

# UPMC Horizon

## GENERAL ORIENTATION HANDBOOK 2019

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# UPMC Horizon: Organizational Review

## Mission, Vision, Values and Performance Management

### Our Mission

The mission of UPMC is to serve our community by providing outstanding patient care and to shape tomorrow's health system through clinical and technological innovation, research, and education.

### Our Vision

UPMC will lead the transformation of health care. The UPMC model will be nationally recognized for redefining health care by:

- Putting our employees, patients, members, and community at the center of everything we do and creating a model that ensures that every patient gets the right care, in the right way, at the right time, every time.
- Harnessing our integrated capabilities to deliver both superb state – of – the – art care to our patients and high value to our stakeholders.
- Employing our partnership with the University of Pittsburgh to advance the understanding of disease, its prevention, treatment, and cure.
- Fueling the development of new business globally that are consistent with our mission as an ongoing catalyst and driver of economic development for the benefit of the residents of the region.
- Serving the underserved and disadvantaged and advancing excellence and innovation throughout healthcare.

### Our Values

These values and principles guide the health system in achieving its mission and vision:

#### QUALITY AND SAFETY

We create a safe environment where quality is our guiding principle.

#### DIGNITY & RESPECT

We treat all individuals with dignity and respect.

#### CARING & LISTENING

We listen to and care for our patients, our health plan members, our fellow employees, our physicians, and our community.

#### RESPONSIBILITY & INTEGRITY

We perform our work with the highest levels of responsibility and integrity.

#### EXCELLENCE & INNOVATION

We think creatively and build excellence into everything we do.

# AIDET Plus the Promise

AIDET Plus the Promise is a framework to help you better communicate with our patients and their families. AIDET Plus the Promise allows us to live our values in every interaction.

## **Q: What is AIDET Plus the Promise?**

**A:** AIDET Plus the Promise is a communication framework that helps us live our values in every interaction and create a better UPMC Experience for our patients, their families, and each other. It's not a script, but a set of key ideas to help you navigate any interaction. By telling our patients what they need to know in the moment, we can ease our patients' anxiety and help them feel like they are a part of their care, a combination that leads to improved clinical outcomes.

## **Q: What does AIDET stand for?**

### **A: AIDET stands for:**

- Acknowledge
- Introduce
- Duration
- Explanation
- Thank

AIDET is used in conjunction with The Promise, or a declaration of commitment to providing safe and high-quality care.

## **Q: How does AIDET Plus the Promise relate to CARE+?**

**A:** AIDET Plus the Promise and CARE+ are closely related and can be used in any customer interaction. However, AIDET Plus the Promise should be especially used in a hospital or clinical setting.

## **Q: Who does AIDET Plus the Promise apply to?**

**A:** Everyone can take advantage of the AIDET Plus the Promise framework, but staff in a hospital or clinical setting should especially use these principles.

## **Q: AIDET Plus the Promise seems too prescriptive to help me in my job. How can I modify it to fit my situation?**

**A:** One of the good things about AIDET Plus the Promise is that it is adaptable to almost any situation. It is not scripting, it's a framework to help you use key words at key times. The elements of AIDET Plus the Promise can be used individually, in any order or combination, at any time. When thinking about how you can use AIDET Plus the Promise in your work, ask yourself the following questions:

- **Acknowledge:** How can you recognize the other person's presence in a way that shows Dignity & Respect?
- **Introduce:** How can you introduce yourself to build trust and a connection with the person?
- **Duration:** Can you give an estimate about how long something will take?

- **Explanation:** Is there anything the other person might need clarity on? Is there something you're doing that you can explain?
- **Thank:** How can you show gratitude to this person for allowing you to help them?
- **The Promise:** What service commitment can you make to this person?

Remember that how you say something is just as important as what you say. Show the other person through non-verbal cues like body language that you're actively listening to them.

**Q: I'm new to UPMC and don't have a lot of experience. How can I introduce myself in a way that instills confidence in the patient?**

**A:** If you don't have many years of experience, tell the patient about the total years of experience your team has. Manage up your team by telling the patient how you all work together to provide excellent care. If you have any special certifications, tell the person about them.

**Q: How can I acknowledge the patient if I don't know their name?**

**A:** If you don't know the patient's name, ask their care team. If their team isn't available, ask the patient what their name is or what they preferred to be called.

**Q: How do you estimate how long something will take?**

**A:** When explaining the duration of a task, wait time, or procedure, base your answer around how long that task takes 80% of the time. It's always better to estimate a longer duration and complete the task in a shorter time. For example, if you tell a patient the wait should be about 40 minutes and they only wait 30 minutes, the patient will be happy. On the other hand, if you estimate the wait will take 30 minutes and they wait 40 minutes, they're more likely to be upset.

**Q: How do you use AIDET Plus the Promise in an emergency or trauma department?**

**A:** AIDET Plus the Promise is about being intentional with your communication and telling the person what they need to hear at that moment. For trauma patients or emergency situations, one person should take the lead on interacting with the patient and tell them only what is necessary in that moment.

Here is an example of how to use AIDET Plus the Promise in an emergency or trauma scenario:

- "Mr. Smith, my name is Mary and I'm one of your nurses. We're going to stabilize you and then I'll explain what's next with your care. We're going to take good care of you."
  - o Acknowledge: "Mr. Smith"
  - o Introduce: "My name is Mary and I'm one of your nurses."
  - o Explain: "We're going to stabilize you, and then I'll explain what's next with your care."
  - o The Promise: "We're going to take good care of you."

**Q: Where can I find more information about AIDET Plus the Promise?**

**A:** Search "AIDET" on Infonet for more information.

## UPMC Horizon Senior Leadership Team

### Your Executive Management Team

We look forward to hearing your ideas to design and deliver the best possible UPMC Experience.



**Don Owrey**  
President



**Al Boland**  
Vice President, Operations



**Marianna Stoneburner**  
Chief Nursing Officer  
Vice President, Patient Care Services



**Charles Rudek**  
Chief Information Officer



**Brian Fritz**  
Chief Financial Officer



**Eric McIntosh**  
Vice President,  
Human Resources



**Samuel Daisley, MD**  
Vice President,  
Medial Affairs



## Ethics and Code of Conduct

### Our Ethics

Through its leadership and excellence, UPMC contributes to the health care industry, acts as a vital resource to the communities it serves, and touches the lives of residents of western Pennsylvania and beyond. UPMC is built on a foundation of honesty and integrity. Every day, the decisions and actions of UPMC personnel impact patients, communities, and the health care industry. Therefore, it is the obligation of every staff member, physician, and faculty member to act honorably and appropriately as a representative of UPMC. To that end, UPMC has developed comprehensive policies that support its business records, political matters, and lobbying and protection of patient, staff, and business information – promote corporate values and compliance with the laws and support UPMC's ongoing commitment to always conduct business in an honest and responsible way. UPMC promotes a culture that encourages ethical conduct as well as compliance with the law.

### Our Code of Conduct

UPMC's Code of Conduct governs the actions of individuals employed by or associated with UPMC and its affiliates. The Code's written guidelines, which are based on UPMC's mission, vision, values, and ethics, outline how people must conduct themselves when providing any service on behalf of UPMC.

UPMC endorses and enforces the Code of Conduct (Code) because:

- At the core of our business, we are focused on providing compassionate, high quality, cost – effective services.

- We demonstrate honesty, fairness, respect, and dignity to everyone within a safe and healthy work environment.
- We communicate honestly, accurately, and appropriately.
- We use all resources – people, financial, physical property, and proprietary information, - in an economical and environmentally conscious manner and we protect those assets against loss, theft, misuse, or damage.
- Our business relationships are based on mutual respect and integrity and we avoid any conflict of interest.
- We expect our consultants, representatives, and agents who act on behalf of UPMC to act in a manner that is consistent with applicable laws, regulations, standards, and
- policies.

**UPMC**  
**POLICY AND PROCEDURE MANUAL**

**POLICY: HS-EC1900**  
**INDEX TITLE: Ethics & Compliance**

**SUBJECT: Code of Conduct**  
**DATE: December 3, 2018**

**I. POLICY**

UPMC has a Code of Conduct (Code) policy that governs the actions of individuals employed by or associated with UPMC and its affiliates. The Code's written guidelines, which are based on UPMC's mission, vision, values, and ethics, outline how people must conduct themselves when providing any service on behalf of UPMC or a UPMC entity (UPMC).

Links to policies referenced within this policy can be found in Section VII.

**II. PURPOSE**

UPMC endorses and enforces the Code because:

- A. At the core of our business, we are focused on providing compassionate, high quality, cost-effective services in a safe, efficient and effective manner.
- B. We value and demonstrate honesty, fairness, respect and dignity.
- C. We want to promote and maintain a safe and healthy work environment.
- D. We communicate honestly, accurately, and appropriately.
- E. We use all resources - people, financial, physical property, and proprietary information - in an economical and environmentally conscious manner and we protect those assets against loss, theft, misuse, fraud or damage.
- F. Our business relationships are based on mutual respect and integrity, and we try to avoid any conflict of interest.
- G. We expect our consultants, representatives, and agents who act on behalf of UPMC to act in a manner that is consistent with applicable laws, regulations, standards, and policies.
- H. We demonstrate respectful off-duty conduct including communications in verbal, written, and/or electronic formats, which do not diminish trust in a staff member's future performance.
- I. We value the patient-caregiver relationship by demonstrating our accountability for patient safety and by safeguarding patient trust, particularly for our most vulnerable patients, especially those within the

pediatric, geriatric and disabled populations.

J. We comply with applicable laws, regulations, and standards

### **III. SCOPE**

A. This Code applies to anyone who provides a service on behalf of UPMC to patients, family members, vendors, contractors, UPMC staff members, students, visitors, volunteers, guests, community members, and other applicable parties.

B. Everyone who represents UPMC is responsible for complying with this Code. This includes, but is not limited to: physicians, staff employees and management (both clinical and non-clinical); residents, interns, and fellows; contract and other contingent staff; volunteers; students participating in a mentorship, shadow, or academic program; consultants, vendors, contractors, outside agencies with a business relationship with UPMC or a UPMC entity or other agents providing services on behalf of UPMC.

C. This Code does not replace professional judgment and it is not all-inclusive. Instead, the Code provides the framework for understanding acceptable workplace behavior and serves as a guide for that behavior. This Code works in conjunction with other UPMC policies and procedures, which can be found on Infonet, UPMC's intranet site. Individual UPMC business units, medical staffs, or credentialing bodies may maintain their own Codes of Conduct to supplement this UPMC Code as long as such codes are not less restrictive than this Code.

This Code and subsequent updates are provided upon hire, annually and as updates are made.

### **IV. GUIDELINES**

A. UPMC will not tolerate physically or emotionally intimidating, disruptive, unprofessional, inappropriate, or unethical behavior from people who represent or provide services on behalf of UPMC. Examples of unacceptable behaviors include, but are not limited to:

- a. Violating the laws, regulations, standards, and/or policies that govern and guide UPMC's protocol, procedures, operations, and activities;
- b. Demonstrating an injurious, offensive, demeaning, intimidating, threatening, belittling, coercing, disrupting and/or abusive disposition in the workplace;
- c. Using profanity or any offensive language;
- d. Making inappropriate advances toward and/or physical contact with others;
- e. Harassment through physical contact, verbalizations, gestures, electronic or non-electronic media, and illustrations/graphics;

- f. Malicious, aggravated, injurious, intimidating, threatening behavior toward a manager or other superior;
- g. Breaching confidentiality of patient, consumer, member, employee, or research information;
- h. Behaviors and/or actions that could or do compromise patient safety, including those that are malicious, careless or risky.
- i. Falsifying records, including medical records, expense reports, governmental reports, and business-related documentation;
- j. Creating or contributing to an unsafe and/or unhealthy work environment;
- k. Destroying property or not safeguarding property against loss, theft, misuse, or damage;
- l. Misusing electronic media, including electronic mail, text messaging, instant messaging, Internet/Web technology, etc. by counterfeiting; pirating intellectual property; or by viewing, sending, or receiving pornography, obscene jokes, or sexually harassing content;
- m. Violating UPMC's Conflict of Interest policies and procedures;
- n. Violating UPMC's Foreign Corrupt Practices Act ("FCPA") and Other Anti-Bribery Statutes policies and procedures;
- o. Engaging in activities that could constitute fraud, waste, or abuse;
- p. Accepting or soliciting tips, gifts, loans or other gratuities from patients, their relatives, caregivers or visitors, except as follows:. Staff members may accept unsolicited token gifts of gratitude from patients, their relatives, caregivers or visitors only if the gift is (1) reasonable in value, (2) not cash or a cash equivalent, (3) given openly and transparently, and (4) not intended to influence the patient's medical care or experience. Acceptable gifts include, for example, baked goods, homemade gifts, and fruit baskets. Accepting cash or cash equivalents, such as gift cards, is strictly prohibited. In the event a patient provides a cash or cash equivalent gift despite efforts to politely refuse it, staff shall deliver the gift to the Medical Health and Sciences Foundation (MHSF), pursuant to UPMC Policy HS-EC1703 regarding gifts to UPMC.

## **V. PROCEDURE**

A. UPMC encourages its employees, agents, and others to report all violations of this Code. Employees are encouraged to make an initial written report to their designated supervisor/manager or to their Compliance Officer. Reports can also be made to the Ethics and Compliance Office (ECO), email [complianceaskus@upmc.edu](mailto:complianceaskus@upmc.edu).

B. Violations considered actions that could constitute fraud should also be referred to Corporate Security and the Corporate Ethics and Compliance Office (ECO)

Fraud Team. Corporate Security can be reached by email at [asksecurity@upmc.edu](mailto:asksecurity@upmc.edu). To reach the ECO Fraud Team email [fraudteam@upmc.edu](mailto:fraudteam@upmc.edu).

C. Anonymous reporting may occur by contacting, among other things, the UPMC Compliance Helpline (1-877-983-8442); the Department of Health; or the Joint Commission. A listing of resources to which an individual may report a violation is found on UPMC's public Internet page, [www.upmc.com](http://www.upmc.com), under the Contact UPMC link.

D. Regardless of the reporting method, any violation of the Code must be addressed once it becomes known. The appropriate administrative and/or management representative will:

a. Raise the complaint, concern, and/or issue with the alleged noncompliant individual;

b. Seek response from the individual and, if necessary, investigate the issue to confirm existing details and/or to obtain additional information;

c. Address the issue by implementing an appropriate response (e.g., educational, counseling, and/or corrective action) as directed by applicable UPMC policies and procedures;

d. Document the issue and response; notify other internal (e.g., administrative or management) or external (e.g., regulatory) representatives, Boards, Committees, etc., as appropriate;

e. Promote and monitor future compliance with this Code and other laws, regulations, standards, and policies; and

f. Follow-up with any aggrieved or complaining party to effectively respond to the original and any subsequent concerns or issues.

E. UPMC prohibits retaliation against anyone for raising, in good faith, a concern or question about inappropriate or illegal behavior under this Code. Refer to UPMC policy HS-EC1802 titled "Reporting and Non-Retaliation".

F. Contracts with agents or representatives providing services on behalf of UPMC may contain language regarding behavioral and/or performance expectations and may reference applicable UPMC policies, procedures, and protocol.

G. Any individual providing services on behalf of UPMC, whether employed by the organization or not, should seek further detail regarding applicable policies, procedures, and expectations from their administrative or management representative.

## **VI. NATIONAL LABOR RELATIONS ACT**

Nothing in this policy is intended to restrict or inhibit the lawful exercise of the rights protected under Section 7 of the National Labor Relations Act and this policy should not be interpreted, applied or construed to do so.

## **VII. REFERENCED AND RELATED POLICIES**

HS-EC1700 Conflict of Interest – General Obligations

HS-EC1802 Reporting and Non-Retaliation

HS-EC1803 Theft and/or Breach of Personal Information that is maintained by UPMC

HS-EC1804 Identity Fraud and Theft Program

HS-LE0017 Internal Fraud Investigations

HS-HR0704 Corrective Action & Discharge

HS-HR0705 Harassment-Free Workplace

HS-HR0745 Workplace Violence

HS-EC1806 Foreign Corrupt Practices Act (“FCPA”) and Other Anti-Bribery Statutes

HS-EC1703 Gift

**SIGNED:** Catherine Yunk  
Vice President and Chief Audit and Compliance Officer

**ORIGINAL:** August 3, 2009

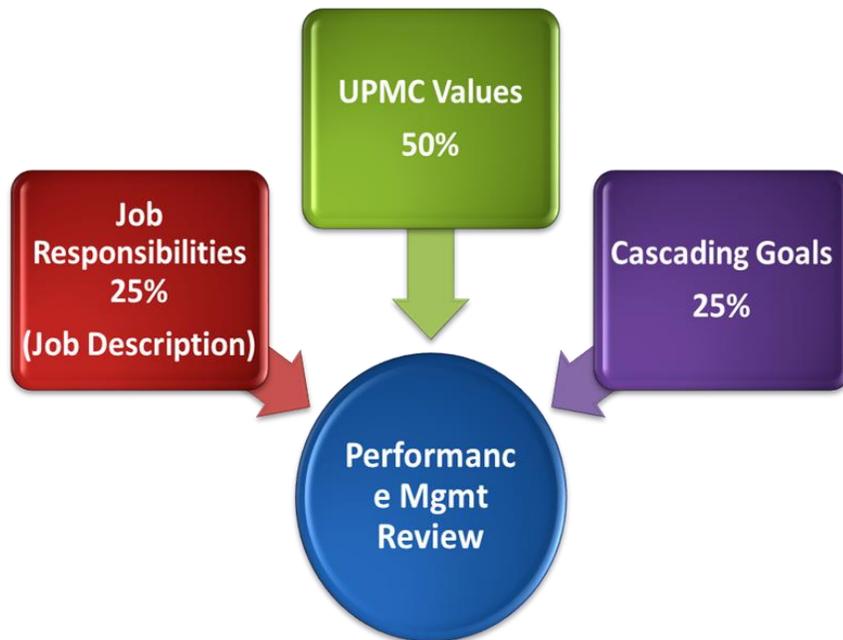
**APPROVALS:**  
Ethics & Compliance Committee of Board of Directors: November 13, 2018  
Policy Review Subcommittee: November 8, 2018

**Executive Staff:** December 3, 2018

**PRECEDE:** February 27, 2018

**SPONSOR:** Vice President and Chief Audit and Compliance Officer

## Performance Management



Here at UPMC our values are very important to us because of our shared goal to create a cohesive, positive experience for all the lives we touch, including our staff. At the core of this experience are the values that define us as an organization, and guide us as individuals. Each of us lives these values every day when we step into our various roles at UPMC. This is why we look at performance through the prism of our values — because **how we do things** is as important as **what we do**.

Because our values mean so much to us, they now make up 50% of all UPMC employees' annual performance reviews. This means your performance will be rated according to how well your actions throughout the year upheld to the values of our organization. Our performance reviews are based on a five-level rating system that include:

- Top Performer – Someone who exceeds expectations 90% or more of the time
- Superior Performer – Someone who exceeds expectations more than 50% of the time, but less than 90% of the time
- Solid/Strong/Good – Someone who meets expectations a majority of the time
- Marginal Performer – Someone who does not meet expectations up to 50% of the time
- Deficient/Poor Performer – Someone who does not meet expectations more than 50% of the time

For each of the five values, your behaviors are rated and placed into one of the five performance levels according to how well you applied the values to your behaviors.

The following looks at UPMC's five values, different performance levels, and examples of behaviors that correlate with each:

## **Quality and Safety**

Top Performer: *Always holds his/her work to high standards of quality, thoroughness, and timeliness.*

- Promptly self corrects his/her work when quality is less than desired
- Proactively makes recommendations to attain higher quality outcomes in the future
- Role model's quality and safe work and inspires others

Solid/Strong/Good: *His/her work meets standards of quality, thoroughness, and timeliness.*

- Monitors own work to ensure quality
- Immediately reports unsafe incidents and conditions
- Follows all safety procedures

Deficient/Poor Performer: *His/her work fails to meet standards of quality, thoroughness, and timeliness.*

- Doesn't monitor the quality of his/her work; waits for others to identify mistakes
- Overlooks potential or actual unsafe conditions
- May bypass safe procedures to save time or avoid confrontation

## **Dignity and Respect**

Top Performer – *Strives for the best results/outcomes by building trust, agreement, collaboration, and teamwork.*

- Stands up for dignity and respect towards others, even when they are not present
- Always tries to learn from others' experiences, values, and beliefs
- Actively works to make situations better if his/her words, actions, and/or responses negatively impact another
- Finds common ground by suspending judgment of others; challenging his/her own assumptions; and asking clarifying questions

Solid/Strong/Good: *Builds trust and agreement through open communications, consistent words/actions, and personal accountability.*

- Understands what influences his/her way of thinking and responding to others
- Has a good sense of how others perceive him/her
- Is mindful of his/her words, actions, and responses toward others
- Considers others' perspectives
- Treats others as they want to be treated
- Communicates respectfully; acknowledges different perspectives; and finds common ground

Deficient/Poor Performer: *Makes minimal to no effort to build trust, agreement, collaboration, and teamwork.*

- Believes that his/her own viewpoint is "right"; does not attempt to incorporate others' opinions, cultures, or viewpoints
- Is influenced by personal biases and judgments about others

- Is not mindful or aware of negative impact that his/her words, actions, and/or responses have on others

## **Caring and Listening**

Top Performer: *Fulfilling the needs of internal/external customers and exceeding expectations is a top priority.*

- Listens carefully, asks questions, checks his/her understanding, and maintains eye contact to understand customers' needs
- Genuinely care for customers; addresses their needs in the manner in which the customer prefers
- Proactively offers input, feedback, and perspective for improving the customer experience
- Incorporates customer feedback to modify and improve his/her service approach

Solid/Strong/Good: *Considers the needs of the internal/external customer when providing service.*

- Listens; shows care and empathy while providing service
- Identifies problems in service; resolves simple and/or routine issues that impact the overall customer experience
- Pursues service recovery when needed
- Asks for customer feedback on service provided

Deficient/Poor Performer: *Does not place high priority on the needs of internal/external customers.*

- Does not demonstrate interest in meeting customers' needs; lacks empathy
- Does not readily identify service problems or work toward resolving them expediently
- Does not seek feedback to improve service

## **Responsibility and Integrity**

Top Performer: *Proactively seeks opportunity to get involved, contribute, and make a positive difference in the unit/department.*

- Seeks information and changes work approach to maximize results
- Quickly adapts to change; demonstrates a positive attitude before, during, and after the change process
- Is viewed in high regard for his/her honesty and integrity in work ethic and interpersonal relationships

Strong/Solid/Good: *Supports the team by getting involved when requested; makes a positive difference.*

- Meets attendance and punctuality guidelines
- Adapts to changes and incorporates new information
- Demonstrates honesty and integrity
- Takes ownership and responsibility for his/her own words and actions

Deficient/Poor Performer: *Does not support the team through active involvement and/or positive contributions.*

- Does not meet attendance and punctuality guidelines
- Is reluctant or resistant to adapting to change
- May appear to others as untrustworthy, dishonest, or having ulterior motives

## **Excellence and Innovation**

Top Performer: *Generates new ideas and encourages others to think creatively.*

- Proactively considers and recommends ways to improve work processes
- Seeks and applies new knowledge and skills, particularly to unusual situations or to both routine and non-routine job duties

Solid/Strong/Good: *Is open to new ideas and new ways of doing things.*

- Considers solutions, especially to routine problems/issues, and shares ideas
- Seeks and applies new knowledge and skills, particularly when executing routine job duties

Deficient/Poor Performer: *Is reluctant to consider new ideas or new ways of doing things.*

- Does not readily consider and/or recommend ways to improve current work processes
- Does not readily seek new knowledge or skills
- Gets stuck in daily routine and/or relies too heavily on others when unusual or non-routine situations arise

## License, Certification, Registration & Clearances

- As a condition of employment, your position may require that you secure the **Act 33 Pennsylvania Child Abuse History Clearance and Act 73 Federal Bureau of Investigation (FBI) Criminal History Record Clearance** dated after your offer of employment for this position. You are required to provide original documentation of this clearance **within 90 days of your hire date**. Failure to provide this information within the specified time frame or unsatisfactory and/or discrepant results may disqualify you from further employment, up to and including termination.
  - Act 33 – Completion of the Child Abuse History Clearance application is the responsibility of each staff member (if applicable). You are responsible for providing the application fee. Human Resources will mail the application along with a money order to the Commonwealth of Pennsylvania. The results of this clearance will be mailed to your *home address* and a copy must be on file in HR within 90 days of your date of hire/transfer. **You will not be permitted to work past the 90 day deadline if the results are not received.**
  - Act 73 – Application registration must be completed at <https://uenroll.identogo.com/>. This website is mobile friendly and can be accessed on a smart device. When completing the application registration, follow the below steps:
    - 1. Enter the Service Code 1KG756 on the main page of the website.
    - 2. Select Schedule or Manage Appointment.
    - 3. Enter the required personal information throughout the next few screens: Essential Info, Employer, Citizenship, Personal Questions, Personal Info, Address, and Documents.
    - **\*\*Please note that all information provided must match the form of I.D. you will present at your fingerprint appointment.**
    - 4. Select the most convenient location, date, and time to schedule an appointment.
    - **\*\*You may select to be a walk-in, but it is highly recommended to schedule a specific appointment.**
    - 5. Review your appointment details and click Done to complete the registration.
    - 6. You will receive confirmation of the scheduled appointment via the preferred method of contact you selected.
    - **\*\*If you selected email, the email confirmation will be titled Identogo Service Confirmation – PA DHS-Employee >=14 Years Contact w/ Children. We recommend saving this email for your records as it can be used in the next step.**
    - Results will be mailed to your home address and a copy of the clearance must be on file in HR within 90 days of your date of hire/transfer. **You will not be permitted to work past the 90-day deadline if the results are not received.**
  - Act 31 -Effective April 15, 2018, all non-licensed employees who are governed by Act 153 and need child abuse clearances for their position will also need to complete the Act 31 training. This training can be completed online at no cost and must be renewed every 5 years.

- A complete list of DOS/Board approved providers can be found on the PA Department of Health website at the link entitled, “Mandated Child Abuse Reporter Training Under Act 31.” As additional providers are approved, the DOS/Board updates this information at [www.dos.pa.gov](http://www.dos.pa.gov). **You will not be permitted to work past the 90-day deadline if the results are not received.**
  
- If you have questions, please contact Human Resources:  
Greenville: 724-589-6323  
Shenango: 724-983-7163

**UPMC  
POLICY AND PROCEDURE MANUAL**

**POLICY: HS-HR0706 \*  
INDEX TITLE: Human Resources**

**SUBJECT: Licensure, Certification, Registration of Staff Members**

**DATE: October 29, 2018**

**I. POLICY/PURPOSE/SCOPE**

It is the policy of UPMC to maintain proper records of licenses, certification and/or registrations of its staff members. This policy applies to any United States based staff member who is required to hold licenses, certifications, or registrations either by law or the Business Unit to which he or she is assigned. Exceptions to this policy may be determined by legislative or regulatory provisions depending on the job.

**II. RESPONSIBILITY**

**A. Staff Members**

1. All staff members whose position requires a license, certification, or registration are required, as a condition of employment, to provide a copy, and in some cases, the original of their current license, certification, or registration to Human Resources or a designee upon request.
2. All staff members are responsible for keeping their license, certification, or registration current and for reporting any loss of, sanctions, or restrictions to their license, certification or registration to their supervisor and Human Resources. Any staff member who fails to notify his or her supervisor and/or Human Resources that his or her licensure, certification, or registration has expired or has had sanctions or restrictions imposed on it, will be subject to Corrective Action up to and including discharge.
3. Failure on the part of the staff member to renew the license, certification, or registration and present the required portions of the renewed license, certification, or registration before expiration will result in his or her immediate suspension without pay upon expiration. Any staff member who fails to produce a valid license, certification, or registration to the Human Resources Department or Department Head after they have been suspended will be discharged from employment.
4. Graduate staff members who have not yet received their license, certification, or registration must adhere to the policies as established by their particular department and by appropriate licensing authority.
5. Where the original license, certification or registration is provided, it is the responsibility of the staff member to obtain the required portions of his or her license, certification, or registration upon termination of employment.

**B. Human Resources/Department Head**

1. **NEW HIRES:** Before an offer of employment is made, the Talent Acquisition Department is responsible for verifying the current status of the applicant's license, certification, or registration.
  - A. The Talent Acquisition Department is required to verify current license, certification, or registration by primary sourcing via a secure electronic communication or by telephone. The Human Resources Department or the Department Head is required to maintain proof of verification.

B. When required by legislative or regulatory provisions, the Human Resources Department or Department Head must maintain the copy, and in some cases the original license, certification, or registration.

2. RENEWALS: The Human Resources Department or Department Head is required to review and/or primary source, as required by legislative or regulatory provisions, the license, certification, or registration of each of his or her staff members prior to its expiration and to notify the staff member that the maintenance of credentials is a condition of employment.

A. The Human Resources Department or Department Head is required to verify current licensure, certification, or registration by primary sourcing via a secure electronic communication or by telephone. The Human Resources Department or Department Head is required to maintain proof of verification prior to expiration.

B. When required by legislative or regulatory provisions, the Human Resources Department or Department Head must maintain the copy and in some cases the renewed license, certification, or registration.

3. Any special circumstances regarding license, certification, or registration of applicable staff members must be discussed with Human Resources.

### **III. OUTSIDE SOURCES**

When an external agency or other outside contractor is used to provide licensed, certified or registered professionals to supplement UPMC staff, the agency or contractor must maintain documentation verifying that such licenses, certifications and registrations are current and in good standing and must agree to make such documentation available to Human Resources upon request. Written agreements with such agencies and contractors shall include this requirement.

### **IV. RELEVANT POLICIES**

HS-EC1801 Sanction & Exclusion Policy & Review Process

HS-HR0704 Corrective Action & Discharge

**SIGNED:** John L. Galley  
Senior Vice President and Chief Human Resources Officer

**ORIGINAL:** October 1, 2000

**APPROVALS:**

Policy Review Subcommittee: October 11, 2018

Executive Staff: October 29, 2018

**PRECEDE:** April 27, 2018

**SPONSOR:** Senior Vice President and Chief Human Resources Officer

**\* With respect to UPMC business units described in the Scope section, this policy is intended to replace individual business unit policies covering the same subject matter. In-Scope business unit policies covering the same subject matter should be pulled from all manuals.**

**UPMC  
POLICY AND PROCEDURE MANUAL**

**POLICY: HS-HR0733 \*  
INDEX TITLE: Human Resources**

**SUBJECT: Orientation Period  
DATE: July 27, 2018**

**I. POLICY/PURPOSE**

It is the policy of UPMC to manage employee performance to support the provision of outstanding patient care, education and research. The purpose of the orientation period is to provide an ongoing, consistent process to facilitate the transition to full competence within their staff members' first six months of his or her position. This is accomplished by providing information about UPMC, the business unit, the department and the position requirements. Further, the new staff member is monitored, assessed and coached to ensure that he or she is performing in accordance with the UPMC system-wide values and performance standards.

Links to policies referenced within this policy can be found in Section V.

**II. SCOPE**

This policy applies to all United States based staff members new to a particular job by being newly hired or rehired, promoted or demoted. Staff members covered by collective bargaining agreements are covered by the terms of their agreements.

**III. DEFINITION**

The initial orientation period refers to a newly hired or rehired staff member's first six months of employment. The time employed as a WorkSource staff member does not count toward the initial orientation period.

**IV. PROCEDURES WITHIN THE FIRST SIX MONTHS**

**A. UPMC Orientation**

The Human Resources Department coordinates a required orientation for all newly hired or rehired staff members including those in supervisory and management positions. This orientation program addresses broad topics, such as the UPMC values, UPMC vision and mission, select human resources policies, benefits programs, infection control, safety and other compliance related issues.

The department head or supervisor is responsible for ensuring that the newly hired/rehired staff member attends and completes the orientation program. In the event the new staff member does not attend the first available orientation, the supervisor is responsible for ensuring that the staff member attends a session.

**B. Department Orientation**

The department supervisor is responsible for providing appropriate department orientation to the newly hired/rehired staff members and those new to the department within the first few weeks on the job. The department orientation is intended to ease the transition of the new staff member into the department by providing general information. Topics should include but are not limited to:

- Job description
- Job competencies and clinical skills when applicable
- Age-specific competencies if applicable
- Mandatory education including HIPAA, OSHA Safety and other compliance related training requirements
- Performance Review Process/Document
- Performance goals, expectations and standards
- Tour of work area/business unit
- Specific department practices and policies and procedures
- Other departments with frequent interaction
- Department's role within business unit and UPMC overall
- Other department specific information deemed relevant for the new staff member
- My HUB access and Employee ID

The department supervisor is responsible for documenting the department orientation by completing a department orientation checklist. A standard form is available from the Human Resources Department or on the Infonet or a department form may be substituted.

A copy of the completed department orientation checklist must be signed by the staff member and supervisor and retained. The department orientation checklist must be completed by the time you submit your staff member's six month evaluation. The staff member's department should also maintain records of staff member orientation, training, mandatory education and job and age-specific competencies as necessary for compliance with the Joint Commission and/or other applicable standards.

#### C. Performance Assessment

The immediate supervisor will closely monitor and assess the new staff member's performance, competencies, behavior and attendance during the orientation period and provide feedback to the individual regarding performance. It is important to identify and address any performance issues in a timely manner as they are identified. Additionally, the supervisor should identify and recognize performance that exceeds expectations.

#### D. Below-Standard Performance during the Orientation Period

1. The immediate supervisor must document any counseling about below-standard performance, behavioral problems or policy violations, including the Code of Conduct. In the event that a newly hired/rehired staff member's performance is below standard and fails to demonstrate consistent and acceptable improvement, the immediate supervisor should contact a Human Resources representative to discuss options, including discharge, consistent with UPMC's employment at will provision.

2. Staff members, who have completed their initial orientation period, are subject to the provisions of UPMC policies HS-HR0704 Corrective Action and Discharge, HS-HR0707 Grievance Procedure, and HS-HR0724 Performance Management.

#### **V. POLICIES REFERENCED WITHIN THIS POLICY**

HS-HR0704 Correction Action and Discharge

HS-HR0707 Grievance Procedure

HS-HR0724 Performance Management

**SIGNED:** John L. Galley  
Senior Vice President and Chief Human Resources Officer

**ORIGINAL:** January 23, 2003

**APPROVALS:**  
Policy Review Subcommittee: July 12, 2018  
Executive Staff: July 27, 2018

**PRECEDE:** June 23, 2017

**SPONSOR:** Senior Vice President and Chief Human Resources Officer

**\* With respect to UPMC business units described in the Scope section, this policy is intended to replace individual business unit policies covering the same subject matter. In-Scope business unit policies covering the same subject matter should be pulled from all manuals.**

## Drug Free Workplace

It is the policy of UPMC to provide a drug free work environment in accordance with the Drug Free Workplace Act of 1988.

The Drug Free Workplace Statement in your Attendance Confirmation packet outlines

- That the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance on UPMC premises or while conducting UPMC business off UPMC premises is absolutely prohibited.
- Violations of this policy will result in corrective action, up to and including discharge.
- That employees must report any criminal convictions for drug-related activity no later than 5 days after conviction.
- UPMC recognizes that abuse or dependency due to a medical condition, illness or injury may occur and provides assistance through *LifeSolutions* for concerns.

**Drug-Free Workplace policy HS-HR0703 \* is located on UPMC Infonet**

## Clean Air/Smoke Free

In order to provide a healthy environment for our patients, guests, and staff members, all UPMC facilities and grounds are smoke-free.

As of July 1, 2014, UPMC staff members are no longer be permitted to smoke or use tobacco products during their work shift, including any breaks on or off campus.

In conjunction with our mission of supporting healthy lifestyles, we join other like-minded health care leaders such as Baylor Health Care System, Cleveland Clinic, and Mayo Clinic in committing to a healthy environment for patients, visitors, and staff.

We encourage you to take advantage of the smoking cessation programs offered through LifeSolutions, our Employee Assistance Program, and the resources accessible through MyHealth.

**Clean Air/Smoke and Tobacco-Free Campus policy HS-HR0744\* is located on UPMC Infonet**

## Attendance Guidelines

UPMC Horizon strives to provide all employees with a clear understanding of the rules and responsibilities associated with time and attendance. The purpose of these guidelines is to define the standard of time and attendance that can be consistently managed across all departments and which will allow the hospital to provide high quality, cost-effective patient care.

### Scheduled Absences:

Pre-approved time off according to departmental guidelines coded in Kronos as STO

It is the employee's responsibility to request and obtain approval for time off according to departmental guidelines.

### Unscheduled Absences:

Time that has not been prescheduled according to department guidelines coded in Kronos as UTO or ITO

All unscheduled absences within a rolling 12 month period may be tabulated towards progressive disciplinary action up to and including termination per UPMC Policy HS-HR0704 Corrective Action. Time lost due to workers' compensation, approved leave of absences, military or jury duty, funeral leave, pre-approved absences and holidays are not used to calculate unscheduled time off. Time off assigned by a supervisor due to low patient census (LCD) will also not be counted as an occurrence of absence regardless of the use of paid time off.

Absence from the job creates morale problems due to interrupted work schedules and extra work load on others. All employees who find it necessary to be absent must notify their department manager as far in advance as possible prior to their scheduled work shift. It is the responsibility of all employees to understand and follow their departmental policies and procedures regarding reporting off work.

Failure to notify the Hospital of an absence in accordance with department policy is a serious problem. Excessive recurrences and identified patterns of absenteeism and/or failure to comply with departmental reporting off policies may lead to corrective action up to and including termination. Absence without notification for three consecutive work shifts will be considered job abandonment.

The Hospital encourages all employees to discuss the need for time off with their supervisors in order to achieve a mutually agreeable solution rather than report off work. If there is a report off from work, the supervisor must determine the reason for each absence.

All absences in excess of 3 scheduled shifts require staff to contact UPMC WorkPartners at 1-800-633-1197 to discuss leave of absence eligibility.

### Tardiness:

Failure to punch in and be ready to perform work duties before 6 minutes after the start of a scheduled shift (Kronos system will identify late and early punches by highlighting the punch in red). Tardiness cannot be offset by Paid Time Off or altering the work schedule.

Failure to arrive at the Hospital in a timely manner in order to start your shift is a serious problem. Excessive recurrences and identified patterns of tardiness and/or failure to comply with UPMC Policy HS-HR0741 Time Entry Submission may lead to corrective action up to and including termination. Employees must notify their department that they will be tardy before the start of their shift per department guidelines.

Alternative coverage may be arranged in cases where staff does not use the proper established practice to notify the department they will be tardy. The employee could forfeit their shift and pay for that shift if such arrangements are made. This could also be considered an unscheduled absence and be included when calculating UTO. Attendance Guidelines is located on the Horizon Home page under Policy Manuals. Corrective action is a consistent method to address behavior concerns, the policy is progressive however; the severity of the incident will determine the appropriate step.

**UPMC  
POLICY AND PROCEDURE MANUAL**

**POLICY: HS-HR0704 \*  
INDEX TITLE: Human Resources**

**SUBJECT: Corrective Action and Discharge  
DATE: April 27, 2018**

### **I. POLICY/PURPOSE**

It is the policy of UPMC to provide guidelines for progressive corrective action and discharge. Each staff member is expected to perform his or her job effectively; demonstrate acceptable behaviors; maintain steady attendance; adhere to department, business unit, and UPMC policies; respond positively to direction; and consider the best interests of the patients, visitors, physicians, and fellow staff members. It is the policy of UPMC that corrective action for failure to meet these standards shall be administered in a manner that is timely, impartial, consistent, reasonable and confidential. The underlying objective of this policy is to correct behavior and promote the individual staff member's growth and development; and to provide quality, safe patient care in an environment conducive to excellence. In order to ensure that adequate time is allotted to correct behavior, a staff member receiving corrective action at or above the Written Warning level will not be permitted to apply for transfer opportunities for six months from the date the action was received.

Links to policies referenced within this policy can be found in Section IX.

### **II. SCOPE**

This policy applies to all non-supervisory, non-management United States based UPMC staff members who have completed their initial orientation period. This policy does not apply to temporary staff members or contracted staff such as physicians or faculty. Corrective action and discharge of temporary staff members will be determined by UPMC WorkSource. (UPMC WorkSource refers to HS-HR0749 WorkSource Corrective Action and Discharge Policy).

### **III. GUIDELINES**

- A. Corrective steps should be taken to identify and to assist in resolving problems of unsatisfactory conduct on the job. The corrective steps consist of counseling and warnings that are intended to help a staff member improve his or her conduct.
- B. The absence of or seriousness of previous corrective events and the length of time between events should be considered as factors in determining corrective action. Subsequent offenses need not be of the same or similar nature to previous warnings to warrant the next level of corrective action or discharge.
- C. Supervisors are encouraged to recommend the services of the Employee Assistance Program (EAP)/LifeSolutions to staff members during verbal counseling. If a staff member is given corrective action at a level higher than a verbal counseling, the supervisor is strongly encouraged to make and document a supervisory referral to LifeSolutions. Supervisors may also make mandatory referrals to LifeSolutions under certain circumstances as described in UPMC policy HS-HR0732, Employee Assistance Program (EAP)/LifeSolutions. Any issues related to staff member's performance should be addressed via UPMC policy HS-HR0724, Performance Management.

## **IV. CORRECTIVE ACTION**

All physicians, managers and staff members involved in investigation or deliberation of corrective action must maintain confidentiality of that information.

### **A. Supervisor Counseling (verbal)**

A counseling session is a meeting between the supervisor and the staff member to discuss any difficulty the staff member is having in meeting standards of conduct and/or attendance. These difficulties may include, but are not limited to:

1. absenteeism, tardiness (in early phases)
2. inadvertent failure to properly report time or report absence
3. unauthorized break or failure to return from break on a timely basis
4. inappropriate dress or conduct
5. violation of UPMC policy HS-HR0744 Clean Air/Smoke and Tobacco -Free Campus Policy
6. is determined to have engaged in risky behavior under A Just Culture

The supervisor should note in writing the date, time, content of discussion, and action decided upon during the counseling session. These records are to be kept by the supervisor.

### **B. Written Warning**

A written warning is used to record continuing behavior problems when prior verbal counseling was unsuccessful in correcting the problem or is used for the first occurrence of a more serious nature. Absent mitigating or aggravating circumstances, as determined by the staff member's Human Resources director or designee, the following single events may be appropriate for a written warning without prior counseling (not intended to be all inclusive):

1. violation of safety or sanitation rules
2. violation of a UPMC or departmental policy, practice or procedure
3. violation of departmental policies regarding reporting hours worked and working overtime
4. unauthorized use of business unit bulletin boards
5. unauthorized absence
6. is determined to have engaged in careless behavior under A Just Culture

### **C. Suspension/Final Written Warning**

A suspension without pay of up to five (5) days or a final written warning is used to address continuing problems as described in A and B above where previous action has been ineffective.

Absent mitigating or aggravating circumstances, as determined by the staff member's Human Resources director or designee, the following single events may be considered serious in nature and result in a suspension without pay (of up to five days unless otherwise specified) or a final written warning without prior corrective action (not intended to be all-inclusive):

1. horseplay
2. profane or inappropriate language or indecent conduct, particularly in proximity to patients or visitors
3. illegal gambling on UPMC premises
4. accepting or soliciting tips, gifts, loans or other gratuities from patients, visitors, or other staff members
5. violation of solicitation policies
6. work negligence or carelessness

7. failure to keep licensure up to date per UPMC policy HS-HR0706, Licensure, Certification, Registration of Staff Members (would result in an unpaid suspension of up to 30 days).
8. failure to complete mandatory education (would result in an unpaid suspension of up to 14 days or a final written warning).
9. inappropriately accessing Protected Health Information (would result in an unpaid suspension of up to 14 days or a final written warning).
10. sleeping on the job, or giving the appearance of sleeping on the job  
Staff members involved in corrective action may receive a final written warning in lieu of suspension.

Staff members involved in corrective action may receive a final written warning in lieu of suspension.

#### **D. Discharge/Suspension Pending Investigation**

Discharge may be used even without prior progressive action to address more serious violations or as a last resort when prior progressive corrective action steps have failed. Discharge requires due deliberation over the facts of a given situation and the nature of a staff member's record. In order to provide the time necessary to assess the appropriateness of discharge, suspension pending investigation may be utilized. The supervisor should, if possible, consult with a human resources representative before taking this action, but in those instances when that is not possible, the supervisor may suspend the staff member pending investigation and then contact the Human Resource department afterwards. Suspensions pending investigation are unpaid. If, after investigation, it is determined that the staff member has not committed an offense warranting corrective action, he or she will be compensated for wages lost due to the suspension.

It is appropriate to suspend a staff member pending investigation:

- where there is probable cause to believe a staff member has committed an offense that is considered to be dischargeable even without prior corrective action;
- immediately after an event in which there was actual or potential harm to patients, visitors, other staff members, or property damage where the staff member may have responsibility for the event. Probable cause is not an element in such cases.

The supervisor must advise the staff member that he or she is placed on suspension pending investigation.

The documentation and action recommended, at the conclusion of the suspension, must be reviewed and approved in advance by: the department head, the administrative director or vice president, and the Human Resources director or designee.

Absent mitigating or aggravating circumstances, as determined by the staff member's Human Resources director or designee, the following events are usually considered cause for discharge, even without prior corrective action (not intended to be all inclusive):

1. unauthorized removal of employer property, possession of stolen goods
2. dishonesty
3. theft
4. sexual harassment or harassment based on race, color, religion, ancestry, national origin, age, sex, genetics, sexual orientation, gender identity, or marital, familial, or disability status as a covered Veteran or any other legally protected group status
5. creating a hostile work environment
6. disclosing or accessing confidential information including Protected Health Information where there was no business need to know

7. smoking in a hazardous area or other serious safety violation
8. grossly negligent, careless, malicious or willful act, which may result in injury, damage, or loss of revenue
9. withholding or providing false, material information in employment application
10. falsification of records
11. intentional altering of time records
12. unlawful and unauthorized manufacture, distribution, dispensation, possession, or use of a controlled substance or alcohol on UPMC premises, while conducting UPMC business off UPMC premises or when on duty
13. charged with, and not found innocent of a crime, which would diminish trust in the staff member's future performance
14. wearing a monitoring device, pursuant to a criminal conviction or other court order, while working
15. fails to notify UPMC within five (5) days of being convicted of any crime other than a summary offense or within 72 hours of an arrest or conviction if required by Act 153
16. off duty conduct which would diminish trust in the staff member's future performance
17. threatening, abusing, or doing harm to others
18. disorderly conduct or fighting on or near UPMC premises while on duty
19. unauthorized possession of any weapon as defined by UPMC Policy HS-FM0231 Possession of Firearms or Weapons
20. Insubordination
  - a. refusal to follow orders of supervisory personnel
  - b. publicly displaying disrespect towards a supervisor
  - c. threatening, intimidating, coercing or interfering with a supervisor
  - d. refusal to cooperate in an internal investigation
21. refusing to submit to a fitness for duty examination
22. intentional/stealthy sleeping on the job or giving the appearance of sleeping on the job
23. walking off the job
24. disruptive, offensive or harmful use of electronic communications
25. acting outside the scope of one's position, authority or certification
26. reporting unfit for duty as defined by UPMC Policy HS-HR0721 Fitness for Duty

The manager, Human Resources director or designee should communicate by letter to the staff member the decision to discharge or to return to work if the staff member was suspended pending investigation. A copy is included in the staff member's personnel file.

## **V. RESPONSIBILITY AND AUTHORITY TO ADMINISTER CORRECTIVE ACTION**

- A. All levels of corrective action should be discussed with a Human Resources representative.
- B. Action involving a "written warning" must be approved by the department head or designee. A record of action at and beyond the "written warning" stage must be permanently maintained in the staff member's electronic personnel file.
- C. Suspensions, final written warnings and discharge must be approved by: the department head, the administrative director or vice president, and Human Resources director or designee before final action is taken.

## **VI. DOCUMENTATION**

- A. All corrective actions and discharges must be documented and should include the following:
1. the level of corrective action being applied (e.g., written warning, suspension, discharge) which should be noted in the title and text of the document;
  2. the date, time, location, and the sequence of events of the current event and the specific reason;
  3. the action plan recommended including referrals to support services, behavioral expectations, and restrictions placed on the staff member for attendance-related problems;
  4. the level and reasons for previous corrective actions and the dates of these actions; and
  5. for corrective action (not discharges) a statement indicating that future/further corrective action may accompany the next violation of policy or failure to perform to standard.
- B. Suspension, final written warnings and discharge documentation must include a reference to the appropriate provision of the grievance procedure as established by UPMC policy HS-HR0707, Grievance Procedure.
- C. Corrective actions should be reviewed, discussed, and signed by the supervisor and the staff member. The staff member may note his or her response on the official documentation. The date of the discussion must be indicated on the documentation. The staff member will be provided with a copy of the documentation.
- D. If the staff member refuses to sign the official documentation of corrective action, the supervisor must note their refusal on the document and initial the document.
- E. After this review has taken place, the original, signed copy of the action must be forwarded, marked confidential, to Human Resources. A Human Resources representative must review the documentation and forward it to the staff member's personnel file.

## **VII. JOB ABANDONMENT**

A staff member who is absent for three consecutive scheduled workdays without notifying his or her supervisor is considered to have abandoned his or her job. The supervisor will process the staff member as having voluntarily terminated for job abandonment. The manager or Human Resources representative or designee will provide a termination letter to the staff member. If the staff member later produces an explanation, that in the sole judgment of UPMC represents a "good cause" for this absence, the department head and the Human Resources director or designee may consider reinstatement of employment.

## **VIII. GRIEVANCE PROCEDURE**

An eligible staff member who considers him or herself unfairly treated by any actions taken under this policy may resort to UPMC policy HS-HR0707 Grievance Procedure. Grievances must be filed within the timeframes as set forth in the grievance policy.

## **IX. POLICIES REFERENCED WITHIN THIS POLICY**

HS-HR0749 UPMC WorkSource Corrective Action and Discharge

HS-HR0732 Employee Assistance Program (EAP)/LifeSolutions  
HS-HR0724 Performance Management  
HS-HR0744 Clean Air/Smoke and Tobacco-Free Campus  
HS-HR0706 Licensure, Certification, Registration of Staff Members  
HS-HR0707 Grievance Procedure  
HS-FM0231 Possession of Firearms or Weapons  
HS-MR1000 Release of Protected Health Information  
HS-IS0147 Electronic Mail, Messaging and Texting  
HS-HR0705 Harassment-Free Workplace  
HS-HR0721 Fitness for Duty  
HS-HR0736 Confidential Information  
HS-EC1900 Code of Conduct

**SIGNED:** John L. Galley  
Senior Vice President and Chief Human Resources Officer

**ORIGINAL:** October 1, 2000

**APPROVALS:**  
Policy Review Subcommittee: April 12, 2018  
Executive Staff: April 27, 2018

**PRECEDE:** November 1, 2017

**SPONSOR:** Senior Vice President and Chief Human Resources Officer

**\* With respect to UPMC business units described in the Scope section, this policy is intended to replace individual business unit policies covering the same subject matter. In-Scope business unit policies covering the same subject matter should be pulled from all manuals.**

**UPMC  
POLICY AND PROCEDURE MANUAL**

**POLICY: HS-HR0707 \*  
INDEX TITLE: Human Resources**

**SUBJECT: Grievance Procedure**

**DATE: October 29, 2018**

**I. POLICY**

It is the policy of UPMC to facilitate communication and prompt resolution of corrective action and other issues that arise in the context of employment. Eligible staff members have the right to seek resolution of their grievances without fear of reprisal. The grievance procedure is an internal process not open to external representation/involvement.

Links to policies referenced within this policy can be found in Section VI.

**II. DEFINITION**

A grievance is an allegation of a violation of any Human Resources policy or the Exclusion from Patient Care policy (HS-HD-CP-08).

**III. ELIGIBILITY**

Nonsupervisory, non-management staff members who have completed their initial orientation period are eligible to use the grievance procedure. UPMC WorkSource temporary and casual staff members are not eligible to use the grievance procedure.

**IV. PROCEDURE**

**Step 1** - If a staff member believes that he or she has a grievance not related to a suspension, final written warning in lieu of suspension or discharge, the staff member must first communicate this grievance within seven (7) calendar days of the time that he or she knows or should have known of the event that is the basis for the grievance. The staff member may communicate the grievance in writing or during a face-to-face discussion with the supervisor. The supervisor should review and issue a decision to the staff member within seven (7) calendar days from receiving the written grievance or conducting the face-to-face discussion. (If the grievance is related to a suspension, final written warning in lieu of suspension or discharge, the staff member should initiate the grievance at Step 3.)

**Step 2** - If the staff member believes that he or she is not able to communicate the grievance with the immediate supervisor, or if the grievance is not satisfactorily resolved after discussion with the immediate supervisor, the staff member must then communicate the grievance in writing or during a face-to-face discussion with the department head within seven (7) calendar days from receiving the written grievance or conducting the face-to-face discussion. The department head will investigate, review, and issue a decision to the staff member within seven (7) calendar days from receiving the written grievance or conducting the face-to-face discussion.

**Step 3** - If the grievance remains unresolved, the staff member must communicate the matter to Human Resources in writing within seven (7) calendar days of the decision at Step 2. Human Resources will review the grievance and issue a decision in writing within fourteen (14) calendar days of receiving the written grievance.

Grievances related to suspension, final written warning in lieu of suspension or discharge must be received in writing by Human Resources within seven (7) calendar days of the date of suspension, final written

warning in lieu of suspension or discharge. Human Resources will review the grievance and issue a decision in writing within fourteen (14) calendar days.

**Step 4** - If the grievance remains unresolved, the staff member must communicate the matter to the business unit's President and/or administrative designee within seven (7) calendar days of the decision at Step 3. The President and/or administrative designee will review the grievance and issue either a status update or final decision (final decision must be in writing) within fourteen (14) calendar days of receiving the grievance letter.

#### **V. TIME FRAMES**

If any of the above time frames for filing appeals are not met, the matter will be considered resolved based upon the decision at the prior step. All time limits may be extended by mutual agreement of the grievant and the employer upon reasons deemed appropriate under the circumstances.

#### **VI. POLICIES REFERENCED WITHIN THIS POLICY**

HS-HD-CP-08 Exclusion from Patient Care

**SIGNED:** John L. Galley  
Senior Vice President and Chief Human Resources Officer

**ORIGINAL:** October 1, 2000

#### **APPROVALS:**

Policy Review Subcommittee: October 11, 2018

Executive Staff: October 29, 2018

**PRECEDE:** November 1, 2017

**SPONSOR:** Senior Vice President and Chief Human Resources Officer

**\* With respect to UPMC business units described in the Scope section, this policy is intended to replace individual business unit policies covering the same subject matter. In-Scope business unit policies covering the same subject matter should be pulled from all manuals.**

## **HARASSMENT/SEXUAL HARASSMENT IN THE WORKPLACE**

### **INTRODUCTION/VALUE STATEMENT:**

UPMC Horizon expects that our work environment is free from sexual harassment or harassment based on race, color, religion, sex, sexual orientation, national origin, age, or disability. Such harassment is forbidden and violates UPMC policy as well as state, federal and local laws. UPMC Horizon believes that prevention is the most effective tool in eliminating sexual harassment in the workplace and will NOT tolerate or condone instances of sexual harassment.

### **BEHAVIORAL OBJECTIVES:**

After reviewing this information, you will be able to:

- ✓ Define harassment and sexual harassment.
- ✓ Identify behavior that is considered harassment or sexual harassment.
- ✓ Identify steps to take if you are being harassed.

### **What is Harassment?**

Harassment is verbal or physical conduct that demeans or shows hostility or hatred toward an individual because of his or her race, color, religion, sex, sexual orientation, national origin, age, or disability, or because of a relationship with relatives, friends or associates.

### **Negative Effects of Harassment**

- It can create an intimidating, hostile, or offensive working environment.
- It can unreasonably interfere with an individual's work performance.
- It can adversely affect an individual's employment opportunities.

### **Examples of Harassment**

- Nicknames, labels, slurs, negative stereotyping.
- Threatening, intimidating or hostile acts that relate to race, color, religion, sex, sexual orientation, national origin, age or disability.
- Written or graphic material that demeans or shows hostility or hatred toward an individual or group because of race, color, etc. that is openly displayed within the work environment.

### **Examples of Behaviors That Could be Defined as Sexual Harassment**

- Pressure for sexual activity.
- Sexual graffiti or visuals, innuendos, jokes or comments.
- Disparaging remarks to a person about his/her gender or body.
- Unwelcome patting, hugging or touching a person's body, hair or clothing.

### **Primary Types of Sexual Harassment:**

- Quid pro quo – which means “this for that”. An employee's job security, pay raise, and/or promotion are a benefit if a sexual favor is provided to a person who holds a higher position.
- Environmental Harassment – the workplace is offensive or intimidating to the victim. This hostile environment may include: crude offensive language, vulgar gestures, demeaning terms, or talk about sexual activities or physical attributes.

### **How do I Know if I am Being Harassed?**

Ask yourself:

- Was the conduct blatantly offensive or gender hostile?
- Was the harasser a co-worker or a supervisor?
- Was this conduct a one-time event or is it repetitive?
- Was the harassment a group action, one gender against the other?

#### **Four Key Steps to Take if Harassment/Sexual Harassment Takes Place:**

1. **CONFRONT THE PROBLEM** – tell him/her that the behavior is offensive and explain how you feel.
2. **IMMEDIATELY REPORT** such harassment to his respective manager or director. If not comfortable reporting to manager or if manager is the harasser, the complaint should be filed with the director of Human Resources.
3. **DOCUMENT OFFENSIVE CONDUCT** – include all details of incident and names of any witnesses.
4. **SEEK SUPPORT** – a friend or colleague may be able to help you feel less isolated and you may find others in the same situation.

#### **How to Avoid Sexual Harassment**

- Respect your co-worker – watch your language, don't tell lewd jokes.
- Innocent fun to you may be interpreted differently by others.
- Your personal life is your OWN business.

#### **Points to Remember:**

- Harassment constitutes discrimination and violates Title VII of the Civil Rights Act of 1964, the Age Discrimination in the Employment Act, the Americans with Disabilities Act, or the Rehabilitation Act of 1973, as applicable.
- Sexual harassment is using sex as a weapon and IS illegal.
- There doesn't have to be an implied threat toward your job.
- Only unwelcome conduct is Harassment/Sexual Harassment.
- Sexual Harassment is an invasion of your own set values and personal space.

## Employee Rights

The purpose of this policy is to establish a mechanism to protect the rights of employees to express their ethical and cultural values and practice their religious beliefs, while assuring that all patients receive appropriate care. Treatment and care will be provided to all persons in need without regard to disability, race, creed, color, gender, national origin, lifestyle, or ability to pay.

- Clinical staff can ask for accommodation if type of care to be delivered infringes on employee's religious, morale or ethical values
- Inform manager and continue to follow assignment until accommodation is made – cannot change or refuse assignment
- Discuss with manager as soon as possible when you have concerns.

## UPMC

### POLICY AND PROCEDURE MANUAL

**POLICY: HS-HR0705 \***

**INDEX TITLE: Human Resources**

**SUBJECT: Harassment-free Workplace**

**DATE: April 27, 2018**

#### **I. POLICY/PURPOSE**

It is the policy of UPMC to maintain an environment that is free from sexual harassment or harassment based on race, color, religion, ancestry, national origin, age, sex, genetics, sexual orientation, gender identity or marital, familial, or disability status or status covered as a Veteran or any other legally protected group status, patients, and any other persons whom contact is made during employment at UPMC. Such harassment is forbidden and violates UPMC policy as well as state, federal and local laws.

This policy establishes the procedure by which staff members and patients can make their complaints known to appropriate administrative staff. It is a violation of UPMC policy to attempt to retaliate against a person who files a complaint of harassment. Retaliation against any staff member because he or she has reported, assisted or participated in any manner in an investigation proceeding, hearing, or lawsuit, pursuant to a harassment claim is prohibited.

#### **II. SCOPE**

Every person associated with UPMC, while on United States premises, including subsidiary staff members, physicians, volunteers, contracted personnel, students, non-employed medical staff, and vendors is required to conform his or her behavior to this policy and to report any violation of this policy.

#### **III. GUIDELINES**

- A. UPMC prohibits harassment on the basis of race, color, religion, sex, genetics, sexual orientation, gender identity, national origin, age, disability or military affiliation.

1. Harassment on the basis of race, color, religion, ancestry, national origin, age, sex, genetics, sexual orientation, gender identity or marital, familial, or disability status or status as a covered Veteran or any other legally protected group status constitutes discrimination in the terms, conditions, and privileges of employment and, as such, violates Title VII of the Civil Rights Act of 1964, the Age Discrimination in Employment Act, the Americans with Disabilities Act, the Rehabilitation Act of 1973, or **POLICY HS-HR0705** or the Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA) as applicable.
2. Harassment is unwelcome conduct that is spoken, written or physical conduct that demeans or shows hostility or hatred toward an individual because of his or her race, color, religion, ancestry, national origin, sex, genetics, sexual orientation, gender identity or marital, familial, or disability status or status as covered Veteran or any other legally protected group status or that of his or her relatives, friends, or associates, and that:
  - a. has the purpose or effect of creating an intimidating, hostile, or offensive working environment;
  - b. has the purpose or effect of unreasonably interfering with an individual's work performance; or
  - c. otherwise adversely affects an individual's employment opportunities.

3. Harassing conduct includes, but is not limited to, the following:

a. nicknames, labels, slurs, negative stereotyping, or threatening, intimidating or hostile acts that relate to race, color, religion, ancestry, national origin, sex, genetics, sexual orientation, gender identity or marital, familial, or disability status or status as covered Veteran or any other legally protected group status; and

b. any form of communication or graphic material that demeans or shows hostility or hatred toward an individual or group because of race, color, religion, ancestry, national origin, age, sex, genetics, sexual orientation, gender identity or marital, familial, or disability status or status as covered Veteran or any other legally protected group status and that is placed on walls, bulletin boards, computers, or elsewhere on the employer's premises or circulated in the workplace.

c. any form of inappropriate and unwelcome physical contact

B. UPMC prohibits Sexual harassment. Sexual harassment is an unwelcome sexual advance, request for sexual favors, or other verbal or physical contact of a sexual nature when:

1. submission to such conduct is either made or implied as a term or condition of employment;

2. submission to or rejection of such conduct by an individual is used as the basis for employment decisions; or

3. the conduct has the purpose or effect of substantially interfering with an individual's work performance or creates a hostile or offensive work environment.

The following are examples of inappropriate behaviors which may constitute sexual harassment (this list is only intended to illustrate the kinds of conduct prohibited by this policy and is not all-inclusive):

1. improper suggestions or gestures;

2. display of pornographic, lewd, indecent, or sexually suggestive objects or pictures;

3. graphic or descriptive comments or discussions about an individual's body or physical appearance;

4. degrading verbal or written comments, including, but not limited to, e-mail messages.

5. sexual flirtations, advances, or propositions;

6. jokes, "off-color" stories, or comments of a sexually explicit nature;

7. unwelcome and intentional physical contact which is sexual in nature, such as touching, pinching, patting, rubbing, grabbing, blocking movement, or brushing against another individual's body,

8. perceived pressure for sexual activity,

9. questions about an individual's sexual conduct, orientation, or preferences.

C. UPMC fully supports and complies with state regulations for Nurses on Avoidance of Sexual Exploitation.

1. Conduct defined by state regulation as a sexual violation or sexual impropriety with a patient during the course of a professional relationship violates standards of nursing conduct.

2. For a registered or licensed nurse involved in providing mental health services, the relationship which shall be deemed to exist for a period of time beginning with the first professional contact or consultation between the nurse and patient and ending 2 years after discharge from or discontinuance of services. For a patient who is a minor, a professional relationship shall be deemed to exist for 2 years or until 1 year after the age of majority, whichever is longer, after discharge from or discontinuance of services.

3. For a registered or licensed nurse not involved in providing mental health services, the relationship which shall be deemed to exist for a period of time beginning with the first professional contact or consultation between a registered nurse and a patient and ending with the patient's discharge from or discontinuance of service by the nurse or by the nurse's employer. The administration of emergency medical treatment or transitory trauma care will not be deemed to establish a professional relationship.

4. Consent of a patient to a sexual impropriety or sexual violation cannot be a defense in a disciplinary proceeding before the Board and that a nurse who engages in conduct prohibited by the amendments is not eligible for placement into an impaired professional program under either the Professional Nursing Law or the Practical Nurse Law.

#### **IV. RESPONSIBILITY**

A. The Human Resources VP/Director will be responsible for the implementation and enforcement of this policy.

B. Management and supervisory staff of UPMC will be responsible for:

1. operating his or her function in a manner consistent with the letter and spirit of this policy,
2. taking immediate and appropriate action once he or she observes or is informed of any act of sexual harassment or harassment based on race, color, religion, ancestry, national origin, age, sex, genetics, sexual orientation, genetic identity or marital, familial, or disability status or status as covered Veteran or any other legally protected group status after consulting with Human Resources to determine the appropriate corrective action; and
3. communicating to all staff members the provisions of this policy, including the procedure for raising issues of workplace harassment.

#### **V. PROCEDURE FOR RAISING ISSUES OF HARASSMENT OR FILING A COMPLAINT**

A. A staff member, patient, or other person who believes he or she has been sexually harassed, harassed on the basis of race, color, religion, ancestry, national origin, age, sex, genetics, sexual orientation, gender identity or marital, familial, or disability status or status as covered Veteran or any other legally protected group status, or has witnessed harassment or has knowledge of harassment is encouraged to promptly provide information regarding the matter to any one of the following individuals:

- the department head, clinical director or administrative representative; or
- the Human Resources VP/Director or any other professional member of the Human Resources staff with whom the staff member feels comfortable.
- Or by contacting the Compliance Helpline, 24 hours a day, seven days a week, by calling 1-877-983-8442.

B. The individual to whom a complaint of harassment is made has the responsibility for reporting the complaint to the Human Resources VP/Director.

C. The Human Resources director or designee will conduct a confidential investigation and determine what corrective action, if any, is appropriate to the situation. All information regarding the investigation will be kept in confidence to the greatest extent practical and appropriate under the circumstance.

D. UPMC reserves the right to place any individual alleged to have engaged in harassing conduct in violation of this policy on unpaid suspension pending the outcome of the investigation.

E. The Human Resources director/VP will issue a written reply to the complainant with the results of the investigation.

## **VI. RETALIATION IS PROHIBITED**

A. Retaliation against any staff member because he or she has reported an incident of harassment, assisted or participated in any manner in an investigation proceeding, hearing or lawsuit, pursuant to a harassment claim is prohibited.

B. If it is determined that an individual(s) has engaged in retaliation against any staff member, who reports an incident of harassment, UPMC shall take appropriate corrective action up to and including termination and in accordance with UPMC policies and procedures, including but not limited to Reporting and Non-Retaliation Policy (HS-EC1802), Code of Conduct (HS-EC1900), and Corrective Action and Discharge Policy (HS-HR074).

## **VII. SANCTION**

Violation of this policy will not be tolerated. Individuals found in violation of this policy will be subject to appropriate corrective action, up to and including termination of employment and/or removal from UPMC premises and in accordance with UPMC policies and procedures.

## **VIII. POLICIES REFERENCED WITHIN THIS POLICY**

HS-EC1802 Reporting and Non-Retaliation Policy

HS-EC1900 Code of Conduct

HS-HR0704 Corrective Action and Discharge Policy

**SIGNED:** John L. Galley  
Senior Vice President and Chief Human Resources Officer

**ORIGINAL:** June 1, 2000

### **APPROVALS:**

Policy Review Subcommittee: January 12, 2018

Executive Staff: April 27, 2018

**PRECEDE:** January 30, 2018

**SPONSOR:** Senior Vice President and Chief Human Resources Officer

**\* With respect to UPMC business units described in the Scope section, this policy is intended to replace individual business unit policies covering the same subject matter. In-Scope business unit policies covering the same subject matter should be pulled from all manuals.**

**UPMC**  
**POLICY AND PROCEDURE MANUAL**

**POLICY: HS-HD-CP-08\***  
**INDEX TITLE: Care of Patients**

**SUBJECT: Exclusion from Patient Care**

**DATE: December 3, 2018**

**I. POLICY**

It is the goal of UPMC to consider a request by a staff member not to participate in an aspect of patient care when such a request is based on beliefs prone to conflict. Under no circumstances; however, will a patient's care be compromised or negatively affected as a result of such a request. UPMC will adhere to the Patients' Notice and Bill of Rights and Responsibilities and UPMC's policy related to Nondiscrimination in Patient Care.

Links to policies referenced within this policy can be found in Section V.

**II. SCOPE**

This policy applies to every person associated with UPMC, while on United States premises, including staff members, volunteers, contractors, physicians, students, vendors and other affiliates, is required to conform his or her behavior to this policy.

**III. PURPOSE**

To acknowledge the beliefs prone to conflict of the employees of UPMC without compromising the care of the patient.

**IV. PROCEDURE**

**Employee**

1. It is the responsibility of the staff member to notify his/her manager or administrator on a timely basis, in writing, of a request to be exempt from participating in a particular aspect of treatment of the care of the patient.
2. The requesting staff member is responsible for providing appropriate patient care until and unless alternate arrangements can be made. Refusal to provide care can/will result in corrective action up to and including termination.

**Manager/Department Head**

1. Should a situation arise that will not permit enough time for a written notice, the staff member will immediately notify the manager or administrator. The manager or administrator will make an immediate decision regarding the request. If the manager or administrator believes patient care will be jeopardized, the request will be denied.

2. Evaluation of appropriate staffing and resolving the issues by assigning another qualified staff member to care for the patient or rejecting the request will be based on current patient needs and staffing demands.

3. The manager or administrator will follow up with a written response to the staff member stating his/her decision and future recommendations and a copy of the written response will be provided to the Human Resources Department for inclusion in the electronic personnel file.

### **Employee**

1. The staff member may appeal the decision in writing to the Human Resources Department by following the UPMC Grievance Procedure Policy.

### **V. POLICIES REFERENCED WITHIN THIS POLICY**

HS-HD-PR-01 Patients' Notice and Bill of Rights and Responsibilities Policy

HS-HD-PR-03 Nondiscrimination in Patient Care

HS-HR0704 Corrective Action and Discharge

HS-HR0707 Grievance Procedure Policy

### **REFERENCES:**

Reference Exclusion from Patient Care Guideline/Process for Managers and Administrators (see attached - Attachment A).

The Joint Commission Leadership: LD 04.02.03 Ethical principles guide the hospital's business practices. The Joint Commission Standards Manual 2013 Edition.

Title VIII of Civil Rights Act of 1964, Code of Federal Regulations, Title 29 C.F.R. Part 1605.2

**SIGNED:** Leslie Davis

Senior Vice President, UPMC

Executive Vice President and Chief Operating Officer, Health Services Division

**ORIGINAL:** October 30, 2015

### **APPROVALS**

Policy Review Subcommittee: November 8, 2018

Executive Staff: December 3, 2018

**PRECEDE:** January 2, 2018

**SPONSOR:** Vice President, Human Resources

\* With respect to UPMC business units described in the Scope section, this policy is intended to replace individual business unit policies covering the same subject matter. In-Scope business unit policies covering the same subject matter should be pulled from all manuals.

## **ATTACHMENT A**

### **Guideline/Process for the Manager and Administrator to Address Staff Request for Exclusion from Patient Care**

In rare instances, staff members may confront a situation when patient care will be against their beliefs prone to conflict. It is the goal of the organization to address both the needs of the patient and the staff member. This document has been developed to provide a guideline for addressing requests for exclusion from patient care.

Every attempt will be made to reassign a staff member in the event a legitimate request is made. A request for "Exclusion from Patient Care" can however, be denied or rejected if the manager or administrator determines that honoring the staff member's request may compromise patient care.

#### **Written Request for Exclusion from Patient Care:**

- 1) When a staff member provides a written request to the manager/administrator for exclusion from patient care due to beliefs prone to conflict- the manager/administrator will evaluate appropriate staffing and resolve the issue by assigning another qualified staff member to care for the patient or reject the request based on current patient needs and staffing demands. A separate request must be made for each specific occurrence.
- 2) The manager/administrator will attempt to make reasonable accommodations for a justified request; however, the requesting staff member is responsible for carrying out all assignments as given until excused from doing so by the manager/administrator. Refusal to provide care can/will result in corrective action up to and including termination.
- 3) The manager/administrator will notify the Human Resources representative of the decision and action to be taken. (i.e: replacement of another qualified staff member or request denial).
- 4) The manager/administrator will follow up with a written response to the requesting staff member stating their decision and future recommendations.
- 5) A copy of the written response will be provided to the requesting staff member and also to the Human Resources representative to be included in the staff member electronic personnel file.

#### **Verbal Request from Exclusion from Patient Care:**

- 1) If a situation arises that does not permit the staff member enough time to provide a written notice, the staff member must immediately notify the manager/administrator for exclusion from patient care due to beliefs prone to conflict.
- 2) The manager/administrator will make an immediate decision regarding the request by evaluating staffing and resolving the issue by assigning another qualified staff member to care for the patient or reject the request based on current patient needs and staffing demands.

3) UPMC will attempt to make reasonable accommodations for a justified request; however, the requesting staff member is responsible for carrying out all assignments as given until excused from doing so by the manager/administrator. Refusal to provide care can/will result in corrective action up to and including termination.

4) The manager/administrator will notify the Human Resources representative of the decision and action to be taken. (E.g.: replacement with another qualified staff member or request denial.)

5) The manager/administrator will follow up with a written response to the requesting staff member stating their decision and future recommendations.

6) A copy of the written response will be provided to the requesting staff member and also the HR representative to be included in the staff member's electronic personnel file.

7) If it potentially compromises staffing or patient care, a request can be denied by the manager/administrator.

#### **Denial of a Request for Exclusion from Patient Care:**

1) The manager/administrator will notify the Human Resources Representative of the decision and action to be taken. (E.g.: request denial due to patient needs; appropriate staffing.)

2) In the event a staff member's request to be excused from patient care is due to beliefs prone to conflict and there is potential to compromise patient care or staffing issues prevent replacement with another qualified staff member for the specific procedure/patient care, the request will be denied.

3) The manager/administrator will follow up with a written response to the requesting staff member stating their decision and future recommendations.

4) A copy of the written response will be provided to the requesting staff member and also to the HR Representative to be included in the staff member's electronic personnel file.

5) The requesting staff member may appeal the decision in writing to the Vice President of Human Resources as per UPMC System policy HS-HR0707 Grievance Procedure.

**Written Request for Exclusion from Patient Care**

Employee Name: \_\_\_\_\_

Employee ID: \_\_\_\_\_

Date of Request: \_\_\_\_\_

Reason for request for exclusion from patient care (please describe in detail the reason for requesting to be reassigned from patient care):

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Signature of Requestor: \_\_\_\_\_

Department Head or Designated Reviewer: \_\_\_\_\_

Date Reviewed: \_\_\_\_\_

Request Granted or Denied:  Granted  Denied

Reason for Denial: \_\_\_\_\_

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Please complete this form in blue or black ink.

Please return the completed form to the Human Resources Office.

## **UPMC Statement of Equal Employment Opportunity**

It is our policy to provide equal employment opportunities (EEO) according to job qualifications without discrimination on the basis of race, color, religion, ancestry, national origin, age, sex, genetics, sexual orientation, gender identity, or marital, familial, or disability status or status as a protected Veteran or any other legally protected group status. UPMC is committed to taking positive steps to eliminate barriers that may exist in EEO and in employment practices. Areas of focus include, but are not limited to: recruiting, hiring, promotion, demotion, transfer, layoff, termination, rates of pay or other forms of compensation, training, and education. UPMC will provide reasonable accommodation to known physical or mental limitations of an otherwise qualified employee or applicant for employment.

It is also our company's policy to prohibit any and all forms of retaliation against any individual who has complained of harassing or discriminatory conduct, or participated in a company or agency investigation into such complaints.

Staff members and others working throughout the UPMC health system at all levels, are expected to implement and abide by the UPMC policy of nondiscrimination in services and employment opportunity. All staff members are expected to make every reasonable effort to carry out their responsibilities to assure that equal employment opportunity is available to all. It is further expected that all staff members will demonstrate sensitivity to and respect for a culturally diverse workforce and demonstrate commitment to UPMC's equal opportunity and affirmative action objectives.

The contractor will not discharge or in any other manner discriminate against employees or applicants because they have inquired about, discussed, or disclosed their own pay or the pay of another employee or applicant. However, employees who have access to the compensation information of other employees or applicants as a part of their essential job functions cannot disclose the pay of other employees or applicants to individuals who do not otherwise have access to compensation information, unless the disclosure is (a) in response to a formal complaint or charge, (b) in furtherance of an investigation, proceeding, hearing, or action, including an investigation conducted by the employer, or (c) consistent with the contractor's legal duty to furnish information.

\*The term contractor in the above paragraph refers to those UPMC owned and operated facilities that have contracts with the federal government.

The importance of fulfilling this policy cannot be overemphasized. Any violation of this policy by a staff member of UPMC may result in corrective action up to and including discharge.

The chief human resource officer of UPMC and the senior Human Resources administrator of each UPMC business unit have the ultimate responsibility to establish the spirit of the affirmative action program. Our program's audit and reporting system enables us to measure the effectiveness of our program, indicate any need for remedial action, determine the degree to which our objectives have been attained, measure our compliance with the program's specific obligations, and document actions taken to comply with these obligations. The Human Resource administrators are assigned the overall responsibility for effective administration of this policy throughout UPMC. The non-confidential portions of the affirmative action program for individuals with disabilities and protected veterans shall be available for inspection upon request by any employee or applicant for employment by contacting the HR Compliance office at 412-647-1192, M-F, 9:00am – 4:00pm.

UPMC will continue to support and promote equal employment opportunity, human dignity, and racial, ethnic, and cultural diversity. This policy applies to admissions, employment, and access to and treatment in UPMC programs and activities. This commitment is made by UPMC in accordance with federal, state, and/or local laws and regulations.

## **Understanding the Fair Labor Standards Act (FLSA)**

Although several federal and state laws govern wage and hour requirements, the Fair Labor Standards Act (FLSA) is the most far reaching. The FLSA is a federal statute that establishes requirements for minimum wage, overtime payments, child labor guidelines, and equal pay. As an employer, UPMC is required to adhere to this law.

Staff members under a collective bargaining agreement are governed by the terms of the agreement, provided that the agreement is consistent with the law.

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### **Exempt and Non-Exempt Status**

According to the FLSA, positions are divided into two categories in order to determine whether overtime wages must be paid. Non-exempt positions are covered by the overtime provisions of the FLSA and require overtime payment of 1½ times a staff member's hourly wage rate.

Exempt positions are excluded from overtime payment provisions. The overtime status of positions is determined by the duties and responsibilities of the job. During the job evaluation process, the human resources department and compensation department use the regulations developed around the FLSA to make this determination.

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### **Non-Exempt**

Non-exempt staff members are subject to the minimum wage and overtime provisions of the FLSA. UPMC is required by law to pay non-exempt staff members overtime wages at a rate of 1½ times their regular rate for hours worked beyond 40 in a work week. The work week at UPMC begins at 12:00 a.m. Sunday and ends at 11:59 p.m. the following Saturday. Positions that are by law non-exempt and require overtime payment cannot be treated as exempt positions under any circumstances. For further discussion of the overtime methods, see the UPMC Compensation Manual.

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### **Exempt**

Exempt staff members are not subject to overtime provisions of the FLSA. The FLSA allows exemptions if the duties and responsibilities of the position fall into one of five categories — executive, administrative, professional, outside sales and computer employees. The FLSA has predefined tests in each of these areas that determine if a position is exempt. By law, UPMC is not required to pay staff members in exempt positions any overtime. In some instances, due to practices within the health care community or other market conditions, UPMC chooses to treat as non-exempt certain positions that are exempt from the overtime provisions of the FLSA. Treating an exempt position as a non-exempt position for the purpose of paying overtime is allowed under the FLSA.

## LifeSolutions

LifeSolutions is a no-cost benefit to staff or members of their household and answers 24 hours a day, seven days a week. The program enables staff to address personal, relationship, job-related, and career needs in a private, confidential environment. Our goal is to help balance staff work, life, and wellness.

Here are highlights of these **completely confidential** services:

<p><b>Services and Programs</b></p> <p><b>Coaching and Counseling</b> -- up to six confidential phone sessions or in-person sessions.</p> <p><b>WorkLife Services</b></p> <p>WorkLife consultants will identify resources to meet your needs. Online resources available by <a href="#">visiting our WorkLife portal</a>.</p> <p><b>Health and Wellness</b></p> <p><b>Community Resources</b></p> <p><b>Disability and Family Medical Leave</b></p>	<p><b>Resources Library</b></p> <p><b>LifeSolutions Newsletters</b></p> <p>LifeSolutions Quarterly Life Solutions Corner The Successful Supervisor Career Moments™</p> <p><b>Multimedia Center</b></p> <p>Videos Podcasts Online Seminars</p> <p><a href="#">LifeSolutions Overall Services flier</a></p> <p><a href="#">Skill Builders List</a></p>
<p><b>Training Programs</b></p> <p><a href="#">Learn more.</a></p>	<p><b>Announcements</b></p> <p>The LifeSolutions <a href="#">website</a> and online resources are available 24/7 to the employee and their household members, either through the Infonet or from home, if you have Internet access.</p>
<p><b>To reach LifeSolutions by phone, call 1-800-647-3327.</b></p>	<p><b>Visit LifeSolutions website for these features and more.</b></p> <ol style="list-style-type: none"> <li>1. Go to <a href="http://www.lifesolutionsforyou.com">www.lifesolutionsforyou.com</a></li> <li>2. Find <b>Current Customers</b> in the lower left section of the page.</li> <li>3. Login by typing <b>UPMC</b> in the field.</li> </ol>

UPMC Horizon provides on-site Employee Health services including treatment for employee injuries and acute illnesses via **MyHealth@Work**.



# Employee Health/Worker's Compensation

## UPMC POLICY AND PROCEDURE MANUAL

**POLICY: HS-HR0700 \***  
**INDEX TITLE: Human Resources**

**SUBJECT: Employee Health**  
**DATE: October 29, 2018**

### **I. POLICY/PURPOSE**

It is the policy of UPMC to provide certain health services to associates, staff members, volunteers, medical staff, and certain student groups entered in clinical programs with the system. Individuals who have been offered employment are subject to certain onboarding health requirements before beginning employment with UPMC. The policy provides information and guidelines concerning post offer pre-placement health assessments, baseline and periodical annual testing immunizations, exposures to infectious diseases, blood borne pathogens and other related employee health topics.

Links to policies referenced within this policy can be found in Section IV.

### **II. SCOPE**

Employee Health Services are provided by various United States based UPMC hospital facilities, affiliates and contracted entities. Appendix A lists many of these locations where Employee Health Services can be obtained for UPMC staff members. These locations are augmented by a number of community practice locations, contracted service providers, and UPMC affiliates.

### **III. SERVICES**

#### **A. Pre-Placement/Post-Offer Health Assessment**

Post-offer applicants for employment must submit to a pre-placement health assessment after receiving an offer of employment and prior to beginning work. The purpose of the health assessment is to determine whether an applicant is medically and physically able to perform the essential job functions of the position he or she has been offered and also to provide to the applicant baseline information about their health. Applicants must receive a clearance on their health assessment prior to starting employment.

1. Pre-placement medical examinations, and/or further diagnostic testing, if required, may be directed by Employee Health Services to a UPMC Specialist or Primary Care Physician (PCP). Additional inquiry may be requested from the candidates treating provider and/or specialist to help determine their ability to safely perform the essential job functions.

2. Storage and maintenance of all pre-placement health assessment requirements is performed electronically. All pre-placement health assessment requirements are categorized via one of three main job categories:

\* Clinical (providing direct patient care)

\* NC-Pt Care Environment (non-clinical, comes in contact with a patient care environment on a regular basis, or walks through daily to get to work station or rounds throughout the facility)

\* NC-Non Pt Care Environment Clinical (non-clinical position, does not regularly come in contact with a patient care environment)

Any new position-level requirements will apply to individuals hired on or after January 1, 2015. Any changes to annual or periodic testing for current associates, staff members, volunteers, medical staff, or

students will be assessed during the individual's annual review period.

3. After the completion of the health assessment, Employee Health Services or the designated Employee Health Department will notify Human Resources whether the applicant has been medically cleared for employment.

4. If the applicant was previously employed by UPMC, and is returning to active employment following thirty (30) or more days of separation, a full assessment/medical record update should be completed using all current pre-placement practices.

#### **B. Responsibilities of Employee Health / Human Resources on Staff Member Transfers/Terminations.**

When a staff member transfers into a different position within UPMC, Employee Health will perform any additional testing and/or evaluations based on the requirements of the position that the person is transferring into. Human Resources is responsible for notifying Employee Health of upcoming transfers and assisting in communicating any required testing and/or evaluations to staff prior to transfer.

#### **C. Guidelines for Pre-Placement/Post Offer Exams**

1. It is the responsibility of UPMC Employee Health Services to determine the scope of the health assessment required for each applicant based upon a review of the individual's responses on the health inventory/evaluation, the essential functions of the job the individual has been offered, and other potentially known occupational hazards identified with the applicant's position.

2. The health assessment for all post-offer applicants should at minimum include the following:

a. A detailed health inventory, which is a comprehensive health questionnaire including information on the applicant's health, communicable illnesses, infectious disease exposures, allergies, and medical restrictions and/or accommodations.

b. A drug screen to determine whether the applicant has recently engaged in the illicit use of drugs.

c. A general health screening that includes health measurements such as height, weight, blood pressure, lipid levels (total cholesterol, triglycerides, HDL, and LDL) and blood glucose.

3. In accordance with certain regulatory guidelines, department specific requirements and/or to safeguard the staff member from possible hazards and/or health affects, additional testing and/or further evaluation may be required. Additional testing performed on the applicant will be coordinated through UPMC Employee Health Services. (See also Section III, D: Guidelines for Additional Baseline and/or Annual Periodic Testing).

4. Abnormal test results and findings discovered during pre-placement will be addressed with the applicant. Further diagnosis and/or treatment recommendations will be referred to the applicants PCP if indicated.

#### **D. Guidelines for Additional Baseline and/or Annual Periodic Testing**

In accordance with certain regulatory and/or department specific requirements, additional baseline and/or periodic testing may be required as a condition of employment. Failure to complete any necessary testing within designated timeframes may result in corrective action up to and including discharge.

**1. Tuberculosis test (PPD):** Staff, students and volunteers may be required to have a documented TB clearance prior to receiving medical clearance depending on work location and/or level of clinical involvement. A two step TB skin testing method will be utilized on applicants who do not submit documented negative PPD results, which are less than one year old. An IGRA (Interferon-Gamma Release Assay) test can be used in lieu of the TB skin test.

a. Applicants with a prior positive TB test and/or IGRA will receive medical clearance by obtaining/providing documentation of a negative PA chest x-ray. Applicants with positive TB skin tests documented during the evaluation will be dealt with on a case-by-case basis.

b. The pre-placement applicant can be cleared after the first TB skin test is read, however this clearance is provisional and the second TB skin test must be completed within 1-3 weeks after the first TB skin test. An IGRA test completes both the first and second TB skin test requirement.

c. The frequency of TB skin testing is based on the business units TB Exposure Control Plan and/or the specific needs of the department. For those facilities that do not have an exposure control plan, then Community Epidemiological TB Incidence Rates and/or the geographically closest hospital facility should be used to gauge the frequency of TB skin testing (if testing is warranted). Those with prior positive TB skin tests should have symptoms of TB reviewed at the same frequency of those receiving the TB skin tests. Conversions should be reported to UPMC Claims and Infection Control.

**2. Mumps, Measles, Rubella, (MMR) Titer:** Baseline testing for clinical staff (staff with potential patient contact). Applicants with documentation of immune status or history of the disease do not require titers.

**3. Varicella Titer:** Baseline testing for clinical staff (staff with potential patient contact). Applicants with documentation of immune status or history of disease do not require titers.

**4. Hepatitis B Immunization/Titer (quantitative HBsAb):** All staff with the potential for blood or body fluid exposure should have Hepatitis B immunization status assessed prior to assignment. Applicants with history of vaccination do not require titers. Additional information on Hepatitis B vaccination requirements are listed in the OSHA Bloodborne Pathogen-Exposure Control Plan policy (HS-IC0604).

**5. Color Vision Testing:** Baseline testing for identified staff requiring color proficiency in job responsibilities (i.e. laboratory staff).

**6. Qualitative / Quantitative Fit Test:** Baseline/Annual testing for identified staff required to wear tight fitting respiratory protection gear. A Respiratory Medical Questionnaire must be completed for medical clearance to wear a respirator. Fit tested staff should report any significant changes in weight loss / facial features to ensure proper fit of respiratory protection devices. Staff unable to be fit tested or wear a respirator will be handled on a case-by-case basis and may be referred for possible use of a PAPR (Powered Air Purifying Respirator) for respiratory protection purposes. PAPR's do not require fit testing. Refer to UPMC Policies HS-FM0205 Respiratory Protection and HS-FM0205-PRO Respiratory Protection Program PROCEDURE for requirements on respiratory programs and fit testing.

**7. Vision:** Snellen eye chart for determination of distance vision acuity as needed.

**8. Audiology Exams:** Baseline and annually for staff with exposure to noises that are greater than 85dB over an eight-hour time weighted average (TWA). These staff members should also be enrolled in a hearing conservation program per OSHA regulations.

9. **MRI screening:** Those required to work with or around MRI equipment will be screened for devices/metal that may pose a safety risk to the staff member. Those with a past history of metallurgical work may require an orbital x-ray before working in the MRI area.

10. **Commercial Drivers License(CDL)/Medical Card:** Those operating vehicles for UPMC which meet the Department of Transportation (DOT) Federal Motor Carrier Safety Administration (FMCSA) requirements for carrying a medical card must complete an initial evaluation and any ongoing evaluations periodically as determined by the evaluating provider.

11. **Tetanus Diphtheria and Acellular Pertussis (Tdap):** Recommended for all health care workers, required by certain departments caring of children / infants.

12. **Flu Vaccination:** As required by Influenza Vaccination Program Policy HS-IC0621.

13. **Other testing:** Departments involved in day care operations and certain residential treatment facilities require biennial evaluations on staff to ensure regulatory compliance. These evaluations must be completed initially and then every two years.

#### **E. Guidelines for Annual/Post Exposure Screenings**

In accordance with appropriate regulations, and also to help safeguard the staff member population, certain staff members may be required to undergo annual/periodic evaluations and/or medical surveillance testing. Hazard identification is the responsibility of the Safety Department in conjunction/consultation with Infection Control, Employee Health, and the Administration for each UPMC entity. Medical testing for any surveillance programs should be coordinated through UPMC Employee Health Services. Attaining acceptable compliance rates associated with any surveillance programs should be the joint responsibility of the Administration and Human Resources.

The following are examples of some of the hazardous exposures that may warrant a medical surveillance program. (See Section III, D: Guidelines for Additional Baseline and/or Annual Periodic Testing, for specific testing requirements).

- 1) Frequent handling of chemotherapeutic medications.
- 2) Glutaraldehyde or Formaldehyde exposures that exceed established exposure thresholds.
- 3) Tuberculosis (if identified as part of a business units exposure control plan).
- 4) Noise Exposures that exceed established OSHA levels.

Review of all results and any coordination of medical surveillance testing and/or evaluations will be the responsibility of Employee Health Services, or the designated Employee Health Department. Employee Health Services will assist in determining the potential health risk for the exposure, and/or whether work restrictions/accommodations are recommended.

#### **F. Immunizations**

Immunizations are given by Employee Health Services in accordance with the Centers for Disease Control (CDC) guidelines, and as required by various business units of UPMC. All immunization requirements will be coordinated through UPMC Employee Health Services. The following list includes examples of some of the immunizations given through UPMC Employee Health Services.

1. Tetanus/Diphtheria/Pertusis (Tdap)
2. Hepatitis B Vaccine (three vaccinations given over a six month period).
3. Flu Vaccine (usually given annually each fall).
4. Measles/Mumps/Rubella Vaccine for susceptible staff.
5. Meningococcal Vaccine when indicated for microbiology / laboratory staff.
6. Varicella Vaccine for susceptible staff.
7. Hepatitis A Vaccine when indicated (i.e. overseas travel).

Other vaccinations may be offered on a case-by-case basis as recommended by federal agencies, and/or as needed/required by UPMC Business Units. Further information regarding specific vaccines and vaccination procedures is available through the various Employee Health Departments. These vaccinations may be given by UPMC Employee Health Services or by an outside entity.

#### **G. Infectious Disease Exposures**

In the event that staff members, are exposed to an infectious disease as defined by the (CDC), the necessary testing and/or follow up and treatment may be provided by Employee Health Services in accordance with federal regulations and CDC recommendations. The designated Infection Control Division will provide input, direction, and support on Infectious Disease related issues.

1. When an infectious disease exposure is suspected, staff should notify Infection Control and/or Employee Health Services. In the event that a staff member is exposed/contracts an infectious disease outside of the work environment, it is the staff member's responsibility to notify the supervisor or department head, who should then notify Infection Control and/or Employee Health for consultation.
2. Infection Control will investigate the exposure and indicate to Employee Health Services which staff members, if necessary, require post-exposure testing, treatment, follow up, and/or return to work clearance.
3. Employee Health Services will facilitate staff members receiving appropriate treatment and follow up. Infection Control and/or Employee Health Services will also notify the department head of any additional requirements or accommodations needed for the exposed staff.
4. Clearance to return to work, after a staff member is diagnosed with certain infectious diseases, must be obtained from Employee Health Services, or in the case of an infection which occurs outside of work, from the staff member's PCP. In cases where clearance is provided by a PCP, review and approval by either Infection Control or Employee Health Services may be required.
5. Department heads should notify Infection Control or Employee Health if a staff member returns to work after an infectious disease exposure or treatment without an appropriate clearance.
6. For purposes of this section, exposure to, and/or diagnosis of any of the following below listed Infectious Disease examples, must be reviewed and/or evaluated by Infection Control:

Chickenpox / Shingles	Lice	Influenza
Bacterial	Measles	Tuberculosis
Conjunctivitis	Meningitis	Infectious Diarrhea
Vancomycin Resistant	Mumps	Staph Aureus (i.e.
Enterococcus	Rubella	MRSA)
Group A	Pertussis	Smallpox
Streptococcus	Scabies	
Hepatitis A, B, or C		
Clostridium Difficile		

## **H. Chemical Hazards Exposures**

Medical surveillance and/or follow up will be completed for employees experiencing acute chemical hazard exposures or as indicated by results of routine exposure sampling.

## **I. Needlesticks or Bloodborne Pathogen Exposures (see also OSHA Bloodborne Pathogen-Exposure Control Plan Policy HS-IC0604)**

1. Immediately after the exposure, wash the area thoroughly with soap and water. If eyes are involved, irrigate with copious amounts of water. If mouth is involved, rinse mouth with plain water or an appropriate antiseptic mouthwash, if available.
2. The exposed staff member must notify his or her supervisor.
3. Exposures should be evaluated as soon as feasible post-exposure (recommend within 2-4 hours).
4. If the exposure occurs on an off-shift or over the weekend, the staff member can report to the nearest UPMC Emergency Department if other consultation is unavailable (additional support is available on off-hours and weekends through an answering service at (412) 784-7402).
5. Exposed staff members should present with the source patient's name and the name of the source patient's attending physician if available.
6. Appropriate treatment and follow up post-exposure will be coordinated by Employee Health Services. Treatment and follow-up for staff of non-hospital-based entities, may be directed by Employee Health Services to a UPMC Primary Care Physician or affiliate facility if necessary, to accommodate geographic considerations.
7. Staff members must notify UPMC Claims and complete the appropriate work related information (even if evaluated by Employee Health and/or the Emergency Department). Worker's Compensation claims can be reported either by calling 1-800-633-1197 or online through MyHub.

## **J. Latex Allergies**

It is the policy of the UPMC to adopt appropriate measures to protect staff members with latex allergies or sensitivity from additional exposure in the performance of their job responsibilities. Staff members developing reactions in the course of their employment should notify their manager and seek treatment if necessary through one of the Worker's Compensation panel providers. Staff Member's reactions are to be reported to UPMC Claims on-line or by calling 1-800-633-1197 or completing an online report via MyHUB. Staff members may also reference the Worker's Compensation policy for additional information.

## **K. Return to Work Issues**

At the manager and/or supervisor's discretion, staff members who are returning to work may need to obtain medical clearance. Clearances may be reviewed by Employee Health and/or UPMC Absence Management Services for further evaluation and/or consultation. For Infectious Disease Return to Work related issues see section III, G. Infectious Disease Exposures for further information. If there is any question regarding medical clearance, the department supervisor should call Employee Health Services to determine if clearance is necessary. Situations that may require the need for additional return to work consultation from Employee Health Services include, but are not limited to, certain infectious disease diagnosis, and/or medical leave of absence or illness where there are questions regarding the staff member's ability to safely perform the job functions.

#### **L. Non Work Related Illnesses**

Staff members who become ill at work (non-occupational illness) should notify their department head or supervisor. The supervisor should determine the staff member's ability to remain on duty. Consultation may be requested by contacting the Employee Health Services Department. Except for Fitness for Duty evaluations, staff members choosing to be evaluated in the Emergency Department, Urgent Care and/or PCP will be responsible for any charges or fees incurred that are not covered by his/her personal medical insurance.

#### **M. Fitness for Duty**

Fitness for Duty evaluations coordinated through UPMC Employee Health Services department focus primarily on substance abuse related testing. Fitness for Duty evaluations may involve a multidiscipline approach to include consultation and evaluation by supervisory staff, Human Resources, LifeSolutions (EAP), and Employee Health Services. Fitness for Duty evaluations can include substance abuse testing, medical evaluation, laboratory testing, and/or additional clinical consultation to determine a staff member's ability to perform their job responsibilities. Situations that arise out of a reasonable suspicion in **POLICY HS-** circumstances that involve a drug diversion that is a narcotic in nature and administered by injection via syringe and needle will include diagnostic testing for blood borne pathogens (BBPs). Staff members may also reference the Fitness for Duty policy (HS-HR0721) for additional information.

#### **N. Medical Records**

Staff member medical records are maintained by UPMC Employee Health Services, or the designated employee health department, in accordance with legal and confidentiality requirements, and per applicable OSHA regulations. Medical records may be released per request of the staff member. Most requests will be completed within two weeks of the request. For former staff members whose records are in storage, a longer period of time may be necessary to retrieve and copy records.

### **IV. POLICIES REFERENCED WITHIN THIS POLICY**

HS-HR0704 Corrective Action

HS-IC0604 OSHA Bloodborne Pathogen-Exposure Control Plan

HS-HR0730 Workers Compensation

HS-HR0721 Fitness for Duty

HS-IC0621 Influenza Vaccination Program

HS-FM0205 Respiratory Protection Program POLICY

HS-FM0205-PRO Respiratory Protection Program PROCEDURE

**SIGNED:** John L. Galley  
Senior Vice President and Chief Human Resources Officer

**ORIGINAL:** March 1, 2000

**APPROVALS:**

Policy Review Subcommittee: October 12, 2017

Executive Staff: November 1, 2017

**PRECEDE:** November 10, 2016

**SPONSOR:** Senior Vice President and Chief Human Resources Officer

**\* With respect to UPMC business units described in the Scope section, this policy is intended to replace individual business unit policies covering the same subject matter. In-Scope business unit policies covering the same subject matter should be pulled from all manuals.**

**Appendix A:**

<b>UPMC Employee Health Locations: LOCATION</b>	<b>ADDRESS</b>	<b>PHONE</b>
UPMC Altoona	4th floor, Outpatient Center 620 Howard Ave Altoona, PA 16601	(814) 889-3824
UPMC Bedford Memorial	10455 Lincoln Highway Everett, PA 15537	(814) 624-4329
UPMC Horizon	110 N. Main Street Greenville, PA 16125  Park Medical Building 2120 Likens Lane Farrell, PA 16121	724 589-6129 (Greenville)  724 983-7187 (Farrell)
UPMC Northwest	One Hundred Fairfield Drive Seneca, PA 16346	(814) 676-7703
Magee-Womens Hospital of UPMC	4 <sup>th</sup> floor 300 Halket Street Pittsburgh, PA 15213	(412) 641-4445
UPMC Presbyterian	1111 Kaufmann Building 3708 Fifth Ave, Pittsburgh, PA 15213	(412) 647-3695
UPMC Shadyside	216 Shadyside Medical Center Building 5200 Centre Ave Pittsburgh, PA 15232	(412) 623-1920
UPMC Passavant	9100 Babcock Blvd Pittsburgh, PA 15237	(412) 784-6420
UPMC St. Margaret	200 Medical Arts Building, Suite 4020 200 Delafield Road Pittsburgh, PA 15215	(412) 784-5104
Children's Hospital of Pittsburgh of UPMC	Floor 1 AOB, Suite 1206 Children's Hospital Drive 45th and Penn Pittsburgh, PA 15201	(412) 692-8450
UPMC McKeesport	D level Mansfield Bldg 1500 Fifth Avenue McKeesport, PA 15132	(412) 664-2360
UPMC Mercy	1515 Locust Street, Suite 225 Pittsburgh, PA 15219	(412) 232-8107
UPMC Jameson	1211 Wilmington Ave, New Castle, PA 16105	(724) 656-4131
UPMC Downtown	12th Floor US Steel Building 600 Grant Street Pittsburgh, PA 15219	(412) 454-8190

UPMC Hamot	300 State, 3 <sup>rd</sup> floor Suite 304 Erie PA 16550	(814) 877-2767
UPMC East	1st Floor, Outpatient Testing Area 2775 Mosside Blvd Monroeville, PA 15146	(412) 357-3014
UPMC Jameson	School of Nursing Building, Suite 105 1211 Wilmington Road New Castle, PA 16105	(724) 656-4131
UPMC Kane	4372 Route 6 Kane, PA 16735	(814) 837-8585
UPMC Chautauqua	51 Glasgow Ave Jamestown, NY 14701	(716) 664-8165
UPMC Susquehanna - Williamsport	700 High Street, 7 <sup>th</sup> Floor Williamsport, PA 17701	(570) 321-1740
UPMC Susquehanna - Muncy	215 Water Street, Suite 185 Muncy, PA 17756	(570) 546-4179
UPMC Susquehanna - Wellsboro	32 Central Avenue Wellsboro, PA 16901	(570) 723-0881

**UPMC  
POLICY AND PROCEDURE MANUAL**

**POLICY: HS-HR0730 \*  
INDEX TITLE: Human Resources**

**SUBJECT: Workers' Compensation**

**DATE: July 27, 2018**

**I. POLICY**

It is the policy of UPMC to provide Workers' Compensation to United States based staff members who are injured or who become ill as a consequence of job-related duties, in accordance with state workers' compensation acts and other applicable laws. All staff member benefits, and eligibility for them, will be determined by each particular state law(s) or governance. UPMC also attempts to provide staff members, who have temporary physical limitations, with productive work while their work-related injuries/illnesses heal. There may be differences in placement opportunities within the Return to Work Assistance Program between business units.

NOTE: Due to the various workers' compensation insurances in place at UPMC for each particular facility, it is very important that the appropriate insurance carrier or administrator be notified. If you do not know who to report a work-related injury/illness to for your facility, please call your Human Resources Representative.

**II. SCOPE/PURPOSE**

The policy is applicable to all employees consistent with the appropriate state workers' compensation law.

Staff members working for UPMC related ventures or employees with employment contracts may be excluded from certain provisions of this policy.

**III. RESPONSIBILITIES (Pennsylvania Self-Insured Programs)**

**A. SUPERVISOR/MANAGER/ADMINISTRATOR-ON-DUTY**

1. Must notify UPMC WorkPartners Claims Management Services of the incident as soon as possible, ideally by the end of the shift but no later than 48 hours. Workers' Compensation claims can be reported through the online option available in My HUB or calling 1-800-633-1197. You will be required to provide the following information:

- a. Staff member's name/address/telephone number (work and home),
- b. Date and time of injury/illness,
- c. Witness name/number (if applicable),
- d. Staff member's department/business entity,
- e. Supervisor name, telephone number and email
- f. Full or part time employment status,
- g. Type of injury/body part(s)/illness,

- h. Time and location of medical treatment received
- i. Sharps device, lot number, and source patient (if applicable).

An email acknowledgement will be sent to the Supervisor/Manager.

2. Access Workers' Compensation information and forms via UPMC Infonet site:<https://infonet.upmc.com/Benefits/HealthandWellness/Workers'Compensation/Pages/default.aspx>

3. Review with the staff member their Rights and Responsibilities under the PA Workers' Compensation Act by providing the staff member a copy of WC Health Care Provider Listing, which includes Staff Member Notification Form (page 1) and Employee's Acknowledgement Under Section 306(f)(l)(i) Form (final page), available via the Infonet at [https://infonet.upmc.com/Benefits/HealthandWellness/Workers'Compensation/Documents2/Employee\\_Acknowledgement.pdf](https://infonet.upmc.com/Benefits/HealthandWellness/Workers'Compensation/Documents2/Employee_Acknowledgement.pdf) or by calling 1-800-633-1197.

4. Have staff member sign the Employee's Acknowledgement under Section 306(f) (1) (i) Form. The signed form should be sent to WorkPartners to be placed in the Worker's Compensation claim and a copy should be provided to the staff member.

If a staff member requires medical care, refer them to the WC Health Care Provider Listing for them to select a provider. An appointment should be scheduled with a provider of choice. Some providers offer walk-in availability as well. Emergency/Urgent care should only be used for injuries of serious nature where immediate care is necessary.

a. Staff members who suffer a needle stick or other possible exposure to bloodborne pathogens should report to the designated Employee Health Department (MyHealth@Work Clinic) or Emergency Department (see Employee Health policy HS-HR0700) for both initial and follow-up treatment. All possible exposures should be reported immediately, but at least within 1 - 4 hours of the incident. If the incident occurs during the hours that the designated Employee Health Department is closed, the staff member should report to the closest hospital emergency department and follow up with the designated Employee Health Department when it re-opens. In all cases, the incident must be reported to UPMC WorkPartners Claims Management Services via the toll free number (1-800-633-1197) or online claim reporting.

5. In the event that a staff member is unable to work for a period of time, pay records must be submitted in UPMC time keeping system for each pay period that the employee is off work, indicating PTO or EIB time, if applicable for first seven days of disability. Periods of absence covered by Workers' Compensation are not paid from the UPMC payroll, but should be coded as "Workers' Compensation Pay" in the staff member's timekeeping record.

6. Contact WorkPartners Leave Management Unit if the staff member will be off work greater than three (3) consecutively scheduled workdays.

## **B. WORKPARTNERS LEAVE MANAGEMENT UNIT**

Send out appropriate leave of absence packets to staff members if they are unable to work due to work-related injury or illness, and address questions concerning related policies. The Leave Specialist will provide updates to the manager and human resources on leave utilization.

## **C. STAFF MEMBER**

1. Must ***immediately*** report injury to supervisor, manager, or Administrator-On-Duty (Seeking treatment at the Emergency Department or at one of the designated WC Health Care Providers does not serve as proper filing of a Workers' Compensation claim.).
2. Sign the Employee's Acknowledgement form and return to supervisor.
3. If medical care is required an appointment should be scheduled with a WC Health Care Provider (if emergency treatment is required, go to the nearest hospital emergency department). Follow up must be with a WC Health Care Provider for the first 90 days of treatment, or UPMC is not obligated to pay for costs associated with a visit to the non-participating provider. The WC Health Care Provider Listing for each facility/business unit is posted on the employee bulletin board(s) at the work sites and can also be found on the UPMC Infonet (<http://panels.upmc.com/WorkPartnersPanels/ControllerServlet>).

Staff members who suffer a needle stick or other possible exposure to bloodborne pathogens should report to the designated Employee Health Department or Emergency Department (see Employee Health policy # HS-HR0700) for both initial and follow-up treatment. All possible exposures should be reported immediately, but at least within 1 - 4 hours of the incident. If the incident occurs during the hours that the designated Employee Health Department is closed, the staff member should report to the closest hospital emergency department and follow up with the designated Employee Health Department when it re-opens. In all cases, the incident must be reported to My HUB or UPMC WorkPartners Claims Management Services via the toll free number (1-800-633-1197).

4. Should an employee's WC Health Care physician deem that he or she is unable to work for the period of this leave of absence; the department may proceed with filling the position in compliance with UPMC leave of absence policies (see FMLA # HS-HR0718 and PLOA # HS-HR0719). Group health benefits will continue for the period of the leave up to a maximum of 26 weeks, at which time the employee will be offered COBRA continuation coverage.

5. If a WC Health Care Provider prescribes invasive surgery for an injury, the staff member may obtain a second opinion from a health care provider of his or her choice. If the second opinion differs from that of the WC Health Care Provider and the staff member chooses to follow this second recommended course of treatment that treatment must be provided by a member of the designated WC Health Care Provider Listing for the first 90 days following the date of initial medical treatment with a WC Health Care provider.

6. After 90 days, the staff member may treat with physician of choice; however, the staff member must notify UPMC WorkPartners Claims Management Services within 5 days of the first visit. UPMC WorkPartners has no obligation to pay for related treatment until this notice is given.

7. The staff member is expected to follow all physician instructions and take every reasonable step to promote a quick recovery so that the staff member may safely resume his or her regular activities and work responsibilities as soon as possible.

8. If physical/work restrictions are provided or time off work is necessary, staff member must:

a. Submit an LIBC-9 or equivalent Work Status Form signed by physician to supervisor and WorkPartners;

b. Request a leave of absence from WorkPartners Leave Management Unit via My HUB or by calling 1-800-633-1197.

c. Contact WorkPartners Leave Specialist or Human Resources for help with any questions regarding FMLA or related policies.

#### **D. UPMC WORKPARTNERS CLAIMS MANAGEMENT SERVICES**

1. Receive report of injury or illness from the supervisor.

2. Email acknowledgement to the supervisor.

3. Notify WorkPartners Leave Management Unit when a staff member misses three or more days of work so the appropriate Leave of Absence packet can be sent out to the staff member.

4. File the appropriate paperwork with the State.

5. Facilitate the effective coordination and management of appropriate medical treatment, return to safe and productive work, efficient claims processing and payment for staff members.

6. Maintain a record of each claim.

7. Maintain appropriate records to comply with State and Federal regulations.

#### **IV. BENEFITS WHILE OFF WORK**

Workers' Compensation benefits cover the cost of reasonable medical care required for the work-related injury/illness and indemnity/lost time benefits (at 66 2/3 percent of pay up to the statutory weekly maximum). Indemnity payments on approved claims begin on the eighth day of absence and are retroactive to the first day of absence after 13 days off work.

1. In the event that a staff member is unable to work for a period of time that is less than the 7-day waiting period, Paid Time Off (PTO) or Extended Illness Bank (EIB) time may be used in accordance with the Paid Time Off Policy # HS-HR0720. If the staff member is subsequently absent for more than 13 days due to injury/illness, he or she would be entitled to be paid applicable Workers' Compensation benefits for the initial 7-day waiting period.

2. Any EIB benefit paid to the staff member must be reimbursed to UPMC through personal check or money order, upon receipt of any applicable Workers' Compensation pay. Once this is completed, the staff member's EIB time will be reinstated.

3. If a staff member utilizes PTO for the 7-day waiting period, and is subsequently absent for more than 13 days, he or she may receive any applicable Workers' Compensation benefit; however, there will be no mandatory repayment or reconciliation of PTO used for the 7-day waiting period prior to the beginning of applicable Workers' Compensation benefits.

4. Any PTO used for missed time beyond the 7-day waiting period in which the staff member is eligible for Workers' Compensation benefits must be reimbursed upon receipt of applicable Workers' Compensation pay. Once this is completed, the staff member's PTO time used will be reinstated.

Payment should be made to UPMC by personal check or money order and sent to:

Employee Service Center  
U.S. Steel Tower, Floor 56,  
600 Grant Street,  
Pittsburgh, PA 15219  
Phone: 1-800-994-2752, option 3  
Fax: 412-647-9299

5. PTO or EIB cannot be used to supplement or replace Workers' Compensation benefits.

6. Staff members covered by this Workers' Compensation policy remain on UPMC Health and Welfare benefits programs for up to 26 weeks so long as the staff member continues to pay his or her portion of any premiums due as a result of prior benefit elections while receiving Worker's Compensation, benefit premiums will occur in arrears and are repaid upon returning to work. If the staff member wishes to remain covered after that time, he or she may do so by converting coverage or applying for a waiver of premium on life insurance and by shifting to a health insurance conversion contract or UPMC plan coverage under the provisions of COBRA at his or her own expense.

7. PTO accrual ceases as of the last eligible paid hour of work or PTO/EIB and/or when the eligible staff member begins receiving Workers' Compensation, whichever occurs first.

## **V. POLICIES REFERENCED WITHIN THIS POLICY**

HS-HR0700 Employee Health

HS- HR0718 Family Medical Leave of Absence (FMLA)

HS-HR0720 Paid Time Off (PTO)

HS-HR0719 Personal Leave of Absence (PLOA)

**SIGNED:** John L. Galley  
Senior Vice President and Chief Human Resources Officer

**ORIGINAL:** December 13, 2001

**APPROVALS:**

Policy Review Subcommittee: July 12, 2018

Executive Staff: July 27, 2018

**PRECEDE:** July 28, 2017

**SPONSOR:** Senior Vice President and Chief Human Resources Officer

**\* With respect to UPMC business units described in the Scope section, this policy is intended to replace individual business unit policies covering the same subject matter. In-Scope business unit policies covering the same subject matter should be pulled from all manuals.**

## Report a Work-Related Injury or Illness

To report a work related injury or illness, it is important that you immediately notify your Supervisor. An incident report will need to be filed via our online reporting service available through My Hub under the Human Resources Tab. Click on “Report a Work Related Injury or Disability” located under the box for the PTO balance. Please follow the prompts to complete your claim. If you cannot file online, please contact WorkPartners at 1-800-633-1197 to file your claim.



Absence Management Services  
P.O. Box 2971  
Pittsburgh, PA 15230  
Fax: 412-667-7100  
[www.workpartners.com](http://www.workpartners.com)

Dear UPMC Staff Member:

UPMC is self-insured and self-administers its Workers' Compensation program. UPMC WorkPartners Claims Management Services administers the program.

Once notice of your work-related incident is received, your claim will be managed in accordance with the rules and regulations of the Pennsylvania Workers' Compensation Act. The first step for entry into this system is to have your supervisor or manager report the work-related incident by calling our toll-free 24-hour reporting line at 1-800-633-1197. If you have not reported your work-related incident to your supervisor or manager, please do so immediately and ask him or her to call the reporting line as soon as possible to provide details of the incident.

In accordance with the Pennsylvania Workers' Compensation Act, a staff member must seek medical treatment from a designated panel provider for the first 90 days of treatment. If a staff member chooses to seek medical treatment from a provider who may not be on the designated panel, even if it is the employee's primary care physician (PCP), UPMC WorkPartners has no obligation to pay for related expenses for treatment. Should you need assistance with finding a panel provider, please call our office at 1-800-633-1197 or visit <http://workerscomp.infonet.upmc.com>.

Once you have chosen a panel provider, he or she will evaluate your work injury or illness to determine if you are able to resume your regular duty job or perform a transition work assignment (light duty), or if you must refrain from work. Transitional work assignments will be identified based on your physical abilities and transferable skills. UPMC WorkPartners cannot guarantee that there will be transitional work available within your own department, but we will try to find the most appropriate work assignment within your abilities. Follow-up panel provider visits will be scheduled before you leave the panel provider's office. These appointments will continue to address your ability to work. Following each appointment, we ask that you provide your supervisor

or manager and UPMC WorkPartners with a copy of your panel provider's work release.

Once your claim has been accepted, all benefits for your medical care and wage loss will be paid by UPMC. Should you be required to miss time from work based on a medical opinion, your compensation check will be issued by UPMC WorkPartners Absence Management Services. The date of your injury will determine the time your checks are issued. These checks are issued at the end of every two-week period of disability. These payments may not coincide with the UPMC payroll system. There is a waiting period of seven days for Workers' Compensation benefits. You may choose to use your Extended Illness Bank (EIB) or Paid Time Off (PTO) for the first seven days of your disability. Eligibility for benefits will not begin until the eighth day. If your disability exceeds more than 8 days, you are entitled to compensation for each day beyond that point.

Once your disability reaches 14 days or more, your benefits for the waiting week are retroactive back to the first day of disability. Workers' Compensation and EIB days cannot be taken for the same period; therefore, if you chose to use EIB during your waiting week, you will need to contact the UPMC Payroll Department to make arrangements to repay these benefits.

If you have any additional questions that have not been addressed regarding your Worker's Compensation benefits, please call UPMC WorkPartners Absence Management Services at 1-800-633-1197.

Any correspondence or medical expenses related to your work injury can be directed to:

UPMC WorkPartners  
Absence Management Services  
P.O. Box 2971  
Pittsburgh, PA 15230  
Fax: 412-667-7100

Sincerely,



## STAFF MEMBER'S ACKNOWLEDGEMENT UNDER SECTION 306 (f)(1)(I)

I recognize and agree that my employer has provided a list of at least 6 designated health care providers, no more than 2 whom are coordinated care organizations and no less than 3 whom are physicians. Therefore, I acknowledge that I must be treated by 1 of these health care providers for 90 days from the date of my first visit. If I fail to be treated by 1 of these designated health care providers, I understand that my employer will not be liable for the payment for services rendered during this 90 period. Subsequent treatment may be provided by any health care provider of my choice. However I must advise my employer within 5 days of my first visit to each and every non-designated health care provider. Failure to do so may effect whether my employer is liable for payment for services rendered prior to appropriate notice.

My employer has informed me of my rights and duties, and my signature acknowledges that I have been so informed and that I understand my rights and duties.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Employer's Name: UPMC

The Health Care Provider Panel Database, located on Infonet, allows employees to choose from a geographic listing of approved providers who facilitate treatment for a work-related injury or illness within the first 90 days. Each department also has a posted list of Panel Providers and the employee rights and responsibilities under the PAWorkers' Compensation Act.

# Environment of Care

## SAFETY MANAGEMENT - EMPLOYEE SAFETY

### **INTRODUCTION:**

The personal safety of each employee, patient, and visitor is of primary importance to UPMC HORIZON. Unnecessary injuries take a high toll every year in the healthcare setting. This packet is designed to provide information that can help you protect yourself and your fellow employees from needless injuries. In addition, Joint Commission Standards on the environment of care require training in Safety.

### **BEHAVIORAL OBJECTIVES:**

After completing this packet, you will know the following:

- ✓ At least 5 safety risks you should be aware of in the environment of care.
- ✓ The procedure for reporting incidents.
- ✓ What actions you can take to help eliminate or minimize safety risks.
- ✓ Where to obtain information on department-specific safety information.

## Safety Management

In the healthcare environment, people's lives depend on your safety awareness and compliance. You must be prepared to act with total safety in mind. Most injuries in the health care industry are associated with sprains and strains, especially injuries to the back. Other injuries such as needle-sticks have the potential for serious illness. The risk of all types of injury can be dramatically reduced through proper training and safe work practices. You should:

1. Get the training that you need to do your job safely.
2. Put your training into practice every day and keep alert for the unexpected.
3. Promote and support safety as you interact with co-workers.
4. Report hazards, accidents/incidents, or "near-miss" accidents promptly to your supervisor with your suggestions for corrections.

### **Purpose:**

The purpose of UPMC Horizon's Safety Management Program is to protect the lives and assure the physical safety of patients, visitors, personnel, and all who use the Hospital's buildings and grounds. To succeed, it must have the support of everyone at the Hospital. We need to promote the proper attitudes toward injury prevention on the part of both supervisors and employees. Only through cooperative effort can a safety program work.

### **Responsibilities:**

The Safety Officer is responsible for the administration of the Safety Program.

## **The Safety Officer at UPMC Horizon is Karen Calhoun, RN.**

The Safety Officer is responsible to act immediately when a hazardous condition exists, which may result in personal injury to individuals or damage to equipment or buildings.

Every employee is responsible for wholehearted, genuine cooperation with all aspects of the safety program, including compliance with all rules and regulations, and for continuously practicing safety while performing his or her duties. Input from staff at all levels of the organization is essential to the success of the program. If you discover a safety problem, report it immediately to the Safety Officer or to your supervisor.

Every department is responsible for training their employees on department-specific hazards and safety issues. If you have a safety question, ask your supervisor about it.

### **10 Fundamental Rules:**

Most accidents can be avoided through adherence to some fundamental, common sense safety rules:

1. Report all potentially hazardous or unsafe conditions or acts to the Safety Officer immediately.
2. All foreign materials on floors should be removed or reported to Environmental Services department to prevent injury to others.
3. All defective or damaged equipment should be reported to the Maintenance or Biomedical department immediately.
4. Walk, DO NOT run! Keep to the right, using special caution at intersecting corridors.
5. Know the Hospital's Fire Safety Plan and the location of fire alarms and extinguishers and how to use them.
6. Become familiar with the relevant work procedures and safe work practices.
7. If doors have glass inserts, be sure that the other side is clear before opening the door. If the other side is not clear, open the door slowly using the handle or push plate.
8. Report all injuries, however slight, to the supervisor and get first aid immediately.
9. Realize that horseplay and practical jokes often result in serious injury. The hospital is no place for such actions.
10. When in doubt about what should be done, ask the immediate supervisor.

### **Safety Risks:**

You may know that back injuries are the most common type of workplace injury. That is because no matter what our jobs, we are constantly using our backs to support our bodies, to bend, sit, twist, stand, or even to lie down. All of these activities put stress on our backs. Understanding how your back works while lifting can help you avoid unnecessary strain and potential injury.

### **Back Basics:**

Your back is made up of movable bones (vertebrae) and shock absorbers (discs) between each vertebra - Ligaments and muscles support these structures and help keep the back aligned in three balanced curves. *Your back is aligned correctly when your ears, shoulders, and hips are in a straight line.* When the three curves of your back are not in balance, there is a greater likelihood of back pain and injury.

### **Lifting Basics:**

When you lift, it is important to keep your back in balance. If you bend at your waist and extend your upper body to lift an object, you upset your back's alignment and your center of balance. You force your spine to support the weight of your body and the weight of the object you are lifting. This situation is called "overload". You can avoid overloading your back by using good lifting techniques. For example, *when you bend at the knees and hug the object close to you as you lift, you keep your back in alignment and let the stronger muscles in your thighs do the actual "lifting".* Therefore, you do not have to extend your upper body and are able to maintain your center of balance.

### **Safe Lifting:**

Safe lifting means protecting your back and yourself while you lift. Before you lift anything, *think about the lift—Can you lift it alone? Do you need help? Is the load too big or too awkward?* When you do lift, be sure to bend at your knees, hug the load close to your body, and raise yourself up with the strong muscles in your thighs. Remember, **NEVER** twist while lifting—instead, move one foot at a time in the direction where you want to go and then turn with your leg muscles. *Above all, safe lifting means keeping your back in balance and avoiding overload.*

### **Handling Materials:**

Lifting is only one aspect of material handling. How you carry and put down a load is just as important as how you pick it up. Reaching, pushing, pulling, and using mechanical aids are other potentially demanding movements that you make every day. Good body mechanics—moving in an efficient, balanced way, can help you handle materials safely and protect your back from pain and potential injury.

### **Reaching:**

Reaching for supplies in high places can hurt if you reach too high or grab something that is too heavy. *Be sure to reach only as high as you can without stretching and use a stool if necessary.* Test the weight of the load before you actually lift it. Contract your stomach muscles to keep your back in neutral position and let the muscles in your legs and arms do most of the work.

### **Pushing and Pulling:**

Pushing and pulling can be hard on your back. *Just as you should do while lifting, stay close to your load and hold your neutral back position to protect yourself.* Tighten your stomach muscles when pushing. Push whenever you can—it's much easier than pulling.

### **Mechanical Aids:**

You cannot lift every load yourself and some loads are even too heavy or too awkward for two to handle. Carts, bins, hand trucks, and dollies can help to lift such loads. Pushcarts and bins are useful for light, awkward loads, while hand trucks and dollies aid in moving heavier, stackable material. *When using mechanical aids, be sure that the load is secured in place before moving.*

### **Prevention of Falls:**

Each year, hundreds of workers die and thousands are left disabled from falls on the job. It may come as a surprise that falls are the most common type of industrial accident. Yet using common safety sense and learning how to recognize and correct typical fall hazards in the work environment can prevent almost all falls.

### **Understanding Falls:**

Falls occur when you lose your balance and footing. Your center of gravity is displaced and there is nowhere to go but down. You may be thrown off balance by a slip on a wet floor or a trip over an electrical cord. *Once you lose your balance and footing, a fall is inevitable.*

### **Common Fall Hazards:**

One of the most common causes of office falls is tripping over an open desk or a file drawer. Bending while seated in an unstable chair and tripping over electrical cords or wires are other common hazards. Loose carpeting, objects stored in halls or walkways, and inadequate lighting are other hazards that invite accidental falls. Fortunately, all of these fall hazards are preventable. The following can help you stop a fall before it happens:

- ✓ *Look before you walk—make sure your pathway is clear.*
- ✓ *Close drawers after every use.*
- ✓ *Avoid bending, twisting, and leaning backwards while seated.*
- ✓ *Secure electrical cords and wires away from walkways.*
- ✓ *Always use an appropriate stepladder for overhead reaching.*
- ✓ *Clean up spills immediately.*
- ✓ *If you see an object on the floor, pick it up!*
- ✓ *Report loose carpeting or damaged flooring to maintenance immediately.*
- ✓ *Make sure that walkways are well lighted.*
- ✓ ***Walk — DO NOT run!!***

### **Ergonomics:**

Ergonomics is the science of fitting the job to the people who work in them. The term encompasses knowledge about physical abilities and limitations, as well as other human

characteristics that are relevant to job design. By taking this knowledge, you can theoretically design a workplace that is safe and efficient for workers.

Musculoskeletal disorders (MSD) are injuries and disorders to the muscles, nerves, tendons, ligaments, joints, cartilage and spinal discs. Exposure to physical work activities and conditions that involve risk factors may cause or contribute to MSDs. Injuries caused by slips, trips, falls, vehicle accidents, or similar mishaps do not usually fall into this category.

MSDs are caused by exposure to repetitive actions, forceful exertions, awkward postures, contact stress or vibration. Common symptoms include the following:

- ✓ Painful joints
- ✓ Pain in wrists, shoulders, forearms or knees
- ✓ Pain, tingling or numbness in hands or feet
- ✓ Shooting or stabbing pain in arms or legs
- ✓ Back or neck pain
- ✓ Swelling or inflammation
- ✓ Stiffness
- ✓ Burning sensation

As with any work related injury, it is essential that the employee report the injury to his/her supervisor as soon as possible so that appropriate action can be taken for treatment of the injury as well as possible engineering controls to help reduce the hazards. Physical changes may be required to reduce the MSD hazards. Examples include changing or redesigning workstations, tools, or equipment. Learning how to “work smart” and recognize symptoms before they become serious can prevent MSDs. Use these tips to prevent injury:

- ✓ Avoid repeating actions when possible. If several different movements are possible, rotate among them. Vary your posture and work position to reduce stress on your body.
- ✓ Try adjusting your work area so that you can keep your wrists straight while filing or performing other repetitive motions.
- ✓ If you work while seated, position your chair high enough so that your elbows are even with, or slightly higher than your hands.
- ✓ Take short breaks and gently stretch and shake out your hands once every hour.
- ✓ Pace yourself – although working at breakneck speed may get the job done faster, in the short-run, a repetitive motion injury could put you out of commission for weeks or longer.
- ✓ Limit how often you lift a patient.
- ✓ Limit twisting your body at the waist during a lift.
- ✓ Hold patients close to your body during a lift.
- ✓ Have more than one person involved in lifting a patient.
- ✓ Avoid prolonged forward bending (such as while caring for patients).

## **Electrical Equipment**

Every day, electricity lights the office and runs the equipment, however, it is easy but dangerous to take electricity for granted. In order to protect your patients, co-workers, visitors, and yourself, practice electrical safety.

## **Electrical Hazards**

Electric wiring, fixtures, equipment, and machinery can be hazardous. Primarily, they can cause fires and explosions. Wood, paper, and some chemicals can catch fire from a simple spark. In addition, electricity can burn, shock, or even kill you depending upon the strength of the electricity. When you are shocked, your muscles can contract violently, causing serious falls or other accidents. Finally, when electric equipment is not turned off after use, the next person to use it may not be aware that the power is still on and they can become shocked or injured.

## **Practice Electrical Safety**

Protect yourself by following these important rules for electrical safety:

- ✓ *Avoid using appliances touching metal while you are wet.*
- ✓ *Unplug equipment or appliances before cleaning, inspecting, repairing, or removing anything from them.*
- ✓ *Keep electrical equipment, machinery, and work areas clean. Oil, dust, waste, and water can be fire hazards around electricity.*
- ✓ *If you are not trained to work in high voltage areas, do not enter them—even in an emergency.*
- ✓ *Make sure that all electrical equipment is properly grounded.*
- ✓ *If someone has been shocked, separate the victim from the current before doing first aid if you can do so safely without injury to yourself. If not, call for help.*
- ✓ *Use “C” rated extinguishers for electrical fires. **NEVER USE WATER!!!***

## **Report Unsafe Conditions**

Report unsafe conditions, such as shocking, sparking, overheating, or smoking equipment. Any damaged outlets, switches, or extension cords should not be used and should be reported immediately.

## **Fires:**

Become familiar with the Fire Program here at UPMC Horizon. Take the Life Safety in-service so that you will know the proper procedures to follow in a fire situation.

## **Hazardous Materials:**

There are many hazardous materials in the health care environment. Become familiar with the safety precautions for those materials in your department. Take the hazardous materials in-service and practice safe working habits around hazardous materials.

# UPMC HORIZON SAFETY MANAGEMENT PLAN CY 2018

## **MISSION STATEMENT:**

The Safety Management Plan and the Patient Safety Plan supports the mission of UPMC and UPMC Horizon by providing a systematic coordination and continuous approach to the improvement and management of safety issues.

## **VISION STATEMENT:**

It is the vision of the Safety Management Program that through proactive risk assessment and continuous monitoring UPMC Horizon will provide for patient safety, safety of facilities and meeting the current/future needs for healthcare delivery relative to facilities in Mercer County.

## **PURPOSE/OBJECTIVES:**

Providing a safe environment for the provision of patient care is essential as part of the hospital's mission. The purpose and objectives of the Safety Management Program and Patient Safety Program are:

- To establish, support, and maintain a Safety Management Program and Patient Safety Program that is based on continuous monitoring and evaluation of organizational experience, applicable law and regulation, and standards of practice.
  - To provide a Safety Program that is focused on developing strategies to reduce risks to employees, patients, physicians, contractors/vendors, volunteers, students, and visitors while inside the hospital or other hospital owned sites and on the property by providing a physical environment free of hazards.
  - To provide for the adequacy of the facilities regarding current facility conditions, ADA compliance and future needs relative to the facilities.

## **SCOPE:**

The Safety Management Plan and Patient Safety Plan applies to all employees, patients, physicians, volunteers, visitors, students, and contractors/vendors in the departments in the hospital and other sites owned by or licensed under the hospital.

## **RESPONSIBILITY:**

### **A. Board of Directors**

1. Strives to assure a safe environment for patients, personnel, and visitors by requiring and supporting the establishment and maintenance of an effective safety management program.
2. Overall authority for the creation and implementation of the Patient Safety Program which shall follow applicable laws and regulations

### **B. President**

1. Has overall responsibility for Safety Management and Patient Safety Program at UPMC Horizon.

2. Ensures compliance with Department of Health regulations, OSHA regulations, Life Safety, HFAP and the Joint Commission Standards, and other regulatory agency requirements.
3. Ensures required records and reports are maintained.
4. Appoints the hospital Safety Officer and Manager of Security.
5. Appoints members to the hospital Infection Prevention/Environment of Care Committee.

**C. Department Manager**

1. Ensures mandatory orientation and annual Safety Management training in general safety, departmental safety, incident/occurrence reporting, Safe Medical Device Act, and specific job-related hazards.
2. Ensures timely reporting of all incidents according to the hospital's internal reporting process.
3. Investigates all accidents, incidents, and hazardous conditions to provide corrective or preventative action.
4. Sets standards for safe use of equipment.
5. Serves on Infection Prevention/Environment of Care Committee as directed by the Patient Safety Officer.
6. Participates in the planning and implementation of various emergency plans as required by the Infection Prevention/Environment of Care Committee.
7. Prepares and ensures implementation of departmental level policies and procedures related to all aspects of the Safety Management Program.

**D. Director of Operations; Environmental Services/Maintenance Managers**

1. Participates in the development and implementation of the Safety Management Program.
2. Provides technical assistance and serves as a member of the Infection Prevention/Environment of Care Committee.
3. Ensures timely reporting of events or situations involving the infrastructure of the facilities or the discontinuation or significant disruption of a service that could compromise safety.

**E. Hospital Employees/Supervisory Personnel**

1. Eliminate physical accident causes whenever possible through inspection, reporting, and correction of unsafe conditions.
2. Prompt reporting of all accidents, incidents, and hazardous conditions.
3. Follow all safety rules at all times.

**F. Infection Prevention/Environment of Care Committee**

1. Meets all objectives established by the Infection Prevention/Environment of Care Committee.
2. Meets monthly to review the effectiveness of the Safety Management Program and develop recommendations for resolving Safety issues.
3. Utilizes subcommittees, as indicated to accomplish a more in-depth review of selected areas.
4. Reviews trends in accidents/incidents and formulate action plans.
5. Performs periodic Safety/Infection Control Tracer surveys as required.
6. Reports all findings and recommendations/action plans to the hospital Department Managers, Medical Staff, Board of Directors, and Quality Council.

7. Performs an annual review of the objectives, scope, organization, and effectiveness of the Safety Management Program.

**G. Safety Officer**

1. Manages the ongoing hospital-wide process to collect and evaluate information about hazards and safety practices that is used to identify safety management issues to be addressed by the Infection Prevention/Environment of Care Committee.
2. Works with appropriate staff to implement the Infection Prevention/Environment of Care Committee's recommendations, monitors the effectiveness of the changes, and then reports the results of that monitoring back to the Infection Prevention/Environment of Care Committee.
3. Takes appropriate action as necessary whenever an immediate threat to life or limb is present to prevent injury or loss of life.

**H. Risk Manager**

1. Investigates all accidents, incidents and hazardous conditions to provide corrective or preventive action.
2. Serves on the Infection Prevention/Environment of Care Committee.
3. Participates in the planning of various emergency plans as required by the Infection Prevention/Environment of Care Committee.
4. Coordinate the Patient Safety Program and carry out specific aspects of the program as the Patient Safety Officer.

**SAFETY MANAGEMENT**

1. **Developing and maintaining a written management plan describing processes implemented to manage the environmental safety of patients, staff and others.**

**Implementation:**

The Safety Management Plan has been developed and is reviewed and/or revised annually.

2. **Identification of a person(s) designated by leadership to coordinate the development, implementation, and monitoring of the Safety Management activities.**

**Implementation:**

A Safety Officer will be appointed by the President to oversee the development, implementation, and monitoring of the hospital-wide Safety Management program.

3. **Identification of a person(s) to intervene whenever conditions immediately threaten life or health or threaten damage to equipment or buildings.**

**Implementation:**

A Safety Officer will be appointed by the President and will be authorized to take immediate action when a hazardous condition exists that is an immediate threat to human life or welfare or hospital property.

4. **Conducting pro-active risk assessment for impact of buildings, grounds, equipment, occupants, and internal physical systems on patients and others.**

**Implementation:**

This is conducted through the environmental tours and risk management programs of the hospital. The Safety Officer has authority to take immediate action to correct an unsafe condition or recommend appropriate corrective action to the Infection Prevention/Environment of Care Committee.

All patient care areas and all non-patient care areas will be inspected at least annually. These tours will be conducted with established and approved hospital and departmental safety and infection control criteria with special attention to hazards related to ages of patients served in the department and safety related compliance. The results of these surveys will be reported to the Infection Prevention/Environment of Care Committee where they will be analyzed to identify concerns and to develop recommendations for resolving these concerns.

**5. Using identified risks to select and implement procedures to achieve the lowest potential for adverse impact on the staff and health of patients and others.**

**Implementation:**

All incident reports are reviewed by the Risk Manager/Patient Safety Officer and appropriate actions are taken as incidents occur. The Patient Safety Quality Peer Review Committee reviews and evaluates all patient incident reports to the Patient Safety Committee for recommendations to reduce risks incidents. A summary of these incidents is reported at each Infection Prevention/Environment of Care Committee meeting and reviewed for any possible patterns or trends, and actions taken as appropriate.

**6. Safety policies and procedures are distributed, practiced, enforced and reviewed at least every three years.**

**Implementation:**

All departmental safety policies and procedures will be reviewed at least every three years by the Infection Prevention/Environment of Care Committee. The results will be reported to the Infection Prevention/Environment of Care Committee.

**7. Responding to safety recalls by appropriate organization representative.**

**Implementation:**

Notification for equipment and product recalls is made through notification from the manufacturer through the University of Pittsburgh Medical Center product recall process and through the National Recall Alert Center. As soon as notification is received, the equipment or product is removed from use and returned to the manufacturer. All safety recalls will be reported to the Infection Prevention/Environment of Care Committee at least quarterly.

**8. Ensuring that all grounds and equipment are maintained appropriately.**

**Implementation:**

The maintenance and supervision of grounds, equipment, vehicles, tractors, fork lift, etc., is accomplished through the buildings and grounds surveillance program which is performed by the Maintenance staff.

**9. An orientation and education program that addresses:**

- a. Safety risks in the hospital environment**
- b. Reporting procedure for incidents involving property damage, occupational illness and injury to patients, staff or visitors**
- c. Actions to eliminate, minimize or report safety risks.**

**Implementation:**

All employees will be provided safety education at the facility and departmental level. It will be accomplished in the following manner:

- a. All new employees will be provided with facility safety and patient safety education during hospital-wide orientation. They will also be oriented to departmental safety responsibilities during their initial three months of employment by the department manager.
- b. All employees will receive at least annual hospital-wide and department-specific safety education through the UPMC uLearn modules.
- c. The departmental programs will be based on employee needs, either requested or assessed, and are coordinated by the respective department managers. The Safety Officer will assist in providing information for departmental programs.

**10. Ongoing monitoring of performance regarding actual or potential risks related to one or more of the following:**

**Implementation:**

Performance improvement standards for Safety Management will be monitored on an ongoing basis and reported to the Infection Prevention/Environment of Care Committee and will include at least one of the following:

- Staff knowledge and skill
- Level of participation
- Monitoring and inspection activities
- Emergency and incident reporting
- Inspection, preventive maintenance and testing of equipment

**ANNUAL EVALUATION OF THE SAFETY MANAGEMENT PROGRAM:**

The plan shall be evaluated on an ongoing basis to assure that it meets the Safety, Risk Management and Performance Improvement needs of the institution. At least annually the objectives, scope, performance and effectiveness of the plan shall be reviewed, and revised if necessary by the Infection Prevention/Environment of Care Committee, with input and assistance from other committees, Administration, Medical Staff Departments and Hospital Departments. Approval of revisions will be made by the Infection Prevention/Environment of Care Committee, Medical Staff and the Board of Directors.

**COMMUNICATION/REPORTING:**

The findings, conclusions, recommendations, actions taken, and follow-up by the Infection Prevention/Environment of Care Committee, as a result of the monitoring and evaluation of the Safety Management Plan are reported at least quarterly to the Quality Council, which includes medical staff, nursing, departmental and administrative representation, Medical Executive Committee and the Board of Directors.

Reviewed: October 2018

## SECURITY MANAGEMENT

# UPMC HORIZON SECURITY MANAGEMENT PLAN CY 2018

### MISSION STATEMENT

It is the mission of the Security Plan to support UPMC Horizon's mission by providing the appropriate policy and procedure for the promotion of the security of patients, visitors, employees and property of UPMC Horizon.

### VISION STATEMENT

It is our vision to continuously expand the security process through pro-active risk assessments and maintain a safe and secure facility for our patients, staff and community.

### PURPOSE/OBJECTIVES

The safety and security of the patients, visitors, employees and property of UPMC Horizon is of vital importance and is essential in providing safe patient care as part of the hospital's mission. The potential for the occurrence of incidents that can impact on the safety and security of an organization cannot be ignored, but must be recognized and appropriate remedial measures taken to prevent or at least reduce the sometimes destructive results of such occurrences. The objectives of the Security Management Program are:

- Establishing, supporting, and maintaining a Security Management Program.
- To provide a safe and secure physical environment for the patients, visitors and employees of UPMC Horizon.
- To monitor the physical environment of the facility for actual or potential hazards.
- To address and correct the concerns/hazards that are discovered through monitoring and surveillance activities.
- To educate all persons concerned with the continued operations of the facility with the importance of maintaining an effective and efficient security program.

### SCOPE:

The Security Management Plan applies to all employees and departments in the hospital, other sites owned by or licensed under the hospital, and all areas of the hospital grounds. Security coverage is provided by a contractual agreement between UPMC Horizon and private security agency, which provides for a security force on duty 24 hours a day. In the event that such police actions are needed, assistance will be sought from local law enforcement agencies.

## **RESPONSIBILITY:**

A collaborative effort between management and staff is needed to maintain the Security Program and to ensure that the program functions in an effective and efficient manner. It is the responsibility of the President of the facility to ensure that the Security Program meets the needs of the facility.

The Security Program will be under the direct supervision of the Director of Operations and the Manager of Environmental Services/Maintenance. A contractual agreement between the facility and the security agency will delineate the design of the program and the specific duties of the security personnel.

## **SECURITY MANAGEMENT PROGRAM INCLUDES:**

1. **Developing and maintaining a written management plan describing processes implemented to manage the security of patients, staff and others.**  
**Implementation:**  
The Security Management Plan has been developed and is reviewed and/or revised annually.
2. **Identification of a person(s) designated by leadership to coordinate the development, implementation, and monitoring of security management activities.**  
**Implementation:**  
The President has designated the Director of Operations, to oversee security in the hospital.
3. **Conducting proactive risk-assessments evaluating potential adverse impact of the external environment and services provided to patients, staff and others. Potential for workplace violence is considered during the risk assessment.**  
**Implementation:**  
This is conducted through environmental tours and security rounds including the following activities at both main campuses. All other outbuildings will call 911 for assistance:
  - a. Monitoring and patrolling designated perimeters, areas, structures and activities of security interest to the hospital.
  - b. Checking designated areas and buildings during other than normal working hours to determine that they are properly locked or are otherwise in order.
  - c. Perform essential escort duties during after hour periods.
  - d. Responding to protective alarm signals within the main campuses or other hazard indicators.
  - e. Acting as necessary in the event of situations affecting the safety and security of the facility including responding to fire and emergency codes.
  - f. Providing staff information on responding to violence in the workplace.
  - g. Maintaining an open line of communication with the Manager of Environmental Services/Maintenance and keeping the Director of Operations informed of situations that will impede upon the safety and/or security of the facility.

Environmental tours include specific security risk assessment criteria. Results are reviewed by the Infection Prevention/Environment of Care Committee.

**4. Using identified risks to select and implement procedures and controls to achieve the lowest potential for adverse impact on security.**

**Implementation:**

All security incidents are reviewed by the Director of Operations and reported quarterly at the Infection Prevention/Environment of Care Committee meeting. Any potential risks identified will be evaluated to implement procedures and controls to prevent security incidents.

**5. Identifies, as appropriate, patients, staff, and other people entering the organization's facilities.**

**Implementation:**

All employees and volunteers will be required to wear a picture identification name badge at all times while on duty. Patients will be required to wear identification armbands. Contractors will be required to wear approved name badges. All vendors will be required to wear identification name badges. Visitors staying overnight will be issued Visitor Badges.

**6. Controls access to and egress from sensitive areas, as defined. (ED, OR, Nursery, Pediatrics, Pharmacy, Medical Records, Critical Care Unit)**

**Implementation:**

- **Emergency Department:** Access to the E.D. is controlled by a card access door lock system. Surveillance cameras monitor the E.D., as well as the department doors being secured 24/7.
- **Operating Room Suite:** Access to the OR Suite is controlled by signage and only authorized personnel are able to enter the department. The staff in the department are responsible for traffic control in the department. The department is locked down on off-shifts.
- **LDR/OB 3<sup>rd</sup> Floor:** Access to the nursery is controlled by surveillance cameras, locked Nursery doors and a specific security system for the Birth Place that includes doors from inside the stairways. Distinct Nursery ID badges and entry of only authorized personnel into the Nursery and Birth Place.
- **Pharmacy:** Access to the Pharmacy is controlled by doors locked at all times, surveillance cameras, remotely monitored alarm systems and entry by only authorized personnel.
- **Medical Records:** Access to Medical Records is controlled by locked doors and entry of authorized personnel.
- **Critical Care Unit:** Access to the Critical Care Unit is controlled with magnetic lock doors and an intercom system. All visitors are verbally screened by CCU staff prior to admission.
- **Egress:** Staff in all sensitive areas are responsible for maintaining clear egress to exit routes at all times.

**7. Implements security procedures taken in the event of a security incident.**

**Implementation:**

Any employee who witnesses or hears of an occurrence requiring security will immediately notify the hospital operator. Upon receiving the call, the operator will call the Security Officer via radio or pager. The Security Officer or Shift Supervisor will use his/her best judgment in determining whether or not to call the police department for assistance. In the event that the police department is notified, the Director of Operations, Shift Supervisor or Security Officer will notify the administrator on call.

a. **Weapons:** Employees, patients, visitors and medical staff of the hospital are not permitted to bring weapons into the hospital. In the event that it is discovered that a person has a weapon in their possession, the security officer on duty must be notified, along with the Director of Operations. The security officer or the Director of Operations will inform the person(s) possessing the weapon of the hospital's weapon policy and request that person(s) remove the weapon from the hospital premises immediately. If the person(s) refuses, the police department will be notified. The only time firearms may be carried in the hospital is by law enforcement officers on official business in the hospital.

b. **Handling of Civil Disturbances:**

Individuals – If it is determined that a visitor is creating a civil disturbance, the person will be escorted out of the hospital by the security guard. If the person objects, the security guard should notify the police department. If assistance is needed, the security guard may have a “Code Purple” announced for assistance until the police arrive.

Groups – If it is determined that a group of individuals are in the hospital on other than official or medically related business, and are creating a civil disturbance, all entrances to the hospital should be secured, and where possible, the group should be isolated by activating the fire doors and preventing them from circulating through the rest of the hospital. The security officer should immediately notify the police. It is important that the security officer try to keep the group calm and not aggravate the situation, as much as possible until the police arrive. If necessary, the security officer may call a “Code Purple” for additional assistance as above.

**8. Implements security procedures for visitor/patient abduction.**

**Implementation:**

In the event of an attempted or actual visitor/patient abduction, a “Code Pink” will be called. The staff will refer to the Code Pink policy.

**9. Implements security procedures for situations involving VIPs or the media.**

**Implementation:**

Situations involving VIPs or the media will be handled in the following manner. The Director of Operations, will be responsible for securing the building if necessary and implementing the necessary security of the hospital. The Director of Operations, will also designate parking for media vehicles so that normal patient, visitor and emergency traffic is not interrupted. The Director of Operations will be responsible for designating an area for any press conferences, and the time and content of such press conferences. The VIP patient will be placed in a private room with security in attendance, if necessary.

**10. Implements security procedures for vehicular access to emergency treatment areas.**

**Implementation:**

Vehicular access to the Emergency Department is monitored by the Security Officer (when needed) outside the entrance of the ambulance access area. Anyone pulling a vehicle into the ambulance area for patient unloading will be assisted and instructed to move the vehicle to an authorized parking area. In the event that construction occurs in this area, an alternate ambulance/vehicle entrance will be assigned and temporary signage will be provided to direct traffic to the alternate area.

**11. An orientation and education program that addresses:**

- a. Processes for minimizing security risks for personnel in sensitive areas
- b. Reporting procedures for security incidents
- c. Emergency procedures followed during security incidents

**Implementation:**

All employees will be provided education regarding security management at the facility and departmental level. It will be accomplished in the following manner:

- a. All new employees will be provided with facility security management education during hospital-wide orientation. They will also be oriented to departmental security management responsibilities during their initial three months of employment by the department manager.
- b. All employees will receive at least annual hospital-wide and department-specific security management education.
- c. The departmental programs will be based on employee needs, either requested or assessed, and are coordinated by the respective department managers. The Safety Officer will assist in providing information for departmental programs.

**12. Ongoing monitoring of performance regarding actual or potential risks related to one or more of the following:**

**Implementation:**

Performance improvement standards for Security Management will be monitored on an ongoing basis and reported to the Infection Prevention/Environment of Care Committee and will include at least one of the following:

- Staff knowledge and skills
- Level of staff participation
- Monitoring and inspection activities
- Emergency and incident reporting
- Inspection, preventive maintenance, and testing of equipment

**13. Outbuildings:**

All outbuildings will notify 911 for any security issues.

**ANNUAL EVALUATION OF THE SECURITY MANAGEMENT PROGRAM:**

The plan shall be evaluated on an ongoing basis to assure that it meets the security needs of the institution. At least annually the objectives, scope, performance and effectiveness of the plan shall be reviewed and revised if necessary by the Infection Prevention/Environment of Care Committee, with input and assistance from other committees, Administration, Medical Staff departments and hospital departments. Approval of revisions will be made by the Infection Prevention/Environment of Care Committee, Medical Executive Committee and the Board of Directors.

**COMMUNICATION/REPORTING:**

The findings, conclusions, recommendations, actions taken, and follow-up by the Infection Prevention/Environment of Care Committee, as a result of the monitoring and evaluation of the Security Management Plan, are reported at least quarterly to the Infection Prevention/

Environment of Care Committee, Quality Council, which includes nursing, departmental and administrative representation, Medical Executive Committee and the Board of Directors.

Reviewed: October 2018

## Workplace Violence: Know the Signs

All of us are responsible for keeping UPMC safe. Sometimes, this means keeping a careful eye out for signs that someone may be intending to commit violence on UPMC property.

Most violent incidents can occur without warning, but there are often nonverbal signs that someone may display before they commit violence. These include:

- Hands on head
- Shouting
- Clenched fists
- Hand wringing
- Finger pointing
- Aggressive lower body stance
- Clothing removal

Someone may display one or more indicators before coming violent.

If you see any of these signs, it's important to stay calm, and do not attempt to handle the situation on your own. UPMC Security personnel are trained in how to defuse situations with the potential to become violent. It's important to call them (or activate your body or panic button, if you're in a facility that uses them) if you see an individual — whether it's a colleague, visitor, or patient — that fits these signs and makes you feel uncomfortable.

Always remember that if you see something abnormal, you need to say something.

Workplace Violence policy HS-HR0745

## LIFE SAFETY MANAGEMENT

### **INTRODUCTION/VALUE STATEMENT:**

UPMC Horizon has developed the Life Safety Management Program to protect patients, personnel, visitors, and property from fire and the products of combustion, and to provide the safe use of buildings and grounds. This packet is designed to provide the basic information you should know regarding the Life Safety Management Program. Life Safety Management is part of the JC Standards for the Environment of Care and may be found in Chapter V of the Environment of Care (EOC) Manual.

### **OBJECTIVES:**

After completing this packet, you will know the following:

- ✓ The use and function of the fire alarm system.
- ✓ Procedures to contain smoke and fire.
- ✓ Your responsibility when at the fire's point of origin.
- ✓ Your responsibility when away from the fire's point of origin.
- ✓ Where to obtain department specific fire safety information, including evacuation plans.
- ✓ Definition and purpose of ILSM (Interim Life Safety Measures).

# UPMC HORIZON

## FIRE SAFETY MANAGEMENT PLAN

### CY 2018

**MISSION STATEMENT:**

The Fire Safety Management Plan is in keeping with the mission of UPMC Horizon to provide a safe environment for the provision of health care.

**VISION STATEMENT:**

Through the Fire Safety Management Plan UPMC Horizon will identify fire risks and continually implement strategies to provide the safest environment possible for patients, staff and visitors.

**PURPOSE/OBJECTIVES:**

The purpose and objectives of the Fire Safety Management Program are:

- Establishing, supporting, and maintaining a program that protects patients, visitors, personnel and property from fire and products of combustion and provides for the safe use of building and grounds.
- Provide basic information to all personnel regarding their responsibilities within the Plan.

The hospital will protect patients, visitors, personnel and property from fire and products of combustion. This is essential in providing safe patient care as part of the hospital's mission. To ensure that all persons are protected, a system of equipment has been installed and the equipment is included in a systematic program of inspection, testing and maintenance. The building features and equipment shall conform to NFPA 101, NFPA 99, and 2000 Life Safety codes as appropriate. Detailed policies/procedures, complete drawings, diagrams, and operating manuals are maintained in the Maintenance Department.

**SCOPE:**

The Fire Safety Management Plan applies to all employees, physicians, licensed independent practitioners, volunteers and students, departments in the hospital, including the skilled care units, and other sites owned by the hospital.

Upon activation of a Code Red, personnel, including physicians, LIP's, who are away from the fire's point of origin shall do the following:

- Be ready to accept patients from near the fire's point of origin if required (especially for areas adjacent to the fire's point of origin). Also, be aware that the fire event in the facility may have an effect on their ability to effectively care for patients.
- Listen for additional instruction.
- Keep patients and visitors in rooms if possible until directed to do otherwise.
- Keep all fire doors closed except when passing through them in order to avoid the spread of smoke and fire.
- Be ready to evacuate if directed.

- DO NOT use elevators.

In addition to the above, upon activation of an alarm, physicians and LIP's are specifically requested to:

- If in a patient area, go to the nurses' station to be available for response to a medical emergency.
- Assist other staff (when needed) in moving patients and visitors to safety, and evacuate with the other staff.

#### **RESPONSIBILITY:**

1. **Environmental Services/Maintenance Manager** in conjunction with the Program Director of Operations participates in the development of the Fire Safety Management Plan. Ensures all elements of the Fire Safety Management Plan are implemented, maintained, and properly documented in compliance with all relevant Department of Health, HFAP and The Joint Commission standards. Provide annual review of this plan for continued adequacy, relevance and update.
2. **Department Manager:** Ensures that all employees receive education in orientation and annually on their role in the Fire Safety Management Plan. Evaluates staff performance when emergency plans are implemented.
3. **Safety Officer:** Manages the ongoing hospital-wide process to collect and evaluate information relating to all elements of the Fire Safety Management Plan. Ensures that all employees receive education in general orientation to the hospital-wide Fire Safety Management Plan. The Safety Officer ensures appropriate actions are taken to resolve problems, documents actions, and reports all such events to the Infection Prevention/Environment of Care Committee, Department Managers, Quality Improvement, Medical Executive Committee, the President, Governing Body, and employees, as appropriate. Additionally, the Safety Officer, with the assistance of the Manager, Environmental Services/Maintenance evaluates the effectiveness of those results as determined by committee action. Provides annual review of this plan for continued adequacy, relevance, and update as may be required in cooperation with the Director of Operations.

#### **FIRE SAFETY MANAGEMENT PROGRAM INCLUDES:**

1. **Developing and maintaining a written management plan describing processes it implements to effectively manage fire safety.**

##### **Implementation:**

The Fire Safety Management Plan has been developed and is reviewed and/or revised annually.

2. **Implementing pro-active processes to protect patients, staff and others, as well as protecting property from fire, smoke, and other products of combustion.**

##### **Implementation:**

This is accomplished through the fire protection systems, orientation and training of staff, and fire drills.

**3. Implementing processes for regularly inspecting, testing, and maintaining fire protection, fire safety systems, equipment and components.**

**Implementation:**

A. The Simplex fire alarm system is a microprocessor that provides continuous circuit testing and alarms immediately if problems are detected in the circuits. Operation and required checks are performed on the fire protection systems by the Maintenance Department or by outside expert contractors. Inspections are performed by checklist and filed in the Maintenance office. The inspection is part of the preventive maintenance system and signed by the person performing the inspection. The following schedule for inspections and maintenance is utilized:

<b>Schedule for Testing/Inspecting Fire Alarm Systems</b>	<b>Frequency</b>
1. Initiating devices	
a. Supervisory signals	Quarterly
b. Valve tamper switches and water flow devices	Semi-annually
c. Duct/heat/smoke detectors, magnetic releasing devices, manual fire alarm boxes	Annually
2. Occupant alarms	Annually
3. Off premises alarms	Quarterly
4. Water based automatic fire extinguishers	Weekly
a. Fire pumps (no flow conditions)	
b. Fire pumps (under flow)	Annually
c. Water storage tank high and low alarms	N/A
d. Water storage tank temp alarms (during cold weather)	N/A
e. Main drains at system risers	Annually
f. Fire department connections	Quarterly
5. Kitchen automatic fire extinguishing systems	Semi-annually
6. Carbon dioxide/other fire extinguishing systems	Annually
1. Portable fire extinguishers (clearly identified)	
a. Inspected	Monthly
b. Maintained	Annually
2. Standpipes	
a. Occupant hoses (new)	5 years > installation
b. Occupant hoses	Every 3 years thereafter
c. System water flow test	Every 5 years
3. Fire Protection Equipment	
a. Fire and smoke dampers (with fusible links removed)	Every 6 years
b. Smoke detection shutdown devices (HVAC)	Annually
c. Sliding/rolling fire doors	Annually

**B. Inspecting, testing, and maintaining a fire alarm or fire detection system (depending on occupancy classification) that upon activation:**

    a. **Minimizes smoke transmission by controlling designated fans and dampers in air-handling and smoke management systems, and**

- b. Transmits the fire alarm to local fire department via Simplex/911 at Greenville and at Shenango.**

**Implementation:**

Operation and periodic checks are performed on the fire protection systems by the Maintenance Department or by outside expert contractors. Inspections are performed by checklist and filed in the Maintenance office. The inspection is part of the preventive maintenance system and signed by the person performing the inspection. The Simplex system is connected directly to Simplex at Greenville and at Shenango. Both companies will call 911 at receipt of alarm. 911 will call the local fire departments. If the fire alarm is activated, it is immediately transmitted as above.

- C. Inspecting, testing, and maintaining all automatic fire extinguishing systems.**

**Implementation:**

All automatic fire extinguishing systems are inspected, tested, and maintained at least annually by outside expert contractors. Records of these inspections are maintained in the Maintenance department.

- D. Managing portable fire extinguishers, including monthly inspection, regular maintenance, and guidelines for their identification, placement and use.**

**Implementation:**

Fire extinguishers in the corridors and throughout the Facility are the H2O, and "ABC" type units. Halon and CO2 extinguishers may be available in areas with specific needs. "K" type fire extinguishers are located in the main Kitchen at each Campus. Fire extinguishers are located in marked areas on each floor of the hospital. Staff are trained to operate the fire extinguishers in orientation and at least annually. Fire extinguishers are visually inspected monthly by the Security Department. Checklists and actions taken are on file in the Maintenance Department. All fire extinguishers are inspected at least annually by outside expert contractors.

- 4. Reporting and investigating LSC and fire protection deficiencies, failures, and user errors.**

**Implementation:**

Life safety code deficiencies may be identified through scheduled hazard surveillance surveys, Department of Health life safety inspections, fire drills, or through observation while performing other duties. These should be reported to the Safety Officer immediately. The Safety Officer will be responsible to assure the reporting of all fire protection system deficiencies, failures, or user errors to the Infection Prevention/Environment of Care Committee.

- 5. The organization develops and implements a fire response plan that addresses the following:**

- A. Facility-wide fire response needs**

- B. Specific responsibilities of staff/physicians/volunteers at fire's origin.
- C. Specific responsibilities of staff/physicians/volunteers away from the fire's origin.
- D. Specific responsibilities of staff/physicians/volunteers in evacuation.

**Implementation:**

Specific roles and responsibilities of staff/physicians/licensed independent practitioners/volunteers at the fire's origin and away from a fire's origin are addressed in the hospital-wide fire plan.

Fire procedures are also addressed as follows:

- A. Facility-wide fire response needs – see Policy EOC-FS-01 of the Environment of Care Manual.
- B. Area-specific needs and fire evacuation routes – see policy EOC-EM-13 of the Environment of Care Manual.
- C. Specific staff responsibilities when fire discovered – see policy EOC-FS-01 of the Environment of Care Manual.
- D. Specific staff responsibilities when alarm sounds – see policy EOC-FS-01 of the Environment of Care Manual.
- E. Specific responsibilities in building evacuation – see policy EOC-EM-13 of the Environment of Care Manual.

**6. The organization reviews purchase of bedding, drapes/curtains, furniture, decorations, wastebaskets, and other equipment for fire safety.**

**Implementation:**

The UPMC Purchasing Department will participate in the review of all proposed purchases of bedding, drapes, furniture, etc., for fire-rated issues.

**7. The hospital prohibits the use of portable space heaters in smoke compartments containing patient treatment or sleeping areas.**

**8. Use and functioning of fire alarm systems**

**FIRE PROTECTION SYSTEMS DESCRIPTION:**

**A. Fire Alarm Central Station:**

The hospital fire alarm system is designed to minimize smoke transmission through fans and dampers and is connected to a central station by telephone line. The alarm circuit is continuously monitored by Simplex, who notifies 911 at the Greenville Campus and at the Shenango Campus. The purpose of the central station connection is to ensure that incidents in which components of the hospital's fire detection and suppression system go into alarm that the fire department is promptly notified.

**B. Alarm Systems**

- 1. **Description and Zones**
  - (a) **Shenango Campus**

This fire alarm system is microprocessor based, with individual device point identification and self-diagnostic capability. The main control panel is located in the Maintenance Office with a sub-panel in the Emergency Department. It is a Simplex model 4100-8201, meeting all NFPA applicable codes at the time of installation (1996). The system, on emergency power, annunciates a wide range of devices throughout the facility. For a more detailed system description, operational and failure plans, maintenance, testing, etc., consult Policy #2.0 in the Fire Safety Management Policy & Procedure Manual.

**(b) Greenville Campus**

This system is a supervisory and trouble signal type system. The main control panels are located in the west basement electrical room with sub-panels at the switchboard and in the Maintenance shop. It is a Simplex system, meeting all applicable NFPA codes at the time of installation (2009, 2010, 2011, 2012). The system, on emergency power, annunciates a wide range of devices throughout the facility.

2. **Smoke Detectors:** Smoke detectors are located in the corridors and other selected areas of the building. The detectors are integrated into the system as alarm indicating devices.
3. **Manual Pull Stations:** Manual pull stations are located throughout the facility in the corridors, at the nurses' station and near exits for the purpose of annunciating an observed alarm condition. The system will indicate the zone in which the manual pull station has been activated. The pull station cannot be reset except at the station proper.

**C. Sprinkler System**

1. **Description/Location:** The sprinkler system consists of Siamese connections, piping, sprinkler heads, inspection valves, fire hose cabinets, and controllers.
2. **Flow Switches/Tamper Switches:** Tamper switches are installed on each valve in the sprinkler system and monitored by the fire alarm system. Flow switches are located in the piping system at strategic points and are monitored by the fire alarm system.
3. **Piping, Valves, and Control:** Are installed in accordance with NFPA 13 criteria in effect at the time of installation.

**D. Automatic Fire Suppression Systems**

There are three such systems at the Shenango Campus, all tied to the main Simplex panel.

1. Wet Chemical System – Kitchen.

- a. Description – installed in the exhaust hood over the stove/oven area.
  - b. Operation – automatic and manual at cylinder location near hood.
2. Wet Chemical System – Serving Line.
    - a. Description – installed in the exhaust hood over the grill area.
    - b. Operation – automatic and manual at the cylinder location on the wall.
  3. CO2 System – MRI Suite (Shenango)
    - a. Description – located in the Control Room of the MRI Suite.
    - b. Operation – double interlocked pre-action system, automatic and manual via detectors/valves. Tied into main fire panel via flow switch.

There are two such systems in the Greenville Campus; all tied to the main Simplex panels.

1. Wet Chemical in the Kitchen.
  - a. Description – installed in the exhaust hood over the stove/oven area.
  - b. Operation – automatic and manual with control on wall near tank east of hood.
2. Wet Chemical in the Serving Area
  - a. Description – installed in the exhaust hood over the stove/oven area.
  - b. Operation – automatic and manual near the hood.
3. Pre-Action Systems in the O.R. and MRI:
  - a. Description – installed in OR rooms 5 and 6 and the MRI scan room.
  - b. Operation – delays discharge until activated by two sensing devices.

#### **E. Fire Extinguishers:**

1. **Description:** Fire extinguishers in the corridors and throughout the facilities are the H<sub>2</sub>O, CO<sub>2</sub> and ABC type units. Fire extinguishers are located in marked areas on each floor of the hospital. Halon extinguishers may be available in areas with specific needs. Nonferrous extinguishers are located in the MRI areas.
2. **Operation:** Remove the fire extinguisher from its cabinet. Remove the pin. Aim the nozzle at the base of the fire. Squeeze the handle to discharge the contents of the extinguisher. Sweep discharging extinguisher at the base of the fire. PASS – Pull, Aim, Squeeze, Sweep

#### **F. Building Safety Features:**

1. **Description:** The hospital provides life safety features that conform to applicable NFPA 101 and 2000 Life Safety codes sections relating to existing, corridors, compartmentation, and other pertinent features.

2. **Smoke Compartments: Compartmentation** is a conscious focus for all construction at UPMC Horizon. Compartmentation features include both smoke walls and fire walls (1 hour and 2 hour) and may be reviewed upon request in the Maintenance Department. Smoke walls, fire walls (2 hour) and hazardous areas (1 hour) are shown on documents and plans that are located in the Maintenance offices.
3. **Smoke Doors:** Located in smoke partitions. They are installed per NFPA requirements and have closures and positive latching hardware or have 5 pounds or greater pressure.
4. **Fire Doors:** They are installed per NFPA requirements and have closures and positive latching hardware.
5. **Magnetic Holders:** Installed on all smoke and fire doors when the door may impede normal flow of routine traffic. The holders are controlled by the Fire Alarm System which will release the door upon alarm.
6. **Elevator Recall:** In the event of an alarm situation in Greenville Elevators A & C are controlled manually and will be grounded when directed by the Fire Response Team or Fire Department. Elevators B, D & E have fire recall programmed controls and will return to the 1<sup>st</sup> floor when tripped by the fire alarm.  
  
Shenango elevators 2,3, and 4 have recall programmed contents and will return to the first floor when tripped.
7. **Exits:** All exits are marked with signage conforming to NFPA 101 codes.

#### F. Fire Response Team

This team consisting of Maintenance, Environmental Services Supervisors and the Shift Supervisor (second/third shifts), will respond to all “**code red**” alarms. The team will be responsible for taking control and directing personnel and activities at the scene until the fire department arrives. This team, in cooperation with the fire department and Administration, will determine when it is safe to clear the “**code red**”. (Note: Refer to Policy #EOC-FS-05).

9. **Orientation/education program that addresses:**
  - b. Specific role at the fire’s point of origin.
  - c. Specific role away from fire’s origin.
  - d. Specific responsibilities of physicians, volunteers, students
  - e. Use and function of the fire alarm systems
  - f. Hospital-specific fire evacuation routes.
  - g. Location and use of equipment for evacuating or transporting patients in a fire.
  - h. Building compartmentalization procedures for containing smoke and fire.

#### Implementation:

All employees, volunteers, medical staff, interns, residents, and students will be provided education regarding fire safety management at the facility and departmental level. It will be accomplished in the following manner:

- a. All new employees and students will be provided with fire safety management education during hospital-wide orientation. They will also be oriented to departmental Fire Safety Management responsibilities during their initial three months of employment by the department manager. Volunteers will be provided with Fire Safety Management during volunteer group orientation. Interns, residents, and medical staff receive education during their own orientation program. Forensic staff and contract staff receive education during their orientation process.
- b. All employees will receive at least annual hospital-wide and departmental specific fire safety education.
- c. The content and quality of the hospital programs must be coordinated between the Education Director and the Safety Officer.
- d. The departmental programs will be based on employee needs, either requested or assessed, and are coordinated by the respective department managers. The Safety Officer will assist in providing information for departmental programs.
- e. At times of impairments to the Fire Safety program, Interim Life Safety Measures (ILSM) will be implemented. This program and its intent will be presented during orientation of new employees, and in greater depth to affected departments at the time ILSM is implemented.

**10. Ongoing monitoring of performance regarding actual or potential risks related to one or more of the following:**

**Staff knowledge and skills**

- **Level of staff participation**
- **Monitoring and inspection activities**
- **Emergency and incident reporting**
- **Inspection, preventive maintenance and testing of equipment**

**Implementation:**

Performance standards for Fire Safety Management will be monitored on an ongoing basis and reported to the Infection Prevention/Patient & Environmental Safety Committee.

**ANNUAL EVALUATION OF THE LIFE SAFETY MANAGEMENT PROGRAM:**

The plan shall be evaluated on an ongoing basis to assure that it meets the fire safety needs of the facility. At least annually the objectives, scope, performance, and effectiveness of the plan shall be reviewed, and revised if necessary by the Infection Prevention/Patient & Environmental Safety Committee, with input and assistance from other committees, Administration, Medical Staff departments, and hospital departments. Approval of revisions will be made by the Infection Prevention/Environment of Care Committee, Medical Executive Committee and the Board of Directors.

**COMMUNICATIONS/REPORTING**

The findings, conclusions, recommendations, actions taken, and follow-up by the Infection Prevention/Environment of Care Committee, as a result of the monitoring and evaluation of the

Fire Safety Management Plan, are reported at least quarterly to the Quality Council, which includes medical staff, nursing, departmental and administrative representation, Medical Executive Committee and to the Board of Directors.

### **FIRE WATCH**

Notify fire department and initiate fire watch if the fire suppression system or alarm system is out of service for 4 or more cumulative hours in a 24 hour period. Fire watch or building evacuation will be implemented.

#### **DESCRIPTION OF FIRE WATCH:**

1. A dedicated person will be assigned fire watch.
2. That person will make rounds hourly through the entire building, verifying no potential for a fire.
3. The person will be assigned a method to directly communicate with local fire department (radio or cell phone).
4. Fire watch will continue until the fire suppression or alarm system is in full operation.
5. Notify local fire department and Department of Health in Digital Event Reporting.

Revised: November 2017

Reviewed: October 2018

## Life Safety

Fires can be devastating to life and property. Knowing what to do in the case of a fire is extremely important in the hospital environment. Not only your own lives, but the lives of patients and visitors rely on quick and responsible actions. The Life Safety Management Program has been prepared to acquaint all Hospital personnel with their individual responsibilities in the event of a fire.

### **What to do if there is a Fire:**

Knowing what to do before a fire occurs will help in eliminating some of the anxiety acquainted with fire response. Here are some basic fire safety points:

- Report **ALL** fires and locations, no matter how minor.
  - Keep calm, do not panic or shout. Fear can do more harm than the fire.
  - Know where the following are located in your area:
    - \*Fire alarm box (pull station)
    - \*Fire extinguishers
    - \*Next compartment for relocation of patients and staff (next smoke or fire barrier)
    - \*Oxygen shut-off valves
- CAUTION:** After receiving clinical approval, Oxygen should be shut off when it is determined to be an immediate threat to life safety.
- Know the Hospital fire code: **“CODE RED”**.
  - The person in charge of the department will be in command of the scene pending the arrival of the Fire Response Team and/or the Fire Department.
  - Don't use elevators! Use the stairs.
  - Do not make unnecessary telephone calls, this only ties up the lines.

### **Reporting a Fire:**

To report a fire, follow these procedures:

- ① Pull the nearest fire alarm box (pull station).
- ② Dial “5511” at the Shenango Valley Facility and “5555” at the Greenville Facility.
- ③ Be sure to give your name, the location and the extent of the fire. This is in addition to pulling the fire alarm.

### **Use and Function of the Fire Alarm System:**

The alarm pull stations are conveniently located on the walls near the exits in every area of the hospital. The following will happen upon activation of the alarm system:

- All fire alarm response systems will be activated. Fire and smoke doors will close to contain fire or smoke.
- The alarm will sound and the announcement will indicate the location of the fire. (Listings for the bell-codes are located on the walls throughout the hospital).
- The switchboard operator will announce the **“CODE RED”** and the location of the alarm.

- Local fire companies will be alerted via 911.
- All smoke and fire doors will close automatically.
- All personnel will initiate the appropriate fire procedures.

### **Fire Drills**

Fire drills will be conducted at each campus at least once per shift per quarter. All personnel are asked to cooperate and conduct themselves as though an actual fire exists.

### **Fire Response - Point of Origin:**

JC Standards require you to be familiar with your responsibilities if you are at the point of origin of a fire. Protecting the safety of patients and fellow workers depends on you knowing the correct procedures. The following procedures have been developed for that purpose:

1. Any patient in immediate danger is removed from the room of fire origin, and all doors to the corridor are closed.
2. The person discovering the fire sounds the alarm or, while removing the patient, assigns a co-worker to sound the alarm. A call to the operator (“5555” – Greenville Campus) / (“5511” – Shenango Valley Campus) should also be made simultaneously in order to confirm the location of the fire. This action will:
  - notify the fire department
  - alert personnel throughout the hospital
3. Persons are evacuated from the threatened area, if needed. Patients in the immediate area of the fire or in danger should be moved to safety immediately. Begin with any patients in the room containing the fire, then evacuate or remove of patients in the adjacent rooms, continuing until the immediate area is evacuated. Patients should first be evacuated horizontally on the same level behind the nearest smoke or fire door. Vertical evacuation will occur if ordered by the Fire Response Team. And/or the Fire Department.
4. To evacuate the immediate area of the fire, patients confined to bed should be evacuated in the bed, if possible, transferred to a carrier, or carried to safety. Patients able to be moved by wheel chair should be wrapped in a blanket and pushed to safety. Ambulatory patients should be wrapped in a blanket and led to safety. The evacuation of patients in the immediate area of the fire must be done quickly but calmly, and does not require the order of the Fire Response Team or Fire Department.
5. Should a fire occur in a patient bed, smother the flames with a pillow or blanket, remove the patient from the bed, then all patients from the room. A hand extinguisher, or even a pitcher of water or wet blanket, can be used to smother small fires (Use caution and common sense in deciding to fight a fire).

6. After the patient(s) has been evacuated from the room, other electrical equipment should be shut off. Oxygen should be shut off if in use after receiving clinical approval. All windows and the doors should be closed.
7. If fire hoses must be used, the fire department will be the only departments authorized to utilize these hoses.
8. Utilities, such as gas, oxygen, and ventilating equipment, are controlled or shut-off. Utility “shut-offs” will be handled by the Maintenance Department. In the case of immediate danger, any employee at the fire’s point of origin may shut off the utilities after receiving clinical approval. Be sure to secure patient care!
9. Control of activities is turned over by the Fire Response Team to the fire department upon arrival.

### **Fire Response - Away From the Point of Origin:**

If the fire alarm sounds, and the announcement indicates that the fire is in another department, you still have responsibilities. The following procedures have been developed in compliance with JC Standards under the Environment of Care for response to fires away from point of origin:

- ① Insure the calm and safety of all patients, visitors, staff, etc.
- ② Ask all patients and visitors to remain in their rooms.
- ③ Turn off all unnecessary lighting, electrical appliances, etc.
- ④ All doors and windows must be closed.
- ⑤ Check all ceilings, floors, stairways, etc. for any sign of smoke or fire.
- ⑥ Do not leave your area/floor, unless absolutely necessary, and never go to the scene of the fire, unless directed to do so.

### **R.A.C.E.:**

UPMC Horizon uses the acronym R.A.C.E. to assist employees in remembering the fire policy procedures.

- R** Rescue people in immediate danger.
- A** Pull Alarm (call the operator and confirm location).
- C** Contain fire and smoke by closing all doors.
- E** Extinguish and evacuate (use good judgment).

### **“No Smoking”**

The most common cause of a fire is careless smoking and the careless mishandling of smoking materials. The hospital prohibits the use of smoking materials throughout its buildings and grounds. UPMC Horizon is a non-smoking facility. Employees are not permitted to smoke during their scheduled shift.

### **Use of Fire Extinguisher**

- Before you decide to fight a fire make sure the fire is confined to a small area and that it is not spreading beyond the immediate area.
- **Always** make sure that you have an unobstructed escape route between you and the fire.
- Make sure that you have read the instructions and know how to use the extinguisher. It is reckless to fight a fire under any other circumstances. Instead, leave immediately and close off the area.
- Be sure you have the right type of extinguisher for the fire. The flyer on the next page explains the different types of extinguishers for different types of fires.

Knowing when to fight a fire and what extinguisher to use will not help you if you don't know how to use an extinguisher. UPMC Horizon has adopted the acronym **P.A.S.S.** to help its employees remember the procedure to correctly use a fire extinguisher. Remember to stand 6 to 8 feet away from the fire and follow the four steps of **P.A.S.S.** If the fire does not begin to go out immediately, leave the area.

Pull the pin between the two handles.

**Aim** at the base of the fire – If you spray the agent directly into fire, the pressure may spread the burning materials.

**Squeeze** handles together.

**Sweep** from side to side. Evenly coat entire area of the fire.

### **Department Specifics:**

*Every department should supplement this plan with department specific steps and procedures. Evacuation plans should be tailored to the area. If you have any questions, ask your supervisor.*

### **Fire Extinguishers:**

Small fires can be contained and extinguished before they can cause damage to persons or property if the right fire extinguisher is used. Fires are rated: A, B, C, or D, depending upon the type of "fuel" that is burning. Fire extinguishers are rated according to the type of fire that they can put out. This information is listed prominently on the extinguisher. Take a moment to learn the four types of fires so that you'll know which extinguisher to use if you find yourself in a fire emergency.

### **Fire Extinguisher Codes:**

Fire extinguishers come in many varieties – water, carbon dioxide, dry chemical or powder, and liquefied gas. Fire extinguishers are coded to reflect the type of fire they can put out: A (green label), B (red label), C (blue label), D (yellow label). Newer extinguishers have picture codes showing the type of fires they can be used on.

# TYPES OF FIRES

Be sure to use the right extinguisher for the type of fire you are confronting. Using the wrong extinguisher can actually make the fire worse.



## **TYPE A:**

Wood, paper,  
cloth, rubbish



## **Type B:**

Flammable gas/liquids



## **Type C:**

Electrical Fires

**Halon:** For electrical fires



## **TYPE A-B-C:**

Wood, paper, cloth, rubbish  
Flammable gas/liquids  
Electrical fires

## **TYPE B-C:**

Flammable gas/liquids  
Electrical fires

## **Type K:**

(For use in kitchen areas)  
For grease fires

# **CLINICAL ENGINEERING**

# **MEDICAL EQUIPMENT MANAGEMENT PLAN**

**UPMC Horizon**

**Rev July 1, 2017  
UPMC BIOTRONICS**

# UPMC Horizon

## MEDICAL EQUIPMENT MANAGEMENT PLAN

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### **INTRODUCTION:**

UPMC Horizon and its affiliates are committed to provide to its patients, visitors and employees a safe environment in terms of medical equipment utilization. The Equipment Management Plan is aligned with the organization's overall mission, vision and values with regard to technology, education and its utilization throughout the institution.

### **MISSION and GOAL:**

The medical equipment management mission is consistent with and supports the larger overall mission of UPMC Horizon through the development, research, promotion and subsequent implementation of a proactive Environment of Care management program. The goal is to implement a system of continuous improvement to ensure that performance is evaluated and opportunities for improvement are identified.

### **SCOPE:**

This plan applies to all UPMC Horizon programs, as well as hospital-related off-site facilities. Requirements involving patients, physicians, staff, and contracted service vendors are also delineated in this plan.

### **CODES, STANDARDS AND REGULATORY REQUIREMENTS:**

The medical equipment management plan has been designed to ensure compliance with all federal, state and local safety requirements. These requirements include, but are not limited to, The Joint Commission, State Department of Health, Centers for Medicare and Medicaid Service (CMS), Food and Drug Administration, NFPA and the Consumer Product Safety Commission.

### **ORGANIZATIONAL INVOLVEMENT:**

Along with the Safety/Environment of Care (EOC), Committee, the following departments all play an intricate part in establishing the components needed to maintain the Medical Equipment Management Plan.

- 1) Clinical Engineering
- 2) Patient Safety/Risk Management
- 3) Training and Educational Development
- 4) Human Resources
- 5) Supply Chain Management
- 6) Nursing/Medical Staff

## **ESTABLISHING, SUPPORTING, MAINTAINING**

### **Equipment Management Program**

- A comprehensive equipment management program will be followed for all portable and fixed equipment used for the diagnosis, treatment, monitoring, and care of patients. All patient care equipment will be evaluated for risk and preventive maintenance inspections will be done according to Equipment Frequency Testing Policy.
- The management program is subdivided into individual policies and procedures outlined within this text which when combined form the basis of the plan in accordance with the Environment of Care Elements of Performance, **EC. 02.04.01 & EC.02.04.03**

#1 SELECTING AND ACQUIRING MEDICAL EQUIPMENT

#2 ESTABLISHING CRITERIA TO INVENTORY

#3 MAINTENANCE STRATEGIES

#4 INSPECTING/TESTING /MAINTAINING/EDUCATION

#5 MONITORING AND REPORTING INCIDENTS AS REQUIRED BY THE SAFE  
MEDICAL DEVICES ACT OF 1990

#6 EMERGENCY PROCEDURES

## **DEVELOPING AND MAINTAINING A WRITTEN MANAGEMENT PLAN**

The Medical Equipment Management Plan has been designed to:

- a. Ensure compliance with all federal, state, and local safety requirements.
  - b. Provide safety compliance with an incoming equipment inspection process.
  - c. Provide technical analysis of pre-purchased medical equipment.
  - d. Institute a Risk Based Testing criteria for equipment within the inventory, classifying equipment as the following; High Risk-(Critical)-Life Support, Medium Risk- (Mid Critical) - Therapeutic and/or Diagnostic, Low Risk-(Non-Critical)
  - e. Perform annual Risk-Base assessment of the equipment inventory.
  - f. Identify equipment on the inventory as "Life Support" or "Non-Life Support"
  - g. Maintain preventive maintenance standards/goals by an equipment inspection process.
  - h. Monitor and act upon user errors regarding manufacturer and/or operator error.
  - i. Maintain and distribute accurate department equipment inventory/letter by an inventory validation process.
  - j. Act upon hazard recalls and alerts and educate the appropriate staff members.
  - k. Assist in providing technical/clinical assessments regarding patient related equipment incidents.
  - l. Upon request, assist in a non-clinical role regarding Emergency Clinical Intervention.
  - m. Provide emergency back-up/spare equipment when warranted.
  - n. Establish repair services protocol for equipment malfunctions.
  - o. Educate and provide training on patient related medical equipment to maintainers and facilitate training of end-users as requested.
  - p. Monitor annual Performance Measurements and facilitate any corrective actions.
  - q. Participate in Medical Equipment Sub Groups, EOC/Safety Committee when applicable
  - r. Monitor Dialysis water testing and sterilizer testing through the Infection Control Department, Renal Dialysis Department, Operating Room and Central Supply.
- The Director of Clinical Engineering shall conduct an evaluation of the Medical Equipment Management Plan on a minimally annual basis or as other incidents indicate. The annual evaluation will assess the program scope, performance effectiveness from a general perspective and recommend revisions, deletions, or additions to any or all parts of this management plan, implementation programs and guidelines. Any changes to the plan will be brought forth to the EOC/Safety Committee for review and approval. The report is reviewed by the entire committee for approval. The final report is then provided to Executive Management and the Board of Trustees. Summaries of the report are distributed to department directors and chairpersons.

## **#1 SELECTING AND ACQUIRING MEDICAL EQUIPMENT**

- An integral function of the Clinical Engineering Department is Technology Assessment in order to augment the medical equipment purchase process. Clinical Patient Related Equipment and items are reviewed by the Director/Coordinator of Clinical Engineering prior to purchase. Clinical Engineering generates and provides standard technical requirements (Terms & Conditions) to the Supply Chain Management Department prior to each purchase.

### **Equipment Evaluation**

- Equipment evaluations are scheduled in conjunction with Supply Chain Management and any of the hospitals' clinical departments. Clinical Engineering will provide a technical assessment as needed to assist with purchasing decisions for the acquisition and standardization of medical equipment technologies for UPMC.

### **Value Analysis Program**

- The Value Analysis Program is responsible for directing a clinically focused and user driven, financially responsible product evaluation and selection process following a seven-step process for product evaluation. All products and services currently in use, as well as those being considered for future use, are analyzed for their need, cost, utilization, and ability to support quality patient care. The program is comprised of an interdisciplinary team representing Nursing, Clinical Engineering, Supply Chain Management, Equipment Users & Operators, Medical Staff and Administration. This program has been sub divided into teams (VAT- Value Analysis Teams) amongst the following hospital disciplines:

- a. VAT Anesthesia
- b. VAT Cardiology
- c. VAT Central Processing
- d. VAT Critical Care Medicine
- e. VAT GI
- f. VAT Infection Control
- g. VAT IV Therapy
- h. VAT Med/Surg
- i. VAT Patient Care
- j. VAT Radiology
- k. VAT Surgical Services
- l. VAT Patient Monitoring
- m. Fleet Maintenance
- n. MACC (Monitoring, Alarm, and Communication Committee)
- o. Alarm Management Committee

These teams meet on a regular basis and develop outlines for further analysis and approval by the Steering Committee. The Steering Committee members encompass Senior Administration, Medical Staff, Supply Chain Management and Clinical Engineering. This committee provides insight to continued evaluations and/or approval of equipment,

procedures, technology and supplies.

### **Equipment Inventory Program**

- All equipment in Equipment Management Program will be evaluated for acceptance into a program under stringent guidelines. After acceptance, equipment information will be entered into BioTronics' computerized maintenance management system (CMMS) database (ITS) and service information will be filed. All patient care equipment will be evaluated for risk and preventive maintenance inspections will be done according to Equipment Frequency Testing Policy.
- **EVALUATION:** Equipment will be evaluated for serviceability by Clinical Engineering Personnel. In order for complete service (pm & repair) to be performed by Clinical Engineering, a complete service manual, proper training, and cost effectiveness of in-house service will be considered.

All Equipment that does not meet above criteria will be serviced by outside vendors with Clinical Engineering monitoring and documenting service calls.

## **#2 ESTABLISHING CRITERIA TO INVENTORY**

### **Equipment Frequency Testing Policy/AEM**

- All testing of equipment not classified as High Risk (Critical) Life Support will be based on risk criteria, manufacturer recommended techniques, equipment repairs, and failures found during preventive maintenance. All equipment will be evaluated yearly. After completing the evaluation process, the equipment will be inspected between zero and thirty-six months. All equipment including zero intervals will be inspected at the time of repair, modification, re-location of equipment, equipment returning to service from storage, with the Incoming Inspection Policy remaining in effect. Clinical Engineering will also perform annual room and department/unit sweeps. Each current department and/or unit will be inspected for new patient related equipment that has not been included into the Clinical Engineering program and equipment that has been removed from Preventive Maintenance inspections, so that any visual defects and/or operational issues are identified and corrected. Equipment on the current inventory will also be validated during annual department/unit sweeps.

#### **PROCEDURE:**

- All equipment types will be evaluated on risk, maintenance strategies, failed preventive maintenance and equipment failures.

Equipment - Type of equipment being evaluated.

Risk - Each risk category includes specific "ID" categories that are assigned points which when added together according to the formula listed below, yield a total Risk Program Weight score.

The formula used to calculate the total number of points is:

$$\text{Total} = E + A + (P + F + U) / 3$$

NOTE: Refer to the **RISK CRITERIA CATEGORY DESCRIPTION** scoring document within the Equipment Frequency Testing policy CE1.7 that describes point assignments for each risk category.

**RISK CATEGORY I: Equipment Function (E)**

Includes various areas in which therapeutic, diagnostic, analytical and miscellaneous equipment is used.

**RISK CATEGORY II: Clinical Application (A)**

Lists the potential patient risk or equipment risk during use, accounting for NFPA 99 chapter 4 Risk Assessment Criteria.

**RISK CATEGORY III: Manufacturers Maintenance Requirements (P)**

Denotes the Manufacturers recommended preventive maintenance requirements.

**RISK CATEGORY IV: Likelihood of Equipment Failure (F)**

Documents the anticipated Mean - Time - Between - Failure rate.

**RISK CATEGORY V: Environmental Use Classification (U)**

Lists the primary equipment use area.

**ADDITIONAL FACTORS IN DETERMINING PREVENTIVE MAINTENANCE INTERVAL**

**Equipment Failures** - Number of equipment failures per piece of equipment within device category.

**Recommended Preventive Maintenance Interval** - whenever new equipment type is received by the hospital, it is evaluated for risk. All other equipment is evaluated annually.

Equipment that scores below thirteen (13) may be added to the preventive maintenance schedule at the discretion of the Director of Clinical Engineering.

Equipment that scores thirteen (13) or higher may only be removed from the preventive maintenance schedule upon the recommendation of the Director of Clinical Engineering and approval by the Safety Committee.

To determine preventive maintenance frequency, a committee consisting of Clinical Engineering personnel will evaluate each group of equipment once per year. The committee will consist of personnel with different expertise.

An annual risk report will be used by the committee to determine preventive maintenance

frequency of zero (0), three (3), six (6), twelve (12), twenty-four (24), or thirty-six (36) months. Below are the guidelines based upon a combine PM & Repair Failure < .3 over a three (3) year period supporting an Alternate Equipment Management Program (AEM).

Risk Weight	Interval	Risk Standard	AEM
0 - 12	Zero (0), annual (12), twenty-four (24), or (36) Month inspections	Low Risk - (Non-Critical)	Yes/No
13 - 16	Semi-Annually (6), Annually (12), or up to (24) Month inspections	Medium Risk - (Mid-Critical) Diagnostic & Therapeutic	Yes/No
17 >	Quarterly, Semi-Annually or Annual inspections	High Risk - (Critical) Life Support	No

**Equipment Classifications requiring manufacturer’s PM procedures/inspection interval:**

- 1) High Risk, (Critical)- Life Support
- 2) Imaging/Radiologic Equipment & Medical Lasers
- 3) New Types of Equipment (all) – Default interval is the recommended manufacturer’s PM procedure/ inspection interval and will remain for a period of three years until service history is established.
- 4) Equipment subject to requiring preventive maintenance inspections due to parts replacement or Regulatory Agencies/Conditions of Participation (CoPs), the recommended manufacturer’s procedure and interval will be used.

**Incoming and Outgoing Electrical Medical Equipment**

- It is the policy of UPMC **Horizon** to strive for an electrically safe environment and to minimize hazards to patients, visitors, staff and contractors, by requiring inspections of electrical medical equipment and appliances either purchased or brought into UPMC **Horizon**
- The purpose of this policy is to ensure electrical medical equipment is inspected and is in compliance with Food & Drug Administration (FDA), National Fire Protection Association (NFPA), Centers for Medicare and Medicaid Service (CMS), and The Joint Commission regulations and standards; and to document all discarded, traded, and sold equipment. This includes but is not limited to the following:
  - Trial Equipment
  - Rental Equipment
  - Patient owned Equipment
  - Borrowed Equipment
  - Purchased Equipment

## Definitions

- Appliances for the most part are electrical equipment, either fixed or portable, which use electrical energy and are designed to be used in a specific manner under certain conditions. Electrical appliances may produce heat, vibration, rotary or reciprocal motion, light or interference with other equipment via line or electromagnetic interference (EMI). Appliances are divided into two categories:

### 1) Electrically-Powered Equipment (Non-Medical)

Appliances used within UPMC **Horizon** that are not used for patient life support, diagnostic work, or therapy. This equipment does not require annual inspection.

Examples are as follows:

- Office equipment
- Appliances
- Hair Dryers & Shavers
- Radio, Electrically powered toys and games
- Cleaning equipment
- Tools and personal or rented electrical equipment
- Various non –electrical devices

### 2) Medical Equipment

All appliances (electrical and non-electrical) used for life support, diagnostic work or therapy related to the treatment of patients and their care.

## Incoming Trial, Purchased, Borrowed, Repaired/Upgraded Medical Equipment

- All incoming trial, purchased, borrowed and repaired/upgraded medical equipment shall undergo a safety, operational and performance inspection or no less than a safety inspection prior to being powered up or connected to any hospital staff member, visitor, patient, or device. \* Proper documentation will be completed according to Clinical Engineering's related policies.

*\* In emergency situations, UPMC patient related equipment that is borrowed from other UPMC facilities may be operated without an incoming inspection as long as the equipment contains a current inspection sticker. The department that requested the equipment is responsible for notifying Clinical Engineering of the equipment control number and inspection tag prior to the equipment's return.*

- All medical equipment shall be in compliance with all applicable standards, e.g., NFPA, Joint Commission, Centers for Medicare and Medicaid Service (CMS), OSHA and NEC. If patient lead wires exist, they also must comply with FDA standards. All AC powered devices shall have a 3 WIRE HOSPITAL GRADE PLUG or be properly labeled as a DOUBLE INSULATED device.

- The department requesting trial, borrowed, or new purchased equipment is responsible for having its requests evaluated by the Clinical Engineering Department and for arranging an equipment inspection prior to use of the equipment. Equipment that is brought into the hospital by the manufacturer/vendor must be accompanied by an equipment inspection record and shall be authorized by the user. An authorized copy of the inspection record supplied by the equipment provider is to be forwarded to Clinical Engineering indicating the operating department. Equipment that requires on-site manufacturer/vendor intervention before patient use must be accompanied by an equipment inspection record and/or a clinical acceptance form and shall be authorized by the user and Clinical Engineering.
- Upon passing inspection, an inspection tag corresponding to the type of equipment shall be placed on the equipment near a control panel or serial number (if applicable) according to Clinical Engineering Tagging/Labeling Policy. A control number and asset tag will be applied to all new purchased medical devices upon being received by the hospital. (If applicable).
- Upon failing the inspection or failure during use, the company, which distributed the equipment, must be notified by Clinical Engineering for the repair or replacement of the equipment. The replaced or repaired unit shall undergo a new incoming inspection.
- Clinical Engineering shall keep records of all inspections via work-order, or electronic database.
- Requisitions for patient care equipment should specify any additional accessories that may be needed for proper operation including any applicable I Safety Data Sheet (SDS) or unusual material handling (delivery) information.
- Office equipment poses little risk to patients, staff and guests and is not included in the medical equipment program, inspected, nor tagged. This type of equipment includes but is not limited to:
  - Computers, Printers, Typewriters, Copiers, Scanners, and video/PC monitors
  - Electric Pencil Sharpeners, Staplers and Clocks
  - Lamps
  - Radios

### **Outgoing Trial, Borrowed, and Repaired Medical Equipment**

- All medical equipment leaving UPMC Horizon must be brought to the attention of Clinical Engineering before removal from the facility.
- The department that requested trial, borrowed, or repaired equipment is responsible for notifying Clinical Engineering prior to equipment removal.
- Trial, borrowed, or repaired equipment leaving UPMC Horizon is the sole responsibility of the equipment owner.
- Clinical Engineering and Supply Chain Management will arrange for equipment that

must be sent outside the facility for repair (if applicable). An incoming inspection will be provided upon the equipment's return.

- Clinical Engineering shall keep records of all outgoing equipment via work-order, or electronic database.

### **Patient-Owned Medical Equipment**

- Patient- Owned equipment entering UPMC shall be visually inspected by the department's charge person where the patient is admitted. Patient Owned equipment and its functionality is the sole responsibility of the patient/user. \* *Refer to Policy # HS-RI1304, Patient Supplied External Medical Devices* before using any non-hospital owned equipment.

### **Rental Medical Equipment**

- During normal business hours all Rental Electronic Patient Related Medical Equipment maintained by Clinical Engineering shall undergo a safety and performance inspection or no less than a safety inspection prior to being powered up or connected to any patient, hospital staff member, visitor, or device.
- Rental Electronic Patient Related Medical Equipment that is used in conjunction for Life Support (ex. Ventilator) that enters UPMC facilities after Clinical Engineering's normal business hours shall undergo a safety and performance inspection or no less than a safety inspection by the Clinical Engineering "on-call - after-hours" technician prior to being powered up or connected to any patient, hospital staff member, visitor, or device. Upon the equipment delivery, the vendor must supply a written "MEDICAL EQUIPMENT DEVICE FORM" to the requesting department or have the form attached to the equipment. The requesting department must send this completed form to the Clinical Engineering department. Also, an electronic copy of the form(s) supplied by the vendor is to be forwarded to Clinical Engineering via email address ([BiotronicsEDS@upmc.edu](mailto:BiotronicsEDS@upmc.edu)) before the 5<sup>th</sup> business day of each month.
- Rental Electronic Patient Related Medical Equipment that is used in conjunction for Non-Life Support (ex. Feeding pump) that enters UPMC facilities after Clinical Engineering business hours may be inspected for proper operation (i.e. power cord, visual defects) by the requesting department or person requesting the device. Upon the equipment delivery, the vendor must supply a written "MEDICAL EQUIPMENT DEVICE FORM" to the requesting department or have the form attached to the equipment. The requesting department must send this completed form to the Clinical Engineering department. Also, an electronic copy of the form supplied by the vendor is to be forwarded to Clinical Engineering via email address ([BiotronicsEDS@upmc.edu](mailto:BiotronicsEDS@upmc.edu)) before the 5<sup>th</sup> business day of each month.
- Clinical Engineering shall keep records of rental equipment as part of the equipment inventory.

### **Obsolete/Storage/Cannot Find Medical Equipment\***

- All equipment discarded, traded, or sold shall be considered obsolete from the hospital and preventive maintenance schedule of Clinical Engineering.
- When equipment is removed from active service or placed into obsolete/storage/cannot find status, the requesting department shall notify Clinical Engineering and the Business Unit Coordinator and complete the Asset Report Form. Equipment appearing on a department's active equipment inventory that has remained in storage or cannot find shall be considered "Obsolete" after one year of the equipment's last Preventive Maintenance and/or inventory validation cycle.

**\* Refer to Safe Medical Device Act Procedure (SMDA), BioTronics Policy CE 1.11 for additional details regarding equipment under FDA tracking requirements.**

- Control number, and/or inspection tags shall be removed before discarding equipment from the hospital premises.
- Clinical Engineering shall keep records of all "OBSOLETE" equipment via work-order or electronic database.

### **#3 MAINTENANCE STRATEGIES**

- All equipment entered into the Equipment Management Program will be reviewed subject to annual maintenance strategies comprised of various segments; Scheduled Maintenance, Performance Verification, Safety Testing, Equipment Mobility, Alarm Management and the components of the Equipment Frequency Testing Policy.

#### **PROCEDURE:**

##### **Scheduled Maintenance (SM)**

The inspecting, cleaning, lubricating, adjusting, or replacing of a device's non-durable parts. Non-durable parts are those components of the device that have been identified either by the device manufacturer or by general industry experience as needing periodic attention or those parts that are subject to functional deterioration and that have a useful lifetime that is less than that of the complete device. Examples include filters, batteries (non-user replaceable), cables, bearings, gaskets, and flexible tubing.

##### **Performance Verification (PV)**

Testing or calibration conducted to verify that the device functions properly and meets the performance specifications that would normally be used during the device's initial (when new) acceptance testing.

- a. Calibration: the checking and adjusting of a device's functions to make those functions conform within a specified tolerance to an identified standard.

### **Safety Testing (ST)**

Testing conducted to verify that the device meets the safety specifications that would normally be used during the device's initial (when new) acceptance testing. Medical equipment shall not require annual safety testing except after any repair or modification that may have compromised electrical safety.

### **Equipment Mobility (EM)**

Equipment that is used throughout each department/facility will be evaluated based upon if the equipment is "fixed" or "mobile". Equipment that is "mobile" has a greater potential of malfunction because of the operator's environment.

### **Alarm Management (AM)**

Equipment/Systems with clinical alarms are evaluated for alarm function, setting of alarm parameters, range and volume. All incoming equipment with clinical alarms will be assessed to determine the risk category that applies based upon the utilization of the equipment in the various hospital settings.

## **#4 INSPECTING/TESTING/MAINTAINING/EDUCATION**

### **Preventative Maintenance and/or Inventory Validation**

- All equipment in the Equipment Management Program will have preventative maintenance done according to PM procedures. Frequency of PM will be done in accordance to the Equipment Frequency Testing Policy. Devices that are included within the equipment inventory will receive at minimum an annual inventory validation.
- All High Risk – (Critical) Life Support (LS) Equipment shall have a 100% completion rate goal for scheduled maintenance. If the LS equipment is unavailable for its scheduled maintenance due to the device being used on a patient, out for repair or is unable to be located that device will not count against the goal. If equipment is in service on a patient, the Clinical Staff utilizing the device shall be informed that it is due for maintenance prior to next patient use. End users will be requested to contact Clinical Engineering when the device is removed from the patient. To aid in identifying the status of the device, Clinical Engineering shall affix an "Inspection Due Before Next Use" hang tag.
- All equipment not classified as High Risk (Critical) Life Support, Imaging/Radiologic or Medical lasers may be maintained by OEM procedures or shall be eligible for Alternate Equipment Maintenance (AEM) procedures and have a 100% completion rate goal for available equipment. If AEM procedures are identified for an equipment type, the procedure shall be completed at a success rate of 100%. If equipment in this category is unavailable for its scheduled maintenance due to the device being used on a patient, out for repair or is unable to be located that device will not count against the goal.
- An updated equipment inventory/letter is distributed to user departments with PM status, number of operator errors and number of hardware failures.

- The department head/manager will be notified for equipment that cannot be found. They will then notify Clinical Engineering if equipment is found so PM's can be performed.
- All owned patient related medical instrumentation must be assigned a Clinical Engineering Control Number. Each piece of equipment must have a current inspection (if applicable) or calibration label. (Tagging/Labeling Policy)
- Patient care equipment without a control number or inspection tag must be brought to the attention of Clinical Engineering for proper tagging and inspection.

All completed PM inspections (Pass) will be documented within the Clinical Engineering database (ITS). Failed inspections will be indicated by entry of a "failed PM" service report.

- To provide supplemental access to technical support documentation, a centralized Medical Equipment Document Library shall be maintained on the BioTronics SharePoint. Access ability shall be granted to all BioTronics staff. An annual review of the library's content shall be performed

### **Operator Errors**

- The purpose of monitoring operator errors is to focus on patient safety and to determine the need for additional medical equipment operator training based on a monthly evaluation of operator errors.
- An operator error report will be generated each month during the database update.
- All operator errors will be reviewed for any significant pattern that may require additional equipment in-servicing.
- Operator error review is also reported monthly to the UPMC Horizon EOC Committee.

### **Equipment Problem/Status Reports**

- All equipment within the Management Program will be monitored for problems with equipment (hardware, operator, "could not verify", and destructive). Clinical Engineering will distribute an equipment problem/status report to each department upon request.
- The Safety Committee through a Clinical Engineering representative will review medical equipment problem/status reports of all departments.

### **Medical Equipment Orientation and Education - Maintainer**

- Upon employment, the individual completes UPMC Horizon standard orientation. Annual mandatory in service education is completed as required.
- It is the policy of the Clinical Engineering Department to maintain the current orientation,

competency and technical certification status of its employees.

- To orient all new employees of Clinical Engineering on hospital and Clinical Engineering operations.
  - To provide and verify attendance at annual mandatory hospital and department in services for all Clinical Engineering staff.
  - To train and certify all new technical staff in their assigned areas of technical service and to assess competency in those areas within the first six months of hire.
  - To train and certify all current technical staff in newly assigned areas of technical service and to assess competency in those areas.
  - To provide ongoing technical in-service education as needed for the continuation of certification and maintaining effective technical support.
  - To provide annual competency assessment for all technical staff members.
  - To provide in service education for equipment users as requested or deemed necessary by Clinical Engineering.
  - To maintain a current education profile of all members of Clinical Engineering.
- General technical competency is recognized by accomplishment of advanced technical education (other than manufacturer service schooling), industry experience and optional AAMI Certification. General technical competency is required (as indicated by job description) for all technical staff members in order to perform adequately within assigned technical areas.
  - All staff members of the Clinical Engineering Department will be subject to a mandatory annual hospital in service via the “U-learn” electronic educational process covering; Emergency Preparedness, Infection Control, Body Mechanics, Equipment Management, Waste Management, Customer Relations, Security and Workplace Violence, Confidentiality and Ethics, Quality Improvement and Corporate Compliance. Additionally, an annual Lock-Out-Tag-Out in-service will be provided by the Clinical Engineering Department.
  - All technical staff members will be subject to department certification/competency requirements prior to solely maintaining health care related equipment within assigned areas of service.
  - Certification and competency will be documented in the UPMC Health System Performance Management Review during each technical employee’s annual performance evaluation.
  - The area supervisor or an appointed technical staff member will conduct competency assessments. Assessment will be performed either by observation, simulation, cognitive testing, review documents, oral presentation, demonstration, or testing (mfg. service school).

- Competency is also monitored throughout the year utilizing the monthly equipment failure report. The failure report generates a listing of equipment experiencing multiple failures within a given month to indicate a problematic condition as well as repair efficacy.
- During the employee's annual performance review, competency assessment will be performed for all authorized categories of service and documented on the UPMC Health System Performance Management Review. Assessment will be performed either by direct observation, simulation, cognitive testing, review documents, oral presentation, demonstration, or testing (Testing may be accomplished by completion of manufacturers training class).

### **Medical Equipment Orientation and Education - Users**

- Standard requirements of all medical equipment purchases include operator's manual and manufacturer in service education (prior to equipment use).
- In service documentation is retained within the user department. In regard to Nursing, a copy of the in-service record is forwarded to Nursing Education.
- Clinical Engineering monitors operator errors and/or associated failures. Should additional in servicing be required based upon database results, either the manufacturer or Clinical Engineering will comply.
- Nursing Division has a general orientation included within their "Patient Care Services" Policy & Procedure. The policy is directed at newly hired professional nurses. Documentation is filed in Human Resources.
  - As the new nursing personnel are assigned to specific areas or as existing nursing personnel change assignments, a "unit specific" orientation is required. Within the process is the demonstration of correct use of medical equipment required to service the patient population. The documentation is filed within the user department.
  - Annually thereafter, nursing is required to complete competencies. Results per nursing unit are filed in Nursing Administration database. Also, a mandatory self-learning packet is required to be completed.
- As stated previously (for general hospital user education), operator errors and equipment occurrences are monitored. Additional in-service education is provided as required.

### **Performance Measurement**

- Operator Errors - not to exceed a pre-determined threshold based on equipment inventory and the facility where the devices are located.
- Destructive Errors - are reviewed monthly against threshold and are analyzed for repetitive problems.

## **#5 MONITORING AND REPORTING INCIDENTS AS REQUIRED BY THE SAFE MEDICAL DEVICES ACT OF 1990.**

- In compliance with the Safe Medical Devices Act of 1990, it is UPMC policy to report deaths, serious illnesses or serious injuries sustained by a patient to the Food and Drug Administration (FDA) or the manufacturer of a medical device that is the cause or suspected cause of death, serious illness or serious injury.
- The Clinical Engineering Department will provide investigative support at the direction of Department of Patient Safety/Risk Management
- Reference Clinical Engineering policy, all trackable devices (medical equipment) set forth under the SMDA will be tracked as set forth in departmental policy following FDA guidelines.
- Tracking of implantable devices is the responsibility of the device manufacturer, user department and/or the purchasing department.
- In addition, to be compliant with the Medical Device Tracking portion of the Safe Medical Device Act of 1990 (published August 16, 1993), any life sustaining, life supporting device and FDA designated devices used outside UPMC must be tracked.

**Designated devices: (Updated list per “Medical Device Tracking; Guidance for Industry and FDA Staff,” dated January 25, 2010.)**

<http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/GuidanceDocuments/ucm071756.htm>

1. Breathing frequency monitors
  2. Continuous ventilators.
  3. DC-defibrillators
  4. Ventricular Bypass (assist) devices
- Each time device is used outside UPMC; the following must be tracked and kept on file: If requested, UPMC must supply the information to the manufacturer within three (3) working days and the FDA within ten (10) working days with approval from the Department of Patient Safety/Risk Management.
    - a. Device name, serial number, and model
    - b. Date device was received.
    - c. Person or manufacturer from whom the device was received.
    - d. Facility name and address
    - e. Location of device
    - f. If applicable, name, address, telephone number and social security number of patient using device.
    - g. If applicable, date the device was provided for use by the patient.
    - h. If applicable, name, address and telephone number of prescribing physician.
  - The information is documented in the Clinical Engineering ITS Database when equipment is donated, sold or permanently disposed.

**Medical Device Hazards and Recalls**

The Clinical Engineering Department's employees should review the appropriate medical

equipment alerts and recalls verifying the possible presence of defective or deficient devices in the hospital. It is the responsibility of UPMC Supply Chain Management and Clinical Engineering to inform the appropriate staff in the Hospital and see that proper action is taken on all hazards or recall notices.

Defective or deficient devices may require any of the following types of action:

- Permanent removal from service
- Modification
- Changes in instructions
- Warning to users

- If the device must be removed from service, all affected units must be located and replacements obtained to meet clinical needs.
- Coordination with clinical users is vital since removal of a device from service may pose a greater risk to patients than does the recalled device. Also, substitution of other devices may require in-service training.
- If modification is required, the affected units should be located and all users should be notified and given interim recommendations until modifications are completed. Arrangements must be made for the modification (who, where, when, how, and how much), and replacements may be needed while modifications are being made. After the modifications are made, a follow-up inspection should be performed.
- If only a warning is required, all users should be notified of the problem.
- The Clinical Engineering Department will complete documentation and distribute as follows:
  1. Product Recall/Product Failure Officer
  2. Appropriate department or user (if applicable)
  3. UPMC Supply Chain Management (if applicable)
- Any action required by Clinical Engineering will be documented with the Clinical Engineering's technology management database for the effected device

## **#6 EMERGENCY PROCEDURES**

### **Medical Equipment Failures**

- In the event of medical equipment failure, the user will make every attempt to support and maintain a safe patient care arena. As equipment malfunctions the user should follow the Medical Equipment tab within the Emergency Reference Guide found in the user department.
  - a) Transportable equipment should be replaced with a spare unit if it is immediately available within a given area.
  - b) When non-portable equipment malfunctions and an immediate repair is required,

the user will contact Clinical Engineering. This event may also require that the patient be moved to another location.

- c) All other equipment failures should be addressed to the attention of Clinical Engineering.

### **Emergency Clinical Intervention**

- Emergency procedures are documented within the UPMC Horizon Patient Care Services Policies and Procedures in conjunction with individual departments. The emergency procedures are updated as needed.

### **Back-up/Spare Equipment**

- When malfunctioning equipment cannot be repaired immediately, the Clinical Engineering Department will install loaner/spare equipment if it is available.
- If a loaner/spare is not available, Clinical Engineering may attempt to contact the equipment manufacturer or alternate provider for such equipment.

### **Contacting Repair Services**

- The Clinical Engineering Department provides twenty-four-hour coverage, seven days per week and can be contacted as follows:
  - a) Placing a service call to the in-house service shop. Greenville:724-589-6847  
Shenango:724-983-7561 or Pagers for Greenville: 724-589-1131 and Shenango:  
724-646-7106
  - b) Using the hospital overhead paging system.
  - c) Contacting the Clinical Engineering on-call technician via the hospital operator.  
724-588-2100
  - d) Contacting BioTronics corporate office at **412-578-9600, or 1-888-881-5218**

Reviewed:11/08/2018

Revised: 11/08/2018

**TITLE: SAFE MEDICAL DEVICE ACT OF 1990**

**PURPOSE:**

To comply with the Safe Medical Device Act of 1990 (SMDA).

Requirement of the Law: Medical device user facilities must submit a medical device report (MDR) to the device manufacturer within ten (10) days after becoming aware of a reportable death, serious injury, or illness.

If the event involves a device-related death, or the manufacturer is unknown, the report must be sent to the FDA. User facilities must also submit a semi-annual summary of reports to the FDA.

**DEFINITION:**

1. Device User Facility – Hospital, ambulatory surgical facility, nursing home, home health agency, ambulance provider, rescue squad, rehabilitation facility, psychiatric facility, or outpatient treatment or diagnostic facility which is not a physician’s office.
2. Medical Device – FDA defines a medical device as any instrument apparatus, or other article that is used to prevent, diagnose, mitigate, or treat a disease or to affect the structure or function of the body, with the exception of drugs. For example, a medical device includes but is not limited to ventilators, monitors, dialyzer, and any other electronic equipment, implants, thermometers, patient restraints, syringes, catheters, invitro diagnostic test kits and reagents, disposable, components, parts, accessories, and related software.
3. Patient of a Facility – is anyone who is being diagnosed, treated or otherwise receiving medical care in a facility.
4. Serious Illness or Serious Injury –
  - a) is life threatening,
  - b) results in permanent impairment of a body function or permanent damage to a body structure, or
  - c) necessitates immediate medical or surgical intervention to preclude permanent impairment of a body function or permanent damage to a body structure.

**POLICY:**

It is the policy of UPMC Horizon to comply with the provisions of the Safe Medical Device Act of 1990 to report to the FDA and/or a device manufacturer any occurrence wherein a medical device possibly caused or contributed to a patient death or serious illness or injury. UPMC

Horizon has also established and maintains reporting procedures as required in the Device Tracking provisions of SMDA.

#### PROCEDURE:

1. Staff members should immediately report, to the manager in charge of the department where the device was in use, any malfunction involving a medical device in patient use, which results in patient death, serious illness or injury. The manager and/or staff member shall then immediately notify the Administrator on Call, Unit Director in charge and the Risk Management Department by phone. Occurrences that are the result of user error are also reportable.
2. Any staff member, physician or house staff who is injured by or through the use of a medical device is considered a patient for reporting purposes, and should notify Risk Management of the injury.
3. All medical device malfunctions should be reported to the Risk Management Department in writing on an Initial Investigation Event Report (IIER). Included within the IIER is white peel-off label/number of the "Defective, Impounded Red Tag".
4. Patient Care Medical equipment/devices including accessories that malfunction during patient use are to be removed from service, red tagged, and impounded. If the device has memory and/or recording strips, these items should be preserved.

Notify Biomedical Engineering for assistance regarding data preservation and/or impounding. No repairs are to be initiated until approved by Risk Management. If immediate repairs are warranted due to patient care demands, Biomedical Engineering shall be notified for service and an IIER should be completed.

5. The Risk Management Department determines if the malfunction or user error falls within the SMDA reporting guidelines. A written report will be submitted to the FDA and/or manufacturer within 10 working days if there is reasonable information suggesting the device caused or contributed to a patient death or serious illness or injury.

#### EDUCATION

1. Information concerning SMDA reportable occurrences is provided to staff members during orientation programs by members of the Risk Management Department.
2. Updates are provided to appropriate clinical personnel and involved department heads on changes in reporting requirements or when the Risk Management staff, clinical directors, or department heads identify a deficiency in reporting that should be shared with staff through memos and/or unit-based in-service programs.

For additional information see Lab policy "Patient's Request for Return of Surgically Removed Specimens", AP3-12.

DISTRIBUTION: All Departments

**RESPONSIBLE DEPARTMENT: Risk Management**

**ORIGINAL DATE: 1990**

**REVISION DATE: July 2008**

**FOR POLICY MANUAL: A**

**APPROVED BY: DATE:**

**A ADMINISTRATIVE**

**Responsible Dept. July 2008**

**D DEPARTMENT**

**Administration July 2008**

**E ENVIRONMENT OF CARE**

**Medical Staff N/A**

**I INFECTION CONT/EMP. HEALTH**

**Board of Directors N/A**

Reviewed: October 2018

## UTILITY SYSTEM MANAGEMENT

### **INTRODUCTION / VALUE STATEMENT:**

Knowing what to do when a utility system fails can mean the difference between life and death in some areas of the hospital environment. Utility failure is part of the JC Standard on the Environment of Care. Only by knowing the proper procedures to follow in the event of a failure, can you be assured of providing a safe environment for patient care as well as personal safety. This packet will provide you with that knowledge.

### **BEHAVIORAL OBJECTIVES:**

After completing this packet, you will know the following:

- ✓ UPMC Horizon's emergency procedure for utility failure.
- ✓ The process for reporting utility problems or failures.
- ✓ The use of the "Urgent" code in a utility failure situation.
- ✓ Where to obtain information on procedures for utility problems or failures that are specific to your department.
- ✓ The importance of knowing the location and use of emergency shut-offs (e.g., O<sub>2</sub>, medical gases, and vacuums) for your department.

### **Utility System Management**

This in-service packet will provide a general outline for utility failures. All utility failures should be reported to the maintenance department as soon as possible. The following are some basic utilities located in the Hospital along with procedures for failures. These procedures will be supplemented, in most cases, by more specific plans within your department.

#### **Elevators**

In the event of a failure to an elevator in which you are riding, there are some basic procedures to follow:

1. Use the emergency phone within the elevator to call for help. (If there is no phone, there should be an emergency horn or buzzer).
2. Never attempt to exit on your own or assist another to exit.
3. Wait for maintenance to arrive for help; they are trained to know what to do.

#### **Medical Vacuum**

Utilities used in direct patient care require special consideration. The employee must act immediately to ensure continuity of care. For failures of medical vacuums and gases:

1. Use clinical intervention as appropriate for patient care.
2. Use alternate outlet if available.
3. In case of a fire or other emergency, know where the shut offs are in your department and all the areas supplied by that shut off. All gases can be shut off at the wall outlets by closing

the appropriate zone valve. All zone valves are identified and indicate the areas served (Do not shut off unless advised to do so by the person in charge of your department.)

4. Report all failures to maintenance. This should be a telephone report because of the urgency of the service.

### **Electrical Systems**

Electrical safety is a very important topic in a hospital. Here are some of the do's and don'ts in our facility:

1. Use the equipment only in the environment for which it was intended. Some devices are designed to work in a wet environment, other devices are not.
2. Do not use extension cords or multi-plug adapters. If additional outlets are needed, contact Engineering and Maintenance.
3. Portable heaters typically are prohibited from being used in this facility.
4. If you notice any cords becoming frayed, immediately remove that piece of equipment from service and notify Maintenance.
5. If someone has an electrical shock in your area:
  - a. Immediately stop the flow of electricity by pulling the plug or turning off the breaker. Do not hit the on/off button.
  - b. Initiate CPR if you are trained to do so.

### **Emergency Situations**

Loss of Electricity:

- Emergency power is provided by motor/generator sets. The following procedures should be supplemented within your department with department specific procedures:
  1. Use clinical intervention as appropriate for patient care.
  2. Emergency power is available at all "RED" wall receptacles. Please use these for equipment necessary for patient care. (e.g., ventilators, I.V. pumps)
  3. Report all failures to maintenance immediately following securing patient care.
  4. Emergency power should be provided in approximately 3 - 8 seconds after loss of normal power.
  5. Lighting is provided in all corridors and all emergency/critical care areas. (Also certain other areas).

Loss of Water:

- Conserve water use to patient needs only.
- Bottled water will be delivered to all business units
  - Assist Maintenance with distribution of bottled water

Loss of Telephone Service:

- Use the emergency telephone system by plugging your phone cord into the phone jack port located on your fax machine
- Limit telephone communication to critical needs only

# UPMC HORIZON UTILITY SYSTEMS MANAGEMENT PLAN CY 2018

## MISSION STATEMENT

It is the mission of the Utility System Management Plan to support the mission of UPMC Horizon by providing the means to ensure that Utility Systems are maintained to support the patient/staff environment.

## VISION STATEMENT

It is the vision of the plan that through proactive monitors and corrective actions utility failures that could affect services provided and patient and environmental safety will be prevented.

## PURPOSE/OBJECTIVES

The management of utilities is an integral part of the hospital's Environment of Care Program and is essential in providing quality and safe patient care as part of the hospital's mission. Implementation of and adherence to this plan will assure the operations reliability, assess the special risks and response to failures of utilities that support the patient care environment. The purpose and objectives of the Utility Management Program are:

- Establishing, supporting, and maintaining a Utility Management Program.
- To manage the Utility Systems in a manner that will provide the greatest measure of safety to patient and employees in order to reduce the risk of personal harm and additionally, to reduce unnecessary expenditures that result from a utility failure or neglect in preventive maintenance.

## SCOPE:

The Utility Management Plan applies to all employees and departments in the hospital, and other sites owned by the hospital. The Utility Management Program applies to the following systems:

- Electrical/Energy Power
- Medical Gases
- Vacuum
- Vertical Transportation
- Steam Heat, Ventilation & A/C
- Alarm Systems
- Natural Gas
- Plumbing

- Communications (nurse emergency call, audible pager, pagers, radios, telephones, computer network, cell phones, etc.)
- Water & Sewage

#### **RESPONSIBILITY:**

1. **Director, Facilities Management:** Notifies department managers when loss of utilities will occur. Manages the preventive maintenance program for the Utility Systems. Documents loss of utilities through Performance Standards Report. Ensures all elements of the Utility Management Plan are implemented, maintained and properly documented. Provide annual review of this Plan for continued adequacy, relevance and update.
2. **Department Manager:** Notifies Maintenance whenever there is a utility problem, failure or user error by means of the Maintenance work order system or occurrence reporting system.
3. **Safety Officer:** Whenever utility problems, failures, or user error have been identified that have or may have an adverse effect on patient safety and/or the quality of care, the Safety Officer ensures appropriate actions are taken to resolve the problem, documents these actions, and reports all such events to the Infection Prevention/Environment of Care Committee, President, Quality Council, Board of Directors and the Pennsylvania Department of Health. Additionally, the Safety Officer, with the assistance of the Environment of Care Team evaluates the effectiveness of those results as determined by committee action. Provides annual review of this plan for continued adequacy, relevance, and update as may be required in cooperation with the Director of Operations and the Maintenance Manager.

#### **UTILITY MANAGEMENT PROGRAM INCLUDES:**

1. **Develop and maintain a written management plan describing the processes to manage effective, safe, and reliable operation of utility systems.**  
**Implementation:**  
The Utility Management Plan has been developed and is reviewed and/or revised annually.
2. **Design and install utility systems that meet the patient care and operational needs.**  
**Implementation:**  
Utility systems were originally designed to meet patient needs. As design and redesign of services change, patient needs will be considered in relation to utility systems.
3. An inventory is developed for utilities, building systems, and applicable equipment and entered into the UPMC Horizon Maintenance TMS Work Order/PM System.

**Risk Category I: Utility Function (U)**

Includes various utility systems or equipment providing infrastructure support.

**Risk Category II: Risk Application (R)**

Lists the potential patient or associate risk that might occur as a result of a utility failure.

**Risk Category III: Maintenance Requirements (M)**

Describes the level and frequency of preventive maintenance that is required to keep the utility system or equipment in proper operating condition.

Each risk category includes specific sub categories that are assigned points, which when added together according to the formula listed below yield a total score or Risk Number from four (4) to twenty (20).

The formula used to calculate the Risk Number is:

$$U + R + M = \text{Risk Number}$$

**Implementation:**

All utility systems will be included in the Utility Management Program.

4. **Maintenance strategies for all utility systems equipment on the inventory.**

**\*Note: May use different maintenance strategies (i.e., interval-based inspections, predictive, corrective or metered maintenance, etc.)**

**Implementation:**

The hospital may use different maintenance strategies, as appropriate (for example: predictive maintenance, interval-based inspections, corrective maintenance, or metered maintenance). The strategy for maintenance will be specified on the individual utility's records.

5. **Defining intervals for inspecting/testing/maintaining utility equipment on the inventory (i.e. pieces on inventory benefiting from scheduled activities to minimize clinical/physical risks) based on criteria such as manufacturer's recommendations, risk levels, and current organizational experience.**

**Implementation:**

Intervals for inspecting, testing, and maintaining components for utilities on the inventory will be established based on the individual utility. The intervals may be based on the risk of the utility, time frames established by the utility manufacturer's recommendations, metered time maintenance, or based on the hospital's established history on the utility. The strategy for maintenance will be specified on the individual utility maintenance records.

6. **Develop and maintain current utility system operational plans to help ensure reliability, minimize risks, and reduce failures.**

**Implementation:**

Policies and procedures will be maintained in the Maintenance Department outlining the operation of each utility system.

7. **Emergency procedures that address:**
  - a. What to do if utility system malfunctions
  - b. Identification of alternative source of essential utilities
  - c. Shutoff of malfunctioning systems and notifying staff
  - d. Obtaining repair services
  - e. How/when to perform emergency clinical interventions if utility systems fail
  
8. **Mapping the distribution of utility systems**

Drawings showing the distribution of utility systems and main shut-off valves will be maintained in the Maintenance Department.
  
9. **Labeling controls of partial or complete emergency shutdown.**

**Implementation:**  
Valves and shut offs are labeled at the respective locations.
  
10. **Minimize pathogenic biological agents in cooling towers, domestic hot/cold water systems, and other aerosolizing water systems.**

**Implementation:**  
Biocide chemicals are added to the cooling towers daily during operating periods through an automatic feed system and tested monthly by an outside contractor. Copper/Silver units have been installed on domestic hot water system to remove the potential for Legionella.

Shenango Campus

Domestic hot water in the Moss Wing is maintained at 160° F in the holding tank and 120° F at the tap.

Greenville Campus

Boilers are treated as required with treatment chemicals. These systems are tested monthly by an outside contractor and adjustments made per their recommendation. Domestic hot water supply maintained at 120° F at the tap.

11. **Install and maintain appropriate pressure relationships, air exchange rates, and filtration efficiencies for ventilation systems that serve areas specially designed to control airborne contaminants (e.g., biological agents, gases, fumes, and dust).**

**Implementation:**

Annual measurements of positive/negative air pressures in all designated areas; quarterly preventive maintenance of ventilation systems in the laboratory and pharmacy. HVAC systems have at least semi-annual preventive maintenance. TSI monitors are installed on positive and negative pressure rooms for continuous monitoring of pressure relations.

12. **Inspect, test, and maintain critical components of piped medical gas system including master signal panels, area alarms, automatic pressure switches, shut off valves, flexible connectors and outlets.**

**Implementation:**

Inspection, testing, and maintaining operating components of piped medical gas system is accomplished by annual testing and inspection of the medical gas system. The main supply valves and area shut-off valves of piped medical gas systems will be clearly labeled and accessible.

13. **Test piped medical gas systems when systems are installed, modified, or repaired, including cross-connection testing, piping purity testing and pressure testing.**

**Implementation:**

Whenever medical gas systems are installed, modified or interrupted for any reason, the system will be tested for purity and pressure. This is accomplished by outside contract in compliance with Joint Commission standards, HFAP, NFPA and State regulations.

**14. REPORTING AND INVESTIGATING UTILITY MANAGEMENT EVENTS**

Utility problems, failures and user errors that are or may be a threat to the successful operation of the patient care environment shall be identified and documented as part of the Utility Management Plan. When utility system problems are identified, they are reported to the Director, Facilities Management, and the UPMC Horizon Infection Prevention & Environment of Care Committee. Actions taken to resolve problems or system failures shall be documented through the TMS System by placing a work order found on Horizon Home. Actions taken shall be monitored and evaluated for effectiveness by the Infection Prevention & Environment of Care Committee. Utility Management events are reported using the following risk categories:

**Risk Category I: Utility Function (U):**

<b>Point Score</b>	<b>Description of Utility Support</b>
10	Life Support/Fire Safety
9	Infection Control
8	Environmental Support
7	Equipment Support
6	Transport
3	Communication/Computer
2	Other

**Risk Category II: Risk Application (R):**

<b>Point Score</b>	<b>Description of Use Risk</b>
5	Death
4	Personal Injury
3	Misdiagnosis/Measurable Material Loss

- 2     **Disruption to Patient Care or Research**
- 1     **No Significant Disruption**

**Risk Category Number= U+R**

**Utility Management events are then classified into three categories (C1, C2 and C3 using U+R Risk Category Number.**

**Class I (C1)** - A failure or significant incident with the potential to affect equipment or systems critical to the safety and functioning of the entire hospital.

**Risk Category Number U+R >12**

**Class II (C2)** - A utility failure or incident which is essential to the operation of a department or major area but secondary to the critical functioning of the entire hospital.

**Risk Category Number U+R= 9 to 12**

**Class III (C3)** - A utility incident which occurs but is not essential to hospital operations and does not meet established failure criteria.

**Risk Category Number U+R= 3 to 8**

Class C1, C2 and C3 events are investigated immediately for corrective action and are reported to the Infection Prevention and Environment of Care Committee.

**15.    Orientation/education program that addresses:**

- a.     Utility system capability/limitations/special uses
- b.     Emergency procedures for utility failures
- c.     Knowledge and skills for utility system maintenance
- d.     Location/instructions for use of emergency shutoff controls
- e.     Process to report utility problems/failures/user errors
- f.     Whom to contact in emergencies

**Implementation:**

- a.     All new employees will be provided with facility utility management education during hospital-wide and department orientation.
- b.     All employees will receive at least annual hospital-wide and utility management education through uLearns.

**16.    Ongoing monitoring of performance regarding actual or potential risks related to one or more of the following:**

**Implementation:**

Performance improvement standards for utility management will be monitored on an ongoing basis and reported to the Infection Prevention/Environment of Care Committee. See EOC Annual Report for goals relative to this plan.

## **ANNUAL EVALUATION OF THE UTILITY MANAGEMENT PROGRAM**

The plan shall be evaluated on an ongoing basis to assure that it meets utility needs of the institution. At least annually, the scope, objectives, performance, and effectiveness of the plan shall be reviewed, and revised if necessary, by the Infection Prevention/Environment of Care Committee, with input and assistance from other committees, Administration, Medical Staff Departments and Hospital Departments. Approval of revisions will be made by the Infection Prevention/Environment of Care Committee, Medical Executive Committee and the Board of Directors.

## **COMMUNICATION/REPORTING**

The findings, conclusions, recommendations, actions taken, and follow-up by the Infection Prevention/Environment of Care Committee, as a result of the monitoring and evaluation of the Utility Systems Management Plan, are reported at least quarterly to the Quality Council, which includes medical staff, nursing, departmental and administrative representation, Medical Executive Committee and the Board of Directors.

Reviewed: October 2018

**TITLE: ALTERNATE UTILITY SERVICES**

RESPONSIBLE DEPARTMENT: EOC/SAFETY - Emergency Preparedness Plan

ORIGINAL DATE: April 1998

REVISION DATE: June 2016

FOR POLICY MANUAL: E  
A ADMINISTRATIVE  
D DEPARTMENT  
E ENVIRONMENT OF CARE  
I INFECTION CONT/EMP. HEALTH

APPROVED BY: DATE  
Responsible Dept. June 2016  
Administration N/A  
Medical Staff N/A  
Board of Directors N/A

**PURPOSE:**

To establish alternate sources for essential utilities, power, water and sewage.

**SCOPE:**

Maintenance, Environmental Services Departments and all departments within the facilities, including skilled care and other facilities owned by the hospital.

**POLICY:**

It is UPMC Horizon's policy to maintain the facilities' physical operations in times of emergency failure of essential utilities by providing alternate sources for electric power, water, fuel and sewage. Incident Command will be initiated. UPMC Med Call will be notified immediately at (412) 647-7000 or 1-800-544-2500.

Should alternate sources for utilities be unable to provide the necessary resources to maintain safe operations and services, President/designee the Incident Commander will determine the need to discontinue services, transfer services and/or patients to the alternate campus.

All utility failures must be reported to the Department of Health as an infrastructure failure.

**PROCEDURE:**

## Electrical Power

1. Contact the Maintenance Staff with all electrical power failures.

- Emergency generators provide power to specifically identified high risk departments.
- Emergency power outlets are identified by “red” outlet covers.
- Battery powered back-up lighting is in place in the operating rooms, including LDRP.
- Portable generators are available as back-up.

2. Refer to departmental utility plan for specific department procedure.

## Water

1. Nutritional Services Manager will order potable water, when directed by the Incident Command Center through the preferred vendor.

2. The Maintenance staff will pick up and deliver potable water under the direction of the Incident Command Center, Administrator-In-Charge or the Maintenance Manager. Each campus will need the following daily amounts:

- Greenville Campus – 300 gallons
- Shenango Campus – 200 gallons

The Nutritional Services Department will monitor inventory daily and order as needed.

3. Environmental Services will distribute non-potable water in buckets under the direction of the Incident Command Center, Administrator-In-Charge or Environmental Services Manager.

4. Nutritional Services will distribute ice under the direction of the Incident Command Center, Administrator-In-Charge or Nutritional Services Manager.

Potable water can be obtained from:

- Dean Dairy
- Office: (724) 962-861
- Cell: 1 (814) 882-6188

or

- GFS Foods – 500 gallons potable water in one gallon plastic containers
- Office (724) 962-8500
- Cell (724) 301-2296
- Non-potable water- contact Mercer County EMA – 911

- Home City Ice, 20282 Hannan Parkway, Walton Hills, OH 44146

Phone: (724) 588-3171

(Extended requests must be made prior to 2:00 p.m. each day)

5. Non-potable water is requested through the County EMA – 1,000 gallons per campus. Environmental Services will use mop buckets to flush toilets.

6. Refer to departmental utility failure plan for department specific procedure.

#### Fuel

1. Maintenance is responsible for all fuel.

2. Additional fuel is obtained from:

Brownie's Oil Company

One Best Heat Way

Greenville, PA 16125

Phone: (724) 588-8800

#### Sewage

1. Maintenance will order portable toilet units to be brought to the facility when directed by the Incident Command Center, the Administrator-In-Charge or the Maintenance Manager.

2. Vendor: Approved Toilet Rentals, Inc.

Phone: (724) 752-1408

Fax: (724) 752-2803

Quantity: Greenville Campus – 30; Shenango Campus – 20

3. Units will be strategically placed around the facilities away from entrances and walkways.

4. The Manager of Maintenance & Security or designee will set up a regular schedule

of unit exchange with the waste removal company to prevent accumulation of waste products.

5. Disposable bed pans and urinals will be used by patients; body waste will be bagged and transported to the portable toilet unit. The disposable bed pans and urinals will then be placed in red biohazard bags for final disposal.

6. Refer to departmental utility failure plans for department specific procedure.

7. Service reduction – in the event that there is a major break or interruption in the sewage system, some services will be reduced as follows:

#### Department

##### Services Reduced

##### Nutritional Services

- Disposable plates, cups and utensils will be used.

##### Laboratory

- Disposable formaldehyde into the sewage will be discontinued
- Formaldehyde for disposal will be stored in 10 gal. containers until the system is operational or disposed by guidelines of Hazardous Waste Management

##### Nursing

- Patients will use disposable bed pans and urinals obtained from the Southside warehouse through Materials Management; waste will be bagged and emptied in portable toilet unit

##### Trash

1. Environmental Services is responsible to arrange additional trash, hazardous and infectious waste pick-ups.

##### Oxygen and Vacuum

1. Maintenance is responsible to contact the oxygen vendor to deliver a bulk oxygen tank to be attached to the Siamese outlet located on the building exterior in the event of an oxygen bulk failure.

2. A) The in-house vacuum system is connected to emergency generator power in the event main power is interrupted.

B) Portable vacuum units are located throughout the house if needed.

DISTRIBUTION: All Departments

Reviewed: October 2018

## EMERGENCY MANAGEMENT

### **INTRODUCTION:**

Certain emergency situations and disasters may put a strain on and disrupt UPMC Horizon's ability to provide patient care. This in-service packet is designed to provide necessary information about the hospital's plan for responding to these emergencies. This in-service is one of the requirements under JC Standards for the Environment of Care.

### **OBJECTIVES:**

After completing this packet, you will know the following:

- The hospital's system of emergency "Codes".
- Your role and responsibility during an emergency and where to obtain information specific to your department.
- What back-up communications are used during emergencies.
- How to obtain supplies and equipment during an emergency.

Hospitals must be prepared to respond to a variety of emergency situations. Some emergencies are internal and require specific types of response. Other emergencies are external and may disrupt the hospital in its ability to care for patients within the facility or those that may arrive due to the emergency. An efficient and effective plan of response aids in preparing for such emergencies and reduces the response time. UPMC HORIZON developed a plan to manage the consequences of natural disasters or other emergencies through a set of emergency "Codes" with specific responses to specific types of emergencies. Each "Code" will activate an appropriate response to the emergency as needed.

### **EMERGENCY CODES & CONDITIONS**

UPMC Horizon developed a plan to manage the consequences of natural disasters or other emergencies through a set of emergency "Codes" and "Conditions" with specific responses to specific types of emergencies. Each "Code" or "Condition" will activate an appropriate response to the emergency as needed.

#### **"Condition A" – Cardiac/Respiratory Arrest**

- ☎ This condition is used to initiate a team to respond to a life-threatening condition. If you have an individual responsibility to respond to "Condition A", you will be told during your departmental orientation.

#### **"Condition C" – Medical Emergency**

- ☎ "Condition C" may be initiated when a patient's condition changes significantly for the worse and additional staff is needed urgently to help manage the care of the patient. The "Condition C" Team will respond within building confines and all immediate entranceways.

### **“Condition Help”**

 Condition Help is a safety resource that allows patients and families to call for help. A call to the “Condition Help” extension will initiate dispatch of a “rapid response team.” “Condition Help” was created to address the needs of the patient in case of an emergency or when the patient is unable to get the attention of a healthcare provider

### **“Condition L” – Patient Lost**

 “Condition L” is a rapid response to locate a missing patient who may have wandered away. The nurse from the unit which the patient is missing will contact the hospital operator and request a “Condition L” be called. The “Condition L” will mobilize security and staff from across the facility to systematically search for the patient.

### **“Code D” - Disaster**

 The purpose of “Code D” is to enable hospital personnel to care for large volumes of casualties resulting from a disaster situation such as a severe flood, tornado, or accident such as a plane crash, explosion, etc. The Emergency Physician will assume control of the situation and upon receiving any information will notify administration. Disaster situations identified in the plan will be set up to handle the victims and each department will carry out their unit specific instructions. Should a “Code D” be announced while you are working within our hospital, immediately report to your hospital supervisor.

### **“Code Pink” - Abduction**

 “Code Pink” is announced over the overhead paging system when unauthorized personnel have abducted an infant, child or adult from its present environment. The crime scene should be protected. An immediate search of the entire area must be performed. Family must be moved to a private area. If the abduction occurs at the change of shift, all personnel should be held in the area until excused by law enforcement officials. Each department in the facility has specific job assignments to perform in the event of a “Code Pink”. Be sure to ask your supervisor what department-specific responsibilities you have in the event of a “Code Pink”.

### **“Code Gray” - Severe Weather**

 “Code Gray” is announced over the paging system when UPMC Horizon receives notification of a “tornado warning” from the National Weather Service. You are to stay within your respective department or area. Each department will then implement that portion of the tornado instruction that pertains to their particular location on campus. Be sure to ask your supervisor what department-specific responsibilities you have in the event of a “Code Gray”.

### **“Code Urgent” - Non-Life Threatening Emergency**

 “Code Urgent” is used to request departmental response to any non-life threatening internal incidents (i.e., Maintenance, URGENT, Kitchen”). In this example, the Maintenance personnel would be summoned to the kitchen for urgent repairs.

### **“Code Purple” - Workplace Violence**

 “Code Purple” is a plan that provides direction to volunteers, employees and medical staff in violent situations which compromise the safety and well-being of employees, medical staff, visitors or patients. UPMC Horizon is committed to ensuring that all employees, including supervisors and managers, comply with work practices that are designed to make the workplace more secure, and do not engage in threats or physical actions that create a security hazard for others in the workplace.

### **“Code S” – Secure Lock-Down**

 This code is used when an event occurs which may jeopardize the safety of building occupants. During a “Code S”, all persons are to remain inside the building until the “All Clear” is given. Security personnel will lock all exterior doors except the ER Ambulance Entrance.

### **“Condition O” – Obstetrical Crisis**

 This condition is a safety response that establishes guidelines for responding to an emergent or potentially emergent obstetric condition in all inpatient and outpatient areas. Condition O is called for:

- Delivered patient brought into the ED
- Imminent delivery of OB patient
- Newborn who delivered outside of the hospital that is brought to the ED
- Emergency or potentially emergent condition arising in the ante partum or postpartum patient.

### **“Bronze Alert” – Active Weapon Incident**

 This alert is a safety response for employees in the vicinity of an active weapon incident. Employees should follow the 3E’s: Evade, Evacuate, Engage.

**To initiate all internal Codes or Conditions dial:**

***Shenango Campus - “5511”***

***Greenville Campus - “5555”***

**UPMC  
POLICY AND PROCEDURE MANUAL**

**POLICY: HS-FM0219-PRO  
INDEX TITLE: Facilities & Safety**

**SUBJECT: Disaster and Emergency Management Program  
DATE: March 23, 2018**

**CORRESPONDING POLICY:  
[HS-FM0219 Disaster and Emergency Management Program](#)**

**I. PROCEDURES/STANDARDS/GUIDELINES**

**A. Hazard Vulnerability Analysis (HVA)**

1. Each hospital and health care facility shall conduct and document an HVA to identify potential emergencies that could affect demand for the hospital's services or its ability to provide those services, the likelihood of the events occurring and the consequences of the events. It will prioritize the hazards that may affect healthcare operations, define mitigation and preparedness actions. The HVA should be assessed, and updated if necessary, at least annually.

2. Where possible, HVAs shall be completed in concert with the local Emergency Management Agency (EMA), and/or community partners.

**B. Emergency Operations Plans (EOPs)**

1. Emergency Operations Plans shall be developed to include response to emergencies identified in the HVA; specific plans shall be included for events identified as having a high risk, high impact on the facility, employees, visitors and patients. Plans shall be formatted to address the following phases/factors:

a. **Mitigation** - The activities undertaken in advance to reduce the impact of emergencies. An example of this is the installation of emergency generators to lessen the impact of a power loss.

b. **Preparedness** - Those activities a business unit undertakes to build capacity and identify resources that may be used if an emergency occurs, for example, the pre-staging of bottled water in preparation for a water loss.

c. **Response** - The activities implemented at the time of an emergency, i.e., activating its incident command system.

d. **Recovery** - The plans/procedures for the re-initiation of services or activities curtailed during the emergency. This also addresses the record-keeping and financial assessment of the emergency.

2. Emergency Operations Plans shall, at a minimum, contain descriptions of the following processes:

a. Mitigation and preparedness actions designed to reduce the risk of and potential damage from an emergency.

b. Initiating response procedures to follow when emergencies occur, such as:

- Maintaining, expanding or curtailing services
- Conserving or supplementing resources from outside the local community
- Closing the hospital or healthcare facility to new patients • Staged or total evacuation

c. Identification of a hospital's capabilities and establishment of response procedures when the hospital cannot be supported by the local community for at least 96 hours.<sup>1</sup>

d. Actions and recovery phases of the plan, including a description of how, when, and by whom the phases are to be activated.

e. The establishment of an incident command structure following the Hospital Incident Command System (HICS).

f. Maintenance of the plan describing recovery strategies and actions designed to help restore the systems that are critical to providing care, treatment and services after an emergency.

g. Processes for initiating and terminating the hospital's response and recovery phases of an emergency, including under what circumstances these phases are activated.

h. Identification of an individual(s) who has the authority to activate the response and recovery phases of the emergency response.

i. Identification of alternative sites for care, treatment and services that meet the needs of the hospital's patients during emergencies.

<sup>1</sup> Hospitals are not required to stockpile supplies to last for 96 hours of operation.

j. Notifying staff when emergency response measures are initiated.

k. Notifying UPMC MedCall (412-647-7000) and external authorities of emergencies, including possible community emergency agencies identified by the hospital, health care facility or business unit.

l. Identifying and assigning staff to cover all essential staff functions under emergency conditions.

m. Managing the following under emergency conditions:

1) Activities related to care, treatment, and services (i.e., maintaining, expanding, conserving or curtailing services; supplementing resources from outside the local community, closing the hospital or health care facility to new patients, controlling information about patients; patient referrals and/or transporting patients).

2) Staff support activities (for example, housing, transportation, incident stress debriefing).

3) Staff family support activities (critical incident stress management, etc.)

4) Logistics relating to response inventory and resource acquisition of critical supplies (internal resources and mutual aid, which may include: pharmaceuticals, supplies, food, linen, water, gas); security issues such as facility access, crowd control, traffic control, and ongoing communication and coordination with agencies charged with community security.

5) Communication with the news media and local/regional/state Joint Information Center, when established, through UPMC Media Relations (UPMC Policy HS-PR1102).

n. Evacuating the entire facility (both horizontally and, when applicable, vertically) when the environment cannot support adequate care, treatment, and services.

o. Establishing an alternative care site(s) that has the capabilities to meet the needs of patients when the environment cannot support adequate care, treatment, and services.

p. Identifying care providers, other licensed professionals and volunteers during emergencies through use of Medical Reserve Corp and SERVPA pre-registered volunteers in which the PA Department of Health has verified licensure and certification (UPMC Policy HS-HR0739 and HS-PS0501).

q. Having in place cooperative agreements among hospitals that together provide services to a contiguous geographic area (for example, among hospitals serving a town or borough) to facilitate the timely sharing of information. UPMC participates in local and regional cooperative planning through the formal process of mutual aid

agreements. UPMC is also a supporter of the National Disaster Medical System (NDMS.) Note: UPMC facilities may have cooperative agreements in addition to those established by the health system.

r. Backup internal and external communication systems in the event of failure during emergencies. As a health system, UPMC subscribes to federal communications programs that provide backup capabilities for communications in the event of an interruption or outage. Additional local, regional and Commonwealth communication systems are in place in the hospitals to provide alternate and redundant communications during an emergency.

s. Alternative means of meeting essential building utility needs when the hospital or health care facility is designated by its emergency operations plan to provide continuous service during an emergency (i.e., electricity, water, ventilation, fuel sources, medical gas/ vacuum systems).

t. Means for radioactive, biological, and chemical isolation and decontamination. These shall be consistent with the UPMC

“Emergency Management Plan for Nuclear, Biological and Chemical Exposure Incidents”.

u. Obtaining and incorporating Hospital Preparedness Program (HPP) funding into the emergency preparedness/response planning process at applicable hospitals.

v. Mortuary services. Each UPMC facility will follow the jurisdiction Mortuary/Mass Fatality plan or the taskforce Mass Fatality Annex

### **C. Leadership**

Each UPMC hospital shall identify an individual to be accountable for the following actions within its business unit:

1. Staff implementation of the four phases of emergency management (mitigation, preparedness, response and recovery);
2. Staff implementation of emergency management across the six critical areas (communications, resources and assets, safety and security, staff responsibilities, utilities, and patient clinical and support activities);
3. Collaboration across clinical and operational areas to implement emergency management hospital-wide; and
4. Identification of and collaboration with community response partners.

## D. Drills/Exercises

1. Drills or tests of Emergency Operations Plans shall be conducted by each hospital or health care facility in compliance with applicable regulatory requirements and shall incorporate applicable NIMS and HICS policies and practices. All UPMC hospitals and the UPMC Corporate Emergency Coordination Center should participate in at least one integrated drill per year as chosen from high risk, high impact conditions identified in the HVA or through that identified by the community in a regional drill. Corrective actions identified through exercises and drills shall be incorporated into the facility's Action Report/Improvement Plan (AAR/IP) or that of the UPMC system.

2. UPMC Business Units shall evaluate the effectiveness of their Emergency Operations Plans by conducting exercises following CMS regulations.

a. Those providing emergency services or identified as community-designated disaster receiving stations shall conduct at least two exercises annually. One exercise shall include an influx of simulated patients and another may be an escalating event in which the local community is unable to support the hospital.

b. Staff in freestanding buildings classified as a business occupancy (as defined by the Life Safety Code) that do not offer emergency services nor are community designated as disaster-receiving stations need to conduct one emergency management exercise annually.

3. Drills or tests of Emergency Operations Plans shall monitor, at a minimum, the following:

a. Communications between both internal and external organizations;

b. Resource mobilization and allocation;

c. Safety and security;

d. Staff roles and responsibilities;

e. Utility systems;

f. Patient clinical and support services; and

g. Volunteers, where possible.

4. The following types of exercises may be considered:

a. Tabletop Exercises (TTX) are considered 'discussion-based' and involve key personnel; Tabletop sessions are acceptable in meeting community and

escalating exercises but cannot be considered as a replacement for an influx of simulated patients. A formal After Action Report/Improvement Plan (AAR/IP) is required for all tabletop exercises.

b. Operations-Based Exercises may be completed:

1) **Drills** – coordinated, supervised activity usually employed to validate a single specific operation or function in a single hospital. Drills are commonly used to provide training for new equipment, develop or validate new policies/procedures, or practice and maintain current skills.

2) **Functional Exercises (FEs)** – designed to validate and evaluate individual capabilities, multiple functions or activities within a function, or interdependent groups or functions.

3) **Full Scale Exercises (FSEs)** – usually multi-agency, multi-jurisdictional, multi-organizational exercises that validate many facets of preparedness.

4) In both FEs and FSEs, events are projected through an exercise scenario to simulate the reality of operations by presenting complex and realistic problems that require response by trained personnel. A formal AAR/IP is required for all operations-based exercises using the Homeland Security Exercise and Evaluation Program (HSEEP) AAR/IP format.

c. Emergency response exercises shall incorporate likely disaster scenarios that allow the hospital to evaluate its handling of communications, resources and assets, security, staff, utilities and patients.

5. **Real World Events**, meaning actual emergency incidents in which a hospital or business unit responds, can serve as an exercise as long as an AAR/IP is completed. Business Units may use observations of those who were involved in the command structure as well as the input of those providing services during the emergency to evaluate deficiencies and opportunities for improvement.

6. Deficiencies and opportunities for improvement, identified in the evaluation of exercises and real world events shall be communicated to the affected UPMC business unit environment of care improvement team for review and modification of business unit Emergency Operations Plans.

## **E. Training**

Staff identified as having a role in emergency preparedness/response shall be trained as indicated by NIMS and complete the applicable final exams. UPMC has established the following levels of training for NIMS:

1. **IS-100.HCb and IS-200.HCa**: Members of the Corporate and Business Unit Incident Command Team below Section Chiefs.
2. **IS-100-HCb, IS-200.HCa and IS-700.a**: Members of the Corporate and Business Unit Incident Command Team from Incident Commander down to Section Chiefs.
3. **IS-100-HCb, IS-200.HCa, IS-700.a, and IS-800.b**: Emergency Management

Coordinators within UPMC Business Units including the Hospitals, Senior Community, Corporate Services, and Physician Services Division, and anyone with responsibility for development of specific Corporate or Business Unit emergency operations plans.

- IS-100.HCb Introduction to the Incident Command System for Healthcare/Hospitals
- IS-200.HCa Applying ICS to Healthcare Organizations
- IS-700.a National Incident Management System (NIMS), An Introduction
- IS-800.b National Response Framework, An Introduction

Note: Several NIMS courses have been updated. Employees successfully completing a previous version of a NIMS training program may want to review the new version; however, for credentialing purposes, the courses are equivalent.

## **II. EVALUATION OF PROGRAM**

The Emergency Management Program, including established goals, objectives and performance measures, shall be evaluated on an annual basis. NIMS implementation shall also be tracked annually. Revisions and plan updates are normally identified through real world incidents, disaster drills, regulatory changes and/or changes in UPMC processes or policies. The results of this evaluation shall serve as the basis for subsequent years' goals, objectives, and performance improvement plans and shall be forwarded to senior hospital leadership for review and prioritization for implementation.

## **III. POLICIES REFERENCED WITHIN THIS POLICY**

HS-FM0219 Disaster and Emergency Management Program

HS-PR1102 Media Relations

HS-HR0739 Emergency Credentialing

HS-PS0501 Credentialing Emergencies Privileges

**SIGNED:** Tami Minnier  
Chief Quality Officer

**ORIGINAL:** September 8, 2006

**APPROVALS:**

Policy Review Subcommittee: March 8, 201  
Executive Staff: March 23, 2018

**PRECEDE** March 30, 2017

**SPONSOR:** Senior Director, Emergency Preparedness

## HAZARDOUS MATERIALS AND WASTE MANAGEMENT

The Pennsylvania Community and Worker Right-to-Know Law (1986) focuses on providing individuals with information on the hazardous substances they may encounter in the performance of their responsibilities in the workplace. This particular law addresses non-manufacturing jobs. It protects employees with certain rights and responsibilities. This packet is designed to fulfill the requirements of that law and JC Standards, and to provide you with the information you need to perform your job safely.

### **BEHAVIORAL OBJECTIVES:**

After completing this packet, you will know the following:

- ✓ The basic emergency procedure for handling spills or exposures.
- ✓ The procedure for reporting spills or exposure incidents.
- ✓ Where to obtain department specific information on the management of hazardous materials or waste.
- ✓ Where to obtain information on safe handling, storing, use and disposal of hazardous materials or waste.
- ✓ What an SDS is, and why it's important to you.

# UPMC HORIZON HAZARDOUS MATERIALS & WASTE MANAGEMENT PLAN CY 2018

## MISSION STATEMENT

To provide a safe and healthy environment through proper handling of hazardous materials and waste.

## VISION STATEMENT

Through appropriate monitoring and continual review of regulations the Plan will be updated to be in compliance with all applicable laws and regulations and a safe environment will be maintained.

## PURPOSE/OBJECTIVES

The purpose and objectives of the Hazardous Materials and Waste Management Program are:

- Establishing, supporting, and maintaining a Hazardous Materials and Waste Management Program.
- Minimizing risks to patients, visitors, personnel and the environment.
- Ensuring that wastes are handled and disposed of in accordance with the Environmental Protection Agency (EPA), Department of Transportation (DOT), and state and local regulations, including training of staff to safely package and prepare for shipment of all hazardous waste.

## SCOPE

The Hazardous Materials and Waste Management Plan applies to all employees, including the skilled care units, and other sites owned by and/or licensed under the hospital, who handle or may come in contact with hazardous materials and waste.

## RESPONSIBILITY

1. **Education**
  - a. Is responsible for providing education in orientation and annually for all employees regarding hazardous materials and waste that they may come in contact with in the course of their employment. The education includes how to read and interpret material safety data sheets, what to do in case of a spill, and the safe packaging of hazardous materials for shipment.
2. **Director of Operations**

- a. Establishes and implements the Hazardous Materials and Waste Management Program.
  - b. Assures that wastes are handled and disposed of in accordance with all rules and regulations.
  - c. Maintains the HazSoft contract and reviews it annually.
  - d. Monitors performance standard and reports to Infection Prevention/Environment of Care Committee.
  - e. Investigates and reports on all hazardous materials and chemical spills.
  - f. Maintains the hazardous waste shipping manifests in the Greenville Campus Environmental Services Office and the Shenango Campus Environmental Services Office.
3. **Department Manager**
- a. Ensures that all employees in their department receive department-specific education in orientation and annually about specific hazardous materials and waste they may come in contact with in their specific job, including maintenance of the chemical inventories and department SDS manuals/HazSoft software.
4. **Department SDS Officer (assigned by Manager)**
- a. Ensures that the departmental SDS manual is current and available within the department.
  - b. Ensures new product SDS sheets are located in the HazSoft program. Reviews departmental SDS signature sheets and inventory sheet annually with managers and directors.
5. **Safety Officer**
- a. Manages the ongoing hospital-wide process to collect and evaluate information relating to all the elements of the Hazardous Materials and Waste Management Program. The Safety Officer ensures appropriate actions are taken to resolve problems, and that documentation and reports of such events are provided to the Infection Prevention/Environment of Care Committee and Chief Executive Officer.

**HAZARDOUS MATERIALS AND WASTE MANAGEMENT PLAN INCLUDES:**

- 1. **Developing and maintaining a written management plan describing the processes it implements to effectively manage hazardous materials and waste.**

**Implementation:**

The Hazardous Materials and Waste Management Plan has been developed and is reviewed and/or revised annually.

- 2. **Creating and maintaining an inventory identifying hazardous materials and waste used, stored, or generated using criteria based on laws and regulations, i.e., EPA, OSHA.**

**Implementation:**

The following criteria will be utilized in defining hazardous materials and waste maintained in the inventory.

- a. **Hazardous Chemical Materials:** Any material that may be explosive, flammable, poisonous, corrosive, oxidizing, irritating, or otherwise harmful and is likely to cause internal or external injury to humans or the environment.
  - b. **Hazardous Gaseous and Vaporous Material:** Any substance that may be dispersed through the air and act as a poison, irritant, or asphyxiate.
  - c. **Infectious Waste Material:** Any material possessing a significant potential for cross-contamination or to be contagious, including sharps.
  - d. **Radioactive Hazardous Material:** Any material that is capable of giving off radiant energy in the form of particles or rays, such as alpha, beta, or gamma rays.
3. **Implementing processes for selecting, handling, storing, transporting, using and disposing of hazardous materials and waste from receipt, use, or disposal, including the following:**

**Implementation:**

- a. **Chemical Wastes:** Hazardous chemical waste is defined as any chemical that is explosive, flammable, poisonous, corrosive, oxidizing, irritating, or otherwise harmful and is likely to cause internal or external injury to humans or the environment. A separate Chemical Contamination Plan is included in the Emergency Operations Plan.
- b. **Chemotherapeutic Wastes:** Chemotherapeutic or antineoplastic waste is defined as waste resulting from the production or use of antineoplastic agents used for the purpose of inhibiting or stopping the growth of malignant cells or killing malignant cells.
- c. **Radioactive Wastes:** Radioactive waste is defined as waste from any material which is capable of giving off radiant energy in the form of particles or rays, such as alpha, beta, or gamma rays. All federal, state, and local regulations governing the use of radiation will be met. A separate Radiation Contamination Plan is included in the Emergency Operations Plans.
- d. **Regulated Medical or Infectious Wastes, Including Sharps:** Regulated medical or infectious waste is defined as any material possessing a significant potential for cross-infection or to be contagious, including sharps.
- e. **Used Batteries:** Used batteries are NOT to be placed in the general waste stream. Each unit or department is to have a container labeled "used batteries". Environmental services will empty the containers on the first day of each month. The batteries will be taken to the maintenance department and stored in the hazardous waste building until disposed of by approved vendor.
- f. **Hazardous Gases and Vapor:** Waste gases are defined as gases that are released through expiration, escape, leeching, decomposition or spillage as a result of use or accident. All persons required to handle waste gas or materials will be provide with appropriate orientation, equipment and on-the-job training.

- g. **Laser Safety:** Appropriate safety precautions must be taken and must be appropriately documented whenever laser surgery is performed. For more information refer to policy OR.PC.13.0 in the Surgical Services manual.
- h. **Regulated Pharmaceutical Waste:** Will be disposed of in “black” RCRA containers located in the soiled holding rooms on each unit.

4. **Providing Adequate Space and Equipment for Safe Handling and Storage of Hazardous Materials and Waste**

**Implementation:**

Appropriate space and equipment will be provided for the safe handling and storage of all hazardous materials and waste based on all applicable federal, state, and local regulating agency requirements.

5. **Monitoring and Disposal of Hazardous Gases and Vapors**

**Implementation:**

**Hazardous Gases and Vapors:** Any substance which may be dispersed through the air and act as a poison, irritant, or asphyxiate (includes waste gas anesthesia, xylene, and formaldehyde).

Empty cylinders and tanks will be disposed of by returning to the distributor.

The results of monitoring will be reported to the Infection Prevention/Environment of Care Committee. Reports will be maintained within the Maintenance department.

6. **Implementing emergency procedures that describe the specific precautions, procedures, and protective equipment used during hazardous material and waste spills or exposures.**

**Implementation:**

**Spill Procedures:** In the event a spill or leak of a hazardous material occurs, the following emergency response procedure is to be used:

- a. Isolate the immediate area for all non-essential personnel and deny entry.
- b. Utilize the HazSoft Program and follow the directions on the SDS sheet.
- c. Obtain appropriate protective safety equipment, such as a spill kit located on each level.
- d. Maintenance will alter ventilation as needed.
- e. Complete an incident report on the spill or leak.

7. **Maintaining documentation, permits, licenses, and adherence to regulations.**

**Implementation:**

The Maintenance Department will maintain all documentation of permits and licenses except for the Nuclear Medicine license, which will be maintained in the Nuclear Medicine Department.

**Safety Data Sheets (SDS):** SDS sheets are to be obtained for every identified hazardous material and chemical used in the hospital. The HazSoft program is to be available to employees at all times via the HazSoft desktop Icon or through Horizon Home. In case of HazSoft downtime or other factors preventing access to this computer-based program, a downtime process is available via **SDS faxback: 866-990-2522 or by calling customer support: 877-682-5602, or via email: [customersupport@hazsoft.com](mailto:customersupport@hazsoft.com)**. Complete UPMC Horizon SDS information will also be maintained on a flash drive in the Maintenance Manager's office.

8. **Maintaining required manifests for handling hazardous materials and waste.**

**Implementation:**

The Facilities Office will maintain all manifests documentation of hazardous materials and waste.

9. **Properly labeling hazardous materials and waste.**

**Implementation:**

The Materials Management Department will be responsible for receiving, identifying, labeling (where necessary) and delivering all hazardous materials used in the hospital if ordered through Materials Management.

Hospital departments ordering hazardous materials directly and receiving shipment directly will be responsible for identifying and labeling their own hazardous materials and waste. The labels must contain the identity of the hazardous chemical or material and an appropriate hazard warning that contains the nature of the hazard (i.e., poison, corrosive, inflammable, etc.). The Receiving Department will ensure all SDS received are located on the HazSoft program.

Pesticides, food drugs, cosmetics, beverages and finished wood, pulp and paper products are exempt from OSHA hazard communication labeling requirements.

10. **Separation of hazardous materials and waste storage and processing from other areas of the facility.**

**Implementation:**

a) **Handling, Storing, Using:** Hazardous materials will be stored in specified labeled containers. Regular Hazardous Materials and Waste Management surveys will be conducted to see that hazardous materials are labeled, handled, stored and disposed properly.

1. Flammable materials should be stored in a cool, dry, well-ventilated storage area, away from combustible materials.
2. The storage area for flammables will be supplied with fire extinguishers.
3. Acids and alkalines will be stored separately in well-ventilated areas.
4. Corrosive materials will be stored separately in well-ventilated areas.
5. Staff using hazardous materials will be educated on the potential hazards of use and appropriate spill procedures.
6. Staff will be educated on the location of SDS sheets and the use of protective equipment available, as appropriate.

7. Used batteries will be disposed of in appropriately labeled containers within each unit or department.

**b) Disposing - The disposal of all hazardous materials will be by one of the following:**

1. Return to provider.
2. Removal by contract service.

**11. Orientation/Education Program for personnel who manage or have contact with hazardous materials and waste that addresses:**

- a. Procedures and precautions for selecting, handling, storing, using, and disposing of hazardous materials and waste.
- b. Emergency procedures for hazardous material and waste spills or exposure.
- c. Health hazards of mishandling hazardous materials.
- d. Procedures for reporting hazardous materials and waste incidents, spills, or exposures.

**Implementation:**

All employees will be provided education regarding hazardous materials and waste management at the facility and departmental level. It will be accomplished in the following manner:

- a. All new employees will be provided with facility education on procedures regarding hazardous materials and waste management during Hospital-wide Orientation. They will also be oriented to departmental hazardous materials and waste management responsibilities during their initial three months of employment by the Department Manager.
- b. All employees will receive at least annual hospital-wide and department-specific hazardous materials and waste management education.
- c. The departmental programs will be based on employee needs, either requested or assessed, and are coordinated by the respective department managers. The Safety Officer will assist in providing information for departmental programs.

**12. Ongoing monitoring of performance regarding actual or potential risks related to one or more of the following:**

**Implementation:**

Performance improvement standards for hazardous materials and waste management will be monitored on an ongoing basis and reported to the Infection Prevention/Environment of Care Committee and will include at least one of the following:

- Staff knowledge and skills
- Level of staff participation
- Monitoring and inspection activities
- Emergency and incident reporting
- Inspection, preventive maintenance and testing of equipment

## **ANNUAL EVALUATION OF THE HAZARDOUS MATERIALS AND WASTE MANAGEMENT PROGRAM:**

The plan shall be evaluated on an ongoing basis to assure that it meets the Safety, Risk Management and Quality Improvement needs of the institution. At least annually the objectives, scope, performance, and effectiveness of the plan shall be reviewed, and revised if necessary, by the Infection Prevention/Environment of Care Committee, with input and assistance from other committees, Administration, Medical Staff Departments and Hospital Departments. Approval of revisions will be made by the Infection Prevention/Environment of Care Committee, Medical Executive Committee and the Board of Trustees.

## **COMMUNICATION/REPORTING**

The findings, conclusions, recommendations, actions taken, and follow-up by the Infection Prevention/Environment of Care Committee, as a result of the monitoring and evaluation of the Hazardous Materials and Waste Management Plan, are reported at least quarterly to the Quality Council, which includes medical staff, nursing, departmental and administrative representation, Medical Executive Committee and the Board of Directors.

Additional Information Sources:

CDC: <http://www.cdc.gov/vhf/ebola/hcp/index.html>

U.S. DOT: <http://phmsa.dot.gov/hazmat/transpoting-infectious-substances>

OSHA: <http://www.osha.gov/SLTC/ebola/index.html>

Revised: January 2018

Reviewed: October 2018

## Hazardous Materials Management

The purpose of this in-service is to provide the employees of UPMC Horizon with needed information about chemical hazards within the hospital. Each hazardous chemical has a Safety Data Sheet (SDS), which we receive from the company that makes the product. As a hospital employee, you need to know the following information about the hazardous chemicals kept in your work area:

- Significant hazardous chemicals in your area.
- Different label types.
- Where to find Safety Data Sheets (SDS).
- How to read and interpret SDS.
- Physical and health hazards of chemicals in your work area.
- How to protect yourself from such hazards.

### **Hazardous Materials:**

Hazardous materials can be defined as those materials that by their nature pose a potential threat to the health and safety of persons coming into contact with them, including materials regulated under SARA TITLE III, and those listed by the state of Pennsylvania. You may be exposed to many hazards every day. You must know the hazards that you face in your work area.

Hazardous chemicals can create two types of hazards:

### **Physical and chemical hazards**--These are chemicals that are:

- **Flammable** = catch fire easily.
- **Explosive** = cause a sudden release of pressure, gas, and heat.
- **Reactive** = burn, explode, or release toxic vapor if exposed to other chemicals, heat, air, or water.

**Health Hazards**-- These can be long-term and may not show up for years (e.g., cancer), or they can have Acute (immediate) effects, such as being:

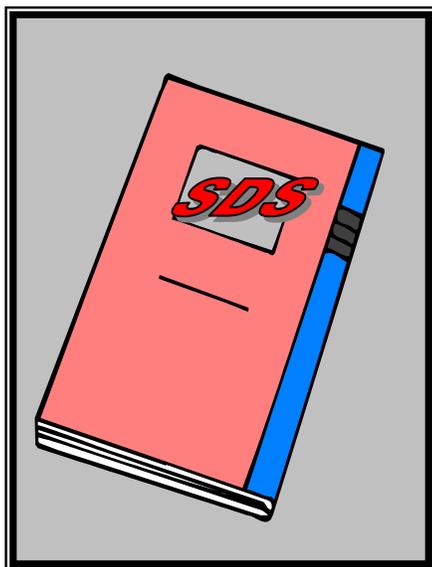
- **Irritating** = causes rashes or other skin irritations.
- **Corrosive** = burns skin or eyes.
- **Toxic** = causes illness or even death.

### **Safety Data Sheets (SDS):**

Safety Data Sheets (SDS) give you all the critical information you need about how to use, transport, and store chemicals in order to protect yourself. They also contain information about what to do in case of emergencies and overexposure. Know where the SDS manual is located in your department. They should be kept with the rest of your employee manuals. This should have been part of your department orientation. If you do not know where your SDS are located, find out, and become familiar with the hazardous materials used in your department. The SDS manual contains a master listing of the chemicals utilized in your department. MSDSs are available online. Each PC has an icon that will access the SDS website. If internet access is not available call 1-877-682-5602.

# Getting The Facts About Chemical Hazards

## Safety Data Sheets



Healthcare facilities use a variety of hazardous chemicals in everyday operation. When handled properly, these chemicals are safe to work with. Safety Data Sheets (SDSs) give you all the critical information you need about how to use, transport, and store chemicals in order to protect yourself. They also contain information about what to do in case of emergencies and overexposure.

SDSs are just one part of your company's HazCom (Hazard Communication) program. This program, which also includes warning labels on containers and training in safe use and handling of chemicals, is designed to protect your health and safety.

### Read It First!

You should always read the MSDS before you begin a job requiring a chemical. Even if you've used the chemical before, the manufacturer may have changed its formula, which may alter the steps you need to take to protect yourself. Taking proper precautions listed on the SDS, such as wearing gloves or other personal protective equipment, can prevent serious long-term illnesses.

### What's On a SDS?

The information for each chemical's SDS is gathered by the manufacturer or distributor for that chemical. This includes:

- *The chemical's name or names and ingredients*
- *The name, address and phone number of the manufacturer*
- *How to handle, store, and dispose of the chemical safely*
- *Which conditions or other substances will cause the chemical to catch fire, explode, melt, or turn into dangerous gases*
- *How it usually looks and smells*
- *How to put out a fire involving the chemical and what to do if it spills or leaks*
- *Safe exposure levels and how to prevent dangerous exposure*
- *Symptoms of overexposure and what to do if you are overexposed*
- *When the SDS was prepared*

XEROX Safety Data Sheet SDS No: D-4403  
Date: 10/3/85  
Revision: 4/2/97  
Supplier: Xerox Corporation Xerox Canada Ltd. Telephone #(s):  
Safety Information: (800) 828-6571  
Rochester, NY 14644 5650 Yonge Street Health Emergency: (716) 422-2177  
North York, Ontario M2M 4G7 Transportation Emergency: (716) 422-1230

**Section I - Product Identification**  
Trade Names/Synonyms: Liquid Erase Correction Fluid Part No.: 8R1158

Chemical Name: None  
WHMIS Status: Class D/Div. 2B, Toxic  
Ingredients (% by wt.) CAS No  
1,1,1-Trichloroethane (65-75%) 1 71-55-6  
Titanium dioxide (20-30%) 13463-67-7  
Resin (5-10%) 9004-57-3

**Section II - Emergency and First Aid**  
**Primary Route of Entry: Symptoms of Overexposure:**  
Skin: May cause neurological, heart, liver, and kidney injury.  
Eyes: Flush thoroughly with water.  
**Medical Conditions Generally Aggravated by Exposure:**  
Skin: None when used as described by product literature.  
Wash with soap and water.  
**Inhalation: Additional Information:**  
Remove from exposure. None  
**Ingestion:**  
Dilute stomach contents with several glasses of water. Do NOT induce vomiting.

### Know Where The SDS Is Kept

SDSs must be readily accessible to employees. A posted sign may tell you where to find it, and you can also find out by reading your facility's written HazCom program. If you're not sure where to find an SDS, your supervisor or HazCom contact will make it available to you. The law requires your employer to keep SDS up to date and to send an SDS to your doctor or designated representative at your request.

### If You're Not Sure, ASK!

If you don't understand something on the SDS, ask your supervisor or your facility's HazCom contact. Safe chemical handling depends on your being fully informed and involved.

# READING SAFETY DATA SHEETS

## Effective Protection You Can Depend On

The Safety Data Sheet, or SDS, is written information that can help protect you from overexposure to chemicals you find on the job. The SDS is part of your company's Hazard Communications Program. Each company can design its own SDS form, and the sections may be in different order. But, the basic kinds of information on any MSDS will be the same.

### Chemical Name

Lists the identity of the substance (the name on the label), date the SDS was prepared, the name & address of the manufacturer & usually a phone number for emergencies and more information

### Hazardous Ingredients/Chemical Identity

Includes names of substances in the chemical that might be dangerous, and safe exposure limits such as Permissible Exposure Limit or PEL (set by OSHA) or the Threshold Value Limit or TVL. Also lists common names for the chemical.

### Physical Characteristics

Describes many physical qualities of the chemical, and lets you know what's usual or safe. For example, how the chemical looks & smells; boiling & melting temperatures (important in case a chemical might become a gas you could breathe); evaporation rate (known as percent volatile); how easily the chemical dissolves; and how heavy it is (this tells you if it will sink, float or dissolve in water)

### Fire & Explosion Data

Tells you the lowest temperature when the chemical could catch fire. ("flash point") Lets you know if it's flammable (catches fire below 100 degrees F) or combustible (catches fire above 100 degrees F). Lists the best way to put out a fire involving that chemical.

<b>Safety Data Sheet</b>	
<i>Chemical Name</i>	_____
	_____
	_____
<b>Hazardous Ingredients / Chemical Identity</b>	_____
	_____
	_____
<i>Physical Characteristics</i>	_____
	_____
	_____
<b>Fire &amp; Explosion Data</b>	_____
	_____

## BACK

### *Reactivity*

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\_\_\_\_\_

### **Health Hazards**

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\_\_\_\_\_  
\_\_\_\_\_

### *Usage, Handling & Storage*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **Special Equipment (PPE) & Precautions**

\_\_\_\_\_  
\_\_\_\_\_

### Reactivity

Describes what happens if this chemical comes in contact with air, water, or other chemicals. Describes conditions (like heat) or materials (like water) that can cause the chemical to react by burning, exploding, or releasing dangerous vapors. The chemical is called "incompatible" or "unstable" with these conditions of substances.

### Health Hazards

Lists ways the chemical might enter your body, like splashing on your skin or being breathed in as vapor as well as possible symptoms of overexposure. Lets you know if overexposure might make existing medical conditions worse, and describes emergency first aid procedures.

### Usage, Handling, And Storage

Describes how to clean up an accidental spill, leak, or release, including special procedures. Tells you how to handle, store, and dispose of chemicals safely. Remember, if there is an accident, notify your supervisor immediately, and take care of it yourself only if you are trained to do so and are wearing the proper equipment.

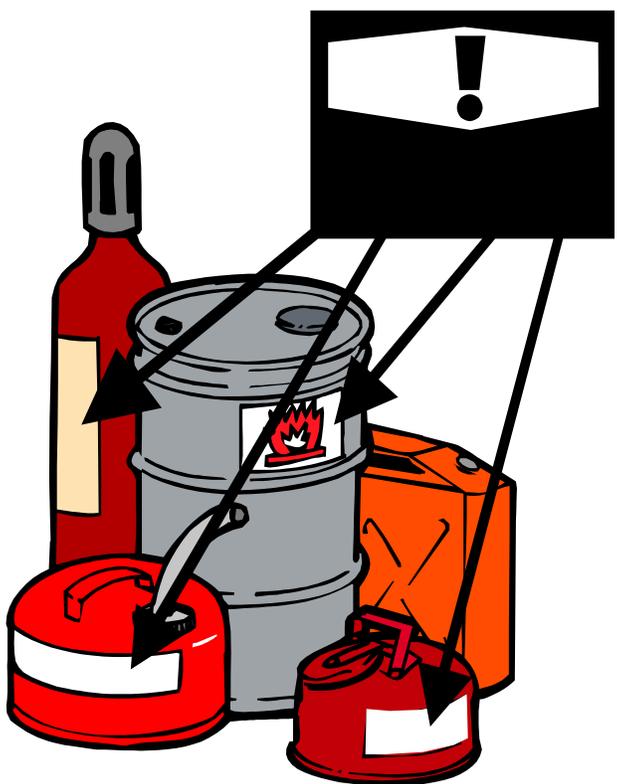
### Special Equipment & Precautions

Explains special Personal Protective Equipment (PPE) and other equipment to use when working with the chemical, special procedures, extra health or safety information, signs that should be posted, and other information not covered in other sections.

## Labels:

Labels come in many formats. Some labels use words to describe hazards. Others use numbers and colors to help you quickly identify the kind and degree of hazard the chemical could present. Although the labels on products in your department may look different than the one shown in this in-service, all labels must contain certain items. The label should always tell you:

- ❑ The identity of the chemical.
- ❑ The name and address of the company that made or imported the chemical.
- ❑ Any physical hazards.
- ❑ Chemical health hazards.



### A Label Tells You...

The identity of the chemical – the common name, chemical name, or both. If the substance contains more than 1 chemical, all will be listed.

The name and address of the company that manufactured or imported the chemical

The chemical's physical hazards. That's what could happen if you don't handle it properly. Is it flammable or combustible? Explosive? Is it reactive? Radioactive?

The chemical's health hazards. These are the possible health problems that could result from overexposure. Is it toxic? An irritant? Could it cause cancer?

Some labels also include important information such as storage and handling instructions. That could include information like "Use only in well-ventilated areas." Or "Store in tightly closed containers."

Basic protective clothing, equipment and procedures that should be used to work safely with the chemical might also be listed. Here you might be told to "avoid contact with skin," or to use eye protection, etc.

### **Identification/Storage/Transportation:**

- The major *identification* used at UPMC Horizon for hazardous waste is the color coded bag system and labeling as specified in the Waste Management Program.
- *Storage* of recyclable wastes should be as specified in the Waste Management Program in approved safety containers, or in their original shipping packages until used or transferred.
- *Transportation* of hazardous chemicals and waste should be in approved safety containers or in their original shipping packages. Materials should only be transported in amounts comparable to regulated daily or weekly limits.

The procedures for properly identifying, storing, and transporting hazardous materials and waste should be covered in your department for any substances that you will be handling. Be sure you know how to handle a substance **BEFORE** handling or transporting.

### **Disposal/Emergency Response:**

Although there will be department specific responsibilities to any hazardous materials incident, there are some basic steps to follow. Proper cleanup of individual chemical spills may vary, therefore, the following basic steps should be taken in the event of a spill:

1. Isolate the immediate area & remove all non-essential personnel.
2. Notify Environmental Services of the spill. Environmental Services will notify Maintenance if changes to the ventilation flow are needed.
3. The affected department will clean all spills. Pharmacy or Oncology staff will clean a chemo spill.
4. Any individual experiencing a chemical exposure must complete an employee report of injury & report to Employee Health Services or the Emergency Department for evaluation per established procedure.

All chemical spill incidents must be reported on the I.I.R. (Initial Investigation Report), so that appropriate review of the incident may occur.

## RADIATION SAFETY

### **INTRODUCTION:**

Used properly, radiation can help detect illness and treat cancer. But, it can be a hazard if accidental exposure occurs. This packet provides the information required for training by the PA Department of Environmental Resources for Imaging Service personnel, Nursing, Maintenance, Environmental Services, and Security personnel. It will help reduce the risks of exposure to unnecessary radiation.

### **BEHAVIORAL OBJECTIVES:**

Upon completion of this packet, you will know the following:

- ✓ The storage requirements for radioactive material.
- ✓ The devices used to monitor radiation exposure.
- ✓ Who is the Radiation Safety Officer is at UPMC Horizon.
- ✓ Who regulates the use of radioactive materials.
- ✓ UPMC Horizon's policy for delivery of packages containing radioactive materials.
- ✓ How to recognize the hazard signs for radioactive materials.

**This in-service is required by the Department of Environmental Protection (DEP) and is to be completed during orientation. The in-service is to be reviewed annually with Imaging Services personnel, Nursing, Maintenance, Environmental Services, and Security. During an inspection, an employee may be asked if they have been in-serviced on Radiation Safety. The following is a list of issues that are to be reviewed:**

- ③ Storage and use of radioactive material:  
ALL radioactive materials are stored in lead containers and used primarily for diagnostic procedures.
- ③ Monitoring of radioactive materials:  
Monitoring devices are located in the Nuclear Medicine Hot Lab to assure there is no radioactivity detected from improper handling. Monitoring devices are located in various areas throughout Imaging Services to determine radiation exposure to the general public.
- ③ The Radiation Safety Officer for UPMC Horizon is **Scott Pickering, MD**.
- ③ The PA DEP regulates use of radioactive materials.

### **Delivery of packages containing radioactive material:**

Couriers are advised which staff member can accept delivery.

A memo is sent annually as a reminder that these packages can only be accepted in Nuclear Medicine and Radiology if the Nuclear Medicine Department is closed.

- ③ All Imaging Services technologists wear film badges to determine their radiation exposure.

- ③ Gamma cameras do not emit radiation, the radioactive material is given to the patient and the camera picks up the radioactivity from the patient.
- ③ Diagnostic doses of radioactivity are much smaller than therapeutic doses of radioactivity.
- ③ All radioactive waste is stored and decayed (no detectable radiation) levels prior to disposal. It is then monitored with a Geiger Counter to assure that there is no radioactivity present.
- ③ Most therapies such as treatment for hyperthyroidism are treated on an out-patient basis.
- ③ A “Caution Radioactive Area” sign is posted where radioactive material is stored and used.
- ③ Packages containing radioactive material are labeled with Radioactive Stickers with I, II, or III on them indicating the amounts of radiation contained.

### **MRI Safety**

MRI utilizes a very strong magnet. Only non - ferrous objects are allowed in the MRI area. Signs are posted in the restricted area. The magnetic field is always active. It is never turned off.

Patients must be thoroughly screened prior to having an MRI procedure. Questions such as the following are asked:

- ◆ Do you have any metal on your body?
- ◆ Do you have any metal in your body such as a metal prosthesis or shrapnel?
- ◆ Do you have a pacemaker?
- ◆ Have you ever welded?

Ferrous material in a magnetic field can be extremely dangerous. The magnetic field will pull the ferrous material to the center of the magnet. The larger the ferrous metal, the greater the danger. For example, a wheelchair could pin someone against the magnet.

# Infection Prevention & Control

## OSHA Bloodborne Pathogens

### Standard Precautions

OSHA regulations are based on the premise that any person may be unknowingly infected with bloodborne pathogens.

- Treat all body fluids as if they are potentially infectious.
- Take precautions to prevent putting yourself at risk.

### **I. Needle sticks or Bloodborne Pathogen Exposures (see also OSHA Bloodborne Pathogen-Exposure Control Plan Policy HS-IC0604)**

1. Immediately after the exposure, wash the area thoroughly with soap and water. If eyes are involved, irrigate with copious amounts of water. If mouth is involved, rinse mouth with plain water or an appropriate antiseptic mouthwash, if available.

2. The exposed staff member must notify his or her supervisor.

3. Exposures should be evaluated as soon as feasible post-exposure (recommend within 2-4 hours).

4. If the exposure occurs on an off-shift or over the weekend, the staff member can report to the nearest UPMC Emergency Department if other consultation is unavailable (additional support is available on off-hours and weekends through an answering service at (412) 784-7402).

5. Exposed staff members should present with the source patient's name and the name of the source patient's attending physician if available.

6. Appropriate treatment and follow up post-exposure will be coordinated by Employee Health Services. Treatment and follow-up for staff of non-hospital-based entities, may be directed by Employee Health Services to a UPMC primary care physician or affiliate facility if necessary, to accommodate geographic considerations.

7. Staff members must notify UPMC Claims and complete the appropriate work related information (even if evaluated by employee health and/or the emergency department). Worker's Compensation claims can be reported either by calling 1-800-633-1197 or online through MyHub.

**Refer to OSHA Exposure Control Plan UPMC System Policy HS-IC0604  
Employee Health POLICY: HS-HR0700**

## INFECTION CONTROL

### **INTRODUCTION / VALUE STATEMENT:**

As an employee of UPMC Horizon, you may be exposed to various microorganisms that can lead to infection. To help reduce the risks of infections for both the healthcare worker and the patient, the Occupational Safety and Health Administration (OSHA) requires employers to provide training in infection control. This packet is designed to protect all employees against the spread of infections.

### **BEHAVIORAL OBJECTIVES:**

After completing his packet, you will know the following:

- ✓ How to outline the chain of infection.
- ✓ Good handwashing technique.
- ✓ How to describe proper measures to handle body secretions.

### **ISOLATION CONTROL INSERVICE**

#### **OBJECTIVES:**

At the completion of this lesson the learners should be able to:

- Describe standard precautions.
- List special measures that must be taken for transmission-based precautions.

#### **OUTLINE:**

Program Purpose:

- To protect patients, health care workers, and visitors from infection in order to provide the safest and best quality care.

#### **STANDARD PRECAUTIONS:**

Used for all patients regardless if they are known to have infection or not, applies to handling of blood, body fluids, secretions, excretions, non-intact skin, and mucous membranes.

- OSHA regulations are based on the premise that any person may be unknowingly infected with bloodborne pathogens.
- Treat all body fluids as if they are potentially infectious.
- Take precautions to prevent putting yourself at risk.

#### **TRANSMISSION – BASED PRECAUTIONS**

In addition to consistent use of Standard Precautions, additional precautions may be warranted in certain situations:

1. Airborne precautions
2. Droplet precautions
3. Contact precautions

## **ISOLATION PRECAUTIONS UPDATE**

For well over 100 years, the control of infection by isolation has been a significant concern in health care facilities. When one looks at the development of isolation practices (see Highlights in Development of Isolation Practices at end of packet), one can see that we have gone from segregating all infected persons from uninfected people, to isolating people by organism or disease, to treating all people and their body substances as potentially infectious. As new infectious diseases, such as Ebola and MERS-CoV, appear and our understanding of how to control methods increases, continued change can be expected. In light of continued change and confusion that health care workers have (e.g., which type of body fluids require precautions, the circumstances in which gowns and gloves are needed, and precautions that are necessary beyond body substances isolation to prevent the spread of infection) the Centers for Disease Control and Prevention (CDC) developed new guidelines for isolation precautions.

## **TWO LEVELS OF PRECAUTIONS**

The revised CDC guidelines contain two tiers or levels of precautions:

1. Standard precautions
2. Transmission-based precautions

## **STANDARD PRECAUTIONS**

Standard Precautions are the minimum infection prevention practices that apply to all patient care, regardless of suspected or confirmed infection status of the patient, in any setting where healthcare is delivered. These practices are designed to both protect Healthcare Workers and prevent them from spreading infections among patients. Standard Precautions include: 1) hand hygiene, 2) use of personal protective equipment (e.g., gloves, gowns, masks), 3) safe injection practices, 4) safe handling of potentially contaminated equipment or surfaces in the patient environment, and 5) respiratory hygiene/cough etiquette. Each of these elements of Standard Precautions are described in the sections that follow.

The goal of Standard Precautions is to reduce the spread of infection by treating blood and body fluids of all patients as though they were infected.

## **THE SPREAD OF INFECTION**

Disease-causing organisms can be transmitted in a variety of ways. The five (5) main routes of transmission are:

1. **Contact**: This is the most common way that nosocomial (facility-acquired) infections spread. Transmission can occur by direct contact which involves contact between the infected person and one who is susceptible or indirect contact that entails a susceptible person touching an object that has been contaminated by an infectious person.
2. **Droplet**: Transmission occurs when droplets from the infected person come in contact with the conjunctiva, oral or nasal cavity. This can occur during talking, sneezing or coughing.

3. **Airborne:** Small droplets are expelled from the infected person and remain in the air or on dust particles for a period of time, to later be inhaled by a susceptible person.
4. **Common Vehicle:** The microorganism is carried by contaminated food, water, or equipment.
5. **Vector borne:** This refers to the spread of infection by vectors such as mosquitoes, flies, and rodents.

The components of Standard Precautions, used in the care of all patients, are as follows:

### **Personal Protective Equipment**

Personal Protective Equipment (PPE) use involves specialized clothing or equipment worn by facility staff for protection against infectious materials. The selection of PPE is based on the nature of the patient interaction and potential for exposure to blood, body fluids or infectious agents

#### **Use of PPE**

##### **Gloves**

Wear gloves when there is potential contact with blood (e.g., during phlebotomy), body fluids, mucous membranes, nonintact skin or contaminated equipment.

- Wear gloves that fit appropriately (select gloves according to hand size)
- Do not wear the same pair of gloves for the care of more than one patient
- Do not wash gloves for the purpose of reuse
- Perform hand hygiene before and immediately after removing gloves

##### **Gowns**

Wear a gown to protect skin and clothing during procedures or activities where contact with blood or body fluids is anticipated.

- Do not wear the same gown for the care of more than one patient
- Remove gown and perform hand hygiene before leaving the patient's environment (e.g., exam room)

##### **Facemasks (Procedure or Surgical Masks)**

Wear a facemask:

- When there is potential contact with respiratory secretions and sprays of blood or body fluids (as defined in Standard Precautions and/or Droplet Precautions) °May be used in combination with goggles or face shield to protect the mouth, nose and eyes
- When placing a catheter or injecting material into the spinal canal or subdural space (to protect patients from exposure to infectious agents carried in the mouth or nose of healthcare personnel) °Wear a facemask to perform intrathecal chemotherapy

##### **Goggles, Face Shields**

Wear eye protection for potential splash or spray of blood, respiratory secretions, or other body fluids.

- Personal eyeglasses and contact lenses are not considered adequate eye protection

- May use goggles with facemasks, or face shield alone, to protect the mouth, nose and eyes

### **Respirators**

If available, wear N95-or higher respirators for potential exposure to infectious agents transmitted via the airborne route (e.g., tuberculosis).

- All healthcare personnel that use N95-or higher respirator are fit tested at least annually and according to OSHA requirements

### **Respiratory Hygiene and Cough Etiquette**

To prevent the transmission of respiratory infections in the facility, the following infection prevention measures are implemented for all potentially infected persons at the point of entry and continuing throughout the duration of the visit. This applies to any person (e.g., patients and accompanying family members, caregivers, and visitors) with signs and symptoms of respiratory illness, including cough, congestion, rhinorrhea, or increased production of respiratory secretions.

### **Equipment**

Equipment that has been soiled with blood, body fluids, secretions, or excretions should be handled in a manner that prevents contact with skin, mucous membrane, clothing, or equipment that is to be used with another patient.

- All equipment used for a patient must be cleaned using a hospital approved disinfectant(s) between each patient use. ( See Policy HS-IC0619 Cleaning of Non-Critical Patient Care Equipment)
- Follow the facility procedure for the proper discarding of disposable supplies.

### **Linen**

Linen that has been soiled with blood, body fluids, secretions, and excretions should not come in contact with the skin, mucous membrane, clothing, or equipment of other people.

- Handle all contaminated linens with minimum agitation to avoid contamination of air, surfaces, and persons
- Do not sort or rinse soiled linens in patient-care areas
- Use leak-resistant containment for linens contaminated with blood or body substances; ensure that there is not leakage during transport
- Employees who have contact with contaminated laundry should wear appropriate PPE.
- Wash/Sanitize hands after handling laundry or linens.

### **Waste Disposal**

Puncture-resistant, leak-proof sharps containers are located in every patient-care area

- All sharps are disposed of in the designated sharps container; do not bend, recap, or break used syringe needles before discarding them into the container

Regular trash and regulated medical waste (e.g., biohazardous material and chemical hazardous waste, including antineoplastic drugs) are disposed of in their designated containers

### **Patient Placement**

Patients who contaminate the environment with their blood, body fluids, secretions, or excretions (such as a patient with dementia who expectorates or plays with feces) should be placed in a private room if possible. If this is not possible, discuss infection control measures with Infection Control or Department manager.

### **Education**

In addition to all the employees of the facility, patients and visitors should be educated regarding infection control measures through formal classes, informal discussion, poster, and the distribution of printed information.

### **TRANSMISSION-BASED PRECAUTIONS**

Special measures must be taken to prevent the spread of infection when a patient is known to be or carries a high risk of being infected. The Transmission-Based Precautions are added to the Standard Precautions; in other words, standard precautions are essential to follow in the care of all patients.

Three categories recognized by the Centers for Disease Control (CDC): Contact, Droplet, Airborne

- These categories can be used in combination such as Airborne/Contact for chicken pox or Droplet/Contact for Respiratory Illnesses

### **CONTACT PRECAUTIONS**

Contact precautions are taken to reduce the spread of infection through:

#### Direct Contact

1. Skin of infected person
2. Skin of susceptible person

Or

#### Indirect Contact

1. Inanimate objects, i.e., bedside commode, bed rails, IV poles

Apply to patients with any of the following conditions and/or disease:

- Presence of stool incontinence (may include patients with norovirus, rotavirus, or Clostridium difficile), draining wounds, uncontrolled secretions, pressure ulcers, or presence of ostomy tubes and/or bags draining body fluids
- Presence of generalized rash or exanthems

Perform hand hygiene before touching patient and prior to wearing gloves

PPE use:

- Wear gloves when touching the patient and the patient's immediate environment or belongings
- Wear a gown if substantial contact with the patient or their environment is anticipated

Perform hand hygiene after removal of PPE; note: use soap and water when hands are visibly soiled (e.g., blood, body fluids), or after caring for patients with known or suspected infectious diarrhea (e.g., *Clostridium difficile*, norovirus)

Clean/disinfect the exam room accordingly

Instruct patients with known or suspected infectious diarrhea to use a separate bathroom, if available; clean/disinfect the bathroom before it can be used again

Scabies, *clostridium difficile*, and multidrug resistant organisms are causes for contact precautions to be used.

Contact precautions include the use of a private room or shared room with a patient who is low risk or who has a similar infection, equipment dedicated solely for the patient's use, and protecting the removal of infected material.

## **DROPLET PRECAUTIONS**

Apply to patients known or suspected to be infected with a pathogen that can be transmitted by droplet route; these include, but are not limited to:

- Respiratory viruses (e.g., influenza, parainfluenza virus, adenovirus, respiratory syncytial virus, human metapneumovirus)
- *Bordetella pertussis*
- For first 24 hours of antibiotic therapy: *Neisseria meningitidis*, group A streptococcus

PPE use:

- Wear a facemask, such as a procedure or surgical mask, for close contact with the patient; the facemask should be donned upon entering the exam room
- If substantial spraying of respiratory fluids is anticipated, gloves and gown as well as goggles (or face shield in place of goggles) should be worn

Perform hand hygiene before and after touching the patient and after contact with respiratory secretions and contaminated objects/materials; note: use soap and water when hands are visibly soiled (e.g., blood, body fluids)

Instruct patient to wear a facemask when exiting the exam room, avoid coming into close contact with other patients, and practice respiratory hygiene and cough etiquette

Clean and disinfect the exam room accordingly

### **AIRBORNE PRECAUTIONS**

Apply to patients known or suspected to be infected with a pathogen that can be transmitted by airborne route; these include, but are not limited to:

- Tuberculosis
- Measles
- Chickenpox (until lesions are crusted over)
- Localized (in immunocompromised patient) or disseminated herpes zoster (until lesions are crusted over)

Place the patient immediately in an airborne infection isolation room (AIIR)

PPE use:

- Wear a Powered Air Purifying Respirator (PAPR) or fit-tested N-95 or higher level disposable respirator, if available, when caring for the patient; the respirator should be donned prior to room entry and removed after exiting room
- If substantial spraying of respiratory fluids is anticipated, gloves and gown as well as goggles or face shield should be worn

Perform hand hygiene before and after touching the patient and after contact with respiratory secretions and/or body fluids and contaminated objects/materials; note: use soap and water when hands are visibly soiled (e.g., blood, body fluids)

### **Resources**

- Infection Prevention/Control Department 724-589-6340 (GV Office) 724-983-5260 (SV Office).

## TUBERCULOSIS

### **Tuberculosis Skin Testing**

Tuberculosis (TB) skin testing is required of all staff that work in a clinical area on a regular basis. The TB skin test is a small intradermal (between the layers of skin) injection of a purified protein derivative that is given usually on the forearm. The area where the test was administered is then evaluated 48 to 72 hours later. The result of the TB skin test should be interpreted by a trained person. The result of this testing is used to gauge whether the person has been exposed to or is infected by tuberculosis. TB skin testing should be documented on a TB skin testing form, or entered into a database.

A two-step TB skin test, usually completed as part of the new hire process, consists of two TB skin tests administered one to three weeks apart. This test helps determine if someone has been previously exposed to tuberculosis and is required by many regulatory agencies.

Staff who have a prior positive TB skin test, or who have an allergy or contraindication to the TB skin test, should have symptoms of TB reviewed annually. It is not necessary for staff to have annual or period chest x-rays unless they experience symptoms of TB. Staff who have been coughing for longer than three weeks for undetermined reasons and/or have any additional symptoms should seek immediate consultation from Employee Health.

## TUBERCULOSIS PREVENTION

### **OBJECTIVES**

This educational program will cover the following topics on Tuberculosis:

- Transmission
- Signs and Symptoms
- Diagnosis and Treatment
- Respiratory Protection
- Exposure Response

### **Tuberculosis**

- Tuberculosis (TB) is a contagious disease caused by the microorganism (germ) **Mycobacterium tuberculosis**.
- TB usually affects the lungs but it can also affect the brain, kidneys, spine, and lymph nodes.

### **How is TB Spread?**

- TB spreads from person to person through:
  - Sneezing

- Coughing
- Talking
- Any time air is forcibly expelled from the lungs.
- People can become infected when they breathe TB contaminated air.

### **High Risk Groups**

Groups of people who are more likely to develop TB include:

- The elderly
- The homeless
- IV drug users
- People with decreased ability to fight infections

Other high risk groups include people who have certain medical conditions, such as:

- HIV
- Cancer
- Diabetes

People with HIV are 400 times more likely to develop active TB disease if exposed to TB contaminated air.

### **Latent TB**

- People with latent TB Infection have the microorganism (germ) that causes TB in their bodies and can have a positive TB skin test, however they can NOT spread TB to others.
- It is possible for them to develop active TB in the future and they may have to receive medication to prevent active disease.

### **Active TB**

- People with active TB typically have symptoms of infection and can transmit the disease to others.
- These patients are prescribed drugs to cure the TB infection.

### **TB Symptoms**

Common symptoms associated with active TB include:

- Coughing
- Fever
- Night sweats
- Weight loss

### **TB Evaluation**

If a person is suspected of having TB infection, they can be evaluated in the following ways:

- Physical examination
- Tuberculin skin test (also called TST or PPD)
- Chest X-ray
- Sputum smear and culture

### **TB Skin Test (TST)**

- This skin test will determine if a person has been exposed to TB, but it will not tell you if a person has active TB.
- The test is performed by injecting a small amount of TST fluid under the skin in the lower arm; (also called a PPD).
- The injection site is evaluated by a RN/Healthcare Practitioner between 48-72 hours later for a reaction.

### **Sputum Smear and Culture Test**

- This test is the only definitive test for TB as it shows if acid-fast bacilli (AFB) are present.
- Sputum samples are collected and sent to the lab for analysis.
  - Sputum collection – at least three (3) consecutive sputum specimens obtained
  - Each specimen collected in 8-24 hour intervals with at least one specimen being an early morning specimen

### **Respiratory Protection**

Proper use of respiratory protection by staff is critical to prevent the spread of TB. This protection is provided by a N-95 Respirator or a Powered Air Purifying Respirator (PAPR). This protection MUST be worn by all staff that enter a TB patient's room and during sputum specimen collection.

### **PAPR-Powered Air-Purifying Respirators**

- Powered Air-Purifying Respirators (PAPR) utilizes a hood and filter/fan system to provide HEPA filtered air to the wearer. PAPR's do not require a fit test.

### **N-95 Respirator**

- The N95 Respirator is a piece of personal protective equipment commonly used by healthcare workers and those who may be exposed to airborne diseases. The mask must be properly fitted to the individual to create a good seal. Because the N95 respirator is for one-time use and the mask must be molded to your face at the time of use, learning the proper technique to fitting the mask is imperative for safety reasons. Employees whose job requires them to wear a respirator, are fit tested initially and then annually.

### **Patient Care Measures**

Patients who have been diagnosed with TB or who are in rule-out status must be housed in a negative airflow isolation room. This room must have a sign posted that identifies the requirement of Airborne Precautions.

Limit transport of the patient to essential purposes only. Maintain precautions during transport. Notify the area receiving the patient of the precautions.

Patients MUST wear a regular mask (not PAPR) if they leave their room or come in for a doctor's appointment.

Patients are no longer considered contagious when:

- They have received effective therapy with clinical improvement.
- Sputum smears are negative 3 times in a row.

The physician and Infection Control determine when isolation can be discontinued.

### **Exposure**

If you believe you have been exposed to TB:

- Follow the post-exposure procedures that are outlined in the UPMC Policy HS-IC0611 Tuberculosis Exposure Control Plan.
- Notify Employee Health at your facility.
- Follow any treatment protocols and follow-up procedures provided by Employee Health.

### **Questions**

- If you have any questions regarding TB prevention, management, or exposure procedures, contact your facilities Infection Control Department or Employee Health.

# Hand Hygiene

## UPMC POLICY AND PROCEDURE MANUAL

**POLICY: HS-IC0615**  
**INDEX TITLE: Infection Control**

**SUBJECT: Hand Hygiene**

**DATE: April 27, 2018**

### I. POLICY

It is the policy of UPMC to reduce the risk of transmission of pathogens and incidence of healthcare acquired infections by promoting and monitoring compliance with hand hygiene guidelines using the World Health Organization's (WHO) five moments of hand hygiene.

Links to policies referenced within this policy can be found in Section VIII.

### II. SCOPE

This policy applies to all Health Care Personnel in UPMC's United States based hospitals, skilled nursing facilities, home care service lines and employed physicians' offices. Similar policies may exist for other care settings within UPMC and are contained in setting-specific policy manuals.

### III. PURPOSE

Effective hand hygiene removes transient microorganisms, dirt and organic material from the hands and decreases the risk of cross contamination to patients, patient care equipment and the environment.

Hand hygiene is the single most important strategy to reduce the risk of transmitting organisms from one person to another or from one site to another on the same patient. Cleaning hands promptly and thoroughly between patient contact and after contact with blood, body fluids, secretions, excretions, equipment and potentially contaminated surfaces is an important strategy for preventing healthcare associated and occupational infections.

### IV. DEFINITIONS

**Health Care Personnel** refers to all employees, faculty, temporary workers, trainees, volunteers, students and vendors regardless of employer that provide care to patients. This includes staff that provide services to or work in any UPMC facilities.

**Direct Patient Contact** refers to anyone who has contact with a patient and/or their environment.

**Indirect Patient Contact** refers to anyone who has contact with a common area or equipment which patients may have had contact (corridors, waiting areas in ancillary areas, common areas, etc.)

**Hand Hygiene** – Performing handwashing, antiseptic handwash, alcohol based handrub, surgical hand hygiene/antiseptis.

**Handwashing** – Washing hands with soap and water.

**Antiseptic hand wash** – Washing hands with water and soap or other detergents containing an antiseptic agent (e.g. chlorhexidine, triclosan, etc.).

**Alcohol based hand rub** – preparation containing alcohol designed for application to the hands for reducing the number of viable microorganisms on the hands. Such preparations contain 60% to 95% isopropyl or ethyl alcohol.

**Artificial Nails** - The definition of artificial fingernails includes, but is not limited to, acrylic nails, all overlays, tips, bondings, extensions, tapes, inlays, and wraps.

**WHO Patient Zone** - contains the patient and his/her immediate surroundings. This typically includes the intact skin of the patient and all inanimate surfaces that are touched by or in direct physical contact with the patient such as the bed rails, bedside table, bed linen, infusion tubing and other medical equipment. It further contains surfaces frequently touched by HCWs while caring for the patient such as monitors, knobs and buttons, trash and linen bins, and other “high frequency” touch surfaces.

**WHO Health-Care Area** - contains all OTHER surfaces in the health-care setting outside the patient zone.

**WHO Clean/Aseptic Procedures**- include activities such as but not limited to: vascular access, giving an injection or performing wound care.

**WHO Critical Sites**- are associated with infection risks. Critical sites can either correspond to body sites or medical devices. Critical sites either 1.) pre-exist as natural orifices such as the mouth and eyes, 2.) occur accidentally such as wounds or pressure ulcers; 3.) are care associated such as an injection sites, vascular catheter insertion sites, or drainage exit sites or, 4.) are device associated such as vascular catheter hubs, drainage bags and bloody linen.

## **V. PROCEDURES**

### **A. Indications for hand hygiene**

In most cases, either an alcohol based hand sanitizer or handwashing with soap and water may be used for hand hygiene.

**Hand hygiene is performed utilizing the World Health Organization’s (WHO) five moments of hand hygiene. The five moments are:**

1. Before touching a patient (or patient zone)
2. Before clean/aseptic procedure (critical sites)
3. After body fluid exposure risk
4. After touching a patient

## 5. After touching patient surroundings (patient zone)

### **Handwashing with soap and water must be performed:**

- When hands are visibly dirty.
- When hands are contaminated with proteinaceous material or visibly soiled with blood/body fluids.
- After using a restroom.
- After caring for patients with suspected or confirmed *Clostridium difficile* or Norovirus.

### **Handwashing procedure:**

- Use running water; moisten hands well and apply soap.
- Lather well and rub hands together for a minimum of (15) seconds. Remember that friction removes the surface organisms, which then wash away in the lather.
- Clean under and around fingernails.
- Rinse hands well; all soap or foam should be removed to avoid skin irritation.
- Dry hands with paper towel and use the paper towel to turn off the faucets.
- Use appropriate hand lotion as needed. Moisturizers alleviate dry or chapped skin. UPMC provides a moisturizing product that is compatible with the hand care products and gloves that are used.
- Unapproved products should not be used; lotions not approved for use can harbor bacteria and/or interfere with the antiseptic properties of some handwashing solutions.

### **Alcohol-Based Hand Rub Procedure:**

- Apply product to palm of one hand and rub hands together, covering all surfaces of hands and fingers until hands are dry.
- Gel dispensers are set to deliver the recommended volume of product, follow the manufacturer's recommendations for the amount of foam product to use.
- **Do not use** if hands are visibly soiled.

### **B. Gloves- GLOVES DO NOT REPLACE THE NEED FOR HAND HYGIENE.**

- Hand hygiene must be performed prior to donning gloves when gloves are being worn for interaction with a patient and/or patient zone.
- Hand hygiene must be performed after removing gloves when gloves are being worn for interaction with a patient and/or patient zone and patient surroundings.
- Remove gloves, clean hands and don a fresh pair of gloves when caring for a patient that requires moving from a dirty site to a clean site. i.e. after caring for a draining wound to changing a central line dressing.
- Do not wear the same pair of gloves between patients.

### **C. Jewelry**

Jewelry has been shown to harbor microorganisms; therefore there are restrictions on jewelry. Please review System Dress Code Policy # HS-HR0714.

#### **D. Fingernails**

- Fingernails both natural and artificial have been shown to harbor microorganisms; therefore there are restrictions on their use. Please review System Dress Code Policy # HS-HR0714.
- Are to be kept neatly manicured and short, i.e. should not extend ¼ inch past the tip of the finger.
- Are to be kept clean.
- Nail polish without embedded enhancements in good repair is permitted.

#### **E. Compliance**

- All staff are encouraged and expected to stop and remind any other staff member in a professional manner to perform hand hygiene if they have not cleaned their hands as outlined above.
- All staff who are reminded to perform hand hygiene will respond in a professional manner and comply with the request to perform hand hygiene.
- All staff are empowered to report to their supervisor any instances in which staff members fail to clean their hands as appropriate or if unprofessional behavior is exhibited.
- Retaliation against staff members who either remind other staff members to clean their hands or who report noncompliance is prohibited.
- Employees found to be non-compliant will be referred to their manager for appropriate follow-up.
- Noncompliance by employees should also be noted at the time of annual performance evaluations.

#### **F. Oversight for Physicians**

- Non-compliant physicians will be referred to the local Medical Leadership (or designee) and follow up will occur for physicians with repetitive non-compliance.

#### **G. Enforcement**

- Managers are responsible for enforcing compliance with all elements of this policy in their departments.

#### **H. Monitoring Compliance with Hand Hygiene**

- Periodic observations will be completed at each facility to assess Healthcare Personnel compliance with the 5 moments of hand hygiene.
- Ongoing monitoring will occur via anonymous trained observers as well as observers who intervene at the time of observation (to provide both positive and negative feedback).

#### **VI. ORGANIZATIONAL RESPONSIBILITY**

- To promote compliance with these requirements alcohol hand sanitizer dispensers, sinks and other means for hand hygiene have been installed, as appropriate, in corridors and rooms throughout UPMC facilities.
- The implementation of this policy should enable and not interfere with workflow.

- Staff providing care to patients in the home environment may be supplied with alcohol based hand sanitizers to facilitate compliance with this policy.

#### **VII. REVIEW & EVALUATION**

All staff including physicians will continue to have their hand hygiene behavior monitored. At a minimum, the summary results of this monitoring will be reported periodically to Hospital Leadership, and the Infection Prevention Committee, and to other Committees as appropriate.

#### **VIII. POLICIES REFERENCED WITHIN THIS POLICY**

HS-HR0714 Dress Code

**SIGNED:** Tami Minnier  
Chief Quality Officer

**ORIGINAL:** October 5, 2004

**APPROVALS:**

Policy Review Subcommittee: April 12, 2018

Executive Staff: April, 27, 2018

**PRECEDE:** June 23, 2017

**SPONSOR:** System Infection Prevention and Control Committee

#### **References**

1. WHO Guidelines on Hand Hygiene in Health Care (2009)
2. UCSF Medical Center Hand Hygiene Policy
3. OSHA Bloodborne Pathogen Standard Exposure Control Plan (HS-IC0604)
4. Isolation/Standard Precautions Policy (HS-IC0609)

# Patient Rights and Safety

## REPORTING AN INCIDENT

### Reporting Employee Events

UPMC employees should immediately report to their supervisor, manager, or administrator-on-duty any injury, illness, or infectious disease exposure that results as a consequence of the employee's job-related duties. All employees are required to follow work-related injury or illness reporting procedures as outlined in the [Workers' Compensation](#) and [Employee Health](#) policies. UPMC employees should call UPMC Work Partners at 1-800-633-1197 to report work-related events. UPMC entities that do not use Work Partners should follow their listed processes to report job-related injuries.

Reports shall provide as much of the following information as reasonably known by the Reporter at the time of reporting:

1. identification of the staff member involved in the occurrence
2. date, time, and location of occurrence
3. brief, factual description of the occurrence
4. identity of any witnesses to the occurrence (this may include other staff, patients, or visitors)

### Reporting Other Events

For events not patient or employee related, complete an event form in Risk Master or contact **Pat Schnorr** in Corporate Insurance Department at 412-432-7696.

### What to Report

**The basic rule of thumb is: When in doubt, report it.**

UPMC staff members should report any and all events that could disrupt the care of a patient and any occurrences within the health care setting that may negatively affect visitors. Keep in mind that this is a quick guide and that any event or occurrence that disrupts the normal routine involving the clinical care of patients and the well-being of visitors is to be reported.

Examples of such events and occurrences are:

- missed or incorrect diagnoses that result in patient injury
- wrong patient, incorrect site or procedure, and other surgical issues
- patient-related medical events involving treatments or procedures such as adverse reaction to contrast material or re-intubation in the operating room or post-anesthesia care unit
- infections
- inappropriate medication administration
- lack of appropriate follow-up care

- falls
- significant birth injury (APGAR < 5 at five minutes)
- loss of limb, organ, or sense
- significant impairment of limb, organ, or sense
- life-threatening injury with permanent residual impairment
- retained foreign body
- patient/family complaints
- laboratory or radiology errors
- equipment malfunctions
- attorney request for records
- skin breakdown (Stage II or higher)
- stolen, missing, or damaged property (including vehicles)
- patient elopements and patients who leave against medical advice
- rape involving a patient

### **How to Report**

Reporting an event is easy. There are three convenient ways to do so:

1. Log on to Risk Master, an online reporting mechanism accessed via [Infonet](#). Select Quick Links located in the upper left-hand corner of the page. Select A-Z Listing from the drop-down menu, and choose the letter “I.” Select the link for “Incident reporting, nonemployee.” Alternatively, you may type <https://rm.upmc.com/webforms/> on your Internet browser.

#### **Risk Master is the preferred reporting mechanism.**

2. Call UPMC Risk Management 412-647-3050 or the UPMC Patient Safety Officer for your facility.
3. Complete a paper Initial Investigation Event Report (IIER) form.

### **Who Has to Report?**

Any staff member, physician, employee, volunteer, student, or other individual who gains knowledge of a reportable event is required to report that event immediately, but no later than 24 hours after the occurrence using one of the three reporting options.

All licensed clinicians are required by Pennsylvania Medical Care Availability and Reduction of Error Act, also known as Mcare, to report any and all events that they have knowledge of within 24 hours of that occurrence or discovery.

When reporting events, all staff members, physicians, employees, volunteers, and other individuals are protected by the state Whistleblower Law, which prohibits retaliation for event reporting. However, if these individuals are aware of any event and do not report it with 24 hours of discovery, disciplinary actions can and will be taken against them.

## **Definitions**

*Incidents.* Under Pennsylvania’s Medical Care Availability and Reduction of Error (Mcare) Act, an “incident” is defined as an event, occurrence, or situation involving the clinical care of a patient that could have injured the patient but did not either cause an unanticipated injury or require the delivery of additional health care services to the patient.

*Serious events.* As defined by Mcare, a serious event is an occurrence or situation involving the clinical care of a patient in a medical facility that results in death or compromises patient safety and results in an unanticipated injury requiring the delivery of additional health care services to the patient.

*Sentinel events.* As defined by the Joint Commission, a sentinel event is an incident, serious event, or unexpected occurrence involving death or serious physical or psychological injury. Serious injury specifically includes loss of limb or function. Any process variation for which a recurrence would carry a significant chance of a serious adverse outcome also is classified as a sentinel event. The following specific events are always considered sentinel events: infant abduction; infant discharged to the wrong family; unanticipated death of an infant born full term; rape (by another patient or staff); hemolytic transfusion reaction; surgery on the wrong patient or wrong body part; suicide of a patient in a setting where the patient received 24-hour care; and hospital-acquired infections associated with unanticipated death or major permanent loss of function.

*Infrastructure failures.* As defined by Mcare, infrastructure failures are undesirable or unintended events, occurrences, or situations involving the infrastructure of a medical facility, or the discontinuation or significant disruption of a service that could seriously compromise patient safety.

## **Why Report?**

It is the policy of UPMC to comply with the requirements of the Joint Commission and the Pennsylvania Medical Care Availability and Reduction of Error (Mcare) Act to report any unexpected events or disruptions of normal routine involving the clinical care of patients.

In addition, the reporting of such events or disruptions is a critical step to promote patient safety and to reduce the risk of event recurrences. In short, a problem cannot be addressed unless it is reported and the appropriate clinical and administrative leaders of UPMC are made aware of it.

## SAFETY MANAGEMENT – PATIENT SAFETY

### **INTRODUCTION:**

UPMC Horizon recognizes that, in rare instances, unexpected events may occur that involve death or serious injury or risk of injury to patients or employees. This in-service will discuss patient safety reporting and the procedures in place to respond to such an incident.

### **OBJECTIVES:**

- Know the types of events to be reported.
- Understand staff role in Patient Safety Reporting.
- Understand why safety errors occur.
- Understand ways to reduce errors.
- Define Root Cause Analysis.

**Patient Safety is a top priority.**

### **Medical Care Availability and Reduction of Error Act (MCare) Act 13**

- **MCare** was established to promote patient safety and reduce soaring malpractice rates.
- In March of 2002, Pennsylvania established Act 13.
  - *MCare requires* Health Care workers to report **serious events** and **incidents** within 24 hours of occurrence or discovery. (Endorses PA Whistleblower Law.)
  - PA Whistle blower Law – No adverse action or retaliation for reporting.

### **MCare Requires:**

- A Patient Safety Officer per provider facility.
- A Patient Safety Committee with community members.
- Written notice of serious events to the patient/adult family member with 7 days of the occurrence or discovery of the occurrence. (Coordinated by the Patient Safety Officer)
- Notify the PA Patient Safety Authority of serious events and incidents. (Coordinated by the Patient Safety Officer)

### **Important Definitions**

**Incident** - an event, occurrence or situation involving the clinical care of a patient, that *could have* injured the patient but *did not* either cause an unanticipated injury or require the delivery of additional services to the patient.

**Serious Event** - an event, occurrence, or situation involving the clinical care of a patient in a medical facility that results in death, or compromises patient safety **and** results in **unanticipated** injury requiring additional health care services to the patient.

**Infrastructure Failure** - an undesirable or unintended event, occurrence, or situation involving the infrastructure of a medical facility, or the discontinuation or significant disruption of a service, which could seriously compromise patient safety.

**Sentinel Event** - an adverse unexpected occurrence involving death or serious physical or psychological injury, or risk thereof, and may include loss of patient life, limb, or function.

- An immediate continuing threat to patient care or safety.
- Potential for serious underlying systems problems.
- More than one event has occurred within 6 months.
- Event potentially undermines public confidence in the hospital.

**A Sentinel Event occurs if it meets one of the following criteria:**

- Suicide of a patient in a care setting where the patient receives around-the-clock care
- Infant abduction or discharge to the wrong family
- Rape
- Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities
- Surgery on wrong patient or wrong body part

*Such events are called “**sentinel**” because they signal the need for **immediate investigation and response**.*

**Root Cause Analysis** – A written review and analysis performed to determine the underlying errors, deficiencies and issues that allowed or caused the event to occur.

**Reasons staff may not report:**

- Too busy to complete
- Fear of disciplinary action or retaliation
- Reluctance to report physicians
- Failure to recognize an incident, serious and/or sentinel event

**Reasons you are REQUIRED to report:**

- Health care workers who fail to report can be subject to professional board disciplinary action.
- The UPMC Health System policy and Patient Safety Plan requires you to report adverse patient events.
- It is the policy of UPMC to comply with the requirements of the Joint Commission and the MCare Act to report any unexpected events or disruptions of normal routines involving the clinical care of the patient. In addition the reporting of such events or disruptions is a critical step to promote patient safety and to reduce the risk of event reoccurrence.
- **REMEMBER** – We can’t fix the problem if we don’t know about it!

### **Reporting Tips:**

**DO** notify within 24 hours of an event

**DO** record factual information in the medical record

***Don't*** delay reporting

***Don't*** make assumptions

***Don't*** assign blame

### **Why do safety errors occur?**

- System errors
- Human factors lead to system errors
  1. Rushing
  2. Frustration
  3. Fatigue
  4. Complacency

These factors increase the chance that something will go wrong.

### **Ways to reduce errors and foster patient safety:**

- Listen to your patients and their families.
- Understand that errors can and do happen.
- Don't be afraid to ask questions.
- Call a "Condition C" if a patient is in distress.
- Improve your work processes and double-check.
- Root Cause Analysis & Corrective Action Plan.
- Report, Report, Report.
- Patient safety posters
- National patient safety goals
- Patient identification
- Restraints
- Pain management

### **Patient Safety Posters**

We are encouraging our patients to SPEAK UP!

We ask for reminders if we do not:

- Introduce ourselves and make sure our ID badge is visible.
- Clean our hands before any procedure.
- Correctly identify patients before any medication or procedure using the 2 identifiers – name and medical record number.
- Explain the care and medications patient will receive.
- Stop treatment if it doesn't seem quite right.

### **National Patient Safety Goals**

At UPMC Horizon, Patient Safety is always our first priority.

- In order to promote patient safety, UPMC complies with The National Patient Safety Goals.
- Joint Commission introduced these goals and Sentinel Event Alert goals to promote specific improvements in patient safety.
- JC publishes SEA's (Sentinel Event Alerts) which identifies the most frequently occurring sentinel events, describes the underlying causes, and suggests steps to prevent occurrence in the future.

### **PATIENT IDENTIFICATION**

***Patient Identification is a very important component of patient safety:***

Staff must confirm **two** patient identifiers:

- Prior to administration of medications or blood/blood products.
- Whenever taking any specimen collections for clinical testing.
- Whenever providing any treatments/procedures.
- When placing patient identification labels on all chart forms or putting any patient chart forms into the medical record.

Staff must confirm two patient identifiers. They are:

- Name AND
  - Either Date of Birth or Medical Record Number
- In addition, patient specimens must be labeled at the patient's bedside with two identifiers (name AND either date of birth or medical record number).
  - If any of the information on the patient's identification band is inconsistent with the information on the requisition or patient demographic sheet, further clarification must be sought before providing any service.

Patient wristbands are not only used as a means of patient identification but also to identify any alerts associated with the patient's condition.

Wristband Colors:

- White – Patient Identification
- Red- Allergy Alert
- Purple- DNR
- Yellow- Fall Injury Risk
- Pink- Do Not Use Extremity
- Green- Latex Allergy

### **RESTRAINTS**

- The UPMC Horizon policy on restraints may be found in the Administrative Manual (TX-04) on the Home Page, or on each facilities SharePoint home page.
- Restraints are used as a last resort and **ONLY** with a physician order.

- Restraints should not be used unless other less restrictive alternatives have been tried or considered.
- The least restrictive, effective intervention should be selected and terminated as soon as it is reasonable to do so.
- A restraint is any manual, physical or mechanical device, material, or equipment that:
  - Immobilizes or reduces the ability of a patient to move his/her arms, legs, body or head freely.
- A chemical restraint is a drug or medication used to manage the patient's behavior or restrict the patient's freedom of movement.
  - It is not a standard treatment or dosage for the patient's condition.

Mechanical restraint devices listed from least restrictive to most restricted:

- Full side rails
- Mitts (only when secured/tied)
- Geri-chair with tray
- Soft limb

### **PAIN MANAGEMENT**

Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage.

- **Acute pain**- temporary and subsides as healing takes place.
- **Chronic pain**- persists a month or more beyond the usual course of acute disease, or is associated with a chronic pathological process
- Take all reports of pain seriously
- Document patient's numerical report of pain
- Document a numeric sedation score
- Accept and act on patient's report of pain
- Proceed with appropriate assessment and treatment

All patients have the right to appropriate assessment and management of pain. Ask your patient to rate their pain on one of the following pain scales to help assess and re-assess their discomfort.

Zero to ten (0-10) Numeric Pain Intensity Scale (8 years and older, approximately)

Wong-Baker FACES Pain Rating Scale (3-7 years and older, approximately)

Word Descriptor (4 years and older) Omitting PIPPS

CRIES Scale (birth – 6 months, approximately)

FLACC Behavioral Pain Scale (NOPPS) - <37 weeks gestation and full term infants until 6 weeks

N-PASS – Neonatal Pain, Agitation & Sedation Scale

### **SAFETY ITEMS**

- The care and safety of the patient is the utmost priority after the identification of a serious/sentinel event.

- Staff members must report a serious/sentinel event immediately to their Department Managers or the Nursing Supervisor, in the manager’s absence.
  - A Root Cause Analysis is not intended to be a punitive or disciplinary review.
  - An “Action Plan” is the product of the root cause analysis. It identifies the strategies the organization intends to implement to reduce the risk of similar events occurring in the future.
  - No matter how knowledgeable or careful people are, errors will occur in some situations and may even be likely to occur.
  - Systems or processes need to be examined in a prospective way to determine ways in which failure can occur.
  - JC publishes ***Sentinel Event Alert***, which identifies the most frequently occurring sentinel events, describes their underlying causes, and suggests steps to prevent occurrences in the future. These alerts at UPMC Horizon’s specific risk reduction strategies are located on Horizon’s Home Page under “Survey Success” and then “Sentinel Events”.
  - The Patient Safety Officer at UPMC Horizon is Karen **Calhoun. RN.**
  - If you, your patients, or their families have concerns about patient care or safety in our hospital, please contact the hospital’s Patient Advocate located within the Quality Improvement Department. If, after reporting these concerns, you believe they have not been addressed, you or your patients and their families may contact the Joint Commission’s Office of Quality Monitoring at 1-800-994-6610 or [complaint@jointcommission.org](mailto:complaint@jointcommission.org); or Healthcare Facilities Program, Quality/Patient Safety Services, Fax: 312-202-8367 or [slautner@hfap.org](mailto:slautner@hfap.org).

## **UNDERSTANDING THE ELDER JUSTICE ACT**

The Health Care Reform legislation (known as the **Patient Protection and Affordable Care Act or PPACA**) includes a new reporting requirement for long-term care providers and workers and vendors who may provide services in the long term care facility. The reporting requirement is in the PPACA as part of the Elder Justice Act and it amends the Social Security Act.

The Elder Justice Act (EJA) is designed to “detect, prevent and prosecute elder abuse, neglect, and exploitation”. One requirement of EJA, is a responsibility for **individual employees** to report suspected crimes against residents of long term care facilities and others who receive care from the facility. The Act creates serious penalties for individuals who **fail to report a crime or suspicion of a crime** and, potentially, for long term care facilities that employ individuals who fail to report.

## Reporting Requirements

- The EJA mandates that each “covered individual” – owners, operators, employees, managers, agents, or contractors – report “any reasonable suspicion of a crime” against any person “who is a resident of, or is receiving care from, the facility”.
- The suspicion must be reported to both the State Survey Agency (the **DOH – Department of Health**, acting as an agent of the Secretary Department of the U.S. Department of Health and Human Services) **and to one or more local law enforcement agencies**. The Act does not designate any particular form by which the report must be made.
- Crucial to this mandatory reporting requirement is the time in which the report must be made.
- Where the suspected crime “results in **serious bodily injury**, the individual shall report the suspicion immediately, but not later than **2 hours after forming the suspicion**.”
- Where serious bodily injury does not result from the suspected crime, the suspicion must be reported “**not later than 24 hours after forming the suspicion.**”
- EJA defines “serious bodily injury” as “an injury – (i) involving extreme physical pain; (ii) involving substantial risk of death’ (iii) involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; or (iv) requiring medical intervention such as surgery, hospitalization, or physical rehabilitation.” Also included in the Act’s definition of “serious bodily injury” is criminal sexual abuse, prohibited by federal statutes, “or any similar offense under State law.”

## Penalties for Failing to Report

- Under EJA, any covered individual – be it the owner, an employee, or even a facility contractor – who does not comply with the reporting requirements is subject to a civil penalty up to \$200,000.
- If the individual fails to report his or her reasonable suspicion of a crime and the failure to report “exacerbates the harm to the victim of the crime or results in harm to another individual” the maximum civil penalty is increased to \$300,000
- In addition, any failure to report exposes the individual to the possibility of being “*excluded from participation in any Federal health care program.*”
- While these civil monetary and exclusion penalties fall upon the individual, any facility that subsequently employs and excluded individual becomes “ineligible to receive Federal Funds under this Act.”

## How Do You Comply With This Law?

### Who Must Report & How:

- Individuals who must comply with this law are: owner(s), operators, employees, managers, agents or contractors of a long term care facility (LTC), nursing facilities, skilled nursing

facilities, hospices that provide services in LTC facilities, and Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) and hospital based Transitional Care Units.

- Individuals reporting suspicion of a crime must **call, fax, or email** both **local law enforcement** and the **state survey agency** (local Department of Health office).
- Individuals suspecting a crime must report the suspicion immediately to the facility administration.

## NATIONAL PATIENT SAFETY GOALS

The purpose of the National Patient Safety Goals is to help healthcare organizations address specific areas of concern in regards to patient safety. **Be sure to know how these goals impact your job duties.**

### **GOAL 1: Identify PATIENTS CORRECTLY**

1. **Use at least two patient identifiers when providing care, treatment and services ) name or Medical record or Date of birth**
  1. **When administering medications, blood or blood components**
  2. **When collecting blood samples or other specimens**
  3. **When completing tests or treatments**
  4. **Label containers used for blood and other specimens in the presence of the patient**
  5. **Using a two person verification before initiating a blood or blood component**

### **GOAL 2: IMPROVE THE EFFECTIVENESS OF COMMUNICATION AMONG CAREGIVERS**

1. Report critical results of tests and diagnostic procedures within one hour of receipt
2. Document communication related to critical results in the medical record.
3. Get the important test results to the right person on time

### **GOAL 3: USE MEDICATIONS SAFELY**

1. **Label all medications, medication containers, & other solutions on and off the sterile field in perioperative and other procedural settings**
  1. Labeling must occur when medications and solutions are not immediately administered and when any medication or solution is transferred from the original packaging to another container
  2. Labels should include:
    1. Medication name
    2. Diluent and volume (if not apparent from container)
    3. Strength
    4. Expiration date when not used within 24 hours
    5. Quantity
    6. Expiration time when expiration occurs in less than 24 hours
2. **Whenever the person preparing a medication or solution is not the person who will be administering it, verify the labels both verbally and visually**
3. **Immediately discard any medication or solution found unlabeled**

### **GOAL 4: Reduce the likelihood of patient harm associated with the use of anticoagulant therapy**

1. **Use Approved protocols for initiation and maintenance of anticoagulant therapy**

2. **Asses the patient baseline anticoagulation status and use of current INR to adjust therapy**
3. **Use Authoritative resources to manage potential food and drug interactions**
4. **Use a programmable pump when heparin is administered intravenously and continuously**
5. **Provide education regarding anticoagulant therapy related to : Importance of follow up monitoring, compliance, drug- food interactions and adverse drug reactions**

**GOAL 5: RECONCILING MEDICATIONS**

1. **Maintain and communicate accurate patient medication information**
  1. Obtain information on the medications the patient is currently taking when he/she is admitted to the hospital or is seen in the outpatient setting
  2. Compare 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
  3. Provide the patient (or family as needed) with written information on the medications the patient should be taking when he/she is discharged from the hospital or at the end of an outpatient encounter
  4. Explain the importance of managing medication information to the patient when he/she is discharged from the hospital or at the end of an outpatient encounter
  5. Encourage patient to take their most recent list of medications to every physician visit

**GOAL 6: IDENTIFY SAFETY RISKS INHERENT IN THE PATIENT POPULATION**

1. **Identify patients at risk for suicide:**
  1. On admission, conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide
  2. Address the patient's immediate safety needs
  3. When a patient at risk for suicide leaves the care of the hospital, provide suicide prevention information (such as a crisis hotline) to the patient and his/her family

**GOAL 7: Hand Hygiene**

2. **Follow the World Health Organizations (WHO) Five Moments of Care:**
3. **Before touching a patient**
4. **Before Clean/aseptic procedure**
5. **After body fluid**
6. **After touching a patient**
7. **After touching a patients surroundings**
8. **Hand washing with soap and water must be preformed:**
  1. **When hands are visibly soiled**
  2. **When hands are soiled from blood and body fluids**
  3. **After using a restroom**
  4. **Caring for a patient with suspected or confirmed C Difficile**

**GOAL 8: PREVENTING MDROIs**

1. **Implement evidence-based practices to prevent health care-associated infections due to multidrug-resistant organisms in acute care hospitals**

1. Educate patients, and their families as needed, who are infected or colonized with a multidrug-resistant organisms (MRSA, VRE, Gram Negative Rods) about health care-associated infection prevention strategies

**GOAL 9: PREVENTING CLABSI**

2. Implement evidence-based practices to prevent health care-associated infections prevent Central line associate blood stream infections ( CLABSI)
3. Educate patients and their families who are infected or colonized with MDRO about health associate infection strategies
4. Prior to insertion of central venous catheter, educate patients about central line- associate blood stream infection prevention
5. Use the catheter checklist and a standardized protocol for central catheter insertions
6. Use Chloraprep for skin preparation during central venous catheter insertion
7. Scrub the Hub for a least 15 seconds before accessing ports
8. Evaluate all central venous catheters daily and remove non essential catheters.

**GOAL10: PREVENTING CAUTI**

1. Implement evidence-based practices to prevent indwelling catheter associated urinary tract infections (CAUTI)
  1. Review reasons for catheter insertion at initial insertion and at daily reassessment
  2. Utilize nurse-driven removal protocol when ordered by the physician
  3. Manage indwelling catheters by:
    1. Securing catheter for unobstructed drainage
    2. Maintaining system sterility
    3. Replacing the system as needed
    4. Properly collecting a urine sample

**GOAL 11: PREVENTING SSI**

1. Implement evidence-based practices for preventing surgical site infections (SSI):
  1. Educate patients who are undergoing a surgical procedure about surgical site infection prevention
  2. Administer antimicrobial agent prophylaxis according to SCIP guidelines

**GOAL12: REDUCE HARM ASSOCIATED WITH CLINICAL ALARM SYSTEMS**

1. Establish alarm signals that are needed or unnecessarily contribute to alarm noise or fatigue
2. Establish procedures that manage alarms
  1. When they can become disabled or changed
  2. Authority to set, change, turn off, and respond to alarm parameters
  3. Educate staff and licensed independent practitioners about alarm systems.

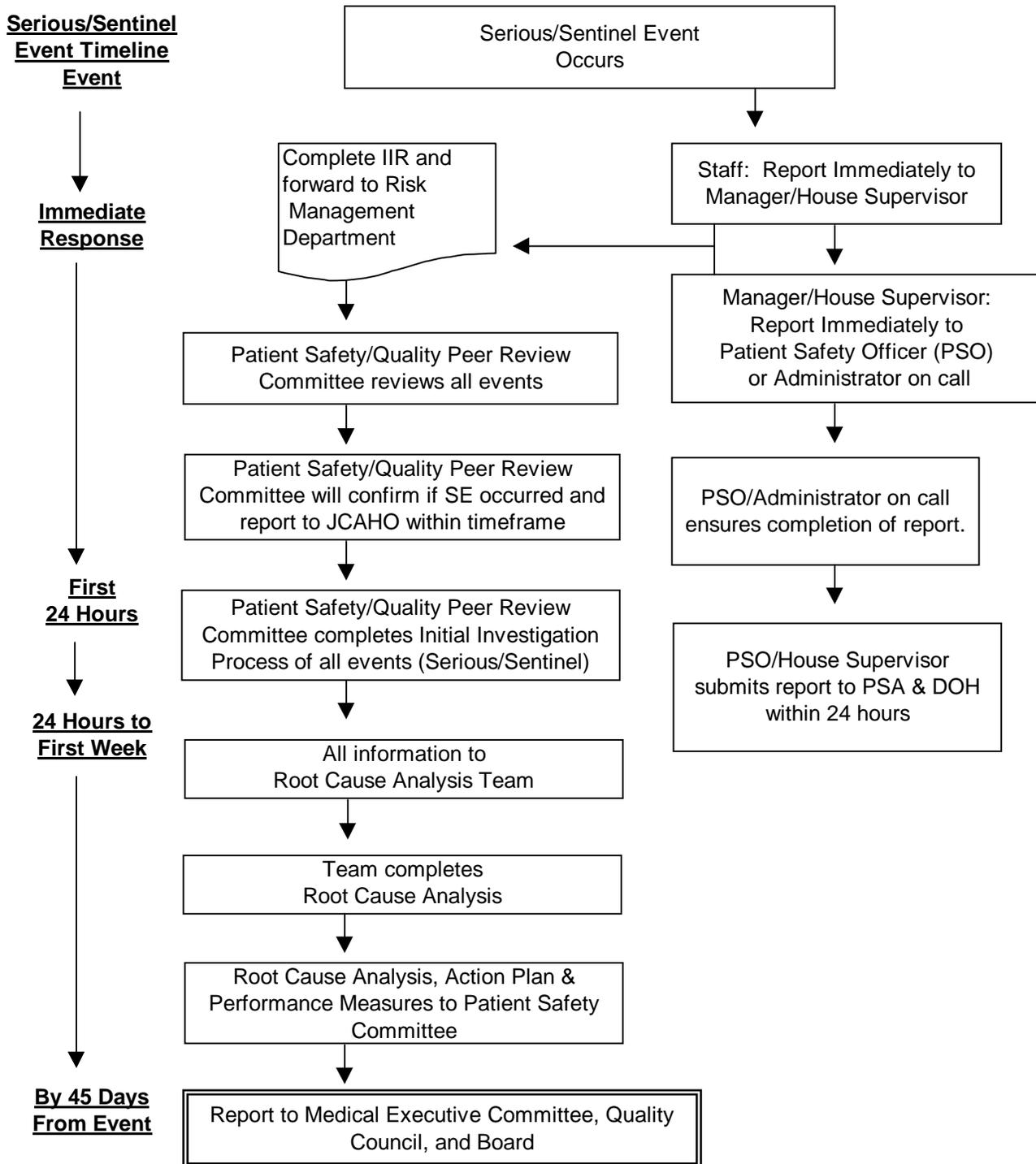
**GOAL 13: UNIVERSAL PROTOCOL FOR PREVENTING WRONG SITE, WRONG PROCEDURE**

1. Conduct a pre-procedure verification process with all relevant documents, information and or equipment.
2. When the procedure is scheduled or at the time of pre-admission testing, entry to the facility

- or before the patient leaves the pre-procedure area. Discrepancies are addressed at this time.
3. Identify procedures that require marking at the time of incision or insertion time with the patient by the MD who is doing the procedure with a unambiguous mark
  4. Time out is performed immediately before the procedure

Complete details of the National Patient Safety Goals can be found on the Joint Commission website.  
[www.jointcommission.org](http://www.jointcommission.org)

## Serious/Sentinel Event Flowchart (Determination, Action, and Reporting Process)



## PRIVACY AND SECURITY AWARENESS

Numerous federal and state laws require that UPMC protect information that is created or collected for a variety of purposes, including patient care, employment, and retail transactions. Education and training is a key element of an effective compliance program. The Privacy and Security Awareness training is an example of UPMC's commitment to educate and promote a culture that encourages ethical conduct and compliance with applicable laws.

After completing this course you should be able to explain:

- your obligations regarding privacy
- your responsibilities for protecting information
- what you should do in the event that you suspect that a breach may have occurred

Additionally, you should become familiar with the UPMC policies that discuss these subject matters. All policies that are mentioned in this course will be reviewed from time to time and may change. It is your responsibility to periodically check these and become familiar with any changes or updates.

### What is Privacy and Security?

Privacy is UPMC's obligation to limit access to information on a need-to-know basis to individuals or organizations so that they can perform a specific function for or on behalf of UPMC. This includes verbal, written, and electronic information.

1. **Security** - ensure that only those who need to have access to information can access the information. Security also includes ensuring the availability and integrity of information.
2. **Need-to-know basis** - information should only be provided to those that need it to perform their assigned job responsibilities.

### Complying with UPMC Privacy and Security Policies

As an employee you are to comply with UPMC's Privacy and Security policies and procedures. To increase patient confidence, and ensure that information is protected at UPMC, all employees are required to:

1. Abide by UPMC policies and all applicable laws
2. protect patient privacy
3. safeguard confidential information
4. read and understand policies related to their job function

**Every employee must respect our patient's expectations that their information will be kept confidential.**

### Consequences for Violating Privacy and Security Policies

Employees who violate any UPMC policy that supports compliance with HIPAA regulations may receive disciplinary action, up to and including termination.

1. The United States Department of Health and Human Services has appointed government agencies to enforce HIPAA compliance. Those who violate HIPAA can face the following penalties:
  - individual fines of up to \$250,000
  - imprisonment up to 10 years

### **What is PHI?**

Protected health information (PHI) includes any health information about our patients and is considered confidential. PHI can include, but is not limited to:

#### **General information:**

- patient's name
- medical record number
- social security number
- address
- date of birth

#### **Health Information:**

- diagnosis
- medical history
- medications

#### **Medical coverage information**

#### **Dental coverage information**

### **Safeguarding Information**

You are only permitted to access and use patient information as it relates to your job. If you see or hear patient information in the course of doing your job, that you do not need to know, remember that this information is confidential. You are not permitted to repeat it or share it with others - even friends, family, or other employees who do not have a need to know it.

- Additionally, you are not permitted to share this information with others when you no longer work for UPMC.
- All UPMC staff members play an important role in safeguarding sensitive information.
- You are obligated to maintain a patient's privacy and safeguard protected health information (PHI) for anyone who receives services at UPMC facilities.

### **Information Without Safeguards**

An unauthorized individual may be able to gain access to information if sufficient safeguards are not in place. This information may reveal confidential patient, staff, financial, research, or other business information.

**Places where this type of information may be accessed:**

- computers that were left logged into
- overheard in cafeterias or hallways
- found on fax machines and/or printers
- found in a wastebasket
- seen lying on a desk or counter

**And it could be used in an inappropriate manner to:**

- reveal confidential information
- sell information to a tabloid
- cause negative publicity

**If this occurs:**

- A patient's privacy rights may have been violated.
- State and federal laws may have been violated.
- UPMC and associated staff may be responsible for damages.

**Potential Threats or Activities that May Compromise Information**

There are many ways that confidential information can be inappropriately accessed or disclosed. All must be reported to your manager or Privacy Officer.

**These may include:**

- unauthorized access to information, either by an unauthorized individual or by an individual who has the right to access to information, but accesses the information for unauthorized reasons
- computer viruses
- inappropriately deleting information
- during a burglary, paper information may be accessed or duplicated
- theft of computer equipment, records, and/or information
- unauthorized disclosure of information

**Oral Communication**

Confidential or sensitive information should only be communicated or accessed on a need-to-know basis. You should access only the minimum amount of this type of information needed to perform your job.

**You can maintain privacy by:**

- disclosing confidential information only to those who have a need to know it
- speaking in an appropriate tone of voice (lower your voice when others are nearby and may be able to overhear your conversation)
- moving the discussions to areas where others cannot overhear

- asking those around you who do not need to know this information to leave the area so you may have privacy
- not conducting conversations which include confidential information in high-traffic areas such as hallways, reception areas, waiting rooms, elevators, and cafeterias.

### **What Should You Do?**

A health care employee was using a cellular telephone when discussing protected health information (PHI) in a restaurant down the street from the hospital. Another hospital employee sitting nearby overheard the conversation and approached the individual.

### **The right thing to do . . .**

- Employees should never conduct hospital business and discuss confidential information in public areas.
- All hospital employees have the responsibility to abide by hospital policies and to protect patient privacy.
- Protecting patient privacy is an expectation of all employees whether on duty or off duty.
- If you overhear others discussing confidential information, let them know that they can be overheard.
- In any event, any information that you overhear should not be repeated or communicated to others.
- You should report inappropriate incidents or situations to your hospital's privacy officer.

### **Physical Security**

Simple measures can be taken to prevent an unauthorized individual from gaining physical access to confidential information.

### **These measures include:**

- Question individuals you do not recognize if they are in or near areas that contain confidential information.
- Offer assistance to those who may be lost.
- Keep file cabinets, doors, and desks locked in nurses' stations, offices, etc.
- Insist that all repair/maintenance personnel show proper identification if they arrive in your work area to service equipment. If necessary, call the service company to have the identity of the repair or maintenance personnel confirmed.
- Accompany visitors and repair/maintenance personnel to and from their destinations.
- Notify Security when there is an unauthorized individual in a secured work area.

- Restrict access to computers and data centers to prevent unauthorized individuals from accessing electronic information.
- Ensure that any vendor representative, especially from the pharmaceutical, biotechnology, medical device, and hospital equipment industries, has registered with UPMC Supply Chain Management before they appear onsite.

### **Photocopiers**

When making copies of confidential information, you should not leave the copier until your job is complete.

Additionally, employees should:

- Remove all papers containing confidential information.
- Check all areas of the photocopier, including the output tray, the input feeder, and the top of the glass surface.
- Not allow others to see the information that you are copying. If someone is standing close enough to see this information, advise him or her that you are copying confidential information. Offer to let the person know when you are finished so that he or she may come back to use the machine.
- Destroy or return any confidential information that has been left on a photocopier to the owner.

### **Fax Machines**

The faxing of protected health information (PHI) should be performed only when absolutely necessary. Other, more secure ways of sending information should be considered (i.e., secure e-mail, registered/insured mail, etc). When you are asked to fax information to a UPMC location, determine if they can access the information electronically which would eliminate the need to fax the information.

If you must fax, you are required to use the UPMC approved standard fax cover sheet. This sheet contains your contact information and a confidentiality disclaimer. This form can be found on the Infonet Quick Links tab under Forms.

**Additionally, employees should:**

- When possible, program automated dial buttons with frequently dialed fax numbers.
- If available, use the button on the fax machine to dial pre-programmed number for the receiving party.
- Confirm the fax and telephone numbers of the person you are faxing to.
- Prior to faxing confidential information, let the person you are faxing to know so he or she may retrieve it from the fax machine immediately.
- Follow up with the person to verify that he or she received the fax.
- Immediately remove confidential information from the fax machine.
- Destroy or return any confidential information that has been left on a fax machine to the owner.

- Destroy confidential information that has been received in error and advise the sender of the error.
- Periodically verify that pre-programmed fax numbers are still correct.
- Contact the privacy officer to report inadvertent faxing to the wrong person.
- Consider using other means as opposed to faxing.

### **Disposal of Confidential Information**

Never discard paper, computer disks, or other portable media that contain patient information in a "routine" wastebasket. This makes the information accessible to unauthorized personnel. Such confidential information should be discarded in accordance with your business unit's policies regarding the destruction of protected health information.

- Always shred or dispose of confidential information in an appropriate designated container.
- Check with your manager or supervisor to find out how your department disposes of confidential information.

### **News Media Inquiries**

The news media may contact your facility for information if a well-known person or someone involved in a newsworthy situation, such as an accident, is being treated at your facility.

- Direct all news media inquiries to UPMC Media Relations.

### **Report Inappropriate Use of Patient Information**

If you feel that a patient's privacy or confidentiality has been violated, report the incident to your facility's or business unit's privacy officer. If they are unavailable or you are not comfortable reporting it to them, you can also use the following options:

- UPMC HIPAA Program Office at 412-647-5757
- Compliance Helpline (anonymous option) toll-free at 1-877-983-8442.

### **Protecting Electronic Information**

- Every UPMC staff member plays an important role in protecting UPMC's electronic patient, business, personnel, academic, and research information. Staff shall take reasonable precautions to ensure that electronic information is available, has integrity, and is secured against unauthorized access.

### **Creating and Protecting Passwords**

A password is a unique combination of letters, numbers, and symbols that you use to verify your identity in a computer system. Your password is the electronic equivalent of your signature.

- Do not share your password with anyone (this includes your boss and the information technology staff).
- You are responsible for all actions performed under your username and password.

- Treat your password as you would treat any piece of personal and confidential information by taking measures to keep it confidential.
- are to verify your identity in a computer system
- should be a unique combination of letters, numbers, and symbols
- is the electronic equivalent of your signature

**You are responsible for any activity that takes place under your username and password.**

### **Creating Complex Passwords**

Knowing how to create a complex password (one that cannot be guessed easily by someone else) is one way to protect your password.

- Don't base your password on information that is commonly known about you, such as your birth date, the names of your children or pets, or a hobby.
- It's also best to avoid common words, such as mother or father.

Passwords should meet the following requirements:

- must not contain all or part of the user's account name
- must be at least seven characters long
- **must contain characters from three of the following four categories:**
  - uppercase characters
  - lowercase characters
  - numbers, 0-9
  - non-alphanumeric characters (!, #, %, \*, )

Examples:

I love to golf! = lluv2GLF!

Opera singer = OpraS!ngr

I owe you \$44.95 = iOu\$449

### **Protecting Your Password**

Once you've selected a complex password, follow these tips to keep it confidential:

- Don't share your password with anyone.
- Memorize your password.
- Never store your password in a computer file or PDA.
- Do not keep a written password in plain view or easily accessible to others. All written passwords are to be kept secured.
- If someone learns your password, you should immediately:
  - change your password
  - tell your supervisor and privacy officer

**Remember, you are accountable for any actions made under your username and password.**

## **Protecting Your Computer from Viruses**

A virus is a computer program that performs unexpected or unauthorized actions. A virus can occur without your permission or knowledge. Viruses threaten all types of information, can render a system unavailable, and corrupt information contained in a system.

### **A virus might:**

- expose or change confidential information
- delete or remove important files
- display unusual messages
- e-mail everyone in your address book
- disable computers
- spread to other computers

### **Signs of a Computer Virus**

Contact the ISD Help Desk at 412-647-HELP (4357) or the help desk for your UPMC facility if you notice any of the following which might indicate your computer is infected with a virus:

- antivirus software pop-up alerts
- missing files
- unusual activity (for example, programs opening that you did not open)
- responses to e-mails that you did not send
- drastic, unexplained reductions in your computer's memory or disk space

### **Preventing Viruses**

Precautions that you can take to help protect your computer from becoming infected with a virus are:

- Never open or run unexpected e-mail attachments or other programs.
- Always use antivirus software and never disable it.
- Scan all e-mails and downloads.

### **Appropriate Use of E-mail**

Electronic mail (e-mail) is provided for the purpose of conducting UPMC business and providing service to our customers. Appropriate use of e-mail can prevent the accidental disclosure of confidential information and the disruption of computer services.

As an employee:

- Use e-mail only for official UPMC business and in accordance with UPMC policies.
- Do not use e-mail in a way that is disruptive, offensive, or harmful.
- Do not use e-mail to sponsor or promote a political party or candidate or to campaign against a political party or candidate.
- Do not use e-mail to solicit employees to support any group or organization.
- Confirm destination of e-mail addresses you are sending to.
- Do not use "reply all" unless necessary.

Although it is delivered electronically, e-mail is still a written form of communication. Approach it as you would other forms of written communication, such as a memo or fax.

**You should:**

- Delete unnecessary e-mail.
- Use additional security methods when sending confidential information.
  - Type "Secure:" (without the quotes) followed by a subject line for your email in order to automatically route the email message to the UPMC Secure E-mail Website and generates a notification email that is sent to the recipients
  - EX Subject Line of Email: Secure: Patient Billing Address
- Include a confidentiality disclaimer on e-mails.
- Don't write something in an e-mail that you would not say in an official memo.

**Printers**

Because many employees often share one printer, it is necessary to take measures to protect confidential information when printing.

**Follow these steps:**

- If your business unit has a Xerox multi-function machine you should use the "Secure" printing option. This means the document will not print until you release it by entering a code number that you select.
- If your business office does not have a Xerox multi-function machine then you should retrieve your documents immediately.

**No matter what type of machine you are printing to, you must:**

- Confirm to which printer you are printing, especially if you share a network printer.
- Immediately remove confidential items.
- Cancel or retrieve any confidential information printed on the wrong printer.
- Deliver or dispose of confidential information found on a printer.
- Only print what is necessary if you need to maintain a hard copy.

**Internet Use**

The Internet is a great source of information and a way to improve business efficiency. UPMC provides Internet access to facilitate business and for educational purposes.

- Do not use the Internet in a way that violates UPMC policies.
- Do not download software that is not approved for UPMC computers, including screen savers and games.
- Do not view information that is offensive, disruptive, or harmful to morale.
- Use antivirus software.

### **Proper Computer Workstation Use**

Be sure to restrict the view or access of others by positioning your computer screen so that others cannot view it. Place your computer workstation in a secure area that is not easily accessible by unauthorized personnel. Make sure your screen saver is set to automatically activate and lock your computer and hide confidential information when your computer is not in use. If you cannot restrict others from viewing your screen, ask your manager to order a privacy screen for you that will be placed over your monitor. The privacy screen prohibits people who are not directly lined up to the monitor from viewing the information on the screen.

#### **Employees should:**

- restrict views of others
- place computers in secure areas
- use automatic screen savers that lock your computer

### **Log on and sign off procedures**

Follow appropriate log on and sign off procedures. Follow these guidelines even when you are remotely logging into the UPMC system and accessing confidential information.

- Never use someone else's username and password or allow someone else to use yours.
- Don't offer to sign onto a computer so someone else may use it.
- Prevent another person from using your sign-on by locking or signing-off your computer workstation when leaving it unattended.
- To lock your workstation, press control/alt/delete, and select lock computer.
- Look away when other individuals are entering their passwords.
- Log off a computer when no longer using it.

### **Confidential Information Storage**

Do not store sensitive and confidential patient information on local computer workstations (C Drive), laptops (C Drive), and mobile devices such as, flash drives or memory sticks unless you are authorized to do so. Instead, store information on your network shared drive or departmental shared folders.

- If you are authorized to store sensitive and confidential patient information on removable media such as, CD-ROMs, DVDs, floppy disks, flash drives, or memory sticks, then you must secure this removable media by keeping them in a locked drawer or cabinet.
- Delete files that are no longer needed.

### **Software installation/removal procedures**

- Follow software installation and removal procedures:
- UPMC must own a valid software license for all software installed on its computers.
- Unlicensed software shall be removed or a valid license shall be acquired immediately.
- Don't download software that is not approved for UPMC computers.

### **Technical Support**

Seek technical support when necessary, especially when installing and removing hardware or software. Do not attempt to fix computer-related problems yourself. You may cause more difficulties by attempting to resolve the problem on your own. Contact the ISD Help Desk at 412-647-HELP (4357) or the designated help desk for your facility about any technical support problems or questions. Do not install or remove hardware - for example, modems, sound cards, video cards, or CD-ROMs yourself. Submit a request to complete the project.

- Seek technical support for hardware installation and removal.
- Do not attempt to fix computer problems.
- Do not install or remove hardware.
- Contact the Help Desk for technical support at 412-647-HELP (4357).

### **Remote Access Procedures**

UPMC offers ways to access its network resources from off-site (remote) locations. Regardless of where you access information, remote or on-site, this information must remain confidential and secure. Follow established remote access procedures. Contact your Help Desk to discuss these solutions.

- You should not install any hardware, such as a modem or software used for remote connections, on a UPMC computer.
- Always contact your Help Desk for this service.
- Use approved solutions for accessing UPMC's network.
- Do not install any hardware that would allow remote connections.

### **Laptops and PDAs**

Laptops and personal digital assistants (PDAs) often contain confidential information. Therefore, all staff should take the following security measures. Contact the ISD Help Desk with any questions.

- Physically secure laptops and PDAs.
- Use a password.
- Encrypt information.
- Do not leave a laptop or PDA unattended in a public place.
- The use of any unsecured wireless network is not allowed, unless the appropriate approval has been obtained.
- Confidential information should not be accessed without approval.

### **Disposal of Electronic Media**

Electronic media must be disposed of properly.

- Floppy disks, CD-ROMs, DVDs, and backup tapes containing confidential information should be physically destroyed.
- This can be done by using a CD-ROM shredder or placing the items in designated shredding bins, which is the preferred method. Caution: The process of manually breaking a CD-ROM can cause sharp pieces of plastic to fly through the air.

- Special measures must be taken to remove confidential information from fax machines, copiers, printers, and other devices capable of data storage.
- Contact the ISD Help Desk at your facility to have the appropriate technical support staff remove all traces of confidential information from a computer hard drive and other devices.

### **UPMC Privacy and Security Policy Overview**

You are required to understand all UPMC privacy and security related policies. This section provides an overview of these policies. In addition to these, your business unit or facility may have additional privacy and security related policies or procedures. If you do not understand a policy or procedure, ask your manager for clarification.

Some forms such as the Authorization for Release of PHI, have been updated in accordance with applicable regulations.

### **UPMC Privacy and Security Related Policies**

UPMC developed privacy and security policies that address a variety of topics. Summaries of these policies are on the next several pages. The complete text of these policies can be found in the system-wide policy manual located on Infonet.

### **Release of PHI**

Strict rules apply to the release of protected health information (PHI) when necessary for reasons other than treatment, payment, or health care operations (TPO). These rules vary based on the sensitivity of the information. Please direct questions related to releasing patient information to your HIM department or your privacy officer.

- If you are involved with disclosing PHI, you are responsible for being aware of these rules.
- Generally patients must sign an Authorization to Release their PHI if for reasons other than TPO.
- If a patient pays for services out of pocket in full and supplies in writing their request that we do not share this information with their insurer we are not to release this information.
- A valid authorization must contain certain information.

### **Notice of Privacy Practices for PHI**

The Notice of Privacy Practices is to be posted and made available in public areas of health care facilities, such as a registration area. The notice also must be given to patients during their first visit to UPMC and offered each additional time a patient registers for services. Patients should acknowledge that they have received a copy of the notice. At UPMC, patients acknowledge they have received the notice by signing the Consent for Treatment Form. If you are unable to obtain a patient's acknowledgement, you must document the effort and the reason why the acknowledgement was not obtained. During emergency situations, the acknowledgement should be obtained within a reasonable amount of time.

- All staff should read the Notice of Privacy Practices. The notice may be downloaded from the HIPAA section of UPMC Infonet.

**Notice of Privacy Practices (NOPP) describes:**

- how PHI may be used or disclosed
- patient rights under HIPAA
- who to contact if patients believe their rights have been violated

**Business Associates (Guidelines for Purchasing)**

A business associate is an external individual, business, or vendor that uses Protected Health Information (PHI) to perform a service or provide a product on behalf of UPMC. These services may include, but are not limited to, legal, actuarial, accounting, consulting, management, administrative, accreditation, data aggregation, or financial services.

- UPMC is required to enter into a contract with a business associate that clearly defines the business associates responsibilities for using, sharing, and safeguarding PHI, including the reporting of any breach of protected health information.
- All business associates must enter into an agreement with UPMC to safeguard PHI.
- For more details about these terms and conditions, business associates should refer to the Purchasing section of UPMC's public website.

**Use of PHI for Marketing**

Marketing is defined as any type of communication that seeks to convince an individual to use or purchase a product or service. UPMC must request and obtain written authorization from an individual to use or disclose his or her PHI for marketing purposes.

**Examples not considered marketing:**

- face-to-face communications, such as when pharmaceutical samples are given to a patient during a doctor's office visit
- communicating additional treatment options, care management activities, or alternative care settings.

**Use of PHI for Fundraising**

Fund raising refers to any activity to raise charitable donations that support research, education, or the advancement of health care activities within UPMC.

- Types of PHI that may be used for fund-raising purposes without obtaining the patient's authorization must be de-identified and include:
- demographic information that does not identify the patient (age, race, gender, etc)
- dates that health care was provided to a patient
- The Notice of Privacy Practices describes how a patient's PHI may be used for fund-raising activities.
- Use of other types of PHI which identifies the patient, requires a separate authorization from the patient.

### **Use and Disclosure of PHI for Research Purposes Pursuant to the HIPAA Privacy Rule**

All research activities must be conducted in accordance with the rules of the Institutional Review Board (IRB).

- Patients must sign a research authorization for their PHI to be used or disclosed.
- De-identified information (as described in the HIPAA Privacy Rule) may be used for research without the patient's authorization.
- UPMC also uses external institutional review boards for clinical trials such as the Independent Investigational Review Board. For a complete list, contact the UPMC Clinical Trials Office.

### **Accounting of Disclosures of PHI**

Accounting of Disclosures (AOD) is a summary of where a patient's PHI was disclosed and includes a list of those people who have received or accessed protected health information.

- Patients have a right to receive an accounting of disclosures and AODs must be maintained for six years.
- Subject to a schedule established by federal law, UPMC must provide an accounting of disclosures of all individuals who have received or accessed a patient's electronic record for a period of three years prior to the date on which the accounting is requested.
- In addition, business associates will also be required to supply an accounting of disclosures when requested.

### **Filing a Complaint - Complaint Management Process**

Patients and staff have a right to file a complaint if they feel their privacy rights have been violated. There are many options for filing a complaint.

Staff can file a complaint by first contacting their manager or supervisor. If they are unable to or uncomfortable with doing so, then complaints can be filed by using the same methods available to patients as described below.

#### **Patients (or parent/guardian/other authorized person) can file a complaint by:**

- Informing a UPMC employee
- Employee receiving a complaint must report it to the entity privacy
- contacting the entity's privacy officer
- Calling the:
  - HIPAA Helpline - 412-647-5757
  - Compliance Helpline - 1-877-983-8442 (anonymous option)
  - Writing (paper or electronic) to the:

Secretary of the United States Department of Health and Human Services, 200 Independence Ave, SW Washington, DC 20201.

### **Patient Access to PHI**

Patients have a right to access and review their PHI. A patient must submit a written request and schedule an appointment at the facility where the treatment was provided in order to access his or her PHI.

#### **UPMC may deny a patient access under certain situations:**

- contains psychotherapy notes
- compiled for court proceedings
- physician determines not appropriate
- could result in danger to another person
- prohibited by law

### **Employees Accessing PHI**

If an employee has an account for a UPMC clinical system, the employee is generally permitted to access the employee's medical information on that system. The exceptions are that (a) an employee is not entitled to access his/her behavioral health or drug/alcohol treatment information; (b) UPMC reserves that right to limit an employee's access to his/her medical information on UPMC Clinical Systems; and (c) an employee's use of UPMC clinical system must not interfere with the employee's or other staff's work.

- Employees are prohibited from accessing medical records of their spouses, children, relatives, and others.
- Employees are permitted only to access information needed to perform their job.
- Employees will be subject to disciplinary action if PHI has been accessed inappropriately and may be subject to fine, imprisonment and termination.

### **Patient Amendment to PHI**

Patients may request to amend or correct their PHI, if they feel that UPMC has recorded incorrect or incomplete information about them. A patient who wants to amend his or her PHI must make a written request to the facility holding this where the medical information was created. The request must include the reason the information should be amended.

#### **UPMC may deny a request when:**

- request to amend is not in writing
- patient does not include a reason to support the request
- information was not created by the facility
- health care provider verifies the existing information is true and accurate
- facility must notify the patient in writing whether the request to amend was approved or denied
- the patient may submit a statement of disagreement which will become part of the patient record when an amendment request is denied.

### **Minimum Necessary Standards for Using PHI**

Protected health information (PHI) is available to UPMC staff on a need-to-know basis. Need-to-know means that you rely on or need PHI in order to do your job.

- However, you should access only the minimum amount of information that you need to perform your job.
- For example, all of the patient's health information is available for a physician, nurse, or other staff member to use to provide direct patient care. However, this same information is not available to the hospital's telephone operator. The need-to-know information the telephone operator requires is the patient's name and room number.
- Accessing patient information that is not relevant to your job may result in disciplinary action, up to, and including termination.
- A log of all users accessing PHI via electronic means is available to monitor this.

If you are required to disclose PHI to someone for purposes other than treatment, payment or operations, such as a court order, **you must verify:**

- who the requesting party is
- that they have a need-to-know this information
- that only the minimum necessary information is provided
- If a patient pays for services out of pocket in full, and supplies in writing their request that we do not share this information we are not to release this information.
- Questions regarding the minimum necessary standards for using or disclosing PHI should be directed to your privacy officer or Health Information Management (medical records) department.

### **Reporting of Suspected Problems**

It is every employee's responsibility to be alert to unethical behavior or possible violations of UPMC policies.

There are many examples of inappropriate use or disclosure of protected health information.

**These include but are not limited to:**

- Faxing - If the patient's information is sent to the wrong fax number or wrong location, the doctor's office or requesting agent must report this to either HIM or their Privacy officer.

- Patient Identification - If a patient presents with identification that does not appear to be consistent with existing information, contact your privacy officer to notify him or her of the possibility of identity theft.
- Access/Disclosure - All inappropriate PHI access or suspected breach in security shall be reported in accordance with appropriate UPMC Policies.

Communicate your concerns and observations in a manner consistent with the chain of command. You should first contact your manager if you need assistance. If you are not comfortable or unable to follow the chain of command, the following additional resources are available:

- privacy officer
- compliance officer
- Corporate Compliance Office
- Human Resource
- Legal
- UPMC Compliance Helpline toll-free at 1-877- 983-8442 (anonymous)

UPMC prohibits retaliation against anyone for raising, in good faith, a concern or question about inappropriate or illegal behavior. Retaliation is not allowed against anyone participating in an investigation or providing information related to an alleged violation.

### **Red Flag Rules: Reporting Suspected Identity Theft**

Congress enacted the Fair and Accurate Credit Transaction Act (FACTA) of 2003 which amended the Fair Credit Reporting Act (FCRA) in response to the increase in identity theft. Subsequently, the Federal Trade Commission (FTC) issued the “Red Flag Rules”.

The Red Flag Rules aim to protect the consumer from identity theft. This rule requires that any business entity (“creditors”) who maintain an account (“covered account”) which allows deferred payment and or credit to a client must implement a program to identify, detect, and respond to identity theft.

Identity theft occurs when someone uses another person's personal information to fraudulently obtain medical services (e.g. name, address, Social Security number, credit card number insurance information or other identifying personal information).

Red Flags are defined as any pattern, practice, or specific activity that could indicate identity theft.

- If you suspect that identity theft has occurred communicate your concerns and observations in a manner consistent with the chain of command. You should first

contact your manager or supervisor who will perform an initial investigation. If you are not comfortable or unable to follow the chain of command, additional resources are available:

- privacy officer
- compliance officer
- UPMC Compliance Helpline toll-free at 1-877- 983-8442 (anonymous)

**UPMC Compliance Helpline** provides the employee with:

- A toll-free number that is answered 24 hours/day, 365 days/year by non-UPMC staff – this is a contracted service with Compliance Concepts Inc.'s *Compliance Line* service
- A means to report questions/concerns, and get answers, anonymously and confidentially – when you call, the *Compliance Line* staff will ask if you wish to remain anonymous. However, you will have to identify your business unit as there must be some means by which the Ethics and Compliance Office can focus its investigation, if necessary. The *Compliance Line* staff will assign a code number and call back time in order for you to call back and hear the answer/resolution to your question/concern.

### **Theft and/or Breach of Personal Information**

#### **In General:**

A breach occurs when there is an unauthorized acquisition, access, use, or disclosure of protected health information. If you suspect that a breach has occurred, you should notify your supervisor or entity Privacy Officer immediately. If it is determined that there was a breach, UPMC will need to report the breach, including providing written notification to the affected patient(s).

- **Example:** Without a work related need, a nurse intentionally opens her co-worker's record.
- **Exceptions:** There are a variety of exceptions where a breach does not need to be reported, including situations, where it is unlikely that the information could be misused. However, this decision may only be made following an investigation by UPMC.

**UPMC  
POLICY AND PROCEDURE MANUAL**

**POLICY: HS-EC1601 \***

**INDEX TITLE: Ethics & Compliance**

**SUBJECT: Complaint Management Process Pursuant to the HIPAA Privacy Rule**

**DATE: January 30, 2018**

**I. POLICY**

It is the policy of UPMC to have a written process which identifies the options available for the filing of a privacy complaint pursuant to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (the Privacy Rule). To the extent not preempted by HIPAA, any applicable state laws shall also apply. The HIPAA Privacy Regulations are located at 45 CFR Parts 160 and 164 or at <http://aspe.hhs.gov/admsimp/final/PvcTxt01.htm>. Terms used herein, but not otherwise defined, shall have the same meaning as those terms in 45 CFR §§160.103 and 164.501.

Links to policies referenced within this policy can be found in Section VII.

**II. PURPOSE/SCOPE**

This policy describes the process and options available for those who want to file a privacy complaint under the HIPAA Privacy Rule. This policy applies to all United States based UPMC entities and locations.

**III. OVERVIEW**

The Notice of Privacy Practices (Notice) is a document required by HIPAA that must be distributed to all patients (or parent/guardian/other authorized person) being treated by a healthcare provider (such as UPMC). One of the functions of the Notice is to advise the patient (or parent/guardian/other authorized person) as to their complaint rights under the HIPAA Privacy Rule.

HIPAA complaint investigations at UPMC are conducted by an appropriate entity Privacy Officer. HIPAA matters throughout the UPMC enterprise, including complaint investigations, are ultimately overseen and reviewed by the UPMC Office of Patient and Consumer Privacy. The Office of Patient and Consumer Privacy consists of corporate staff from various departments, falling under the collaborative direction of: 1) the Vice President and Chief Audit & Compliance Officer, and 2) the Vice President of Privacy and Information Security & Associate Counsel. The

Vice President of Privacy and Information Security & Associate Counsel shall serve as the UPMC enterprise Chief Privacy Officer.

Any patient filing a complaint shall follow the guidelines set forth in the Notice. This policy and the Notice identifies the following options for patient (or parent/guardian/other authorized person) initiated complaints:

- file the complaint directly with a UPMC entity employee who then contacts the UPMC entity's Privacy Officer for resolution (and documentation) or by contacting the entity's Privacy Officer directly (as is instructed in the Notice); or,
- file the complaint via the toll-free Compliance HelpLine number (1-877-983-8442) whereby the complaint is initially documented and passed-on (to UPMC for resolution) by the HelpLine's contracted staff; or,
- file the complaint via the web based Compliance HelpLine reporting system at [www.mycompliancereport.com](http://www.mycompliancereport.com) (Access ID: UPMC) whereby the complaint is logged electronically and passed-on (to UPMC for resolution); or,
- file the complaint via the HIPAA or Privacy HelpLine number whereby the complaint is initially documented and passed-on (for resolution) by the Office of Patient & Consumer Privacy staff; and/or,
- file the complaint directly with the Secretary of the US Department of Health and Human Services.

It must also be noted that Corporate Compliance and/or Corporate Risk Management are also a source for HIPAA complaints and that these complaints are to be communicated to the Office of Patient & Consumer Privacy (to assure appropriate follow-up and documentation) as they are received.

Consistent with the Notice, this policy describes the procedures for filing such complaints and the process by which UPMC will accept and investigate these complaints.

UPMC shall not retaliate against anyone who in good faith files a HIPAA privacy complaint.

#### **IV. REQUIREMENTS**

##### **A. Filing a Complaint with UPMC**

###### **1. Filing a Complaint Directly with a UPMC Entity Staff Member**

a)A complaint may be filed directly with a UPMC entity. When such a complaint is received at the entity level, it shall be reported and referred to the entity Privacy Officer. The entity Privacy Officer shall:

- Initiate (within 3 business days) an investigation into the complaint and resolve the complaint within a reasonable period of time;
- Email (or fax) the completed Investigation Form to the Office of Patient & Consumer Privacy;
- The Office of Patient & Consumer Privacy will review the Investigation Form for consistency and appropriateness and enter the complaint specifics into an electronic database for future data analysis and reporting. In addition, they will maintain files of these Investigation Forms (and any associated documentation) for six years as required by HIPAA.

b)Corporate Risk Management may also receive a HIPAA related complaint. If so, Risk Management shall report all such complaints and the results of the investigations to the appropriate UPMC entity Privacy Officer for subsequent handling and disposition as identified in step A.1.a above. Additionally, Corporate Risk Management shall report the complaint and the resolution to the Office of Patient & Consumer Privacy for tracking.

c)The Office of Patient & Consumer Privacy of the Ethics and Compliance department may also receive complaints via the Compliance Helpline or the HIPAA or Privacy HelpLines. All numbers are published in the UPMC Notice of Privacy Practices which is distributed to all patients. In this situation, the Office of Patient & Consumer Privacy will contact the entity Privacy Officer and convey the details of the complaint. The UPMC entity Privacy Officer is responsible for subsequent investigation/handling and disposition as identified in step A.1.a above. Should Corporate Ethics and Compliance receive a complaint directly, the Office of Patient & Consumer Privacy should be notified so as to facilitate investigation/handling as identified in step A.1.a above.

## 2. Filing a Complaint Using the UPMC Compliance HelpLine

a) Consistent with the instructions provided in the Notice, the UPMC Compliance HelpLine (the HelpLine) may be used by patients and employees as a simple and centralized mechanism to file a HIPAA complaint against any health care provider entity within the UPMC covered entity. The contracted Compliance HelpLine staff has been given detailed instructions as to how to document HIPAA complaints.

b) The HelpLine (toll-free number 1-877-983-8442) and the online reporting system ([www.mycompliancereport.com](http://www.mycompliancereport.com) Access ID: UPMC) are tools that a person can utilize to document a question, concern or complaint twenty-four (24) hours a day seven (7) days a week.

Reports to the HelpLine are initially managed by an independent third party communications specialist who will assign the report a private code number that can be referred to during any follow up. The individual making the report is not required to identify themselves. The calls are not recorded, and the online reports are not traceable by UPMC.

c) Once a complaint is received via the HelpLine, a written report is generated to the Office of Patient & Consumer Privacy. The Office of Patient & Consumer Privacy will forward this report to the appropriate UPMC entity Privacy Officer for subsequent investigation/handling and disposition pursuant to the procedure identified in step A.1.a above. In addition, a resolution report is prepared and sent back to the Compliance HelpLine so the complainant may be informed of this resolution should they choose to follow up on the status of the report.

d) If the entity privacy officer has any questions and concerns about investigating a complaint and/or how to resolve a complaint, they are advised to contact the Office of Patient & Consumer Privacy for instruction. The Office of Patient & Consumer Privacy staff will consult with the UPMC Privacy Officer as necessary in order to provide advice to an entity Privacy Officer.

## **B. Filing a Complaint with the Secretary of the US Department of Health and Human Services**

- A complaint to the Secretary of Health and Human Services must: 1) be filed in writing, either on paper or electronically; 2) name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the Privacy Rule; and 3) be filed within 180 days of when the complainant knew or should have known that the act or omission complained of occurred.
- Most often the Secretary of Health and Human Services will direct the complaint to the UPMC Privacy Officer and/or the UPMC Compliance Officer. These individuals shall notify the appropriate UPMC entity Privacy Officer for subsequent investigation/handling and disposition pursuant to the procedure identified in step A.1.a above.

## **V. RESPONSIBILITY**

It shall be the responsibility of each UPMC entity to implement processes and procedures to meet the requirements set forth in this policy based on the facilities unique systems and processes.

## **VI. NON-COMPLIANCE**

An employee's failure to abide by this policy may result in disciplinary action pursuant to UPMC policy HS-HR0704 entitled "Corrective Action and Discharge". Other non-employee work force members may be sanctioned in accordance with applicable UPMC procedures.

## **VII. POLICIES REFERENCED WITHIN THIS POLICY**

HS-HR0704 Corrective Action and Discharge

**SIGNED:** Douglas Heusey

Interim Chief Compliance Officer

**ORIGINAL:** April 14, 2003

### **APPROVALS:**

Policy Review Subcommittee: January 12, 2018

Executive Staff: January 30, 2018

**PRECEDE:** September 22, 2016

**SPONSOR:** UPMC Office of Patient & Consumer Privacy

**\* With respect to UPMC business units described in the Scope section, this policy is intended to replace individual business unit policies covering the same subject matter. In-Scope business unit policies covering the same subject matter should be pulled from all manuals.**

**UPMC**  
**POLICY AND PROCEDURE MANUAL**

**POLICY: HS-EC1602 \***  
**INDEX TITLE: Ethics & Compliance**

**SUBJECT: Use & Disclosure of Protected Health Information (PHI) Including: Fundraising, Marketing and Research**

**DATE: January 30, 2018**

## **I. POLICY**

It is the policy of UPMC to comply with the Health Insurance Portability and Accountability Act rule, as revised by the 2013 HIPAA Final Rule (HIPAA), as well as the privacy requirements that are contained within the American Recovery and Reinvestment Act of 2009 (ARRA) and any applicable related state laws that are not preempted by HIPAA.

Links to policies referenced within this policy can be found in Section VIII.

## **II. PURPOSE/SCOPE**

This policy identifies the requirements for adhering to the HIPAA and ARRA privacy regulations regarding a patient's right to request restrictions to be placed on the patient's record, the "minimum necessary" rule, and uses and disclosures of PHI for the purposes of fundraising, marketing and research. This policy applies to all United States based UPMC entities and locations.

## **III. DEFINITIONS**

**CFR** refers to the Code of Federal Regulations.

**Fundraising** generally means the organized activity of requesting charitable gifts in support of research, education, training or other aspects of the advancement of health care delivery.

**Business Associate** refers to an individual or organization that is not a member of the UPMC workforce and that acts on behalf of UPMC to assist in performing functions that involve the use or disclosure of PHI. These functions may include providing legal, accounting, consulting, management, administrative, accreditation or financial services.

**Marketing** means (1) to make a communication about a product or service to encourage recipients of the communication to purchase or use the product or service, unless the communication is made (a) to describe a health related product or service (or payment for such product or service) that is provided by, or included in a plan of benefits of, UPMC, including communications about: the entities participating in a health care provider network or health plan network; replacement of, or enhancement of, or enhancements to, a health plan; and health related products or services available only to a health plan enrollee that add value to, but are not part of, a plan of benefits; (b) for treatment of the individual; or (c) for case management or care coordination for the individual,

or to direct or recommend alternative treatments, therapies, health care providers or settings of care to the individual; (2) an arrangement between UPMC and another entity whereby UPMC discloses PHI to the other entity in exchange for direct or indirect remuneration, for the other entity or its affiliate to make a communication about its own product or service that encourages recipients of the communication to purchase or use that product or service.

**Protected Health Information (PHI)** means information collected from an individual that is (1) created or received by UPMC, (2) relates to the past, present or future physical or mental health or condition of an individual, (3) relates to the provision of health care to an individual or to the past, present or future payment for providing health care to the individual and (4) that identifies or could identify the individual. PHI includes clinical and demographic information.

**UPMC Foundation** means a foundation that qualifies as a nonprofit charitable foundation under Section 501(c)(3) of the Internal Revenue Code and that has in its charter statement of charitable purposes an explicit linkage to UPMC.

#### **IV. REQUIREMENTS**

##### **A. MINIMUM NECESSARY STANDARD FOR THE USE & DISCLOSURE OF PHI.**

1. UPMC shall limit access and use of PHI to only those persons or classes of persons, as appropriate, who need such access to carry out or perform their job responsibilities. UPMC related policies include (a) System Management and Change Control Policy, HS-IS0217, (b) Authentication and Access Controls HS-IS0204, (c) Information Systems Security Policy Administration HS-IS0201 and (d) Physical Access, HS-IS0205.

2. UPMC shall identify the category or categories of PHI which these individuals need access to along with any conditions appropriate to such access.

3. All disclosures of PHI shall be limited to the amount reasonably necessary to achieve the purpose of the disclosure.

4. *Minimum necessary does not apply.* This requirement does not apply to:

- (i) Disclosures to or requests by a health care provider for treatment;
- (ii) Uses or disclosures made to the individual, as permitted under paragraph (a)(1)(i) or as required by paragraph (a)(2)(i) of 164.502;
- (iii) Uses or disclosures made pursuant to an authorization under 164.508;
- (iv) Disclosures made to the Secretary in accordance with subpart C of 45 CFR 160;
- (v) Uses or disclosures that are required by law, as described by § 164.512(a); and
- (vi) Uses or disclosures that are required for compliance with applicable requirements of HIPAA

5. UPMC shall be entitled to rely (if reasonable under the circumstances) on a requested disclosure as the minimum necessary for the stated purpose when:

- a) making permitted disclosures to public officials if such official represents that the information requested is the minimum necessary

b) the information is requested by another “Covered Entity” (as defined in the privacy regulations at 45 C.F.R. § 160.103)

c) the information is requested by a professional or a UPMC business associate for the purpose of providing professional services to UPMC, provided they represent the information being requested is the minimum necessary or

d) representations that comply with the requirements of § 45 C.F.R. § 164.512 (l) have been provided by a person requesting the information for research purposes.

6. UPMC shall only request information that is reasonably necessary to accomplish the purpose of the request.

7. UPMC shall use reasonably necessary efforts to secure and maintain the confidentiality of PHI, regardless of form or media.

## **B. USE & DISCLOSURE OF PHI FOR FUNDRAISING**

1. UPMC may use or disclose to a Business Associate or a UPMC Foundation the following PHI for the purpose of raising funds to benefit UPMC, without an authorization and provided the UPMC Notice of Privacy Practices contains a statement that UPMC may contact the individual to raise funds for UPMC:

(a) demographic information that can include, but not be limited to, name, address, other contact information (e.g., phone numbers, emails), age, race, gender and date of birth;

(b) dates that health care was provided to a patient;

(c) general department of service information (e.g., cardiology, pediatrics);

(d) treating physician;

(e) outcome information (e.g., patient deceased or had a bad outcome) and

(f) health insurance status.

2. All fundraising communications made to an individual (including those made verbally) must contain clear and conspicuous instructions for how the patient can opt-out of receiving such communications in the future. The method for an individual to elect not to receive further fundraising communications may not cause the individual to incur an undue burden or more than a nominal cost. Requiring patients to write a letter to opt out is considered an undue burden and is therefore not acceptable. Examples of acceptable opt-out methods include (1) a toll-free or local telephone number, (2) an email address, (3) a pre-printed, pre-paid postcard and (4) other similar simple, quick and inexpensive opt-out mechanisms. The following language is “sample” opt-out language:

***If you do not want to receive future fundraising requests supporting [UPMC or Name of Specific Campaign], you can call \_\_\_\_\_ and communicate to us that you do not want to receive fundraising requests. There is no requirement that you agree to accept fundraising communications from us, and we will honor your request not to receive fundraising communications from us after the date we receive your notice.***

3. In the event that a patient does opt-out of receiving information related to fundraising, the opt-out request must be recorded by the respective UPMC development area and the patient shall not receive future fundraising communications from the respective entity.

4. An opt-out decision does not lapse. For example, if a patient opts-out but then makes a donation, that donation does not serve (absent a separate election to opt back in), to automatically add the patient back into the mailing list for fundraising communications.

5. UPMC may not condition treatment or payment on whether a patient has elected to receive fundraising communications.

6. If there are questions on whether a particular scenario related to fundraising requires patient authorization or not, the respective entity's Fundraising department and/or the Privacy Officer should be contacted.

### **C. USE & DISCLOSURE OF PHI FOR MARKETING**

1. UPMC must have a patient's prior written marketing authorization to use or disclose PHI for marketing communications. Exceptions to this include:

- a. When the communication occurs during a face to face encounter between UPMC and the patient.
- b. The communication involves a promotional gift of nominal value provided by UPMC.

### **D. USE & DISCLOSURE OF PHI FOR RESEARCH PURPOSES**

UPMC has determined that it is not necessary to have multiple (i.e., research and health care provider specific) HIPAA Notice of Privacy Practices provided to and signed by the patient-subject. UPMC, in providing services whereby PHI is created due to clinical research activity, has a treatment relationship with the patient. As such, the patient-subject will sign a UPMC Consent to Treatment, Payment and Operations form acknowledging receipt of the UPMC Notice of Privacy practices when they present for services. In accordance with federal regulations and the ethics professional literature, patients involved in Quality Improvement activities are not research subjects. All researchers that in any way use UPMC clinical services in conducting their research, must utilize a HIPAA authorization form [See "HIPAA Privacy Rule Guidance for Researchers" for model language at the University of Pittsburgh Human Research Protection Office (Pitt HRPO) website]. The HIPAA research authorization may be combined with the study informed consent document as is explained below.

All researchers who conduct research at or within a UPMC entity, or request access to PHI held by UPMC for research purposes, or use a UPMC entity to fulfill orders for required services pursuant to a research protocol, shall adhere to these research provisions. This policy, as well as any related procedures, shall be distributed along with instructions to all Institutional Review Boards (IRB), if requested, known to provide services to affected researchers.

All IRBs that approve research protocols involving the use of a UPMC provider entity (existing or newly created PHI) will be expected to support UPMC with its HIPAA compliance initiative. This includes: providing HIPAA compliance training (with the assistance of UPMC); providing guidance to

all affected researchers; examining study documentation to ensure HIPAA research authorization language is appropriate; and cooperating with audits that may be conducted by UPMC to assure compliance with UPMC HIPAA policies and procedures related to research.

All researchers who conduct research involving the recording of existing PHI (held by a UPMC entity) or creation of PHI (by a UPMC entity) pursuant to the research protocols must secure and maintain an approved HIPAA research authorization (as specified by UPMC) from patient-subjects upon their enrollment into a research study. [An alternative (de-identification) procedure exists for previously held (existing) PHI – see below]. Obtaining the HIPAA research authorizations shall be in addition to obtaining the written informed consent of patient-subjects using the IRB-approved informed consent document (see noted exception below). All researchers must provide copies of these HIPAA research authorizations to any UPMC provider entity as requested. [Note: The required language of the HIPAA research authorization may be combined with the language in the informed consent document if the researcher so chooses. The researcher is directly responsible for assuring the appropriate combination of the HIPAA information.]

The UPMC template HIPAA research authorization will be provided to the researchers, upon request, for their use in assuring HIPAA compliance. The researcher must customize this template research authorization and explain its content to the patient-subject. Other pertinent requirements regarding the research authorization are as follows:

- the researcher must obtain the patient-subject's signature upon enrolling them into a research study; and, the researcher must maintain the signed research authorization for a period of no less than six years (or longer if required by applicable law or UPMC policy), and must make a copy available to UPMC upon request.
- the researcher must adequately describe how the patient's protected health information will be used or disclosed for future research.

Compound authorizations for conditioned and unconditioned studies are permissible under HIPAA, but must clearly differentiate between the conditioned and unconditioned study components. Additionally, the patient-subject must be given the option to opt-in to the unconditioned study's activities as outlined in the authorization. The researcher must make clear to the patient-subject that their choice not to opt-in will not impact treatment, payment or benefits.

Relative to research studies that involve the collection and analysis of existing PHI held by a UPMC provider entity:

- the researcher must submit the research study for IRB approval prior to its implementation (see UPMC policy HS-PS0497 IRB Approval of Human Research at UPMC and,
- the researcher must secure a HIPAA research authorization from each patient-subject whose PHI they desire access to and must present this authorization to the appropriate UPMC Health Information Management (Medical Records) department, or area where records are held, in order to access records; or, alternatively,
- the researcher may use the services of an honest broker to obtain the PHI in a de-identified manner. De-identification means that the patient-subjects cannot be identified (by the researcher or others) directly or indirectly through identifiers linked to the patient-subject.

De-identification must be done in accordance with HIPAA regulations. The honest broker will de-identify medical record information by automated (e.g., de-ID computer application for electronic/computer stored PHI) and/or manual methods (for paper record PHI). All honest brokers shall be approved in advance by both the IRB of record and the UPMC Privacy Officer. If an honest broker system/service is not part of the UPMC covered entity, they must execute a valid business associate agreement with UPMC to access UPMC-held PHI for de-identification. If an honest broker system/service is to be used to obtain de-identified PHI, this fact must be identified in the study's IRB submission and addressed per the attachment A;

- in certain circumstance(s), a researcher may request a waiver of HIPAA authorization. Pitt HRPO, serving as the UPMC Privacy Board, has the authority to approve waivers within HIPAA requirements.

HIPAA generally permits access by a patient to his/her own medical records with a few limited exceptions. One exception is for research-related PHI. HIPAA permits the researcher to specify in the research authorization any limits they are placing on a patient-subject's access to their own medical records due to their study participation for the duration of the study. However, UPMC has made the following policy decisions relative to patient access to medical records held by UPMC (as a result of fulfilling researcher orders for services):

- Researchers generally may not put any restrictions on PHI that is in the possession of UPMC as a result of currently or previously providing health care services to the patient/research subject;
- A researcher may petition a UPMC provider's Health Information Management (HIM) department manager or the designated medical record contact, on a patient-by-patient basis, to restrict patient/subject access to PHI held by a UPMC provider entity. After consultation with the UPMC Privacy Officer, this restriction may be granted or denied.

HIPAA permits the researcher and UPMC to condition research participation on the patient-subject's signing of a research authorization. The UPMC research authorization will condition research participation (research-related hospital and other provider services) and any consequent need to obtain previously created PHI, on the patient-subject's signing both the research authorization and the IRB-approved informed consent document or the combined document.

If a decisionally-impaired individual is incapable of providing directly the requisite HIPAA authorization/informed consent for research participation, such authorization/consent must be obtained from the individual's authorized representative. If the individual has been declared mentally incapacitated by the court, the respective court documents should be reviewed to determine if legal authority for consent for participation in research is addressed and, if so, to whom such authority is granted. If the court documents do not address proxy consent for participation in research, the individual should be excluded from participation unless the IRB specifically grants a waiver of the informed consent requirement for this individual. In the absence of a declaration of mental incapacity by a court-of-law, who should serve as the authorized representative to consent on behalf of the decisionally-impaired individual should be consistent with existing hospital orders and/or Commonwealth of Pennsylvania rules addressing consent for

clinical care of the decisionally-impaired individual. Commonwealth of Pennsylvania regulations specify that proxy consent for clinical care should follow "lines of sanguity". For research involving the evaluation of "emergency" procedures, an exception to the authorization/consent requirement must be approved by the IRB. If applicable, patient-subjects enrolled in the research study under the authorization/consent of their authorized representative shall personally sign the HIPAA research authorization and the IRB-approved informed consent document as soon as they recover the decisional capacity to sign such documents.

HIPAA permits customization of a research authorization to specify in detail that Treatment, Payment and Health Care Operations (TPO) uses/disclosures may be more limited than would be otherwise permissible under the TPO consent document. It will be the policy of UPMC to not permit customization (by a researcher) of the UPMC research authorization to limit TPO PHI (created by a UPMC entity pursuant to research order fulfillment) uses and disclosures by UPMC. If there are extenuating circumstances, the researcher may petition the UPMC Privacy Officer for an exception.

If an exception is granted, it will be the researcher's responsibility to clearly communicate to the UPMC entity's director of health information management, or the individual designated by that entity to receive such information, what limitations on uses and disclosures have been placed on an individual patient's PHI created (by the UPMC entity) pursuant to research orders. This communication must include documentation of the Privacy Officer's permission along with a copy of the signed research authorization.

For reviews of PHI preparatory to research (hypothesis/protocol development), HIPAA permits UPMC to make available the PHI to a researcher based solely on the researcher's written representations that no PHI shall be recorded for the purpose of research and/or removed from the provider entity and that the PHI reviewed by the researcher shall be limited to that necessary to prepare a research protocol. UPMC shall permit researchers to review PHI, held by a UPMC entity, for the purpose of preparing a research hypothesis and research protocol. Researcher should use the attachment B for this purpose. The researcher must submit the completed request form to [OSPARS@upmc.edu](mailto:OSPARS@upmc.edu) for review.

Once approved, the researcher must submit this signed agreement to the director of the entity's HIM department or an individual designated by the entity to receive such information in order to access the records/PHI.

UPMC, if presented a signed Use and Disclosure of Protected Health Information (PHI) for Research Purposes Pursuant to the HIPAA Privacy Rules Policy applicable to Decedent PHI (see attachment C), may grant access to and permit researchers to record the PHI of deceased individuals, held by a UPMC entity, under the following conditions:

- If the information is de-identified by an honest broker service; or,
- Pursuant to a valid research authorization signed by the administrator or executor of the deceased individual's estate or the person who is listed as next of kin; or,

- Pursuant to a request to access decedent PHI signed by the UPMC Privacy Officer for a research protocol approved by CORID (see UPMC policy HS-RS0004, Research and Clinical Training Involving Decedents) or an IRB. The researcher must attest to the fact that the PHI sought is solely for this research study; access to this PHI is necessary for this research; and that s/he or study staff have verified the death of the individuals whose PHI is sought. Approval for such requests will be limited to circumstances where it is truly impossible to get authorization for access to the PHI.

UPMC recognizes that there are databases containing PHI that reside on PCs and servers in the various locations which the researchers work and see patients. These database files serve a variety of purposes including pure research, pure treatment, or a mixture of both. Databases exclusively used for treatment are not covered by the HIPAA regulations on research. The PHI in these databases shall not be used for research purposes unless such use is compliant with HIPAA and research regulatory requirements as previously stated in this policy.

#### **E. PATIENT RESTRICTIONS**

UPMC patients have the right to request restrictions on the use and disclosure of their PHI. To do so, they are to submit a written request to where they had services provided and tell UPMC (1) what information they want limited, (2) whether they want to limit the use, disclosure or both and (3) the person or institution the limits apply to (for example, their spouse). UPMC is not required to, and except in extenuating circumstances, does not agree to requests for restrictions.

If UPMC does agree to a request for restriction, the restriction may be removed if (1) the patient agrees to or requests the termination in writing, (2) the patient orally agrees to the termination and the oral agreement is documented, or (3) UPMC informs the patient in writing that it is terminating its agreement to a restriction, and if so, such termination will only be effective for PHI created or received after UPMC has informed the patient.

#### **V. RESPONSIBILITY**

It shall be the responsibility of each UPMC entity and, with respect to fundraising, of each supporting foundation, to implement processes and procedures to meet the requirements set forth in this policy based on the facilities unique systems and processes.

It shall be the responsibility of the Health Information Management Department to review and approve any restriction, to ensure that the restriction is appropriate and to ensure that the restriction can be honored. The Health Information Management Department shall also be responsible for the removal of a restriction described in section IV.E.

#### **VI. RESEARCH RELATED RESPONSIBILITIES**

It shall be the responsibility of researchers that conduct research within UPMC or request access to PHI held by UPMC for research purposes to implement processes and procedures within their work setting to meet the requirements set forth in this policy.

It shall be the responsibility of the Pitt IRB and other external IRBs of record (e.g. central IRBs employed by the UPMC Clinical Trials Office), to implement processes and procedures to meet the requirements set forth in this policy.

It shall be the responsibility of the UPMC HIM department managers or the designated medical record contact, to implement processes and procedures within their work setting to meet the requirements set forth in this policy.

## **VII. NON-COMPLIANCE**

An employee's failure to abide by this policy may result in disciplinary action pursuant to UPMC policy HS-HR0704 entitled "Corrective Action and Discharge". Other non-employee work force members may be sanctioned in accordance with applicable UPMC procedures.

## **VIII. POLICIES REFERENCED WITHIN THIS POLICY**

HS-IS0217 System Management and Change Control  
HS-IS0204 Authentication and Access Controls  
HS-IS0201 Information Systems Security Policy Administration  
HS-IS0205 Physical Access  
HS-HR0704 Corrective Action and Discharge  
HS-PS0497 IRB Approval of Human Subjects Research at UPMC  
HS-RS0004 Research and Clinical Training Involving Decedents

**SIGNED:** Douglas Heusey

Interim Chief Compliance Officer

**ORIGINAL:** April 14, 2003

### **APPROVALS:**

Policy Review Subcommittee: January 12, 2018

Executive Staff: January 30, 2018

**PRECEDE:** January 27, 2017

**SPONSOR:** UPMC Office of Patient & Consumer Privacy

**\* With respect to UPMC business units described in the Scope section, this policy is intended to replace individual business unit policies covering the same subject matter. In-Scope business unit policies covering the same subject matter should be pulled from all manuals.**

## Attachment A

### SAMPLE AGREEMENT

#### Use and Disclosure of Protected Health Information (PHI) For Research Purposes

*Pursuant to the HIPAA Privacy Rules Policy applicable to living subject PHI.*

#### DATA USE AGREEMENT

This Data Use Agreement (the "Agreement") is made this \_\_\_\_ day of \_\_\_\_\_, 20\_\_ by and between UPMC and \_\_\_\_\_ ("Recipient").

WHEREAS, 45 CFR 164, Subpart E (titled "Standards for Privacy of Individually Identifiable Health Information" and herein referred to as the "HIPAA Privacy Rule") allows UPMC to make available for the purposes of research, public health or health care operations a Limited Data Set to Recipient, provided that Recipient agrees to be bound by the terms of this Agreement; and

WHEREAS, Recipient desires for UPMC to make available the Limited Data Set as described below and agrees to be bound by the terms and conditions of this Agreement; and

WHEREAS, UPMC agrees to make available such Limited Data Set, provided that Recipient agrees to abide by the terms and conditions of this Agreement as well as applicable UPMC policies and IRB requirements.

NOW, THEREFORE, in consideration of the mutual covenants and promises hereinafter set forth, the parties hereto agree as follows:

#### A. DEFINITIONS

For the purposes of this Agreement, terms used herein shall have the same definition as set forth in the HIPAA Privacy Rule.

#### B. DATA TO BE PROVIDED

The Limited Data Set provided pursuant to this Agreement contains data acquired from [NAME LOCATION AND/OR SOURCE SYSTEM] and related to [IDENTIFY THE TYPE OF DATA AND/OR DATA FIELDS]. Such data shall be limited to data that is the Minimum Necessary to reasonably accomplish the Authorized Purposes identified in Section (C)(1) of this Agreement.

For the purpose of this Agreement and consistent with the HIPAA Privacy Rule, "Minimum Necessary" is defined as that protected health information that is "*reasonably necessary to achieve the purpose of the disclosure*" and is disclosed to only "*Those persons or classes of persons, as appropriate, in its workforce who need access to protected health information to carry out their duties.*" © 2017 UPMC All Rights Reserved

Consistent with the HIPAA Privacy Rule, in no case will the Limited Data Set include any of the following identifiers:

1. Names
2. Postal address information (other than town or city, state and zip code)
3. Telephone numbers
4. Fax numbers
5. E-mail addresses
6. Social security numbers
7. Medical record numbers
8. Health plan beneficiary numbers
9. Account numbers

10. Certificate/license numbers
11. Vehicle identifiers & serial numbers, including license plate numbers
12. Device identifiers & serial numbers
13. Web Universal Resource Locators (URL's)
14. Internet Protocol (IP) address numbers
15. Biometric identifiers, including finger and voice prints
16. Full face photographic images and any comparable images

#### C. PERMITTED USES AND DISCLOSURES

1. Recipient agrees to limit the use and disclosure of the Limited Data Set to the following purposes ("Authorized Purposes"): [ADD PURPOSES]

2. The Recipient shall allow only the following individuals access to the Limited Data Set for the Authorized Purpose and consistent with the assurances and obligations set forth in this Agreement: [ADD LIST OF AUTHORIZED INDIVIDUALS].

3. Recipient acknowledges that such individuals have a need to access the Limited Data set to carry out their duties.

#### D. ASSURANCES

1. Recipient shall not use or further disclose the Limited Data Set other than as permitted by this Agreement or as otherwise Required By Law.

2. Recipient shall use appropriate safeguards to prevent use or disclosure of the Limited Data Set other than as permitted by this Agreement.

3. Recipient shall report to the UPMC Privacy Officer any use or disclosure of the Limited Data Set not provided for by this Agreement of which Recipient becomes aware.

4. Recipient shall ensure that any agents, including a subcontractor, to whom it provides the Limited Data Set agrees to the same restrictions and conditions that apply to the Limited Data Set Recipient with respect to such information.

5. Recipient shall not re-identify the information or contact the individuals for whose records are contained within the Limited Data Set.

#### E. BREACH AND TERMINATION

1. In the event that this Agreement is breached by Recipient, UPMC, at its sole discretion, may a) terminate this Agreement upon written notice to Recipient or b) request that Recipient, to the satisfaction of UPMC, take appropriate steps to cure such breach. If Recipient fails to cure such breach to the satisfaction of UPMC or in the time prescribed by UPMC, UPMC may terminate this Agreement upon written notice to Recipient.

2. Should this Agreement be terminated for any reason, including, but not limited to Recipient's decision to cease use of the Limited Data Set data, Recipient agrees to destroy or return all Limited Data Set data provided pursuant to this Agreement (including copies or derivative versions thereof).

F. MISCELLANEOUS

1. Notices Any notice permitted or required as provided for herein shall be in writing and to the contact and address as noted below or as may be provided by either party to the other in writing from time to time. Notice to UPMC shall be to:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

\_\_\_\_\_  
Notice to Recipient shall be to:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

2. Governing Law

This Agreement shall be governed by, and construed in accordance with, the laws of the Commonwealth of Pennsylvania.

**UPMC Recipient**

Name (print): \_\_\_\_\_ Name (print): \_\_\_\_\_

Title: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Signature: \_\_\_\_\_

Reserved

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**Attachment B**

**SAMPLE AGREEMENT**

**Use and Disclosure of Protected Health Information (PHI) For Research Purposes**

Pursuant to the HIPAA Privacy Rules Policy applicable to Reviews Preparatory to Research.

**HIPAA RESEARCH AGREEMENT – PHI USAGE FOR REVIEWS PREPARATORY TO RESEARCH**

This Health Insurance Portability and Accountability Act (HIPAA) Research Agreement (The “HIPAA Agreement”) is made this day of , 20\_\_ by and between UPMC and (The Researcher).

HIPAA sets forth a rule (the Privacy Rule) governing the privacy of a patient’s identifiable health information (referred to in the Privacy Rule as protected health information or “PHI”). The Privacy Rule sets forth guidelines intended to preserve the integrity and confidentiality of PHI. The Privacy Rule applies to health plans, health care clearinghouses and health care providers. The Privacy Rule can be found at 45 CFR, Part 164, Subpart E or at <http://aspe.hhs.gov/admsimp/final/pvctx01.htm>.

Section 164.512(i) of the Privacy Rule titled “Standard: Uses and Disclosures for Research Purposes” provides that UPMC may disclose a patient's PHI to the Researcher for reviews preparatory to research based on the following representations from the Researcher, to which Researcher agrees to comply:

(a) Such use or disclosure is solely for purposes of reviewing the PHI as necessary to prepare a research protocol or for similar purposes preparatory to research (e.g., to design a study or to assess the feasibility of conducting a study).

Describe, below, the purpose(s) of your desired review of PHI:

(b) The PHI being sought to be disclosed is limited to the minimum necessary to achieve the purpose(s) of the review.

**Describe, below, the specific nature of the PHI that you are requesting for review and indicate why each of the data elements being requested is necessary to achieve the purpose(s) of the review:**

(c) The PHI being sought to be disclosed is necessary for the research project.

**Address, below, why the PHI that you are requesting for review is necessary in order to prepare a research protocol:**

(d) The Researcher will not remove any PHI from UPMC in the course of the research review.

(e) The Researcher will comply with IRB requirements for all research studies that result from this review performed preparatory to research.

Researcher:

(Print or type name)

(Signature)

UPMC

(Print or type name)

(Signature)

**Attachment C**

**SAMPLE AGREEMENT**

Use and Disclosure of Protected Health Information (PHI) For Research Purposes  
Pursuant to the HIPAA Privacy Rules Policy applicable to Decedent PHI.

**TO:** UPMC Privacy Officer or designee (CORID or Pitt IRB)

**FROM:** Name of Principal Investigator:

**RE:** Request to review Decedent Protected Health Information for Research

Name of Research Study:

Pitt IRB # or CTO # if available:

I, and my research study staff would like to review Protected Health Information (PHI) of UPMC patients to gather information for the research study listed above. It is my assertion that:

1. This PHI sought is solely for this research study;
2. Access to this PHI is necessary for this research because .
3. I and/or my staff have verified the death of the individuals whose PHI is sought.

De-identified data or a limited data set will not provide me with the information necessary for this research because:

I am unable to obtain the authorization for access to the necessary PHI by contacting the subject's next of kin because:

I understand that I am bound by University of Pittsburgh and UPMC policy, as well as state and federal law, to handle this PHI in a manner that protects the confidentiality of the decedents.

Signature of PI Date

Reviewed and approved by Research Compliance Officer or designee

Signature of Research Compliance Officer / Designee Date

**UPMC  
POLICY AND PROCEDURE MANUAL**

**POLICY: HS-EC1603 \*  
INDEX TITLE: Ethics & Compliance**

**SUBJECT: Notice of Privacy Practices for Protected Health Information (PHI) Pursuant to HIPAA  
DATE: December 31, 2018**

**I. POLICY**

It is the policy of UPMC to comply with the Health Insurance Portability and Accountability Act (HIPAA) rule pertaining to the notice requirements of its uses and disclosures of PHI and any applicable related state laws that are not preempted by HIPAA. The HIPAA Privacy Regulations can be located at 45 C.F.R. Parts 160 & 164.

In order to achieve such compliance, UPMC will provide its Notice of Privacy Practices (the Notice) which informs the patient as to how information about the patient may be used and disclosed, how the patient can obtain access to this information and the patient's rights under HIPAA. This Notice shall be provided to the patient at the time of registration and thereafter upon the request of the patient. Additionally, the patient will also have the right to request and receive additional copies of the Notice. The list of entities covered by UPMCs Notice can be found at <http://www.upmc.com/patients-visitors/privacy-info/Pages/notice-of-privacy-practice.aspx>.

Links to policies referenced within this policy can be found in Section VI.

**II. PURPOSE/SCOPE**

This policy identifies the requirements as provided by HIPAA relating to the UPMC Notice of Privacy Practices. This policy applies to all United States based UPMC entities and locations.

**III. REQUIREMENTS**

1. An individual has a right to receive notice of how UPMC may use and disclose PHI, the individual's related rights and UPMC's duties with respect to PHI.

**Exceptions:** An inmate does not have a right to such notice.

2. UPMC shall provide its Notice in writing and in plain language. Such notice will contain the required elements as set forth in HIPAA.

3. UPMC shall revise and make available its Notice whenever there is a material change to the uses or disclosures, the individual's rights, UPMC's legal duties, or other privacy practices stated in the Notice.

4. UPMC shall make the Notice available on request to anyone and on UPMC's website.

5. If UPMC has a direct treatment relationship with an individual (one which does not involve the use of another health care provider), they shall:

(i) Provide the Notice no later than the date of the first service delivery, including service delivered electronically, to such individual after the compliance date for the covered health care provider. For emergency treatment situations, this requirement is extended to until reasonably practicable after the emergency situation;

(ii) Make a good faith effort to obtain the individual's written acknowledgment of receipt of the Notice no later than the date of first service delivery, including service delivered electronically. This requirement does not apply to emergency treatment situations. If an individual refuses to sign or otherwise fails to provide an acknowledgment, UPMC shall document its good faith efforts along with the reason why the acknowledgment was not obtained. The UPMC "Consent for Treatment, Payment and Health Care Operations" form is where the individual is to initial that he or she received the Notice. This form is to also be used to document if the individual fails to acknowledge such receipt along with a reason.

(iii) If UPMC maintains a physical service delivery site, they shall:

(a) Have the Notice available at the service delivery site for individuals to request to take with them; and

(b) Post the Notice in a clear and prominent location where it is reasonable to expect individuals seeking service from UPMC to be able to read the Notice; and

(c) Whenever the Notice is revised, make the Notice available upon request on or after the effective date of the revision.

6. UPMC may provide the Notice required by this section to an individual by e-mail, if the individual agrees to electronic notice and such agreement has not been withdrawn. If UPMC knows that the e-mail transmission has failed, a paper copy of the Notice must be provided to the individual.

7. For purposes of this section, if the first service delivery to an individual is delivered electronically, UPMC shall provide electronic Notice in response to the individual's first request for service.

8. The individual who receives the electronic Notice retains the right to obtain a paper copy of the Notice from UPMC upon request.

9. UPMC shall document compliance with the notice requirements by retaining copies of the Notices, including all amended or replacement versions issued, as required by HIPAA. These copies shall be retained by the UPMC Ethics and Compliance department.

#### **IV. RESPONSIBILITY**

It shall be the responsibility of each UPMC entity to implement processes and procedures to meet the requirements set forth in this policy.

#### **V. NON-COMPLIANCE**

An employee's failure to abide by this policy may result in disciplinary action pursuant to UPMC policy HS-HR0704 entitled "Corrective Action and Discharge." Other non-employee workforce

members may be sanctioned in accordance with applicable UPMC procedures.

## **VI. POLICIES REFERENCED WITHIN THIS POLICY**

HS-HR0704 Corrective Action and Discharge

**SIGNED:** John Houston

Vice President, Privacy and Information Security & Associate Counsel

**ORIGINAL:** April 14, 2003

**APPROVALS:**

Policy Review Subcommittee: December 14, 2018

Executive Staff: December 31, 2018

**PRECEDE:** January 2, 2018

**SPONSOR:** Vice President, Privacy and Information Security & Associate Counsel

**\* With respect to UPMC business units described in the Scope section, this policy is intended to replace individual business unit policies covering the same subject matter. In-Scope business unit policies covering the same subject matter should be pulled from all manuals.**

**UPMC  
POLICY AND PROCEDURE MANUAL**

**POLICY: HS-EC1606  
INDEX TITLE: Ethics & Compliance**

**SUBJECT: Privacy and Security Training Related to Protected Health Information (PHI)**

**DATE: August 24, 2018**

**I. POLICY**

It is the policy of UPMC to comply with the Health Insurance Portability and Accountability Act (HIPAA) rule pertaining to necessary training requirements with respect to PHI and any applicable related state laws that are not preempted by HIPAA.

Links to policies referenced within this policy can be found in Section VI.

**II. PURPOSE/SCOPE**

UPMC shall provide privacy and security training in accordance with the requirements set forth in this policy. This policy applies to all United States based UPMC entities and locations.

**III. REQUIREMENTS**

1. UPMC shall provide privacy and security education and training to the members of its workforce (which includes vendors, volunteers, contract employees, students and related staff) to comply with the federally mandated HIPAA Privacy and Security Regulations which were subsequently amended by the Health Information Technology for Economic and Clinical Health Act (HITECH) and the HIPAA Omnibus Rule. Such education and training shall occur periodically thereafter. Additionally, UPMC shall provide regular privacy and security training on an annual basis, or more frequently as warranted, to individuals identified as being required to complete UPMC annual mandatory training. This education and training shall include, but may not be limited to, the policies and procedures with respect to PHI as necessary and appropriate for the members to perform their function. Additionally, UPMC will identify and provide any specialized or additional training to those members as necessary and appropriate for the member to perform their function.

2. UPMC shall train new members of its workforce, as part of the orientation process, within a reasonable period of time once such member joins the workforce, on the policies and procedures with respect to PHI as necessary and appropriate for the member to perform their function. The training is available on uLearn via My Hub.

3. UPMC shall train and retrain as appropriate the members of its workforce whose functions are affected by a material change in such policies or procedures within a reasonable period of time.

4. The policies and procedures which may be discussed in such education and training may include the following topics:

- Uses and Disclosures of PHI

- Uses and Disclosures of PHI for which an authorization is required
- Uses and Disclosures of PHI requiring an opportunity for individual to agree or to object
- Uses and Disclosures of PHI not requiring a consent, authorization or an opportunity to agree or object
- Notice of Privacy Practices for PHI
- Rights to request privacy protection for PHI
- Access by individuals to PHI
- Amendment of PHI
- Accounting of Disclosures of PHI
- Use of PHI in Fundraising
- Use of PHI in Marketing
- Guidelines for Purchasing
- Administrative requirements
- Transition requirements
- HIPAA Compliance dates
- Uses and Disclosures of PHI – other requirements
- Information Security
- HITECH Breach Notification Requirements

5. Each UPMC entity shall maintain documentation evidencing that training has been provided.

6. UPMC will have ongoing training and educational tools available to its members through the UPMC website.

#### **IV. RESPONSIBILITY**

It shall be the responsibility of each UPMC entity to implement processes and procedures to meet the requirements set forth in this policy based on the facilities unique systems and processes.

#### **V. NON-COMPLIANCE**

An employee's failure to abide by this policy may result in disciplinary action pursuant to UPMC policy HS-HR0704 entitled "Corrective Action and Discharge". Other non-employee work force members may be sanctioned in accordance with applicable UPMC procedures.

#### **VI. POLICIES REFERENCED WITHIN THIS POLICY**

HS-HR0704 Corrective Action and Discharge

**SIGNED:** John Houston

Vice President, Privacy and Information Security & Associate Counsel

**ORIGINAL:** January 6, 2003

**APPROVALS:**

Policy Review Subcommittee: August 9, 2018

Executive Staff: August 24, 2018

**PRECEDE:** August 23, 2017

**SPONSOR:** Vice President, Privacy and Information Security & Associate Counsel

## PATIENT RIGHTS & ORGANIZATIONAL ETHICS

### **BEHAVIORAL OBJECTIVES:**

After reviewing this material the reader will be able to:

- Understand the rights and responsibilities of patients.
- Define ethics and ethical dilemmas in the organizational setting.
- Identify major areas of ethical dilemmas in an organization.
- Recognize how rights of patients are protected by ethical decision making.

Active participation in care decisions is not a patient's privilege it is a fundamental right. If however, patients are not given the information needed to evaluate their options, they cannot exercise this right.

As healthcare givers, we must understand these rights so that all activities involving the patient are conducted with concern for him/her, and above all, the recognition of his/her dignity as a human being. Standards have been set which promote consideration and respect of individual values and preferences and includes the decision to discontinue treatment. Important activities related to these standards include advising patients of their responsibilities in the care process and making sure they fully understand the benefits and risks associated with planned procedures.

All hospital employees and medical staff are responsible for ensuring that the patient, parent and/or guardian are involved in all aspects of care. Patients must be involved in at least the following areas:

- A. making care decisions; giving informed consent;
- B. resolving dilemmas about care decisions;
- C. formulating advance directives;
- D. withholding resuscitative services;
- E. forgoing or withdrawing life-sustaining treatment and planning care at the end of life.

Standards also recommend that the family be allowed to participate in care decisions, while recognizing the patient's right to exclude any or all family members. Sometimes it is mandatory that people other than or in addition to the patient be involved in decision-making. This is especially true in the case of un-emancipated minors, when the family or guardian is legally responsible for approving care. Often a surrogate decision-maker must be identified in the event that the patient lacks the mental or physical capacity to make decisions or communicate them.

Ethical decisions regarding care can present all sorts of difficult questions and conflicts for the organization, patients, family members and other decision-makers. Defining ethics and understanding the areas of ethical dilemmas can help us make choices that have a positive impact on individuals and groups involved with the organization.

**Ethics** deals with right and wrong in the values and actions of individuals and the communities and organizations that they are a part of. Many ethical issues involve factors that make the

choice of “right” and “wrong” decisions less than clear. These are called **ethical dilemmas**. There are three (3) major areas where ethical dilemmas may occur within an organization. They include: 1) managing human resources; 2) managing stakeholders (customers, shareholders, suppliers, 3) government agencies, accrediting agencies, etc.); and managing one’s own personal career in relation to organizational loyalty.

Ethical decision-making is extremely complex and should be the result of sound reasoning. Four questions should be asked and evaluated thoroughly to help guide a person to an ethical decision. **FIRST** – consider who is affected by the decision. The more specific you can be about individuals and groups who may experience benefits or costs from a particular decision, the more likely it is that ethical decisions will be made. **SECOND** – what are the benefits and costs to these individuals or groups? Answering this question requires determining the interests and values of the specific individuals or groups. **THIRD** – who has rights, or who is entitled to the benefits of the decision? **FOURTH** – what are the decision rules? Is there government or accrediting agencies that have certain laws, rules or guidelines that must be taken into consideration when making decisions? Certainly, however, ethical decision-making goes beyond laws.

Dealing appropriately with ethical issues and educating patients and their families about their rights are empowering practices. The hospital’s efforts in these areas foster patient’s dignity, autonomy, and positive self-regard. Through education and consideration of ethical issues, patients are made aware of resources, environmental demands, individual strengths and weaknesses, and what they can expect from their on-going relationship with staff and the organization as a whole.

UPMC Horizon has developed a policy that specifically identifies the rights and responsibilities of its patients. A copy of this policy (included in the learning package) is offered to all patients in the form of a PE (patient education) pamphlet. When the patient is incapacitated, the responsible party receives the information. Simply giving the patients a list of their rights, however, is not enough. Instruction should be personal and interactive.

Likewise, a “Code of Ethical Behavior” has also been developed. The policy states that “...no patient will be denied admission to the hospital based on his/her ability to pay; billing statements will be provided for the time frame of service, with any billing complaints addressed immediately; patient confidentiality will be maintained; there will be full disclosure of conflicts of interest for decision makers at all levels of the organization; marketing of UPMC Horizon services or educational programs will not mislead the customer; contractual arrangement with other healthcare providers, educational institutions and payers will define each party’s responsibility; respect for the patient and family in all areas of care will be maintained; patients will be transferred to other institutions which can provide appropriate care when UPMC Horizon cannot; and UPMC Horizon staff and physicians will report all cases of abuse or suspected abuse in accordance with the laws.

## Customer Service



C.A.R.E. is the service recovery actions we take when caring for a difficult customer. The four parts of C.A.R.E. are in a logical order to help us think through:

- Our actions  
And
- Our attitude as we interact with a customer from start to finish.

**C. –Connect**

Establishing a favorable rapport and putting the customer at ease.

**A. -Actively Listen**

Fully engaging in hearing responses and reading body language.

**R. –Respond**

Clarifying what you heard and proposing next steps for agreement.

**E. –Empathize and Thank**

Being aware of, and sensitive to, the expressed feelings, thoughts, and experiences of another person without actually having the feelings, thoughts, or experiences yourself

## DOMESTIC VIOLENCE

**Upon completion of this packet, Domestic/Family Violence, the learner will be able to:**

- Define domestic violence vs. intimate partner abuse.
- Describe the health effects of intimate partner abuse.
- Discuss criteria for identifying victims of abuse.
- Define child abuse.
- Differentiate the four generally recognized types of elder abuse.
- Identify important advocacy and support organizations available to the domestic violence victim.

### **INTRODUCTION:**

Violence within the home is a problem that has afflicted families for ages. It is perpetrated by men and women, husbands and wives, rich and poor, and members of every race and religion. When parents or other partners physically or mentally abuse one another, it has disastrous effects on the family. ***For this reason, it is the policy of UPMC Horizon to screen all patients for potential violence, abuse, or neglect and to provide appropriate intervention.***

### **UPMC Horizon Criteria For Identifying Victims Of Abuse**

- Review of medical record information, eyewitness report, or statement of attending physician reveals suspicion or evidence of past history of abuse.
- Evidence of serious physical or mental injury unexplained by the available history and physical findings.
- Evidence that the injury has resulted from acts of omission by the person responsible for the patient's welfare.
- The patient's statement of alleged abuse.
- Display of inappropriate behavior toward the caretaker (e.g. exhibition of fear of caretaker.)
- Display of abuse witnessed by healthcare giver.
- Physical signs that a person may have been abused include:
  1. Multiple injuries at various stages of healing.
  2. Patterns left by whatever was used to inflict injury (teeth, ropes, hands, or utensils).
  3. Telltale burns - those shaped like a cigarette tip or curling iron or resembling a glove or sock because the extremity was immersed in scalding water.
  4. Injuries on unusual parts of the body, on several different surfaces, or in central areas – for example, the face, neck, throat, chest, abdomen, or genitals.
  5. Fractures that require significant force or that rarely occur by accident – for example, a spiral fracture, the result of a twisting motion.
- Behavioral indicators of abuse that you may see include:
  1. Recurrent episodes of injury attributed to being “accident-prone”.
  2. Repeated visits to health care facilities.
  3. Complaints of pain without tissue injury.
  4. Thoughts about or attempts at suicide.

5. Confused, anxious, withdrawn, timid or depressed.
6. Substantial delay between onset of injury and presentation for treatment.
7. Suspected abuser insists on remaining close to the patient and answers all questions.
8. Fear of returning home.

### **Intimate Partner Violence**

The term **domestic violence** is used synonymously with other terms such as wife battering, spouse abuse, and battered wife syndrome. Its definition has expanded over the last few years to include all types of abuse that happens within the home such as child abuse, sibling abuse, elder abuse, and abuse between intimates. For this reason, the Centers for Disease Control and Prevention (CDC) has asked that we use the more specific term **“intimate partner violence” (IPV)** when discussing the issues of spouse abuse, etc. The CDC defines **intimate partner violence** as, “the intentional and/or physical abuse by a spouse, ex-spouse, boyfriend/girlfriend, or date”. It can also be described as “a pattern of assaultive and coercive behaviors used in the context of dating or intimate relationships”. Intimate partner violence can include actual or threatened physical injury, sexual assault, psychological abuse, economic abuse and /or progressive social isolation.

This packet often refers to the battering of women, since **90% - 95% of intimate partner violence** is directed against women according to the U.S. Department of Justice, Bureau of Justice Statistics. *However, it can also occur against men.*

### **Statistics**

- Approximately 1 to 2 million women are battered each year by their partners (1 in 4 lifetime prevalence).
- 1 in 5 pregnant women and 1 in 4 pregnant teens are abused.
- It is now the leading cause of injury to American women, accounting for more hospital emergency room visits than car accidents, muggings, and rapes combined.
- The prevalence of intimate partner violence among patients in ambulatory care settings has been estimated to be between 25% and 35%.
- **IPV remains extensively under-detected.**
- Although battered women seek medical care frequently, the practitioners to whom they turn for help accurately identify only 1 in 20.
- Inability to identify abuse is largely due to lack of knowledge and training, however, one's own experience with abuse or the feeling like intervention will not help may be a barrier.
- **Battered women expect healthcare providers to initiate discussions about abuse.**

### **Risk Factors**

Risk factors for victimization of the female include:

- pregnancy
- age range between 17 and 28 years of age
- unmarried (single, separated or divorced)
- poverty (now emerging as a risk factor)

### **Why Women Stay In Abusive Relationships**

There are many reasons women stay in abusive relationships that go beyond the scope of this in-service. Further, it is not our goal to have the woman leave her abuser when she presents to us, but to be non-judgmental and supportive in meeting her immediate physical and emotional needs. Offers of consults to social service and women's advocacy groups are appropriate, however, a woman needs a well thought out plan before she leaves her abuser. **In fact a woman is at greatest risk for serious injury or homicide when she leaves the relationship.**

### **Health Effects to the Victim of IPV:**

Physical health effects to the victim include:

- acute trauma.
- chronic pain (this is the #1 health complaint of abuse victims).
- pelvic pain.
- recurrent sexually transmitted diseases (STD'S), HIV.
- eating disorders.
- non-compliance with the treatment of chronic illnesses.

Behavioral health effects to the victim include:

- somatization (expressing a mental condition or stress into a physical ailment).
- drug/alcohol abuse.
- sleep disturbances.
- chronic fatigue.
- anxiety, panic disorder, and depression.
- response to stress is six times faster than those who have not experienced abuse.

Impact on maternal/child health include:

- pre-term labor.
- low infant birth weight.
- STDs including HIV.

### **Screening Victims of Intimate Partner Violence**

**The goals of screening include:**

- Identify abuse that impacts the physical and emotional well-being of your patient.
- Provide information and education regarding resource and referral services that will promote informed decision-making regarding safety and options.

### **Where and How Should Screening Be Done?**

Screening should be done:

- By the professional staff.

- In a private setting and never in front of another person (do not screen if this is not possible).
- Questions should be face to face as part of the healthcare encounter.
- Written questions should be reviewed and reinforced.
- Our attitude should be non-judgmental.
- Confidentiality must be assured.
- Document assessment, intervention and referrals in the medical record.

**Find screening questions that are comfortable for you.**

The following may be helpful:

- Are you emotionally and physically safe with the person (partner) you are with?
- Because violence is so common in many people’s lives, I have routinely started to ask all my patients about it.
- Are you currently in a relationship where you are threatened or made to feel afraid?
- Tell me what happens when you and your partner argue.

<i>Assessment</i>	<i>Actions</i>
Patient denies violence/abuse – no conflicting indicators	<ul style="list-style-type: none"> <li>• Document “negative screen”.</li> </ul>
Patient denies violence/abuse but has conflicting indicators	<ul style="list-style-type: none"> <li>• Re-direct the screening question to the patient, i.e. “Many times when I see patients with injuries like yours it means that someone has tried to hurt them. Is this happening to you?”</li> </ul>
Patient continues to deny abuse	<ul style="list-style-type: none"> <li>• Offer referral to resource according to needs.</li> <li>• Document actions.</li> </ul>
Patient says “Yes”	<ul style="list-style-type: none"> <li>• Validate patient’s message, i.e. “I am sorry this is happening to you, you are not to blame”.</li> <li>• Assess type and severity of abuse; document findings in medical record.</li> <li>• Assess safety needs &amp; discuss indicators for lethality &amp; concerns about safety.               <ul style="list-style-type: none"> <li>• increase in frequency/severity of abuse.</li> <li>• attempted strangulation; use of weapons to inflict abuse.</li> <li>• threats of homicide or suicide.</li> <li>• forced sexual contact.</li> <li>• violence towards the children.</li> <li>• physical abuse during pregnancy.</li> <li>• drug/alcohol abuse.</li> </ul> </li> <li>• Discuss patient options, referral resources &amp; planning for safety.</li> </ul>

	<ul style="list-style-type: none"> <li>● <u>Consult Social Service</u> for safety planning &amp; to coordinate shelter needs if appropriate.</li> <li>● Discuss greater risk for injury when woman decides to leave abuser.</li> </ul>
Patient decides to stay in relationship	<ul style="list-style-type: none"> <li>● Develop a safety plan with patient to include: <ul style="list-style-type: none"> <li>● memorizing emergency numbers.</li> <li>● access to a list of referral services.</li> <li>● practicing how to get out of the house quickly.</li> <li>● Keeping a bag packed with essentials (birth certificate, medications, etc.) for quick exit.</li> <li>● Identifying someone to stay with if they must leave quickly.</li> <li>● If fight is unavoidable, go to room with exit; stay away from rooms where weapons may be available (kitchens).</li> <li>● If children must be left behind, call police as soon as she reaches safety.</li> </ul> </li> </ul>
Patient decides to leave relationship	<ul style="list-style-type: none"> <li>● Discuss patient's need for careful planning and increased risk for injury when she leaves her partner.</li> <li>● Refer them to a shelter advocate to help plan for safety and legal advocacy services.</li> </ul>

1. Document all physical injuries:
  - Detailed description of injuries including type, size, number, location and possible causes.
  - Document an opinion as to whether the injuries are consistent with the patient's account of injury.
  - Take photographs for forensic documentation with patient consent.
2. The family or primary care physician should be contacted to obtain the patient's past medical history & definitive treatment.
3. Assess for behavioral health needs and make appropriate referrals.
4. Include intimate partner abuse as part of diagnosis/problem list.
5. Police Reporting:
  - Notify police department of locale where incident occurred or state police.
  - Reporting should never be done without the knowledge of the patient experiencing abuse; careful safety planning must be in place.
  - Consult Risk Manager for questions about police reporting in cases of IPV.
6. The nurse shall offer the services of an A.W.A.R.E. counselor or provide the National Domestic Hotline number. (A.W.A.R.E. counselors may stay with victim during physical exam and police investigation). Phone numbers are as follows:

#### **A.W.A.R.E. Counselors**

**Mercer County (724) 981-1457 (24 hour hotline)**  
**(888) 981-1457 (24 hour toll-free hotline – from any state)**  
**(724) 981-3753 (Business)**

**Crawford County (814) 724-4637 (24 hour number)**  
**Lawrence County (724) 652-9236**  
**Trumbull County (330) 393-1565**  
**Mahoning County (330) 747-4040**

**National Domestic Hotline**  
**(800) 799-SAFE (7233) or (800) 787-3224 (for hearing impaired)**

### **Sexual Abuse/Assault**

- Treat any and all emergency problems, life threatening situations, & emotional problems.
- Take the patient to a private room.
- Notify police if patient has not done so.
- Offer to call AW/ARE counselor prior to physician exam (Counselor or other family member may stay with victim during exam if she chooses).
- Obtain and record complete medical history on Emergency Record and “Sexual Assault Victim Evidence Kit” to include:
  - Time & place of incident.
  - Nature of suspected physical assault/sexual assault.
  - Interval between assault and examination.
  - Patient’s physical & mental state.
  - Determine if patient has taken shower or douched since assault.
  - Record menstrual history including date of LMP.
- Document information on the “Victim’s Medical History and Assault Information” form; provide appropriate copies to the medical record, evidence kit, and law enforcement agency doing investigation after exam is complete.
- Explain exam to patient & obtain written consent on evidence kit consent form.
- Emergency or Attending physician is responsible for collecting various specimens following directions in the evidence kit.
- Give specimens to police officer investigating the case.
- Place copy of consent & the assessment form from the evidence kit on the patient’s record.
- Follow the physician orders for HIV, STD and pregnancy testing and medication prophylaxis.

### **What to do if you become a Victim of Domestic Violence**

- If you believe you are in danger, leave your home and if there are children, take them with you.
- If you are unable to leave, ask someone you trust to stay with you.
- Develop an “exit plan” in advance for you and your children. Pack an overnight bag in case you have to leave in a hurry. Include toilet articles, medications, and extra set of keys, clothing, and a special toy for each child.
- When you decide to leave take the following items: drivers license or some acceptable type of identification card, money, checkbooks, credit cards, address book, Green card(s) for

immigration verification, yours and children's birth certificates, title to your car, lease, rental agreement, house deed, bankbooks, insurance papers, pictures, medical records for the whole family, social security cards, welfare identifications, school records, work permits, passport, divorce papers, jewelry and other valued items.

- Once you move be careful to whom you give your new address and phone number. Be aware that addresses are a part of restraining orders and police records. If you go to court, you should consider using only your post office box or perhaps using your lawyer's address as your own.

### **What is Child Abuse & Neglect?**

The Child Abuse Prevention and Treatment Act defines child abuse and neglect as the physical or mental injury, sexual abuse or exploitation, negligent treatment, or maltreatment of a child, by a person who is responsible for the child's welfare under circumstances which indicate that the child's health or welfare is harmed or threatened thereby. As a result of the Child Abuse Amendments of 1984, the Act also includes as child abuse the withholding of medically indicated treatment for an infant's life-threatening conditions.

#### **Statistics:**

- ***In 1995, an estimated 3 million children were reported for abuse and/or neglect to public social service/child protective services agencies, according to the National Child Abuse and Neglect Data System Project.***
- A large number of children who are abused and neglected are never reported to the authorities that can help them and their families.
- A child of any age, race, sex, religion, and socioeconomic background can fall victim to child abuse and neglect.
- Child abuse is a community concern. No one agency or professional alone can prevent and treat the problem; rather all concerned citizens must work together to effectively identify, prevent, and treat this horrific problem.

### **Types of Maltreatment Suffered by Children**

Based on 1 million confirmed child abuse cases in 1995, children suffered according to the following breakdown:

- 52% involved Neglect.
- 25% involved Physical Abuse.
- 13% involved Sexual Abuse.
- 5% involved Emotional Abuse.
- 3% involved Medical Neglect.
- The remainder involved other types of maltreatment such as abandonment, threats to harm the child, and congenital drug addiction.

Included under physical abuse is **Munchausen Syndrome by Proxy**. It is an abusive situation where the parent or guardian falsifies the history and may injure the child with drugs, add

blood or bacterial contaminants to urine specimens, etc. to simulate illness. The child often goes through painful medical procedures before the situation is recognized.

### **Who Are the Abusers?**

- Based on data from 43 states, about 80% of abusers were parents.
- An additional 10% were other relatives.
- 2% were foster parents, childcare providers, and staff at other care taking facilities.
- 5% were non-caretakers, including strangers, other household members not responsible for the care or supervision of the child, friends, neighbors and others.

### **Emotional Abuse Suffered by Children**

Emotional Abuse is defined as a pattern of behavior that can seriously interfere with a child's positive emotional development. Those patterns of behavior can include:

- Constant rejection of the child.
- Terrorizing the child.
- Refusal to provide basic nurturance.
- Refusal to get help for a child's psychological problems.
- Failure to provide physical or mental stimulation that a child needs to be able to grow.
- Exposing a child to corruption including drug abuse, criminal behavior, etc.

Emotional abuse can be very hard to diagnose or even to define. In some instances, an emotionally abused child will show no signs of abuse. For this reason, emotional abuse is the most difficult form of child maltreatment to identify and stop. This is because child protective services must have demonstrable evidence that harm to the child has been done before they can intervene.

Although visible signs can be hard to identify, this type of abuse leaves hidden scars that manifest themselves in numerous behavioral ways such as:

- Insecurity & poor self-esteem.
- Destructive behavior & angry acts (i.e. fire setting, cruelty to animals).
- Withdrawal & poor development of basic skills.
- Alcohol or drug abuse.
- Suicide.
- Difficulty forming relationships.
- Unstable job histories.

All children need acceptance, love, encouragement, discipline, consistency and positive attention. Emotionally abused children often grow up thinking that they are deficient in some way and the ultimate tragedy of this kind of abuse is that when these children become parents, they may continue the cycle with their own children.

### **Laws Regarding the Reporting of Child Abuse**

- **UPMC Horizon staff and physicians shall report all cases of child abuse or suspected child abuse in accordance with Pennsylvania and Ohio laws.** The law states that any person

who, in the course of his/her employment, occupation, or professional practice, comes in contact with an abused child or when abuse is suspected, must report or initiate a report of the abuse or suspected abuse.

- Any person, institution, or agency making such a report in good faith shall have immunity from civil or criminal liability.

### **Guidelines for Reporting Child Abuse**

- Contact hospital social workers (designated agents for UPMC Horizon in managing suspected child abuse).
- Make a telephone referral to the appropriate Child Line Hotline BEFORE the child is released from the hospital.
- Contact appropriate county Child & Youth Services (CYS) & report incident of suspected abuse or neglect.

**Pennsylvania: 1-800-932-0313**

**Ohio (Columbus): 1-614-466-9824**

- Complete "Report of Suspected Child Abuse CY-47" form & mail original to appropriate CYS agency within 24hours. Place copy on medical record.
- Also, send copy of nurse & physician assessment, photographs and reports of medical testing to CYS with CY-47 form. *(A signed release from a patient/parent is **NOT** required before sending information to CYS.)*

Be observant of interactions of parents, family members and other close contacts with children under our care. Reportable events that constitute child abuse are repeated hitting or hitting with a closed fist, or a single blow that knocks the child down or causes physical trauma. (Verbal abuse or shoving does not constitute significant reasons to report.)

### **Other Issues for Newborns/Children at Risk for Abuse/Neglect**

#### **Newborns**

- Report newborns with a positive drug screen to CYS.
- Nursing and CYS will assess the parents' ability to parent. Provide referrals as needed.

#### **Infants/Children Returning for Care (Hospital or Physician Office)**

- When significant risk for child abuse or neglect is identified, make a referral to CYS.
- If necessary, CYS may obtain a restraining order from Juvenile Court (prevents the parent(s) from removing the infant/child until a shelter hearing is held).
  - Place restraining order on patient's chart.
  - Social worker will confirm that CYS counselor explained restraint order to birthmother/parent.
  - CYS will arrange for foster care placement or designate to whom the infant/child is to be discharged.

## **Restraining Orders**

- Physicians, with help from the social worker/nurse, may ask for a restraining order from Juvenile Court when parents resist placement of their child outside the home or threatening to remove the child against medical advice.
- Contact CYS to help obtain order.
- Note date, time, and name of judge who issued the order on the patient's chart.
- Place a copy of the restraining order on the patient's medical record.
- If a verbal restraining order cannot be obtained because a judge is not available or a situation reaches crisis proportions, it may be necessary to invoke the 24-hour protective custody provision of the Child Protective Service Law.
  - Physician, in consultation with social worker, should inform parents that, under the guidelines of Pennsylvania State Child Protective Service Law, the hospital is assuming protective custody of the child.
  - Social work will immediately:
    - Report the circumstances to Child Line (1-800-932-0313).
    - Notify Safety and Security that protective custody has been assumed.
    - Document action/reason for action on medical record.
    - Contact CYS to inform them that emergency custody has been taken.
- CYS may conduct site visit & arrange for court order to permit custody to last beyond 24 hours. (In no case should protective custody remain past 72 hours.)

## **Child and Youth Services Telephone Numbers and Addresses**

### **PENNSYLVANIA**

#### **Mercer County Child and Youth Services**

8425 Sharon-Mercer Road

Mercer, PA 16137

**Telephone: (724) 662-2703, Monday – Friday, 8:30 AM –4:30 PM**

**Emergency Hotline: (724) 662-3112 (after hours, weekends, & holidays)**

#### **Lawrence County Child and Youth Services**

1001 East Washington Street

New Castle, PA 16101

**Telephone: (724) 658-2558, 24 hours per day**

#### **Crawford County Child Welfare**

632 Arch Street, Suite B 101

Meadville, PA 16335

**Telephone: (814) 724-8380, Monday – Friday, 8:30 AM – 4:30 PM**

**(814) 724-2548 (after hours, weekends, & holidays)**

**OHIO**

**Ashtabula County Children Services Board**

P.O. Box 458

Ashtabula, Ohio 44004

**Telephone (440) 998-1811      Hotline: 1-888-998-1811, 24 hours per day**

**(Written report required; will accept the form that is used to report abuse or suspected abuse in Pennsylvania).**

**Trumbull County Children Services Board**

2282 Reeves Road N.E.

Warren, Ohio 44481

Telephone: (330) 372-2010, 24-hr number—hold through the recording & leave message after hours.

**(Requires telephone referral for initial report; may request written report & copy of Emergency Department Record at a later date).**

**All Other County Agencies:**

**PENNSYLVANIA**

**Child-Line: 1 (800) 932-0313**

**OHIO**

**Child-Line: 1 (614) 466-9824**

**Violence and the Older Adult (Elder Abuse)**

Elder abuse is defined as the occurrence of one or more of the following acts to a person 60 years of age or older:

- Abandonment – desertion of the elder by a caretaker.
- Abuse – infliction of physical injury, unreasonable confinement, intimidation with resulting injury, willful deprivation by caretaker of good or services necessary to maintain physical or mental health, sexual harassment, rape, or abuse as defined in the Protection from Abuse Act.
- Exploitation – conduct by a caretaker or other person against an elder or the elder’s resources without the informed consent of the elder or consent obtained through misrepresentation, coercion or threats of force that results in monetary, personal or other benefit to the perpetrator or personal loss to the elder.
- Neglect - failure to provide for oneself or failure of caretaker to provide goods or services essential or physical or mental health.

**Statistics**

- The National Aging Resource Center on Elder Abuse estimates the incidence of abuse in domestic settings (not institutions) at approximately 2 million cases per year.

- Researchers estimate that only 1 out of 14 incidents of elder abuse actually comes to the attention of law enforcement or human service agencies.
- Elderly people may be victims of neglect or physical violence, verbal, sexual, or psychological abuse or financial exploitation.
- Elder abuse seems to be related to the inability of one party to meet the care demands required by the elderly, by him- or herself, or by the situation.
- More than two thirds of older abuse perpetrators are family members of the victim, typically serving in a care giving role.
- At greatest risk is the frail and/or isolated.

### **Reporting Guidelines**

#### **Non- Hospital Affiliated Persons**

- Voluntary
  - Any person who believes that an older adult is being abused, neglected exploited or abandoned may file report 24 hours a day with any Area Agency on Aging or call statewide elder abuse hotline at 1 (800) 490-8505.
  - Reporters may remain anonymous.
  - Anyone reporting such activity has legal protection from retaliation, discrimination and civil or criminal prosecution.
- Mandatory
  - Employees & administrators of nursing homes, personal care homes, domiciliary care homes, adult day care centers and home health agencies are required to report elder abuse to local Areas on Aging.
  - If abuse involves serious injury, sexual abuse or suspicious death, reporters must also call the state police. A written report must also be made to the local law enforcement agencies within 48 hours.
  - Local Area Agency on Aging must report deaths, serious physical injury to PA Department of Aging, and in deaths that are suspicious to the Coroner orally and in writing within 24 hours of oral report.

#### ***Consequences for Not Complying with Reporting Guidelines***

- Administrator or facility owner who intentionally or willfully fails to comply, or obstructs compliance with reporting guidelines may be subject to administrative or criminal sanctions.
- An employee or administrator who fails to report under this act may be found guilty of a summary offense or a misdemeanor.

#### **Hospital Employee/Volunteer**

- Skilled Nursing Facility is required to notify Department of Health within 24 hours of any report of alleged abuse.

- Required to report and investigate suspected resident abuse, neglect and misappropriation of property by any individual used by facility to provide services to residents.
- After completing an investigation of allegation, the Skilled Nursing Facility is required to complete Report Form PB-22 and file it with Department of Health Division of Nursing Care Facilities.
- For any employee alleged to have committed abuse, the facility will immediately implement a plan of supervision or, where appropriate suspend the employee.

### **Rights of Victims under the Provision of Protective Services**

Victims of abuse or suspected abuse have certain rights that must be guaranteed. They are:

- the right to be told that someone has reported that they might be a victim of abuse and need protective services;
- the right to refuse protective services;
- the right to legal counsel when the Area Agency on Aging attempts to obtain an emergency, involuntary intervention court order;
- the right to confidentiality in all matters concerning their case.

*Alleged abusers have the right to be notified after substantiation of a report and given an opportunity to challenge the findings of an investigation.*

### **Procedures for Screening and Intervention**

- Nurse and physician should assess the patient's general appearance, mental status, ability to communicate, hygiene, and/or unexplained physical injuries.
- If physical evidence of abuse is present, obtain consent for photographing & placement of the picture in the medical record.
- Social Work may be consulted to provide further assessment of the situation and provide appropriate follow-up care and referrals.
- An older adult who is "incapacitated or unable to perform or obtain services to maintain physical or mental health" and who is without a responsible caretaker, may be admitted to the hospital for medical treatment and evaluation by Social Services and/or the Area Agency on Aging.
- If the patient meets the criteria for suspicion of abuse, the staff must notify the Area Agency on Aging by telephone. The Elder Advocate or Acting Ombudsman will determine need for agency intervention.
- Medical record documentation of abuse notification to the Area Agency on Aging should include time of report, name of person accepting report and his/her recommendations.
- Access to the patient's medical record by an outside agency will follow hospital policy.

**Telephone numbers for reporting cases for older adult abuse:**

**PENNSYLVANIA:**

Mercer County: (724) 662-6222  
(724) 662-2949 (after hours, weekends or holidays)  
Lawrence County: (724) 658-3729  
Crawford County: (800) 321-7705

**OHIO:**

Ashtabula Count: (440) 994-2020  
Trumbull Counties: (330) 746-2938

***UPMC Horizon has a policy on Domestic Violence and Abuse that can be found in the Administrative Policy Manual. © 2017 UPMC All Rights Reserved***

Pennsylvania law, the UPMC facility is assuming Twenty-Four (24) hour protective custody of the child. If the UPMC facility asserts emergency custody over the child, the clinical social work staff should immediately inform the Administrator on Duty and the appropriate child welfare agency of the county where the child resides. The appropriate child welfare agency will evaluate if protective custody should be continued, arrange and plan for a court shelter hearing or obtain a court order permitting the child to remain in protective custody beyond Twenty-Four (24) hours.

# **NEWBORN PROTECTION/SAFE HAVEN**

## **POLICY HS-HD-AP-01**

### **Attachment B**

#### **I. PURPOSE**

The intent of this policy is to provide hospital personnel with guidelines consistent with Pennsylvania law regarding the provision of services to parents who express, either orally or through conduct, the intent to have the hospital accept their newborn. A newborn is defined as a child less than 28 days of age reasonably determined by a physician. UPMC hospitals accept all newborns that are voluntarily relinquished by a parent. The parent relinquishing the newborn will not be reported to law enforcement officials unless the medical assessment of the newborn reveals evidence of abuse or criminal misconduct. A parent of a newborn shall not be criminally liable under any provision of Title 18 (relating to crimes and offenses) if the criteria set forth in 18 Pa.C.S. § 4306 (relating to newborn protection/safe haven) are met.

#### **II. PROCEDURE**

A. Efforts should be made by the medical staff not to confront the parent or prolong the parent's stay in the Emergency Department.

B. There are no questions asked concerning the name of the mother, father or newborn.

C. Answer the parent's questions and assure her/him that the newborn will receive appropriate care.

D. Develop an Emergency Department record and have the Emergency Physician assess the newborn. The newborn should be triaged as a high priority patient. Register the newborn as John/Jane Doe.

E. An attempt should be made to obtain the following information:

1. Newborn's date of birth

2. If the newborn was born premature

3. Labor and delivery problems

4. Mother's history of drug, alcohol, medications, or smoking history during the pregnancy

5. Mother's or father's history of medical conditions that may be inherited to the child

F. Notify the nursing supervisor, the clinical social worker, and the appropriate administrator that a newborn has been brought to the hospital for acceptance. Do not notify anyone from the media.

G. Notify the local Office of Children, Youth, and Families (immediately by phone and within 48 hours in writing) and local police department or Pennsylvania State Police if no municipal jurisdiction exists that a newborn has been accepted by the hospital.

H. If your hospital is not equipped to admit a newborn the newborn should still be accepted. However, the transfer of the newborn to Children's Hospital, Magee-Women's Hospital, or other higher level of care hospital is appropriate after an oral report is given to the receiving Emergency Physician. An accompanying written report must accompany the transfer of the newborn.

I. If the newborn is abused or neglected notify the police. Do not attempt to physically detain the parent while waiting for the police to arrive.

J. Offer medical and/or behavioral health care to the parent relinquishing the newborn.

K. Once a parent abandons the newborn, hospital employees cannot return the newborn to the parent. The parent should be referred to the local Office of Children, Youth, and Families, which will determine the appropriate disposition and placement of the newborn. Also, please notify the Corporate Risk Management Department.

# Regulatory Compliance

## The Joint Commission Standard

All employees play a role in helping to promote a safe patient care environment. If you have any concerns about patient care quality or patient safety, please discuss them with your supervisor, director, or the patient safety officer. If you have done so and believe the hospital has not addressed your concerns related to preventing or correcting problems that can have or have had a serious adverse impact on patients, you may contact The Joint Commission's Office of Quality Monitoring at 1-800-994-6610 or [complaint@jointcommission.org](mailto:complaint@jointcommission.org). UPMC prohibits disciplinary retaliation for reporting instances of wrongdoing, which were made in good faith. This includes both formal disciplinary actions as well as informal punitive actions.

UPMC Horizon is surveyed for accreditation purposes by the Joint Commission every three years.

## PA Department of Health (DOH)

The Department of Health regulations are developed in accordance with requirements imposed by the Centers for Medicare and Medicaid Services (CMS). The DOH regulations include information regarding a healthcare facility's compliance with regulatory requirements for licensure and for certification. Licensure permits the facility to operate in Pennsylvania. Certification permits the facility to claim and receive payment for services rendered from the Medicare and Medicaid programs. The Department of Health, as state licensing agency and State Survey Agency for CMS, conducts both routine and special inspections of health care facilities to determine ongoing compliance with regulatory requirements which is a condition of licensure and certification.

If, during an inspection, the Department determines a facility does not meet regulatory requirements for licensure and certification, the Department notifies the facility in a Statement of Deficiencies. Health care facilities are required to submit a Plan of Correction in response to the Statement of Deficiencies. The Plan of Correction is mandatory, regardless whether the facility agrees with Department findings or not, and is the means by which the Department monitors and ensures correction of deficiencies. As long as the facility submits a Plan of Correction, the facility may continue to operate and receive Medicare and Medicaid payment, while deficiencies are being corrected. A Plan of Correction, for purposes of licensure and certification, is not an admission of wrongdoing on the part of the facility.

UPMC Horizon has on-going unannounced DOH inspections and visits.

If you have any concerns about patient care quality or patient safety, please discuss them with your supervisor, director, or the patient safety officer. If you have done so and believe the hospital has not addressed your concerns related to preventing or correcting problems that can have or have had a serious adverse impact on patients, you may file a facility complaint by contact Pennsylvania Department of Health Quality Assurance Complaint Hotline at 1-800-254-5164 . UPMC prohibits disciplinary retaliation for reporting instances of wrongdoing, which were made in good faith. This includes both formal disciplinary actions as well as informal punitive actions.

### **HFAP**

The Acute Care Hospital program serves all acute care facilities; that is, general acute care, specialty hospitals and long term acute care hospitals (LTACH).

The standards are set up in such a way that they are easy to read and understand. The Centers for Medicare and Medicaid Services (CMS) Conditions of Participation (CoP) are embedded within the HFAP standards, along with additional standards covering patient safety and quality of care. A hospital accredited by HFAP is deemed to meet all Medicare requirements for hospitals (except the requirements for Utilization Review which the State agencies have jurisdiction over, and the special conditions for psychiatric hospitals.)

UPMC Horizon is accredited by HFAP (formerly AOA) due to our Osteopathic Residency Program.

### **Reporting a Complaint Against a Healthcare Organization**

If you have any concerns about patient care quality or patient safety, please discuss them with your supervisor, director, or the patient safety officer. If you have done so and believe the hospital has not addressed your concerns related to preventing or correcting problems that can have or have had a serious adverse impact on patients, and want to take further action, you need to contact the Quality/Patient Safety Services Department at HFAP by viewing online at <http://www.hfap.org/resources/complaintinformation.aspx>. UPMC prohibits disciplinary retaliation for reporting instances of wrongdoing, which were made in good faith. This includes both formal disciplinary actions as well as informal punitive actions.

## CORPORATE COMPLIANCE

### **INTRODUCTION:**

It is our goal that every **employee, physician, contract employee and agent** attains the highest standards for ethical conduct. IT IS SIMPLY THE RIGHT THING TO DO.

UPMC Horizon has developed the Corporate Compliance Program to:

- inform employees of their legal and ethical responsibilities,
- provide a mechanism for employees to ask about ethical work issues & confidentiality,
- & report suspected misconduct.

### **BEHAVIORAL OBJECTIVES:**

After completing this packet, you will know the following:

- ✓ The basics of UPMC Horizon's Corporate Compliance Plan.
- ✓ Your responsibility related to Corporate Compliance.
- ✓ The mechanism for reporting instances of suspected fraud or misconduct.

### **Definitions:**

**Corporate Compliance:** Refers to following the federal, state and local laws, regulations, and your organization's policies/procedures that combat fraud, abuse and waste in healthcare.

**Ethics:** Simply a set of values. In healthcare it is a way to provide care that is honest, legal, and respects the rights of others. It reflects our organization's mission.

**Fraud:** Healthcare fraud is willingly and knowingly making false statements to obtain payment or benefit that would not have been correctly paid for. Fraud requires demonstration of intent.

### **Why UPMC Health System Has Established a Compliance Office:**

The Office of the Inspector General (OIG) of the Department of Health and Human Services encourages health care organizations to establish voluntary compliance programs to combat fraud, abuse, and waste in the health care industry.

The Health System understands the need for a compliance program to remain attuned to the complex and continuously changing regulatory requirements that govern the Health System's interaction with the Medicare and Medicaid programs. As a result the Health System has established, funded, and staffed a Compliance Office function since late 1997.

### **Goals of the Compliance Program**

The UPMC Health System's Corporate Compliance Program is designed to promote outcomes consistent with the following set of goals:

- Assist UPMC facilities and programs to communicate the Standards of Conduct (see below) to the employees.
- Educate employees to recognize their ethical and legal responsibilities.
- Provide a confidential means for employees to ask about work-related ethical issues and report instances of suspected misconduct.

### **Mission and Code of Ethics**

UPMC Health System's Code of Ethics is a guide for staff and physicians that assures that the Health System fulfills its mission: "to provide premier programs in patient care, biomedical and health service research, and teaching that will contribute to the prevention, diagnosis, and treatment of human disease and disability."

A component of the Health System's voluntary compliance program, the Code of Ethics consists of a statement of values and standards of conduct that are intended to assist staff and physicians as they carry out their responsibilities.

### **Values**

The UPMC Health System Code of Ethics includes the following seven values:

- We value patient satisfaction among our highest priorities and strive to ensure a compassionate, patient-centered environment.
- We nurture highly skilled and ethical physicians and other health care professionals and encourage multidisciplinary collaboration.
- We strive to provide an environment that supports and encourages the active participation of both full-time and voluntary faculty.
- We seek to be responsive to the needs of individuals of all backgrounds and serve as a vital resource to the local community.
- We believe that each member of the faculty and staff is responsible for the continuous improvement of quality in all aspects of the services we provide.
- We strive to set the standard of excellence in cost-effective, quality health care.
- We commit to establishing mutually supportive liaisons with other local and regional health care facilities in the areas of research, patient care, and teaching.

### **Standards of Conduct**

Seven standards of conduct are included in the UPMC Health System Code of Ethics. They are as follows:

- Quality health service that anticipates and responds to the needs of the people and communities served is a primary responsibility.
- UPMC Health System will fulfill its mission through compliance with the laws and regulations and by dealing with others in an honest, ethical, and fair manner.
- Information will be processed and communicated in an honest, accurate and appropriate manner. Misrepresenting facts or falsifying records will not be tolerated.
- Business relationships will be based on mutual respect and integrity while avoiding conflicts of interest or even the appearance of conflicts between personal interests and those of UPMC Health System.
- Consultants, representatives, and agents will not act on behalf of UPMC Health System in any manner that is inconsistent with applicable laws, regulations, or UPMC Health System's standards of conflict.

- Employees and agents of UPMC Health System are responsible for using resources in an economical manner while protecting against loss, theft, misuse, or damage. Resources include people, physical property, and proprietary information.
- At UPMC Health System, the most important asset is the contributions of individuals. Every individual, in every department, in every job, represents a valuable contribution toward compassionate, high quality, and cost-effective health care. In turn, UPMC Health System is committed to honesty, just management, and fairness; providing a safe and healthy environment and respecting the dignity due everyone.

### **Compliance Questions, Compliance Problem Resolution and Compliance Help Line**

Employees who have compliance questions or wish to report suspected misconduct are encouraged to use the standard chain of problem resolution. In other words, start with your supervisor. If an employee is uncomfortable reporting a problem to their supervisor, then they are encouraged to call the Compliance Office directly at **412-623-6923**. If the employee is uncomfortable speaking with either their supervisor or a member of the Compliance Office, then they can make an anonymous call to the UPMC Health System Compliance Help Line toll-free at **1-877-983-8442**.

The Help Line is staffed and managed by an outside company. The outside company will provide the employee caller a call identification number and give a date for the employee to call back to get an answer to their question or problem. The outside company sends all information provided by the employee caller to the Compliance Office for investigation and resolution. The Compliance Office sends a report to the Help Line Company to be read to the employee caller when they call back.

### **Benefits of a Compliance Program**

An effective compliance program can bring about the following benefits to the UPMC Health System:

- Promote honest and responsible conduct by all employees.
- Promote and provide methods to ask questions and report potential problems.
- Promote and provide efficient corrective action to identified problems.
- Minimize the organizations exposure to penalties by systematic risk assessment and risk mitigation.

## EMTALA

### UPMC POLICY AND PROCEDURE

POLICY: HS-LE0007 \*

INDEX TITLE: Legal

SUBJECT: Emergency Medical Treatment and Active Labor Act (EMTALA)

DATE: October 29, 2018

#### I. POLICY

UPMC seeks to comply with all applicable laws and regulations relating to the provision of emergency services, including the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C.1395dd.

#### II. PURPOSE

This policy sets forth the system hospitals' requirements under EMTALA, including guidelines for providing the appropriate setting (department) for conducting medical screening.

#### III. SCOPE

This policy applies to all United States based UPMC hospitals. Each hospital may develop its own procedures for implementing this policy, provided that such procedures are consistent with the policy.

#### IV. DEFINITIONS

1. UPMC Dedicated Emergency Department means any department or facility of the hospital, whether located on or off the main hospital campus that: (a) is licensed by the State as an emergency department; or (b) is held out to the public as a place that provides care for emergency medical conditions without an appointment. While urgent care centers can be included under EMTALA under specific conditions, UPMC Urgent Care centers are non-hospital affiliated and do not fit the other EMTALA conditions; these are governed by UPMC Physician Services policy CO-015 Emergency Medical Conditions in the Clinical Office.

2. Emergency Medical Condition is "a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part; or with respect to a

pregnant woman who is having contractions that there is inadequate time to effect a safe transfer to another hospital before delivery, or that the transfer may pose a threat to the health or safety of the woman or the unborn child”.

3. Medical Screening Exam (MSE) is an exam within the capability of the hospital to determine whether an emergency medical condition exists.

4. Stabilization of an "emergency medical condition" should allow that no material deterioration of the condition is likely, within reasonable medical probability, from or during transfer of the individual from a facility. In pregnancy at-term, stabilization includes delivery of the child and the placenta (unless the latter cannot occur safely without transfer).

5. Qualified Medical Person (“QMP”) is a licensed physician or other qualified individual as determined by each hospital’s medical staff bylaws or rules and regulations.

6. Prudent Layperson Observer Standard – when an individual comes to a hospital’s dedicated emergency department absent a request for examination or treatment, if a Prudent Layperson Observer (as opposed to a health professional) would believe based upon individual’s appearance or behavior an examination or treatment for a medical condition exists, said care will occur. It only applies in circumstances where an individual is unable to request examination or treatment.

## V. PROCEDURE

1. If an individual seeking emergency medical care comes to the hospital’s Dedicated Emergency Department a QMP shall offer a Medical Screening Exam. If an individual seeking emergency medical care comes to any other portion of the hospital campus, including on-campus clinics, sidewalks, driveways, and parking lots, and requests emergency medical care, a QMP will offer a Medical Screening Exam to that person. Hospital property is the hospital’s campus, defined as an area that is 250 yards around the main hospital building, but it does not include other areas or structures of the main hospital building that are not a part of the hospital, such as physician offices, rural health centers, skilled nursing facilities, or other entities that participate separately in Medicare or restaurants, shops or other nonmedical facilities. In the absence of a request for emergency medical care made by the patient or their representative, a QMP medical screening exam will be offered if the Prudent Layperson Observer standard is met.

2. Under no circumstances shall the QMP or other staff inquire as to insurance status or method of payment of a patient seeking emergency treatment so as to delay the initiation of a Medical Screening Examination or further stabilizing treatment of that patient.

3. If necessary, following the Medical Screening Exam, QMPs shall offer further medical examination and treatment required to stabilize the medical condition within the hospital’s resources.

4. If the patient leaves before undergoing a medical screening exam, the QMP or staff shall note this in the Emergency Department record or log. If the patient or their representative refuses treatment, the QMP or other staff shall note the type of treatment refused in the Emergency Department record or log and take reasonable steps to secure a written informed refusal by the patient or their representative.

5. Following the Medical Screening Exam, a patient who has been determined to have an Emergency Medical Condition that has not been stabilized may be transferred if requested. The hospital must assure that the individual or legally responsible person is first informed of the hospital's obligation under EMTALA, such as, the hospital's obligation to provide stabilizing treatment within its capability and capacity, regardless of the individual's ability to pay. The individual's request for a transfer must be in writing and include either the signature of the patient requesting the transfer and/or the legally responsible person. If the patient or legally responsible person requests to be transferred, the QMP or other staff will seek to obtain a signed Release Against Medical Advice AMA form.

If the hospital determines that it does not have appropriate medical and/or staffing resources to properly stabilize the patient, transfer to an appropriate facility may be made if a physician certifies that the medical benefits of the transfer are expected to outweigh the risks of transfer; or if a QMP certifies that the benefits of transfer are expected to outweigh the risks of transfer, that must be certified by a physician.

When a patient is transferred, the QMP or other staff will obtain the consent of the receiving hospital to accept the patient and document this in the medical record. In the case of transfer from a UPMC facility, the UPMC facility shall send to the receiving facility, copies of all pertinent medical records available at the time of transfer, and effect the transfer through qualified personnel and transportation equipment.

6. The QMP must certify on a certification form OR in the medical record. The certificate or documentation will state the reason for transfer, patient condition, benefit/risks of transfer, receiving hospital, mode of transportation, and patient consent. If a physician is not physically present in the emergency department at the time an individual is transferred, a QMP must sign the certification after consulting with a physician who agrees with the transfer. The physician must thereafter countersign the certification as soon as practicable.

7. If a patient or their representative refuses to be transferred, the physician or QMP shall note in the medical record the proposed transfer and the risks and benefit of the refusal. The physician or QMP shall take reasonable steps to secure a written acknowledgement of refusal by the patient or their representative. Patients will be asked to sign a Release Against Medical Advice AMA form which addresses the patients refusal to be transferred.

8. If a UPMC facility has specialized capabilities or facilities (including but not limited to, facilities such as burn units, shock-trauma units, neonatal intensive care units), it will accept an appropriate transfer of an individual who requires such specialized capabilities or facilities from

the Dedicated Emergency Department of a referring hospital within the boundaries of the United States. This does not apply to patients who have been admitted to a referring facility.

9. UPMC physicians, professional or other staff shall report to the Hospital Regulatory/Accreditation and/or Risk Manager, who shall consult with the Chair of the system Department of Emergency Medicine, the system Chief Quality Officer (CQO), the Vice President Risk Management/Senior Associate Counsel (VPRM), and the Director Systemwide Regulatory and Accreditation (DSRA), all suspected EMTALA violations arising from the transfer of a patient by another facility to a UPMC facility. The Hospital Regulatory/Accreditation and/or Risk Manager shall investigate and report to the Chair, CQO, VPRM and the DSRA who shall decide whether any report to the Centers for Medicare and Medicaid Services (CMS) or the Pennsylvania Department of Health or other appropriate government agencies shall be made.

10. The facility shall post clear and visible signage that identifies the rights of the individual under EMTALA with respect to examination and treatment for Emergency Conditions and indicates the hospital's participation in the Medicare and Medicaid programs.

11. The facility shall maintain medical and other records related to individuals transferred to or from the hospital for a period of at least ten (10) years from the date of transfer.

12. Each UPMC hospital Emergency Department shall maintain a list of physicians who are on call 24/7 to provide further evaluation and/or treatment necessary to stabilize an individual with an Emergency Medical Condition. Physicians on-call are required to personally attend to the patient when requested to do so by the treating physician or QMP. The on-call physician records are maintained similar to the medical record.

13. Each hospital facility shall maintain a log in the Emergency Department identifying each individual who seeks emergency medical treatment at that facility, and indicate whether they refused treatment, or whether they were transferred, admitted, or discharged. These logs shall be retained for five (5) years.

14. Each UPMC hospital shall maintain policies and procedures to (a) respond to situations in which a particular specialty physician is not available or if the on-call physician is not able to respond due to circumstances beyond his or her control; and (b) provide that emergency services are available if the hospital elects to permit its on-call physicians to schedule elective surgery during the time that they are on call or permit physicians to participate in simultaneous on-call service.

SIGNED: Donald Yealy, MD

Senior Medical Director, Health Services Division, UPMC

ORIGINAL: August 3, 2004

APPROVALS:

Policy Review Subcommittee: October 11, 2018

Executive Staff: October 29, 2018

PRECEDENT: January 2, 2018

SPONSOR: System ED Advisory Committee

System Regulatory Experts

\* With respect to UPMC business units described in the Scope section, this policy is intended to replace individual business unit policies covering the same subject matter. In-Scope business unit policies covering the same subject matter should be pulled from all manuals.

**uLearn Modules**

1. Privacy Awareness for Staff
2. Harassment-Free Workplace
3. Stroke Awareness
4. Emergency Preparedness
5. Patient Safety
6. Information Security Awareness
7. Infection Prevention
8. Environment of Care
9. Creating an Inclusive Workplace
10. Compliance & Ethics Review
11. FLSA for Non-exempt Employees
12. Bloodborne Pathogens
13. HRZ Specific - Urgent Conditions Response

## UPMC HORIZON GENERAL ORIENTATION POST –TEST

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Department: \_\_\_\_\_

### True or False

1. \_\_\_ The Vision of UPMC Horizon placing employees, patients, health plan members and community at the center of everything we do.
2. \_\_\_ The letter “I” in AIDET stands for Impress.
3. \_\_\_ Quality and Safety is not one of the five UPMC Values.
4. \_\_\_ Sexist jokes and/or remarks are not considered sexual harassment.
5. \_\_\_ UPMC’s Code of Conduct contains the expectation that consultants, representatives and agents who act on behalf of UPMC, act in a manner consistent with all policies.
6. \_\_\_ The UPMC Values make up 50% of the total performance review score.
7. \_\_\_ Failure on the part of the UPMC staff member to renew the required license, certification or registration before expiration will result in immediate suspension without pay upon the date of expiration.
8. \_\_\_ It is permissible to smoke on UPMC Horizon’s campus at designated entrances and exit areas or off campus during shift in on break or meal time.
9. \_\_\_ All staff, including volunteers and students, must wear a nametag while on duty.
10. \_\_\_ The acronym, RACE, stands for Rescue, Alarm, Contain, Extinguish/Evacuate.
11. \_\_\_ Medical equipment that has malfunctioned should be taken out of service and tagged as such immediately.
12. \_\_\_ The acronym PASS stands for Pull Aim Scream Sweep.
13. \_\_\_ In the case of an electrical failure, Emergency Power is available at all RED wall receptacles.
14. \_\_\_ Condition C is used to initiate a team to respond to a life-threatening condition.
15. \_\_\_ Condition L is a rapid response to locate a missing patient who may have wandered away.
16. \_\_\_ “Condition D” may be initiated when a patient’s condition changes significantly for the worse and additional staff is needed urgently.
17. \_\_\_ Safety Data Sheets (SDS) give you all the critical information you need about hazardous chemicals and products.
18. \_\_\_ An example of a Sentinel Event would be infant abduction or discharge to the wrong family.
19. \_\_\_ Hand washing is the least effective strategy to reduce the risk of transmitting organisms from one person to another.
20. \_\_\_ Personal protective equipment (PPE) protects you from contact with blood or other potentially infectious materials.
21. \_\_\_ Annual flu shots are required only of employees.
22. \_\_\_ Active participation in care decisions is a patient’s right.
23. \_\_\_ While working in the hospital, you notice your neighbor’s name on the patient census, so you should go home and tell your neighbors so they may send a get well card.
24. \_\_\_ The Safety Officer at UPMC Horizon is Karen Calhoun, RN.

25. \_\_\_ SAFE HAVEN is a program that permits the hospital to accept a child less than 28 days old if voluntarily relinquished by parent.
26. \_\_\_ All patients have the right to appropriate assessment and management of pain.
27. \_\_\_ Abuse and neglect only causes physical harm.
28. \_\_\_ UPMC Horizon now accepts that ALL patients are at risk of fall, and requires basic preventions know as Universal Fall Interventions.
29. \_\_\_ Privacy is UPMC's obligation to limit access to information on a need-to-know basis to individuals or organizations so that they can perform a specific function for or on behalf of UPMC. This includes verbal, written, and electronic information.
30. \_\_\_ Corporate Compliance demonstrates honesty and responsible behavior.
31. \_\_\_ EMTALA requires a hospital to provide an appropriate medical examination to any person who comes to the hospital campus and requests treatment.
32. \_\_\_ UPMC's service recovery acronym is CARE+.