# TABLE OF CONTENTS

Instructions for Completion........................................................................................................4
How to Access LearningLink .......................................................................................................4
CHOP’s Mission and Values .........................................................................................................5
History ..........................................................................................................................................5
Values .........................................................................................................................................6
Equal Employment/Affirmative Action (HR Policy 2-1) .......................................................6
Clearance Standards Policy (HR Policy 2-20, 2-20a, 2-20b) ............................................7
Safe Keeping at CHOP ..............................................................................................................7
Joint Commission National Patient Goals ..............................................................................8
Patient’s Bill of Rights and Responsibilities (Patient Care Manual) ......................................9
Language and Spiritual Care Services.....................................................................................9
Population Specific Competency ...............................................................................................9
Non-Discrimination / Anti-Harassment (HR Policy No. 5-1) ..............................................10
Rules of Conduct (HR Policy 5-2) ..........................................................................................10
Identification and Name Badges .............................................................................................10
Conflict of Interest - (Administrative Policy A-3-1) .............................................................11
Attendance/Punctuality ...........................................................................................................11
Non-Smoking Policy ................................................................................................................11
Personal Phone Calls .............................................................................................................11
Hours of Work ........................................................................................................................12
Meal Periods and Work Breaks .............................................................................................12
Drug and Alcohol Policy .........................................................................................................13
Severe Weather Emergency .................................................................................................13
Dress Code and Personal Appearance ................................................................................13
Termination of Assignment Procedures ..............................................................................13
Conclusion ...............................................................................................................................14
Appendix A - Mandatory Education ....................................................................................15
Appendix B - Policies ...............................................................................................................88
INSTRUCTIONS FOR COMPLETION

This Handbook is a guide to help you better understand the policies and procedures at The Children’s Hospital of Philadelphia (CHOP). Policy referrals are given where applicable in each section of the handbook for your convenience. You are encouraged to contact your supervisor or refer to the Human Resource Policy and Procedure Manual on the CHOP intranet for more detailed information.

The audience for this Handbook and Attestation includes, but is not limited to: patient care and non-patient care vendors, healthcare and non-healthcare profession students, physicians in a training program whose home institution is not CHOP and physicians whose home institution is not CHOP.

This Handbook does not create a contract of any kind or constitute a guarantee that your contract or assignment will continue for any specified period of time, or end only under certain conditions.

HOW TO ACCESS LEARNINGLINK

1. Open a browser and enter the following address: www.chop.edu/learninglink
2. Enter your Username. It is the same as your Windows/Outlook/STAR user name login.
3. Enter your Password. It is the same as your Windows/Outlook/STAR user name login.
4. Click the Login button.
5. Complete the assigned Orientation and Mandatory Education Attestation in the “To Do” section of your Learner Home Page on or before your start date.

All information contained within this resource should be considered company confidential.

© 2014, The Children’s Hospital of Philadelphia, 3535 Market Street, Philadelphia, PA 19104
HISTORY

THE CHILDREN’S HOSPITAL OF PHILADELPHIA

The Children’s Hospital of Philadelphia (CHOP), established in 1855 as the nation’s first Children’s Hospital, is a leader in providing comprehensive health care, cutting edge Research and quality and professional education. The Hospital has nearly 500 beds and records more than 28,000 inpatient admissions and close to 1.2 million outpatient visits annually.

CHOP is autonomous medically, administratively and financially. Children’s Hospital is the pediatric teaching resource for the University of Pennsylvania. The Hospital is the major provider of primary health care services for children of West and South Philadelphia.

THE CHILDREN’S HOSPITAL OF PHILADELPHIA RESEARCH INSTITUTE

The Children’s Hospital of Philadelphia Research Institute is home to one of the largest pediatric research programs in the country with more than $200 million in total federal awards and an annual budget of more than $200 million.

With more than 450 investigators and a research staff in the thousands, the Children’s Hospital of Philadelphia Research Institute continues groundbreaking research on diabetes, neonatal seizures, childhood cancer, hemophilia, pediatric heart disease.

CHOP’S MISSION AND VALUES

MISSION

The Children’s Hospital of Philadelphia (CHOP), the oldest hospital in the United States dedicated exclusively to Pediatrics, strives to be the world leader in the advancement of health care for children by integrating excellent patient care, innovative research and quality professional education into all of its programs.

Directly or in partnership with others, the Hospital seeks to provide accessible, fiscally responsible, comprehensive, innovative, high quality medical and surgical care to children in Pennsylvania, New Jersey, Delaware and other states and countries.

The Hospital focuses its educational mission on physician and allied health professionals at all levels, with an emphasis on training future leaders who are devoted to the care of children. As a means of achieving this mission, the hospital forges relationships with other institutions that include education and research among their goals.

The Hospital improves the general health of children and demonstrates world leadership by generating new knowledge through its commitment to basic and clinical research.
VALUES

COMPASSION
All patients, families and employees are treated with kindness, empathy and understanding.

INNOVATION
CHOP sets the standard in advanced medical research, treatment, education and care.

SERVICE EXCELLENCE
CHOP strives to provide accurate, courteous and effective service at all levels of the institution.

TEAMWORK
Only through the collaborative efforts of CHOP staff, both clinical and administrative, can CHOP provide outstanding care and service.

RESPECT
CHOP acknowledges the values, beliefs and cultural backgrounds of each of its patients, families and staff members.

COMMUNICATION
Information is shared in a timely and accurate manner.

FAMILY-CENTERED CARE
Healthcare is delivered through mutually beneficial partnerships among patients, families and staff at CHOP

COMMITMENT
Dedicated delivery of services and adherence to CHOP’s mission.

EQUAL EMPLOYMENT/AFFIRMATIVE ACTION (HR POLICY 2-1)
The Hospital is committed to providing equal employment opportunity for all applicants and employees without regard to race, color, religion, sex, age, national origin, ancestry, sexual orientation, gender identity, genetic information, marital status, disability, victim of domestic or sexual violence status, covered veteran status, or other protected classifications to the extent required by applicable laws.

As a matter of policy, the Hospital reaffirms its commitment that there will be no discrimination against any employee because of race, sex, religion, color, age, national origin, or any other protected classifications in matters of employment, upgrading/promotion, demotion, transfer, recruitment or recruitment advertising, layoff or termination, rates of pay and other compensation, and selection for training.

CLICK TO VIEW THE POLICY
CLEARANCE STANDARDS POLICY (HR POLICY 2-20, 2-20A, 2-20B)

The Children’s Hospital of Philadelphia has implemented clearance standards to protect the safety and welfare of its patients and staff. All Staff and any other persons or entities acting or providing services on behalf of the Hospital must comply with applicable standards requirements prior to, and or during their engagement with the Hospital. This policy applies to all CHOP staff, (paid and unpaid). It also applies to any other persons or entities acting or providing services on behalf of the Hospital. This does not apply to patients or families of patients or visitors of patients.

SAFE KEEPING AT CHOP

PURPOSE
Employee and Patient safety is central to quality health care at The Children’s Hospital of Philadelphia (CHOP). CHOP’s Safe Keeping articulates the organization’s sustained commitment to patients, families, employees and medical staff to provide the safest care possible.

GOAL
The Children’s Hospital of Philadelphia strives to ensure the highest quality of care and service to children and families by working towards providing care that is safe, effective, Family Centered, timely and efficient.

SAFE KEEPING AT CHOP PROVIDES THE FRAMEWORK TO:
1. Reduce the risk of injury and harm from preventable medical errors.
2. Establish mechanisms that support effective responses to actual incidents.
3. Integrate employee and patient safety priorities into the design and redesign of all relevant organizational processes, functions and services.

SAFETY NET - REPORTING PATIENT SAFETY CONCERNS
Safety Net is an electronic reporting system that is internet based. We encourage reporting events and problems. If you have any concerns about quality or safety, they can be reported to the Joint Commission without any risk of punitive action. Please refer to the Patient’s Rights document for more information on how to contact the Joint Commission.
JOINT COMMISSION NATIONAL PATIENT GOALS

The Patient Safety Advisory Group works with Joint Commission staff to identify emerging patient safety issues, and advises The Joint Commission on how to address those issues in NPSGs, Sentinel Event Alerts, standards and survey processes, and National Patient Safety Goals.

IMPROVE THE ACCURACY OF PATIENT IDENTIFICATION.
  a. Use of Two Patient Identifiers (NPSG.01.01.01)
  b. Eliminating Transfusion Errors (NPSG.01.03.01)

IMPROVE THE EFFECTIVENESS OF COMMUNICATION AMONG CAREGIVERS.
  a. Timely Reporting of Critical Tests and Critical Results (NPSG.02.03.01)

IMPROVE THE SAFETY OF USING MEDICATIONS.
  a. Labeling Medications (NPSG.03.04.01)
  b. Reducing Harm from Anticoagulation Therapy (NPSG.03.05.01)
  c. Reconciling Medication Information (NPSG.03.06.01)

IMPROVE THE SAFETY OF CLINICAL ALARM SYSTEMS.

REDUCE THE RISK OF HEALTH CARE–ASSOCIATED INFECTIONS.
  a. Meeting Hand Hygiene Guidelines (NPSG.07.01.01)
  b. Preventing Multidrug-Resistant Organism Infections (NPSG.07.03.01)
  c. Preventing Central Line–Associated Blood Stream Infections (NPSG.07.04.01)
  d. Preventing Surgical Site Infections (NPSG.07.05.01)
  e. Preventing Catheter-Associated Urinary Tract Infections (NPSG.07.06.01)

REDUCE THE RISK OF PATIENT HARM RESULTING FROM FALLS.

THE ORGANIZATION IDENTIFIES SAFETY RISKS INHERENT IN ITS PATIENT POPULATION.
  Identifying Individuals at Risk for Suicide (NPSG.15.01.01)

UNIVERSAL PROTOCOL FOR PREVENTING WRONG SITE, WRONG PROCEDURE, AND WRONG PERSON SURGERY™
  a. Conducting a Preprocedure Verification Process (UP01.01.01)
  b. Marking the Procedure Site (UP01.02.01)
  c. Performing a Time-Out (UP01.03.01)
PATIENT’S BILL OF RIGHTS AND RESPONSIBILITIES (PATIENT CARE MANUAL)

CHOP is committed to the basic rights of the children and families it serves. Those rights apply to the patient and/or parents and/or guardian, as appropriate for the age and level of understanding of the child. Your attitude, behavior and actions should reflect the expectations of our patients and their families as outlined in the Patients’ Bill of Rights.

CLICK TO VIEW THE POLICY

LANGUAGE AND SPIRITUAL CARE SERVICES

Through access to resources, education and training, we can all work together to provide the best possible care to everyone who comes to CHOP. To do this, we provide:

- Language Access Services: Interpreter and Translation Services and Signage.
- Culturally Competent Care: Dietary, Spiritual, and Cultural Preferences; Diverse Staff and Leadership; and, Awareness and Education.
- Organizational supports: Data Collection, Community Partnerships, and Organizational Self-Assessment.

POPULATION SPECIFIC COMPETENCY

The Children’s Hospital of Philadelphia provides a number of resources to assist staff in working with patients in all age ranges. Please review the requirements for your assigned area with your department preceptor or supervisor. A competency assessment will be conducted based on your job role and level of patient contact.
NON-DISCRIMINATION / ANTI-HARASSMENT (HR POLICY NO. 5-1)

The Hospital is committed to maintaining an environment that encourages and fosters appropriate conduct among employees, and all staff with respect for individual values. Accordingly, the Hospital is committed to the enforcement of its Non-Discrimination and Harassment Policy at all levels within the work place, in order to create an environment free from discrimination and/or harassment on the basis of race, color, religion, sex, age, national origin, sexual orientation, marital status, disability, veteran’s status, or other protected classifications, to the extent required by applicable laws. In all instances, the Hospital will continue to comply with applicable federal, state and municipal regulations governing employment practices.

RULES OF CONDUCT (HR POLICY 5-2)

Rules and regulations are essential to the efficient operation of the Hospital. We recognize that self-discipline and proper standards of conduct are necessary to protect the health and safety of all employees and staff as well as patients and the public, to maintain uninterrupted service, and to protect the Hospital’s good will as well as property. As a general guiding principle, The Children’s Hospital of Philadelphia seeks to treat all employees and staff fairly in the application of disciplinary procedures.

IDENTIFICATION AND NAME BADGES

Employees are required to wear name badges while on duty unless they interfere with the performance of duty (to be determined by appropriate supervisor). The badge must be worn so that the employee’s name is clearly visible to patients and visitors. Employee Identification badges will be issued on the first day of the assignment and will require an updated photo every four (4) years. CHOP ID Badges are to be worn at all times. Badges are to be returned to your supervisor on your last day of work.
CONFLICT OF INTEREST - (ADMINISTRATIVE POLICY A-3-1)

The Hospital is committed to conducting its affairs in accordance with the highest ethical and legal standards. In order to maintain these standards, it is the policy of the Hospital that potential, perceived and actual conflicts of interest are to be avoided. This applies to all employees, staff and employees of affiliated institutions. Potential, perceived and/or actual conflicts of interest of goods or services offered by the Hospital include: gifts, inside information, and outside interests, activities, and solicitation.

ATTENDANCE/ PUNCTUALITY

Good attendance and punctuality are necessary for a work environment to be productive. Please be punctual at all times. If, for some reason, you must arrive late or be absent, it is YOUR responsibility to inform your CHOP supervisor no later than two hours before your start time.

NON-SMOKING POLICY

Because of our concerns for the health of our patients, staff and visitors, Children’s Hospital is a smoke-free institution.

PERSONAL PHONE CALLS

No personal phone calls are to be made or received during working hours. There are public telephones throughout the Hospital facilities. To call locations within the Hospital, use any beige house phone and dial the extension. No personal calls are permitted while at the residence of a Hospital patient. Emergency calls should only be placed with express permission from the location’s owner.

CLICK TO VIEW THE POLICY
**HOURS OF WORK**

**WORK WEEK**
The work week for the Hospital begins at 12:00 AM on Sunday.

**STARTING TIME**
The department head or his/her designee will determine the appropriate starting time for the position within their own department.

**HOURS WORKED PER WEEK**
Clinicians, temporary and contracted personnel will be paid for time worked, which includes not only the activities which are part of their regular job requirements but also for activities not directly associated with job requirements, but that are considered to benefit the Hospital.

Time that is considered not worked and for which clinicians, temporary and contracted personnel are not paid includes the meal period and time away from the jobs due to personal business.

Compensation for students, if any, will be dependent on the agreements made with the sponsoring institution.

---

**MEAL PERIODS AND WORK BREAKS**

**BREAKS**
All employees and staff are entitled to one break per shift per day, not to exceed 20 minutes, if operations permit, and as assigned by their supervisor.

**MEAL PERIOD**
The Hospital grants an unpaid meal period of 30 minutes. Department heads will not schedule a meal period or break at the beginning or end of the scheduled workday to cover for lateness or an employee leaving early. Whenever possible, employees should be granted a twenty minute rest period once during the workday which shall be considered time worked.

There are cafeterias for your convenience serving both hot and cold food and drinks in the Main Hospital Building, Abramson Research Building and Colket Translational Research Building. There is a convenience store located on the 1st floor of the Wood Building. Vending machines are available in those locations outside of the hours of normal operation.
DRUG AND ALCOHOL POLICY
The Children’s Hospital of Philadelphia, its ambulatory care facilities and its other affiliated institutions prohibits temporary employees and staff from being under the influence of illegal drugs, alcohol or prescribed drugs that may impair performance while on assignment or at a client facility. In addition, it is prohibited to use, sell, or possess alcoholic beverages or illegal drugs while on assignment.

SEVERE WEATHER EMERGENCY
(HR POLICY 7-4)
It is the policy of The Children’s Hospital of Philadelphia to maintain essential services and operations during any severe weather/emergency condition while providing for the protection, safety, and health of all patients, families, employees and medical staff. Essential services include maintaining hospital operations, operating research facilities, and providing necessary support and administrative services.

DRESS CODE AND PERSONAL APPEARANCE
(HR POLICY 5-7)
Employee dress, hygiene and grooming should be appropriate to the work situation. Neat and clean dressing, grooming, and identification are important to good patient care, the satisfaction of patients and their families, and good employee-patient relations.

Employees are expected to dress in a manner that presents a professional and neat personal appearance in accordance with the expectations of the job. It is understood that all employees will maintain normal and reasonable personal hygiene and grooming standards.

TERMINATION OF ASSIGNMENT PROCEDURES
The Hospital recognizes that temporary, contracted and student assignments will end. When a staff member is no longer able to continue in the assignment for any reason, the courtesy of reasonable notice is requested. Notice should be directed to your immediate supervisor or to the sponsoring agency as soon as possible to ensure continuity of work on the unit.

The Hospital reserves the right to terminate Temporary, Contracted or Student assignments for policy or performance reasons, with or without notice. Questions on termination of assignment should be directed to the appropriate Human Resource Service Team representative.
CONCLUSION

The Hospital recognizes that the information provided in this handbook is not all inclusive, but covers most areas of employee concern.

The policies, regulations, and procedures are subject to change at any time. Additionally, except as otherwise prohibited by law, the Hospital reserves the right to terminate and/or discipline any employee, contractor, student, and temporary agency employee for reasons it considers appropriate with or without cause.
APPENDIX A
MANDATORY EDUCATION
INFECTION PREVENTION & CONTROL

WHY IS INFECTION PREVENTION IMPORTANT?

1 in 25 patients—or 722,000 people—in the U.S. acquire hospital acquired infections (HAIs) each year.

10% of pediatric patients will experience an HAI.

Last year CHOP patients experienced over 600 HAIs.
WHEN AND HOW SHOULD YOU CLEAN YOUR HANDS?

In 2013 CHOP maintained an impressive rate of greater than 95% compliance with hand hygiene. We follow the World Health Organization’s (WHO) 5 Moments for Hand Hygiene.

1. **Before Touching a Patient**
   - **WHEN?** Clean your hands before touching a patient when approaching him/her.
   - **WHY?** To protect the patient against harmful germs carried on your hands.

2. **Before Clean/Aseptic Procedure**
   - **WHEN?** Clean your hands immediately before performing a clean/aseptic procedure.
   - **WHY?** To protect the patient against harmful germs, including the patient’s own, from entering his/her body.

3. **After Body Fluid Exposure Risk**
   - **WHEN?** Clean your hands immediately after an exposure risk to body fluids (and after glove removal).
   - **WHY?** To protect yourself and the health-care environment from harmful patient germs.

4. **After Touching a Patient**
   - **WHEN?** Clean your hands after touching a patient and her/his immediate surroundings, when leaving the patient’s side.
   - **WHY?** To protect yourself and the health-care environment from harmful patient germs.

5. **After Touching Patient Surroundings**
   - **WHEN?** Clean your hands after touching any object or furniture in the patient’s immediate surroundings, when leaving – even if the patient has not been touched.
   - **WHY?** To protect yourself and the health-care environment from harmful patient germs.
SOAP AND WATER VS. HAND RUB

• When not visibly soiled, alcohol hand rub is the preferred method to perform hand hygiene in the healthcare environment.

• Continue rubbing hands until they are completely dry to effectively kill germs

• There are certain times hands must still be washed with soap and water

TIMES WHEN EVERYONE SHOULD CLEAN THEIR HANDS WITH SOAP AND WATER

• Before, during, and after preparing food
• Before eating food and after eating with your hands
• After using the toilet
• After changing diapers or cleaning up a child who has used the toilet
• After blowing your nose
• Anytime hands are visibly soiled

BE AWARE OF PATIENT SURROUNDINGS

Remember; even if you haven’t touched a patient; clean your hands after contact with anything in the patient surroundings when leaving the patient room. Examples of patient surroundings include the bedside table, monitors, infusion pumps, bedside carts and bed rails.

CHOP Ambulatory areas follow a modified version of patient surroundings in which items in the exam room are included as patient surroundings. Examples include keyboards, otoscopes, cabinets, etc.
GLOVES

Gloves should never be used in place of hand hygiene! Don’t overuse gloves. Gloves should be worn for patients on isolation, when touching blood or body fluids and contaminated items.

Change gloves between tasks and procedures on the same patient when going from a dirty to clean procedure or when gloves are visibly soiled.

Dispose of gloves when leaving the patient room and always remember to perform hand hygiene after removing gloves.

DON’T FORGET ABOUT NAILS!

Studies have shown that healthcare workers with chipped nail polish, long nails or artificial nails can harbor organisms on their fingertips and this is associated with outbreaks of disease and hospital deaths.

• Natural nails should be no longer than ¼ inch (6.35 mm) in length
• No artificial nails, extenders or overlays, including gel nail polishes may be worn by direct patient care providers and employees in the Sterile Processing Department and Perioperative Complexes
• Remove chipped nail polish (nail polish should be changed at least every 4 days)
Stop the spread of germs that can make you and others sick! You may be asked to put on a facemask to protect others. If you don’t have a tissue, cough or sneeze into your upper sleeve or elbow, not your hands. Wash hands often with soap and warm water for 20 seconds. If soap and water are not available, use an alcohol-based hand rub.

**PROPER RESPIRATORY ETIQUETTE**
- Cover your cough
- Do not sneeze or cough into your hands!

**HUMAN RESOURCES SICK POLICY**

**Stay home when you are sick!** Keeping our patients and employees safe year round is our first priority. We expect employees will not come to work if they have the following symptoms:

- Fever and body aches/chills
- Acute onset of significant respiratory or GI symptoms with or without fever (e.g. cough, congestion, runny nose, vomiting or diarrhea)

An employee is expected to stay home until they are fever free without medication 24 hours and they have significant improvement of other symptoms as noted above.
In addition to hand hygiene and posted isolation sign, recognize that High Level Contact Precautions indicates a patient has a documented multi-drug resistant organism such as MRSA or VRE or a resistant gram negative (RGN).

Even if no sign is posted, please use the proper protective equipment when there is potential for exposure to blood or body fluids (standard precautions).

Ambulatory areas follow modified isolation precautions unless otherwise directed.
CLEANING THE PATIENT ENVIRONMENT OR YOUR OWN WORKSPACE

Make sure to use the correct cleaning product and follow the instructions for proper contact times.
- “Redtop” Sani-cloth Plus = 3 minutes

INPATIENT VISITATION POLICY

Throughout the year, sick visitors (including siblings) are asked to remain at home until they are well. Healthy siblings are welcome to visit and should stop at the front desk to be screened for illness prior to each visit.

Siblings with symptoms of illness, including fever, cough, running nose, diarrhea or vomiting will be asked not to visit.

All visitors under 18 must be accompanied by a parent or adult guardian at all times. Visitors and siblings must be screened for illness and receive a sticker every time they visit.

Every year during viral season (approximately December through March), we ask that families limit visitors to healthy siblings plus four healthy visitors designated by the family.

HOW CAN YOU GET ADDITIONAL HELP OR INFO?

You can help improve patient safety by raising questions or concerns about infection prevention to the Infection Prevention and Control Department.

Main Hospital, A Level, Suite AE21
Phone: Ext 4-2096
(215-590-2096)
On call Pager: 7-7745

Speak with your manager about concerns you may have.

Visit us on the intranet:
Keyword Search:
Infection Control
Looking for adventure?

Make sure you have safety gear

and CHOP employees can get adventure-size discounts on safety items for adults and kids at CHOP’s Safety Center

Visit the website at www.chop.edu/childssafety
WHAT IS COMPLIANCE?

DO THE RIGHT THING!

Compliance means that, as an organization and as individual employees, we follow the rules that govern the hospital and how it does business. It means following federal, state, and local laws, as well as Hospital policies and procedures.

These rules are for things such as how the hospital bills for the services it provides to patients, how we interact with patients and their families, how we conduct relationships with our suppliers, and how we must follow the legal requirements of the agencies that license the hospital.

In a nutshell, compliance means doing the right thing. Everyone at CHOP should be familiar with our Organizational Ethics Statement and our Compliance Standards of Conduct, both of which can be found on the Compliance intranet site.

CHOP’S COMPLIANCE PROGRAM CONSISTS OF:

- CHOP’s Office of Compliance and Privacy
- Written standards guiding our work and relationships
- Reporting options for compliance concerns / violations
- Regular “checkups” called Compliance Monitoring
- Regular training about compliance
- Investigation of compliance problems or violations
- Advising / disciplining on compliance violations
- And...YOU!

Each day, no matter what your role, you can help ensure all CHOP activities follow the legal and ethical standards that apply to our organization and protect our patients.
YOUR ROLE IN COMPLIANCE

In addition to following the rules and standards put in place to protect our patients and institution, it is your obligation to do the right thing by speaking up and raising any compliance questions or concerns.

You must commit to reporting any conduct you reasonably believe is or may be illegal, unethical, in violation of CHOP policy, or otherwise questionable. CHOP policy forbids retaliation for concerns brought forward in good faith. You can learn more about whistleblower protection on the Compliance intranet site.

You must participate in training programs to learn about compliance at CHOP.

REFLECT ON YOUR WORK

Can you imagine situations where legal, ethical, professional standards, or CHOP policies and procedures could be violated in your work area?

• Research operations and practices
• Patient care
• Vendor / supplier relations
• Patient billing

AN EXAMPLE OF COMPLIANCE STANDARDS IN BILLING:

When billing for services we follow standards including: only billing for services and items actually provided, only billing for medically necessary services, using accurate coding in our billing, following relevant rules when submitting requests for government payment in other contexts such as for research grants.

HOW TO RAISE CONCERNS

Internal:
• Speak with your supervisor or a member of the management staff.
• Contact CHOP’s Office of Compliance and Privacy at 267-426-6044 or via email at compliance@email.chop.edu
• Call the Children’s Hospital Compliance Hotline at 1-866-246-7456 or visit www.mycompliancereport.com. When prompted, enter “CHOP”, when the access ID of your organization is requested.

Outside of CHOP:
For PA Medicaid issues: in addition to the methods listed above, you have the option of calling the toll-free Medical Assistance (MA) Provider Compliance Hotline at 1-866-DPW-TIPS (1-866-379-8477). Also visit www.dpw.state.pa.us.

Additional Resources:
• CHOP’s Compliance Intranet site: http://intranet.chop.edu/sites/compliance/
• Organizational Ethics Statement: http://www.chop.edu/export/download/pdfs/articles/org_ethics.pdf
• Compliance Standards of Conduct: http://intranet.chop.edu/system/galleries/download/patcare/a-1-5.pdf

Laws like the Federal False Claims Act prohibit fraudulent or otherwise improper billing or requests for payment. Any individual who knowingly or recklessly submits a false claim for payment to a federal or state healthcare program may be subjected to fines and penalties. See Compliance Standards of Conduct for more detail.
COMPLIANCE SCENARIOS

SCENARIO 1
You have noticed that two coworkers periodically clock in for one another. On some mornings, it is hours before the missing coworker shows up to work. You believe this is improper and report it to your manager. She tells you that she will look into it. Months later, you see the coworkers still clocking in for each other, and you believe your manager has not done anything about it.

WHAT SHOULD YOU DO?
Clocking in for another employee who is not working results in the falsification of payroll records and is wrong. You were right to report the issue to your manager, but if you believe your manager has not acted promptly or at all, you have an obligation to report this conduct to someone else.

If you are concerned that going over your manager’s head could get you in trouble or make your work environment more difficult, you should remember that you are protected when reporting possible compliance issues. You always have the option to report any compliance matter anonymously by calling the Compliance Hotline.

SCENARIO 2
As part of your efforts to provide the best care possible, you often recommend products or services to patient families that will assist them in continuing care for the patient at home. One of the companies that makes healthcare products for home use requests time to show you a new product that they have available. After the demonstration, the company representative thanks you for your time and offers you tickets to a Phillies game the following weekend.

WHAT SHOULD YOU DO?
You should not accept the tickets. The Hospital has policies that prohibit the acceptance of any free gifts from companies that do business or seek to do business with CHOP. It is important to avoid even the perception that a CHOP workforce member could be influenced by free gifts from current or potential vendors. If you are unsure about CHOP’s policies on the matter, you should check with your supervisor or the Office of Compliance and Privacy for guidance.

SCENARIO 3
Your manager tells you to change information in the billing record and you know the new information he provided is not correct. You tell him the information is wrong and will cause the bill to overstate the services provided, but he tells you to do it anyway. Other team members were asked to do the same thing. You are worried that if you do not do what your manager has requested, you will be penalized. But you know putting the false information in the record is not right.

WHAT SHOULD YOU DO?
You should report your concerns to someone at a higher level, or to the Office of Compliance and Privacy. Your manager is asking you to violate Hospital policy, and potentially place the Hospital at risk for violation of federal and state law by entering false information in the Hospital’s billing records. You have the duty to help safeguard the interests of the Hospital by reporting your concern, and you have done nothing wrong by discussing it with someone at a higher level so that the matter can be properly investigated. Always remember that you may also report compliance issues anonymously by calling the Compliance Hotline.
SCENARIO 4
You are approached by a director in another department who asks you to do some extra work for him on your lunch break and on occasional weekends. He tells you to keep track of your hours and you will be paid by CHOP as an outside consultant. You are not completely comfortable with this arrangement but because he is a member of management you assume he is following the rules.

WHAT SHOULD YOU DO?
If you are unsure of the rules, you should ask someone who knows. As a general rule, CHOP employees cannot be paid to perform work that is not within the scope of their job duties. In this case there were a number of options, including raising your concerns with your own supervisor, Human Resources, or the Office of Compliance and Privacy.

SCENARIO 5
You have access to patient records as part of your job at CHOP. You heard a rumor that one of your neighbors was injured at your neighborhood playground and admitted to the hospital. Even though you are not involved in your neighbor’s care, you are tempted to access the medical record in EPIC just to see if he is okay.

WHAT SHOULD YOU DO?
You should not access the patient record. At CHOP, we are committed to patient privacy and no member of our workforce should ever access information about a patient or a patient’s family when it is for a purpose unrelated to performing his/her job at CHOP. Even if your intentions are good, it is still not appropriate to access a patient record for a non-work related purpose.
PRIVACY

WHY IS PATIENT PRIVACY IMPORTANT?
Our patients and families trust The Children’s Hospital of Philadelphia (CHOP) to care for them and to protect the information they share with us. Violating our patient’s confidentiality damages that trust and CHOP’s reputation.

State and federal laws (such as HIPAA – the Health Insurance Portability and Accountability Act) as well as CHOP policies and professional ethics set clear boundaries regarding the use and sharing of patient information.

WHAT PATIENT INFORMATION IS CONFIDENTIAL AND MUST BE PROTECTED?
All information about CHOP patients, whether spoken, written, or electronic that:

- May identify an individual;
- Is created or received by CHOP; and/or
- Relates to an individual’s past, present or future physical/mental health or condition, health care or payment for health care.

PRIVACY RULE #1
Handle all patient information you come in contact with at CHOP as confidential and take action to protect it from loss, theft, or unauthorized access or release.
HOW CAN PATIENT INFORMATION BE USED AND SHARED?

Patient information may only be accessed, used or shared when necessary to do your job. Any access, use or sharing of patient information for any other purpose is a violation of Hospital policy and can result in disciplinary action up to and including termination and/or removal from the medical and research staffs, as appropriate, depending on the seriousness of the violation.

Many people at CHOP must access, use, and share patient information every day to perform their job. Knowing for what activities patient information can be used, and shared without patient authorization is essential.

The CHOP “Notice of Privacy Practices” explains how CHOP may use and share the patient’s information. This Notice is given to patients when they first come to CHOP for care.

PRIVACY RULE #2
Only access, use, or share patient information to perform your job.

BELOW IS A HIGH LEVEL OVERVIEW OF CHOP’S NOTICE OF PRIVACY PRACTICES:

Use & Sharing allowed without authorization generally includes:

• To treat patients.
• To obtain payment for services.
• To perform health care operations activities at CHOP such as quality assurance reviews, educate CHOP staff, and investigate and resolve complaints from patient families.
• To comply with laws such as sharing patient information with:
  • Health departments to report infectious diseases or conditions.
  • Child welfare agencies to report suspected child abuse or neglect.
  • Attorneys, judges and law enforcement officers in response to subpoenas and court orders.

Use & Sharing requiring written authorization generally includes:

• Most releases of patient information outside of CHOP such as sharing information directly with a patient’s school, daycare provider or camp.
• Access, use or release of patient information by CHOP staff for a purpose unrelated to treatment, payment or healthcare operations activities or an activity permitted by law.
• Generally the release of highly sensitive information including:
  • Mental health information
  • Substance (drug and alcohol) abuse treatment information
  • HIV/AIDS testing, diagnosis or treatment information
Unless patients or their families have requested otherwise, CHOP may also use and share limited patient information:

- To list individuals in the Hospital’s inpatient directory so visitors and callers can locate them.
- With another individual involved in the patient’s care or payment for care who is not the patient’s parent or legal guardian.
- For CHOP fundraising communications.

**PRIVACY RULE #3**

Know when written authorization is needed from the patient/parent to use and share information and make sure to obtain it.

**PRIVACY RULE #4**

When patient information is accessed, used, or shared for research purposes additional requirements apply.

**PRIVACY RULE #5**

If your job involves releasing patient information, by phone, fax, mail, etc. you need to be familiar with the processes that must be followed to document the information being released to meet the HIPAA accounting for disclosure requirements.

**WHAT RIGHTS DO PATIENTS HAVE WITH RESPECT TO THEIR HEALTH INFORMATION?**

Our Notice of Privacy Practices explains the rights patients have regarding their health information, and explains how they can exercise these rights. These rights include the right to:

- Receive a copy of our Notice of Privacy Practices.
- Look at and obtain a copy of the patient's record.
- Request a change to information in the patient's record.
- Obtain a list of certain disclosures of information made by CHOP from the patient record.
- Request a restriction on how CHOP may use and share the patient’s information.
- Request special confidential communications from CHOP such as to receive phone calls only at home and not at work.
- Revoke a previously signed authorization to share the patient’s information.
- Receive notice from CHOP of a breach of the patient’s information.
- File a privacy complaint with CHOP or directly with the federal government, without being subject to intimidation or retaliation.
PRIVACY RULE #6
Know what rights patients have regarding their health information and ask your manager for guidance when a patient family is trying to exercise one of these rights.

PRIVACY RULE #7
Recognize that adolescent patients under the age of 18 control release of certain information in their record (for example reproductive health care services). As a result, such information cannot be shared by CHOP with a patient’s parent unless the adolescent patient gives CHOP permission to do so. In addition when authorization is required to release such information outside of CHOP to a third party, the authorization of the patient is required. If you work with adolescent patients, be sure to ask your supervisor about special considerations you need to be aware of and follow to avoid unauthorized release of adolescent controlled information.

WHAT IS A PRIVACY BREACH AND HOW CAN I PREVENT ONE?
A privacy breach occurs whenever patient information is seen or heard by someone who is not authorized to see or hear it. It is the responsibility of everyone at CHOP to safeguard patient information to prevent unauthorized individuals from seeing or hearing it.

Remember that patient information comes in many forms. It may be a letter you are faxing to another care provider, a paper document you are handing to a parent, an electronic record you are accessing, or a conversation you are having with a coworker. You must be aware of your environment and actively work to prevent accidental disclosure of patient information. Pay attention to detail by self-checking using STAR (Stop, Think, Act, Review) whenever accessing, releasing, storing or disposing of patient information.

The CHOP Data Protection course will provide you with more specific examples of how the confidentiality of patient information may be put at risk and how you can act to avoid a privacy breach.

PRIVACY RULE #8
You are responsible for taking precautions to keep patient information private and secure to prevent a breach of a patient’s confidentiality.
WHERE TO GO IF YOU HAVE PRIVACY QUESTIONS, CONCERNS OR NEED GUIDANCE?

There are resources available to assist you. You should first bring any privacy concerns or questions to your supervisor for guidance.

You may contact the Office of Compliance and Privacy at PrivacyOffice@email.chop.edu or call 267-426-6044. In addition, resources posted on the Patient Privacy intranet site, including Hospital privacy policies, may address your question; just type PRIVACY or HIPAA in the intranet search box.

You can also report a concern and remain anonymous if you wish by contacting the Hospital’s Compliance Hotline 24 hours a day, 7 days a week, by:
• Phone - 1-866-246-7456 or
• Online - www.mycompliancereport.com (use “CHOP” for the access code).
CHOP does not retaliate against workforce members for reporting incidents.

**PRIVACY RULE #9**
You must report incidents that involve the mishandling of patient information.

**PRIVACY RULE #10**
Remember it is up to YOU to protect our patient’s information.
4 EVERYONE
4 EVERY PROBLEM
4-HELP

Call 4-HELP (215-590-4357) every time you need technical assistance. A ticket request through this line helps us provide the best service. Thanks!

The Children’s Hospital of Philadelphia®
INFORMATION SERVICES

Operations Center - The ticket to good care.

Information Security is your responsibility.

Protect our patients: Secure their confidential data.
WHY FOCUS ON PROTECTING DATA?

Patients and their families come to CHOP to receive world class health care. Providing this level of care requires that we protect confidential information.

Failure to protect confidential information can result in harm to our patients and our institution. Protecting confidential information is required by CHOP policy, state and federal laws, and it is the right thing to do.

It is the responsibility of each of us to follow data protection behaviors to keep confidential information private and secure.

DATA BREACHES HAPPEN IN HEALTHCARE!

A data breach is an incident in which patient information has been seen or heard by an individual not authorized to see or hear it. Data breaches occur whenever the confidentiality of patient information is compromised. Since 2009, more than 24 million people have been affected by healthcare data breaches. In almost half the incidents a lost or stolen laptop, USB drive, external hard drive or paper documents caused the incident. In the majority of cases human error and poor data handling practices were found to be the cause of the incident.
DATA BREACHES HAPPEN AT CHOP

In the past 12 months CHOP notified over 500 patient families that their information was involved in a data breach incident. Two of these incidents involved over 100 patients each. Since 2009 when the data breach notification rule went into effect CHOP has notified close to 2,000 patient families of a data breach that occurred either at CHOP or at one of our vendors. These incidents remind us of the ongoing need to practice data protection behaviors every time we touch patient information to keep our patients’ information private and secure.

DATA BREACHES CAN BE PREVENTED

By following good data security practices the likelihood of a data breach occurring can be greatly reduced. This is where you come in.

Knowledge is the first step.

DATA BREACHES THREATEN OUR MISSION

Failure to protect confidential information can have serious consequences.

Legal and Enforcement Actions: Violations can result in government fines, sanctions, and even criminal charges. Individuals have even been imprisoned for using confidential patient information for personal gain.

Trust and Reputation: When the confidentiality of patient information is compromised, health care organizations must inform those affected, the government and, at times, the media. This can negatively affect an organization’s reputation as well as the public’s trust.

Audits: To date, the federal government has conducted 115 audits of health care organizations, focusing on the protection of patient information with additional audits to occur this year and in the future.

DATA PROTECTION IS NOT OPTIONAL

All staff is required to abide by the laws, regulations, and accreditation standards that have been established to protect a patient’s confidential information.

HIPAA (The Health Insurance Portability and Accountability Act): is a set of regulations that protect the privacy and security of confidential patient information. HIPAA carries stiff penalties for organizations that fail to comply.

HITECH (The Health Information Technology for Economic and Clinical Health Act): is a law that works to protect patient information. This law requires organizations that fail to protect patient information to inform the affected patients, the government, and in some cases, the media.

STATE LAWS: In addition to Federal laws, states like Pennsylvania and New Jersey have their own laws that require organizations who fail to protect the confidential information of patients or consumers to notify those individuals.
THE JOINT COMMISSION: is an organization that accredits all teaching hospitals in the United States and Canada. It has strict requirements for hospitals to keep confidential information safe.

PCI / DSS (Payment Card Industry Data Security Standard): is a standard for organizations that handle credit/debit card information. CHOP must adhere to PCI standards in order to process payment card transactions. Consult with CHOP’s IS department before accepting credit or debit cards as part of a new business process.

MEANINGFUL USE: is the effective use of electronic health records (EHR) and related technology within a health care organization. CHOP needs to show we are using certified EHR technology (such as EPIC) in a secure way.

WHAT DATA DO WE PROTECT?
Confidential Information includes information about CHOP’s patients, members of the CHOP workforce, and the institution itself, whether it is oral, written, or electronic.

PATIENT INFORMATION
Any information that may identify an individual and is created or received by the Hospital and relates to an individual’s past, present, or future physical / mental health or condition, health care or payment for health care. Some examples include:

- Demographics: patient name, initials, address, e-mail address, phone/fax number
- Dates: birth, admission, discharge, death
- Numbers: ID numbers, Social Security numbers, medical record numbers, health plan beneficiary numbers, billing account numbers, vehicle or device numbers, certificate and license numbers
- Unique Characteristics: facial photographs, finger / voice prints, other unique characteristics, codes or numbers that could identify a patient
- Other: web URL, Internet Protocol (IP) address

INSTITUTIONAL INFORMATION
Any information that involves hospital workforce information (e.g., payroll, or other identifiable information), non-public hospital business information, non-public research information, vendor trade secrets, or other confidential hospital information. Some examples include:

- An employee’s Human Resources record
- Payroll records and salary information; employee performance reviews
- Other confidential information that CHOP has about its workforce members (such as social security numbers, driver’s license numbers, financial account information, etc.)
- Non-public Hospital business information (e.g., long range financial plans, written legal advice)
- Non-public research information (e.g., inventions)
- CHOP intellectual property
- Research trial protocol results
- Vendor trade secrets
THE CHILDREN’S HOSPITAL OF PHILADELPHIA

THREATS TO CHOP’S CONFIDENTIAL INFORMATION

The following are some of the threats to the CIA of data at CHOP:

- Storing data on unencrypted devices such as USB flash drives and smart phones
- Communicating CHOP data to an incorrect recipient by hand or by mail, fax, or email
- Failing to secure paper documents during storage, transport, or disposal
- Accessing patient information unrelated to your job
- Responding to a “phishing” email aimed at tricking you into sharing your user ID and password
- Using weak passwords; sharing passwords
- Clicking on links that download viruses / malware to CHOP’s network via inappropriate websites, social networking sites and email from unknown individuals
- Failing or delaying to report a possible security incident

WHAT IS A SECURITY INCIDENT?

A security incident is unauthorized access or attempt to access confidential CHOP information, or interference with an information system such as EPIC.

Security incidents result from:

1. **Unintentional actions** or human errors such as releasing confidential patient information to the wrong party or sharing your user ID and password.

2. **Intentional actions** such as accessing patient or institutional information unrelated to your job responsibilities.

3. **Failing to practice** basic data protection behaviors that protect the confidentiality, integrity, or availability of CHOP information.

Security incidents involving patient or workforce member information can easily lead to a data breach which may require notification to affected individuals, the media, and the Office for Civil Rights (OCR).

SECURITY IS ALL ABOUT C.I.A.

**Confidentiality:**
Protecting information from unauthorized access or disclosure.

**Integrity:**
Protecting information from unintended modification, destruction, or deletion either maliciously or accidentally.

**Availability:**
Maintaining timely and reliable access to information.
8 BEHAVIORS FOR PROTECTING DATA

1. I will not access systems or information I do not need to perform my job. To do so would violate the Access Control of Information Systems Policy.

2. I will alert my manager if I have access to information or systems that is not required to perform my job.

3. I will not access, share, or release confidential information without clearly understanding and complying with all relevant Hospital policies.

4. I will not share my CHOP user ID or password or provide it in response to an email request, even one that claims to come from the IS Service Desk.

5. I will keep portable devices and paper documents containing confidential information secure.

6. I will not allow anyone to use my ID badge.

7. I will not prop doors open or provide physical access to secure areas to anyone unauthorized to enter those areas.

8. I will not store CHOP confidential information on any non-CHOP-managed electronic devices (personal laptop, home computer, smart phone) or any unencrypted USB flash drive/external storage device or on any unauthorized “cloud storage” or websites.

PASSWORDS
Review the list below of most commonly used passwords that place data at risk:

<table>
<thead>
<tr>
<th>Password</th>
<th>Welcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>123456</td>
<td>shadow</td>
</tr>
<tr>
<td>12345678</td>
<td>ashley</td>
</tr>
<tr>
<td>abc123</td>
<td>football</td>
</tr>
<tr>
<td>qwerty</td>
<td>Jesus</td>
</tr>
<tr>
<td>monkey</td>
<td>sunshine</td>
</tr>
<tr>
<td>letmein</td>
<td>michael</td>
</tr>
<tr>
<td>dragon</td>
<td>Mustang</td>
</tr>
</tbody>
</table>

TO PROTECT CONFIDENTIAL INFORMATION, CHOP HAS MINIMUM STANDARDS FOR WHAT MAKES A STRONG PASSWORD.

Your CHOP password has to:

• Be a combination of numbers, upper/lower case letters, and symbols
• Have a minimum of eight characters
• Be unique; it can be two or more words together to form a passphrase (e.g., “data protection is for everyone at CHOP” = dpis4e1@CHOP)

Your password to any CHOP system or device SHOULD NOT: be written down or shared with anyone under any circumstances.
CHOP HAS A SET OF PRACTICAL REQUIREMENTS FOR THE STORAGE, HANDLING, TRANSPORT, AND DISPOSAL OF CONFIDENTIAL INFORMATION.

1. Save electronic information to a CHOP network drive (or the research SAN) instead of your CHOP computer hard drive. Network drives are secure and backed up to reduce the potential of loss of data. For example, storing confidential information on a hard (C:) drive threatens the CIA and security of the data.

2. Use only CHOP-managed encrypted portable devices such as an encrypted laptop that is secured with a strong password. If a USB flash drive must be used to store confidential data make sure it is encrypted by plugging it into a CHOP windows PC and following the prompts. Encryption is a security measure of encoding information in a way so that it can only be read by an authorized user. Eavesdroppers or hackers cannot read or understand it if the device is lost or stolen. CHOP-managed portable devices are equipped with encryption software.

3. Ensure safeguards are in place to prevent the loss, theft, damage, or unauthorized access of paper records and documents. Safeguards include locking file cabinets, limiting access to file rooms, using locked transport cases, using fax cover sheets, keep logs to track documents, proper disposal using shredding or "confidential trash", and reducing risk of fire or flooding.

4. Use a CHOP courier to transport paper documents containing confidential information between CHOP locations or use a locked transport case and take steps to protect it from loss or theft. Such measures include not leaving the locked bag unattended in a parked car or a publicly accessible area.

5. Always type [send secure] in the subject line of an email to encrypt it before sending confidential information outside of CHOP. Note: a password protected file attachment to an unencrypted email is NOT secure.

6. Use VPN (Virtual Private Network) software and your access token for remote access to a CHOP system, network drive, or Research SAN using a CHOP-managed laptop.

7. For remote access to CHOPone, Kronos, and limited CHOP Intranet while working away from CHOP, use the Connect to CHOP website (https://connect.chop.edu) and your CHOP user name and password. If you have an access token, use when requested.

8. CHOP policy prohibits storage of confidential information on non-CHOP-managed devices such as your personal home computer. Deleting files does not permanently remove the file from a device. Contact the IS Service Desk for assistance with permanently deleting files.

9. Use the correct procedures for disposing of documents and equipment/devices that may contain confidential information. Call the IS Service Desk to schedule for the devices to be picked up and disposed of securely. Make use of shredders or confidential waste bins for paper disposal.

10. Use a 2-step patient identifier to assure that the right confidential information is released to an authorized person at the correct fax number and mailing address or in-person. A 2-step identifier includes verifying at least two data points to assure that when you release confidential information, it is going to the right person at the right place.

11. Devices that are CHOP-managed, including CHOP-issued laptops and personal devices enrolled in the Mobile Device Management program, should be secured against theft or loss at all times. They should never be left unattended, shared, or loaned to unauthorized individuals. They should be secured against accidental damage.
12. If traveling with portable devices, keep them on your person at all times. CHOP-managed devices should be placed in carry-on luggage when traveling by air (not checked) and should never be left in an unoccupied car or left unattended in a public area.

13. Never use an unencrypted USB flash drive to store confidential information. For help assuring that your USB flash drive is encrypted, contact the IS Service Desk.

14. Never access patient records or any other confidential information if it is not necessary to do your job. CHOP monitors access to secure systems and inappropriate access may result in disciplinary action.

REPORT IT!
How do you report possible security incidents or data breaches involving CHOP confidential information and/or devices? Follow these guidelines for reporting an actual or suspected security incident.

**Electronic Data or Devices:**
Call the IS Service Desk at 215-590-4357 or 4-HELP. Also let your manager know about it.

**All other incidents:**
Contact the Privacy Office at (267) 426-6036. PrivacyOffice@email.chop.edu.

If you wish to remain anonymous:
Use CHOP’s Compliance Hotline at 1-866-246-7456.
Or visit www.mycompliancereport.com and use CHOP as the access ID.

CHOP’s data protection efforts are jointly supported and championed by the Information Security Department and the Office of Compliance and Privacy.

Policies, guidelines and other helpful information are available on CHOP’s intranet under Information Security and Privacy.

Every year 6.6 million children die unnecessarily around the world. Learn how you can contribute to the CHOP Global Health Center activities.

**LEARN. ENGAGE. HOPE.**

Visit us on the Employee Intranet at http://intranet.chop.edu/sites/international medicine/global-health
RULES OF CONDUCT

Rules and regulations are essential to the efficient operation of the Hospital. We recognize that self-discipline and proper standards of conduct are necessary to protect the health and safety of all employees and staff as well as patients and the public, to maintain uninterrupted service, and to protect the Hospital’s good will as well as property. As a general guiding principle, The Children’s Hospital of Philadelphia seeks to treat all employees and staff fairly in the application of disciplinary procedures.

The sincere desire of management is to help you in every way so that you may go forward to a successful future. However, breaches of the established rules will be dealt with firmly under a uniform policy, which applies to all departments and individuals.

IDENTIFICATION AND NAME BADGES

Employees are required to wear name badges while on duty unless they interfere with the performance of duty (to be determined by appropriate supervisor). The badges must be worn so that the employee’s name is clearly visible to patients and visitors. Employee Identification badges will be issued on the first day of the assignment. Badges are to be worn at all times. Badges are to be returned to your supervisor on your last day of work.

ATTENDANCE/PUNCTUALITY

Good attendance and punctuality are necessary for a work environment to be productive. Please be punctual at all times. If, for some reason, you must arrive late or be absent, it is YOUR responsibility to inform your CHOP supervisor no later than two hours before your start time.

NON-SMOKING POLICY

Because of our concerns for the health of our patients, staff and visitors, Children’s Hospital is a smoke-free institution.

PERSONAL PHONE CALLS

No personal phone calls are to be made or received during working hours. There are public telephones throughout the Hospital facilities. To call locations within the Hospital, use any beige house phone and dial the extension. No personal calls are permitted while at the residence of a Hospital patient. Emergency calls should only be placed with express permission from the location’s owner.
 SUSPECTED CHILD ABUSE, NEGLECT & FAMILY VIOLENCE

WHAT DO THE STATISTICS SAY?

- In 80 percent of suspected child abuse or neglect cases, the perpetrator is a family member.

- The highest child abuse rates are in the 0-3 year age group.

- Medically fragile children are an especially vulnerable population.

- Women who are in abusive relationships are at a higher risk for abuse during a pregnancy.

WHAT IS CHILD NEGLECT?

Child neglect, a very common type of child abuse, is a pattern of failing to provide for a child’s basic needs, whether it be adequate food, clothing, hygiene, medical care or supervision. Child neglect is not always easy to spot. Sometimes, a parent might become physically or mentally unable to care for a child, such as with a serious injury, untreated depression, or anxiety.

WHAT IS FAMILY VIOLENCE?

Family Violence can be defined as a pattern of behavior in any relationship that is used to gain or maintain power and control over an intimate partner. Abuse is physical, sexual, emotional, economic or psychological.

Actions or threats actions that influence another person. This includes any behaviors that frighten, intimidate, terrorize, manipulate, hurt, humiliate, blame, injure or wound someone.

Red Flags: Child (or parent) appears fearful, staff observes visible bruises, marks, scars on child or parent. Parent does not remove sunglasses once inside CHOP. Parent appears to be under the influence of drugs and/or alcohol.

WHO ARE MANDATED REPORTERS?

People “who, in the course of their employment, occupation or practice of their profession, come into contact with children shall report or cause a report to be made” Mandated reporters are staff that have direct patient contact (e.g. physicians, nurses, social workers, admissions and discharge planning workers).

While administrative staff are not mandated reporters, they do have the responsibility to provide “care in a safe and secure setting free from verbal or physical abuse.” (Patient and Family Bill of Rights and Responsibilities)
WHAT TO DO IF YOU SEE SOMETHING THAT’S JUST NOT OK?

Your intervention is to contact the appropriate staff. This is what the family and child need from you to make sure that they are treated with privacy, respect and consideration for any Hospital action that may impact them. Remember, we all lose our cool sometimes. Speak in a tone that communicates respect and acknowledge that sometimes, situations like coming to the Hospital can feel overwhelming.

The responding Social Work representative, SCAN team member or security officer will determine what support or resources the family needs. The SCAN (Suspected Child Abuse and Neglect) team is a multidisciplinary group that evaluates suspected cases of child abuse and neglect. Team members include: physicians, social workers, psychologists, other specialists as needed.

If it appears very serious and someone is in immediate danger of injury contact Security at ext 4-5500 or call 911 at the ambulatory sites.

In situations where the threat is less immediate at the Main Hospital call:
- Social Work: ext #4-2072 (9 a.m. - 5 p.m.); beeper 10048 (after hours)
- SCAN team: beeper
- In ambulatory settings, alert a social worker, physician or nurse

While waiting for assistance, words to use could be: “I see you are having a difficult time with your child, can I sit with you for a few minutes?” or “Is there anyone or anything I can get to help?”

REPORT CHILD ABUSE OR NEGLECT

If the child is in immediate danger; call 911 first.
PA: 1-800-932-0313
NJ: 1-877-652-2873
DE: 1-800-292-9582

RESOURCES FOR CAREGIVERS SEEKING TO GET OUT OF AN ABUSIVE RELATIONSHIP

Lutheran Settlement House
1340 Frankford Ave., Phila., PA 19125
215-360-3547 (cell); 215-426-8610 x279 (office); Pager: 79953

Philadelphia Domestic Violence Hotline
866-SAFE-014
WHAT IS CULTURAL EFFECTIVENESS?

The field of culturally and linguistically competent care has recently emerged as a strategy to address disparities in access to and provision of healthcare services. Cultural competence in healthcare is the ability of organizations to provide care to patients with diverse beliefs, values, and behaviors.

It is the skill you use to work comfortably and well with all patients and families whatever their cultural, linguistic, dietary or spiritual preferences. It is the essence of Family Centered Care: considering each individual patient and family’s preferences and needs.

WHY DOES CULTURAL EFFECTIVENESS MATTER?

Delivering care to patients and families in a culturally effective manner benefits everyone. It increases patient satisfaction, patient safety, patient compliance and may even improve patient health outcomes. It improves your job performance and can increase your job satisfaction. It will help maintain our standing as the best Children’s Hospital in the United States.

WHAT DO I NEED TO KNOW TO BECOME CULTURALLY EFFECTIVE?

While knowing some general information about different cultural groups may be helpful in figuring out how to approach a patient or family, it does not tell you everything you need to know about any particular patient or family. For this you need to know how to ask respectful questions and listen carefully to the answers. Just because a patient or family identifies themselves as being part of a cultural, ethnic, racial, regional, or religious group, does not mean that they subscribe to or follow all of that group’s beliefs.

Skillsoft Knowledge Centers: Support your professional development throughout your career at CHOP.

1. Log into LearningLink and at the bottom of your learner home page, click CHOP Leadership Institute (CLI) under the Departments heading.

2. Click “Skillsoft” from the left-hand pane and then select the correct Knowledge Center for your role and needs.
PENNSYLVANIA’S SAFE HAVEN LAW

WHAT IS THE SAFE HAVEN LAW?
The law allows parents to relinquish newborns up to 28 days old at any hospital in the state of Pennsylvania without the fear of criminal prosecution as long as the baby has not been harmed. Babies can be left with any hospital staff member.

WHY IS SAFE HAVEN IMPORTANT?
Safe Haven gives parents a safe, legal and confidential alternative to abandoning their baby. Pennsylvania is one of 48 states that has passed a Safe Haven Law.

WHY IS SAFE HAVEN NECESSARY?
Young girls and women who might be hiding their pregnancies or aren’t ready to be mothers are often scared, and don’t know where to turn. Out of fear or shame, some mothers abandon their baby hours after birth. Safe Haven gives parents an option that is both safe for their child and confidential.

YOUR ROLE IN PROVIDING A SAFE HAVEN
If you are approached by someone asking you to take a newborn, ask only the following questions:

A. Is there any family medical history we need to know about? Would you be willing to complete a brief medical history form? If the person is willing to do this take him/her to the ED.

B. Did you observe any problems during birth?

C. Do you need medical care for yourself?

Upon taking a newborn, staff may share: “We will take good care of the baby” if they feel the need say something.

Take the newborn to the Emergency Department.

If you are not a clinical employee, approach the first registered nurse or physician and transfer the newborn to that person.

Additional information is available on the intranet by searching “Safe Haven”.

EMERGENCY DEPARTMENT PROCEDURES:

1. The ED attending physician will assess the newborn and assume protective custody of the newborn.

2. If the parent is willing to complete a medical history questionnaire the form is available to be printed through Standard Registry.

3. The Emergency Department charge nurse will notify the County Children and Youth Services, Department of Human Services 215-683-6100.

4. The ED charge nurse will notify the Director of Nursing on-call, Security, and Risk Management.

5. The ED social worker will notify the Department of Human Services at 215-683-6100 and the Philadelphia police at 911.

6. The ED Social Worker will coordinate the completion of the birth certificate for the newborn.
WORKPLACE VIOLENCE

WHAT IS WORKPLACE VIOLENCE?
The National Institute for Occupational Safety and Health (NIOSH) defines workplace violence as any physical assault, threatening behavior or verbal abuse occurring in the workplace. Violence includes overt and covert behaviors ranging in aggressiveness from verbal harassment to murder.

The Children’s Hospital of Philadelphia has a zero tolerance policy for acts of violence or threats of violence in the workplace. It is the responsibility of all employees of the CHOP community to report any direct or perceived threats or other matters that the individual believes may result in harm to persons or property in the workplace.

BE AWARE OF YOUR SURROUNDINGS
You should be mindful of individuals who display these Behaviors of Concern:

- Obsessions
- Blaming others
- Holding grudges
- Prolonged anger
- Extreme anxiety or sadness
- Hypersensitivity to criticism
- Angry outbursts
- Intimidation & Bullying
- Prolonged sadness / depression
- Signs of domestic violence
- Sudden changes in behavior
- Suddenly distancing themselves from others

MYTHS OF WORKPLACE VIOLENCE
- “It happened out of the blue...”
- “He just snapped...”
- “If left alone, events will resolve themselves”
- “We can’t do anything to stop it...”
- “It couldn’t happen here...”

HOW TO REPORT BEHAVIORS OF CONCERN
Immediately report concerns to:
- Security - extension 4-5500
- Your Manager or Supervisor
- Human Resources
- CHOP’s EAP (Employee Assistance Program)

WORK FROM A MINDSET OF AWARENESS
- Don’t ignore Behaviors of Concern
- They will not go away and typically escalate
- Learn how to recognize and diffuse potentially violent situations

BASIC STATISTICS
According to a 2010 report, healthcare institutions are confronting steadily increasing rates of crime, including violent crimes such as assault, rape, and homicide.

-(Joint Commission’s Sentinel Event Database)

These statistics show aggressive crime. Employees should be aware that less aggressive behaviors may be even more common and also fall under CHOP’s zero tolerance policy.
ARE YOU PREPARED?

I thankfully, many CHOP employees don’t have a lot of experience with fire. Being prepared and knowing what to expect can be life-saving! In the event of fire, knowing how to respond can be life-saving.

Fire is HOT! Generally speaking the temperature of a fire at ignition can be above 900 degrees Fahrenheit and will increase exponentially from there every minute that it burns.

Fire is FAST! Consumers are often unaware that household items such as furnishings and electronics and are made of highly combustible materials that contain petroleum based products such as plastics and polyurethane foam. These items can ignite and burn rapidly and engulf a room in minutes.

Fire is DEADLY! Fire produces smoke and toxic gases that are equally or more deadly as the heat and flames. In a fire, the majority of injuries and deaths occur due to exposure to hazardous smoke and toxic gasses released during the fire and not actual burns. In addition, smoke often obscures vision and thereby decreases the ability of fire victims to escape.
WHAT IS FIRE?

Fire is the rapid oxidation of a material in the exothermic chemical process of combustion, releasing heat, light, and various reaction products.

WHY IS THE THREAT OF FIRE SO SIGNIFICANT IN HEALTHCARE SETTINGS?

Fire Prevention – fortunately, fires are preventable with the effort made by every CHOP employee to recognize the more common fire hazards that exist in healthcare and business settings and to report concerns to one’s manager/supervisor, security, and the office of Environmental Health and Safety.

Fire Safety – the ability to use CHOP’s fire safety tools and procedures to help yourself and others in the event of a fire. Employees should know the specific procedures for their work area/unit/building; be able to locate the nearest fire stair tower; and locate nearby fire extinguishers. Speak with your manager and go to the intranet to see fire plans for your work area.

Fire procedures vary by location and are based on the type of patient care being provided. Be proactive and learn the specifics for your site and building type.

• How to use RACE for your work area? (Rescue, Alarm, Contain, Evacuate or Defend in Place)
• What will the alarm and overhead announcements sound like for your area?
• How does your specific floor/building evacuate? Is it a staged evacuation and what can you expect?
• Where is nearest stair tower or building exit?
• Where is the nearest pull station for activating a fire alarm?
• Where is the nearest fire extinguisher?
• Fire Plans are available for all CHOP locations and are located on the Environmental Health and Safety page on the CHOP intranet site.

The presence of oxygen, which accelerates a fire, and the challenge of evacuating our sickest patients are two factors that make hospital fires particularly dangerous.
WHAT ARE THE COMMON FIRE HAZARDS AT CHOP?

While fire or smoke events are rare at CHOP they do occur. Here are a few examples:

• Cooking / Catering – Improper or unauthorized use of open flame (sterno) or unattended cooking
• Construction Related Activities – Improper hot work procedures such as welding
• Electrical Equipment Malfunction – Overloading of electrical circuits or power strips
• Smoking – Smoking in unauthorized areas such as roofs or mechanical areas

USING R.A.C.E.

WHAT IS R.A.C.E.? R.A.C.E. is an all hazard approach to emergency situations. It is used at all CHOP locations and serves as a memory aid that helps employees recall the correct steps to use during a fire or other emergency situation.

RESCUE: RESCUE ANYONE FROM IMMEDIATE DANGER
ALARM: ALERT SECURITY OR THE FIRE DEPARTMENT
CONTAIN: CLOSE DOORS TO CONTAIN THE THREAT
EXTINGUISH / EVACUATE: EVACUATE YOURSELF TO SAFETY

HOW DOES R.A.C.E. WORK AT MY LOCATION?

MAIN CAMPUS - HEALTHCARE SETTING (MAIN BUILDING, SEASHORE HOUSE, WOOD CENTER)

WHAT TO EXPECT: OVERHEAD VERBAL ANNOUNCEMENTS:
When a fire alarm is activated at Main Hospital, Wood Center or Seashore House, you will hear one or more of the following:

• Condition Red – suspected fire or fire drill
• Condition White – a confirmed fire or smoke event
• Condition Green - all clear

Unit procedures may vary based on the type of care provided to patients and other unit specific conditions. Fire plans include instructions for what to do when the alarm sounds and are based on the location of the alarm condition:

1) The fire is not in the unit - When the fire is not in the unit, “Defend in Place”. Precautions are taken such as closing all doors on the unit and clearing corridors. Staff are reminded to listen for instructions that will be provided by a Charge Nurse, Nurse Supervisor or Department Supervisor on the next steps. Staff should begin planning for a potential unit/department evacuation or receiving of patients.

2) The fire is on the unit - When the fire is within the unit, the steps of R.A.C.E. are followed. Individual fire plans document the specific instructions for “who is responsible for what” (actions and communications) when a fire is occurring. In many instances, everyone has a responsibility: moving patient charts, identifying patients, or giving oxygen shut off orders.
HOW DOES R.A.C.E. WORK AT MY LOCATION? (CONTINUED)
MAIN CAMPUS OR DOWNTOWN HIGH-RISE BUILDINGS (ABRAMSON, COLKET, WANAMAKER, 3535)

WHAT TO EXPECT: OVERHEAD VERBAL ANNOUNCEMENTS
When a fire alarm is activated at one of our high rise buildings a “staged evacuation” is employed:

• Listen to overhead announcements which detail evacuation instructions.
• In general, for locations off of the Main Campus, staff should follow R.A.C.E. and notify the Fire Department by pulling a fire alarm pull station or calling 911.
• CHOP locations have Fire Wardens/ Site Managers. Know who this person(s) is at your location.
• Staff should follow the fire alarm announcements - Listen and follow instructions. There may be unique instructions depending on the location and nature of the fire.
• When evacuating use stair towers, never use elevators.
• Consult your building’s fire plan on the CHOP Intranet.

CHOP BUSINESS AND AMBULATORY CARE SATELLITE LOCATIONS

WHAT TO EXPECT: OVERHEAD ALARM
When a fire alarm is activated at one of our satellite locations you should immediately evacuate the building and head to your predetermined meeting location.

*Special procedures for surgical procedures (sedated patients and patients undergoing procedures) should be evacuated only when a fire is confirmed. Until a fire is confirmed, surgical staff should standby for further information, preparing for evacuation procedures if necessary.

• Staff should follow R.A.C.E., evacuate and notify the Fire Department by pulling a fire alarm pull station or calling 911.
• CHOP locations have Fire Wardens / Site Managers. Know who this person(s) is at your location.
• When evacuating use stair towers, never use elevators.
• Consult your building’s fire plan on the CHOP Intranet.
CHOOSING AND USING A FIRE EXTINGUISHER

Fire extinguishers should only be used if the fire is small and you have a clear path of escape. Trying to tackle a fire on your own can be dangerous and cause you to use up valuable time when help is needed elsewhere; when in doubt, use R.A.C.E. as your first line of defense against fire. There are three common types of fire extinguishers that you will see in the workplace. Pay special attention to the pictograms located on each extinguisher; these give you general information as to what type of fire each extinguisher is capable of fighting.

WATER EXTINGUISHERS

- can be used for paper, wood, cloth, and plastic fires; filled with air-pressurized water.
- Class A

DRY CHEMICAL EXTINGUISHERS

- can be used on all types of fires; filled with powder and pressurized with nitrogen.
- Combination Class ABC

CARBON DIOXIDE EXTINGUISHERS

- can be used for electrical and flammable liquids fires; contain carbon dioxide, a non-flammable gas.
- Combination Class B C

Remember the acronym PASS if you encounter a small fire and are able to quickly access a fire extinguisher. PASS should help you recall the correct steps for using the extinguisher during an emergency. Follow these steps for PASS:

P - pull the pin that locks the extinguisher handle to release.
A - aim the nozzle of the extinguisher at the base of the fire. Do not aim it at the top of the fire.
S - squeeze the handle to release the substance inside the extinguisher.
S - sweep the extinguisher from side to side at the base of the fire in order to coat the area with the extinguishing substance.
FIRE PREVENTION TECHNIQUES

**DO NOT**

leave appliances unattended!

US fire departments respond to an average of 7,000 home structure fires per year in which a microwave oven was involved in ignition. These fires caused an annual average of two civilian deaths, 140 civilian injuries, and $22 million in direct property damage (www.NFPA.org). Ensure that you are reading the package labels before setting your microwave time; never leave a microwave unattended while it is operating.

prop open doors!

Keep doors closed! Many doors are fire-rated to prevent the travel of fire and smoke from one area to another. Door closure devices are intended to automatically close doors. With closed doors, smoke and fire can be contained long enough to allow people to escape if needed.

**COMMON HAZARDS AND WAYS TO PREVENT THEM**

**Heating Equipment:** the use of portable space heaters and fans is prohibited. If you have heating or air conditioning issues contact facilities or your administrator.

**Electrical:** extension cord and multiple outlet strip misuse is the most common cause of office fires! Make sure cords and plugs are in good condition; don’t overload electrical circuits, outlets or power-strips.

**Cooking Equipment:** microwave ovens and coffee makers are the only approved devices allowable for cooking. Toasters, toaster ovens, hot plates, sternos, electric grills and stoves used for food warming are prohibited devices. When cooking or reheating food items pay special attention to package directed cook times and never walk away from a microwave while it is in operation!

**Excessive storage:** keep storage of combustible materials to a minimum. Maintain proper clearance as stored materials may obstruct exits, walkways, electrical panels, or sprinklers. Ensure materials and equipment do not impede fire safety devices or passageways.

**Smoking:** is prohibited on CHOP owned property. Obey smoking rules and “No Smoking” signs.

**Flammable Liquid:** storage and handling: flammable liquids, such as alcohol hand gel and solvents, can lead to dangerous “flash” fires. Store and handle liquid chemicals properly and report or clean up spills promptly.

**Spontaneous Combustion:** improper storage of oily rags, chemicals or leaves can lead to spontaneous combustion. Place oily rags in metal containers with lids and remove daily.
THE EMPLOYEE WELLNESS OFFICE
Stop by room 2484 in Main and learn about available services to improve your health and well-being.
This story answers the question: Why? Abducted as an infant, Carlina was just 19 days old in 1987 when she developed a fever and her parents brought her to Harlem Hospital. There, authorities say, they were comforted by a woman posing as a nurse. They left the hospital, but when they returned, their baby was gone.

For the next 23 years, the grief-stricken parents mourned the loss of their daughter, expressing they had lost a piece of themselves. Walking down a street, they’d spot a parent strolling with a child and wonder if the baby could be theirs.

In January of 2011, Carlina (renamed Nejdra Nance) was reunited with her parents and according to FBI, the woman accused of kidnapping the baby and posing as her mother for 23 years, admitted to the crime claiming she was unable to have a child of her own.

Stories like this are rare but help us see the importance of being aware of patient security and how to prevent missing children from our facilities.

Our commitment to being the safest children’s hospital means that patients are secure in our facilities. All employees are responsible for ensuring children do not leave our facilities without our knowledge or without following correct procedures. The CODE AMBER procedure instructs employees at the Main Hospital campus on how to respond in the event a patient is found “missing” from the Hospital due to elopement or abduction. Prevention measures are part of this program. When a CODE AMBER notification goes out, consider checking areas where a patient might elope to: stair-towers, playrooms, cafeterias, family lounges, Connelly Center, etc.
ELOPEMENT
Elopement is when a patient leaves the Hospital without notification to Hospital staff and before one’s scheduled discharge. Example of elopement: patients who may walk/ run away.

RISK FACTORS:
• Patients who lack understanding or insight into the importance of remaining in the hospital
• Patients who talk about leaving the hospital
• Patients who are angry, anxious or upset
• Patients with a head injury or neurological disorder who exhibit poor impulse control and/or behavioral outbursts
• Patients with a history of running away from home/hospitals/school

ABDUCTION
Abduction is the unlawful removal of a patient from the Hospital against his/her will by someone other than the Patient’s Representative. Example of abduction: A stranger attempts to leave the building with someone else’s child.

RISK FACTORS:
• Patients with social or family issues
• Infants younger than 6 months of age
• Patients awaiting foster placement
• Patient where parental custody is in dispute

Insist on identification: patients, visitors including contractors, and employees should have proper identification at all times.

Do not make exceptions.
PREVENTION
General Safety Measures include: patient transport procedures, patient monitoring, identification, and security officers.

TRANSPORTATION
• Proper ID is required to transport patients.
• When a patient is moved to another location, parents are encouraged to accompany them.
• Infants and young children are transported one at a time using appropriate conveyance, such as a bassinet, carriage, or stroller.
• Patients are never carried during transport.
• Patients are never left unsupervised in any areas of the Hospital.

PATIENT MONITORING
• Patients under the age of 18 should be accompanied by a staff member, hospital volunteer or an adult family member when off the patient unit.
• Hospital staff and parents notify the nurse when leaving patient care area with a patient. Exceptions require planning and discussion with the patient/family and the health care team.
• Infant to 3 months, a complete physical assessment of the baby is documented in the medical record, including unique physical characteristics or findings, such as birthmarks or skin tags.
• In outpatient areas, parents/guardians should not leave children unattended while in the waiting room or relinquish that duty to others.

IDENTIFICATION
These are some of the more common measures taken to make sure all people in our buildings are identified and have a rightful purpose.

• Employee ID Badges: All employees wear a CHOP identification badge at all times. Children are only released into the care of employees with badges.

• Parent/Visitor ID: Parents and visitors, over the age of 18, are required to wear hospital-issued identification. The identification wristbands or parent pass must be worn at all times at the hospital.

YOUR ROLE: ABDUCTION PREVENTION
If a patient is at high risk for abduction:
1. Do not place infants in rooms physically located next to stairwells or elevators.
2. Children involved with custody or abuse issues should receive greatest priority for this room placement.
3. Security and Social Work should be notified of their high-risk status.
4. Patient is placed on constant observation.

REFLECT AND RESOLVE
If you see a patient that isn’t with a staff member or adult, ask if they need help finding something. Also, be aware of door alarms. If an alarm is active; check the door and contact Security at 4-5500.
YOUR ROLE: RESPONDING TO ELOPEMENT

A patient verbalizes intent or you suspect a patient might leave:
• Place on Constant Observation
• Assess elopement risk
• Use resources
• Develop a plan to prevent elopement
• Notify Security with description of patient and potential for patient elopement

A patient attempts to leave the unit / Hospital:
• Place on Constant Observation
• Talk to patient and provide age-appropriate direction regarding what they must do
• Contact Security if patient continues to attempt to leave

A patient attempts to leave the CHOP campus:
• Pursue patient to Hospital/campus boundaries
• Attempt to escort back to building
• Supervise until preventive measures are in place.
• Contact Security, treatment team, and family/guardian

YOUR ROLE: ABDUCTION EMERGENCY

A patient is being taken from the unit/hospital or campus:
1. “STOP!”: Make a verbal effort to stop the abductor
2. Alert: Immediately call Security @ 45500, communicate fire tower and brief description of abductor and patient
3. Follow: maintain a visual on the child/abductor until Security arrives.  KEEP YOUR DISTANCE!

WHEN CODE AMBER GOES INTO EFFECT:

Level 1 of the protocol: all staff are notified via ASCOM phones by the Security Command Center of the description of the patient and last known location.

What you do: Report a child missing to Security immediately at extension 4-5500.

What will happen: Command Center monitors cameras/alarm, Unit/area searched by Security and staff, main entrances/exits blocked, staff work together to determine if abduction or elopement has occurred, Unit/area staff is interviewed; inquiry regarding visitors to the missing patient.

Level 2 of the protocol: At this level we will be calling 911 and cordoning off the room for a police investigation. All communication to staff will be handled in Level 1 of the protocol.
Bloodborne pathogens are microorganisms found in human blood and other human bodily fluids. Without proper knowledge of procedures, life threatening infections can be transferred from person to person.

The most common infections occurring from bloodborne pathogen exposure are Hepatitis B, Hepatitis C, and Human Immunodeficiency Virus (HIV).

Why do you need to know this? Anyone working with patients, patient surroundings, or blood/body fluids may be at risk even if you do not perform direct patient care!
**ARE YOU AT RISK?**

Even if your risk seems low, you can be exposed and suffer the long-term consequences of a bloodborne pathogen infection. The physical locations where exposure occurs most often are patient rooms and operating rooms. The job category incurring the highest rate of exposure is nursing. However, all staff should be alert to the risk and take the necessary precautions.

**WHAT ARE THE MOST NOTABLE BLOODBORNE PATHOGENS?**

**HEPATITIS B**

Is an infection of the liver caused by the hepatitis B virus (HBV). It can lead to serious problems such as liver cancer or chronic liver disease.

*How is it spread?* HBV is spread by direct contact with infected blood and body fluids. HBV can survive in dried blood on surface up to 7 days.

*What are its symptoms?* Many people infected with HBV have no symptoms. Others may have symptoms that include fatigue, poor appetite, fever, vomiting, dark urine or jaundice (a yellowing of the skin and whites of the eyes).

*Is there a vaccine?* The Hepatitis B vaccine is a safe, effective series of three shots and is recommended for all healthcare workers who have contact with blood and bodily fluids. The vaccine is available free of charge through CHOP's Occupational Health Department (OHD), x 4-1928.

---

Distribution of occupational transmission of HIV among health care workers by occupation, 1981-2002. Among the documented cases of HIV following occupational exposure, 84% resulted from percutaneous exposure (Source: CDC [2003])
HEPATITIS C
Is a liver disease caused by infection with the hepatitis C virus (HCV). It can lead to serious problems, such as liver disease and liver failure.

How is it spread? HCV is spread by direct contact with infected blood and bodily fluids. This occurs most commonly through needle sticks. The risk of getting HCV is no greater in healthcare workers than in the general population.

What are its symptoms? The most common symptom of HCV infection is extreme fatigue (tiredness), although many people have no symptoms.

Is there a vaccine? There is no vaccine to prevent HCV infection. Prevention and disease treatment are the only options.

HUMAN IMMUNODEFICIENCY VIRUS (HIV)
Is a virus that causes Acquired Immunodeficiency Syndrome (AIDS). The virus attacks the body’s immune system, eventually leaving it unable to fight infection.

How is it spread? HIV is spread by direct contact with infected blood and body fluids. However, HIV is much less contagious than Hepatitis B.

What are its symptoms? When first infected with HIV, there may be symptoms of fever, headache, fatigue, muscle aches, rash or swollen glands.

Is there a vaccine? There is no vaccine to prevent HIV infection. However, potent drug therapy has been successful in preventing progression or prolonging the time it takes to develop AIDS.

The human body fluids that contain bloodborne pathogens are: Blood and Other potentially infectious fluids (OPIF).

Any human body fluid containing visible blood; semen; vaginal secretions; cerebral spinal fluid; fluids surrounding internal organs (fluid in the sac of the heart), the joints, or a fetus (amniotic fluid)

The human body fluids that do not carry BBP unless mixed with blood are: Sweat, tears, urine, vomit, stool, saliva and sputum.

COMMON EXPOSURE METHODS
• Needle stick injuries
• Cuts from scalpels, sutures, sharp objects contaminated with blood
• Splashes to the eyes, nose or mouth
• Contact with broken, chapped or cut skin

COMMON TRANSMISSION METHODS
• Mucous membranes (eyes, nose, mouth)
• Into bloodstream through scraped, cut, abraded or punctured skin
• Sexual transmission
• Transmission to a child before/during birth from infected mother
HOW DO I PREVENT EXPOSURE?

Use Safety Behaviors
CHOP has standards (controls) in place to protect employees from bloodborne pathogens exposure. In addition, employees are always encouraged to use Safety Behaviors every day. In this instance, Safety Behaviors would include:

1. Practicing your work with a questioning attitude
2. Staying alert to problems with equipment, processes, or other environmental factors
3. Communicating questions or concerns you may have relating to devices or general bloodborne pathogen safety

USE PERSONAL PROTECTIVE EQUIPMENT (PPE)
Select PPE based on your expected exposure. Anticipate the procedures/tasks you will be performing as well as the standard precautions specified in any patient area. PPE at CHOP includes but is not limited to:

- Gowns and gloves protect your skin from exposure; gowns prevent soiling of your clothes when your work may involve splashes or sprays of blood and bodily fluids. Never reuse disposable gloves.
- Wear eye protection and a mask to protect the mucous membranes of your eyes, nose and mouth when work may involve splashes or a spray of blood or bodily fluids.

PRACTICE CORRECT HAND HYGIENE:

1. Rub hands palm to palm;
2. Right palm over left dorsum with interlaced fingers and vice versa;
3. Palm to palm with fingers interlaced;
4. Backs of fingers to opposing palms with fingers interlocked;
5. Rotational rubbing of left thumb clasped in right palm and vice versa;
6. Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;
Employees must perform hand hygiene before and after contact with patients and patient surroundings. If gloves are worn, perform hand hygiene immediately after removal of gloves and after exposure to blood or bodily fluids. If hands are not visibly soiled, an approved alcohol hand rub may be used instead of soap and water. If in doubt, wash with soap and water as an added precaution.

**USE ENGINEERING CONTROLS**

Engineering controls are tools, equipment, and products that are used at CHOP to reduce or eliminate bloodborne pathogen exposure.

Needleless systems and safety devices at CHOP include: Insyte safety IV catheters, Safety Glide needles, Blood transfer devices, Safety lancets, and Safety scalpels (in most areas).

Sharps Containers: always dispose of sharp items in rigid sharps containers; never leave a used needle on a table, tray, or any other surface where you or a coworker could be stuck.

Bio-safety Cabinets: protect users from droplets and aerosols in contaminated specimens; see CHOP’s Bio-safety Manual on the intranet for more information.

**USE WORK PRACTICE CONTROLS**

Follow proper procedures for cleaning and disinfection using hospital approved disinfectant.

Place soiled linen in a leak-proof bag in a covered hamper.

Place infectious waste in red bag trash; all items saturated with blood and bodily fluids including bloody diapers, certain waste coming from isolation rooms, and some lab waste.

Clean-up spills of blood and bodily fluids as soon as possible using a hospital approved disinfectant. Major blood spills require a 1:10 dilution of sodium hypochlorite solution for effective disinfection.
A FOCUS ON SHARPS

CHOP evaluates and implements devices and work practices that decrease the risk of bloodborne pathogen exposure.

Although safety devices are designed to minimize risk, they can also be hazardous if employees are not aware of how to properly handle them after contamination. In 2012, the following safety devices used for blood collection were selected for this education to help employees better understand how to handle them to avoid a needle stick.

All employees who work in patient care areas should be aware of this information.

BD Blood Collection Push Button Device - always use the black push button on the device to retract the needle BEFORE removing from patient.

Vacutainer Blood Transfer Device - never place a finger inside the barrel while handling - there is an inner needle that may not be obvious.

Point-LOK - the Point-LOK is a stand-alone needle protection device that is designed to lock onto a contaminated needle. Dispose of the needle and device into a sharps disposal container. For clinical staff, if you do not know already, ask your manager where the Point-LOK devices are kept on your unit.
HOW DO I RESPOND IF I AM EXPOSED?
TAKE ACTION PROMPTLY USING THE FOLLOWING STEPS.

CLEAN
Cleanse the puncture or cut wound with soap and water. Flush the involved tissue or mucous membrane with clean water or physiological saline.

REPORT
Report any exposure to your manager/supervisor or your Charge Nurse in addition to the office of Occupational Health. In the event of exposure, you and your supervisor must fill out an Employee Occupational Accident or Illness Report. Report all needle sticks occurring after hours to the Nursing Supervisor (nights, weekends, evenings and holidays). In addition, report exposure to your Charge Nurse or your manager/supervisor. This applies to all employees at all locations.

EVALUATE PROMPTLY
Promptly determining the HIV status or the risk of HIV in the source patient is essential. When needed, the ideal time to start post-exposure medication is within 2 hours of the BBP exposure. Contact the OHD 7:30 A.M. to 4:00 P.M., M-F or the Nursing Supervisor when after hours.

TESTING FOR BLOODBORNE PATHOGEN TRANSMISSION
1. Testing for HBV, HCV, and HIV is offered to employees with a documented exposure.
2. If exposure is high risk for HBV or HIV transmission, medication for prevention of transmission is started promptly.
3. Follow up care is determined.
4. Employees are contacted with exposure lab results as soon as they are available.
5. Employees receive a written post-exposure notification detailing Hepatitis B status and any follow up recommendations.

SOURCE PATIENT TESTING
Informed Verbal Consent must be obtained (written was required in the past) in order to begin Source Patient Testing. No Source Patient HIV-related test may be performed without the following: providing an explanation of the test to the Source Patient; this is any person whose body fluids have been the source of a Significant Exposure, obtaining the verbal consent of the Patient/Personal Representative, documenting in the medical record that consent was obtained or declined.

Documenting Verbal Consent- If you are an ordering clinician, you will need to document the Source Patient consent. When ordering Labs and Documenting in Epic:
1. Go to Order Sets Type the following: EMP
2. Uncheck any orders that you do not need
3. Remember to check the “informed consent” check box (this is a hard stop)
RESPONDING TO A MEDICAL EMERGENCY AT CHOP

WHAT IS A MEDICAL EMERGENCY?
A medical (health) emergency is any type of medical condition or injury that requires immediate medical attention.

Any patient, CHOP visitor, or CHOP employee could experience a medical emergency.

If you witness a medical emergency at CHOP, it’s simple! Depending on your location, call either 4-CODE/Medical Emergency @ ext. 42633 or call 911.
THAT SEEMS EASY ENOUGH! SO WHAT’S THE PROBLEM?

Employees may resist using the correct medical emergency procedure for different reasons. Here are the more common ones:

- You hesitate, thinking 4-CODE or 911 seems too urgent or too disruptive
- You think there is a more direct route to getting help
- You are under the impression that 4-CODE and 911 are not used for CHOP patients
- You (or a team) are medically trained and can deliver care to the individual
- You simply don’t know what to do and respond the best you can without knowledge of the correct procedure

WHO TO CALL AND WHAT TO CALL FOR

MAIN CAMPUS (MAIN HOSPITAL, SEASHORE HOUSE, WOOD BUILDING):

CALL CODE BLUE / 4-CODE FOR:
- Patients with a medical emergency / immediate, life-threatening problem.
- Non Patients (i.e. patient family, guests, employees, etc.) with a medical emergency / immediate, life threatening problem, acute medical need or injury, needs assessment, (may require transfer to CHOP or HUP ED).
- Employee with a serious or life-threatening work related injury.

CALL SECURITY - EXT. 45500 FOR:
- Fires, security issues, and all other non-medical emergencies.

CALL OCCUPATIONAL HEALTH - EXT. 41928 FOR:
- Non-life-threatening work related injury requiring follow up

MAIN CAMPUS (ABRAMSON)

CALL CODE BLUE / 4-CODE AND 911 FOR:
- All medical emergency situations.

BUSINESS OCCUPANCIES AND ALL SITES WITHIN THE AMBULATORY NETWORK

Business addresses: 3440, 3550, 3535, COLKET, WANAMAKER

CALL 911 FOR:
- All medical emergency situations.
- For non-medical emergencies, such as fires.

WHAT TO EXPECT WHEN YOU CALL

When calling 4-CODE, you will be asked a series of questions. At any time you may forgo answering questions and request the code team. The full code team will respond. All calls for patients (inpatient, outpatient) will activate the code team, regardless of where the patient is located around Main Campus.
WHAT TO EXPECT WHEN CALLING 4-CODE/
Your response to these questions helps determine the correct response team.
1. Is this a CHOP patient?
2. Is the person unconscious?
3. Is the person having trouble breathing?
4. Is the person having chest pain?

WHAT TO EXPECT WHEN CALLING 911:
911 has a standardized format for collecting information. They may ask questions relating to the following:

1. The location of the emergency, including the street address
2. The phone number you are calling from
3. The nature of the emergency – it is a medical emergency!
4. Details about the emergency such as injuries or symptoms
5. Because CHOP is known as a medical facility/Hospital, let the call-taker know whether or not medical personnel is assisting. 911 responders are still needed even if medical staff is on site.

You may be required to follow instructions to assist with choking, deliver first aid, or perform CPR. Do not hang up until the call-taker instructs you to hang up.

IF CALLING FOR A NON-PATIENT:
Your response to these questions helps determine the correct response team.
1. Does the individual have chest pain?
2. Is the individual having difficulty breathing?
3. Is there a loss of consciousness?

If you answer YES to any of the questions above, an ED Tech, ED RN and Respiratory Therapist will respond, and transport the patient to the ED with security escort.

If you answer NO to all three questions, an ED Tech will respond and transport the patient to the ED with security escort.

AT ANY TIME
At any time, you may upgrade the call and request the code team.

At any time, the ED response team (ED Techs, ED Nurses) may upgrade the call and request the code team.
HELP IS ON THE WAY:
Once you have placed the call, follow these additional steps to assist with the medical emergency.

4-CODE (AT MAIN HOSPITAL):
1. Call out for someone nearby to assist you.
2. Have someone bring the code cart and, where available, the AED (automated external defibrillator) to the emergency location.
3. Actively guide the response team to your location or delegate this to someone else.

911 (BUSINESS OCCUPANCIES AND ALL SITES WITHIN THE AMBULATORY NETWORK)
1. Call out for someone nearby to assist you.
2. After calling 911, have someone alert building security so they may assist in guiding responders to the emergency location.
3. When available, have someone locate and bring the nearest AED (automated external defibrillator) and/or other medical supplies that may be needed.
4. Continue to provide any life-saving care within the scope of your practice and training or follow other instructions provided by the 911 operator until help arrives.

KNOW THE LOCATION OF MEDICAL EQUIPMENT:

RESUSCITATION CART
Is a medical cart that has the supplies a medical team may need at the site of the emergency. Code Carts are located on each floor of the Main Hospital, Wood Building, Seashore House, and Care Network practices that provide patient care. Speak with your leadership to familiarize yourself with the location of the code cart in your area.

AUTOMATED EXTERNAL DEFIBRILLATOR (AED)
Is a portable electronic device that automatically diagnoses the life-threatening cardiac arrhythmias of ventricular fibrillation and ventricular tachycardia in a patient, and is able to treat them through defibrillation. AED is located on or near the code cart.

AED LOCATIONS OFF MAIN CAMPUS
Wanamaker: Floors are 4, 6-9 located in pantries aka employee lounge.
3535 Market Street: Floors are 8-16 located in hallway immediately outside to each elevator bay / lobby on each floor.
University Ave. and Science Center on Curie Blvd: located on first floor of high rise garages in elevator bay area.
Main Hospital garage: located on walls outside elevator lobbies for Glass Elevator and South Tower Elevator.
Wood garage: located on walls outside elevator lobbies A Level and B Level.
EMERGENCY PATIENT CALLS (CODE BLUE) NON-ICU LOCATIONS

The Code Blue button will be available in two locations at each patient bedside via the Staff Assist/Code Blue Panel and the Staff Terminal. The Code Blue button functions the same whether the call is generated from the Staff Assist/Code Blue Panel or the Staff Terminal.

CODE BLUE ACTIVATION

Pressing the CODE button at either location will:

1. Open up a voice path to the Transport Communication Specialist where they will triage the call and dispatch the hospital CODE team if necessary.
   - When the Staff Assist/Code Blue Panel is used to activate a code the voice path will open from the speaker on the Patient Station located on the headwall.
   - When the Staff Terminal is used to activate a code the voice path will open from the speaker on the Staff Terminal.

2. Send a page with the location and Code message to:
   - All staff “on duty” in the Responder 5 application.
   - Members of the preconfigured unit Emergency Group in the Responder 5 application.

3. Display on the PC console application and ring on the Clerk Console phone.

4. Ring at Staff Duty stations throughout the unit.

5. Illuminate the dome light outside of the patient room with 4 blue lights.

CANCELLING A CODE ACTIVATION (NON-ICU AREAS)

1. If the button was pressed in error, it is important to stay on the line and communicate this to the Transport Communication Specialist. If the button is activated and then cancelled prior to a conversation with the Transport Communication Specialist then the CODE Team will be dispatched to the location.

2. After the CODE team has arrived, or after speaking to the Transport Communication Specialist and canceling an inadvertent Code Button press, the call must be manually cancelled. If the call was initiated on the Staff Assist/Code Blue Panel, press the green cancel button on the top of the panel. If it originated from the Staff Terminal, press the Cancel button on the Staff Terminal.
EMERGENCY PATIENT CALLS (CODE BLUE) ICU LOCATIONS

The Code Blue button will be available in two locations at each patient bedside via the Staff Assist/Code Blue Panel and the Staff Terminal. The Code Blue button functions the same whether the call is generated from the Staff Assist/Code Blue Panel or the Staff Terminal.

CODE BLUE ACTIVATION

Pressing the CODE button will:

1. Annunciate location of Code through the Tweeter System and illuminate the directional dome lights
2. Send a page with the location and “Code” message to:
   - Internal Code Team
   - Internal Code Team
   - Internal Code Team
   - All staff “on duty” in the Responder 5 application
   - Members of the preconfigured unit Emergency Group in the Responder 5 application
3. Display on the PC console application and ring on the Clerk Console phone.
4. Ring at Staff Duty stations throughout the unit.
5. Illuminate the dome light outside of the patient room with 4 blue lights

CANCELLING A CODE ACTIVATION

1. If the button was pressed in error, it is important to stay on the line and communicate this to the Transport Communication Specialist. If the button is activated and then cancelled prior to a conversation with the Transport Communication Specialist then the CODE Team will be dispatched to the location.
2. After the CODE team has arrived, or after speaking to the Transport Communication Specialist and canceling an inadvertent Code Button press, the call must be manually cancelled. If the call was initiated on the Staff Assist/Code Blue Panel, press the green cancel button on the top of the panel. If it originated from the Staff Terminal, press the Cancel button on the Staff Terminal.
The very same chemicals that serve us well at CHOP can also be harmful if not used correctly and with care. Knowing the risk of hazardous materials/chemicals is another step toward making us the safest Children’s Hospital.

Whether you handle hazardous materials directly or not, they are present in your work environment. It is important for all staff to know the risks of hazardous materials and how they could impact your own safety or the safety of others.

HAZARDOUS MEDICATION

Specific information pertaining to the safe handling of hazardous medications can be found starting on page 63.
SAFETY BEHAVIORS FOR “EXPOSURE PREVENTION”

Read each story and think about how these questions could have improved these outcomes.

1. Did I read the label on the container?
2. Does something seem unusual, suspicious or wrong; and should I tell someone?
3. Do I know what I need to know to protect myself from chemical exposure?
4. Is my coworker doing that task correctly and, if not, should I correct him/her?

**Labeling:** In September 2004, a UC Berkeley researcher poured extra isopropanol into a container for unwanted chemicals labeled “isopropanol”. An immediate chemical reaction caused the plastic container to rupture and spray the mixture around the area; the researcher received acid burns as a result. He later learned that the container actually held concentrated nitric acid.

**Protection:** A recent study in the US indicates that nearly 17 percent of nurses working with cancer patients have been accidentally exposed to “second hand” chemotherapy. The study was published online on Aug. 16, 2011 in the journal BMJ Quality and Safety.

**Handling:** In 2010, a 15 year employee of Mercy Medical Center-North Iowa died following a chemical spill involving sodium hydroxide, a cleaning/laundry agent, at the hospital’s laundry facility. An autopsy would need to confirm if chemical inhalation was related to his death. Firefighters reported a burning sensation after working at the site of the spill.

WHERE ARE HAZARDOUS MATERIALS USED THROUGHOUT CHOP?

Hazardous materials are used in controlled settings CHOP wide in a variety of ways.

- House Keeping Cleaning products
- Facilities Plant Operations
- OR anesthetics and antiseptics
- Clinical and Research Laboratories
- Construction Activities

HOW CAN HAZARDOUS MATERIALS BE HARMFUL TO YOU?

Hazardous Materials can be harmful to you if they are not handled or stored properly. Review the risks that can follow if correct procedures are not followed:

**Physical Hazards** – Chemicals can cause a fire, suddenly discharge, and / or cause an unstable reaction or explode.

**Health Hazards** – Chemicals contain irritants (coughing), corrosives (burning), cryogens (freezing), reproductive hazards (sterility), carcinogens (cancer).
HOW CAN HAZARDOUS MATERIALS ENTER THE BODY?

The routes of entry into the body help determine appropriate engineering, administrative, and work practice controls to protect employees. When working with hazardous materials, be aware of these ways they may enter the body and take protective measures.

- Inhalation: you breath it
- Ingestion: you eat or drink it (most often by not properly washing hands and then eating food.)
- Absorption: it passes through the skin or eyes
- Injection: it enters through a puncture or cut

WHAT’S THE RISK?

Just because you work with hazardous materials, doesn’t mean you will be exposed.

ASK YOURSELF:

1. How much am I using?
2. Where am I using it? Is there ventilation?
3. In what form am I using it? Solid, Liquid, Gas can change the level of risk and how exposure occurs.
4. Am I using correct protection and handling procedures?
5. Is the chemical being stored properly?

Answers to these questions determine the risk level of the material being used.

HOW DOES CHOP PROTECT ITS EMPLOYEES?

Environmental Health & Safety, the Office of Research Safety, and PENN’s Radiation Safety Department work to evaluate and reduce your risk of exposure to hazardous materials.

SAFETY MEASURES INCLUDE:

- Monitoring
- Health hazard evaluation
- Risk assessments
- Engineering controls
- Personal protective equipment recommendations
- Education
TAKE ACTION TO FIX HAZARDS WHEN IDENTIFYING THEM.

These are the types of safety errors that occur that require action. Often people pass by, have a concern, but do nothing. Take action to fix problems when you spot them! Communicate with your manager or call the Office of Environmental Health and Safety if you have a safety concern. Always contact Security for an immediate threat.

HOW TO RESPOND TO A SPILL OR EXPOSURE?

Knowing how to properly respond to an accidental exposure or chemical spill can improve the outcome. Response to Chemical Spills Policy and Procedure can be found on the intranet under the Environmental Health & Safety Department’s Safety Manual.

General exposure: Rinse the affected area immediately with water for a minimum of 15 minutes (use an emergency eyewash or shower if needed) and remove any contaminated clothing. Report the incident to your Manager/Supervisor and follow-up with the Occupational Health Department.

Chemical spill: Isolate the area and from a safe location contact Security X 45500.

Radioactive exposure: Contact Security and request assistance from PENN’s Radiation Safety Department. Clear personnel from area. Wash contaminated skin gently with soap and tepid water.
THE NEW LABELING SYSTEM

The Global Harmonization System (GHS) is an international approach to the Occupational Safety and Health Administration’s (OSHA) hazard communication standard that will be used worldwide! This system provides simple and standard criteria for classifying and labeling chemicals according to their physical and health hazards. The symbols shown here are part of the GHS system. Familiarize yourself with these symbols.

Failure to read labels increases the risk of harm to you and others. Become familiar with meaning of the symbols for the GHS system:

<table>
<thead>
<tr>
<th>Health Hazard</th>
<th>Flammables</th>
<th>Oxidizers</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Health Hazard Symbol" /></td>
<td><img src="image" alt="Flammables Symbol" /></td>
<td><img src="image" alt="Oxidizers Symbol" /></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Irritant</th>
<th>Gasses Under Pressure</th>
<th>Explosives</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Irritant Symbol" /></td>
<td><img src="image" alt="Gasses Under Pressure Symbol" /></td>
<td><img src="image" alt="Explosives Symbol" /></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Corrosives</th>
<th>Environmental Toxicity</th>
<th>Acute Toxicity</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Corrosives Symbol" /></td>
<td><img src="image" alt="Environmental Toxicity Symbol" /></td>
<td><img src="image" alt="Acute Toxicity Symbol" /></td>
</tr>
</tbody>
</table>

SAFETY DATA SHEETS (SDS)

Safety Data Sheets (SDS) are document information relating to a potential chemical hazard and specify how to work safely with the material. SDS is an excellent resource for preventing exposure in that it lists very specific information about each hazardous material including safe handling, containment, disposal procedures, and the recommended Personal Protective Equipment to use for each material.

Use the electronic SDS service on CHOP’s intranet (located under Employee Resources) to perform a general search of SDS for all chemicals used at CHOP. One of the most convenient views within the database is “search by location”. Once your location is selected, you can see all SDS sheets that are relevant to you and your work area.
HOW CAN YOU AVOID EXPOSURE?

Evaluate your risk whenever you approach a location where hazardous materials are in use. Ensure that you are properly protected, read all signage, and respect instructions requesting you to avoid hazardous areas.

In many instances when working with hazardous materials, it is necessary to have proper training and wear personal protective equipment (PPE) such as:

• Safety glasses or face shields
• Lab coats or splash resistant aprons
• Gloves
• Masks and respirators

NEVER FORGET HAND HYGIENE!

When in contact with chemicals, wash your hands even if you wore gloves. Hand washing helps to minimize chemical contact with the skin and also reduces the chance of ingestion.

Prevent Exposure with STAR

STAR (Stop, Think, Act, Review)

1. Be alert and aware of your surroundings.
2. Be proactive to create safe environments.
3. Don’t make assumptions.
4. Act on your concerns rather than dismissing them.

SAFE HANDLING OF HAZARDOUS DRUGS

Hazardous Drugs are drugs that meet one of the following criteria:

Genotoxic (causing damage to DNA),
Carcinogenic (causing cancer in humans),
Teratogenic (causing genetic mutations or malformations in the developing fetus),
causes serious toxicity at low doses in treated patients or causes impaired infertility

CHOP further classifies hazardous drugs based on exposure route, drug form, and available toxicology data.

* A complete and up to date list of hazardous drugs at CHOP is available on the employee intranet
Keyword Search: “Hazardous Drug List”
PHARMACY - PREPARATION
The Procedure for the Safe Preparation of Hazardous Drugs is available on the employee intranet. Keyword Search: “safe prep haz drugs”

DELIVERIES TO PHARMACY
• When deliveries from suppliers are received nitrile gloves must be worn.
• Hazardous drugs should be stored separate from other drugs with secondary containment and labeling

PREPARATION IN PHARMACY
• All injectable hazardous drugs must be handled in a Class II Biosafety Cabinet
• Staff must wear Chemotherapy gloves and gowns when preparing drugs - Gloves must be changed hourly or when compromised by tear or spill
• All supplies needed to perform compounding must be placed in the Biosafety Cabinet prior to preparation - Compounding involves the potential for aerosolization of hazardous drugs to supplies that may be under pressure.
• All hazardous drugs will be Labeled as such by Pharmacy prior to being dispensed and Placed in a secondary container prior to being dispensed
• A closed system transfer device (CSTD) must be used when applicable.
• Decontamination of the Biosafety Cabinet to occur daily and in the event of a spill
• If a hazardous drug tablet or capsule needs to be crushed or opened look for the liquid suspension first.
• When crushing or opening a tablet or capsule is required, this must be performed in a Biosafety Cabinet and placed in a ointment jar.

PATIENT ADMINISTRATION
The Procedure for the Safe Administration of Hazardous Drugs is available on the employee intranet. Keyword Search: “safe admin haz drugs”

The job aid for the Closed System Transfer Device is available on the employee intranet. Keyword Search: “Closed System Transfer Device”

INJECTABLE ADMINISTRATION
A hazardous drug that is administered via lumbar puncture, intravenous, intramuscular, and subcutaneous routes.

Personal Protective Equipment (PPE) - Clinical staff must don PPE prior to handling hazardous drugs.
• Nitrile gloves (required for all injectable administrations)
• Fluid resistant gown (required for all injectable administrations)
• Surgical mask with face shield (required for lumbar punctures)
INJECTABLE ADMINISTRATION GUIDELINES

- All items required for the hazardous drug administration such as the syringe/needle, alcohol pads, etc. should be placed on a plastic backed absorbent pad to prevent cross contamination.
- IV set must be primed with non-hazardous solution utilizing a closed system transfer device (CSTD).
- Observe for leakage during administration; use plastic backed absorbent pad to catch potential leakage.
- Use sterile gauze at push sites.

ORAL ADMINISTRATION

A hazardous drug that is administered as a tablet, capsule or liquid via the oral route. This also includes the use of an oral syringe, and drugs mixed with food.

Personal Protective Equipment (PPE) - Clinical staff must don PPE prior to handling hazardous drugs.
- Nitrile gloves (required for all oral administrations)
- Fluid resistant gown (required if the patient is likely to spit)
- Surgical mask with face shield (required if the patient is likely to spit)

ORAL ADMINISTRATION GUIDELINES

- Patients who cannot tolerate swallowing a tablet or capsule should be prescribed a suspension form of the drug.
- If the suspension form is not available work with Pharmacy to determine the best administration option.
- If a tablet or capsule is opened or crushed by Pharmacy clinical staff may add soft food to the ointment jar; this will minimize aerosolization and the potential for surface contamination.
- Do Not pour the crushed drug onto food.
- Never crush a tablet or capsule. This should only be performed by Pharmacy under a Biosafety Cabinet.
- Crushing hazardous drug tablets or opening capsules involves the potential for aerosolization of the hazardous drug due to fine powders that may be generated. Performing this in a Biosafety cabinet will prevent accidental exposure to staff.

AEROSOLIZED ADMINISTRATION

A hazardous drug that is administered via inhalation through the use of a mechanical aerosolization process.

Personal Protective Equipment (PPE) - Clinical staff must don PPE prior to handling hazardous drugs.
- Nitrile gloves (required for all aerosolized administrations)
- Fluid resistant gown (required for all aerosolized administrations)
- N95 respirator (are required for all aerosolized administrations)
- If staff wear contacts goggles should be worn.
AEROSOLIZED ADMINISTRATION GUIDELINES

- If staff are required to wear an N95 respirator they must be fit tested and trained, within the past year.
- Respiratory Therapist places proper signage on the patients door.
- Staff (other than Respiratory), family members and visitors should be kept at a minimum to reduce exposure to the hazardous drug.
- Wait the required post-administration time to enter patients’ room without the required N95 respirator.

HAZARDOUS DRUG SPILLS AND EXPOSURES

The Procedure Response to Hazardous Drug Spills and Exposures is available on the employee intranet.

Keyword Search: “hazardous drug spills”

EXPOSURE

In the event of skin or eye contact immediately remove contaminated PPE and flush with tepid water for 15 minutes then report exposure to Manager and Occupational Health.

SPILL:

- Isolate the area of spill to prevent additional contamination.
- Obtain Chemotherapy Spill Kit from your unit or Materials Distribution and don the gown, gloves, goggles and booties.
- Spill clean up should proceed from the area of least contamination to the area of greatest contamination.
- All spill clean up materials are to be placed in the yellow bin.

After the above steps contact Environmental Services to clean the spill site three times using detergent and clean water. Staff should wash hands thoroughly with soap and water after handling hazardous drugs.

PRECAUTIONS

After administration place inpatients on Hazardous Drug Precautions for the next 48 hours if required.

- Reference the Hazardous Drug List (on the employee intranet) in the Procedure document to define whether a patient is required to be on precautions.
- Place sign at patient room indicating the start and stop time for precautions.
- Staff handling excrement must wear gloves and fluid resistant gown during the time a patient is on precautions.
- Any urine spilled during the precaution period must be handled as a hazardous drug spill.

PERFORM PROPER HAND HYGIENE

Wash hands thoroughly with soap and water after handling hazardous drugs. Alcohol based hand rubs are not effective in removing contamination from the hands.
DISPOSAL
Return any unused doses to Pharmacy
Hazardous drugs may not be transported in the pneumatic tube system

- Partially used doses must be disposed of in the black hazardous waste sharps container (EHSD)
- Empty needles and syringes can be disposed of in the red sharps container
- All other items such as administration sets, bottles, tubing, bags, etc. can be disposed of in the yellow bin (Materials Distribution)
- PPE can be disposed of in the regular trash (white can), unless it is contaminated then it should go in the yellow bins
- Refer to the Waste Segregation Chart available on the employee intranet

Keyword Search: “waste segregation”

FAMILY EDUCATION SHEET
If families have questions regarding hazardous drug precautions you can provide them with the family education sheet. This sheet is available on the employee intranet.
Keyword Search: “drug precautions families”

Tell us about it! - Intranet Keyword Search: good catch
Research IS
Here to meet your research computing needs!

Need a new computer-related item or service? Visit http://isrequest.chop.edu

Problem with existing service? Call 4-HELP
CHOP IS A DRUG-FREE WORKPLACE

THE GOALS OF CHOP’S DRUG-FREE WORKPLACE POLICY:

• To maintain a workplace free from the possession, manufacture, sale, purchase, distribution or use of prohibited drugs or alcohol.

• To provide resources for all employees who may need help with substance abuse.

• To identify appropriate corrective action for employees who violate the Drug-Free Workplace policy.

This policy applies to all employees, all of the time. Under no circumstances should an employee come to work under the influence of any substance that can impair one’s physical state, behavior, performance, and judgment. This policy also applies to entities affiliated with CHOP including but not limited to: Children’s Health Care Associates, Children’s Anesthesiology Associates, Children’s Surgical Associates, Radiology Associates of Children’s Hospital and their New Jersey counterparts.
WHY DRUG-FREE MATTERS FOR SAFETY…

CHOP is committed to maintaining a safe, drug-free workplace for the benefit of our patients and families. Read about the ways a drug-free environment contributes to safety at CHOP.

Employees contribute their best work and uphold CHOP’s high standard of care.

Reliable judgments, decisions, and responses are made relating to patient care, minimizing the risk of safety errors.

Our patients trust us; and our reputation grows toward our goal to be the safest children’s hospital.

Professional and therapeutic relationships develop: coworkers, patients, and families all depend on our professionalism.

WHY DRUG-FREE MATTERS FOR YOU…

Your health and wellbeing are also a priority at CHOP. Read about how a problem with drugs or alcohol can affect you.

Physical/Mental Health: misuse of drugs and alcohol takes its toll on your brain and body and may even lead to death.

All Relationships: families and friends are often the victims of drug and alcohol abuse.

Employment and Licensure: misuse of drugs and alcohol can lead to mandatory leave, termination, and loss of licensing/professional credentials.

Freedom: certain behaviors linked to drug use and addiction, such as diverting drugs, are illegal and can lead to imprisonment.

THE EMPLOYEE ASSISTANCE PROGRAM (EAP)

The Employee Assistance Program (EAP) is a resource provided by CHOP through Penn Behavioral Health. The EAP can assist with issues and challenges that may arise in your personal or professional life. Services are available 24 hours a day, 7 days a week. Call 1-888-321-4433 or online.

www.pennbehavioralhealth.org

Intranet Keyword Search: EAP
WHAT IS IMPAIRMENT?
Impairment is a person’s condition when drugs and/or alcohol interfere with one’s professional judgment, safe work practices, and responsible behavior in the workplace. Impairment can be caused by legal substances too, such as excessive alcohol use or the misuse of over-the-counter and prescription drugs.

These are just a few of the signs / symptoms that might indicate that someone is impaired or has an issue with drugs or alcohol:

SIGNS THAT JEOPARDIZE SAFETY
• Error Prone; misses signs of distress; may leave patients or work unattended

SIGNS RELATING TO A PERSON’S PERFORMANCE
• Lateness or absenteeism; missing from the unit

SIGNS YOU CAN SEE – A PERSON’S PHYSICAL STATE
• Sweating / tremors (impending withdrawal)

SIGNS SHOWING CHANGES IN A PERSON’S PERSONAL LIFE
• Alienated friends and colleagues

WHAT IF YOU DRANK LAST NIGHT?
Employees are expected to have a blood alcohol level of zero (0.00) while at work.

<table>
<thead>
<tr>
<th>You stop drinking</th>
<th>You’re in bed</th>
<th>You drive to work</th>
<th>You arrive at work</th>
</tr>
</thead>
<tbody>
<tr>
<td>2:00 AM</td>
<td>4:00 AM</td>
<td>7:00 AM</td>
<td>7:45 AM</td>
</tr>
<tr>
<td>Blood Alcohol at</td>
<td>Blood Alcohol</td>
<td>Blood Alcohol at</td>
<td>Blood Alcohol at</td>
</tr>
<tr>
<td>.15-.20% Legally</td>
<td>.08-.10%</td>
<td>.05% Mild</td>
<td>.02% Impaired</td>
</tr>
<tr>
<td>drunk</td>
<td>Legally drunk</td>
<td>intoxication</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
IMPAIRMENT MAY LEAD TO ADDICTION…
Addiction is a chronic, often relapsing brain disease that causes compulsive drug seeking and use, despite harmful consequences to the addicted individual and to those around him or her. Abuse and addiction can exist for a long time before impairment becomes apparent in the workplace.

ADDITION CAN LEAD TO DIVERSION…
Diversion, the theft of any drug at CHOP, is a violation of the law and cause for immediate termination. Law enforcement, as well as regulatory, licensing and credentialing bodies oversee these cases to determine further penalties.

OUR POLICY SUPPORTS ACTION!

1. Have you ever suspected a coworker may be impaired and you did nothing?

If you answered yes, this is called Zero Action! What stopped you from reporting? What are the consequences for doing nothing?

2. Have you ever covered up, made excuses, or completed work for another coworker knowing he/she may be impaired?

If you answered yes, this is called Gloss Over Action! You may attempt to protect a coworker’s career or reputation but this comes at the expense of the health and wellbeing of the person who is impaired and the safety of patients.

3. Have you thought about reporting someone who seemed impaired but were concerned you might be wrong?

You have the right to exercise “reasonable suspicion” if you suspect a coworker is impaired, and report your concerns to your manager. Reasonable suspicion is more than a “hunch” or feeling about a person; it is based on a person’s behavior and any observable signs or symptoms of impairment.

Do you know how to help your patients cope?

www.healthcaretoolbox.org
Learn about medical traumatic stress.
Download resources to help kids and families cope with medical situations.
Find assessment tools and interventions.
Earn CE credit through online programs.
WHAT IS REASONABLE SUSPICION?

Reasonable suspicion is when an employee has a sound belief that another employee is using or is under the influence of drugs or alcohol. This suspicion should be based on either specific physical, behavioral, or performance indicators (what did you see or hear that leads you to this belief?) and/or evidence of repeated errors on the job, Hospital rule violations, unsatisfactory time and attendance patterns, behavior or actions that differ from normal behavior or actions under the circumstances, or inappropriate or disoriented behavior.

Reporting reasonable suspicion

Your reasonable suspicion should be communicated to your manager who will then work with an HR Business Partner to better determine next steps to ensure the safety and wellbeing of all. This may include removing the individual from his/her work and initiating “for cause” testing through the office of Occupational Health.

Your responsibility

It is every employee’s responsibility to report a coworker who may be impaired, who is suspected of having an ongoing problem with drugs/alcohol, or who may be engaging in diversion (stealing drugs from CHOP).

No Action or Gloss Over Action are common because employees may not feel confident in their suspicions or they feel sympathetic toward their coworker. Don’t contribute to inaction and put patient and employee safety at risk!

HOW CAN I HELP MYSELF IF I HAVE A PROBLEM?

1. Stress and depression can often lead to the misuse of prohibited substances. Incorporate wellness activities into your life.

2. Speak to your doctor to identify your specific health issues.

3. Seek assistance from the Hospital’s Employee Assistance Program or the Physician Health Program in confidence.

MANAGERS: HELPING YOUR STAFF

As a manager, when you become aware of impairment:

1. Evaluate the safety of patients.

2. Consult your resources including your HR Business Partner, Occupational Health Department (OHD), and policy A-4-23: Drug-Free Workplace (Appendix A – For Cause Drug Testing, Appendix B – Observation Form) on CHOP’s intranet.

Suspected Impairment. What’s next?

1. Manager reasonably suspects impairment.

2. Records observations via observation form.

3. OHD and HR are consulted.

4. Manager escorts employee to OHD for evaluation and potential testing. If after hours (between 4pm-8am and weekends) managers should contact Security for assistance. For locations outside CHOP’s Main campus managers should take employees to the nearest hospital or emergency care facility.

5. Employee is removed from work pending results.

6. Manager should arrange for transportation to take the employee home; the employee should not be allowed to operate any type of motor vehicle.
APPENDIX B
POLICIES
1. PURPOSE:

The Children’s Hospital of Philadelphia (“Hospital”) recognizes that a diverse workplace broadens perspectives, enhances the quality of the work environment and work product and supports the Hospital’s mission. This Equal Employment Opportunity and Affirmative Action policy reflects the Hospital’s commitment to diversity in the workplace.

2. POLICY:

The Hospital is committed to providing equal employment opportunity for all applicants and employees without regard to race, color, religion, sex, age, national origin, ancestry, sexual orientation, gender identity, genetic information, marital status, disability, victim of domestic or sexual violence status, covered veteran status, or other protected classifications to the extent required by applicable laws. The Hospital will comply with federal, state and local laws and regulations governing employment practices. In addition, the Hospital will make reasonable accommodations when necessary to qualified applicants and employees with disabilities provided that such accommodations do not cause an undue burden on the Hospital.

3. COVERAGE:

This policy applies to all applicants to and employees of The Children’s Hospital of Philadelphia and affiliated institutions.

4. PROCEDURES:

A. It is the policy of the Hospital to recruit, hire, transfer, train and promote persons in all job titles without regard to race, color, religion, sex, age, national origin, ancestry, sexual orientation, gender identity, genetic information, marital status, disability, victim of domestic or sexual violence status, covered veteran status, or other protected classifications to the extent required by applicable laws.

B. All employment decisions are consistent with the principle of equal employment opportunity, and only valid job qualifications will be considered.

C. All personnel actions, such as compensation decisions, benefits, transfers, Hospital sponsored training including tuition assistance, social and recreational programs, are administered without regard to race,
color, religion, sex, age, national origin, ancestry and sexual orientation, gender identity, genetic information, marital status, disability, covered veteran status, or other protected classifications to the extent required by applicable laws.

D. The Hospital has three established Affirmative Action Plans (AAPs) – one for women and minorities, one for individuals with disabilities and one for covered veterans. We have prepared these plans in accordance with the implementing regulations of the Office of Federal Contracts Compliance Programs, 41 C.F.R. Part 60. These AAPs are designed to provide guidance to management with respect to the Hospital’s commitment to fully implement its Equal Employment Opportunity/Affirmative Action policy. The Hospital’s official policy statement signed by its President and CEO is included in the Plan.

E. Employees and applicants will not be subjected to harassment, intimidation, threats, coercion, or discrimination because they have filed a complaint, assisted or participated in an investigation, opposed an unlawful act or practice, or exercised any rights protected by the equal opportunity laws or their implementing regulations.

5. RESPONSIBILITY:

The Human Resource Department is responsible for ensuring compliance in all of its dealings with job applicants and employees.

The Office of Diversity and Inclusion is responsible for oversight and coordination of the Affirmative Action planning process.

Administrative supervisors and department heads are responsible for ensuring that all supervisors or others in the departments who interview job applicants or employees for possible promotion comply fully with this policy.


**Policy: Clearance Standards**

<table>
<thead>
<tr>
<th>Type:</th>
<th>Human Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicable to:</td>
<td>CHOP Enterprise-wide</td>
</tr>
<tr>
<td>Process owner:</td>
<td>HR Operations Manager</td>
</tr>
<tr>
<td>Effective Date:</td>
<td>04/15/2014</td>
</tr>
<tr>
<td>Supersedes:</td>
<td>N/A</td>
</tr>
<tr>
<td>Approved by:</td>
<td>Senior Vice President, Human Resources</td>
</tr>
<tr>
<td>Document ID #:</td>
<td>2-20</td>
</tr>
<tr>
<td>Accountable for:</td>
<td>Senior Vice President, Human Resources</td>
</tr>
</tbody>
</table>

1. **Policy Statement**
   The Children’s Hospital of Philadelphia has implemented clearance standards to protect the safety and welfare of its patients and staff. All Staff and any other persons or entities acting or providing services on behalf of the Hospital, must comply with applicable standards requirements prior to, and or during their engagement with the Hospital.

2. **Scope**
   This policy applies to all CHOP staff, (paid and unpaid). It also applies to any other persons or entities acting or providing services on behalf of the Hospital.
   
   **NOTE:** This does not apply to patients or families of patients or visitors of patients.

3. **Guidelines**
   This policy and associated job aids [2-20a Compliance Standards and Reference Guide](#) and [2-20b CHOP Clearance Standards Definitions](#), are meant as summary references. These summarize key compliance requirements already documented in other policies which can be found in the Human Resources, Occupational Health and Administrative Policy Manuals. These Standards do not replace or supersede any existing policies.

   If you still have questions about particular matters after reviewing this document, please contact your Human Resources Business Partner.

4. **Exceptions**
   Any exceptions to this policy must be approved by the Senior Vice President of Human Resources, or his or her Designee.

5. **Definitions**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff</td>
<td>Those who work at CHOP; payrolled and non-payrolled. This can include vendors and volunteers, students, observers, contractors, interns, amongst other personnel.</td>
</tr>
</tbody>
</table>
## Policy: Clearance Standards

### 5 Outcome Monitoring
Human Resources will monitor compliance with the Hospital Clearance Standards.

### 6 Related Documents

<table>
<thead>
<tr>
<th>Document Type</th>
<th>Document Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policies</td>
<td>• HR Policy 2-10 Use of Contract Labor</td>
</tr>
<tr>
<td></td>
<td>• HR 2-2 Recruitment</td>
</tr>
<tr>
<td></td>
<td>• A-3-8 Control of On-Site Activity by Vendors</td>
</tr>
<tr>
<td></td>
<td>• A-1-5 Compliance Standards of Conduct</td>
</tr>
<tr>
<td>Job Aids</td>
<td>• 2-20a- Clearance Standards and Reference Tools</td>
</tr>
<tr>
<td></td>
<td>• 2-20b- CHOP Clearance Standards Definitions</td>
</tr>
<tr>
<td>Regulatory References</td>
<td>Joint Commission Standards</td>
</tr>
<tr>
<td></td>
<td>• HR.01.02.05</td>
</tr>
<tr>
<td></td>
<td>• HR.01.04.01</td>
</tr>
<tr>
<td></td>
<td>• HR.01.05.03</td>
</tr>
<tr>
<td></td>
<td>• HR.01.06.01</td>
</tr>
<tr>
<td></td>
<td>• HR.01.07.01</td>
</tr>
</tbody>
</table>
# CHOP Clearance Standards Reference Grid 2-20a, Effective 4/15/2014

The purpose of this document is to ensure those entering the CHOP enterprise facilities have the defined clearances as required by the facility. This document is owned and maintained by CHOP’s Human Resources Department. This does not apply to Medical Staff, refer to Medical Staff Affairs.

## Clearance Requirements (e.g. CHOP, TJC, DOH, CNB, etc.)

<table>
<thead>
<tr>
<th>Payrolled Staff</th>
<th>Clinical Temporary Worker</th>
<th>Non-Clinical Temporary Worker</th>
<th>Volunteers</th>
<th>Non-Clinical Staff (Non-Payrolled)</th>
<th>Clinical Students/Non-Payrolled Interns (Non-Patient care area)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(CHOP employee who are on CHOP’s payroll or fulfill a part of their responsibilities)</td>
<td>(Contracted staff who provide direct patient care, treatment, services, part-time, or full-time)</td>
<td>(Contracted staff who conduct service in hospital facilities where patients are seen)</td>
<td>(Students, including Health Profession students, who are 100% offsite and in patient care areas where patients are seen)</td>
<td>(Non-payrolled Students)</td>
<td>(Students, including Health Profession students, who are 100% offsite and in non-patient care areas where patients are seen)</td>
</tr>
<tr>
<td><strong>Examples</strong></td>
<td>includes students on CHOP payroll - Residents, fellows</td>
<td>PA, FT, PTOT, RA. Physiology/Anatomy</td>
<td>On-Site Management by the Volunteer Department</td>
<td>Non-payrolled Students</td>
<td>Non-payrolled Nursing Students, PFTO Staff, Social Work interns, Students on an Affiliation Agreement</td>
</tr>
</tbody>
</table>

### Verified SSN and Birth Date (CHOP compliance requirement)

| X | Birth Date Only | Birth Date Only | Birth Date Only | Verify SSN (for background check only) | Birth Date Only |

### Verified licensure, certification, registration and professional references (HR 0.1.02.05)

| X | X | If applicable | If applicable | NA | NA | If applicable |

### Verified education, experience and competence (HR 0.1.02.05)

| X | NA | NA | NA | X |

### Verified 7 year criminal and Act 73 Clearances (PA State Criminal, FBI Fingerprint, and PA Child Abuse clearances and Sex Offender Registry Search) (HR 0.1.2.02.05)

| X | (Plus PA Child Abuse Clearances in other states where staff member has lived for 7 years) | X | X | X | X |

### Completed health screening requirements (HR 0.1.02.06)

| X | X | (if defined as a "Healthcare Worker" by the facility) | X | (Orientation & Medication Education - Orientation & Medication Education (completed by CHOP and Contracted Agency)) | (Completed by CHOP) | X |

### Completed and documented orientation (HR 0.1.04.01.01/A3)

| X | Orientation & Medication Education Handbook & Orientation Handbook | X | X | X | X |

### Department / Unit specific orientation(s) (HR 0.1.04.01/A1)

| X | Orientation & Medication Education Handbook & Orientation Handbook (completed by CHOP and Contracted Agency) | X | (Completed by CHOP) | X | X | X |

### Ongoing Training (HR 0.1.05.02)

| X | (Completed by CHOP and Contracted Agency) | X | (Completed by CHOP) | X | X | X |

### Competency Assessed (HR 0.1.06.01)

| X | (Completed by CHOP and Contracted Agency) | X | (Completed by CHOP and Contracted Agency) | X | X | X |

### Job Performance Evaluated (HR 0.1.07.01)

| X | (Completed by CHOP and Contracted Agency) | X | (Completed by CHOP and Contracted Agency) | X | X | X |

### Immunizations and TB Testing

| X | If defined as a Healthcare Worker | X | X | NA | X | X |

### Drug Screen

| X | X | X | X | X | X | X |

### State and Federal Exclusion Checks

| X | X | X | X | X | X | X |

### Responsible for securing clearances

| CHOP HR | Contracted Labor Supplier | Contracted Labor Supplier | Contracted Labor Supplier | Volunteer Department | CHOP HR |

### Important clarifications

- Clearance requirements are to be followed by those who conduct ad-hoc, unplanned or emergency services.
- Requirements are subject to change as required by location security requirements and or Policy A-1.3 Control of On-Duty Activity by Vendors. Vendors are defined as entities and persons that do not exist in order to bring into business relationships with the Hospital e.g., to provide any equipment, product, supply, facility, hire an individual or perform any service for payment (with or without consideration). Vendors are referred to in this document as a collective noun.
- The Contracted Labor Supplier is responsible to secure and store clearances for vendors under supplier agreements that meet temporary labor classifications. For Vendors visiting the Main Hospital Buildings that do not qualify as temporary labor, Vendors must be a minimum clearance repository that offers enrollment at a fee for easy access and badge issuance (unlimited regular and pay fee at kiosks - system prints out temporary badge).

**Note:**
- Employees should follow Policy 2.0.5 Placement of Non-Physician Educational Observerships.
- Vendors, including vendors that conduct ad-hoc, unplanned or emergency services would be required at minimum to comply with location security requirements and or Policy A-1.3 Control of On-Duty Activity by Vendors. Vendors are defined as entities and persons that do not exist in order to bring into business relationships with the Hospital e.g., to provide any equipment, product, supply, facility, hire an individual or perform any service for payment (with or without consideration). Vendors are referred to in this document as a collective noun.
- The Contracted Labor Supplier is responsible to secure and store clearances for vendors under supplier agreements that meet temporary labor classifications. For Vendors visiting the Main Hospital Buildings that do not qualify as temporary labor, Vendors must be a minimum clearance repository that offers enrollment at a fee for easy access and badge issuance (unlimited regular and pay fee at kiosks - system prints out temporary badge).
<table>
<thead>
<tr>
<th>Action</th>
<th>Purpose or Definition</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verify SSN and Birth Date (CHOP compliance requirement)</td>
<td>Social Security Number and Birth Date are CHOP requirements for purposes of compliance and information security. This is a no-exception policy. All information will be kept strictly confidential.</td>
<td>N/A</td>
</tr>
<tr>
<td>Verify licensure, certification, registration and professional references</td>
<td>Primary Source Verification at the time of hire/renewal. The copy of the actual license does not meet this compliance standard.</td>
<td>Joint Commission (HR.01.02.05)</td>
</tr>
<tr>
<td>Verify education, experience and competence</td>
<td>Any education, experience, competence required for the job must be verified and demonstrated.</td>
<td>Joint Commission (HR.01.02.05)</td>
</tr>
<tr>
<td>Verify 7 year state and county criminal clearances, sex offender registry search, Act 73 Clearances (PA State Criminal, FBI Fingerprint and Child Abuse Clearance) and Sex Offender Registry Search</td>
<td>Results of the required criminal background checks, FBI fingerprinting, and the Child Abuse Clearance (CAC) must be verified before the staff member can perform any work; or, if a 30-day provisional status is authorized by HR. Per legal, same background check required for all employees and non-employees, for example Volunteers, unless otherwise specified.</td>
<td>Joint Commission (HR.01.02.05)</td>
</tr>
<tr>
<td>Completion of health screening requirements.</td>
<td>PPD, drug screening, immunizations, and flu vaccine; as needed by role and location. Drug screening may not be required for Volunteers and students</td>
<td>Joint Commission (HR.01.02.05)</td>
</tr>
<tr>
<td>Complete and documented orientation</td>
<td>Mission and goals, hospital and unit-specific policies and procedures, infection control, cultural diversity and sensitivity, rights of patients, ethical care, patient privacy, compliance, patient safety/risks in hospital environment (fire, emergency, security, etc.), safety event reporting procedures, pain management, etc. as required by role. Supplier employees are required to log into CHOP's Learning Link System to review the required Orientation Material. Instructions for accessing CHOP's Learning Link System are provided in the Supplier Handbook: <a href="http://www.chop.edu/export/download/pdfs/articles/neo/temp-employee-handbook.pdf">http://www.chop.edu/export/download/pdfs/articles/neo/temp-employee-handbook.pdf</a></td>
<td>Joint Commission (HR.01.04.01)</td>
</tr>
<tr>
<td>Department / Unit-specific orientation(s)</td>
<td>Training topics based on role and location.</td>
<td>Joint Commission (HR.01.04.01)</td>
</tr>
<tr>
<td>Ongoing Training</td>
<td>Training topics based on role and location.</td>
<td>Joint Commission (HR.01.05.03)</td>
</tr>
<tr>
<td>Competency Assessed</td>
<td>Defined by job description and ability to perform. Assessed during orientation period and ongoing competence assessments.</td>
<td>Joint Commission (HR.01.06.01)</td>
</tr>
<tr>
<td>Job Performance Evaluated</td>
<td>Required as per HR Policy.</td>
<td>Joint Commission (HR.01.07.01)</td>
</tr>
<tr>
<td>Immunizations and TB Testing</td>
<td>1. TB Test • Negative TB skin test (TST) or Interferon-gamma Release Assay (IGRA), within 30 days prior to the start of work. 2) 2-step TB skin test (1-3 weeks apart) within 30 days of hire, if no documentation of TST within last 12 months • Positive TST or IGRA - 1) Negative PA &amp; Lateral chest x-ray, 2) Annual TB questionnaire • Repeat TB skin test or IGRA annually 2. Measles (rubella), Mumps and rubella Immune status (vaccine or laboratory evidence) for Measles (rubella), mumps and rubella (Positive IgG for each or 2 doses of live MMR vaccine, on or after first birthday) 3. Varicella Immune status (vaccine or laboratory evidence) for Chickenpox (Positive IgG or 2 doses of live varicella (VZV) vaccine at least 28 days apart) 4. Tetanus/Diphtheria/Pertussis (Tdap) Vaccination One-time dose of tetanus/diphtheria/pertussis (Tdap) vaccine as an adult 5. Hepatitis B Status (OSHA required for anyone at risk of coming in contact with human blood or body fluids)</td>
<td>Joint Commission (HR.01.07.01)</td>
</tr>
<tr>
<td>Drug Screen</td>
<td>11 panel Drug testing to be completed by a licensed laboratory. MRD to confirm a positive result. 11 substances are: Amphetamines, Barbiturates, Benzodiazepines, Cocaine Metabolites, Marijuana Metabolites, Methadone, Methaqualone, MDA-Analogues, Opiates, Phencyclidine, Propoxyphene</td>
<td>Office of Inspector General; System for Award Management; PA Medcheck; NJ Treasury</td>
</tr>
<tr>
<td>State and Federal Exclusion Checks</td>
<td>Federal and state exclusion lists. Checked at time of engagement/hire and monthly thereafter.</td>
<td>Office of Inspector General; System for Award Management; PA Medcheck; NJ Treasury</td>
</tr>
<tr>
<td>Influenza Vaccine</td>
<td>Vaccine required for anyone working with patients or in a patient building during flu season</td>
<td>Authoritative guidelines</td>
</tr>
</tbody>
</table>
Policy: BILL OF RIGHTS AND RESPONSIBILITIES (formerly # RI-2-01)

**Type:** Patient Care Manual

**Applicable to:** CHOP Enterprise-wide

**Policy owner:** Director, Family Relations Department

**Effective Date:** March 24, 2011

**Approved by:** Ethics Committee

**Accountable for:** Michele Lloyd, Senior VP of HIM and Family Services

1. **Policy Statement**

The Hospital informs each patient, or where appropriate: parent, Patient Representative or Support Person of their rights and responsibilities upon admission as an inpatient or outpatient.

Staff receives orientation and ongoing education regarding the Bill of Rights and Responsibilities.

Bill of Rights and Responsibilities are posted in each clinical department.

Admission Coordinators document receipt of the Bill of Rights and Responsibilities in the EPIC registration system when patients are admitted to the hospital as an inpatient.

Hospital Management staff conduct investigations of alleged violations of patients’ rights and responsibilities and ensure enforcement of patients’ rights.

New Jersey licensed facilities provide a written copy of the patient rights and responsibilities.

2. **Exceptions**

Children’s Hospital Home Care (CHHC) is excluded from this policy since CHHC has its own policy and procedure for Patient Rights and Responsibilities policy, #1.01.

3. **Definitions**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Representative</td>
<td>A person who, under state law, has the authority to act on behalf of an individual in making decisions related to health care. The parent of a Minor is generally treated as a Minor’s Patient Representative as is any person designated by Court Order as the Minor’s legal guardian or as a person who can otherwise make medical decisions on behalf of the Minor. A person designated by Court Order as the legal guardian of an Adult is treated as the Adult’s Patient Representative, as are an Adult’s Health Care Agent and an Adult’s Health Care Representative.</td>
</tr>
<tr>
<td>Support Person</td>
<td>A person designated by the patient or patient representative, including but not limited to: a spouse, a domestic partner (including same-sex domestic partner), another family member, or</td>
</tr>
</tbody>
</table>
A Support Person is not an authorized decision-maker for the patient unless otherwise noted in the patient’s Advance Directive.

4 Related Documents

<table>
<thead>
<tr>
<th>Document Type</th>
<th>Document Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policies</td>
<td>Visitation of Patients</td>
</tr>
<tr>
<td>Procedures</td>
<td>Visitor Restriction Guidelines (# RI-3-02)</td>
</tr>
<tr>
<td></td>
<td>Family and Visitor Guidelines (# RI-3-01)</td>
</tr>
<tr>
<td>Job Aids</td>
<td>Bill of Rights and Responsibilities</td>
</tr>
<tr>
<td>Regulatory References</td>
<td>The Center for Medicare and Medicaid Services: 42 CFR Part 482</td>
</tr>
</tbody>
</table>
Policy: SAFETY EVENT AND NEAR MISS REPORTING (formerly #TX-13-01, Incident Reporting)

<table>
<thead>
<tr>
<th>Type:</th>
<th>Patient Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicable to:</td>
<td>CHOP Enterprise-wide</td>
</tr>
<tr>
<td>Policy owner:</td>
<td>Director, Office of Patient Safety and Quality</td>
</tr>
<tr>
<td>Effective Date:</td>
<td>July 31, 2012</td>
</tr>
<tr>
<td>Supersedes:</td>
<td>2/22/2012; Patient Care Manual policy #TX-13-01, Incident Reporting (effective date 7/14/97)</td>
</tr>
<tr>
<td>Approved by:</td>
<td>Chief Medical Officer and Patient Safety Officer</td>
</tr>
<tr>
<td>Accountable for:</td>
<td>Michael Apkon, MD, PhD Chief Medical Officer</td>
</tr>
</tbody>
</table>

1 Policy Statement

Hospital employees and medical staff shall report all patient safety and all safety concerns or events within 24 hours of the discovery or notification of an event. Medication errors shall be reported in the same manner in which patient safety events are reported. Adverse Drug Reactions (ADR) will be reported in compliance with policy TX-7-07, Adverse Drug Reaction Reporting. Retaliation against any individual for reporting a safety event or near miss is strictly prohibited.

Staff are trained on Safety Event and Near Miss Reporting during the new staff orientation period.

The Hospital reports safety events to the Pennsylvania Patient Safety Reporting System (PA-PSRS).

Reporting of employee and visitor incidents shall adhere to the following guidelines:

- **Main campus locations:** Security should be called to respond to employee and visitor incidents. Security tracks employee and visitor incidents at the main campus as per their department policy.

- **Off-site locations:**
  - Call 911 for patients, employees or visitors that require immediate medical attention.
  - For visitor incidents, complete the “Visitor Incident Report for Use at Locations Outside of CHOP’s Main Campus” Job Aid and submit to Risk Management.
  - “Non-injury” related employee reports at locations outside of CHOP’s main campus should be reported to Security (for example: vehicle damage, building graffiti, employee harassment).

2 Scope

All patient safety events or concerns should be reported through the electronic event reporting system, regardless of location within the CHOP enterprise.

3 Exceptions

ALL locations: Employee accidents and injuries should be reported to Occupational Health utilizing the paper form entitled “Employee Accident/Injury Report,” as per Human Resources policy #6-3, “Work-Related Injuries and Illness.”
Policy: SAFETY EVENT AND NEAR MISS REPORTING (formerly #TX-13-01, Incident Reporting)

4 Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Event Report</td>
<td>Any safety event or near miss which is submitted to the electronic event reporting system.</td>
</tr>
<tr>
<td>Medication Errors</td>
<td>Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use. These are submitted to the electronic event reporting system and the attending physician is notified and if unavailable the covering physician or designee is notified and the attending is notified when available.</td>
</tr>
<tr>
<td>Safety Event</td>
<td>A deviation from the generally accepted performance standards that may or may not cause harm.</td>
</tr>
<tr>
<td>Serious Safety Event</td>
<td>A safety event that reaches the patient and causes moderate to severe harm or death.</td>
</tr>
</tbody>
</table>

4 Related Documents

<table>
<thead>
<tr>
<th>Document Type</th>
<th>Document Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policies</td>
<td>Adverse Drug Reaction Reporting, #TX-7-07</td>
</tr>
<tr>
<td>Procedures</td>
<td>Manager Review of Safety Net Reports</td>
</tr>
<tr>
<td></td>
<td>Patient Safety Event and Near Miss Reporting</td>
</tr>
<tr>
<td>Job Aids</td>
<td>Entering Patient Related Events into Safety Net</td>
</tr>
<tr>
<td></td>
<td>Entering Non-Patient Related Events into Safety Net</td>
</tr>
<tr>
<td></td>
<td>Reviewing Events in Safety Net</td>
</tr>
<tr>
<td></td>
<td>Visitor Incident Report for Use at Locations Outside of CHOP’s Main Campus</td>
</tr>
<tr>
<td>Regulatory References</td>
<td>PA PSRS Act 13 &amp; Act 52</td>
</tr>
<tr>
<td></td>
<td>CMS Part 42CFR 482.25(B)(6)</td>
</tr>
<tr>
<td></td>
<td>Joint Commission standard HR.01.05.03</td>
</tr>
</tbody>
</table>
POLICY
The Hospital is committed to maintaining an environment that encourages and fosters appropriate conduct among employees and respect for individual values. Accordingly, the Hospital is committed to enforcement of its Non-Discrimination and Harassment Policy at all levels within the workplace in order to create an environment free from discrimination and/or harassment. In all instances, the Hospital will continue to comply with applicable federal, state and municipal regulations governing employment practices.

Sexual Harassment and Quid Pro Quo Harassment are forms of sex discrimination and are also prohibited by this policy. Discrimination, including Sexual Harassment and Discriminatory Harassment is unacceptable in the workplace and in other work-related settings such as business trips, conferences and business-related social events. Such conduct will not be tolerated, and is prohibited by this policy and will be dealt with according to Human Resource’s Rules of Conduct Policy 5-2 section: V, subsection C.

Retaliation in any way against anyone who has, in good faith, complained, has raised concerns or formally reported about discrimination, Sexual Harassment or Discriminatory Harassment regardless whether that complaint or concern relates to the individual raising the concern or complaint will not be tolerated, and is prohibited by this policy, and by applicable law.

No Executive, manager, supervisor, employee or other person is authorized by the Hospital to engage in discrimination, Sexual Harassment or Discriminatory Harassment. Management level personnel are expected to serve as role models to other employees with regard to appropriate workplace conduct, and will be held to a higher standard of accountability with respect to their actions in the workplace. Management personnel should not only refrain from actions that violate this policy, but should refrain from any activity that would give the appearance of impropriety.

PURPOSE
It is the policy of the Hospital to prohibit discrimination and harassment on the basis of race, color, religion, sex, age, national origin, ancestry, sexual orientation, gender identity, marital status, disability, covered veteran status, genetic information, victim of domestic or sexual violence status or other protected classifications to the extent required by applicable laws.

SCOPE
This policy applies to Trustees and Officers of the Hospital and The Children’s Hospital Foundation and entities affiliated with either of them, employees of The Children’s Hospital of Philadelphia, its ambulatory care facilities, members of the Hospital Medical Staff, members of the Hospital Research Staff, directors and employees of CHOPPA practice plans (currently Children’s Anesthesiology Associates, Ltd., Children’s Health Care Associates, Children’s Surgical Associates, Ltd., and Radiology Associates of Children’s Hospital, Inc.), and other persons whose presence at or affiliation
with the Hospital may place them in a position of power over employees of the Hospital or staff and other persons designated by the President, Executive Vice President or Department Chairs.

This policy also prohibits harassment by Hospital personnel against any person, as well as any harassment directed towards Hospital personnel by contractors, consultants, suppliers, vendors, visitors, and other non-employees, when such conduct occurs at Hospital property or in connection with Hospital activities or the performance of Hospital work.

**RELATED DOCUMENTS**

Human Resources Policy and Procedures Manual  5-2  [Rules of Conduct](#)

Human Resources Policy and Procedures Manual  5-3  [Employee Separation from Employment](#)

Human Resources Policy and Procedures Manual  5-4  [Demotion](#)

**DEFINITIONS and EXAMPLES**

I. **Definitions:**

A. **Discriminatory Harassment:** Unwelcome verbal or physical acts against or differential treatment of an individual because of his or her race, color, religion, sex, age, national origin, sexual orientation, gender identity, marital status, disability, covered veteran status, genetic information, victim of domestic or sexual violence status or other protected classifications to the extent required by applicable laws, where such conduct interferes with an individual’s work performance or creates an intimidating, hostile or offensive working environment.

B. **Hostile Work Environment:** Conduct that has the purpose or effect of unreasonably interfering with an individual’s work performance, or creates an intimidating, hostile or offensive working environment.

C. **Sexual Harassment:** A form of discrimination that consists of unwelcome sexual advances, requests for sexual favors or other verbal or physical acts of a sexual or sex-based nature where:
   1. Submission to such conduct is made either explicitly or implicitly a term or condition of an individual’s employment; or
   2. An employment decision is based on that individual’s acceptance or rejection of such conduct.

D. **Quid Pro Quo Harassment:** A form of Sexual Harassment that occurs when a manager or supervisor threatens an individual with loss of job benefit, or changes working conditions because the employee will not submit to sexual demands. It also occurs when sexual activity is required in return for getting or keeping a job or job-related benefit.

Quid Pro Quo Harassment occurs between a manager/supervisor and employee due to the nature of the manager/subordinate relationship. A manager/supervisor is defined as someone who can affect individual working conditions because he/she can take action such as hiring,
firing, promoting, disciplining and deciding raises.

II. Examples:

A. Discriminatory Harassment:

1. Prohibited acts of Discriminatory Harassment can take a variety of forms ranging from subtle racial or religious joking to actual physical contact or violence. At times the offender may be unaware that his or her conduct is offensive or harassing to others. Examples of conduct that could be considered Discriminatory Harassment include:

   a. Offensive statements, materials, unwelcome jokes or gestures directed toward another, which involve the other’s race, color, religion, sex, age, national origin, sexual orientation, gender identity, marital status, disability, covered veteran status, genetic information, victim of domestic or sexual violence status or other protected classifications to the extent required by applicable laws, or similar degrading comments about another;

   b. Preferential treatment of another employee, or a promise of preferential treatment to an employee on the basis of his or her race, color, religion, sex, age, national origin, sexual orientation, gender identity, marital status, disability, covered veteran status, genetic information, victim of domestic or sexual violence status or other protected classifications to the extent required by applicable laws; or the denial or threat of denial of employment, employment benefits or advancement on the basis of his or her race, color, religion, sex, age, national origin, sexual orientation, gender identity, marital status, disability, covered veteran status, or other protected classifications to the extent required by applicable laws;

   c. The display of offensive pictures, cartoons or other materials involving race, color, religion, sex, age, national origin, sexual orientation, gender identity, marital status, disability, covered veteran status, genetic information, victim of domestic or sexual violence status or other protected classifications to the extent required by applicable laws;

   d. Physical assault against another or against another’s property because of the other’s race, color, religion, sex, age, national origin, sexual orientation, gender identity, marital status, disability, covered veteran status, genetic information, victim of domestic or sexual violence status or other protected classifications to the extent required by applicable laws;

   e. Retaliation against an individual for disclosing, reporting or complaining about discriminatory harassing conduct.

2. Prohibited acts of Discriminatory Harassment can take a variety of forms ranging from subtle racial or religious joking to actual physical contact or violence. At times the offender may be unaware

B. Hostile Work Environment:

1. Offensive conduct can be verbal, physical or both;

2. Conduct is repetitive and frequent;
3. Conduct is hostile and openly offensive;
4. The alleged harasser is a co-worker or supervisor;
5. Co-workers joined in perpetuating the harassment; and/or
6. Harassment is directed at more than one individual.

C. **Sexual Harassment:**

   Prohibited acts of Sexual Harassment can take a variety of forms ranging from subtle pressure for sexual favors or contact to actual physical contact. At times the offender may be unaware that his or her conduct is offensive or harassing to others. However, such lack of awareness will not excuse a violation of this policy. Examples of conduct that could be considered Sexual Harassment under this policy include but are not limited to:
   1. Repeated instances of unwelcome flirting, pressure for dates, sexual comments or unnecessary/unwelcome touching;
   2. Sexually suggestive jokes or gestures, or sexually orientated or degrading comments about another;
   3. Preferential treatment, or a promise of preferential treatment to an employee, in exchange for dates or sexual conduct; or the denial or threat of denial of employment, employment benefits or advancement for refusal to consent to sexual advances (Quid Pro Quo Harassment);
   4. The display of sexually oriented pictures, posters, or other sexually oriented material;
   5. Rape, attempted rape and other forms of non-consensual physical sexual contact;
   6. Retaliation against an individual for disclosing, reporting or complaining about sexually harassing conduct.
   7. Inappropriate references to anatomy or discussions surrounding such topics not directly related to patient care, in the work or common areas
   8. Sexual Harassment may occur between employees of the same or of different rank, and between persons of the same or a different gender.

D. **Quid Pro Quo Harassment:**

   1. Some benefit is achieved in return for a favor that is usually sexual in nature;
   2. Employee is submitted to un-welcome sexual conduct in exchange for a job-related award or to avoid a job related penalty;
   3. Harassment that occurs between a manager/supervisor and employee due to the nature of the manager/subordinate relationship.

**IMPLEMENTATION**

A. All personnel are encouraged to express displeasure at offensive conduct by telling the individual engaging in the conduct that it is unwelcome or offensive, and to report that conduct, through the use of the Hospital’s complaint procedures.

B. The Hospital will not tolerate, condone or allow discrimination, including Sexual Harassment, or Discriminatory Harassment, whether engaged in by fellow employees, supervisors or others affiliated with the Hospital or by outside vendors, patients, visitors or other non-employees who
conduct business with the Hospital. All employees are required by this policy to report all incidents of discrimination, or sexual or Discriminatory Harassment, regardless of the offender or the person toward whom the offensive conduct is directed.

C. Any individual who believes that he or she is being subjected to conduct or actions by another person that violates this policy is encouraged to notify the offender firmly and promptly that his or her behavior is unwelcome or inappropriate. In the event that such informal, direct communication would be either ineffective or impossible, the following steps should be taken to report a discrimination or sexual or Discriminatory Harassment.

1. Reporting of Incident: Any employee, who believes that he or she has been subjected to discrimination including Sexual Harassment or Discriminatory Harassment prohibited by this policy, or who has witnessed such discrimination or harassment, has a responsibility to immediately report the circumstances in accordance with the procedure set forth below. In addition, all management and supervisory personnel have an affirmative duty to promptly report any discrimination or harassment that they observe, which is made known to them by others, or that they reasonably suspect has occurred. The following procedures are designed to investigate and resolve a complaint. A report/complaint can be initiated in the following way:
   a. Reporting the matter to the employee’s own immediate supervisor in the form of a written summary of their concerns;
   b. If the matter involves the employee’s own immediate supervisor or if, for any reason, the employee feels uncomfortable talking to his or her immediate supervisor, the employee may report the matter to (a) the department or division’s assigned Human Resources Business Partner or (b) any other Human Resources Business Partner.

2. Because a complainant may prefer to report harassment to someone of the same or opposite gender or sexual orientation, or the same or different race, color, national or ethnic origin, disability, religion or other classification as that of the complainant, Human Resources will attempt, to the extent possible, to have available a reasonably diverse group of individuals to whom such reports may be made.

3. Investigation of Report/Complaint:
   a. Once a complaint has been received, it will be promptly and fairly investigated. The Hospital will, to the extent practicable, maintain confidentiality, consistent with a full and fair investigation. The supervisor or the Human Resources Consultant or designee will initiate an investigation of the suspected discrimination or sexual or Discriminatory Harassment. If appropriate, the representative of the Hospital investigating the complaint may designate another supervisory or management employee to assist him or her in the investigation. The investigator(s) may be external to the Hospital.
   b. The investigation may include interviews with the employee(s) who made the initial report and the person(s) towards whom the suspected discrimination or harassment was directed, the employee(s) suspected of the discrimination or harassment and/or any other person who may have information regarding the incident. Relevant documents may also be reviewed. All employees have an affirmative duty to cooperate with any investigation by
providing truthful and accurate information.

4. Results: After the investigation is completed, the person responsible for investigating the complaint shall advise relevant management of the findings of the investigation. The employee(s) who made the initial report, the employee(s) to whom the alleged discrimination or harassment was directed, and the employee(s) accused of the discrimination or harassment will be informed of the findings. In response to the findings, the Hospital will, in its sole discretion, take such action as appropriate to prevent any future unacceptable conduct, up to and including discharge of any employee found to have violated this policy. It is within the Hospital’s discretion to determine appropriate action.

5. Timeframe for reporting of complaint: The Hospital requires a prompt reporting of complaints so that prompt response and appropriate action may be taken. However, due to the sensitivity of these problems and because of the emotional toll such misconduct may have on the individual; there is no fixed deadline for reporting discrimination or sexual or Discriminatory Harassment complaints. Delayed reporting of complaints will not in and of itself preclude the Hospital from taking appropriate action.

6. Protection against Retaliation: The Hospital will not in any way retaliate against an individual who, in good faith, reports discrimination or sexual or Discriminatory Harassment, nor permit anyone to do so. Retaliation is a serious violation of this Non-Discrimination and Harassment policy and should be reported immediately a Human Resources Consultant or to his or her own supervisor. Any person found to have retaliated against another individual for reporting discrimination or sexual or Discriminatory Harassment will be subject to the same disciplinary action provided for discrimination or sexual or Discriminatory Harassment offenders.

7. Disciplinary Sanctions:
   a. The Hospital will discipline any employee found to have engaged in conduct that violates this policy. An employee in violation of this policy shall be subject to the full range of institutional disciplinary sanctions and procedures. This includes, without limitation, discharge and other disciplinary actions set forth more fully in the Hospital’s Human Resource Policy and Procedures Manual, including Policy No. 5-2 (Rules of Conduct), Policy No. 5-3 (Employee Separation) and Policy No. 5-4 (Demotion). The Hospital has the right to discharge for violations of this policy. Any discipline imposed is within the sole discretion of the Hospital.
   b. As described in Human Resource Policy No. 5-2, a first violation of this policy may warrant suspension or discharge. Discipline for a violation of this policy need not be progressive. Where a Hostile Work Environment has been found to exist, the Hospital will take prompt and effective action to eliminate the conduct creating such an environment.
   c. If an investigation results in a finding that the complainant knowingly or maliciously made a false accusation against another of discrimination or sexual or Discriminatory Harassment, the complainant will be subject to appropriate sanctions, including the possibility of termination of employment.
## RESPONSIBILITY FOR MAINTENANCE OF THIS POLICY

**PRESIDENT AND CHIEF OPERATING OFFICER**

<table>
<thead>
<tr>
<th>Supersedes</th>
<th>Approved by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/20/2012</td>
<td>______________________________</td>
</tr>
<tr>
<td></td>
<td>Robert Croner – Senior Vice President Human Resources</td>
</tr>
</tbody>
</table>

This Administrative Policy is the property of The Children's Hospital of Philadelphia and is to be used solely by employees of the Hospital, the Hospital Medical Staff and those acting on the Hospital's behalf either on the premises of the Hospital in connection with Hospital matters or in their Hospital duties involving the care of Hospital patients. This Policy may not be copied, photocopied, reproduced, entered into a computer database or otherwise duplicated, in whole or in part in any format. Any personal or other use is strictly prohibited.

THE CHILDREN’S HOSPITAL OF PHILADELPHIA © 2014
Policy: Rules of Conduct

<table>
<thead>
<tr>
<th>Type:</th>
<th>Human Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicable to:</td>
<td>The Children’s Hospital of Philadelphia (“CHOP”) Enterprise Wide</td>
</tr>
<tr>
<td>Process owner:</td>
<td>Sr. Human Resources Business Partner</td>
</tr>
<tr>
<td>Effective Date:</td>
<td>7/1/2013</td>
</tr>
<tr>
<td>Supersedes:</td>
<td>4/1/2013</td>
</tr>
<tr>
<td>Approved by:</td>
<td>Health System Director, Human Resources</td>
</tr>
<tr>
<td>Document ID #:</td>
<td>5-2</td>
</tr>
<tr>
<td>Accountable for:</td>
<td>Robert E. Croner, Sr. Vice President, Human Resources</td>
</tr>
</tbody>
</table>

1. PURPOSE:

The purpose of this policy is to establish rules and guidelines that communicate attendance, conduct and performance expectations to employees and discipline that could result from violations of the Rules of Conduct.

2. POLICY:

The Children’s Hospital of Philadelphia (Hospital) has established these Rules of Conduct to promote a safe and efficient work environment and to support high performance. However, nothing in this policy creates a contract of employment or is intended to create a contract of employment between an employee and the Hospital. The Hospital maintains the right to discipline or terminate employees consistent with the doctrine of at-will employment as applicable.

An employee will be subject to progressive disciplinary actions ranging from Level 1: General counseling to termination for committing or participating in any of the acts listed in this policy. The intent of progressive discipline is to change inappropriate behavior or conduct or to address performance-related issues. The levels of discipline listed are only a guide. The Rules of Conduct do not address every situation, nor is corresponding disciplinary action limited to the listed violations. The Hospital reserves the right to impose the level of discipline it, in its sole discretion, deems appropriate based on each specific set of circumstances.

3. COVERAGE:

All employees of The Children’s Hospital of Philadelphia, and its other affiliated Hospitals unless otherwise noted. For purposes of this policy, an affiliate of The Children’s Hospital of Philadelphia is one that is controlled by the Hospital or under common control with the Hospital.

4. PROCEDURES:

The following procedures are general guidelines for progressive discipline and corrective action.

1. Rules of conduct are categorized as Attendance, (see Section III), or Conduct, (see Section IV). Discipline is administered in a progressive manner based on the seriousness of the offense. All
steps require documentation. The following is the range of disciplinary actions from least severe to most severe. All levels of discipline must be documented using the Disciplinary Action Report. (See Disciplinary Action Report, Appendix A)

- Level 1: General Counseling
- Level 2: Oral Warning
- Level 3: Written Warning
- Level 4: Final Warning
- Termination

II. **Progressive Discipline**

A. Progressive discipline means that when an employee violates a rule of conduct he or she will move to the next higher step in the discipline process after repeated incidents of the same violation (e.g., a disciplinary violation following a written warning for the same rule violation will result in a Level 4: Final warning).

B. An employee’s attendance, conduct or performance record must be clear of violations of the same rule for 12 months to avoid progressive discipline. ([Progressive Discipline Flow Chart, Appendix B](#))

C. The Hospital reserves the right to take disciplinary action with regard to conduct by any employee that is detrimental to the Hospital, or when such disciplinary action is in the best interest of the Hospital.

D. The Hospital has adopted a performance management framework referred to as a fair and just culture. This is a key component in our journey to safekeeping. A fundamental tenet of performance management is to help employees achieve desired outcomes through feedback, coaching and corrective action, and to fully understand the causes of unsatisfactory performance outcomes. In a fair and just culture, employees can expect to be held accountable for not following appropriate work processes, protocols or policies, while managers are expected to investigate events to determine if system or process issues may have contributed to an employee's action. As such, managers are expected to utilize the Performance Management Decision Guide (PMDG) in the process of diagnosing rule of conduct violations.

E. Management personnel should consult with their HR Business Partner when questions arise involving the application of this policy. A Human Resources Business Partner must be consulted prior to the issuance of any discipline above the Level 3: Written warning level.

F. Original copies of disciplinary actions must be sent to the HR Business Partner for filing and a copy retained in the employee’s departmental file. A copy must also be provided to the employee.

G. The Hospital may determine that it is within the best interests of the Hospital, its employees, visitors and/or patients, to place an employee on administrative leave.
pending the outcome of an investigation into a rule violation. In such circumstances, the employee will be required to use unscheduled paid personal leave (UPPL) or, if the employee has no available PPL time, the employee will receive no pay for missed work days during administrative leave (salaried employees will receive a full days’ pay for partial days worked; hourly employees will be paid at the employee’s regular hourly rate only for hours worked). If the investigation reveals that the employee did not violate the applicable rule, the Hospital will restore the PPL days used during the administrative leave or, pay the employee for time unpaid due to administrative leave, as applicable. Employees who are placed on administrative leave and subsequently terminated due to the findings of a rule of conduct investigation will be terminated effective their last day worked.

III. Attendance & Related Work Rules – (A)

Employees are encouraged to manage their time off and to work with their managers to schedule time off needs in advance. The following is a list of attendance related rules of conduct. Managers must document all attendance violations. Incidents that do not result in discipline will clear upon the 12-month anniversary of the occurrence except as otherwise noted in this policy.

Notice Requirement
Each employee is expected to notify his/her department of an absence or lateness in accordance with the notice requirement established by the Hospital. An employee must notify his/her supervisor, manager or other authorized designee a minimum of 2 hours before the start of their shift. Failure to notify the department within established hospital guidelines could result in disciplinary action (See paragraph A5 below). However, failure to notify the department of an absence at all is considered a no call/no show, which will warrant a Level 4: Final warning. (See paragraph A10 below).

Family and Medical Leave Act (FMLA) Reminder:
Whether the employee is seeking to take a continuous (three days or longer), intermittent, or reduced schedule leave of absence under the Hospital’s Family and Medical Leave of Absence (“FMLA”) Policy, the employee must contact both UNUM (1-866-679-3140) and his or her department (supervisor, manager or other authorized person) as explained in the Notice section of the FMLA Policy (Leave of Absence Policy, 5-14). Employees seeking FMLA leave are expected to consult the FMLA policy and comply with all notice requirements in that policy.

Level 1: General Counseling
A1. Non-exempt employees are expected to swipe in and out each scheduled shift. Failure to swipe in and/or out two times during a payroll cycle will warrant a Level 1: General counseling and may cause payment for any time owed to be delayed until the next payroll cycle.

A2. Non-exempt employees are not to swipe in or out more than five minutes from the start or end of their shift. A non-exempt employee who swipes in and out more than five minutes from the start or end of the shift, or who works unauthorized additional hours without the express permission of the supervisor, will warrant a Level 1: General counseling.

A3. Non-exempt employees are to swipe at the clock designated by department standards. Failure to swipe in and/or out at the designated clock will warrant a Level 1: General counseling.
Policy: Rules of Conduct

Level 2: Oral Warning

A4. Non-exempt employees are expected to notify a supervisor or timekeeper of a missed swipe as soon as they realize it but no later than the last day of the pay period. Failure to properly notify the supervisor or timekeeper of a missed swipe will warrant a Level 2: Oral warning and may cause any payment for the time owed to be delayed until the next payroll cycle. Employees should use the Star Time Record Update Request Form to record the date and time of missed swipes. (Star Time Record Update Request Form, Appendix D)

A5. An Employee is expected to notify his or her department of an absence a minimum of two hours before the start of his or her shift. Failure to notify the department within established guidelines will warrant a Level 2: Oral warning.

A6. An employee who is on or is seeking a leave of absence under the Hospital’s FMLA Policy is required to notify his or her department and UNUM in accordance with the rules described in the Notice section of the FMLA Policy. Failure to provide notice that is in accordance with those rules may result in delay or denial of FMLA and a Level 2: Oral warning, unless such notice was not practicable.

Example 1: FMLA may be delayed or denied and discipline issued for an employee who was on intermittent leave for migraines and notified the department of absence five minutes after the start of the scheduled shift (instead of the required two hours before), but could offer no acceptable reason as to why calling on time was not practicable.

Example 2: FMLA may be delayed or denied and discipline issued for an employee who scheduled a surgery 60 days ahead of time, but did not notify his department or UNUM until the week before the surgery.

Example 3: FMLA may be delayed or denied and discipline issued for an employee who applied for a continuous leave of absence for a leg injury, but who failed to notify both UNUM and the department each day of the absence until the FMLA was approved, and offered no acceptable reason as to why such notification was not practicable.

Level 3: Written Warning

A7. Employees are expected to follow departmental on-call procedures. Failure to respond to a page or call, in accordance with departmental policy, when on-call will warrant a Level 3: Written warning.

Level 4: Final Warning

A8. When an employee has requested time off, the request is denied and then the employee does not honor the denial and fails to report to work as scheduled, the employee’s conduct is considered an insubordinate absence, will warrant a Level 4: Final warning and will receive an incident of UPPL.

A9. Failure to call or report to work within two hours of the start of the employee’s scheduled shift is considered a no-call no/show, will warrant Level 4: Final warning and are required to use UPPL.

A10. An employee, who is on or is seeking a leave of absence under the Hospital’s FMLA Policy, is required to notify his or her department and UNUM in accordance with the rules described in the Notice
section of the FMLA Policy. Failure to provide notice within two hours of the start of the employee’s scheduled shift is considered a no call no show and may result in delay or denial of FMLA and a Level 4: final warning, unless such notice was not practicable.

**Termination**

**A11.** Employees are not permitted or authorized to record another employee’s time in the STAR System (through swipe, data entry or any other means); nor may employees allow others to record their time in the STAR System. Employees who record another’s time or allow another to record their time, without the express permission of a department head, will be Terminated.

**A12.** Failure to call or report to work on two consecutive scheduled days will be considered job abandonment and will warrant Termination.

**Cumulative Occurrences**

**A13.** Employees are not permitted to be absent from work without using paid personal leave (PPL) except for certain types of approved leaves of absence. (See Leave of Absence Policy, 5-14 for guidelines regarding use of PPL while on a leave of absence). If an employee is absent and does not have PPL time in his or her bank to cover the absence, this is considered absence after exhaustion of PPL. Absence after exhaustion of PPL is progressively disciplined as follows:

- First Incident: Level 3: Written warning
- Second Incident: Level 4: Final warning
- Third Incident: Termination

**Discipline for incidents of absence after exhaustion shall expire after 18 months.**

*Employees who exhaust PPL as a result of having been placed on administrative leave will not be subject to discipline for exhaustion.*

**A14.** Lateness is a failure to be present and prepared to work at the scheduled start time. Employees who fail to report and be prepared to work on time will be considered late. All lateness incidents will be documented. Incidents of lateness that do not result in discipline will clear upon the 12 month anniversary of the occurrence. Discipline for lateness is administered in a progressive and cumulative fashion, according to the following sequence:

- 6 late occurrences: Level 1: General counseling
- 3 additional late occurrences: Level 2: Oral warning
- 3 additional occurrences: Level 3: Written warning
- 3 additional occurrences: Level 4: Final warning
- 2 additional occurrences: Termination

Lateness in excess of two hours from the scheduled start of an employee’s shift will be considered an incident of UPPL.

**A15.** An unscheduled paid personal leave (UPPL) incident is an unapproved absence from work (for any number of regular, overtime or on-call hours). A UPPL absence of up to and including five consecutive calendar days for the same reason will be considered as one UPPL incident. Employees who have six UPPL incidents within a rolling 12 month period will warrant a Level 1: general counseling Discipline for UPPL is
Policy: Rules of Conduct

administered in a progressive and cumulative fashion according to the following sequence:

- 6 UPPL incidents: Level 1: General counseling
- 3 additional UPPL incidents: Level 2: Oral warning
- 2 additional UPPL incidents: Level 3: Written warning
- 2 additional UPPL incidents: Level 4: Final warning
- 1 additional UPPL incident: Termination

Incidents of UPPL that do not result in discipline will clear upon the 12 month anniversary of the occurrence.

Example 1
Employee: Jane Doe
Documented UPPL Incidents

<table>
<thead>
<tr>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 23, 2012</td>
</tr>
<tr>
<td>January 28, 2012</td>
</tr>
<tr>
<td>May 29, 2012</td>
</tr>
<tr>
<td>October 30, 2012</td>
</tr>
<tr>
<td>November 23, 2012</td>
</tr>
</tbody>
</table>

Manager reviews the prior 12 months and notes that since last November Jane has had 5 documented UPPLS – alerts Jane that one more could result in discipline.

<table>
<thead>
<tr>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 9, 2013</td>
</tr>
</tbody>
</table>

Manager meets with Jane, provides written documentation along with a completed Disciplinary Action Report.

Example 2
Employee: John Doe
Documented UPPL Incidents

<table>
<thead>
<tr>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 24, 2012</td>
</tr>
<tr>
<td>January 19, 2013</td>
</tr>
<tr>
<td>April 22, 2013</td>
</tr>
<tr>
<td>September 18, 2013</td>
</tr>
<tr>
<td>December 26, 2013</td>
</tr>
<tr>
<td>December 29, 2013</td>
</tr>
</tbody>
</table>

Manager reviews the prior 12 months, and notes that John had 5 incidents since December 29, 2012, informs John that one more occurrence before January 19 would result in discipline.

<table>
<thead>
<tr>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 20, 2014</td>
</tr>
</tbody>
</table>

Prior incidents of December 24, 2012 and January 19, 2013 have cleared by this date.

<table>
<thead>
<tr>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 1, 2014</td>
</tr>
</tbody>
</table>

Manager reviews prior 12 months and notes that since February 1 2013, John has had 6 incidents of UPPL, meets with John and provides him written documentation along with a completed Disciplinary Action Report.

The Hospital recognizes its obligation to comply with the Family and Medical Leave Act (FMLA) and corresponding state laws. A UPPL occurrence, for reasons that qualify under the FMLA or corresponding state laws, is not treated as an incident for purposes of this policy. See HR Policy 5-14.
Policy: Rules of Conduct

Employees who are in the “Weekend Nursing Program” or other such programs are subject to the guidelines for attendance outlined in the policies regulating those programs.

As a general rule, three sequential incidents of routine, predictable UPPL within a three-month period are considered a patterned UPPL and will warrant an Level 2: Oral warning (for example if an employee routinely and predictably has a UPPL absence the day after his/ her softball game, such absences are patterned UPPL.)

IV. Conduct Related Work Rules – (C)

Level 1: General Counseling

C1. Employees are expected to work in their assigned areas until the end of their scheduled shift. Stopping work early or preparing to leave the work area before authorized to do so (this includes, but is not limited to, stopping work before being authorized to do so for breaks and the end of the work day) will warrant a Level 1: General counseling.

C2. For safety and the overall appearance of the Hospital, employees are expected to maintain good housekeeping and sanitation standards in their work areas, lockers, break rooms, etc. Violating good housekeeping practices, such as creating unsanitary conditions, will warrant a Level 1: General counseling.

C3. Employees are required to follow both the standards set by their department and Employee Appearance Policy, HR Policy 5-7. Failure to comply with Hospital or departmental standards of appearance, dress, uniform, personal hygiene or work image will warrant a Level 1: General counseling.

Level 2: Oral Warning

C4. Employees are not permitted to solicit, conduct or transact unauthorized or non-Hospital related business on Hospital premises. Soliciting or transacting unauthorized personal business on Hospital premises will warrant a Level 2: Oral warning through Termination, depending on the seriousness of the violation.

C5. Employees are expected to follow the safety rules and guidelines established by the department of environmental health and safety, occupational health and the employees’ supervisors. Violations of the Hospital’s rules and guidelines governing safety, including safety related to environmental health and patient safety, will warrant a Level 2: Oral warning through Termination, depending on the seriousness of the violation.

C6. Employees are not permitted to smoke anywhere in the Hospital in accordance with HR Policy 5-16. Smoking areas have been designated and marked on the exterior of the Hospital. Violation of no smoking rules will warrant a Level 2: Oral warning through Termination, depending on the seriousness of the violation.

C7. Employees are expected to interact with others in a polite and professional manner. Rude, insulting and/or discourteous behavior is unacceptable and will warrant a Level 2: Oral warning.

C8. Employees are expected to conduct themselves in a manner that supports the Hospital’s mission, vision and values. Engaging in any activity that has an adverse impact on the operation of the Hospital, whether or not that activity is explicitly delineated in these Rules of Conduct will warrant a Level 2: Oral warning.
warning through Termination, depending on the seriousness of the violation and the impact on the Hospital.

C9. Employees are expected to perform work duties as assigned in the job description or pursuant to supervisory instruction. Those found not performing at an acceptable Level regarding the quantity of work will warrant a Level 2: Oral warning.

C10. Employees are expected to perform work duties as assigned in the job description or pursuant to supervisory instruction. Those found not performing at an acceptable Level regarding the quality of work will warrant a Level 2: Oral warning.

Level 3: Written Warning

C11. Employees are issued or permitted to use Hospital systems or property in the course of assigned work duties. Unauthorized use of Hospital systems or property is prohibited.

Unauthorized use (use other than in the course of assigned work duties) of any Hospital property including, but not limited to, ID badges, access cards, keys, the e-mail system, cellular phones, intranet/internet connection, equipment or materials whether owned or leased will warrant a Level 3: Written warning.

C12. Employees are only permitted to be on the Hospital's property for a scheduled shift to conduct work-related business or to visit or accompany a patient. Returning to, or remaining on, the premises during non-working time, or for reasons not described above, will warrant a Level 3: Written warning.

C13. Employees are expected to be in their assigned work areas except for scheduled (assigned) lunch or breaks. Any unauthorized absence from an assigned work area (as defined by supervisor) of less than one hour will warrant a Level 3: Written warning.

C14. Employees are expected to be alert and prepared to work their scheduled shift. Impaired employees are expected to notify their supervisors that they are unable to perform their job duties. Sleeping on the job will warrant a Level 3: Written warning through Termination, depending on the seriousness of the violation.

Level 4: Final Warning

C15. Employees are required to undergo certain health-related screenings and inoculations to help ensure the health, safety and well-being of CHOP patients, families, employees and other staff. Employees who fail to comply with health-related requirements as set by the Occupational Health Department including but not limited to annual tuberculosis screening (PPD) and annual influenza vaccination will be placed on administrative leave until the employee is compliant and may be subject to disciplinary action up to and including Termination for incidents of non-compliance. The Hospital will consider legitimate requests for medical and religious accommodations related to health screenings and inoculations consistent with legal requirements.

C16. Employees are expected to behave and interact in a professional manner at all times. Disorderly conduct or disruptive behavior on Hospital property will warrant a Level 4: Final warning.

Termination
C17. Employees are expected to be in their assigned work areas except for scheduled (assigned) lunch or other breaks. Any unauthorized absence from their assigned work area (as defined by the supervisor) of more than one hour will warrant a Level 4: Final warning or Termination.

C18. Employees are required to be truthful in all work-related activities. Falsification by omission or commission, either verbally or in writing with respect to work-related materials or information will warrant Termination.

C19. Employees are to behave in accordance the Hospital’s Non-Discrimination and Harassment Policy, A-4-18. Failure to do so will warrant discipline up to and including Termination.

C20. Employees are expected to participate in all investigative interviews. Failure or refusal to participate in an investigative interview will warrant a Level 4: Final warning or Termination.

C21. Employees are expected to perform the duties and assignments their supervisors direct them to perform (except when doing so will endanger themselves or others). Direct violation of an order is considered insubordination. Insubordination will warrant a Level 4: Final warning or Termination.

C22. Employees are expected to work in a courteous and professional manner. Disputes should be approached with a calm demeanor with the intent to resolve the issue. If necessary, the employee(s) should seek assistance from supervisory personnel in resolving disputes.

   A. All verbal and/or physical threats, bullying, vicious or malicious words, or forms of aggressive behavior are prohibited and will warrant a Level 4: Final warning or Termination.

   B. Fighting (including provoking or instigating fights) on Hospital property (whether or not an injury actually occurs) will warrant Termination.

C23. Unauthorized possession, use or disclosure of the confidential or proprietary information of the Hospital, including confidential information regarding the Hospital’s employees, will warrant a Level 4: Final warning or Termination. (See Confidentiality of Patient and Hospital Information, Patient Care Manual No. IM-1-01 & Social Media Guidelines)

C24. The Hospital is committed to a drug free work place (HR Policy 5-10). Unauthorized possession, diversion, use, sale, manufacture, purchase or distribution of a drug including intoxicants, hallucinogens, narcotics or other prohibited substances will warrant discipline up to and including Termination.

C25. Any unauthorized possession or use of the Hospital’s property outside of the employee’s work assignment is prohibited. Theft, improper possession or handling of lost or mislaid property, or destruction of Hospital property or the property of other employees, patients or visitors will warrant Termination.

C26. Employees are expected to be knowledgeable of the policies that address the receipt of funds from the Hospital (including, but not limited to, funds received for travel and tuition) and to abide by those policies. Employees are also required to notify the Hospital of overpayments such as errors in calculation of funds they receive from the Hospital. Failure to report tuition, scholarship, travel authorization, over-compensation or other overpayments in accordance with any agreement within those policies will warrant Termination.
Policy: Rules of Conduct

C27. Patient and employee safety are essential parts of the Hospital’s culture and work environment. Possession of explosives or firearms or other weapons during working time or on Hospital property is prohibited and will warrant Termination.

C28. Employees are expected to report the following events to the Hospital: (1) (a) any criminal activity that results in conviction or (b) participation in any civil action that could have an impact on the Hospital (for example, being the subject of a protection from abuse order or being a party or witness in a court case that could require time away from work); (2) receipt of a notice of exclusion, suspension, debarment, or proposed exclusion, suspension or debarment from participation in any federal or state healthcare, procurement, non-procurement or reimbursement program (for example, Medicare or Medicaid), or of an investigation that could result in such a notice. Failure to report any of the above events will result in discipline up to and including Termination. Involvement in any of the above events that is or may be deleterious to the Hospital or to the ability of the employee to perform his/her job will warrant Termination.

C29. Employees who seek assistance for their drug or alcohol-related impairment or who are observed by a supervisor to have a drug or alcohol-related impairment must submit to a “for cause” test or functional capability evaluation. Refusal to submit to “for cause” testing or a functional capability evaluation will warrant Termination. (See HR Policy 5-10)

C30. Employees are permitted to park in Hospital garages and lots only in adherence with the guidelines established by the Security Department and in accordance with legal requirements. Employees found to be in violation of these guidelines will be subject to discipline up to and including Termination and/or revocation or suspension of parking privileges and may be subject to ticketing or towing. Examples of Hospital parking violations include, but are not limited to the following: parking in the Wood Building lot without paying at times other than those the Security Department has designated as free for employees; transferring parking benefits to another individual (such as paying for parking in the Curie garage and giving a family member your access card so that he or she may park while attending classes at Penn); using parking privileges while not working (such as leaving your car in a CHOP lot without moving it for weeks to avoid home parking costs); unauthorized parking (such as parking in a spot designated for the disabled without a State-issued license or placard authorizing such parking); using parking validation without the express permission of a manager; and any other unauthorized use of Hospital parking privileges. Information about Hospital parking guidelines may be found at [Parking and Transportation]

C31. Those who fail to comply with the Confidentiality of Patient and Hospital Information Policy (Patient Care Manual, No. IM-1-01) and the laws governing the protection of patient health information will receive a Level 2: Oral warning through Termination depending on the seriousness of the violation.

C32. Employees are expected to perform work duties as assigned in the job description or pursuant to supervisory instruction. Those found to be holding back, slowing down; hindering or limiting work will be Terminated.

C33. Employees are permitted to have minimal personal use of Hospital Technology Resources. Hospital Technology Resources belong to the Hospital and by using those resources, the employee assumes personal responsibility for the acceptable use of these Technology resources in accordance with Administrative Policy A-3-6. Inappropriate use of Hospital Technology Resources will warrant discipline up, to and including Termination.
C34. Employees are expected to complete all mandatory training by the assigned deadline. Failure to complete mandatory training will result in disciplinary action up to and including Termination.

C35. The Rules of Conduct are not exhaustive and do not list all activities or behaviors that may have an adverse impact on the Hospital. Other acts considered by the Hospital to be gross or willful misconduct will warrant Termination. Similarly, not all policy violations are listed in these Rules of Conduct. Violations of Hospital policies regardless of whether they are listed in these Rules of Conduct will warrant discipline, up to and including Termination.

V. Multiple Violations

A. When two unrelated disciplinary actions are issued and the second is within the active status period of the first (the active status period is the 12 month period (or another length of time if another length is required under this policy) from the date the discipline was issued), the employee will be subject to the Multiple Violations Rule. This means that additional rule violations, whether related or unrelated, will move the employee to the next level of progressive discipline. Should a violation independently warrant discipline at a level higher than the next step under progressive discipline, the employee will receive the more severe discipline (e.g., if the next step in progressive discipline for the multiple violations is a Level 2: Oral warning, but the most recent incident is conduct, such as diverting drugs, which warrants termination, the employee will be terminated). Attendance violations may be aggregated with other attendance violations for purposes of the Multiple Violations Rule, but not with performance or conduct violations and vice versa. Consistent with Section II.B of these Rules, the employee will progress to the next level of progressive discipline under the Multiple Violations Rule so long as the conduct at issue occurred within the active status of the prior discipline. (Multiple Violations Rule Flow Chart, Appendix C)

B. Nothing in this section is intended to reduce the level of discipline recommended in the Rules of Conduct.

VI. Appeals

A. When a non-bargaining unit employee, who has successfully completed their introductory period, has been subject to a specific discipline and thinks that such action was not justified, he/she may present a complaint through the grievance procedure as delineated in HR Policy 5-5.

5. RESPONSIBILITY:

The department head or designee is responsible for the enforcement of the Hospital’s rules and regulations and for the handling of any disciplinary action that may be required and maintenance of employee records related to disciplinary action.
POLICY
The Hospital is committed to conducting its affairs in accordance with the highest ethical and legal standards. In order to maintain these standards, it is the policy of the Hospital that potential, perceived and actual conflicts of interest are to be avoided.

PURPOSE
The purpose of this Policy is to establish the standards for determining the existence of conflicts of interest, the requirements for disclosing conflicts, and the process for reducing, managing or eliminating conflicts.

SCOPE
This Policy applies Enterprise-wide to all persons affiliated with the Hospital, including without limitation Trustees, officers, employees, members of the Medical Staff, and Scientists engaged in research under the auspices of the Hospital. Hospital Personnel who are members of the faculty of the University of Pennsylvania must also abide by applicable University policies.

RELATED POLICIES
Administrative Policy Manual No. A-1-4 Organizational Ethics Statement
Administrative Policy Manual No. A-1-5 Compliance Standards of Conduct
Administrative Policy Manual No. A-3-5 Confidentiality of Patient and Institutional Information
Administrative Policy Manual No. A-3-7 Interactions with Vendors

Copyright 2013 by The Children's Hospital of Philadelphia. All rights reserved.
DEFINITIONS

A. **Exempt Entity**: A Federal, state, or local government agency, an institution of higher education as defined at 20 U.S.C. 1001(a), an academic teaching hospital, a medical center, or a research institute that is affiliated with an institution of higher education.

B. **Hospital**: The Children’s Hospital of Philadelphia, including The Children’s Hospital of Philadelphia Research Institute, the CHOPPA Practice Plans (currently Children’s Anesthesiology Associates, Children’s Health Care Associates, Children’s Surgical Associates, Radiology Associates of Children’s Hospital, and their New Jersey affiliates) and entities controlling, controlled by or under common control with The Children’s Hospital of Philadelphia, including, without limitation, The Children’s Hospital of Philadelphia Foundation.

C. **Hospital Personnel**: Trustees, directors, officers, members of Board committees, employees, members of the Medical Staff and Scientists engaged in research under the auspices of the Hospital, and any other persons whose presence at or affiliation with the Hospital may place them in a position to make or influence Hospital decisions, to disclose or use Hospital information, to have obligations to the Hospital under other Hospital policies, and other persons designated by the Chief Executive Officer (“CEO”), Senior Management or a Department Chair.

D. **Investigator**: The project director or principal investigator and any other person, regardless of title or position, who is responsible for the design, conduct, or reporting of research, which may include, for example, collaborators or consultants.

E. **Institutional Responsibilities**: A Hospital Personnel’s professional responsibilities on behalf of the Hospital or the University of Pennsylvania.

F. **Scientist**: A person who is, or expects to become, an Investigator with respect to research under the auspices of the Hospital.

G. **Senior/Key Personnel**: The project director or principal investigator and any other person identified as senior/key personnel by the Hospital in the grant application, progress report, or any other report submitted to the U.S. Public Health Service (“PHS”) by the Hospital.

H. **Significant Financial Interest**: A financial interest consisting of one or more of the following interests:

   1. With regard to any publicly traded entity, when the value of any remuneration (salary and any payment for services not otherwise identified as salary, for example consulting fees, honoraria, paid authorship) received from the entity in the twelve (12) months preceding disclosure of the interest aggregated with
the value of any equity in the entity (for example, stock, stock options, or other ownership interests as determined through reference to public prices or other reasonable measures of fair market value) as of the date of the disclosure exceeds $5,000;

2. With regard to any non-publicly traded entity, when the aggregated value of any remuneration received from the entity in the twelve (12) months preceding disclosure of the interest exceeds $5,000 or any equity in the entity; or

3. Intellectual property rights and interests (e.g., patents, copyrights) upon receipt of income related to such rights and interests.

The term Significant Financial Interest does not include the following types of financial interests: salary, royalties, or other remuneration paid by the Hospital to a person if the person is currently employed or otherwise appointed by the Hospital, including intellectual property rights assigned to the Hospital and agreements to share in royalties related to such rights; any ownership interest in the Hospital held by the person, if the Hospital is a commercial or for-profit organization; income from investment vehicles, such as mutual funds and retirement accounts, as long as the person does not directly control the investment decisions made in these vehicles; and income from service on advisory committees or review panels for, or from seminars, lectures, or teaching engagements sponsored by, an Exempt Entity.

I. ADMINISTRATION OF THE POLICY

The CEO (the Designated Official for purposes of PHS-funded research) has final decision-making authority under this Policy and may delegate such authority (and in the event he or she is conflicted, shall delegate such authority) to a person or committee. Actions with respect to a conflict of interest may be taken by Senior Management, Department Chairs, Division Chiefs, and Department Heads for those reporting up to these individuals and by the Conflict of Interest Committee. The CEO may require that such actions be reported to the CEO or his or her designee. Such actions are subject to the right of the CEO to review and reconsider any issue.

II. GENERAL PRINCIPLES

A. A conflict of interest is any circumstance where personal, professional, financial or other private interests of a person or institution do, or have the potential to, influence the exercise of professional judgment or obligations related to such person’s Institutional Responsibilities, or may be perceived as doing so. Conflicts of interest may arise from interests or activities of Hospital Personnel, or interests or activities of other persons with relationships to Hospital Personnel (such as a relative, fiancé or close friend). Conflicts of interest may arise in all aspects of the Hospital’s activities, including regarding clinical care, research, education and business matters.
B. Hospital Personnel should be aware of conflicts of interest and address them as they arise, seeking advice from supervisors or the Conflict of Interest Office when faced with circumstances that have the potential to create a conflict of interest.

C. Although this Policy applies broadly throughout the Hospital, there are specific provisions applicable to those required to submit annual disclosures (see Section III), those who are or may be engaged in research activities (see Section IV), and those who engage in consulting activities (see Section V).

D. The following are examples of circumstances that, if related to Institutional Responsibilities, may give rise to conflicts of interest and are generally subject to disclosure and management.

   1. **Outside Activities**
      Providing services, whether or not compensated, to an outside organization that does or seeks to do business with the Hospital, or competes with the Hospital, or engaging in any other activity that may give the appearance of impairing independence of judgment in the exercise of Institutional Responsibilities.

   2. **Outside Interests**
      Seeking to do business with the Hospital or competing with the Hospital, or having an ownership interest in an outside organization that does or seeks to do business with the Hospital or to compete with the Hospital.

   3. **Intellectual Property**
      Having rights as an inventor or author related to inventions, patents, patent applications, licenses, or copyrights, the value of which could be affected by actions taken in the course of carrying out Institutional Responsibilities. This does not apply to authorship or copyrights in peer-reviewed articles and publications.

   4. **Fiduciary Role**
      Serving as a member of the governing board of an entity, including serving on its board of directors, or holding a position of authority or responsibility to act in the best interest of the entity, including being an officer, manager, partner, or member (this does not include working on a scientific advisory board).

E. The following are examples of circumstances that may give rise to conflicts of interests and are generally prohibited.

   1. **Gifts or Favors**
      Accepting a gift or favor from the following:

       a. Hospital vendors. See [Interactions with Vendors policy](#).
b. Companies or other entities with which the Hospital has or may have a sponsored research or licensing relationship in which the person will or may be involved. Exceptions to this prohibition may be granted with advance written approval by the Vice President of Research Administration or his or her designee.

2. **Hospital Information**
   Obtaining, disclosing, or using Hospital information:
   
a. For direct or indirect personal interest, profit, or advantage of Hospital Personnel.
b. For any purpose that may be detrimental to the Hospital.
c. Without authorization.

   See also [Confidentiality or Patient and Institutional Information policy](#).

3. **Soliciting Hospital Employees, Medical Staff, or Scientists, and Others**
   
a. Soliciting or assisting others in soliciting Hospital employees, members of the Hospital’s Medical Staff, or Scientists, to:
   
   i. Cease or limit their relationship with the Hospital.
   ii. Compete with the Hospital, or to enter into an employment or other contractual relationship with a person or entity that competes with the Hospital.

   a) Soliciting Hospital Personnel for the benefit of competitors may be permitted with the advance written permission of the CEO or his/her designee. Additionally, residents and fellows may be solicited when done in the best interests of the Hospital by the Hospital Graduate Medical Education Committee (or persons authorized by the Committee).

   b. Soliciting or assisting others to solicit patients to seek services from a person or entity that competes or seeks to compete with the Hospital, except that a clinician may recommend a caregiver to his or her patient or the patient’s family when asked for a recommendation and when in the best interest of the patient to do so.

4. **Diversion of Corporate Opportunity**
   Appropriating or diverting for personal advantage a business or financial opportunity with knowledge that the Hospital is pursuing, intending to pursue, or would have an interest in pursuing if it were aware of the opportunity.

F. Conflicts of commitment arise when outside activities and interests interfere with the performance of Hospital duties. Generally, outside activities such as consulting services should be performed on days
and at times when Hospital Personnel are not engaged in Hospital activities (e.g., vacation, nights and weekends when not scheduled to work). Faculty of the University of Pennsylvania may be subject to additional limitations.

III. ANNUAL DISCLOSURES

A. The following persons are required to disclose on an annual basis:

1. All Hospital Personnel whose role is that of manager or above.

2. All members of the Medical Staff who are Hospital Staff.

3. All Hospital employees in the Investment Department and the Office of Technology Transfer.

4. All Hospital employees who are known to select or place orders with vendors (other than persons involved with only de minimis purchases such as an administrative assistant who orders small quantities of office supplies from the Hospital vendor for office supplies).

5. Scientists.

6. Any other person designated by management.

7. Individual Hospital Personnel may be exempted from the annual disclosure requirement based on a determination that disclosure is not necessary to protect the interests of the Hospital.

B. The required disclosers must disclose information about outside activities, outside interests, gifts, memberships, management roles in entities other than the Hospital, rights and interests related to intellectual property, and any other information deemed necessary to implement the provisions of this Policy.

C. The required disclosers may be required to update their disclosures to reflect new rights, interests, activities, and relationships as required by this Policy or otherwise at the discretion of the CEO or his or her designee.

D. Disclosures are reviewed by the appropriate Hospital Personnel responsible for implementing this Policy. Necessary actions will be taken to manage, reduce, or eliminate conflicts of interest and to comply with other Hospital policies and procedures, regulations, and any other applicable authority.

E. Hospital Personnel are strongly encouraged to disclose at any time a matter that may raise a potential conflict of interest and seek guidance or review.
F. Trustees are required to disclose on an annual basis such information as is required to determine whether they have any actual, potential, or perceived conflicts of interest. The annual disclosures of the Trustees, Officers, and members of senior management are reviewed by the Boards of Trustees or their designees. Any substantial personal or business interests of Trustees that conflict with the interests of the Hospital are prohibited.

IV. FINANCIAL CONFLICTS OF INTEREST IN RESEARCH

A. Applicability

This Section applies to all proposed and on-going PHS-funded research, human subjects research, and any other research under the auspices of the Hospital that may be designated as subject to these requirements.

B. Financial Conflict of Interest (“FCOI”) Determination Pathway

Below is a summary of the process that will be used to determine if an FCOI is present, as more fully described in the remainder of Section IV below.

1. Is the interest a Reviewable Interest (see Section IV.D.1.)? If yes:↓
2. Is the Reviewable Interest related to the research (see Section IV.D.2.)? If yes:↓
3. Could the Reviewable Interest directly and significantly affect the design, conduct, or reporting of the research (see Section IV.E.2)? If yes:↓
4. An FCOI is present and must be managed (and, where appropriate, reported).

C. Investigator Disclosure to Hospital

1. Project-Specific Disclosure
   In addition to the annual disclosure requirement (see Section III above), at the time of application for research funding and/or application to the IRB for approval of research, all Investigators must confirm that their disclosures on file with the Hospital are correct and complete, or provide updated information when warranted, as well as provide any additional information required by the Hospital regarding financial interests related to the Investigator’s Institutional Responsibilities.

2. Travel
   As part of the annual and project-specific disclosures, Investigators must disclose to the Hospital any travel related to their Institutional Responsibilities that is reimbursed or
sponsored other than by the Hospital or an Exempt Entity (“Travel”). Such disclosures must include, at a minimum, the following information: (a) the purpose of the trip; (b) the identity of the sponsor/organizer of the trip; (c) the destination of the trip; and (d) the duration of the trip. The Hospital maintains procedures prescribing the details of Travel disclosures, including the timing and when additional information is necessary to determine whether Travel constitutes an FCOI pursuant to Section IV.E below. Investigators must provide in a timely manner any additional information requested by the Hospital that is related to their Travel.

3. Disclosure Update
   Investigators are required to update the Hospital within thirty (30) days in the event that they discover or acquire a new interest that would be disclosable to the Hospital if it had been known at the time of the annual or project-specific disclosure.

D. Hospital Review of Disclosures and Relatedness Determination

1. Reviewable Interests
   The Hospital is responsible for reviewing any disclosures of (i) Investigator Travel or (ii) Significant Financial Interests belonging to an Investigator, the Investigator’s spouse, or the Investigator’s dependent children, to the extent either reasonably appear to relate to the Investigator’s Institutional Responsibilities ((i) and (ii) collectively, “Reviewable Interests”). The Hospital may, in its discretion, identify through procedures or other guidance documents additional interests that qualify as Reviewable Interests.

2. Relatedness Determination
   Each Reviewable Interest will be evaluated to determine whether it relates to the Investigator’s research. A Reviewable Interest will be found to relate to the Investigator’s research when it is reasonably determined that the Reviewable Interest could be affected by the research, or is in an entity whose financial interest could be affected by the research. The Investigator may be asked to provide information to assist in the assessment of whether a Reviewable Interest is related to the Investigator’s research.

3. Timing of Review
   a. Initial Reviewable Interests
      For PHS-funded research, Reviewable Interests disclosed at the time of the funding and/or protocol application will be evaluated prior to the expenditure of funds. For all other research subject to this Policy, Reviewable Interests disclosed at the time of the funding and/or protocol application will be evaluated prior to the initiation of the research activities.
   b. Updated Reviewable Interests
To the extent a new Reviewable Interest is disclosed to the Hospital in the course of an on-going research project (i.e., an Investigator who is new to participating in the research discloses a Reviewable Interest or an existing Investigator discloses a new Reviewable Interest), the Hospital will, within a reasonable period of time that for PHS-funded research will not exceed sixty (60) days from the date of the disclosure: (i) determine if the Reviewable Interest relates to the Investigator’s research; (ii) if it relates, determine if it qualifies as an FCOI (pursuant to Section IV.E below); and (iii) if it is an FCOI, implement on at least an interim basis a management plan in accordance with Section IV.F below. The Hospital may, depending on the circumstances, conclude that additional interim measures are necessary with regard to the Investigator’s participation in the research between the date of disclosure and the completion of the Hospital’s review.

E. Hospital Determination of FCOI

1. Evaluation of Related Reviewable Interests
The Hospital will evaluate each Reviewable Interest that is found to relate to an Investigator’s research to make a reasonable determination whether an FCOI exists.

2. FCOI Standard
An FCOI will be found to exist when a Reviewable Interest related to the Investigator’s research could directly and significantly affect the design, conduct, or reporting of the research.

3. FCOI Process and Criteria
The Hospital maintains a process and criteria for making FCOI determinations. The process and criteria applied will be subject to on-going evaluation and revision as appropriate.

4. Reporting FCOIs in PHS-Funded Research
If the research is PHS-funded, the identified FCOI must be reported to the relevant awarding agency in accordance with Section IV.H of this Policy.

F. Management of FCOI

1. Management of FCOI
For any identified FCOI, the Hospital will take appropriate action to manage the conflict in order to reduce the potential for it to compromise the safety or validity of the research. Research in which an Investigator is found to have an FCOI will not be permitted to proceed until the Investigator has agreed to implement an acceptable management plan. The appropriate techniques identified by the Hospital to manage an identified FCOI will be outlined in a written management plan. Examples of conditions or restrictions that might be imposed to manage an FCOI include, but are not limited to:
a. Public disclosure of the FCOI (e.g., when presenting or publishing the research).
b. For research involving human subjects, disclosure of the FCOI directly to participants.
c. Appointment of an independent monitor capable of taking measures to protect the design, conduct, and reporting of the research against bias resulting from the FCOI.
d. Modification of the research plan.
e. Change of personnel or personnel responsibilities, or disqualification of personnel from participation in all or a portion of the research.
f. Reduction or elimination of the financial interest (e.g., sale of an equity interest).
g. Severance of relationships that create FCOI.

2. Disclosure for PHS-Funded Drug/Device Research
   In any case in which the U.S. Department of Health and Human Services determines that a PHS-funded project of clinical research whose purpose is to evaluate the safety or effectiveness of a drug, medical device, or treatment has been designed, conducted, or reported by an Investigator with an FCOI that was not managed or reported by the Hospital, the Investigator will be required to disclose the FCOI in each public presentation of the results of the research and to request an addendum to previously published presentations.

3. Management of Other Interests
   When a disclosed interest is not a Reviewable Interest or a Reviewable Interest is determined not to constitute an FCOI, the Hospital may nonetheless determine that some type of management or oversight of the interest is appropriate before certain research activities may proceed. The Hospital may develop additional procedures and/or guidance regarding these types of interests and any associated limitations or requirements.

4. Compliance with Management Plans
   Investigators have an on-going obligation to adhere to an imposed management plan and failure to do so may be grounds for sanctions under this Policy.

G. Retrospective Reviews; Mitigation Reports

1. Identification of Reviewable Interests Not Timely Disclosed or Reviewed
   In the event the Hospital identifies a Reviewable Interest that was not disclosed in a timely manner by an Investigator or, for whatever reason, was not previously reviewed by the Hospital in accordance with this Policy during an on-going research project (e.g., was not timely reviewed or reported by a subrecipient), the Hospital will, within a reasonable time period that for PHS-funded research will be within sixty (60) days of identifying such a Reviewable Interest: (i) determine if the Reviewable Interest relates to the Investigator’s research; (ii) if it relates, determine if it qualifies as an FCOI; and (iii) if it is an FCOI, implement on at least an interim basis a management plan in accordance with Section IV.F of this Policy to manage the FCOI going forward. Depending on the nature of the FCOI, if a retrospective review for bias is
required pursuant to Section IV.G.2 below, the Hospital may determine that additional interim measures are necessary with regard to the Investigator’s participation in the research between the date that the FCOI is determined and the completion of the Hospital’s retrospective review. For PHS-funded research, the identified FCOI must be reported to the relevant awarding agency in accordance with Section IV.H of this Policy.

2. **Retrospective Review for Bias**
   There may be times when an FCOI is not identified or managed in a timely manner, including: failure by the Investigator to disclose a Reviewable Interest that is determined by the Hospital to constitute an FCOI; failure by the Hospital to review or manage such an FCOI; or failure by the Investigator to comply with an FCOI management plan. In the event such noncompliance is identified, the Hospital will, within a reasonable time period that for PHS-funded research will be within 120 days of the Hospital’s determination of noncompliance, complete a retrospective review of the Investigator’s activities and the research to determine whether there was any bias in the design, conduct or reporting of the research or any portion thereof during the time period of the noncompliance. The Hospital maintains written procedures regarding the conduct and documentation of the retrospective review, as well as notification of the relevant awarding agency as appropriate, within any applicable required timeframes. Any FCOI report submitted with respect to such research (see Section IV.H.2. below) will be updated as necessary in light of the results of the retrospective review.

3. **Documentation of Retrospective Review**
   For PHS-funded research, the Hospital will document at least the following information regarding any retrospective review:
   
   a. Project number.
   b. Project title.
   c. Project director (PD)/principal investigator (PI) or contact PD/PI if a multiple PD/PI model is used.
   d. Name of the Investigator with the FCOI.
   e. Name of the entity with which the Investigator has the FCOI.
   f. Reason(s) for the retrospective review.
   g. Detailed methodology used for the retrospective review (e.g., methodology of the review process, composition of the review panel, documents reviewed).
   h. Findings of the review.
   i. Conclusions of the review.

4. **Notification of Awarding Agency; Mitigation Report**
   If bias is found in the design, conduct or reporting of PHS-funded research during the period of noncompliance, the Hospital will promptly notify the relevant PHS awarding agency and will submit a mitigation report, which will include at least the elements documented in the
retrospective review (see Section IV.G.3 above) and a description of the impact of the bias on the research project and the Hospital’s plan or action of actions taken to eliminate or mitigate the effect of the bias.

H. Hospital Notification and Reporting to PHS Awarding Agencies

1. PHS Notification
   For PHS-funded research, the Hospital will provide all required notifications and reports to the relevant PHS awarding agency, in accordance with applicable regulations and this Policy.

2. FCOI Reports
   The Hospital will report any identified FCOI that is related to PHS-funded research to the relevant PHS awarding agency, whether identified in advance of commencing a PHS-funded research project (an “Initial FCOI Report”) or in the course of an on-going PHS-funded research project as a result of new FCOI information (“Updated FCOI Report”). For any identified FCOI related to on-going PHS-funded research that was previously reported in an Initial FCOI Report, the Hospital will provide an annual FCOI report that addresses the status of the FCOI (including any changes in the value of the previously reported interest) and any changes to the management plan (“Annual FCOI Report”). Such Annual FCOI Reports will be provided for the duration of the PHS-funded research.

3. Timing of FCOI Reports
   The Hospital will provide required FCOI reports in accordance with the following timeframes:

   a. Initial FCOI Reports: prior to the expenditure of funds.
   b. Updated FCOI Reports: within sixty (60) days of identification of a new FCOI pursuant to Section IV.D.3.b of this Policy (whether due to a new Investigator or a new FCOI disclosed by an existing Investigator) or identification of an FCOI that was not timely disclosed or managed pursuant to Section IV.G.2.
   c. Annual FCOI Reports: at least annually, in accordance with the awarding agency’s specifications. For NIH-funded research, the Annual FCOI Report is due at the same time as the Hospital is required to submit the annual progress report for a grant, including a multi-year funded progress report if applicable, or at the time of the extension.

4. Content of FCOI Reports
   Any FCOI Report shall provide sufficient information to enable the PHS awarding agency to understand the nature and extent of the FCOI and to assess the appropriateness of the Hospital’s management plan. Any FCOI Report will include at least the following information:

   a. Project number.
   b. PD/PI or contact PD/PI if a multiple PD/PI model is used.
c. Name of the Investigator with the FCOI.

d. Nature of the financial interest (e.g., equity, consulting fee, travel reimbursement, honorarium).

e. Value of the financial interest, provided in dollar ranges, or a statement that the interest is one whose value cannot be readily determined through reference to public prices or other reasonable measures of fair market value.

f. A description of how the financial interest relates to the PHS-funded research and the basis for the Hospital’s determination that the financial interest conflicts with such research.

g. A description of the key elements of the Hospital’s management plan, including:
   i. The role and principal duties of the conflicted Investigator in the research.
   ii. The conditions of the management plan.
   iii. How the management plan is designed to safeguard objectivity in the research.
   iv. Confirmation of the Investigator’s agreement to the management plan.
   v. How the management plan will be monitored to ensure Investigator compliance.
   vi. Any other information the Hospital deems necessary to meet its obligations under applicable regulations and this Policy.

5. Additional Notifications

In addition to the required FCOI reports, the Hospital will promptly notify the relevant PHS awarding agency in the event that it finds that an Investigator’s failure to comply with this Policy or an imposed management plan has biased the design, conduct, or reporting of PHS-funded research (such notification will include the corrective action taken or to be taken in response to the identified Investigator non-compliance).

I. Requirements for Subrecipients of PHS-Funded research

The Hospital may from time to time carry out aspects of PHS-funded research through a subrecipient with which the Hospital contracts through a subaward agreement or other similar contract to provide research funding. The Hospital will grant such subawards where the subrecipient has its own policy on FCOIs and certifies, through the subaward agreement or other contract, that the policy complies with applicable PHS regulations. In rare circumstances, the Hospital will make an exception and allow the subrecipient to apply the Hospital’s policy as its own for the purposes of the subaward. The subaward agreement or other contract will specify the time period(s) for the subrecipient to report all identified FCOIs to the Hospital, which will be sufficient to allow the Hospital to provide timely reports to the PHS funding agency as applicable and in accordance with this Policy.

J. Public Access

For any PHS-funded study, any person may request certain information regarding the FCOIs of Senior/Key Personnel following the process established by the Hospital and published on its web site. The Hospital will provide, within five (5) business days of the receipt of a request (as defined by the
Hospital), the following information about a Senior/Key Personnel who continues to hold an identified FCOI:

1. The Investigator’s name.
2. The Investigator’s title and role with respect to the research project out of which the FCOI arises.
3. The name of the entity in which there is a Significant Financial Interest that forms the basis of the FCOI.
4. The nature of the Significant Financial Interest (or Travel, if applicable).
5. The approximate value of the Significant Financial interest provided in dollar ranges, or a statement that the interest is one whose value cannot readily be determined through reference to public prices or other reasonable measures of fair market value.

K. Training

1. Content of Training
   All Scientists and Investigators must complete training on:
   a. The PHS regulations applicable to FCOIs, as may be amended from time to time.
   b. The portions of this Policy governing conflicts of interest in research.
   c. Their obligations regarding disclosure to the Hospital of interests related to their Institutional Responsibilities.

2. Timing of Training
   Scientists and Investigators must complete this training prior to engaging in research under the auspices of the Hospital, or as otherwise required by a relevant awarding agency, and at least every four years following the initial training. Additionally, Scientists and Investigators will be required to receive training immediately in any of the following circumstances:
   a. The Hospital revises the portion of its policy governing conflicts of interest in research or procedures in any manner that affects the requirements applicable to Scientists or Investigators.
   b. A Scientist or Investigator is new to the Hospital.
   c. The Hospital finds that a Scientist or Investigator is not in compliance with the portion of the Hospital’s policy governing conflicts of interest in research or an imposed management plan.
V. CONSULTING RELATIONSHIPS

A. General Principles

1. Consulting relationships have the potential to increase the knowledge and experience of Hospital Personnel in clinical and research areas, to broaden their exposure to external experts in their fields or related fields, and to advance the public interest. Nevertheless, consulting relationships also have the potential to conflict with the obligations that Hospital Personnel have to the Hospital, including to Hospital patients and research subjects, and can be at odds with the Hospital’s Organizational Ethics Statement (A-1-4) and its Compliance Standards of Conduct (A-1-5).

2. Examples of consulting relationships include engagements to serve: as a member of a scientific advisory board or data safety monitoring board; as a speaker or moderator at a company-sponsored event, on the company’s speakers’ bureau or at a company-sponsored focus group; or as an adviser or consultant to a company in connection with its research or products.

3. Consulting relationships may raise other legal and ethical concerns such as:

a. Jeopardizing Hospital intellectual property rights.
b. Misuse of the Hospital’s name in a manner that suggests Hospital endorsement of a product or entity.
c. Excessive compensation that may be considered an illegal kickback or referral fee.
d. Interference with confidentiality obligations to the Hospital, patients, and research subjects.
e. Restrictions or obligations that interfere with the consultant’s Hospital and academic duties.
f. Inappropriate use of Hospital resources.
g. Acting as a member of a speaker’s bureau not in accordance with Hospital policy. See Interactions with Vendors policy (A-3-7).

B. Advance review and approval

1. Any Hospital Personnel may seek review of a consulting relationship on a voluntary basis and those in a clinical role are strongly encouraged to do so. The following persons must have their consulting relationships reviewed and approved in advance:

a. Hospital Staff (as defined in the Hospital’s Medical Staff Bylaws).
b. Scientists.
c. Other persons who are faculty members at the University of Pennsylvania who perform some or all of their duties under the auspices of the Hospital. (Faculty members at the University of Pennsylvania who hold privileges at the Hospital but do not perform any duties under the auspices of the Hospital do not have to submit consulting relationship to the Hospital for review.)

2. Consulting relationships subject to advance review and approval are any arrangements to provide services to an outside person or entity when such services are related to the consultant’s Institutional Responsibilities, except:

   a. Advising or consulting for non-governmental public health organizations such as the World Health Organization.
   b. Service on or for federal, state, and local government agencies, boards, commissions, committees, review panels, or granting agency review panels unless administered by a for-profit government contractor.
   c. Seminars, lectures, teaching engagements, and service on advisory committees and review panels for Exempt Entities.
   d. IRB memberships at outside institutions of higher learning and academic medical centers.
   e. Editorial boards for peer-reviewed journals.
   f. Service as an expert witness in any litigation in which neither the Hospital nor its affiliates is a party.
   g. Any other arrangements as may be determined by the Hospital to not require advance review and approval.

3. All consulting relationships requiring advance review and approval must be set forth in a written agreement.

4. All proposed consulting agreements are reviewed and approved in advance in accordance with the procedures established by the Hospital’s Office of General Counsel, Office of Technology Transfer, and Conflict of Interest Office. Such review is intended to avoid conflicts of interest and protect the Hospital.

VI. INSTITUTIONAL CONFLICTS

A. In certain instances the Hospital may have an institutional conflict of interest based on the financial or other interests of the Hospital itself or of its leadership. Where such conflicts have the potential to be significant, they should be reported to the CEO or his designee, an appropriate Executive Vice President, the General Counsel or the Chief Compliance Officer, provided such person is not believed to have a personal conflict, or to the Chair or Vice Chair of the Board Audit & Compliance Committee.
B. In addition to financial interests of the Hospital’s leadership, institutional conflicts of interest include situations in which the financial investments or holdings of the Hospital, gifts to the Hospital (including restricted or unrestricted monetary gifts), or other financial interests of the Hospital might affect or reasonably appear to affect institutional processes for the design, conduct, reporting, review or oversight of human subjects or other research.

C. Process for identification of potential institutional conflicts of interest with respect to human subjects or other research: In addition to information from the annual conflicts disclosures of the Hospital’s leadership, information on the Hospital’s financial interests should be reported to the President or his designee, at such frequency and according to such criteria as determined by the CEO or his designee, by the following offices:

1. Office of Technology Transfer, for licensing arrangements, patents, invention disclosures; and

2. Development office, for gifts to the Hospital from any for-profit organization or philanthropic unit associated with a for-profit organization.

D. If the institutional conflict of interest is considered to be significant, the matter should be evaluated to determine an appropriate response, which may include eliminating the conflict or instituting a management plan that seeks to have persons without a stake involved in the decision-making.

E. Examples of institutional conflicts of interest management plans might include the following: having the Audit & Compliance Board Committee involved in both the decision-making and on-going oversight of a transaction where the Hospital proposes to make a major purchase from a for-profit company and the CEO of the Hospital is a director of the company; and having an external expert panel determine whether and under what conditions the Hospital should undertake clinical trials involving intellectual property owned by the Hospital where the potential economic return to the Hospital is significant if such trials show favorable results.

VII. ENFORCEMENT AND SANCTIONS

A. The Hospital has the authority to require appropriate management and oversight of matters disclosed or reviewed in accordance with this Policy. Management may include the reduction or elimination of any interest or participation in an activity.

B. The Hospital will monitor compliance with management and oversight requirements in such manner as deemed appropriate. The Hospital will investigate and take corrective action as necessary.

C. Any Hospital Personnel who violates any provision of this Policy, or any conditions imposed pursuant to this Policy, may face sanctions up to and including suspension or termination of employment, loss of the privilege of conducting research at or in connection with the Hospital, loss of Medical Staff
privileges, loss of administrative appointments, cessation of business with a vendor, liability for damages, and other appropriate actions at the Hospital’s discretion.

**RESPONSIBILITY FOR MAINTENANCE OF THIS POLICY:**

GENERAL COUNSEL

**RESPONSIBILITY FOR OVERSIGHT AND REVIEW:**

CHIEF EXECUTIVE OFFICER
AUDIT & COMPLIANCE COMMITTEE
CHIEF COMPLIANCE OFFICER

---

**Supersedes**

8/24/2012

**Approved by:**

Steven M. Altschuler, MD, Chief Executive Officer

---

This Administrative Policy is the property of The Children’s Hospital of Philadelphia and is to be used solely by employees of the Hospital, the Hospital Medical Staff and those acting on the Hospital’s behalf either on the premises of the Hospital in connection with Hospital matters or in their Hospital duties involving the care of Hospital patients. This Policy may not be copied, photocopied, reproduced, entered into a computer database or otherwise duplicated, in whole or in part in any format. Any personal or other use is strictly prohibited.

THE CHILDREN’S HOSPITAL OF PHILADELPHIA © 2013

Copyright 2013 by The Children’s Hospital of Philadelphia. All rights reserved.
PURPOSE
The purpose of this policy is (i) to maintain a workplace free from the possession, manufacture, sale, purchase, distribution or use of Prohibited Drugs or Alcohol; (ii) to provide resources for employees and members of the Medical Staff (employees and members of the Medical Staff will be referred to at times in this policy individually and collectively as “Staff Members”) seeking help to address a drug and/or Alcohol abuse problem; and (iii) to identify appropriate corrective action for Staff Members found to have violated this policy.

POLICY
The Children’s Hospital of Philadelphia (Hospital) is committed to maintaining a safe and productive work environment for the benefit of its patients, Staff Members and the public. In furtherance of this commitment and in compliance with applicable laws:

(1) The Hospital strictly prohibits the possession, manufacture, sale, purchase, distribution or use of Prohibited Substances in the workplace or while performing services for the Hospital regardless of where those services are performed.

(2) Staff Members are also prohibited from appearing for work Under the Influence of Prohibited Substances, regardless of when or where the use occurred.

Staff Members found to have violated this policy may be subject to mandatory rehabilitation and/or discipline, up to and including immediate discharge from employment/Medical Staff depending on the nature of the offense and the totality of the circumstances.

SCOPE
All employees and Medical Staff Members of The Children’s Hospital of Philadelphia and entities affiliated with it, including but not limited to Children’s Health Care Associates, Children’s Anesthesiology Associates, Children’S Surgical Associates, Radiology Associates of Children’S Hospital and their New Jersey counterparts.

RELATED DOCUMENTS

<table>
<thead>
<tr>
<th>Job Aid</th>
<th>Observation Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Job Aid</td>
<td>Monitoring Agreement</td>
</tr>
<tr>
<td>Job Aid</td>
<td>Consent and Release for Drug/Alcohol Testing</td>
</tr>
</tbody>
</table>

Human Resources Manual 5-2 Rules of Conduct
DEFINITIONS

A. **Alcohol**: all intoxicating beverages that contain Alcohol.

B. **Convicted or Conviction**: being Convicted of a crime, including a finding or verdict, resolution of guilt, an admission of guilt, a plea of nolo contendere, receiving probation without a verdict, entering into an accelerated rehabilitative disposition program, or any other verdict, plea or disposition that results in a finding other than not guilty or dismissal.

C. **Divert**: to take a Hospital drug and use it for any purpose not authorized by the Hospital (for example, a Staff Member who takes morphine ordered for a patient and uses it for him or herself has Diverted that drug; a Staff Member who takes morphine from the Pyxis machine and gives it to her husband has Diverted that drug). A drug that is Diverted is a Prohibited Drug under this Policy.

D. **Fit For Duty**: that a Staff Member is able to safely and effectively perform the essential functions of his or her specific job with or without reasonable accommodation.

E. **Fitness for Duty Evaluation**: an assessment of a Staff Member’s ability to perform the essential functions of his or her job with or without reasonable accommodation. The Occupational Health Department will arrange a Fitness for Duty Evaluation at the request of a Manager, supervisor, Medical Director or Division Chief if appropriate. A Manager, supervisor, Medical Director or Division Chief may refer a Staff Member for a Fitness for Duty Evaluation if the Staff Member has exhibited behaviors or performance thought to be related to physical or mental health issues.

F. **Manager**: a leader to whom the Staff Member reports, either directly or at a progressively higher level and has additional meanings for attending physicians, residents and fellows as follows: for attending physicians, Manager means the clinical supervisor (i.e., the Medical Director, Division Chief, Department Chair), ECMS leader or Vice President Medical Operations & Chief Safety Officer; for residents and fellows Manager means the Program Director or Vice President Medical Operations & Chief Safety Officer.

G. **Prohibited Drug**: any drug: (i) which is not legally obtainable (e.g., cocaine); (ii) which is legally obtainable but has not been legally obtained (e.g., morphine purchased on the street or Diverted
from the Hospital); or (iii) which has been legally obtained, but is not being used for prescribed purposes (e.g., codeine if prescribed to someone other than the person taking it; Xanax prescribed to the person taking it if taken in a manner other than as prescribed).

H. **Prohibited Substance:** (a) Alcohol at a level the Hospital has determined to be unacceptable for any Staff Member; or (b) Prohibited Drug.

I. **Staff Member:** either a Hospital employee or member of the Hospital’s Medical Staff or both.

J. **Test Positive or Positive Test:** a drug or Alcohol test result that is verified by the Hospital’s designated Medical Review Officer (MRO) and that reflects the presence of a Prohibited Substance at a level the Hospital has determined to be unacceptable for any Staff Member. Drug or Alcohol tests may be by urine, saliva, blood, breath or by any other means acceptable in the industry and permissible under the law.

K. **Under the Influence:** describes a Staff Member who is affected by a drug and/or Alcohol in any detectable manner wherein such use or influence may affect the safety of the Staff Member, co-workers, patients, or members of the public, the Staff Member’s job performance or the safe and efficient operation of the Hospital. Examples of symptoms that may indicate that a Staff Member is Under the Influence of drugs or Alcohol are outlined in the job aid “Observation Form”.

**PROCEDURES**

A. **Staff Member Self-Disclosing Certain Medications and Drug/Alcohol Dependence:**

1. A Staff Member who is under the care of a licensed physician/practitioner and is taking medication that could influence or impair performance or behavior must (a) obtain information from the physician/practitioner regarding any potential affect the medication may have on the Staff Member’s performance or behavior; and (b) inform the Occupational Health Department (OHD) of such potential impairment. OHD will determine the Staff Member’s Fitness for Duty and will communicate any work restrictions to the Manager/supervisor or Medical Director/Division Chief, as applicable.

2. A Staff Member who self-discloses a problem with a Prohibited Substance will be required to be evaluated in OHD and if the Staff Member is not in an appropriate treatment program, he or she will be given the opportunity to receive treatment and will not be subject to disciplinary action unless an investigation reveals a rule violation that otherwise warrants discipline. For example, a Staff Member who has Diverted drugs is subject to termination (from employment for employees
and from the Medical Staff for non-employed Medical Staff).

**B. Evaluating A Staff Member for Suspicion of Drug or Alcohol Abuse:**

1. When a Staff Member exhibits behavior that indicates that the Staff Member may be Under the Influence of a Prohibited Substance, the Manager/supervisor or Medical Director/Division Chief must follow the procedures outlined in Appendix A, For Cause Drug Testing Procedures, which includes completing the Observation Form.

2. In circumstances in which a Staff Member appears impaired and/or is a threat to the safety of him or herself or of patients, the Manager/supervisor or Medical Director/Division Chief, as applicable, will first remove the Staff Member from his or her job/Medical Staff responsibilities, escort him or her to a safe place and contact Human Resources (or Security if off hours) before completing the Observation Form and taking the other steps required under the For Cause Drug Testing Procedures, Appendix A.

**C. Possible Outcomes of Occupational Health Assessment and Testing**

1. If, after assessment, OHD determines that the Staff Member is not Under the Influence of a Prohibited Substance and for-cause testing, therefore, is not warranted, the Manager/supervisor or Medical Director/Division will thank the Staff Member for his or her cooperation and return the Staff Member to work.

2. If, after assessment, OHD determines that for-cause testing is warranted, the Staff Member will be tested, sent home (via cab or with a friend/relative) and, if a Hospital employee will be suspended from employment without pay pending the results of the test. Such processes as they pertain to non-employed Medical Staff will be addressed in accordance with the Medical Staff Bylaws.

3. An employed Staff Member who tests negative for a Prohibited Substance will be reinstated with back pay for the period of the suspension. The Manager/supervisor or Medical Director/Division Chief, as applicable, will inform the employed Staff Member of the confidential and voluntary resources available through the Employee Assistance Program for additional support. Such processes as they pertain to non-employed Medical Staff will be addressed in accordance with the Medical Staff Bylaws. If any Staff Member’s behavior or performance raises a question of the Staff Member’s Fitness for Duty despite negative drug testing, Occupational Health will assess the need for a Fitness for Duty Evaluation.

4. A Staff Member who tests positive for a Prohibited Substance or who self-discloses a problem with a Prohibited Substance, will be offered the opportunity to engage in treatment for substance...
abuse and return to work under a Monitoring Agreement. The Monitoring Agreement will be instituted after there is a completion of a substance abuse treatment program and a clearance to return to work by the substance abuse treatment provider. If there is evidence of Diverted drugs or any engagement in other conduct warranting termination under Hospital policy or the Medical Staff Bylaws, the Staff Member’s Monitoring Agreement is void.

5. Physicians who Test Positive may also be referred to the Pennsylvania Physician Health Program or other applicable physician health program. Members of the Medical Staff and OHD will work with the Hospital Physician Health Committee and the applicable Department Chair, Division Chief or Medical Director to determine whether such a referral is appropriate. OHD will manage the actual for-cause test and Hospital Physician Health Committee will then be the responsible for any practice implications.

D. Return to Work

1. An employee requesting to return to work following treatment for substance abuse must contact OHD and present a note from his or her substance abuse treatment provider verifying participation in a formal treatment program, identifying the substance upon which dependency occurred and clearing the employee to return to work. Professionally licensed employees must also meet the requirements of the appropriate licensing body prior to returning to work. A physician who has participated in a physician health program must provide documentation to the Occupational Health Department that he or she has satisfied and will continue to satisfy any conditions imposed by that Program.

2. Staff Members may not return to work until the OHD completes the appropriate return to work screening and notifies the Manager/supervisor or Medical Director/Division Chief that the Staff Member is cleared to return to work.

3. A Staff Member who returns to work following substance abuse treatment is required to work under a Monitoring Agreement for at least two years. The terms of this Agreement are subject to change depending on the facts and circumstances at issue for each Staff Member, including recommendations from the Staff Member’s substance treatment provider and the physician health program, as applicable.

E. Employment/Medical Staff Consequences

1. A Staff Member who Diverts drugs from the Hospital will be terminated from employment and

---

1 Further description can be found in Appendix B - Return to Work.
from the Medical Staff, as applicable, consistent with the Medical Staff Bylaws.

2. A Staff Member who refuses to be tested for a Prohibited Substance, who refuses treatment for substance abuse once he or she has Tested Positive for a Prohibited Substance, or who fails to comply with a treatment program or Monitoring Agreement will be terminated from employment and from the Medical Staff, as applicable, consistent with the Medical Staff Bylaws.

3. A Staff Member who returns to work on a Monitoring Agreement and Tests Positive for a Prohibited Substance, either during the duration of the Monitoring Agreement or after, will be terminated from employment and from the Medical Staff, as applicable, consistent with the Medical Staff Bylaws.

F. Legal/Regulatory Compliance and Reporting

1. The use, sale, purchase, theft or possession of an illegal drug and drug Diversion are violations of the law. The Hospital will refer such illegal drug activities to the applicable authorities, including law enforcement, regulatory, licensing and credentialing bodies as appropriate.

2. The Manager/supervisor or the Medical Director/Division Chief, in the case of a physician, will notify the applicable Vice President or, in the case of a physician, the President of the Medical Staff and the Department Chair of any use, sale, purchase, theft or possession of a Prohibited Substance or of any Drug Diversion or of any Staff Member Conviction of a local, state or federal controlled substances law. The Director of Pharmacy will report any drug loss or misuse to the appropriate authorities (other than licensing boards). Reports to professional licensing board will be handled as set forth in paragraph 3 below.

3. The Director of the Department in which the employee worked, or Division Chief/Medical Director in the case of a physician, will make reports, as appropriate, to the applicable professional licensing board for the substance-related activities of a Staff Member.

4. A Staff Member who is Convicted of a crime in connection with the violation of any local, state or federal controlled substances law must notify Human Resources or Medical Staff Affairs in the case of a non-employed Staff Member, within five calendar days of the Conviction and Human Resources or Medical Staff Affairs, as applicable, will immediately notify the Director or Division Chief/Medical Director, as applicable, and the Director of Pharmacy, who will make reports, as appropriate, to the licensing board (Director or Division Chief/Medical Director, as applicable) and/or authorities (Director of Pharmacy).

5. A non-physician Staff Member who is otherwise involved in any legal proceeding related to a Prohibited Substance (including an arrest or prosecution, i.e. DWI) is obligated to report such
involvement to Human Resources when he or she becomes aware of it. Medical Staff Members must make such notifications in accordance with the Medical Staff Bylaws.

6. The Director, Division Chief/Medical Director and the Director of Pharmacy will consult with the Office of the General Counsel before making any reports to licensing boards and/or authorities under this policy.

7. Staff Members must report all events involving clinical care that could have injured a patient, compromised patient safety and/or resulted in unanticipated injury to patient safety through the Hospital’s electronic event reporting system. Serious patient injuries should also be reported to Risk Management.

CONSUMPTION OF ALCOHOL AT HOSPITAL-SPONSORED EVENTS
Occasionally the Hospital may sponsor an on or off site event where Alcohol is served. The moderate consumption of Alcohol is permitted during these events. However, it does not relieve a Staff Member from meeting reasonable and acceptable standards of conduct. Under no circumstances should a Staff Member who delivers patient care consume Alcoholic beverages prior to going to work.

ASSISTANCE PROGRAMS
Employees may seek assistance from the Hospital’s Employee Assistance Program (EAP) in confidence. It is the responsibility of each employee to seek assistance from the EAP before Alcohol or drug problems lead to corrective action that can include termination. Once a violation of this policy occurs, subsequently using the EAP on a voluntary basis will not alter the corrective action. Information about the EAP may be found on the Benefits website on the Hospital intranet. Medical Staff Members may contact the Hospital’s Physician Health Committee, which can suggest resources for assistance with drug and Alcohol problems.

On a regular basis, the Hospital will inform Staff Members about the dangers of drug and Alcohol abuse in the workplace, its policy of maintaining a drug-free workplace, available drug and Alcohol counseling, rehabilitation and employee assistance programs and the penalties that may be imposed upon Staff Members for violations of this policy.

RESPONSIBILITY FOR MAINTENANCE OF THIS POLICY
PRESIDENT AND CHIEF OPERATING OFFICER
ATTACHMENTS
APPENDIX A: FOR CAUSE DRUG TESTING PROCEDURES
APPENDIX B: RETURN TO WORK PROCEDURES
### APPENDIX A: FOR CAUSE DRUG TESTING PROCEDURES

#### ASSESSMENT AND EVALUATION FOR IMPAIRMENT

<table>
<thead>
<tr>
<th>Required Action Steps</th>
<th>Performed By</th>
<th>Supplemental Guidance</th>
</tr>
</thead>
</table>
| 1. Complete parts 1 and 2 of job aid – Observation Form.                             | Manager               | 1. Incorporate any reported observations  
2. Consider asking another Manager to witness/confirm that the Staff Member appears impaired |
| 2. Contact Human Resources Business Partner to discuss observations and next steps (e.g., questioning the Staff Member, whether an Occupational Health Assessment is warranted). | Manager               | If unable to reach your business partner during regular business hours, contact the main Human Resources reception desk at x65337. If timely consultation is not possible, the Manager/supervisor will proceed with the procedures outlined below and notify Human Resources as soon as possible. |
| 3. Contact Occupational Health if for cause testing is indicated.                    | Manager or Human Resources | 1. If during normal business hours, contact Occupational Health at X41928  
2. If Occupational Health is closed, contact Security at X42374  
3. If the Staff Member is in the nursing department, also contact the nursing supervisor at pager 10224.  
4. If at an ambulatory site off hours, contact the nursing supervisor for direction.  
**Note:** both Security and the nursing supervisor have access to off-hours pager for Occupational Health. |
<p>| 4. Remove the Staff Member from the work environment.                               | Manager/Supervisor     | Provide a safe, supervised place for the Staff Member (e.g. Manager’s office) |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Tell the Staff Member you are bringing him/her to Occupational Health for an assessment for fitness for duty based on your observations or reported behavior.</td>
<td>Manager/Supervisor</td>
<td>If after hours, security will bring the Staff Member to the OH department, or keep the Staff Member in the command center until the OH nurse or nursing supervisor arrives.</td>
</tr>
<tr>
<td>6. If the Staff Member admits to Alcohol or drug use/abuse, acknowledge the admission and inform him or her that Occupational Health will discuss next steps.</td>
<td>Manager</td>
<td></td>
</tr>
<tr>
<td>7. If the Staff Member reports a medical reason for his or her behavior, inform the Staff Member that he or she need not share such information with you but can bring it to the attention of Occupational Health during the assessment.</td>
<td>Manager</td>
<td>Staff Member personal medical information is confidential and the Staff Member should not feel obligated to share this with a Manager.</td>
</tr>
<tr>
<td>8. If the Staff Member refuses to undergo the assessment, inform him or her that the assessment is a condition of employment and/or appointment to the Medical Staff per the Drug-Free Workplace Policy and the Medical Staff Bylaws and refusal to participate may lead to discipline up to and including termination.</td>
<td>Manager/Human Resources</td>
<td>Do not coerce testing; simply inform the Staff Member of the policy and consequences of refusing.</td>
</tr>
<tr>
<td>9. Bring the Staff Member to the Occupational Health Department.</td>
<td>Manager/Human Resources</td>
<td>If at an ambulatory site, OH will direct the Manager. If off hours, contact the nursing supervisor for direction.</td>
</tr>
<tr>
<td>10. Notify the Physician Health Committee of any Medical Staff Member who is subject to a for cause test.</td>
<td>Occupational Health Nurse</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX B: RETURN TO WORK PROCEDURES

A Staff Member who participates in an approved substance abuse rehabilitation program, and who complies with all prescribed care to prevent relapse, is eligible for consideration for return to work, consistent with the CHOP Family and Medical Leave of Absence Policy, 5-14 and the Medical Staff Bylaws, as applicable.

<table>
<thead>
<tr>
<th>Required Action Steps</th>
<th>Performed by</th>
<th>Supplemental Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Contact the Occupational Health Department, Manager, and Human Resources Business Partner when return to work is anticipated.</td>
<td>Staff Member</td>
<td>Prior to returning to work, the Occupational Health Department must receive at least the following information from the substance abuse treatment provider in writing: verification of participation in a formal treatment program; identification of the prohibited substances of abuse; details of the ongoing plan of care.</td>
</tr>
<tr>
<td>2. Obtain a verification of return to work in writing and plan of care from the substance abuse treatment provider.</td>
<td>Staff Member, Occupational Health Nurse, Physician, Health Committee (for Medical Staff)</td>
<td>If the Occupational Health Nurse has any concerns regarding fitness for duty, he or she will obtain consent from the Staff Member to discuss these concerns with the treatment provider prior to initiating the return to work process.</td>
</tr>
<tr>
<td>3. Schedule a meeting with the returning Staff Member, his or her Manager, the Human Resources Business Partner, the Occupational Health Nurse and the Staff Member’s union delegate (for union Staff Members) or PHC representative (for Medical Staff).</td>
<td>Occupational Health Nurse</td>
<td>This meeting must occur prior to Staff Member returning to work.</td>
</tr>
<tr>
<td>4. Explain the conditions of return to work to all participants present.</td>
<td>Occupational Health Nurse, Human</td>
<td>If the Staff Member is a licensed healthcare worker (e.g. nurse, physician, pharmacist, RT, PT, OT), he or she must</td>
</tr>
<tr>
<td>Required Action Steps</td>
<td>Performed by</td>
<td>Supplemental Guidance</td>
</tr>
<tr>
<td>-----------------------</td>
<td>--------------</td>
<td>------------------------</td>
</tr>
</tbody>
</table>
| required to enroll in a monitoring agreement for a minimum of 2 years.  
  • The Staff Member will be randomly tested a minimum of 12 times and a maximum of 24 times during this period.  
  • The Staff Member will notify the Occupational Health Nurse of any change in treatment, including any medications, and will provide documentation of compliance with the Monitoring Agreement. | Resources Business Partner and PHC representative. | meet the requirements of the applicable licensing board prior to return.  
  HR and OH will work with the Staff Member’s CHOP department to assess this. |
| 5. Obtain signatures on the Monitoring Agreement from all meeting participants. | Occupational Health Nurse | The Occupational Health Nurse will instruct the Manager to leave the meeting after the Staff Member has signed the Monitoring Agreement. |
| 6. Obtain appropriate samples from the Staff Member (e.g., urine, saliva) and test for drugs and/or alcohol as applicable. | Occupational Health Nurse | Negative test results must be obtained prior to clearance for return to work.  
  As health care technology changes, the methods for drug and alcohol testing change as well. The Hospital will use testing methods acceptable in the industry and permissible under the law. |
| 7. Notify the Staff Member and Manager of test results when received. Notify the HR Business Partner and PHC of positive test results. | Occupational Health Nurse | The Staff Member can return to work once negative results are documented and communicated to the Manager. |
Policy: SEVERE WEATHER & EMERGENCY

<table>
<thead>
<tr>
<th>Type:</th>
<th>Human Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicable to:</td>
<td>The Children’s Hospital of Philadelphia (“CHOP”) Enterprise Wide</td>
</tr>
<tr>
<td>Process owner:</td>
<td>Sr. Human Resources Business Partner</td>
</tr>
<tr>
<td>Effective Date:</td>
<td>12/3/12</td>
</tr>
<tr>
<td>Supersedes:</td>
<td>10/1/05</td>
</tr>
<tr>
<td>Approved by:</td>
<td>Health System Director, Human Resources</td>
</tr>
<tr>
<td>Document ID #:</td>
<td>7-4</td>
</tr>
<tr>
<td>Accountable for:</td>
<td>Robert E. Croner, Sr. Vice President of Human Resources</td>
</tr>
</tbody>
</table>

1. PURPOSE:

To define the Hospital’s policy and procedures regarding weather conditions which effect absence, late start or early dismissal.

2. POLICY:

When severe weather/emergency conditions exist, due to the nature of our work, employees are expected to make every possible effort to arrive at work. During severe weather/emergency conditions, there may be occasions when the Hospital will dismiss certain employees from work early. Early dismissal due to weather conditions are judgments made only by the Senior Administration of the Hospital.

3. COVERAGE:

All employees of The Children’s Hospital of Philadelphia, its ambulatory care facilities, and its other affiliated institutions.

4. DEFINITIONS:

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe Weather Conditions</td>
<td>Including but not limited to heavy snow or ice accumulations, flooding, hurricane and/or tornado damage that significantly affect the normal operations of CHOP.</td>
</tr>
<tr>
<td>Emergency Conditions</td>
<td>States of emergency as determined by Senior Administration of the Hospital, taking into consideration states of emergency declared by the Governor(s) and/or Mayor(s) of affected areas.</td>
</tr>
<tr>
<td>Essential personnel</td>
<td>All CHOP employees are deemed essential unless or until instructed otherwise by management. During severe weather conditions, or when a state of emergency has been issued, all personnel must report to or remain at work unless instructed otherwise as noted above.</td>
</tr>
</tbody>
</table>

5. PROCEDURES:
I. Declaration of Weather/Emergency Conditions

The Administrator On-Call, will declare severe weather/emergency conditions when appropriate. This declaration will be announced promptly via email, voice mail, and updated on the CHOP home page on the internet. At the discretion of the Administrator On-Call, the Incident Command Center may be put into operation. Contact numbers for the emergency command center and specific directions will be included in the communications and on the internet.

For CHOP Care Network sites, declarations of severe weather/emergency conditions will be made by each site. The Practice Manager for the site in question will communicate the declaration of severe weather/emergency conditions to the Vice President of the CHOP Care Network, who will relay this information to the Administrator On-Call.

II. Department Emergency Communications Procedure

Each department head shall develop an emergency contingency plan including an emergency home telephone listing of all employees which can be referenced during weather and transportation emergencies. This listing should be updated at least twice yearly. This will help to ensure that appropriate personnel can be brought to the Hospital during such emergencies.

III. On Call/Standby

On Call and Standby guidelines are defined by HR Policy 4-3, Standard Pay Practices. The Administrator On-Call will determine and promptly communicate any applicable changes or exceptions to established on call or standby guidelines during weather/emergency conditions.

IV. Absenteeism/Unscheduled PPL

Should a weather emergency be declared and severe weather conditions prevent an employee from reporting to work, the employee will be permitted to use accrued PPL for the absence. This time will be noted as an unscheduled absence (UPPL). Exempt employees whose departments or sites are closed during the weather emergency will have the PPL time noted as scheduled (SPPL). Non-exempt employees will have the option of going unpaid or using SPPL for the day. It is the employee’s responsibility to communicate their option to their manager for timekeeping purposes.

If a manager sends an employee home prior to the end of their shift due to lack of work (low volume or site closure), exempt employees will get paid for the rest of the day, due to exempt status, and non-exempt employees will have the option of going unpaid or using SPPL for the remainder of the shift. Non-exempt employees must communicate their option directly to their manager for timekeeping purposes.

Each Department Head or designee will be responsible for informing staff regarding department or site closing decisions.

For CHOP Care Network sites, site closing decisions will be made by each site. The Practice Manager for the site in question will communicate site closing decisions to the Vice President of the CHOP Care Network, who will relay this information to the Administrator On-Call.
V. Exceptions

The Administrator On-Call may declare exception(s) to this policy based on the circumstances of the emergency in consultation with the appropriate senior management staff.

VI. Severe Weather Accommodations

CHOP may offer sleeping accommodations, at CHOP, in the event of severe weather/emergency. Employees wishing to use such accommodations must receive approval from their Department Head. Whether or not an employee elects to use such accommodations is the employee’s choice. CHOP will provide Weather Emergency pay to those staff approved to stay over as explained below. The Weather Emergency pay code will be administered as follows:

- Managers are responsible to recommend to their VP those staff members in their area who qualify for this payment; VPs will be responsible to approve these requests in advance. Both exempt and non-exempt staffs that stay over are eligible.

- Managers will use the “Weather Emergency” pay code in STAR which will pay at a rate of $2.00/hr.

- Earnings charged to Weather Emergency will not count towards overtime.

- The Weather Emergency pay code applies to non-working hours before or between shifts with manager pre-approval. Under no circumstances is the Weather Emergency pay code to be utilized concurrently with another pay code.

- Employees scheduled for On Call shifts during a severe weather/emergency event are ineligible to receive Weather Emergency pay. They may, however, be afforded overnight accommodations with Department Head approval.

- If circumstances warrant an employee to return to work while under the Weather Emergency pay code, Weather Emergency would cease and regular pay would commence at that point.

6. RESPONSIBILITY:

I. Decisions regarding the implementation of this policy shall be the responsibility of Senior Administration. Senior Administration will notify the Human Resources Department in the event of authorized excused lateness, excused unscheduled absences or early dismissal.

II. The Department Head is responsible for deciding who can be dismissed early based on work needs in accordance with the administrative decision.

III. Human Resources will communicate excused lateness, excused unscheduled absences or early dismissal notice to departments.
Policy: Employee Appearance

1. **PURPOSE:**
   
   This policy exists to establish an appropriate and consistent professional employee appearance and identification standard. Employees are expected to dress in a manner that presents a professional and neat personal appearance and ensures safety. It is also expected that all employees will maintain normal and reasonable personal hygiene and grooming standards that in no manner distracts or could have an adverse effect on patient care, interaction with patients, co-workers, parents and visitors, or other work related interactions.

2. **POLICY:**
   
   Employees’ dress, hygiene and grooming should be appropriate to the work situation. Neat and clean dressing, grooming and identification are important to good patient care, satisfaction of patients and their families and good employee-patient relations.

3. **COVERAGE:**
   
   All employees of The Children’s Hospital of Philadelphia (the “Hospital”), and it’s other affiliated institutions unless otherwise noted.

4. **PROCEDURES:**
   
   a. Identification and Name Badges – all employees, contractors, students, and volunteers, and any individual performing services for the Hospital are required to wear name badges while in the Hospital on duty. The badge must be worn in such a manner that the individual’s name can be visible and easily read (e.g., attached to a lanyard worn around the employee’s neck).

   b. Clothing or accessories that present safety concerns, including but not limited to open toed shoes, sandals or excessive jewelry are not permitted in patient care areas. At the discretion of the manager, an employee may be asked to remove an item that poses a safety hazard to his/her work environment (e.g., acrylic nail tips).
Policy: Employee Appearance

c. Employees are permitted to wear only those items of apparel, insignia and/or other identifiable objects that are regular and customary for clothing being worn in an Institution and/or businesslike work environment.

- Reasonable accommodations will be made based on religious and/or cultural observances or practices such as, but not limited to, style of dress, head coverings, facial hair grooming requirements unless such accommodations pose an undue hardship on the operations of the Hospital. The Hospital will engage in an interactive process with the employee to discuss any requests for a religious accommodation.
- Clothing should be clean and pressed.
- Jewelry should be worn in moderation.
- Appropriate undergarments should be worn and in a manner that is not visible to others.
- Piercings, other than on the ears, and tattoos should not be visible.
- Cologne, perfume or scented oils may be prohibited or restricted if found to have an adverse effect on patients, families or co-workers.
- Clothing or accessories that contain statements of profanity refer to drug or alcohol, or other inappropriate insignia are not permitted.

d. Each department may set its own additional standards of employee appearance to fit the specific needs of their department and to address matters such as the use of electronic devices (visible personal cell phones, pagers, or other personal technology items).

e. Failure to follow the guidelines as indicated in this Appearance Policy and maintenance of the standards set by this policy will result in disciplinary actions in accordance with the CHOP Policy 5-2 - Rules of Conduct

5. RESPONSIBILITY:

a. Employees are responsible for abiding by the standards of this policy.

b. Department heads and supervisors are to review this policy with employees on a periodic basis and inform employees when they are in violation of this policy.
The following steps should be taken in order to enter any type of event into Safety Net:

1) Open Internet Explorer and go to the CHOP intranet homepage ([http://intranet.chop.edu/employee/jsp/home.jsp](http://intranet.chop.edu/employee/jsp/home.jsp))

2) Locate the Safety Net link on the lower right-hand corner beneath the “Popular Features” section of the webpage.

3) Click on the Safety Net link and you will be taken to the login screen for Safety Net.

4) The username and password are already filled in for you so you only need to click on “Log In to STARS”
Job Aid for Entering Patient Related Events into Safety Net

5) Upon logging in you will have a new window pop up with choices for what type of event you want to enter. The choices are “Patient Safety Event” and “Issue or Concern which is Not Patient Specific”. For this we will choose “Patient Safety Event”.

6) Next you are taken to the Patient Demographics Page. If you have the patients MRN or Account Number and their last name, click on the “Patient Lookup” button.
a) Once the pop-up window opens you will need to put in at least 3 letters of the patient's last name and either the MRN or Account Number in order to look up a patient. Two of the 3 fields must be filled in and the patient last name is mandatory. Once filled in click Search.

i. If a patient exists the system the screen will populate with every encounter this patient is tied to. Click on the appropriate encounter and click OK.

b) If you do not have any patient information on hand, you can fill in the blanks by hand. Only those marked with an asterisk are necessary to enter an event
Job Aid for Entering Patient Related Events into Safety Net

7) The next page you will encounter is the Core Questions page. This page holds many questions that are relevant to the event you are reporting. The last page of this job aid explains the Event Type fields in more detail.

8) Once filled in, click “Next” on the bottom right side to move on.

a) You must fill in all asterisk questions in order to move on. The following fields are mandatory:

i. Date of Event – This is the date the event happened, it can be back dated

ii. Time of Event – Approximate time the event happened. If unknown, click Time Unknown

iii. CHOP Entity – High level breakout of CHOP as an institution

iv. Location where the event occurred – Specific area this event took place, this field changes depending on what you choose as a CHOP entity.

v. How was this event discovered – how you found out about this event

vi. Event Type – Major high level type of event you are entering

vii. Event Type (Level 2) – Breakdown of more specific types of event, based off Event Type

viii. Did this event reach the patient – Whether or not this event interacted with the patient at all, both adversely or not.

ix. Reporter Staff position – position you hold at CHOP

x. Reporter’s Name – this is NOT mandatory, but it is suggested that this be filled in for easier follow-up from senior staff
Job Aid for Entering Patient Related Events into Safety Net

9) The next area you enter will change depending on the Event Type chosen in the prior page. For our purposes the Event Type “Fall” was chosen.

10) Depending on what Event Type is chosen, this page may or may not have mandatory fields on it. Once completed, click “Next” on the bottom right.

11) The final page before submission is called the Synopsis of Event page. This page is where any other information not directly filled out on any prior pages should be explained. 

* All fields on this page are mandatory!
Job Aid for Entering Patient Related Events into Safety Net

a) Physician Notified – Yes or No, if yes you will be prompted with a question about the name of the physician. This field would be filled in as Last Name, First Name

b) Descriptive field – This field has a 254 character limit. This means that all information here should be factual, brief and abbreviated whenever possible. 254 characters is approximately 2-3 sentences depending on how well you do the above.

c) Did the patient require treatment or intervention – Yes or No. If you choose yes you will get another field that looks identical to the descriptive field. This field has two meanings.

   a. It can be used to describe whether or not the patient actually did need any treatment or intervention because of the event being entered. This field also has a 254 character limit.

   b. It can be used to extend the explanation from the prior question regarding the description of what happened.
Job Aid for Entering Patient Related Events into Safety Net

Explanations of the Event Type Fields:

Event Type – This field outlines the 10 major event types that you can choose from. Some of them can be somewhat cryptic and thus there is a small blue “bubble” with a question mark in it to the right. Clicking on this bubble will take you to an intranet page which has a brief crosswalk of which event types should be chosen depending on what you really want to submit. The next page of this document also contains this same crosswalk.

1) Adverse Drug Reaction
2) Blood Products / Transfusion
3) Complication of Procedure / Treatment / Test
4) Equipment, Supplies, Medical Devices
5) Errors related to Procedures, Treatments, Tests, Respiratory, Labs, Nutrition
6) Falls
7) Medications, IV, HAL, Vaccines
8) Skin Integrity (Not IV Infiltrates)
9) Transfer / Transport of a Patient
10) Other / Miscellaneous

Event Type (Level 2) – Depending on which of the major categories you chose for Event Type this list will drill down into more specific areas to report on. The crosswalk on the last page of this job aid can help guide you to the right event types to submit a safety event under.

Event Type (Level 3) – Some of the Level 2 events can trigger a 3rd level of information. Again, this list will be drilled down depending on what Event Type Level 2 you choose.
## Safety Net: Which Event Type to Choose?

<table>
<thead>
<tr>
<th>If you want to report a(n):</th>
<th>Event Type 1</th>
<th>Event Type 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adverse drug reaction</td>
<td>Adverse Drug Reaction</td>
<td></td>
</tr>
<tr>
<td>Alarm Issue</td>
<td>Equipment/Supplies</td>
<td>Other</td>
</tr>
<tr>
<td>Anesthesia event</td>
<td>Complication of Procedure/Treatment/Test</td>
<td></td>
</tr>
<tr>
<td>Breast Milk problem</td>
<td>Error Related to Procedure/Treatment/Test</td>
<td>Dietary</td>
</tr>
<tr>
<td>Broken item(s)</td>
<td>Equipment/Supplies</td>
<td></td>
</tr>
<tr>
<td>Burn (electrical, chemical, thermal)</td>
<td>Skin Integrity</td>
<td></td>
</tr>
<tr>
<td>Cardiopulmonary arrest outside of ICU setting</td>
<td>Complication of Procedure/Treatment/Test</td>
<td></td>
</tr>
<tr>
<td>Complication following care or a procedure</td>
<td>Complication of Procedure/Treatment/Test</td>
<td></td>
</tr>
<tr>
<td>Consent missing/inadequate (blood)</td>
<td>Blood Products/Transfusion</td>
<td></td>
</tr>
<tr>
<td>Consent missing/inadequate (surgery or procedure)</td>
<td>Other / Miscellaneous</td>
<td>Other</td>
</tr>
<tr>
<td>Dietary related event</td>
<td>Error related to Procedure/Treatment/Test</td>
<td></td>
</tr>
<tr>
<td>Disconnected tubing</td>
<td>Equipment/Supplies</td>
<td></td>
</tr>
<tr>
<td>Drain related event</td>
<td>Equipment/Supplies</td>
<td></td>
</tr>
<tr>
<td>Electric shock to patient</td>
<td>Other/Miscellaneous</td>
<td></td>
</tr>
<tr>
<td>Equipment malfunction, misuse or not available</td>
<td>Equipment/ Supplies</td>
<td></td>
</tr>
<tr>
<td>Equipment safety situation</td>
<td>Equipment/Supplies</td>
<td></td>
</tr>
<tr>
<td>Event related to blood product</td>
<td>Blood Products/Transfusion</td>
<td></td>
</tr>
<tr>
<td>Extravasation of drug or radiologic contrast</td>
<td>Complication of Procedure/Treatment/Test</td>
<td></td>
</tr>
<tr>
<td>Fall</td>
<td>Fall</td>
<td></td>
</tr>
<tr>
<td>Hand off communication issue</td>
<td>Transfer/Transport of Patient</td>
<td></td>
</tr>
<tr>
<td>Inadequate pain management</td>
<td>Medication Error</td>
<td></td>
</tr>
<tr>
<td>Inadequate supplies</td>
<td>Equipment/Supplies</td>
<td></td>
</tr>
<tr>
<td>Inappropriate discharge</td>
<td>Other/Miscellaneous</td>
<td></td>
</tr>
<tr>
<td>Inappropriate mode of transport</td>
<td>Transfer/Transport of Patient</td>
<td></td>
</tr>
<tr>
<td>Infusion/ IV/Enteral</td>
<td>Equipment/ Supplies</td>
<td></td>
</tr>
<tr>
<td>IV site complication or infiltration</td>
<td>Complication of Procedure/Treatment/Test</td>
<td></td>
</tr>
<tr>
<td>Laboratory test problem</td>
<td>Error related to Procedure / Treatment / Test</td>
<td></td>
</tr>
<tr>
<td>Laceration</td>
<td>Skin Integrity</td>
<td></td>
</tr>
</tbody>
</table>

**Effective Date: 7/1/2011**
## Job Aid for Entering Patient Related Events into Safety Net

<table>
<thead>
<tr>
<th>Event Description</th>
<th>Category</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Complication</td>
<td>Complication of Procedure/Treatment/Test</td>
<td></td>
</tr>
<tr>
<td>Medical device problem</td>
<td>Equipment/Supplies</td>
<td></td>
</tr>
<tr>
<td>Medication list incorrect</td>
<td>Medication Error</td>
<td></td>
</tr>
<tr>
<td>Wrong Medication Dose</td>
<td>Medication Error</td>
<td>Wrong</td>
</tr>
<tr>
<td>Medication related event (except ADR)</td>
<td>Medication Error</td>
<td></td>
</tr>
<tr>
<td>Monitoring error (includes contraindicated drugs)</td>
<td>Medication Error</td>
<td></td>
</tr>
<tr>
<td>No identification band - lab</td>
<td>Error related to Procedure/Treatment/Test</td>
<td></td>
</tr>
<tr>
<td>No Identification Band during transport</td>
<td>Transfer/Transport of Patient</td>
<td></td>
</tr>
<tr>
<td>Not on this list?</td>
<td>Choose the most logical event type or Other</td>
<td></td>
</tr>
<tr>
<td>Onset of hypoglycemia during care</td>
<td>Complication of Procedure/Treatment/Test</td>
<td></td>
</tr>
<tr>
<td>Outdated item(s)</td>
<td>Equipment/Supplies</td>
<td></td>
</tr>
<tr>
<td>Perfusion/ECMO/Dialysis issues</td>
<td>Equipment/Supplies</td>
<td></td>
</tr>
<tr>
<td>Preventive maintenance not complete</td>
<td>Equipment/Supplies</td>
<td>Equipment Safety situation</td>
</tr>
<tr>
<td>Prescription/refill Delayed</td>
<td>Medication Error</td>
<td></td>
</tr>
<tr>
<td>Pressure ulcer</td>
<td>Skin Integrity</td>
<td></td>
</tr>
<tr>
<td>Pyxis narcotic discrepancy</td>
<td>Still need to use a paper form (for now)</td>
<td></td>
</tr>
<tr>
<td>Radiographic equipment issues</td>
<td>Equipment/Supplies</td>
<td></td>
</tr>
<tr>
<td>Radiology/imaging test problem</td>
<td>Error related to Procedure/Treatment/Test</td>
<td></td>
</tr>
<tr>
<td>Rash/Hives</td>
<td>Skin Integrity</td>
<td></td>
</tr>
<tr>
<td>Sterilization problem</td>
<td>Equipment/Supplies</td>
<td></td>
</tr>
<tr>
<td>Surgery/invasive procedure problem</td>
<td>Error related to Procedure/Treatment/Test</td>
<td></td>
</tr>
<tr>
<td>Transfer/Transport problem, delay or event</td>
<td>Transfer/Transport of Patient</td>
<td></td>
</tr>
<tr>
<td>Transport not consistent with patient needs</td>
<td>Transfer/Transport of Patient</td>
<td></td>
</tr>
<tr>
<td>Skin ulcer, abrasion, blister</td>
<td>Skin Integrity</td>
<td></td>
</tr>
<tr>
<td>Unplanned extubation</td>
<td>Error related to Procedure/Treatment/Test</td>
<td></td>
</tr>
</tbody>
</table>