July 2023

CommonSpirit Health© Standards of Conduct:

Our Values in Action

Policy and Reference Guide

July 2023

CommonSpirit®

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Welcome

The CommonSpirit Health name was inspired by scripture:

"Now to each one the manifestation of the Spirit is given for the common good." (1 Corinthians 12:7 NIV)

These words embody why we formed CommonSpirit in 2019 and continue to motivate and guide us every day. Our pledge of corporate responsibility is tied to our values and commitment to the common good.

Personal responsibility and integrity on the part of everyone who works for and with CommonSpirit is fundamental to our corporate responsibility and the advancement of our mission. This means:

- Our daily conduct mirrors our values.
- We behave ethically and appropriately.
- We meet our obligations and are good stewards of our resources.
- We hold ourselves accountable for the decisions we make and the actions we take.
- When in doubt, we seek guidance.

Health care settings are governed by a complex set of rules and laws that are often difficult to understand and apply. This guide is a resource designed to help you make decisions at work. Please become familiar with the standards of conduct defined in this guide.

The examples provided in this guide help illustrate the importance of honesty, directness and respect in your interactions with everyone we serve: patients, residents, family members, colleagues, and business and community partners.

If at any time you believe our standards of conduct are being or have been compromised, please use the CommonSpirit Reporting Process to report your concerns. If the situation is related to human resources, you may also contact your local Human Resources department.

All of us at CommonSpirit share a proud heritage and strive to uphold the legacy of our participating congregations. We carry on their tradition of living our values and maintaining a strong ethical culture, with this guide as an important tool.

Thank you for your continued dedication to our healing ministry.

Sincerely,

Wright Lassiter III
Chief Executive Officer

Nima Davis
Chief Compliance Officer

Our Standards of Conduct Reference Guide and Corporate Responsibility Program

This is a guide to our Corporate Responsibility Program (CRP), which all CommonSpirit employees are obligated to follow. Our Corporate Responsibility Program provides resources for making ethical decisions based on our values and standards of conduct and helps us to understand and comply with legal, ethical and professional standards for the provision of health care and prevent or resolve activity that could lead to fraud, waste or abuse.

This guide is designed to help you work in a responsible, professional and ethical way that demonstrates our values. At a minimum, this means obeying the law and avoiding improper activities.

The Table of Contents helps locate specific topics within the guide.

Additional tools and resources for corporate responsibility include:

- Local and national policies and procedures, including those specific to corporate responsibility.
- Corporate responsibility reference and guidance documents.
- Educational offerings, including training in complex or high-risk areas.
- Consultation with local and national Corporate Responsibility Officers.
- Federal and state laws and regulations.
- Consultation with the CommonSpirit Legal Team.

The CRP collaborates with multiple functional areas to provide guidance to support compliance. By understanding and using this guide, we demonstrate our commitment to our mission and values.

This guide is designed to help you work in a responsible, professional and ethical way that demonstrates our values.

Organizational Beliefs

Mission

As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

Vision

A healthier future for all — inspired by faith, driven by innovation, and powered by our humanity.

Values

Compassion

- Care with listening, empathy and love
- Accompany and comfort those in need of healing

Inclusion

- Celebrate each person's gifts and voice
- Respect the dignity of all

Integrity

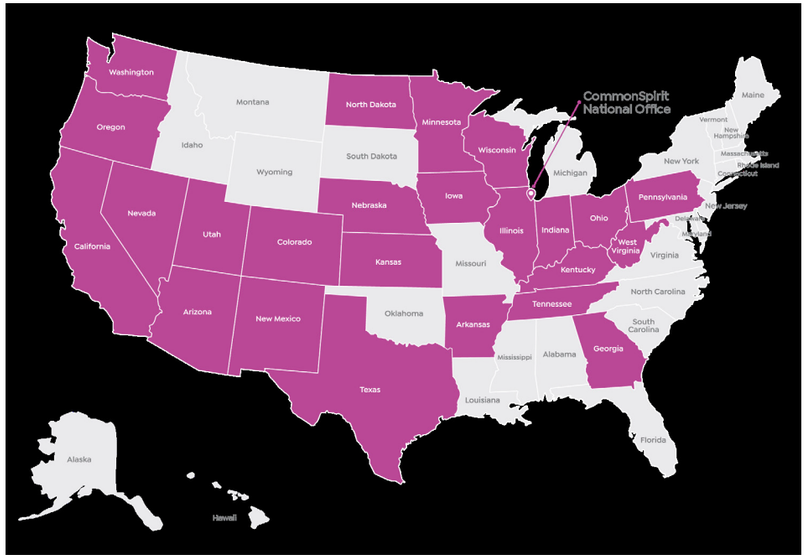
- Inspire trust through honesty
- Demonstrate courage in the face of inequity

Excellence

- Serve with fullest passion, creativity and stewardship
- Exceed expectations of others and ourselves

Collaboration

- Commit to the power of working together
- Build and nurture meaningful relationships



CommonSpirit Health brings health and humankindness to people in 24 states (as of July 2023).

Ethical Standards, Conduct and Guidance

Each employee is accountable to abide by CommonSpirit's mission, vision and values. As part of this commitment, you are expected to follow our ethical standards and conduct while working on behalf of CommonSpirit.

Ethical Standards

CommonSpirit abides by all rules, regulations and laws that govern the health care industry. Our heritage calls us to a higher standard: we follow regulations, but we also engage in ethical decision-making by applying our values to business decisions.

Ethical Conduct

We are expected to be responsible stewards of our ministry by behaving in an ethical manner. Building ethical relationships with employees, patients and families, and business and community partners is important to our ministry.

Guidance for Employees

When you're in a situation that raises questions about ethical conduct, follow these steps:

- Be accountable: Take ownership of your actions and assume responsibility for addressing the situation.
- Apply our values: Your decisions or actions must demonstrate our values of Compassion, Inclusion, Integrity, Excellence and Collaboration.
- Follow the rules that govern us: Identify and adhere to applicable policies, procedures, laws and regulations.
- Report concerns: Contact your manager, Human Resources representative, or Corporate Responsibility Officer.

Deciding to NOT take action may result in serious consequences for the organization and our employees.

Reporting Concerns

Each employee is responsible for promptly reporting potential violations of law, regulation, policy or procedure using the following reporting process.

CommonSpirit Reporting Process:

1. Speak with your manager or another manager.
2. If your manager is not available, you are not comfortable speaking with them, or you believe the matter has not been adequately resolved, contact your Human Resources representative or your local Corporate Responsibility Officer.
3. If you want to anonymously report a concern to a neutral third party 24 hours a day, seven days a week, you have two options.
    a. Call this reporting hotline number: **1 (800) 845-4310**
    b. File a report online: **https://compliancehotline.commonspirit.org.**

All calls to the hotline are received by external, trained staff who document and forward information to your local Corporate Responsibility Officer for appropriate action. You may remain and communicate anonymously if you wish. If you choose to identify yourself, there is no guarantee your identity will remain confidential, however, it is easier for Corporate Responsibility staff to respond. Retaliation against any employee who in good faith reports potential or suspected violations is unlawful and will not be tolerated.

Relevant CommonSpirit Policies

- No-Retaliation Policy

Whistleblower Protection

The federal False Claims Act protects anyone who files a false claim lawsuit – which alleges that improper or false claims have been submitted to the government for payment – from retaliation by their employer.

Failure to Act

CommonSpirit, like other health providers, is regulated by many governing entities and must demonstrate compliance in all aspects of its business. Therefore, all CommonSpirit employees must conduct all business activities in a way that complies with and is consistent with our mission, values, policies and this guide. Failure to do this may result in consequences including but not limited to risks to the safety of those we serve, refund of payments received from government programs, civil or criminal liability, exclusion from federal payment programs, and loss of tax-exempt status. Individuals may also be subject to criminal liability and substantial fines from governing entities.

CommonSpirit reserves the right to implement appropriate disciplinary action, including but not limited to suspension or termination of employment, termination of a non-employed service provider relationship or removal from office or board membership.

Standards of Conduct

The following standards of conduct describe and demonstrate CommonSpirit's commitment to honest and ethical conduct and provide guidance to employees facing uncertain situations. All board and committee members, officers, employees, volunteers, medical staff and others working with CommonSpirit must act in accordance with the following standards of conduct:

Demonstrate fairness, honesty and integrity in all interactions in support of our mission.

Uphold a high standard of skill and knowledge to deliver exceptional quality care, service and outcomes.

Abide by the laws, regulations and policies that govern what we do.

Maintain the integrity and protect the confidentiality of our patient, resident, client, employee and organizational information.

Use our resources wisely to protect our assets, reduce our environmental impact and increase our public health footprint.

Create an environment that promotes community, respects dignity and supports safety and well-being.

Properly disclose and manage situations that pose potential or actual conflicts of interest.

Foster a diverse and inclusive work environment in reverence to our employees, partners and those we serve.

Standard 1

Demonstrate Fairness, Honesty and Integrity in all Interactions in Support of Our Mission

Employee Expectations

In performing your job duties as an employee of CommonSpirit, you are expected to:

- Take responsibility for your actions.
- Know and comply with all policies, guidelines, procedures and practices, including federal health care program requirements. Please refer to this guide and all policies and procedures as they apply to your job responsibilities.
- When in doubt about your job responsibilities or obligations, seek guidance as provided in this guide; as outlined in our policies, guidelines, procedures and practices; or from your manager.
- Refrain from involvement in any illegal, unethical or other improper acts.
- Promptly report any known, potential or suspected violation of our policies or applicable laws and regulations.
- Assist authorized personnel in investigating alleged violations of our policies or applicable laws and regulations.

CommonSpirit provides employees with policies, training and other aids to help fulfill work responsibilities under our standards of conduct.

Management Expectations

Management is responsible for the implementation and enforcement of all compliance efforts. In carrying out these responsibilities, managers are expected to:

- Adhere to applicable policies when screening candidates and supervising employees.
- Inform employees of our Corporate Responsibility Program and their obligation to adhere to all of its requirements.
- Train employees on the requirements in this guide in accordance with applicable laws, regulations, policies, guidelines and procedures.
- Create and maintain a trusting work environment that allows for a free exchange of information about compliance without fear of retaliation.
- Conduct periodic reviews to provide reasonable assurances of employees' adherence to the Corporate Responsibility Program.
- Promptly report any known, potential or suspected violation of law, regulation, policy or procedure.
- Set a proper example of ethical conduct for employees to follow.

Standard 2

Uphold a High Standard of Skill and Knowledge to Deliver Exceptional Quality Care, Service and Outcomes

Documentation Standards

Financial and Business Records

CommonSpirit's financial books and records must not contain false, misleading or deceptive information. Financial reports must fairly and consistently reflect CommonSpirit's performance and accurately disclose the results of operations in accordance with generally accepted accounting principles and other applicable rules and guidelines. Financial reports must also provide a sufficient platform to complete cost reports and requests for payment for services provided to beneficiaries of federal and state health care programs such as Medicare, Medicaid and TRICARE (formerly known as CHAMPUS).

Ethical Use of Technology

The evolution of Artificial Intelligence (AI) and Machine Learning (ML) technology in health care is transforming patient care and operational insights. CommonSpirit is committed to the trustworthy, responsible and ethical use of these technologies in service of the ministry's mission and values. Consequently, CommonSpirit and its employees must ensure that all AI/ML technology is acquired and utilized in objective, compliant and nondiscriminatory ways to minimize undue bias and promote transparency with the communities we serve.

Internal Controls

An internal control is any process or procedure designed to help perform activities safely, accurately and in a way that is consistent with applicable laws, policies and best practices to meet operational objectives. These processes are designed and intended to protect CommonSpirit, its employees and other members of our workforce from errors, fraud or other issues that could lead to non-compliance with applicable laws, regulations or operational goals.

All CommonSpirit employees share responsibility for maintaining and complying with required internal controls. In carrying out their documentation, review, evaluation, financial reporting and recordkeeping responsibilities, employees must provide complete and accurate documentation consistent with CommonSpirit standards and requirements.

In fulfilling their financial reporting obligations, employees must also disclose all material facts related to financial matters to avoid any false or misleading financial reporting.

Employees must cooperate in all audits and investigations, and must not influence, coerce, manipulate or mislead any person or entity involved in the audit or investigation.

Medical Records

CommonSpirit complies with health care program requirements, including federal rules governing documentation and billing of medical necessity determinations and procedures performed in all care settings.

Medical records must be a timely, meaningful, authentic, accurate and legible description of the patient's clinical condition and treatment course. Medical record documentation must meet documentation standards and be consistent with applicable medical staff rules and regulations, policies and health information best practices.

Relevant CommonSpirit Policies

- Medical Record Documentation Standard

Q Clinicians on our unit sometimes perform a service or provide treatment to a patient but do not document it in the chart until later. Is this okay?

A Documentation is to be accurate and completed on a timely basis. A delay in documentation may jeopardize patient care and could impact our ability to receive payment from a federal or state health care program. We are obligated to follow our organization's policies and procedures, bylaws and all applicable federal and state laws regulating documentation.

Coding and Billing

Federal and state laws control third-party billing for patients, residents and others in our care. CommonSpirit submits accurate, complete and timely claims for payment. CommonSpirit could be required to refund payments for filing inaccurate or fraudulent claims, and CommonSpirit and its employees could be subject to criminal prosecution.

Our policy is to provide, document and bill for medically necessary services for the diagnosis or treatment of an illness or injury, in the appropriate location, ordered by a physician or other health care provider.

Clinical, health information management, billing and coding employees and others responsible for creating charges must:

- Provide accurate and timely work that complies with our policies as well as federal and state laws and regulations.
- Bill only for services provided and appropriately documented, using accurate billing and diagnosis codes.
- Immediately notify a manager or a local Corporate Responsibility Officer of inaccuracies so they can be corrected.
- Retain billing and medical record data as required by law and our record retention policies.

Q If documentation is not available when we are ready to submit a bill, is it okay to submit the bill?

A No. Do not submit the bill until appropriate documentation is on file. This verifies the services were provided to the patient.

Q Can we perform services for patients who are not registered in our patient registration system?

A No. All services must be documented and appropriately billed, so all patients must be registered.

Maintaining Licensure Requirements and Qualifications

All individuals whose positions with CommonSpirit have license requirements must:

- Perform job duties within the scope of the license.
- Maintain an active and current license and provide verification on request in compliance with CommonSpirit policies.
- Comply with all licensing and credentialing requirements to remain in good standing and active with the requisite local, state or other licensing authority.
- Immediately inform Human Resources if their license becomes inactive.

Relevant CommonSpirit Policies

- License and Certification Policy

Training and Education

CommonSpirit is committed to providing the training and education necessary to carry out your job duties and conduct yourself in an ethical and responsible way. Training in regulatory compliance, privacy and security is provided at the time of hire and annually thereafter. Failure to complete required training will be noted in your annual evaluation.

Relevant CommonSpirit Policies

- Required Training Policy
- Privacy Education and Training Policy

Standard 3

Abide By the Laws, Regulations and Policies That Govern What We Do

If a government agent contacts you, ask for a government identification card and obtain proof of identification to verify the agent's name, department and agency.

Responding to Government and Regulatory Agencies

CommonSpirit responds to requests from all government and regulatory entities in a timely and cooperative manner. If a government agent contacts you, or you receive a subpoena or search warrant, follow the guidance below:

- Be calm and respectful.
- Ask for a government identification card and obtain proof of identification to verify the agent's name, department and agency.
- Advise the agent that you will contact a manager to assist with their request; ask them to wait.
- Refer any request for information to a manager. Immediately call the following persons, in the order given, until you reach one of them:
    a. Manager or administrator on call
    b. Local Corporate Responsibility Officer or designee
    c. CommonSpirit Corporate Responsibility Officer
    d. Local Legal Team attorney
    e. Reporting hotline number: 1 (800) 845-4310

If a government agent asks to speak with you, you may agree to speak with the agent, but you are not legally required to do so. You have the right to legal representation during an interview. You may tell the agent that you, or someone on your behalf, will contact the agent to discuss their concerns.

If a government agency conducts an interview or investigation, or serves and executes a search warrant, do not:

- Interfere with the agent.
- Alter, remove, or destroy documents or records belonging to CommonSpirit, including but not limited to paper, electronic, phone or computer records.
- Provide false, misleading or incomplete information.
- Suggest to any employee that they not cooperate with government investigators.
- Offer any item of value to a government official, including food or beverage.

Relevant CommonSpirit Policies

- Government Contact Protocol

Physician Self-Referral Law (Stark Law)

Stark Law is a set of federal laws that prohibit a physician from referring Medicare and Medicaid patients to a health care provider if the physician (or an immediate family member of the physician) and provider have any type of financial arrangement. However, referrals are permitted if the arrangement complies with certain exceptions to the Stark Law. If the arrangement does not fully comply with an exception, the provider cannot bill for certain services ordered or referred by the physician.

Stark Law is subject to "strict liability." This means even unintentional violations may have significant financial penalties. If you have any questions about whether an arrangement with a physician is compliant with Stark Law, contact your local Corporate Responsibility Officer or Legal Team attorney for guidance.

Q A physician provides medical director services to our hospital and is paid for these services. Under Stark Law, does this result in a financial relationship?

A Yes. For the purposes of Stark Law, a financial relationship occurs whenever anything of value is exchanged between a hospital and a physician (or a physician's immediate family members). This arrangement may be permissible if it meets the personal services exception under Stark Law.

Q Who qualifies as an "immediate family member" under Stark Law?

A The term "immediate family member" is defined broadly to mean husband or wife; birth or adoptive parent, child or sibling; stepparent, stepchild, stepbrother or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

Anti-Kickback Statute

The federal Anti-Kickback Statute (AKS) prohibits individuals and entities from knowingly offering, paying, soliciting or receiving "remuneration" (anything of value, or "kickbacks") to induce or reward referrals of items or services paid for by Medicare, Medicaid or other federally funded programs.

No person may directly or indirectly ask for, pay or provide anything of value to physicians or other health care providers to refer patients to our facilities or other health care entities. If you are in doubt about whether a situation may be problematic, before proceeding, contact your Corporate Responsibility Officer or Legal Team attorney for guidance.

The AKS is intended to prevent:

- Compromised medical judgment and treatment decisions due to financial incentives.
- Overuse of items or services covered by federal health programs.
- Increased costs to the Medicare and Medicaid programs because unnecessary or excessive care has been provided.
- Unfair competition (also see Antitrust section).

Q What are "kickbacks?"

A Kickbacks can be gifts or anything of monetary or other value given with the intent, expectation or

understanding that an individual will make referrals to us or be rewarded for past referrals. In addition to cash and cash equivalents (for example, gift certificates or gift cards), other examples of activities or items of value prohibited under the AKS includes:

- Free supplies, space, personnel or equipment.
- Free travel and lodging.
- Discounts, account adjustments or write-offs (other than those defined in charity care or other discount policies).

Q What types of arrangements are inappropriate to offer physicians and may be considered a kickback?

A Examples include:

- Anything of value given with an expectation of future referrals or as a reward for past referrals.
- Providing office space at less than fair market value.
- Providing items or services free of charge or at less than fair market value (for example, hazardous waste disposal service).
- Writing off a physician's bill or recruitment loan.

Q Dr. Jones occasionally sends patients to our hospital. He said he would send us more patients if we provide him with free or discounted office space. Can we do this?

A No. We must charge and the physician must pay fair market value for office space. Free or discounted lease arrangements may appear to be an incentive for referrals from the physician, also known as a "kickback."

Physician Agreements and Transactions

CommonSpirit maintains positive working relationships with physicians in compliance with applicable state and federal laws and may enter into employment or other arrangements with physicians to provide access to care for our patients. Our policies provide an efficient framework to transact business with physicians in compliance with those laws. All agreements involving payments or other compensation between CommonSpirit or CommonSpirit facilities and physicians or physician-owned entities will comply with policies and applicable law.

For information regarding physician agreements and transactions, contact your Legal Team attorney for guidance before proceeding.

Relevant CommonSpirit Policies

- Physician Transaction Review and Signature Authority Policy
- Physician Non-Monetary Compensation Policy
- Purchases from Physician-Owned Entities Policy
- Gifts and Gratuities To and From Business Sources Policy

Excluded Providers

The federal government prohibits a health care provider from receiving payment for services provided in part or in whole by an individual or entity that the government has excluded from participating in a federally funded health care program. CommonSpirit does not knowingly employ, conduct business with or contract with excluded providers. CommonSpirit conducts pre-employment, pre-contracting, pre-credentialing and ongoing excluded provider status checks on individuals, providers and affiliated entities. Any relationship with an employee, individual or entity found to be an excluded provider may result in termination of that relationship.

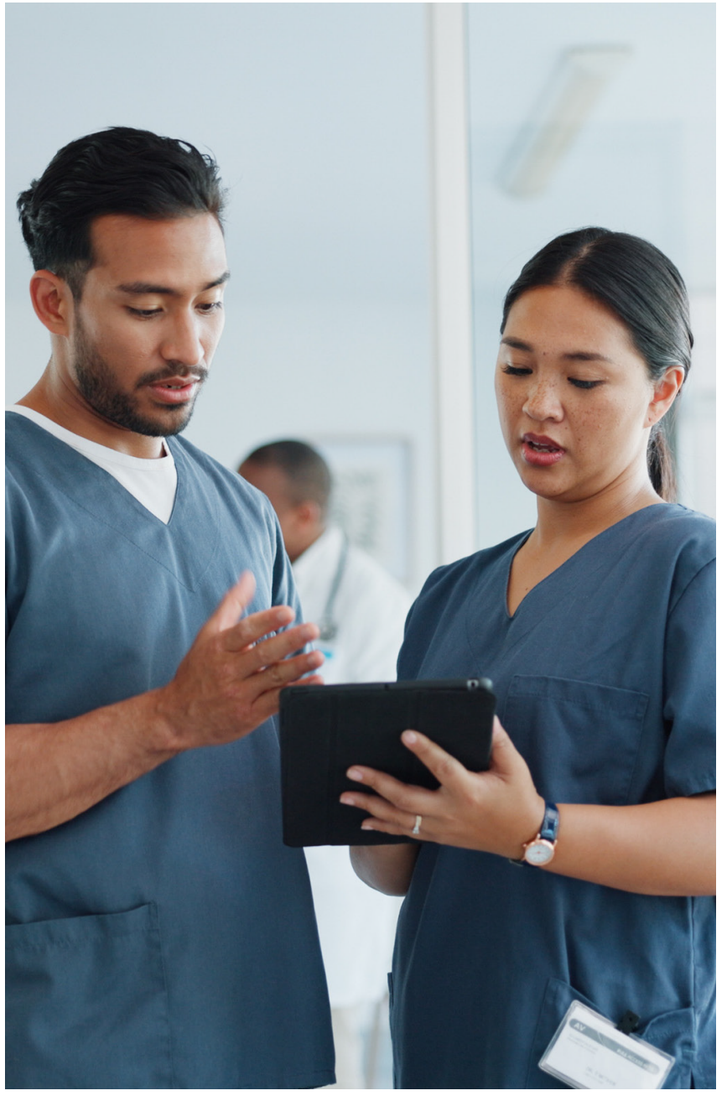
Relevant CommonSpirit Policy

- Screening for Excluded Providers Policy

Antitrust and Trade Regulation Rules

CommonSpirit does not participate in activities that illegally reduce or eliminate competition, control prices and markets or exclude competitors. The purpose of antitrust and trade regulations is to protect the public, CommonSpirit and other companies from unfair trade practices and to support competition.

Because antitrust matters can only be analyzed on a very fact-specific basis, the CommonSpirit Legal Team must be consulted on any arrangement that could affect market competition.



- Do not engage in:
  - Price fixing, which is an agreement between organizations about the prices one or both will charge others for goods or services.
  - Bid rigging, which is any agreement between organizations about who will or will not bid.
  - Customer allocation, which is an agreement between organizations or individuals to divide customers, patients or other business among themselves.
- Do not discuss with any competitor:
  - Prices, terms or conditions of sales.
  - Where CommonSpirit intends to sell or bid.
  - To whom CommonSpirit intends to sell or bid.
  - Whether or at what price, CommonSpirit intends to sell or bid.
- If any representative of a competitor attempts to discuss any of these subjects with you, terminate the conversation immediately and report it to your manager.
- Do not improperly use a competitor's confidential information or trade secrets, or engage in conduct that may be perceived as intimidating or threatening.

Emergency Medical Treatment and Labor Act (EMTALA)

CommonSpirit requires our facilities with dedicated emergency departments to comply with the federal Emergency Medical Treatment and Labor Act (EMTALA), sometimes called the "Anti-Dumping Law." Numerous states have also enacted similar laws, and some are more stringent than the federal law.

Consistent with our commitment to people who are poor and underserved, any person, regardless of their ability to pay, who comes to one of our emergency departments is provided an appropriate medical screening examination to determine if an emergency medical condition exists; or, for pregnant women, if active labor exists. Appropriate stabilizing treatment is provided within the capability of the staff and the facility for patients determined to have an emergency medical condition. EMTALA also applies when the need for emergency care is apparent or requested by an individual on the facility's property outside of the dedicated emergency department.

CommonSpirit facilities may not delay medical screening examinations or stabilization to obtain financial or demographic information from the patient. CommonSpirit facilities may only transfer unstable patients with an emergency medical condition to another health care facility if:

1. The patient requests the transfer and has been informed of the facility's obligations and the risks and benefits of transfer; or
2. The facility does not have the capability to provide necessary stabilizing treatment and a physician certifies the medical benefits provided at another facility are reasonably expected to outweigh the increased risks involved with the transfer.

Q Does the EMTALA law permit us to register an individual who comes into our emergency department before we perform a medical screening examination and stabilization procedures?

A You may register an individual first only if the process does not:

1. Delay the medical screening examination and any necessary stabilizing treatment.
2. Include questions about the individual's method of payment or ability to pay.

Registration processes must not discourage the individual from remaining in the emergency department for further evaluation. CommonSpirit facilities shall not request prior authorization from the individual's insurance company or managed care plan before completing a medical screening examination or beginning stabilization treatment.

False Claims Act

The federal False Claims Act makes it a crime for any person or organization to knowingly make a false record or file a false claim with the government for payment. "Knowingly" means the person or organization:

- Knows the record or claim is false.
- Seeks payment while ignoring whether the record or claim is incomplete or false.
- Seeks payment with reckless disregard for whether the record or claim is false.

Under certain circumstances, an inaccurate claim submitted to the government could be alleged to be a false claim. Examples of possible false claims include:

- Knowingly billing Medicare or other government payers for services not provided.
- Billing for services provided, but not medically necessary.
- Submitting inaccurate or misleading claims about the type or level of services provided.
- Making false statements to obtain payments for products or services.
- Failing to repay the federal or state government for an identified overpayment.

A person who has information regarding improper or false claims submitted to the government for payment may file a lawsuit in federal court on behalf of the government (known as a "Qui Tam" or "whistleblower claim").

Fraud, Waste and Abuse

Federal and state governments pay for a large share of health care in the United States. To ensure that it is appropriately paying for Medicare and Medicaid beneficiary health care services, the government actively checks for and investigates potential fraud, waste and abuse (FWA) by health care companies and beneficiaries. According to the government, billions of dollars are improperly spent due to FWA.

CommonSpirit works to actively prevent, detect and correct FWA. Medicare Advantage Plans require that they be notified of FWA. Identification of potential FWA may require that we notify the government or our health plan partners. To remain compliant with federal and state laws, we have policies, procedures and plans in place to detect and prevent FWA.

- Fraud includes intentionally submitting false information to the government to get payment. An example is knowingly billing the government for patient services that did not occur.
- Waste occurs when a health provider's actions result in unnecessary costs to the government without unlawful intent, such as the ordering of too many or unnecessary laboratory tests.
- Abuse takes place when the government pays for services when there is no legal entitlement to that payment, such as when a provider misuses codes on a claim resulting in increased payment.

Marketing Practices

CommonSpirit marketing, communications, fundraising and advertising activities educate our communities about health issues, increase awareness of our services and facilitate employee recruitment. Any advertising or marketing conducted by CommonSpirit must:

- Present truthful and accurate information to the public.
- Distinguish opinion from fact when presenting issues.
- Obtain the consent of any person whose name or likeness will be used before the advertising or marketing material is shared with the public.
- Comply with applicable federal and state laws and system policies for marketing and advertising activities, including any marketing and advertising activities provided for or with non-employed physicians or physician groups.

Q Two oncologists who are not employees of the hospital just joined the medical staff to provide a new service. We would like to send an announcement to the community to highlight this new service. Is this a permitted marketing practice?

A Yes, it is generally acceptable for a hospital to market a new service line. However, this type of announcement and its cost must be in accordance with applicable state and federal fraud and abuse laws and CommonSpirit physician marketing guidelines. Consult your local Corporate Responsibility Officer or Legal Team attorney to determine the applicable requirements and the restrictions for non-employed physician and physician group advertising and marketing activities.

Relevant CommonSpirit Policies

- Uses and Disclosures of Protected Health Information for Marketing
- Uses and Disclosures of Protected Health Information for Fundraising

Patient Care and Rights

We deliver quality care without regard to race, color, national origin, ancestry, sex, pregnancy, childbirth or related medical condition, marital status, religion, creed, physical/mental disability, medical condition, age, gender identity, sexual orientation, citizenship, payer source or ability to pay, or any other protected categories as defined by law. We treat every person in our care with dignity and respect. Our commitment to quality and service is shared by our board and committee members, employees, officers, volunteers, medical staff and other representatives of our organization. Our commitment to our distinctive Catholic culture enables us to obtain desired outcomes.

We provide individuals in our care with information regarding their rights and responsibilities, and we protect those rights. Individuals in our care have the right to

accurate, timely information about their health, payment options (including charity care) and other information to help them make decisions about their treatment. It is our responsibility to provide this information. Please refer to your organization's guidelines for a description of patient rights.

Q To whom do I report quality of care issues?

A Such issues may include many aspects of care and must first be discussed with your manager. More serious issues may need to be evaluated by the Quality and Risk Management Departments or the Patient Grievance Committee. If you believe a quality of care

issue is not being addressed, use the CommonSpirit Reporting Process.

Q If I see that an individual in our care is not being treated with the proper courtesy and respect, what should I do?

A First, make sure the individual is not in harm's way. Then, talk with your manager. If your manager does not provide a satisfactory response, contact your local patient advocate, patient experience or risk manager, or use the CommonSpirit Reporting Process.

Q What am I to do if I know a medical error has occurred? Should I tell the patient or family?

A CommonSpirit supports compassionate disclosure whenever an error has occurred. To assist the family in making any additional and well-informed care decisions, the disclosure must take place in a coordinated manner. Contact your manager and your quality or risk manager for guidance on handling the disclosure appropriately.

Q How can I help a patient or family member get the information they need to make informed decisions?

A Work with your team to make sure all educational documentation is provided in an easy-to-understand format. Use teach-back methods to build understanding. If you think a patient or family is being pressured to make a particular decision, talk with your manager, your local patient advocate, patient experience manager, or quality or risk manager.

Relevant CommonSpirit Policies

- Patient Rights and Responsibilities

Research Integrity

CommonSpirit is committed to high standards of ethics and integrity when engaging in research. Any dishonesty, misconduct, fraud or harm to research subjects may damage the reputation and credibility of researchers, the scientific community at large, and CommonSpirit. Researchers must be knowledgeable about applicable laws and regulations as well as CommonSpirit policies and procedures related to research compliance.

Grant and Contract Management

CommonSpirit may receive money, in the form of grants and contracts, to conduct specific research studies. The grant/contract awarding organization may be a state or federal government agency or a nonprofit or for-profit company. Effective grant/contract management requires CommonSpirit to demonstrate accountability with sponsor's funds and comply with the specific terms and conditions of each contract and grant. Proper processes must be in place to remain compliant with all federal, state and agency rules and regulations as well as CommonSpirit policies and procedures related to research and grant management. Understanding these requirements prior to accepting an award is important because this information, as well as additional approvals, may be necessary for the application and award acceptance processes.

Human Subjects Research

All human subjects research at CommonSpirit shall have designated Institutional Review Board (IRB) approval or determination of exemption from IRB oversight. The IRBs also perform Privacy Board responsibilities as required under HIPAA. It is important to determine if a project is classified as research or another activity, such as performance improvement, quality assurance or program evaluation.

Human subjects research includes obtaining information or biospecimens through intervention or interaction with an individual and using, studying or analyzing the information or biospecimens; or obtaining, using, studying, analyzing or generating identifiable private information or identifiable biospecimens. IRB approval is required for creation of a biorepository or database if one purpose of the biorepository/database is for research, even if it is not the primary purpose. Individuals shall obtain IRB approval or a determination of exemption from IRB oversight before accessing any tissue, other biospecimens or data including patient information for systematic analysis.

Clinical Research Billing Compliance

Clinical research tests and procedures may be paid for by the sponsor of the study or may be reimbursable by a federal, state or private payer, subject to coverage criteria. Determining how each research test and procedure will be paid and accurately communicating the coverage to the research subject and billing departments is essential for accurate billing.

Animal Subjects Research

CommonSpirit-designated Institutional Animal Care and Use Committees (IACUC) shall approve all vertebrate animal research. Researchers are responsible for proper animal care and handling of animals used in their studies, in accordance with applicable federal and state regulations and CommonSpirit policies and procedures.

Conflict of Interest Management

Potential conflicts of interest shall be identified and managed to promote objectivity and eliminate bias or the appearance of bias in research. A research conflict of interest may exist when a researcher's personal financial, intellectual or equity interest could directly and significantly affect the design, conduct or reporting of the research. Researchers shall report personal interests related to their institutional responsibilities as required by federal and state regulations and CommonSpirit policies and procedures.

Relevant CommonSpirit Policies

- Research Conflicts of Interest ADDENDUM F

Research Misconduct

Federal regulations prohibit misconduct in research, which includes intentional fabrication, falsification or plagiarism in proposing, conducting, reviewing or reporting research results. Honest errors or differences of opinion do not constitute research misconduct. The CommonSpirit Research Integrity Officer follows formal research misconduct inquiry and investigation procedures to determine if research misconduct occurred and protect the rights of all individuals involved. Anyone who suspects research misconduct must immediately contact the Research Corporate Responsibility Officer to discuss their concerns.

Relevant CommonSpirit Policy

- Reporting and Investigating Allegations of Research Misconduct Policy

Contact your Research Institute/Center or the Research Corporate Responsibility Officer if you have any questions related to these requirements.

CommonSpirit is committed to high standards of ethics, integrity and compliance with law when engaging in research.

Tax-Exempt Status

CommonSpirit and most of its related organizations are nonprofit, tax-exempt entities operated solely for religious and charitable purposes. This status gives CommonSpirit certain benefits. To maintain our tax-exempt status, we must use our resources to further the religious and charitable purposes of our mission. Tax laws prohibit our tax-exempt organizations from:

- Providing goods, services, leases, compensation or other benefits to organizational insiders (such as an officer, director, key employee or physician) without receiving equivalent value in return. Some examples include:
  - Paying more than fair market value for services, products or leases.
  - Providing courtesy discounts and other uncompensated benefits to physicians, officers, directors and trustees, other than those provided for by organizational policy.
  - Accepting research grants from third parties when the researcher keeps the funds for personal use or the CommonSpirit organization is not paid for the use of its time, equipment or facilities in connection with the research.
  - Allowing a physician to market their private business inside our clinic/hospital (such as a botox clinic or skin care line, or any product that may be used in the clinic/hospital).
- Providing goods, services, leases, compensation or other benefits to a third party (who is not an insider) without receiving equivalent benefit in return, subject to certain exceptions. Some examples include:
  - Taking part in a joint venture, partnership or similar transaction that results in an improper private benefit (gain) to a third party.
  - Recruiting physicians or other key employees with incentives or compensation plans in excess of fair market value or that do not serve an identified community need.
  - Leasing a facility to a third party at less than fair market value.
  - Providing services to a third party at less than fair market value, such as billing services to private physicians or providing health care services at less than fair market value, except where permitted by CommonSpirit's charity, prompt pay or other discount policies.
  - Permitting any person to buy, sell, lease or use organizational property at less than fair market value.
  - Use of tax-exempt space for private practice or for-profit purposes.

Political Activities

The tax-exempt status of CommonSpirit carries certain restrictions on political activities. The law delineates between political campaign activity (such as involvement with the nomination, appointment or election of candidates for public office) and policy activities (such as advocacy and lobbying to influence public policy). Participation by tax-exempt organizations in political campaign activity is not permitted. As a result, CommonSpirit does not use corporate resources for political purposes and complies with all applicable state and federal laws.

As allowed by law, CommonSpirit actively participates in public policy advocacy, particularly on behalf of people who are underserved. Our advocacy and lobbying activities focus on attempts to influence the development of legislation and regulations (including ballot questions, including referenda, initiatives, constitutional amendments, and bond measures, which are considered to be legislation). The CommonSpirit Advocacy Team and our employees participate in these activities to influence public policy at the local, state and federal level.

"Substantial" lobbying activity at the local, state or federal level is not permitted for tax exempt organizations. There is no precise definition of "substantial," but a general rule is committing more than 5% of an organization's total expenditures to lobbying. The Internal Revenue Service

watches and investigates the political activities of tax-exempt organizations. Because violation of this rule could jeopardize our tax-exempt status, CommonSpirit closely monitors and tracks spending on political activities.

The following guidelines provide an overview of what is and is not allowed.

Permissible Political Activities for a Tax-Exempt Organization

- Encouraging individuals to call or write a letter to elected officials to express the organization's view on public policy issues or legislation.
- Arranging personal visits with elected officials, legislators and government agencies to provide the organization's perspective on public policy issues or legislation.
- Holding public forums, lectures and debates to raise awareness of public policy issues and to inform voters of their impact on the organization.
- Providing financial and in-kind support to groups sponsoring ballot initiatives, referenda and similar measures.
- Hosting candidate forums, debates and visits as long as all candidates for office are given an opportunity to appear and speak to employees.
- Allowing a candidate to appear at an organization if the appearance is based on the candidate's status as an expert, public figure or celebrity, as long as no mention is made of the candidacy and there is no campaign or election-related activity.
- Using the organization's resources, facilities and personnel to sponsor non-partisan voter registration drives.

Permissible Political Activities for Employees of a Tax-Exempt Organization

- Personally endorsing, supporting or opposing a candidate as long as the employees do not imply that they are representing CommonSpirit, use their CommonSpirit titles, or use organizational resources (such as phones, office supplies and email).
- Contributing personal funds to support or oppose a candidate or to a political action committee (PAC).

Impermissible Political Activities for a Tax-Exempt Organization

- Endorsing, supporting or opposing a candidate for public office.
- Contributing organizational funds or resources to a candidate, election campaign committee or PAC.
- Sponsoring a fundraiser or another event that endorses a candidate on or off the property of the organization.
- Inviting a candidate or a select group of candidates to appear at a tax-exempt organization for the purpose of conducting election-related activity or promoting a candidacy.
- Permitting candidate, political party or PAC literature to be placed or distributed on the organization's premises.

Impermissible Political Activities for Employees of a Tax-Exempt Organization

- Engaging in activities or making statements that imply CommonSpirit endorses, supports or opposes a candidate.
- Asking or pressuring a fellow employee to endorse, support or oppose a candidate.
- Using the organization's resources (such as phones, office supplies and email), facilities or personnel to solicit support, opposition or contributions for a candidate or PAC.

Use of Copyrighted, Trademarked or Licensed Material

Employees must not copy documents or computer programs that are protected by copyright laws or licensing agreements. Employees must not use confidential business information improperly obtained from competitors or that may violate any employee or organizational contractual obligation.

Standard 4

Maintain the Integrity and Protect the Confidentiality of Our Patient, Resident, Client, Employee and Organizational Information

HIPAA Privacy and Security

HIPAA is a federal law that safeguards the privacy and security of protected health information. Privacy and security are separate rules within HIPAA, but go hand-in-hand.

- The Privacy Rule focuses on health care entities' uses and disclosures of patients' protected health information (PHI). It covers the confidentiality of PHI in all formats, including electronic, paper and oral. The rule safeguards PHI from unauthorized use and disclosure.
- The Security Rule focuses on administrative, technical and physical safeguards as they relate to electronic PHI (ePHI). Protecting ePHI from unauthorized access, whether external or internal, stored or in transit, is covered by the security rule. Typically, ePHI is stored in:
  - Electronic services and applications such as email, Google Drive, electronic medical records (EMRs), department file shares and personal drives.
  - Internet-based services such as cloud storage, third-party services, vendor-hosted applications, etc.
  - Computer hard drives, magnetic tapes, disks, memory cards and removable/portable storage devices.

Confidentiality

Confidential information includes information about patients, residents, employees and other members of our workforce, as well as proprietary information used while conducting business. It is vital that we protect this information in any form – such as paper and electronic records, email, digital media and oral discussions – and do not share it with anyone unless there is a job-related need to know. Improper use or sharing of confidential information can harm our mission, our reputation, individuals in our care and our business partners. Texting is one example of sharing information improperly. Texting patient information can pose a significant risk to patient privacy and confidentiality as it can be easily intercepted or misdirected. Only approved secure methods can be utilized for texting communications for the protection of this sensitive protected health information (PHI).

Refer to CommonSpirit's policies and standards for privacy, security and confidentiality for more information. Violating these policies, standards, laws or regulations may result in disciplinary action and civil or criminal penalties against the individuals involved or CommonSpirit. If you have any questions, please contact your local Privacy Officer or your local Security Officer.

Relevant CommonSpirit Policies

- Privacy Policies and Standards

Q We just hired a new employee in our department. She has not yet received her computer login information, and she cannot begin her work assignments. She asked me to share my username and password with her so she could begin her new assignment. What should I do?

A Passwords are confidential information and must not be shared with others, including managers and IT employees. Sharing your username and password violates CommonSpirit's information security policies. If you share passwords you will be held accountable for any actions taken under that password, as well as for violation of our policies. Ask your new colleague to speak to their manager and to contact the Information Technology Services (ITS) Help Desk to gain appropriate access.

Relevant CommonSpirit Policies

- Data Asset Usage Policy

Q In order not to fall behind on my assignments, I sometimes take work home. May I email confidential information or work documents to my personal email address, copy them to a portable storage device or save them to my personal laptop computer for this purpose?

A No. You must not email, copy or save work-related documents to an external personal email address, portable storage device or personal computer if the reason is to work from home. All work done for our organization must be done on equipment the organization provides and/or authorizes for work purposes. Use of your personal email address is not permitted for work purposes and use of any portable storage device must be authorized by Information Technology. If you are authorized by your manager to work during times when you are not at our facility, and you are paid hourly as a non-exempt employee, you must also track all time worked for timely and proper payment of wages. Beyond this, you must only use organization equipment provisioned to you or equipment authorized for work purposes. Consult with your manager and your Human Resources Business Partner before engaging in work outside your scheduled work hours and location.

Q Why am I not allowed to use my own USB drive to back up my work files or work from home?

A Many USB drives are not encrypted, and they are easy to lose. Some of the largest breaches of confidential information in health care have been due to lost, unencrypted USB drives.

In addition, USB drives are not a good backup solution and are less reliable than saving information on a Google/network drive. If you have critical files and are concerned about backing them up you are to contact IT and request a network share to be allocated.

Once CommonSpirit information is copied to any removable media device, the organization may not be able to maintain custody or an adequate level of security over the information. Personal computers/laptops do not maintain the same level of protection against computer viruses and hacking as the CommonSpirit network.

Q Can I reuse passwords from other workplace or personal accounts? Can I use a password vault, so I do not have to remember so many passwords?

A CommonSpirit requires that you use strong and unique passwords for business accounts. Reuse of passwords, even strong passwords, may compromise our business accounts as well as any other accounts you have with that same password. Password vault services are not permitted for our business accounts because of the risk of data breaches. Several publicly available password vault applications have experienced breaches that put all stored credentials at risk. Also, password vaults are often tied to your mobile device, which could be lost, stolen or compromised by malware.

CommonSpirit allows users with certain privileges to use an enterprise-grade password management system. However, this is only intended for sensitive system accounts and is not available to store user account information.

Q I am excited about the work I do at CommonSpirit and would like to post information about my work on social media to share with friends. Is it okay to do this?

Individual employees are not authorized to speak, comment or make representations on behalf of CommonSpirit in social media posts.

A Please limit the work-related information you post on social media to general comments. Your personal social media posting must be done during non-working time. Remember that individual employees are not authorized to speak, comment or make representations on behalf of CommonSpirit, nor use our logo, workplace photos, coworker photos or other company insignia in social media posts. If you have questions, contact your Human Resources representative.

You are not permitted to comment on or reference patients or patient events, including but not limited to confidential information. Posting confidential information – such as patient names or other PHI, photographs, videos or business information – violates HIPAA and CommonSpirit privacy and security policies and may result in disciplinary action.

Relevant CommonSpirit Policies

- Corrective Action for Privacy and Security Violations Policy

Employee Information

Employees trust us to keep their personally identifiable information confidential by following applicable laws, regulations and human resources policies. This information includes wages and salaries; employment contracts, history and status; Social Security numbers; and financial and banking information.

Q I work in payroll. A friend who also works at the hospital is being promoted to a management position. He asked me to access our systems to look up how much other managers are making. Can I do so and share the information I accessed from our systems if I do not give specific names?

A No. You may not use our systems to access information that you have no legitimate business purpose for in performing your job duties. This constitutes unauthorized access. Questions about compensation must be referred to your Human Resources representative.

Business Information

We maintain and protect the confidentiality of our proprietary information. This includes but is not limited to information about our intellectual property, competitive position, business strategies, contract terms or negotiations, payments, reimbursements and negotiations with employees or outside organizations. Proprietary information can be used only for legitimate business purposes and protections are in place to prevent unauthorized use or disclosure. If your employment or association with CommonSpirit or our associated businesses ends, you have an ongoing obligation to maintain the confidentiality of this information. Competitive information obtained in violation of a covenant not to compete, a prior employment agreement, or other contract relationship may not be used to conduct business on behalf of CommonSpirit.

Q Before coming to work at CommonSpirit, I had a consulting relationship with a competitor and obtained confidential information about the competitor that would help CommonSpirit negotiate contracts. Should I share the information?

A No. It is inappropriate to use a competitor's confidential information in any business dealings. It would also be unethical for you to share CommonSpirit's confidential information with another employer.

Patient and Resident Information

We follow federal and state privacy and confidentiality laws such as HIPAA. Violating these laws may result in civil or criminal penalties for CommonSpirit or the responsible individuals. Our standards of conduct speak to the importance of confidentiality for our patients, residents and clients.

Employees, affiliated physicians and health care partners may only use and disclose PHI to care for our patients and residents; as allowed for treatment, operations and payment functions; or as allowed or required by other applicable laws and regulations. Any other use or disclosure of PHI requires a specific authorization from the patient, resident or client.

If you think PHI is being improperly used, accessed or disclosed, report your concern to your local Privacy Officer or by using the CommonSpirit Reporting Process.

Q In the break room, I heard my coworker discussing the condition of a physician's spouse who is receiving treatments at our hospital. What should I do?

A Physicians and their families are entitled to have their health information kept confidential in the same manner as other patients. This situation may violate HIPAA and our policies. Report the issue to your manager or local Privacy Officer or use the CommonSpirit Reporting Process.

Q One of my family members is in the intensive care unit. May I look at her medical information to let other family members know how she is doing?

A No. You may not access medical information without proper authorization from the patient. Being an employee of a health care organization does not give you greater access rights to the medical information of your family members. You may only access the information if it is part of your assigned job duties, or if the patient signs an authorization allowing you to access their records.

Q As a CommonSpirit employee, can I look at my own medical information?

A You must follow the same procedures required of any individual in our care by requesting access to your information from local Health Information Management (HIM), your designated release of information representative, or the patient portal. Being an employee of a health care organization does not give you greater access rights, even to your own medical information.

Relevant CommonSpirit Policies

- Permissible Uses and Disclosures of Protected Health Information
- Uses and Disclosures of PHI Requiring Authorization
- Privacy Complaint and Breach Investigation Management
- Right of Access to the Designated Record Set
- Minimum Necessary Standard for Use and Disclosure of PHI

Job Shadowing

HIPAA allows:

- Health care systems to use and disclose PHI when conducting training programs for students, trainees or practitioners learning under supervision to improve their skills as practitioners.
- Students engaged in a program formally affiliated with CommonSpirit.

To remain compliant with HIPAA, shadowing activities must meet the following requirements:

- Education and orientation about privacy and security practices.
- Compliance with Data Asset Usage Policy.

- Adequate supervision to prevent actual or potential access to PHI.
- Written patient authorization from any patient whose PHI would be viewed, accessed or disclosed.

No video/audio recording or photography of any kind can occur during any type of job shadowing, and additional consents and authorizations are required.

Relevant CommonSpirit Policies

- Data Asset Usage Policy
- Shadowing, Tours and HIPAA Implications

Social Media Guidance

We do not want patients to worry about their privacy before, during or after their visit to one of our facilities. We must protect – both during and after the work day – any information about a patient that employees access, use or otherwise learn about while performing their jobs. Do not:

- Post or share any patient-related information on any social media platforms, including private pages or private groups.
- Take photographs or videos of patients on a personal cell phone or post any patient-related images to the internet, even if you believe the patient cannot be identified.
- Discuss patients or hospital/clinic events, including patient information or employee information, in internet chat rooms or on any internet site, including social media forums, even if the information is publicly known outside our health system.
- Use personal cell phones to send or receive patient information.
- Use personal cell phones or data devices except on breaks from regular work assignments and in non-patient care areas.

Relevant CommonSpirit Policies

- Social Media: Guidelines and Best Practices For Your Personal Social Media Use

Standard 5

Use Our Resources Wisely to Protect Our Assets, Reduce Our Environmental Impact and Increase Our Public Health Footprint

Protecting our Assets

CommonSpirit is committed to protecting our assets, including our financial resources, supplies, equipment and reputation. Employees are accountable for making wise and ethical decisions so that our assets are used to support our healing ministry. As responsible stewards of our resources, you are responsible for:

- Following this guide, as well as all policies and procedures.
- Keeping accurate and reliable financial records and reports.
- Using organizational equipment, supplies, materials and services for authorized purposes only, and protecting assets from loss, theft and misuse.
- Using the CommonSpirit Reporting Process to report any improper use of organizational assets.

Environmental Responsibility

Advancing the care and stewardship of the planet is part of our commitment to the common good. Local, national and global communities must nurture a sustainable and healthy environment. As a responsible corporate citizen, CommonSpirit is committed to:

- Expanding and strengthening environmental actions to meaningfully improve the outcomes of our health care ministry.
- Seeking proactive solutions to enhance the health and well-being of all, while avoiding adverse impacts to people and the environment.
- Minimizing and managing adverse impacts where avoidance is not possible, while seeking meaningful alternatives to promote the greater good.
- Enhancing and expanding partnerships and stakeholder engagement at all levels of society to build resilience and reinforce common goals that are life-affirming and mitigate environmental risk.

The ecological crisis we now face, with climate change being one of the most evident manifestations, is serious and urgent. CommonSpirit's efforts to see everything as connected – called integral ecology – underlies our commitment to addressing poverty and inequality among all people and to protecting and conserving our common home for present and future generations.

We promote a balanced approach to all social efforts to maximize patient, employee and community health and safety.

Social Responsibility

CommonSpirit is dedicated to advancing the care and stewardship of all people. This is a commitment to the common good, recognizing that local, national and global communities must promote social and economic justice. As a responsible corporate citizen, CommonSpirit will:

- Expand and strengthen social actions to meaningfully improve the outcomes of our health care ministry.
- Seek proactive solutions to enhancing the health and well-being of all, while avoiding adverse impacts to people.
- Minimize and manage adverse impacts where avoidance is not possible, while seeking meaningful alternatives to promote the greater good.
- Enhance and expand partnerships and stakeholder engagement at all levels of society to build resilience and reinforce common goals that are life-affirming and mitigate social risk.
- Seek to promote safety and security for colleagues, communities and society by addressing and preventing violence in all its forms. This includes directly prohibiting human trafficking within the organization and among all who interact with the organization.

Social responsibility is based on the concept that sustainable development must be founded on a "universal respect for, and observance of, human rights and fundamental freedoms for all" . CommonSpirit does not promote or contribute to violations of international human rights obligations and treaties. CommonSpirit will support the protection and fulfillment of human rights, including addressing, reducing and preventing the negative impacts of social determinants of health.

CommonSpirit promotes a balanced approach to all social efforts to maximize patient, employee and community health and safety.

Standard 6

Create an Environment that Promotes Community, Respects Dignity and Supports Safety and Well-being

Health and Safety

CommonSpirit facilities maintain a safe and healthy working environment. Employees:

- Must be adequately trained on and adhere to all safety policies and procedures.
- Must conduct themselves in a manner that minimizes health and safety hazards and promptly notify their manager of any actual or potential unsafe working conditions or practices.
- Must properly generate, store and dispose of biological, medical, chemical and other hazardous waste according to applicable laws and policies designed to protect human, environmental and community health.
- Who are authorized to operate incinerators, sterilizers, decontaminators and underground storage tanks (containing fuel for emergency generators) and other equipment containing chemicals must be adequately trained to operate devices according to all permits, regulations and applicable procedures.

Prohibitions on Discrimination, Harassment and Retaliation

CommonSpirit is committed to ensuring a safe, inclusive and collaborative work environment where employee talents, ideas and expertise are respected and encouraged. Consistent with our policies prohibiting discrimination, harassment or retaliation, the work environment must be free of discrimination, harassment, intimidation/bullying or retaliatory conduct. As an employee in any role, you are expected to comply with our policies and prohibitions on discrimination, harassment and retaliation in all aspects of your work with our organization.

Relevant CommonSpirit Policies

- No-Retaliation Policy
- Anti-Discrimination and Harassment-Free Workplace

Human Trafficking

CommonSpirit's Human Trafficking Response Program equips physicians, advanced practice providers and staff to identify patients who may be victims of human trafficking or other types of abuse, neglect and violence, and to provide trauma-informed, healing-centered care to affected patients and families. This includes victim-centered intervention assistance, such as warm referrals (i.e., personal introductions) to community agencies and continued care that promotes healing and recovery. If you have concerns that a patient may be affected by abuse, neglect or violence, including labor trafficking or sex trafficking, refer to the Abuse, Neglect, and Violence CommonSpirit policy (located in the Human Trafficking Response Program link below). To learn more about human trafficking, see the CommonSpirit educational course, *Human Trafficking 101: Dispelling the Myths,* in the CommonSpirit learning management system.

Relevant CommonSpirit Policies

- Human Trafficking (HT) Response Program

CommonSpirit facilities maintain a safe and healthy working environment. Employees must adhere to all safety policies and procedures.

Standard 7

Properly Disclose and Manage Situations that Pose Potential or Actual Conflicts of Interest

Conflicts of Interest

Conflicts of interest occur when personal interests or activities influence or appear to influence our ability to act in the best interests of CommonSpirit. Actions or relationships that could create a conflict of interest must be disclosed in writing, in advance, and managed appropriately according to policy. CommonSpirit employees must properly disclose and cooperate in the management of situations that pose potential or actual conflicts of interest.

Gifts and Gratuities

CommonSpirit defines a gift as an item of value, including cash; cash equivalents, such as a gift certificate or a voucher; grants; scholarships; educational funding; meals, lodging and transportation; and tickets to a sporting, cultural or community event, including any fees associated with that event. Accepting gifts from vendors can create the perception that decisions are made based on personal benefit rather than what is in the best interests of CommonSpirit. This perceived conflict of interest can undermine the trust of patients and community members.

Improper gift giving and receiving may also violate the federal Anti-Kickback Statute, which prohibits individuals and entities from knowingly offering, paying, soliciting or receiving remuneration (anything of value, or "kickbacks") to induce or reward referrals of items or services paid for by federally funded programs. If a vendor's gift causes concern, talk with your manager and local Corporate Responsibility Officer to review the facts and circumstances of the situation.

Relevant CommonSpirit Policies

- Gifts and Gratuities To and From Business Sources Policy (includes a FAQ)

Outside Activities and Employment

If you own or have any type of employment or consulting arrangement with an outside entity (including vendors), the arrangement must be disclosed to your manager for review and approval. If your manager approves, any consulting or other business activities must be conducted on your personal time (not work time) using non-CommonSpirit resources, and must not conflict with or affect your work performance.

Relevant CommonSpirit Policies

- Payments and Arrangements Between Business Sources and Employees Policy

Vendor Relations

Business relationships with vendors must be conducted fairly and in the best interests of CommonSpirit, without inappropriate personal ties to or bias toward vendors. Employees must disclose to their manager any personal relationships and business activities with contractors, vendors and referral sources or referral recipients. Use the CommonSpirit Reporting Process to:

- Ask questions if you are concerned about a contractor relationship.
- Report attempts by contractors to inappropriately influence business activities.

Participation on Outside Boards of Trustees/ Directors

CommonSpirit encourages employees to be active in their communities. This may include serving on the boards of charitable, community and civic organizations. You must not accept a position on a board if that participation conflicts, or may conflict, with the interests of CommonSpirit. If you choose to accept such a position when there is or may be a conflict of interest and appropriate steps are not taken to mitigate or manage the conflict, such action will be treated as a violation of the Conflicts of Interest Policy. If you have any questions as to whether such a conflict exists, check with your manager or your local Corporate Responsibility Officer.

When serving on outside boards:

- Do not participate in actions on matters that might affect the interests of CommonSpirit.
- Do not identify yourself as speaking on behalf of CommonSpirit unless permitted to do so by the conflict of interest management plan.
- Conduct outside board service on your personal time, not work time, using non-CommonSpirit resources. Outside board service must not conflict with or affect your work performance.

Relevant CommonSpirit Policies

- Conflicts of Interest Policy

Endorsement and Testimonial Guidance

Employees may not provide endorsements, testimonials or other forms of external communications on behalf of CommonSpirit or your local organization unless you have written approval in accordance with applicable CommonSpirit policies. You may not provide statements, testimonials or endorsements for use by a vendor, contractor, the media or other third parties except as allowed by CommonSpirit's Endorsements/ Advertisement Policy (see link below).

Q I have been asked to serve on a speaker panel at a vendor-sponsored event, what do I need to do?

A You must:

- Obtain the written approval of your manager, the CommonSpirit Senior Vice President of Marketing and Communications Officer and the Senior Vice President of Brand, or their respective designees.
- Confirm your participation in the event is not an explicit endorsement, but a collaborative partnership that improves patient care, operational performance, community health or environmental sustainability.
- Verify your presentation slide deck is branded as CommonSpirit and not co-branded.

Relevant CommonSpirit Policies

- Endorsements/Advertisement Policy

Employees may not provide endorsements or testimonials on behalf of CommonSpirit unless you have written approval.

Standard 8

Foster a Diverse and Inclusive Work Environment in Reverence to Our Employees, Partners and Those We Serve

Diversity, Equity, Inclusion and Belonging

CommonSpirit's commitment to Diversity, Equity, Inclusion and Belonging (DEIB) strengthens our ministry's values. We work to embed DEIB best practices in every aspect of our ministry – from the delivery of quality health services to employee and physician engagement, patient experience, clinical quality and safety, leadership development and culture. Our key goals include:

- Valuing and acknowledging the diversity of our employees, patients and the communities we serve.
- Acting with inclusion by creating a welcoming and kind engagement of those who share in the work of our health care ministry, celebrating everyone's gifts and voice.
- Ensuring fair and equitable health care practices for all people.
- Striving to create a sense of belonging by connecting our shared experiences as community, patients and employees for a safe and trusting environment.
- Sharing our collective commitment to health equity by removing barriers to a fair and just opportunity to be as healthy as possible.

Conclusion

CommonSpirit's values and standards of conduct, as found in this guide, serve as guiding principles for ethical behavior. It is our responsibility to understand and follow these standards of conduct. Contact your manager, Corporate Responsibility Officer or call the reporting hotline number: 1 (800) 845-4310 with questions or concerns. No retaliatory action will be taken against anyone who makes a good-faith report of a potential violation of the standards, guidelines and policies outlined in this guide. By promoting our values and ethics, we can strengthen our organization and live out the mission of CommonSpirit.

Appendix A: Acknowledgement and Certification

I acknowledge I have received an electronic or physical copy of the CommonSpirit Standards of Conduct: Our Values in Action Policy and Reference Guide.

- I agree to read it completely.
- I agree to discuss any questions or concerns regarding this guide with my manager or other appropriate CommonSpirit leader.
- As a policy document, I certify that I will comply with the standards and guidelines in this guide and any other standards or applicable policies set by CommonSpirit.
- I understand:
  - It is my responsibility to report any concerns regarding possible violations of these standards, guidelines or policies.
  - I may be asked to cooperate in an investigation of matters that may affect or relate to compliance with applicable standards, guidelines or policies and agree to do so.
  - Neither CommonSpirit nor the local organization I serve will retaliate against me for making a report in good faith.
  - CommonSpirit or the local organization I serve will conduct an excluded provider background check prior to my employment or association and periodically thereafter. CommonSpirit reserves the right to terminate my employment or other association if I am an excluded provider/individual.
  - This guide contains standards of conduct within CommonSpirit and is not a contract for employment or other services.
  - These standards may be amended, modified or clarified at any time, and I will receive periodic updates to these standards.

PLEASE PRINT

Name

Department, Board, Board Committee or Other Affiliation

Organization

Signature

Date

Your acknowledgment and certification above will be collected and retained. Consult with Human Resources or your local Corporate Responsibility Officer if you have any questions about this process.

CHI St. Vincent

POLICY NUMBER	**ON107PCS**
ORIGINAL DATE:	**September 2010**
TITLE:	**CONFLICT MANAGEMENT**
KEYWORDS:	Dispute, disagreement, bullying

ACCOUNTABILITY:

SVP & Chief Nursing Officer
VP Patient Care Services
VP Human Resources

OBJECTIVES:

The Mission of Catholic Health Initiatives is to nurture the healing ministry of the Church, supported by education and research. Fidelity to the Gospel urges us to emphasize human dignity and social justice as we create healthier communities. To fulfill this mission, CHI St. Vincent will commit to protect the quality and safety of care by managing conflict between staff and or leadership groups.

DEFINITIONS:

Conflict: when two or more values, perspectives and opinions are contradictory in nature and have no current alignment or agreement.

Facilitator: an individual who is skilled in conflict management. Skill can be obtained through education, experience or training. A facilitator can be internal or external.

POLICY:

1. When conflict arises between individuals or groups that, if not managed, could adversely affect patient safety or quality of care, the following process will be implemented and coordinated by Human Resources.
    A. Utilize Chain of Command for resolution.
    B. If the conflict cannot be resolved between the two individuals or groups privately, a facilitator will be identified. Staff may have the option of confidentially expressing concerns regarding staff members or situations without retribution to management or Human Resources.
    C. The facilitator is to meet with the involved parties as early as possible to identify the root cause and/or contributing factors behind the conflict.
    D. The facilitator should consider, if additional information can be gained/obtained by talking with other stakeholders or leadership group members, reviewing policies or business plans, observing meeting interactions and considering other methods of gathering information as appropriate to the conflict.

E. The facilitator arranges a schedule of meetings with the involved parties in order to manage and when possible resolve the conflict.
F. The facilitator works with the involved parties to develop, implement and sustain a plan of action.
G. The facilitator follows up with the involved parties to debrief the conflict and the management process to help prevent or minimize future conflicts and protect the safety and quality of care.

SOURCES:
The Joint Commission Leadership Standard LD.02.04.01

ANA Code of Ethics, 2015, Provision One.
Approved by Market Policy Review Committee, November 2023

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Owner/SME:	Alexander, Sunetta *Director*
Manager:	Lambert, Teresa *Vice President*
Author(s):	Morgan, Melissa *Director*
Approver(s):	Longing, Angie *Chief Nursing Officer*
Publisher:	Wilson, Jessica *Regulatory*

CHI St. Vincent

POLICY NUMBER	**ON096PCS**
ORIGINAL DATE:	**September 2010**
TITLE:	**CHAIN OF COMMAND**
KEYWORDS:	Conflict, Reporting, Supervisor

ACCOUNTABILITY:

Chief Medical Officer
SVP & Chief Nursing Officer

OBJECTIVES:

The Mission of Catholic Health Initiatives is to nurture the healing ministry of the Church, supported by education and research. Fidelity to the Gospel urges us to emphasize human dignity and social justice as we create healthier communities. To fulfill this mission, CHI St. Vincent will provide co-workers an organized system for reporting and resolution of issues involving conflicts in patient care, the plan of care, to obtain a necessary intervention in patient care, support patient safety, and provide adequate risk management by mitigating risk.

POLICY:

I. Co-workers will be provided with a system through which they may obtain resolution of issues or where they have identified a need which is beyond their power and resources to meet. Issues may include, but are not limited to:
   A. Conflicts concerning the plan of care for patients
   B. Unclear or potentially unsafe orders
   C. Unavailability or unresponsiveness of a care provider
   D. Unprofessional or non-compliant behaviors
   E. Lack of needed equipment for patient care

II. **When a need has been identified it should be brought forth to the immediate supervisor, nurse in charge or manager at once. If considered urgent (patient safety, lack of needed equipment, etc) the employee should not leave without initiating a request for assistance through the chain of command.**

III. The chain of command is as follows:
   A. Nursing (Days Monday-Friday):
      i. RN in Charge
      ii. Nurse Manager / Supervisor
      iii. Clinical Director
      iv. CNO/VP Patient Care Services of facility

v. President of facility
vi. Chief Executive Officer (CEO)

B. Nursing (Evenings/Nights/Weekends/Holidays):
   i. RN in Charge
   ii. CHI SVI/CHI SVHS/CHI SVN House Supervisor (or ED Nurse in Charge at CHI SVM)
   iii. Administrator on Call (AOC)

C. Non-Nursing (Days Monday-Friday)
   i. Department/team lead and/or supervisor
   ii. Department Director
   iii. Reporting Leader
   iv. VP Patient Care Services of facility / Chief Medical Officer (if clinical / patient care issue)
   v. President of facility
   vi. Chief Executive Officer (CEO)

D. Non-Nursing (Evenings/Nights/Weekends/Holidays):
   i. Department team lead or supervisor
   ii. CHI SVI / CHI SVHS House Supervisor (or ED Nurse in Charge at CHI SVN/CHI SVM)
   iii. Administrator on Call (AOC)

E. Medicine (Days, Monday-Friday):
   i. Attending Physician
   ii. Section chief if applicable
   iii. Department chair (Medicine and Surgery only)
   iv. Chief Medical Officer
   v. Chief of Staff

F. Medicine (Evenings/Nights/Weekends/Holidays):
   i. Attending Physician
   ii. Section chief if applicable
   iii. Department chair (Medicine/Surgery only)
   iv. Administrator on Call (AOC)
   v. Chief Medical Officer (CMO)

IV. The chain of command may continue, or a direct call may be made to the Administrator on call (AOC), VP Patient Care Services (VP PCS) of facility, President or Chief Medical Officer (CMO) in urgent situations. After hours the administrator on call may be reached via the house supervisor.

V. The speed and level at which the chain of command is accessed depends upon the urgency of the situation and the specific circumstances.

VI. Any matter involving patient safety must be addressed immediately using the chain of command process.

SOURCE:
ANA Scope and Standards of Practice; Standard 11, 2nd Edition, 2010.
ANA Code of Ethics for Nurses, Provision 4, 2015.

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Manager:	Ross, Douglas *Chief Medical Officer*
Approver(s):	Ross, Douglas *Chief Medical Officer* Longing, Angie *Chief Nursing Officer*
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CHI St. Vincent

POLICY NUMBER:	**602**
ORIGINAL DATE:	**July 01, 2003**
TITLE:	**CODE OF CONDUCT**
KEYWORDS:	

ACCOUNTABILITY:
VP of Human Resources

OBJECTIVES:
The Mission of Catholic Health Initiatives is to nurture the healing ministry of the Church, supported by education and research. Fidelity to the Gospel urges us to emphasize human dignity and social communities as we create healthier communities.

POLICY:

It is the Policy of CHI St. Vincent to hold all employees to a high standard of service in the following key areas:

- Communication with Patients and Customers
- Addressing the needs of Patients/Customers
- Respecting fellow employees
- Maintaining an appropriate work environment

COMMENTS:

CHI St. Vincent has established quality standards to ensure that the organization fulfills its goal of achieving the most exceptional service quality in the area.

Positive and memorable patient/customer interactions are essential in the delivery of patient care and are significant factors in attracting patients and ensuring that existing patients continue to desire service at CHI St. Vincent. These standards are developed to exceed the expectations of patients, their families, visitors, physicians as well as our internal customers.

STANDARD:

Communication with Patients/Customers

- When meeting patients/customers introduce yourself and explain your role.
- Offer warm, sincere greetings and ask what name the patient/customer prefers; use this name whenever possible.
- Answer all telephone calls within three rings when possible and use professional telephone etiquette.
- Identify yourself and the name of your department when answering the telephone; ask for the caller's name and use it throughout the conversation.

- Immediately acknowledge a person upon their arrival at your workstation. If you are on the telephone, acknowledgement can be displayed by gesturing or nodding to communicate you will be with them in a moment.
- Maintain eye contact when speaking with patients/customers and smile when appropriate.
- Connect a caller to a recorded message only if they have requested access to voice mail.
- Offer assistance if a patient/customer appears lost or confused.
- Refer patients or visitors to someone who can directly give assistance when they require help you cannot provide.
- Provide patients/customers with information (appropriate to your position). Inform patients/customers immediately if there is a delay and the reason for it, if appropriate.
- Communicate with patients and visitors in a manner appropriate to their age specific needs.
- Avoid hospital jargon, acronyms and other confusing terms when speaking to patients (i.e., I.C.U. = Intensive Care Unit; E. R. = Emergency Room, etc.).
- DO NOT ignore patients/customers or speak about them as if they are not there. Avoid interrupting a patient while he or she is speaking.
- Make sure there is no other assistance you can provide before ending a conversation with a patient/customer.
- End every patient/customer contact with a courteous "good-bye."

Addressing the Needs of Patients/Customers

- Escort patients/customers personally whenever possible.
- Allow patients and visitors right of way when entering elevators, opening doors or walking down hallways.
- Respect patient/customer privacy and confidentiality
- Provide additional service amenities for patients who have been inconvenienced or who may need special assistance.
- Take ownership of complaints received from patients/customers and follow through until the concern is resolved.

Respecting Fellow Employees

- Recognize and respect differing viewpoints.
- Communicate approximate time for the delivery of a service and consistently meet this deadline.
- Accept responsibility for your own actions and practices.
- Promote growth and development of yourself and others.
- Give positive feedback publicly; give constructive criticism thoughtfully and privately.
- Be punctual for meetings and appointments.
- When leaving a voicemail message, speak clearly and state your name, phone number and the time you can be reached.
- Be considerate when paging staff. Page only if necessary and be available to staff who have been paged when they call you.
- Use proper etiquette when sending and receiving electronic mail messages. Be respectful of employee and patient confidentiality when using electronic communication devices.
- Send electronic mail messages only to those who have a need for the information.

Maintaining an Appropriate Work Environment

- Protect patient/customer safety and security.
- Do not eat at your workstation
- Take care with equipment or facilities and report all problems immediately to the appropriate area.
- Use material resources prudently
- Maintain a well-organized, clutter-free work area.
- Ask patients/customers what you can do to make their environment more comfortable.
- Manage time in a manner that is productive and is not wasteful.
- Offer, promote and adapt to change and the process improvement.
- Remain sensitive to costs associated with time, materials, and utilities.
- Comply with the CHI St. Vincent Dress Code Policy.

Manager's Responsibility

Each manager is responsible for establishing job-specific quality standards within the work unit. These standards are to ensure patients and customers are provided with high quality, reliable and consistent service. All standards are to be reviewed with new employees as part of the departmental orientation. Additionally, managers are responsible for monitoring employee compliance with these standards on an on-going basis.

Document Metadata

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CHI St. Vincent

POLICY NUMBER	**ON038PCS**
ORIGINAL DATE:	**September 1981**
TITLE:	**INCIDENT REPORTING INFORMATION SYSTEM (IRIS)**
KEYWORDS:	incident reports, Safety Reports, variance reporting, Risk Management, occurrence, Safety, death

ACCOUNTABILITY:

SVP & Chief Nursing Officer
VP Patient Care Services, CHI SVHS (Interim policy accountability for SVP&CNO)
Market Vice President of Quality & Professional Services

OBJECTIVE:

As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all. To fulfill this mission, CHI St. Vincent will identify any occurrences, risk situations, and potential risks that may result in loss to CHI St. Vincent, as well as to assure the reporting of clinically related adverse patient occurrences.

POLICY:

I. A reportable occurrence, also known as an incident or event, is **any occurrence which is a deviation from generally accepted performance stands (GAPS) in the care of a particular patient or any happening which is a deviation from GAPS in the routine, normal operation of the hospital/facility that has the potential to adversely impact a patient or a visitor.**

A. A reportable occurrence may or may not result in physical harm.

B. An incident report should be submitted for any event potentially affecting a patient while receiving care during their stay that falls into one of the categories of events listed below with the exception of events such as theft, assaults, or motor vehicle accidents:

1. Adverse Drug Reactions
2. Behavioral
3. Equipment/product related occurrences
4. Falls
5. Blood/transfusion related occurrences
6. Lab/test
7. Maternal/Childbirth
8. Surgical/Anesthesia
9. Patient Care Event
10. Medication event (also refer to Medication Safety Policy) such as adverse reactions, errors or omissions

C. Incident reports are not to be used as a punitive measure or a vehicle for airing interpersonal or interdepartmental disagreements.

II. A security/visitor event includes any event that occurs on the premises. Refer to section XIV below for further details.

III. Risk Management or the House Supervisor will be notified *verbally (with an electronic incident report to follow)* of any of the following (see XI below for chain of notification). Also refer to the "Sentinel Event Policy".
   A. Unexpected deaths – suicides, sudden cardiopulmonary arrest (with or without CPR) under age 50.
   B. Unanticipated neurological, sensory and/or systemic deficits, brain damage, permanent paralysis, including paraplegia and quadriplegia, partial or complete loss of sight or hearing, kidney failure or sepsis.
   C. Birth-related injuries – maternal or fetal death, anesthesia-related injuries, low Apgar scores <7 at 5 minutes, any infant resuscitation, fractures or dislocations, Cord pH <7.20
   D. Significant and/ or severe burns – thermal, chemical, radiological, electrical
   E. Severe internal injuries – laceration of organ, infectious process, foreign body retention
   F. Injuries **which limit activities of daily living** – fracture, amputation, disfigurement

IV. The Incident Reporting Information System (IRIS) is to be utilized by any and all staff members who have access to the CHI St. Vincent Insider, including, but not limited to:
   A. Physicians/LIP
   B. Pharmacists
   C. Laboratory and other ancillary service personnel
   D. EVS personnel
   E. Transport personnel
   F. Food Services personnel
   G. Nurses
   H. Security

V. An incident report should be submitted electronically at the time of the occurrence by the individual having the most knowledge about the event – the person involved in the occurrence, or the person who witnessed the occurrence, or to whom the occurrence was reported.
VI. The incident report should be objective, accurate, factual and timely. Do not record opinions, conclusions, or assignment of blame.
VII. If the event/occurrence is discovered on a different shift, the employee discovering the event/occurrence will initiate the incident report. When applicable, the shift primary RN should be notified of the event for further assessment and follow-up.
VIII. When the occurrence involves another department/unit, the discovering department/unit will initiate in the incident report.

IX. Downtime:
   A. The incident reporting system can be accessed on the SVInsider by clicking on web apps and selecting IRIS Report.
   B. Only in the event the incident reporting system is inaccessible, a paper version is available on the SVInsider under Forms, Patient Safety, then Downtime Incident Reporting Form. Paper forms may also be available through your immediate supervisor (Charge Nurse/ Director/ Supervisor). In the event incident reporting system is down, all paper incident reports must be faxed or emailed individually to Risk Management.

X. Incident reports will be collected and analyzed by Risk Management to determine trends that represent potential or actual safety issues that negatively impact or could negatively impact an individual or the normal, routine operation of the facility. Results of this analysis will be distributed and discussed with the individuals and departments involved, appropriate quality and safety committees, councils and at other forums/venues as may be necessary or appropriate.

XI. Chain of Notification, in addition to completing an incident report, staff should:
A. Report occurrences to immediate supervisor (Charge Nurse/ Director/ Supervisor).
B. Nurse/ Department Supervisor will assess the patient and the extent of injury or harm.
C. Nurse/ Department Supervisor will notify the Attending Physician or Resident/Intern on Call as indicated.
1. If the patient has fallen, call the Resident/Intern on Call prior to calling the Attending Physician.
2. When necessary, the Director or Supervisor is to be notified to assist in assessment and decision concerning need for immediate action.
3. If the injury or harm produces a potentially life-threatening situation, the Director or Supervisor is to be notified immediately and appropriate action taken.
4. As soon as the situation allows, notify Risk Management.

XII. Documentation:
A. The incident report is a confidential document and separate from the medical record. The incident report is **NEVER** to be made part of a patient's medical record. **DO NOT** document anywhere in the medical record that an incident report (IRIS) was initiated. **DO NOT** document anywhere in the incident report to refer to the medical record. **DO NOT** print or distribute the incident report.

B. Patient's Medical Record: document occurrence (event itself) under appropriate section.

C. Complete report of concise, factual information to include:
1. Patient's Statement
2. Objective Observations
3. Action Taken
4. Evaluation or patient response
5. Examples:
a. Patient states fell out of bed, found sitting on floor beside foot of bed, side rails up x 4. Patient able to move all four extremities without pain. Approx. 3 inch diameter blue discoloration on mid line right buttock. Patient alert, oriented to person, place and time. Patient states "I needed to go to bathroom and did not want to bother anyone."
b. Patient assisted to bathroom and returned to bed. Resident/Intern on Call notified and examined patient. Patient instructed to call for assistance when getting out of bed. Bed check ordered and placed on bed. Patient states that she understands need to call for assistance when getting out of bed.

D. Ancillary Departments: Physician or Supervisor will make appropriate entry on department progress notes.

XIII. Director/ Manager of the involved department will be responsible for review and appropriate follow up on the occurrence. The Director/Manager must complete his/her review within 7 calendar days from the date the event is reported. The Director/Manager's follow up will be documented electronically on the incident report. If additional follow up is required, Risk Management will notify the appropriate Director/ Manager.

XIV. Security/Visitor events:

A. Security/Visitor event includes events that occur on the premises that do not fall into one of the categories listed in above section I. B. Examples of Security/Visitor events include:
   1. Medical emergencies on a CHI St. Vincent campus or inside a CHI St. Vincent facility involving visitors or employees (refer to Code First Aid policy).
   2. Motor Vehicle Accident
   3. Vandalism
   4. Burglary
   5. Disorderly Conduct and Workplace Violence
   6. Lost/Damaged property/valuables
   7. Visitor falls

B. The employee that witnesses the occurrence of a Security/Visitor event will immediately notify the Security Department. A security officer will initiate the incident report as a visitor event.

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CHI St. Vincent

POLICY NUMBER:	**615**
ORIGINAL DATE:	**July 01, 2003**
TITLE:	**FITNESS FOR DUTY**
KEYWORDS:	Return to work, injury, impairment

ACCOUNTABILITY:
VP of Human Resources

OBJECTIVES:

The Mission of Catholic Health Initiatives is to nurture the healing ministry of the Church, supported by education and research. Fidelity to the Gospel urges us to emphasize human dignity and social communities as we create healthier communities.

PURPOSE:

CHI St. Vincent seeks to provide a safe and healthy environment and to promote the health and welfare of its patients, visitors, and employees. The Hospital strictly prohibits the possession, use, sale, attempted sale, purchase, attempted purchase, adulteration, conveyance, distribution, transfer, cultivation, and/or manufacture of illicit drugs or other intoxicants. The Hospital prohibits the use, abuse misuse, or possession of alcohol while working, operating any Hospital vehicle. In addition, the Hospital prohibits employees from reporting for work after having recently consumed alcohol, being in an impaired condition due to prescription medication, illicit drugs or alcohol, or being unable to perform Jus/her job effectively due to any injury or condition, work related, or otherwise.

POLICY STATEMENT:

It is the policy of the CHI St. Vincent that all employees be in good health and able to safely and competently perform the duties within his or her physical and mental capacity. CHI St. Vincent is committed to assisting the employee with return-to- work opportunities during his/her recovery process and immediately following periods of injury, illness or treatment for health problems or drug and alcohol problems. Our goal is to return the employee to the position and functionality he/she occupied prior to leave, or to explore other opportunities that match his/her experience, capabilities and qualifications.

DEFINITIONS:

1. **Employee Fitness-for-Duty**: The ability to perform assigned duties competently and efficiently, without impaired judgment, coordination, or skill, and in a manner that does not jeopardize the health and safety of CHI St. Vincent patients, visitors, other employees or self. The presence of any blood alcohol or illicit substances or legal drugs that may impair judgment, coordination, or awareness found as a result of a test for substance abuse shall render the employee unfit-for-duty.

2. **Physical or Mental impairment**: Temporary physical or mental conditions primarily due to communicable, infectious disease processes, chronic conditions, injury (work related or otherwise), or the use of illicit drugs, alcohol, or legal drugs that may impair judgment, coordination or awareness. Employees should not typically work more than 16 hours in a 24 hour period or more than 60 hours in a seven day period or 120 hours in pay period regardless of whether work is performed at CHI St. Vincent or other places of employment.
3. **Illicit Drugs:** includes all drugs, narcotics, and intoxicants for which possession or misuse is illegal under federal, state or local law, and includes prescription medication for which the individual does not have a valid prescription. The deliberate use of prescription medication and/or over-the-counter drugs in a manner inconsistent with prescription or dosing directions, and in a manner which may result in impairment, also is considered illicit drug use. In addition, the use of chemical intoxicants in a manner inconsistent with their intended or other than a legitimate and therapeutic purpose is considered illicit drug use. Exhibit 1C may be required for any prescription drugs that an employee is taking.
4. **Presence of alcohol or illicit drugs:** any detectable level of alcohol or illicit drugs in an employee's test sample.
5. **Legal Drugs; Prescribed Drugs:** includes alcohol, prescribed and over-the-counter drugs legally obtained and being used for the purpose for which they were prescribed and/or manufactured.

PROCEDURE:

A. Reporting for Duty: Upon reporting for duty, an employee must report to his/her supervisor, or designee, if the immediate supervisor is unavailable, any temporary physical or mental impairment due to communicable, infectious disease processes, chronic conditions, it my (work related or otherwise), or the use of illicit drugs, alcohol, or legal drugs that may impair judgment, coordination or awareness.

B. Determination of Fitness-for-Duty:

1. Any supervisor or department manager who witnesses an apparent abn01mal behavior or condition that indicates that any employee may not be fit-for-duty, must document the same and instruct the employee to report to his/her immediate supervisor or the Manager.
2. Documentation must be related to either the employee's inability to satisfactorily perform his/her work duties or other observations indicating that the employee may not be fit-for-duty.
3. Possible abnormal behaviors or conditions may include, but are not limited to, the following:
    i. Drowsiness or sleepiness;
    ii. Odor of alcohol;
    iii. Slurred or incoherent speech;
    iv. Unusually aggressive behavior;
    v. Unexplained work errors;
    vi. Unexplained change in mood;
    vii. Lack of manual dexterity;
    viii. Lack of coordination in walking;

ix. Frequent unexplained absence from work area during shift;
x. Any other signs or symptoms that may indicate an infectious disease process, or injury.

4. If the manager or house supervisor observes or receive a report one of the behaviors above or any other behavior that would objectively lead the supervisor to the conclusion that the employee is not fit-for-duty, the manager or house supervisor should do the following:

ii. Interview the employee in private to determine the need for a Fitness-for-Duty evaluation. If the need for a Fitness-for-Duty evaluation is established, notify the Manager and Director of Human Resources or designee immediately that a Fitness-for-Duty evaluation is requested and proceed with the evaluation as outlined below.
iii. Escort the employee to the location designated by the Manager or
iv. Director of Human Resources or designee.
v. If the employee is subsequently determined to not be fit-for-duty, take the employee off the work schedule.

5. An employee must sign an Authorization for Fitness-for-Duty Evaluation, Exhibit 1A and, as applicable, a consent to submit to Drug and/or Alcohol Testing Refusal to sign the Authorizations is grounds for immediate termination.

C. **Fitness-for-Duty Evaluation:** Fitness-for-duty examinations are objective assessments of the health of an employee in relation to his/her specific job, in order to ensure he/she can do the job and would not be a hazard to themselves or others. Fitness-for-duty examinations should always be conducted with reference to the specific job the employee holds or intends to hold. The circumstances that require these examinations occur at the time of application or consideration for entry into employment and assignment to a specific job (pre-placement), return-to-work after illness or injury (return-to-work), and when the employee's behavior demonstrates concern regarding the employee's mental or physical ability to perform the essential functions of the specific job or position.

1. Once a supervisor or Manager determines that an employee's behavior or condition indicates that the employee may not be fit-for-duty, an employee must report as instructed for a Fitness-for-Duty evaluation, which may include, but not be limited to: drug and/or alcohol testing, referral for a physical or psychiatric evaluation, or any other reasonable evaluation or follow-up deemed necessary by the consulting physician.
2. A qualified medical provider or medical review officer should perform a physical exam in cases of physical illness or injury.
3. A psychiatrist, psychologist or qualified mental health provider should perform a psychological assessment in cases of mental health illness or condition.
4. Testing for alcohol and/or drugs needs to be conducted in accordance with the CHI St. Vincent policy.
5. Send the employee's job description with the essential functions and physical and mental demands to all11tness-for-duty examinations.

6. Determine and clarify the type of disability being evaluated for the employee's current (mental and physical) status.
7. Ensure the employee has reached Maximum Medical Improvement or a Permanent and Stationary Status before addressing issues of permanent impairment.
8. Complete all forms fully, objectively, accurately and timely.

D. **Fitness-for-Duty Outcomes:** There are 2 possible outcomes, the appropriateness of which may depend on the type of examination. Employee will be notified of the outcome of the Fitness-for-Duty Evaluation in writing. The employee may also be notified in person or via telephone as determined appropriate by the Manager, or Director of Human Resources or designee. These categories are defined as:

1. **FIT:** This outcome means that the employee is able to perform the job without danger to self or others, without reservation or any accommodation. The subcategory "temporarily" can be used for all types of medical assessments except pre-placement. "Permanently" should never be used with a judgment of "fit" since physicians cannot predict the future.

2. **FIT, SUBJECT TO WORK MODIFICATIONS OR ANY ACCOMMODATIONS:** An outcome in this category indicates the employee could be a hazard to self or others if employed in the job as described but would be considered fit to do the job if certain working conditions were modified (e.g., changing the way the work is performed or the working environment). The modifications required must be clearly described in the comments section. If the accommodation(s) can be made, the employee is considered fit for the modified job. If the modifications cannot be reasonably accommodated, the employee is identified temporarily or permanently unfit. "Temporarily" means that if the person's condition improves with time and or treatment, the requirement for work modification may be lifted. "Permanently" usually means that the employee will never be fit for the job without the modifications. Any employee considered fit subject to work modifications must be fully informed of botl1 the medical findings and the modifications.

3. **UNFIT:** An outcome in this category describes tile employee who is unable to perform the job without being a hazard to self or others. This category and the subcategories "temporarily" and "permanently" can be used with any type of fitness-to-work examination. "Temporarily" means that the medical or mental condition may improve with time and treatment which would allow return to work or transfer to another job or position. "Permanently" usually means that the employee is unable to do any available job, with or without work modifications. A statement describing this position should be made in the examination report.

E. **Employee Determined Not Fit-for-Duty**

1. An employee determined to not be fit-for-duty shall be sent home and may use accrued leave benefits.
2. Safe transportation home should be arranged by the CHI St. Vincent if needed.
3. The employee may not return to work until he/she is re-evaluated and determined to be fit-for-duty.
4. An employee who tests positive for illicit drugs or alcohol should be handled in accordance with the CHI St. Vincent's policy.

5. All documents containing personal health information related to the employee's Fitness-for-Duty Evaluation should be placed in the employee's medical/or employee health file. Documents without personal health information are to be maintained in the employee's personnel file.

F. Granted special privileges or exemption: from normal administrative or disciplinary procedures related to unavailability for work, inability to satisfactorily perform the essential functions of the job, or repeated incidents of being found not fit-for-duty.

G. Confidentiality of Employee Drug Testing: Per CHI St. Vincent's policy, any collection, screening, testing, and results will be maintained in a confidential manner. Although the CHISV will have access to all test results, the CHSV will not retain the results in an employee's personnel file. The test results should be maintained in a separate medical or employee health file. Authorized supervisory personnel may have access to the results on a need to know basis only. However, the CHI St. Vincent will produce the results as required or permitted by law.

H. Fitness-for-Duty Examination.

1. Determine the presence or absence of a permanent impairment that substantially limits one or more major life activities.
2. Evaluate the patient's work capacity (mental and physical) and delineate workplace restrictions as specifically as possible.
3. Assess the workplace demands (mental and physical) and clearly define the essential functions of the job as specifically as possible.
4. Determine the patient's ability to perform the essential functions of the job with, or without, accommodations.
5. Obtain appropriate consents signed and dated by employee for personal medical information (Exhibit lA, Authorization for Fitness-for-Duty Evaluation).
6. Clearly delineate the nature and extent of all impairments (mental and physical);
7. Identify any impairments that pe1tain to a claim for workers' compensation or disability benefit programs;
8. Document in detail all limitations (mental and physical) and workplace restrictions (Exhibit lB, Medical Certification of Fitness-for-Duty).

Attachments:

1. Exhibit 1A, Authorization For Fitness-for-Duty Evaluation
2. Exhibit 1B, Medical Certification of Fitness-for-Duty.

EXHIBIT lA

AUTHORIZATION FOR FITNESS-FOR-DUTY EVALUATION

I, _____, have been informed that CHI St. Vincent or the parent, affiliated or related hospital facilities (collectively "Hospital"), its employees, agents or members of the medical staff of the Hospital, is requesting that I submit to a Fitness-for-Duty

Evaluation. I hereby authorize the physician or practitioner identified below to perform such evaluation.

I have been informed and I understand that my agreement to submit to the requested Fitness-for- Duty Evaluation is completely voluntary on my part, and that I have the right to refuse to submit to the evaluation. I am aware and have been told that my refusal to submit to the evaluation may be grounds for disciplinary action against me, including termination.

I understand and consent to the release and disclosure of such health care records and information concerning my current medical condition as is necessary to determine my fitness- for-duty to the Hospital Human Resources Director or designates. I understand this information will be kept confidential and disclosed as permitted by law or as necessary per Hospital policies.

Re-disclosure: I understand that the information used and/or disclosed by this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of my health information may potentially re-disclose it.

Expiration: This authorization will expire once stated purpose above is served.

Revocation: I understand that I may revoke this Authorization at any time by written notice to Hospital at 2 St. Vincent Circle Little Rock, AR 72205 and directed to the Human Resources Director.

This Authorization is binding: The statements made in this Authorization are binding, controlling, and I understand that they take precedence over statements made in the Hospital's Notice of Privacy Practices.

I furthe1· agree to release, waive and discharge from liability, agree not to sue and forever hold harmless, the Hospital and its Board of Directors, and its parent affiliates, officers, trustees, directors, contractors, providers, agents, employees, physicians and any other individual authorized to provide or receive information from any and all liability, claims, demands or other causes of action that I may have now OJ' may have in the future which may arise from the Hospital, or its designees requesting, receiving, performing, disclosing and using information acquired pursuant to this Authorization and Release.

I have read and understand the above information and have voluntarily agreed to submit to the requested Fitness-for-Duty Evaluation by:

_____

_____

_____

Signature_____ Date_____

Witness_____ Date_____

EXHIBIT1B

MEDICAL CERTIFICATION FOR FITNESS-FOR-DUTY

This form is to be completed by the physician performing the fitness-for-duty evaluation pursuant to the employee's request and authorization. It must be returned to the employee's supervisor prior to the employee's return-to-work.

Name of Employee:	
Employee ID Number:	
Job Title:	
Department:	
Days Absent:	
Reason for Leave:	

Statement of Physician	
Physician Name:	
Address:	
City, State, Zip:	
Telephone:	
Field of Specialty:	
License No.:	
Medical Facts Regarding Patient's Condition:	
Date Condition Commenced:	
Probable Duration of Condition:	
Has Patient reached the end of his/her healing period? (Yes/No)	
Is patient able to perform all of the functions of his/her regular job? (Yes/No)	
If patient is unable to perform some or all of the functions of patient's regular job, is patient able to perform work of any kind? (Yes/No)	
If Yes, please explain:	
Is patient able to work his/her normal work schedule? (Yes/No)	

If not, please identify the number of hours per day and the number of hours per week that the patient can work and the expected duration of the reduced schedule:	
When can patient return to work with restrictions?	
Without restrictions?	
Comments:	
Physician Signature:	
Date:	

RELEASE TO WORK FORM WITH PRESCRIPTION MEDICATIONS

This form is to be completed by the physician who prescribes employee medications for employees who may be in a clinical or safety sensitive position.

Employee Section:

Name of Employee:_____

Employee ID Number: _____

Job Title:_____

Employee may provide physician with a job description.

Medications currently being taken include:

_____

_____

_____

I understand that SVHS has the right to seek a second opinion from a qualified physician. I attest the foregoing information is complete and correct:

Employee Signature:_____ Date:_____

Physician Section:

As the attending physician, I have prescribed the following medications to be taken from _____ to _____.

Medication:	Dosage:
Medication:	Dosage:
Medication:	Dosage:

Please check one of the following:

- ○ Employee may not perform safety-sensitive duties while taking this medication.
- ○ Employee is released to perform safety-sensitive duties while taking this medication.

As the physician, I am aware that this information will be shared with Employee Health and that the Physician Medical Director of Employee Health may contact me.

_____ _____

Physician's Printed Name Phone Number

_____ _____

Signature Date

Document Metadata

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CHI St. Vincent

POLICY NUMBER:	**301**
ORIGINAL DATE:	**July 01, 2003**
TITLE:	**EMPLOYEE APPEALS**
KEYWORDS:	

ACCOUNTABILITY:
VP of Human Resources

OBJECTIVES:

The Mission of Catholic Health Initiatives is to nurture the healing ministry of the Church, supported by education and research. Fidelity to the Gospel urges us to emphasize human dignity and social communities as we create healthier communities.

POLICY:

It is the Policy of CHI St. Vincent to provide all employees with a means to have individual employment related disputes reviewed and responded to in a timely and appropriate manner. Employees are encouraged to make use of this process and will not be subjected to retaliation or be penalized in any way for doing so. This process is to be used to appeal corrective action, Performance Improvement Plans and/or Terminations. Human Resources will serve as the facilitator throughout the process.

PURPOSE:

This process is intended to supplement rather than discourage or replace informal discussion. It is established to open the doors of communication at all levels of the organization and to provide a fair and equitable means to resolve individual employment related disputes at the lowest possible level of the process.

A manager should make every reasonable effort to resolve issues brought forth outside the formal appeals process.

COMMENTS:

This process is available to all non-probationary, non-union employees (*see the Collective Bargaining Agreement regarding the union process*).

PROCEDURE:

Since many issues can be discussed and resolved between the parties, employees are encouraged to direct all their individual disputes to their immediate supervisor. A three-step process has been adopted to ensure a fair, equitable and open discussion of issues unresolved during the normal course of business.

1. An employee appeal should be presented to Human Resources within 10 working days of the incident resulting in the complaint. An attempt will be working days of the incident resulting in the complaint. An attempt will be made to mediate and respond to the situation within 5 working days from notification. If the employee is still dissatisfied following attempts by Human Resources to facilitate/mediate the problem; he/she may obtain an Appeals Form from Human Resources. This form must be completed and returned to Human Resources within 5 working days. This form will be forwarded to the appropriate Senior Vice President, Clinical Administrator or Executive for review. The Executive or Administrator will meet with the employee and provide a written decision within 5 working days after meeting with the employee.
2. If the employee is not satisfied with the decision from Step 2 within working days, he/she must request, in writing, a review of the appeal and the Executive or Administrator's decision by the Appeals Committee. The Appeals Committee will be facilitated by a Human Resources Business Partner and is composed of members who do not know the employee and have not been involved earlier in this process including two Employee Council members,

a Sister or chaplain, a department manager, and a Director, Administrative Staff member or Executive Team member and the Chair. The chair will vote only in the event of a tie. The date is set by the organization. If the employee does not attend the meeting, the committee will review the available information to make a decision.

The appeal meeting is scheduled for two hours. Information regarding the appeal will be provided to the chair in advance of the appeal meeting. Committee members will receive the information when they arrive for the meeting. The meeting will be opened with the chair advising the members of the procedure. The chair will also moderate the meeting. The Human Resource Representative will keep notes of the meeting. Decisions regarding the appeal are based on majority vote. The chair votes only in the event of a tie. An outline of the agenda is as follows:

- 10 Minutes: Committee Chair instructs committee on proceedings, and the Human Resources representative provides copies of the documents to committee.
- 20 Minutes: Committee reviews documents
- 30 Minutes: Grievant states his/her case
- 10 Minutes: Committee is given an opportunity to question the grievant
- 30 Minutes: Supervisor states his/her case
- 10 Minutes: Committee is given an opportunity to question the supervisor
- 10 Minutes: Committee deliberates and makes a decision

The employee may bring one person with him/her who will not take a role in the process. Because this is an internal, non-legal proceeding, no attorneys may participate and no recording devices are permitted. The Appeals Committee will meet within 2 weeks from the date the Human Resources Department receives the employee's request for a review by the Committee. The chair of the Appeals Committee will then review findings with the Vice President of Human Resources prior to communicating the Appeals Committee's decision with the employee. This step concludes the appeals process.

The Vice President of Human Resources will review the decisions of the Appeals Committee with the President/CEO of the Health System as appropriate.

Employee Appeal Form Step1

Name:_____

Date:_____

Department:_____

Title:._____

Mailing Address:_____

Phone:_____

*Email Address: _____

*Alternate Phone:_____

(*Note: Email address and alternate phone are not required.)

I wish to state my intent to appeal the disciplinary action issues to me on _____

Based on the following circumstances (be as specific as possible):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

A just and fair solution to my appeal would be:

_____

Employee Appeals:

_____

_____

Employee Signature:

_____

(Note: This form must be completed and returned to Human Resources within 10 working clays of incident resulting in the complaint.)

Employee Appeal Form Step 2

Name:_____

Date:,_____

I wish to request review of the step 1 appeal decision by the appropriate Executive or Administrator.

(Note: This form must be completed and returned to Human Resources within 5 working days of employee's receipt of step 1 decision.)

Employee Signature:_____

Employee Appeal Form Step 3

Name:_____

Date:_____

I wish to request review of the step 2 appeal decision by the Appeals Committee.

(Note: This form must be completed and returned to Human Resources within 3 working days of employee's receipt of step 2 decision.)

Employee Signature:_____

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March 2023

POLICY NUMBER:	**305**
ORIGINAL DATE:	**July 01, 2003**
TITLE:	**PROGRESSIVE CORRECTIVE ACTION**
KEYWORDS:	work performance, violations, hospital rules, warning, verbal, written, final, termination

ACCOUNTABILITY:
VP of Human Resources

OBJECTIVES:
The Mission of Catholic Health Initiatives is to nurture the healing ministry of the Church, supported by education and research. Fidelity to the Gospel urges us to emphasize human dignity and social communities as we create healthier communities.

POLICY:
It is the policy of CHI St. Vincent that inadequate work performai1ce, unacceptable work habits and violations of work rules, policies and procedures be addressed between an employee and his/her supervisor, The Progressive Corrective Action procedure is a process designed to identify and connect problems that affect an individual's work performance and deal with violations of hospital rules, policies and procedures.

COMMENTS:
The four step corrective action procedure is a developmental tool designed for all staff members. The procedure provides an employee and his/her supervisor with the opportunity to talk about specific problems and discuss how the employee can correct these problems. Progressive corrective action refers to the steps listed below:

- Verbal warning (documented)
- Written warning (a work improvement plan may be implemented at this step or those following)
- Final Warning (sometimes with a suspension for no more than three (3) workdays)
- Termination

Progressive corrective action is intended to be used to correct problems related to minor performance deficiencies, excessive absenteeism and relatively minor violations of hospital work rules, policies and procedures. Corrective action should not be advanced if more than twelve (12) months have passed since the prior corrective action for the same violation. Should a problem recur twelve (12) months after the last documented corrective action step, the former step should be repeated,

However, in the case of more serious performance deficiencies affecting patient care or more serious violations of hospital work rules, policies or procedures, any of the steps identified above may be skipped or not followed in sequence. An employee may be suspended and/or discharged on the first offense without res01iing to progressive corrective action, depending upon the seriousness of the offense. Such offenses include but are not limited to:

- Violation of patient safety guidelines
- Violation of St. Vincent Corporate Responsibility standards and regulations
- Insubordination, refusal, or intentional failure to perform assigned work
- Soliciting tips or gifts from patients
- Harassment, including sexual harassment. Harassing behavior may include, but is not limited to, threatening or abusive language or acts, making of false or malicious statements about others.
- Illegal possession of controlled substances or possession of illegal drugs
- Working under the influence of alcohol or drugs
- Falsifying facility documents including employment applications, attendance records, etc.
- Possession of any firearms, explosives or weapons
- Theft
- Carelessness or misjudgment having critical impact on patient care or system operations
- Abusive, careless or inconsiderate treatment of patients, their families, visitors or co-workers
- Felony conviction
- Breach of confidentiality
- Violation of fire or safety regulation
- Absence from work without permission or notification
- Deliberate or careless damage to property or equipment
- Engaging in horseplay, disorderly conduct or fighting
- Threatening, intimidating, or coercing others including abusive, profane or threatening language
- Gambling on St. Vincent properly
- Sleeping on the job, watching TV in unauthorized areas, excessive personal phone calls
- Fraudulent misuse of benefits
- Misuse of Badge for facility access other than coworker

Responsibilities:

Please note that by law, union employees have a right to union representation present if they have a reasonable belief a meeting with management may result in discipline. In such situations, a union steward has a right to be present during the meeting.

Managers and supervisors are routinely held to a higher standard of performance, due to their added responsibilities, a greater exercise of independent judgment comes with their positions. As a result, their performance problems will be dealt with on a case-by-case basis.

RESPONSIBILITIES:

- The supervisor has the authority and the responsibility to initiate the corrective action procedure. Once a supervisor begins corrective action, as many steps as are needed to resolve the problem should be pursued.
- The supervisor should investigate all aspects of a problem thoroughly, verify all conditions, statements by witnesses, etc., and carefully record the information for future actions.
- The supervisor must consult with his/her supervisor and with Human Resources prior to initiating a suspension.
- Should immediate suspension pending investigation (administrative leave) be judged necessary by a supervisor on the evening/night shift or weekends, the supervisor should do so and then consult with his/her superior and Human Resources at the earliest opportunity.
- Should the corrective action progress to termination, both the supervisor and Human Resources must be consulted in advance. All involuntary discharges must first be approved by the Vice President responsible for the area, as well as by the Vice President of Human Resources before **any** formal discharge.
- The Department of Human Resources will provide assistance and training for supervisors upon request, on the interpretation and/or execution of all steps in the Progressive Corrective Action procedure.

PROCEDURES:

STEP I **Verbal Warning (***bargaining unit employees have the right to have union representation present)*

The supervisor must identify the problem and hold a private discussion with the employee, in which the supervisor describes the problem, explains its significance, and solicits a frank discussion about the problem behavior or performance.

This discussion provides the supervisor and the employee an opportunity to talk over (discover and understand) reasons for the problem and to determine when and how the problem can be corrected. Agreements on actions to be taken by both parties are made, if appropriate.

The supervisor must make the employee aware of future actions that may occur if the problem is not corrected.

Although the first step is verbal, a written record should be kept that the discussion took place. The "written" document should be given to the employee for signature, indicating the employee has received the corrective action, not necessarily that the employee agrees with it. This "written verbal warning," giving date, subject matter and decisions, should be maintained in the department.

STEP2 **Written Warning** (*bargaining unit employees have the right to have union representation present)*

When undertaking Step 2, the supervisor should meet and talk with the employee before preparing the written warning and work improvement plan, if applicable.

Information received at this meeting could influence the decision of whether or not to write a corrective action and/or the content of the notice.

Summarize the problem and what performance is expected of the Employee on the corrective action form (bargaining unit employees have a right to have union representation).

Be as specific and detailed as possible. Include any actions the employee agrees to perform to connect the problem.

Discuss the material outlined on the form with the employee. Again discuss the expectations and indicate confidence in the employee to improve.

Advise the employee when his or her record will be reviewed again and what the next action will be if the problem continues.

Both supervisor and employee are expected to sign this notice.

If the employee refuses to sign, a co-manager and Human Resources should be asked to witness this fact on the written notice.

At the employee's request, his/her rebuttal of a written notice will be placed in his/her file.

Distribution of copies of the form:

Staff members may request copies of this form should go to the employee, Human Resources, and a copy should be maintained for the departmental file. If the employee refuses his/her copy, this should be noted on the document.

STEP3 **Written Warning with Possible Suspension** *(appropriatefor minor, continuing work problems)*
(Bargaining unit employees have the right to h a v e union representation present) In a private meeting with the employee review the previous actions and the present situation.

Indicate that a suspension is being imposed and why such action is necessary. The suspension should be for not more than three (3) days without pay. Employee Relations.

During this period the employee should be encouraged to decide upon his/her future behavior within this organization.

To remain with CHI St. Vincent, the employee must resolve his/her own problems.

Make the employee aware that any future reoccurrence of the problem within 1 year will be cause for termination.

Document the suspension on the corrective action form.

Should suspension fail to result in satisfactory improvement, proceed to Step 4.

Immediate Suspension Pending Investigation *(appropriate for extreme infractions)*

The suspension must be imposed immediately. It remains in effect until Management concludes its investigation.

Document the suspension on the col1'ective action form.

A thorough investigation should be conducted by the Supervisor in coordination with Human Resources.

If a decision is made to retain the employee, he/she must be made aware of the conditions of continued employment. An occurrence of the same or similar extreme violation will result in termination. The manager and a Human Resources representative in consultation may determine that back pay for time spent on suspension should be restored.

If the decision is made to terminate, following appropriate approvals, the employee must be officially advised as soon as possible. To terminate, follow Step 4.

STEP4 **Termination** *(bargaining unit employees have the right to have union representation present)*

Consult with the Vice President of Human Resources or his/her designee before terminating an employee.

Upon review of the circumstances, the Vice President of Human Resources or his/her designee may provide approval to terminate the employee.

Discuss the problem and notify the employee of the termination. Indicate why such action is being taken.

Document the termination on the corrective action form.

Complete the Termination Report and distribute the copies as appropriate.

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CHI St. Vincent

POLICY NUMBER:	**604**
ORIGINAL DATE:	**July 01, 2003**
TITLE:	**PERFORMANCE MANAGEMENT**
KEYWORDS:	

ACCOUNTABILITY:
VP of Human Resources

OBJECTIVES:

The Mission of Catholic Health Initiatives is to nurture the healing ministry of the Church, supported by education and research. Fidelity to the Gospel urges us to emphasize human dignity and social communities as we create healthier communities.

POLICY:

I. Frequency

a. The work performance of all employees is reviewed at least annually. The required annual performance review is conducted for each fiscal year.

II. Competency

a. *Competence* is an individual's capacity to perform job functions; whether they have the knowledge, skills, behaviors and personal characteristics necessary to function well in the job. *Competency* is defined as an individual's actual performance in a particular job. It describes how well the individual integrates job knowledge, attitudes, skills critical decision making, and desired behaviors in delivering care according to expectations.
b. Initially, determination of competence prior to performance is accomplished through the department-specific orientation and initial competency self-assessment process and validation which is documented on the orientation record. The functional accountabilities in the Performance Management Tool require validation through observation or medical record review. Leaders must ensure that the compliance of all staff members is assessed, maintained, demonstrated and improved continually.
c. The department director will determine which competencies must be assessed annually based on whether or not the competency is high risk, problem prone, seldom used or a new procedure or piece of equipment. Competencies needing validation may change from year to year depending on the department's scope of service and focus, new equipment, new procedures, identified trends and patterns of performance.
d. Competency assessments address the ages of patients served relative to determining each patient's age-related patient care activities. BLS and other life-saving interventions are included in observation of performance, testing, certifications, and educational pursuits, equipment credentialing and other activities. The process may be accomplished by leaders, a peer review process, or other mechanisms. Assessment tools may vary from service or department to department as long as the intent of this policy is met. All annual written supporting documents for competency assessment will be attached to the Performance Management Tool.

e. There are several ways competency may be assessed:
    i. Education/training pertinent to the required competency, i.e., BLS
    ii. Computer-aided instruction
    iii. Proficiency demonstrated in skills lab or nursing unit
    iv. Correct verbalization of policy and procedures
    v. Review of policy and procedures
    vi. Written evidence of competency, i.e., written exam or case study, care plan, chart audit
    vii. Peer/manager review—visual assessment of generic or unit specific competencies
    viii. Facilitation of small group activity with a standardized exam
    ix. Audio-visual reviews, programmed study modules
    x. Self-paced learning modules

GOALS:

Along with the performance appraisal, employees and their leader develop goals and development opportunities for the upcoming year to perform in such a way that will promote quality, further CHI St. Vincent's business strategies, achieve customer service standards, and demonstrate its core values.

WORK IMPROVEMENT PLAN:

Employees not meeting performance expectations may be placed on a work improvement plan to move their performance into the competent range as soon as possible. Work improvement plans can last up to 90-ddays. Unsuccessful efforts to improve performance to a level of competence will result in termination of employment.

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CHI St. Vincent

POLICY NUMBER	**ON017PCS**
ORIGINAL DATE:	**February 1997**
TITLE:	**SENTINEL EVENT - NEVER EVENT REPORTING AND FOLLOW-UP**
KEYWORDS:	Root Cause Analysis; Injury; Death; Never Event

ACCOUNTABILITY:
Market Chief Executive Officer
SVP & Chief Nursing Executive
Mkt VP Patient Care Services
Mkt VP Quality

OBJECTIVES:
The Mission of Catholic Health Initiatives is to nurture the healing ministry of the Church, supported by education and research. Fidelity to the Gospel urges us to emphasize human dignity and social justice as we create healthier communities. To fulfill this mission, CHI St. Vincent will establish and ensure risk prevention activities by the health system in response to a sentinel event or never event and by improving patient care through gaining and sharing knowledge about sentinel or never events and their prevention.

DEFINITION:
Sentinel event: A sentinel event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, permanent harm, or severe temporary harm.
Never events: As defined by National Quality Forum, are unambiguous, largely preventable, and serious, as well as adverse, indicative of a problem in a healthcare setting's safety systems, or important for public credibility or public accountability.

Sentinel Events and Never Events List

- ***Sentinel Events are in bold and italicized font***

1. SURGICAL OR INVASIVE PROCEDURE EVENTS

1A. Surgery or other invasive procedure performed on the wrong site
1B. Surgery or other invasive procedure performed on the wrong patient
1C. Wrong surgical or other invasive procedure performed on a patient
1D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure
1E. Intraoperative or immediately postoperative/post procedure death in an ASA Class 1 patient

2. PRODUCT OR DEVICE EVENTS

2A. Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting
2B. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended
2C. Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting

3. PATIENT PROTECTION EVENTS

3A. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person
3B. Patient death or serious injury (permanent or severe temporary harm) associated with patient elopement (disappearance)
3C. Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting or within 72 hours of discharge, including from the hospital's emergency department

4. CARE MANAGEMENT EVENTS

4A. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
4B. Patient death or serious injury associated with unsafe administration of blood products: administration of blood or blood products having unintended ABO and non-ABO incompatibilities, hemolytic transfusion reactions, or transfusions resulting in severe temporary harm, permanent harm, or death
4C. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting ***(Sentinel event: ANY intrapartum (related to the birth process) maternal death)***
4D. Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy
4E. Severe maternal morbidity leading to severe or permanent harm
4F. Severe neonatal hyperbilirubinemia (>30 mg/dL)
4G. Patient death or serious injury associated with a fall while being cared for in a healthcare setting including the following: any fracture; surgery, casting, or traction; required consult/management or comfort care for a neurological (e.g., skull fracture, subdural or intracranial hemorrhage) or internal (e.g., rib fracture, small liver laceration) injury; a patient with coagulopathy who receives blood products as a result of the fall; or death or permanent harm as a result of injuries sustained from the fall (not from physiologic events causing the fall)
4H. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting
4I. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
4J. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results

5. ENVIRONMENTAL EVENTS

5A. Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting
5B. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances
5C. Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting

- ***Fire, flame or unanticipated smoke, heat, or flashes occurring during direct patient care caused by equipment operated and used by the hospital. Equipment must be in use at the time of the event to be considered a sentinel event.***

5D. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting

6. RADIOLOGIC EVENTS

6A. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area
*6B. **Fluoroscopy resulting in permanent tissue injury when clinical and technical optimization were not implemented and/or recognized practice parameters were not followed***
6C. Any delivery of radiotherapy to the wrong patient, wrong body region, unintended procedure, or >25% above planned radiotherapy dose

7. POTENTIAL CRIMINAL EVENTS

7A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
7B. Abduction of a patient/resident of any age
7C. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting
7D. Homicide of any patient receiving care, staff member providing care, or visitor while onsite
7E. Death or serious injury (permanent harm or severe temporary harm) of a patient or staff member (including visitors and vendors) resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting

Major permanent loss of function: is defined as a sensory, motor, physiological or intellectual impairment not present on admission requiring continued treatment or life-style change. When major permanent loss of function cannot be immediately determined, the event is not considered a sentinel event until either the patient is discharged with continued major loss of function, or two weeks have elapsed with persistent major loss of function, whichever occurs first.

Severe temporary harm: Severe temporary harm is critical, potentially life-threatening harm lasting for a limited time with no permanent residual, but requires transfer to a higher level of care/monitoring for a prolonged period of time, transfer to a higher level of care for a life-threatening condition, or additional major surgery, procedure, or treatment to resolve the condition.

Root cause analysis: A root cause analysis is an intensive assessment for identifying the most basic or causal factors that underlie the variation in performance, including changes that should be made in systems and processes that would reduce the risk of such events occurring in the future. Root cause analysis focuses primarily on systems and processes, not on individual performance.

POLICY:

I. All significant adverse patient outcomes will be brought to the attention of the Vice President of Quality or Risk Manager as soon as possible after the event by any staff member, provider, employee or independent contractor by telephone and the completion of an Incident Report in the IRIS System.

II. The Vice President of Quality or Risk Manager will conduct a preliminary investigation and manage the situation working with the physician, staff and family. The Vice President of Quality, in consultation with administration and others as necessary, will determine whether a significant incident is a sentinel or never event as defined by this policy. The Chief Nursing Officer and CMO will be notified within one business day.

III. There should be prompt and proper care of the patient who has been affected by a sentinel or never event. Care may involve stabilizing the patient, performing necessary tests or surgery, providing medications and taking whatever actions are deemed necessary to prevent further harm.

IV. The manager of the service area where the event occurs will take any immediate steps indicated to mitigate any current risk.

V. Preservation of evidence: Preserving the evidence is important in order to learn from the error/event and understand why it occurred. The manager of the area should take steps to secure any biological specimens, medications, medical equipment, medical or other records and any other material that may be pertinent to the investigation of the event and deliver to location as directed by the Risk Manager.

VI. Notification of appropriate persons: When a sentinel event is confirmed, the Chief Executive Officer will be promptly notified by the CNO or the CMO.

A. Notification of patient or surrogate decision-maker: The licensed independent practitioner responsible for managing the patient's care, treatment, and services, or such practitioner's designee, in conjunction with a representative from leadership will inform the patient about unanticipated outcomes of care, treatment, and services related to the sentinel event when the patient is not already aware of the occurrence or when further discussion is needed. Information and notification to the patient will be in accordance with any applicable policy or procedure.

VII. Upon determination of a sentinel event, the Risk Manager will immediately engage a sentinel event response team (SERT)

A. Immediate Crisis Management: Is the process by which the SERT immediately responds to an event, which includes actions within the first 24 hours of the event to attend to the needs of the patient and staff involved, secure the area, gather facts and notify all appropriate people.

B. Sentinel Event Response Team (SERT) is a rapid response team consisting of the following people:

1. Vice President of Quality
2. Risk Manager
3. SVP & Chief Nursing Officer
4. SVP & Chief Medical Officer, and
5. Public Relations (if applicable).

C. The SERT will oversee the immediate crisis management (including investigation) of the event and the root cause analysis process.

D. Root Cause Analysis: A root cause analysis will be performed within 45 days of the event or of becoming aware of the event.

1. The Risk Manager coordinates a RCA Team to conduct a root cause analysis and implement an action plan which identifies the strategies that the health system intends to implement in order to reduce the risk of similar events occurring in the future. The action plan should address responsibility for implementation, oversight, pilot testing as appropriate, time lines, and strategies for measuring the effectiveness of the actions. Action plans will be approved and monitored by the Quality & Patient Safety Council.
2. A RCA Team will facilitate the root cause analysis, as defined above, of the event. The RCA Team will be composed of the following as needed:
    i. Vice President of Quality
    ii. Risk Manager
    iii. Director of Quality & Resource Management
    iv. Clinical Director/Vice President of impacted areas;
    v. Nurse Manager over impacted areas
    vi. Lab
    vii. Pharmacy
    viii. Radiology
    ix. Education
    x. Involved Physician(s)
    xi. CMO
3. All information generated as a result of the identification, investigation and analysis of a sentinel event is peer review/quality management information and is confidential and protected from discovery under Arkansas Law.
4. The Risk Manager is responsible for maintaining all documentation related to the root cause analysis of a sentinel event.

SOURCE

The Joint Commission Comprehensive Accreditation Manual for Hospitals (CAMH), *Update 1 July 2023,* CAMH E-dition, July 1, 2023.
National Quality Forum (NQF), *National Voluntary Consensus Standards for Public Reporting of Patient Safety Event Information: A Consensus Report*, NQF: Washington, DC; 2011.
Leapfrog Hospital Survey, *Never Events Policy Statement*, https://www.leapfroggroup.org/survey-materials/survey-and-cpoe-materials; April 2023.
National Quality Forum, *Serious Reportable Events aka Never Events*, http://www.qualityforum.org/Topics/SREs/Serious_Reportable_Events.aspx, 2023.
The Joint Commission Standards

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POLICY NUMBER:	**FAC034**
ORIGINAL DATE:	**NOVEMBER 2022**
TITLE:	**WORKPLACE VIOLENCE PREVENTION- CHI ST. VINCENT HOT SPRINGS**
KEYWORDS:	Workplace, Violence, Prevention

ACCOUNTABILITY:
Director, Security- Safety Officer
Director, Human Resources
President, Hospital

OBJECTIVES:
As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all. To fulfill this mission, CHI St. Vincent strives to ensure a safe environment for all co-workers, patients, and providers and prevent workplace violence.

POLICY:
It is the Policy of CHI St. Vincent Hot Springs (SVHS) to provide a work environment that is safe, secure and free from violence. CHI St Vincent Hot Springs is committed to providing a work environment that is safe, secure and free from violence by adopting a workplace violence prevention plan to protect patients, visitors, vendors, staff, volunteers, physicians and contract employees from aggressive and violent behavior, and establishing a process to investigate and take corrective action to address the violent behavior of an employee, up to and including termination of employment.

Acts or threats of physical violence, including but not limited to, coercion, intimidation, harassment, or destruction of property that involves or affects patients, visitors, vendors, staff, volunteers, physicians and contract employees of SVHS will not be tolerated.

The CHI St. Vincent Hot Springs Facilities ("Facility" is defined as CHI St. Vincent Hot Springs hospital, offsite centers, CHI St Vincent affiliated clinics and St. Vincent Hospital office buildings/property) understand that hospitalization and outpatient care environments are stressful for patients and their family members/visitors. The Facilities recognize and respect patient rights and are committed to responding appropriately to patient complaints about care. Actions and interactions related to disruptive behavior will include consideration of the patient's health care needs and psychosocial issues as well as the facility's obligations related to the safety of its employees, visitors, vendors and patients and responsible use of institutional resources.

Weapons, and other items that may be used as weapons, other than those required and approved in the course of assigned roles, responsibilities and duties are strictly prohibited within the facilities or property.

The Facility shall not take punitive or retaliatory action against an employee for, seeking assistance and intervention from local emergency services or law enforcement when they perceive that a violent incident has or will occur.

Ongoing conversations about workplace violence are encouraged by leadership in unit huddles and staff meetings. Discussions should include team leaders asking if any team members have been victims of physical or verbal abuse or if any patient/family situations may be prone to violence.

PROCEDURE:

A. Workplace Prevention Plan.

1. Develop and provide a system for responding to, and investigating violent incidents and situations involving violence or the risk of violence involving patients and/or family members.

a. An Emergency Mgmt. team meeting may be requested by any member of the medical team, employee and/or administrative team, Risk Mgmt., Security or designee on an ad hoc basis to evaluate threatening/unsafe situations involving patients. The Facility and outpatient care environments are to manage situations where disruptive behavior continues to escalate despite attempts at intervention. The team will continue to evaluate and develop a plan to address the behaviors. Possible plans for resolution may include:

i. Leadership and Risk Mgmt. (or designee) support for setting limits with patients and/or families.

ii. Team meeting with patient and/or family.

iii. Develop care/behavior modification plan.

iv. Discuss with the patient and/or family any of the applicable patient rights and responsibilities documents that reference rules and regulations affecting patient care and conduct.

v. If no resolution notify nurse manager (or designee) and Security or designee to discuss further action needed (i.e. restriction of visitation and/or discontinuation of care) in conjunction with the attending/primary physician.

b. Medically stable patient and/or family/caregiver refusing discharge.

i. Notify MD, Case Management and Nursing Supervisor.

ii. Security and/or designee may be required to escort through the hospital or care center. Law enforcement may also be required.

c. Violation of Drug & Alcohol Screening policy, Policy# HR-Policy-101

i. Follow procedures set forth in that specific policy.

2. For all potential work place violence events, utilize engineering controls wherever possible to remove a hazard from the workplace or create a barrier between the worker or other person at risk and the hazard including but not limited to: electronic access controls/locks to employee occupied areas; lighting; separate rooms or areas for high risk patients; removing/securing objects with weapon potential; closed circuit television monitoring.

3. Human Resources will follow the CHI St. Vincent background check policy and verification of licensure boards of prospective employees.

4. The Facility shall establish a system to identify patient specific risk factors such as the prior use of drugs or alcohol, psychiatric condition or diagnosis, any condition or disease that would cause confusion or disorientation, have a history of violence and/or who display disruptive behavior which may increase the likelihood or severity of a workplace violence incident and to assess visitors or other persons who display disruptive behavior or demonstrate a risk of committing workplace violence.

a. Patient specific risk factors may be communicated to receiving Facilities by paramedic and other emergency services or law enforcement prior to or upon arrival to the Facility.

B. Response to Actual or Suspected Workplace Violence:

1. Immediate Danger

a. If an emergency exists with the risk of imminent harm, the person shall:

i. Call Security Services. Methods for calling Facility/clinic/site Security or designee may include but is not limited to:

- Direct Security ext. 2323 or designee phone line(s)
- Direct 2-way radios, in areas where used.
- Desk/Fixed Panic Button, in areas where deployed/used.
- Initiate internal emergency codes or other designated alerts by calling switch board ext. 5555
- If outside of building or offsite call 9-1-1

b. If an emergency exists with an extreme level of threat (Combative Person, Active Shooter or threat by deadly weapon, etc.):

i. Call local Law Enforcement immediately by dialing 9-1-1 (from Red phone or cell phone) or 9-9-1-1 (from office/internal phone).

ii. Call Security or designee, using one of the methods described above in section (B.1.a.i).

iii. Take emergency steps to protect oneself from immediate harm, such as the run, hide, fight strategy.

c. Call Security Assistance, using one of the methods described above in section (b.1.a.i), when someone is, or is becoming, verbally aggressive, physically aggressive with a chair or other equipment of any kind. Call Security Alert if someone has a knife, gun, etc.
   i. Code- Security Alert- Active Shooter/Physical Assault, Policy# ON322PCS

d. Facilities operators shall call local Law Enforcement if Security or designee is not on-site by dialing 9-1-1 or 9-9-1-1, and take emergency steps to protect oneself from immediate harm, such as leaving the area.

2. Post-Incident Notification of Assault or Battery:

a. In situations not posing an imminent danger, employees shall immediately notify Security/management/house supervisor of any assaultive conduct so that appropriate action can be taken.

i. Employees responding to acts of aggression/assaultive behavior should utilize de-escalation techniques and defensive logistics.

ii. If self-defense is needed to handle a situation, the least amount of force should utilized.

iii. Assistance from fellow staff should be requested if needed and under certain circumstances leaving the area may be the best course of action.

b. Call Security or designee to inform of the incident and involve them in the initial securing of the area. If Security or designee is not available on site, call 911. At the earliest opportunity thereafter, notify the identified site security leadership of the incident.

c. Examine the workplace for security risk factors associated with the incident to protect employees from imminent hazards

immediately, and to take measures to protect employees from identified serious hazards within seven days of the discovery of the hazard, where there is a realistic possibility that death or serious physical harm could result from the hazard. If immediate resolution is not achievable, implement interim measures to abate the imminent or serious nature of the hazard while completing the permanent control measures.

This may include but is not limited to:

i. Any person who makes substantial threats, exhibits threatening behavior or engages in violent acts on the premises shall be removed from the property as quickly as safety permits, and may be asked to remain away from the premises pending the outcome of an investigation into the incident. SVHS Facilities reserve the right to respond to any actual or perceived acts of violence in a manner sufficient to address the event based on the specific facts and circumstances related to the event.

ii. Identify all employees involved in the incident.

iii. Any staff member assaulted or battered will be relieved of their duties immediately by management/designee while a statement of the incident and assessment of their injuries is completed.

iv. Provision of emergency medical care in the event of any violent act upon an employee.

v. Providing additional employee education/training.

vi. Relocation of a patient to another patient care unit, area or care center.

vii. Reassignment of a staff member.

viii. Assignment of a safety attendant (sitter) or assignment of additional security personnel.

ix. Post-event counseling or debriefing for those employees desiring such assistance.

x. Obtaining a restraining order as appropriate.

xi. Proactive security measures for the involved employee including special parking arrangements, escorts, and modifications to work location and shift.

xii. Post-incident debriefing as soon as possible after the incident with the injured employee, management, and Security or designee, if applicable, involved in the incident.

d. Management will notify Human Resources and Security Leadership of actual or suspected acts of workplace violence.

e. Management will notify Employee Health and facilitate the completion of an Employee IRIS report by the employee. Employees are also permitted to make these notifications directly.

3. Telephone Threats

a. Employees shall immediately inform management and security or designee or call law enforcement if they receive a threat over the telephone. The employee should note the time, date, and the threat was received and phone number of the caller if available.

b. If the threat involves and imminent act of violence, such as a bomb threat, report it **immediately** to Security or designee and activate a facility internal emergency.
   i. Code- Security Alert- Bomb Threat, Policy# ON321PCS

4. Written Threats

a. Employees shall immediately inform management and Security or designee of written threats, whether on paper, via electronic mail or social media

   i. Handle written material and any envelope as little as possible and only by the corners.

   ii. Place both the written material and the envelope in a larger envelope.

   iii. Note the names of anyone who may have handled the material after its arrival.

5. If an employee obtains a restraining order against another person, including another employee, the employee should inform management and Human Resources within a reasonable timeframe, and include a description of the

individual, a photograph, if available, and a copy of the restraining order.

a. A copy of the restraining order and photograph shall be filed with Human Resources and Security or designee.

b. Human Resources and Security or designee will review the situation and take the appropriate steps to ensure a safe environment for all employees.

6. If an employee identifies the unexpected arrival of an individual who has made prior threats, the employee shall inform management of this individual's arrival and notify security or designee if available and/or law enforcement.

C. Management Investigation

1. If the incident complaint is directed at a staff member:

a. The manager, together with Human Resources, will determine if the employee(s) who is the subject of an allegation of workplace violence should be placed on administrative leave pending investigation.

b. Human Resources shall conduct a thorough investigation which may include some or all of the following:

i. Complete a criminal background check on the individual regardless of any prior check being completed.

ii. Review the employee's personnel file, looking for any information that indicates a trend toward violence, and/or other pertinent facts.

iii. Interview all witnesses to the alleged act of violence, including appropriate employees from the work environment of the suspected employee.

2. Based upon the outcome of the investigation, management and Human Resources will determine the appropriate action to be taken, which may consist of corrective action up to and including termination of employment.

3. Employees who are determined to have intentionally falsely accused other of workplace violence may also be subject to corrective action, up to and including termination of employment.

4. Employee reports to supervisor any injury, no matter how small.

a. An injury is reported in IRIS and is filled out in detail by management

and employee.

b. Notification Reports and/or manager's Report (IRIS) form shall be completed on all employees when they have sustained an injury.

c. Completed IRIS reports are to be sent to Employee Health within 24 hours of incident.

D. Record Keeping/Handling

1. All actual or perceived threats of violence will be entered into the IRIS system.

2. All employee injuries resulting from workplace violence will be entered in the Workers' Compensation claims administration system.

a. Information about each incident will be based on information solicited from the employees who experienced the workplace violence.

b. Omit any element of personal identifying information sufficient to allow identification of the person involved in the violent incident, such as the person's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the person's identity.

3. Annual Review of IRIS Work Place Violence with annual security management plan

4. Evidence of annual education will be maintained for a minimum of one year.

5. Security reports are filed within the IRIS system.

E. Administrative Oversight

1. Emergency Mgmt. team shall annually assess and improve upon factors that may contribute to or help prevent workplace violence, including, but not limited to, the following:

a. Security risk assessment to identify locations and situations where violent incidents are more likely to occur.

b. Review and evaluate workplace violence incidents which results in a serious injury or fatality.

c. Staffing, including staffing patterns and patient classification systems

that contribute to, or are insufficient to address, the risk of violence.

d. Sufficiency of security systems, including alarms, emergency response, and security personnel availability.

e. Security risks associated with specific units, areas of the facility with:

- Uncontrolled access
- Late-night or early morning shifts
- Employee security in areas surrounding the facility such as employee parking areas, poor illumination or blocked visibility, lack of physical barriers or effective escape routs
- Obstacles and impediments to accessing alarm systems and/or where alarm systems are not operational
- Presence of furnishings or any objects that could be used as weapons
- Storage of high-value items, currency, or pharmaceuticals

f. Update the Plan whenever necessary as follows:

- Review and respond to information indicating that the Plan is deficient in any area
- To reflect new or modified tasks and procedures which may affect how the Plan is implemented (i.e. changes in staffing, engineering controls, construction, modification of the facility, evacuation procedures, alarm systems and emergency response)
- Include newly recognized workplace violence hazards

2. Consult (individually, in groups or in committee) with affected employees, recognized collective bargaining agents (if applicable) in the development/revision of the workplace prevention plan as appropriate.

3. The Emergency Mgmt (EM) team members may include but not be limited to:

- Safety Officer
- Regulatory
- Risk Mgmt
- Emergency Department
- Facilities
- Security
- Senior Leader

4. Regularly distribute these workplace violence reports/summaries throughout the organization, including to Quality/Risk and up to the executive and

governance levels.

F. Education and Training – training will be provided to employees that address the workplace violence risks they are reasonably anticipated to encounter in their jobs.

1. Employees, including Security, will receive Tier 1 awareness training on workplace violence when newly hired.

2. The education and training shall cover topics that include, but are not limited to, the following:
   a. How to recognize potential for violence, factors contributing to the escalation of violence and how to counteract them, and when and how to seek assistance to prevent or respond to violence.

   b. Strategies to avoid physical harm including Run, Hide, Fight.

   c. How to recognize and respond to alert, alarms, or other warnings about emergency conditions (i.e. active shooter-Run, Hide, Fight), and how to use identified escape routes or locations for sheltering as applicable.

   d. How to communicate concerns about workplace violence without fear of reprisal.

   e. How to report violent threats to law enforcement.

   f. Any resources available to employees for coping with incidents and situations involving violence or the risk of violence.

   g. An opportunity for interactive questions and answers with a person knowledgeable about the workplace violence prevention plan.

   h. Training not given in person shall provide for interactive questions to be answered within one business day by a person knowledgeable about the workplace prevention plan.

   i. The role of private security personnel, if applicable.

3. Employees assigned to respond to alarms or other notifications of violent incidents receive additional training:

   a. Verbal intervention and de-escalation techniques and physical maneuvers to defuse and prevent violent behavior.

   b. Appropriate and inappropriate use of medications as chemical restraints.

4. All training must be documented and maintained in the employee's education training file for a minimum of one year.

5. Employees performing patient contact activities and those employees' supervisors shall be provided refresher training at least annually, applicable to those employees to review topics included in the initial training as well as the results of the annual workplace violence prevention plan effectiveness reviews.

G. Notifications to Law Enforcement and Regulatory Agencies

1. Applicable notifications will be made to law enforcement or The Joint Commission by the Quality (or designee) Management Department in conjunction with Security.

DEFINITIONS:

Assault: Assault is an unlawful attempt, coupled with a present ability, to commit a violent injury on the person of another.

Battery: Battery is any willful and unlawful use of force or violence upon the person of another.

Injury: A fatality or an injury that requires inpatient hospitalization for a period in excess of 24 hours for other than medical observation or in which an employee suffers a loss of any member of the body or suffers any serious degree of permanent disfigurement.

Urgent or emergent threat to the welfare, health, or safety of hospital personnel: Hospital personnel are exposed to a realistic possibility of death of serious physical harm.

Coercion: The practice of persuading someone to do something by using force or threats.

Intimidation: To frighten or threaten someone, usually in order to persuade the person to do something he or she does not want to do.

Harassment: The act of systematic and/or continued unwanted and annoying actions of one party or a group, including threats and demands.

Patient Contact: Providing a patient with treatment, observation, comfort, direct assistance, bedside evaluations, office evaluations, and any other action that involves or allows direct physical contact with the patient.

Threats or Acts of Violence: "Threat of violence" means a statement or conduct that causes a person to fear for his or her safety because there is a reasonable possibility the person might be physically injured, and that serves no legitimate purpose.

Workplace Violence: "Workplace violence" means any act of violence or threat of violence that occurs at the work site. The term workplace violence shall not include lawful acts of self-

defense or defense of others. Workplace violence includes the following:

A. The threat of use of physical force against an employee or other person at the Facility that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee or person sustains an injury;

B. An incident involving the threat or use of a firearm or dangerous weapon, including the use of common objects as weapons, regardless of whether the employee or other person sustains an injury;

C. Four workplace violence types:

1. "Type 1 violence" means workplace violence committed by a person who has no legitimate business at the work site, and includes violent acts by anyone who enters the workplace with the intent to commit a crime.

2. "Type 2 violence" means workplace directed at employees by customers, clients, patients, students, inmates, or visitors or other individuals accompanying a patient.

3. "Type 3 violence" means workplace violence against an employee by a present or former employee, supervisor, or manager.

4. "Type 4 violence" means workplace violence committed in the workplace by someone who does not work there, but has or is known to have had a personal relationship with an employee.

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CHI St. Vincent

POLICY NUMBER	**ON148PCS**
ORIGINAL DATE:	**March 2001**
TITLE:	**MEDICATION SAFETY**
KEYWORDS:	Near Miss; Medication Errors; IRIS

ACCOUNTABILITY:
SVP & Chief Nursing Officer
Regional Senior Director of Pharmacy

OBJECTIVES:

The Mission of Catholic Health Initiatives is to nurture the healing ministry of the Church, supported by education and research. Fidelity to the Gospel urges us to emphasize human dignity and social justice as we create healthier communities. To fulfill this mission, CHI St. Vincent will establish procedures for handling medication errors and the subsequent analysis of those errors to improve the safety of the medication use process.

DEFINITIONS:

Medication Error - Any preventable event that may cause or lead to inappropriate medication use or patient harm. This may include prescribing, order communication, product labeling, packaging and nomenclature, compounding, dispensing, distribution, education, monitoring, and administration errors.

Potential Medication Error ("Near Miss" or "Good Catch") – An error process that is stopped or interrupted before it reaches the patient either by chance or through a check-and-balance in the medication-use process, such as recognition of the problem and intervention by an experienced practitioner.

Medication Safety Committee (MSC) – An interprofessional committee established at CHI SVI/SVN/SVM to provide a team-based diverse, multidisciplinary group of healthcare professionals to promote the highest standards related to the safe and effective use of medications and focus on proactive solutions to quality and safety issues. The committee acts as a source of medication safety expertise, providing a platform for collaboration in which to identify and prioritize medication safety issues and develop risk-reduction strategies to improve medication safety within the medication use process. The MSC reports to the Pharmacy & Therapeutics (P&T) Committee at CHI SVI/SVN/SVM. The P&T Committee carries out the functions of the MSC at CHI SVHS.

POLICY:

I. It is the responsibility of health care professionals to report all actual and potential medication errors.

A. The medication error reporting process shall be initiated by the health care professional who discovers the error.

B. This information will be used to take immediate action, when necessary, to minimize patient harm. Information gathering and follow-up will be positive, proactive and non-punitive to facilitate improvement in all aspects of medication administration.

C. Actual Medication Error:

1. Contact the physician.
2. Notify the Department Manager/House Supervisor or charge nurse.
3. Notify the pharmacist in charge for assistance when needed.
4. Documentation requirements:
    a. Document notification of provider in the EHR.
    b. For errors involving ordered medications, document details on the eMAR to indicate what was actually administered (e.g. actual dose, route, form, time, etc.).
    c. For errors involving medications that were not ordered, document all relevant information related to the medication event including drug, dose, route, form, and time of medication administered in error on the provider notification document or in a separate event note.
    d. For errors involving medications that were charted but not administered, unchart the dose(s) involved and utilize the steps above to document details related to the medication event in the EHR.
5. Report the incident using the electronic incident reporting system. (Refer to "Incident Reporting Information System" policy)
6. Refer to Sentinel Event Reporting and Follow-Up policy to determine events that should be reported as sentinel events.

D. Potential Medication Error ("Near Miss"): Patient care staff members who discover a potential error should report the incident using the electronic incident reporting system indicating that the error did not reach the patient.

II. Medication Error Review/Analysis:

A. Medication errors reported in the incident reporting system will be reviewed by the manager of the area involved in the error, the Director of Risk Management or designee, and the Medication Safety Officer, Director of Pharmacy, or pharmacy designee.

B. Managers for the involved areas will:

1. **Verify the physician was informed of the error and patient response.**
2. Analyze the error to evaluate process errors and determine if corrective action is needed or opportunity for system changes or education exists. (Refer to "Just Culture Algorithm")
3. Add comments to the incident report when appropriate to provide specifics related to the incident and document any action taken.
4. Close out the report when the incident has been resolved.

C. Medication Safety Officer, Director of Pharmacy, or pharmacy designee will:

1. Analyze each incident and add comments to the incident report when appropriate.

2. Will categorize each report into one of the following severity levels:

(A) Circumstances or events that have the capacity to cause error.
(B) An error occurred but the error did not reach the patient.
(C) An error occurred that reached the patient but did not cause patient harm.
(D) An error occurred that reached the patient and required monitoring to confirm that it resulted in no harm and/or required intervention to preclude harm.
(E) An error occurred that may have contributed to or resulted in temporary harm and required intervention.
(F) An error occurred that may have contributed to or resulted in temporary harm and required initial or prolonged hospitalization.
(G) An error occurred that may have contributed to or resulted in permanent patient harm.
(H) An error occurred that required intervention necessary to sustain life.
(I) An error occurred that may have contributed to or resulted in patient death.

3. Will, in collaboration with MSC, P&T, and pharmacy leadership, evaluate the medication system, based on the findings of the reported errors to determine if system changes can be implemented to improve safety.

4. Will generate reports from the electronic incident reporting system that can be analyzed by MSC for any identifiable trends. Noted trends and a summary of medication error severities will be reviewed by the P&T Committee at least quarterly.

5. Will coordinate with the Medication Safety Committee and/or P&T Committee to take proactive steps to prevent future errors by reviewing trends, *ISMP Medication Safety Alert* bulletins, medication safety related articles in the medical literature, and potentially high-risk formulary additions.

SOURCES:

Table 6: Categories of Medication Error Classification. Content last reviewed August 2012. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/match/matchtab6.html

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