The Ellenville Regional Hospital - Mandatory In-Service Newsletter 2018

This newsletter has been developed to help you to meet the mandatory education requirements of the New York State Department of Health, and the Occupational Safety and Health Administration (OSHA). To meet your annual requirements, you must read the entire newsletter and successfully complete the post-test. If you have any questions while reading the newsletter or taking the test, please call Debbie Briggs, VP, Human Resource at (845) 647-6400 ext. 286.

**Patient’s Rights**
In accordance with the New York State Health Code, the Patients’ Bill of Rights is provided to each inpatient and ambulatory surgery patient or his/her representative. On admission the Registrar will inform the patient that their rights are included in the patient kit. At this time, the patient will sign the Acknowledgment Sheet. Outpatient and Emergency Department patients can receive a copy upon request from the Registrar. Signature on the General Consent or Treatment Form also acknowledges receipt of Patients Rights and Responsibilities. Copies of the Patients Bill of Rights are posted in conspicuous locations throughout the Hospital.

Special needs of patients with visual or hearing impairment or language barrier are addressed as necessary. For the visually impaired individual, the registrar will verbally inform the patient and/or his/her representative of the Patient’s Rights and Responsibilities. Please see the Interpreter Services section for more detailed information.

**Parent’s Rights**
Key sections:
As a parent, legal guardian or person with decision-making authority for a pediatric patient receiving care in this hospital, you have the right, consistent with the law, to the following:
• To inform the hospital of the name of your child’s primary care provider, if known, and have this information documented in your child’s medical record.
• That your child not to be discharged from our hospital or emergency room until any tests that could reasonably be expected to yield critical value results are reviewed by a physician, physician assistant, and/or nurse practitioner and communicated to you or other decision makers, and your child, if appropriate. Critical value results are results that suggest a life-threatening or otherwise significant condition that requires immediate medical attention.
• That your child’s primary care provider, if known, to be provided all laboratory results of this hospitalization or emergency room visit.
• To request information about the diagnosis or possible diagnoses that were considered during this episode of care and complications that could develop as well as information about any contact that was made with your child’s primary care provider.

**Release of Medical Records**
All requests for medical record information will be transferred and processed by the HIM Department. In an Emergency situation when HIM is closed and records are needed for a patient’s care at a hospital or provider’s office, an ERH Staff member who has access to a patient’s EMR can fax the medical record. However, these steps must be taken in the situation:
• Hospital and/ or Provider’s office in need of medical records must send a request on their letterhead with Patient Information and a list of information that is needed, including a fax number to send the information.
• Once request is received –
  o Medical record can be faxed with a completed ERH fax coversheet- with liability statement on bottom
  o Fax coversheet must include sender’s name, sender’s phone number &ext. #, sender’s fax number, date, number of pages and recipient’s name and fax number
  o Wait for fax verification printout – stating fax transaction was properly sent
  o Staple together: Letterhead request, fax coversheet, medical records sent, and fax verification and send to HIM to be entered in the EMR’s Release of Information.
Restraint Philosophy
Restrains may be used in clinically justified situations. They are used only in an emergency to prevent injury to self or others, and only after preventative alternatives have been exhausted. Verbal calming, music, diversion activities, and environmental changes must be attempted prior to the application of restraints.

Physical Restraint – Any type of device (physical or mechanical) that restricts a patient’s freedom of movement, physical activity and normal access to the body. Restraints include (but are not limited to): Side-rails, Geri-chairs, Mitts, Waist belts, Vests, Soft limb, and Leather or Hard restraints.

Chemical Restraint – Any round the clock tranquilizers, barbiturates, depressant drugs and neuromuscular paralyzers. Sleeping pills and mild tranquilizers used during the acute patient stay for comfort/rest is not considered a chemical restraint. When restraints are necessary for medical/surgical or behavioral conditions, strict nursing documentation and notification guidelines must be followed. Annual mandatory education of nursing staff is provided on this topic. For further information refer to the Restraint/Seclusion policy and procedure.

Products that present a health or physical hazard to employees will be appropriately labeled to alert employees to the hazards of the product and to identify safe procedures to follow when working with it within the hospital. Containers of any hazardous chemicals must be labeled with the identity of the material and appropriate hazard warnings. If materials are transferred from the labeled container to another container, the chemical name and hazard-warning label must be affixed to the secondary container. Should there be a chemical spill, identify the chemical, and have MSDS available.

Patient Confidentiality
Access to patient information is limited to employees who require such information to perform the duties of their job. Each employee is responsible for respecting patient privacy and confidentiality. Unauthorized disclosure of confidential information concerning a patient or hospital business, whether inside or outside the hospital, is a major violation of HIPAA and the Privacy policies of ERH. Violations will lead to disciplinary action, which could include immediate termination. In addition, it is a violation of the NYS Health Code 405.3 regarding Patient Rights, which guarantees privacy while in the hospital and confidentiality of all information and records regarding care.

Patient information includes but is not limited to:
- Acknowledgment that the patient is hospitalized
- Any medical record data
- Any computer or electronic data including protected health information
- Internal communications (i.e.: OR schedules, patient condition reports)

Authorized purposes for access to patient information include:
- Patient care
- Information directly related to job role
- Assessment of the quality & appropriateness of patient care
- Department review of work performance
- Surveys
- Educational purposes e.g.: Student affiliations
- State & Federal regulatory agencies upon proof of identification

Computer system and electronic health record login information and access codes are not to be disclosed to anyone for any reason nor should anyone attempt to access information on any computer system using another person’s Login and password. If an employee has reason to believe that the confidentiality of their Login, password
and/or access code has been compromised, they must inform their Department Manager or IT immediately. Suspect passwords and codes will be eliminated and new ones will be issued.

**Advance Directives**

Adults in New York State have the right to accept or refuse medical treatment, including life-sustaining interventions. Adults can also request Do Not Resuscitate (DNR) orders when they do not want caregivers to attempt cardiopulmonary resuscitation (CPR). A DNR order is only a decision about CPR and does not relate to any other treatment. A Do Not Intubate (DNI) order indicates the patient does not want to be intubated and placed on a ventilator. A patient can opt to be a DNR and DNI. Since the NYS Health Care Proxy Law was passed in 1991, state residents have had the right to appoint someone, a proxy, to make decisions for them. The hospital is required to ask all persons on admission if they have Advanced Directives and provide help with completion of proxy forms, if requested. No attorney is needed to designate a proxy, only two adult witnesses. Some persons also choose to document instructions about the medical treatment they would or would not want if they become permanently and irreversibly ill. This is called a Living Will. It is required that a patient’s decisions regarding Advance Directives be documented in the medical record.

**Back Safety**

Back injuries affect eight (8) out of ten (10) Americans, and can result in pain, lost work time, medical bills, and disability. To avoid back injuries certain principles of good body mechanics need to be followed:

Evaluate the load to be lifted or removed, and obtain assistance when indicated. This assistance may include a co-worker, use of devices such as a transfer belt or board, or mechanical lift.
- When lifting or moving a heavy object, establish a wide base of support by placing your feet apart.
- Bend your knees, not your back.
- Lift with your leg muscles.
- Tighten the abdominal muscles to help support the spine when lifting.
- Keep the load being lifted close to your body.
- Keep your back upright; maintaining the normal curves of the spine.
- Don’t forget head position. Keep your chin from jutting forward.
- Avoid twisting, move your feet to turn or pivot.
- Continue breathing; do not hold your breath when lifting a heavy object.
- For the clinical staff you will be trained on both the Sara steady and Rifton tram.

**Safe Patient Handling**

Our Safe Patient Handling and Movement Policy sets forth an approach for ensuring that our employees practice safe patient handling and movement techniques when working with or on patients who are at risk of falling, unable to weight-bear, and/or incapable of following directions. ERH accepts the reality that the manual lifting or transferring of dependent patients is a high-risk activity, both for the health-care worker and for the patient being transferred. Therefore, we shall ensure that sufficient resources are available to maintain quality care for its patients and a safe work environment for its employees. To accomplish this, there shall be an infrastructure in place that conforms to all components of this policy and includes equipment (mechanical lifts and adequate back up power sources batteries, friction-reducing devices, lift assist devices, walking belts); ongoing patient assessment; health-care worker training and competency testing; a method of communication with front-line caregivers; and a “cultural safety” approach to quality care. Direct patient care staff shall assess patient handling tasks in advance to determine the appropriate transfer methods. Employees may refuse to perform or be involved in patient handling or movement that the employee reasonably believes in good faith will expose a patient or ERH employee to an unacceptable risk of injury. In this situation, the employee should consult with his/her manager or supervisor on how to proceed. Manager/supervisor to determine if task...
is unsafe and should not be performed, if the task should be reassigned to another staff member, or if the employee should be directed to perform the task. If the employee is directed, but continues to refuse, then disciplinary action will be considered.

For further information see Safe Patient Handling and Movement Policy in the Human Resources section of the policy & procedure manual

Radiation Safety
Radiation is energy that travels in waves. It is all around us, microwaves from cell phones and light are both types of radiation. In diagnostic imaging, we use forms of radiation to produce pictures of the inside of the body. The radiation used is ionizing radiation known as X-Ray or Gamma radiation. This type of radiation can interact with the body in ways that can be harmful. There is a natural background X and gamma radiation everywhere. It comes naturally from the sun and from other stars in outer space. The Radiology Department staff follows a principle known as ALARA to keep the exposure to the least possible dose needed to obtain diagnostic images. ALARA stands for “As Low As Reasonably Acceptable”. Staff that are exposed to radiation frequently are also protected. Areas where X-Rays are used are clearly marked. Staff in these areas are monitored for exposure by wearing film badges. These badges track recent and lifetime exposure to radiation to ensure safe practices are being followed. If you are a visitor to these areas, such as a nurse caring for a patient, you will be instructed on what to do to protect yourself by a Rad Tech or other trained professional. Most of the safe guards are built in. If warranted, walls are lined with lead and glass with high lead content is used. If you need to be in the area where radiation is present, you will be asked to wear a lead apron. It is important to remember that the most effective way to protect yourself, even outside of the immediate area, is to increase distance from the radioactive source and reduce time exposed. If you have any questions or concerns and ESPECIALLY IF YOU ARE PREGNANT, speak to one of the Technologists, who are highly trained and always willing to help.

Infection Control
Prevent the spread of infection!
It is estimated that each year in the United States over two (2) million infections occur as a result of hospitalizations. The main mode of transmission for organisms within the hospital environment is on the hands of Health Care Workers (HCW). Therefore, efforts to control the spread of infection are directed to every hospital employee. A goal of Ellenville Regional Hospital’s Infection Control Department is to identify and reduce nosocomial (hospital acquired) infections and provide education to patients and staff on how to prevent the spread of infection.

Hand washing is the single most important procedure to prevent the spread of infection. The CDC now recommends the use of alcohol based hand rubs (please follow manufacturer’s directions).

NOTE: The use of gloves does not eliminate the need for good hand hygiene in preventing the spread of infection. Routine hand washing involves a rigorous rubbing together of well-lathered hands for at least twenty (20) seconds followed by a thorough rinsing under running water for visible soil.

To ensure compliance with hand hygiene practices, a secret observer program has been instituted. The secret observers will monitor and record staff members following the guidelines below. The secret observers will report all results monthly to the infection control nurse.

Hand hygiene should be performed:
- Before and after direct patient care;
- Before and after wearing gloves or other Personal Protective Equipment (PPE);
- After touching items that may have been contaminated;
- Before eating;
- After using the bathroom
**Bloodborne Pathogens**
The purpose of OSHA’s Bloodborne Pathogen Standard is to reduce or eliminate Health Care Workers (HCW’s) exposure to bloodborne pathogens such as Hepatitis B Virus (HBV), Hepatitis C Virus (HCV), and Human Immunodeficiency Virus, (HIV) by preventing contact with blood and other potentially infectious material.

**PROTECT YOURSELF! MAKE THE REQUIREMENTS A PART OF YOUR ROUTINE PRACTICE!!**

- Hepatitis B, Hepatitis C, HIV and other pathogens may be present in blood and in other body fluids.
- An occupational exposure includes any contact with skin, eye, mucous membrane, non-intact skin, or other potential contact with blood or other potentially infectious material that an employee may come in contact with while performing his/her job duties.
- The Hepatitis B Vaccine is a safe and effective means of preventing Hepatitis B. The vaccine is available to all those identified in the exposure control plan as having the risk of occupational exposure. Employees who are non-immune to HBV will be offered the 3-part series as soon as immune status is determined. If declined, the employee must sign a HBV Declination but can change their mind at any time they elect to have the HBV series.
- The Bloodborne Pathogen Exposure Control Plan is located in the Infection Control Manual.
- **BIOHAZARD** labels exist on containers with potentially infectious material.
- **Prevent accidental injuries!**
  - Discard needles in puncture-resistant containers. Check needle boxes regularly. Change them when they become ¾ full.
  - **Do not recap needles!** If recapping is necessary, a single-handed scoop method or recapping device is used.
  - Dispose of contaminated laundry in appropriate bags on the unit. All laundry is treated as contaminated.
  - There is no eating, drinking, applying cosmetics or handling contact lenses in patient care areas.
  - **If an exposure occurs:**
    - Wash the area thoroughly with soap and water;
    - Report the incident to the supervisor/manager and complete an event report.
    - Notify Employee Health of the incident immediately
    - Report to the Emergency Dept. for confidential medical evaluation ASAP (within one hour), if Employee Health Office is closed;
    - Report to the Employee Health Service as soon as possible (within 24 hours) for follow-up and counseling

**Standard Precautions**
Staff should consider ALL body fluids as potentially infectious when caring for ALL patients. *A phrase to remember: IF IT’S WARM AND IT’S WET AND IT’S NOT YOURS DON’T TOUCH IT!!!* Three categories of isolation are used for patients with infections: contact, droplet and airborne. When isolation is required, a sign is placed on the door which reads “please check with the nurse before entering”. The sign is color coded according to the specific type of isolation (**ORANGE FOR CONTACT, GREEN FOR DROPLET, AND BLUE FOR AIRBORNE/RESPIRATORY**). An isolation box or cart is placed outside the patient room as well, and provides the necessary personal protective equipment for staff and visitors.

Infection Control resources are:

- Hospital Policy and Procedure manuals;
- The Infection Control Department by phone or written requests;
- Your Supervisor or Manager.

**Tuberculosis and Ebola Update**
Tuberculosis (TB) is a disease that is spread person-to-person through the air. TB usually affects the lungs but can also affect other organs of the body. TB is spread when a person who has the active disease in the lungs exhales or expels respiratory secretions, which contain TB bacteria into the air, and another person inhales the bacteria. The symptoms of TB include weight loss, fatigue, and chest pain, loss of appetite, fever, persistent cough, night sweats and coughing up blood. People with a positive PPD test (skin test for TB) have been exposed to TB bacteria but may not be infectious or have active disease. They cannot spread the bacteria to others, but they may require medication to prevent the development of active TB disease. People with active TB disease usually have one or more of the symptoms of TB. These people are often capable of giving the infection to others. Medications that treat TB are prescribed for these people. Anyone can get TB but some groups of people are at higher risk for TB. These people are:

- People sharing the same air space with someone who has TB disease of the lungs or larynx;
- The homeless;
- The medically underserved;
- People from group living facilities;
- People with HIV
- Foreign-born people from countries where many people have TB.

There are two ways to test for TB, a skin test called PPD or a blood test. Health care workers are required to be tested annually for TB. If it is positive, further tests may be ordered to determine TB exposure or TB disease. ERH patients who are suspected of having TB are placed in a single, negative pressure airflow rooms with the HEPA filtration, with the door closed and a sign on the door labeled “Airborne Isolation”. Health care workers caring for those patients must wear special masks labeled N95 Particulate Respirators.

Ebola Virus Disease (EVD) is caused by a virus that is transmitted through contact with bodily fluids. Ebola was first identified in 1976 near the Ebola River in Africa. The largest outbreak of Ebola occurred in West Africa starting in 2014; currently CDC is working on containing additional flare ups of the virus. New York State Department of Health and CDC have implemented protocols for all United States hospitals to follow to identify, contain and treat any possible patient with Ebola symptoms. At ERH, protocols have been implemented in compliance with NYS Commissioner of Heath’s order. Given that the transmission and occurrence of Ebola virus and occurrence of Ebola virus disease in West Africa has been greatly reduced, healthcare facilities are currently not required to perform advanced screening. ERH staff have been trained on PPE donning and doffing. EBOLA Virus Disease – Prevention and Control Policy is accessible to all staff on the hospital portal. For further information see EBOLA Virus Disease-Prevention and Control Policy in the Administration section of the policy & procedure manual.

Confidentiality HIV Testing
HIV counseling and testing is available to any patient or hospital employee who consents to it. It is recommended that any person who engages in risky behavior be (voluntarily) counseled and tested for HIV. Early identification of HIV infection allows early treatment. Risky behavior includes:

- Having a sexually transmitted disease;
- Engaging in unprotected sex;
- Having sex with a prostitute
- Sharing needles for illegal drug use;
- Have unprotected sex with a person who engages in risky behavior

New York state public health law states that HIV testing must be offered to all persons between the ages of 13-64 receiving hospital or primary care services, with limited exception. The offering must be made to inpatients; persons seeking services in emergency departments; persons receiving primary care services as an outpatient at a clinic; or physician, physician assistant, nurse practitioner or mid wife. The individual will be provided with the seven points of information about HIV, required by the public law and give informed consent prior to HIV testing. The consent form will be placed in the patients chart. The Licensed Medical Provider will enter the order for
the testing in our Electronic Medical Record. Confidential HIV related information includes: whether a patient has an HIV infection, an HIV related illness or AIDS; and information which could identify the patient as having such condition. Healthcare and other HIV test providers authorizing HIV testing must arrange an appointment for medical care for persons confirmed positive.

**Confidential HIV related information is NEVER communicated by telephone or fax.**

Deceased, comatose or persons otherwise incapable of providing consent, and who are the source of an occupational exposure, may now be tested for HIV in certain circumstances without consent. Confidential HIV information may be released without written statement prohibiting re-disclosure when routine disclosures are made to treating providers prior to health insurers to obtain payment.

**Performance Improvement (PI)**

Performance Improvement is a collaborative effort involving multiple departments and disciplines working together to ensure that all patients are provided superior safe and quality care. By doing so we are providing an environment that is conducive to improving overall patient well-being. Collectively, we all have the responsibility of developing, measuring, assessing and improving our performance. ERH’s PI committee outlines the process for systematically measuring, assessing, improving, and reassessing performance to enhance and improve patient health outcomes. Primary focus is shifted from the performance of an individual to the performance of the organization’s systems and processes. Barriers are eliminated between departments by creating multi-departmental working teams to discuss PI mechanisms and activities. All data is analyzed routinely to identify trends and patterns. Each employee is obligated to report any activity that could cause patient harm and/or lead to unsafe working conditions.

**Compressed Gas Cylinders**

The gaseous content of compressed gas cylinders is highly pressurized. Handle these tanks with care. If tanks become stacked, broken or the valve stem separates, the cylinders may cause injury. All compressed gas cylinders must be chained to the wall or in approved carrying devices when in use.

**Electrical Safety**

All electrical equipment used in the hospital must be inspected by the Maintenance Department on a regular basis. Any defective electrical equipment should be removed from use, labeled with what the problem is, and the Maintenance Department notified for repair. Personal electrical appliances are restricted for use in the hospital.

**Disaster Plan**

The code for disaster is **CODE BLACK** and is announced over the hospital PA system.

When **CODE BLACK** is activated, the following events should take place:
1. Directors and Department Managers report to the command center
2. The Incident Commander (I.C.) will have complete charge of all personnel and will assign roles and duties as needed
3. Nurse Manager or House Supervisor will assume the responsibilities of the I.C. until relieved of these duties.
4. Personnel will be assigned to arrange for 24/7 department coverage until the disaster is concluded.
5. Personnel will be available to relocate Medical Records if necessary.
6. Security Manager will be responsible for traffic control
7. Director of Facility Services will be responsible for facility issues
**Hazard Communication Standard**
A Hazardous Chemical is defined by OSHA as any chemical in all physical forms liquids, solids, gases, vapors and fumes, which at least 1% of the chemical (or product) is toxic, corrosive, flammable or reactive.

A master of Material Safety Data Sheets (MSDS) for all hazardous materials used in the hospital is maintained in the Emergency Department and is accessible at all times.

Products that present a health or physical hazard to employees will be appropriately labeled to alert employees to the hazards of the product and to identify safe procedures to follow when working with it within the hospital. Containers of any hazardous chemicals must be labeled with the identity of the material and appropriate hazard warnings. If materials are transferred from the labeled container to another container, the chemical name and hazard-warning label must be affixed to the secondary container. Should there be a chemical spill, identify the chemical, and have MSDS available.

**Domestic Violence**
Domestic violence is a widespread community health problem as well as a serious crime. Nationwide, at least six million people are victims of some form of family violence each year. Three to four million of the individuals are women battered by their spouses or partners. Although men can be victims of domestic violence, at least 94 percent of the victims are women. Women are also at high risk of serious injury in domestic violence incidents and of experiencing continuing and escalating violence. Protocols, therefore, focus on battered women, although the medical responses and legal relief outlined are appropriate and necessary for any adult victim of domestic violence. In addition, battering is a major factor in a range of psychological problems including suicide attempts, alcoholism, and child abuse. Hospital emergency services can provide effective care for domestic violence victims if staff is aware of the dynamics of abuse, sensitive to the victim’s needs and knowledgeable about resources available in the community.

**Child Abuse**
Any health care professional engaged in the administration, examination, care or treatment of children must report their suspicions of child abuse, maltreatment or neglect. The report is made to the New York State Child Abuse Hotline (800-635-1522), and is followed by a written report. The hospital has the authority to assure protective custody until the child’s release is authorized by the local Child Protective Services. Individuals who are not mandated reporters but who wish to report suspected child abuse, maltreatment of neglect may call 800-342-3720.

**Elder Abuse**
Federal definitions of elder abuse, neglect, and exploitation appeared for the first time in the 1987 Amendments to the Older Americans Act. The definitions were provided in the law only as guidelines for identifying the problems and not for enforcement purposes. Currently, state laws define elder abuse, and state definitions vary considerably from one jurisdiction to another in terms of what constitutes the abuse, neglect, or exploitation of the elderly. In addition, researchers have used many different definitions to study the problem. Broadly defined, however, there are three basic categories of elder abuse:
1. Domestic elder abuse
2. Institutional elder abuse
3. Self-neglect or self-abuse

In most cases, state statutes addressing elder abuse provide the definitions of these different categories of elder abuse, with varying degrees of specificity. Domestic elder abuse generally refers to any of several forms of maltreatment of an older person by someone who has a special relationship with that person (e.g. a
spouse, a sibling, a child, a friend or a caregiver in the older person’s own home or in the home of a caregiver.)

Institutional abuser, on the other hand, generally refers to any of the above-mentioned forms of abuse that occur in residential facilities for older persons (e.g. nursing homes, foster homes, group homes, board and care facilities). Perpetrators of institutional abuse usually are persons who have a legal or contractual obligation to provide elder victims with care and protection (e.g. paid caregivers, staff and professionals).

When elder abuse is suspected or confirmed, a plan of care should be developed for the individual. Case Management should be notified to help with this process.

**Event Reporting**

An event is any occurrence that is not consistent with the routine operation of the hospital or the routine care of a particular patient. All events/occurrences involving patients, visitors, students, employees, volunteers, public and business representatives will be reported on an ERH Event Reporting form which is easily accessible on the hospital portal. Reports should be completed as soon as possible; preferably at the time of the event or on the shift during which the event occurred, but no later than twenty-four (24) hours. All reports are automatically delivered to the Department Manager and the Vice President of Quality Management electronically. Once the investigation form has been completed, the investigation form is electronically sent to the Vice President of Quality Management. The supervisor is also electronically notified of the event and the report. For events reportable to the NYSDOH, the administrator on call MUST be notified outside of regular business hours. Each employee is obligated to report any near miss or actual events that could cause patient harm and/or lead to unsafe working conditions.

**Employee Events**

Employee events must be reported to a charge person, supervisor, or department manager IMMEDIATELY. Employees should be instructed to complete the employee event report electronically (available on the hospital portal), which is automatically sent to the Employee Health Nurse. When possible, the Event Report must be completed prior to reporting for evaluation and/or treatment. All employees will be evaluated in the Employee Health Office during regular business hours. If an employee is evaluated or treated in the Emergency Dept. during off shifts and weekends, he/she must contact Employee Health Services on the next business day. If an employee has loss of time from work due to a work-related injury, Human Resources must be immediately notified.

**Staff Medical Device Act**

Federal legislation states that medical device-related events that cause serious illness, serious injury or death to a patient must be reported to the manufacturer and/or FDA within ten (10) working days. Such events must be reported to the Risk Manager and an Event Report completed. The purpose of this regulation is to identify and report medical device-related events in order to initiate corrective action, or prevent or minimize the occurrence of a similar event. All products/equipment involved in such an event must be maintained and any packaging saved so that lot numbers, etc. can be documented. Defective products should not be discarded. Malfunctioning equipment should be reported appropriately, taken out of service until placed in a secured area until proper investigation can occur. ERH will submit all reports to the manufacturer and/or FDA per federal regulation.

**The Emergency Medical Treatment and Active Labor Act**

The Emergency Medical Treatment and Active Labor Act (EMTALA) is a statute which governs when and how a patient may be (1) refused treatment or (2) transferred from one hospital to another when he/she is in an unstable medical condition. EMTALA is also known as Section 1867(a) of the Social Security Act, was passed as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986. It is included as part of the section of the U.S. Code which governs Medicare. EMTALA applies only to “participating hospitals” - i.e., to hospitals which have entered into “provider agreements” under which they will accept payment from the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) under the Medicare program for services provided to beneficiaries of that program. Its provisions apply to all patients, and not just to Medicare patients. EMTALA imposes a number of duties upon hospitals, but the most significant are:

• To provide a medical screening to any patient who presents to a hospital emergency department
• To determine whether an emergency medical condition exists
• To stabilize the condition
• If necessary, to transfer the person to another facility, if the benefits of transfer outweigh the risks.

The general purpose of the statute is to prevent hospitals from rejecting patients, refusing to treat them, or transferring them to “charity hospitals” or “county hospitals” because they are unable to pay or are covered under the Medicare or Medicaid programs. EMTALA is a non-discrimination statute. It mandates that no patient who presents with an emergency medical condition and who is unable to pay may be treated differently than patients who are covered by health insurance.

A hospital which negligently violates the statute may be subject to civil money penalty and / or have their provider agreement with Medicare revoked. Risk Management investigates liability claims against the hospital and its staff. Potential liability risks are identified and analyzed to determine effect on patient care, hospital operations, and community image. Policy and procedure changes are recommended to promote risk control. Employee role and responsibility for risk management includes being familiar with and adhering to all safety policies and procedures, completing incident reports according to policy and being aware of and reporting any unsafe conditions. ERH has a policy and procedure to describe and comply with the Emergency Medical Treatment and Labor Act (EMTALA) for Licensed Medical Providers and staff and its application to Ellenville Regional Hospital.

Billing Department: How to pay your bill
Ellenville Regional Hospital’s billing department is available Monday thru Friday 8am and 4:30pm. If a patient or family member has a question regarding their bill, please direct them to call the Billing Department or to visit them on the Ground level of the Hospital.

Payment arrangements and financial assistance are available for patients and employees. Patients can qualify up to 100% discount on services. You can access Financial Assistance information under the P: Drive- Financial Assistance Application Documents folder, or at Registration Window or Billing Office. For any additional questions please seek the help of an ERH Billing representative.

Sexual Harassment
The Hospital will not tolerate the sexual harassment of its employees, providers or volunteers (noted as employees in this policy). The purpose of this policy is to ensure that employees of the Hospital are free from sexual harassment in the workplace or at any other location where Hospital-sponsored activities occur, since such conduct may be unlawful and negatively affect our employees and the Hospital. If you believe that you or another employee is being sexually harassed by a supervisor, employee, client, vendor or other third parties with whom you interact as part of your job, you are directed to bring the matter to the Hospital’s attention immediately in the manner set forth below.

All employees are encouraged to report any instances of sexual harassment, whether the harassment is directed toward you or another employee and whether committed by a supervisor, fellow employee, or non-employee. If you feel that you have been subjected to harassment, or if you witness conduct that you believe is sexual harassment, report the matter immediately to your immediate supervisor. If you are not sure to whom you should speak about an issue of sexual harassment, or if you have not received a satisfactory response within five (5) business days after reporting any incident of what you perceive to be sexual harassment, immediately contact the VP of Human Resources. The VP of Human Resources will ensure that an investigation is immediately conducted. Every report of perceived sexual harassment will be fully investigated and corrective action will be taken where appropriate.

Any employee who engages in inappropriate conduct deemed to be sexual harassment, or who otherwise violates this policy will be subject to disciplinary action, up to and including termination of employment. It is unlawful and against the Hospital’s policy to retaliate against an employee for making a sexual harassment complaint or for cooperating in an investigation of a sexual harassment complaint; such retaliation is also grounds for disciplinary action up to and including termination.
Information resulting from complaints filed under this procedure will be kept confidential by the Hospital’s management to the extent possible. Questions regarding the policy should be directed to the V.P. of Human Resources.

For further information see Workplace Harassment in the Human Resources section of the policy & procedure manual.

Other Forms of Harassment
The Hospital does not tolerate harassment in the workplace or at any other location where the Hospital sponsored activities occur, whether the harassment is based on a person’s actual or perceived race, color, religion, creed, sex, sexual orientation, national origin, age, ancestry, ethnicity, disability, citizenship, alienage, marital status, partnership status, familial status, military or veteran status, genetic information, predisposing genetic characteristic, status as a victim of domestic violence, stalking and sex offenses, or any other status protected by federal, state or local law. The purpose of this policy is to ensure that our employees are free from all forms of harassment in the workplace, since such behavior has a negative impact on both the employee and the hospital, and may be unlawful. If you believe that you or another employee is being harassed by a supervisor, employee, client, vendor, or other third parties with whom you interact as a part of your job, you are directed to bring the matter to the Hospital’s attention immediately in the manner set for the below.

Harassment is any conduct that: (1) has the purpose or effect of creating an intimidating, hostile, or offensive working environment; or (2) has the purpose or effect of unreasonably interfering with an individual’s work performance; or (3) otherwise adversely affects an individual’s employment opportunities. Examples include vulgar or offensive conversation or jokes; unwelcome comments about an employee’s physical characteristics, religious beliefs, ethnic background, medical condition, or disability; teasing, slurs, threats, derogatory comments, or other similar verbal, non-verbal or physical conduct directed toward a person, which is sufficiently severe or pervasive to create an unprofessional and hostile working environment.

All employees are encouraged to report any instances of harassment, whether the harassment is directed toward you or another employee. If you feel that you have been subjected to harassment or if you witness conduct that you believe is harassment, report the matter immediately to your immediate supervisor. If you are not sure to whom you should speak about an issue of harassment, or if you have not received a satisfactory response within five (5) business days after reporting any incident of what you perceive to be harassment, immediately contact the VP of Human Resources. The VP of Human Resources will ensure that an investigation is immediately conducted. Every report of perceived harassment will be fully investigated and corrective action will be taken where appropriate.

Any employee who engages in inappropriate conduct, or who otherwise violated this policy, will be subject to disciplinary action, up to and including termination of employment. It is against the Hospital’s policy to retaliate against an employee for filing a harassment complaint or for cooperating in an investigation of a harassment complaint; such retaliation is also grounds for disciplinary action up to and including termination.

Information resulting from complaints filed under this procedure will be kept confidential by the Hospital’s management to the extent possible. Questions regarding the policy should be directed to the VP of Human Resources at ext. 286.

For further information see Harassment, Other Forms of in the Human Resources section of the policy & procedure manual.

Workplace Violence
ERH is committed to preventing workplace violence and to maintaining a safe work environment. Given the increasing violence in society in general, ERH has adopted a Workplace Violence policy to deal with intimidation, harassment, or other threats of (or actual) violence that may occur on its premises. All employees should be treated with courtesy and respect at all times. Employees are expected to refrain from fighting, "horseplay," or other conduct that may be dangerous to others. Firearms, weapons, and other dangerous or hazardous devices or substances are prohibited from the premises of ERH without proper authorization.
Conduct that threatens, intimidates, or coerces another employee, a patient, or a member of the public will not be tolerated. This prohibition includes all acts of harassment, including harassment that is based on an individual's sex, race, age, or any characteristic protected by federal, state, or local law. The hospital will not discriminate against victims of workplace violence. Individuals who make threats, exhibit threatening behavior, or engage in violent acts on hospital property will be removed from the premises by the appropriate law enforcement agency as quickly as possible and may be subjected to arrest and criminal prosecution.

If an employee feels threatened or at risk of an assault, security should be notified immediately. (If Security is the source of the threat, than the Administrator on Call should be notified immediately). After the threat has been neutralized, the employee must report the incident to their supervisor, and the Human Resources Department. For further information see Workplace Violence in the Human Resources section of the policy & procedure manual.

Compliance, HIPAA and Privacy (ARRA and HITECH)

In support of ERH's mission, statement, and in compliance with all government (federal, state, and local) and accreditation agencies’ regulations and mandates, ERH has adopted a comprehensive compliance and privacy plan to ensure our organization provides services to our community with integrity and without waste or fraud. The purpose of the plan is to provide ERH the ability to maintain adherence to mandates and guidelines as well as provide a vehicle to improve performance, to reduce waste and gain efficiencies, and to build a central repository for critical regulations, guidelines, standards, and data necessary to monitor compliance and progress.

All employees must act in a manner which is consistent with our Mission and act in a manner which is in accordance with State, Federal, and local laws and supporting Ellenville Regional Hospital (ERH) policies and procedures. Employees should note that a compliance audit is completed each month to gauge unauthorized access to electronic health record. Any unauthorized activity that does not match employee’s assigned roles and responsibilities may lead to disciplinary action up to and including termination.

The scope of this plan crosses all lines throughout the organization including:
- Patient Rights and Freedom of Choice
- Clinical Practice Standards and Guidelines
- Employment Agreements
- Contracts/Service Agreements/Joint Ventures
- Coding and Billing
- Documentation and Record Retention
- Routine identification of risk
- Employee protection (Whistleblower Policy)
- Compliance with Federal and/or State regulations

Employees should report to the Corporate Compliance Officer (CCO) with any concerns of suspected violations or general questions regarding compliance by using the Hotline number, writing a letter. Emailing the CCO or in person
- HOTLINE # - ext. 400 (confidential)
- Email: compliance@ellenvilleregional.org
- Provide specific details when reporting to facilitate investigations
• Calls may be anonymous
• Employees should not fear retaliation for reporting information
• All reports will be documented and investigated
• Corrective action will be taken when problems are identified by reporting to governmental agencies, disciplinary actions, refunds, changing policies & procedures and continued audits/monitoring

Reportable issues include, but are not limited to:
• Billing/Coding
• Conflict of Interest
• Fraud
• Health Violation
• Human Resources
• Breach of Confidentiality
• Medical Staff
• Patient Care
• Policy Violation
• Prejudice
• Workplace Harassment
• Substance abuse
• Theft
• Time/Attendance
• Workplace Violence

The Health Information Technology for Economic and Clinical Health (HITECH) Act, part of the American Recovery and Reinvestment Act (ARRA) of 2009, has established new notification requirements to report the loss or theft of patient information (Protected Health Information – PHI) that is not protected by encryption. These requirements apply in both the clinical and research context. Examples of such security breaches include compromise of unprotected PHI through (1) Lost or stolen laptops, USB drives, CD/DVD/Zip drives, etc. with stored data; (2) A compromised account which is used to look up data, /e.g./, if it appears that someone other than the owner of the account has access to the account; (3) A compromised workstation or server that contains data; (4) Accidental disclosure of data to unauthorized recipients, /e.g./, accidentally sending an email containing data to an incorrect recipient; etc.

Ellenville Regional Hospital employees, medical staff and general users of patient data are required to *immediately report any security breach* to their supervisor and to Corporate Compliance Officer.

Information Technology requires that all portable data files stored on USB, CD/DVD, and mobile laptops that include PHI be *encrypted* /and/ *password-protected* at all times.
All electronic transmission of patient information over the Internet must be *encrypted*. This includes email, file transfers and other data transfer modalities.

The Privacy Rule protects the privacy of your health information. It establishes who can look at and receive your health information, and also gives you specific rights over that information. In addition, the Patient Safety Act and Rule establish a voluntary reporting system to enhance the data available to assess and resolve patient safety and health care quality issues and provides confidentiality protections for patient safety concerns.

A routine risk assessment of Information technology infrastructure including our electronic health record is performed by the Information Technology Security Officer. This risk assessment must be done annually at a minimum. Any threats or vulnerabilities identified are addressed with a plan of correction.

**Calls From the Media**
Any calls or visits from the media must be referred immediately to the office of the Chief Executive Officer or to one of the hospital Administrators. Employees are not authorized to speak to the media as a representative of ERH.

**Service of a Summons**
The CEO or the Executive Assistant to the CEO are the only parties authorized to accept service of a Summons or Subpoena issued against Ellenville Regional Hospital. If the CEO or his/her Executive Assistant is not available, then the process server must be directed to the office of the Chief Financial Officer, who may accept the Summons or Subpoena in their absence. Acceptance of service of a Summons or Subpoena issued against an employee of ERH for a personal reason will not be allowed during working hours, as it is disruptive to the work environment. A Summons or Subpoena for a non-ERH employee (e.g., a licensed medical provider) will not be accepted by ERH. The Medical Records Manager, the Medical Records Specialist and the Medical Records Clerk are the only parties authorized to accept service of a Subpoena for ERH Medical Records.

For further information see Acceptance of Summons policy in the Administration section of the Policy & Procedure manual.

**Cell phone Usage**
Excessive personal calls during the workday, regardless of the phone used, can interfere with employee productivity and be distracting to others, including hospital patients. Cell phone usage during work hours is prohibited, except if the employee is in a position that is pre-authorized for cell phone usage as part the employee’s job duties. Employees may use their personal cell phones before work, after work, and during authorized work breaks. Employees may not use their personal cell phone for texting of patient care related issues, especially with information containing Protected Health Information (PHI). For emergency phone calls, employees are instructed to ask their families to call them on the hospital phone system. Cell phones must be turned off, no ringing or vibrating, while the employee is on duty. Texting via personal cell phones for communicating patient care related information especially PHI is cause for discipline, up to and including termination. In the event that the hospital phone system is not operational, Administration will authorize the use of personal cell phones for verbal communication of work-related information, including patient information.

For further information see Cell Phone Usage policy in the Human Resources section of the policy & procedure manual.

**Internet Usage**
Ellenville Regional Hospital (ERH) has established this Internet Usage Policy for all employees, consultants, physicians and other persons when they act on behalf of the Hospital, or otherwise use facilities computers, communication systems, equipment, electronic devices such as tablets, cell phones or software owned, provided, or possessed by ERH. This policy applies to all aspects of the Internet, including the World Wide Web (www), on-line bulletin boards, and all other external on-line systems. Violation of this Internet Usage Policy will subject the user to disciplinary action, up to and including termination, and may also subject the user to litigation if
and when appropriate. Employees should have no expectation of privacy as to his or her electronic communications or technical resources usage. Use of ERH’s technical resources constitutes consent to this access and disclosure.

1. ERH provides Internet access solely for the purpose that its employees, consultants, agents, and representatives can carry out their responsibilities on behalf of ERH.
2. By the way of example and not limitation, you may NOT use ERH resources to:
   - establish a separate Internet or Internet service electronic mail account for your personal use or for use in the duties of your job and your responsibilities to ERH without prior written consent of your Administrator and HR;
   - access, download, transmit, or store pornographic, obscene, violent, illegal, racist, or sexually explicit information or material in any form;
   - access, download, transmit, or store information or material owned by another party that are protected by patent, copyright, trade secret or other intellectual property rights without the proper consent of the owner of such rights. A copy of such consent or associated license shall be forwarded immediately upon receipt to your Administrator and HR;
   - harass, demean, or defame any person, or discriminate against any person on the basis of that person's race, gender, ethnicity, religion, age, color, or other criterion prohibited by federal or state law;
   - access or transmit any confidential, proprietary or trade secret information of ERH including, without limitation, information concerning ERH finances, business operations, patients, goals and results, services and service development efforts, without the prior written consent of your Administrator and HR;
   - make any statements about or offer opinions or analysis of ERH or any of its physicians, employees, or affiliates without written consent of your Administrator and HR;
   - conduct or solicit for political, personal, religious or charitable causes, or other commercial ventures outside the scope of your employment and responsibilities to ERH;
   - interface with in any manner or perform an unauthorized access of ERH's or any person's hardware, software, or data; and
   - creating, sending, or forwarding chain letters;
   - access personal email accounts on an ERH PC, laptop or tablet
3. ERH reserves the right to review, audit, intercept, disclose, access, restrict access to or remove any information that you permanently or temporarily download, and all records and logs relating to such information (including URLs searched), at any time and for any reason. Employees should have no expectation of privacy as to his or her electronic communications or technical resources usage. Use of ERH’s technical resources constitutes consent to this access and disclosure.
4. Any information that you download, either permanently or temporarily, must be filed on the "C" drive of your personal computer and immediately scanned for viruses before it is used. You are solely responsible for ensuring any information you download is virus free. You may only use passwords and encryption keys that have been authorized in writing by ERH. You may not disclose passwords or encryption keys to other persons, except as authorized in writing by your Administrator.
5. Any violation of this Internet Usage Policy will subject you to disciplinary action, up to and including termination, and may also subject you to prosecution or litigation, if and when appropriate.

For further information see Internet Usage policy in the Human Resources section of the policy & procedure manual.

**Family Medical Leave Act (FMLA)**

FMLA Provides up to twelve (12) weeks of unpaid job-protected leave in a rolling twelve (12) month period for specified family and medical reasons, and for qualifying exigency arising out of the fact that a covered military member is on active duty, or has been notified of an impending call or order to active duty. Additional protection is provided for the care of a covered service member with a serious injury or illness.

To be eligible for FMLA benefits, an employee **must**:
- work for a covered employer;
• have worked for the employer for a total of twelve (12) months;
• have worked at least one thousand two-hundred fifty (1250) hours over the previous twelve (12) months; and
• work at a location in the US or any territory or possession of the US where at least fifty (50) employees are employed by the employer within (seventy-five) 75 miles.

Leave entitlement includes one or more of the following reasons:
• for the birth and care of a newborn child of the employee;
• for the placement with the employee of a son or daughter for adoption or foster care;
• to care for a spouse, son, daughter, or parent with a serious health condition;
• to take medical leave when the employee is unable to work because of a serious health condition; or
• for qualifying exigencies arising out of the fact that the employee’s spouse, son, daughter, or parent is on active duty or call to active duty status as a member of the National Guard or Reserves in support of a contingency operation;
• To care for a spouse, child, parent or next of kin in the Armed Forces (including the reserves and National Guard) who is undergoing medical treatment, recuperation, or therapy, is otherwise in an outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness.

Employees seeking to use FMLA are required to provide thirty (30) day advance notice of the need to take FMLA when the need is foreseeable and such notice is practicable. When the need for leave is not foreseeable, the employee must provide notice to the ERH as soon as practicable. Certifications supporting the need for FMLA leave are required and periodic reports from the employee as ERH deems appropriate or necessary during the employee’s leave regarding the employee’s status and intent to return to work; and medical certification of the employee’s fitness for duty before the employee will be permitted to return to work, if the leave was taken for the employee’s serious health condition. If an employee is eligible for leave under both the PFL and FMLA, they will run concurrently. PFL time cannot be added to FMLA time to extend the overall leave.

Employees who obtain FMLA leave for reasons other than disclosed to us will be subject to disciplinary action up to and including immediate termination of employment.

For further information see the Family Medical Leave Act policy in the Human Resources section of the policy & procedure manual or the informational poster located by the time clock.

**Paid Family Leave Policy**

Ellenville Regional Hospital (ERH) will provide eligible employees with paid time off pursuant to the New York State Paid Family Leave (PFL) program. Benefits are provided by the hospital’s Disability Insurance carrier. The carrier makes all determinations regarding eligibility and benefits.

**Employee Eligibility:**

Employees must be employed by ERH at the time they apply for Paid Family Leave. Employee eligibility requirements are as follows:

- Employees with a regular work schedule of 20 or more hours per week are eligible after 26 continuous weeks of employment.
- Employees with a regular work schedule of less than 20 hours per week are eligible after 175 days worked in a 52-week period.

**Bonding with a Child**
A parent may take Paid Family Leave during the first 12 months following the birth, adoption, or fostering of a child. Spouses with different employers are both eligible to take Paid Family Leave at the same time. If both spouses work for ERH, ERH can deny Paid Family Leave to one of the spouses if they have asked for the same period of time-off to bond with the same child.

**Family Care**

If an employee’s family member has a serious health condition, they are eligible to care for them under the Paid Family Leave program. Family members include:

- Spouses
- Domestic Partners
- Children
- Parents
- Parents-in-law
- Grandparents
- Grandchildren

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves:

- Inpatient care in a hospital, hospice, or residential health care facility; or
- Continuing treatment or supervision by a health care provider.

Ordinarily, conditions such as the common cold, the flu, ear aches, upset stomach, minor ulcers, routine dental or orthodontia problems, periodontal disease, etc. do not meet the definition of a serious health condition.

Paid Family Leave is available when a spouse, child, domestic partner or parent of the employee is on active military duty abroad or has been notified of an impending call or order of active military duty abroad.

In 2018, employees are eligible to receive 50% of their average weekly wage (AWW) up to 50% of the New York State Average Weekly Wage (SAWW) for up to 8 weeks. Ellenville Regional Hospital will collect the cost of Paid Family Leave through payroll deductions. The Paid Family Leave rate is set by NY State and can be adjusted on an annual basis effective January 1.

When an employee has a foreseeable situation, they should provide ERH 30 days advance notice of their intention to use Paid Family Leave. If the event was not foreseeable, the employee must notify ERH as soon as practical. An employee should submit a completed claim package to ERH’s Paid Family Leave insurance carrier within 30 days of their first day of paid leave. The insurance carrier must process the claim and issue a determination within 18 days. A claim form and insurance carrier contact is available in the Payroll office. Claim forms can also be obtained from our Paid Family Leave insurance carrier, or on the NYS Paid Family Leave website.

For further information see the Paid Family Leave policy in the Human Resources section of the policy & procedure manual.
Social Media Policy
Ellenville Regional Hospital (ERH) recognizes that Social Networking (such as personal websites, blogs, Facebook, Twitter, Linked In, SnapChat, online group discussions, text messaging, message boards, chat rooms, etc.) are used by many of our employees. ERH respects the right of our employees to maintain a blog or post a comment on social networking sites. However, ERH has a business interest in protecting its logo, company name, and other intellectual property and in making sure that its employees do not violate criminal or civil law or violate HIPAA or reveal confidential, identifying, or personal information about any patient.

To protect ERH’s identity, integrity and reputation, employees must adhere to the following rules:

- Employees may not post on a blog or social networking site during their working time or at any time using Company equipment or property.
- If an employee identifies himself or herself as an employee of ERH on any social networking site, and the communication involves ERH and/or ERH business, or any topic ERH would customarily comment upon, the communication must include a disclaimer that the views expressed are those of the author and do not necessarily reflect the views of ERH.
- All rules regarding confidential and proprietary business information apply in full to blogs and social networking sites.
- Any conduct which is impermissible under the law if expressed in any other form or forum is impermissible if expressed through a social networking site. For example, posted material relating to ERH and its employees that is discriminatory, obscene, defamatory, libelous or contains malicious gossip is not permitted. ERH’s policies prohibiting discrimination, retaliation, and/or harassment based on age, race, sex, religion, national origin/ancestry, sexual orientation, gender identity or any other protected basis, as well as ERH’s Workplace Violence policies apply equally to employee comments concerning ERH and its employees on social networking sites, even if done on nonworking time. Employees are encouraged to review those sections of the Policy and Procedure Folders for further guidance.
- Employees are prohibited from misappropriating or using without permission ERH’s corporate logo and Company intellectual property on any social networking site or other online forum. Employees are reminded that there are civil and criminal penalties for posting copyrighted material without authorization.

Any employee who violates this policy may be subject to disciplinary action, up to and including termination. ERH reserves the right to monitor all public blogs and social networking forums for the purpose of protecting its interests and maintaining compliance with this policy.

For further information see the Social Media policy in the Administration section of the policy & procedure manual.

Interpreter Services
Ellenville Regional Hospital will provide interpretive services for patients, free of charge, for which English is not their primary language, or for those with hearing, speech and visual impairments who need assistance. Examples of circumstances in which interpretive services might be necessary include, but are not limited to are:

- To collect medical and social assessment data
- To assess and diagnosis an ailment, injury, or condition
- To provide information regarding patient rights advanced directives, informed consent, or permission for treatment
- To explain hospital policies and procedures or unit rules
- To explain tests, procedures, treatment options or surgical procedures
- To provide information about prescribed medications and discharge instruction
- To explain complex billing and insurance issues and to obtain needed billing information

Once a person is assessed to have limited English proficiency (LEP) the hospital staff will:

- Identify the need for an interpreter
- Identify the language spoken by the patient, determine the appropriate method of providing interpretation
Once a patient or family member has been identified as needing interpreter services, a qualified staff interpreter from the approved list available on the portal should be contacted. If there are no approved qualified staff interpreters available, than a qualified community interpreter on the approved list should be called. Only qualified employees and community members available, the Manager or Supervisor will approve a call to our 24/7 contracted service, Language Line Services, Inc. @ 1-866-874-3972 to arrange for the appropriate interpreter. On weekends, the House Supervisor will approve the call to the contracted Language Line Service. Our Client ID Number 272282. Staff must advise the patient or family member that this service is provided free of charge. If Patient Registration is not involved in securing interpreter services for a patient, then the staff member must notify the Patient Registration staff of the need for the interpreter, and the language assistance provided. The Interpreter Log is maintained in the Patient Registration Department. The Patient Registration staff is responsible for maintaining the Interpreter Log.

- Patient primary care provider should write an order for these services.
- Adult family members and friends are prohibited as medical interpreters with two exceptions: 1) Adult family members and friends may be used as medical interpreters in an emergency involving imminent threat to safety or welfare of an individual or the public where there is no qualified interpreter immediately available; 2) Adult family members and friends may be used as medical interpreters when the LEP person specifically requests that the accompanying adult interpret or facilitate communication and the accompanying adult agrees to provide such assistance. An LEP person’s consent to utilize an adult family member or friend must be verified through a qualified interpreter. The ERH employee must document the use of an adult family member or friend, including confirming consent from LEP person and adult family member or friend. This does not relieve ERH from our legal duty to provide qualified medical interpreters if appropriate under the circumstances.
- Minor children are prohibited as medical interpreters and staff should not rely on minor children to facilitate communication with the LEP patient except in an emergency involving imminent threat to safety or welfare of an individual or the public where there is no qualified interpreter immediately available.
- Hospital staff providing interpretive services must assure an accurate interpretation and communicate effectively to those individuals requiring the information. Hospital staff will document in the patient’s chart when interpreter services are utilized.
- ERH will maintain a list of in house interpreters and update as needed.
- For deaf and hearing impaired patients, a TTY phone will be available. The nursing supervisor will arrange for its use. The Language Line can provide American Sign Language interpreters via videoconferencing. In addition, we have use of laptop computers and we may have available employees and/or community members who have been competencyed in American Sign Language. In the event that we are unable to access the Language Line Videoconferencing service (ie: internet is not available), ERH has contracted with 2 services that can provide on-site sign language interpretation. The nurse supervisor will arrange for this service, Contact information is kept in the Emergency Department with the Language Line phone and/or videoconferencing workstation. The cost of the service is not passed on to the patient.
- Speech impaired patients must be assessed for the best way to communicate with them. American Sign Language interpretation can be provided as outlined above. In addition, we have use of laptop computers for the purposes of communicating.
- For visually impaired patients, both pre-admission information and discharge instructions will be available to patients or patient’s representative in large print version or, upon request, on an audio CD. CDs will be dictated and burned by a licensed professional, such as a Registered Nurse, and provided to the patient free of charge. A large print version of Pre-Admission information will be available from the registration staff. A large print version of Discharge Instructions will be available from the Nursing Staff.
- Hospital staff will never require an LEP patient to provide his/her own interpreter during medical encounters and will never coerce an LEP patient to decline language assistance services.

For further information see the Interpreter Services in the Administration section of the policy & procedure manual.

Treating Transgender Patients
Transgender is a broad term that can be used to describe people whose gender identity is different from the gender they were thought to be when they were born. “Trans” is often used as shorthand for transgender.

Gender identity is your internal knowledge of your gender

Gender expression is how a person presents their gender on the outside, often through behavior, clothing, hairstyle, voice or body characteristics.

When a person begins to live according to their gender identity, rather than the gender they were thought to be when they were born, this time period is called gender transition.

Transgender male – a person transitioning from female to male or identifies as male

Transgender female - a person who is transitioning from male to female or identifies as female

Some transgender people identify as neither a man nor a woman, or as a combination of male and female, and may use terms like non-binary or genderqueer to describe their gender identity. Those who are non-binary often prefer to be referred to as “they” and “them.”

Gender identity and sexual orientation are two different things. Gender identity refers to your internal knowledge of your own gender—for example, your knowledge that you're a man, a woman, or another gender. Sexual orientation has to do with whom you're attracted to. Like non-transgender people, transgender people can have any sexual orientation.

Not every person will follow the same steps of transition, and each person is different. Do not assume that because a person still has biological sex characteristics they were born with that it is their preferred gender. This may mean that a person who identifies as male may still have breasts or a vagina, and a person who identifies as female will have a penis or not have breasts. Some, but not all, transgender people undergo medical treatments to make their bodies more congruent with their gender identity and help them live healthier lives. While transition-related care is critical and even life-saving for many transgender people, not everyone needs medical care to transition or live a fulfilling life.

- To treat a transgender person with respect, you treat them according to their gender identity, not their sex at birth.
- A person who identifies as male should be addressed as he or him, regardless of physical appearance.
- A person who identifies as female should be addressed as she or her, regardless of physical appearance.
- If you are unsure how a person identifies, it is ok to ask how they prefer to be addressed or what their preferred pronouns are.
- It is important to use accurate pronouns. This may take practice and getting used to. If you do use the wrong pronoun by mistake, apologize.
- Legal names and preferred names may not always match (there are many steps required to legally change one’s name), use the patient’s preferred name when addressing them or giving report.
- Patients will reveal only what they feel comfortable with. If it does not directly affect their current medical condition asking about surgeries related to transition is inappropriate.
- Identifying patients and using proper pronouns will help gain trust and respect.
- In regular interactions with someone who is transgender (non-medical, social interactions) it is never ok to ask about surgeries or genitalia. If that person feels comfortable they will reveal this on their own.
- It is never ok to reveal someone as transgender to other people (unless it is the case of patient care to necessary personnel). Transgender people are at high risk for violence against them.
- Medical professionals are often hesitant when dealing with transgender patients. They are unsure of what to say, how to address the patient, what questions to ask. Like learning anything knew, being prepared and education can help relieve some of the anxiety and awkwardness associated with these interactions for both the provider and the patient. The information provided is just the tip of the iceberg. More information is available at the links provided below.
Links and resources:

- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5182227/
- http://www.ftmguide.org/tandhealth.html