GARFIELD PARK
BEHAVIORAL HOSPITAL

HARTGROVE
BEHAVIORAL HEALTH SYSTEM

Personal Information

Full Name: _____
Last First Middle

Address: _____
Street Address Apartment/Unit

_____
City State Zip Code

_____
County Country

Preferred Phone: (____)_____ Email: _____

Birth Date: _____ Social Security Number: _____

Job Information

Position Title: _____ Start Date: _____

Supervisor: _____ Department/Unit: _____

Emergency Contact Information

Full Name: _____
Last First Middle

Address: _____
Street Address Apartment/Unit

_____
City State Zip Code

Preferred Phone: (____)_____ Relationship: _____

Emergency Medical Information

Physician's Name: _____
Last First Middle

Address: _____
Street Address Apartment/Unit

_____
City State Zip Code

Preferred Phone: (____)_____

Parking & Vehicle Information

All Garfield Park Hospital/Hartgrove Behavioral Health System employees, students, and contractors/partners are expected to provide the below details related to his/her vehicle as well as update this information (should the vehicle change) during his/her tenure with the organization. The purpose of this information is for the Hospital to be able to easily identify the above mentioned individual's vehicle on Hospital property.

Vehicle/s – YES or NO

First & Last Name:_____

Vehicle Make:_____

Vehicle Model:_____

Vehicle Color:_____

Vehicle License Plate/State:_____

Vehicle Make:_____

Vehicle Model:_____

Vehicle Color:_____

Vehicle License Plate/State:_____

Contact Number: _____

I agree and confirm the above information I provided is current and accurate.

Signature/Date:_____

CFS 689
Rev 7/2012

State of Illinois
Department of Children and Family Services

AUTHORIZATION FOR BACKGROUND CHECK

Child Abuse and Neglect Tracking System (CANTS)

For Programs NOT Licensed by DCFS

NOTE: Do not use this form if you are an applicant for licensure or an employee/volunteer of a licensed child care facility. Please contact your licensing representative.

Name: _____
Last First Middle

Date of Birth: ☐ -- ☐ -- ☐ Gender: ☐ Male ☐ Female Race: _____

Current Address: _____
Street/Apt #

_____
City State Zip Code

If you currently reside in Illinois, please list all previous addresses for the past five years.
OR
If you currently reside out-of-state, please provide ALL Illinois addresses in which you did reside while living in Illinois.

(Street/Apt#/City/County/State/Zip Code)	Dates From/To

List maiden name and/or all other names by which you have been known: (last, first, middle)

I hereby authorize the Illinois Department of Children and Family Services to conduct a search of the Child Abuse and Neglect Tracking system (CANTS) to determine whether I have been a perpetrator of an indicated incident of child abuse and/or neglect or involved in a pending investigation. I further consent to the release of this information to the agency listed below.

_____
Signed Date

Submit by mail OR fax OR email.
Mail to: Department of Children and Family Services
406 E. Monroe – Station # 30
Springfield, IL 62701
FAX to: 217-782-3991
Scan/Email to: CFS689Background@illinois.gov

Please type, use bold letters or label:

773-413-1700 (Submitting Agency Fax Number)
aminat.kolawole@uhsinc.com (Submitting Email Address)

Hartgrove Behavioral Health System (Agency Name)
Aminat Kolawole (Contact Person)
5730 West Roosevelt Road (Address)
Chicago, IL 60644 (City/State/Zip)

Print Form

GARFIELD PARK BEHAVIORAL HOSPITAL

HARTGROVE

BACKGROUND CHECK PERMISSION

In connection with application for employment with Garfield Park Hospital and/or Hartgrove Behavioral Health System (the "Hospital"), I hereby agree as follows:

1. GENERAL CONSENT TO BACKGROUND INVESTIGATION

As a condition of Hospital's consideration of my employment I give permission to Hospital to investigate my personal and employment history. I understand that this background investigation will include, but not limited to, verification of all information on my employment application.

2. CONSENT TO CONTACT PAST EMPLOYERS

I specifically give permission to Hospital to contact all of my prior employees for references. I further give permission to all current or previous employers and/or managers or supervisors to discuss my relevant personal and employment history with Hospital, consent to release of such information orally or in writing, and hereby release them from all liability and agreement not to sue them for defamation or other claims based upon any statements they make to any representative of Hospital. I further waive all rights I may have under law to receive a copy of any written statement provided by any of my former employers to Hospital. I further agree to indemnify all past employers of any liability they may incur because of their reliance upon this agreement.

3. CONSENT TO CONTACT GOVERNMENT AGENCIES

I further fiver permission to the Hospital to receive copy of any information obtained in the file of any federal, state or local court or government agency concerning or relating to me. I further consent to the release if such information and waive and right under law concerning notification of the request for a release of such information. In the event a law does not provide for prospective employers to have access to information. I hereby delegate Hospital as my agent for receipt of information. I understand the scope of this investigation will be limited as required by law.

4. COOPERATION WITH INVESTIGATION

I agree to fully cooperate in Hospital's background investigation and sign any waiver or releases that may be necessary or desirable to obtain access to relevant information. In the event that any former employer or federal, state, or local government agency will not release reference information or criminal history information directly to the employer, I agree to personally request such information to the extent permitted by law.

5. MISCELLANEOUS

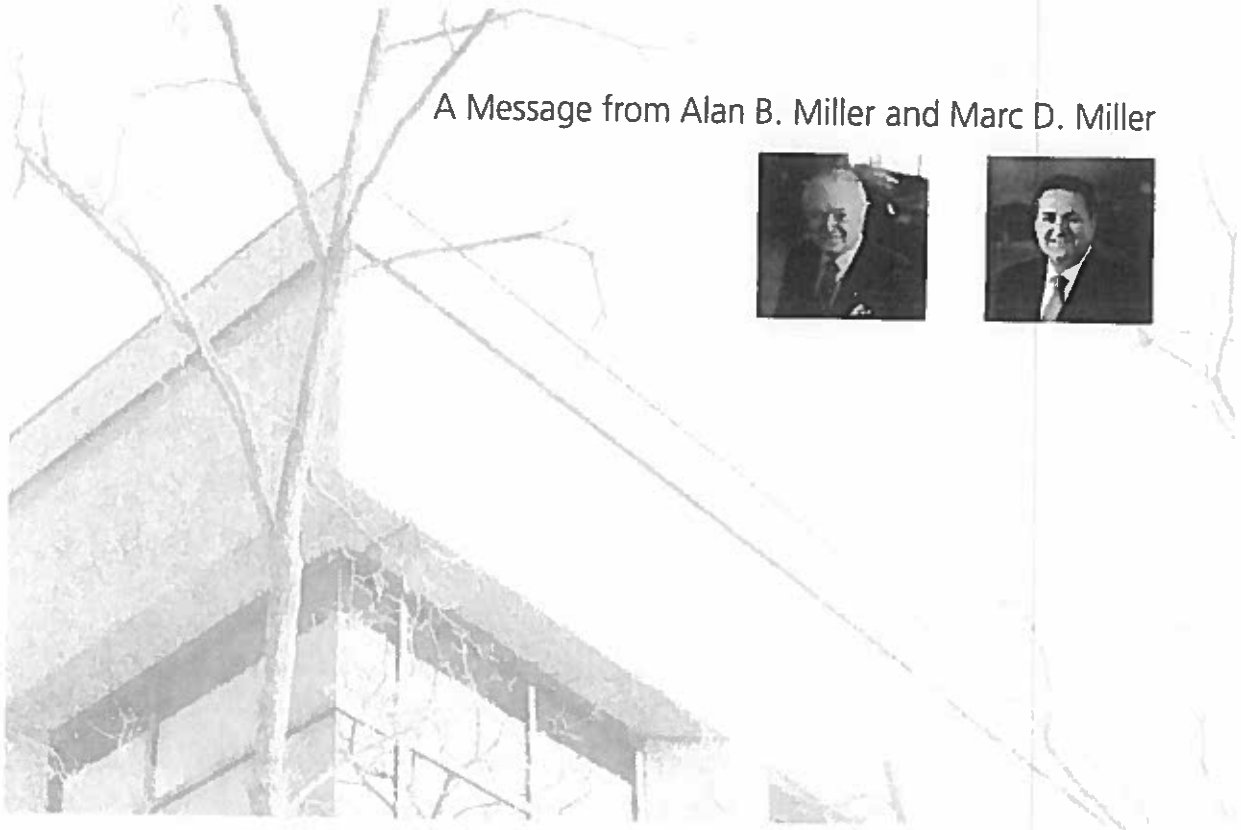
This agreement represents the entire understanding and agreement relating to its subject matter. The Hospital shall be entitled fully to rely on this agreement. I understand that I have no guarantee of employment and that the Hospital may determine not to hire me for my lawful reason.

_____	_____	_____
Printed Name	Signature	Date

UHS CODE OF CONDUCT

Our commitment to ethical conduct and compliance depends on all UHS personnel.

If you find yourself in an ethical dilemma or suspect inappropriate or illegal conduct, discuss it with your supervisor or use the reporting process in this Code of Conduct, including the Compliance Hotline (toll free at **1-800-852-3449**) or internet-based reporting at **www.uhs.alertline.com**



A Message from Alan B. Miller and Marc D. Miller

Ethics and accountability are central to the core values and mission of UHS. Our patients and their families put their trust in us, as do our personnel, clinicians, vendors, business partners, investors and others, including the communities we serve. We share the important responsibility to continuously strive to achieve the highest standards of ethical conduct.

The Board of Directors and senior management of UHS are committed to compliance and ethical behavior. UHS has written this Code of Conduct to provide guidance on expectations for acceptable behavior for those who work on behalf of UHS. It provides a broad overview of compliance concepts and builds on the Code of Business Conduct and Corporate Standards, the UHS Compliance Manual, as well as the policies and procedures of our Compliance Program.

The Code of Conduct is one of the most important communications you will ever receive. It is the cornerstone of all UHS practices. You will need to read it from cover to cover. We expect you to understand and follow the Code of Conduct and help to make sure others do as well. Although no single document can provide all the answers, the Code of Conduct is a valuable resource designed to give guidance on where to turn if you see any inappropriate or unethical conduct or decisions being made.

Lead by example, ask questions if you don't know the answer, and report any problems or concerns about inappropriate or unethical actions. You can go to your supervisor, to management, to your facility compliance officer, UHS Compliance Office, or use other avenues described in this document, including the toll-free Compliance Hotline (**1-800-852-3449**) or via the internet at **www.uhs.alertline.com**. UHS will not retaliate or tolerate any retaliation against you for reporting in good faith.

If we work together, we can achieve our goals — a work environment that puts patient care first and fosters service excellence, compassion, and the ethical and fair treatment of all.

Sincerely,

Alan B. Miller
Chairman and
Chief Executive Officer

Marc D. Miller
President

Introduction

UHS is dedicated to adhering to the highest ethical standards. Common sense, good business judgment, ethical personal behavior, as well as compliance with applicable laws, policies and procedures are what we expect from all UHS personnel. The Code of Conduct details the fundamental principles, values and framework for action within the organization. It is intended to deter wrongdoing and promote:

- Honest and ethical conduct
- Compliance with all applicable governmental laws, rules and regulations
- Prompt internal reporting of violations and compliance concerns

The Code of Conduct is intended to provide a general overview of basic compliance concepts and to give guidance on acceptable behavior for UHS personnel, including all those who work on behalf of UHS — our personnel, vendors, physicians, and others affiliated with us or doing business in UHS facilities or offices. The Code of Conduct is not intended to fully describe the laws that apply to personnel or to detail company policies and procedures. An expanded overview of the UHS Compliance Program is provided in the UHS Compliance Manual, available from your supervisor, human resources department, compliance officer, the UHS Compliance Office, or on our company website at **www.uhsinc.com**. Personnel are also required to follow the standards governing business conduct in the Code of Business Conduct and Corporate Standards, available online at **www.uhsinc.com/corporategovernance1.php**.

Mission Statement

UHS is committed to providing superior quality healthcare services that patients recommend to families and friends, physicians prefer for their patients, purchasers select for their clients, personnel are proud of, and investors seek for long-term results. We will realize this vision through our commitment to the following principles:

Service Excellence:
We will provide timely, professional, effective and efficient service to all of our customer groups.

Continuous Improvement in Measurable Ways:
We will identify the key needs of our customers, assess how well we meet those needs, continuously improve our services, and measure our progress.

Employee Development:
We understand that the professionalism and drive of our people are the most important factors in the quality of the service UHS provides. We will hire talented people, increase their skills through training and experience, and provide opportunities for personal and professional growth within the company.

Ethical and Fair Treatment of All:
We are committed to forming relationships of fairness and trust with our patients, the physicians, purchasers of our services, and our personnel. We will conduct our business according to the highest ethical standards.

Teamwork:
We will work together to provide ever-improving customer service. This team approach to our work will supersede traditional departmental organization and create a true customer focus. People at all levels of the organization will participate in decision-making and process improvement.

Compassion:
We will never lose sight of the fact that we provide care and comfort to people in need. The patients and families who rely upon us are fellow human beings, and they will receive respectful and dignified treatment from all of our people at all times.

Innovation in Service Delivery:
We will invest in the development of new and better ways of delivering our services.

Patient Care

UHS is committed to providing high-quality patient care in the communities we serve, and advocates a responsive management style and a patient-first philosophy based on integrity and competence. We treat our patients with respect and dignity, providing high-quality, compassionate care in a clean, safe environment.

The Code of Conduct applies to all UHS personnel, including those who work on behalf of UHS — personnel, vendors, healthcare professionals, and all other personnel affiliated with UHS or doing business in our facilities and offices.

Healthcare Professionals:

The Code of Conduct applies to healthcare professionals who work with or are affiliated with UHS facilities. In addition to the guidelines set forth in the Code of Conduct, healthcare professionals are expected to carry all required licenses and follow the ethical and professional standards dictated by their respective professional organizations and licensing boards.

Leadership Responsibilities:

We expect our leaders to set the example — to be in every respect a role model. Our leaders should help to create a culture that promotes the highest standards of ethics and compliance. We must never sacrifice ethical and compliant behavior in the pursuit of business objectives.

Compliance

UHS is committed to full compliance and expects its personnel to obey all applicable state, federal and local laws, to comply with UHS and facility policies and procedures, and to follow the guidelines in this Code of Conduct. Compliance will be an important aspect of performance evaluations. A violation of this Code of Conduct, UHS or facility policies and procedures, or any law or regulation will be handled through normal disciplinary procedures, and may lead to serious disciplinary action, up to and including immediate termination.

UHS and Facility Policies and Procedures:

UHS personnel are required to understand and follow all policies and procedures that apply to their work at UHS. If anyone has a question about the applicable legal, policy or procedural requirements, they should ask their supervisor. The UHS Compliance Program policies and procedures are available on the web at www.uhsinc.com or by contacting the applicable Facility Compliance Officer or the UHS Compliance Office.

Code of Business Conduct and Corporate Standards:

UHS personnel are expected to perform their duties in good faith to the best of their ability and not engage in any illegal, unfair or deceptive conduct relating to business practices, conforming with the standards for business conduct set forth in the Code of Business Conduct and Corporate Standards, available through the applicable human resources department or online at www.uhsinc.com/corporategovernance1.php.

Laws and Regulations:

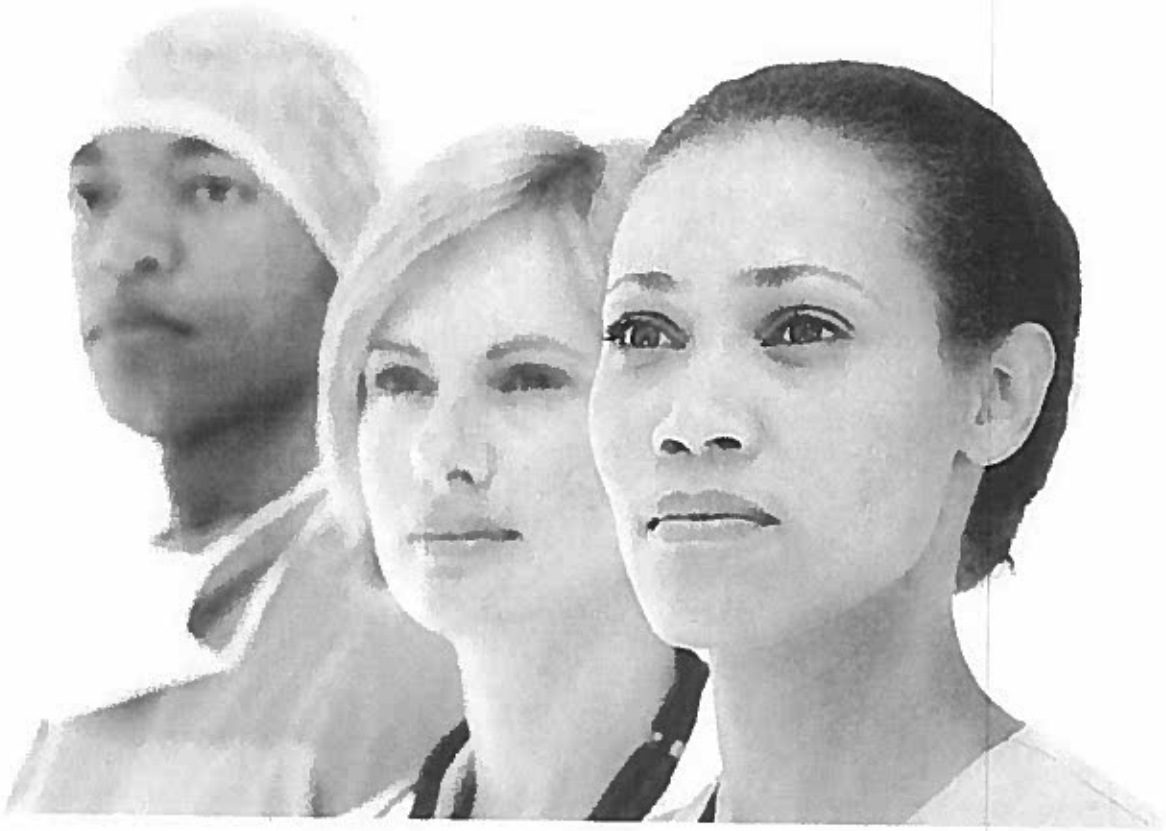
UHS expects its personnel to fully comply with all applicable laws and regulations federal, state, and local. Failure to comply with legal requirements can lead to serious disciplinary action, up to and including immediate termination. Key healthcare compliance laws which are addressed in more detail in the UHS Compliance Manual include the following:

The physician self-referral law, known as the Stark Law, which prohibits hospitals from submitting any claim for certain services called designated health services if the referral comes from a physician with whom the hospital has a prohibited financial relationship.

The Federal anti-kickback statute and similar state statutes, which prohibit payments (direct or indirect) made to induce or reward the referral or generation of government healthcare program business.

The Emergency Medical Treatment and Labor Act (EMTALA), which contains requirements for the evaluation and treatment of emergency patients.

Laws authorizing the Office of Inspector General (OIG) to exclude healthcare providers from participation in federal healthcare programs that provide unnecessary or substandard items or services provided to any patient.



Privacy and security laws and regulations that protect patient information, including protected health information (PHI) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009.

Federal and state false claims statutes and whistleblower protections that serve a key role in preventing and detecting fraud, waste, and abuse in the federal healthcare programs.

Coding and Billing Integrity:

All billing practices as well as the preparation and filing of cost reports must comply with all federal and state laws and regulations as well as UHS and facility policies and procedures. Personnel will assist UHS in identifying and appropriately resolving any coding and billing issues or concerns. UHS will refund overpayments made by a federal healthcare program or other payers in accordance with applicable law.

Relationships with Federal Healthcare Beneficiaries:

Federal fraud and abuse laws prohibit offering or providing inducements to beneficiaries in government healthcare programs and authorize the OIG to impose civil money penalties (CMPs) for these violations. Government healthcare programs include Medicare, Medicaid, Veterans Administration and other programs. UHS personnel may not offer valuable items or services to these patients to attract their business (including gifts, gratuities, certain cost-sharing waivers, and other things of value).

Fraud and Abuse, the False Claims Act and Whistleblower Protections:

UHS intends to fully comply with the federal False Claims Act (FCA) and any similar state laws that fight fraud and abuse in government healthcare programs. The FCA contains a qui tam or whistleblower provision, which permits a private person with knowledge of a false claim for reimbursement by a government agency to file a lawsuit on behalf of the U.S. government. In addition, there are individual state laws providing that persons who report fraud and abuse by participating healthcare providers in the Medicaid Program may be entitled to a portion of the recovery. Under both the FCA and similar state laws, there are protections against retaliation.

Ineligible Persons, Excluded Individuals and Entities:

UHS does not do business with, hire, or bill for services rendered by excluded or debarred individuals or entities. UHS personnel must report to their supervisor or human resources department immediately if they become excluded, debarred or ineligible to participate in any government healthcare program, or become aware that anyone doing business with or providing services for UHS has become excluded, debarred or ineligible.

Monitoring and Investigation:

UHS is committed to monitoring and investigating compliance concerns relating to laws, regulations and/or UHS or facility policies. When a violation is substantiated, UHS will initiate corrective action including, as appropriate, resolving overpayments, making required notifications to government agencies, implementing systemic changes to prevent recurrences, and instituting disciplinary action.

Medical Records

UHS strives to ensure facility medical records are accurate and to provide information that documents the treatment provided and supports the claims submitted. Tampering with or falsifying medical records, financial documents or other business records of UHS will not be tolerated. The confidentiality of patient records and information must be maintained in accordance with privacy and security laws and regulations that protect patient information, including protected health information (PHI) under HIPAA and HITECH and applicable state laws.

Employment

UHS promotes diversity and strives to provide a workplace environment that is in full compliance with all applicable employment-related laws as well as UHS and facility policies and procedures. It is UHS policy to provide equal employment opportunities to all personnel, prospective and current, without regard to race, color, religion, sex, age, national origin, marital status, disability, or veteran status, and UHS will do its best to make reasonable accommodations for known disabilities. UHS personnel who have questions concerning or are aware of any breach of the Equal Employment Opportunity (EEO) guidelines, should contact the applicable human resources department. UHS prohibits workplace violence, threats of harm, and harassment of its personnel of any kind.

Environment and Workplace Safety

UHS expects its personnel to obey all state, federal and local environmental and workplace safety laws, regulations and rules, including those promulgated by the Environmental Protection Agency and the Occupational Safety and Health Administration (OSHA).

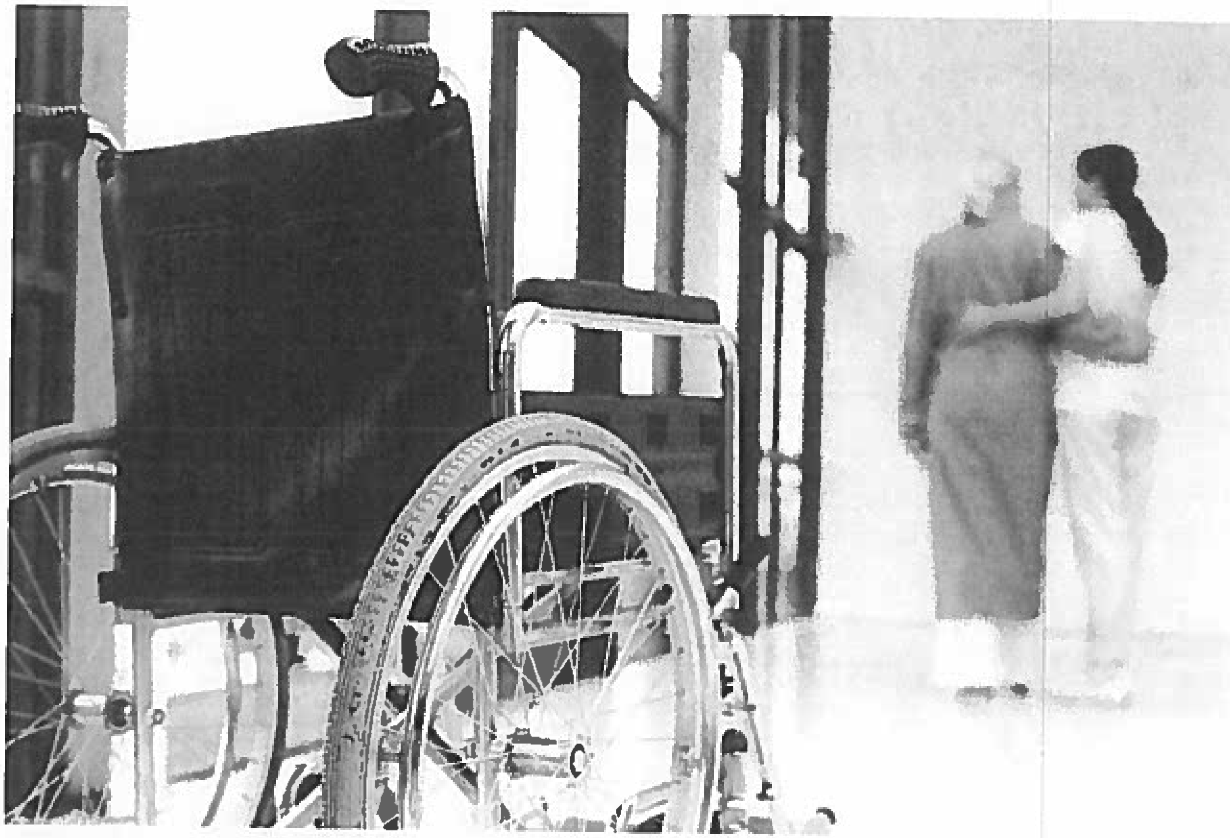
Reporting Suspected Wrongdoing

UHS is committed to complying with all applicable laws and regulations, including those designed to prevent and deter fraud, waste and abuse. UHS personnel with knowledge of or who in good faith, suspect any wrongdoing are expected to promptly report the matter, using one of the processes described below.

There are many ways to report suspected improper conduct. In most cases, concerns should be brought to the attention of a supervisor first. If this does not result in appropriate action, or if personnel are uncomfortable discussing these issues with their supervisors, they can use one or more of the other reporting methods described below:

- Report to an immediate supervisor, manager, risk manager, Facility Compliance Officer, applicable Human Resource Director, or the UHS Compliance Office.
- Use the toll-free Compliance Hotline (**1-800-852-3449**) or via the internet at **www.uhs.alertline.com** — these reports may be made anonymously.

Self-reporting is encouraged — anyone who reports their own wrongdoing or violation of law will be given due consideration in potential mitigation of any disciplinary action. Retaliation in any form against anyone who makes a good faith report of actual or suspected wrongdoing or cooperates in an investigation is strictly prohibited. Anyone who feels that they have been retaliated against should report this immediately, using any of the methods described above.



The UHS commitment to compliance and ethical conduct depends on all personnel. Should you find yourself in an ethical dilemma or suspect inappropriate or illegal conduct, remember the internal processes that are available for guidance or reporting, including reporting to your supervisor or using the toll-free compliance hotline at **1-800-852-3449** or via the internet at **www.uhs.alertline.com**

Any reference in this Code of Conduct to "UHS personnel" [illegible] [illegible] [illegible] Universal Health Services, Inc., including UHS of Delaware, Inc.

ACKNOWLEDGEMENT AND AGREEMENT TO COMPLY WITH THE UHS CODE OF CONDUCT

Name: _____

Department: _____

Facility: _____

Title: _____

I certify that I have completed the UHS Code of Conduct Training and agree to abide by the UHS Code of Conduct during the term of my employment. I acknowledge that I have a duty to report any alleged or suspected violation of the UHS Code of Conduct.

I certify that I will promptly report any potential violation of which I become aware. I understand that any violation of the UHS Compliance Program, the Code of Conduct, or any relevant policy or procedure may subject me to disciplinary action, up to and including discharge from employment.

Today's Date: _____

Signature: _____

Print Name: _____

GARFIELD PARK BEHAVIORAL HOSPITAL

HARTGROVE BEHAVIORAL HEALTH SYSTEM

CODE OF CONDUCT

To promote our strong dedication and commitment to providing excellence in behavioral health services and to promote our Vision of being the Premier Provider of Behavioral Health Services, this organization has established guidelines for appropriate professional conduct and appearance for its employees, medical staff, and students. In order to maintain a safe, secure, therapeutic and processional environment:

ALWAYS:

1. Provide the highest standards of Service Excellence: Do unto others as they would have you do unto them. (Platinum Rule)
2. Focus of safety, security and quality of care – safety is our number ONE priority!
3. Create a positive lasting impression for our patients, families, guests and each other
4. Promote a professional, empathic, compassionate, therapeutic and engaging environment
5. Dress professionally to promote a professional demeanor and environment
6. Treat every patient with the utmost dignity and respect, while providing for their care, welfare, safety, and security
7. Demonstrate Service Excellence with saying, "It's my pleasure," "Not a problem," "Sure," "Absolutely," for any requests made from our patients.
8. Anticipate our guests' needs and always attempt to exceed their expectations
9. Answer phones by introducing the hospital, unit you are working, your first name, and ask how you can help.
10. Extend a welcome or an acknowledgement to all guests and towards each other in passing
11. Practice service recovery so that our patients/guests have a positive experience – always try to turn a negative situation into a positive outcome
12. Provide Constant Observations and be compliant with required documentation
13. Attempt to verbally deescalate an agitated patient, without physical confrontation
14. Use physical restraints as an absolute last resort and for the shortest duration possible
15. Wear ID badges at chest level for easy identification
16. Make every effort to conceal personal tattoos. Be a role-model for our patients/families
17. Protect patients' confidentiality (HIPAA Compliance). Avoid talking about patients' personal health information in hearing range of other patients/guests. For confidentiality purposes, when someone calls in requesting patient information, always ask for the PIN
18. Wear closed toe shoes and appropriate attire in all clinical areas

NEVER:

19. Use vulgarity or raise your voice. Don't ever yell down hallways or at patients
20. Wear clothing with advertisements, slogans and/or other potentially offensive material
21. Use cell phones or other electronic devices in patient care areas; focus on the patients
22. Wear denim, except on designated days or when approved by administration
23. Wear buttoned, untucked shirts unless it is a box or square cut (male identifying staff)
24. Wear a T-shirt, unless provided by the hospital (collared shirts for male identifying staff)
25. Wear shorts, skirts above the knees, tight, shear, or ill-fitted clothing, sweats/jogging suits

ALWAYS REMEMBER TO SMILE
YOU NEVER GET A SECOND CHANGE TO MAKE A LASTING IMPRESSION!

There is ZERO TOLERANCE for a lack of Professionalism or for failing to treat everyone with the utmost of dignity and respect, at all times!

GARFIELD PARK BEHAVIORAL HOSPITAL

HARTGROVE BEHAVIORAL HEALTH SYSTEM

Attestation Statement for Code of Conduct

I have received a copy of, reviewed and fully understand Code of Conduct and my signature attests my commitment to providing the highest quality care in the most safe and secure way, while creating the most positive lasting impression. Failure to do so will have a negative impact on my job performance evaluation(s) or may lead to termination.

This is not an attempt to provide a comprehensive list of our rules, policies or guidelines; rather it is a brief list of some of the most basic but important rules and expectations that everyone should be aware of and expected to comply with at all times. It is the ultimate responsibility of every employee to be familiar with the organizations policies and procedures for which you are held responsible. Every unit has a policy and procedure manual readily available for review. Per our policy, any employee violating policies and procedures could be disciplined, up to and including termination. Please see your supervisor or the Human Resources Department, if you have any questions, concerns or need further clarification.

By way of your signature, you understand that the organization has Zero Tolerance for any behavior, attitude or conduct that is less than professional, rude, insensitive, judgmental, or disrespectful. Every representative is expected to treat every patient, family member, visitor and each other with consummate professionalism, dignity and respect. Nothing less will be tolerated with immediate consequences up to and including termination.

Employee's Printed Name: _____

Employee's Signature: _____ Date: _____

GARFIELD PARK BEHAVIORAL HOSPITAL

HARTGROVE BEHAVIORAL HEALTH SYSTEM

Code of Ethics

Based on the mission, vision, and values statements of Hartgrove Behavioral Health System and/or Garfield Park Behavioral Hospital, all employees/vendors are expected to act in a manner which is professional, sensitive, and consistent with excellent patient care. Staff is expected to be courteous and helpful at all times to the patrons of the hospital including but not limited to: patients and their families, referral sources, Medical Staff, Allied Health Professional Staff, Privileged Service Providers, and other employees. Special attention should be paid to the following:

1. Staff must demonstrate respect for rights and dignity of patients at all times.
2. Patient confidentiality must be protected by staff in all communications, consistent with the Illinois Mental Health Code, Confidentiality Act, and HIPPA. *Confidentiality applies to verbal communication and written information about the patient.* Additionally, discussions regarding patients between treatment team members should not occur in any public area inside or outside of the hospital.
3. Staff treatment interventions must be conducted within the guidelines of the treatment plan and the guidance of the attending psychiatrist.
4. Patients are to be treated fairly and equally without regard to race, creed, gender, sexual orientation, disability, financial status, or ability to pay.
5. Staff is required, under the Abused and Neglected Child Reporting Act (III.Rev. Stat.,Ch. 23), to report cases in which child abuse and/or neglect is suspected.
6. Socialization or communication with patients or their families outside scheduled work hours, and after patient discharge is not permitted. If staff has had a personal, familial, or professional relationship (outside of Garfield Park Hospital) with a patient prior to the patient's hospitalization, this should be disclosed to their supervisor.
7. Personal problems or concerns of staff should not be discussed with patients or their family members.
8. Staff cannot accept, give money, or give gifts to patients or their families.
9. Staff members may be in a patient's room only with the door open; this is to protect staff and to avoid false patient allegations of staff misconduct.
10. Non-clinical staff is discouraged from initiating conversations with patients. If patients initiate conversation, staff is expected to respond courteously but minimally. Patient questions should be referred to treatment team members.

I have received and read a copy of the Employee/Vendor Code of Ethics and Hartgrove Behavioral Health System and/or Garfield Park Behavioral Hospital's Rule of Engagement. I agree to abide by the provision of the Code of Ethics.

_____

Employee's Printed Name

_____

Employee's Signature

_____

Date

THERAPEUTIC BOUNDARIES

All contractors, business partners, and students are expected to adhere to the therapeutic boundaries policy.

- Patient relationships in psychiatric settings are quite different than other professional relationships.
- Psychiatric patients are among the most vulnerable individuals in any healthcare setting, and there is an unequal power advantage over the patient.
- You might be privy to confidential, and sometimes intimate, information about the patient that would not normally be revealed.
- You may not touch a patient nor should they be allowed to touch you. It is not uncommon for some patients to become infatuated with people they come in contact with on the unit or become over-involved or flirtatious.
- You may not share personal information with patients nor may you solicit information about them.
- Do not discuss your personal problems or any aspect of your intimate life patients.
- Do not be in a situation where you are alone with patient.
- Do not accept gifts from patients. Never give gifts to patients or agree to take presents to the patient from another person.
- Be aware that many normal items are considered contraband on a closed psychiatric unit. Things like lighters, keys, and even pens can be used as a weapon or to self-harm.
- Be circumspect in your language and communication when in the presence of patients. Loud voices, off color language and even joking can be upsetting to patients.
- Ask a staff person for assistance/redirection if a patient focuses on you.
- If an investigation determines that a contractor has engaged in sexual activity with a patient, that person will be barred from the facility and subjected to any and all professional sanctions, including loss of licensure and criminal prosecution.
- Non-employees are not permitted to physically touch, hold, grab, or in any way restrain a patient in the facility.
- Similarly, no patient should be blocked or prevented from moving about the unit with the areas designated for their use.
- In the event that a "Code Yellow" is called, non-employees may NOT participate in the restraint or seclusion of that patient.
- If a patient becomes aggressive toward you, makes verbal threats, or challenges you in anyway, immediately remove yourself from the area and seek staff assistance.

If a patient becomes physically aggressive:

- First try to remove yourself from the situation and solicit staff assistance
- Use defensive measures (i.e. blocking punches with your arm) while avoiding engaging or retaliating against the patient.

By signing this Agreement, I understand and agree to abide by all of the conditions imposed above.

Name (Printed) Signature Date

GARFIELD PARK BEHAVIORAL HOSPITAL

HARTGROVE BEHAVIORAL HEALTH SYSTEM

CODE OF RESPECT

CONTRACT TO PROVIDE A THERAPEUTIC ENVIRONMENT

As a Hartgrove Behavioral Health System and/or Garfield Park Behavioral Hospital employee, I am aware that my job is to create and maintain a professional, supportive environment. I am also aware that patients, their families, guests and visitors may at times behave in ways that are highly provocative, irrational, threatening, and demanding. My job is stressful and involves responding to many challenging situations. I recognize that it is my responsibility as a mental health professional to act as a role model, to remain under control and to be courteous as well as respectful at all times. I am aware that it is the treatment philosophy of Hartgrove Behavioral Health system Garfield Park Hospital that patients, staff and all other customers are to be treated with dignity, respect and in a professional manner at all times. As a commitment to this goal, I agree to the following Code of Respect.

- I will not yell in anger. I will not use my anger to intimidate or threaten. I will exercise control over my anger. I will not use profanity.
- I will not talk about patients, staff or other customers in a manner that is hostile, humiliating, condescending, or degrading. I will not use name-calling to characterize others.
- When in public areas of the hospital, I will not talk about patients, staff or other customers in a manner that others can hear what is being said.
- I will not threaten to use physical or chemical restraints.
- I will not behave towards others in a manner that is provocative and likely to escalate a confrontation.
- I will not use physical discomfort in any manner as a behavioral consequence.
- I will not use non-verbal expressions to flagrantly communicate dissatisfaction. Instead, I will express my concerns and reactions directly and appropriately.
- I expect and welcome my colleagues to provide me with feedback – both positive and negative regarding my adherence to the Code.
- I will utilize constructive negative feedback as a tool of self-monitoring and professional development.

Employee's Printed Name: _____

Employee's Signature: _____ Date: _____

GARFIELD PARK BEHAVIORAL HOSPITAL

HARTGROVE BEHAVIORAL HEALTH SYSTEM

AGREEMENT WITH RESPECT TO PATIENT CONFIDENTIALITY

I, _____, acknowledge that I am familiar with and agree to comply with the provision of the Mental Health and Development Disabilities Confidentiality Act; specifically as such provisions may apply to my involvement with Hartgrove Behavioral Health System and/or Garfield Park Behavioral Hospital patients. I understand that the Mental Health and Developmental Disabilities Confidentiality Act are designed to protect the confidentiality of records and communications of recipients of mental health or developmental disability services. This act specifies that all records and communications shall be confidential and shall not be disclosed except as specified within the provisions of the act.

NOTE: Since a patient's name, address, and other vital statistic are considered part of his/her hospital record, it is in violation to disclose such information to any individuals and/ or agencies not employed or affiliated with Hartgrove Behavioral Health System and/or Garfield Park Behavioral Hospital, except as provided in the Mental Health and Developmental Disabilities Act.

Employee's Printed Name: _____

Employee's Signature: _____ Date: _____

CONFIDENTIALITY

All contractors, business partners, and students are expected to adhere to the HIPAA and PHI policy.

Under the Health Insurance Privacy & Portability Act (HIPAA) all information about patients is considered PROTECTED HEALTH INFORMATION (PHI) and protected by federal law.

PHI is information that identifies an individual and describes his/her medical condition and/or treatment. This may be as simple as a patient's name or as detailed as their medical record. PHI cannot be used or disclosed by anyone unless it is permitted by the privacy rule or authorized by the client. Healthcare providers are permitted to disclose PHI only in the following situations:

- For treatment, payment, and healthcare operations
- With authorization from the client
- For disclosure to the client

You may not obtain, use or disclose, purposefully or unintentionally, any patient information that you discover while working in the facility. Report any known breach to an employee or manager. Security threats that should be reported are:

- A loss of PHI from human error, computer failure, fire, water, power failures, etc.
- Theft of PHI (computer hackers, computer viruses, PHI removed from trash)
- Unauthorized disclosure of PHI, whether accidental or intentional

By signing this Agreement, I understand and agree to abide by all of the conditions imposed above.

Name (Printed) Signature Date

UHS

Information Security and Privacy Agreement

Universal Health Services Facilities and other UHS subsidiaries (collectively, "UHS" or "UHS companies") are committed to maintaining high standards of confidentiality. The responsibility to preserve the confidentiality of information in any form (electronic, verbal, or written) rests with each User granted access to UHS information systems who may have access to Confidential Information, including Protected Health Information (PHI), Electronic Protected Health Information (ePHI), employee information, physician information, vendor information, medical, financial, or other business-related or company confidential information. Any information created, stored or processed on UHS systems, or systems maintained on UHS' behalf by a vendor or other individual or entity, is the property of UHS, as is any information created by or on behalf of UHS, whether written, oral or electronic. UHS reserves the right to monitor and/or inspect all systems that store or transmit UHS data, the data stored therein, as well as all documents created by or on behalf of UHS.

Definitions:

Agreement means this *UHS Information Security and Privacy Agreement*.

Confidential Information means confidential information that is created, maintained, transmitted or received by UHS and includes, but is not limited to, Protected Health Information ("PHI"), Electronic Protected Health Information ("ePHI"), other patient information, Workforce member information, employee, physician, medical, financial and other business-related or company private information in any form (e.g., electronic, verbal, imaged or written).

Protected Health Information ("PHI") means individually identifiable health information that relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual. PHI can be oral, written, electronic, or recorded in any other form.

Electronic Protected Health Information ("ePHI") means Protected Health Information in electronic form.

User means a person or entity with authorized access to any UHS network and/or other information systems, including computer systems.

Workforce means employees, volunteers, trainees, and persons whose conduct, in the performance of work for UHS, are under the direct control of UHS, whether or not they are paid by UHS. Workforce also include management and employed medical staff.

I HAVE READ AND UNDERSTAND THIS ENTIRE AGREEMENT, AND I AGREE TO THE FOLLOWING:

(Note: Please initial each line in the space provided after reading it.)	*Initials:*
1. I understand it is my personal responsibility to read, understand and comply with all applicable UHS company policies and procedures, including Security policies. I understand that these policies provide important information about the acceptable use of information systems, protection from malicious software, Mobile device usage, and data encryption, and other important information. If I am provided access to PHI or ePHI, I also	

agree to comply with the Privacy policies.	
2. I have been provided access to the Security (and Privacy policies as applicable).	
3. I agree not to disclose any PHI, ePHI or any other Confidential Information obtained by accessing the UHS network and/or other information systems, including computer systems, or otherwise to any unauthorized party. I agree not to access or use any PHI, ePHI or any other Confidential Information unless I am authorized to do so. I agree that all patient-related information shall be held to the highest level of confidentiality.	
4. I agree to access the UHS network and/or other information systems, including computer systems, only for purposes related to the scope of the access granted to me.	
5. I understand that UHS regularly audits access to information systems and the data contained in these systems. I agree to cooperate with UHS regarding these audits or other inspections of data and equipment, including UHS inquiries that arise as a result of such audits.	
6. I agree that I will not share or disclose User IDs, passwords or other methods that allow access to UHS network and/or other information systems, including computer systems, to anyone, at any time, nor will I share my account(s). I also agree to store all UHS company-related data onto the system servers rather than on hard drives of individual workstations, personal computers or other devices.	
7. I agree to contact my supervisor (or for non-employees, the applicable UHS Department Director or Business Contact) and IS Security Officer immediately if I have knowledge that any password is inappropriately revealed or any inappropriate data access or access to Confidential Information has occurred.	
8. I understand that Confidential Information includes, but is not limited to PHI, ePHI, other patient information, employee, physician, medical, financial and all other business-related or company private information (electronic, verbal or written).	
9. I agree that I will not install or use software that is not licensed by UHS (or that is otherwise unlawful to use) on any UHS information systems, equipment, devices or networks. I understand that unauthorized software may pose security risks and will be removed by UHS.	
10. I agree to report any and all activity that is contrary to this Agreement or the UHS Security or Privacy policies to my supervisor, Department Director, IS Security Officer or Privacy Officer.	
11. I understand that for employees this form will be part of the employee file at UHS and that failure to comply with this Agreement and the UHS Security and Privacy policies may result in formal disciplinary action, up to and including termination. I understand that for non-employees, failure to comply with this Agreement and the UHS Security and Privacy policies may result in revocation of access and the termination of any agreements or relationships with UHS.	
12. I understand that all information and/or data transmitted by or through or stored on any UHS device, or system maintained on any UHS company's behalf by a vendor or other individual or entity, will be accessible by UHS and considered the property of UHS, subject to applicable law. I understand this includes, without limitation, any personal, non-work related information. I do not have any expectation of privacy with regard to information on any UHS network and/or other information systems, including computer systems, and understand that UHS has no obligation to maintain the privacy and security of	

the information. I understand that UHS reserves the right to monitor and/or inspect all systems that store or transmit UHS data, the data stored therein, as well as all documents created by or on behalf of UHS.	
13. I agree to comply with UHS requirements to encrypt electronic Confidential Information in accordance with UHS security policies, including the requirement that encryption software be installed on all UHS-owned laptop computers and that emails transmitted over an electronic network outside of UHS be encrypted, as described in the UHS Security policy *Data Encryption and Decryption.*	
14. I agree that all devices used by me that are connected to a UHS network and/or other information systems, including computer systems, whether owned by me or not, will be continually running approved and updated anti-virus software.	
15. I will follow the requirements for Users described in all UHS Security policies, including but not limited to the UHS Security policy *Acceptable Use Policy.*	

The UHS Information Security and Privacy Policies are available through my supervisor, manager, UHS business contact or the UHS Corporate Compliance Office.

By signing this Agreement, I understand and agree to abide by the conditions imposed above.

_____ _____

Signature Print Name

_____

Date

Please check appropriate box:

☐ *Employee* ☐ *Non-Employee*

If Non-Employee, please provide your employer (or practice name) and your title/position below:

_____

Employer or Practice Name Title/Position

Form Revision Date: October 25, 2011

GARFIELD PARK BEHAVIORAL HOSPITAL

HARTGROVE BEHAVIORAL HEALTH SYSTEM

ACKNOWLEDGEMENT OF MANDATED REPORTER STATUS

I, _____ (Name), understand that as an employee of Hargrove Behavioral Health System and/or Garfield Park Behavioral Hospital, as a _____ (Job Title), I will become a mandated reporter under the Abused and Neglected Child Reporting Act. This means that I am required to report or cause a report to be made to **the DEPARTMENT OF CHILDREN AND FAMILY SERVICES (1-800-25-ABUSE)** whenever I have reasonable cause to believe that an abused child known to me in my professional or official capacity may be abused or neglected. I am also required to report suspicion of elder abuse for nay adult 60 years of age or older who resides in a domestic living situation, who because of dysfunction us unable to seek assistance for himself/herself to the **DEPARTMENT OF AGING (1-800-252-8966)**, I understand that there is no charge when calling these hotlines numbers and that the hotlines operates 24 hours per day, 7 days per week, 365 days per year.

I further understand that the privileged quality of communication between me and my patient or client is not grounds for failure to report suspected child abuse or neglect or elder abuse. I know that if I willfully fail to report suspected abuse or neglect I may be found guilty of a Class A misdemeanor. This does not apply to physicians who will be referred to the Illinois State Medical Disciplinary Board of action.

I also understand that if I am subject to licensing under Illinois Nursing Act, the Medical Ac, and the Psychologist Registration Act. The Social Worker Registration Act, the Dental Practices Act, the School Code, or "an Act to regulate the practice of Podiatry", I may be subject to license suspension or revocation if I willfully fail to report suspected child abuse or neglect.

I affirm that I have read this statement and have knowledge and understanding of the reporting requirements which apply to me under the Abused and Neglected Child reporting Act. I acknowledge receipt of a Department of Children and Family Services brochure, which explains the Act and my responsibilities with respect to it. I also understand that a full copy of the Act is available to me upon request from the Human Resources or Social Services Department at Garfield Park Hospital.

_____ _____

Employee's Printed Name Employee's Signature

_____ _____

Human Resources Signature Date

GARFIELD PARK BEHAVIORAL HOSPITAL

HARTGROVE BEHAVIORAL HEALTH SYSTEM

Promotional Consent for Use of Individual's Image, Voice, and/or Statement

Important note: This form secures your consent and authorization to use your image, voice, and/or statements in promotional context – please review it carefully.

I hereby consent to authorize Hartgrove Behavioral Health System and Garfield Park Behavioral Hospital, UHS of Delaware, Inc., and all of their affiliates (collectively "UHS") to use my image, voice, and/or statements in commercial promotions, advertisements, social media, education pieces, or in any other manner at UHS' sole discretion. I understand that my image, voice, and/or statements may be recorded in videotapes, audiotapes, photographs, or interviews, and my consent and authorization applies to any such recording and may be used in whole or in part by UHS at its discretion.

I understand and agree that I have no rights to images or material generated by UHS in reliance on my consent and authorization, and I waive any rights I may have to prior approval of the use of my image, voice and/or statements by UHS. I hereby release UHS and all of its respective employees, officers, directors, and agents from liability of any kind based on the use of my image, voice, and/or statement. I further waive any rights to any form of payment or compensation I may have in connection with UHS' use of image, voice, and/or statements.

I understand that I may revoke my promotional consent and authorization at any time by informing UHS of Delaware, Inc., attention Marketing Department, in writing that I am revoking my consent and authorization. I understand that my revocation does not apply to the extent UHS has already used my recording in reliance on this authorization or if immediate revocation would cause additional expense or hardship to UHS in completing its current promotional campaigns.

I have had the opportunity to read an consider the contents of this consent and authorization. My signature below indicates that I understand and agree to the terms herein.

Employee's Printed Name: _____ Date: _____

_____

Signature (Parent of Legal Guardian must sign if individual is a minor)

Title:	Electronic Media Communication System	Policy No. **HR -126** Revision #2
Originator:	Human Resources Director	Page 1 of 4 Effective Date: 04/01/2004 Reviewed Date: 02/02/2015

I. SCOPE:

Hartgrove Hospital/Garfield Park Hospital

II. PURPOSE:

To ensure that all employees are responsible, productive users of our electronic media communication systems ("Electronic Media") (e.g., telephone system, pagers, e-mail, Internet, local area network ("LAN"), frame relay network, wide area network ("WAN"), etc.). Employees must use Electronic Media appropriately to protect patient information and the company's public image and liability.

III. POLICY:

Access to Electronic Media has been provided to staff members for the benefit of the organization and the customers it serves. Every staff member has a responsibility to maintain and enhance the company's public image, and to use Electronic Media in a productive manner. These Electronic Media tools are company assets just like the desks and computers and are to be used at all times only for legitimate business purposes.

GENERAL OVERVIEW:

Acceptable Uses:

Employees accessing these systems are representing the company. All communications should be for professional reasons. Employees are responsible for seeing that Electronic Media are used in an effective, ethical and lawful manner. Internet databases may be accessed for business information as needed. Pagers, e-mail and telephones are to be used for business purposes, and personal messages and calls should be kept to an absolute minimum.

Unacceptable Use:

Under absolutely no circumstance is any company property to be utilized to solicit, harass, or otherwise offend, or for any other unlawful purpose, such as accessing inappropriate, illegally distributed or otherwise unlawful material. Use of the Internet or other Electronic Media must not disrupt the operation of the company network or the networks of other users. It must not interfere with employee productivity.

Communications:

Each employee is responsible for the content of all text, audio and images that they place or send via Electronic Media. Fraudulent, harassing or obscene messages are prohibited. No abusive, profane or offensive language is to be transmitted through Electronic Media.

Software:

To prevent computer viruses from being transmitted through the system, there will be no unauthorized downloading or installing of any software. No inappropriate software may be copied onto Hospital owned computer systems (e.g., pornographic material, pirated software, discriminatory information, advertisements used for commercial enterprises, etc.). All software installs will be done through the IS Department.

Copyright Issues:

Employees must abide by all software licensing agreements and copyright laws. Employees using the Internet or e-mail may not transmit copyrighted materials belonging to entities other than this company. One copy of copyrighted material may be downloaded for your own business use in research. Users are not permitted to copy, transfer, rename, add or delete information or programs belonging to other users unless given express permission to do so by the owner. Failure to observe copyright or license agreements may result in corrective action from the company and/or legal action by the copyright owner.

Security:

All messages created, sent or retrieved on the Electronic Media are property of the company, and should be considered public information. The company reserves the right to monitor or review any information stored or transmitted on or via its equipment, at its discretion, to ensure that it is being used properly. Employees should be aware that e-mail could be retrieved and even subpoenaed for court cases.

Harassment:

Harassment of any kind is prohibited. No messages or images with derogatory or inflammatory remarks about an individual or group's race, religion, national origin, age, physical attributes, sexual preference, disability, etc. should be transmitted. Transmitting pornography is forbidden and illegal.

Privacy:

Electronic Media, specifically e-mail and fax, offers no guarantee of employee privacy. The company has the right to inspect the content of any information, including e-mail messages sent or received.

Confidentiality:

Electronic media offers no guarantee of employee confidentiality. Employees should exercise significant caution when managing sensitive information. It is a violation of this policy to communicate identifiable patient information using Internet, including external e-mail messages.

Violations:

Violations of any guidelines listed in this policy may result in corrective action up to and including immediate employment termination.

PROCEDURES:

1. The e-mail storage system contains a finite amount of space and messages cannot be stored indefinitely. Consequently, e-mail messages must be brief and concise. Employees should not save e-mail messages unless it is truly important to store the information. Employees must also monitor the size of the attached files, which consume valuable server storage space.

2. Employees must be current with their Electronic Media, monitoring your e-mail often will serve to keep everyone informed and improve efficiency.

3. Employees must also guard against computer viruses. Any attached file could contain a potentially damaging computer virus. This is particularly true of files that were generated outside of our organization (e.g., vendors, external users, etc.). Files should be scanned for viruses before they are opened. Any file that contains or is thought to contain a virus should not opened or sent to anyone else.

4. No employee may use Electronic Media to download or distribute pirated material.

5. No one may run, install, or download files that may interfere, alter, or damage Hospital computer systems. This includes but is not limited to classes of programs known as computer viruses, Trojan Horses, worms, etc.

6. All e-mail and Electronic Media system passwords are strictly confidential. Passwords provide employees safeguards from the system being misused in their name. Employees are not permitted to attempt to obtain passwords from another user.

7. Access to any Hospital terminal is granted solely to Hospital authorized personnel. No one may circumvent security or data protection schemes. The user community is expected to cooperate with the IS staff in monitoring all Electronic Media. The IS department must be immediately notified of any violation of policy or breeches in the security system.

8. Accessing Electronic Media resources/files without proper authorization or intentional misuse of information is in violation to this policy.

9. No one may deliberately perform an act, which may seriously compromise the operation of computer systems, peripherals, or networks. This includes but is not limited to tampering with components of the LAN, WAN, blocking communication lines, interfering with operational readiness of systems, etc.

10. No one may use Hospital network resources to gain unauthorized access to remote computers or systems.

11. No one may deliberately perform computer routines which may inappropriately utilize computer resources. Monopolizing computer resources and interfering with the productivity of other employees are not permitted (e.g., music, video, large direct mail pieces, chain letters, creating multiple jobs/processes, large printing jobs, etc.).

12. No unauthorized individual may monitor, read, copy, change, or delete another user's files/data communication without appropriate security and permission.

13. The use of Electronic Media may not be used for personal or financial gain.

14. All software installs, modifications, and/or deletions must be coordinated with the IS Department or authorized individuals. No unauthorized software should be installed or run on the Hospital's resources.

15. Should a unique situation arise that is not specifically addressed within this policy, please notify the IS Department for further clarification.

GARFIELD PARK BEHAVIORAL HOSPITAL

Effective:	*07/2019*
Last Reviewed:	*07/2019*
Last Revised:	*09/2018*
Next Review:	*07/2020*
Area:	*Human Resources*

HR - 131 Dress Code

I. Purpose:

To promote our dedication to providing excellence in behavioral health services, Garfield Park Behavioral Hospital has established guidelines for appropriate attire and appearance for its employees.

II. Policy:

Hospital employees are to maintain personal cleanliness, good grooming and appropriate attire safe and suitable for the work to be performed. A professional, neat, clean and modest appearance is required at all times. Appropriate uniforms or scrubs may be worn if approved by the Department Head.

III. Scope:

Garfield Park Behavioral Hospital

IV. Procedure:

1. Supervisory personnel will ensure personal appearance standards are understood by employees and that the standards are reasonably and consistently enforced.
2. Supervisory personnel will ensure employees are dressed appropriately for duties being performed to ensure the safety of the employees and patients and to maintain propriety of appearance.
3. Guidelines of appropriate grooming and dress for employees may include, but are not limited to the following:
    A. Clothing – General attire will be clean, neat, free of holes and appropriate for the type of work being performed.
        1. Ill-fitting clothing (too tight/too loose) is prohibited, no leggings are allowed. See-through, sheer or revealing clothing, low cut tops, inappropriately unbuttoned shirts/blouses, short skirts or skorts exposing midriff or back, large slits in skirts or dresses, halter tops, jogging suits, camouflage, tank tops, collarless T-shirts or "muscle shirts" are prohibited. Split skirts/skorts are allowed if they are below the knees. No sweat pants or sweat suits are allowed. Proper and appropriate undergarments are required at all times.
        2. Shirts with names of bands, advertisements, slogans and other potentially offensive material are not allowed. Dress shirts with tails are to be tucked in.

3. Denim is only allowed on Fridays as Fridays are considered casual days. Dark colored jeans are preferred. Denim (of any color/style) is not allowed on any other day, unless approved by the CEO or HR Director for special employee engagement event.

B. Jewelry – Excessive jewelry, such as large dangling or heavy chains and bracelets, long earrings or keys/name badges on ropes or chains that do not easily break-away may be prohibited in patient care areas, if deemed by management to be relevant to safety, professionalism or a therapeutic milieu.

1. Large loop or dangling earrings are not allowed, as they pose safety hazards. Excessive piercing in ears is not allowed. Preferably no more than two earrings in each ear would be considered acceptable. The determination of acceptable and unacceptable numbers of piercings is at the discretion of the CEO.
2. Employees will not be allowed to wear pierced jewelry or plugs in any visible part of the body other than ears (Nose, lip, eyebrow, tongue or other facial areas).

C. Visible Tattoos – Every effort should be made to conceal tattoos. Any tattoo considered offensive or inappropriate by a supervisor must be concealed.

D. Headgear – A neat and professional appearance is required at all times. Hats/caps/headgear is not allowed to be worn inside the hospital. Special accommodations will be made by management for anyone required to wear headgear due to religious reasons.

E. Foot Attire / Hosiery – Foot attire must provide safe, secure footing and offer protection against hazards. Shoes should be appropriate for the work being performed. Hosiery must be worn with shoes at all times in patient care areas.

1. Shoes must be appropriate and not pose a safety hazard. Shoes should cover toes and not easily slip off in an emergency situation (Codes). Open toe shoes are not allowed in any area of the hospital due to safety reasons, as defined by Regulatory Agencies.
2. Strong, supportive athletic shoes are generally acceptable as long as they are in good, clean condition and are worn for safety reasons as opposed to brand recognition.

F. Fingernails – Natural fingernails must be maintained in a clean and groomed manner. Fingernails are to be trimmed and maintained to a safe length (fingernail tips are to be less than 5mm or ¼ inch) to avoid harm to patients or fellow employees in an emergency situation (Codes). Nail polish must be presentable, not chipped, cracked, worn away and/or peeling. Pierced jewelry in fingernails, pointed fingernails, artificial nails, extenders or decorative fingernails that may cause harm to others is strictly prohibited.

G. Hair / Grooming Aids – Good personal hygiene is required of all employees.

1. Hair must be clean and well groomed to the satisfaction of supervisory personnel. Employees in work areas subject to specific codes, such as Health Department Standards, will follow prescribed regulations or codes.
2. Unorthodox hairstyles or coloring are not permitted.
3. No strong or heavily scented perfumes, colognes or grooming aids are allowed.

H. Name Tags / Badges – All employees and visitors are required to display hospital issued and approved identification. Identification badges must be worn and visible by all employees while on duty at waist level or higher, ideally chest level or higher.

Supervisors are responsible for enforcing this policy at all times. Should a supervisor ask an employee to refrain from wearing a particular outfit or to change his/her attire, the employee must comply. In addition, employees not adhering to the dress code may be asked to go home immediately. In any case, an employee may be asked not to wear a particular garment, even if it is otherwise appropriate, when one of our patients reacts adversely to the presence of the garment.

Employees will adhere to all hospital and individual departmental dress codes. Employees who do not adhere to hospital and departmental dress codes, may be issued a corrective action up to and including termination of employment.

Attachments

No Attachments

Approval Signatures

Approver	Date
Teresa Poprawski: CMO	07/2019
Steven Airhart: Chief Executive Officer	07/2019
Kevin Ahrens: Chief Operating Officer	07/2019
Alanna Barker: Group Director of Human Resources	07/2019
Kevin Ahrens: Chief Operating Officer	06/2019
Angie Scott: Dir. RM/PI	06/2019

Title: Dress Code

Policy No. **HR - 131**

Originator: Human Resources Director

Effective Date: 06/1989
Reviewed Date: 02/02/2015

Purpose:

To ensure staff's professional appearance and maintain a safe working environment without unduly restricting personal taste. To promote our dedication to providing excellence in behavioral health services, Hartgrove Hospital has established guidelines for appropriate attire and appearance for its employees.

II. Policy:

Hospital employees are to maintain personal cleanliness, good grooming and appropriate attire safe and suitable to the work to be performed. A professional, neat, clean and modest appearance is required at all times. Appropriate uniforms or scrubs may be worn if approved by the Department Head.

III. Scope:

Organization-wide

IV. Procedure:

1. Supervisory personnel will ensure personal appearance standards are understood by employees and that the standards are reasonably and consistently enforced.

2. Supervisory personnel will ensure employees are dressed appropriately for duties being performed to ensure the safety of the employees and patients and to maintain propriety of appearance.

3. Guidelines of appropriate grooming and dress for employees may include, but are not limited to the following:

A. Clothing – General attire will be clean, neat, free of holes and appropriate for the type of work being performed.

(1) Ill-fitting clothing (too tight/too loose) is prohibited. See-through, sheer or revealing clothing, low cut tops, inappropriately unbuttoned shirts/blouses, short skirts or skorts exposing midriff or back, large slits in skirts or dresses, halter tops, jogging suits, camouflage, tank tops, collarless T-shirts or "muscle shirts" are prohibited. Split skirts/skorts are allowed if they are below the knees. No sweat pants or sweat suits are allowed, as well as hooded sweat shirts or hooded tops. Proper and appropriate undergarments are required at all times.

(2) Shirts with names of bands, advertisements, slogans and other potentially offensive material are not allowed. Dress shirts with tails are to be tucked in.

(3) Denim of any color is not allowed unless approved by the CEO or appointed designee, as a special day.

B. Jewelry – Excessive jewelry, such as large dangling or heavy chains and bracelets, long earrings or keys/name badges on ropes or chains that do not easily break-away may be prohibited in patient care areas, if deemed by management to be relevant to safety, professionalism or a therapeutic milieu. A professional appearance is expected at all times while at work.

(1) Large loop or dangling earrings are not allowed, as they pose safety hazards. Excessive piercing in ears is not allowed, preferably not more than two earrings in each ear.

(2) Employees are not allowed to wear pierced jewelry in any visible part of the body other than ears (Nose, lip, eyebrow, tongue or other facial areas are prohibited).

C. Visible Tattoos – Every effort should be made to conceal tattoos. Any tattoo considered offensive or inappropriate by a supervisor must be concealed.

D. Headgear – A neat and professional appearance is required at all times. Hats/caps/headgear is not allowed to be worn inside the hospital.

E. Foot attire / Hosiery – Foot attire must provide safe, secure footing and offer protection against hazards. Shoes should be appropriate for the work being performed. Hosiery must be worn with shoes at all times.

(1) Shoes must be appropriate and not pose a safety hazard. Shoes should cover toes and not easily slip off in an emergency situation (Codes). Open toe shoes are not allowed in any area of the hospital due to safety reasons, as defined by Regulatory Agencies.

(2) Tennis shoes or other athletic shoes are generally unacceptable. Employees engaged in recreational or similar activities or on designated business casual days are an exception.

F. Fingernails – Must be maintained in a clean and groomed manner. Fingernails are to be trimmed and maintained to a safe length to avoid harm to patients or fellow

employees in an emergency situation (Codes). No pierced jewelry in fingernails.

G. Hair / Grooming Aids – Good personal hygiene is required of all employees.

(1) Hair must be clean and well groomed to the satisfaction of supervisory personnel. Employees in work areas subject to specific codes, such as Health Department Standards, will follow prescribed regulations or codes.

(2) Unorthodox or bizarre hairstyles or coloring are not permitted.

(3) No strong or heavily scented perfumes, colognes or grooming aids are allowed.

H. Name Tags / Badges – All employees and visitors are required to display hospital issued and approved identification. Identification badges must be worn and visible by all employees while on duty.

Supervisors are responsible for enforcing this policy at all times. Should a supervisor ask an employee to refrain from wearing a particular outfit or to change his/her attire, the employee must comply. In addition, employees not adhering to the dress code may be asked to go home immediately. In any case, an employee may be asked not to wear a particular garment, even if it is otherwise appropriate, when one of our patients reacts adversely to the presence of the garment.

Employees will adhere to all hospital and individual departmental dress codes. Employees who do not adhere to hospital and departmental dress codes, may be disciplined up to and including discharge.

GARFIELD PARK BEHAVIORAL HOSPITAL

HARTGROVE BEHAVIORAL HEALTH SYSTEM

ACKNOWLEDGEMENT OF DRESS CODE

I have read and agree to comply with the dress code policy which includes but is not limited to:

- No jeans (except on casual Fridays)
- No sweat suits or pants
- No hats
- No open toed shoes
- No stilettos heels or any heels more than 1 ½ inches
- No large hoop earrings
- No low cut or midriff tops
- No shorts or hip huggers
- No T-shirts
- Will wear shirt tails tucked in at all times
- Will maintain clean nails under 1/ inch in length
- Will wear ID badge on my person and above my waist
- Will have my hospital keys on my person at all times

ACKNOWLEDGEMENT OF ELECTRONIC MEDIA AND COMMUNICATIONS POLICY

I have read and agree to comply with the Electronic Media and Communications policy, which states there will be no usage of this equipment while on duty at Garfield Park Hospital (unless the job you were hired for requires it) this includes but is not limited to:

- No cell phone usage of any kind including checking messages, checking the time, playing games, text messaging, etc.
- No I-Pods
- No Blue Tooth
- No Internet usage
- No portable DVD players
- No reading of newspapers or magazines while on duty except with the patients

Failure to follow these policies will result in progressive discipline up to and including termination.

Employee's Printed Name: _____

Employee's Signature: _____ Date: _____

CODE RED Fire Safety Training

In case of fire, do not yell "FIRE" or incite panic.

Follow the RACE response procedures:

R is for Rescue - Move people in immediate danger to a safe location.

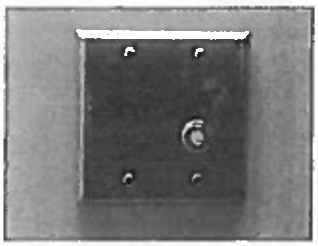
A is for Alarm - Go to the nearest fire pull station and use your fire key with the red border to open up the fire station pull box. Pull stations are located in the nurse's stations and throughout the hospital next to egress doors. Once the fire alarm box is opened, you will find the alarm activation key already inserted in the proper slot. Turn the alarm activation key in a clockwise direction to activate the alarm.

Next, Call extension #333, to announce the Fire to the Emergency Hotline. The receptionist will announce the Code Red and call 911.

Continue to follow the RACE Procedures by "C" containing the fire. Close all doors on the unit/area.

E is for Extinguish and Evacuate. If the fire is contained in one area, staff will move patients horizontally to the other end of the building, away from the fire. Make sure you maintain a constant head count of the patients at all times during the crisis. The Charge Nurse is the Fire Captain.

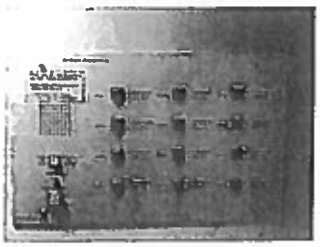
Stairwells are not safe places to wait in case of fire. If you are in the stairwell and need assistance during a Code Red, press the Rescue Assistance Call Button found on each landing.

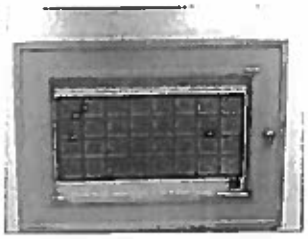


Your location will be identified by a red light next to the identified zone on the Rescue Assistance panel located in the hospital lobby. This panel has a built in intercom system which will allow personnel in the hospital lobby to communicate with you and provide the needed assistance.

The intercom button is right above the green light in the lobby panel. Employees in the lobby can press the button to speak and then release to listen.

Rescue Alarm Panel in Hospital Lobby:





The site of the tripped alarm is also displayed in the fire alarm display panel in the lobby. The hospital receptionist will announce the location of the fire during the Code Red announcement and you can also listen for the fire chime codes.

The fire alarm chime codes are a series of chimes that represent areas in the hospital. The first floor southeast end is represented by a 1-1-1 sequence of chimes. The first floor northwest end is represented by a 1-1-2 sequence. The chime codes chart indicating the chimes and their associated locations are posted on all floors and units on the Life Safety Plan map that also shows egress routes for evacuation.

The Hospital cannot resume normal operations until the Code Red All Clear announcement has been made, even if the fire alarm stops sounding.

A General Evacuation or full evacuation of the hospital can only be activated when the CEO or Safety Officer gives the directive to do so. Egress routes are illustrated on the Life Safety Plan diagrams on every floor and every unit.

EMERGENCY CODES

Emergency codes are announced on the intercom system. In the event of a code, follow instructions provided by the staff person in your location.

CODE RED: FIRE

CODE YELLOW: AGRESSION

CODE GREEN: ELOPMENT

CODE BLUE: MEDICAL

CODE ORANGE: BOMB THREAT

CODE GRAY: SEVERE WEATHER

CODE DR. FREEZE: WEAPONS THREAT

CODE EXTERNAL LOCKDOWN: EXTERNAL THREAT

By signing below I acknowledge I have received information regarding Emergency Codes.

Name (Printed) **Signature** **Date**

DOOR & KEY CONTROL/ELEVATOR USAGE

Garfield Park Hospital and Hartgrove Behavioral Health System are locked facilities. Entrance and egress is controlled. Authorized contractors, business partners, and students may be issued keys to areas they are allowed access. Badge/keys are not to be shared with unauthorized personnel nor should individuals without access be given access by badge/key holders.

Garfield Park Hospital and Hartgrove Behavioral Health System have security sensitive areas in which only assigned staff are allowed. This includes:

*Medication rooms and rooms containing patient charts
*Pharmacy
*Medical Records
*Mechanical rooms and electrical closets

Never hold the door open for a person who is not accompanying you. Assure doors are securely closed and locked behind you. In the event that a patient leaves a unit as you are entering, IMMEDIATELY notify staff of their elopement. Never touch, hold, or grab a patient to prevent their elopement. Leave patient management to staff unless otherwise instructed. You must always enter and exit the building through the main entrance and check in with the receptionist unless otherwise instructed.

Please be advised that the elevator in the emergency services vestibule is for patient care only. It is not to be used by staff to go to the cafeteria/basement or the units. This elevator is secured on the units and in emergency services and necessitates controlled and limited access.

The main elevators by the lobby are to be used by staff, maintenance workers, and visitors to get from the units or the cafeteria to the lobby.

I acknowledge I have received my GPH/HGBH identification/security badge.

I acknowledge I am responsible for the security of the identification/security badge and keys in my possession.

I acknowledge if my keys are lost or stolen, I will immediately notify Human Resources.

I acknowledge when my assignment ends I will return my identification/security badge and keys to Human Resources within 72 hours of separation.

I acknowledge I have received information regarding elevator usage.

By signing this agreement, I understand and agree to abide by all of the conditions imposed above.

_____	_____	_____
Printed Name	Signature	Date

HARTGROVE HOSPITAL/GARFIELD PARK HOSPITAL
FIRE & SAFETY QUIZ

Name:_____ Department:_____
Date:_____ Score:_____
(Passing: 90% or above)

1) What does the acronym R-A-C-E stand for?
   R.
   A.
   C.
   E.

2) When a fire is identified the staff should always practice vertical evacuation first.
   a) True
   b) False

3) What should staff do when they hear a fire alarm?
   a) Close all doors on unit.
   b) Remove patients from unsafe areas to safe areas
   c) Do head counts of all patients
   d) All of the above

4) In the case of fire when would you evacuate the entire building?

5) When do you know it is safe to resume normal duties?

6) What does the acronym P-A-S-S stand for?
   P.
   A.
   S.
   S.

7) What do you do if you receive a bomb threat?
   a) Do not search for it
   b) Keep caller on the line and try to obtain as much information about the bomb as possible
   c) Notify the Safety Officer
   d) All of the above

8) Are stairwells considered a safe place to wait in the case of a fire?

9) When would a code yellow be called?

10) Which code is called for medical emergencies?

11) What is a code green? What are staff's responsibilities during a code green?

12) What is the three digit number to alert the operator that there is an emergency?

Name:_____
Date:_____

13) What should you do to keep your center of gravity low when lifting an object?
- a) Flex your hips and knees
- b) Use an assistive device
- c) Use a transfer sheet
- d) Ask for help from a coworker

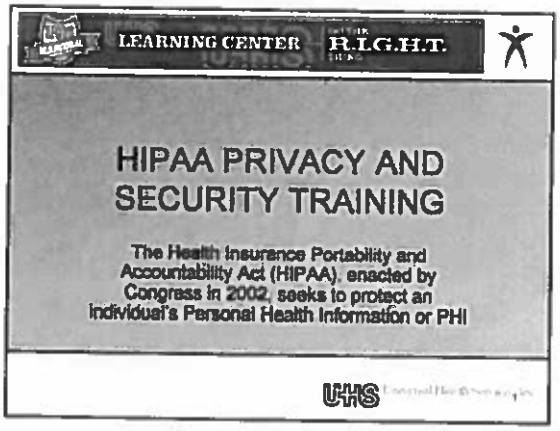
14) Which of the following actions is most likely to cause an injury?
- a) Lifting heavy objects close to the body
- b) Taking rests during repetitive-movement tasks
- c) Being out of shape
- d) Using mechanical lift equipment

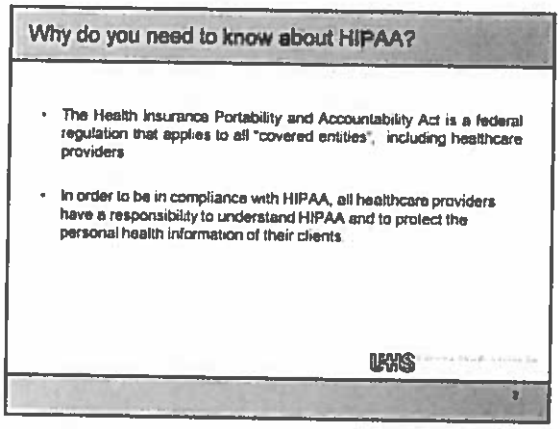
15) When lifting a heavy object, you should:
- a) Face away from the direction you plan to move
- b) Bend at the waist, not the knees
- c) Point your chin forward
- d) Stand up by straightening your knees, using your leg and hip muscles

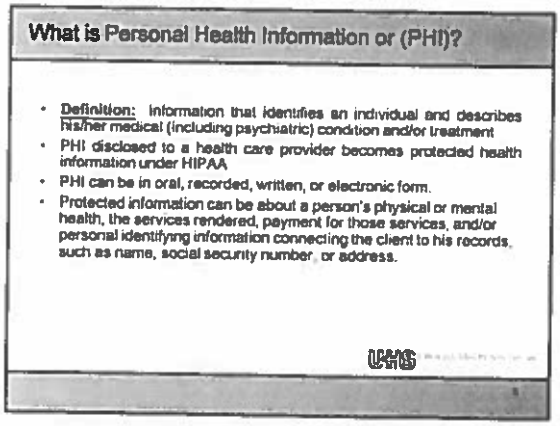
16) What should you do first if you notice blood or body fluids on the floor of the hallway?
- a) Assume Housekeeping will clean it up
- b) Secure the area and prevent patients from entering the area
- c) Absorb the spill with paper towels
- d) Put on PPE and absorb the spill with paper towels

17) Infectious wastes should be separated from regular waste for disposal.
- a) True
- b) False

18) The "right to know" portion of OSHA's Hazard Communication Standard ensures workers' right to information about hazardous materials in their workplace, the risks they pose to health and safety, and the right to tell their doctor about these materials.
- a) True
- b) False


LEARNING CENTER
R.I.G.H.T.
HIPAA PRIVACY AND SECURITY TRAINING
The Health Insurance Portability and Accountability Act (HIPAA), enacted by Congress in 2002, seeks to protect an individual's Personal Health Information or PHI
UHS


Why do you need to know about HIPAA?
• The Health Insurance Portability and Accountability Act is a federal regulation that applies to all "covered entities", including healthcare providers
• In order to be in compliance with HIPAA, all healthcare providers have a responsibility to understand HIPAA and to protect the personal health information of their clients.
UHS


What is Personal Health Information or (PHI)?
• Definition: Information that identifies an individual and describes his/her medical (including psychiatric) condition and/or treatment
• PHI disclosed to a health care provider becomes protected health information under HIPAA
• PHI can be in oral, recorded, written, or electronic form.
• Protected information can be about a person's physical or mental health, the services rendered, payment for those services, and/or personal identifying information connecting the client to his records, such as name, social security number, or address.
UHS

Privacy and Security

- There are 2 major sections of the HIPAA regulations
  - Privacy of PHI
  - Security of PHI

Privacy Regulations

- The privacy regulations protect the use and disclosure of Personal Health Information (PHI) including……
- Who can access the information, use the information, and pass on the information to others.

Use and Disclosure

- With few exceptions, PHI cannot be used or disclosed by anyone unless it is permitted by the Privacy Rule or authorized by the client.
- A healthcare provider is permitted to use or disclose PHI *only* in the following situations:
  - For treatment, payment, and healthcare operations,
  - With authorization from the client, or
  - For disclosure to the client.

Who Can Disclose PHI

- Disclosure of PHI *for purposes other than treatment, payment, or healthcare operations* should be handled through the Health Information Department (Medical Records) at your facility
- Client authorization is always required for:
  - Disclosure of psychotherapy notes
  - Research
  - Release to any third party

Never disclose PHI for any reason or in any form (oral, written, electronic) unless your job specifically authorizes you to do so. Then, make sure you are following all applicable hospital policies for that release.

UHS

Proper Authorization to Release PHI

- Must contain the following:
  - Description of the information to be released
  - Name of person(s) authorized to use or disclose the information
  - Name of person(s) to whom the information is to be released
  - The purpose of the use/disclosure
  - When the authorization expires
  - A dated signature of the client or authorized representative

UHS

When Is Authorization Not Required?

- Public health notification related to disease prevention and control.
- To report victims of abuse, neglect or domestic violence.
- Regulatory, licensing, or accrediting agency audits, surveys, and/or requests
- To coroners or medical examiners.
- To avoid serious injury or death

Always assure that the person you are releasing the PHI information to is who they say they are. Check for identification.

UHS

Minimum Necessary

- Federal regulations limit PHI disclosure and access to the minimum amount of information necessary to respond to the request
- Every facility must take the necessary steps to limit who has access to PHI and the amount of information that is accessible

If you observe PHI exposed to staff or visitors who do not have "a need to know" please report that exposure immediately to the HIPAA Officer of your facility.

UHS

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Minimum Necessary

- Healthcare providers are required to:
  - identify the staff who need access to PHI,
  - what types of PHI they have access to,
  - and the conditions appropriate for access

UHS

11

Client Rights

- Every client must receive a Notice of Privacy Practices when they first enter care
- This notice explains the client's rights under HIPAA and how they can access their own PHI
- The notice also explains the provider's responsibility to maintain the privacy of the client's PHI

You should see the Notice of Privacy Practices posted around the admissions area of your facility.

UHS

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Client Rights

- Clients can review, and have copies of, their own PHI, if approved (in writing) by their attending physician or therapist and not therapeutically contra-indicated

UHS

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Client Rights

- Clients may request "corrections" to their PHI, however,
- Providers have NO obligation to make "corrections" to accurate information
- Any client request for a "correction" must be documented

UHS

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Privacy Wrap Up

- Store all personal health information of clients securely
- Always discuss client information in private
- Avoid unnecessary discussion of client information
- Review restrictions on use and disclosure of PHI, and consult with an "expert" before releasing PHI

UHS

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Security Regulations

- The HIPAA Security Regulations protect information considered confidential under the Privacy Rules.
- Security regulations are intended to ensure PHI is available to those who need it and is not available to those who don't.
- Security regulations address how we store and maintain PHI.

Remember, you can't ensure that information is kept private if it is not secure.

UHS

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Four Requirements of The Security Regulations

- Ensure the confidentiality, integrity, and availability of PHI
- Protect information and storage systems from threats and hazards which may cause exposure or destruction of PHI
- Protect against non-authorized use or disclosure
- Ensure compliance by the workforce.

These regulations require us to be sure the information in our systems is kept confidential, has not been tampered with in some way, and is available to all who are authorized to see and use it.

UHS

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Scope of Security Regulations

- The HIPAA Security regulations were developed to protect electronic PHI
- However the regulations require the enforcement of the Privacy Regulations which cover all forms of media, including paper records.

UHS

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It's Everyone's Business

- Just like the Privacy regulations, the Security regulations make securing PHI the responsibility of everyone who comes in contact it
- Security threats you should look for and report immediately include:
  - Loss of PHI from human error, computer failure, fire, water, power failures
  - Theft of PHI
  - Unauthorized disclosure of PHI, whether accidental or intentional

UMS

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Theft of Information

- How Information is Stolen
  - Computer system penetration by hackers.
  - Disclosure caused by computer viruses.
  - Information taken from the trash.

UMS

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How to Protect Information

- Computer System Firewalls
- User ID's and Passwords
- Antivirus Software
- Encryption
- Being Vigilant

UMS

21

Guidelines for Computer Use

- Log ON and OFF the network
- Never let others use your ID or password
- Choose a secure password
- Regularly update your password
- Secure your workstation
- Never disable antivirus software
- Never install unapproved software

UHS

Known Risks

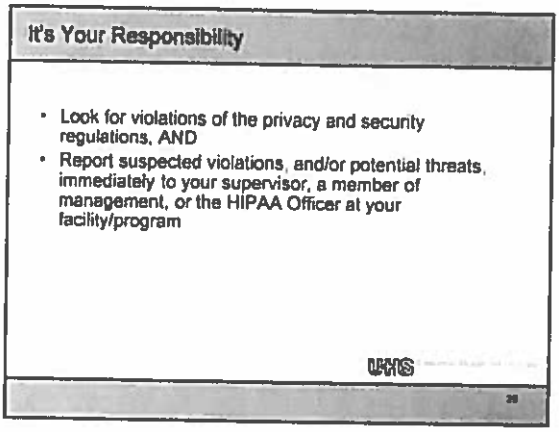
- Visitor sign-in logs containing client names
- Unit bulletin boards containing PHI
- Fax machines in unsecure locations
- Loose filing in areas where unauthorized staff or clients can see
- Calling out personal health information within hearing distance of others
- Computer screens that are visible to other than the computer operator
- Client special diet and allergy information posted in public view

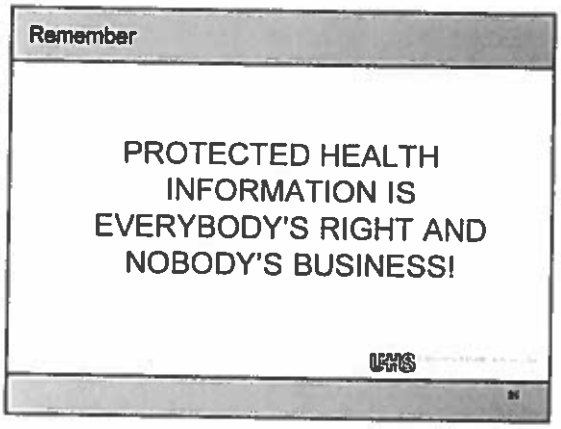
UHS

Security Wrap Up

- Log on and off your computer
- Never let others use your log on
- Follow your facility's policy for password protection
- Never disable anti-virus software
- Never install unapproved software

UHS


It's Your Responsibility
• Look for violations of the privacy and security regulations, AND
• Report suspected violations, and/or potential threats, immediately to your supervisor, a member of management, or the HIPAA Officer at your facility/program
UHS


Remember
PROTECTED HEALTH INFORMATION IS EVERYBODY'S RIGHT AND NOBODY'S BUSINESS!
UHS

HARTGROVE HOSPITAL/GARFIELD PARK HOSPITAL
Health Insurance Portability and Accountability Act (HIPAA)

Name:_____Department:_____
Date:_____Score:_____

1) The major goals of the HIPAA Privacy Rule are to:

A. Allow information needed to care for the patient to flow between caregivers and to protect the public's health and well-being

B. Limit healthcare to those who can afford to pay and to prevent the spread of disease in the community

C. Promote quality healthcare by allowing access to patient information to those who need it and to impose fines on healthcare providers making a profit

D. Develop standards allowing access to all health information by anyone and to protect the interests of the general public

2) Which of the following is/are possible consequences of a HIPAA violation?

☐ No violation exists if staff member was not trained.
☐ Lawsuits against the organization.
☐ Sanctions, including possibly losing your job.
☐ Fines of up to $25,000 for incidental (minor) violations

3) Which of the following is/are examples of Protected Health Information? (*select all that apply)*

☐ The name of the patient
☐ A patient diagnosis
☐ A recent surgery bill or insurance claim
☐ School immunization records for a child
☐ The Social Security number of the patient.
☐ E-mailed lab results
☐ A voicemail message about medication
☐ The address of the hospital or clinic

4) People who don't work with patient records are not responsible for maintaining the confidentiality of PHI.

A. True B. False

5) What is a Notice of Privacy Practices?

☐ A marketing brochure sent to patients from a healthcare organization
☐ A government notice sent to hospitals on HIPAA guidelines
☐ A document describing the organization's PHI policy given to new patients
☐ The Public Health Department notification sent to all doctors

6) You may not disclose patient information to an insurance provider unless the patient has signed an Authorization for Disclosure.

A. True B. False

7) Which rights do patients have regarding their PHI? (*select all that apply)*

☐ The right to an accounting of all outside disclosures of their PHI
☐ The right to file a complaint if they believe their confidentiality has been violated
☐ The right to request changes to their PHI if identifying information is inaccurate
☐ All of the above

8) HIPAA security regulations apply only to healthcare records that are stored electronically:

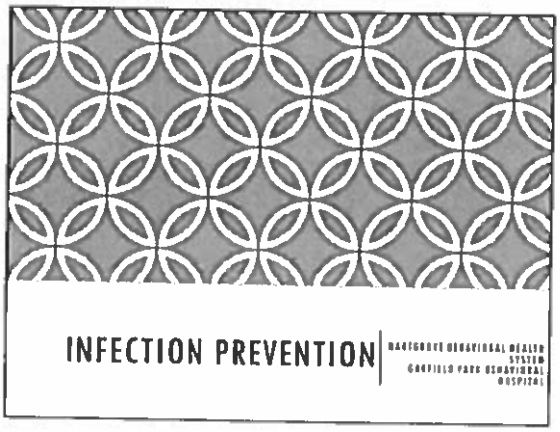
A. True B. False

9) Which of the following is/are your responsibility? (*select all that apply)*

☐ Reporting breaches of confidentiality
☐ Knowing how to report privacy violations
☐ Maintaining a secure password to your computer
☐ Changing progress notes at the patient's request

10) Hospitals must take steps to ensure that the information is limited to the minimum amount necessary to meet the desired purpose. The "minimum necessary" rule applies to the uses or disclosures by members of the healthcare workforce and uses or disclosures made on a routine or non routine basis.

A. True B. False



INFECTION PREVENTION

The goal of the Infection Prevention Program is to identify and reduce the risks of acquiring and transmitting infections to patients, visitors, employees and the community at large.

INFECTIONS

Infection: Presence of an organism or pathogen and the reaction of the tissue to that presence.

- **Healthcare-Associated Infection:** Not present or incubating at the time of admission but is acquired after admission.
- **Community Acquired:** Present or incubating at the time of admission.

MULTI DRUG RESISTANT ORGANISMS (MDRO'S)

- MDRO's are defined as organisms predominantly bacteria that are resistant to one or more classes of antimicrobial agents/ antibiotics
- MDRO's may be present on inanimate surfaces for prolonged periods of time.
- Examples:
  - MRSA - Methicillin-resistant Staphylococcus aureus
  - VRE - Vancomycin-resistant enterococci
  - ESBL - Extended-spectrum beta-lactamase
  - KPC - Klebsiella pneumoniae Carbapenemase
  - CRE - Carbapenem-resistant Enterobacteriaceae
  - Multidrug-resistant Acinetobacter baumannii
- *Special precautions are required*

STANDARD PRECAUTIONS

- Assumes that all blood, body fluids, secretions, excretions, mucous membranes and non-intact skin are potentially infectious
- **Hand washing/Hand antisepsis before and after patient contact and after removing gloves**
- Using Personal Protective Equipment when necessary

TRANSMISSION BASED PRECAUTIONS

- Additional measures to protect from highly transmissible pathogens requiring additional practices beyond standard precautions
- The types of *modified* isolation that our hospitals utilize include:
  - Contact (ex. patient with lice)
  - Droplet (ex. patient with strep throat)
  - Airborne (ex. patient with TB)

ISOLATION

- Sometimes, MDs may order a patient to be in isolation due to an infectious disease/condition.
- Patients on isolation because of an infection due to an MDRO are at more risk for having adverse events, less contact with their care providers, and higher rates of depression and/or anxiety.
- Contact isolation would require the employees to wear a gown and gloves when coming in contact with the patient.
- Droplet isolation would require the employees to wear a gown, face mask, and gloves when coming in contact with the patient.
- Airborne isolation would require the employee to wear a gown, N95 mask, and gloves when coming in contact with the patient.

NEEDLESTICK PREVENTION
PRACTICE SHARPS SAFETY

BE PREPARED

- Anticipate injury risks and prepare the patient and work area with prevention in mind.
- Use a sharps device with retractable needle whenever it is available.

BE AWARE

- Learn how to use the safety features on sharps devices.
- Keep the exposed sharp in view.

DISPOSE WITH CARE

- Activate safety features after use.
- Dispose of devices in rigid sharps containers; do not overfill containers.

EXPOSURE TO BLOODBORNE PATHOGENS

- You can be exposed to bloodborne pathogens when an infected patient's blood comes into contact with your eyes, nose, mouth, or broken skin.
- In the case of an occupational exposure to blood…
  - ✓ Immediately wash the site with soap and water.
  - ✓ Report the incident to your supervisor. They will give you a number to Sedgwick WC Clinical Consultation line to report the incident.
  - ✓ Sedgwick will provide guidance and follow up care instructions.

HAND HYGIENE
"WHEN TO PERFORM"

- Before and after patient contact
  - Both direct and indirect
    - Ex: Before and after taking patient vital signs, each medication pass, meeting with patients, any form of patient care
- Before/after handling food or eating
- After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient
- After blowing your nose, coughing, or sneezing
  - Before/after touching your mucous membranes
- After using toilet
- After removing gloves
- After touching garbage
- After equipment cleaning

HAND HYGIENE
"TWO METHODS"

- **Wash with soap and water:**
  - When hands are *visibly dirty*
  - Before eating
  - After using a restroom
  - After known or suspected exposure to *C.botulinum difficile*
  - After known or suspected exposure to patients with infectious diarrhea during norovirus outbreaks
  - If exposure to *Bacillus anthracis* is suspected or proven
- **Use alcohol based hand sanitizer:**
  - For everything else

HAND HYGIENE
"TWO METHODS"

Hand washing technique:

- Wet your hands first with water, apply the soap, and rub your hands together vigorously for at least *15-20seconds* covering all surfaces of the hands and fingers.
  - Hint: Have the "Happy Birthday" song from beginning to end twice.
  - Avoid using hot water, to prevent drying of skin
- Rinse hands well and dry with paper towel
- Turn off faucet with clean paper towel
- Open door with clean paper towel

Hand Sanitizer:

- Put product on hands and rub hands together
- Cover all surfaces until hands feel dry
- This should take around 20 seconds

PERSONAL PROTECTIVE EQUIPMENT (PPE)

- Gloves
- Gowns
- Mask/Goggles
- Face Shields
- Arm Guards
- Shoe coverings

CLEANING OF EQUIPMENT

Hartgrove Hospital & Garfield Park Hospital will comply with the Joint Commission National Patient Safety Goals and CDC guidelines on proper cleaning and disinfecting techniques in order to reduce the number of viable microorganisms on hospital equipment to prevent transmission or reduce incidence of healthcare associated pathogens.

CLEANING AND DISINFECTING

- Ensure you wait the appropropriate "kill time" before using items on another patient


2 Minutes


4 Minutes

- Clean all equipment before and after use. Some examples include:
  - ✓ Restraints
  - ✓ Blood Pressure Cuff
  - ✓ Stethoscopes
  - ✓ Washer/Dryers
  - ✓ Beds, Mattresses and Hard Surface Furnishings
  - ✓ Patient and Staff Refrigerators
  - ✓ CPR Mannequins
  - ✓ Wheelchairs/Gurney
  - ✓ Ambu/Resuscitation Bag
  - ✓ Nebulizer

NON BIOMEDICAL WASTE VS. BIOMEDICAL WASTE

Non Biomedical:

- Paper towels
- Gloves without visible blood
- Soiled diapers
- Tissues

Biomedical waste:

- Saturated dressings wet or dry
- Plastic tubing with ***visible blood or any other biomedical waste fluid, eg. Foley tubing***
- Bloody gloves
- Syringes without needles

If you have any doubt about what type of body fluid it is, place it in a red bag

THESE SUBSTANCES ARE NOT CONSIDERED BIOMEDICAL WASTE UNLESS THEY ARE VISIBLY SOILED WITH BLOOD:

- Feces
- Nasal Discharges
- Saliva
- Sputum
- Sweat
- Tears
- Urine
- Vomitus

- In the absence of visible blood, solidify liquids before disposal or dispose of liquids into the sewage system. If solidified, place in the regular waste containers.
- If there is visible blood, dispose as biomedical waste!

CLEANING & DISINFECTING FOR SMALL SPILLS (LESS THAN 100 ML'S)

- Small spills of bio-medical waste can be disinfected with hospital approved disinfectant sprays (Lysol) or wipes (Sanwipes).
- Follow manufacturer's instructions.
- Some need to stay wet up to 10 minutes to be effective!
- This approach is adequate for less than 100 ml's.
- Call House Keeping for assistance if necessary.

CLEANING AND DISINFECTING FOR LARGER SPILLS (MORE THAN 100 MLS)

- Spill kits for blood/body fluid, located in the clean utility rooms, are used for larger spills.
- Put on PPE (gown, gloves, mask w/ eye protection and shoe covers) located behind the nurses station.
- Absorb the material by sprinkling a solidifying agent over the spill. Use two spill kits if more solidifier is needed.
- Scoop the absorbed material with the small shovel from the kit, and place it into the red bag.
- Absorb any remaining material with the absorbable wipes.
- Disinfect the area with disinfectant anti- wipes or spray (Lysol) following manufacturer's recommendations.
- Place all material used for the spill in the red biomedical bag in the kit.
- Remove shoe covers, gloves, mask w/ eye protection and gown and place those in the red biomedical bag.
- Use the disinfectant wipes for your hands, then wash your hands with soap and water!

DECONTAMINATING BIOMEDICAL WASTE SPILLS

- Always wear gloves to clean up a spill, then perform hand hygiene after removal of the gloves.
- There is a difference between cleaning and disinfecting blood or body fluid spills!
- Cleaning requires wiping the spill.
- Disinfecting requires: Cleaning surface and disinfecting (sometimes a second disinfectant wipe is adequate)

INFLUENZA

- The flu is a contagious respiratory illness caused by influenza viruses that infect the nose, throat, and sometimes the lungs.
- It can cause mild to severe illness, and at times can lead to death.
- The best way to prevent the flu is by getting a flu vaccine each year.

INFLUENZA
REASONS TO GET A FLU VACCINE

- Flu vaccination can keep you from getting sick from flu.
- Flu vaccination can reduce the risk of flu-associated hospitalization, including among children and older adults.
- Flu vaccination also may make your illness milder if you do get sick.
- Getting vaccinated yourself also protects people around you.
- The flu vaccine is mandatory at Hartgrove Hospital and Garfield Park Hospital!

INFLUENZA
COMMON MYTHS

- Myth #1: Flu shots can cause the flu

No, a flu shot cannot cause flu illness. The most common side effects from the influenza shot are soreness, redness, tenderness or swelling where the shot was given

- Myth #2: You don't need a flu shot this year if you got one last year

Flu viruses are constantly changing. So vaccines are reviewed every year and updated as needed. Last season's vaccine was developed to fight last year's virus, but probably wouldn't be effective this season.

- Myth #3: Flu shots don't work

Recent studies show that vaccination reduces the risk of flu illness between 40% and 60%.

SEXUALLY TRANSMITTED INFECTIONS (STIS)

- STIs are the most commonly diagnosed infection.
- Chlamydia and Gonorrhea are the most prevalent.
- The majority of STI diagnoses are concentrated among adolescents and young adults.

TUBERCULOSIS

- Tuberculosis is caused by the bacteria mycobacterium tuberculosis spread through Airborne Transmission.
- TB bacteria are put into the air when a person with active TB disease of the lungs or throat coughs, sneezes, speaks, or sings. People nearby may breathe in these bacteria and become infected.
  - Active TB usually causes a bad cough that causes mucus or blood and chest pain.
- TB bacteria can live in your body without making you sick. This is called **latent TB infection (LTBI).**

HEPATITIS B (HBV)

- Viral infection of the liver
- Prevention:
  - Wash Hands
  - Use of Standard Precautions
  - Administer Vaccine
    - Three doses over six months
    - Side effects: fatigue, fever, nausea, vomiting, headache, injection site reaction

COVID-19

- **What is COVID-19?**
  - COVID-19 is a new disease, caused by a novel (or new) coronavirus that has not previously been seen in humans.
- **How does COVID-19 spread?**
  - The virus that causes COVID-19 is thought to spread mainly from person to person, mainly through respiratory droplets produced when an infected person coughs or sneezes. These droplets can land in the mouths, noses, or eyes of people who are nearby or possibly be inhaled into the lungs. Spread is more likely when people are in close contact with one another (within about 6 feet).
- **What are some symptoms of COVID-19?**
  - Some symptoms include, but are not limited to, cough, shortness of breath, difficulty breathing, fever, chills, muscle pain, sore throat, new loss of taste or smell. Symptoms may appear 2-14 days after exposure to the virus.

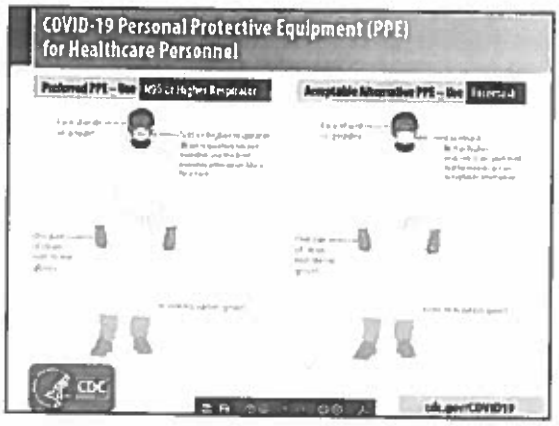
WHAT ARE WE DOING AT OUR HOSPITALS?

- Every person entering the hospital must go through a risk screening and symptom screening, including temperature check, prior to entering the hospital.
- We have adopted CDC's recommendations for universal masking. This means that every employee must wear a face covering at all times while in the hospital. Please think of the mask as part of your attire.
- Before accepting patients, we inquire about recent travel & exposure, any signs/symptoms of infection, and COVID-19 test results, in applicable.
- At HGH, we have installed negative air pressure machines, should we have a patient who becomes a Person Under Investigation (PUI).
- Should a patient become a PUI while at GPH, the patient will be transferred to a medical facility or to HGH for further treatment.

WHAT ARE WE DOING AT THE HOSPITAL?

- The Executive Team & Infection Preventionist (IP) meet on a consistent basis to review and make any necessary changes to our current practices.
- Any employee who calls off sick is cleared by HR and the IP, prior to the employee returning.
- We are encouraging social distancing whenever possible.
- We have the proper PPE available if we had a PUI in the hospital, and we continue to actively secure more and more PPE.

Please note, we are not actively accepting patients who have COVID-19, but have implemented safety measures should we see ourselves in a position to have a patient with COVID-19.



REMEMBER INFECTION CONTROL BASICS...

- Wash hands with soap for 15-20 seconds or use hand sanitizer
- Clean high touch surfaces– use cleaning supplies and sani-wipes which are EPA approved for COVID-19 virus.
- Cover cough/sneezes– cough in elbow or use tissues
- Don't touch your T-Zone– mucus membranes of eyes, nose, and mouth. This is the only way respiratory illness enters the body.
- If you have a fever or symptoms of a respiratory infection, such as cough and sore throat, stay home!

HARTGROVE / GARFIELD PARK BEHAVIORAL HOSPITAL
Infection Control Competency Quiz

Employee: ☐ Hartgrove Hospital ☐ Garfield Park Hospital

Name /Title: _____ Date:_____ Score: ___
(Passing Score 90%)

1. Which strategies have been shown to reduce the transmission of Multi Drug Resistant Organisms (MDROs) in health care organizations?
   A. Hand hygiene
   B. Environmental cleaning
   C. Contact isolation
   D. All of the above

2. What is the single most important way that health care workers can help prevent the spread of infectious diseases?
   A. Isolating infected patients
   B. Practicing hand hygiene
   C. Active surveillance
   D. None of the above

3. Which patients are at risk for MRSA?
   A. Patients with medical conditions
   B. Patients with frequent contact with the health care system
   C. Patients older than 65
   D. All of the above

4. Patients placed on isolation because of an infection due to an MDRO have more adverse events, less contact with their care providers, and higher rates of depression and anxiety, than patients not on isolation.
   A. True
   B. False

5. Many MDROs are present on inanimate surfaces for prolonged periods of time.
   A. True
   B. False

6. The concept of the Standard Precautions is that:
   A. All blood, body fluids and tissues must be handled as if they are infectious
   B. All healthcare workers have the same risk of acquiring infections
   C. All exposure incidents must be thoroughly investigated
   D. All healthcare facilities should implement the same infection control plan

7. If your hands are visibly dirty, you should:
   A. Use an alcohol-based hand sanitizer
   B. Wash them with soap and water
   C. Use and antiseptic hand wipe
   D. Wipe them with a paper towel

8. Personal protective equipment (includes gowns, gloves, masks, goggles, shoe coverings) should be used by all individuals entering the MDRO patient's room, even if he or she does not anticipate having direct physical contact with the patient, and removed before exiting the patient's room.

A. True
B. False

9. In the case of an occupational exposure to blood:

A. Scrub or wash the site with soap and water
B. Report the incident to your supervisor
C. Seek follow up care immediately
D. All of the above

10. Hepatitis B is caused by:

A. Bacteria
B. Virus
C. Fungus
D. Protozoa

11. Tuberculosis is spread primarily through:

A. Contact with contaminated environmental surfaces
B. Airborne particles from coughs or sneezes of infected persons
C. Exposure to blood and blood products that contain the bacteria
D. All of the above

12. A person with inactive TB can spread the disease to other people.

A. True
B. False

13. TB patients can no longer spread TB to other patients when:

A. They have received medication for one month
B. Their tuberculin skin test is negative
C. They produce three back-to-back sputum samples showing that no TB germs are found, they have received the proper medication for the right amount of time, and their symptoms have improved.
D. Their chest x-ray is clear

14. Active TB usually causes:

A. Increased appetite, weight gain, and tiredness
B. Nausea, vomiting, and diarrhea
C. A bad cough that causes mucus or blood and chest pain
D. Headache, trouble breathing, and neck stiffness

15. You can be exposed to bloodborne pathogens when an infected patient's blood comes into contact with your eyes, nose, mouth, or broken skin.

A. True
B. False

16. Staff will wear gloves each time the blood pressure cuff is cleaned with hospital approved disinfectant wipes and allowed to dry completely whenever visibly soiled or when coming in contact with skin of a patient with signs and symptoms of an infection.

A. True
B. False

17. Employees should check the lint trap and remove any lint from the dryer after each use:
    A. True
    B. False

18. Labeled food and/or beverages in the patient refrigerators (located in the third dayroom) will be discarded from the refrigerator within:
    A. 1 day from opening
    B. 2 days from opening
    C. 3 days from opening
    D. None of the above

19. When using hand sanitizer, product should be placed on hands and hands should be rubbed together covering all surfaces until hands are dry (approximately 20 seconds).
    A. True
    B. False

20. Obtaining the influenza vaccination is the most effective way to prevent the spread of the influenza virus.
    A. True
    B. False

21. When administering an injection, which of the following procedures allows for safe administration?
    A. Always use a retractable needle when available.
    B. When using a retractable needle ensure to retract prior to withdrawing from the patient.
    C. Never over fill sharps containers.
    D. All the above.