Student Orientation

Welcome to the online student orientation. We would like the initial start of your student experience at UP Health System - Marquette to be a positive one. Students are required to complete orientation prior to their start date.

It will be necessary for you to read and review all topics contained in this packet. Once you have reviewed all components of orientation, there will be a short quiz to take to complete orientation. You will need to pass the 15-question quiz with a score of 100%. If for any reason you do not pass the first time review the material in the packet and try the quiz again.

We look forward to seeing you here at UP Health System - Marquette. We hope it proves to be a rewarding and fulfilling experience!

Information covered in this packet

- ☐ HIPAA
- ☐ Code of Conduct
- ☐ Confidentiality & Security Agreement
- ☐ UPHS Standards of Performance
- ☐ Emergency Codes
- ☐ Fire Life Safety
- ☐ Infection Prevention, PPE, Handwashing
- ☐ Back Safety
- ☐ No Pass Zone
- ☐ Parking Map

Included Policies

- ☐ Dress Code
- ☐ Drug and Alcohol-Free Workplace
- ☐ E-mail and Internet Use Policy
- ☐ Use of Tobacco Products
- ☐ Fall & Injury Prevention
- ☐ Hazardous Materials & Waste Management

Link to Quiz: https://www.surveymonkey.com/r/UPHSMstudent

Did you know?

The hospital offers tuition reimbursement for students who hold positions for us while they are in school. Many of our positions can be PRN and provide flexibility around student schedules. You will even get more hands-on experience in clinical departments and experience how great it is to be an employee here. Once you graduate, we will work with you to find a position that is aligns with your degree.

HIPAA

Health Insurance Portability and Accountability Act of 1996

Protected Health Information (PHI)

Covers patient information in any form – written, verbal, or electronic

PHI Includes

- Any information that can be used to identify the patient such as: name, address, social
- security number, medical record number, telephone number, patient account number
- Anything about the patient's medical conditions and treatment – past, present, or possible
- Billing and Payment records

**Breaches can occur even if you de-identify

Why is Privacy Important?

- It is a patient's right
- It builds trust between the patient and their caregivers
- It contributes to customer satisfaction
- It allows us to provide quality care

Before You Access Patient Information, Ask Yourself:

Is the patient information I am about to access necessary for me to complete my job?

Am I accessing only the minimum necessary to complete my job, no more and no less?

If I am accessing, using, or disclosing this information, should I have a signed authorization from the patient?

When is it Okay to Share PHI?

1

Share only the minimum amount of PHI necessary to fulfill the job responsibility

2

Share PHI only with those with a clinical or business need to know

3

Share only the amount of PHI requested. The entire medical record may not be needed.

Examples of Minimum Necessary

01

A billing clerk may need to know what laboratory test was done, but not the result

02

An admissions clerk does not need to have access to the full medical record in order to carry out his/her job

03

A patient transporter typically does not need to access the full medical record to do his/her job

Snooping and Casual Disregard

Our Greatest Risk

- Accessing the medical records of family members, friends, ex-spouses, neighbors, celebrities, etc.
- Failure to verify the authority of the individual receiving the PHI
- Improper use of technology such as camera phones, texting, and social networking sites
- Employees exceeding their scope of job duty

Incidental Uses & Disclosures

An incidental use or disclosure is not a violation of HIPAA provided the facility has applied reasonable safeguards and implemented the minimum necessary standard.

Examples of incidental uses and disclosures:

- Discussions during teaching rounds
- Calling out a patient‘s name in the waiting room
- Sign in sheets in hospitals and clinics containing the minimum information necessary

Protecting Patient Privacy

DO:

- Close curtains and speak softly when discussing treatments in semi-private rooms
- Log off of the computer when not attended
- Dispose of patient information in accordance with hospital policy and procedure
- Clear patient information off of your desk and place in a secure location when not in use
- Verify fax numbers and addresses before sending PHI

DO NOT:

- Discuss a patient in public areas such as elevators, hallways, cafeteria, or outside the facility or office
- Share your computer username, ID, or password
- Look at information about a patient unless you need it to do your job
- Take information about patients (including nursing report notes) home
- Discuss patient information in front of visitors without explicit, documented
- authorization of the patient
- Post any patient related information in church bulletins, newsletters, Facebook, or any
- other social networking websites
- Bring friends or family into areas of the facility or clinic where they can see or hear patients receiving care or where they might have access to PHI

Sharing PHI with Family & Friends

- ☑ The patient must be given the opportunity to agree, restrict, or object to providing PHI to family members, friends, or others identified by the patient as involved in the patient's care or payment for health care
- ☑ Document the patient's decision
- ☑ Use professional judgment to determine if disclosing PHI would be in the patient's best interest if the patient is unable to agree or object

Areas of Concern

Friends/Family/Self

- When you are seeking information on your family, friends, or yourself, you are not acting as an employee and you must access PHI using the procedures required for non-employees. This means you need a written authorization for release of information which can be obtained in Medical Records
- You are *not* permitted to access your own medical records

Employees as Patients

- Information available to the facility as a healthcare provider is not generally available to it in the role of an employer. For example, if an employee comes into the ED – his/her supervisor or co-workers should not be accessing his/her ED information
- This can be a challenging area: call the Facility Privacy Officer if questions arise

Examples of Potential HIPAA Violations

Releasing information to a caller who is not properly identified as being authorized to receive information

Mailing/faxing PHI to the wrong person

Looking at the PHI of a co-worker, supervisor, family, friend, or self for non- work reasons

Posting information about a patient or specific information about a day at

your workplace on a social networking site such as Facebook

Text messaging medical information about a patient to anyone!

An employee passing on information to her son about his spouse or their children

Allowing a former employee, friends, family, or co-workers into off-limits areas where PHI is located – this includes children

Taking pictures of patients with a cell phone camera

No Excuses

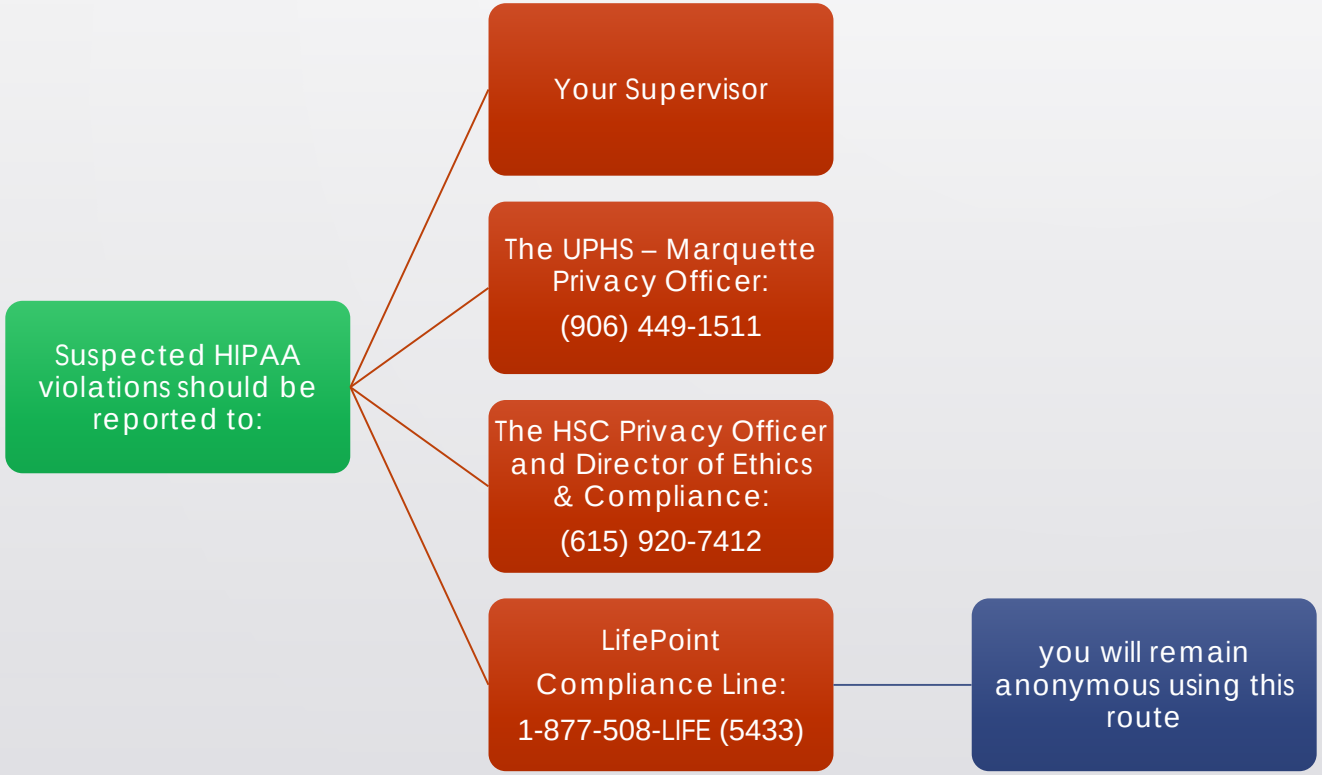
Good intentions such as “I needed to let his mother know he was in the hospital” or “She is my best friend and she wouldn’t mind me looking” do not count.

Just plain nosiness is NO excuse.

What can happen if I violate UPHS Policy or break the law?

- State and federal authorities may hold workforce members individually responsible for their actions
- Charged fines from $100 to as much as $1,500,000
- Criminal prosecution and jail time may occur depending on the type of violation
- Civil suits by state Attorney General against the facility
- Violation of UPHS policy will result in disciplinary action up to and including termination

Reporting Suspected Violations



Non-Retaliation

UPHS policy and state and federal laws provide protection from retribution or retaliation against any person for reporting actual or suspected violations.

Patient Rights

- The patient must be given the opportunity to opt-out from the directory
- Unless the patient opts-out, the following PHI may be included in the facility directory and given to those individuals who inquire about the patient by name:
  - Name
  - Location
  - Condition of the patient in general terms (e.g. good, critical, serious)
  - Only members of the clergy may have access to the religious affiliation of the patient, if provided
- If the patient has opted-out of the patient directory, no information may be discussed. Simply say, “I have no information on that person.”

Under the HIPAA Privacy Regulations, patients have the right to:

- Receive the Notice of Privacy Practices
- Inspect and request a copy of their PHI
- Know to whom their information is being disclosed to in certain situations
- Request restrictions on use and disclosure of their PHI
- Request an amendment to their PHI
- Request confidential communications of their PHI

Common Ground
Code of Conduct

LIFEPOINT HEALTH®

Dear Colleague,

At LifePoint, we take pride in the fact that our facilities share a vision – to create places where people choose to come for healthcare, physicians want to practice and employees want to work.

To make this vision a reality, each of us must share a deep commitment to the highest legal and ethical standards. We call this shared commitment "common ground." Only upon common ground can we continue to build the success of our hospitals, outpatient clinics, physicians, providers and our entire company.

The Code of Conduct included in this publication was developed to help guide us in our daily interactions with colleagues, patients, affiliated physicians and others with whom we work. We ask that you review the Code carefully, as your understanding of and commitment to it is crucial to our success.

Much of the Code's content may seem second nature to you. This is understandable. In fact, we expect that you will not be surprised by these provisions. We depend on you to have your own personal code of ethics to help underscore and reinforce the principles discussed in this Code. In many cases, the Code simply serves to strengthen our understanding of how we should conduct ourselves and our business.

Nevertheless, ours is a complex professional environment. Situations arise that are confusing. At one time or another, you may have questions about ethical or legal issues, and this Code contains information to help address and resolve these concerns. If you have additional questions or you are faced with a situation that you believe is not consistent with the Code, we urge you to consult immediately with your supervisor, another member of management at your facility, your local ethics and compliance officer or the Health Support Center (HSC) ethics and compliance officer. You also may call the HSC ethics and compliance hotline at 1-877-508-LIFE (5433). Please be assured that there will be no retribution for any inquiry or for reporting a possible breach of the Code. You and every other LifePoint employee play an important role in our future. We hope you will join us in upholding our Code of Conduct. We know that together, standing on common ground, we can achieve our mission of ***Making Communities Healthier***.

Sincerely,

William F. Carpenter III
Chief Executive Officer and Chairman of the Board

Note: The terms "LifePoint," "LifePoint Health," "Company" or "Organization" as used in this Code of Conduct refer to LifePoint Health, Inc. and its affiliates or subsidiaries, unless otherwise stated or indicated by context. The term "facilities" or "hospitals" refer to entities owned or operated by subsidiaries of LifePoint Health, Inc. References to "LifePoint employees" or to "our employees" refer to employees of subsidiaries of LifePoint Health, Inc.

Table of Contents

Special Sections

Purpose of Our Code of Conduct

Our Code of Conduct provides guidance to all LifePoint employees and assists us in carrying out our daily activities within appropriate ethical and legal standards. These obligations apply to our relationships with patients, affiliated physicians, third-party payors, subcontractors, independent contractors, vendors, consultants and one another.

The Code is a critical component of our overall ethics and compliance program. We developed the Code to ensure that we meet our ethical standards and comply with applicable laws and regulations.

The Code is intended to be a statement that is comprehensive and easily understood. In some instances, the Code deals fully with the subject covered. In many cases, however, the subject discussed has so much complexity that additional guidance is necessary for those directly involved with the particular area to have sufficient direction.

Though we promote the concept of local management autonomy to meet local needs, the policies set forth in this Code are mandatory and must be followed.

LifePoint's Guiding High Five Principles

At LifePoint, we share a common vision to provide high quality, accessible, compassionate and cost-effective healthcare to non-urban communities. To achieve this, we are committed to five core principles known as our High Five Guiding Principles:

Delivering High Quality Patient Care

Our highest priority is caring for people — the friends, family and neighbors whom we serve in our communities.

Creating Excellent Workplaces for our Employees

We are committed to providing employees with an environment based on respect and one that encourages personal and professional growth.

Supporting Physicians

We support physician practices by providing innovative facilities, advanced technology and a well-trained, organized clinical staff.

Taking a Leadership Role in Our Communities

We take pride in being a vital resource for each community we serve. Most LifePoint facilities are the sole healthcare providers in their area and are actively involved in their communities, supporting local civic and charitable organizations.

Ensuring Fiscal Responsibility

We are fiscally responsible, ensuring that we meet the capital needs of our facilities and the expectations of our stakeholders.

Leadership Responsibilities

While all LifePoint employees are obligated to follow our Code, we expect our leaders to set the example — to be in every respect a model. Leaders must ensure that those on their team have sufficient information to comply with law, regulation and policy, as well as the resources to resolve ethical dilemmas. They must help create a culture within LifePoint that promotes the highest standards of ethics and compliance. This culture must encourage everyone in the organization to raise concerns when they arise. We must never sacrifice ethical and compliant behavior in the pursuit of business objectives.

Our Fundamental Commitment to Stakeholders

We affirm the following commitments to LifePoint stakeholders:

To our patients: We are committed to providing high quality care that is sensitive, compassionate, promptly delivered and cost-effective.

To our employees: We are committed to providing a work setting that treats all employees with fairness, dignity and respect, and affords them an opportunity to grow, develop professionally, and work in a team environment in which all ideas are considered.

To our affiliated physicians: We are committed to providing a work environment that has excellent facilities, modern equipment and outstanding professional support.

To the communities we serve: We are committed to understanding the needs of those communities and providing them with high quality, cost-effective healthcare. We realize that we as an organization have a responsibility to help those in need. We proudly support charitable contributions and events in the communities we serve in an effort to promote goodwill and further good causes.

To our shareholders: We are committed to the highest standards of professional management, which we are certain can create unique efficiencies and innovative health care approaches and thus provide favorable returns on our shareholders' investments over the long-term.

To our third-party payors: We are committed to dealing with our third-party payors in a way that demonstrates our commitment to contractual obligations and reflects our shared concern for quality healthcare and bringing efficiency and cost effectiveness to healthcare. We encourage our private third-party payors to adopt their own set of comparable ethical principles to recognize explicitly their obligations to patients, as well as the need for fairness in dealing with providers.

To our regulators: We are committed to an environment in which compliance with rules, regulations and sound business practices is woven into the HSC culture. We accept the responsibility to aggressively self-govern and monitor adherence to the requirements of law and to our Code of Conduct.

To our joint venture partners: We are committed to fully performing our responsibilities to manage any jointly owned facilities in a manner that reflects the mission and values of each organization.

To our suppliers: We are committed to fair competition among prospective suppliers and the sense of responsibility required of a good customer.

To our volunteers: The concept of voluntary assistance to the needs of patients and their families is an integral part of the fabric of healthcare. We are committed to ensuring that our volunteers feel a sense of meaningfulness from their volunteer work and receive recognition for their volunteer efforts.

Relationships With Our HealthCare Partners

PATIENTS

Patient Care and Rights

It is our priority to provide high quality healthcare to all of our patients. We treat all patients with respect and dignity and provide care that is both necessary and appropriate. We make no distinction in the admission, transfer or discharge of patients or in the care we provide based on race, color, religion or national origin. Clinical care is based on identified patient health care needs, not on patient or organization economics.

Upon admission, each patient is provided with a written statement of patient rights. This statement includes the rights of the patient to make decisions regarding medical care and conforms to all applicable state and federal laws.

We assure patient involvement in all aspects of their care and obtain informed consent for treatment. As applicable, each patient or patient representative is provided with a clear explanation of care including, but not limited to, diagnosis, treatment plan, right to refuse or accept care, care decision dilemmas, advance directive options, estimates of treatment costs, organ donation and procurement, and an explanation of the risks and benefits associated with available treatment options. Patients have the right to request transfers to other facilities. In such cases, the patient will be given an explanation of the benefits, risks and alternatives.

Patients are informed of their right to make advance directives. Patient advance directives will be honored within the limits of the law and the organization's mission, philosophy and capabilities.

Patients and their representatives will be accorded appropriate confidentiality, privacy, security and protective services, opportunity for resolution of complaints and pastoral counseling. Any restrictions on a patient's visitors, mail, telephone or other communications must be evaluated for their therapeutic effectiveness and must be fully explained to and agreed upon by the patient or patient representative. During prolonged stays in the hospital, patients have the right to refuse to perform tasks in or for the hospital.

Patients are treated in a manner that preserves their dignity, autonomy, self-esteem, civil rights and involvement in their own care. LifePoint employees receive training about patient rights in order to clearly understand their role in supporting them.

At LifePoint, we are committed to providing care to our patients in a safe and reliable way. Our culture fosters patient safety, speaking up when safety is threatened or breached and continuous learning and process improvement to provide reliable care to every patient with every encounter.

Compassion and care are part of our commitment to the communities we serve. We strive to provide health education, health promotion and illness prevention programs as part of our efforts to improve the quality of life of our patients and our communities.

Relationships With Our HealthCare Partners cont.

Emergency Treatment

We follow the Emergency Medical Treatment And Labor Act (EMTALA) in providing emergency medical treatment to all patients, regardless of their ability to pay. Anyone with an emergency medical condition is treated and admitted based on medical necessity. In an emergency situation, financial and demographic information will be obtained only after the immediate needs of the patient are met. We do not admit or discharge patients simply on their ability to pay.

Patients will only be transferred to another hospital upon their request or if their medical needs cannot be met at the LifePoint hospital and appropriate care is knowingly available at another hospital. Patients will only be transferred after they have been stabilized within the capabilities and capacity of the transferring hospital, and are formally accepted for treatment at the receiving hospital.

Patient Information

We collect information about the patient's medical condition, history, medication and family illnesses to provide the best possible care. We realize the sensitive nature of this information and are committed to maintaining its confidentiality. We do not release or discuss patient-specific information with others unless it is necessary to serve the patient or authorized by law.

LifePoint employees must never disclose confidential information that violates the privacy rights of our patients. No LifePoint employee, affiliated physician or other health care partner has a right to any patient information other than that necessary to perform his or her job.

Patients can expect that their privacy will be protected and that patient-specific information will be released only to persons authorized by law or by the patient's written consent. In an emergency situation, when requested by an institution or physician then treating the patient, the patient's specific authorization is not required by law, but the name of the institution and the person requesting the information must be verified.

AFFILIATED PHYSICIANS

Any business arrangement with a physician must be structured to ensure precise compliance with legal requirements. Such arrangements must be in writing and approved by the HSC Legal Department.

In order to ethically and legally meet all standards regarding referrals and admissions, we will adhere strictly to two primary rules:

1. **We do not pay for referrals.** We accept patient referrals and admissions based solely on the patient's clinical needs and our ability to render the needed services. We do not pay or offer to pay anyone — employees, physicians or other persons— for referral of patients or to induce referrals. Violation of this policy has grave consequences for the organization and the individuals involved, including civil and criminal penalties and possible exclusion from participation in federally funded health care programs.

2. **We do not accept payments for referrals that we make.**
   No LifePoint employee or any other person acting on behalf of the organization is permitted to solicit or receive anything of value, directly or indirectly, in exchange for the referral of patients. Similarly, when making patient referrals to another healthcare provider, we do not take into account the volume or value of referrals that the provider has made (or may make) to us.

All referral source data must be used only for the purpose of understanding service line, provider and quality deficiencies, and to improve quality, access, and patient and physician satisfaction. Such data may never be used to direct referrals, intimidate or embarrass physicians and other referral sources into redirecting their referrals, or for purposes that are prohibited under LifePoint's policies. All employees, medical staff members and privileged practitioners should immediately report violations or suspected violations to a supervisor or member of management, the local ethics and compliance officer, the HSC ethics line or the HSC ethics and compliance officer.

Relationships With Our HealthCare Partners cont.

THIRD-PARTY PAYORS

Coding and Billing for Services

We will take great care to ensure that all billings to governmental and other payors reflect truth and accuracy and conform to all pertinent federal and state laws and regulations.

We prohibit any employee or agent of LifePoint from knowingly presenting or causing to be presented claims for payment or approval that are false, fictitious or fraudulent.

We will operate oversight systems designed to verify that claims are submitted only for services actually provided and that services are billed as provided. These systems will emphasize the critical nature of complete and accurate documentation of services provided. As part of our documentation effort, we will maintain current and accurate medical records.

Any subcontractors engaged to perform billing or coding services must have the necessary skills, quality assurance processes, systems and appropriate procedures to ensure that all billings for governmental and other payors are accurate and complete. LifePoint prefers to contract with such entities that have adopted their own ethics and compliance programs. Third-party billing entities, contractors and preferred vendors that we consider must be approved consistent with our HSC policy on this subject.

For coding questions, contact the 3M Nosology line at 1-800-537-1666. For questions concerning billing issues, contact your local business office director.

Cost Reports

Our business involves reimbursement under government programs that require the submission of certain reports of our costs of operation. We will comply with federal and state laws relating to all cost reports. These laws and regulations define which costs are allowable and outline the appropriate methodologies to claim reimbursement for the cost of services provided to program beneficiaries. Given their complexity, all issues related to the completion and settlement of cost reports must be communicated through or coordinated with our Reimbursement Department.

Regulatory Compliance

Facilities affiliated with LifePoint provide varied healthcare services in many states. These services generally may be provided only pursuant to appropriate federal, state and local laws and regulations. Such laws and regulations may include subjects such as certificates of need, licenses, permits, accreditation, access to treatment, consent to treatment, medical record keeping, access to medical records and confidentiality, patients' rights, terminal care decision-making, medical staff membership and clinical privileges, corporate practice of medicine restrictions, and Medicare and Medicaid regulations. The organization is subject to numerous other laws in addition to these health care regulations.

We will comply with all applicable laws and regulations. All employees, medical staff members, privileged practitioners and contract service providers must be knowledgeable about and ensure compliance with all laws and regulations and should immediately report violations or suspected violations to a supervisor or member of management, the local ethics and compliance officer, the HSC ethics line or the HSC ethics and compliance officer.

LifePoint will be forthright in dealing with any billing inquiries. Requests for information will be answered with complete, factual and accurate information. We will cooperate with and be courteous to all government inspectors and provide them with the information to which they are entitled during an inspection.

During a government inspection, you must never conceal, destroy or alter any documents, lie or make misleading statements to government representatives. You should not influence another employee to provide inaccurate information or obstruct, mislead or delay the communication of information or records relating to a possible violation of law.

In order to ensure that we fully meet all regulatory obligations, LifePoint employees and affiliated physicians must be informed about stated areas of potential compliance concern. The Department of Health and Human Services, and particularly its Inspector General, has routinely notified healthcare providers of areas in which it believes that insufficient attention is being given to government regulations. We should be diligent in following such guidance and reviewing appropriate elements of our system to ensure their correctness.

LifePoint will provide its employees with the information and education they need to comply fully with all applicable laws and regulations.

Dealing With Accrediting Bodies

LifePoint will deal with all accrediting bodies in a direct, open and honest manner. No action should ever be taken in relationships with accrediting bodies that would mislead the accreditor or its survey teams, either directly or indirectly. Where LifePoint determines to seek any form of accreditation, all standards of the accrediting group are important and must be followed.

The scope of matters related to accreditation of various bodies extends beyond the scope of this Code of Conduct. The purpose of our Code of Conduct is to provide general guidance on subjects of wide interest within the organization.

Business Information

Accuracy, Retention and Disposal of Documents and Records

Each LifePoint employee is responsible for the integrity and accuracy of our organization's documents and records, not only to comply with regulatory and legal requirements but also to ensure that records are available to defend our business practices and actions. No one may alter or falsify information on any record or document.

Medical and business documents and records are retained in accordance with the law and our record retention policy. Medical and business documents include paper documents such as letters and memos, computer-based information such as e-mail or computer files on disk or tape, and any other medium that contains information about the organization or its business activities. It is important to retain and destroy records appropriately according to our policy. You must not tamper with records or remove or destroy them prior to the date specified in company policy for such action.

Confidential Information

Confidential information about our organization's strategies and operations is a valuable asset. Although you may use our confidential information to perform your job, you must not share this information with others outside of LifePoint or your department unless you are doing so within the scope of your job responsibilities, and the person to whom you intend to disclose the information has a legitimate business need to know this information. Violation of this policy may subject an employee to termination and other legal action.

As a condition of your employment with LifePoint, you will not seek to benefit personally or permit others to benefit through the use or disclosure of our confidential information. Your obligations are not limited to documents and materials that are specifically marked as "confidential."

If, however, a document is expressly marked as "confidential," you are expected to follow all instructions noted on such document pertaining to the photocopying, transmitting or disclosing of any information contained therein. Examples of confidential information include personnel data maintained by the organization, patient lists and clinical information, pricing and cost data, information pertaining to acquisitions, divestitures, affiliations and mergers, financial data, research data, strategic plans, marketing strategies, techniques, employee lists, supplier and subcontractor information, training materials, proprietary computer software and other information not generally known by the public.

This provision does not restrict the right of an employee to disclose, if he or she wishes, information about his or her own compensation, benefits or terms and conditions of employment.

Business Information cont.

Electronic Media

All communications systems, electronic mail, intranet, Internet access or voicemail are the property of the organization and are to be primarily used for business purposes. Highly limited reasonable personal use of LifePoint's communications systems is permitted; however, you should assume that these communications are not private. Patient or confidential information should not be sent through the intranet or the Internet unless security measures are in place that assure confidentiality.

LifePoint reserves the right to periodically access, monitor and disclose the contents of the intranet, e-mail and voicemail messages. Access and disclosure of individual employee messages may only be done with the approval of the HSC Legal department.

Employees may not use internal communication channels or access the Internet at work to post, store, transmit, download or distribute any threatening, knowingly reckless, maliciously false or obscene materials. This prohibition includes anything constituting or encouraging a criminal offense, giving rise to civil liability or otherwise violating any laws. Additionally, these channels of communication may not be used to send chain letters, personal broadcast messages or copyrighted documents that are not authorized for reproduction, nor are they to be used to conduct a job search or open misaddressed mail.

Employees may not install personal software on LifePoint computer equipment, and LifePoint- owned software may not be installed on employees' personal computers. While there are exceptions, there are very few. Please contact your local director of information systems or refer to the LifePoint PC Software License Management policy for more details.

Employees who abuse our communications systems or use them excessively for non-business purposes may lose these privileges and be subject to disciplinary action.

Financial Reporting and Records

We have established and maintain a high standard of accuracy and completeness in the documentation and reporting of all financial records. These records serve as a basis for managing our business and are important in meeting our obligations to patients, employees, shareholders, suppliers and others. They are also necessary for compliance with tax and financial reporting requirements.

All financial information must reflect actual transactions and conform to generally accepted accounting principles. No undisclosed or unrecorded funds or assets may be established.

LifePoint maintains a system of internal controls to provide reasonable assurances that all transactions are executed in accordance with management's authorization and are recorded in a proper manner so as to maintain accountability of the organization's assets.

Workplace Conduct and Employment Practices

Conflicts of Interest

A conflict of interest may exist if your outside activities or personal interests influence or appear to influence your ability to make objective decisions in the course of your job responsibilities. A conflict of interest may also exist if the demands of any outside activities hinder or distract you from the performance of your job or cause you to use LifePoint resources for non-Lifepoint purposes. It is your obligation to ensure that your interests remain free of conflicts in the performance of your responsibilities at LifePoint. If you have any question about whether an outside activity might constitute a conflict of interest, you must obtain the approval of your supervisor before pursuing the activity.

Controlled Substances

Some of our employees routinely have access to prescription drugs, controlled substances and other medical supplies. Many of these substances are governed and monitored by specific regulatory organizations and must be administered by physician order only. It is extremely important that these items be handled properly and only by authorized individuals to minimize risks to LifePoint and to patients. If you become aware of the diversion of drugs from the organization, you should report the incident immediately.

Copyrights

LifePoint employees may only make copies of copyrighted materials pursuant to the organization's policy on such matters.

Diversity and Equal Employment Opportunity

Our employees provide us with a wide complement of talents that contribute greatly to our success. We are committed to providing an equal opportunity work environment where everyone is treated with fairness, dignity and respect. We will comply with all laws, regulations and policies related to non-discrimination in all of our personnel actions. Such actions include hiring, staff reductions, transfers, terminations, evaluations, recruiting, compensation, corrective action, discipline and promotions.

No one may discriminate against any individual with a disability with respect to any offer, term or condition of employment. We will make reasonable accommodations to the known physical and mental limitations of otherwise qualified individuals with disabilities.

Harassment and Workplace Violence

Each LifePoint employee has the right to work in an environment free of harassment. We will not tolerate harassment by anyone based on the diverse characteristics or cultural backgrounds of those who work with us. Degrading or humiliating jokes, slurs, intimidation or other harassing conduct is not acceptable in our workplace.

Any form of sexual harassment is strictly prohibited. This includes unwelcome sexual advances or requests for sexual favors in conjunction with employment decisions. Moreover, verbal or physical conduct of a sexual nature that interferes with an individual's work performance or creates an intimidating, hostile or offensive work environment has no place at LifePoint.

Workplace Conduct and Employment Practices cont.

Conduct that includes behaviors and communication that intimidate individuals and result in a barrier to work performance are not tolerated at LifePoint. At LifePoint we strive to foster a culture of learning, mutual respect and professionalism and individual accountability for our behaviors and performance.

Harassment also includes incidents of workplace violence. Workplace violence includes robbery and other commercial crimes, stalking cases, violence directed at the employer, terrorism and hate crimes committed by current or former employees. As part of our commitment to providing a safe workplace for our employees and physicians, we prohibit possession of firearms, other weapons, explosive devices or other dangerous materials on LifePoint premises. Employees who observe or experience any form of harassment or violence should report the incident to their supervisor, the Human Resources department, a member of management, their local ethics and compliance officer, the HSC ethics line or the HSC ethics and compliance officer.

Health and Safety

All LifePoint facilities must comply with all government regulations and rules and with LifePoint policies or required facility practices that promote the protection of workplace health and safety. Our policies have been developed to protect you from potential workplace hazards. You should become familiar with and understand how these policies apply to your specific job responsibilities, and seek advice from your supervisor or the safety officer whenever you have a question or concern. It is important for you to advise your supervisor or the safety officer of any serious workplace injury or any situation presenting a danger of injury so that timely corrective action may be taken to resolve the issue.

Hiring of Former and Current Government Employees

The recruitment and employment of former or current U.S. government employees is subject to complex rules that change frequently and vary by employee. Similar rules may also apply to current or former state or local government employees or legislators and members of their immediate families.

If a former government employee or consultant wishes to become employed by (or a consultant to) LifePoint, care should be exercised to ensure that the requirements of conflict of interest laws are not violated. Each situation should be considered on an individual basis and you should consult with the HSC Human Resources or HSC Legal departments on issues related to recruitment and hiring of former or current government employees.

Workplace Conduct and Employment Practices cont.

Inside Information and Securities Trading

In the course of your employment, you may become aware of non-public information about LifePoint that may be material to an investor's decision to buy or sell the organization's securities. Non-public, material information may include plans for mergers, marketing strategy, financial results or other business dealings. You may not discuss this type of information with anyone outside of the organization. Within the organization, you should discuss this information on a strictly "need to know" basis only with others who require this information to perform their jobs.

Securities law and LifePoint policy prohibit individuals from trading in the marketable securities of a publicly held organization or influencing others to trade in such securities on the basis of non-public, material information. These restrictions are meant to ensure that the general public has complete and timely information on which to base investment decisions.

If you obtain access to non-public, material information about the organization while performing your job, you may not use that information to buy, sell or retain securities of LifePoint or any other company. Even if you do not buy or sell securities based on what you know, discussing the information with others such as family members, friends, vendors, suppliers and other outside acquaintances is prohibited until the information is considered to be public. Information is considered to be public three days after a general release of the information to the media.

License and Certification Renewals

Employees and individuals retained as independent contractors in positions that require professional licenses, certifications or other credentials are responsible for maintaining the current status of their credentials and shall comply at all times with federal and state requirements applicable to their respective disciplines. To ensure compliance, LifePoint may require evidence of the individual having a current license or credential status. LifePoint will not allow any employee or independent contractor to work without valid, current licenses or credentials.

Seeking Help

For help with an ethics or compliance issue or to report a possible violation of the Code of Conduct, contact your supervisor, another member of local management, your local ethics and compliance officer, the HSC ethics and compliance officer, or the HSC ethics line at:
1-877-508-LIFE (5433).

For assistance with coding questions, call: 1-800-537-1666.

Workplace Conduct and Employment Practices cont.

Personal Use of LifePoint Resources

It is the responsibility of each LifePoint employee and/or physician to preserve our organization's assets including time, materials, supplies, equipment and information. Organization assets are to be maintained for business-related purposes. As a general rule, the personal use of any LifePoint asset without the prior approval of your supervisor is prohibited.

The occasional use of items such as copying facilities or telephones, where the cost to LifePoint is insignificant, is permissible. Any community or charitable use of organization resources must be approved in advance by your supervisor. Any use of organization resources for personal financial gain unrelated to LifePoint business is prohibited.

Relationships Among LifePoint Employees

In the normal day-to-day functions of an organization like LifePoint, there are issues that arise that relate to how people in the organization deal with one another. It is impossible to foresee all of these, and many do not require explicit treatment in a document like this. A few, however, routinely arise.

One involves gift giving among employees and/or physicians for certain occasions. While we wish to avoid any strict rules, no one should ever feel compelled to give a gift to anyone, and any gifts offered or received should be appropriate to the circumstances. A lavish gift to anyone in a supervisory role would clearly violate organization policy.

Another situation that routinely arises is fundraising or similar efforts. No one should ever be made to feel compelled to participate in any fund- raising or charitable efforts.

Relationships With Subcontractors, Suppliers and Educational Institutions

We must manage our subcontractor and supplier relationships in a fair and reasonable manner, consistent with all applicable laws and good business practices. We promote competitive procurement to the maximum extent practicable. Our selection of subcontractors, suppliers and vendors will be made on the basis of objective criteria including quality, technical excellence, price, delivery, adherence to schedules, service and maintenance of adequate sources of supply.

Our purchasing decisions will be made on the supplier's ability to meet our needs and not on personal relationships and friendships. We will always employ the highest ethical standards in business practices in source selection, negotiation, determination of contract awards and the administration of all purchasing activities. We will not communicate to a third party confidential information given to us by our suppliers unless directed in writing to do so by the supplier. We will not disclose contract pricing and information to any outside parties. (The subject of business courtesies, which might be offered by subcontractors or suppliers, is discussed later in this Code.)

All facilities having a relationship with an educational institution must have a written agreement that defines both parties' roles and the facility's retention of the responsibility for the quality of patient care.

Workplace Conduct and Employment Practices cont.

Research

We follow high ethical standards and all legal requirements in any research conducted by our physicians and professional staff. We do not tolerate intentional research misconduct. Research misconduct includes making up, changing or copying results from other studies without performing the research.

All patients asked to participate in a research project are given a full explanation of alternative services that might prove beneficial to them. They are also fully informed of potential discomforts and are given a full explanation of the risks, expected benefits and alternatives. The patients are fully informed of the procedures to be followed, especially those that are experimental in nature. Refusal of a patient to participate in a research study will not compromise their access to services.

All personnel applying for or performing research of any type are responsible for maintaining the highest ethical standards in any written or oral communications regarding their research projects, as well as following appropriate legal and research guidelines. As in all accounting and financial record keeping, our policy is to submit only true, accurate and complete costs related to research grants.

Substance Abuse and Mental Acuity

To protect the interests of our employees, physicians and patients, we are committed to an alcohol- and drug-free work environment. All employees and physicians must report for work free of the influence of alcohol and illegal drugs. Reporting to work under the influence of any illegal drug or alcohol, having an illegal drug in your system, or using, possessing or selling illegal drugs while on LifePoint work time or property may result in immediate termination. We may use drug testing as a means of enforcing this policy.

It is also recognized that individuals may be taking prescription drugs that could impair judgment or other skills required in job performance. If you have questions about the effect of such medication on your performance, consult with your supervisor.

Common Ground

If you are faced with an ethical or compliance issue:

Consider the facts and how the situation affects stakeholders.

Observe the policies, procedures, laws and regulations outlined in the Code of Conduct. Also consider your own values. What applies to this situation?

Measure your alternatives for resolving the situation.

Make a decision about the best course of action.

Organize your thoughts and ask yourself once more: Is this the right thing to do? Do my actions support our Code of Conduct?

Notify management in a timely manner.

Marketing Practices

Antitrust

Antitrust laws are designed to create a level playing field in the marketplace and to promote fair competition. These laws could be violated by discussing LifePoint business with a competitor, such as how our prices are set, disclosing the terms of supplier relationships, allocating markets among competitors or agreeing with a competitor to refuse to deal with a supplier. Our competitors are other health systems and facilities in markets where we operate.

At trade association meetings, be alert to potential situations where it may not be appropriate for you to participate in discussions regarding prohibited subjects with our competitors. Prohibited subjects include any aspect of pricing, our services in the market, key costs such as labor costs, and marketing plans. If a competitor raises a prohibited subject, end the conversation immediately.

Document your refusal to participate in the conversation by requesting that your objection be reflected in the meeting minutes and notify the HSC Legal Department of the incident.

In general, avoid discussing sensitive topics with competitors or suppliers unless you are proceeding with the advice of the HSC Legal Department.

You must also not provide any information in response to oral or written inquiry concerning an antitrust matter without first consulting the HSC Legal Department.

Gathering Information About Competitors

It is not unusual to obtain information about other organizations, including our competitors, through legal and ethical means such as public documents, public presentations, journal and magazine articles, and other published and spoken information.

However, it is not acceptable for you to obtain proprietary or confidential information about a competitor through illegal means. It is also not acceptable to seek proprietary or confidential information when doing so would require anyone to violate a contractual agreement, such as a confidentiality agreement with a prior employer.

Marketing and Advertising

We may use marketing and advertising activities to educate the public, provide information to the community, increase awareness of our services and recruit employees. We will present only truthful, fully informative and non-deceptive information in these materials and announcements. All marketing materials will appropriately reflect the level of services available.

Environmental Compliance

It is our policy to comply with all environmental laws and regulations as they relate to LifePoint operations. We will act to preserve our natural resources to the fullest extent reasonably possible. We will comply with all environmental laws and operate each of our facilities with the necessary permits, approvals and controls. We will diligently employ proper procedures with respect to handling and disposal of hazardous and biohazardous waste, including medical waste.

In helping LifePoint comply with these laws and regulations, you must understand how job duties may impact the environment, adhere to all requirements for the proper handling of hazardous materials, and immediately alert your supervisor of any situation regarding the discharge of a hazardous substance, improper disposal of medical waste or any situation that may be potentially damaging to the environment.

Business Courtesies

General

Nothing in this part of the Code of Conduct should be considered in any way as an encouragement to make, solicit or receive any type of entertainment or gift. For clarity purposes, note that these limitations govern activities with those outside of LifePoint. This section does not pertain to actions between the organization and its employees nor actions among LifePoint employees themselves.

Receiving Business Courtesies

We recognize that there will be times when you may wish to accept, from a current or potential business associate, an invitation to attend a social event in order to further develop your business relationship. These events must not include expenses paid for any travel costs (other than in a vehicle owned privately or by the host company) or overnight lodging. The cost associated with such an event must be reasonable and appropriate. As a general guideline, this means that the cost will not exceed $150.00 per person.

Sometimes a business associate will extend training and educational opportunities that include travel and overnight accommodations to you at no cost to you or LifePoint. Similarly, there are some circumstances in which you are invited to an event at a vendor's expense to receive information about new products or services. Prior to accepting any such invitation, you must receive approval to do so consistent with the HSC policy on this subject.

As a LifePoint employee, you may accept gifts with a total value of $75.00 or less in any one year from any individual or organization who has a business relationship with LifePoint. For purposes of this paragraph, physicians practicing in LifePoint's hospitals are considered to have such a relationship. Perishable or consumable gifts given to a department or group are not subject to any specific limitation. You may never accept cash or financial instruments (e.g., checks, stocks). Finally, under no circumstances may you solicit a gift.

Extending Business Courtesies to Non-referral Sources

No portion of this section applies to any individual who makes, or is in a position to make, referrals to a LifePoint hospital.

There may be times when you wish to extend to a current or potential business associate (other than someone who may be in a position to make a patient referral) an invitation to attend a social event in order to further develop your business relationship. The purpose of the entertainment must never be to induce any favorable business action. During these events, topics of a business nature must be discussed and the host must be present. These events must not include expenses paid for any travel costs (other than in a vehicle owned privately or by the host entity) or overnight lodging. The cost associated with such an event must be reasonable and appropriate. As a general guideline, this means that the cost will not exceed $150.00 per person.

Business Courtesies cont.

With regard to the $100.00 guideline, if you anticipate an event will exceed the $100.00 guideline or if circumstances arise where an entertainment event was contemplated prior to the event to meet the guideline but unforeseeably exceeded it, HSC policy on this subject must be followed. LifePoint will under no circumstances sanction participation in any business entertainment that might be considered lavish.

Also, LifePoint's hospitals may routinely sponsor events with a legitimate business purpose. Provided that such events are for business purposes, reasonable and appropriate meals and entertainment may be offered. In addition, transportation and lodging can be offered. However, all elements of such events, including these courtesy elements, must be consistent with the HSC policy on such events.

It is critical to avoid the appearance of impropriety when giving gifts to individuals who do business or who are seeking to do business with LifePoint. We will never use gifts or other incentives to improperly influence relationships or business outcomes. Gifts to business associates who are not government employees must not exceed $50.00 per year per recipient. You may never give cash or financial instuments (e.g., stocks, checks). The HSC policy on business courtesies may from time to time provide modest flexibility in order to permit appropriate recognition of the efforts of those who have spent meaningful amounts of volunteer time on behalf of LifePoint.

U.S. federal and state governments have strict rules and laws regarding gifts, meals and other business courtesies for their employees. LifePoint's policy is to not provide any gifts, entertainment, meals or anything else of value to any employee of the executive branch of the federal government, except for minor refreshments in connection with business discussions or promotional items with the LifePoint or hospital logo valued at no more than $10.00.

With regard to gifts, meals and other business courtesies involving any other category of government official or employee, you must determine the particular rules applying to any such person and carefully follow them.

Extending Business Courtesies to Possible Referral Sources

Any entertainment or gift involving physicians or other persons who are in a position to refer patients to our healthcare facilities must be undertaken in accordance with HSC policies. We will comply with all federal laws, rules and regulations regarding these practices.

Political Activities and Contributions

LifePoint political participation is limited by law. LifePoint's funds or resources are not to be used to contribute directly to political campaigns or for gifts or payments to any political party or any of their affiliated organizations. Organization resources include financial and non-financial donations such as using work time and telephones to solicit for a political cause or candidate or the loaning of LifePoint property for use in the political campaign. LifePoint operates a federal Political Action Committee (PAC) that is funded solely through individual contributions. Where permitted by law, LifePoint may choose to contribute to a particular state PAC or State Hospital Association PAC. The conduct of any political action committee is to be consistent with relevant laws, regulations and internal policies.

It is important to separate personal and HSC political activities in order to comply with the appropriate rules and regulations relating to lobbying or attempting to influence government officials. You may, of course, participate in the political process on your own time and at your own expense.

While you are doing so, it is important not to give the impression that you are speaking on behalf of or representing LifePoint in these activities. You cannot seek to be reimbursed by LifePoint for any personal contributions for such purposes.

At times, LifePoint may ask employees to make personal contact with government officials or to write letters to present our position on specific issues. In addition, it is a part of the role of some LifePoint management to interface on a regular basis with government officials. If you are making these communications on behalf of the organization, be certain that you are familiar with any regulatory constraints and observe them.

Guidance is always available from the HSC Government Relations and Legal departments as necessary.

The Health Support Center Ethics and Compliance Program

Program Structure

The HSC ethics and compliance program is intended to demonstrate, in the clearest possible terms, the absolute commitment of LifePoint to the highest standards of ethics and compliance. That commitment permeates all levels of the organization. There is an oversight committee of the board of directors, an HSC ethics and compliance officer, an HSC ethics and compliance committee consisting of senior management and local ethics and compliance officers. All of these individuals or groups are prepared to support you in meeting the standards set forth in this Code.

Resources for Guidance and Reporting Violations

To obtain guidance on an ethics or compliance issue or to report a suspected violation, you have several options. We encourage the resolution of issues at a local level whenever possible. It is expected good practice, when you are comfortable and think it appropriate, to raise concerns first with your supervisor.

Another important resource who may be able to address issues arising out of this Code of Conduct is the Human Resources Director. Human Resources Directors are highly knowledgeable about many of the compliance risk areas described in this Code of Conduct that pertain to employment and the workplace and are responsible for ensuring compliance with various employment laws. If a concern relates to specific details of an individual's work situation, rather than larger issues of organizational ethics and compliance, the Human Resources Director is the most appropriate person to contact.

If it is uncomfortable or inappropriate to raise your concern with your supervisor or Human Resources Director, another option is to discuss the situation with another member of management at your facility or within LifePoint. You are always free to contact the HSC ethics line at 1-877-508-LIFE (5433) or the HSC ethics and compliance officer directly by email at ethicsandcompliance.officer@LPNT.net.

Confidentiality and Retaliation

LifePoint will make every effort to maintain, within the limits of the law, the confidentiality of the identity of any individual who reports possible misconduct. There will be no retribution for reporting a possible violation in good faith. Any employee who deliberately makes a false accusation with the purpose of harming or retaliating against another employee will be subject to discipline.

Specific Reporting Requirements

All LifePoint employees are required to report immediately, within one business day or as soon thereafter as possible, all known or suspected violations of Federal or State fraud and abuse laws, Federal or State self referral laws, and/or the underlying Compliance and Legal policies that support such compliance, through the process set forth in the Reporting Requirements policy. Any person who fails to report such violations will be subject to disciplinary action, up to and including termination.

The Health Support Center Ethics and Compliance Program cont.

Personal Obligation to Report

We are committed to a culture of learning and safety and to ethical and legal conduct that is compliant with all relevant laws and regulations and to correcting wrongdoing wherever it may occur in the organization. Each employee has an individual responsibility for reporting any activity by any employee, physician, subcontractor or vendor that appears to violate applicable laws, rules, regulations or this Code.

Internal Investigation of Reports

We are committed to investigate all reported concerns promptly and confidentially to the extent possible. The Health Support Center ethics and compliance officer will coordinate any findings from the investigations and immediately recommend corrective action or changes that need to be made. We expect all employees and physicians to cooperate with investigation efforts.

Corrective Action

Where an internal investigation substantiates a reported violation, it is the policy of LifePoint to initiate corrective action, including, as appropriate, making prompt restitution of any overpayment amounts, notifying the appropriate governmental agency, instituting whatever disciplinary action is necessary and implementing systemic changes to prevent a similar violation from recurring in the future at any LifePoint facility.

The Health Support Center Ethics and Compliance Program cont.

Discipline

All violators of the Code of Conduct will be subject to disciplinary action. The precise discipline utilized will depend on the nature, severity and frequency of the violation and may result in any of the following disciplinary actions:

- verbal warning
- written warning
- written reprimand
- suspension
- termination and
- restitution (if necessary).

Internal Audit and Other Monitoring

LifePoint is committed to the aggressive monitoring of compliance with its policies. Much of this monitoring effort is provided by Internal Audit and the Compliance department, which routinely conduct audits of issues that have regulatory or compliance implications. The organization also routinely seeks other means of ensuring and demonstrating compliance with laws, regulations and LifePoint policies.

Acknowledgment Process

LifePoint requires all employees to sign an acknowledgment form confirming that they have received the Code of Conduct and understand that it represents mandatory policies of LifePoint. New employees will be required to sign this acknowledgment as a condition of employment.

Adherence to and support of LifePoint's Code of Conduct and participation in related activities and training will be considered in decisions regarding hiring, promotion and compensation for all candidates, employees and physicians.

Notice to All Employees Regarding Fraud

The Deficit Reduction Act of 2005, signed into law by President Bush on February 8, 2006, contains specific requirements regarding entities that receive more than $5 million annually from Medicaid. The law, effective January 1, 2007, requires that entities covered by the law have specific policies dealing with matters of fraud and abuse. In addition, employees are to be informed about a federal law known as the False Claims Act, a civil anti-fraud statute providing that any person who knowingly submits or causes the submission of false claims for government funds or property is liable for damages and penalties. Entities that knowingly violate this law can be liable for triple damages and a penalty from $5,500 to $11,000 per claim.

The False Claims Act contains provisions for individuals who are known as "relators," or whistle blowers. The law provides certain protection for employees who are retaliated against by an employer because the employee filed a whistle blower lawsuit. Individuals who have questions regarding the specifics should refer to LifePoint's policies for additional information.

Confidentiality and Security Agreement

I understand that the facility or business entity named below (the "Company") in which or for whom I work, volunteer or provide services, or with whom the entity (*e.g.*, physician practice) for which I work has a relationship (contractual or otherwise) involving the exchange of health information (the "Company"), has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their patients' health information. Additionally, the Company must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning, communications, computer systems and management information (collectively, with individually identifiable health information and protected health information, "Confidential Information").

In the course of my employment / assignment at the Company, I understand that I may come into the possession of this type of Confidential Information. I will not use company systems to access patient information if it is not necessary to perform my job related duties. This includes NOT accessing my own health information or that of my child or person's for which I am personal representative via the company systems. The Company's Privacy and Security Policies are available through the Company , copies of which will be provided upon request. I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information.

1. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it.
2. I will not in any way divulge, copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized.
3. I will not discuss confidential information where others can overhear the conversation, even if the patient's name is not used. I will make every reasonable attempt to refrain from practices that might lend itself to unintended breach of patient confidentiality.
4. I will not make any unauthorized transmissions, inquiries, modifications, or deletions of Confidential Information.
5. I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with the Company.
6. Upon termination, I will immediately return any documents or media containing Confidential Information to the Company.
7. I understand that I have no right to any ownership interest in any information accessed or created by me during my relationship with the Company.
8. I will act in the best interest of the Company and in accordance with its Company's Privacy and Security Policies at all times during my relationship with the Company.
9. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of Company employment, suspension and loss of privileges, and/or termination of authorization to work within the Company, in accordance with the Company's policies.
10. I will only access or use systems or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.
11. I understand that I should have no expectation of privacy when using Company information systems. The Company may log, access, review, and otherwise utilize information stored on or passing through its systems, including e-mail, in order to manage systems and enforce security.
12. I will practice good workstation security measures such as locking up electronic media devices when not in use, using screen savers with activated passwords appropriately, and position screens away from public view.
13. I will practice secure electronic communications by transmitting Confidential Information only to authorized entities, in accordance with approved security standards.
14. I will:
    a. Use only my officially assigned User-ID and password (and/or token (e.g., Multi-Factor Authentication "MFA").
    b. Use only approved licensed software.
    c. Use a device with virus protection software.
15. I will never:
    d. Share/disclose user-IDs, passwords or MFA.
    e. Use tools or techniques to break/exploit security measures.
    f. Connect to unauthorized networks through the systems or devices.
16. I will notify my manager, Facility Information Security Officer, or appropriate Information Services person if my password has been seen, disclosed, or otherwise compromised, and will report activity that violates this agreement, privacy and security policies, or any other incident that could have any adverse impact on Confidential Information.
17. I will only access software systems to review patient records or Company information when I have a business need to know, as well as any necessary consent. By accessing a patient's record or Company information, I am affirmatively representing to the Company at the time of each access that I have the requisite business need to know and appropriate consent, and the Company may rely on that representation in granting such access to me.
18. I will accept full responsibility for the actions of my employees who may access the Company software systems and Confidential Information and will ensure that any such employee will execute their own Confidentiality and Security Agreement.
19. I understand that the Company may, at its sole reasonable discretion, rescind any person's access to any information system at any time. I further understand that if I am a member of the medical staff, any violation of the terms contemplated herein or of the facility's rules and regulations, may subject me to disciplinary action pursuant to the facility's medical staff bylaws .

Signing this document, I acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions stated above.

Employee/Consultant/Vendor/Office Staff/Physician **Signature** **You will sign this during the quiz**	Facility Name and COID UPHS Marquette	**Date**
Employee/Consultant/Vendor/Office Staff/Physician **Printed Name**	Business Entity Name LifePoint Hospitals	

STANDARDS OF PERFORMANCE

Integrity

I will greet everyone with eye contact and a smile at 10 feet and acknowledge them with a greeting within 5 feet as I approach (10/5 rule)

I will share my knowledge and experience with coworkers, patients, and community in order to ensure a positive experience for everyone.

I will do the right thing at all times, even when nobody is watching.

I will treat everyone the way I would like to be treated; with honesty, compassion and respect.

I will be responsible for taking corrective action when things don't go as expected.

I will take pride in my hospital, the work I do, and I will share successes with patients, co-workers and the community.

I will give 100 % every time, and look for ways to go above and beyond.

I will present myself with professional and appropriate attire in adherence with the organizational dress code.

I will ensure that the personal use of my cell phone does not distract me from interacting with others (used only at official "break" times and in cases of emergency).

I understand and appreciate the poor impression that is left with patients, family members and visitors who observe staff interacting on social media during work time, and I will ensure that my actions do not contribute to such impressions.

Compassion

I will offer encouragement, empowerment, and empathy to all patients, families, and coworkers by striving to put their needs above my own.

I will personally exceed the expectations of the organization, my coworkers, and my patients and families by always putting patients first every time and treating them like my own family.

I will make every patient feel like my top priority by using the principles of the RELATE model:

Reassure
Explain
Listen
Answer
Take Action
Express Appreciation

I will introduce myself and explain my role to patients and families and I will "Manage Up" my coworkers and my organization whenever possible.

I will be courteous to all department members on the phone and in person. I will respond with a sincere; "Thank you", "It's my pleasure", and I will learn and use names of patients, coworkers, and family members.

I will provide opportunities for patients and families to maintain their dignity and respect by including them in the Plan of Care and decision making (i.e.. utilize communication boards, bedside shift report, share unbiased information in easy to understand language), listen and seek to understand, and expect organizational support in these efforts.

Trustworthiness

I will build rapport with patients and their loved ones to establish a trusting relationship.

I will lead by example to uphold the No Pass Zone to provide safe and excellent care.

I will hold myself and coworkers accountable for completing tasks safely, reliably, and accurately.

I will seek out all available resources to give patients the best care.

I will provide unbiased, respectful patient care to the best of my abilities.

I will treat others how I would want and expect to be treated.

Legal & Ethical Compliance

I will respect the diversity of each person by actively listening and being sensitive to culture, age, gender, sexual orientation, education, religion, and all other forms of diversity.

I will uphold confidentiality and HIPAA at all times, in accordance with the law.

I will speak up for serious patient safety matters by immediately stating the need for a "Safety Double Check" or calling a "Code Safety" when it is appropriate.

I will speak up for ongoing patient safety by reporting any unsafe working conditions, near misses, errors, and/or accidents by reporting the incident in RL Solutions, while supporting a blame free culture.

I will utilize the Learning Boards to communicate concerns, opportunities, and other issues to our leadership team.

Honesty

I will approach each action/ interaction with honesty, transparency, and respect.

I will be honest in my efforts and abilities in all tasks that are asked of or assigned to me.

I will hold myself accountable for my professional attitude, performance, and behaviors in my interactions with patients, family members and, visitors.

I will expect all employees of UPHS-Marquette, which includes all outlying clinics and departments throughout the UP, to hold each other accountable to the same standards of performance, values, and culture that I hold myself to.

At UP Health System—Marquette, we understand that it is an honor and a responsibility to have the trust of our patients and their families in our hands.

We are committed to a focus on safety, quality, and service for every person, everywhere, during every encounter, every day.

Our Service Standards represent this commitment and are an expectation of all employees.

UP HEALTH SYSTEM
MARQUETTE
A Duke LifePoint Hospital

EMERGENCY CODES

Dial 5555 for any emergency

Code RED	FIRE	R- Rescue A- Alarm C- Contain E- Extinguish	P- Pull A- Aim S- Squeeze S- Sweep
Code BLUE	Medical Emergency	Inpatient team will respond to overhead pages	
Code PINK	Child Abduction	All employees hospital wide will search areas and monitor exits	
Code GREEN	Patient Elopement	All employees hospital wide will search areas and monitor exits	
Code GRAY	Assistance Needed	Any employee in the area will report to location called. Only those trained in Code Gray are permitted to touch patient/ visitor	
Code ORANGE	DECON	Staff trained in HAZMAT processes will report to designated location	
Code SILVER	Weapon/ Shooter	Call 911 or 5555 RUN-HIDE-FIGHT	

UP HEALTH SYSTEM MARQUETTE

A Duke LifePoint Hospital

Fire Life Safety

Robin Mackie

Hospital Fire Response

In a Health Care occupancy,
a **Defend in Place** strategy is used.

This relies on:

- ✓building design
- ✓fire detection and suppression systems
- ✓fire prevention procedures and planning

Hospital Fire Response

If you discover fire or smoke or the alarm is activated in your area, the appropriate response will be the **R.A.C.E.** procedure.

Dial **5555**

Hospital Fire Response

Fight the fire using the **P.A.S.S** procedure only if you are not placing yourself in danger

Fire extinguishers are located at exits and every 75 feet along paths of travel

Hospital Fire Response

If the fire is above, below, or next to your work area:

- Have patients return to their room
- Close all doors
- Remove items from the corridors
- Prevent elevator usage
- Listen for overhead pages for status updates and further instruction

Hospital Fire Response

If the fire is not located near your work area:

- Be prepared to accept patients from areas near the fire
- Prevent elevator usage
- Listen for overhead pages for status updates and further instruction

Hospital Evacuation

Evacuation will not occur until directed by:

- ✓ Chief Executive Officer
- ✓ Administrator / Administrator on call
- ✓ House Supervisor
- ✓ Fire Department.

- At any time patients, visitors, or staff are in immediate danger, moving them to a safer area can be done without these approvals.
- Elevators are not to be used.

Types of Evacuation

Stage 1 – Horizontal

Stage 2 – Vertical

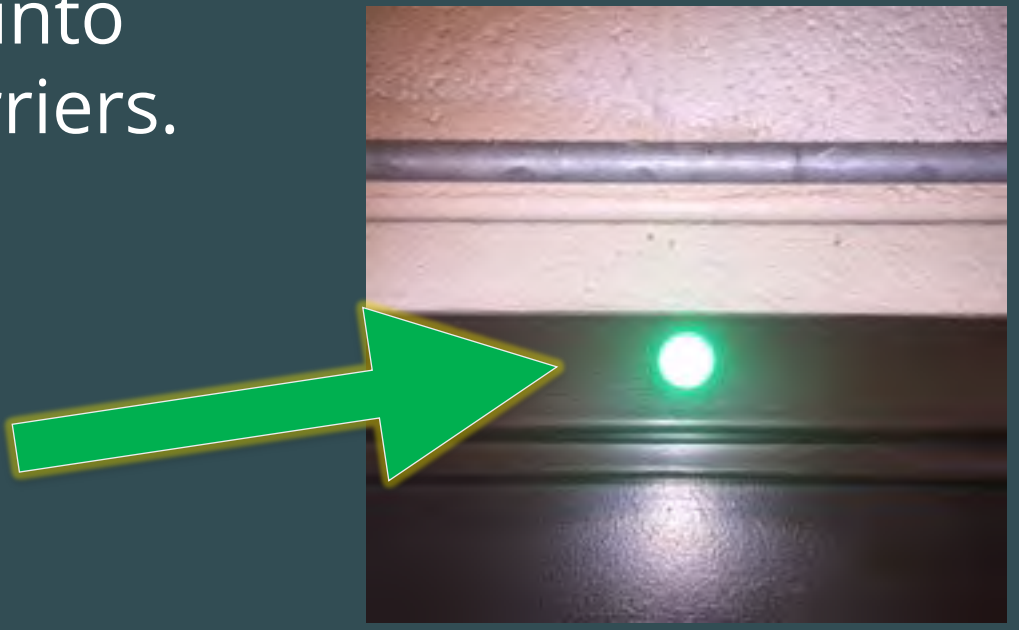
Stage 3 – Building

Stage 1- Horizontal Evacuation

Move to an adjacent smoke compartment.

Each floor of the hospital is divided into smoke compartments by smoke barriers.

Smoke barrier doors are identified with a reflective green dot on the top of the door frame



Stage 2- Vertical Evacuation

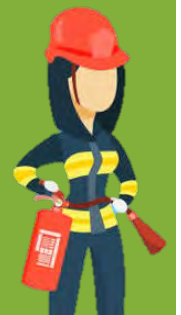
Move one floor down using the nearest stairwell

Stage 3- Building Evacuation

All staff, patients and visitors will exit the building and patients will be moved to alternate care sites.

Meet at your departments assigned evacuation assembly point and wait for further instruction.

Evacuation Assembly Points



Parking Deck

Level 3:
Seventh Floor
Sixth Floor
Level 2:
FBC, CS, Surgical & Interventional
Anesthesia
Level 1:
Fourth Floor
Ground:
Fifth Floor

Lot E

IT/Data Center
Maint/Plant Ops
Bulk/MM/Printing
BioMed

Lot D

Lab
Imaging
Pharmacy
HR
Accounting
Quality
Care Managmt.

Lot C

ED patients to the EMS bay on the north side of the ED.

Lot C

ED
Administration
Admit/Reg/PAT

Lot F

EVS
MSU-CHM
EMS
Mail Room
Logistics
Spiritual/Vol
Visitors

Lot A

MOB – All Floors; All Depts.

Lot B

Lobby, Gift Shop
Coffee Shop
Food & Nutrition
Cafeteria
OP Waiting

UP HEALTH | MARQUETTE
1ST FLOOR

GRESHAM SMITH AND PARTNERS

UP HEALTH SYSTEM MARQUETTE
A Duke LifePoint Hospital

MOB Fire Response

If the fire is located in a Business Occupancy, respond with the **R.A.C.E.** and **P.A.S.S.** procedures

- Business Occupancies do not Defend in Place and **must evacuate immediately**.
- Proceed to the nearest exit and meet at your departments assigned evacuation assembly point.

Staff Responsibilities

Always keep exit corridors free of furniture and equipment

Do not prop open or block fire or smoke doors

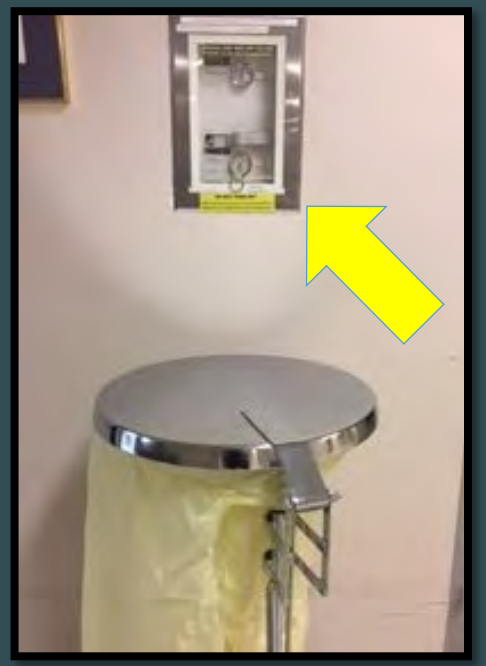
Staff Responsibilities

Do not place items in front of

fire alarm pull stations fire extinguishers

electrical panels

medical gas valve boxes



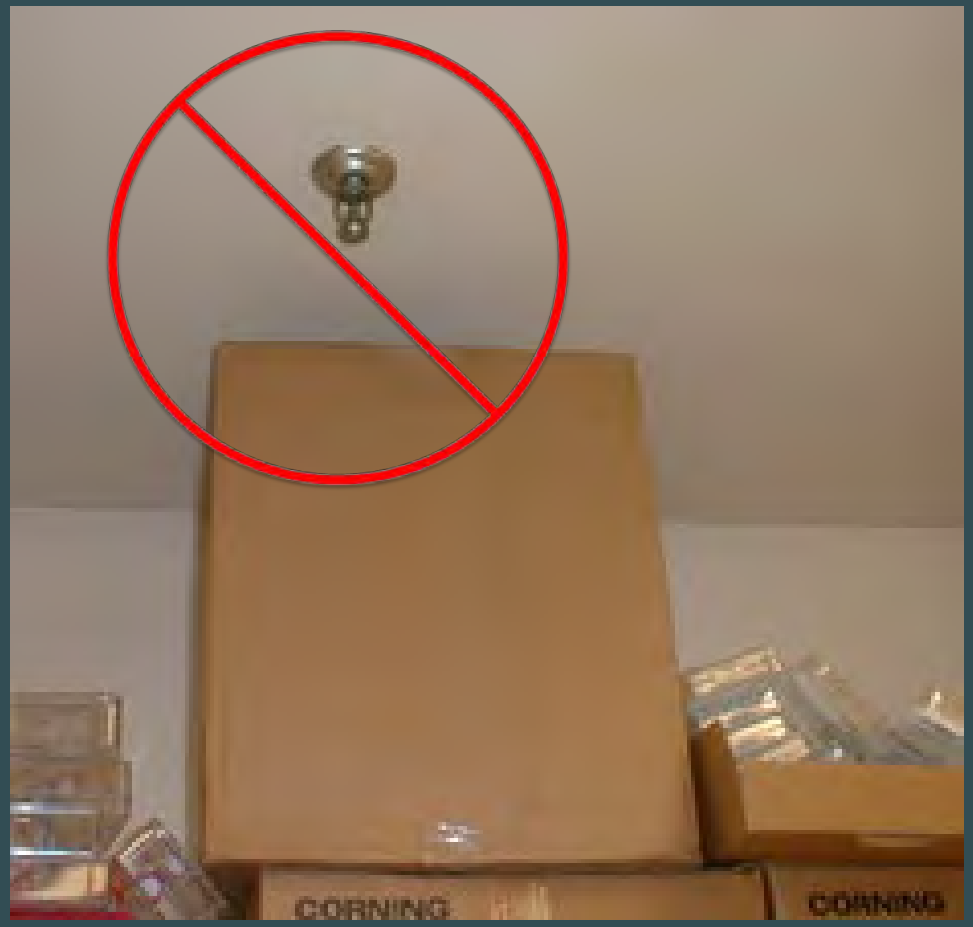
Staff Responsibilities

Familiarize yourself with the location of medical gas valves.

Only Respiratory, Maintenance, or Fire Department can shut these valves off.

Staff Responsibilities

Do not store items within 18 inches of the bottom of a sprinkler head.

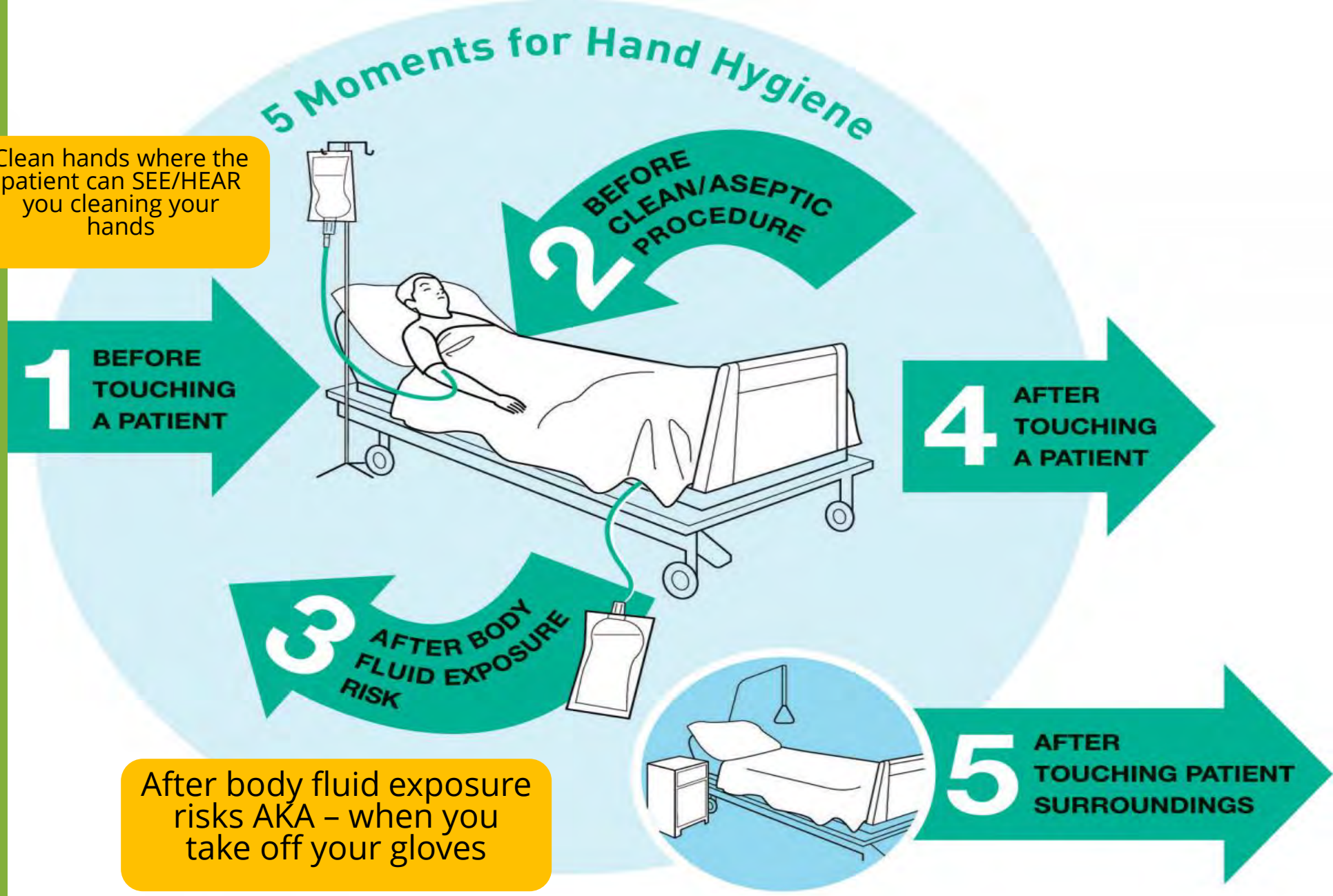


Infection Control

Amy Kilroy, MPH, CIC

Hand Hygiene

Clean hands where the patient can SEE/HEAR you cleaning your hands



After body fluid exposure risks AKA – when you take off your gloves

World Health Organization. WHO Guidelines for Hand Hygiene in Health Care. Geneva: World Health Organization; 2009.

Hand Hygiene

In addition to the 5 moments, get into the habit if cleaning your hands on every patient room entry and exit.

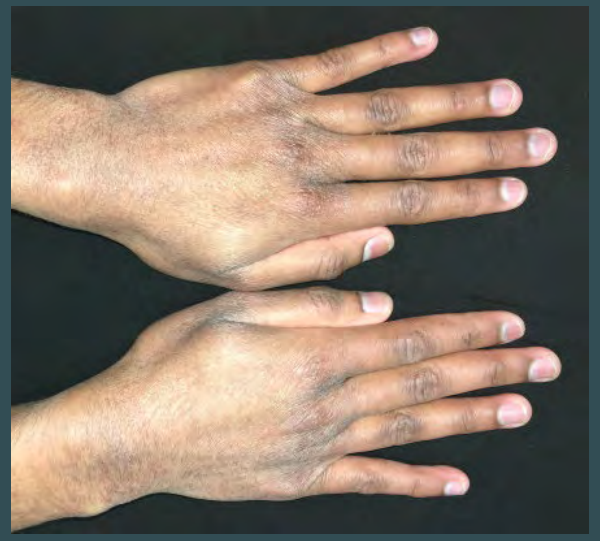
Hand Hygiene

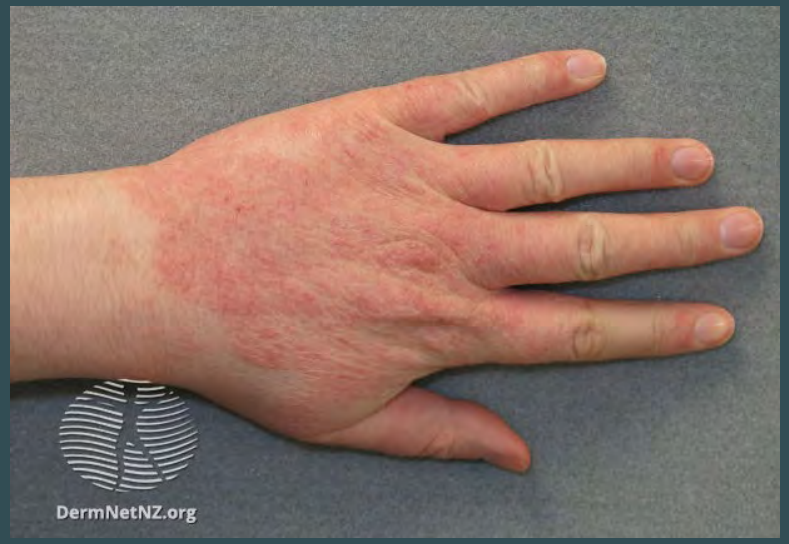
Use alcohol-based sanitizer (Purell) as much as possible over soap and water

-Purell is less drying and will help keep your skin healthier.

-Over-washing, especially with hot water can lead to contact dermatitis.

-Damaged skin increases your risk of infection





Hand Hygiene

You MUST use soap and water instead of Purell:

- Whenever there is risk of fecal-oral transmission of *C. diff* or norovirus:
  -after using the restroom
  -before eating
  -exiting Enteric Precautions rooms

- Whenever hands are visibly dirty – need mechanical friction to remove debris. The “Cheetos effect!”

Hand Sanitizer

1. Use enough to cover all surfaces of your hands and wrists
2. Rub hands together until dry

   (whole process takes 10-15 seconds)

How to wash hands with soap & water

Wet hands and apply soap

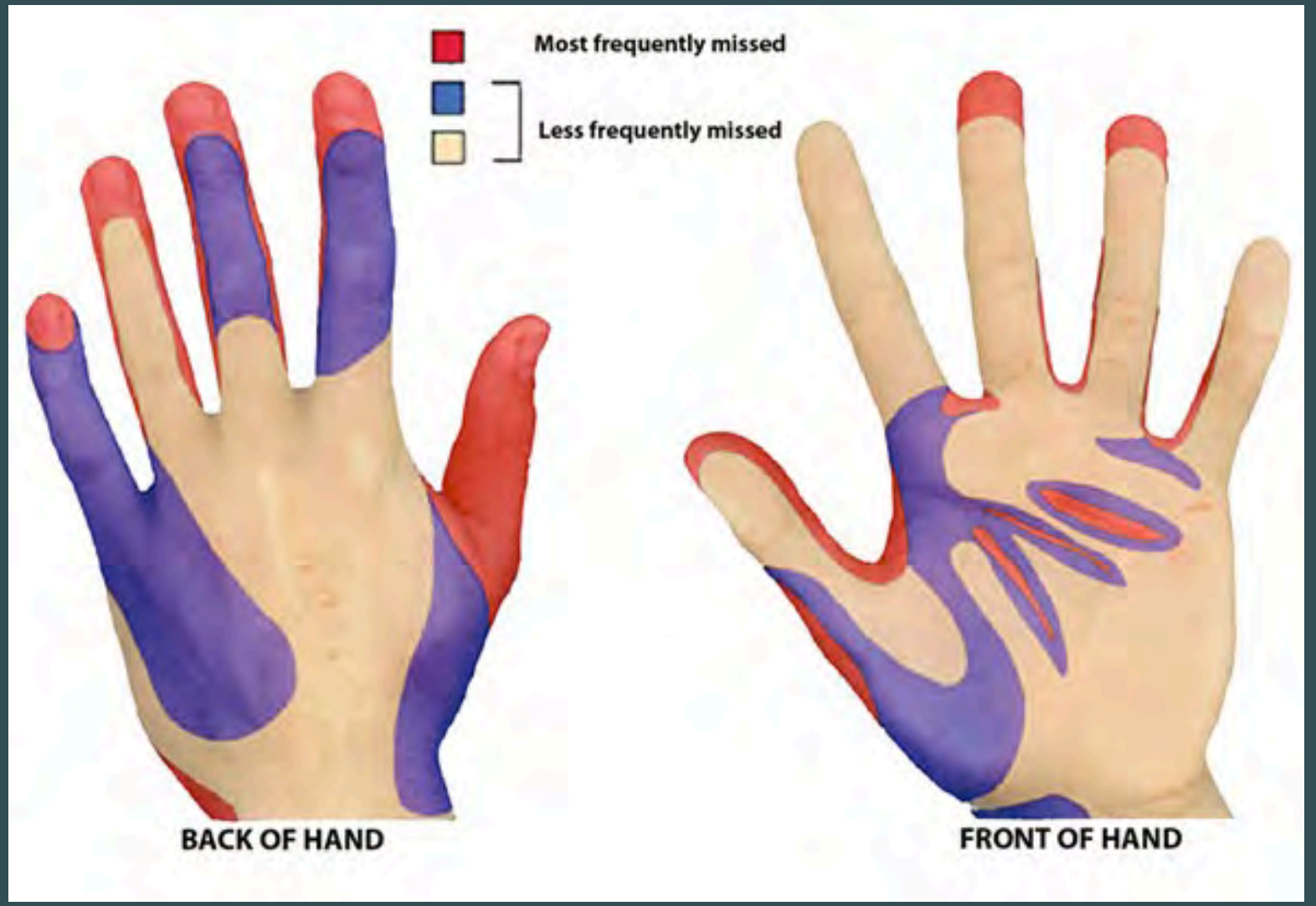
Lather for a full 15 seconds covering all surfaces

Rinse hands and dry them with paper towel

Turn off faucet with paper towel

- ✓ avoid <u>contamination</u>
- ✓ elbow/sleeve turn off method is not recommended – germs will get on the front for your shirt.

Frequently missed hand surfaces during cleaning

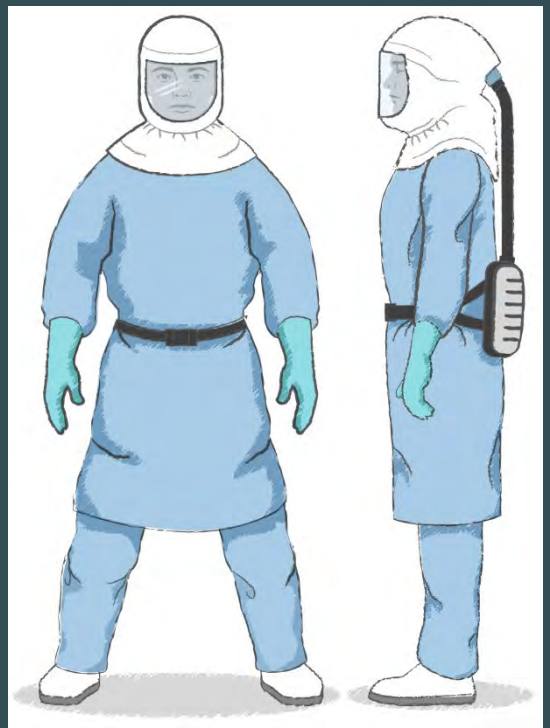


Standard (Universal) Precautions

- Do not touch any non-intact skin with your bare skin
  - cuts, burns, incisions, ulcers, blisters, vesicles, rashes, mouth, eyes, inside of the nose, ostomies, or other mucous membranes
- Avoid contact with infectious materials with personal protective equipment
  - Mask and eye protection currently required for all patient contact due to COVID-19

Personal Protective Equipment

- Gowns
- Gloves
- Masks
- Eye protection (this is not standard glasses)
- N-95 respirators, P-100 respirators
- Powered air purifying respirators (PAPRs)



What is eye protection?

Safety glasses protect from projectiles, but not from aerosolized droplets which can change trajectory in the air

PPE & Standard Precautions

When to put PPE on:

- If you think you might come into contact with any blood, body fluid, or other potentially infectious material (OPIM)

When to take PPE off:

- When finished with anticipated contact with blood, body fluid, or OPIM.
- Gowns and/or gloves: Remove when finished with contact with a single patient and his/her surroundings, or a contaminated body site on a patient.
- When there is an indication for hand hygiene, such as moving from a dirty task to a clean task.
- If the PPE is damaged.

How can personnel be exposed to BBP at work?

- Dirty needle stick
- Poked by other bloody sharp such as a scalpel or suture needle
- Blood splashes into the eyes, nose, or mouth
- Blood gets onto an open cut or other non-intact skin
  - Hangnails
  - Cuts
  - Rash
  - Burn
  - Mucous membrane
- Any entry of someone else's blood into the body

What should you do if you think you may have had an exposure incident?

- Clean the effected area with water soap
- Notify your supervisor
- Go to the ED
- Bring the source patient's sticker if you can to speed up their bloodwork for HIV, Hep B and Hep C

HIV PEP IS MOST EFFECTIVE WITHIN 2 HOURS OF EXPOSURE

Contact Precautions

For infections spread by direct and indirect contact:

MRSA*

ESBL*

VRE*

* if incontinent or has draining wound, >risk of environmental contamination

Always use contact precautions for superbugs:

CRE

MDR-*Acinetobacter*

MDR-*Pseudomonas*

- Gown and gloves to enter room
- Use dedicated/disposable equipment
- Clean equipment with a PDI Super Sani-

Enteric Precautions

For spore-forming and ammonia-resistant germs spread by direct and indirect contact

Clostridium difficile (C. diff) and Norovirus

- Rule out and known cases
- Both are resistant to non-cleach disinfectant and Purell

⬆ Bouffant cap goes over the Purell dispenser to promote hand washing

- Gown and gloves to enter room
- Use dedicated or disposable equipment
- Clean equipment with a PDI Bleach wipes
- **Hand wash with soap and water at exit** – Purell may be covered with a red bouffant as a visual reminder

Droplet Precautions

Influenza

- Rule out & confirmed

Pertussis

Bacterial meningitis

- Rule out
- *Haemophilus influenza (H. flu), Neisseria meningitidis (meningococcal meningitis)*

- Personnel/visitors wear mask inside room
- Patient wears a mask outside room

Airborne Precautions

Tuberculosis (TB)

- Rule out & pulmonary infection
- NOT for latent infection

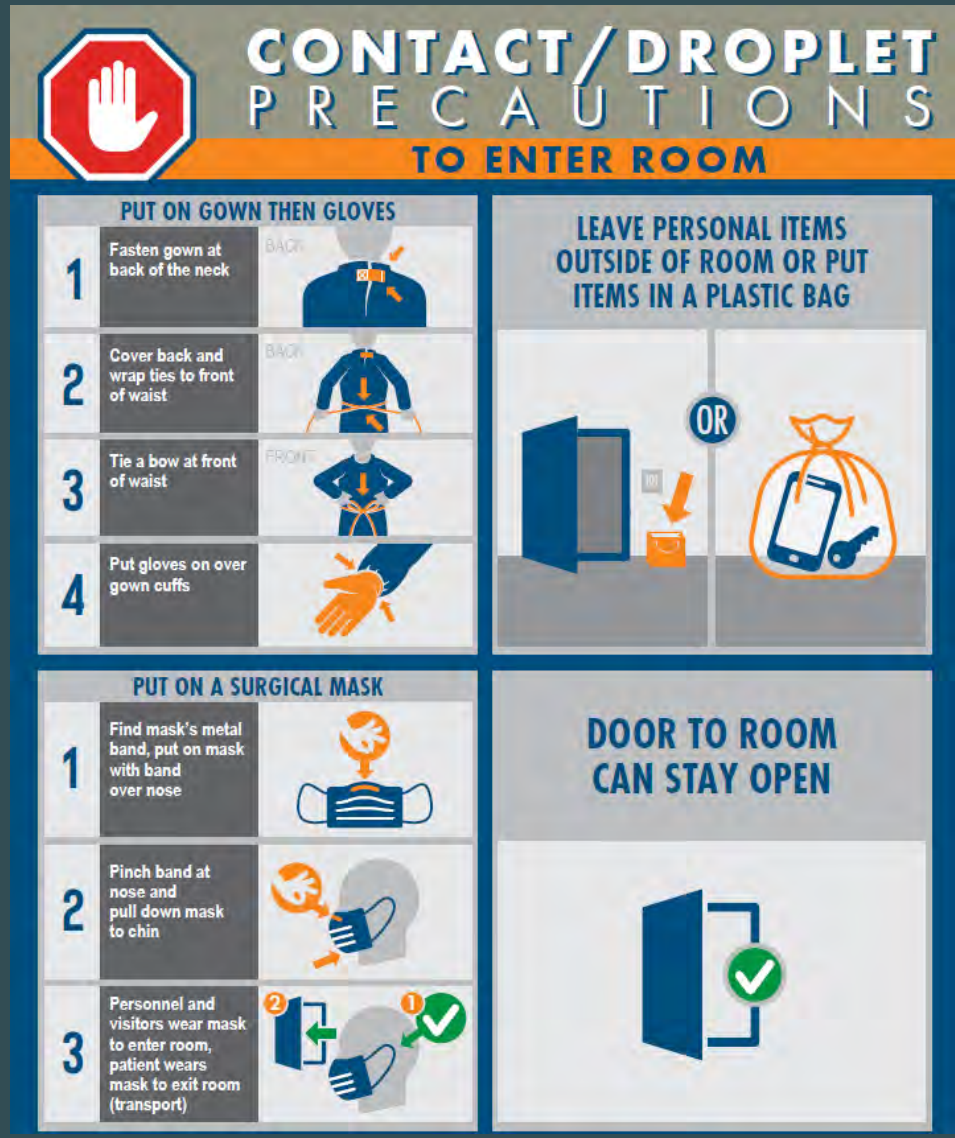
Measles

- **Personnel wear respirator or PAPR inside room**
- **Personnel/visitors wear mask inside room**
- **Patient wears a mask outside room**
- **Negative pressure room, door stays closed**

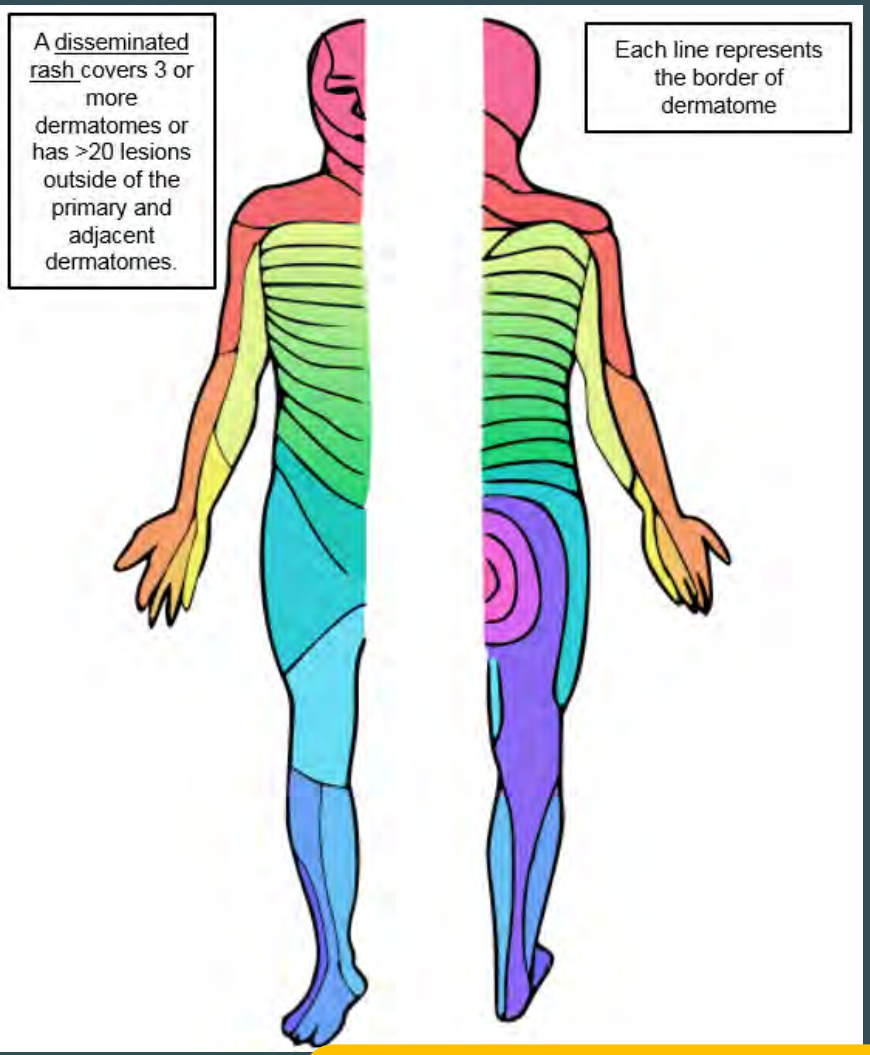
Contact/Droplet Precautions

For viruses that spread by droplet & through contact:

- **Adenovirus**
- **Human metapneumovirus**
- **Parainfluenza**
- **RSV in infants, young children, & immunocompromised adults due to increased contamination and shedding risk**



Contact & Airborne Precautions



⬆ Dermatome dude is a great tool to determine local vs. disseminated shingles

Chickenpox

Disseminated shingles in any patient

Localized shingles in an immunocompromised patient

Neutropenic Precautions

Neutropenic precautions is used to protect patients from infections and is sometimes called ‘reverse isolation.’

Used for patients with ANC < 1500 per microliter

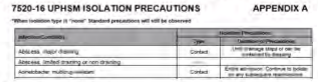
Positive pressure rooms are not required – the ‘protective environment’ of positive pressure is only recommended for solid organ transplant and allogeneic hematopoeitic stem cell transplant recipients

- **Patient wears a mask outside room**
- **No fresh or dried plants are allowed in the room, no standing**

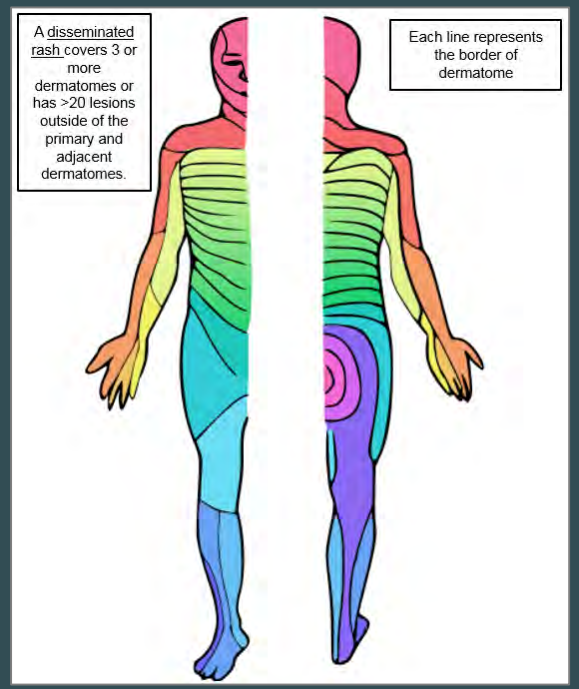
Isolation Supplies

ISOLATION INFO

- Isolation cart restock list
- Isolation steps for Contact Precautions
- Discharge checklists for Contact Precautions
- Isolation steps for Enteric Precautions
- Discharge checklists for Enteric Precautions
- Isolation steps for Droplet Precautions
- Discharge checklists for Droplet Precautions
- Isolation steps for Airborne Precautions
- Discharge checklists for Airborne Precautions
- MRSA, ESBL, VRE, C. diff and other MDRO decision tree
- List of isolation type and duration by infection or condition (Appendix A)

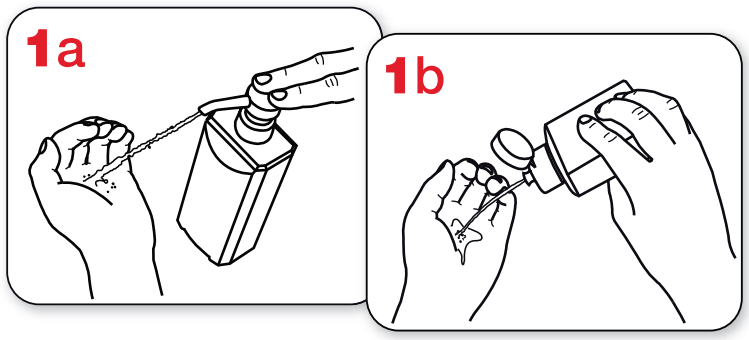

7520-16 UPHSM ISOLATION PRECAUTIONS APPENDIX A

- Varicella zoster/shingles/chickenpox decision tree and dermatome map for disseminated vs. localized shingles



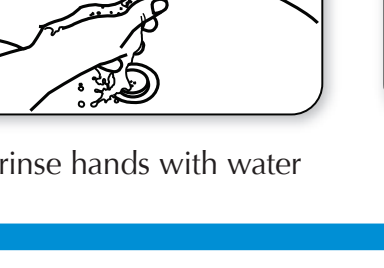
Iso carts also have binders with how to start and stop iso, types of iso needed by organism, and dermatome (dude) maps

How to handrub?
WITH ALCOHOL-BASED FORMULATION



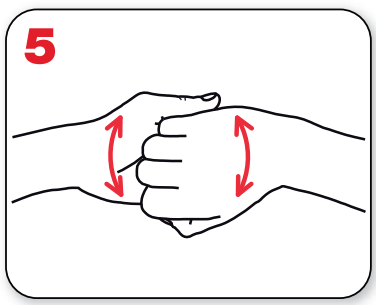
Apply a palmful of the product in a cupped hand and cover all surfaces.

Rub hands palm to palm

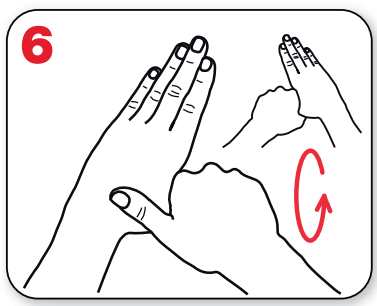


right palm over left dorsum with interlaced fingers and vice versa

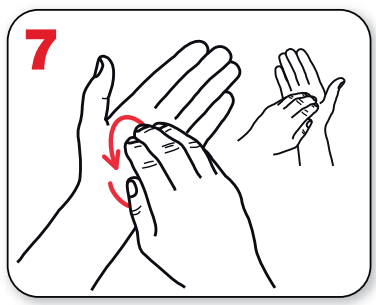
palm to palm with fingers interlaced



backs of fingers to opposing palms with fingers interlocked

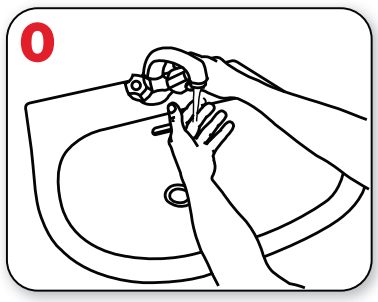


rotational rubbing of left thumb clasped in right palm and vice versa

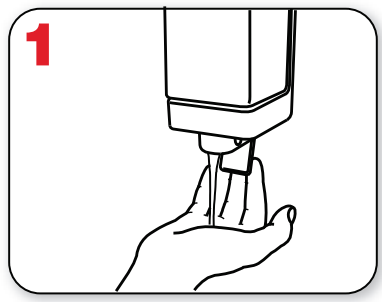


rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa

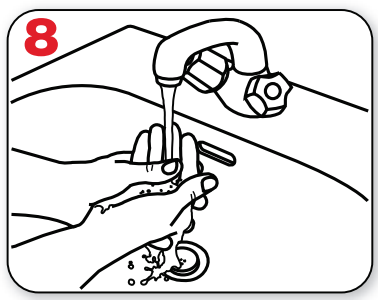
How to handwash?
WITH SOAP AND WATER



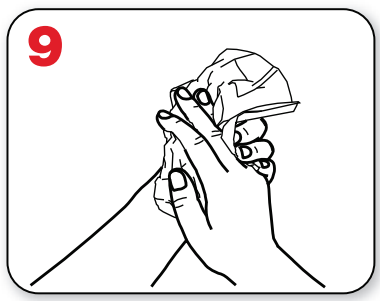
Wet hands with water



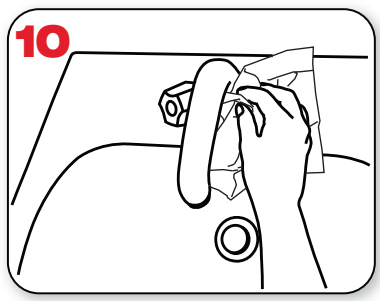
apply enough soap to cover all hand surfaces.



rinse hands with water

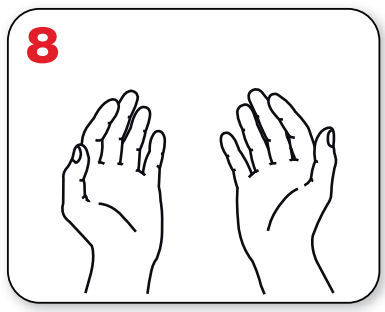


dry thoroughly with a single use towel

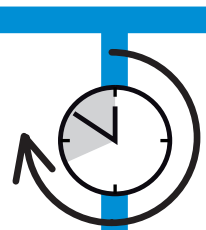


use towel to turn off faucet

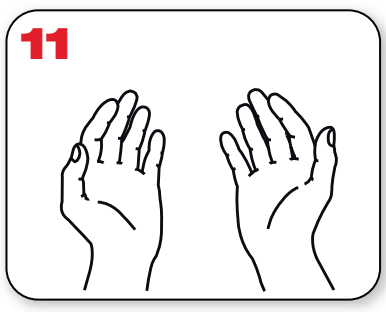
20-30 sec



…once dry, your hands are safe.



40-60 sec



…and your hands are safe.

WHO acknowledges the Hôpitaux Universitaires de Genève (HUG),
in particular the members of the Infection Control Programme, for their active participation in developing this material.

World Health Organization

October 2006, version 1.

Design: mondofragilis network

LIFTING DO'S & DON'TS

DO LIFT AS A TEAM

Do lift bulky or heavy loads as a team. Doing so is smart and the safe way to work.

DO TURN WITH LEGS

Do move your legs and feet when turning or lowering the load. Avoid twisting at your waist.

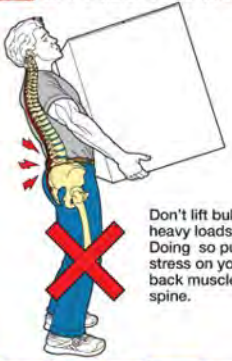
DO USE YOUR LEGS

Do lift the load using your powerful leg and buttocks muscles. Your feet should be wide apart, head and back upright. Keep abdominal muscles tight and the load in close.

DO USE EQUIPMENT

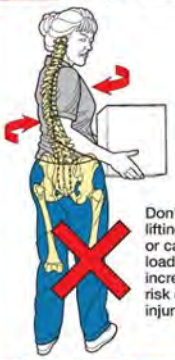
Do use equipment like hand trucks, dolly's, or forklifts to do the heavy lifting. It's much less work and less risk of injury.

DON'T LIFT BULKY LOADS ALONE



Don't lift bulky or heavy loads alone. Doing so puts great stress on your low back muscles and spine.

DON'T TWIST WHEN LIFTING



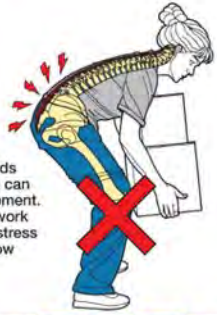
Don't twist when lifting, lowering, or carrying any load as this increases your risk of back injury.

DON'T USE YOUR BACK

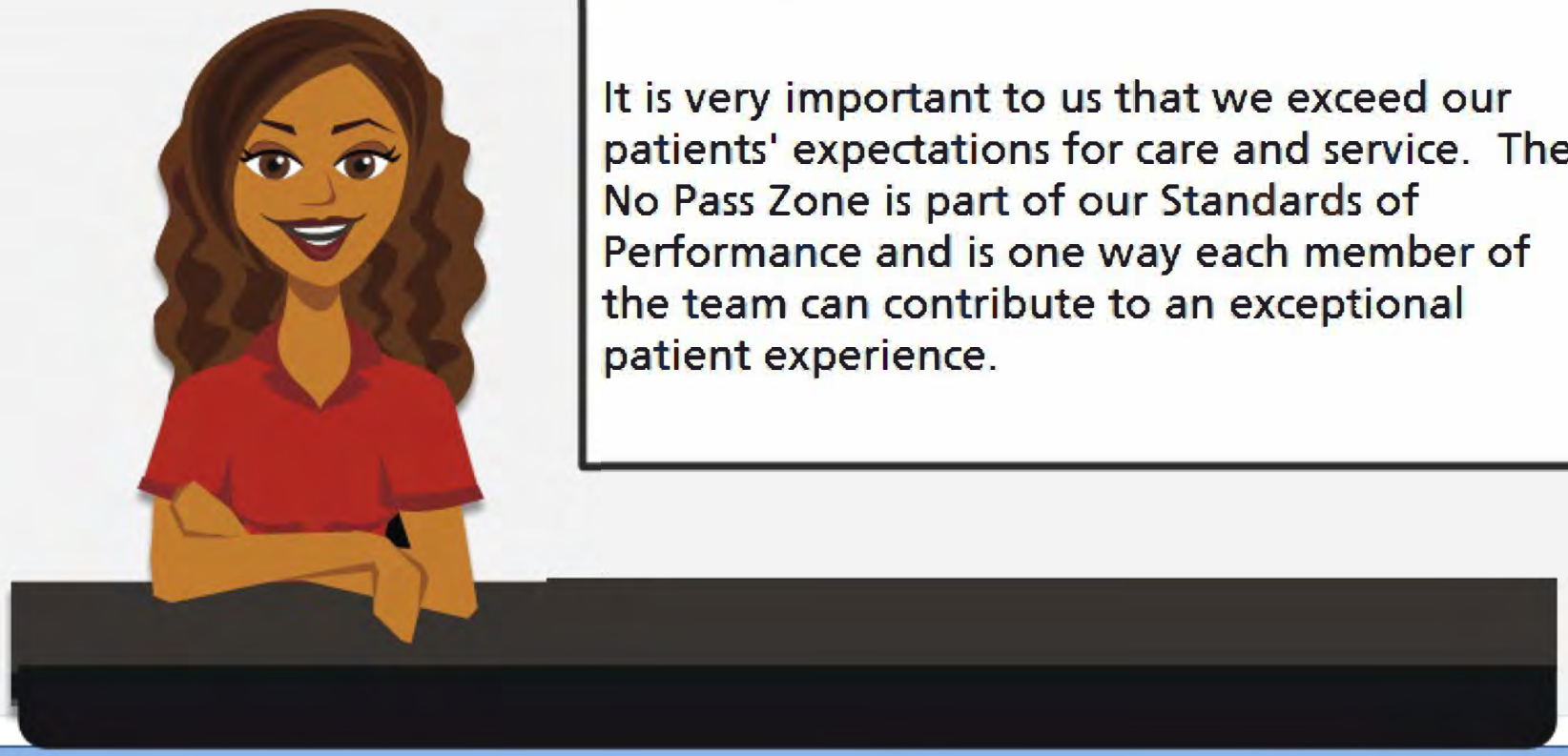
Don't lift the load with your rear end high and your lead low. Use your leg muscles, not your weaker low back muscles.

DON'T LIFT HEAVY LOADS

Don't lift heavy loads when you can use equipment. It is less work and less stress on your low back.



No Pass Zone



At UP Health System Marquette, we measure patient experience using the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient satisfaction survey.

It is very important to us that we exceed our patients' expectations for care and service. The No Pass Zone is part of our Standards of Performance and is one way each member of the team can contribute to an exceptional patient experience.

10/5 Rule

All employees are expected to:

- Make eye contact and smile when passing by someone within 10 feet
- Offer a greeting within 5 feet, such as "Good morning."

❖ Don't wait for them to approach you and ask. Simply ask, "What can I help you find?"

❖ If you are unsure where the department is they are looking for, go to the closest department and ask for assistance or ask another employee passing by.

Everyone's Responsibility to:

✓ Keep our facility clean and tidy.

✓ Pick it up any trash on the floor and dispose of it.

✓ Keep all work areas clutter-free and professional looking.

❖ Trash on the floor or cluttered workspaces can leave our guests feeling like we are not "clean" and may also pose safety risks.

Call Lights

It is everyone's responsibility to provide a compassionate and timely response to a patient's needs within their scope of care.

There is also an expectation that our nurses are respectful and responsive when approached by a non-nursing teammate who is relaying a call light inquiry.

Hand Hygiene

- Cleanliness and low infection rates are a top priority for the well being of our patients, employees, and guests.
- All employees are expected to never pass up an opportunity for hand hygiene.
- Please refer to our Hand Hygiene Procedure for complete instructions and required moments for decontaminating hands.

No Pass Zone: Call Lights

- **N** - Never pass them by
- **O** - Observe patient privacy

- **P** - Provide what they are asking for, OR
- **A** - Access someone who can
- **S** - Safety First, never put patients at risk
- **S** - Smile & use Words That Work

The No Pass Zone has been developed with patient safety as our first responsibility.

If anything seems questionable or the staff member is not comfortable with the patient request, seek the nurse for assistance.

Everyone CAN help by:

- Reposition the call light, telephone, bedside table, chairs, trash can, tissues or other personal items within reach.
- Assist with making phone calls or answering the telephone.
- Change TV channels or turn the TV on or off.
- Turn lights on or off.
- Obtain personal items such as blanket, pillow, towel, washcloth, slippers, toiletries, pens, pencils, books, magazines, etc.
  - CAUTION: You cannot use a pillow to reposition a patient and you cannot cover a wound with a blanket.
- Open and/or close privacy curtains and window blinds.

Non-nursing staff CANNOT:

- Manage an IV and/or infusion pump, including positioning of tubing.
- Get food or drink for a patient (some patients are waiting for a procedure)
- Offer pain relief
- Remove meal trays or water pitchers (some patients have their diet intake measured/recorded)
- Assist patients with eating and drinking
- Physically assist a patient, including but not limited to moving a patient from bed to chair or vise-versa, assisting to the bathroom, and repositioning.
- Turn off any alarms
- Explain clinical matters/treatments
- Raise or lower a patient bed, including the head of the bed.

Droplet Precaution Rooms

- Do not enter a droplet / respiratory precautions room. This call light will need to be answered by the nurse.

Contact Precaution Rooms

- If possible, stand near the door and ask how you can help. Otherwise you must utilize the appropriate PPE on the cart before entering the room.
- When in doubt, do not enter the room and find a nurse.

Prisoner Rooms

- From the doorway you can ask the guard what type of assistance is needed and relay that information to the nurse.

Communication is Key

Words that Work:

- Hello, my name is (name), from the (department). I noticed that your call light is on. Is there something that I can help you with?
- If you can: Yes, I can help you with that.
- If you cannot: Let me find the appropriate person to help you. I will let you know how long it will take.
- Remember to ask before leaving: Is there anything else I can do for you? I have the time.
- You're the reason we're here, I'm happy to help.
- We're never too busy to help you.

❖ Use the nurse's name and "Manage Up" at every opportunity.

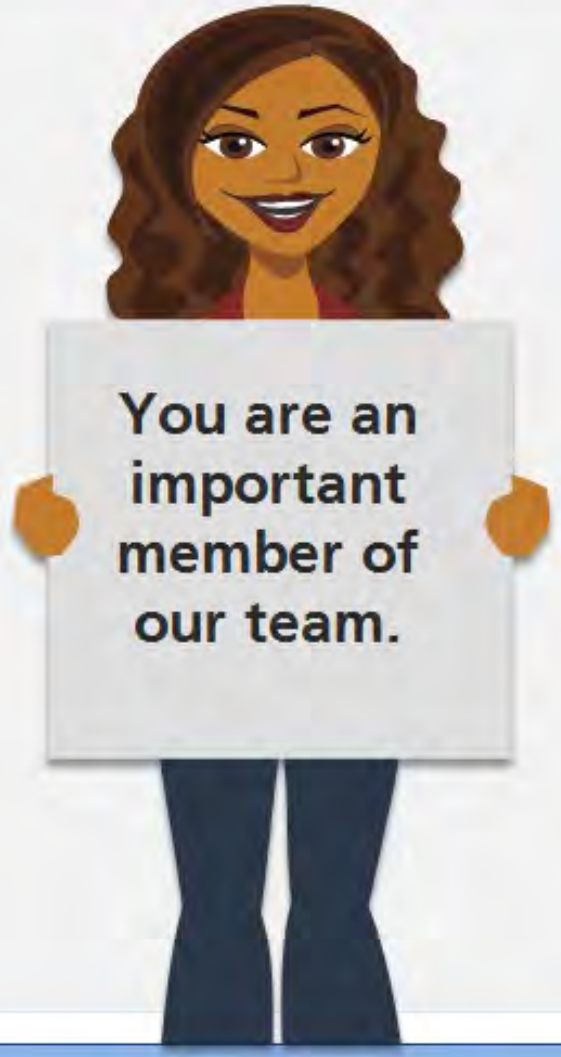
Look at Patient White Boards

The white board contains information about the patient; their name, goals, diet, medication information, name of their nurse, etc. Do not try to interpret information on the board for the patient or use it to determine whether you can help them.

You can use the whiteboard to:

- Determine who their nurse if you need to find her/him.
- Find out what the patient prefers to be called.

No Pass Zone



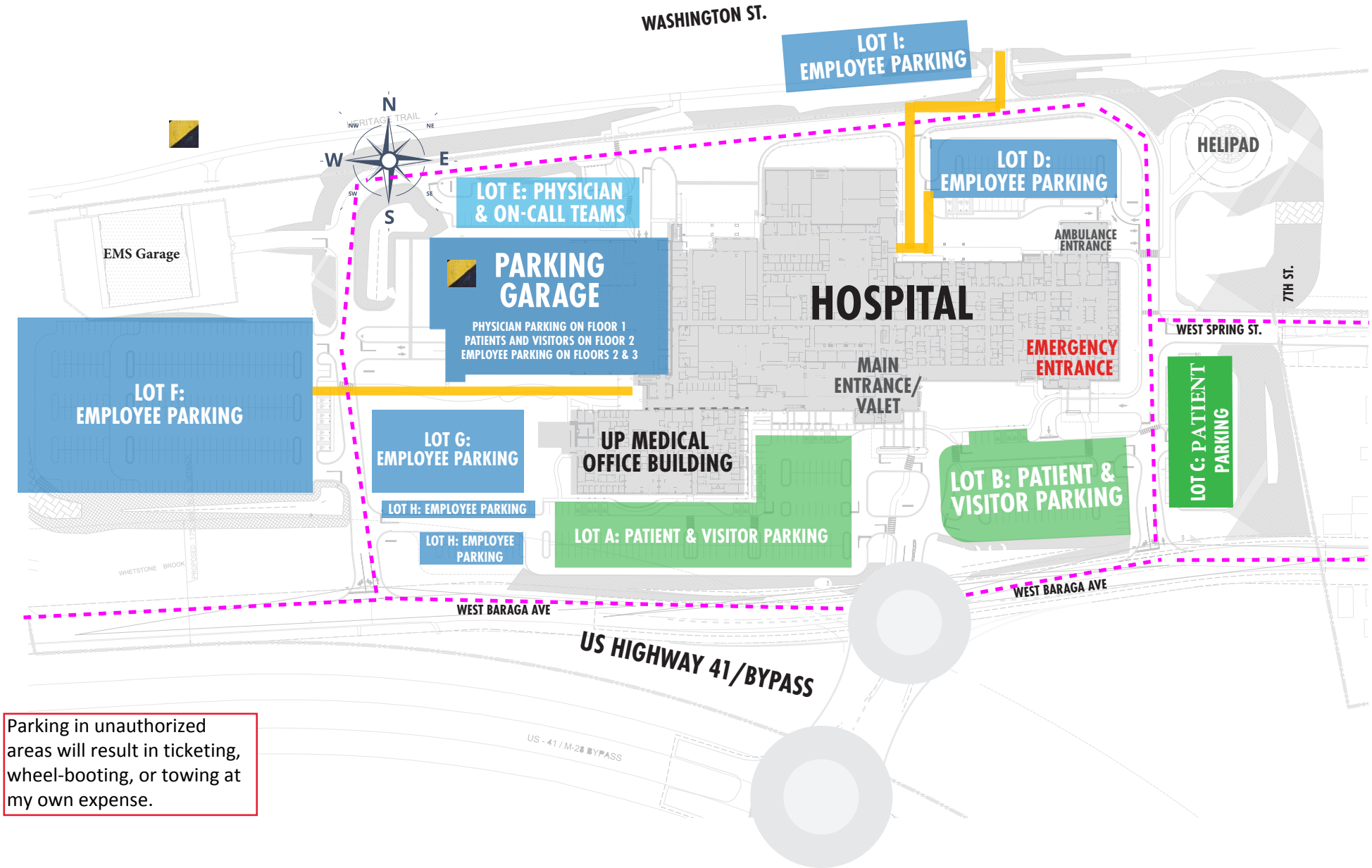
By doing what you can when answering call lights, you help create positive patient perceptions and support our nursing staff.

How we respond to our patient's needs has a great impact on their experience while they are with us.

Always remember to use your "Words That Work", smile and speak warmly, and keep our patient's safety in the forefront of all you do.

Parking Map

UP HEALTH SYSTEM
MARQUETTE
A Duke LifePoint Hospital



Parking in unauthorized areas will result in ticketing, wheel-booting, or towing at my own expense.

Current Status: *Active*	**PolicyStat ID:** HR 200-052

Effective:	**6***/3/2020*
Approved:	6/3/2020
Review:	**1/1/2024**
Editor:	**HRD**
Policy Area:	*Human Resources*

HR 200-052 Dress Code and Appearance

SCOPE:

This policy applies to UPHS- Marquette and its affiliates with employees who provide services in the Hospital's primary and secondary service area (the "Company"). References to Facility or Facilities throughout the policy are meant to include the Hospital and/or its affiliates with employees providing services in UPHS- Marquette's primary and secondary service area.

PURPOSE:

UPHSM associates work extensively with the public, physicians, educational institutions, and other medical and professional personnel. While personal preference and individual styles of dress considered important avenues for expression, certain minimum standards must be maintained in presenting a professional image and maintaining a safe environment.

POLICY:

All Employees

1. **Badges** must always be worn. It must be showing at shoulder level with picture and name clearly visible to the observer. (except where prohibited for infection control purposes). For safety reasons, lanyards should not be used. In the event your badge is lost or stolen, report it to Human Resources where a replacement ID badge must be obtained (for a nominal fee, see badge policy). ID badges may only be used by the individual the badge is issued to.

2. **Hair** must be of natural color, clean, dry, neat, and out of the face.
    a. **Beards, moustaches, and sideburns** must be neatly and properly groomed. Employees working in departments requiring the use of respirator masks must ensure that any facial hair does not interfere with proper fit of their mask.

3. **Fingernails** should be kept clean and should not be excessive in length and in compliance with the Hand Hygiene Policy.

4. **Pierced jewelry** that is visible is limited to earrings. In general, earrings should not extend more than one inch below the bottom of the ear.

5. **Proper body hygiene** must always be maintained.
    a. **Fragranced products**, such as lotions, perfumes, and after-shaves, should be used sparingly in non-patient care areas due to the negative affect may have on persons sensitive to them.

6. **Tattoos**, which may be considered offensive to those we serve, must be covered. If in doubt whether your tattoo may be considered offensive, please discuss with your Manager, Director, or the Human Resources Department.

7. **Dress apparel** should be neat, clean and professional. Associates represent UPHSM through their actions and dress.
    a. **Shoes** must be neat and appropriate for the work area and/or as indicated by individual department policy to meet safety or infection control standards. Athletic sandals/thongs/flip flops are not acceptable footwear for any position. Dress sandals and open toe shoes are acceptable in non-clinical departments unless prohibited by individual department policy, or as required to meet safety standards. Hosiery/socks to cover exposed leg, ankle and foot, must be worn by all employees providing direct patient care or working in a patient care department.
    b. **Skirts and dresses** must be worn at a professional and modest length.
    c. **Underclothing** must be worn and inconspicuous.
    d. **Examples of appropriate dress include**: professional attire, open-collared shirts, golf and polo shirts (may include UPHSM logos), tee shirts if part of a pre-approved initiative, sweaters, khakis, other casual slacks and pant, and casual shoes.
    e. **Examples of inappropriate dress include**: denim apparel jeans (except on Fridays if participating in the Jeans for a Cause program), sweat shirts and sweat pants, shoulder, back or midriff baring tops, beachwear, shorts, cutoffs, tight clothing (e.g. knit, spandex, workout gear, immodest attire, etc.) or shirts with visible slogans, photos, or advertisements.

8. **Additional General Considerations**
    a. On occasion, associates may be allowed to wear clothing to support a specific cause or holiday (i.e. Christmas sweaters). Participation in such a cause/event requires approval by the applicable Executive and Human Resources.
    b. Associates wearing inappropriate clothing will be counseled by their supervisor on a one-to-one basis and may be sent home to change clothes. Time away from work for this reason will not be compensated. Associates may be subject to corrective actions when these standards are violated.
    c. Requirements may vary within individual clinical and non-clinical departments, dependent upon departmental activities, anticipated customer contacts, and/or designated specific departmental policy. Associates in clinical areas, departments requiring designated uniforms (i.e. Food and Nutrition), or those areas with more restrictive standards must also adhere to department dress policies.
    d. Department directors and managers will enforce these standards for all associates, volunteers, agency staff and contractors working in their areas.
    e. All students affiliating at UPHS Marquette hospital and associated clinics are expected to adhere to the same dress code and appearance requirements. Any school designated uniform must be properly maintained for cleanliness and professional appearance.

Direct Patient Care Staff

In addition to the minimum standards identified above, the following requirements are to be followed to ensure an appropriate professional image is presented to patients, families, and visitors, enhancing our patients' confidence in the quality of services we provide. Some companies/departments utilize clothing that identifies certain job classifications and staff responsibilities to assist recognition for patients/customers. Uniformity standards are identified below for patient care positions:

1. **Clothing**: associates will be responsible for purchasing, maintaining, and laundering their apparel.
    a. Certain positions must follow designated colors for their uniforms. Please check with you supervisor if you must wear a uniform that designates a specific color.
    b. T-shirt, turtleneck, or mock-turtleneck shirts may be worn under scrub tops.
    c. Scrub tops, warm-up/scrub jackets may be solid white or the designated color, or a conservative

print design if the design includes the designated color.
d. Uniform pants must be standard ankle length (no cropped/capri length).
e. Professional business-casual attire maybe worn in/by a clinical area/position as approved by the department director.
f. Clean shoes with closed toes are required in all clinical areas.

2. **Fragranced products** are not permitted to be worn in patient care areas due to the negative affect may have on persons sensitive to them.

3. **Jewelry** must not interfere with patient care.

4. **Hair** must be held back so it does not fall into open wounds during treatments or otherwise touch the patient.

5. **Staff attending in-services or meetings** on campus are required to adhere to the General Dress Requirements set forth in the requirements for All Employees above.

Provided Scrubs

It is UPHSM policy to provide surgical scrub attire for associates who work in Surgical Services and Obstetrics and to also provide scrub attire to those associates who contaminate their personal clothing at work. Exceptions to the preceding require executive approval.

1. Unless otherwise designated by departmental policies, in the area that require scrub attire, UPHSM will select, furnish, launder, and otherwise maintain the apparel at no cost to the wearer. These scrubs should not be home laundered
2. Scrub attire will be donned at the beginning of the associates work shift.
3. Used scrubs must be returned to the specified department soiled linen collections receptacle at the conclusion of the associates work shift.
4. Scrub garments that are furnished by UPHSM and are part of a multi-system circulating linen inventory. All scrubs must be returned for laundering after each use to maintain sufficient inventory.
5. Disposable cover gowns will be provided for departments where certain tasks require this protection.

Current Status: *Active*

UP HEALTH SYSTEM MARQUETTE
A Duke LifePoint Hospital

Effective: *10/01/2016*

Approved: *TBD*

Review: **TBD**

Editor: **HRD**

Policy Area: *Human Resources*

HR.011, Drug & Alcohol Free Workplace

SCOPE:

THIS POLICY APPLIES TO [HOSPITAL] AND ITS AFFILIATES WITH EMPLOYEES WHO PROVIDE SERVICES IN THE HOSPITAL'S PRIMARY AND SECONDARY SERVICE AREA (THE "COMPANY"). REFERENCES TO FACILITY OR FACILITIES THROUGHOUT THE POLICY ARE MEANT TO INCLUDE THE HOSPITAL AND/OR ITS AFFILIATES WITH EMPLOYEES PROVIDING SERVICES IN [HOSPITAL]'S PRIMARY AND SECONDARY SERVICE AREA.

PURPOSE:

TO PROMOTE A WORKPLACE THAT IS FREE FROM THE INFLUENCE OF DRUGS AND ALCOHOL AND FOR THE PROTECTION OF OUR PATIENTS, EMPLOYEES AND ALL OTHER PERSONS WORKING OR VISITING THE COMPANY; AND TO ELIMINATE THE POTENTIAL FOR SUBSTANCE ABUSE WITHIN THE COMPANY AND TO ESTABLISH A CONSISTENT METHOD FOR TESTING CANDIDATES AND EMPLOYEES IN ITS ATTEMPT TO ENSURE A WORKPLACE THAT IS FREE FROM THE INFLUENCE OF DRUGS AND ALCOHOL. STUDENTS, VOLUNTEERS, AUXILIARY, OR ANYONE WITH ACCESS TO PATIENTS AND PATIENT CARE AREAS ARE SUBJECT TO THIS POLICY.

DEFINITIONS:

N/A

POLICY:

A. Policy

It is the policy of the Company to promote a workplace that is free from the influence of drugs (including marijuana even if medically prescribed) and alcohol. The Company believes that such a policy is in the best interest of all our employees and the patients whom we serve. The Company's number one priority is providing excellent patient care and for that reason all of our employees serve in roles that affect the safety of our patients. Being under the influence of marijuana and other drugs in the healthcare setting can negatively impact patient care because drug use may impair the user's physical and/or cognitive functioning. Accordingly, the Company prohibits the use of drugs (see section D for use of legal medications) and has selected a laboratory with the technological sophistication to conduct Zero Tolerance Drug Testing on all samples submitted for testing.

This policy supersedes all previous drug and alcohol policies of the Company, whether found in an Employee Handbook, Policy and Procedure Manual, or in any other document or communications. **All positive test results will be reported to the applicable licensing board/agency when required by licensed/registered health professionals.**

B. Drugs and Alcohol

As used in this Policy, the term "drug" means any illegal or illicit drug, any substance or drug (including marijuana even if medically prescribed) producing effects on the central nervous system, or any controlled substance (including all drugs, narcotics, and intoxicants for which possession or misuse is made illegal under federal, state, or local law); and the term "alcohol" means the intoxicating agency in beverage alcohol, ethyl alcohol (e.g., beer, wine, liquor), or other low molecular weight alcohols including, but not limited to, methyl and isopropyl alcohol. In addition, the term "drug" will include legal prescription drugs for which the employee does not have a prescription.

C. Prohibited Conduct

The following shall be grounds for termination:

1. Use, sale, attempted sale, manufacture, possession, conveyance, purchase, attempted purchase, distribution, cultivation, transfer, or dispensing, (except as required by your employment or contract) of drugs (illegal or illicit);

2. Being under the influence of illegal or non-prescription drugs or alcohol, or having drugs or alcohol:
   a. In one's system, or
   b. On any Company premises or worksites, or
   c. In any area under the control of the Company, (including, but not limited to, the parking area), or
   d. During Company time, or
   e. In your possession illegally, or
   f. In or occupying Company property (including, but not limited to, Company vehicles) or property under the control of the Company.

3. Use or abuse of alcohol on or off the job that impairs, to any extent, performance on the job.

D. Legal Medications

This Policy does not prohibit the legal use of medications (prescription or over-the-counter, excluding marijuana), including medications containing alcohol. The Company requires that all employees disclose to Human Resources in advance of working when taking a legal use of medication containing alcohol or any legal use of medication that poses a significant risk of substantial harm to the health or safety of the individual or others, or when taking any medication containing alcohol, or any medication that affect the safety of our patients or impair the user's physical and/or cognitive functioning. Where required, the Company will make reasonable accommodations if appropriate (transfer, reassign, place an employee on leave of absence, or take other appropriate action during the time the employee uses medication that may affect the employee's ability to perform safely). It is the employee's responsibility to consult with the employee's licensed healthcare professional to determine if any medication would adversely affect the employee's ability to perform the essential functions of the job safely and requires disclosure to Human Resources.

E. Employee Assistance Program

The Company makes available an Employee Assistance Program to assist employees who may have problems with drugs or alcohol, however, this program does not insulate an employee from termination for a violation of Company policy, nor will it insulate any employee after the employee has been requested to participate in a drug or alcohol test. Employees who believe they have a problem with alcohol or drugs (legal or illegal) - are encouraged to seek assistance before the Drug and Alcohol Policy is violated. The EAP is available to employees seeking assistance with drug and/or alcohol related issues. The EAP can provide information regarding the dangers of drug and alcohol abuse, evaluate an employee for possible drug and/or alcohol dependence, and assist an employee to locate appropriate services and rehabilitation programs that emphasize education, prevention, counseling, and treatment. Each request for assistance will be treated as confidential, and only those persons with a "need to know" will be informed of an employee's request.

F. Designated Social Functions

The alcohol provisions of the policy shall not apply at Company designated social functions (whether on or off premises), although it is not the policy of the Company to condone alcohol abuse at such functions.

All employees are expected to conduct themselves at all times in accordance with the Code of Conduct and other Company policies. Inappropriate conduct, disruptive behavior or any other inappropriate actions caused by alcohol at designated social functions (whether on or off premises) will be cause for disciplinary action up to and including termination of employment.

G. Testing

NOTE: For purposes of this policy, the following will result in termination of employment or no further employment consideration of an applicant: a) refusal to undergo or consent to a drug/alcohol test, or b) when an applicant or employee is unable to provide a urine specimen ("shy bladder"), absent a valid medical reason, within a 3 hour period it will be viewed as a positive result.

1. **Pre-Employment Drug Test** – all prospective employees and contract/agency personnel (See Section G 8) will be required to undergo a pre-employment drug test and **may not begin work prior to review of the test results.** This applies to students, volunteers and auxiliary personnel. A refusal to undergo the test, or a positive test result, attempt to tamper with, substitute, adulterate, or otherwise falsify a test sample will result in denial of employment (see G11 for consequences of positive test results).

2. **Post-Accident Drug Test** – Employees involved in a work related "accident" will be required to undergo a drug test as state law allows (see HR State Law Addendum) if there is a reasonable possibility that employee impairment contributed to the accident. The hospital CEO or designee (i.e., Human Resources Director, Hospital Supervisor, and/or Risk Manager) shall review the

circumstances of all work related "accidents." Typically, an "accident" is any event, incident, or judgment in which the employee's acts, or failure to act, appear to have caused or contributed to the accident which resulted in:

a. Bodily injury
b. Death to any person
c. Damage to any property

At the discretion of management, employees who are required to undergo a post-accident drug test will be placed on administrative paid leave pending the results of such test provided reasonable suspicion exists. If the results are positive, the employee will be terminated retroactive to the date of the accident. A refusal to undergo the test, positive test results, attempt to tamper with, substitute, adulterate, or otherwise falsify a test sample will be grounds for termination. The test should be administered as soon as practicable following the work related incident (before the employee leaves the work location, but no later than the following day).

If the Company believes that there is a reasonable possibility that employee impairment has caused or contributed to a work-related accident and there are objective signs that the involved employee may have used alcohol (i.e. slurred speech, staggering gait, odor of alcohol), the employee will be required to submit to a blood alcohol test in addition to the urine drug test.

3. **Voluntary Disclosure** – An employee's decision to seek assistance under this policy will be considered voluntary only if the employee seeks assistance before the employee's alcohol or drug-abuse problems lead to a violation of this or another Company policy justifying disciplinary action and before being asked to take a drug and/or alcohol test. If an employee voluntarily discloses that he/she has a drug/alcohol problem and requests assistance, then the employee will be referred to the EAP and will be required to follow the Voluntary Disclosure Procedure outlined below:

   a. The employee will be referred to the Employee Assistance Program (EAP) and the appropriate Licensing Board, as applicable, for counseling and development of a treatment program, and will be placed on a leave of absence (i.e., FMLA or General Leave) as appropriate.
   b. The employee will be required to sign an *Authorization for Release of Confidential Information* form in order for the counselor(s) to report his/her findings and recommendations to the Facility Human Resources Director.
   c. The employee will be allowed to return to work, whether from an in-patient or out-patient treatment, after undergoing a drug/alcohol test conducted under Company policy with a negative result, provided he/she is released and able to perform the essential functions of his/her position with or without a reasonable accommodation. If the employee is unable to perform the essential functions of his/her previous position, then he/she may be placed in another available position (at the appropriate pay rate for the new position) for which he/she is qualified and for which he/she can perform the essential job functions with or without a reasonable accommodation. If a suitable position is not available, then the employee will be terminated in accordance with the established leave of absence policy.
   d. The employee will be required to undergo a minimum of twelve (12) unannounced drug/alcohol tests within a twelve (12) month period following the return to duty test. This period may be extended for up to sixty (60) days.
   e. The employee will be required to cooperate with and to follow the recommendations of the counselor(s), including satisfactory completion of any prescribed rehabilitative program and to submit to further tests. **Failure to do so will result in termination.**
   f. If at any time the employee tests positive during this process, the employee will be terminated.

   Note: Entering a drug and/or alcohol assistance program will not protect an employee from the consequences of substandard work performance, misconduct or policy violations.

4. **Reasonable Suspicion Drug and Alcohol Test** - If the Company has reasonable suspicion to believe that an employee or group of employees are violating this policy, the employee(s) will be required to undergo a drug and alcohol test. Reasonable Suspicion Testing requires the approval of the Human Resources Director and/or the CEO. If reasonable suspicion exists, the employee will be placed on administrative unpaid leave pending the results of the testing and investigation. Reasonable suspicion may include, but is not limited to, the employee's behavior or conduct, physical manifestations, evidence that an employee has caused or contributed to a work-related accident, there are objective signs that the involved employee may have used alcohol (i.e. slurred speech, staggering gait, odor of alcohol), reports from others, work related "accident," missing or unaccounted for patient medications, speech, etc. The Company will document information supporting the Reasonable Suspicion testing (see Observation Checklist, Warning Signs of Chemical Dependency and Testing Referral forms).

   In the event of suspected diversion of medications, an internal investigation should be conducted and appropriate licensing boards notified as required by law (see Diversion Prevention Tips). In the event of a suspected diversion of drugs it may be necessary to test a group of employees. In this event, the employees may remain on duty unless an employee(s) appears to be in an altered state, then the employee(s) will be placed on administrative unpaid leave pending drug test results. If the reasonable suspicion drug/alcohol tests are positive, the employee will be terminated. If the reasonable suspicion drug/alcohol tests are negative, the employee should be compensated for the period of unpaid leave. In the event the reasonable suspicion drug test is negative, upon return to work any performance or conduct issues that formed the basis of the reasonable suspicion drug or alcohol test will be addressed through the corrective action process.

5. **Other Drug or Alcohol Test** – The Company will require any employee to undergo any drug or alcohol test required by law, and may require any employee to undergo any drug or alcohol test not prohibited by law.

6. **Drug/Alcohol Testing of Minors Under Age 18** – All prospective employees (pre-employment, post-offer, post-accident and reasonable suspicion) are covered under this policy. However, those prospective employees who are minors under the age of 18 must obtain notarized parental/legal guardian consent on Section II of the *Drug/Alcohol Test Release & Consent for Minors < Under Age 18* form to undergo a drug/alcohol test. In order to release the results of such test to the minor's parent/legal guardian, the minor must sign Section III of this form. Failure to obtain parent/legal guardian consent for testing will disqualify the minor from potential or continued employment.

7. **Drug Testing of Students**– Students with access to patients and patient care areas are subject to this policy. The Human Resources Department should work in conjunction with the management team and school officials to ensure that the contractual agreement includes a statement that delineates the party responsible for the provision of drug screens prior to student assignment to the facility. Human Resources would be responsible to monitor compliance.
8. **Drug Testing of Volunteers and Auxiliary –** Volunteers and auxiliary with access to patients and patient care areas are subject to this policy and should be tested prior to starting their assignment.

9. **Drug Testing of Contract/Agency Personnel** – All entities that provide contract and agency personnel (including contract/agency physicians) that provide patient care, treatment and services must provide the facility Human Resources Department with evidence of drug testing results prior to contract staff starting assignment.

10. **False Information** – Any employee or applicant who provides false information when completing paperwork required or responding to required questions for an alcohol or drug screen test will be terminated and/or their application will be withdrawn from hiring consideration.

11. **Consequences of a Positive Test -** An employee or applicant, whose drug or alcohol test is positive, regardless of the reason for the test, is considered to be in violation of Company policy and will be terminated. Employment will be terminated for a confirmed positive test, even for a first offense. An employee or applicant whose drug or alcohol test is positive will be ineligible for rehire for a minimum of one year.

12. **Refusing a Test / Tampering** – If an employee attempts to avoid or refuses to submit to drug and/or alcohol testing, the action will be considered insubordination and the employee will be terminated. Attempts to tamper with, substitute, adulterate, or otherwise falsify a test sample are considered refusals to submit to testing. Applicants that refuse to submit to drug and alcohol testing will be withdrawn from consideration for employment. Employees and applicants that refuse to submit to the drug and alcohol test will be considered ineligible for rehire and will not be considered for future employment with the Company.

13. **Consent** - No alcohol test will be administered, sample collected, or drug test conducted on any sample without a signed chain of custody form of the person to be tested. However, testing is a condition of employment and a person's refusal to submit to a proper test will be viewed as insubordination which will result in termination of employment. The Company will pay the costs of all drug and/or alcohol tests it requires of job applicants and employees.

14. **Collection and Chain-of-Custody** - Persons being tested will be asked to provide a test sample by the collection site person. Procedures for collection of urine specimens will allow for reasonable individual privacy. Urine samples will be tested for temperature, and may be tested for adulterants or subject to other validation procedures, as appropriate. The collection site person and the person being tested will maintain chain-of-custody procedures at all times.

15. **Testing Methods** - All urine samples will be screened using an immunoassay technique and/or mass spectrometry technique and all presumptive positive tests will be confirmed using mass spectrometry (MS) or other equally sensitive methodology. **All confirmatory** tests will be performed by a laboratory certified by the federal Substance Abuse Mental Health Services Administration (SAMHSA) for federal workplace testing (see Attachment A for a list of current testing profiles).

    A blood-alcohol test will be used to detect the presence of alcohol. An alcohol test will be considered positive if it shows the presence of 0.02 percent or more alcohol in an individual's system. All blood-alcohol samples will be screened by Gas Chromatography and all presumptive positive tests will be confirmed using by Gas Chromatography/Flame Ionization Detection.

    Tests will seek information about the presence of drugs and alcohol in an individual's system, and will not test for any medical condition.

16. **Notification & Review of Positive Results** - Any individual whose test is positive for the presence of an illicit drug or drugs will be so notified by an independent Medical Review Officer ("MRO") (a medical doctor with an expertise in toxicology), and given an opportunity to provide the MRO, in confidence, with any legitimate explanation he or she may have that would explain the positive drug test (all documentation must be sent to the MRO no later than five business days after notification).

If the individual provides an explanation acceptable to the MRO that the positive drug test result is due to factors other than illicit drugs (such as a prescription for the drug detected), the MRO will order the laboratory to disregard the positive test and will report the test as negative to the Company.

Upon request, the Human Resources Director will provide the individual with a copy of their own positive test report. In addition, an individual who tests positive for drugs may request within 72 hours of notification that his or her second container from the split-specimen collection be sent to an independent laboratory for a second confirmatory test at the individual's expense. The individual shall choose from a provided list of independent laboratory certified by the federal Substance Abuse Mental Health Services Administration (SAMHSA) for federal workplace testing for the second confirmatory test. The Company will suspend the individual pending the results of any such re-test. If the retest is negative, the Company will reimburse the employee the cost of the second test.

All test results will be treated as confidential, and shared within the Company only on a need-to-know basis. Test results will not be released outside the Company without the written consent of the tested individual, except as required by law or to defend the Company in any threatened or actual legal action. An individual may request a copy of his or her results at any time. Test results will be stored separately from employee personnel files in a secure location.

17. **Compliance With All Applicable Laws** - The Company will implement this Policy, including the drug- and alcohol-testing provisions, in a manner that complies with relevant federal, state, and local laws.

H. Searches

The Company reserves the right, at all times and without further notice, to have Company representatives conduct searches and inspections of any or all Company premises to enforce this Policy or determine if this Policy has been violated.

All vehicles and containers, including bags, backpacks, boxes, purses, and lunch containers, brought onto Company premises may be searched if the Company has a reasonable suspicion that the employee has brought drugs or alcohol onto Company premises. Employees are expected to cooperate in any searches, and consent to a search is required as a condition of employment. A refusal to consent to a search will result in termination, even for a first refusal.

I. Other Action

Safety of Employee and the Public – When an individual subject to this policy is sent home or referred for drug or alcohol testing, the supervisor will help him/her get home safely. An individual who is referred for reasonable suspicion drug or alcohol testing and/or sent home as unfit to work should be dissuaded from driving and he/she should be advised that law enforcement will be notified. If the employee insists on driving the supervisor shall contact law enforcement.

STATE LAW:

Nothing in this policy is intended to restrict whatever rights you may have under Federal, State or local laws.

REFERENCES:

FAIR CREDIT REPORTING ACT

AMERICANS WITH DISABILITIES ACT

UNITED STATES DEPARTMENT OF LABOR

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

HR STATE LAW ADDENDUM

All revision dates: 6/17/2002

ATTACHMENTS:

ACKNOWLEDGEMENT FORM

TESTING REFERRAL

OBSERVATION CHECKLIST

DRUG/ALCOHOL TEST RELEASE & CONSENT FOR MINORS UNDER AGE 18

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION (VOLUNTARY DISCLOSURE)

MARQUETTE GENERAL HEALTH SYSTEM

Human Resources Policy: INTERNET & SOCIAL MEDIA USAGE

Effective Date: 02/10/2014

Revision Date: [Revision Dates]

SCOPE:

This policy applies to Marquette General Hospital and its affiliates with employees who provide services in the Hospital's primary and secondary service area (the "Company"). References to Facility or Facilities throughout the policy are meant to include the Hospital and/or its affiliates with employees providing services in Marquette General Hospital's primary and secondary service area.

PURPOSE:

The Company, through its Marketing, Communications, and Human Resource functions, will establish and maintain a Company sponsored presence on Social Media sites. This presence will facilitate expanding communication opportunities for patients, workforce members, and other stakeholders in the communities served by the Company. The Company herein provides the workforce with guidelines for usage of Social Media sites.

BACKGROUND:

The health care industry, like many other industries, has embraced the use of Social Media and Blogs. Social Media sites and Blogs facilitate communication, education, collaboration with others, research, business travel, remote work, etc. For many, the Internet is a tool to aid in daily business practices that improves work quality and job satisfaction. The Internet provides a wide array of resources, services, and interconnectivity between Company's and workforce members. However, there are also risks associated with inappropriate Internet access and use of Social Media sites and Blogs, which must be addressed through appropriate safeguards, policies and practices, education and training, and appropriate corrective action when necessary. Monitoring appropriate use of the Internet, Social Media sites, and Blogs by workforce members is a joint responsibility of the Company's leadership, information technology (IT&S) support staff, marketing and human resources leaders.

DEFINITIONS:

Blog: A blog is a website maintained by an individual, group or company with regular entries of commentary, descriptions of events, or other materials such as graphics or video. Blogs may provide commentary or news on a particular subject; others function as personal on-line diaries and personal information sites.

Social Media: For the purposes of this Policy "Social Media" is an on-line social structure made up of individuals or Companies that are tied by one or more specific types of interdependency, such as values, visions, ideas, financial exchange, friendship, business operations, professional exchange, etc. Social Media sites operate on many levels, from friends and families up to the national and international level, and play a critical role in determining the way information is exchanged, problems are solved, Companies are run, and the degree to which individuals succeed in achieving their

goals. Examples of Social Media sites include, but are not limited to, Facebook, MySpace, LinkedIn, Twitter, or other similar sites.

Workforce: Under HIPAA, the workforce is defined to include employees, medical staff members, volunteers, trainees, and other persons whose conduct, in the performance of work for a covered entity, is under the direct control of such entity, whether or not they are paid by the covered entity.

POLICY:

1. The Company supports work-related access to the Internet and certain Social Media sites by authorized workforce members through the provision of Internet access at work. Internet access (at work) and use is a privilege and must be carried out in a manner that is consistent with job responsibilities and Human Resources policies and guidance addressing appropriate use of scheduled work time and resources. Authorized access to the Internet and Social Media Sites are provided through IT&S.

2. Workforce members engaged in personal or professional Social Media communications who reference Company-related content shall do so in a manner consistent with the Company's mission, values, and all applicable enterprise and Company policies and procedures, including those designed to ensure the privacy and security of patient-identifying information, as well as proprietary business information of the Company.

3. It is the Company's expectation that any use of Social Media sites while on personal time for non-work-related activities will not violate Company policies. At no time shall workforce members utilizing personal or professional Social Media, including Blogs, share patient-identifying information or proprietary business information without proper written authorization for the use and disclosure of the information from the patient/patient's legal representative and approval of the HIPAA Privacy Officer or the Corporate Privacy Officer. All uses and disclosures of patient-identifying information shall be carried out in a manner compliant with applicable HIPAA privacy and security policies, regulations, and standards.

4. The Organization, through its Marketing, Communications, and Human Resource Recruiting functions, will establish and maintain an Organizational presence on popular Social Media sites. This presence will facilitate expanding communication opportunities for patients, workforce members, and other stakeholders in the communities served by the Organization. Individual MGH departments and/or service lines are not permitted to create a web site page or Facebook page, or any other stand-alone social media site. All public messaging, including social media messaging, must be channeled through the official MGH web page, MGH Facebook and other official MGH social media outlets. Those outlets and their content are under the direction of the Marketing Department.

5. The Company has established the Social Media Task Force as an enterprise-level oversight structure to develop and manage the Company's Social Media communication strategy, as well as to respond to issues and concerns related to the use of Social Media and Blogs. The Social Media Task Force shall serve as a resource for questions and concerns regarding the appropriate use of Social Media by workforce Members. The use of Social Media for Organization-sponsored business operations shall be under the oversight of the responsible business unit (examples below):

A. Marketing/Business Development
B. Human Resource
C. Information Technology & Services Operations
D. Compliance – Privacy Officer

6. The Company has developed a fact sheet (Attachment A) entitled "Social Media Guidelines for Workforce Members" to provide guidance regarding communicating Company-related content through Social Media and Blogs. All communications conducted on the Company's computers or other electronic communication devices are subject to review and auditing by the IT&S Department regardless of whether those communications are personal or professional in nature.

7. The inappropriate use of Social Media by workforce members includes any use that conflicts with the Company's mission and values, violates enterprise or Company/business unit policies, procedures, and practices and/or compromises the privacy or security of patient identifying information or propriety business information. Inappropriate use shall be subject to Corrective Action, up to and including termination. In addition, breach of patient identifying information may also be subject to legal proceedings and/or criminal charges. Prior to discussing Company-related content on Social Media sites, the individual must consider:

   A. Does the discussion positively promote the individual's role as a health care workforce member?

   B. Does the discussion reflect positively on individual's co-workers/colleagues? The individual's work unit? The Company?
   C. Does the discussion conflict with the Organization's mission, culture, and/or values?
   D. Does the discussion reveal patient-identifying information or proprietary business information of the Company?

8. Do not include any information that could directly (e.g., name, Social Security number, address, etc.) or indirectly (e.g., provider name, date of birth, diagnosis, images, etc.) identify a patient under the care of the hospital, physician or other provider.

Nothing in this policy is intended to restrict whatever rights you may have under Federal, State or local laws.

REFERENCES:
HIPAA.GEN.004 – Release of Information Standards
HIPAA.GEN. 007 – Protected Health Information Incident Response
HIPAA.PRI.001 – Minimum Necessary PHI Matrix
HIPAA.PRI.012 – Use of Protected Health Information for Marketing Policy
LPNT IS.SEC.001, Information Security Program Requirements Policy
LPNT.IS.SEC.002, Electronic Communications
LPNT.IS.SEC.005, Confidentiality and Security Agreements
Social Media Guidelines for Workforce Members

External Regulating Authority: HR GOV
Policy Owner: Human Resources
Policy Number: HR.023

All references to "Marquette General Hospital", the "Facility" or the "Company" used in this policy refer to one or all of Marquette General Hospital and/or its affiliates with employees who provide services in Marquette General Hospital's primary and secondary service area.

Current Status: *Active* **PolicyStat ID:** *7713410*

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Owner:	*Robin Waters: Director*
Policy Area:	*Hospital Wide*
References:	
Applicability:	*U P Health System – Marquette*

Fall & Injury Prevention Program Policy & Procedure

(Replaces Fall Prevention Program 100-131)

References: LifePoint ELF Program Policy & Procedure (2009); Guidance Statement – Clinical Process Reducing Falls and Fall Related Injuries (06.01.15)

PURPOSE

To reduce or prevent patient falls and injuries related to patient falls. UPHS-Marquette is committed to providing a safe environment for patients receiving services in all settings. A fall prevention program has been established to screen patients for fall and injury risk and to implement interventions that minimize the risk of falls and falls with injury. This policy and procedure outlines screening tools used, as well as documentation and communication of risk. It also denotes processes assigned to various staff and care partners.

POLICY

Patients will be cared for in a safe environment. Fall prevention is based on assessment of the patient, determination of the patient's risk for fall, and implementation of interventions that reduce the intrinsic and extrinsic fall risks identified. Interventions for fall and injury prevention will be initiated and monitored for effectiveness throughout the patient's stay. Staff will act within their scope of practice to participate in fall prevention procedures.

DEFINITIONS

Patient Fall

A patient fall is a sudden, unintentional descent, with or without injury to the patient, that results in the patient coming to rest on the floor, on or against some other surface, on another person, or on an object. If a patient who is attempting to stand or sit falls back onto a bed, chair, or commode, this is only counted as a fall if the patient is injured.

Assisted Fall

A fall in which any staff member was with the patient and attempted to minimize the impact of the fall by slowing the patient's descent. The patient did not intend to go to the floor; the staff eased the patient's descent to reduce the likelihood of injury.

Suspected Intentional Fall

An intentional fall event occurs when a patient age 5 or older falls on purpose or falsely claims to have fallen. Patients may fall intentionally or falsely claim to have fallen for various reasons, including seeking attention or obtaining pain medication. When the nursing staff has reason to suspect that a reported fall is an intentional fall event, it should be reported as such. However, the fall must be witnessed in order to be excluded from falls reports numbers.

Baby/Child Drops

A fall in which a newborn, infant, or child being held or carried by a healthcare professional, patient, family member, or visitor falls or slips from that person's hands, arms, lap, etc. This can occur when a child is being transferred from one person to another. This is considered a fall regardless of the surface on which the child lands. Falls in which a child rolls off a bed, crib, chair, table, etc. are considered falls, but are not classified as drops. The fall is only considered a drop if the child was being held or carried.

Developmental Fall

A fall in which an infant, toddler, or preschooler who is learning to stand, walk, run, or pivot falls as part of the developmental process of acquiring these skills. Generally, the child will be less than 8 years old. Older children may have developmental delays with limited ability to acquire these skills. Only falls that occur as normal parts of this learning process are considered developmental falls. Falls from a bed or chair are not developmental falls. Developmental falls should be reported ONLY when they result in injury.

Physiological Fall

A fall attributable to one or more intrinsic, physiological factors. Physiological factors include: falls caused by a sudden physiologic event such as hypotension, dysrhythmia, seizure, transient ischemic attack (TIA), or stroke; falls occurring due to side effects of known "culprit drugs" (e.g. CNS-active drugs, certain cardiovascular drugs); falls attributable to some aspect of the patient's physical condition, such as delirium, intoxication, dementia, gait instability, or visual impairment.

Anticipated Physiological Fall Occurs in patients who have a predictable risk for falling. These are preventable when fall risk has been identified using a validated assessment tool and care planning/ interventions are implemented.

Unanticipated Physiological Fall Occurs in patients who have low or no risks for falls and are caused by unexpected physiological changes (ex/ seizure or cardiac event). These may not be preventable.

Accidental Fall

Occurs in patients who have low or no risks for falls. Usually preventable through universal fall precautions. Are usually caused by an environmental hazard or unsafe condition or error in judgement.

Near Fall

A sudden loss of balance that does not result in a fall or other injury. This can include a person who slips, stumbles, or trips but is able to regain control prior to falling.

Un-witnessed Fall

When a patient is found on the floor and neither the patient nor anyone else knows how he/she got there.

Fall Risk Factors

- **Intrinsic Risk Factors** include factors that address a person's physiological condition; i.e. history of falls, incontinence, mobility, dizziness, age, osteoporosis, overall poor health, etc.
- **Extrinsic Risk Factors** include factors that address the physical environment; i.e. wet floor, cluttered room, poor lighting, inadequate handrail support, inappropriate or lack of foot wear, low toilet seat, wheels on beds or chairs, restraints, prolonged length of stay, unsteady IV poles, broken equipment, beds left in high position.

LEVEL OF INJURY

C = No Injury

D = Minor Injury (abrasion, bruise, laceration/skin tear)

E = Moderate Injury (requiring sutures, skin glue, splints)

F = Major Injury (fractures, injury required surgery/casting/further exam/blood product transfusion as a result of the fall)

G = Major Injury that Resulted in Death (died as a result of injuries sustained in the fall, not from physiologic events causing the fall)

FALL PREVENTION ROLES

All employees & partners play an important role in fall and injury prevention. Staff will look for the fall risk identifiers before moving, transferring or interacting with the patient and will initiate their role in fall prevention. Staff roles are specific; however, general descriptions include the following:

- **Nursing** – assessment, fall risk screening, care planning, implementation of interventions, monitoring, hand-off communication, patient education, consultation with other disciplines, documentation & team leader r/t fall prevention measures indicated for the individual patient
- **Medical** – review patient risks r/t nursing assessment, H&P, diagnosis, signs/symptoms that may be indicative of undiagnosed medical conditions, medication effects, physical/mental/condition attributes that may affect potential for fall. Review medications for fall risk and adjust as indicated. Consider referrals to services such as physical medicine and rehabilitation, audiology, ophthalmology, cardiology. Optimize treatment of underlying medical conditions. Evaluate and treat pain.
- **Pharmacy** – clinical pharmacology r/t fall prevention, mechanisms of action, drug effects, drug/drug interactions, food/drug interaction, correlation of drug regime/dosing/lab monitors, consideration of data & information used by the pharmacist to recommend safer drug regimens to reduce potential for falls
- **Physical/Occupational Therapy** – strength/gait/balance assessment to identify physical needs of the patient, patient education/training/assessment/monitoring r/t use of assistive devices, PT or OT as ordered
- **Housekeeping & Maintenance** – perform duties to reduce fall/slip/trip hazards r/t wet or shiny surfaces, equipment safety, obstacles/hazards in the environment. Patient care areas cleaned with fall prevention techniques in place. Furniture, equipment, fixtures, walkways, handrails purchased and maintained with fall prevention strategies in place (locked wheels, furniture placement to fit needs of patient, slip resistant surfaces, clutter free egress, sturdy handrails, etc.). Use checklists as a quality control measure r/t fall prevention

ADULT IN-PATIENT (NON-BEHAVIORAL HEALTH); ADULT OUT-PATIENT UNDERGOING SURGERY OR PROCEDURE WITH SEDATION

FALL RISK ASSESSMENT & PLAN OF CARE:

Adult inpatients or adult outpatients undergoing surgery/procedures with sedation will be assessed and reassessed by an RN using the Johns Hopkins Fall Risk Assessment Tool (attached) to identify those who are at risk for falling. Intervals for assessment & reassessment include:

- On admission
- With each shift assessment
- With change in condition
- With change in level of care
- Immediately post fall

Screening criteria will assign risk points based on risk factors. The final score will determine the level of risk for fall and if fall precautions are indicated.

Obtain a Johns Hopkins Fall Risk Scale Score by using the variables and numeric values listed in the Johns Hopkins Fall Risk Assessment Tool. Note: Each variable is given a score and the sum of the scores is the Fall Risk Score. Do not omit or change any of the variables. Use only the numeric values listed for each variable.

Outpatients scheduled for surgery or invasive procedures will be assessed by an RN who will screen the patient for risk of fall at the time of the nursing assessment. The fall risk status will move to high risk post-procedure until discharge of the outpatient.

Implement the interventions that correspond with the patient's fall risk level.

Fall Risk Score 0-5

Low Risk

Universal Fall & Injury Prevention Interventions

- Lowest bed height except when raised for transfers or when needed for exiting bed
- Eliminate trip hazards; manage cords
- Equipment and furniture wheels locked
- Use assistive devices as indicated for patient during transfers and ambulation; keep available
- Clean spills immediately; use signs to indicate "wet floor". Keep path of clear egress available at all times
- Inspect patient's shoes or slippers for slip resistance
- Educate/Teach Back and demonstrate back for use of call light and bed controls; identify those who may not be able to participate and require other strategies to remain safe
- Implement hourly rounds with **5 Ps**
    - **Potty** – ask/prompt toileting
    - **Personal needs** – call light, phone, remote, & personal possessions (glasses, hearing aids, drinks, etc.) close
    - **Partner** with patient & family – educate & include in fall prevention plan
    - **Pain** – monitor & manage
    - **Position/Pressure reduction** – assist with repositioning at least every 2 hours.

- Assess bed safety when specialty overlay mattress indicated
- Use safe exit side. Replicate home environment layout when possible
  - Note safe exit side on communication board in room
- Toilet/offer toileting prior to medicating for pain

Fall Risk Score 6 – 13

Moderate Risk Fall Prevention Interventions

Implement Universal Fall Prevention Interventions PLUS

- Yellow indicators in place
  - Yellow armband on same arm as ID band
  - Fall risk tab pulled at room entrance
  - Fall risk identified on communication board in room
  - Yellow chart tab on front of blue chart
  - Yellow non-skid socks placed on patient
- Educate the patient/family/caregiver of their risk for falls and the fall prevention plan recommended for the individual patient:
  - Orient to room, pointing out the safety/fall prevention interventions in the environment
  - Verbally inform the patient and family of fall prevention interventions; reeducate as needed
  - Provide handouts to reinforce education if appropriate
  - Ask the patient to perform teach back and demonstrate back (as appropriate) for use of slip resistant footwear – non-slip socks or rubber soled shoes at all times when up, posture techniques to assure balance, and recommended bed egress and identification of strong side
  - Instruct to call for assistance when getting out of bed
- Re-orient to environment, time, person, and place as indicated
- Consider supervision and assistance with toileting, transfer and ambulation activities
- Consider implementing alarms (bed, chair, seatbelt, etc.)

Fall Risk Score >13

High Risk Fall Prevention Interventions

Implement Universal and Moderate Fall Prevention Interventions PLUS

- Consider placing patient in room close to nurse's station vs minimizing distracting noise
- Remain with patient at all times when standing, ambulating, or up to toilet
- Consider implementing toileting schedule with patient involvement as to the interval
- Implement Alarms (bed, chair, etc.) as appropriate
- Consider consulting pharmacist regarding patient's high risk for fall
- Consider obtaining order for physical therapist to evaluate patient for strength, balance and need for assist device

Risk Score >13 with mental status alterations

High Risk with Mental Impairment Fall Prevention Interventions

Implement Universal and Moderate & High Risk Fall Prevention Interventions PLUS

- Consider increasing frequency of purposeful rounding. Assess ability of patient to follow instructions, participate cognitively, and estimate abilities/limitations accurately

- Consider bed placement to promote staff's observation
- Place bed/chair exit alarm and instruct patient and family regarding indication and use
- For confused patients, ask family members to stay with the patient – role is to remind the patient not to get up without staff assistance, to orient the patient and to monitor patient needs and communicate to staff. Instruct to notify nursing staff if they need to leave the patient's room so that more frequent rounding can be implemented.
- Consider Patient Safety Companion (PSC) for patients meeting the following indications:
  - High risk for fall with confusion and failure to remember instructions **and**
  - No family/friend/caregiver available to monitor patient at bedside **and**
  - Patient able to attempt bed egress and ambulation
- Consider shock absorbing floor mat
- Do not leave patient unsupervised when patient is off unit

Refer to Nursing Procedure S-003 Posey Monitoring Device

INJURY PREVENTION INTERVENTIONS – ALL PATIENTS

- Floor mats (only when in bed/chair – remove when out of bed) if:
  - Requires assistance to get up, but neglects to call
  - Climbs out of bed
  - Overestimates own ability
  - Cognitively impaired or not able to participate cognitively
  - Impulsive

IN ADDITION TO SCREENING FOR RISK OF FALL, screen each adult inpatient for the risk of INJURY FROM FALL using the Institute for Healthcare Improvement (IHI) ABCS risk screening tool with the same frequency that fall risk assessments are performed.

The ABCS injury risk screening tool provides a reliable method to determine which patients are most likely to sustain trauma/injuries when a fall occurs, and proactively take measures to prevent injury or lessen the severity of harm through use of recommended interventions specific to the ABCS risk categories.

Patients identified to be at risk for injury using ABCS screening require individualized care planning to incorporate interventions designed to prevent injury or reduce the severity of injury likely to result from a fall.

ABCS INJURY RISK SCREENING & INTERVENTIONS:

A Age > 85 or Frail due to clinical condition

- **Medication review** – alert pharmacist/consider alternatives
  - Identifies opportunities to adjust medication choice/dosing to reduce risk of medication-related physiological instability

B Bone related risk factors/conditions (osteoporosis, osteopenia, post-menopausal women or men >70 years of age who smoke, previous fracture as an adult, prolonged steroid use >3 months duration, metastatic bone cancer)

- Provide education on increased risk and interventions

C Coagulation On anticoagulation, coagulopathy, bleeding/clotting disorder, or at risk of bleeding, subdural hematoma, or other trauma through underlying conditions

- Consider **helmet/protective headgear** for Traumatic Brain Injury (TBI) patients or patients with altered mental status
- Evaluate use of anticoagulation – verify appropriate dose

S Surgery Recent lower limb amputation, recent major abdominal or thoracic surgery (risk of dehiscence)

- Pre-op and post-op education re. fall prevention
- Pain management strategies to enhance appropriate level of mobility

INPATIENT ADULT BEHAVIORAL HEALTH: EDMONSON PSYCHIATRIC FALL RISK ASSESSMENT

FALL RISK ASSESSMENT & PLAN OF CARE

Adult inpatients admitted to the Behavioral Health Unit will be assessed and reassessed using the Edmonson Psychiatric Fall Risk Assessment Tool (attached), which was created specifically for the unique needs of the psychiatric inpatient population to identify those who are at risk for falling. Intervals for assessment & reassessment include:

- On admission
- Twice daily
- With change in condition
- With change in level of care
- Immediately post fall

Screening criteria will assign risk points based on risk factors. The final score will determine the level of risk for fall and if fall precautions are indicated.

Obtain an Edmonson Psychiatric Fall Risk Scale Score by using the variables and numeric values listed in the Edmonson Psychiatric Fall Risk Assessment Tool. Each variable is given a score and the sum of the scores is the Fall Risk Score. Do not omit or change any of the variables. Use only the numeric values listed for each variable. Fall risk is identified with a total score of 90 or greater. Note: More than one item may be counted in each category if appropriate for the patient.

Fall Risk Score > or = 90

Fall Prevention Interventions

- Place the patient in a room near the nurse's station, if appropriate
- Orient the patient to room and unit
- Instruct on use of non-skid footwear and encourage patient to use them
- Assist with ADL's and toileting
- Safety/Environmental checks per unit routine
- Keep walkways and room free of obstructions and spills
- Provide adequate lighting
- Use assistive devices if appropriate
- Monitor for orthostatic hypotension; instruct patient to rise slowly from sitting or lying positions
- Suggest PT/OT for patient with balance problems
- Evaluate effectiveness of medications
- Instruct family and friends on activity and precautions
- Specialty bed as needed

PEDIATRIC INPATIENT OR OUTPATIENT (INCLUDING ED)

FALL RISK ASSESSMENT & PLAN OF CARE:

Pediatric patients will be assessed and reassessed using the appropriate Humpty Dumpty Fall Assessment Scale (Inpatient, Outpatient or Emergency Department - attached) to identify those who are at risk for falling:

- On admission
- With each shift assessment
- With change in condition
- With change in level of care
- Immediately post fall

Screening criteria will assign risk points based on risk factors. The pediatric patient is considered at risk for fall if the score is 12 or above. The Humpty Dumpty minimum fall risk score is 7 and the maximum score is 23. The final score will determine if fall precautions are indicated. A total risk score of 12 or greater will require high risk fall precautions.

Humpty Dumpty Fall Risk Score 7-11

Low Risk

Universal Fall & Injury Prevention Interventions

- Orientation to room
- Bed in low position unless patient is directly attended, brakes on
- Side rails X 2 up, assess large gaps such that a patient could get extremity or other body part entrapped, use additional safety procedures.
- Use non-skid footwear for ambulating patients
- Use appropriate size clothing to prevent risk of tripping.
- Call light is within reach of patient and family and they are trained in how to use.
- Environment clear of unused equipment, furniture in place and clear of hazards.
- Furniture designed for tip-over prevention
- Assess for adequate lighting; leave floor level nightlight on
- Implement at minimum hourly rounds with **5 Ps**
    - **Potty** – ask/prompt toileting; assist as needed
    - **Personal needs** – call light, phone, remote, & personal possessions (glasses, hearing aids, drinks, etc.) close
    - **Partner** with patient & family – educate & include in fall prevention plan
    - **Pain** – monitor & manage
    - **Position/Pressure reduction** – assist with repositioning at least every 2 hours.
- Remove all unused equipment from the room.
- Place protective barriers to close off spaces, gaps in the bed. Do not use in cribs.
- Place patient in crib as per policy and developmental age.
    - Infants and Toddlers require crib with side rails.
    - Crib mattress in lowest position and side rails in highest position
    - Never leave unattended on bed or exam table.

- In Infant, toddler and young children care settings, playrooms:
    - Assure no climbing potential with bookcases or chairs.
    - Keep large toys and bumper pads out of cribs or playpens so they cannot be used for climbing aids.
    - Supervise at arm's length in the bathtub and assure slip resistant surface intact.
    - Do not place infant seats on elevated surfaces. (bouncers, car seat or Boppy®)
    - Use helmets for pediatric patients with balance impairment during play.
    -

Humpty Dumpty Fall Risk Score 12 and above

High Risk Fall Prevention Interventions

In addition to the Low Risk or Universal Fall Prevention Interventions above:

- Fall risk identification in place:
    - Identify patient with a yellow arm band on same arm as ID band
    - Fall risk tab pulled at the room entrance
    - Fall risk identified on communication board in room
    - Yellow chart tab on front of blue chart
    - Yellow non-skid socks placed on patient
- Educate patient/family of fall prevention precautions to include the following key educational points:
    - Orient to room pointing out the safety/fall prevention in the environment
    - Verbally inform patient and family of fall prevention interventions
    - Ask the patient/family to perform teach back and demonstrate back as method to reinforce education and build confidence and competence with fall prevention techniques. Re-educate as indicated.
- Accompany patient with ambulation
- IV-line management or saline lock prior to ambulation for toddlers and young children
- Consider moving patient close to the nursing station to promote audibility and observation.
- Assess need for 1:1 supervision
- Evaluate medication administration times

ADULT OUTPATIENT UNDERGOING TEST AND/ OR TREATMENT

Patients entering a UPHSM facility or clinic for laboratory or diagnostic imaging tests or for treatment are screened for fall risk by the registration clerk using established criteria. A fall risk screen for the outpatient is accomplished by completing the Fall Risk Screen for the Outpatient Form (attached). Patients identified as being at risk for falls are transported to the test or treatment area with staff assistance or by wheelchair and are instructed not to stand or ambulate without assistance. A yellow armband is placed on the patient to alert staff of the fall risk. The screening form is transported with the patient to the testing or treatment area and acts as a form of Hand-off Communication. The person receiving the patient signs the form acknowledging that they understand the risk for falls.

The screening begins when the patient is registered either in person or by telephone. The patient should be asked questions pertaining to the items listed if they cannot be visually observed during registration.

A fall Risk Alert will be recorded in the ADT Form at the Visit Level for any patient meeting any of the criterion, with the exception of advancing age as the only criterion met. The applicable Fall risk Criteria will be recorded in the Alert Comment field.

When a patient has been placed in Fall Risk Alert status, basic safety measures will be used:

- Assist with ambulation or use of an assistive device/wheelchair
- Assist patient with undressing or dressing as needed for the exam
- Instruct patient NOT to get up on an exam table until someone can assist
- After exam/testing, assist patient off the exam table
- Assess environment for safety and reduce clutter or trip hazards, as needed
- Lock wheelchairs, exam tables and stretchers
- Use bathroom closest to patient's location if needed
- Instruct patient and/or family on requesting assistance
- Review fall concerns with patient and/or family. Stress the importance of careful maneuvers and our priority of patient safety.

ADULT EMERGENCY DEPARTMENT PATIENTS

FALL RISK ASSESSMENT & PLAN OF CARE

Emergency Department patients will be screened for fall risk during intake/triage using EDIS fall assessment criteria (attached). Patients identified at risk will have the ED fall prevention plan initiated.

Fall Risk Score 0-5

Low Risk

Universal Fall Prevention Interventions

- Maintain safe environment: Remove excess from hallways. Assure adequate lighting. Keep floors clutter free. Coil and secure excess electrical wires when possible. Clean spills immediately
- Provide basic safety interventions: Orient patient to surroundings. Reorient confused patient. Place call light & frequently used items within reach. Answer call lights promptly. Raise 2 bed side rails.
- Provide patient education: Instruct on use of bed, call light, fall risk assessment and interventions, risk of injury, and when & how to call for assistance.
- Hourly Rounds: Ensure completion of hourly rounds on all shifts. Assess for pain/comfort, toileting needs, repositioning, food/fluids, hygiene, and inform patient when you will return.

Fall Risk Score 6 – 13

Moderate Risk Fall Prevention Interventions

Implement Universal Fall Prevention Interventions PLUS

- Communicate MODERATE Fall Risk: Institute flagging system:
  - Yellow armband on same arm as ID band
  - Fall risk tab deployed at room entrance
  - Fall risk identified on communication board in room
  - Yellow non-skid socks placed on patient
- Supervise and/or assist bedside sitting, personal hygiene, and toileting as needed.
- Use Alarms (bed, chair, etc,) as indicated

Fall Risk Score >13

High Risk Fall Prevention Interventions

Implement Universal and Moderate Fall Prevention Interventions PLUS

- Remain with patient at all times when standing, ambulating, or up to toilet.
- Consider placing patient in room close to nurse's station
- Evaluate need for a Patient Safety Companion

HAND-OFF COMMUNICATION IN THE HOSPITAL

Ticket to Ride: Hand-off communication is provided anytime the patient leaves the unit for test, treatment or transfer to another level of care. The ticket to ride (form attached) documents the following related to fall risk:

- Fall risk level assessed for the patient
- Assistive devices required for patient handling
- Hearing or speech impairment affecting communication with the patient

Shift Report: The patient's last fall risk assessment score, interventions implemented, patient's response to fall prevention, changes in the patient's status, treatment, procedures, medications that have changed the fall risk level and any special needs relating to patient safety will be communicated to the oncoming nurse. The receiving nurse holds the responsibility to communicate patient needs and intervention expectations to the care team or other staff as indicated.

Transfer or Discharge: Fall risks are to be communicated to the nurse, caregiver and patient at the time of transfer or discharge from the hospital. Interventions recommended for the level of care after discharge will be determined by the caregiver in the setting. Patients discharged to home will be educated and receive instructions regarding fall prevention in the home setting.

DOCUMENTATION IN THE HOSPITAL

Documentation in the medical record will include:

- Patient assessment
- Fall risk screening score
- Individualized patient plan of care
- Consultation made to other clinical disciplines for assistance in assessment and recommendations for reducing fall risks.
- Patient education provided and patient's response/willingness to participate in the fall prevention safety plan
- Implementation of interventions
- Monitoring of patient response to fall prevention initiatives and evaluation of the effectiveness or need for modification
- Reassessment relating to fall risk as the patient's status changes, new medications are initiated, treatments or procedures are performed, or change in shift occurs
- Revisions to the plan to prevent patient falls
- Evidence of hand-off communication
- Assessment and findings after a fall, including required notifications.
- Intervention/treatment and modification of the fall prevention plan after a fall

MONITORING THE EFFECTIVENESS OF THE PATIENT'S FALL PREVENTION PLAN

The effectiveness of the fall prevention plan is considered as the nurse evaluates the patient or family member's compliance with the plan. The extrinsic risk factors and modifications to the environment are checked with each staff round or interface with the patient. The intrinsic risk factors modified through medical and nursing management, physical therapy or clinical pharmacology are evaluated for effectiveness during patient reassessment or response to treatment. The plan of care may be modified as the patient's risks are reduced and no longer indicated.

Discontinuing Fall Prevention Interventions:

The RN will discontinue fall precautions when it is determined through re-assessment that the patient no longer meets a moderate or high Fall Risk Score. The nursing staff will be responsible for removing fall risk identifiers and revising the plan of care.

ADULT PHYSICIAN OFFICE VISIT

Patients entering a UPHSM physician practice (clinic) will be screened for fall risk using the established criteria. The screening begins when the patient is registered in person. If it is noted visually that the patient is having trouble, or it is verbally communicated, the medical staff is notified. The intake staff will observe the patient for signs that they are a risk for falls. The intake staff will ask the patient if they have fallen in the last 3 months on intake at every visit.

Fall Risk Criteria:

A. Advancing Age (65 years or older)
B. Unsteady gait/poor balance
C. Requiring Assistance of Family Member/Friend
D. Assistive Device: walker, cane
E. Shortness of Breath or Portable Oxygen
F. Fell in the last 3 months

A Fall Risk Alert will be recorded on the white board and/or as a pop up note in the EMR for any patient meeting any of the criterion, with the exception of advancing age as the only criterion met. If they are noted to be at risk for a fall, the information is then given to the physician, so that this problem can be addressed at the visit.

When a patient has been placed in Fall Risk Alert status, basic safety measures will be used:

- Assist with ambulation or use of an assistive device/wheelchair
- Assist patient with undressing or dressing as needed for an exam
- Instruct patient NOT to get up on an exam table until someone can assist
- After exam/testing, assist patient off the exam table
- Assess environment for safety and reduce clutter or trip hazards, as needed
- Lock wheelchairs
- Instruct patient and/or family on requesting assistance
- Review fall concerns with patient and/or family. Stress the importance of our priority of patient safety.

A Fall Risk Screening is also completed during the Medicare Annual Wellness Visit (AWV) to include:

- Has the patient fallen 2 or more times in the past year?
- Did the patient have a fall with injury in the past year?
- Does the patient have a problem with gait or balance?

CARDIAC REHAB FALL RISK ASSESSMENT - According to the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR). These are the guidelines followed for certification.

Guidelines for identifying risk factors for fall or injury:

1. Muscle weakness
2. History of falls
3. Gait deficit
4. Requires assistive device
5. Visual deficit
6. Arthritis
7. Physical impairment
8. Cognitive impairment
9. Age 80 or older

The risk factors are assessed by an Exercise Physiologist during initial evaluation. Patient is placed in a fall risk category according to the number of risk factors they have.

Risk Assessment:

1. Low Risk: 0 Risk Factors
2. Moderate Risk: 1-3 Risk Factors
3. High Risk: 4+ Risk Factors

If patients are considered a moderate or high risk, precautions are taken.

1. Assist with ambulation or use of assistive device/wheelchair
2. Assess environment for safety and reduce clutter or trip hazards as needed
3. Instruct patient and/or family on requesting assistance
4. Assist to the bathroom if needed
5. Instruct patient NOT to get off of equipment until someone can assist.

POST FALL ACTION PLAN

All falls should be reported via RL Solutions Event Reporting.

If the fall was the result of an environmental factor, Building Services or Facilities Management and the Hospital Supervisor (if appropriate) should be notified immediately.

INPATIENT

The following interventions are taken immediately after a fall to determine the causes of and injuries sustained from the fall. Findings are documented in the patient's medical record.

Rapid assessment of patient for injury:

- Patient's mental status
- Vital signs, including blood pressure, pulse, and respirations
- If blood pressure is stable and no obvious signs of injury are noted, the patient may be moved
- If vital signs are unstable or there are obvious injuries, the physician is notified immediately.
- Check blood sugar (finger stick) (not just for diabetic patients)
- Check pulse oximetry
- Assess for pain
- Injuries noted from the fall
- Description of the fall
- Determined causes of the fall, including equipment that was in use at the time of the fall

Notification:

- The Unit Director/Manager & Nursing Supervisor are notified
- Family members or next of kin will be notified of the fall (with the patient's permission)
- Physician is notified and orders obtained if needed

Following a fall, high risk fall prevention interventions are implemented.

Post Fall Huddle:

As soon as possible after a patient fall (within 15-60 minutes), the Clinical Director or Clinical Manager will convene all staff present for a brief post fall huddle. The focus of the post fall huddle is to raise awareness of the factors that contributed to the fall and quickly identify/implement interventions that will reduce the likelihood of the patient falling again. This information will be shared at each shift huddle for the next 48 hours. See the Post-Fall Huddle Form (attached) for additional instructions.

OUTPATIENT/PHYSICIAN OFFICE

Should a fall occur or be reported, UPHSM staff should take immediate supportive action including an offer of further evaluation in the nearest ED or with attending physician if desired by the patient. The patient should be checked for significant injury and alert the Hospital Supervisor or EMS as necessary if an injury occurs. A Post-Fall Huddle is performed and the Post-Fall Huddle form completed and forwarded to Quality Management. If a fall occurs in a UPHS Marquette Clinic, the Physician Practice Post-Fall Huddle should be completed and forwarded to Quality Management. (See attachment)

PERFORMANCE IMPROVEMENT

Patient fall data will be collected, aggregated, analyzed and reported as a component of the organization wide performance improvement program. Monthly fall statistics will be maintained within RL Solutions, accessible to Clinical Directors, Clinical Managers, and the Executive Team. Falls with injury will be reported on the Duke LifePoint Balanced Scorecard and to the Patient Safety and Clinical Quality Committee (PSCQC).

Evaluation of patient falls, injuries, and outcomes will be used to identify opportunities to improve safety.

All falls are reviewed by the Patient Safety Officer. Based on the outcome, likelihood of recurrence and systems issues identified, the Patient Safety Officer may conduct a Learning from Defects or Root Cause Analysis.

The UPHSM Fall & Injury Prevention workgroup will review fall data and research, trial and implement fall prevention interventions and/or equipment. This group may consist of representatives from Nursing, Quality Management, Pharmacy, Clinical Engineering, Information Technology, Education, and Rehabilitation Services. The group may also review departmental specific PI plans addressing fall prevention and make recommendations to departments with high fall indices.

Clinical Directors and Clinical Managers will evaluate compliance with the Fall Prevention Program by performing chart reviews and safety rounds.

STAFF EDUCATION/COMPETENCE

All staff will be educated in their role in identification of fall risks, fall prevention, response to a fall and reporting requirements during orientation and annually thereafter.

ENVIRONMENT OF CARE - FALL PREVENTION

UNIVERSAL FALL & INJURY PREVENTION INTERVENTIONS

- Call lights within reach of patients
- Slip resistant flooring intact
- Hallways/walkways free of clutter and not obstructed
- Clean spills immediately; use signs to indicate "wet floor". Keep path of clear egress available at all times
- Eliminate trip hazards; manage cords
- Handrails sturdy
- Sturdy furniture
- Equipment and furniture wheels locked
- Bathroom grab bars in place and sturdy

CARE ENVIRONMENT FALL PREVENTION INTERVENTIONS – INPATIENT ONLY

- Floor level night lights
- Height appropriate toilet
- No full-length bedrails

TERMINAL CLEANING OF PATIENT ROOMS

During terminal cleaning of patient rooms, environmental services staff will conduct an evaluation for environmental hazards to include the following:

Room

- Do all lights work?
- Is the flooring intact?
- Is the floor dry?
- Are there any slippery areas?
- Are all wheels locked?
- Are bed alarms functioning correctly?
- Is the call light working correctly?

Bathroom

- Is the call light working correctly?
- Is the handrail secure?
- Do all lights work?
- Is the flooring intact?
- Is the floor dry?
- Are there any slippery areas?

Environmental hazards identified will be corrected prior to release of the room.

As the patient is oriented to their room, another environmental evaluation is performed by nursing staff to assure any safety issues have been corrected. The environment will be organized to meet the patient's needs.

ENVIRONMENTAL ROUNDS

Environmental safety rounds are conducted to evaluate fall risk hazards in the hospital and on campus.

A Facility Risk Assessment for Fall Prevention (attached) is conducted at least annually.

Attachments

1-Hopkins Fall Risk Scale
10-Facility Risk Assessment for Fall Prevention
2-Edmonson Fall Risk Assessment
3-Humpty Dumpty INPATIENT
4-Humpty Dumpty OUTPATIENT
5-Humpty Dumpty ED
6-Fall Risk Screen for the Out-Patient
7-Adult EDIS-Emergency Department Fall Risk Assessment
8-Post Fall Huddle Instructions & Forms
9-Ticket To Ride

Approval Signatures

Step Description	Approver	Date
	Lisa Hoyle: CNO	03/2020
	Robin Waters: Director	02/2020
	Robin Waters: Director	02/2020

Applicability

U P Health System - Marquette

Current Status: *Active* **PolicyStat ID:** *8814763*

Origination:	*07/1976*
Effective:	*11/2020*
Approved:	*11/2020*
Last Revised:	*11/2020*
Expiration:	*11/2023*
Owner:	*Cheryl Bollero-Oberstar: Facilities Project Manager*
Policy Area:	*Hospital Wide*
References:	
Applicability:	*U P Health System – Marquette*

Use Of Tobacco Products

UP Health System–Marquette is committed to promotion of health, which includes prevention as well as treatment of illness. Second hand smoke and tobacco related illnesses compromise the largest proportion of preventable diseases. The increased danger of fire associated with smoking presents additional hazard to our facility, workers and visitors. For these reasons, UP Health System–Marquette prohibits smoking and tobacco use inside and outside all facilities owned and leased, on adjacent grounds and sidewalks, parking lots, ramps and in UP Health System–Marquette owned vehicles and personal vehicles at all main campus, home health and clinic locations. Additionally, this policy is in compliance with Public Act 188 of 2009 Michigan's Smoke Free Air Law and Marquette City Smoking Ordinance.

All employees, patients, visitors, physicians, contractors and subcontractors, faculty, students, and all others at or on UP Health System–Marquette facilities, grounds, parking lots, ramps, and in UP Health System–Marquette owned vehicles on Main Campus, Home Health, and Clinic locations are covered by this policy.

Tobacco products covered by this policy are cigarettes, electronic cigarettes, pipes, cigars and chewing tobacco, and are not solely limited to these items.

All UP Health System–Marquette employees who smoke and desire to quit are encouraged to go to lifepointbenefits.net, Wellness, Tobacco Cessation.

ENFORCEMENT of POLICY

Enforcement is the responsibility of all employees of UP Health System–Marquette.

- All new employees will be informed of the policy at interview, hire, and orientation.
- Employees observing a co-worker violating the policy are requested to courteously remind the offender of the policy and suggest desisting from the use of nicotine.
- Employees are expected to inform any manager or supervisor if they witness another employee violating this policy. The manager receiving the report will then inform the offending employee's direct supervisor. All information regarding the source of the information will be confidential.
- Infractions of this policy are subject to corrective action, up to and including termination.

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
	Steven Salyer: COO	11/2020
	Cheryl Bollero-Oberstar: Facilities Project Manager	11/2020

Applicability

U P Health System - Marquette

Origination: *07/2018*
Effective: *03/2021*
Approved: *03/2021*
Last Revised: *03/2021*
Expiration: *03/2024*
Owner: *David Rickman: Director*
Policy Area: *Hospital Wide*
References:
Applicability: *U P Health System – Marquette*

Hazardous Materials & Waste Management Plan

Hazardous Materials and Waste Management Plan

EC01.01.01 EP6

I. **SCOPE**

The Hazardous Material and Waste (HazMat) Management Plan describe the methods for handling hazardous materials and waste through risk assessment and management. The plan addresses the risks associated with those materials, wastes or energy sources that can pose a threat to the environment, staff, patients, and to minimize the risk of harm at UP Health System Marquette (UPHSM). The program is also designed to assure compliance with applicable codes and regulations as applied to the buildings and services at UP Health System Marquette. The processes include education, procedures for safe use, storage and disposal, and management of spills or exposures. The program is applied to the Operations of UP Health System Marquette.

II. **FUNDAMENTALS**

A. The hazardous materials and waste are identified in the organization's inventory and the associated hazards defined as required by law or regulation in Safety Data Sheets (SDS), guidelines, good-practice recommendations, or similar available documents.

B. Safe use of hazardous materials and handling of waste requires participation by leadership, at an organizational level and a departmental level, and other appropriate staff in the design and implementation of all parts of the plan.

C. Protection from hazards requires all staff that use or are exposed to hazardous materials and waste to be educated as to the nature of the hazards and to use equipment provided for safe use and handling when working with or around hazardous materials and waste.

D. Rapid, effective response is required in the event of a spill, release, or exposure to a hazardous materials or waste.

E. Special monitoring processes or systems may be required to manage certain hazardous gases, vapors, or radiation undetectable by humans.

III.OBJECTIVES

The Objectives for the HazMat Management Program are developed from information gathered during routine and special risk assessment activities, annual evaluation of the previous year's program activities, performance measures, incident and injury reports, and environmental tours. The Objectives for this Plan are:

- *Complete training of Spill Response Team for each shift.*
- *Ensure the department SDS's are up to date, Request SDS's list from Tae clinics and update the SDS Respiratory.*

IV.ORGANIZATION & RESPONSIBILITY

A. The Board of Directors and Patient Safety and Clinical Quality Committee (PSCQC) receives regular reports of the activities of the HazMat Management Program from the multidisciplinary improvement team, the Environment of Care® (EOC) Committee, which is responsible for the Physical Environment issues. They review reports and, as appropriate, communicate concerns about identified issues and regulatory compliance. They also provide financial and administrative support to facilitate the ongoing activities of the HazMat Management Program.

B. The Chief Executive Officer (CEO), or other designated leader, collaborates with the EOC Committee Chairperson to establish operating, and capital budgets for the HazMat Management Program.

C. The Hazardous Material Coordinator in collaboration with the committee, is responsible for monitoring all aspects of the HazMat Management Program. This individual advises the EOC Committee regarding HazMat issues which may necessitate changes to policies and procedures, orientation or education, or expenditure of funds.

D. Department heads are responsible for orienting new staff members to the department and, as appropriate, to job and task specific HazMat procedures. They are also responsible for the investigation of incidents occurring in their departments. When necessary, the Hazardous Material Coordinator provides department heads with assistance in developing department HazMat Management Programs or policies.

E. Individual staff members are responsible for learning, retaining and following job and task-specific procedures for safe HazMat operations.

I. **PERFORMANCE ACTIVITIES**

The performance measurement process is one part of the evaluation of the effectiveness of the HazMat Management Program. Performance measures have been established to measure at least one important aspects of the HazMat Management Program.

The performance measure for the HazMat Management Program is:

- 95% of employees can identify the proper way to handle hazardous spills.

VI. PROCESSES FOR MANAGING THE RISK OF HAZARDOUS MATERIAL AND WASTE - EC.02.02.01

Hazardous Materials and Waste Inventory- EC.02.02.01 EP1

The organization develops and maintains an inventory of hazardous materials and waste, including chemicals, biological, radiological, chemotherapeutic, and chemicals. Each manager provides information on the hazardous materials and waste *used, stored, or generated* in that department. The Hazardous Material

Coordinator manages the inventories received from each department and evaluates for completeness with assistance from the appropriate staff, including the Radiation Safety Officer.

Spills and Exposures- EC.02.02.01 EP3-4

The Hazardous Material Coordinator develops and maintains emergency procedures for the Hazardous Materials and Waste program.

Procedures have been developed that include, precautions and personal protective equipment and the response to spills. The individuals that evaluate or respond to spills will determine if outside assistance is necessary. A minor (incidental) spill is one that can be cleaned up by the staff involved, with their training and personal protective equipment. If a spill kit is used, replace the kit contents.

A spill that exceeds the capability of the immediate staff to neutralize and clean up requires a response from outside the facility. In these cases, the area may be evacuated, ventilation controlled, and/or the Fire Department HazMat Team or outside contractor is called. The Fire Department or outside contractor takes control of the site and cleanup, or arrange for it to be cleaned up. Once determined safe, the hospital staff will disinfect the area and recovery. Staff, including housekeeping staff, is trained to recognize the potential for a spill that is not safe to handle, and to contact their manager, and/or the Hazardous Material Coordinator. During off-shifts, the Nursing Supervisor will make the determination. Staff is cautioned to err on the side of safety, and not to handle chemical spills that exceed their training, or the personal protection they have available.

Incidents involving spill kits or a response from any outside agency are documented on Incident Report Forms for documentation of the incident.

Hazardous Chemical Risks- EC.02.02.01 EP5

A process has been established and maintained for identifying, selecting, handling, storing, transporting, using, and disposing of hazardous chemical materials and waste from receipt or generation through use and/or final disposal. The department leadership assures their safe selection, storage, handling, use, and disposal. The department is responsible for evaluating the SDS for hazards before purchase of departmental supplies, to assure they are appropriate and the least hazardous alternative practical. The department managers work with the Hazardous Material Coordinator and appropriate individuals, such as the Radiation Safety Officer or Infection Control Practitioner, to develop procedures for handling of hazardous materials. The following materials and wastes are managed:

- Chemical materials are identified and ordered by department leadership. Appropriate storage space is maintained by each department, and reviewed as part of environmental tours in that area. Chemical materials are maintained in labeled containers, and staff is trained in understanding SDS, and in the appropriate and safe handling of the chemicals they use.
- Chemical waste is held in the generating department or accumulation room, until arrival of the licensed contractor. The contractor packs the chemicals, completes the manifest and removes the packaged waste. A disposal copy of the manifest is returned to verify legal disposal of the waste.

Radioactive Risks- EC.02.02.01 EP6

A process has been established and maintained for identifying, selecting, handling, storing, transporting, using, and disposing of hazardous radioactive materials and waste from receipt or generation through use and/or final disposal. The department leadership assures their safe selection, storage, handling, use, and disposal. The department is responsible for evaluating SDS and other documentation for hazards before purchase of

departmental supplies to assure they are appropriate, and the least hazardous alternative practical. The department managers work with the Hazardous Material Coordinator and appropriate individuals, such as the Radiation Safety Officer, to develop procedures for handling of hazardous materials:

- Radioactive material is handled subject to the hospital's NRC License, and the Radiation Safety Officer manages their safety. Materials are handled in accordance with the requirements of the facility license.
- Radioactive waste is held in a 'hot room' until decayed to background, then handled as the underlying hazard of the materials for disposal. The Radiation Safety Officer manages the waste and determines when it is no longer considered a radioactive hazard.

Hazardous Energy Sources- EC.02.02.01 EP7

Hazardous energy sources include, but are not limited to, ionizing (radiation and x-ray) and non-ionizing (lasers and MRI) will be selected and used in accordance to manufacturer's recommendations and regulatory requirements. Specific policies pertaining to operational safety and use of each hazardous energy sources are found in each department that utilizes such equipment. The Department Director or a designated representative will conduct identification and evaluation of hazardous energy sources.

The primary source of hazard information will be from the manufacturer and/or supplier. Engineering controls and/or work practices should be developed to reduce exposures and potential injury. All employees involved in the operation and use of hazardous energy sources will be provided with appropriate training as part of their initial departmental orientation. Staff will follow the procedures established in the departmental policies and procedures to identify and mitigate exposure to potential risks associated with hazardous energy sources. Department Directors will maintain required documentation including applicable regulations, required permits and licenses for each hazardous energy source.

Hazardous Medication Risks- EC.02.02.01 EP8

A process has been established and maintained for disposing of hazardous medications and waste. Department leadership assures safe disposal of their hazardous medications. The pharmacy department is responsible for evaluating available information for hazards prior to the purchase of hazardous medications to assure they are appropriate, and if possible is the least hazardous alternative practical. Department managers work with the Hazardous Material Coordinator and appropriate individuals, to develop procedures for handling of hazardous medications.

- Chemotherapeutic (anti-neoplastic), other hazardous medications, and the materials used to prepare, administer, and control these materials are controlled and the waste materials collected for special disposal. Staff utilizing these materials is trained in the handling, and emergency response to spills or leaks.
- Chemotherapeutic residual waste and other hazardous medications are handled as part of the Regulated Waste stream, with additional labeling to assure appropriate incineration and final destruction.
- The disposal of hazardous pharmaceutical material is managed by the Pharmacy in accordance to the appropriate regulations and requirements.

Hazardous Gas & Vapor Risks- EC.02.02.01 EP9-10

The Hazardous Material Coordinator is responsible for managing the program for minimizing risks of and monitoring of hazardous gases and vapors. Hazardous gas and vapors include list of gases or vapors, such as formaldehyde, xylene, and Gluteraldehyde (i.e., Cidex), ethylene oxide (ETO), oxide and nitrous oxide gases; vapors generated by glutaraldehyde; cauterizing equipment, such as lasers; waste anesthetic gas

disposal (WAGD), and laboratory rooftop exhaust (For full text, refer to NFPA 99-2012: (For full text, refer to NFPA 99-2012: 9.3.8; 9.3.9). If a test result was above the federal established action level, corrective action and additional testing should be done to demonstrate a safe working environment.

Permits, Licenses, Manifests and Safety Data Sheets (SDS)- EC.02.02.01EP 11

Permits and licenses have been obtained and maintained for handling and disposal of hazardous wastes, including chemical wastes, and radioactive materials from the appropriate federal, state, and municipal agencies and SDS for the chemical waste and hazardous medications waste.

Each load of hazardous waste removed from the facility is documented by a manifest, as mandated by federal or state agencies. The manifests have multiple copies, and a copy is left at the time the hazardous waste is removed. Another copy travels with the waste, and is returned to the hospital once the wastes have been legally disposed of, to document the completion of the activity. These copies are matched, to assure that no load has been lost or misplaced, and kept for the record. If a completed copy of the manifest is not returned within the deadline established by law and regulation number of days, the appropriate governmental agency is notified, and the information is also shared with the EOC Committee.

Information identifying the hazards and emergency responses associated with these materials and wastes are available to staff, patients, and visitor at all times from such resources as SDS, Centers for Disease Control (CDC) Guidelines, Department of Transportation (DOT) and Nuclear Regulatory Commission (NRC) regulations. Various methods for retrieving the information are available from the vendor SDS company, Internet, fax, and/or on-line severs. To ensure availability at all times, a hard copy of the SDS associated with the material is identified on the inventory in the Emergency, Security, or Materials Management Department.

Process for Labeling Hazardous Material & Waste- EC.02.02.01 EP12

All hazardous materials and wastes are properly labeled from receipt or generation until disposal including secondary containers. Storage areas are also properly labeled.

Chemotherapeutic Waste: Chemotherapeutic waste is placed into labeled containers (labeled with the OSHA and international symbol for carcinogenic wastes). These wastes are handled along with the red bag wastes. Bulk quantities of chemotherapeutic waste are handled as hazardous chemical waste.

Chemical Materials & Waste: Chemical materials are labeled throughout their use, handling, and disposal. The label is on the container prior to receipt or is placed on containers when filled or mixed within the hospital. Labeling is evaluated during environmental tours, to assure the labels are maintained and legible. In many cases the waste is labeled by the original chemical name, in other cases, where collection cans or containers are used, the container is labeled. These labels are required by the vendors of chemical disposal services to maintain the identity of the materials, and if the identity is lost, the materials are tested and analyzed to identify them for proper handling and disposal.

Hazardous Energy Sources: Hazardous energy sources are labeled in accordance to OSHA, NRC and other appropriate agencies. Warning alarms may also be installed to identify the risk or radiation when these sources are energized.

Radioactive Materials & Waste: Radioactive materials are labeled according to NRC, OSHA, or International agencies. Wastes are held to decay to background, when the labels are removed or covered, and wastes handled as the other hazards they may reflect. Labeling is evaluated during environmental tours, to assure the labels are maintained and legible.

Monitoring Staff- EC.02.02.01 EP17

Staff who is in close proximity to computed tomography (CT), positron emission tomography (PET), nuclear medicine (NM) equipment or fluoroscopy services will be monitored. Staff dosimetry results are reviewed at least quarterly by the RSO, diagnostic medical physicist or health physicist to assess whether staff radiation exposure levels are "As Low As Reasonably Achievable" (ALARA) and below regulatory limits. The RSO will report all badge reports and over exposures to the Radiation Safety Committee and the EOC Committee.

Radiation Exposure- EC.02.02.01 EP18

Staff that works with radiation will be checked periodically for radiation exposure. The method of exposure will be measured through exposure meter or badge tests. The results will be shared with the staff member and the EOC Committee.

Trash Disposal- EC.02.02.01 EP19

The Environmental Services (EVS) Department has determined procedures for the proper routine storage and prompt disposal of trash.

Evaluating the Management Plan- EC.04.01.01 EP15

Every 12 months, the Hazardous Material Coordinator evaluates the scope, objectives, performance, and effectiveness of the Plan to manage the risks of hazardous materials and waste to the staff, visitors, and patients.

Attachments

No Attachments

Approval Signatures

Step Description	Approver	Date
	Steven Salyer: COO	03/2021
	Alyson Sundberg: Dir, Safety/Risk Management	03/2021

Applicability

U P Health System - Marquette