Kaleida Health Research Associate Orientation Manual
Research Associate Orientation Packet

Attestation*

Federal and New York State False Claims Act Overview
Kaleida Health Harassment Policy
Health Insurance Portability and Accountability Act (HIPAA)
Infection Control Policy
Patient Safety and Quality Improvement
Corporate Compliance
Risk Management
Patient Rights
Request for Laboratory Support

Abbreviated General Orientation – Self-Learning Assessment*

* Must be returned to:

Kaleida Health
Office of Research and Sponsored Projects
726 Exchange Street
Suite 270
Buffalo, New York 14210
Attn: Lorraine Duthe
KALEIDA HEALTH

Attestation Form

Orientation for Research Associate

I hereby certify that I have listened to and/or read and understand the Kaleida Health Orientation information. I understand that I am required to comply with all Kaleida Health policies, rules and regulations. I understand that if this attestation is found to be false or untrue, the provision of any false or misleading information on this form may subject me to disciplinary action up to and including dismissal or termination of my privileges.

I agree to conduct myself in a professional manner at all times while on the Kaleida Health campus and will support the hospital’s mission and vision of providing excellence in health care.

______________________________
Name (Please Print)

______________________________  _______________________
Signature                          Date

RETURN COMPLETED ATTESTATION TO:
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Federal and New York State False Claims Act Overview
Federal and NYS False Claims Act Overview

Kaleida Health is committed to preventing and detecting any fraud, waste or abuse in the organization related to Federal and New York State health care programs. To this end, for several years Kaleida Health has maintained a vigorous compliance program and strives to educate all employees on fraud and abuse policies and regulations, including the importance of submitting accurate claims and reports to the Federal and State governments. Kaleida Health prohibits the knowing submission of a false claim for payment from a Federal or State funded health care program. Such a submission is in violation of Federal and State law and can result in significant administrative and civil penalties under the Federal False Claims Act, a statute that allows private citizens to help reduce fraud against the United States government. In addition, in New York State the submission of a false claim can also result in civil or criminal penalties.

To assist Kaleida Health in meeting its legal and ethical obligations, any Kaleida Health employee who reasonably suspects or is aware of the preparation or submission of a false claim or report or any other potential fraud, waste or abuse related to a Federally or State funded health care program is required to report such information to his/her supervisor or to the Kaleida Health Compliance Officer or to the Kaleida Health Office of General Counsel. Any Kaleida Health employee who reports such information will have the right and opportunity to do so anonymously and is protected against retaliation or retribution for coming forward with such information under Kaleida Health policies, and Federal and State law. However, Kaleida Health retains the right to take appropriate action against an employee who has participated in a violation of Federal or State law or hospital policy.

As an organization, Kaleida Health obligates itself to investigate any suspicions of fraud, waste or abuse swiftly and thoroughly through its internal compliance programs and processes. Reports may be made anonymously if an employee desires anonymity. If an employee believes that Kaleida Health is not responding to his or her report within a reasonable period of time (as determined on a case-by-case basis), the employee has the ability to bring his/her concerns to the appropriate government agency under the relevant Federal and/or State laws. More information on reporting may be found in the Kaleida Health Code of Conduct & Business Ethics and False Claims Act Education policy, posted internally on KaleidaScope and externally at www.KaleidaHealth.org.
Kaleida Health

Harassment Policy
I. INTRODUCTION
Kaleida Health is committed to maintaining work environment where every workforce member is treated with dignity and respect and is valued for his/her diversity. Kaleida Health will not tolerate harassment or bullying of workforce members by other workforce members or consultants, contractors or vendors doing business with Kaleida Health.

All workforce members are expected to comply with this policy and take appropriate measures to ensure that violations of this policy do not occur. Further, this policy establishes a procedure for the reporting, investigating and appropriate follow-up to harassment complaints.

Persons who engage in harassment or bullying will be subject to discipline up to and including termination of employment or contract. In determining whether the conduct at issue violates this policy, the totality of the circumstances will be considered.

II. AUDIENCE
This policy and procedure applies to all Medical Staff members, hospital staff, clinic and nursing home staff at Kaleida Health, including employees, students, interns, residents and volunteers. It also governs consultants, contractors and vendors of Kaleida Health, as applicable. For purposes of this policy, the term "hospital staff" shall include nursing home staff, and the term "hospital" shall include Kaleida Health hospital based skilled nursing facilities, except as otherwise noted in this policy.
III. COMMUNICATION AND RESPONSIBILITY
The site human resources departments administer this policy. The Purchasing Department may administer this policy for all contractors and vendors. Each manager is responsible to lead by example, to establish a businesslike work atmosphere, to treat every employee with dignity, and create a climate of work relationships free from harassment and bullying. Each manager is responsible to communicate this policy to all current staff as well as new employees. Further, it is the responsibility of all managers to respond *promptly* to any complaint of harassment. Each manager and employee has an obligation to report all complaints and/or incidents of harassment to the Human Resources Department. Confidentiality will be maintained to the extent practicable. The procedures set herein are to be used as guidelines for management action and may be changed with or without prior notice.

IV. POLICY AND PROCEDURE
No employee will be retaliated against for reporting a complaint of harassment. All complaints will be investigated.

A. Definitions

1. Workforce Member:
   a. *Workforce member* means employees, volunteers, and other persons whose conduct, in the performance of work for Kaleida Health, is under the direct control of Kaleida Health, whether or not they are paid by Kaleida Health.
   b. This includes full and part time employees, affiliates, associates, staff from third party entities that provide service to Kaleida Health, directors, officers, managers, supervisors, volunteers, physicians employed by or otherwise affiliated with Kaleida Health, medical residents, nursing students or others receiving training at any Kaleida Health facility, and others who provide goods or services to Kaleida Health.

2. Harassment:
   a. Harassment can be described in simple terms as unwelcome behavior, including bullying, that affect the dignity of the individual concerned. It includes actions or comments viewed as demeaning or unacceptable by the recipient and may also be conduct that creates an intimidating, hostile or offensive atmosphere for the complainant(s).
   b. Conduct that is acceptable to one person may prove to be unwelcome to another and the test applied must be that the conduct, whether unwitting or deliberate, is unacceptable to the recipient and would be judged as harassment by any reasonable person.
c. When defining harassment, the intentions of the person complained about are irrelevant.

d. Harassment may take many forms and includes behavior related to race, color, religion or belief, national origin, ancestry, age, sex, sexual orientation, marital status, veteran status, occupation, physical disability, mental disability, medical condition, or other personal characteristics. However, harassment can occur without being related to any of these.

e. The complainant does not have to be the person harassed, but could be anyone negatively impacted by the offensive conduct or who observes such conduct.

f. Examples of behavior that is likely to constitute harassment are given on Attachment 1. The list is not exhaustive and other forms of harassment will be viewed equally seriously.

3. Sexual Harassment

a. The U.S. Equal Employment Opportunity Commission (EEOC) has issued guidelines prohibiting unlawful harassment including sexual harassment.

b. Sexual harassment, as defined by these guidelines, is unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when:

(1) submission to this conduct explicitly or implicitly is a term or condition of employment; or

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

(3) such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creates an intimidating, hostile or offensive work environment.

c. It shall be a violation of this policy for anyone who is authorized to recommend or take personnel actions affecting an employee, or who is otherwise authorized to transact business or perform other acts or services on behalf of the Kaleida system to:

(1) Make sexual advances or requests for sexual favors when submission to or rejection of such conduct is the basis for either implicitly or explicitly recommending, imposing, granting withholding or refusing terms and conditions that either favor or adversely affect the employment of the employee or individual.
(2) To recommend, impose, grant, withhold or refuse to take any employment related or other action consistent with his or her duties and responsibilities because of sexual favors or as a reprisal against an employee or other individual who has rejected or reported sexual advances.

(3) To disregard and fail to investigate allegations of sexual harassment whether reported by the employee or individual who is the subject of the alleged harassment or a witness, and to fail to take immediate corrective action in the event misconduct has occurred.

d. Sexual harassment can occur in a variety of circumstances, including but not limited to, the following:

(1) The alleged offender may be a woman or man. The individuals involved do not have to be of the opposite sex.

(2) The alleged offender can be the employee's supervisor, an agent of the employer, a supervisor in another area, a co-worker, or a non-employee.

(3) The complainant does not have to be the person harassed, but could be anyone negatively impacted as described above by the offensive conduct or who observes such conduct.

(4) Sexual harassment may occur even if it does not result in economic injury to the employee.

B. Workforce members responsibility:

1. Workforce members who believe they are being harassed should not feel that it is their fault or that they have to tolerate it.

2. Workforce members should encourage a person who says they have been harassed to make their concerns known to Kaleida Health management.

3. Workforce members should be sensitive to the feelings of individuals who believe they have been harassed and refrain from taking part in, and actively discourage, gossip or comment on the part of others about the alleged or actual harassment.

C. Procedure for Filing a Complaint - Workforce members who feel aggrieved because of any form of harassment have several ways to make their concerns known:

1. Aggrieved individuals should make it clear to the person causing the offence that they find the behavior unacceptable and ask the person to stop. Unwillingness to approach the individual will not be interpreted to mean that the behavior is acceptable nor will it prejudice any complaint that may be brought.
2. Any aggrieved person who does not wish to communicate directly with the person whose conduct is offensive, or if direct communication does not stop the offensive behavior, should promptly report the behavior to an immediate supervisor or manager.

3. If the immediate supervisor or manager is the alleged offending party, report the offensive behavior to the next level of management for prompt investigation and appropriate action.

4. Aggrieved individuals may report the incident directly to the Site’s Human Resources Department.

5. Employees may also file a formal grievance in accordance with the Kaleida Health Corporate Policy and Procedure HR.008, Problem Resolution or their collective bargaining agreement.

D. In dealing with reports of alleged harassment, information will be handled sensitively and discretely and only disclosed to those who need it for the purposes of considering the case.
   1. It will be management’s responsibility to determine the level of appropriate corrective action and/or follow-up action based on the information obtained during the investigation process
   2. The complainant will not be informed of any confidential human resources action taken against the alleged offender; however, the complainant will be apprised of the outcome of the investigation.

E. Confidentiality
   1. Each party contacted in connection with the investigation of a complaint of harassment, including any witnesses, will maintain confidentiality throughout the investigation.
   2. The manager who is conducting the investigation will advise all parties that breach of such confidentiality by any party will be considered an independent violation and cause for discipline regardless of the merits of the underlying charge.

F. Non-retaliation
   1. To prevent harassment, it is critical that individuals not be deterred from reporting it. Kaleida Health will not retaliate, nor will it tolerate retaliation, against individuals who report conduct that they reasonably and in good faith believe to be harassment, or who participate in any investigation of harassment.
   2. The initiation of a complaint of harassment will not cause any reflection on the complainant nor will it affect such person’s employment, compensation or work assignments.
   3. Individuals who retaliate against a complainant may be subject to discipline up to and including termination of employment or contract.
V. QUALITY OF CARE-N/A

VI. REFERENCES-N/A
See also the following Kaleida Health Corporate Policies and Procedures:
- ADM.20, *Disruptive Medical Staff Member Policy*
- HR.008, *Problem Resolution*
- HR.015, *Standards of Personal Conduct*
- IS.5, *Internet Access Policy and Procedure*
- LE.5, *Code of Conduct and Business Ethics*

VII. REVISIONS
It shall be the responsibility of the Senior Vice President of Human Resources, or designee, to initiate revisions to present policy and procedures.
Examples of behavior that is likely to constitute harassment:

- Behavior of an offensive nature related to an individual’s race, color, religion or belief, national origin, ancestry, age, sex, sexual orientation, marital status, veteran status, occupation, physical disability, mental disability, medical condition, or other personal characteristics;
- Any behavior that may cause distress, such as name-calling, ridicule, insults, jokes, graffiti, physical abuse, display of pornographic images, etc.;
- Sending inappropriate jokes or comments through e-mail, text, websites or other electronic media;
- The invasion of personal space;
- Displaying offensive material (on paper or electronically);
- Spreading malicious rumors;
- Intentional isolation or exclusion;
- Persistent, unwelcome contact; may include text messages, e-mails, phone calls, gifts, letters, calling a home, cell or work phone;
- Stalking;
- Making or threatening reprisals after a negative response to unwelcome conduct;
- Drawing unwelcome attention to or abusing someone’s religious beliefs;
- Any threat, physical or verbal, of violence towards another person;
- Verbal and/or physical intimidation; threats, shouting; sarcastic remarks;
- Abuse of power or behavior that causes fear or distress for others;
- Making unfounded or inappropriate threats and/or comments about job security;
- Public ridicule, sarcasm or humiliation.

Examples of behavior that is likely to constitute sexual harassment:

- Engaging in sexist language, risqué or lewd jokes or gestures with sexual overtones;
- Display or distribution of written, graphic or electronic materials or objects that are of a sexual nature;
- Physical assaults such as attempted rape, or rape;
- Offensive sexual behavior such as:
  - Suggestive looks
  - Leering and remarks
  - Offensive flirtations
- Unwanted physical contact, such as pinching, stroking, brushing against the body, sexually suggestive touching, attempted kissing or fondling, persistent and unwelcome flirting
- Unwanted sexual advances
- Compromising invitations
- Offers of favored treatment in return for sex or threats of disadvantage if refused;
- Making public that someone is gay, lesbian, or bisexual when they would prefer to keep this information private.

NOTE: This list is not exhaustive and other forms of harassment will be viewed equally seriously.
Kaleida Health

Health Insurance Portability and Accountability Act (HIPAA)
CONFIDENTIALITY OF PROTECTED HEALTH INFORMATION

1. **Definition of Protected Health Information**
   The term “protected health information” means any patient information, including very basic information such as their name or address, that (1) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and (2) either identifies the individual or could reasonably be used to identify the individual.

2. **Public Viewing/Hearing of Protected Health Information**
   a. Staff are expected to keep protected health information out of public viewing and hearing. For example, protected health information should not be left in conference rooms, out on desks, or on counters or other areas where the information may be accessible to individuals who do not have a need to know the protected health information.
   b. Staff should also refrain from discussing protected health information in public areas, such as elevators and reception areas, unless doing so is necessary to provide treatment to one or more patients.
   c. Staff should also take care in sharing protected health information with families and friends of patients. Such information may generally only be shared with a personal representative in accordance with Kaleida Health policy, or with a family member, relative, or close personal friend who is involved in the patient's care or payment for that care. Even in the latter circumstance, information cannot be disclosed unless the patient has had an opportunity to agree or object to the disclosure, and staff may only disclose information that is relevant to the involvement of that family member, relative or close personal friend in the patient’s care or payment for the patient’s care, as the case may be.
   d. When transporting papers containing protected health information from one location to another, it should be done in a secure method (ex., in a sealed envelope, in a secured case/container, etc.)

3. **Databases and Workstations**
   a. Staff are expected to ensure that they exit any confidential database upon leaving their workstations so that protected health information is not left on a computer screen where it may be viewed by individuals who are not authorized to see the information.
   b. Staff are expected to secure laptop computers with security cables when leaving laptops unattended.
   c. Staff are also expected not to disclose or release to other persons any password, personal identification number, token or access card, or electronic signature.
   d. **Each staff member will be liable for all activity occurring under his or her account, password and/or electronic signature.**
   e. HIPAA Security Rule requires that these activities be monitored.

4. **Accessing of Protected Health Information**
   a. Staff should only access the protected health information that they need to carry out their specific Kaleida Health job function.
   b. Staff should **not access** the protected health information of their co-workers, their children, their family members, their friends, their neighbors, or themselves unless they have a specific treatment, payment or health care
operations relationship with that individual/patient. If there is such a relationship, only the minimum necessary information that is needed to carry out their specific Kaleida Health job function should be accessed.

c. Staff should not look up co-workers’ birthdates in the Kaleida Health information system in order to send them birthday cards or to find out their ages.

d. Staff should not look up their co-workers’ telephone numbers in the Kaleida Health information system. They should use the phone book.

5. **Downloading, Copying or Removing Information**

   a. Staff should not download, copy or remove from the facility any protected health information, except as necessary to perform their duties.

   b. Upon termination of employment or contract with the facility, or upon termination of authorization to access protected health information, staff members must return any and all copies of protected health information in their possession or under their control.

6. **Emailing and Faxing Information**

   a. Staff should not transmit protected health information over the Internet (including email) and other unsecured networks unless using a secure encryption procedure. Including “@E” in the subject line of the email will encrypt email going outside of Kaleida Health from our Microsoft Outlook application.

   b. Transmission of protected health information is permitted by fax if the staff member sending the information ensures that the intended recipient is available to receive the fax as it arrives, or confirms that there is a dedicated fax machine that is monitored for transmission of sensitive information.

   c. Staff should use fax cover sheets that include standard confidentiality notices (see Kaleida Health Policy and Procedure MR.14) and should request that the recipient call the staff member upon receipt of the fax.

7. **Violations**

   a. Staff who violate the confidentiality of a patient’s protected health information will be subject to disciplinary action up to and including termination of employment or contract.

   b. Anyone who knows or has reason to believe that another person has violated the confidentiality of a patient’s protected health information should report the matter promptly to his or her supervisor or the Kaleida Health Privacy Officer or call the Compliance Hotline. The Privacy Officer can be reached at 859-8516. The Compliance Hotline number is 859-8559.

   c. All reported matters will be investigated, and, where appropriate, steps will be taken to remedy the situation.

   d. Where possible, Kaleida Health will make every effort to handle the reported matter confidentially.

   e. Any attempt to retaliate against a person for reporting a violation of confidentiality will itself be considered a violation that may result in disciplinary action up to and including termination of employment or contract.

8. **Questions**

   If you have questions about any aspect of the HIPAA Privacy Rule, please contact your department supervisor, Dick Hopkins (Kaleida Health Privacy Officer) at 859-8516 or Nancy Pawlowicz (Sr. Compliance Auditor) at 859-8517. It is important that all questions be resolved as soon as possible to ensure protected health information is used and disclosed appropriately.
Kaleida Health

Infection Control
Infection Control

The Infection Control program at Kaleida Health is a shared responsibility of all system members. For each person who works at Kaleida Health, there is an expectation that they will do whatever they can to prevent the transmission of infections from one patient to another, from a patient to a health care worker, and between and among colleagues. Several important pieces of information are presented in this booklet; however, you have the responsibility to explore further to make sure you take all the necessary steps to fulfill your obligation.

Infection Control Manual – The Infection Control Manual can be found on-line on KaleidaScope. Ask your manager to show you how to locate and review the index. You will find policies covering employee health, tuberculosis control, exposure control and department specific infection control policies.

Employee Health – Each employee must have an initial health assessment including a review of childhood disease immunizations and a tuberculin skin test. Employee health also covers post-exposure follow-up and communicable disease exposure follow-up. You also may have your immunizations updated through Employee Health. An annual mandatory update will include a skin test for tuberculosis.

Approach to Patient Care Regarding Infection Control

There are basically two approaches used for patient care within Kaleida Health. Standard Precautions and Transmission-based precautions work together to provide mechanisms for protecting health care workers and patients from exposure to infectious agents.

- **Standard Precautions** are used in the care of all patients and are designed to reduce the spread of pathogens from blood and body fluids regardless of the diagnosis. This involves the use of basic infection control measures:

  - **Gloves** are required for any anticipated contact with blood, body fluids, mucous membranes or non-intact skin.
    - Examples: Starting an IV, drawing blood, suctioning a patient, handling a specimen, handling contaminated items.

  - **Gowns** are required when splashing of body fluids can be anticipated. This is to prevent soiling of clothing, uniform or your person.
    - Examples: Large volumes of blood or body fluids, irrigating a wound, handling heavily soiled linen.

  - **Mask, goggles, and face protection** are required for situations when it can be anticipated that body fluids may be aerosolized to splash the eyes, nose or mouth.
Infection Control (Continued)

- Examples: Dental procedures, surgical procedures, irrigating a wound, suctioning.

All barriers must be removed and disposed of properly when tasks are completed and before the next patient contact.

Hands must be washed after removing any physical barrier, including gloves.

Transmission-based Precautions are used for patients who are suspected of, or have infections which are highly transmissible and pose a risk to other patients or employees. These precautions include Contact, Droplet, and Airborne precautions. If you suspect or confirm that a patient has a communicable illness or MDRO, an order for contact, droplet or airborne precaution is required.

- **Contact Precautions** – Prevent the spread of infection by skin to skin contact or by contact with contaminated objects.

- **Droplet Precautions** – Prevent the spread of illness transmitted by large particle droplets created by certain medical procedures or by coughing, talking, or sneezing.

- **Airborne Precautions** – Prevent spread of infectious dust particles or small particle droplets that remain suspended in the air found in such diseases as Varicella (Chicken Pox) and Tuberculosis (TB). These precautions require special air handling and ventilation.

- **Tuberculosis Control**
  - Relies on early recognition of symptoms and isolation of patients.
  - Patient should be in negative pressure isolation when ordering serial AFB’s to rule out pulmonary TB.
  - Anyone entering the room must wear a PFR 95 or HEPA respirator.
  - Patients may leave the room only for medical essential procedures.
  - Patients must be masked when they leave the room.
  - Isolation may be discontinued only when TB has been ruled out.
  - An early morning sputum tested for AFB on three consecutive days may help to rule out TB.
  - Exposure to patients with active pulmonary TB, who were not isolated, will be followed by Employee Health.

- **Hand Hygiene** - this is the single most important step to stop the spread of infection.
Infection Control (Continued)

When:
- Arriving at work.
- Before entering and when leaving patient care area.
- Between each patient contact.
- After contact with contaminated items.
- Before serving or handling food.
- Before preparing or administering medications.
- After removing gloves or other protective barriers.
- When leaving for a break.
- Before and after eating, smoking, or using the lavatory.
- When visibly soiled.

How:
- Wet hands with warm water.
- Apply a small amount of soap in the palm of your hand.
- Lather for 15 seconds. Be sure to wash between fingers and on the back of hands.
- Examine under fingernails to make sure they are clean.
- Rinse well and dry with paper towels.
- Use paper towel to turn the faucet off; otherwise, you will recontaminate your hands OR:
  - Apply the instant hand sanitizer and rub hands together for 10 to 15 seconds until dry.
- Soap and water are required if hands are visibly soiled.

Additional Infection Control Measures

- **Bloodborne Pathogens** – Healthcare workers are at increased risk of exposure to bloodborne pathogens, including Hepatitis B (HBV), Hepatitis C (HCV), and Human Immunodeficiency Virus (HIV), the virus which causes AIDS, as well as other diseases which may be carried in the bloodstream of patients.

  Please review the bloodborne pathogen information included in this section.

- **Transmission** – Healthcare workers are at risk for exposure through three types of exposure routes:
  - Percutaneous – accidental needle stick or puncture with a blood-contaminated sharp instrument or object.
  - Cutaneous – open cuts or non-intact skin on hands or other surfaces contaminated with blood.
Infection Control (Continued)

- Mucous membrane splash – blood or other body fluid splashes the eyes, nose or mouth.

The general public is at risk of exposure through sexual contact, sharing of needles among IV drug users, transfusion or transplant tissues, and from mother to infant in-utero or when breast feeding.

- **Transmission Risks** – The risk of acquiring an infectious agent as the result of a blood-contaminated needle stick varies with each agent, type of injury, and amount of virus circulating in the source patient’s bloodstream.

  The risk of acquiring:
  - HBV from a needle stick is 1 in 6 to 1 in 30, or about a 10% chance overall.
  - HCV from a needle stick is about 1 in 100 to 3 in 100, about 2% overall.
  - HIV from a needle stick is less than 1 in 250 or about 0.4% overall.

- **Hepatitis B Vaccine**
  - Safe and effective.
  - Administered in a series of three injections over a six month period.
  - Non-infectious.
  - Provides lasting immunity in more than 90% of those immunized.
  - Recommended for any employee with blood or body fluid exposure risk.
  - Provided at no cost to employee.
  - Must sign a declination statement if you do not wish to be vaccinated.

- **Work Practice Controls** – Include measures taken to reduce the risk of exposure to blood pathogens.
  - Wearing protective barriers where you may be exposed to blood and other body fluids.
  - Not eating, drinking, or applying make-up in areas where blood and other body fluids may be handled.
  - Handling and using sharps in a safe manner.
  - Not bending, breaking, recapping or removing needles from disposable syringes.

- **Engineering Controls** – Include the use of devices that isolate the healthcare worker from potentially dangerous situations:
  - Sharps container located in patient care areas.
  - Needle-less devices.
  - Resheathing or blunting devices or sharps.
  - Fluid shields in the laboratory.
Infection Control (Continued)

- **Post Exposure Follow-up** – All exposures to blood or fluids need to receive immediate medical attention.
  
  o Acknowledge to yourself that the exposure occurred.
  o Cleanse the area with soap and water. Flush mucous membranes with cold water for several minutes.
  o Report immediately to the Emergency Department for medical evaluation.
  o Follow-up with Employee Health as necessary.
  o Post-exposure prophylactics is provided at no cost by the health system.
  o Maintain strict confidentiality.

**Training**

Each employee is required to attend or participate in at least one infection control related program annually. The program(s) will review infection control practices as they relate to blood borne pathogens and tuberculosis control.

If you have any questions concerning infection control issues, please contact the infection control practitioners listed on the page in the appendix, or at the system site in which you are working.
I. Introduction
Standard Precautions is a blend of Universal Precautions and Body Substance Isolation. It is an approach to infection control which recognizes that all body fluids or substances, from all persons, living or dead, may contain potentially infectious organisms. Standard Precautions is the foundation of basic infection control practices to prevent the transmission of infectious microorganisms.

II. Communication and Responsibility
Clinical and Administrative Department Heads

III. Scope of Practice
All patient care personnel

IV. Policy

A. **Standard Precautions** apply to **ALL PATIENT CARE**
   1. blood
   2. all body fluids, secretions and excretions (except perspiration), regardless of whether or not there is visible blood
   3. non-intact skin
   4. all mucous membranes

B. **Standard Precautions**
   1. **Hand Hygiene:** Use alcohol-based hand rub or wash hands after touching blood, body fluids, secretions, excretions, or (potentially) contaminated items, **whether or not gloves are worn.** Perform hand hygiene after removing personal protective equipment (PPE), before leaving patient’s room.

   2. **Gloves:** Wear gloves when contact with blood, body fluids, secretions, excretions or (potentially) contaminated items is anticipated. Change gloves before and after touching mucous membranes or non-intact skin. Change gloves between patients and between
performing different tasks/procedures on the same patient. Because of a number of factors, including potential leakage, use of gloves does not negate the need for hand hygiene.

3. **Mask, Face and Eye Protection:** Wear a mask and goggles or mask with face shield during patient care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, or excretions.

4. **Gown:** Wear a gown to protect skin and to prevent soiling of your uniform or clothing if planned activities might result in exposure to blood, body fluids, secretions or excretions. Remove soiled gown as promptly as possible. Remove gown and all other PPE and perform hand hygiene upon exiting the patient’s room.

5. **Patient Care Equipment:** Patient care equipment must be cleaned and disinfected between patients.

6. **Environmental Control:** Cleaning and disinfection of environmental surfaces, beds, bed rails, equipment, patient rooms and frequently touched surfaces must be done routinely with an approved disinfectant detergent.

7. **Linen:** Handle all used linen in a manner that minimizes exposure to skin, mucous membranes, clothing, or other patients in the environment.

8. **Occupational Health and Bloodborne Pathogens:** Prevent sharps injuries. Never recap used needles. Place used disposable needles and sharps into hard plastic biohazard containers at the point of use. Place reusable syringes, needles, and sharps in puncture-resistant containers for transport to reprocessing areas. Place items that are saturated with blood into red biohazard bags.

9. **Patient Placement:** Place patients who contaminate their environment, or who cannot maintain appropriate personal hygiene into private rooms, when it becomes available. Avoid cohorting pre-surgical or non-infected patients in room with patients who have active infections or purulent draining wounds. (Consult with an infection control professional.)

10. **Infant Isolation:** Under certain conditions, an isolette may be utilized to achieve isolation for infants. (This does not apply to newborn nursery.)

11. Maintain Standard Precautions along with Transmission-based Precautions or Isolation should they be required during the course of a hospital visit.

12. Hands Hygiene must be performed before and after placement/removal of PPE, including gloves.

Kaleida Health developed these policies and procedures in conjunction with administrative and clinical departments. These documents were designed to aid the qualified health care team in making clinical decisions about patient care. These policies and procedures should not be construed as dictating exclusive courses of treatment and/or procedures. No health care team member should view these documents and their bibliographic references as a final authority on patient care. Variations of these policies and procedures in practice may be warranted based on individual patient characteristics and unique clinical circumstances. Please contact the print shop regarding any associated forms.
Kaleida Health

Patient Safety
and
Quality Improvement
Patient Safety/Quality Improvement

The patient safety program will help ensure that Kaleida Health system members incorporate methods to improve the safe administration/delivery of care into all processes, and develop a culture that perceives safety as a major factor when changes in clinical processes/systems are planned.

The program is based on the premise that no clinician intends to do harm, that most “errors” are system/process failures and patients, their families, organization staff and leaders (must) identify and manage actual and potential risks to patient safety. The Patient Safety Program uses the following beliefs:

- A safer environment for patients will be created through the adoption of a culture that encourages the disclosure of errors and invests in error prevention and recovery.
- Most clinicians involved in an error do not intend to harm patients.
- Programs will be provided to maximize human performance and restrict or assist health care workers who do not meet competency or integrity expectations.
- The majority of errors are caused by system failures.
- Safety is realized through communication, feedback and teamwork as well as strict adherence to approved policies and procedures.
- The safety of health care delivery is enhanced by the involvement of the patient, as appropriate to his/her condition, as a partner in the health care process.
- Any employee who has concerns about safety or the quality of care provided by the organization may report these concerns to the New York State Department of Health and The Joint Commission with out fear of disciplinary action to that employee.

Kaleida Patient Safety Initiatives

- Medication Safety
- Falls Prevention – Think Yellow
- Surgical Safety – STOP and follow the UNIVERSAL PROTOCOL/ TIME OUT immediately prior to beginning a procedure in the OR, bedside or special unit. This must include ALL of the following elements, EVERY TIME: correct patient; information corroborated; site and side of surgery verified; signature, date and time.
- STARS event reporting
- Prevention of Decubitus Ulcers
Patient Safety/Quality Improvement (Continued)

- Patient Identification – PLUE (Patient Link Up Enterprise)
- Use of Restraints
- Sentinel Events Alert Assessments
- Staff Development
- Take the Time to Date and Time- all entries in the medical record
- Ticket to Ride- hand off communication tool.
Patient Safety/Quality Improvement (Continued)

Commonly Asked Questions and Procedures Regarding Patient Safety

What is a medication error?

It is any error or potential error at any point in the medication system from the time the drug is ordered until the patient receives it.

- Follow the five “Rs” of medication administration: Assure the Right patient, Right medication, Right dose, Right time and Right route.
- If you notice a medication error, ensure the patient’s safety, fill out an incident report and notify your manager and the patient’s physician.

What is a sentinel event?

It is an unexpected occurrence that involves serious physical or psychological injury or death, or the risk of such an event. Examples include suicides, infant abduction, and surgery on the wrong patient or body part.

- Report the event immediately.
- Organize a Root Cause Analysis (RCA) under the direction of the Risk Management Department. An RCA analyzes the systems and processes related to the sentinel event to identify the cause and contributing factors that led to the event to prevent it from happening again.
- Establish and implement a plan to address opportunity for improvement in the future.
- Familiarize yourself with two Kaleida polices that relate to sentinel events: LE 8 – Corporate Incident Reporting Policy and PI 1 – Sentinel Events.

Who is allowed to give an order to place a patient in restraints?

Only an independent licensed practitioner may write an order to place a patient in restraints. This includes both MD’s and Nurse Practitioners (NPs). Physician Assistants (PAs) and RN’s who have completed a special education competency are also able to evaluate the patient and write orders for restraints.
Patient Safety/Quality Improvement (Continued)

Falls are a major cause of patient injury.

Look for the yellow circle stickers on patient’s armbands, on the spine of the chart, on the patient’s door, and on the Kardex. This indicates that a patient is at risk for falling. Review and document on the Falls Risk Assessment.

- Lock wheels on beds, carts, and wheelchairs
- Put beds in low position as soon as care is completed
- Make sure all items (i.e.: tissues, phone, call light, bed pan) are within a patient’s reach.
- Bed rails should be in the up position for patients that are sedated, confused, semi-conscious, or unconscious or any patient in need of protection. (Please review the restraint policy for requirements.)

Surgical Safety

STOP and follow the UNIVERSAL PROTOCOL/TIME OUT immediately prior to beginning a procedure in the OR, bedside or special unit, EVERY TIME, without exception. ALWAYS include checking: correct patient; information corroborated; site and side of surgery verified; signature, date and time.

Evacuation of Patients

Training and preplanning allows you and your coworkers to develop proper methods of evacuation. Follow these steps:

- Reassure all patients in immediate danger.
- Follow your department specific plan
- Evacuate ambulatory patients first.
- Evacuate via the horizontal route.
- Evacuate via the vertical route.

Methods for Emergency Evacuation

Wrong-patient errors occur in all aspects of treatment and diagnosis

**THE GOAL:**
- Reliably identify the person to receive the treatment
- Match the treatment to that person

**WHEN?**
- Whenever taking specimens, giving meds/blood products
- Prior to start of any surgical or invasive procedure
- Prior to start of any patient treatment/service

**HOW?**
- Use the two identifiers of NAME and DATE OF BIRTH (DOB)
- Compare the ID band to order/MAR/document with PLUE sticker
- Patient may state name/DOB while you compare with document
- DO THIS *EVERY TIME*. No Exceptions!

**WHY?**
- To ensure that the right patient obtains the correct treatment
- To avoid patient harm
I. INTRODUCTION

It is the policy of Kaleida Health to ensure a prompt, thorough and credible investigation and action when a serious incident occurs to facilitate quality care or treatment for patients. Any event resulting in an unexpected, serious occurrence must be reported to the Risk Management department. (Events involving patients are those resulting in an unexpected, serious occurrence not related to the patient’s normal disease process or routine care)

II. AUDIENCE

This policy and procedure applies to the entire system including all sites (inpatient and outpatient), home care and long term care.
III. COMMUNICATION AND RESPONSIBILITY

Administrative and Clinical Department Heads

IV. POLICY & PROCEDURE

A. GOALS

The goals of this sentinel event policy include the following:

- To have a positive impact in improving care
- To focus attention on underlying causes and risk reduction
- To increase the staff’s general knowledge about sentinel events, their causes and prevention
- To maintain public confidence in the health care system

B. PURPOSE

The purpose of this policy is to delineate the organization’s mechanism for the identification and management of sentinel events and near misses. In order to ensure patient, employee and visitor safety, any incident meeting the definition of a sentinel event, as stated below, will be investigated by the Risk Management Department to discover the systems and processes underlying the apparent cause of the event, and to identify the system and/or process changes that will reduce the likelihood of a similar sentinel event occurring in the future, making the environment safer for the patient.

C. DEFINITIONS

A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or risk thereof. The event is called sentinel because it sends a signal or sounds a warning that requires immediate attention.

Joint Commission Definition of Sentinel Event: The following applies to sentinel occurrences reportable to the Joint Commission on a voluntary basis.
The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition,\(^1\) or the event is one of the following (even if the outcome was not death or major permanent loss of function\(^2\))

- Suicide of a patient in a setting where the patient receives around the clock care (e.g., hospital, residential treatment center, crisis stabilization center) OR within 72 hours of discharge
- Infant discharged to the wrong family
- Rape\(^3\)
- Hemolytic transfusion reaction involving administration of blood products having major blood group incompatibilities
- Surgery on the wrong patient, wrong side, or wrong body part\(^4\)
- Unanticipated death of a full-term infant\(^5\)
- Death or major permanent loss of function due to a nosocomial infection.
- Abduction of any individual receiving care, treatment or services
- Unintentional retention of foreign object in patient after surgery or other procedure
- Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter)
- Prolonged fluoroscopy with cumulative dose >1500 rads to a single field or delivery of radiotherapy to the wrong body region *(Not* done at Kaleida Health) or >25% above the planned radiotherapy dose *(Not* done at Kaleida Health)

**NOTE:** Joint Commission Sentinel Event Alerts, published periodically at www.jcaho.org, recommendations for changes in processes to provide improved and safer patient care. Staff members can access the Joint Commission website to obtain this additional information.

**NYPORTS** (New York Patient Occurrence Reporting and Tracking System): The New York State Department of Health has a mandated incident reporting system. *(See

\(^1\) A distinction is made between an adverse outcome that is related to the natural course of the patient's illness or underlying condition (not reportable) and a death or major permanent loss of function that is associated with the treatment, or lack of treatment of that condition.

\(^2\) "Major permanent loss of function" means sensory, motor, physiological, or intellectual impairment not present on admission requiring continued treatment or life-style change. When "major permanent loss of function" cannot be immediately determined, reporting is not expected until either the patient is discharged with continued major loss of function, or two weeks have elapsed with persistent major loss of function, whichever occurs first.

\(^3\) The determination of "rape" is to be based on the health care organization's definition consistent with applicable law and regulation.

\(^4\) All events of surgery on the wrong patient or wrong body part are reportable regardless of the magnitude of the procedure.

\(^5\) Cases reviewable by Joint Commission are any perinatal death or major permanent loss of function unrelated to a congenital condition in an infant having a birth weight greater than 2,500 grams.
Attachment A). Joint Commission-defined sentinel events are reportable to NYPORTS, as are other occurrences of a less serious nature.

D. ROOT CAUSE ANALYSIS (RCA)

A root cause analysis is an intensive, in-depth analysis of a problem event to learn the most basic reason(s) for the problem, which if corrected, will minimize the recurrence of that event. The goal of a root cause analysis is to conduct a thorough and credible investigation to identify the underlying factors that contributed to the event, in order for corrective actions to resolve the causal factors, and prevent recurrences of the problem.

The responsibility for facilitating the timely investigation of a sentinel event and conducting a root cause analysis is held by the Risk Management Department. The Manager for Quality Improvement and Regulatory Affairs will work collaboratively with representatives from Medical Affairs, Site Operations staff, and Nursing, as well as those disciplines involved in the event. In certain circumstances, for events that are not sentinel event occurrences, the Risk Management Department may, in its best judgment, decide not to conduct a full root cause analysis.

Components of the Root-Cause Analysis (RCA) are the following:

- The analysis initially attempts to delineate the specific sequence of events leading up to the event and the department/services/personnel involved.
- The analysis then attempts to uncover the proximate cause(s) of the event. In many cases the first layer of “cause” is due to human error, equipment failure, procedural error.
- Finally, the analysis attempts to identify what needs to be done, what systemic improvements are needed to reduce the risk of another sentinel event.
- After corrective action plans and risk reduction strategies are implemented, data are collected to ensure effectiveness and reduce potential for future recurrences of the event.
- The objective of a RCA is one of education. It is not punitive and not solely related to any specific individual. It is to identify processes that break down and then educate the staff regarding changes to improve future performance. The Risk Management Department will determine if an RCA is to be completed. If so, the RCA must be completed within 30 days of the determination that a sentinel event has occurred.

In summary, the characteristics of an acceptable root cause analysis encompass the following:

- Proximate factors
- Analysis of systems and processes
- Addresses all areas of concern
- Identifies possible underlying systemic factors
- Potential improvements
- Action plan
- Measurement strategy
- Review of literature for best practices and lessons to be learned

E. PROCEDURE

1. Immediately upon discovering the occurrence of an unexpected adverse event, the staff member is to notify his/her Supervisor.

2. The Supervisor or designee is to notify the site President and COO, and the Risk Management Department of the occurrence as soon as he/she receives the notification. In their absence, the Administrator on call for the site is to be notified.

3. The Supervisor or designee is to complete the institution’s internal event report via STARS electronic event reporting system located on KaleidascopE.

4. The Manager for Quality Improvement and Regulatory Affairs will initiate with the site President and COO, the site CMO, and the site CNO, an initial assessment to determine if the incident meets the definition and criteria to be considered a sentinel event or a serious NYPORTS event. This will be a collaborative, interdisciplinary process.

5. If is determined that the event meets criteria for a full root cause analysis, the Manager for Quality Improvement and Regulatory Affairs and the site CMO or designee, and the site CNO or designee will conduct a full RCA by convening a site investigatory team composed of the various disciplines applicable to the event. The analysis of the event and identification of improvements must be completed within 30 days of the determination that a sentinel event has occurred.

6. The Executive Management team members for the involved departments bear the overall responsibility for assuring improvements to prevent future adverse events are implemented and monitored. The Risk Management Department will monitor that the corrective actions of the department are actually put into place as outlined in the Root Cause Analysis.

7. The incident and the risk reduction strategies for improvement will be presented to the Kaleida Health Nurse Executive Council and to the Kaleida Health Quality Improvement and Patient Safety Committee thus taking site-specific actions system wide, as applicable.

F. SUMMARY

Upon notification of a potentially serious event, the Risk Management Department assumes the responsibility for facilitating the investigation of the event. The Manager for Quality Improvement and Regulatory Affairs will convene an interdisciplinary investigating team to collaboratively analyze the event and conduct a root cause analysis if applicable. The Quality Improvement and Patient Safety Committee and Nurse Executive Council will receive monthly reports. The committees will assist in evaluating the
effectiveness of the risk reduction strategies by reviewing post implementation data, as applicable.

G. CONFIDENTIALITY

Employees are not to discuss any serious event with the patient, family members or other employees. It is the responsibility of the attending physician, along with a senior representative from the area where the problem occurred (if advisable), to discuss the event with the patient and/or family members. This discussion should be documented in the medical record. The discussion should be an honest, brief account of the facts and once any investigations (s) are complete, the patient and or family member may be provided with additional appropriate information under the guidance of the Chief of Service and the site CMO, based on recommendations from the Associate General Counsel for Corporate Risk Management. The discussion shall not include speculation as to the cause of the event or which healthcare providers, if any, are responsible.

NOTE:
For further information please see the policy, “Disclosure to Patients of Medical Outcomes.” (Corporate policy #: RM.2)

All documentation (except for the medical record itself) that is related to the event will be considered confidential and protected from disclosure as part of the quality improvement, peer review and risk management processes. The privacy and confidentiality of all involved parties should be protected at all times.

H. REPORTING OF SENTINEL EVENTS TO JOINT COMMISSION

At this time, notification to the Joint Commission remains voluntary. Due to the risk of potential discovery and New York State law, sentinel events will not routinely be reported to the Joint Commission in Chicago, Illinois. The Chief Executive Officer (CEO) will make the final decision regarding reportability. Upon inquiry from the Joint Commission root cause analysis reports are made available to the Joint Commission.

V. QUALITY OF CARE-N/A

VI. REFERENCES-N/A

VII. REVISIONS
Revisions shall be initiated by the Risk Management Department.

Kalsida Health developed these policies and procedures in conjunction with administrative and clinical departments. These documents were designed to aid the qualified health care team in making clinical decisions about patient care. These policies and procedures should not be construed as dictating exclusive courses of treatment and/or procedures. No health care team member should view these documents and their bibliographic references as a final authority on patient care. Variations of these policies and procedures in practice may be warranted based on individual patient characteristics and unique clinical circumstances.
Kaleida Health

Corporate Compliance
Corporate Compliance

Why is it needed?
- An extension of corporate values, vision, & mission statements
- Abuse and fraud in health care has heightened government intervention to eliminate abuse and fraud involving Medicare, Medicaid, and other regulatory matters
- Promotes integrity
- Improve quality in procedures and systems
- **It simply makes good business sense**

How does it start?
- Policies and Procedures apply to:
  - Board of Directors
  - Executive and senior management
  - Directors, managers, and supervisors
  - Medical staff
  - All other employees
  - Volunteers
  - Non-employees, vendors, independent contractors

Code of Conduct & Business Ethics
- Legal Compliance
- Business Ethics
- Respect for Patients
- Confidentiality
- Conflict of Interest
- Business Relationships
- Protection of Assets

HIPPA TIPS
- Refraining from displaying in public areas anything that contains identifiable patient information
- Positioning computer screens with patient information in a way so that the information cannot be easily read
- Closing patient charts and medication books if they are left unattended

If you believe someone’s privacy rights have been violated while a patient at Kaleida Health, notify your immediate supervisor or contact the Kaleida Health Privacy Officer at (716) 859-8516 or call the Compliance Hotline at (716) 859-8559

For detailed information access Kaleida Health Policy and Procedures from the Kaleidascope Homepage
DO THE RIGHT THING

If you have concerns about . . .

- Violations of Kaleida Health Policy
- Violations of Laws, Regulations or Rules
- Fraud or Abuse
- Possible Conflicts of Interest
- Any Non-Compliant or Illegal Activity
- The safety or quality of care provided by Kaleida Health

. . . you can make a **confidential report**.

- Call the Kaleida Health Compliance Hotline at **859-8559**, or
- Submit a written report using a copy of the form that follows this notice, or
- Arrange for a personal meeting with the Kaleida Health Compliance Officer by calling **859-8516**, or
- Contact a member of the Audit & Corporate Compliance Committee of the Kaleida Health Board, or
- Call the Joint Commission, or
- Access the STARS program on KaleidaScope, or
- Contact the appropriate government agency under the relevant Federal and/or State laws.

Help assure a compliant workplace!

**There will be no retribution or retaliation by Kaleida Health or its staff against an employee whistleblower who makes a report.**
COMPLIANCE REPORT FORM

Any employee using this form to report non-compliant behavior is assured that by making this report there will be no retribution or retaliation by Kaleida Health or any staff member against the employee making the report. Federal and New York State laws, as well as Kaleida Health policies, protect employee whistleblowers in this regard. The report will be maintained in a confidential file and the reporting employee’s name will be treated confidentially unless disclosure is required as a matter of law. An employee may make a report verbally by calling the Compliance Hotline at 859-8559.

Date: _______________________

Name of Employee Making Report (optional): ________________________________

Site: □ BGH □ MFG □ WCHOB □ MFS □ DMH □ Other (specify): ________________

Department: ________________________________

Subject of Report (Please be as detailed as possible, providing dates, individual and department names, and details of incident(s) or activities believed to be non-compliant.):
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Convenient times, locations and telephone numbers where you can be reached if additional information is needed:

Time: __________ Location: ___________________________ Phone #: ________________

Time: __________ Location: ___________________________ Phone #: ________________

Time: __________ Location: ___________________________ Phone #: ________________

Time: __________ Location: ___________________________ Phone #: ________________

Please place this report in a sealed envelope and send it to: Richard O. Hopkins, Compliance Officer
Kaleida Health
726 Exchange St., Suite 200
Buffalo, NY 14210
Kaleida Health

Risk Management
Risk Management

To promote a safe, secure, caring, healthy, working and learning environment that ensures the protection of patients, employees, visitors, volunteers, and property through the identification of risks as well as developing programs to manage, control and minimize loss.

The four areas of Risk Management include:

- Commercial Insurance
- Emergency Management
- Litigation
- Regulatory Affairs

Commercial Insurance

Manage Insurance Portfolio for Organization:

- Automobile
- Crime
- Directors and Officers (D&O)
- Excess
- Fiduciary
- Property
- Work with Legal to incorporate appropriate insurance limits, terms and conditions in contracts.

Emergency Management

- All staff should know the most likely hazards that could affect their facility.

- **Internal emergencies** may include:
  - Fire
  - Bomb Threat
  - Infant Abduction
  - Loss of Power

- **External emergencies** may include:
  - Winter Storm
  - Pandemic
  - Terrorism
Risk Management (Continued)

Joint Commission – Emergency Management

- Six critical areas that must be managed during an emergency
  - Communication
  - Staff Responsibilities
  - Utilities Management
  - Resources and Assets
  - Patient clinical and support activities
  - Safety and Security

Code Orange

- Call 7911 if you notice an emergency situation that requires an emergency response
- Announcement of CODE ORANGE activates the site Emergency Operations Plan
- All staff should know their role and relationship that their department or unit plays in the overall response found in each site’s Emergency Operations Plan
- Events may happen with little or no warning
- Be prepared for anything
  - Think your actions through before something happens

Emergency Plans Training and Exercises

- Specialized staff training in emergency management is available.
  - Incident management training may be required for some managers.
- Exercises simulating emergencies are conducted each year, you may be asked to carry out your duties under the Site Emergency Operations Plan during them.

Personal Preparedness

- Our communities rely on our staff during emergencies, plan to come to work!
- Prepare your families
- Develop personal preparedness plans and kits
- Prepare for the care of your pets during an emergency
- Make sure you consider all requirements during an emergency for those with special needs (physical, mental, language, etc.)
Risk Management (Continued)

Management of Litigation:

- Medical Malpractice and General Liability litigation against Kaleida Health.
- Kaleida is self insured for medical malpractice and general liability – all employees and residents are covered under this plan.
- Work closely with local law firms to defend suits and claims.

Event Reporting

- Should be entered into the STARS on-line event reporting system found on Kaleidascop e whenever there is an event that is not consistent with the routine operation of the facility or the routine care of a patient or a Great Catch.
  - Examples: Great Catch, Errors – lab, labeling, equipment, treatment, etc, Falls, Complications – known and unknown, Medication Errors – Actual or Potential

- Event Reports:
  - Collect and analyze 10,000-12,000 reports per year.
  - Used to identify risk areas.
  - Gives us ability to track and trend problems.
  - Focus on areas that require process improvement.
  - Completed by staff and reviewed by supervisor.
  - They are Confidential and Protected.
  - Internal use ONLY. Do not provide copies.
  - They are not used for finger pointing or placing blame.

- Event Reporting Regulatory Affairs
  - Sentinel or Serious Event Investigation
  - Some events are reportable to Department of Health (DOH.)
  - Risk Management determines and reports required events through the DOH Liaison for Kaleida Health.

- Available to help with Medical/Legal issues:
  - Consent Questions
  - Do Not Resuscitate (DNR) Orders
  - Sensitive patient/family issues
  - Medical Errors
  - Guidance on Legal Documents
  - Training (Formal and Informal)
Risk Management (Continued)

We stay informed with what is going on in the system through

- Committee work
- Evaluation
- Policy development
- Form development
- Staff meetings
- Involvement at the locations

Process Servers
- Subpoenas
- Summons

- Never accept service for another person.
- Refer Process servers to Administration or Risk Management.
- If served, notify your Manager and Risk Management the next business day.

Resource for All Staff

- We function blamelessly.
- We do not discipline.
- We maintain confidentiality in order to promote positive change.
- We are your consultants.
The involvement of both Kaleida staff and management is necessary to ensure that the STARS electronic event reporting systems capabilities are utilized to its fullest.

ALL staff are encouraged to report any concerns or events into the STARS system on Kaleidoscope. It is then manager’s responsibility to review these events and take the necessary actions to resolve and improve on the issues identified.

By collecting and analyzing the data that both staff and management enter into the system, Risk Management and Quality Improvement can identify areas of concern. Kaleida can then focus resources to those areas to improve processes and increase patient safety.

You will be receiving training on how to enter an event in STARS. Please use this important tool to report any incident, adverse event, compliment, complaint or concern.
Kaleida Health

Patient Rights
PATIENTS’ BILL OF RIGHTS

AS A PATIENT IN A HOSPITAL IN NEW YORK STATE, YOU HAVE THE RIGHT, CONSISTENT WITH LAW, TO:

1. Understand and use these rights. If for any reason you do not understand or you need help, the hospital MUST provide assistance.

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

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

4. Receive emergency care if you need it.

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

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

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

8. Receive all the information that you need to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.

9. Patients have the right to the appropriate assessment and management of pain.

10. Receive all the information you need to give informed consent for an order not to resuscitate. You shall have the right to designate an individual to give consent for you if you are too ill to do so. If you would like additional information, please ask for a copy of the pamphlet “Do Not Resuscitate Orders - A Guide for Patients and Families.”

11. Refuse treatment and be told what effect this may have on your health.

12. Refuse to take part in research. In deciding whether or not to participate, you have the right to a full explanation.

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

14. Participate in all decisions about your treatment and discharge from the hospital. The hospital must provide you with a written discharge plan and written description of how you can appeal your discharge.

15. Review your medical record without charge. Obtain a copy of your medical record for which the hospital can charge a reasonable fee. You cannot be denied a copy solely because you cannot afford to pay.

16. Receive an itemized bill and explanation of all charges.

17. Complain without fear of reprisals about the care and services you are receiving and to have the hospital respond to you when you request written response. If you are not satisfied with the hospital’s response, you can complain to the New York State Department of Health and/or the Joint Commission. The hospital must provide you the Health Department and Joint Commission telephone numbers.

18. Authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors.

19. Make known your wishes in regard to anatomical gifts. You may document your wishes in your health care proxy or on a donor card, available from the hospital.
PATIENTS' RESPONSIBILITIES

1. It is your responsibility to provide to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to your health. You have the responsibility to report unexpected changes in your condition to the physician. In addition, you are responsible for making it known whether the contemplated course of action is understood and that you know what is expected of you.

2. It is your responsibility to follow the treatment plan recommended by the physician primarily responsible for your care. This may include following the instructions of nurses and the allied health personnel as they carry out the coordinated plan of care and implement the responsible physician's orders, and as they enforce the applicable hospital rules and regulations.

3. By refusing treatment or not following the physicians' instructions, you are responsible to accept the consequences of your actions.

4. While hospitalized here, you are responsible for complying with hospital rules and regulations affecting patient care and conduct.

5. It is your responsibility to be considerate of the rights of other patients and hospital personnel, and for assisting in the control of noise, smoking, and the number of visitors. You are responsible for being respectful of the property of other persons and of the hospital.
Language Assistance Services

What Is Language Assistance Services?

- Designed to provide assistance with interpreting and translation services for Limited English Proficient (LEP) patients.
- Kaleida Health is required by law to provide these services free-of-charge to ensure compliance with federal and state laws.

Why Offer Language Assistance Services?

- Kaleida Health is committed to providing the best possible health care to our patients.
- Without effective communication, meaningful access to and the participation in quality healthcare can be compromised.
- Every patient or patient representative who enters our facilities with a communication barrier should be advised of his or her right to Language Assistance Services, free-of-charge. Kaleida Health uses medical interpreting as a primary method to remove those barriers.

Who Uses Language Assistance Services?

- Visually impaired.
- Hearing impaired.
- Limited English Proficiency (LEP) – the patient does not speak English as their primary language and have a limited ability to read, write, speak or understand English.

Six Points to Remember

1. Always offer interpreter services free-of-charge.
2. Always use the Language Line telephone to offer an interpreter to a patient with limited English proficiency (LEP).
3. Never use a staff member to interpret unless Kaleida Health has determined that they are a qualified interpreter.
4. Always arrange for interpreter services to be available in a timely manner. **Timely is:**
   For emergency services, within 10 minutes of the request for an interpreter.
   For inpatient/outpatient services within 20 minutes of the request for an interpreter.

5. Never allow children under the age of 16 to interpret.
6. Always document that interpreter services were offered and that the service was either accepted or declined.

If Services Are Accepted Document

- Name of agency providing the service.
- Name of person interpreting.
- Language being interpreted.
- Method of interpretation (telephonic, face-to-face, TTY).
- Date and time services were requested.
- Date and time services were provided.
- Topic of discussion during interpretation.

If Services Are Declined

- Complete and have patient sign the Waiver of Interpreter/Translator in the patient’s primary language.
- If the waiver is not available in the patient’s primary language, use Language Line to interpret the waiver.
- Document the name of the interpreter who explained the waiver (unless it was by the patient in his/her primary language) and the patient’s reason for refusing.
Kaleida Health

Laboratory Request for Research Support
Dear Investigator,

Kaleida Health Department of Pathology and Laboratory Medicine is pleased to offer support for your research project.

In order to facilitate your request and meet your needs, please complete all areas on the attached “Request for Research Support” form and forward to me, 115 Flint Road, Williamsville, NY 14221 or fax to 626-7274. We also will require a copy of the IRB approval for this study.

To ensure that we can effectively meet all of your needs, we greatly appreciate the attached “Request for Research Support” form submitted 30 days prior to the beginning date of the study.

We are happy to support your efforts and appreciate that you have selected Kaleida Laboratories. If you have any additional comments and/or questions, please do not hesitate to contact me at 626-7912 or Meg Ponvert at 626-7916 or Jeff Russell at 626-7925.

Sincerely,

Victoria R. Frano
Project Manager for Research
Kaleida Health
Department of Pathology
& Laboratory Medicine
Phone 716-626-7912
Fax 716-626-7274
vfrano@kaleidahealth.org

Enclosure
Request for Research Support

Name of Research Project: ________________________________

Date of Request: ________ Research Start Date: ________

Researcher's Name: ________________________________

Duration of Study: __________ Anticipated # of Participants: ______

Results Sent To: ________________________________

Address: __________________________ City: ______________ State: _____ Zip: ______

Phone #: __________________________ Contact Person: __________________________

Phone # To Call Results: ________________ (If different # from above)

Phone # For Critical Results: ________________ (Availability 24hr/7days)

Fax #: __________________________

Email Address: ________________________________

Charting: Reports Will Be Issued Upon Completion of the Testing.
Please list the lab tests that you would like performed and estimated volume. Call 626-7912 or 626-7925 or 626-7916 if you have any questions.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Billing Sent To: __________________________________________________________

Address: ______________________ City: __________ State: ___ Zip: ______

Phone #: ______________________ Contact Person: ______________________

Email Address: ______________________

Source of Funding: Grant ___ Departmental ___ Pharmaceutical ___

Other (Specify) ______________________________________________________________________

Copy of Research Protocol Attached: Yes/No ___

IRB Approval Attached: Yes/No ___

**A copy of the IRB is required for the Research Pricing to be applied.

******All testing will be billed to the Requesting Researcher.

Signature of Primary Investigator ______________________ Date ______

For Laboratory Use Only:

Account Number: ______________________

Account Set Up Date: ______________________
GENERAL STATEMENT:

To provide a consistent procedure for investigator’s to follow when requesting a research account. This procedure will also provide guidelines for laboratory staff to follow, allowing for expediency and consistency when initiating the account.

SCOPE:

All research activities, testing, and sample handling.

POLICY:

Research request procedure must be followed to ensure timely and appropriate handling of research accounts. Appropriate paperwork must be completed, relevant signatures must be obtained, information must be entered into the computer and pertinent staff members notified of the new account. A lead time of thirty (30) days is requested.

ADMINISTRATION:

Laboratory Administration and Management.

PROCEDURE:

I. "Request for Laboratory Support" Form

   A. Primary investigator requests research support from Outreach Manager, Kaleida Laboratories or designee. An information request form along with covering memo outlining procedure is forwarded to investigator.

   B. Form is to be completed and signed by the investigator. Investigator will return information to the Outreach Manager.
II. Setting up the Research Account

A. Outreach Manager will review the form for completeness and follow through on setting up the account and complete the following:
   1. Request a client number using account start up form and procedure.
   2. Generate file folder with account name/number.
   3. In conjunction with Laboratory Administration, provide pricing for testing, phlebotomy, and sample handling as applicable.
   4. Investigate the feasibility of any special requests (i.e. aliquoting of specimens, special stains, smears etc.) and follow the guidelines below:
      a. The laboratory will accept research samples for testing on-site or at a reference laboratory.
      b. Storage of research samples will be for a maximum of seven days at the appropriate temperature for the test(s).
      c. A fee per sample will be assessed to cover the cost of preparation and shipping to a non-affiliated laboratory. A test code will be created to allow tracking of the samples to the testing facility.
      d. Phlebotomy will be provided at designated sites. A fee will be charged for drawing the sample.
      e. If Kaleida Laboratories cannot provide services to the researcher, it will assist by providing, if at all possible, a list of laboratories or phlebotomy services that supply the needed services.

5. Make special arrangements for specimen pick up with dispatch.

6. Provide laboratory request forms as needed.

7. Obtain appropriate approvals as per the new account start form.

8. Contact investigator to pick up requisitions and to arrange start date of service.

9. Distribute account start up form and particulars of study to all affected parties including:
   1. Technical Director’s/Medical Director’s whose laboratory will be directly impacted by the study
   2. Laboratory Administration
   3. Laboratory Manager
   4. Others as appropriate

The original paperwork will be kept on file at the Center for Laboratory Medicine.

II. Follow up on Research Accounts

A. The investigator may request changes to an existing account. The Outreach Manager will evaluate request and
   make changes as needed or possible:

B. The Outreach Manager will follow through as necessary and facilitate review and resolution of specific
   problems i.e. investigator not receiving results. The Outreach Manager will bring to the attention of
   the Technical Director’s/Medical Director’s etc. any issue that needs their input. If necessary, meetings will be
   arranged with key people when an especially involved research study is to be done.

C. "Research" will be a standing agenda item at the Administrative Council meeting.
RESPONSIBILITY:

The Outreach Manager will be responsible for handling the day-to-day routine duties involved in setting up/changing accounts. The Outreach Manager will be responsible for notifying appropriate Management staff of problem areas or extenuating circumstances.

DISTRIBUTION:

This policy shall be distributed to all pathologists, technical and support staff of the Department of Pathology and Laboratory Medicine.

REVISION:

It shall be the responsibility of those designated in Prepared by or Approved by above, or their designees, to initiate revisions to this Policy as appropriate and necessary.
Kaleida Health

Abbreviated General Orientation
Self-Learning Assessment
Abbreviated General Orientation – Self-Learning Assessment

<table>
<thead>
<tr>
<th>Name</th>
<th>Department/Work Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Position</td>
<td>Manager/ Supervisor</td>
</tr>
<tr>
<td>Date of Hire</td>
<td>Scheduled New Hire General Orientation Date (if applicable)</td>
</tr>
</tbody>
</table>

Please review the below questions and circle the appropriate answer.

Note: There is only one (1) correct answer for each question. If more than one answer is selected for any question, it will be marked as incorrect.

(Last section to be completed by physicians only)

Infection Control

1. When should hands be washed?
   a. Before preparing or administering medications
   b. Between each patient contact
   c. After removing gloves or other protective barriers
   d. All of the above

2. Which type of exposure route involves blood or other body fluid splashing the eyes, nose, or mouth?
   a. Cutaneous
   b. Mucous
   c. Percutaneous
   d. All of the above

3. During Tuberculosis control, anyone entering the room must wear a N95 mask or HEPA respirator.
   a. True
   b. False

4. Which of the following is not a Transmission-based Precaution?
   a. Standard precaution
   b. Droplet precaution
   c. Contact precaution
   d. Airborne precaution
Abbreviated General Orientation – Self-Learning Assessment

Patient Safety

1. What color indicates that a patient is at risk for falling?
   a. Red
   b. Yellow
   c. Pink
   d. Blue

2. In regards to patient complaints, employees should NOT:
   a. Personally handle the complaint
   b. Contact his/her manager if unable to handle the complaint personally
   c. Tell the patient to go to someone else, because it is not their job to handle complaints
   d. Continue to move up the chain of command until the complaint is satisfactorily resolved

3. Any employee who has knowledge of patient abuse must:
   a. Report it to management
   b. Confront the employee who is abusing the patient
   c. Confront the patient who is being abused
   d. Wait for a manager to notice and take action

4. In order to ensure medication safety, one must be certain of:
   a. Right patient
   b. Right Medication
   c. Right Dose
   d. Right time
   e. Right Route
   f. All of the above

5. What is NOT an example of a sentinel event?
   a. Infant abduction
   b. Suicide
   c. Surgery on the wrong body part
   d. All are examples of sentinel events

6. Who is allowed to give an order to place a patient in restraints for medical reasons?
   a. An independent licensed practitioner
   b. A nurse
   c. Any employee caring for a patient
   d. All of the above

7. To prevent the risk of falling, any patient in need of protection should have their side rails up as soon as care is completed.
   a. True
   b. False
Abbreviated General Orientation – Self-Learning Assessment

Quality Improvement

1. When is medication reconciliation required?
   a. Upon admission to inpatient care
   b. Transfer to another level of care within the hospital
   c. At discharge
   d. All of the above

2. When must two patient identifiers be used?
   a. Whenever taking specimens
   b. Giving meds/blood products
   c. Prior to the start of any surgical or invasive procedure
   d. Prior to the start of any patient treatment/service

3. The two patient identifiers routinely used in the acute care hospital are:
   a. Name and address
   b. Name and date of birth
   c. Name and social security number
   d. Name and photo id

4. According to the Verification of Correct Patient, Procedure, and Surgical Site Policy, the proceduralist’s responsibilities include:
   a. Review of the surgical consent and completion of attestation
   b. Marking the site with their first and last initials if the procedure involves laterality
   c. Calling for the time out immediately prior to the start of the procedure
   d. All of the above
Abbreviated General Orientation – Self-Learning Assessment

Corporate Compliance

1. The Policies and procedures of corporate compliance apply to:
   a. Directors, managers, and supervisors
   b. Medical Staff
   c. Volunteers
   d. Vendors and Contractors
   e. All of the above

2. According to HIPAA, employees should keep patient’s records in areas that are not accessible to passersby.
   a. True
   b. False

3. Staff may only access the “protected health information” that they need to carry out their specific job function.
   a. True
   b. False

4. Language assistance services include all of the following except:
   a. provide assistance with interpreting and translation for Limited English Proficient (LEP) patients
   b. must be made available within 1 hour
   c. are provided free of charge in compliance with Federal and State laws
   d. are available to all patients through a language line telephone

5. Any event that is not consistent with the routine care of the patient or operation of the facility must be entered into the STARS online event reporting system found on Kaleidascope.
   a. true
   b. false

Print Name: ________________________________
Signature: ________________________________ Date: ________________

Please submit this completed form to:

Kaleida Health
Office of Research & Sponsored Projects
726 Exchange Street
Suite 270
Buffalo, New York 14210