Medical Staff Information – Education Packet
2017

This document contains a number of important Medical Staff and Hospital policies, procedures and other pertinent informational documents relating to patient quality and safety, appropriate utilization, regulatory compliance and many other topics.
April, 2017

Dear Medical Staff Member:

This document contains a number of important Medical Staff and Hospital policies, procedures and other pertinent informational documents relating to patient quality and safety, appropriate utilization, regulatory compliance and many other topics. These complement the Medical Staff Bylaws, Rules and Regulations and other Hospital policies and procedures to create what we call our “governing documents,” as together they describe and set expectations for optimal professional performance and conduct.

Medical Staff members should be generally aware of this material and especially know where to locate it when specific questions arise. Due to the volume of this educational content, we now make it available as this web-based resource that we can update as needed.

Thank for taking the time to locate and familiarize yourself with this information, and please feel free to contact the Medical Staff Office at 610-431-5224 if you have any questions, comments or need additional information.

Sincerely,

Richard (Signature)

Senior Vice President for Medical Affairs/CMO
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*Updated April 2017*
Abuse and Neglect

Neglect
All patients have the right to be free from neglect, exploitation and verbal, mental, physical, and sexual abuse. Should any staff member at any time feel that a patient may be experiencing any type of neglect; the staff member must report this information to a nursing supervisor or hospital administrator immediately.

Identifying Signs of Abuse and Neglect
Abuse and neglect do not discriminate. They occur within the privacy of individual’s homes and even within the very health care organizations that have sworn to protect and care for patients. Health care staff are responsible for identifying signs that abuse and neglect are occurring outside their facilities and for ensuring that they understanding/recognize that abuse and neglect take a number of forms that can be categorized as follows:

- **Physical abuse** – Physical abuse can include assault, rough handling, sexual abuse, or the withholding of physical necessities such as food, personal care, hygienic care, or medical care. Indicators of physical abuse include frequent, unexplained injuries; the tendency to seek care at a number of locations; reluctance to seek treatment for injuries or denial of their existence; disorientation or gogginess and fear in the presence of a caregiver, fellow patient or resident, or family member.

- **Psychosocial/Mental abuse** – Psychosocial/mental abuse can include humiliation, harassment, threats of punishment or deprivation, verbal assault, social isolation, lack of affection, or not allowing individuals to participate in decisions about their own lives. Those who perpetrate psychosocial abuse lack normal displays of emotional warmth toward the abused individual, exclude the individual from discussions about major decisions, and verbally assault him or her. A victim of psychosocial abuse may seem socially isolated.

- **Financial abuse** – Financial abuse involves the misuse of money or property, including fraud or inappropriate use of an individual’s funds. Indicators of financial abuse include cashing of pension checks without proper authorization; not paying bills and expenses; the mysterious, sudden sale of an individual’s property; sudden inappropriate revision of an individual’s last will and testament to name a new beneficiary; and gaining power of attorney under suspicious conditions. A victim of financial abuse is also likely to have a standard of living inferior or inappropriate for his or her income level and to make disproportionately high contributions to household expenses.

- **Neglect** – Neglect is withholding minimal services or resources needed to meet an individual’s basic needs. Neglect includes withholding or inadequately providing food and hydration (without physician, client or surrogate approval), clothing, medical care, and good hygiene. It may also include placing the individual in unsafe or unsupervised conditions. Neglect can lead to any of the three types of abuse listed above and can be either active or passive. In passive neglect, the caregiver unintentionally injures the individual; in active neglect, the caregiver consciously fails to meet the needs of the individual. Signs of neglect include malnutrition in a person who cannot get food without help, decline in personal hygiene, lack of needed medication or other aids, and the absence of items to meet basic needs.

Educating Staff
In health care, the idea that all staff need training in abuse and neglect detection and response has been gaining momentum because most victims will interact with the health care system at some point. All involved personnel with some direct care duties should be educated about the organization’s protocol as well as state laws and organizational policy related to reporting abuse and neglect.

Training for all staff enhances and refreshes staff members’ knowledge base regarding many subjects – including what
their roles are in recognizing and preventing abuse and neglect, and how identified cases are managed and coordinated.

**Domestic Violence**
Domestic violence is a health issue for an estimated four million women in the United States each year. Although health care providers are often the first professionals to assess a victim, many domestic violence cases still go undetected. Domestic violence towards men and women can be emotional, psychological, or physical. Domestic violence can be inflicted towards people of any race, ethnicity, socioeconomic status, and sexual orientation.
For additional information, please refer to Administrative Policies & Procedures – Suspected Domestic Violence – Policy 7.27

**Disruptive Behaviors**
Disruptive behavior has been defined by the Joint Commission as “conduct by a health care worker that intimidates others working in the organization to the extent that safety and quality are compromised.” From harassment and intimidation to abuse and assault, disruptive behavior in the workplace has a devastating impact on morale and productivity.

All staff, employees and independent contractors should have an opportunity to come to work every day and be free from working a hostile work environment. For more information, please refer to Human Resources and Organizational Development Policies and Procedures - Code of Conduct, Standards of Behavior, and the Disruptive Physician policy in Hospital Policies and Procedures and in the Medical Staff Bylaws.

**Abuse and Neglect Resource**
If you have questions about this information, contact the Medical Staff Office, a Nursing supervisor or any member of Administration.
Antibiotic Stewardship

According to the Centers for Disease Control and Prevention, antibiotic-resistant bacteria cause more than two million illnesses and at least 23,000 deaths annually in the United States. As most providers know, excess and/or inappropriate prescribing of antibiotics contributes to antibiotic resistance and therefore represent threats to patient safety. Efforts to reduce bacterial resistance globally by prescribing antibiotics more carefully, correctly and thoughtfully are collectively known as “Antibiotic Stewardship.” Healthcare providers can aid in stewardship efforts by employing the following specific measures:

- **Prescribe judiciously**
  - Avoid treating viral syndromes with antibiotics, (strongly suspected and especially laboratory-confirmed) even when patients ask for them.
  - When antibiotics are indicated, prescribe only the appropriate dose for the recommended duration.
  - Be aware of antibiotic-resistance patterns in the area so that you can choose the right antibiotic (consult with the Laboratory Microbiology Department as a valuable resource). Annual antibiograms are posted on the CCH Team page.
  - Include cultures whenever possible and reassess antibiotic choice based on the culture results. Adjust, change or stop the antibiotic as indicated.

- **Collaborate with colleagues...**
  - Especially infectious disease specialists, laboratorians, infection preventionists, and pharmacists regarding antibiotic indications, choices, duration of therapy, and management of adverse effects. At Chester County Hospital, these professionals sit on an Antibiotic Stewardship Committee whose recommendations are disseminated to the Medical Staff.
  - Discuss appropriate antibiotic use with your patients, who often initiate the demand for antibiotic prescriptions.
  - Utilize patient and provider resources offered by the Centers for Disease Control and Prevention (CDC), professional organizations such as Society for Healthcare Epidemiology, and as mentioned above, the Hospital’s Antibiotic Stewardship Committee.

- **Prevent the spread of resistant organisms**
  - Follow hand hygiene and other infection control measures with every patient.

Active participation in antimicrobial stewardship will improve individual patient outcomes, reduce the overall burden of antibiotic resistance, and save healthcare dollars.

Antibiotic Stewardship Resources:

**Charleen Faucette, MT(HEW)**
Director, Infection Prevention
Tel: 610-431-5485 | Cell: 484-467-6746 | Fax: 610-738-2589
Email: Charleen.Faucette@uphs.upenn.edu

**James A. Curtis, Pharm.D., BCPS, BCCC**
Associate Director of Pharmacy
Tel: 610-732-6745 | Fax: 610-738-2616
Email: James.Curtis@uphs.upenn.edu
AUTOPSY GUIDELINES

from

HOSPITAL ADMINISTRATIVE POLICY AND PROCEDURE MANUAL #7.15

Policy/Purpose:

I. GUIDELINES FOR AUTOPSIES

A. The following categories of cases fulfilling the requirement(s) for forensic jurisdiction are referred to the Chester County Coroner’s Office.

1. Sudden*, violent, or suspicious deaths.
   a. Homicide
   b. Poisoning
   c. Trauma

2. Patients delivered to the Emergency Department “Dead on Arrival” (DOA).
   a. Automobile accident

3. Deaths with no known cause.

4. Deaths due to mine accidents

5. Deaths due to drownings, cave-ins, or subsidences (sinking or setting).

6. Stillbirths greater than 16 weeks gestation.

7. Infant deaths within 24 hours after birth.

8. Deaths of premature born infants where the cause of death is not properly certified.

9. Deaths of individuals under 18 years of age.

10. Intraoperative deaths.

11. Postoperative deaths within 24 hours.

12. Deaths where the cause of death is not certified by a duly authorized person

   *Sudden deaths are defined with the meaning of the law as any death “if it occurs without prior medical attendance by a person who may lawfully execute a certificate of death in the Commonwealth of Pennsylvania or if, within 24 hours of death, the decedent was discharged from such a medical attendance began within 24 hours of death and the medical attendant refuses or is unstable to certify the cause of death.

B. The following cases of significant medical and scientific interest are referred to the Department of Pathology, Chester County Hospital**, if criteria in part II are met.

(Reference: College of American Pathologists, 1990)

1. Unexpected or unexplained deaths which are apparently due to natural causes and are not subject to a forensic medical jurisdiction.

2. Cases in which the cause of death is not known with reasonable certainty or clinical grounds.
3. Cases in which unknown or unanticipated medical complications have ensued.

4. Cases in which it is believed that an autopsy would affect survivors or recipients of transplant organs.

5. Cases known or suspected to have resulted from environmental or occupational hazards or which may have a public health effect.

**The pathologist reserves the right to refuse any autopsy depending upon his evaluation of the circumstances.**

C. If the family desires an autopsy where the criteria listed under section B do not apply, in such situations, the following criteria apply:

1. A qualified pathologist must agree to perform the postmortem procedure.

2. Proper documentation and signed authorization procedures must be completed.

3. The family is responsible for financial arrangements and prepayment may be required.

4. There must be a physician listed who has accepted responsibility for the report.

5. The responsible next of kin must be informed that the report will be made to the physician and not to the next of kin.

II. AUTOPSY PERMISSION/AUTHORIZATION

A. Cases fulfilling the requirement(s) for forensic jurisdiction, as Coroner's Cases do not require next of kin (family) to provide "Autopsy Authorization."

1. The Coroner or Deputy Coroner signs an “Autopsy Permit” requesting the procedure in accordance with the laws of the Commonwealth of Pennsylvania and a Coroner's Pathologist performs the postmortem examination.

B. Cases of significant medical and scientific interest in patients who have been admitted to The Chester County Hospital and which are not subject to forensic medical jurisdiction require the legal permission or "Autopsy Authorization," as well as the approval, consent, or knowledge of the attending physician(s).

1. The attending physician of the deceased patient makes initial contact with the family and is responsible for obtaining permission in the form of the "Autopsy Authorization" document, which must be accurate and complete.

2. During authorization procurement, the attending physician must determine if any limitations or restrictions are imposed by the family and shall convey such requests to the pathologist verbally and in writing on the signed authorization document.

3. The following order must be considered in determining the legal next of kin. Unless declared incompetent by court order, those highest on the list take precedence over all those below:
   a. Spouse (surviving husband or wife, even if separated, but not divorced)
   b. All adult children (>18 years)
   c. All adult grandchildren
   d. Father and mother, unless there is lawful exclusive custody
   e. All brothers and sisters
   f. All nephews or nieces
   g. Grandparents
   h. Uncles and aunts
   i. Cousins
   j. Stepchildren
   k. Relatives or next of kin of previously deceased spouse
I. Any other relative or friend who assumes custody of the body for burial

Relatives of equal rank must give consent if at all possible. If two or more persons who are entitled to authorize postmortem examination assume the responsibility for burial, the written authorization of one is sufficient. Telegraphic or telephonic permission/authorization must be certified by two persons (witnessed) present as it is received.

III. THE REFERRED AUTOPSY

A. At Chester County Hospital, the Hospital Autopsy is considered a “High Risk” procedure by Joint Commission Quality Standards due to the “Low Volume” of requests for this procedure.

B. There are two categories of Hospital Autopsy Procedures (non-Coroner Autopsies).
   1. Medically Indicated/Medically Necessary Physician Request
   2. Family Request

C. To provide for optimal patient care it has been determined and approved by Chester County Hospital to refer postmortem examinations to an institution which performs this service with “routine” frequency (daily) and has a recognized department/service dedicated to this discipline. The referring institution will provide appropriate services in compliance with College of American Pathologists guidelines to include: turnaround time, documentation, records, reporting, etc.

   1. Chester County Hospital is responsible for transportation to referral institution and procedure fee for “Medically Indicated/Medically Necessary” Physician Request cases.

      Transportation to HUP/CHOP is contracted with Trans-Care (610-648-1648) after completion of documents. HUP/CHOP directly releases the decedent to the family for burial and the family will arrange transportation and payment to their funeral facility.

   2. The family is responsible for all transportation and procedure fees for “Family Request” cases.

D. The Autopsy Referral Document Packet is completed before the decedent leaves The Chester County Hospital. At the time of death, the process is initiated by the physician and nurses attending the patient, who complete all documents and forward to Medical Records with patient chart documents ASAP. The Nursing Supervisor facilitates this process. Medical Records will coordinate with Chester County Hospital Pathology Department who makes the contact with the Autopsy Referral Institution and reviews relevant chart documents, which need to accompany decedent.

E. Adult Autopsy
   1. The Hospital of the University of Pennsylvania (HUP) is an approved reference department with a contractual agreement.
      a. Current fee = $1,500.00 - $2,000.00
      b. Required documents to accompany decedent:
         i.) Adult Referral Packet available in Nursing Office and Medical Records:
            • Adult Autopsy Referral Checklist
            • HUP Authorization to Autopsy
            • HUP Clinical Information Sheet

F. Infants and Children
   1. The Children’s Hospital of Philadelphia (CHOP) is an approved reference department.
      a. Current fee = $2,560.00 - $3200.00
      b. Required documents to accompany decedent:
         i.) Infant/Child Referral Packet available in Nursing Office and Medical Records:
            • Infant/Child Autopsy Checklist
            • CHOP Referral Checklist
            • CHOP Authorization for Autopsy (CHOP Consultation Protocol is attached)
            • Clinical Information CHOP Autopsy
            • Authorization for the release of remains
            • Appropriate relevant chart documents
c. Cytogenetics are processed through the Hospital Laboratory – not CHOP

d. CHOP is not involved in the “Humanity Gift Program” and is unable to support this request for final disposition.

e. CHOP performs all procedures “free of charge” if the decedent was evaluated or treated at CHOP prior to death (includes in utero evaluations).

G. For medically necessary physician requested house cases, the Pathology Department will process a check authorization form and submit it to Accounts Payable. If signed and available, it is attached it to the Referral Document Packet to accompany the body.

Related Documents:
- Anatomic Pathology Policy: Autopsy Guidelines
- Referred Autopsy Packet for HUP: Adults
- Referred Autopsy Packet for CHOP: Infants and Children

Key Contact: Department of Pathology
Revised Sept 2013
Case Management Guidelines

Admissions, Observations, 2-Midnight Rule & Qualifying stays for Skilled Nursing Facilities

In the fall of 2013 the Center for Medicare and Medicaid Services (CMS) promulgated new rules related to distinguishing inpatient admissions from observations. Several years before that when CMS and its auditors began reclassifying some short inpatient stays as outpatient “observations” (and reducing reimbursement commensurately), hospitals across the country began proactively categorizing shorter stays as observations, where “shorter” usually meant 24 hours or less. However, some observation cases stayed longer than 24 hours, sometimes even up to three days, which added to the inpatient-observation confusion and became a financial burden for those patients needing transfer to a skilled nursing facility (SNF), since an observation stay (even one that is 3-days long) is not considered “qualifying” for Medicare coverage of the SNF stay.

The change that took effect on October 1, 2013 is that a patient’s hospital stay must “cross” at least two midnights to be considered “admitted” or “inpatient.” It’s arbitrary and at times may even seem unfair, since a patient admitted just before midnight could have a 25-hour inpatient stay, while someone getting a bed just after midnight could have a 46-hour observation.

CMS also issued new documentation requirements relating to (1) the actual order for admission, and (2) certifying the need for admission (the latter occurring via a new physician certification statement). The order for inpatient admission must be placed on or before the time of admission and specify the admitting practitioner’s recommendation to “admit to inpatient,” “as inpatient,” “for inpatient services,” or similar language. It is therefore no longer enough to say simply “Admit” or “Admit to service of . . .” etc.

That CMS distinguishes “order” and “need” obviously means that the order doesn’t automatically justify the need. This can be somewhat counter-intuitive for physicians accustomed to thinking that whatever they order must, by definition, be necessary. Instead, there must also be sufficient documentation in the H&P and progress notes supporting the medical necessity of an inpatient stay, including a reasonable prediction about the anticipated duration (starting with the expectation that it will at least “cross” those two midnights), a description of the plan of care and why it needs to occur in the hospital, and finally the plan for post-hospital care. This certification for inpatient stay must occur at some point prior to discharge and, for longer stays, the physician must recertify it on days 12, 30 and every 30 days thereafter.

Exceptions to the 2-midnight rule (i.e., a stay less than two midnights but still considered inpatients) are as follows: procedures reimbursed under the Outpatient Prospective Payment System but classified as “inpatient only” because of the complexity, need for extended recovery, condition of the patient, etc. (there’s a long list); and patients that expire or are transferred to another acute care hospital before staying two midnights.

Part of the result of these changes is that in order for the Hospital to be able to bill for an inpatient stay under CMS Part A, and in order to represent a “qualifying stay” for a subsequent transfer to a skilled nursing facility, it is not enough to simply write that the stay will be inpatient—clinical criteria that justify the inpatient status must be present and documented as well. This means is that if the physician writes “inpatient” but the documentation doesn’t justify it and the physician doesn’t change it to observation, the Hospital will be forced to bill under Part B (i.e., outpatient, which would represent a significant reduction in revenue), and any SNF would not be able to accept the transfer except on a cash basis, since it would not be covered under Medicare/CMS rules.
The Case Management Department and Physician Advisor are resources to assist the Medical Staff with ensuring that the clinical presentation and documentation support the status designation (i.e., inpatient vs. observation). The Medical Staff is expected to respond to Case Management observation-vs-admission queries as quickly as possible, since assigning the appropriate status is obviously time-sensitive.

**Procedural Patient Classification Status**

The Case Management Department has developed processes and classifications for patients to meet the requirements outlined by Center for Medicare and Medicaid Services (CMS), and identified areas to minimize risk for denial of services.

**POST-PROCEDURE PATIENTS**

*Extended Recovery* is the outpatient status designation for outpatient surgical patients the physician feels should stay in the Hospital overnight, rather than the use of Observation status for these post-operative/post-procedural outpatients. This should prevent confusion that a physician's determination that a post-procedure outpatient needing additional time in the Hospital to be "observed" represents the more formal Observation status.

- **Extended Recovery applies to:**
  - Commercial payer patients who are pre-certified as outpatient and do not have a surgical complication or change in procedure from what was pre-certified; and
  - Medicare/CMS patients who have procedures that are not on the CMS Inpatient-Only Procedure List and do not have a surgical complication or change in procedure from what was originally intended

Inpatient orders must be entered prior to the start of the procedure for Medicare patients having procedures listed on the CMS Inpatient Only Procedure List. Holding room nurses will ask that surgeons enter the IP order at the time of site verification, but this can be done earlier if desired as long as the orders have been entered at the time of surgery. Such patients will be identified based on the CPT code the surgeon's office places on the reservation form; if applicable, the physician or extender will be asked to place an order prior to the procedure.

*These processes are for billing compliance and will not impact the care patients receive. For questions and concerns, please contact:*

**Michael McGarrigle, RN MSN**
Director of Case Management
Chester County Hospital
Tel: 610-431-5589
Email: Michael.McGarrigle@uphs.upenn.edu
Chemical Safety

Within our workplace various chemical products allow us to do our jobs more easily and effectively. At the same time some chemicals can present a danger if not used safely. Hazardous chemicals can be flammable, poisonous, corrosive, radioactive or carcinogenic, or those that pose reproductive hazards. If your job requires handling any of these substances you have a right to know the hazards involved and how to properly protect yourself.

**Hazardous Materials**
The best source of this information is the Safety Data Sheet, commonly called the S.D.S. Supplied by the manufacturer of the product, it contains the following:
- Name of product
- Ingredients
- Intended use
- Manufacturer’s name and phone number
- Hazards
- Safety precautions
- First Aid
- How to manage spills
- How to extinguish in case of fire

**Chemical Information**
Each hazardous chemical is listed by manufacturer, product and product number, and maintained in a list specific to each department. To quickly access the information when needed, the hospital subscribes to a service that can provide the S.D.S. 24-hours-a-day by fax or email within 15 minutes of a request. To obtain a specific S.D.S. dial 1-800-451-8346 and give the dispatcher the hospital’s name, the product name and number, the manufacturer and your fax number. This procedure is posted in every department.

A second source of information is the label on the container. It provides a reminder each time a product is used. To ensure this information is available, chemicals should not be transferred out of their original containers unless special procedures have been established in your department.

**Safe Handling**
Part of working safely with chemicals is making sure that you use the proper personal protective equipment. Depending on the particular chemical involved this might include such things as goggles, gloves, gowns or masks. The hospital provides these and requires that they be worn when indicated.

**Chemical Spills** • Refer to the Green Chemical Spill Poster found in your department.
- Remove any patient or others in the immediate vicinity.
- Cover the spill to help prevent spreading.
- Close the door if in a particular room.
- Call the Spill Team at extension 2222 or (9) 911 (for off-site).

Refer to Penn Medicine UPHS Safety Policy CS-00-04 and CCH Department of Plan Operations. Policy 7005.0

**MSDS to SDS**
OSHA revised its Hazard Communication Standard (HCS) to align with the United Nations’ Globally Harmonized System of Classification and Labeling of Chemicals (GHS). Two significant changes contained in the revised standard require the use of new labeling elements and a standardized format for Safety Data Sheets (SDSs), formerly known as, Material Safety Data Sheets (MSDSs). The new label elements and SDS requirements will improve worker understanding of the hazards associated with the chemicals in their workplace. (Effective June 1, 2015)

Information the employee would expect to see on the new labels, including the:
- **Product identifier**: how the hazardous chemical is identified. This can be (but is not limited to) the chemical name, code number or batch number. The manufacturer, importer or distributor can decide the appropriate product identifier. The same product identifier must be both on the label and in Section 1 of the SDS (Identification).
- **Signal word**: used to indicate the relative level of severity of hazard and alert the reader to a potential hazard on the label. There are only two signal words, “Danger” and “Warning.” Within a specific hazard class, “Danger” is used for the more severe hazards and “Warning” is used for the less severe hazards. There will only be one signal word on the label no matter how many
hazards a chemical may have. If one of the hazards warrants a “Danger” signal word and another warrants the signal word “Warning,” then only “Danger” should appear on the label.

✓ Pictogram: OSHA’s required pictograms must be in the shape of a square set at a point and include a black hazard symbol on a white background with a red frame sufficiently wide enough to be clearly visible. A square red frame set at a point without a hazard symbol is not a pictogram and is not permitted on the label. OSHA has designated eight pictograms under this standard for application to a hazard category.

✓ Hazard statement(s): describe the nature of the hazard(s) of a chemical, including, where appropriate, the degree of hazard. For example: “Causes damage to kidneys through prolonged or repeated exposure when absorbed through the skin.” All of the applicable hazard statements must appear on the label. Hazard statements may be combined where appropriate to reduce redundancies and improve readability. The hazard statements are specific to the hazard classification categories, and chemical users should always see the same statement for the same hazards, no matter what the chemical is or who produces it.

✓ Precautionary statement(s): means a phrase that describes recommended measures that should be taken to minimize or prevent adverse effects resulting from exposure to a hazardous chemical or improper storage or handling.

✓ Name, address and phone number of the chemical manufacturer, distributor, or importer
• Employees might use the labels in the workplace for the following reasons. For example,
  ✓ The label can be used to ensure proper storage of hazardous chemicals.
  ✓ The label might be used to quickly locate information on first aid when needed by employees or emergency personnel.
• General understanding of how the elements work together on a label. For example,
  ✓ Explain that where a chemical has multiple hazards, different pictograms are used to identify the various hazards. The employee should expect to see the appropriate pictogram for the corresponding hazard class.
When there are similar precautionary statements, the one providing the most protective information will be included on the label.

Chemical Safety Resources
If you have questions about this information or the products in your area, contact your department manager, supervisor, or one of the following resources.
John Felicetti
Director of Safety, Security and Emergency Management
Phone: 610-431-5558
Email: John.Felicetti@uphs.upenn.edu
Spill Team
Phone: x2222 or (9) 911 (for off-site)
Safety Data Sheet
Phone: 1-800-451-8346
Provide the dispatcher the hospital’s name, the product name and number, the manufacturer and your fax number/email address.
Corporate Compliance

Penn Medicine Chester County Hospital (“CCH”) is committed to a high standard of individual and organizational conduct, as evidenced by the establishment of a Corporate Compliance Program designed to prevent and detect violations of federal, state, and local laws, rules and regulations and third party payer guidelines. Medical Staff members have specific responsibilities in ensuring this compliance, particularly in the following areas:

- documenting medical necessity when providing treatment and/or ordering ancillary studies;
- promptly and appropriately managing patients with emergency medical conditions as specified in The Medical Staff Bylaws;
- safeguarding the confidentiality of protected health information;
- following regulatory guidelines that address financial relationships with referral sources and vendors;
- voluntarily reporting exclusion from participation in federally funded healthcare programs or other sanctions.

CCH has developed a written Code of Conduct that addresses Corporate Compliance in more detail, in addition to specific policies and procedures that govern medical information privacy and the submission of claims to CMS (the Center for Medicare and Medicaid Services). The Hospital will also conduct regular audits designed to determine the accuracy and validity of claims for outpatient testing (including a review of coding, diagnostic information, and record keeping), monitor electronic access to confidential medical information, and report any violations and remit any overpayments to the Office of Inspector General (OIG).

Additionally, as part of the routine procedure for appointment and reappointment, the Medical Staff Office will check the OIG Sanction List to identify Medical Staff members who have been excluded from participation in federally funded healthcare programs.

For any questions related to any of the above or any other compliance-related issues, feel free to contact Carl Adkins, Vice President and Compliance Officer (610-431-5322 or Carl.Adkins@uphs.upenn.edu), or Dr. Richard Donze, Senior Vice President for Medical Affairs (610-431-5480 or Richard.Donze@uphs.upenn.edu).
**Electrical Safety**

Healthcare depends on electricity. Electricity powers much of the medical equipment used to help patients. Equipment powered by electricity includes diagnostic equipment such as EKG’s, therapeutic devices such as physical therapy equipment, and life-support equipment such as incubators and respirators. However, electricity can be dangerous if it’s not used safely. Dangers could include shock, explosion, fire and burns. All can result in injury, disability, and even death.

**Expected knowledge by all health-care team members**

- Understand the hazards of electricity.
- Follow all required safety precautions.
- Report all safety problems.
- Recognize that an electrical hazard can harm anyone in a health-care facility – especially patients.

**Electrical Safety Plan**

- Cooperate with safety education programs.
- Understand the safe maintenance guidelines for medical equipment.
- Know the risk assessments and inspections.
- Be aware of the reporting procedures for safety problems

**Report safety problems**

- All safety-related injuries, illnesses and damage to property.
- Dangerous situations (i.e. a puddle in a hall, a frayed extension cord, etc.).

**Basics of Electricity**

**Circuits** – Electricity travels in a circuit (for example, from an outlet to a machine and back). If you break the circuit, by shutting off the machine or unplugging it, you stop the flow of electricity. People can become part of a circuit and receive a shock.

**Conductors** – Conductors carry electricity. Metal, such as wire, and water are conductors. If they are part of a circuit carrying electricity, you can get a shock if you touch them.

**Insulators** – Insulators, like wood, rubber, glass and plastic, protect you from shock because electricity can’t pass through them. The casing around wires is an insulator.

**Possible sources of shock in a health-care facility**

If electricity is flowing through the following, you can get a shock from touching them:

- A metal bed frame.
- Wet bedding.
- Faulty electrical equipment.
- A frayed cord.

**Plugs and Wires**

**Connections**

- All plugs should be hospital-grade, designated by a green dot. Use child-proof caps and plugs in areas where there are children.
- Plugs should fit firmly into outlets.
- If any connection feels warm, pull out the plug. Tag the plug and outlet and report the problem. Don’t use the plug or outlet until the problem has been repaired.
- Always grasp the plug to remove it from the outlet. Never pull the cord.
- Never use “cheaters,” which convert three-pronged plugs into two-pronged plugs. The third prong helps protect you against shock.

**Power Strips/Surge Suppressors**

- Surge suppressors are only to be used for electronic computer components. They are not to be used for pencil sharpeners, refrigerators, coffee pots, etc.

**Cords**

- Check cords frequently for fraying and other defects.
• Keep cords away from oil, grease or any material that could damage them.
• Keep cords out of the way of traffic.
• Avoid using extension cords and never overload them.

**Safe Medical Device Handling**

• Oxygen equipment: Sparks can cause oxygen cylinders to explode. Take care in oxygen therapy areas to prevent sparks.
• Anesthesia equipment: Because oxygen is used with anesthesia machines, uncontrolled sparks can cause the surgical site to catch fire. Be alert for electrical hazards and anything else that can cause a flame near anesthesia equipment.
• Defibrillators: Devices that deliver an intense shock to the heart. Persons should stand clear of the patient when a defibrillator is discharging. Additionally, a defibrillator should not be discharged in an oxygen enriched environment.
• Electro-surgery units (ESU): Surgical devices that deliver high levels of electrical energy. Caution should be used when using an ESU near anesthesia and oxygen equipment.

**Electrical Safety Tips**

• Don’t put anything wet on electrical equipment.
• Turn equipment off before unplugging it.
• Use separate outlets for devices that use a lot of electricity.
• Read and follow manuals for all equipment.
• Never try to repair equipment, unless you’re authorized.

**Some Hazardous Areas**

**Kitchen and Laundry**

• All large appliances should have three-pronged plugs.
• Never touch an electrical appliance and plumbing at the same time.
• Never run a cord across a sink, a wet floor, a stove or other hot surface.

**Building maintenance and storage areas**

• Use special, non-sparking tools in dusty or potentially explosive areas.
• Protect cords from oil, water and anything sharp or rough.
• Keep cords out of the way of traffic.
• Make sure circuits aren’t overloaded.
• Always shut off valves and switches before working on electrical systems.

**Small Electrical Fires**

• Use care. If a small fire is confined to a piece of equipment such as a motor, break the circuit by pulling the plug, turning off the switch or tripping the circuit breaker. Follow the R.A.C.E. procedure.

**Electrical Shock**

• In case of an electrical shock, don’t touch the person or equipment, wire, etc., causing the shock.
• Shut off the power by turning off the circuit breaker or unplugging the fuse, if possible.

**Electrical Safety Resource**

If you have questions about this information, contact your department manager, supervisor, or the following resource.

Ron Gaudi  
Director, Plant Operations  
Phone: 610-431-2475  
Email: Ronald.Gaudi@uphs.upenn.edu
Emergency Management Overview for Physicians and Licensed Independent Practitioners

Overview

The Joint Commission requires physicians and other licensed independent practitioners to know what their role will be in an emergency or disaster. Hospitals are required to communicate in writing with each licensed independent practitioner regarding his or her role and to whom he or she reports during an emergency or disaster. (EM.02.02.07 EP8)

This summary is designed to provide an overview to you of the Emergency Operations Plans (EOP) in place for the Chester County Hospital.

The Emergency Operations Plan is a guideline for coordinating the Hospital’s response to handling any emergency event that impacts the operation of the Hospital, impedes access to the facility, requires a large commitment of staff and resources or in any way provides an extraordinary burden on the normal functions of the hospital or the related satellite locations.

The Emergency Operation Plan is a multi-part plan that is activated by the respective Hospital leadership in response to the impact an emergency incident has on normal operations. Examples of such emergency incidents include a mass casualty event, severe weather conditions, loss of a major utility, loss of a major IS system, a fire or other event which impacts the infrastructure of the institution or the ability to provide service. Impacted areas may include hospital based or off-site locations.

Concept of Operations

When a significant adverse event occurs, either internal to the facility or externally in the local/regional area, an assessment will be made by senior leadership of the impact of that incident on hospital/practice operations and the ability of the hospital/practice to continue to provide care and support to patients, visitors, and staff. The sequence of activity includes:

- Recognizing that a significant event has occurred which has or will impact Hospital operations.
- A determination by the Director of Emergency Management, Senior Administration, the Administrator-on-Call, or Administrative Supervisor that an emergency should be declared.
- An overhead announcement (Code Yellow) is made in the Hospital that the emergency operations plan is in effect.
- Mass communication/notification systems are utilized to alert key staff members that the Emergency Operations Plan has been activated.
- Opening of the Hospital’s Command Center to coordinate the response activities related to the emergency and to provide a focal point for communication and coordination. (See page 3 for additional information on Hospital’s Command Centers)
- Assembling an Incident Command Team of key stakeholders to make an assessment of the emergency and to develop an appropriate action plan. This would include physician leadership at the Hospital.
- Providing support, coordination, and resources to respond to the event while continuing to maintain normal operations in patients areas (inpatient or outpatient) not affected by the emergency.

Roles & Responsibilities

The Director of Emergency Management, Chief Operating Officer or the “Administrator on Call” is typically the “Incident Commander” and has overall responsibility and accountability for the operation of the Hospital during an emergency event. On off-hours, the Administrative Supervisors may be the initial Incident Commander.

For most physicians, as well as staff members, their roles in the Hospital’s Emergency Operations Plan is to continue to provide care to patients and/or perform your duties unless directly affected by the emergency incident or instructed to do otherwise by a supervisor or the Command Center.

Physician representation in the Hospital Command Center typically includes the Chief Medical Officer or their designee. A Medical-Technical Specialist (persons with specialized expertise in areas such as infectious disease, legal affairs, risk management, medical ethics, etc.) may be asked to provide the Hospital Incident Management Team staff with needed insight and recommendations. In an External Emergency there may be physician representatives from the Emergency Department depending on the nature of the emergency incident. Clinical Chairs and Chiefs of Service will
be kept informed of the nature of the emergency incident, the impact on their respective areas and the assistance that may be required from their services. For external emergencies, such as a Mass Casualty Event where many injured victims would be coming into the ED, physicians are requested not to respond to the ED unless requested by the Command Center.

**How the Plan is Organized**

Hospital Emergency Operation Plans are required to follow an Incident Command System (ICS) format in its structure and organization. ICS is a standardized emergency incident management system tool used at the Local, State, and Federal levels to provide a coordinated organization model with a clear chain of command and responsibilities for response to an incident. ICS is part of the National Incident Management System (NIMS) guidelines and the use of the ICS model provides command, control, coordination and communication to help responders from multiple agencies work together in an efficient manner.

**Hospital Command Centers**

When an emergency incident is identified that requires activation of the Hospital Emergency Operations Plan the hospital’s command center will be opened. The locations are:

- Board Room. Command Center phone number is 610-431-5063
- MIRA Conference Room. Command Center phone numbers are 610-431-2332/2333.

**Summary**

The Hospital’s Emergency Operations Plan is designed to respond to the impact an incident/event has on Hospital operations. This “all-hazards” approach is a standard emergency management method that ensures a coordinated response to an event, good communications, and effective control of personnel and resources while maintaining a safe environment for patients, visitors, and staff.

For more information on Emergency Management or to view a complete version of the Emergency Operations Plan for CCH, go to CCH team page, click on the Emergency MNGT. Tab located on the left side of the page to view the Emergency Operations Plan.
Emergency Codes and Email Notification Guidelines

Code Yellow
News of an impending influx of patients usually arrives first at the Emergency Department which in turn contacts the highest administrative officer in house. Depending on the time of day and day of week this could be the President, Senior Vice President of Operations, a Vice President, or the Nursing Administrative Supervisor. Together they decide if the incident will require the mobilization of additional resources. If the answer is yes, a “Code Yellow” is overhead paged.

During a Code Yellow, the Hospital Command Center is established in the Cornwell Board Room. The Command Center team is responsible for the overall emergency response, allocating supplies and personnel, and providing problem solving.

All volunteers, student nurses and physicians who are in-house must report to the Library upon hearing a Code Yellow announced. Staff who are called in from home should also report to the Library upon their arrival at the Hospital.

Some departments have special assignments to carry out during a Code Yellow. Other departments continue with their normal operations unless asked otherwise by the Command Center team. Check with your department supervisor or manager to find out if your department has special pre-assigned duties.

Emergency Preparedness drills are held twice a year to provide practice and allow us to make improvements to our plan. Some drills are held in conjunction with local Emergency Services, others are Hospital-only. If you have specific questions, please refer to The Chester County Hospital Emergency Operations Plan or contact John Felicetti, Director of Emergency Management by calling ext. 5558.

Code Blue and Code Pink
Code Blue is the Hospital’s code used when a cardiac arrest occurs in an adult. Code Pink is the internal code for a cardiac arrest in a child under 18 years of age. Dial 4444 and tell the operator “Code Blue” or “Code Pink” and location of the patient. For off-site locations, call 911 to report a cardiac arrest.

Code Green
Code Green is the Hospital’s code used when it is believed that an infant or child abduction has taken place. Check with your department supervisor to find out if your department has special pre-assigned duties. Dial 2222 to activate Code Green. For off-site locations call 911 to report an infant or child abduction.

Code PCI
Code PCI (Percutaneous Coronary Intervention) is the Hospital’s code for a newly diagnosed myocardial infarction patient who needs to go emergently to the cath lab for potential angioplasty/stenting, and calling a Code PCI automatically summons the pertinent on-call cath lab team including the interventional cardiologist. Code PCI can be initiated for patients arriving in the Emergency Department and/or for inpatients. Dial 2222 or for off-site locations, 911 to report a patient with signs and symptoms of an MI.

Code Gray
Code Gray is the Hospital’s code for a patient who presents with or develops new or worsening symptoms of stroke. The Code Gray call initiates processes for rapid assessment including NIH Stroke
Scale assessment, 45 minute windows for receiving CT and lab results, and rapid initiation of the thrombolytic agent tPA if the patient is a criteria-based candidate. The RN or other patient care provider initiates a Code Gray for patients or others (visitors, staff) who develop signs or symptoms of stroke, including:

- Sudden numbness or weakness in the face, arm or leg, especially on one side of the body
- Sudden confusion, trouble speaking or understanding
- Sudden trouble seeing in one or both eyes
- Sudden trouble walking, dizziness, loss of balance or coordination
- Sudden severe headache with no known cause

A Code Gray is called by dialing 2222. Provide the operator with your location and ask to have a Code Gray called. For off-site locations call 911 to report a patient with signs and symptoms of a stroke.

**Capacity Management Plan (formerly known as “Code Purple”)**
The steps outlined in this plan are used when the Hospital has reached a maximum capacity situation. When this occurs admitted patients are usually being held in the Emergency Department awaiting a Hospital bed impeding the ability to receive and treat new patients arriving into the Emergency Department. The Capacity Management Plan is initiated by the Chief Nurse Executive when certain triggers have been met.

**Code Red**
Code Red is the verbal alarm for a fire. Avoid the use of the word fire, as it may cause unnecessary panic. When an alarm is activated, the switchboard operators will page “CODE RED.”

**Code Armstrong**
Code Armstrong is the code used to identify a situation in which a patient is beginning to exhibit aggressive or violent behavior. The team members who respond to the code will provide de-escalation techniques to defuse a potentially violent situation or restrain a patient using approved techniques. It may also be used when more than Security staff alone is required to address the situation. Upon determination of a Code Armstrong event, dial 2222 from any hospital phone and notify the operator of:

- a. Location of the code
- b. Reason for code
- c. Name of caller

**Active Shooter**
An active shooter is an individual(s) with a firearm engaged in the attempt kill or cause serious injury to persons in the hospital or on the hospital campus. The first employee to identify an active shooter situation should call 911 and the hospital emergency number 2222 (in the hospital) and announce Active Shooter, with the location of the incident and a description of the person(s) with the weapon(s) i.e. handgun, rifle, etc. Evacuate patients and visitors if safe to do so. Upon notification the switchboard operator will announce: “Security alert + active shooter + location + take cover” three times, as well as on the hospital pager system.

General practices for coping with an active shooter situation:

- Engage the survival mindset (awareness, preparation, rehearsal)
- Utilize the four A’s response measures (Accept, Assess, Act, Alert)
  - Accept that situation is real—use your training reacting/responding to health crises
  - Assess- what going on? Where is the shooter?
Act (Avoid-Barricade-Fight)
- Avoid-get away from the shooter-report the event
- Barricade-keep the shooter from reaching you; hide in a room; lock/block the door
- Fight-Only if face to face with shooter
Alert- call the emergency number/use panic alarms if available

Rapid Response Team (Adult or Pediatric)
The Chester County Hospital and Health System is committed to implementing recommended changes in care that have been proven to prevent avoidable deaths. One of these changes involves the deployment of the Rapid Response Team. The Rapid Response Team is a group of clinicians who bring critical care expertise to the bedside when a patient’s condition becomes unstable. The teams also provide needed support for the frontline staff, especially nurses. Experienced nurses have the ability to “sense” when a patient is deteriorating, even when the clinical signs may not be obvious.

Research data demonstrates that patients begin to display signs of clinical deterioration an average of hours prior to an actual “Code Blue” episode occurring. By establishing this team, The Chester County Hospital is able to reduce the number of “Code Blues” by empowering staff to call our team of clinicians to treat patients as soon as they begin to show signs of distress.

Rapid Response Team Processes
Critical Care Nurse Practitioners respond as team leaders. CHOP physicians lead the pediatric Rapid Response Team. Nurses contact the attending physician, but do not wait for the physician to return the call before allowing the team to treat the patient. These calls also provide an opportunity for coaching and education of team members.

The team may be summoned for the following reasons:
- Staff member is worried about a patient
- Acute change in heart rate
- Acute change in blood pressure
- Acute change in respiratory rate
- Acute drop in oxygen saturation
- Acute change in mental status
- Acute change in urine output
- Chest Pain
- Symptoms of stroke
- Potentially serious medical error
- No response to treatment

Dial 2222 or (9) 911 (for off-site) to enact the Rapid Response Team. Specify Adult or Pediatric Rapid Response Team. Provide the location of a patient, visitor or employee who is ill and in need of immediate medical assistance.

Email Notification Guidelines - IT will send out IT broadcast emails using the following guidelines:

<table>
<thead>
<tr>
<th>Broadcast Message</th>
<th>Notification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yellow</td>
<td>Upcoming scheduled downtime/ outage</td>
</tr>
<tr>
<td>Red</td>
<td>Sudden unplanned system downtime</td>
</tr>
<tr>
<td>Green</td>
<td>System is All Clear and available following downtime</td>
</tr>
</tbody>
</table>
Fire Safety
Chester County Hospital works to meet fire safety standards. These standards are set by state and local governments; the Occupational Safety and Health Administration (OSHA) and other federal agencies; the National Fire Protection Association (NFPA); and The Joint Commission.*

Chester County Hospital follows a comprehensive fire safety plan that describes how it is working to protect patients, visitors and staff from fire. The plan ensures that fire detection and extinguishing systems are inspected, tested and maintained regularly, and that all staff members take part in fire drills and other training.

Common causes of hospital fires
• Careless smoking by patients, visitors and staff.
• Poor housekeeping or improper storage of items that can explode or catch fire easily.
• Faulty electrical equipment or the improper use of equipment.
• Improper use of oxygen for patient care.
• Arson (Some fires may be set intentionally).

Expected knowledge by all health-care team members
• Ways to prevent fires.
• How to sound the fire alarm.
• How to react properly if the fire alarm sounds.
• How to remove patients from danger, if necessary.
• What steps to take to prevent the spread of smoke and fire.
• How to fight small fires effectively.

Passageways and Exits
• Keep passageways and exits clear and clean from waste and spills.
• Don’t let furniture or equipment block stairways, halls or exits.
• Make sure exit paths and doors are well lit and clearly marked.
• Assure all aisles are clear of obstacles with everything to one side.

Fire doors
• Check fire doors to be sure nothing is blocking them.
• Door wedges or any other type of device are not permitted to prop open or keep a door from latching.

Trash
• Put waste in approved containers.
• Keep waste cans away from heat sources.
• Put flammable substances in approved metal cans or containers.

Flammable Items
• Keep heat sources away from items that can catch fire – Cloth (linens, mattresses, etc.); Paper (magazines, charts, etc.); Plastics (pitchers, trays, etc.)

Electrical Equipment
• Check connections and cords. Be alert for damaged cords, plugs and outlets.
• Avoid using extension cords and never overload them.
• Keep cords out of the way of traffic.
• Use equipment safely. Read all instructions.
• Don’t put anything wet on electrical equipment.
• Turn equipment off before unplugging it.
• Always unplug by pulling on the plug, not the cord.
• Don’t use any appliance that sparks or gives the slightest shock.
• Never try to repair equipment unless you’re authorized.
• Report any damaged equipment or other problems immediately.

Potential hazards
• Oxygen can accelerate a fire. To reduce the danger:
  o Secure cylinders properly. Make sure valve caps are in place.
  o Keep equipment that can spark out of the area.
  o Make sure “No Smoking” signs are visible and obeyed.
• Hazardous substances, such as cleaners, chemicals, gases and other materials, can explode or catch fire. To reduce the danger:
  o Read container labels and the Safety Data Sheet (SDS) for every chemical with which you work.
  o Store all hazardous substances in approved containers or tanks.
  o Make sure hazardous substances are stored in a non-smoking area. Check to see that “No Smoking” signs are in place.

Fire Prevention
• Check for hazards regularly. Be sure work areas are neatly maintained and free of trash and other hazards. Promptly report any conditions that could pose fire danger.
• Follow and enforce the No Smoking Policy** and rules. Remind patients, visitors and team members to do the same.
• Prevent arson. Follow all procedures for securing supplies and locking rooms. Alert Security or other staff if you see anyone or anything suspicious.

Fire Safety Plan
• Understand your specific role and responsibilities in case of fire. Be sure you know the Emergency Code phrase, the proper procedures for sounding the fire alarm, and how to remove patients from danger.
• Participate in drills and training programs. In-service trainings (orientation, fire drills, etc.) are very important because lives may be at stake.
• Know the location of fire alarms, extinguishers, emergency exits, and other safety equipment. Use only safe stairwells in the event of a fire; never use elevators.
• Be properly trained to know how to shut off oxygen. Respiratory Care Services makes the decision to shut off oxygen; listen for their instructions.

Fire Safety Plan – Acronym: R.A.C.E.
• Rescue/Remove – In a calm manner, get everyone away from immediate danger. The method you use to remove patients depends on the patient and situation.
• Alarm – Report the fire by pulling the nearest fire alarm and dialing 2222 or (9) 911 (for off-site) to report the exact location.
• Confine – Close doors and windows to help keep fire and smoke from spreading.
• Extinguish/Evacuate – Try to extinguish the fire, but only if it’s small and you can do so safely. Otherwise, evacuate.
Fire Extinguisher Types
- Class A – Use for wood, cloth, paper and rubbish fires. Do not use on electrical fires or burning liquids. You can also fight a small Class A fire by drenching it with water or smothering it with a blanket.
- Class B – Use for oil, paint, grease propane and flammable liquid fires.
- Class C – Use on electrical fires.
- Class ABC – A multipurpose fire extinguisher that can be used on all three types of fire.

Fire Extinguisher – Acronym: P.A.S.S.
- Pull the pin. Some extinguishers may have a latch or other device you must release instead.
- Aim the extinguisher low. Point the nozzle or hose at the base of the fire.
- Squeeze the handle to release the extinguishing agent.
- Sweep back and forth. Keep doing this until the fire appears to be out. Watch the fire area to be sure it doesn’t start again. Repeat the process if it does.

* The Joint Commission was formerly known as the Joint Commission Accreditation of Healthcare Organizations (JCAHO).

** No Smoking Policy: Chester County Hospital is committed to the promotion of healthy decisions and the prevention of disease, and therefore is an established smoke-free environment.

Fire Safety Resource
If you have questions about this information, contact your department manager, supervisor, or the following resource.

Chris Hagan
Fire Marshall/Director Property Management
Phone: 610-431-5515
Email: Chris.Hagan@uphs.upenn.edu
HCAHPS
HCAHPS = Hospital Consumer Assessment of Healthcare Providers and Systems
The HCAHPS survey tool was developed by Medicare to provide a standard method to measure hospitalized patients’ perspectives on care they received in the hospital. The HCAHPS survey is used by hospitals across the USA who receive payments from Medicare. Participation is required for hospitals that expect payment from Medicare.

There are 3 broad goals of HCAHPS:
• Patients get an opportunity to rate their hospital experience and give feedback to the hospital.
• People can go online to Hospital Compare and compare HCAHPS survey results among several hospitals. Healthcare consumers can compare the hospital they usually use against other hospitals in the community. Many healthcare consumers will use this information to select the hospital they use.
• Hospitals are held to a higher level of quality. Medicare reviews the survey results and calculates our score. Medicare compares our present score to our previous scores. They also compare our scores against other hospitals’ scores. Through a series of calculations, Medicare has established an incentive payment system. Hospitals with better scores will get more money withheld from Medicare.

Hospitals must send the HCAHPS survey to at least 300 patients per quarter. Surveys are sent to patients age 18 and older who stayed in the hospital at least one night and were discharged home. It is important to remember that the surveys are not sent only to Medicare patients. The surveys are mailed to patient’s homes and the patient is instructed to complete the survey and return it in a postage paid envelope. Press Ganey compiles our survey results for the patient satisfaction questions.

HCAHPS is divided into categories:
The Patient Satisfaction Survey section is divided into smaller categories. Patients rate:
• Their care from nurses
• Their care from doctors
• Their experiences involving Hourly Rounding
• Medication Teaching
• Pain Management
• Cleanliness and Quietness of the Admission
• Their satisfaction with discharge planning and preparation for self-care at home
• Their overall rating of the hospital.

Patients use the following scale to rate their level of satisfaction:
• Never
• Sometimes
• Usually
• Always

Medicare will only give hospitals payment for “Always” ratings.

Everyone can help us get ALWAYS scores for patient satisfaction!
• Keep noise level low. Ask patients, “May I close your door so you won’t be disturbed by any noise?”
• Use courtesy & respect to all patients
• Listen carefully to patients
• Explain things carefully in words the patient can understand
• Answer call lights right away
• Keep patient rooms and bathrooms clean and tidy.
• Offer patients help getting to the bathroom.
• Offer help with providing relief from pain
• Teach patients about their medicines, including side effects
• Use the Teach Back method to educate our patients and to prepare them for discharge.
• Give patients handouts about their condition, such as Exit Care, so they have information to read at home.

**Key Points**

We need every patient to give us an “Always” response on the satisfaction survey for each of the survey questions.

Employees in all departments can contribute to helping patients always have a positive experience.

Ask your Manager to show you our most recent HCAHPS scores.

Discuss measures your department can take to improve our patient satisfaction scores.

**HCAHPS Resource**

If you have questions about this information, contact your department manager, supervisor, or the following resource.

**Bev Drake**
Director of Nursing Education
Phone: 610-431-5173
Email: Beverly.Drake@uphs.upenn.edu

**Carli Meister, M.Sc(A), RN**
Director, Customer Relations and Risk
Phone: 610-431-5254
Email: Carli.Meister@uphs.upenn.edu
**HIPAA Privacy and Security Rules**
The main concept of HIPAA, which stands for Health Insurance Portability and Accountability Act, is to promote simplification in the health-care industry. The privacy part of this act protects patients’ rights to privacy about their personal “protected health information.” The security part provides standards to safeguard protected health information specifically in electronic form. U.S. Congress requires all HIPAA covered entities (health plans, clearinghouses and providers) to follow the HIPAA rules. The Chester County Hospital and Health System is a covered entity.
HIPAA rules are mandatory. All hospitals, health insurance companies, doctor’s offices, clinics, pharmacies, health-care providers in all settings must follow the HIPAA rules. In summary, EVERYONE who has access to a person’s protected health information MUST adhere to HIPAA.
Persons who have access to medical information include direct-care providers who provide treatment, persons involved in the billing process, and persons involved in health-care operations.

**Treatment** Provider examples
- Doctors and nurses, student nurses, medical students, interns and residents, nursing school instructors.
- Nursing assistants, technicians, persons who transcribe orders.
- Lab techs, phlebotomists, radiology techs, cardiology technicians.
- Dietitians, pharmacists, physical therapists, speech therapists, respiratory therapists.
- Case managers, patient educators, wound care nurses, nurse practitioners.
- Nurse and ancillary department managers, infection control practitioners.

*Treatment means the provision, coordination, or management of health care and related services by one or more health-care providers, including the coordination or management of health care by a health-care provider with a third party; consultation between health-care providers relating to a member; or the referral of a member for health care from one health-care provider to another.

**Billing and Payment** Personnel examples
- Billing clerks, accounts payable and accounts receivable personnel.
- Collections representatives.
- Persons involved in checking health insurance information

*Payment means the activities undertaken by The Chester County Hospital and Health System to obtain or provide reimbursement for the provision of health care. Determinations of eligibility or coverage (including coordination of benefits or the determination of cost-sharing amounts); Adjudication or subrogation of health benefit claims; Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related health-care data processing; Review of health-care services with respect to medical necessity, coverage under a health plan, appropriateness of care or justification of charges; Utilization review activities, including pre-certification and preauthorization of services, concurrent and retrospective review of services.

**Health Care Operations** Personnel examples
- Risk Manager, Quality Improvement Director, Staff Development Instructors. Persons who access charts for the purpose of auditing documentation, for getting data that the hospital has to report, such as number of patients in restraints, or number of patient falls per month.
- Medical Records personnel.
- Compliance and HIPAA Officers.

* Health Care Operations includes but is not limited to the following: Quality assessment and improvement activities; Outcomes evaluation; Development of clinical guidelines; Population-based activities relating to improving health or reducing healthcare costs; Protocol development; Case management and care coordination; Contacting healthcare providers and members with information
about treatment alternatives; Reviewing the competence or qualifications of healthcare professionals; Conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as healthcare providers; Accreditation, certification, licensing, or credentialing activities; Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs; Business management and general administrative activities, Resolution of internal grievances.

HIPAA Privacy and Security rules apply to all the people named above and all other people who work in a hospital setting, as well as all people who work in health care outside of a hospital.

HIPAA Privacy Rule effective date= April 14, 2003. 
HIPAA Security Rule effective date= April 20, 2005.

The purpose of the HIPAA Privacy and Security rules is to prevent the wrong people from prying into personal health information and to assure that only the right people who need to know have access to information necessary to conduct their jobs.

In today's world of facsimile machines, e-mail, cell phones, and computers, protected health information can be transmitted very quickly. HIPAA Privacy and Security Rules were established to protect this information. Everyone, yourself included, has a right to protected health information (PHI). The main goal of HIPAA is to protect the confidentiality, preserve the integrity of that PHI and make sure it is available for health care (treatment, payment and operations) to occur. You need to know and follow the HIPAA privacy and security rules (via The Chester County Hospital and Health System policies) that affect your job. HIPAA defines actions that are acceptable and actions that are not permitted. HIPAA also gives patients more control over their health information.

Training

This learning packet provides an overview of policies and procedure you need to know. Your manager will review unit or department specific policies and procedures with you. HIPAA is one of your required annual in-services and your annual review of this document is one way to achieve this requirement. All new employees receive HIPAA training during orientation.

Notice of Privacy Practices

Providers must notify patients about their privacy rights and how their information can be used. All patients receive two handouts upon admission or upon using The Chester County Hospital and Health System services (e.g. Emergency Department, outpatient areas, ACC, clinics, network services etc.). The first handout is a brochure that provides a broad overview about HIPAA Rules. The other handout is the Notice of Privacy Practices that spells out HIPAA information. The handouts are given to patients by Admissions and Registrars. Each patient is asked to sign a statement verifying that the Notice was received at the time of registration. If a patient refuses to sign or cannot sign the Notice acknowledgment, as the workforce member you are to indicate on the form your name and the reason why. If there is a change to any of the HIPAA Rules, patients will get a revised copy of the handouts so that they have the most up to date HIPAA information. The patient information is available in Spanish English.

Emergency Situations

In an emergency treatment situation, provide the HIPAA information as soon as it is reasonably practical to do so after the emergent situation has ended. The Hospital is to make a good-faith effort to get HIPAA information to the patient once stabilized. The Hospital can also mail HIPAA information to the patient after he or she has been discharged.

Other Requirements

Copies of the current Notice of Privacy Practices are posted in public areas for patients, visitors and employees to see. HIPAA handouts are updated to ensure that current information is given to patients.
Any questions or concerns about HIPAA should be put in writing and sent to:
Penn Medicine Chester County Hospital, Attention Privacy Officer
701 E. Marshall St. West Chester, PA 19380

HIPAA Privacy and Security Rules Examples
You may recognize that many of the HIPAA Rules were taught to you during school or on-the-job training. They are in place to protect patients. Now that these rules are the law, you must do each of the actions listed in this handout. Violations of these rules and policies can result in progressive disciplinary action for The Chester County Hospital and Health System workforce members. You must make these rules part of your everyday routine at work.

Some of you will have more HIPAA rules to follow that are specific to your department or job role. Your manager will review them with you.

Discussions about Patients
• Avoid speaking about patients in public places such as elevators, cafeteria, lobby, etc.
• Never discuss a patient case outside of the Hospital.
• Use a low-volume voice when discussing patient information to another health-care provider.
• Be sure to select an area where you will not be overheard.
• When reviewing medical information with a patient in a hospital room, close the door so others will not hear you.

Vigilance
All workforce members are responsible to watch for unauthorized use or disclosure of protected health information. Be sure to offer assistance should a person appear lost or out of place. Look for visitor tags and validate the identity of contractors and others. Never allow an outside person access to The Chester County Hospital and Health System computer system for any reason unless expressly authorized by the Information Technology Department and/or your Manager.

Telephone Issues
• **Volume:** Use a low-volume voice when discussing patient information on the phone.
• **Privacy:** Use a phone that is out of the main traffic pattern if you have to call a patient and discuss personal health information. Respect privacy when telephoning patients. It is okay to leave a message on an answering machine, or with someone other than the patient. But, do NOT leave a message that contains personal health information. Discuss telephone calls and telephone messages with your manager, if patient phone calls are part of your job duties.

**Example of appropriate message:** This message is for John Doe. Please call Chester County Hospital. We are calling to see how you are doing. Please Call [Department] at 610-431-XXXX.

**Pre-Admission Conversations:** It is acceptable to call a patient prior to a scheduled test or procedure if you need to get some medical history information or other information. Tell the patient that when he comes to CCH he will get handouts about his health information privacy rights.

**Family Spokesperson:** Ask each patient (or family) to give you the name and phone number of one person who will be his designated “spokesperson” and record this information. Instruct the patient and spokesperson that information about the patient’s condition will only be given to the spokesperson. The spokesperson is responsible for communicating updates to other family members or persons in the patient’s life. This accomplishes several goals: Staff has one person to contact with information. It saves time, particularly in the morning when some patients have many relatives and friends who call to see how the patient is doing. Information is given only to the spokesperson. Other callers are instructed to call the spokesperson. Information is not given to others.
Media: Do not give out patient information to the media. See Administrative Policy – “Releasing Patient Information to the Media”.

Facsimiles and Printers
Avoid routine use of a fax machine to transmit patient health information outside of the Hospital. The HIPAA Privacy and Security Rules permit The Chester County Hospital and Health System physicians to disclose protected health information to another health-care provider for treatment purposes. This may be done by fax or other means. However, anyone who uses fax machines must obey policies and procedures to safeguard and protect the privacy of health information that is sent by fax. This includes making sure printers and fax machines are located in secure areas, away from public foot traffic as much as possible. Always use The Chester County Hospital and Health System standard Fax Cover Sheet and confirm the correctness of the fax number. Any misdirected fax usage must be reported to your Manager. Discuss fax use with your manager.

Computer Technology
Penn Medicine Chester County Hospital follows strict guidelines and procedures to provide you access to the most appropriate systems necessary to conduct your job.

- Procedures include ways to validate your authorization to access electronic information and to change authorization if your job function changes. Systems access is revoked when you leave Penn Medicine Chester County Hospital. Procedures are also in place to monitor the number of times a user attempts to log-in using an incorrect identification or password.
- Be sure to arrange your computer monitor screen so that another person cannot look over your shoulder and read patient information. Most displays will be configured to go blank or display a screen saver and/or to automatically log off where appropriate. (The use of these technical controls is dependent upon the technology and the department operations). However, you should always log off of the computer when you leave it. Do NOT leave a computer screen unattended that has a patient’s protected health information on it.
- Do not share computer passwords. Try to create passwords that are not easily guessed by others, and do not post your passwords on desktops or bulletin boards. If someone inappropriately accesses patient information or an unauthorized website, and uses your password, you may be held responsible.
- Technology continues to evolve. As it does, new computer products and devices such as personal digital assistants are easily purchased. The Chester County Hospital and Health System attempts to provide for efficiency while being sure to keep the technical environment as secure as possible. Check policies and procedures and/or consult your Manager before using new technical devices.
- Never introduce diskettes or CD’s from personal or unknown sources to Chester County Hospital systems. Should you become aware of a computer virus or other malicious software, report it to your Manager and the Information Technology Department immediately.
- Any suspicious security activity, security incident (such as another workforce member attempting to access unauthorized information) or other known suspected breaches of Privacy or Security policies should be reported immediately. This should be reported directly to your Manager.

PENN MEDICINE CHESTER COUNTY HOSPITAL uses a state-of-the-art computerized patient charting system called PennChart, which has many of its own security procedures.

Email Rules and Regulations
Appropriate Use:

- Email is a privilege which should be used responsibly and productively to facilitate Chester County Hospital business.
- Employees should actively monitor and manage email mailbox contents. Periodically, delete unnecessary email messages. Set the email preference to automatically discard deleted messages.
• Keep all distribution lists and email addresses up to date to avoid misdirected information.
• Email may be sent to any recipient within The Chester County Hospital and Health System global address list and should only contain the minimum amount of protected health information necessary to accomplish the purpose for which it is being sent. No protected health information should be sent to personal email addresses.
• Should you have a business need to send protected health information outside of The Chester County Hospital and Health System firewall (for example, to send a list of patients to an accreditation organization or to the state for reporting purposes), go to the team website and select IM Apps (Interdoc) log on and follow the directions to send the email via “secure” or encrypted methods. You may need to contact the Information Management Department for assistance.
• The use of “All Users” in email is limited and strictly monitored. Anyone requiring a full-system broadcast message should contact the Information Technology department for instructions and permission.

Inappropriate Use
• When replying to or forwarding an email, review the prior message(s) before sending.
• Personal use of email should be limited and may not interfere with your work duties.
• Do not distribute copyrighted material without written permission.
• Never access another user’s email account without his/her permission.
• Do not use capital letters. This is like shouting in writing.
• Do not send chain letters. These use vast system resources.
• Do not send any email message that you would be embarrassed to find printed under your name on the front page of the local newspaper.

General Clinical Guidelines
Practice reasonable efforts to protect privacy.
• Speak in a low-volume voice, close the privacy curtain, or close the door when discussing a patient’s condition, results, plan of care, providing patient teaching, etc. Ask visitors to leave the room as appropriate for the situation. For example, an adult patient is visited by his coworkers. Visitors can go to the lounge while you discuss issues or provide health care to the patient.
• Although it is okay to talk to a patient about his health information even if a patient is in a semiprivate room, when possible, if sensitive, personal health information needs to be discussed, take the patient to a private area and post a “do not disturb” sign on the door. If the patient is too ill, take the roommate and any visitors to the lounge area. If it is not possible to move either patient, speak in a low-volume voice and take measures to protect the patient’s privacy.
• In areas that are open with multiple employees, patients, or visitors, take measures to provide some privacy such as using cubicles, curtains or dividers.
• Ensure that any areas that house patient files, such as clinics and the Medical Records Department, are supervised or locked.
• When calling out patient names or using a sign-in sheet, only use the amount of information needed to complete the task. For example, avoid announcing personal health information when you call out the name of the next patient.

Charts
Keep charts, patient folders, etc. out of main traffic patterns so they cannot be viewed by others.
• Departments that keep medical records files should be locked when personnel are not in the area. Medical records charts files should be supervised during hours that the department is
open. For example, keep charts at the nurses’ station where there is usually at least one person present.
• Limit access to a patient’s chart to those who need the chart in order to perform their job. For example: A nurse may access her patient’s health information chart, as she needs this information to do her ob. Other care providers involved in that patient’s care may access the chart because they need the information to do their jobs. Physicians, physical therapists, case managers, dietitians, etc. involved in that patient’s care may access the chart. However, a nurse, another health-care provider and other employees who are not assigned to that patient, may not access the chart. Or for example, if you work on 1 West and your neighbor is a patient on 2 West, you may not access your neighbor’s chart. Health care providers/employees of all job descriptions may not access medical information that is not part of their assignment. This includes but is not limited to these situations:
  • You may not access the chart of your spouse, child, relative, friend, neighbor, or acquaintance.
  • You may not access the chart of a co-worker or other Chester County Hospital employee.
  • You may not access the chart of a hospitalized V.I.P.
  • You may not access these charts even if the patient gives you permission.

Penn Medicine Chester County Hospital’s computer systems record user actions including viewing and altering protected health information. Whether the chart is in paper form or information kept on the computer network, you are only allowed to view, and/or work with records of patients assigned to you. If your job is not directly related to needing to see a chart to do your job, you do not have access to any charts. Examples include but are not limited to: plant operations, housekeeping, secretaries, and clerical staff who do not transcribe orders, cafeteria staff, dietary hostesses, materials management personnel, etc. Each employee is responsible for safeguarding protected personal medical information. If you see an employee who is not assigned to the patient and who has no need to view the chart, you need to approach that person and tell him/her that she/he is not allowed to read the chart. If the person does not cooperate, immediately tell your supervisor/manager.

Also note the following:

  • It is permissible to have the patient clipboards (flow sheets, I&O sheet, etc.) at the patient’s door. However, use a cover sheet and turn the clipboard toward the wall so that no identifying information (e.g., name) or health information is visible.
  • It is appropriate to post signs such as falls risk, isolation signs, or NPO at a patient’s door or bedside. Chester County Hospital’s current practice for isolation signs is that they are posted without the disease or infectious diagnosis on the sign.
  • It is acceptable in areas such as a clinic or doctor’s office for the patient chart or folder to be temporarily stored in a plastic box outside the exam room. Open areas such as ED, ACC, Endo, etc. should take reasonable measures to keep patient charts out of the public traffic pattern and supervise/restrict access to patient records.

Copying Medical Information and Charts:

  • It is appropriate to make a copy of the record when a patient is transferred to another hospital or health-care site, as this is for treatment purposes.
  • It is appropriate for Chester County Hospital to request a copy of a patient’s chart from another health-care facility.
  • It is appropriate for the Emergency Department to give a patient’s payment information (e.g. health insurance) to an ambulance service provider that gave the
patient treatment.
• It is appropriate for a doctor to request a copy of a patient’s chart for a specialist consulted on the case.
• The health Information Management Department (a.k.a. the Medical Records Department) has policies and procedures about copying records for agencies such as Funeral Directors, Department of Health, deceased individual’s authorized executor, etc. If a patient gives permission to copy his medical information to a non-health-care provider such as a life insurance company, the Hospital will do so by first getting a signed authorization form.
• HIPAA defines some situations where a request to copy a chart may be a non-routine situation. A routine situation could be copying a chart for transfer to another hospital. Non-routine situations include:
  o A request from a researcher who has appropriate documentation from the Institutional Review Board.
  o A request from the Public Board of Health.
  o Other non-routine requests to copy a chart should be told to your immediate supervisor. Tell the requestor that she/he may not view the chart until your supervisor gives permission. See your department manager for details about how your department manages these situations.

Reporting Protected Health Information to Outside Agencies
Our policies for giving out information to outside agencies will follow HIPAA rules. This allows us to create a limited set of data if appropriate.
• It is not necessary to get patients’ permission to report diseases, infections or illnesses that are required by Law to be reported to the Center for Disease Control (CDC), to the State Health Department or Public Health Department.
• It is appropriate to contact the person with the reportable disease/infection in order to determine the cause of the disease or to allow for actions to prevent further illness or notify persons who are at risk due to exposure.
• It is appropriate to report vital statistics, such as births, deaths, injuries (e.g. patient falls), health surveillance, investigations or interventions.
• It is appropriate to use protected health information to communicate a patient’s eligibility for programs such as Medicare, Medicaid, etc.
• It is not necessary to get patient’s permission to report suspected or actual abuse to appropriate authorities (child abuse, domestic abuse, neglect, and elder abuse). See The Chester County Hospital and Health System Administrative Manual for the policy about reporting abuse.
• It is appropriate to report suspected or actual drug/equipment problems to the FDA. It is NOT acceptable to sell or give patient names to drug or equipment companies that may use this information for their marketing purposes.

Occupational Health
• Employers who are required by law (e.g. OSHA or State laws) must follow existing laws regarding the findings of pre-employment physicals, drug tests, and fitness for duty examinations.
• It is appropriate for an occupational health center to report to the employer that an applicant/employee did not pass a drug screen, or did not meet requirements for hire/job duties. Covered health providers (e.g. Occupational Health Department) who make these disclosures must provide the individual with written notice that the information is to be disclosed to the employer. This notice may be posted at the site where the physical or screening is done.
• Monitoring employees’ exposure to certain substances: The agency that does the monitoring may report the test result to the employer without authorization from the employee.
• Workers’ Compensation: The Hospital is to provide the minimum necessary protected health information necessary to accomplish the intended purpose, as covered by State Law, to the insurance company or person’s employer.

Research Studies
Penn Medicine Chester County Hospital has policies and procedures about conducting research. Our current policies are very detailed and specify the conditions under which research may be conducted. We have an Institutional Review Board (IRB) that must review and give approval to any and all research on human subjects done at the Hospital.

HIPAA Privacy Rules describe conditions that must be met when using or disclosing personal health information for research purposes. HIPAA rules describe disclosure to patients about how their protected health information is used and how the patient must be informed and what types of research requires patient authorization. If your department conducts research (e.g. drug protocol trials, or equipment trials) speak to your manager or contact the secretary of the IRB at ext. 5064 for details about how HIPAA privacy rules are applied to research.

Power of Attorney / Personal Representative
A situation may arise when a patient cannot act on his own behalf and is unable to sign HIPAA papers at the time of admission or during his hospital stay. Some people, due to their medical condition and/or conditions such as mental illness, dementia, or confusion are unable to make decisions regarding their care and treatment. State Laws and other laws outline the situations when another person may be authorized through “Power of Attorney” to make decisions on behalf of the patient. The Power of Attorney is a formal legal action that gives others the ability to exercise the rights of or make treatment decisions related to an individual. Often, the Power of Attorney is a relative of the patient. HIPAA calls the Power of Attorney the “personal representative” of the patient. HIPAA rules have not changed the role of the Power of Attorney.

When a patient has a Power of Attorney, HIPAA requires the Hospital to:
• Verify a personal representative’s authority. See your manager about your department’s procedure for verification. Give the HIPAA Patient Handouts to the Power of Attorney and have the Power of Attorney sign the form confirming that she/he received the HIPAA information.
• Use the Power of Attorney as the designated contact person for all of the patient’s personal health information. The nurses/physicians/other health-care providers contact the power of attorney to give or receive health information about the patient and to make health decisions regarding the plan of treatment and care.
• The Power of Attorney may have access to the health information as needed to make decisions about treatment and care.
• If there is more than one personal representative for the patient, discuss with the personal representatives and physician the extent of authority.
• In situations where it is believed that the personal representative is in an abusive relationship with the patient, or endangers the patient, the health-care provider may deny the personal representative access to the chart. You should discuss these concerns with your manager and the physician.

Minors
• HIPAA Privacy Rules list many statements about minors and emancipated minors. If you work in an area that provides care or services to minors and/or emancipated minors, see your manager
for the details.
• The HIPAA Privacy Rules allow a parent to see their child’s medical record in most situations. HIPAA defines some exceptions, so see your manager for details. Most HIPAA rules are unchanged from current practice regarding giving/receiving a child’s health information to a parent or legal guardian.

Miscellaneous
• Disposal of Protected Health Information: Paper documents containing health information are to be shredded or disposed of in the most secure manner available to you.
• Some departments have relationships with business associates who are not The Chester County Hospital and Health System employees. These associates include accounting services, attorneys, independent medical transcriptionists, etc. Each department that has these relationships must establish policies and procedures for disclosure of protected medical information. They must have a Business Associate Agreement in place.
• Should protected health information be carried from one building to another, it must be transported in a secure manner.

Acceptable Practices
• The Hospital can send out mailings to former patients about health-related products or services offered by The Chester County Hospital and Health System. For example, we can mail an announcement about a new program for heart fitness or the introduction of a new piece of diagnostic equipment.
• An ambulance service can provide the Hospital information about the patient’s medical history, treatment given to the patient, without the patient’s authorization.
• The Hospital can maintain a census list and tell visitors a patient’s room number. It is okay to tell clergy the room number and names of patients.
• We can send reminder mailings for appointments or to remind patients that they are due for a health screening.
• Information about changes to health plan benefits, e.g. changes to their health insurance, can be mailed.
• A Hospital social worker or case manager may share a patient’s medical record with various nursing homes in the course of recommending that the patient be transferred to a nursing home.

Unacceptable Practices
• Hospitals, and other health-care providers, may not use Protected Health Information to market/sell goods and services to patients.
• A health-care provider cannot give patients’ names or other protected information to a telemarketer without the patient’s written authorization.
• Health-care workers cannot market durable medical equipment that is needed by the patient for home care. (e.g. home oxygen tanks, hospital beds or commodes for home use, etc.)

HIPAA Privacy Rules in settings outside of a hospital
You and other users of health-care services may be personally affected by the HIPAA Rules. For more details, please talk to your personal health-care provider, such as your physician, your physical therapist, and the pharmacist where you fill your prescriptions, etc.
• You should get a copy of the HIPAA Privacy Rules at all sources where you get health services (doctors’ offices of all specialties, pharmacy, outpatient clinics, etc.)
• The HIPAA Notice of Privacy Practices should be posted at all doctors’ offices.
• Your pharmacy can send you reminders for prescription refills.
• If you believe your privacy rights have been violated, you have a limited amount of time to file a report with the Office for Civil Rights.
Patient Information Breach Notification

In certain circumstances, when there has been a breach, which is the acquisition, access, use of disclosure of patient protected health information, the individual whose information was breached will need to be notified. A breach excludes

- Any unintentional acquisition, access or use of PHI by a workforce member or person acting under the authority of a covered entity or business associate if made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted.
- Any inadvertent disclosure by a person who is authorized to access PHI at a covered entity or a Business Associate to another person authorized to access protected health information at the same covered entity or Business associate and the information received is not further used or disclosed.
- A disclosure of PHI where a covered entity or Business Associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

The following are examples of breaches of unsecured protected health information:

- Workforce members access the electronic health records of a celebrity who is treated within the facility.
- Stolen or lost laptop containing unsecured protected health information.
- Papers containing protected health information found scattered along roadside after improper storage in truck by business associate responsible for disposal (shredding).
- Posting of patient’s HIV health status on Facebook by a laboratory tech that carried out the diagnostic study.
- Misdirected email of listing of drug-seeking patients to an external group list.
- Lost flash drive containing database of patients participating in a clinical study.
- EOB (Explanation of Benefits) sent to wrong guarantor.
- Provider accessing the health record of divorced spouse for information to be used in a custody hearing.
- Workforce members’ accessing electronic health records for information on friends or family members out of curiosity without a business-related purpose. This is never appropriate, even if the patient gave you permission to access his/her record.
- EMT takes a cell phone picture of a patient following a motor vehicle accident and transmits photo to friends.
- Misfiled patient information in another patient’s medical records which is brought to the Hospital’s attention by the patient.
- Medical record copies in response to a payer’s request lost in mailing process and never received.
- Misdirected fax of patient records to a local grocery store instead of the requesting provider’s fax.
- Briefcase containing patient medical record documents stolen from car.
- PDA with patient-identifying wound photos lost.
- Intentional and non-work related access by staff member of neighbor’s information.
- Medical record documents left in public access cafeteria.
- Printed hospital census left unattended on a hospital bench.

Following the discovery of a potential breach, Hospital employees should notify their supervisor who will
notify the Privacy Officer. Notify the Privacy Officer directly if the supervisor is not reachable. The Hospital as directed by the Privacy Officer and in cooperation with the security and compliance officers, shall begin an investigation, conduct a risk assessment and based on the results of the risk assessment, begin the process to notify each individual whose PHI has been, or is reasonably believed by the Hospital to have been, accessed, acquired, used, or disclosed as a result of the breach. The Hospital shall also begin the process of determining what external notifications are required or should be made. Upon determination that the breach notification is required, the notice shall be made without unreasonable delay after the discovery of the breach by the Hospital involved or the business associate involved. It is the responsibility of the Hospital to demonstrate that all notifications were made as required, including evidence demonstrating the necessity of delay. It is important for you to understand the penalties for data breaches. Penalties will be based on the Hospital’s culpability for the HIPAA violation. The Secretary of the Department of Health and Human Services will base its penalty determination on the nature and extent of both the violation and the harm caused by the violation. The Secretary still will have the discretion to impose corrective action without a penalty in cases where the person did not know (and by exercising reasonable diligence would not have known) that such person committed a violation. Workforce members can be held liable for a breach.

Identity Theft
Employees with registration responsibilities need to review and understand the Administrative Policies Medical Identify Theft and Identity Theft prevention Program.

HIPAA Resources
If you want more detailed HIPAA information, see your department manager, supervisor, or contact one of the following resources:

Carl Adkins
Compliance and Privacy Officer
Phone: 610-431-5322
Email: Carl.Adkins@uphs.upenn.edu
Infection Prevention

Bloodborne Pathogens
All members of Chester County Hospital are expected to know the meaning of standard precautions and its requirements. Employees and Medical Staff are expected to follow these mandatory practices as a routine part of their daily work activities to prevent exposure to blood and body fluids.

• All patients are treated the same (regardless of diagnosis, age, or any other factor) and all blood and body fluids are considered to be infectious.
• Staff is required to wear proper protective attire, gown and gloves, if they might touch or spill blood or other body fluid. Masks, goggles, head covers and/or foot covers should be worn whenever there is a chance that they might be splashed by blood or body fluid from anyone...including newborns, the elderly and postmortem patients.
• Perform good hand hygiene before and after touching patients, their equipment, furniture or specimens. Gloves DO NOT eliminate the need for hand hygiene and hands should be cleaned each time gloves are removed.
• Learn about, and use, all safety devices and techniques available. Be sure to activate safety mechanisms on sharps before disposal. This will help prevent you, and co-workers, from getting a needle stick or cut from blades, needles or other devices used in patient care.
• Be sure to discard all disposable sharps, immediately after use, in a puncture resistant container available specifically for that purpose. Never attempt to remove anything from a sharps container. Never recap needles.

Hospital-Acquired Infections
These are infections that patients can develop after they are admitted to the hospital. Studies show many patients get hospital-acquired infections each year. Often, these infections are caused by health-care workers who fail to change their gloves or clean their hands properly. Cleaning your hands, with soap and water or alcohol based hand gel is the simplest, most effective thing you can do to prevent the spread of infections.... Here at work and at home.

Gloves: Gloves should be changed between each patient contact and any time you think they have become contaminated. Gloves do not eliminate the need to clean hands so perform hand hygiene every time you remove your gloves.

Hand Hygiene: You should clean your hands with soap and water or an alcohol-based hand cleaner before and after every patient contact, even if you wore gloves. You should clean your hands any time you think your hands have become soiled. If you’re not sure...clean your hands! You can never do it too often. Clean hands save lives!

• Alcohol-based hand cleaner: Alcohol gels should be allowed to dry on your hands and not rinsed off. The CDC recommends the use of alcohol gels to keep hands clean in most health care situations.
• Soap and water: Washing with soap and water is necessary if hands are heavily soiled, if you’ve been to the restroom, and before or after eating. At these times, alcohol gels should not be used. Soap and water is also recommended when caring for someone with infectious diarrhea, like C. difficile or Norovirus. The CDC recommends that hands be washed vigorously by lathering with soap and water for 15 seconds (sing “Happy Birthday” to make sure you lather long enough) followed by a thorough rinsing under running water.
Remember: Artificial fingernails of any kind (nail wraps, overlays, extensions, etc.) are not to be worn by anyone working or volunteering in a patient care area.

It is part of everyone’s job to promote patient safety and help prevent hospital-acquired infections. Protect your patients; protect yourself. Clean your hands often.

Immunity to infectious diseases ....
Many people have had, or been vaccinated to prevent, certain infectious illnesses like chickenpox, measles, mumps, and whooping cough (pertussis).

We are required to keep records of the immune status of all members of the hospital team. The Occupational Health Center is expanding their files to include this information. Vaccines for these illnesses will be offered to staff that do not have proof of prior illness or vaccination.

Isolation Precautions
To help prevent the spread of communicable illnesses, to other patients and our staff, the hospital uses a system of isolation called Transmission-Based Precautions also referred to as “isolation”. There are four categories of Isolation Precautions:

- **Contact** – noted by an orange sign
- **Enhanced Contact** – noted by a brown sign
- **Droplet** – noted by a pink sign
- **Airborne** – noted by a blue sign

See Infection Control Manual Section 3

Standard Precautions should be followed with every patient. Transmission-Based Precautions (Isolation) are always used in addition to Standard Precautions. Patients in Isolation Precautions are required to remain in their rooms as much as possible. An isolation sign is placed at the entrance to the patient’s room, is there to alert anyone entering the room that there are special steps necessary...like wearing a cover gown, gloves, or mask.

It is important to remember that patients in isolation, and their families, need help to understand why additional precautions are necessary. If you are unclear, refer to the online Infection Prevention manual or check with the Infection Prevention department.

Another important step to prevent the spread of infections involves cleaning patient care equipment. You can use the alcohol-free disinfec tant wipes on most surfaces or use the hospital approved spray disinfectant provided by Environmental Services. Remember to check the contact time on the product and make sure surfaces remain wet as long as necessary to kill germs per the manufacturer’s recommendations. Sensitive items like bar code readers or computer screens may need a special type of disinfectant so check with Information Technology staff before using any cleaner on those surfaces.

Multi-drug resistant organisms (MDROs)
MDROs are bacteria that have, over time, become resistant to many of the antibiotics that are used to treat infections. Examples include MRSA (Methicillin resistant Staph aureus), VRE (Vancomycin resistant Enterococci), and C. diff (Clostridium difficile). Most people who have infections caused by MDROs are placed in Contact precautions while here in the hospital. Patients with C. diff need Enhanced Contact precautions. Following these precautions and making sure you clean your hands frequently will help prevent the spread of resistant organisms to other patients and to caregivers.
Tuberculosis

Tuberculosis (TB) is caused by a bacteria spread through the air when an infected person talks, coughs or sneezes. The most common symptoms of TB are:

- Persistent cough lasting three weeks or more.
- Bloody sputum.
- Night sweats.
- Unexplained weight loss.

Patients who show symptoms along with other diagnostic evidence of TB should:

- Be placed into Airborne Precautions in a private room with negative air pressure while being further evaluated. Doors and windows to room must remain closed to prevent contaminated air from flowing into nearby areas.
- Wear a surgical mask if they leave their room for any reason, such as x-rays or other tests.

Remember: Anyone entering a negative pressure room or caring for a patient with TB must wear a special N95 mask to protect them from TB exposure. Staff needs to be fit tested for these special masks every year.

TST Tests – Tuberculin Skin Test (previously called PPD’s)

All people working in a health-care environment have an increased risk for exposure to TB. Personnel working in close contact with patients have the most exposure risk. New employees are tested for past TB exposure using the Mantoux TST when hired. All employees who work in the building are required to have a TST done once each year. You may also need an additional skin test if you have been exposed to someone with active TB. Employees with a history of a positive skin test in the past are not required to repeat the TST. Instead, they must complete a health questionnaire once per year. Employees who develop a positive skin test will be evaluated at the Occupational Health Center and may require preventative treatment.

Remember: A positive TST means that a person has been exposed to TB. It is not proof of active disease.

A skin test or questionnaire is required of everyone who works in this facility, including volunteers and physicians. TSTs are offered on the first Tuesday of every month here on the hospital campus.

Be sure to keep up to date with your testing or questionnaire. It is a requirement and is included on your annual performance appraisal.

Infection Prevention Resource

If you have questions about this information, or need more information, contact your department manager, supervisor, the online Infection Prevention and Control Manual, or the following resource.

Charleen Faucette, MT
Director, Infection Prevention
Phone: 610-431-5485
Email: Charleen.Faucette@uphs.upenn.edu
Beeper: 0155
Fax: 610-738-2589
Latex Safety

For people who have an allergy to natural latex rubber, even a small exposure can result in a serious, even catastrophic reaction.

Chester County Hospital is working diligently to provide a latex safe environment for our patients and our staff. We have replaced all exam gloves and most sterile gloves, with a latex free alternative. Many other patient care items are also latex free and we are still working to replace those few others for which alternative products are not yet available. All new products being considered for purchase are now reviewed for latex content.

When a latex allergy exists, it is noted in the medical record of patient. Upon admission, every patient is asked about allergies including latex. An allergy bracelet must be applied when any allergy is identified. When a latex allergy has been noted, it is everyone’s responsibility to insure that no product containing latex is brought into the patient care environment. Latex allergy signs must be posted outside the patient’s door and a notation made in the chart.

We should also monitor visitors, and remind them that things like latex balloons cannot be brought into the hospital. We all have a responsibility to guarantee a safe environment at Chester County Hospital.

Latex Safety Resource

If you have questions about this information, or need more information, contact your department manager, supervisor, the online Infection Prevention and Control Manual, or the following resource.

Charleen Faucette, MT
Director, Infection Prevention
Phone: 610-431-5485
Email: Charleen.Faucette@uphs.upenn.edu
Beeper: 0155
Fax: 610-738-2589
Medical Records Completion Policy and Delinquent Chart Notification Process

Policy:
Medical records must be completed within thirty days of discharge. Attending physicians can have admitting privileges and, if applicable, privileges for operative and other procedures suspended for failure to adhere to this policy.

Purpose:
Prompt completion of medical records enhances patient care by improving the availability of clinical information for continuity of care, clinical decision making and to meet all regulatory and licensure guidelines. Secondarily it enhances the management of patient accounts.

Scope:
This policy applies to all employees and staff of Chester County Hospital (CCH). This policy also applies to: (i) those practices and sites that are off campus facilities or departments of CCH and operating under its license and (ii) personnel that provide contracted clinical services to CCH patients.

IMPLEMENTATION
The Chair of the Medical Executive Committee, the Clinical Chairs/Chiefs, and the Hospital Administration including the Executive Director, Chief Medical Officer, Chief Quality and Safety Officer and Health Information Management Department are responsible for the implementation of this policy.

The Attending Physician at the time of discharge is responsible for the timely completion of the medical record. The Health Information Management Department, Medical Record Committee, Clinical Effectiveness and Quality Improvement Committee (CEQI) and the Medical Executive Committee are responsible for monitoring compliance with this policy.

Procedure:
A. Definition of Incomplete or Delinquent Record

A medical record not completed within 30 days of discharge is considered a “delinquent record”.

A medical record is not complete until all of the following conditions have been met:
1. The Discharge Document containing final diagnoses and procedures, discharge medications and follow-up instructions to the patient is completed by the attending physician or his designee (including house staff or auxiliary health care providers within the scope of their privileges).

2. The attending physician must review, co-sign, date and time all preliminary discharge summaries, after which they will be considered final. Discharge summaries are expected to be finalized by attending physicians within 14 days of discharge.

3. A discharge summary will be required for all discharges and will include all diagnoses, procedures, significant findings, hospital course, discharge medications and follow up care documentation.

4. Operative reports should be completed immediately after the procedure. If dictated or, if otherwise not immediately available, a brief operative note or procedure progress note must be written immediately following the procedure. This note must include the name of the surgeon and assistants, procedure performed, description of the procedure findings, estimated blood loss, specimens removed and the postop diagnosis. A dictated
operative or procedure report must then be dictated within 24 hours following the procedure, authenticated by the surgeon or attending physician, as applicable, and entered in the medical record as soon as possible after the procedure.

Although the completion of components of the medical record may be performed by other physicians and healthcare providers caring for the patient who is knowledgeable about the patient’s condition and care during the hospitalization and discharge plans, the ultimate responsibility for the medical record completion is that of the attending physician of record on the day of discharge.

B. Record Completion Procedure
1. Medical record information on patients is maintained electronically within the EMR (electronic medical record). Any documentation created on paper will be retained in a secure place on the patient care unit until the Health Information Management Department personnel can pick up the paper documentation concurrently prior to the patient’s discharge.

2. The Health Information Management Department will notify the nurse manager of the patient’s care unit regarding any paper documentation not received by Health Information Management Department.

3. Medical records of patients will be available for completion electronically via the EMR.

4. Office of the General Counsel may restrict the viewing of records from the Health Information Management Department. If restricted, review or completion is allowed only by authorized personnel. The Health Information Management Department will notify the physician responsible for completion if circulation of the record is restricted.

5. Original medical records must not be removed from the Hospital except by court order or subpoena.

C. Notification Procedure
1. Thirty (30) days are allowed for medical record completion.

2. A medical record is deemed delinquent on the 31st day after discharge.

3. Automatic notification will be sent to the physician’s in-box within the EMR, alerting them to documentation which requires completion.

In addition, electronic summary notices will be sent to each attending physician on a weekly basis through their inbox within the EMR. This notice will alert the physician of all incomplete records. Pre delinquency notices will be communicated to each attending physician, on the 21st day post discharge and on the 28th day post discharge.

4. Delinquency notices will be communicated to each attending physician, the appropriate Clinical Chair/Chief (and their Business Administrator) and the VP of Medical Affairs.

5. Incomplete record status reports for all medical staff will be communicated every week to the appropriate Clinical Chair/Chief (and their Business Associate).

6. Pre-suspension notices as described in section D below will be communicated to each attending physician, the appropriate Clinical Chair/Chief (and their Business Associate), and the Chair of the Medical Records Committee.
D. Administrative Suspension of Admitting Procedures
1. If one (1) or more medical records are not complete as defined in this policy on the 31st day after discharge, the Attending Physician's admitting privileges can be administratively suspended. Although patients may be admitted, no new non-emergency admissions may be scheduled until all of the medical records are completed. Should an admission occur, based on review by Patient Access, not be considered an emergency, it will be reported to the Department Chairman.

2. Prior to administrative suspension, the Director of Health Information Management and the VP of Medical Affairs will confirm, when requested, applicability of administrative suspension.

3. Copies of administrative suspension notices are sent to the suspended physician, Patient Access, Clinical Department Chair, Chair of the Medical Executive Committee, the Medical Staff Office, and Executive Director.

4. This letter becomes a part of each physician’s permanent file and will be used as part of the documents reviewed during the Medical Staff reappointment/re-credentialing process.

5. Reinstatement of admitting privileges following administrative suspension for incomplete medical records as defined in this policy will occur immediately upon completion of the medical record(s) which were the subject of administrative suspension. Copies of the reinstatement notices are sent to the suspended physician, Patient Access, Clinical Department Chair (and his/her Business Associate), Chair of the Medical Executive Committee, the Medical Staff Office, Executive Director, and are placed in the physician’s permanent file.

6. Physicians may request an extension of time to complete records if they will be absent for more than five (5) days of the allotted time. The request must be submitted in writing, to the Director of Health Information Management prior to the completion deadline.

Health Information Management/Medical Records Resource

Kim Hagerty, RHIA  
Senior Manager of Operations  
Corporate HIM - UPHS  
O (610) 431-5142  
C (484) 354-0963  
Email: Kimberly.Hagerty@uphs.upenn.edu
Patient Rights and Ethics

Every employee and Medical Staff member is responsible for promoting customer satisfaction at all levels. Our Mission, Vision, Values, and Performance Standards define our goals and expectations in making every encounter with a patient and his/her family a positive one from the moment we say “hello”. Our patients are surveyed both by Press Ganey and by the Centers for Medicare and Medicaid Services (HCAHPS) for their level of satisfaction with the care and service we provided to them. We want every patient to rate our care and services as ‘Very Good,’ the highest possible score we can receive on our Press Ganey surveys, and as well that we “Always” provide the care they expect, which is the ideal answer for HCAPS. The HCAHPS data is publicly reported; thus inviting our patients to make choices based on how they rate the quality of care and service they both expected and received.

Responding to Customer Concerns and Complaints

Chester County Hospital is committed to responding to patient and family concerns about services and care provided. It is the responsibility of the person to whom a concern is expressed to initiate service recovery. When concerns are addressed immediately, they convey the message of caring and compassion.

Patients and families can also express concerns or complaints by calling the Operator to access the Customer Concern Line in the Quality Management Department, the Director of Customer Relations/Risk or Nursing Supervisor depending on the time of the request. The Patient Information channel also contains this information.

Either during the hospital visit or once patients return home, they may contact Administration by letter or phone call to lodge a Grievance. The Director of Customer Relations/Risk in collaboration with leadership and Medical staff, follows up on these Grievances in writing, a CMS requirement. Our ED and inpatient Patient Handbooks contain all of the above information; it is important that the patients receive and review the handbook(s) at the start of the episode of care.

Patient’s Bill of Rights

Everyone who takes care of patients or works at Chester County Hospital is responsible for protecting the rights of patients and families. The hospital is committed to the “Patient’s Bill of Rights” outlining these rights and responsibilities. Copies are included in the Patient Handbook, given to every patient upon admission to the hospital, posted in the Admissions Office, given to patients registered in the Emergency Department and all patient-care areas. Some of the rights outlined include: considerate and respectful care, reasonable access to care, the right to privacy and confidentiality, visitation rights, the right to consent or refuse treatment, the right to be told the identity of those who are taking care of them, the right to review or receive copies of their medical records and management of their pain. The Patient’s Bill of Rights is available in English, Spanish and on audiotape. Chester County Hospital introduced Open Visitation in July, 2013.

Cultural and Spiritual Diversity

Chester County Hospital is committed to respecting patients’ expression of cultural and/or religious beliefs during their stay, including dietary requirements or practices related to family or holiday events. Practice of cultural and religious beliefs is respected as long as they do not adversely affect the patient’s health-care needs.

Community Clergy and lay ministers are welcome to visit their parishioners while hospitalized. Random visitation by uninvited clergy or distribution of spiritual materials is not permitted. Patients may access clergy by dialing 2911 or asking their nurse. If emergency support is needed, the nurse or operator can call clergy for assistance.
As a hospital, we are committed to providing communications in the customer’s language of comfort whenever possible. For our Spanish-speaking patients, we provide availability to interpreters 24 hours per day. In addition, numerous educational materials are also made available in Spanish. For those patients whose language of comfort is other than Spanish, the Spectracorp service provides medical interpretation in multiple languages. The Spectracorp is available 24 hours a day and may be accessed via the Nursing Supervisor’s office. For those patients with hearing impairments, we have available amplification devices, TDD, amplified telephones, and individuals fluent in American Sign Language. Staff members must remember to document in the medical record what methods and individuals were utilized to provide appropriate communications for patients and families, recalling that family or staff are not to be used for translation.

Patients’ Rights – Self Determination
There are Federal and State Laws that protect the rights of adults to make decisions about health care in advance of the time when they can no longer speak for themselves. As a hospital, we are required to ask patients if they have such a directive. For those patients who do have one, we must ask to have a copy for the medical record. We also must provide them with additional information as requested. These documents, called “Advance Directives,” may take the form of Living Wills or Durable Power of Attorney for Health Care. The Advance Directive may identify general or specific treatments that patients do or do not want at the end of their lives and may also identify another person known as a ‘proxy’, ‘surrogate,’ or “health care representative/agent” who they want to make these decisions on their behalf. In Pennsylvania, Advance Directives may be considered operative only under certain end of life conditions and limited in circumstances such as pregnancy and emergency interventions outside of the hospital.

Ethics
Chester County Hospital strives to assure that all persons working for or affiliated with the hospital maintain ethical practices in both patient care and business dealings. The hospital’s Ethics Committee is a forum that may be used by staff, patients and families to address ethical issues. The Ethics Committee assists in education about ethical issues and trends, policy development and consultations concerning the ethical aspects of patient care.

EMTALA/COBRA
EMTALA (The Emergency Medical Treatment Active Labor Act) is a portion of COBRA (Consolidate Omnibus Reconciliation Act), a federal law of 1986, which requires hospitals to evaluate and stabilize all persons who come to the hospital seeking care for an emergency medical or surgical condition, and women in active labor. Commonly know as the “anti-dumping” law, this measure prevents hospitals from transferring or refusing to treat patients based on their ability to pay including inappropriate or premature discharge or transfer from an inpatient unit. Chester County Hospital does not transfer or refuse to treat patients based on their ability to pay for care. Patients are transferred to another facility upon a physician’s order. This may be done due to a patient or family’s request or when care or services are unavailable here.

Integrity and Responsibility
These principles are essentially two sides of the same coin. By focusing on customer service and equitable treatment of all patients, we protect the patients’ rights when they are in the vulnerable position of being a patient. These rights are safeguarded in laws such as EMTALA, HIPAA and in the Patient’s Bill of Rights.

At the same time, we attend to our own ethics to safeguard ourselves and our coworkers from behavior that is not in line with our standards for acting with integrity. These rules are outlined in such places as Human Resources and the policy and safety manuals that are available in each department.

Employees are expected to become familiar with each of these resources. It is part of everyone’s job to
know all the ways Chester County Hospital is committed to providing excellence to our customers, ourselves and our community.

Patient Rights and Ethics Resources
If you have questions about this information, contact your department manager, supervisor, or one of the following resources.

**Carli Meister**
Director of Customer Relations and Risk
Phone: 610-431-5254
Email: Carli.Meister@uphs.upenn.edu
Beeper: 0254

**Jacqueline A. Felicetti**
Chief Human Resources Officer
Phone: 610-431-5010
Email: Jacqueline.Felicetti@uphs.upenn.edu
Patient Safety & Quality

Chester County Hospital fosters a culture, which values safety, disclosure of mistakes, and ongoing performance improvement. The Patient Safety Plan, which is updated annually, reflects the hospital’s ongoing effort to maintain an integrated and organization-wide system for maximizing a highly reliable and safe culture.

Important information regarding the Patient Safety Plan:

Patient Safety and Quality Officer (PSQO)
The Patient Safety and Chief Quality Officer (PSCQO), the Patient Safety Analyst, Quality Manager, and the Director of Customer Relations and Risk work closely with all hospital staff and management to make sure all reports of serious events and near misses are reported and investigated and that appropriate actions are taken to ensure patient safety.

Patient Quality and Safety Council
This Committee is an interdisciplinary group of Medical and hospital staff and community members, who meet monthly to review and discuss the hospital’s performance in key areas of quality and safety. This committee is also responsible for evaluating and reviewing the hospital’s patient safety program, including sentinel/serious events.

Non-Punitive Reporting of Patient Safety Events – A “Just” Culture
The hospital recognizes that most medical mistakes are due to flawed systems, not individuals. As such, when an event occurs, the focus of the investigation will be on the hospital’s systems, rather than an individual staff member. This is called a “Just” Culture. Also, in order to identify all mistakes, errors and other safety concerns, the hospital has a non-punitive event reporting policy that encourages open communication. Employees and professional staff who report an occurrence in good faith will not be subjected to any retaliatory action for reporting and are protected by the Whistleblower Law. However, the hospital may take appropriate action against staff for failure to meet defined performance expectations or take corrective actions against staff for unprofessional conduct, including making false reports or failure to report a serious event.

Event Reporting System
All hospital team members are required to report any defect, error, medical mistake/accident, near miss, event, significant procedural variance and other risks to safety that could result in patient injury, hazardous condition or risks in the environment. Staff must complete an Electronic Safety Report immediately or as soon as possible, but within 24 hours after an occurrence or discovery of one. Sentinel and/or serious events must be immediately brought to the attention of your manager, supervisor, clinical leader and patient’s physician to assure patient safety. Managers are expected to review and submit any follow up information via the electronic safety report program (MIDAS) in a timely manner so that events can be analyzed and entered into the Pennsylvania Patient Safety and Reporting System (PAPSRS) without delay.

Definitions:

**Serious Event** – An event, occurrence or situation involving the clinical care of a patient in a medical facility that results in death (sentinel) or compromises patient safety and results in an unanticipated injury requiring the delivery of additional health care services to the patient. Example: Surgery is performed on the wrong patient or body part.

**Incident** – An event, occurrence or situation involving the clinical care of a patient in a medical facility which 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.

**Near Miss** – An event, occurrence or situation that could have injured the patient but was intercepted before it actually reached the patient. No injury to the patient occurs. Example: Pharmacy dispenses the wrong dose of medication, but the nurse identifies the mistake and does not administer the incorrect dose 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.

**Informing Patients and Families of Events**
It is the policy of the hospital to inform patients and appropriate family members, about events resulting in unanticipated outcomes of care. When a sentinel/serious event occurs, the Customer Relations and Risk Director will investigate and work closely with the patient’s physician to coordinate the disclosure of information.

*Compliance with the Patient Safety Plan and the Performance Improvement Plan is required as a condition of employment and/or credentialing with Chester County Hospital.*

**Patient Safety Resources**
If you have any patient safety questions related to your area, contact your department manager, supervisor, or one of the following resources.

**Mary Lou Lafreniere**  
Patient Safety and Quality Officer  
Phone: 610-431-5435  
Email: MaryLou.Lafreniere@uphs.upenn.edu

**Carli Meister**  
Director of Customer Relations and Risk  
Phone: 610-431-5254  
Email: Carli.Meister@uphs.upenn.edu
**RERAINT USE**

Excerpts from Hospital Policy

• In response to inappropriate over-utilization of patient restraints, the Joint Commission requires a hospital policy on prevention, appropriate use and timing of restraints.

• The Hospital’s Restraint Use and Prevention Policy, intended to protect patients from harming themselves and/or others, encourages the least restrictive type of restraint to accomplish such protection, and only after less restrictive measures have been found to be ineffective (e.g., addressing treatable causes of agitation and confusion, use of sitters, etc.)

• All restraint orders must be entered electronically and include the following specifics:
  o Indication(s) for restraint use,
  o Type of restraint device to be applied,
  o Start and end times (not to exceed 24 hours).

• A verbal order is acceptable, but must be co-signed by the ordering physician within 24 hours of the application of restraints.

• A physician or other Licensed Independent practitioner (LIP) must do a face-to-face assessment of the patient within 60 minutes of restraint application.

• Restraint orders must be renewed within 24 hours.

• Medical Staff members are encouraged to review the comprehensive Restraint Use and Prevention policy in its entirety, available for review on each Nursing Unit and on the Team Website http://www.cchosp.com/team/ (Click on “Policies and Procedures” and look for Administrative Policy # 7.74, “Management of Restraints”).

**Restraint Management Resource:**

**Beverly Drake MSA, BSN, RN-BC**
Director of Nursing Education
Tel: 610-431-5173
Email Beverly.Drake@uphs.upenn.edu
**Safe Haven**

Chester County Hospital complies with PA Newborn protection Act of 2002 which authorizes the hospital to accept protective custody of the abandoned newborn.

The purpose of this act is to protect newborns that might otherwise be abandoned in an unsafe environment. Parents are protected from criminal prosecution when the infant has not been a victim of child abuse or other crime. Parents who are overwhelmed and feel they can no longer cope are provided with a “safe haven” to leave their baby at places such as hospitals. The hospital, through Case Management and Children & Youth Services, will follow up to provide appropriate custody of the infant.

Take the following actions if you are in this situation:
As an employee, you could discover an abandoned baby on hospital grounds, or in the hospital building. You could also be approached by a parent who may hand you an infant and tell you she/he can no longer cope with the infant. Take the following actions if you are in this situation:

- If the newborn is received in a place other than the Emergency Department, the staff member should immediately contact Security by calling 2222 and report the situation. Then take the baby to the treatment area of the Emergency Department.
- If the ED staff receiving the baby is a non-licensed employee, the individual is to approach the first Nurse or Physician encountered and transfer the care of the baby to that individual. Any information obtained from the individual bringing the baby to the hospital will be shared at that time.

The Emergency Department will provide appropriate follow up with Case Management and Children & Youth Services. The Emergency Department will provide appropriate medical care if needed.

Personnel in Security and the Emergency Department receive additional education about their responsibilities for the Save Haven Program.

**Safe Haven Resource**

If you have questions about this information, contact your department manager, supervisor, or the following resource:

**Beverly Drake MSA, BSN, RN-BC**  
Director of Nursing Education  
Tel: 610-431-5173  
Email Beverly.Drake@uphs.upenn.edu
Safety and Security

To contact the Security Department in an emergency on the main campus, dial 2222 unless there is an active shooter incident, with this type of event, dial (9) 911 first, then 2222. Tell the switchboard operator the location and nature of the emergency and Security will be immediately notified. Calling the 2222 number will connect you to the Switchboard STAT phone. For an emergency involving an off-site location call (9) 911. There are two Emergency Call Towers located in the Employee Parking Lot. Pushing the red button automatically connects you to the Switchboard.

Security Services

The Security Department is available to assist employees in a variety of instances, such as emergencies, building access, new identification badges, or assistance to your car. For routine services, call extension 5111 or enter your request through the Hospital SOS work-order system.

Your Duty to Warn

A study by the National Institute of Occupational Safety and Health Administration found that in the United States violence was the second leading cause of death in the workplace (second only to vehicle accidents). Perhaps even more tragic is the fact that in the majority of cases, those who committed the violent act made prior mention of their intent to another person, who then failed to bring it to the attention of those who could intervene. If anyone makes a threatening statement in your presence, immediately notify the Security Department.

Procedures have been developed to provide confidentiality while at the same time intervening to prevent violence from occurring. See Administrative Policy & Procedure Manual Section 8.5.
If you notice a visitor who seems lost, or out of place, ask if you can help them. If they seem evasive or “just don’t seem right,” call Security. See Administrative Policy & Procedure Manual Section 8.1.

Identification Badges

For patient and employee reassurance, all team members are required without exception to prominently display their hospital-issued ID badges at all times. If you come to the hospital after 8 p.m., you will be asked to show your hospital identification by Security as you enter. In the event of a crisis situation, if the hospital is in a lock-down condition, police or other authorities may ask you for your ID. Badges also identify us to fellow employees, making it easier to know who is on staff and who is not. It is a state requirement that all health-care workers visibly display badges with their name and title/position.

Medical Staff Parking

Medical Staff and hospital parking policies are designed to provide convenient and adequate parking for our patients and visitors while designating specific staff parking areas. Parking in the wrong location is in violation of these policies and is unfair to our visitors and other staff members who park in the appropriate areas.
All employees and Medical Staff appointees who drive vehicles to work must register their vehicle(s) with the HROD department.

Designated short-term parking spaces are available for clinicians requiring rapid access and egress (e.g., providers coming from office to Hospital and going back to office within short time frames. Providers spending more than few hours or all day at the Hospital are expected to park in the designated spaces in the parking garage or open lot.

There is NO staff parking in the following areas at any time:
• Any drive or fire lane of the hospital
• Ambulatory Care Center (ACC) visitor’s lot, any time Mon-Fri and 3rd shift Sundays.
• Loading dock and Maintenance garage area.
• Any handicapped parking space without permit.
• Any non-hospital parking area, specifically any adjacent medical offices or apartment complex parking areas.

Wireless Communication Devices
Cell phones have become common communications tools. However, in a hospital, such devices if not used properly have the potential to interfere with various types of medical equipment. The hospital policy regarding wireless devices is to “play it safe,” and not allow cell phone use within 3 feet from any operating electronic medical equipment.

To provide for patient privacy, cell phone camera functions are generally not to be used in any area of the hospital except for legitimate medical purposes. Appropriate signage is posted at appropriate areas.

Red Emergency Wall Phone
Red emergency wall phones will be located throughout the hallways and will automatically connect the caller to the Stat Line when the receiver is lifted. Please provide the Operator with the detail and location of your emergency.

Safety and Security Resources
If you have questions about the products in your area, contact either your department head or one of the following resources.

John Felicetti  
Director of Safety, Security and Emergency Management  
Phone: 610-431-5558  
Email: john.felicetti@uphs.upenn.edu

Security Department (in an emergency)  
Phone: x2222 or (9) 911 (for off-site)
Background: Penn Medicine Chester County Hospital (CCH) is certified by The Joint Commission (TJC) as a Primary Stroke Center. Biennial re-certification includes an on-site review of (a) practice standards and protocols, (b) data and activities which support process improvement, and (c) documentation that pertinent providers have had specific education, per these excerpts from TJC standards: “Practitioners have education, experience, training, and/or certification consistent with the programs’ scope of services, goals and objectives, and the care provided” and “The organization’s clinical staff has knowledge of the process used to notify designated practitioners of the need to respond to patients with an acute stroke.”

To comply with the above, please note the following:

- The internal process for a stroke alert is “Code Gray,” initiated when a patient exhibits new or worsening signs/symptoms of stroke.
- A Code Gray page alerts the Rapid Response Team (RRT), the Pharmacy, Radiology, the Phlebotomist and the Nursing Supervisor/Stroke Coordinator.
- The Code Gray event is managed by the RRT Leader, a Critical Care Nurse Practitioner (CCNP).
- The initial assessment during a Code Gray includes an National Institutes of Health Stroke Scale score (NIHSS), and CCNPs have specific training/education in the use of the NIHSS.
- A STAT Head CT scan (no contrast) is the priority in a Code Gray event, and must be performed and resulted within 45 min of the Code Gray call.
- Neurological consultation may be internal to community providers or via telephone consultation with a Penn Medicine stroke neurologist by calling 877–937–PENN (7366).
- In rare cases IV tPA may be indicated and if so, would be administered per the AHA/ASA Guidelines for the Management of Patients with Ischemic Stroke, but recognizing the expanded tPA window of 4.5 hours for selected patients.
- As a “drip and ship” hospital, CCH would transfer any patient receiving IV tPA for stroke to the Hospital of the University of Pennsylvania, with transfer arrangements made via Penn Neuro Rescue at 1-877–937–PENN (7366).
- CCH participates in the national Get With The Guidelines Registry for Stroke. Stroke measures include documentation of anti-platelet administration, a lipid panel, VTE prophylaxis, STATIN administration, anti-coagulation for afib/flutter and a rehab assessment.
- All patients with suspected stroke/TIA have an aspiration risk assessment done at admission. The nurse will place an order for NPO and a Speech/Language evaluation for patients who are at risk for aspiration, and request orders for rectal or IV administration of anti-platelets and other medications if unable to safely swallow.

Resource

C. Sandra Garrison RN BSN MBA
Cardiovascular Disease Management
Primary Stroke Center
Tel: 610-431-5059 | Cell: 484-883-0346 | Fax: 610-738-2696
Email: sandy.garrison@uphs.upenn.edu

References


UNAPPROVED ABBREVIATIONS

**Policy:** The use of unapproved abbreviations in the medical record is prohibited. The list applies to all orders, preprinted forms, and handwritten or electronic medication-related documentation.

A trailing zero may be used only when required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report the size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

**Purpose:**
To eliminate the use of potentially-dangerous abbreviations and dose expressions used in prescribing medications.

**Scope:** This policy applies to all employees and Medical Staff of Chester County Hospital and its off-site locations.

**Procedure:** The use of the following unapproved abbreviations is not permitted.

<table>
<thead>
<tr>
<th>Unsafe Abbreviation, Symbol or Dose</th>
<th>Intended Meaning</th>
<th>What Can Happen? Potential Misinterpretation</th>
<th>Correct Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zero after decimal (e.g. 1.0 mg)</td>
<td>1 mg</td>
<td>Misread as 10 mg if the decimal point is not seen.</td>
<td>Do not use terminal zero for doses expressed in whole numbers. Always use a zero before a decimal.</td>
</tr>
<tr>
<td>No zero before decimal dose; e.g., .5</td>
<td>0.5 mg</td>
<td>Misread as 5 mg</td>
<td></td>
</tr>
<tr>
<td>U or u</td>
<td>Unit</td>
<td>Read as a zero (0) or a four (4) causing a 10 fold overdose or greater (4U seen as “40” or 4U seen as “44”).</td>
<td>Write out “Unit”</td>
</tr>
<tr>
<td>IU</td>
<td>International unit Every day</td>
<td>Misread as IV (intravenously) Mistaken as q.i.d, especially if the period after the “q” or the tail of the “q” is misunderstood as an “i”.</td>
<td>Write “International Unit” Write “daily” or “every day”.</td>
</tr>
<tr>
<td>q.d. or QD</td>
<td>Every day</td>
<td>Misinterpreted as “q.d.” (daily) or “q.i.d” (four times daily) if the “o” is poorly written.</td>
<td>Write “every other day”.</td>
</tr>
<tr>
<td>q.o.d. or QOD</td>
<td>Every other day</td>
<td>Misinterpreted as “q.d.” (daily) or “q.i.d” (four times daily) if the “o” is poorly written.</td>
<td></td>
</tr>
<tr>
<td>MgSO4</td>
<td>Magnesium sulfate Morphine sulfate</td>
<td>Morphine sulfate Magnesium sulfate</td>
<td>Write “magnesium sulfate” Write “morphine sulfate” or “morphine”</td>
</tr>
<tr>
<td>MS</td>
<td>Morphine sulfate</td>
<td>Magnesium sulfate</td>
<td>Write “morphine sulfate” or “morphine”</td>
</tr>
</tbody>
</table>
Utility Failure

As health care becomes more technical, our dependence on the utility systems increases. At the same time, the number of these systems has increased. The hospital has facility-wide plans for dealing with interruptions in service and each department has a plan for its area.

Refer to the Blue Utility Failure Poster located in your department that outlines the basic steps in the event of various utility failures.

Back-up Systems

Electric – Make sure vital patient care equipment is always plugged into the red outlet. These outlets are linked to the back-up emergency generators, which become immediately operational in the event of a power failure.

Phone – The dark brown “bypass” phones continue to operate during a phone failure. The numbers and locations of these phones are listed in the CCH Online Phone Book.

Medical Gas – An alarm alerting for low pressure sounds on the unit when the piped oxygen or medical air system fails. Contact Respiratory Care Services (x5484) or via the Operators and switch patients over to portable tanks.

Utility Failure Resource

If you have questions about this information, contact your department manager, supervisor, or one of the following resources.

Ron Gaudi
Director/Plant Operations
Phone: 610-738-2475
Email: Ronald.Gaudi@uphs.upenn.edu

Respiratory Care Services
Phone: x5484
Violence in the Workplace

What is it? Where does it occur?

Teaching Tools - Tips

• 50% of non-fatal injuries occur in health care and social settings.
• What is workplace violence?
  o Threats
  o Physical Assaults
  o Muggings
  o Arson, bombing, sabotage, hostage taking, shooting

Workplace violence is any act that creates a hostile work environment and that affects employees’ physical or psychological well-being and can involve anyone and either someone you know or a stranger. Most acts of workplace violence occur by strangers.

A co-worker using verbal, threatening behavior, physical assault to another co-worker is violence in the workplace.

Violent behavior can occur by:

• Patients
• Visitors
• Strangers
• Previous patients
• Vendors
• Co-Workers (current and past)
• Family members
• Spouses
• Boyfriend, girlfriend (current or ex)
• Anyone

Why are we more vulnerable?

• We are a 24/7 facility
• We are centrally located
• We have controlled substances in the facility

Pay attention to any types of threatening behaviors, inappropriate texting, emails, phone calls, verbal and non-verbal communication (clenching fist, gritting teeth), stalking, and/or verbalizing obscenities. Pay attention to any expression of intent to cause physical and/or mental harm to another. Violent behavior can be exhibited in person or not in person (phone calls, letters, email, etc).

Employees and Medical Staff

Threats and intimidating behaviors must be reported, just like you would report a physical incident. Some threatening and intimidating behaviors are:

1. “I have a gun at home and I might just throw it in my car on the way to work one of these days.”
2. “I’d like to blow him up.”
3. “I’d like to wipe him out!”
4. Breaking or throwing objects.
Violence can strike anywhere at any time and in any department.

**Effects of Violence**
- Death
- Psychological trauma
- Temporary physical disability
- Permanent physical disability
- Minor physical injuries
- Serious physical injuries

**Prevention of Workplace Violence**
All employees have a general duty to provide their employees with a workplace free from recognized hazards likely to cause death or serious physical harm. (See the Duty to Warn Policy in the Administrative Policy and Procedure Manual).

Employees and Medical Staff must report, immediately any threats or perceived threat of violence, and those who report will not be subjected to reprisal or retaliation.

What do you do with a violent patient, visitor, stranger, or co-worker?
- Remain non-confrontational
- Attempt to diffuse without using physical control
- Alert staff and security
- STAY CALM
- Take the “moral” high road (take the time to listen, do not argue, do not try to win.)
- Allow the person to suggest a solution if appropriate
- Move toward a win-win resolution
- Understand the mindset of the potentially violent person
- CALL 2222 for Security on the hospital campus, (9) 911 for offsite locations, or use panic buttons when necessary. Call (9) 911 first in the event of an active shooter.
- Notify your supervisor.

Please note that many of our leadership, clinical and security staff have received CPI training aimed at deploying de-escalation techniques in order to avoid a violent episode.

**Your reporting will be handled in a confidential manner and you will not be reprimanded or retaliated against for making a claim. Always request an escort to your vehicle whenever you feel threatened, security will be happy to assist!**

**Violence in the Workplace Resource**
If you have questions about the products in your area, contact either your department head or one of the following resources.

**John Felicetti**  
Director of Safety, Security and Emergency Management  
Phone: 610-431-5558  
Email: John.Felicetti@uphs.upenn.edu

**Security Department** (in an emergency)  
Phone: x2222, non-emergency ext. 5555, or (9) 911 (for off-site)
Vision and Values

VISION

The Unifying Vision of Penn Medicine Chester County Hospital is to be the leading provider of care in the region and a national model for quality, service excellence, and fiscal stewardship. This recently-revised vision captures our aspiration to become the top medical center between Philadelphia and Lancaster and a national leader for quality and patient care.

VALUES

Our five values form a set of beliefs that will guide our actions and behaviors toward each other, our patients, and our community. To remain true to our Vision, we intend to reinforce our Values on a daily basis.

Innovation:
Since health care is dynamic we will constantly challenge ourselves and the way we approach patient care and service excellence; but rather than automatically accepting what’s new for its own sake, we will carefully evaluate the latest technologies and cutting-edge clinical practices and readily adopt them once proven, along with pursuing quality and safety initiatives that lead to optimal patient care.

Collaboration:
Providing excellent patient care requires a cohesive, well-functioning team focused on achieving our Vision to be the leading provider of care in the region and a national model for quality, service excellence and fiscal stewardship.

Accountability:
We will hold ourselves and each other accountable for knowing and acting on our Values and the specific patient care and service excellence strategies that derive from them in pursuit of our Vision.

Respect:
Fundamental to our culture is expecting and demanding respect and professionalism from and toward each other, our patients and visitors, and members of our community, based on an even more fundamental understanding that diversity of ideas, knowledge, cultures and beliefs makes us a stronger Health System.

Excellence:
Our ultimate goal is to deliver superior results and to exceed expectations at every level of the organization.