities

All supervisors and managers who receive a complaint or information about suspected sexual harassment, observe what may be sexually harassing behavior or for any reason suspect that sexual harassment is occurring, **are required** to report such suspected sexual harassment to the Human Resources Department.

In addition to being subject to discipline if they engaged in sexually harassing conduct themselves, supervisors and managers will be subject to discipline for failing to report suspected sexual harassment or otherwise knowingly allowing sexual harassment to continue.

Supervisors and managers will also be subject to discipline for engaging in any retaliation.

Complaint and Investigation of Sexual Harassment

All complaints or information about sexual harassment will be investigated, whether that information was reported in verbal or written form. Investigations will be conducted in a timely manner, and will be confidential to the extent possible.

An investigation of any complaint, information or knowledge of suspected sexual harassment will be prompt and thorough, commenced promptly and completed as soon as possible. The investigation will be kept confidential to the extent possible. All persons involved, including complainants, witnesses and alleged harassers will be accorded due process, as outlined below, to protect their rights to a fair and impartial investigation.

Any employee may be required to cooperate as needed in an investigation of suspected sexual harassment. The Hospital will not tolerate retaliation against employees who file complaints, support another's complaint or participate in an investigation regarding a violation of this policy.

While the process may vary from case to case, investigations will generally include the following steps:

- A thorough review of the allegations;
- Take steps to obtain and preserve any relevant documents or other information;
- Interview the appropriate parties and witnesses;
- Document the investigation per the Hospital's standard policies and procedures;
- Notify the necessary individuals of the final determination;
- Provide any additional information, such as a reminder of non-retaliation to the appropriate parties; and
- Implement any appropriate corrective actions.

Legal Protections And External Remedies

Sexual harassment is not only prohibited by the Hospital but is also prohibited by state, federal, and, where applicable, local law.

Aside from the internal process at the Hospital, employees may also choose to pursue legal remedies with the following governmental entities. While a private attorney is not required to file a complaint with a governmental agency, you may seek the legal advice of an attorney.

In addition to those outlined below, employees in certain industries may have additional legal protections.

State Human Rights Law (HRL)

The Human Rights Law (HRL), codified as N.Y. Executive Law, art. 15, § 290 et seq., applies to all employers in New York State with regard to sexual harassment, and protects employees, paid or unpaid interns and non-employees, regardless of immigration status. A complaint alleging violation of the Human Rights Law may be filed either with the Division of Human Rights (DHR) or in New York State Supreme Court.

Complaints with DHR may be filed any time **within one year** of the harassment. If an individual did not file at DHR, they can sue directly in state court under the HRL, **within three years** of the alleged sexual harassment. An individual may not file with DHR if they have already filed a HRL complaint in state court.

Complaining internally to the Hospital does not extend your time to file with DHR or in court. The one year or three years is counted from date of the most recent incident of harassment.

You do not need an attorney to file a complaint with DHR, and there is no cost to file with DHR.

DHR will investigate your complaint and determine whether there is probable cause to believe that sexual harassment has occurred. Probable cause cases are forwarded to a public hearing before an administrative law judge. If sexual harassment is found after a hearing, DHR has the power to award

relief, which varies but may include requiring your employer to take action to stop the harassment, or redress the damage caused, including paying of monetary damages, attorney's fees and civil fines.

DHR's main office contact information is: NYS Division of Human Rights, One Fordham Plaza, Fourth Floor, Bronx, New York 10458. You may call (718) 741-8400 or visit: www.dhr.ny.gov.

Contact DHR at (888) 392-3644 or visit dhr.ny.gov/complaint for more information about filing a complaint. The website has a complaint form that can be downloaded, filled out, notarized and mailed to DHR. The website also contains contact information for DHR's regional offices across New York State.

Civil Rights Act of 1964

The United States Equal Employment Opportunity Commission (EEOC) enforces federal anti-discrimination laws, including Title VII of the 1964 federal Civil Rights Act (codified as 42 U.S.C. § 2000e et seq.). An individual can file a complaint with the EEOC anytime within 300 days from the harassment. There is no cost to file a complaint with the EEOC. The EEOC will investigate the complaint, and determine whether there is reasonable cause to believe that discrimination has occurred, at which point the EEOC will issue a Right to Sue letter permitting the individual to file a complaint in federal court.

The EEOC does not hold hearings or award relief, but may take other action including pursuing cases in federal court on behalf of complaining parties. Federal courts may award remedies if discrimination is found to have occurred. In general, private employers must have at least 15 employees to come within the jurisdiction of the EEOC.

An employee alleging discrimination at work can file a "Charge of Discrimination." The EEOC has district, area, and field offices where complaints can be filed. Contact the EEOC by calling 1-800-669-4000 (TTY: 1-800-669-6820), visiting their website at www.eeoc.gov or via email at info@eeoc.gov.

If an individual filed an administrative complaint with DHR, DHR will file the complaint with the EEOC to preserve the right to proceed in federal court.

Local Protections

Many localities enforce laws protecting individuals from sexual harassment and discrimination. An individual should contact the county, city or town in which they live to find out if such a law exists. For example, employees who work in New York City may file complaints of sexual harassment with the New York City Commission on Human Rights. Contact their main office at Law Enforcement Bureau of the NYC Commission on Human Rights, 40 Rector Street, 10th Floor, New York, New York; call 311 or (212) 306-7450; or visit www.nyc.gov/html/cchr/html/home/home.shtml.

Contact the Local Police Department

If the harassment involves unwanted physical touching, coerced physical confinement or coerced sex acts, the conduct may constitute a crime. Contact the local police department.

Appendix B
Reviewed 7/2021,Eff. October, 2018

Montefiore Nyack Hospital Sexual Harassment Complaint Form

New York State Labor Law requires all employers to adopt a sexual harassment prevention policy that includes a complaint form to report alleged incidents of sexual harassment.

If you believe that you have been subjected to sexual harassment, you are encouraged to complete this form and submit it to the Human Resources Department. You will not be retaliated against for filing a complaint.

If you are more comfortable reporting verbally or in another manner, you may do so.

For additional resources, visit: ny.gov/programs/combating-sexual-harassment-workplace

COMPLAINANT INFORMATION

Name:

Work Address: Work Phone:

Job Title: Email:

Select Preferred Communication Method: ☐Email ☐Phone ☐In person

SUPERVISORY INFORMATION

Immediate Supervisor's Name:

Title:

Work Phone: Work Address:

COMPLAINT INFORMATION

1. Your complaint of Sexual Harassment is made about:

   Name: Title:

   Work Address: Work Phone:

   Relationship to you: ☐Supervisor ☐Subordinate ☐Co-Worker ☐Other

2. Please describe what happened and how it is affecting you and your work. Please use additional sheets of paper if necessary and attach any relevant documents or evidence.

3. Date(s) sexual harassment occurred:

   Is the sexual harassment continuing? ☐Yes ☐No

4. Please list the name and contact information of any witnesses or individuals who may have information related to your complaint:

The last question is optional, but may help the investigation.

5. Have you previously complained or provided information (verbal or written) about related incidents? If yes, when and to whom did you complain or provide information?

If you have retained legal counsel and would like us to work with them, please provide their contact information.

Signature: _____ *Date:* _____

Status Active PolicyStat ID 11500326

Montefiore Nyack

Origination	07/2021
Last Approved	07/2021
Effective	07/2021
Last Revised	07/2021
Next Review	06/2024

Contact Linda Taff: Executive Assistant

Licenses

Policy

As a fully licensed and registered professional healthcare facility of New York State, Montefiore Nyack Hospital strictly adheres to the New York State Department of Education licensing requirements for purposes of staffing and hiring.

As such, all prospective and current employees either seeking employment or already employed in positions deemed by the State to require licensing, registration or certification, must have these certificates up to date, verified, and in place at the time of and or throughout the course of their employment. Licensure and or Certifications will be re-verified every three years or as required for the discipline and copies will be kept with the employee's personnel file.

Inasmuch as employees are individually licensed by the State according to their job classification, it is the responsibility of the employee to ensure that their licensing records are kept current and renewed at the appropriate time. Employees who do not renew their licensing requirements, or have them revoked for any reason, will no longer be permitted to work at the Hospital in a licensed capacity.

Procedure

- At the time of hire, the Human Resources Representative shall inform each applicant of the need to possess a particular credential and instruct the applicant to present the original document prior to hire. The Human Resources Representative shall visually review the original license, registration, or certification and conduct a primary source verification of the credential with the certifying agency. Such verification may be authenticated via a printed copy of an electronic communication or confirmed by an approved vendor.
- A copy of the original license, registration or certification shall be maintained in the official employment record.
- Employees shall be responsible for maintaining the license, registration or certification, which

is a condition for continued employment.

- Department heads shall ensure that employees have renewed their licenses, certificates or registrations by verifying same through the certifying agency. Verification shall be documented and a copy of the current credential maintained in the practitioner's employee file.
- Staff members whose credentials lapse shall immediately be removed from their positions and Human Resources must be notified immediately. Human Resources will attempt to place the affected staff member in another position for which they are qualified. If placement within two (2) weeks is not successful, the staff member's employment will be terminated.
- If a license, certificate or permit should become a requirement for a particular position after a staff member is working in that position, the staff member shall be given a reasonable amount of time to obtain such credentials, so long as the granting of such a grace period does not place the Hospital or the individual in violation of applicable laws.

All Revision Dates

07/2021

Approval Signatures

Step Description	Approver	Date

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Appendix B - Quiz

Name: _____ Date: _____ Department _____

Read the questions below and indicate if statements are TRUE or FALSE. Check your response.

1. [ ] TRUE [ ] FALSE The hospital WE CARE standards and the Code of Conduct only apply to MNH Senior Leadership and the hospital Board of Trustees.
2. [ ] TRUE [ ] FALSE Anyone at MNH, including staff members, employees, contractors or patients, may report an impaired professional or disruption behavior without fear of retaliation.
3. [ ] TRUE [ ] FALSE HIPAA law allows patients to have the right to amend their Medical Health Record.
4. [ ] TRUE [ ] FALSE For hospital emergencies, such as a "Code Blue or Hazardous Spill" call ext 2222 from any hospital phone.
5. [ ] TRUE [ ] FALSE MNH protects patient right's to be FREE of abuse, neglect, exploitation and human trafficking.
6. [ ] TRUE [ ] FALSE HCAHPS is a national initiative tied to hospital performance based on reported data on patient's experience and their satisfaction with care.
7. [ ] TRUE [ ] FALSE Core Measures help to improve patient care by tracking important data (such as time to arrival, medication adherence) in both inpatient and outpatient care areas.
8. [ ] TRUE [ ] FALSE Non-Violent/Non Self-Destructive Restraints are to be ordered by a Licensed Independent Practitioner every 24 hours.
9. [ ] TRUE [ ] FALSE Restraint documentation has to be done every 30 minutes and more frequent if necessary.
10. [ ] TRUE [ ] FALSE COVID-19 positive patients may co-hort in double rooms.
11. [ ] TRUE [ ] FALSE To prevent medical errors or near-misses, The Joint Commission requires that two patient identifiers be used for every patient at every encounter.
12. [ ] TRUE [ ] FALSE Just Culture work environment provides a structured process to guide managers and investigators through the evaluation of an event, near miss and includes blame for possible system failures.
13. [ ] TRUE [ ] FALSE Compliance Department oversees MNH compliance program that promotes adherence to applicable rules and regulations and prevention of fraud, waste and abuse through education, monitoring and corrective action.
14. [ ] TRUE [ ] FALSE Only chemotherapy medications are hazardous.
15. [ ] TRUE [ ] FALSE All hazardous medication have the same level of risk.

Return this form to your Department Manager/Supervisor for your file.

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Appendix C - Attestation Form

ATTESTATION FORM

MONTEFIORE NYACK HOSPITAL

I attest that I have been given a copy of the MNH Orientation Booklet intended for Medical Staff, Students, Agency RN's, Forensic Staff, Temps, Volunteers, Vendors, and/or Contractors to support my onboarding at Montefiore Nyack Hospital.

I attest that after reading this booklet and reviewing the designated policies, I feel confident in my roles and responsibilities as a Medical Staff, Allied Health Student, Agency RN, Forensic Staff, Temp, Volunteer, Vendor, and/or Contractor.

The contractor (named here) _____ shall also ensure that all personnel files, including documentation of health screening and required trainings, are complete and are available to Client upon request to respond to inquiries during a Joint Commission or state or federal survey or as needed to respond to a patient compliant survey.

Furthermore, by signing below, I attest that I have provided the organization with required onboarding documentation including but not limited to: license, CPR, certifications, and/or immunization records as required for my position.

Your Name (Print)	**Your Signature**
Department or School	**Date**
Title (Med Staff / Student / Temp / Volunteer / Vendor / Contractor / Agency, etc.)	

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Appendix D - PHI Policy and HIPAA Form

MONTEFIORE NYACK HOSPITAL

SECURITY & CONFIDENTIALITY AGREEMENT

PRINT YOUR NAME | DEPARTMENT/PHYSICIAN/MHS AFFILIATE/COMPANY NAME/SCHOOL NAME | HOSPITAL EXTENSION OR TELEPHONE NUMBER

CHECK ONE: **[ ] MONTEFIORE NYACK HOSPITAL EMPLOYEE [ ] MEDICAL STAFF [ ] HIGHLAND MEDICAL, P.C. EMPLOYEE**
[ ] INDEPENDENT CONTRACTOR [ ] MHS AFFILIATE [ ] VOLUNTEER [ ] STUDENT
[ ] OTHER: _____

In accordance with Montefiore Nyack Hospital policies, access to confidential protected health information is permitted only on a need-to-know basis within the confines of your responsibilities as an employee, volunteer, trainee, medical staff member, or independent contractor providing or performing services at Montefiore Nyack. **All patient, employee and business information from any source and in any form, including paper records, oral communication, audio recordings and electronic displays is strictly confidential.**

As an employee, volunteer, trainee, medical staff member, or independent contractor of Montefiore Nyack, and as a condition of my employment, affiliation or arrangement, I agree to the following:

1. I understand that I am responsible for complying with Montefiore Nyack's Privacy policies and procedures, (attached) which were provided to me and which I have reviewed and understand.
2. I will treat all information received in the course of my employment or arrangement with Montefiore Nyack that relates to patient health information (ePHI/PHI) as confidential and privileged information.
3. I will not access ePHI/PHI unless need to know this information in order to perform my duties. If received in error, I will immediately report it to the Privacy Officer.
4. I will not disclose ePHI/PHI to any person or entity, other than as necessary to perform my duties and as permitted under Montefiore Nyack's policies and procedures. All release of information requests must go through the Medical Records Department.
5. I will not log on to any of Montefiore Nyack's computer systems that currently exist or may exist in the future using a password other than my own.
6. I will safeguard my computer password and will not post it in a public place, such as the computer monitor or a place where it will be easily lost, such as on my nametag.
7. I will not allow anyone, including other employees or workforce members, to use my password to log on to the computer.
8. I will not leave my personal computer unattended. I will log off of the computer as soon as I have finished using it or when I walk away from my desk.
9. I will notify my supervisor, Privacy Officer and the Information Technology Help Desk immediately if I believe my computer password has been compromised.
10. I will not send by email or any other electronic means, including text message any ePHI/PHI unless I am in compliance with Montefiore Nyack's Electronic Data Transmission Policy.
11. I will not take ePHI/PHI off Montefiore Nyack's premises in paper or electronic form without first receiving permission from the Privacy Officer.
12. Upon cessation of my employment, affiliation or arrangement with Montefiore Nyack, I agree to continue to maintain the confidentiality of any information I learned while at Montefiore Nyack, and agree to turn over any keys, access cards, computers or any other device that contains Montefiore Nyack information.
13. I understand that improper disclosure or misuse of patient information, whether intentional or not, is a breach of Montefiore Nyack Hospital policy.

For Physicians with remote access in their offices in addition to the above:

14. I accept complete responsibility for all access to Montefiore Nyack Hospital's electronic health records using my user ID and password, whether from my office, home or elsewhere and I will take all necessary precautions to ensure that unauthorized access to patient information does not occur. I accept full responsibility for the actions of my employees and office staff that are granted access to Montefiore Nyack's Electronic Health Record.

I understand that if I fail to comply with Montefiore Nyack's Privacy policies and procedures I may be subject to disciplinary or corrective action, including possible termination of my employment, affiliation or arrangement.

I have read and agree to comply with the terms of this Agreement.

SIGNATURE _____ DATE _____

Montefiore Nyack Hospital
160 North Midland Avenue
Nyack, NY 10960
845-348-2000
montefiorenyack.org

Montefiore | Nyack

List of Important Montefiore Nyack Hospital Contacts

AHA Training Center (CPR):	AHA@montefiorenyack.org
Administration Office:	845-348-2110
Center for Learning Development:	StaffDevelopment@montefiorenyack.org or 845-348-2385
Compliance	845-348-7293
Corporate Compliance Hotline:	888-568-8548
Emergency Department:	845-348-2345
Employee Health Services:	845-348-2553
Environmental Services:	845-348-2502
Facilities:	845-348-2105
Health Information:	845-348-2574
HIPAA Security Officer:	845-348-2947
Human Resources:	845-348-2155
Infection Prevention:	845-348-2028
IT Help Desk:	845-348-6740
Information Technology:	845-348-6740
Laboratory:	845-348-2250
Hospital Operator:	845-348-2000
Nursing Office:	845-348-2680
Patient Complaints:	845-348-6778
Safety Officer:	845-348-3061
Poison Control:	800-222-1222
Privacy Officer:	845-348-2034
Radiology:	845-348-2450
Risk Management:	845-348-7293
Security:	845-348-2244

EMERGENCIES in-house dial EXT 2222

Montefiore Nyack Hospital
160 North Midland Avenue
Nyack, NY 10960
(845) 348-2000
montefiorenyack.org

CE - 006 Revised 11/2023

Montefiore Nyack Hospital complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, religion, sex, national origin, disability, sexual orientation, gender identity or expression, physical appearance, or age. Montefiore Nyack Hospital does not exclude people or treat them differently because of race, color, religion, sex, national origin, disability, sexual orientation, gender identity or expression, physical appearance, or age.

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