HACKENSACK MERIDIAN *HEALTH* GRADUATE MEDICAL EDUCATION POLICIES AND PROCEDURES

Subject: EMPLOYEE ASSISTANCE PROGRAM	Policy Number: 6.A
Approved by GMEC: May 9, 2018	Approved by MEC: June 7, 2018

1. INTRODUCTION AND PURPOSE

To offer professional counseling assistance to all Ocean Medical Center (OMC) residents or fellows and their family members who may experience personal or emotional difficulties which may affect job performance. Hackensack Meridian Health (HMH) has contracted with Hackensack Meridian Health Life Solutions, to provide this free and confidential service.

2. SCOPE

The Employee Assistance Program (EAP) is offered to all regular full and part-time OMC postgraduate medical education students and their family members.

3. APPLICABLE REGULATIONS AND GUIDELINES

ACGME Institutional Requirements IV.H., IV.H.1.
HMH **PolicyStat ID:** *3591282*
Office of Academic Affairs Resident Manual

4. ATTACHMENTS

5. RESPONSIBILITY

6. DEFINITIONS

Resident refers to all interns, residents and subspecialty residents (fellows) engaged in post graduate education at Ocean Medical Center. They are also identified by their year of postgraduate training (e.g. PGY 1).

7. PROCESS OVERVIEW

A. Policy

Through this program, OMC expresses a social and caring attitude about its residents and recognizes that most human problems such as marital or family distress, substance abuse, legal problems or other concerns can be treated successfully, particularly when identified early. Early identification, treatment and resolution serve to minimize human costs and the potential of

difficulty with job performance. While OMC has no intention of becoming involved in a resident's private life, it is our policy to provide help when a resident requests help for personal problems or offer help when deteriorating job performance and reduced productivity suggest problems outside of the work environment may be contributing to work problems.

1. Requirements
    a. OMC encourages residents and their family members to utilize the professional counseling services available through the EAP. In addition, supervisory staff members should utilize the resources of the EAP as an integral part of an intervention program to deal with poor job performance.
    b. OMC acknowledges that use of the EAP does not in any way alter management's responsibility or authority as an employer.
    c. Participation in the EAP will not in any way jeopardize future employment or career advancement; participation will not, however, protect the resident from disciplinary action for continued substandard job performance or rule infractions.
2. Confidentiality
    a. All information shared with the Employee Assistance counselor is strictly confidential.
    b. No records of resident participation or the content of their discussion with the EAP and its staff members are kept in the medical or personnel records.
    c. No release of information is made to anyone without specific written consent of the resident concerned, except where required by law.
    d. All information regarding a resident or family member's participation in the EAP is part of the clinical record maintained by Hackensack Meridian Health Life Solutions and is subject to state and federal confidentiality laws governing such medical records.
3. Sessions
    a. Appointments with the EAP should be scheduled during non-work hours.
    b. Each resident and his/her family member is entitled up to three (3) free, confidential consultation sessions, per problem, with the EAP which is staffed by experienced professionals who are prepared to help with any type of behavioral health problem. If the concern is outside the EAP counselor's area of expertise, or if there is a need for longer term treatment, the EAP counselor will (with the client's consent) make a referral for appropriate services.
4. Referral Procedures
    a. Self Referrals: The resident or family member may request an assessment/evaluation by contacting the EAP. **The EAP is available 24 hours a day, seven days a week at 1-800-273-0220.**
    b. An appointment will be scheduled within three days, where mutual schedules permit. Emergencies will be seen immediately.

c. Following the initial assessment, referral for treatment or service will be made to appropriate providers in the community if this is deemed appropriate. Referrals will be based on clinical need, geographical convenience and health plan considerations.

d. At no time will the names of residents or their family members be revealed or acknowledged to OMC without written consent.

5. Supervisor Referrals

   a. Program Directors are responsible for observing job performance and, when appropriate, referring residents to the program based upon decline or difficulties in job performance. A referral form can be obtained from the EAP.

   b. The decision to seek and/or accept help is entirely the responsibility of the resident. No attempt will be made to force or require residents to use the EAP. Whether help is sought or not, each resident will continue to be judged on the basis of his/her job performance. No special advantages or disadvantages will accrue because a resident participated in this program. This policy does not constitute a waiver of each Program Director's responsibility to maintain appropriate performance standards or to take disciplinary action when necessary. Nor does this policy constitute a waiver of any resident's rights under law.

   c. The Program Director will be requested to provide the EAP with written documentation specifying the resident's job difficulties; action taken thus far; and consequences of failure to correct performance problems.

   d. All information shared with the Employee Assistance counselor is strictly confidential.

   e. The content of all sessions is confidential and will not be released to management or other individuals without the specific written consent of the resident.

   f. With the resident's consent, the Program Director will receive feedback from the EAP reporting whether the resident has followed through with the referral by attending an EAP consultation session. No other personal or diagnostic information will be supplied unless specifically authorized in writing by the resident and a release of information has been signed listing the specific information to be released. This information will not be included in the resident's Human Resources file or any files maintained by the resident's department.

Hackensack Meridian *Health*

Origination Date:	*01/2003*
Last Approved:	*09/2013*
Last Revised:	*09/2013*
Next Review:	*09/2016*
Owner:	*Victoria Riveracruz: SR MGR TM & LABOR RELATIONS*
Policy Area:	*Human Resources*
Applies To:	
Applicability:	*Legacy Meridian Health Group*

Substance Abuse

Purpose:

Team member involvement with drugs and alcohol can adversely affect job performance and team member morale, jeopardize team member and guest safety, and undermine the public's confidence. Such involvement is particularly unacceptable in an industry like ours in light of the nature of our role in society and the potentially disastrous consequences to guests which may result from a team member's impaired condition. Our goal, and the purpose of this policy, therefore, is to establish and maintain a safe workplace and a healthy and efficient work force free from the effects of drug and alcohol abuse, and to extend to team members having an addictive disease an opportunity for effective treatment and rehabilitation.

Scope:

All team members of Meridian Health and its partner companies, including Meridian Hospitals Corporation and its hospitals.

Policy:

Meridian Health (MH) is committed to programs that promote safety in the workplace, team member health and well-being, and which promote a positive image of the institution in the community. Consistent with the spirit and intent of this commitment, MH has developed this policy regarding the sale, use, possession or distribution of drugs and alcohol by all MH team members and agents.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

MH encourages any team member with a drug or alcohol problem to contact the Employee Assistance Program (EAP), the Occupational Health Department, or any recognized external evaluation, referral or treatment agency for assistance. MH subscribes to the premise that addictive diseases are entitled to the same consideration and offer of treatment which is extended to any other disease. All communications and records will be maintained on a confidential basis. team members will not be subject to discipline for voluntarily acknowledging their drug/alcohol problems, nor will job security or promotional opportunities be jeopardized as a consequence only of having an addictive disease, except to the extent that the manifestations of the disease interfere with the team member's performance of his or her job. (1)

However, this will not excuse violations of the substance abuse policy for which the team member is subject to discipline. team members who utilized the MH team member assistance program or any other treatment resource will be expected to meet existing job performance standards and established work rules within the

framework of established administrative practices. A request for assistance does not exempt the team member from routine performance expectations, nor does it confer any immunity, legal or disciplinary, from the consequences of misconduct.

RULE REGARDING DRUGS AND ALCOHOL

Clearly, in situations involving potential team member impairment, the paramount concern and responsibility of MH has to be that of ensuring the safety and welfare of the patient. In those instances in which team member impairment may jeopardize the well-being of patients or the institution, the concern for the team member will, of necessity, have to be subordinated to the overriding responsibility to the patients and interests of MH. Therefore, whenever the capacity of an team member to function on the job has been diminished to the point where patient care may be compromised, supervisory personnel will have the responsibility for taking immediate action to 1) remove the impaired team member from patient contact; 2) initiate standard fitness for duty guidelines and/or disciplinary procedures; and 3) refer the individual to the EAP. The justification for taking such actions shall be observable unsatisfactory job performance or behavior. For further information, please refer to the Fitness for Duty Guidelines.

A. Use, Possession, Transportation, Sale, Distribution

The use, possession, sale or distribution of drugs or alcohol while on MH property or MH business shall be cause for immediate discharge. Illegal substances will be cause for immediate discharge. Illegal substances will be confiscated and the appropriate law enforcement agencies may be notified.

B. Drugs/Alcohol in System

1. Alcohol

A team member found to have a blood alcohol concentration of .04% or more (or its equivalent as determined by a different diagnostic test such as a Breathalyser) while on MH property or on MH business, shall receive a five day suspension on the first offense and shall be required to participate in the EAP. In addition, if the team member refuses to participate in the EAP and the terms of a chemical dependency treatment agreement and/or violates any rules set forth in this policy at any time thereafter, he/she shall be subject to immediate discharge.

2. Marijuana/Hashish

A team member found to have detectable concentrations of marijuana (or its metabolites) in his/her system shall receive a five day suspension on the first offense and shall be required to participate in the EAP. In addition, the team member shall be subject to random drug and alcohol testing. If the team member refuses to participate in the EAP and the terms of a chemical dependency treatment agreement and/or violates any rules set forth in this policy at any time thereafter, he/she shall be subject to immediate discharge.

3. Drugs Other than Marijuana or Alcohol

A team member found to have detectable concentrations of any drug other than marijuana or alcohol in his/her system, including, but not limited to heroin, cocaine, morphine, phencyclidine (PCP), amphetamines, barbiturates, or hallucinogens (or metabolites of any such drugs), shall receive a five

day suspension on the first offense and shall be required to participate in the EAP. In addition, the team member shall be subject to random drug and alcohol testing. If the team member refuses to participate in the EAP and the terms of a chemical dependency treatment agreement and/or violates any rules set forth in this policy at any time thereafter, he/she shall be subject to immediate discharge.

4. Testing for Drugs/Alcohol in System

A team member may be required to submit to blood, breath, urine or other diagnostic tests to detect alcohol and/or drugs (or drug metabolites) in his/her system whenever the team member is involved in an on-the-job accident or the team member's observed behavior raises a reasonable suspicion of drug or alcohol use. See Fitness for Duty Guidelines for criteria for what constitutes reasonable suspicion. A bargaining unit team member is entitled to have a union representative present, if immediately available, during the initial collecting of a specimen. If an initial screening test indicates positive findings, a confirmatory test will be conducted. Team members with a prior violation of the substance abuse policy will be subject to random testing. Any team member who refuses to submit to testing shall be subject to disciplinary action up to and including discharge.

C. Other Rules and Provisions

1. Searches

MH reserves the right to carry out reasonable searches of team members and their property, including but not limited to, lockers, lunch boxes, and private vehicles if parked on MH property. A bargaining unit team member whose person or property is being searched is entitled to have a union representative present, if immediately available, while the search is being conducted. A team member who refuses to submit immediately to such a search shall be subject to disciplinary action up to and including discharge.

2. Drug Paraphernalia

Team members are prohibited from bringing drug paraphernalia onto MH property at any time. A team member who possesses or distributes such paraphernalia while on MH property shall be subject to disciplinary action, up to and including discharge.

3. Off-Duty Arrests/Convictions

A team member who is arrested for, or convicted of a drug offense which involves the off-duty sale, distribution or possession of illegal drugs, must promptly inform MH of the arrest, the nature of the charges, and the ultimate disposition of the charges. Failure to do so is grounds for discipline, up to and including discharge. Such arrest/conviction may subject the team member to discipline, up to and including discharge, depending upon the circumstances involved.

4. Over-the-Counter or Prescribed Medications

Over-the-counter or prescription medications may have pharmacological effects which can impair job

functioning and performance. Additionally, many such medications may be abused even if obtained through legal means by exceeding the customary dosage. Team members taking such medications are responsible for using such drugs in an appropriate manner, becoming aware of the potential side effects of any such drug, and informing their supervisor of their use of medications which might potentially impair their job performance. Team members who intentionally abuse medications such as but not limited to, tranquilizers, sedative-hypnotics, analgesics, anti-depressants, or diet pills shall be subjected to the same disciplinary sanctions prescribed for illicit drugs in this policy, i.e., a five day suspension, random testing and referral to the EAP. Team members whose impairment can be demonstrated to be the result of an inadvertent unpredictable or a typical reaction to an over-the-counter or prescription medication shall be absolved of any responsibility for such an incident.

5. Reporting Violations of the Substance Abuse Policy

   It is each team member's responsibility to immediately report unsafe working conditions or hazardous activities that may jeopardize his/her safety or the safety of fellow team members, patients or visitors. This responsibility includes the responsibility to immediately report any violation of the substance abuse policy. A team member who fails to report such a violation may be subject to disciplinary action up to and including discharge.

6. Job Applicants

   Applicants for employment with MH will be given blood, breath, urine or other diagnostic tests to detect alcohol and/or drugs (or drug metabolites) in their system. Successful completion of the test is a condition of employment.

7. Re-Employment

   Any individual who leaves MH through layoff, resignation or termination for a period exceeding 90 days will be required to submit to blood, breath, urine or other diagnostic tests to detect alcohol and/ or drugs (or drug metabolites) in their system prior to re-entry into the workforce. Positive test results for alcohol or drugs will be considered in deciding whether the team member shall be permitted to return to work.

8. Progressive Discipline Not Applicable

   The disciplinary steps set forth in the team member handbook and the Guidelines for Cooperation and Discipline policy providing for progressive discipline (e.g., 1st written warning, 2nd written warning, probation, discharge) or the three step process for level II infractions, do not apply to violations of the substance abuse policy. The discipline to be imposed for violations of the substance abuse policy shall be governed solely by the provisions set forth herein.

   Any questions regarding this policy and procedure may be referred to the Human Resources Site Leader, the Human Resources Generalist, the Director of Human Resources, or the Senior Vice President of Human Resources. Questions may also be directed to the Employee Assistance Program at 1-866-379-0244 24 hours/day, seven days/week.

Special Notes / Appendix

1. There may be limited exceptions to this guarantee in 1) instances where there may be a clear and present danger presented to the welfare of the team member or another person; 2) where the impaired, functioning on the part of a licensed healthcare professional would mandate a report being made to the appropriate state licensing board; 3) where records or testimony might be subject to subpoena or other legal process; or 4) where the team member consents to disclosure.

Related Documents

The following is a list of other documents related to the current document. Changes you make to the current document may affect the documents listed.

Pre-PolicyStat Number: MHS-HR-01-2604

Attachments:

No Attachments

Applicability

Bayshore Medical Center, Hackensack Meridian Health Inc. , Jersey Shore University Medical Center, Legacy Meridian Health, Ocean Medical Center, Raritan Bay Medical Center - Old Bridge Division, Raritan Bay Medical Center - Perth Amboy Division, Riverview Medical Center, Southern Ocean Medical Center

HACKENSACK MERIDIAN *HEALTH*
OCEAN MEDICAL CENTER
GRADUATE MEDICAL EDUCATION
POLICIES AND PROCEDURES

Subject: **SUBSTANCE ABUSE/PHYSICIAN IMPAIRMENT**	**Policy Number:** **6.b**
Approved by GMEC: March 7, 2016	**Approved by MEC: June 7, 2018**

ACGME Institutional Requirements IV.H., IV.H.2. Effective July 1, 2018
HMH **PolicyStat ID:** *3591282*
Office of Academic Affairs Resident Manual

Current Status: *Active* **PolicyStat ID:** *3591282*

Hackensack Meridian *Health*

Origination Date:	*01/2003*
Last Approved:	*09/2013*
Last Revised:	*09/2013*
Next Review:	*09/2016*
Owner:	*David Works*
Policy Area:	*Human Resources*
Applies To:	
Applicability:	*Legacy Meridian Health Group*

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Pre-PolicyStat Number: MHS-HR-01-2604

Attachments:

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Assign Acknowledgments

Select Users or User Groups

Note Acknowledgments have not yet been assigned. Clicking the button below will assign them.

Automatically assign when new versions with changes are approved

Assign Acknowledgments

3591282

HACKENSACK MERIDIAN *HEALTH*

OCEAN MEDICAL CENTER

GRADUATE MEDICAL EDUCATION

POLICIES AND PROCEDURES

Subject: **HARRASSMENT**	**Policy Number:** **6.C**
Approved by GMEC: March 7, 2016	**Approved by MEC: June 7, 2018**

Reference Human Resources Policies and Procedures Document #: **PolicyStat ID:**
*3591287*ACGME Institutional Requirement IV.H., IV.H.3. Effective July 1, 2018

Hackensack Meridian *Health*

Origination Date:	*01/2003*
Last Approved:	*07/2016*
Last Revised:	*07/2016*
Next Review:	*07/2019*
Owner:	*Victoria Riveracruz: SR MGR TM & LABOR RELATIONS*
Policy Area:	*Human Resources*
Applies To:	
Applicability:	*Legacy Meridian Health Group*

Harassment

Purpose:

This policy is intended to clearly articulate Meridian Health's zero tolerance for harassment in the workplace.

Scope:

All team members, physicians, contracted team members, volunteers and applicants for positions of Meridian Health and its partner companies, including Meridian Hospitals Corporation and its hospitals.

Policy:

It is Meridian Health's (MH) policy to maintain a working environment free from harassment based on sex/ gender, race, age, religion, ethnicity, disability, creed, color, national origin, marital status, nationality, atypical hereditary cellular or blood trait, sexual orientation, gender identity or expression, veteran status, disability and any other form of forbidden harassment of any team member or applicant for employment, physician, volunteer, or contracted partner. This also applies to harassment that occurs outside the workplace but in connection with Meridian activities or the performance of Meridian business. Meridian policy prohibits harassment by Meridian team members against any person as well as harassment toward Meridian team members by volunteers, contractors/partners, consultants, suppliers, vendors, and guests/patients. This includes, for example, sexual harassment by a person against another person of the same sex or gender. Such harassment in any manner or form by anyone is expressly prohibited. All team members and applicants are to be treated in a respectful and professional manner, and no individual is to be subjected to any unwelcome conduct that is or should be known to be offensive because of his or her gender, race, age, religion, ethnicity, disability, creed, color, national origin, marital status, nationality, atypical hereditary cellular or blood trait, sexual orientation, gender identity or expression, veteran status or other protected category. Further, no team member shall engage in unwelcome and offensive conduct motivated by an individual's gender, race, age, religion, ethnicity, disability, creed, color, national origin, marital status, nationality, atypical hereditary cellular or blood trait, sexual orientation, gender identity or expression or other protected category. "Harassment" in this policy includes all conduct contrary to this policy.

All reported or reasonably suspected occurrences of forbidden harassment will be investigated in a confidential manner and as promptly and thoroughly as is practicable and necessary. Where forbidden harassment has occurred, MH will take appropriate disciplinary and/or other corrective action, up to and including termination of employment.

There will be no retaliation against anyone who has complained about or reported alleged harassment or who

has cooperated with an investigation of alleged harassment.

GUIDELINES

Conduct Prohibited by the Policy:

1. Hostile Environment Harassment: Hostile environment sexual harassment may occur when there are unwelcome sexual advances, requests for sexual favors, or other verbal or physical conduct of a sexual nature. Also, unwelcome and offensive non-sexual conduct directed at an individual because of the individual's gender (female or male) may create a hostile environment. Racial, age-based, religious, ethnic, disability-related, sexual orientation-related, and other forbidden forms of harassing conduct (for example, those listed above) may also occur when it is motivated by or relates to an individual's race, age, religion, ethnicity, disability, sexual orientation, or other legally protected characteristics. In all such cases, hostile environment harassment occurs when such conduct is sufficiently severe or pervasive and 1) unreasonably interferes with an individual's work performance, or 2) creates an intimidating, hostile or offensive work environment.
2. "Quid Pro Quo" Sexual Harassment: "Quid Pro Quo" sexual harassment may occur when there are unwelcome sexual advances, requests for sexual favors, or other verbal or physical conduct of a sexual nature, when 1) submission to such conduct is an explicit or implicit condition of employment; or 2) submission to or rejection of such conduct is used as the basis for employment decisions.
3. Forbidden Harassing Conduct: This policy also prohibits unwelcome harassing conduct, even if the conduct is not sufficiently severe or pervasive enough to create a hostile environment or is not "quid pro quo" harassment.

   Examples of Forbidden Conduct

   It is impossible to list all conduct that may violate this Policy or is otherwise unacceptable. Following are examples only:

   - All unwelcome and offensive jokes, stories, comments, or verbal abuse of a sexual, age-based, religious, racial or ethnic nature, or relating to or motivated by gender, race, age, religion, disability, sexual orientation, or other protected category.
   - Use of any degrading or derogatory words or language to describe or refer to any person, or any harsh or unfair conduct motivated by a person's gender, age, race, religion, disability, sexual orientation or other protected category.
   - Displaying - in the workplace or while on MH business - of objects or pictures which expressly or implicitly degrade individuals or groups on the basis of race, age, gender, religion, ethnicity, disability, sexual orientation or other protected category.
   - Offering, promising or granting preferential treatment to a team member or applicant because of that individual's age, religion, race, ethnicity, gender, sexual orientation or disability, or as a result of, or in anticipation of, that individual's engaging in or agreeing to engage in sexual or romantic conduct, even if the conduct is consensual.
   - Use of MH e-mail, voicemail or Internet access for any purpose which reasonably is or should be known to be offensive because of its sexual, religious, racial or ethnic content, or its relationship to gender, sexual orientation or disability or based on any other protected category. NOTE: No MH staff shall use MH equipment to access Internet web sites known to contain sexually prurient

material, or that promote or advocate sexism, racism or other forms of bigotry based on gender, age, race, religion, disability, sexual orientation or other protected category or otherwise contrary to common sense standards of behavior.

- Unwelcome flirtation, sexual advances, propositions, or pressures for sexual favors, and unwelcome inquiries into someone's sexual experience or activity, including, without limitation, sexually foul language, leering and whistling, or other unwelcome sexually or otherwise suggestive conduct.
- Unwelcome and unnecessary physical contact.

4. Respect and Professionalism: It is not the purpose of this Policy to dictate a detailed code of respect and professionalism. But the best way to avoid situations that may be construed as harassment and to ensure that all staff work in a positive environment, is to encourage all staff to treat each other in a respectful and professional manner. However, not every instance of actual or perceived incivility or unprofessional behavior will be a violation of this Policy. There are too many occasions, especially in working situations that are, at times, fast-paced and pressure-filled and where personalities vary widely, where people with even the best intentions can say things or act in ways perceived as offensive or undesirable. While MH hopes that such occurrences will be the exception rather than the rule, we cannot treat such occurrences as necessarily constituting "harassment" under this Policy, and we expect staff to use good judgment and common sense before reporting or accusing someone of "harassment" in such situations.
5. Consensual Banter/Private Conversations: Human relationships sometimes involve occasional banter or conversations with a sexual content potentially offensive to others. No employer can police inter-personal relationships to the point of eliminating from private consensual conversations all terms which might be offensive to someone. But be sensitive that private conversations, though not offensive to the parties involved, may be offensive to others if overheard because MH will be held accountable if we fail to take appropriate safeguards. At the same time, even private conversations in the workplace are not to involve sexually crude terms or the use of jokes or comments that are derogatory or perpetuate stereotypes on the basis of gender, race, religion, ethnicity, age, disability, sexual orientation, or other legally protected characteristics.
6. Responsibilities: This Policy prohibits harassment by MH staff against any person, as well as harassment directed toward MH staff by contractors, consultants, suppliers, vendors, visitors, volunteers, physicians, and other non-team members, when such conduct occurs at MH locations or in connection with MH activities or the performance of MH work.

   MH will make reasonable efforts to see that our actions, and those of our agents and supervisory team members, are free from forbidden harassment of MH staff and will take appropriate corrective action when we investigate and verify such forbidden harassment. MH will also take appropriate corrective action where we, our agents or supervisory team members, learn of forbidden harassment of any MH staff.

   All levels of management and supervisory team members will:

   - Reject any offer or promise of sexual or other favors made by any team member or applicant for employment in anticipation of or in exchange for some employment decision and at the same time advise such team member or applicant for employment that such an exchange violates policy and will not be tolerated.
   - Avoid involvement in even consensual romantic or sexual relationships with team members in less-senior or non-supervisory positions because such involvement may lead to unforeseen complications and expectations.

- Avoid forbidden harassment, including the appearance of such harassment, by refraining from actions, languages and jokes, and by disposing of materials such as posters or magazines, which, due to their sexual or racial content, for example, could reasonably be anticipated to offend an team member or applicant.
- Report to designated members of ;leadership, as stated below, any forbidden harassment that they observe, that is made known to them by others, or that they reasonably suspect has occurred.
- Assure MH team members as necessary that all forms of forbidden harassment are expressly prohibited, that MH will investigate reported and suspected occurrences of forbidden harassment, and that MH will take appropriate corrective action when forbidden harassment is found to have occurred.

7. Procedures:

Notification Procedures: Any team member or applicant who suspects that he or she may be a victim of forbidden harassment or who knows of or suspects the occurrence of forbidden harassment should promptly and in confidence inform one of the local MH human resources leaders, director of team member and labor relations or senior vice president of human resources. If, for any reason, a person feels uncomfortable reporting possible harassment to one of these individuals, that person should report the matter to any member of leadership.

In addition, all leadership and supervisory staff have an affirmative duty to promptly report to one of the individual's designated above any harassment that they observe, that is made known to them by others, or that they reasonably suspect has occurred.
Investigation Procedure: All reported occurrences of forbidden harassment will be investigated as promptly and thoroughly as is practicable and required under the circumstances. Anyone who is the target of the alleged harassment, who reports possible harassment, or who participates in the investigation, will be assured that all forms of forbidden harassment are expressly prohibited, that MH will conduct a confidential investigation and that it will take appropriate corrective action if forbidden harassment is found to have occurred.

MH will designate the individual responsible for investigating reported incidents of harassment. The timing, scope and extent of the investigation will be determined by MH on a case-by-case basis, considering the circumstances of the alleged harassment. All investigations will be conducted to protect, as much as possible, the privacy of, and minimize the suspicion toward, all persons concerned. MH team members contacted in connection with an investigation are to cooperate fully by telling the full truth.

Procedure Pending Investigation: Pending the outcome of an investigation, reasonably necessary and prudent interim measures, such as separation of the complainant and the alleged offender, temporary leave for the alleged offender and/or complainant, etc., will be at MH's sole discretion, taking into consideration the complainant's wishes, the seriousness of the accusations, the background of the situation, and other relevant information.

Resolution and Outcome of Investigation: Following an investigation, MH will take the action necessary or appropriate under the circumstances:

No Violation: In the event that the investigation discloses no violation of this Policy or is inconclusive, all necessary parties will be so advised.

Violation: In the event that the investigation discloses a violation of this Policy, MH will communicate its findings to both the complainant and the alleged offender. Based upon the totality of the circumstances, appropriate disciplinary and/or other corrective action, up to and including termination, will then be taken. The disciplinary steps set forth in the team member handbook and the Guidelines for Cooperation and Discipline policy providing for a progressive discipline (e.g., written warnings, probations, suspension and/or discharge) do not apply to violations of the Harassment Policy. The discipline imposed for violations of the Harassment Policy shall be governed solely by provisions set forth herein. The action taken will be reasonably calculated to prevent any further unacceptable conduct. It is within MH's sole discretion to determine the appropriate corrective action.

If an investigation of possible harassment reveals no forbidden harassment but instead reveals that someone has abused the Policy by lodging a knowingly false or frivolous complaint, by fabricating facts, by failing to tell the truth, or by knowingly omitting important facts, MH will take appropriate disciplinary and/or other corrective action, up to and including termination of employment.

8. No Retaliation

No one who legitimately reports or complains about harassment or unacceptable conduct, or who assists MH in its investigation, will be subject to retaliation. Anyone who feels that he or she has been the victim of, or threatened with, retaliation, should immediately inform any leadership team member for prompt investigation and action.

Any questions regarding this policy and procedure may be referred to the Human Resources Site Leader, the Human Resources Generalist, the Director of Human Resources, or the Senior Vice President of Human Resources.

Special Notes / Appendix

TItle VII of the Civil Rights Act of 1965 (Amendment of Title VII if applicable)

Related Documents

The following is a list of other documents related to the current document. Changes you make to the current document may affect the documents listed.

External Related Documents

N/A

Pre-PolicyStat Number: MHS-HR-01-2607

Attachments:

No Attachments

HACKENSACK MERIDIAN *HEALTH*
OCEAN MEDICAL CENTER
GRADUATE MEDICAL EDUCATION
POLICIES AND PROCEDURES

Subject: **ADA COMPLIANCE POLICY**	**Policy Number:** **6.D**
Approved by GMEC: March 7, 2016	**Approved by MEC: June 7, 2018**

Reference Human Resources Policies and Procedures #: **PolicyStat ID:** *3574252*

Effective Date: July 1, 2018

Hackensack Meridian *Health*

Origination Date:	*03/2009*
Last Approved:	*01/2015*
Last Revised:	*01/2015*
Next Review:	*01/2018*
Owner:	*Victoria Riveracruz: SR MGR TM & LABOR RELATIONS*
Policy Area:	*Human Resources*
Applies To:	
Applicability:	*Legacy Meridian Health Group*

ADA Compliance Policy

Scope:

All team members of Meridian Health and its subsidiary companies, including Meridian Hospitals Corporation and its hospitals. This policy also applies to all applicants for employment with Meridian Health to the extent required by law.

Policy:

Meridian Health is committed to providing reasonable accommodations for eligible individuals with qualifying disabilities as defined by federal, state and local law. Meridian Health's intent is to advise team members and/or applicants for employment making requests for accommodation under the ADA of the accommodation process. Meridian Health is committed to following the requirements of the ADA and all appropriate federal and/or state laws, rules and regulations.

PROCESS

The process for determining reasonable accommodation is designed to be an interactive dialogue. The team member or applicant needing an accommodation generally has the responsibility to initiate the request for the accommodation by discussing the need with Human Resources.

In order to determine whether an accommodation request is reasonable, the individual may be required to provide additional information regarding the nature of his/her disability, the requested accommodation, as well as submit documentation from his/her health care provider certifying the individual's disability and need for an accommodation. Human Resources will engage in an interactive process with the individual in order to determine the reasonableness of any accommodation which would permit the individual to perform all of the essential functions of his/her position. Meridian Health retains the sole authority to determine whether an accommodation is reasonable and whether to grant or deny an accommodation request.

NOTE: All medical information obtained throughout the determination process is considered a "confidential medical record", and must be solicited and received by Human Resources who will provide only information about necessary restrictions and accommodations to leaders and supervisors. All medical information and the completed Reasonable Accommodation Request form will be kept by Human Resources as confidential medical record files, separate from personnel records.

Human Resources shall inform the team member of its decision to grant or deny the request.

Procedure:

All requests for reasonable accommodation are to be submitted in writing on the appropriate form(s) and with the appropriate supporting documentation for consideration and/or review. The review of the request may, at the discretion of Meridian Health, include an evaluation and determination of the scope of the disability and, if appropriate, a request for additional medical documentation, examinations and/or opinions.

Any questions regarding this policy and procedure may be referred to the Team Member and Labor Relations Specialist, Team Member and Labor Relations Manager, Team Member and Labor Relations Sr. Manager, Director of Human Resources, or the Senior Vice President of Human Resources.

Related Documents

The following is a list of other documents related to the current document. Changes you make to the current document may affect the documents listed.

Pre-PolicyStat Number: MHS-HR-01-2704

Attachments:

No Attachments

HACKENSACK MERIDIAN *HEALTH*

OCEAN MEDICAL CENTER

GRADUATE MEDICAL EDUCATION

POLICIES AND PROCEDURES

Subject: PATIENT SAFETY AND DISCLOSURE	**Policy Number: 6.E**
Approved by GMEC: March 7, 2016	**Approved by GMEC: June 7, 2018**

Reference Human Resources Policies and Procedures Document # PolicyStat ID: *5005115*

Effective July 1, 2018

Hackensack Meridian *Health*

Origination Date:	*05/2009*
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Owner:	*Deeba Siddiqui: VP PATIENT SAFETY HMH*
Policy Area:	*Patient Safety*
Applies To:	*Hackensack Meridian Health Network*
Applicability:	*Hackensack Meridian Health Network*

Patient Safety and Disclosure

Purpose:

To outline Hackensack Meridian Health's (HMH) Patient Safety Plan and advance our culture of safety, process improvement, learning and transparency. This policy details HMH's culture of:

- Reporting of all patient safety events, including serious preventable adverse events, never events, unanticipated outcomes, near misses and circumstances that create an unsafe situation for our patients and residents;
- Using process and system analysis to identify, evaluate, and design measures to prevent adverse events that may cause harm from occurring;
- Applying knowledge learned from others regarding patient/resident safety; and
- Sharing the knowledge learned from our own experiences with others.

Hackensack Meridian supports and agrees to the following principles:

- We will apologize to the patient and/or family affected by the never event
- We will report the event to external agencies in accordance with our Reportable Events Policy and Patient Safety Organization Patient Safety Evaluation System Policy
- We agree to perform an event analysis (root cause analysis/apparent cause analysis)
- We will waive all costs charge by Hackensack Meridian Health entities directly related to a never event
- We will make a copy of this policy available to patients, patients' family members and payers upon request.
- We will interview only patients and/or families who are willing, able and agreeable, to gather evidence for the event analysis (root cause analysis/apparent cause analysis) and will inform the patient and/or his/her family of the action(s) that our hospital will take to prevent future recurrences of similar events based on the findings from the root cause/ apparent cause analysis.
- We will have a protocol in place to provide support to caregivers involved in patient safety events, and make that protocol known to all caregivers and affiliated clinicians (We Care Program).
- We will perform an annual review to ensure compliance with each element of Leapfrog's Never Event Policy for each never event that occurred.

Scope:

All patient care divisions, departments and services of the Hackensack Meridian Health Enterprise.

Policy:

A. RESPONSIBILITIES

Board of Trustees

The authority for the Patient Safety Plan rests with the HMH Board of Trustees. The Board of Trustees delegates authority to implement and maintain the Patient Safety Plan described herein to the Patient Safety Officer of HMH.

Board oversight of the Patient Safety Plan is delegated to the Quality and Safety Committee of the Board. A report on the status of the effectiveness of the Patient Safety Plan will be provided to the Quality and Safety Subcommittee of the Board at least annually.

SAFETY COMMITTEE STRUCTURES

Hackensack Meridian Health Safety Council

The Hackensack Meridian Safety Council's focus includes patient, resident, team member, medical staff and guest safety. The group meets monthly in accordance with the Hackensack Meridian Safety Council Work Plan. The Council's objectives are as follows:

- Develop Hackensack Meridian's strategic safety goals and fulfill the requirements of the Patient Safety Act
- Assure system-wide alignment of Hackensack Meridian's strategic safety initiatives and Patient Safety Plan
- Provide oversight for designated areas on Hackensack Meridian's System Risk Assessment
- Refer safety issues to appropriate subject matter experts for evaluation and development of system-wide solutions, as needed
- Review aggregate safety data from the Safety Event Classification Committee to assure timely reporting of serious preventable adverse events to the N.J. Department of Health and Patient Safety Organization
- Review/approve safety policies for network-wide implementation
- Review/approve Apparent Cause Analyses and monitor effectiveness
- Oversee evaluation of Sentinel Event Alerts and implementation of risk reduction strategies
- Develop and recommend implementation of measures to minimize the risk of preventable adverse events
- Review developments in evidence-based patient safety practices and recommend appropriate modification of policies and procedures to enhance patient safety
- Analyze aggregated patient safety event data and common cause analysis data to identify and determine patterns or trends of events or similar problems for further analysis
- Review root cause analyses (RCA) for system-wide learning
- Monitor RCA corrective action plans after implementation to determine the impact on preventable adverse events
- Foster attitudes, beliefs and behaviors supporting open communications about adverse events and near misses throughout Hackensack Meridian Health

The Patient Safety Officer serves as Chair of the Hackensack Meridian Safety Council and reviews and oversees the system's ongoing efforts to identify risks to patient, resident, team member, medical staff and guest safety and reduce the likelihood of injury. The Chief Risk Officer serves as the co-Chair.

Core Membership of Hackensack Meridian's Safety Council:

Core membership of Hackensack Meridian's Safety Council consists of the Executive Vice President & General Counsel for the Hospital Enterprise, Senior Vice President & Chief Quality Officer, Chief Nursing Executives, Chief Medical Officers, Chief Quality Officers, Vice President for Ambulatory Services, Senior Manager Nursing Education, Associate Program Director of Infectious Diseases, HRO Directors, Medical Director of Quality, Senior Claims Officer, Clinical Program Manager, Pharmacy Administrator, Director of Case Review, Administrator for Safety and Quality, Director of Environmental Health & Safety, the Outcomes and Risk Managers from each Hospital and key representative(s) from all partner companies providing patient/resident care services.

Hackensack Meridian Health RCA Sub-Committee:

The Hackensack Meridian Health RCA Subcommittee supports and advances the Network's Patient Safety Plan by reviewing the quality of network -wide root cause analyses, strength and ease of implementation of the corresponding action plans and fulfills the following N.J. Patient Safety Act requirements by:

- Reviewing root cause analyses for system-wide learning with particular focus on serious preventable adverse events, serious safety events and precursor events, and as appropriate, recommending modification of facility systems, technology, policies or procedures to enhance patient safety
- Utilizing a Safety Assessment Code Matrix to rank hazards and vulnerabilities. The Subcommittee then utilizes the Action Hierarchy, to evaluate if the action is strong, intermediate or weak in preventing recurrence, and a Corrective Action Plan Implementation Index to describe the ability to implement as, green - easier to implement, yellow - moderately challenging and red - significantly challenging, which determines level of support required for successful implementation.
- Documenting whether each RCA is accepted, rejected, or modified and recommending cases for presentation to the Network Safety Council
- Developing and distributing safety alerts/messages to share lessons learned from cause analyses

The HRO Director and Medical Director of Quality serve as co-chairs of the RCA Sub- Committee. Core membership includes the Vice-President for PI, Chief Medical Officer, RPI Specialists, and Patient Safety leaders from across the network including the partner companies.

HMH Leadership Responsibilities

Administrative, management and medical staff leaders throughout HMH are responsible for:

- Correcting work conditions, processes, and procedures that increase the chance a patient/resident will be harmed;
- Ensuring that employees under their direction receive relevant information and education concerning the Patient Safety Plan;
- Ensuring prompt reporting of events or situations of actual or potential patient/resident harm; and
- Promoting a fair and "just" work environment that supports and encourage reporting and continuous patient/ resident safety improvement

DEFINITIONS

Adverse Event
An event that is a negative consequence of care that results in unintended injury or illness, which may or may not have been preventable.

Failure Mode Effects Analysis (FMEA)
A systematic approach for identifying the ways that a process can fail, why it might fail, and how it can be made safer.

Near Miss
An unsafe situation that is indistinguishable from a preventable adverse event except for the outcome. A patient is exposed to a hazardous situation, but does not experience harm either through luck or early detection..

Patient Safety
Freedom from injury while receiving healthcare services.

Patient Safety Event
Any unanticipated outcome, identified error, adverse event, near miss, sentinel event, medication variance, significant procedural variance, or other threat to safety that could result in patient/resident injury. Patient/resident harm does not need to occur for an event to be called a Patient Safety Event.

Patient Safety Work Product
Data, reports, records, memoranda, analyses or written or oral statements which are either reported to Hackensack Meridian's Safety Council and Patient Safety Committee or developed under the auspices of Hackensack Meridian's Safety Council and Patient Safety Committee for the conduct of patient/resident safety activities.

Preventable Event
An event that could have been anticipated and prepared against, but occurs because of an error or other system failure.

Root Cause Analysis
A structured, problem-solved technique for identifying the factors that underlie variation in performance, understanding causes of error, as well as developing and implementing plans for improvement and prevention of reoccurrence.

Root Cause Analyses:

- Are interdisciplinary involving; an executive sponsor, RCA team leader, analyst, stakeholder and subject matter expert
- Continually dig deeper by asking why, why, why at each level of analysis
- Identify deviation, causal factors, and missed opportunities
- Identify root causes and types of human error (rule, knowledge, skill based)
- Identify changes that need to be made to processes/systems
- Develop corrective action plans
- Share learnings across the system

Apparent Cause Analysis

- Performed on less significant events with medium to low risk and recurrence is minimal
- Usually completed at unit level and shared for transportability
- Examines facts and conditions
- Few hours with significantly fewer resource demands
- Swift turnaround
- Goal: Fix mistake or failure to prevent recurrence

Sentinel Event
A sentinel event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:

- Death
- Permanent harm
- Severe temporary harm*

*Severe temporary harm is critical, potentially life-threatening harm lasting for a limited time with no permanent residual, but requires transfer to a higher level of care/monitoring for a prolonged period of time, transfer to a higher level of care for a life-threatening condition, or additional major surgery, procedure, or treatment to resolve the condition. Adapted from: Throop C, Stockmeier C. The HPI SEC & SSER Patient Safety Measurement System for Healthcare. 2011 May.

Never Event
Never events are adverse events that are serious, largely preventable, and of concern to both the public and health care providers for the purpose of public accountability.

Serious Preventable Adverse Event
An adverse event that is a preventable event and results in death or loss of a body part, or disability or loss of bodily function lasting more than seven (7) days or is still present at the time of discharge from a health care facility.

Significant Unexpected Outcome
Unanticipated, unintended, undesired, and significant consequence(s) of medical treatment.

Human Factors
Understanding the effect of workspace, equipment, tasks, and other sociotechnical aspects of a workers' environment on how the work is performed.

Staff Member

Team members (employees) of Hackensack Meridian Health, members of HMH Medical Staff, Contract/Agency staff, Students and Volunteers of Hackensack Meridian Health.

Unexpected Outcome
A result that differs significantly from that which was intended or anticipated to be the result of treatment or a procedure.

A. PHILOSOPHY FOR REPORTING PATIENT SAFETY EVENTS

Hackensack Meridian Health

- Believes that most Patient Safety Events are due to process and system failures. Our goal is to identify and remediate those systems and processes which allow Patient Safety Events to occur;
- Recognizes that to create and maintain a safe environment for our patients/residents, we must establish a culture in which caregivers can report and learn from Patient Safety Events without fear that the reporting of the event will result in negative consequences. Hackensack Meridian Health promotes openness and requires that all Patient Safety Events be reported immediately upon recognition;
- Believes that failure of a staff member to report a Patient Safety Event that he or she has knowledge of creates a situation where additional harm can occur. Failure to report a Patient Safety Event is subject to disciplinary action.

Procedure:

A. REPORTING RESPONSIBILITIES

All Hackensack Meridian Health leaders, team members and medical staff, as well as contract/agency staff, students and volunteers are required to report Patient Safety Events.

Hackensack Meridian has a fair and "just" work environment that supports and encourages the reporting of all Patient Safety Events. This environment holds individuals accountable for their own performance in accordance with their job responsibilities, but not for system/process failures or flaws over which they have no control. A "performance management" algorithm has been developed to guide this decision-making process based on best practices utilized throughout the United States.

However, if a staff member reports a Patient Safety Event immediately upon recognition, there will be no disciplinary action taken against the reporting staff member even if the staff member was involved in the Patient Safety Event, except in the circumstances noted below. In these situations, progressive discipline may be warranted from verbal counseling, up to and including termination from employment. Discipline will be determined at the sole discretion of Hackensack Meridian Health.

Exceptions to "no disciplinary action":

- The staff member fails to participate in the detection and reporting of Patient Safety Events in accordance with this policy
- The staff member fails to participate in the system or process improvements resulting from Patient Safety Event Reviews.
- The staff member has demonstrated an inability or unwillingness to learn from or accept remediation

- There is reason to believe criminal activity or criminal intent may be involved in causing or reporting a Patient Safety Event
- The event is attributable to voluntary impairment of the staff member (e.g. drug or alcohol impairment) as delineated in the Hackensack Meridian Health, "Fitness for Duty Guidelines" Human Resources Policy
- False information is provided in the reporting, documentation, or follow-up of a Patient Safety Event

NOTE: This policy does not preclude the initiation of counseling or remedial education/training for a staff member as may be indicated under the circumstances.

B. PROCEDURES FOR REPORTING OF PATIENT SAFETY EVENTS

1. Staff members are to report all Patient Safety Events to their immediate supervisor as soon as the staff member is aware of the occurrence, to the online reporting system, or by calling their site's safety hotline.
2. Supervisors will ensure the Patient Safety Event is appropriately reported as outlined in procedures # 3 - 6 below.
3. Upon recogniton of any Patient Safety Event, the staff member reporting the event will prepare and submit an occurrence report via the Hackensack Meridian Onelink on-line reporting system or site adverse event reporting system. The report will be reviewed in accordance with Hackensack Meridian's Occurrence Reporting Policy
4. If the Patient Safety Event is a potential sentinel event, the supervisor/manager receiving the report will ensure that the Risk Manager and respective Administrator are immediately notified in accordance with Hackensack Meridian's Sentinel Event Policy. The Risk Manager or Administrator shall notify the site Patient Safety Lead of the event who is responsible for bringing the matter to the Safety Event Classification Committee for review.
5. If the Patient Safety Event is a potential serious preventable adverse event reportable to the NJDOH, the supervisor/manager receiving the report will ensure that their respective Administrator, Risk Manager, and NJDOH Patient Safety Liaison are immediately notified in accordance with Hackensack Meridian's Reportable Events to NJDOH Policy. The Risk Manager, Administrator or NJDOH Patient Safety Liaison shall notify the Patient Safety Officer of HMH and bring the matter for review/discussion at the Safety Event Classification Committee or schedule an emergent case conference for further discussion.
6. If the Patient Safety Event is a medication variance, the event will be reviewed according to level of severity per Hackensack Meridian's Medication Variance Reporting Policy.
7. Any staff member may report a Patient Safety Event to the Patient Safety Officer of Hackensack Meridian Health or to their site's Quality, Safety and/or Outcomes Department.

C. ACTION(S) TO INSURE PATIENT SAFETY

Staff member(s), involved in a Patient Safety Event will take immediate action to ensure safety of the patients, residents, staff and others in the environment. Preservation of all items involved in the incident will be the responsibility of the area manager or designee. If an immediate procedural change is determined to be necessary, the involved manager(s) and professional staff members will work with the Risk Manager and on-call division Administrator or designee to implement immediate changes that might be required.

D. SUPPORT FOR INDIVIDUAL(S) INVOLVED IN PATIENT SAFETY EVENTS

Patient/Resident and Family

The attending physician, medical, nursing and administrative staff, as appropriate, will mobilize appropriate support in a coordinated fashion to assist the patient/resident and their family following the event. Support may include but is not limited to, services from the Pastoral Care, Social Work and/or Patient/Guest Relations Departments and Administration.

Staff Members

Hackensack Meridian Health recognizes that when a Patient Safety Event occurs with a significant unanticipated

outcome for the patient/resident, the staff members involved in that event are greatly affected on a personal and professional level. The attending physician, medical, nursing and administrative leadership, as appropriate, will mobilize appropriate support in a coordinated fashion to assist the involved staff. Support may include but is not necessary limited to services rendered from the We Care Support Program (second victim support).

E. ONGOING DATA COLLECTION, EVALUATION AND RISK ASSESSMENT

The goal of data collection, evaluation and risk assessment is to compile information about Patient Safety Event frequency and type in order to identify and reduce the likelihood of patient/resident incidents or negative experiences that have potential to result in injury, accident, or other loss to patients/residents. Data collection, evaluations and analyses associated with patient safety activities, including peer review activities, are considered "patient safety work product" within the context of the Patient Safety and Quality Improvement Act of 2005 and the N.J. Patient Safety Act. As such, documents developed as a result of these activities will be treated as confidential and privileged.

Ongoing Data Evaluation

Aggregated patient safety data will be presented at the Hackensack Meridian Patient Safety Committee and Safety Council quarterly to identify patterns, trends, or problems that require further analysis. Both Committees will insure the sharing of pertinent internal and external experiences across the system in order to determine the need for system-wide solutions or changes.

In addition, on-going review of evidenced-based patient safety practices will be performed and applied as needed to reduce the probability of preventable adverse events.

Design, Redesign, Improvement (Robust Process Improvement Methodology)

When undesirable variations in performance are identified, specific plans for improvement will be developed and implemented. Hackensack Meridian uses the Robust Process Improvement approach as its performance improvement model. Appropriate methods and tools will be utilized when applying this methodology to effect process and system improvements. Changes recommended by the Hackensack Meridian Safely Council will be monitored to determine the impact on the facility.

Proactive Risk Assessments

At least every eighteen months, each Joint Commission accredited organization will select a minimum of one high-risk process for proactive risk assessment using the Failure Mode and Effects Analysis methodology (FMEA). When selecting high-risk processes for proactive risk assessment, each division will consider data obtained from the performance improvement process, as well as information published by professional organizations and accrediting bodies that identify the most frequently occurring types of Patient Safety Events (i.e., Joint Commission Sentinel Event Alerts, Institute of Safe Medication Practices Alerts, NJDOH Patient Safety Reports, etc).

In addition, each division will conduct at least one root cause analysis of a near-miss or a preventable adverse event not subject to mandatory State reporting requirements. Consideration will be given to the seriousness of the resulting potential disability, observed trends or patterns, and the likelihood that a particular event will be repeated.

F. EDUCATION/COMMUNICATION

1. Each hospital division and partner company providing patient care services will disseminate internal and external generated data and information to appropriate staff members within their respective organizations to ensure that the lessons learned are communicated and utilized to reduce the risk of Patient Safety Events. When possible, under the auspices of the Risk Management and/or Patient Safety Departments, case studies will be identified to communicate lessons learned.
2. Education for staff members on the Patient Safety Plan will be on-going and included in the Hackensack Meridian General New Hire Orientation, New Leader Orientation, Medical Resident Orientation and Annual Basic Training

(ABT) Programs. Information will include Hackensack Meridian's key policies and procedures to promote patient safety, the requirements of the N.J. Patient Safety Act, and how to recognize and report Patient Safety Events to the Hackensack Meridian Safety Council.

3. Staff members and medical staff members who provide care, treatment or services and who have concerns about the safety or quality of care provided may report these concerns or a patient safety event anonymously to the N.J. Department of Health, Joint Commission or to a designated Patient Safety Organization certified by the US Department of Health and Human Services. Persons making such reports are not subject to adverse employment actions for so doing.

   Note: Staff members may consider reporting to the Patient Safety Officer of HMH first.

G. ANNUAL REVIEW

Annually, the Patient Safety Officer will submit a report to the Board of Trustees on the effectiveness of the Patient Safety Plan and including actions taken to improve patient safety, both in response to actual occurrences and proactive findings.

H. DISCLOSURE OF SIGNIFICANT UNEXPECTED OUTCOMES (SUOs) DISCLOSURE OF EVENT TO PATIENT/ RESIDENT AND FAMILY (Reference NJ Regulation 8:43E-10.7)

When a serious preventable adverse event or an adverse event resulting from an allergic reaction that was not previously documented in the patient's or resident's medical history, the patient/resident, and when appropriate, their families should be informed. This should occur as soon as reasonably possible. In almost all instances, disclosure should be handled by the attending physician who has responsibility for overall care of the patient. It is recommended that appropriate hospital representatives participate along with the physician at any disclosure discussion so that the patient or resident or family members have the opportunity to ask questions of all concerned (see "Disclosure of Significant Unanticipated Outcomes" guidelines and "Frequently Asked Questions About Disclosure" below for details).

Disclosure to Patients/Residents

The physician responsible for the treatment or treatment plan should prepare patients or residents for the possibility of risk of complications from treatment by obtaining an informed consent and explaining common and/or serious complications, hazards, and risks of any procedure or treatment. All physicians are, therefore, directed to Hackensack Meridian Health's Informed Consent Policy and protocols for reference.

- All healthcare professionals can facilitate the consent process by helping to clarify the patient's concerns and questions at the time of admission and throughout the hospital stay and by referring those concerns to the attending physician.
- When a serious preventable adverse event or an adverse event resulting from an allergic reaction not previously documented in the medical history occurs or is identified, the physician responsible for that patient is usually the most appropriate person to explain the outcome and impact on the patient's present and future condition. The patient's or resident's attending physician, facility administrator or another health care professional authorized in accordance with facility polices shall make disclosure within 24 hours of the time the facility discovers the event.
- The patient or resident or in the case of a minor or incompetent adult, the patient's or resident's personal representative, guardian, parent or other family member, as appropriate shall be 1) told in person if the patient or resident is still admitted to the facility; 2) by telephone if the patient or resident has left the facility and the facility cannot arrange a face to face meeting; 3) by certified mail if the facility cannot reach the patient or resident; or 4) if the physician determines that informing the patient or resident would adversely affect the patient's or resident's health, the family member can be informed if confidentiality laws are not violated. In disclosing an event to a family member, the first preference is the spouse, partner in a civil union, adult children or parents and then siblings. The physician should document in the medical record why the patient or resident cannot be told of the event.

- The following should be recorded in the medical record: 1) the time date and individuals present when the disclosure was made and to whom the disclosure was made; 2) a statement of the occurrence of the event; and 3) the facility may request written acknowledgment from the patient or resident or family that they received information about the event or allergic reaction. The patient or family must be told that the acknowledgement is voluntary and is not a release from liability by the patient or resident or an admission of liability on the part of the physician.
- In the case of an allergic reaction, the facility shall inform the patient or resident of other circumstances, if known in which the same allergic reaction might occur, known preventive measures and shall advise the patient or resident to inform any health care professional providing future care of the allergic reaction.
- The information concerning the note in the medical record may not be subject to discovery or admissible as evidence or otherwise disclosed in a civil, criminal or administrative action or proceeding

Disclosure is a process. All questions need not be answered at the first meeting with the patient or the patient's legally authorized surrogate decision-maker. Disclose only what is known at the time of the discussion.

Frequently Asked Questions About Disclosure (F.A.Q's):

1. What medical outcomes should be disclosed?

   Significant and unexpected outcomes of medical treatment should be disclosed.

2. To whom should the disclosure be made?

   Disclosure of SUO's should be made to the affected patient or resident. If the patient or resident is deemed incapable of understanding a discussion of this nature, then the information should be made available to the appropriate person on the patient's or resident's behalf and documented inthe patient's or resident's medical record.

3. Who ought to disclose events to patients or residents?

   In almost all instances, the primary responsibilty for disclosing SUO's rests with the patient's/resident's attending/ treating physician.

   In certain cases, the SUO may be most associated with non-physician staff, such as nursing or other health care professionals. In such cases, the duty of disclosure will rest with those responsible for the staff (such as Nursing Manager) and those with the most immediate and intimate knowledge of the SUO. Prior to any such disclosure, the nursing or other health professional shall advise the patient's/resident's attending/treating physician of the nature of the disclosure. Every effort should be made to have the attending physican present at the time of disclosure.

4. When should disclosure take place?

   Disclosure of the SUO should take place as soon as is practically possible after an SUO is identified.

5. If a physician or other health care provider is unsure as to whether or not an adverse outcome should be disclosed to a patient, where can this person seek advice?

   When uncertain as to whether or not an unexpected outcome should be disclosed pursuant to this policy, physicians and/or hospital staff should contact Risk Management.

6. What should happen if the responsible health care provider does not disclose to a patient a significant unexpected outcome?

   Generally speaking, the determination of what is a "significant" and "unexpected" outcome rests with the patient's/ resident's treating physician. If a disagreement should arise as to the need for disclosure, the circumstances should be brought to the attention of the chairperson of the affected Medical Staff Department using the customary chain of command.

7. Are there outcomes or events where disclosure is discretionary?

Disclosure of certain events may be a matter of clinical judgment. For example:

- Outcomes which have been discussed with patients or residents prior to treatment during an informed consent disclosure discussion may or may not be subject to disclosure depending on rarity and/or severity of the treatment outcome.
- Events that are not unexpected or that do not harm patients / residents do not require disclosure to patients or residents. However, disclosure may for other reasons be appropriate or justified. In these cases, practitioners should discuss with Risk Management.
- Significant unexpected outcomes discovered after patient or resident discharge or after the patient or resident has recovered full health may still require disclosure to the patient / resident. Again, when in doubt, discuss the situation with Risk Management.

8. What are the benefits of disclosure of significant unexpected outcomes?
   - Patients or residents will receive prompt care and advice for unexpected significant changes in their medical condition
   - Provides an opportunity for improvement in care and patient or resident relations
   - Lessons learned from identification of Patient Safety Events and reporting will facilitate correction of system problems that underlie harmful patient safety events

Special Notes / Appendix

This was formerly a Hackensack Meridian Hospitals Corporation policy: HMHC-ADMIN-02-1274, which was originally created January 9, 2006.

Approved by:

Hackensack Meridian Health Safety Council, May 2018

Meridian Health Safety Council June 2017

Meridian Health Patient Safety Committee, June 2016

Meridian Health Safety Council, June 2016

Meridian Health Safety Council, February 2015

Meridian Health Safety Council, April 2014

Pre-PolicyStat Number: HMHS-ADMIN-01-1077

Attachments:

No Attachments

Approval Signatures

Step Description	Approver	Date
	Deeba Siddiqui: VP PATIENT SAFETY HMH	06/2018

Applicability

All Document Search Site, Bayshore Medical Center, Hackensack Meridian Health Inc. , Hackensack University Medical Center, Jersey Shore University Medical Center, Ocean Medical Center, Palisades Medical Center, Raritan Bay Medical Center - Old Bridge Division, Raritan Bay Medical Center - Perth Amboy Division, Riverview Medical Center, Southern Ocean Medical Center