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INSTRUCTIONS FOR COMPLETION

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

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

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

HOW TO ACCESS LEARNING

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

*Note for Volunteers at CHOP: you do not have access to Learning and are not required to complete the attestation. Contact the Volunteer Office with specific questions you have.

LOGIN/TECHNICAL SUPPORT

• Contact the CHOP IS Service Desk @ 4-HELP (215-590-4357) with any issues/questions.
• Please have your employee ID number handy for identification purposes.
HISTORY

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

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

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

With more than 550 investigators and a research staff in the thousands, the Children’s Hospital of Philadelphia Research Institute continues groundbreaking research on diabetes, neonatal seizures, childhood cancer, hemophilia, pediatric heart disease.

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

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

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

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

OUR VALUES
At Children’s Hospital of Philadelphia, we are committed to making breakthroughs for children every day. We advance health care for children through the integration of family-centered, safe and high quality care with innovative research and quality professional education. Every employee has the ability and opportunity to contribute to breakthroughs in care and service, whether large or small. By defining our collective values, we create the framework for delivering these breakthroughs as we partner with the children and families we serve.

ICARE
We embrace the following values in all we do:

Integrity
Compassion
Accountability
Respect
Excellence

SERVICE STANDARDS
Everyone who works here is dedicated to creating an environment in which families feel welcome, respected and confident that their child is receiving the best care. By doing so, we also create an environment in which each employee can flourish, feel valued and contribute to making new breakthroughs for children.

Be Present, Physically and Mindfully
Communicate Clearly
Practice with a Questioning Attitude
Take Ownership to Solve Problems

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

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

CLICK TO VIEW THE POLICY
CLEARANCE STANDARDS POLICY (HR POLICY 2-20, 2-20A, 2-20B)
The Children’s Hospital of Philadelphia has implemented clearance standards to protect the safety and welfare of its patients and staff. All Staff and any other persons or entities acting or providing services on behalf of the Hospital, must comply with applicable standards requirements prior to, and or during their engagement with the Hospital. This policy applies to all CHOP staff, (paid and unpaid). It also applies to any other persons or entities acting or providing services on behalf of the Hospital. This does not apply to patients or families of patients or visitors of patients.

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

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

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

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

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

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

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

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

IMPROVE THE SAFETY OF CLINICAL ALARM SYSTEMS.

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

REDUCE THE RISK OF PATIENT HARM RESULTING FROM FALLS.

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

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

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

CLICK TO VIEW THE POLICY

LANGUAGE AND SPIRITUAL CARE SERVICES

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

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

POPULATION SPECIFIC COMPETENCY

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

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

CLICK TO VIEW THE POLICY

RULES OF CONDUCT (HR POLICY 5-2)

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

CLICK TO VIEW THE POLICY

IDENTIFICATION AND NAME BADGES

Employees are required to wear name badges while on duty unless they interfere with the performance of duty (to be determined by appropriate supervisor). The badge must be worn so that the employee’s name is clearly visible to patients and visitors. Employee Identification badges will be issued on the first day of the assignment. CHOP ID Badges are to be worn at all times. Badges are to be returned to your supervisor on your last day of work.
ATTENDANCE/PUNCTUALITY
Good attendance and punctuality are necessary for a work environment to be productive. Please be punctual at all times. If, for some reason, you must arrive late or be absent, it is YOUR responsibility to inform your CHOP supervisor no later than two hours before your start time.

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

CONFLICT OF INTEREST - (ADMINISTRATIVE POLICY A-3-1)
The Hospital is committed to conducting its affairs in accordance with the highest ethical and legal standards. In order to maintain these standards, it is the policy of the Hospital that potential, perceived and actual conflicts of interest are to be avoided. This applies to all employees, staff and employees of affiliated institutions. Potential, perceived and/or actual conflicts of interest of goods or services offered by the Hospital include: gifts, inside information, and outside interests, activities, and solicitation.
HOURS OF WORK

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

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

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

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

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

MEAL PERIODS AND WORK BREAKS

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

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

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

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

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

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

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

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

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

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

If you are reviewing this document as part of the Orientation and Attestation LearningLink course, return to the course to view the mandatory ed content by clicking the button called “2. Mandatory Education”. Otherwise, use the link below.

All Mandatory Education content is now available online, on all devices at this link - Mandatory Education
APPENDIX B
POLICIES
## Policy: Equal Employment Opportunity & Affirmative Action

<table>
<thead>
<tr>
<th>Type:</th>
<th>Human Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicable to:</td>
<td>The Children’s Hospital of Philadelphia (“CHOP”) Enterprise Wide</td>
</tr>
<tr>
<td>Process owner:</td>
<td>Senior Human Resources Business Partner</td>
</tr>
<tr>
<td>Effective Date:</td>
<td>3/24/2014</td>
</tr>
<tr>
<td>Supersedes:</td>
<td>2/7/2012</td>
</tr>
<tr>
<td>Approved by:</td>
<td>Senior Manager, Diversity, Equity and Inclusion</td>
</tr>
<tr>
<td>Document ID #:</td>
<td>2-1</td>
</tr>
<tr>
<td>Accountable for:</td>
<td>Robert E. Croner, Sr. Vice President, Human Resources</td>
</tr>
</tbody>
</table>

1. **PURPOSE:**

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

2. **POLICY:**

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

3. **COVERAGE:**

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

4. **PROCEDURES:**

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

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

C. All personnel actions, such as compensation decisions, benefits, transfers, Hospital sponsored training including tuition assistance, social and recreational programs, are administered without regard to race,
Policy: Equal Employment Opportunity & Affirmative Action

color, religion, sex, age, national origin, ancestry and sexual orientation, gender identity, genetic information, marital status, disability, covered veteran status, or other protected classifications to the extent required by applicable laws.

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

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

5. RESPONSIBILITY:

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

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

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

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

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

2 Scope
This policy applies to all CHOP staff, (paid and unpaid). It also applies to any other persons or entities acting or providing services on behalf of the Hospital.

NOTE: This does not apply to patients or families of patients or visitors of patients.

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

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

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

5 Definitions

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

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

6 Related Documents

<table>
<thead>
<tr>
<th>Document Type</th>
<th>Document Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policies</td>
<td>• HR Policy 2-10 Use of Contract Labor</td>
</tr>
<tr>
<td></td>
<td>• HR 2-2 Recruitment</td>
</tr>
<tr>
<td></td>
<td>• A-3-8 Control of On-Site Activity by Vendors</td>
</tr>
<tr>
<td></td>
<td>• A-1-5 Compliance Standards of Conduct</td>
</tr>
<tr>
<td>Job Aids</td>
<td>• 2-20a- Clearance Standards and Reference Tools</td>
</tr>
<tr>
<td></td>
<td>• 2-20b- CHOP Clearance Standards Definitions</td>
</tr>
<tr>
<td>Regulatory References</td>
<td>Joint Commission Standards</td>
</tr>
<tr>
<td></td>
<td>• HR.01.02.05</td>
</tr>
<tr>
<td></td>
<td>• HR.01.04.01</td>
</tr>
<tr>
<td></td>
<td>• HR.01.05.03</td>
</tr>
<tr>
<td></td>
<td>• HR.01.06.01</td>
</tr>
<tr>
<td></td>
<td>• HR.01.07.01</td>
</tr>
<tr>
<td>Clearance Requirements (e.g. CHOP, TJC, OSHA, CMS, etc.)</td>
<td>Payrolled Staff</td>
</tr>
<tr>
<td>---------------------------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>CHOP employees who are on CHOP's payroll must follow all policies, procedures, and standards for standard of care and/or work performance, including dress code, attendance, and any other aspects of work environment or behavior.</td>
<td>(Non-patient care areas)</td>
</tr>
<tr>
<td>Orientation (handbook)</td>
<td>X</td>
</tr>
<tr>
<td>Verification of education, experience, and competence (A23) effective 4/15/2014</td>
<td>X</td>
</tr>
<tr>
<td>Clearance Requirements (CHOP) effective 4/15/2014</td>
<td>X</td>
</tr>
<tr>
<td>Verified education, experience, and competence (A23) effective 4/15/2014</td>
<td>X</td>
</tr>
<tr>
<td>CHOP Clearance Standards Reference Grid 2-20a, Effective 4/15/2014</td>
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</tr>
</tbody>
</table>

Notes:  
*Clinical Students/Non-Payrolled Interns includes students who are 70% or more involved in patient care (not including education). Requirements are specific to student involvement in patient care and are determined on an individual basis.** 
**Volunteers are required to follow the CHOP Volunteer Handbook and must complete a background check and/or drug screen.**

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<table>
<thead>
<tr>
<th>Action</th>
<th>Purpose or Definition</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verify SSN and Birth Date (CHOP compliance requirement)</td>
<td>Social Security Number and Birth Date are CHOP requirements for purposes of compliance and information security. This is a no-exception policy. All information will be kept strictly confidential.</td>
<td>N/A</td>
</tr>
<tr>
<td>Verify licensure, certification, registration and professional references</td>
<td>Primary Source Verification at the time of hire/renewal. The copy of the actual license does not meet this compliance standard.</td>
<td>Joint Commission (HR.01.02.05)</td>
</tr>
<tr>
<td>Verify education, experience and competence</td>
<td>Any education, experience, competence required for the job must be verified and demonstrated.</td>
<td>Joint Commission (HR.01.02.05)</td>
</tr>
<tr>
<td>Verify 7 year state and county criminal clearances, sex offender registry search, Act 73 Clearances (PA State Criminal, FBI Fingerprint and Child Abuse Clearance) and Sex Offender Registry Search</td>
<td>Results of the required criminal background checks, FBI fingerprinting, and the Child Abuse Clearance (CAC) must be verified before the staff member can perform any work; or, if a 30-day provisional status is authorized by HR. Per legal, same background check required for all employees and non-employees, for example Volunteers, unless otherwise specified.</td>
<td>Joint Commission (HR.01.02.05)</td>
</tr>
<tr>
<td>Completion of health screening requirements.</td>
<td>PPD, drug screening, immunizations, and flu vaccine; as needed by role and location. Drug screening may not be required for Volunteers and students</td>
<td>Joint Commission (HR.01.02.05)</td>
</tr>
<tr>
<td>Complete and documented orientation</td>
<td>Mission and goals, hospital and unit-specific policies and procedures, infection control, cultural diversity and sensitivity, rights of patients, ethical care, patient privacy, compliance, patient safety/risks in hospital environment (fire, emergency, security, etc.), safety event reporting procedures, pain management, etc. as required by role. Supplier employees are required to log-into CHOP’s Learning Link System to review the required Orientation Material. Instructions for accessing CHOP’s Learning Link System are provided in the Supplier Handbook: <a href="http://www.chop.edu/export/download/pdfs/articles/neo/temp-employee-handbook.pdf">http://www.chop.edu/export/download/pdfs/articles/neo/temp-employee-handbook.pdf</a></td>
<td>Joint Commission (HR.01.04.01)</td>
</tr>
<tr>
<td>Department / Unit-specific orientation(s)</td>
<td>Training topics based on role and location.</td>
<td>Joint Commission (HR.01.04.01)</td>
</tr>
<tr>
<td>Ongoing Training</td>
<td>Training topics based on role and location.</td>
<td>Joint Commission (HR.01.05.03)</td>
</tr>
<tr>
<td>Competency Assessed</td>
<td>Defined by job description and ability to perform. Assessed during orientation period and ongoing competence assessments.</td>
<td>Joint Commission (HR.01.06.01)</td>
</tr>
<tr>
<td>Job Performance Evaluated</td>
<td>Required as per HR Policy.</td>
<td>Joint Commission (HR.01.07.01)</td>
</tr>
</tbody>
</table>
| Immunizations and TB Testing | 1. **TB Test**  
• Negative TB skin test (TST) or Interferon-gamma Release Assay (IGRA), within 30 days prior to the start of work.  
2) 2-step TB skin test (1-3 weeks apart) within 30 days of hire, if no documentation of TST within last 12 months  
• Positive TST or IGRA - 1) Negative PA & Lateral chest x-ray, 2) Annual TB questionnaire  
• Repeat TB skin test or IGRA annually  
2. Measles (rubella), Mumps and rubella  
Immune status (vaccine or laboratory evidence) for Measles (rubella), mumps and rubella (Positive IgG for each or 2 doses of live MMR vaccine, on or after first birthday)  
3. Varicella  
Immune status (vaccine or laboratory evidence) for Chickenpox (Positive IgG or 2 doses of live varicella (VZV) vaccine at least 28 days apart)  
4. Tetanus/Diphtheria/Pertussis (Tdap) Vaccination  
One-time dose of tetanus/diphtheria/pertussis (Tdap) vaccine as an adult  
5. Hepatitis B Status  
(OSHA required for anyone at risk of coming in contact with human blood or body fluids) | |
| Drug Screen | 11 panel Drug testing to be completed by a licensed laboratory. MRO to confirm a positive result. 11 substances are: Amphetamines, Barbiturates, Benzodiazepines, Cocaine Metabolites, Marijuana Metabolites, Methadone, Methaqualone, MDA Analogues, Opiates, Phencyclidine, Propoxyphene | |
| State and Federal Exclusion Checks | Federal and state exclusion lists. Checked at time of engagement/hire and monthly thereafter. | Office of Inspector General; System for Award Management; PA Medcheck; NJ Treasury |
| Influenza Vaccine | Vaccine required for anyone working with patients or in a patient building during flu season | |

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1 Policy Statement

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

- A written copy of the Patient and Family Rights and Responsibilities will be provided during the registration process and are posted throughout clinical areas.
- A hospital representative will ask the patient and/or their family if they would like their physician, family member or representative to be notified of their admission. If indicated the identified family member/representative and physician will be notified of the hospital admission.

Staff receives orientation and ongoing education regarding the Patient and Family Rights and Responsibilities.

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

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

2 Exceptions

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

3 Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Representative</td>
<td>A person who, under state law, has the authority to act on behalf of an individual in making decisions related to health care. The parent of a Minor is generally treated as a Minor’s Patient Representative as is any person designated by Court Order as the Minor’s legal guardian or as a person who can otherwise make medical decisions on behalf of the Minor. A person designated by Court Order as the legal guardian of an Adult is treated as the Adult’s Patient Representative.</td>
</tr>
</tbody>
</table>
Policy: PATIENT AND FAMILY RIGHTS AND RESPONSIBILITIES (formerly # RI-2-01)

| Support Person | A person designated by the patient or patient representative, including but not limited to: a spouse, a domestic partner (including same-sex domestic partner), another family member, or a friend. A Support Person is not an authorized decision-maker for the patient unless otherwise noted in the patient’s Advance Directive. |

4 Related Documents

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

<table>
<thead>
<tr>
<th>Type:</th>
<th>Patient Care Manual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicable to:</td>
<td>CHOP Enterprise-wide</td>
</tr>
<tr>
<td>Policy owner:</td>
<td>Director, Patient Safety</td>
</tr>
<tr>
<td>Effective Date:</td>
<td>January 15, 2016</td>
</tr>
<tr>
<td>Supersedes:</td>
<td>December 2, 2015</td>
</tr>
<tr>
<td>Approved by:</td>
<td>VP Medical Operations and Chief Safety Officer</td>
</tr>
<tr>
<td>Accountable for:</td>
<td>Jan Boswinkel, MD VP Medical Operations and Chief Safety Officer</td>
</tr>
</tbody>
</table>

1 Policy Statement

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

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

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

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

- **Main campus locations:** Security should be called to respond to employee and visitor incidents. Security tracks employee and visitor incidents at the main campus as per their department policy.
- **Off-site locations:**
  - Call 911 for patients, employees or visitors that require immediate medical attention.
  - For visitor incidents, reporting should occur through the electronic event reporting system.
  - “Non-injury” related employee reports at locations outside of CHOP’s main campus should be reported to Security (for example: vehicle damage, building graffiti, employee harassment).

2 Scope

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

3 Exceptions

**ALL locations:** Employee accidents and injuries should be reported to Occupational Health utilizing the KAPS safety system. Employees will click on the Employee Event icon and will be directed to their My Health account. Reporting will be done electronically. Further information is available in Human Resources policy #6-3, “Work-Related Injuries and Illness” and on the Occupational Health website.
Policy: SAFETY EVENT AND NEAR MISS REPORTING (formerly #TX-13-01, Incident Reporting)

4 Definitions

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

5 Related Documents

<table>
<thead>
<tr>
<th>Document Type</th>
<th>Document Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policies</td>
<td>Adverse Drug Reaction Reporting, #TX-7-07</td>
</tr>
<tr>
<td></td>
<td>Sentinel Event Policy</td>
</tr>
<tr>
<td>Procedures</td>
<td>Manager Review of Safety Events</td>
</tr>
<tr>
<td></td>
<td>Patient Safety Event and Near Miss Reporting</td>
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<tr>
<td>Resources</td>
<td>KAPS File Entry Tipsheet</td>
</tr>
<tr>
<td></td>
<td>KAPS File Manager Tipsheet</td>
</tr>
<tr>
<td></td>
<td>KAPS ICON and Specific Event Type Tipsheet</td>
</tr>
<tr>
<td>Regulatory References</td>
<td>PA PSRS Act 13 &amp; Act 52</td>
</tr>
<tr>
<td></td>
<td>CMS Part 42CFR 482.25(B)(6)</td>
</tr>
<tr>
<td></td>
<td>Joint Commission standard HR.01.05.03</td>
</tr>
</tbody>
</table>
POLICY
The Hospital is committed to maintaining an environment that encourages and fosters appropriate conduct among employees and respect for individual values. Accordingly, the Hospital is committed to enforcement of its Non-Discrimination and Harassment Policy at all levels within the work place in order to create an environment free from discrimination and/or harassment. In all instances, the Hospital will continue to comply with applicable federal, state and municipal regulations governing employment practices.

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

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

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

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

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

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

**RELATED DOCUMENTS**

- Human Resources Policy and Procedures Manual 5-2 Rules of Conduct
- Human Resources Policy and Procedures Manual 5-3 Employee Separation from Employment
- Human Resources Policy and Procedures Manual 5-4 Demotion

**DEFINITIONS and EXAMPLES**

I. Definitions:

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

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

C. **Sexual Harassment**: A form of discrimination that consists of unwelcome sexual advances, requests for sexual favors or other verbal or physical acts of a sexual or sex-based nature where:

   1. Submission to such conduct is made either explicitly or implicitly a term or condition of an individual’s employment; or
   2. An employment decision is based on that individual’s acceptance or rejection of such conduct.

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

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

II. Examples:
   A. Discriminatory Harassment:
      1. Prohibited acts of Discriminatory Harassment can take a variety of forms ranging from subtle racial or religious joking to actual physical contact or violence. At times the offender may be unaware that his or her conduct is offensive or harassing to others. Examples of conduct that could be considered Discriminatory Harassment include:
         a. Offensive statements, materials, unwelcome jokes or gestures directed toward another, which involve the other’s race, color, religion, sex, age, national origin, sexual orientation, gender identity, marital status, disability, covered veteran status, genetic information, victim of domestic or sexual violence status or other protected classifications to the extent required by applicable laws, or similar degrading comments about another;
         b. Preferential treatment of another employee, or a promise of preferential treatment to an employee on the basis of his or her race, color, religion, sex, age, national origin, sexual orientation, gender identity, marital status, disability, covered veteran status, genetic information, victim of domestic or sexual violence status or other protected classifications to the extent required by applicable laws; or the denial or threat of denial of employment, employment benefits or advancement on the basis of his or her race, color, religion, sex, age, national origin, sexual orientation, gender identity, marital status, disability, covered veteran status, or other protected classifications to the extent required by applicable laws;
         c. The display of offensive pictures, cartoons or other materials involving race, color, religion, sex, age, national origin, sexual orientation, gender identity, marital status, disability, covered veteran status, genetic information, victim of domestic or sexual violence status or other protected classifications to the extent required by applicable laws;
         d. Physical assault against another or against another’s property because of the other’s race, color, religion, sex, age, national origin, sexual orientation, gender identity, marital status, disability, covered veteran status, genetic information, victim of domestic or sexual violence status or other protected classifications to the extent required by applicable laws;
         e. Retaliation against an individual for disclosing, reporting or complaining about discriminatory harassing conduct.
      2. Prohibited acts of Discriminatory Harassment can take a variety of forms ranging from subtle racial or religious joking to actual physical contact or violence. At times the offender may be unaware
   B. Hostile Work Environment:
      1. Offensive conduct can be verbal, physical or both;
      2. Conduct is repetitive and frequent;
3. Conduct is hostile and openly offensive;
4. The alleged harasser is a co-worker or supervisor;
5. Co-workers joined in perpetuating the harassment; and/or
6. Harassment is directed at more than one individual.

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

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

IMPLEMENTATION
A. All personnel are encouraged to express displeasure at offensive conduct by telling the individual engaging in the conduct that it is unwelcome or offensive, and to report that conduct, through the use of the Hospital’s complaint procedures.
B. The Hospital will not tolerate, condone or allow discrimination, including Sexual Harassment, or Discriminatory Harassment, whether engaged in by fellow employees, supervisors or others affiliated with the Hospital or by outside vendors, patients, visitors or other non-employees who
conduct business with the Hospital. All employees are required by this policy to report all incidents of discrimination, or sexual or Discriminatory Harassment, regardless of the offender or the person toward whom the offensive conduct is directed.

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

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

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

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

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

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

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

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

**PRESIDENT AND CHIEF OPERATING OFFICER**

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

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

THE CHILDREN’S HOSPITAL OF PHILADELPHIA © 2014
1. **PURPOSE:**

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

2. **POLICY:**

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

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

3. **COVERAGE:**

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

4. **PROCEDURES:**

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

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

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

II. **Progressive Discipline**

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

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

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

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

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

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

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

III. **Attendance & Related Work Rules – (A)**

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

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

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

**Level 1: General Counseling**

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

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

**A3.** Non-exempt employees are to swipe at the clock designated by department standards. Failure to swipe in and/or out at the designated clock will warrant a Level 1: General counseling.
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Level 2: Oral Warning

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

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

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

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

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

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

Level 3: Written Warning

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

Level 4: Final Warning

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

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

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

**Termination**

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

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

**Cumulative Occurrences**

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

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

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

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

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

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

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

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

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

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

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

Example 1
Employee: Jane Doe
Documented UPPL Incidents
UPPL January 23, 2012
UPPL January 28, 2012
UPPL May 29, 2012
UPPL October 30, 2012
UPPL November 23, 2012
Manager reviews the prior 12 months and notes that since last November Jane has had 5 documented UPPLS – alerts Jane that one more could result in discipline.
UPPL January 9, 2013
Manager meets with Jane, provides written documentation along with a completed Disciplinary Action Report.

Example 2
Employee: John Doe
Documented UPPL Incidents
UPPL December 24, 2012
UPPL January 19, 2013
UPPL April 22, 2013
UPPL September 18, 2013
UPPL December 26, 2013
UPPL December 29, 2013
Manager reviews the prior 12 months, and notes that John had 5 incidents since December 29, 2012, informs John that one more occurrence before January 19 would result in discipline.
UPPL January 20, 2014
Manager reviews prior 12 months and notes that since February 1 2013, John has had 6 incidents of UPPL, meets with John and provides him written documentation along with a completed Disciplinary Action Report.

The Hospital recognizes its obligation to comply with the Family and Medical Leave Act (FMLA) and corresponding state laws. A UPPL occurrence, for reasons that qualify under the FMLA or corresponding state laws, is not treated as an incident for purposes of this policy. See HR Policy 5-14.
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Employees who are in the “Weekend Nursing Program” or other such programs are subject to the guidelines for attendance outlined in the policies regulating those programs.

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

IV. Conduct Related Work Rules – (C)

Level 1: General Counseling

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

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

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

Level 2: Oral Warning

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

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

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

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

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

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

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

Level 3: Written Warning

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

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

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

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

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

Level 4: Final Warning

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

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

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

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

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

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

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

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

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

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

C23. Unauthorized possession, use or disclosure of the confidential or proprietary information of the Hospital, including confidential information regarding the Hospital’s employees will warrant discipline in accordance with the Job Aid: Guidelines to Determine Corrective/Disciplinary Action Related to Violations of Hospital Privacy/Information Security Policies. (Also see Confidentiality of Patient and Institutional Information, Patient Care Administrative Policy Manual No.-3-5 and Social Media Guidelines).

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

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

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

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

C28. (a) All Employees must report the following events to the Hospital: (1) any criminal activity that results in conviction; (2) participation in any civil action that could have an impact on the Hospital (for example, being the subject of a protection from abuse order or being a party or witness in a court case that could require time away from work); (3) receipt of a notice of exclusion, suspension, debarment, or proposed exclusion, suspension or debarment from participation in any federal or state healthcare, procurement, non-procurement or reimbursement program (for example, Medicare or Medicaid), or of an investigation that could result in such a notice or (4) disciplinary action, sanction or other adverse action against a professional license or certification required to perform one’s job. (See HR Policy 2-16).

(b) Health Care Workers as defined below must report any of the following events within 72 hours of its occurrence: (1) being named as a perpetrator in an indicated or founded report of child abuse; (2) an arrest for or conviction of any crime that would preclude employment under the law in a child care setting (Refer to Policy 2-13a, Provisional Employment Employee Statement paragraphs (e) and (f) for a description of crimes that would preclude employment in a child care setting). A Health Care Worker is an employee who works in a building where patients are cared for or who delivers care to CHOP patients (e.g., Homecare). This includes employees who work on patient units, regardless of the frequency of that work.

(c) Failure to comply with the reporting requirements in Rule C-28 will result in discipline up to and including Termination. Involvement in any of the above events that is or may be deleterious to the Hospital or to the ability of the employee to perform his/her job will warrant Termination.

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

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

C31. Failure to comply with the Confidentiality of Patient and Institutional Information Policy Administrative Policy Patient Care Manual, No. A-3-5, and the laws governing the protection of patient health information will warrant discipline in accordance with the Job Aid: Guidelines to Determine Corrective/Disciplinary Action Related to Violations of Hospital Privacy / Information Security Policies.

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

C33. Employees are permitted to have minimal personal use of Hospital Technology Resources. Hospital Technology Resources belong to the Hospital and by using those resources, the employee assumes personal responsibility for the acceptable use of these Technology resources in accordance with Administrative Policy A-3-6. Inappropriate use of Hospital Technology Resources will warrant discipline up, to and including Termination.

C34. Employees are expected to complete all mandatory training by the assigned deadline. Failure to complete mandatory training will result in disciplinary action up to and including Termination.

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

V. Multiple Violations

A. When two unrelated disciplinary actions are issued and the second is within the active status period of the first (the active status period is the 12 month period (or another length of time if another length is required under this policy) from the date the discipline was issued), the employee will be subject to the Multiple Violations Rule. This means that additional rule violations, whether related or unrelated, will move the employee to the next level of progressive discipline. Should a violation independently warrant discipline at a level higher than the next step under progressive discipline, the employee will receive the more severe discipline (e.g., if the next step in progressive discipline for the multiple violations is a Level 2: Oral warning, but the most recent incident is conduct, such as diverting drugs, which warrants termination, the employee will be terminated). Attendance violations may be aggregated with other attendance violations for purposes of the Multiple Violations Rule, but not with performance or conduct violations and vice versa. Consistent with Section II.B of these Rules, the employee will progress to the next level of progressive discipline under the Multiple Violations Rule so long as the conduct at issue occurred within the active status of the prior discipline. (Multiple Violations Rule Flow Chart, Appendix C)
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B. Nothing in this section is intended to reduce the level of discipline recommended in the Rules of Conduct.

VI. Appeals

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

5. RESPONSIBILITY:

The department head or designee is responsible for the enforcement of the Hospital’s rules and regulations and for the handling of any disciplinary action that may be required and maintenance of employee records related to disciplinary action.
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POLICY

The Hospital is committed to conducting its affairs in accordance with the highest ethical and legal standards. In order to maintain these standards, it is the policy of the Hospital that potential, perceived and actual conflicts of interest are to be avoided.

PURPOSE

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

SCOPE

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

RELATED POLICIES

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

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

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

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

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

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

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

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

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

1. With regard to any publicly traded entity, when the value of any remuneration (salary and any payment for services not otherwise identified as salary, for example consulting fees, honoraria, paid authorship) received from the entity in the twelve (12) months preceding disclosure of the interest aggregated with
I. ADMINISTRATION OF THE POLICY

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

II. GENERAL PRINCIPLES

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

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

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

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

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

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

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

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

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

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

2. Hospital Information
   Obtaining, disclosing, or using Hospital information:

   a. For direct or indirect personal interest, profit, or advantage of Hospital Personnel.
   b. For any purpose that may be detrimental to the Hospital.
   c. Without authorization.

   See also Confidentiality or Patient and Institutional Information policy.

3. Soliciting Hospital Employees, Medical Staff, or Scientists, and Others

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

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

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

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

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

III. ANNUAL DISCLOSURES

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

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

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

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

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

5. Scientists.

6. Any other person designated by management.

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

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

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

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

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

IV. FINANCIAL CONFLICTS OF INTEREST IN RESEARCH

A. Applicability

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

B. Financial Conflict of Interest ("FCOI") Determination Pathway

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

1. Is the interest a Reviewable Interest (see Section IV.D.1.)? If yes:↓

2. Is the Reviewable Interest related to the research (see Section IV.D.2.)? If yes:↓

3. Could the Reviewable Interest directly and significantly affect the design, conduct, or reporting of the research (see Section IV.E.2)? If yes:↓

4. An FCOI is present and must be managed (and, where appropriate, reported).

C. Investigator Disclosure to Hospital

1. Project-Specific Disclosure

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

2. Travel

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

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

D. Hospital Review of Disclosures and Relatedness Determination

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

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

3. Timing of Review
a. Initial Reviewable Interests
For PHS-funded research, Reviewable Interests disclosed at the time of the funding and/or protocol application will be evaluated prior to the expenditure of funds. For all other research subject to this Policy, Reviewable Interests disclosed at the time of the funding and/or protocol application will be evaluated prior to the initiation of the research activities.

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

E. Hospital Determination of FCOI

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

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

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

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

F. Management of FCOI

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

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

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

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

G. Retrospective Reviews; Mitigation Reports

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

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

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

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

H. Hospital Notification and Reporting to PHS Awarding Agencies

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

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

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

4. Content of FCOI Reports
   Any FCOI Report shall provide sufficient information to enable the PHS awarding agency to understand the nature and extent of the FCOI and to assess the appropriateness of the Hospital’s management plan. Any FCOI Report will include at least the following information:
   
a. Project number.
b. PD/PI or contact PD/PI if a multiple PD/PI model is used.
c. Name of the Investigator with the FCOI.

d. Nature of the financial interest (e.g., equity, consulting fee, travel reimbursement, honorarium).

e. Value of the financial interest, provided in dollar ranges, or a statement that the interest is one whose value cannot be readily determined through reference to public prices or other reasonable measures of fair market value.

f. A description of how the financial interest relates to the PHS-funded research and the basis for the Hospital’s determination that the financial interest conflicts with such research.

g. A description of the key elements of the Hospital’s management plan, including:
   i. The role and principal duties of the conflicted Investigator in the research.
   ii. The conditions of the management plan.
   iii. How the management plan is designed to safeguard objectivity in the research.
   iv. Confirmation of the Investigator’s agreement to the management plan.
   v. How the management plan will be monitored to ensure Investigator compliance.
   vi. Any other information the Hospital deems necessary to meet its obligations under applicable regulations and this Policy.

5. Additional Notifications

In addition to the required FCOI reports, the Hospital will promptly notify the relevant PHS awarding agency in the event that it finds that an Investigator’s failure to comply with this Policy or an imposed management plan has biased the design, conduct, or reporting of PHS-funded research (such notification will include the corrective action taken or to be taken in response to the identified Investigator non-compliance).

I. Requirements for Subrecipients of PHS-Funded research

The Hospital may from time to time carry out aspects of PHS-funded research through a subrecipient with which the Hospital contracts through a subaward agreement or other similar contract to provide research funding. The Hospital will grant such subawards where the subrecipient has its own policy on FCOIs and certifies, through the subaward agreement or other contract, that the policy complies with applicable PHS regulations. In rare circumstances, the Hospital will make an exception and allow the subrecipient to apply the Hospital’s policy as its own for the purposes of the subaward. The subaward agreement or other contract will specify the time period(s) for the subrecipient to report all identified FCOIs to the Hospital, which will be sufficient to allow the Hospital to provide timely reports to the PHS funding agency as applicable and in accordance with this Policy.

J. Public Access

For any PHS-funded study, any person may request certain information regarding the FCOIs of Senior/Key Personnel following the process established by the Hospital and published on its web site. The Hospital will provide, within five (5) business days of the receipt of a request (as defined by the
Hospital), the following information about a Senior/Key Personnel who continues to hold an identified FCOI:

1. The Investigator’s name.

2. The Investigator’s title and role with respect to the research project out of which the FCOI arises.

3. The name of the entity in which there is a Significant Financial Interest that forms the basis of the FCOI.

4. The nature of the Significant Financial Interest (or Travel, if applicable).

5. The approximate value of the Significant Financial interest provided in dollar ranges, or a statement that the interest is one whose value cannot readily be determined through reference to public prices or other reasonable measures of fair market value.

K. Training

1. Content of Training
   All Scientists and Investigators must complete training on:

   a. The PHS regulations applicable to FCOIs, as may be amended from time to time.
   b. The portions of this Policy governing conflicts of interest in research.
   c. Their obligations regarding disclosure to the Hospital of interests related to their Institutional Responsibilities.

2. Timing of Training
   Scientists and Investigators must complete this training prior to engaging in research under the auspices of the Hospital, or as otherwise required by a relevant awarding agency, and at least every four years following the initial training. Additionally, Scientists and Investigators will be required to receive training immediately in any of the following circumstances:

   a. The Hospital revises the portion of its policy governing conflicts of interest in research or procedures in any manner that affects the requirements applicable to Scientists or Investigators.
   b. A Scientist or Investigator is new to the Hospital.
   c. The Hospital finds that a Scientist or Investigator is not in compliance with the portion of the Hospital’s policy governing conflicts of interest in research or an imposed management plan.
V. CONSULTING RELATIONSHIPS

A. General Principles

1. Consulting relationships have the potential to increase the knowledge and experience of Hospital Personnel in clinical and research areas, to broaden their exposure to external experts in their fields or related fields, and to advance the public interest. Nevertheless, consulting relationships also have the potential to conflict with the obligations that Hospital Personnel have to the Hospital, including to Hospital patients and research subjects, and can be at odds with the Hospital’s Organizational Ethics Statement (A-1-4) and its Compliance Standards of Conduct (A-1-5).

2. Examples of consulting relationships include engagements to serve: as a member of a scientific advisory board or data safety monitoring board; as a speaker or moderator at a company-sponsored event, on the company’s speakers’ bureau or at a company-sponsored focus group; or as an adviser or consultant to a company in connection with its research or products.

3. Consulting relationships may raise other legal and ethical concerns such as:
   
   a. Jeopardizing Hospital intellectual property rights.
   b. Misuse of the Hospital’s name in a manner that suggests Hospital endorsement of a product or entity.
   c. Excessive compensation that may be considered an illegal kickback or referral fee.
   d. Interference with confidentiality obligations to the Hospital, patients, and research subjects.
   e. Restrictions or obligations that interfere with the consultant’s Hospital and academic duties.
   f. Inappropriate use of Hospital resources.
   g. Acting as a member of a speaker’s bureau not in accordance with Hospital policy. See Interactions with Vendors policy (A-3-7).

B. Advance review and approval

1. Any Hospital Personnel may seek review of a consulting relationship on a voluntary basis and those in a clinical role are strongly encouraged to do so. The following persons must have their consulting relationships reviewed and approved in advance:

   a. Hospital Staff (as defined in the Hospital’s Medical Staff Bylaws).
   b. Scientists.
c. Other persons who are faculty members at the University of Pennsylvania who perform some or all of their duties under the auspices of the Hospital. (Faculty members at the University of Pennsylvania who hold privileges at the Hospital but do not perform any duties under the auspices of the Hospital do not have to submit consulting relationship to the Hospital for review.)

2. Consulting relationships subject to advance review and approval are any arrangements to provide services to an outside person or entity when such services are related to the consultant’s Institutional Responsibilities, except:
   
a. Advising or consulting for non-governmental public health organizations such as the World Health Organization.
   
b. Service on or for federal, state, and local government agencies, boards, commissions, committees, review panels, or granting agency review panels unless administered by a for-profit government contractor.
   
c. Seminars, lectures, teaching engagements, and service on advisory committees and review panels for Exempt Entities.
   
d. IRB memberships at outside institutions of higher learning and academic medical centers.
   
e. Editorial boards for peer-reviewed journals.
   
f. Service as an expert witness in any litigation in which neither the Hospital nor its affiliates is a party.
   
g. Any other arrangements as may be determined by the Hospital to not require advance review and approval.

3. All consulting relationships requiring advance review and approval must be set forth in a written agreement.

4. All proposed consulting agreements are reviewed and approved in advance in accordance with the procedures established by the Hospital’s Office of General Counsel, Office of Technology Transfer, and Conflict of Interest Office. Such review is intended to avoid conflicts of interest and protect the Hospital.

VI. INSTITUTIONAL CONFLICTS

A. In certain instances the Hospital may have an institutional conflict of interest based on the financial or other interests of the Hospital itself or of its leadership. Where such conflicts have the potential to be significant, they should be reported to the CEO or his designee, an appropriate Executive Vice President, the General Counsel or the Chief Compliance Officer, provided such person is not believed to have a personal conflict, or to the Chair or Vice Chair of the Board Audit & Compliance Committee.
B. In addition to financial interests of the Hospital’s leadership, institutional conflicts of interest include situations in which the financial investments or holdings of the Hospital, gifts to the Hospital (including restricted or unrestricted monetary gifts), or other financial interests of the Hospital might affect or reasonably appear to affect institutional processes for the design, conduct, reporting, review or oversight of human subjects or other research.

C. Process for identification of potential institutional conflicts of interest with respect to human subjects or other research: In addition to information from the annual conflicts disclosures of the Hospital’s leadership, information on the Hospital’s financial interests should be reported to the President or his designee, at such frequency and according to such criteria as determined by the CEO or his designee, by the following offices:

   1. Office of Technology Transfer, for licensing arrangements, patents, invention disclosures; and

   2. Development office, for gifts to the Hospital from any for-profit organization or philanthropic unit associated with a for-profit organization.

D. If the institutional conflict of interest is considered to be significant, the matter should be evaluated to determine an appropriate response, which may include eliminating the conflict or instituting a management plan that seeks to have persons without a stake involved in the decision-making.

E. Examples of institutional conflicts of interest management plans might include the following: having the Audit & Compliance Board Committee involved in both the decision-making and on-going oversight of a transaction where the Hospital proposes to make a major purchase from a for-profit company and the CEO of the Hospital is a director of the company; and having an external expert panel determine whether and under what conditions the Hospital should undertake clinical trials involving intellectual property owned by the Hospital where the potential economic return to the Hospital is significant if such trials show favorable results.

VII. ENFORCEMENT AND SANCTIONS

A. The Hospital has the authority to require appropriate management and oversight of matters disclosed or reviewed in accordance with this Policy. Management may include the reduction or elimination of any interest or participation in an activity.

B. The Hospital will monitor compliance with management and oversight requirements in such manner as deemed appropriate. The Hospital will investigate and take corrective action as necessary.

C. Any Hospital Personnel who violates any provision of this Policy, or any conditions imposed pursuant to this Policy, may face sanctions up to and including suspension or termination of employment, loss of the privilege of conducting research at or in connection with the Hospital, loss of Medical Staff...
privileges, loss of administrative appointments, cessation of business with a vendor, liability for damages, and other appropriate actions at the Hospital’s discretion.

**RESPONSIBILITY FOR MAINTENANCE OF THIS POLICY:**

GENERAL COUNSEL

**RESPONSIBILITY FOR OVERSIGHT AND REVIEW:**

CHIEF EXECUTIVE OFFICER
AUDIT & COMPLIANCE COMMITTEE
CHIEF COMPLIANCE OFFICER

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Signature: ___________________________

Steven M. Altschuler, MD, Chief Executive Officer

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

THE CHILDREN’S HOSPITAL OF PHILADELPHIA © 2013
PURPOSE
The purpose of this policy is (i) to maintain a workplace free from the possession, manufacture, sale, purchase, distribution or use of Prohibited Drugs or Alcohol; (ii) to provide resources for employees and members of the Medical Staff (employees and members of the Medical Staff will be referred to at times in this policy individually and collectively as “Staff Members”) seeking help to address a drug and/or Alcohol abuse problem; and (iii) to identify appropriate corrective action for Staff Members found to have violated this policy.

POLICY
The Children’s Hospital of Philadelphia (Hospital) is committed to maintaining a safe and productive work environment for the benefit of its patients, Staff Members and the public. In furtherance of this commitment and in compliance with applicable laws:

(1) The Hospital strictly prohibits the possession, manufacture, sale, purchase, distribution or use of Prohibited Substances in the workplace or while performing services for the Hospital regardless of where those services are performed

(2) Staff Members are also prohibited from appearing for work Under the Influence of Prohibited Substances, regardless of when or where the use occurred

Staff Members found to have violated this policy may be subject to mandatory rehabilitation and/or discipline, up to and including immediate discharge from employment/Medical Staff depending on the nature of the offense and the totality of the circumstances.

SCOPE
All employees and Medical Staff Members of The Children’s Hospital of Philadelphia and entities affiliated with it, including but not limited to Children’s Health Care Associates, Children’s Anesthesiology Associates, Children’s Surgical Associates, Radiology Associates of Children’s Hospital and their New Jersey counterparts.

RELATED DOCUMENTS

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<tr>
<th>Job Aid</th>
<th>Observation Form</th>
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<td>Job Aid</td>
<td>Monitoring Agreement</td>
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<td>Job Aid</td>
<td>Consent and Release for Drug/Alcohol Testing</td>
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Human Resources Manual 5-2 Rules of Conduct

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DEFINITIONS

A. Alcohol: all intoxicating beverages that contain Alcohol.

B. Convicted or Conviction: being Convicted of a crime, including a finding or verdict, resolution of guilt, an admission of guilt, a plea of nolo contendere, receiving probation without a verdict, entering into an accelerated rehabilitative disposition program, or any other verdict, plea or disposition that results in a finding other than not guilty or dismissal.

C. Divert: to take a Hospital drug and use it for any purpose not authorized by the Hospital (for example, a Staff Member who takes morphine ordered for a patient and uses it for him or herself has Diverted that drug; a Staff Member who takes morphine from the Pyxis machine and gives it to her husband has Diverted that drug). A drug that is Diverted is a Prohibited Drug under this Policy.

D. Fit For Duty: that a Staff Member is able to safely and effectively perform the essential functions of his or her specific job with or without reasonable accommodation.

E. Fitness for Duty Evaluation: an assessment of a Staff Member’s ability to perform the essential functions of his or her job with or without reasonable accommodation. The Occupational Health Department will arrange a Fitness for Duty Evaluation at the request of a Manager, supervisor, Medical Director or Division Chief if appropriate. A Manager, supervisor, Medical Director or Division Chief may refer a Staff Member for a Fitness for Duty Evaluation if the Staff Member has exhibited behaviors or performance thought to be related to physical or mental health issues.

F. Manager: a leader to whom the Staff Member reports, either directly or at a progressively higher level and has additional meanings for attending physicians, residents and fellows as follows: for attending physicians, Manager means the clinical supervisor (i.e., the Medical Director, Division Chief, Department Chair), ECMS leader or Vice President Medical Operations & Chief Safety Officer; for residents and fellows Manager means the Program Director or Vice President Medical Operations & Chief Safety Officer.

G. Prohibited Drug: any drug: (i) which is not legally obtainable (e.g., cocaine); (ii) which is legally obtainable but has not been legally obtained (e.g., morphine purchased on the street or Diverted
from the Hospital); or (iii) which has been legally obtained, but is not being used for prescribed purposes (e.g., codeine if prescribed to someone other than the person taking it; Xanax prescribed to the person taking it if taken in a manner other than as prescribed).

H. **Prohibited Substance:** (a) Alcohol at a level the Hospital has determined to be unacceptable for any Staff Member; or (b) Prohibited Drug.

I. **Staff Member:** either a Hospital employee or member of the Hospital’s Medical Staff or both.

J. **Test Positive or Positive Test:** a drug or Alcohol test result that is verified by the Hospital’s designated Medical Review Officer (MRO) and that reflects the presence of a Prohibited Substance at a level the Hospital has determined to be unacceptable for any Staff Member. Drug or Alcohol tests may be by urine, saliva, blood, breath or by any other means acceptable in the industry and permissible under the law.

K. **Under the Influence:** describes a Staff Member who is affected by a drug and/or Alcohol in any detectable manner wherein such use or influence may affect the safety of the Staff Member, co-workers, patients, or members of the public, the Staff Member’s job performance or the safe and efficient operation of the Hospital. Examples of symptoms that may indicate that a Staff Member is Under the Influence of drugs or Alcohol are outlined in the job aid “Observation Form”.

**PROCEDURES**

A. **Staff Member Self-Disclosing Certain Medications and Drug/Alcohol Dependence:**

1. A Staff Member who is under the care of a licensed physician/practitioner and is taking medication that could influence or impair performance or behavior must (a) obtain information from the physician/practitioner regarding any potential affect the medication may have on the Staff Member’s performance or behavior; and (b) inform the Occupational Health Department (OHD) of such potential impairment. OHD will determine the Staff Member’s Fitness for Duty and will communicate any work restrictions to the Manager/supervisor or Medical Director/Division Chief, as applicable.

2. A Staff Member who self-discloses a problem with a Prohibited Substance will be required to be evaluated in OHD and if the Staff Member is not in an appropriate treatment program, he or she will be given the opportunity to receive treatment and will not be subject to disciplinary action unless an investigation reveals a rule violation that otherwise warrants discipline. For example, a Staff Member who has Diverted drugs is subject to termination (from employment for employees
and from the Medical Staff for non-employed Medical Staff).

B. Evaluating A Staff Member for Suspicion of Drug or Alcohol Abuse:

1. When a Staff Member exhibits behavior that indicates that the Staff Member may be Under the Influence of a Prohibited Substance, the Manager/supervisor or Medical Director/Division Chief must follow the procedures outlined in Appendix A, For Cause Drug Testing Procedures, which includes completing the Observation Form.

2. In circumstances in which a Staff Member appears impaired and/or is a threat to the safety of him or herself or of patients, the Manager/supervisor or Medical Director/Division Chief, as applicable, will first remove the Staff Member from his or her job/Medical Staff responsibilities, escort him or her to a safe place and contact Human Resources (or Security if off hours) before completing the Observation Form and taking the other steps required under the For Cause Drug Testing Procedures, Appendix A.

C. Possible Outcomes of Occupational Health Assessment and Testing

1. If, after assessment, OHD determines that the Staff Member is not Under the Influence of a Prohibited Substance and for-cause testing, therefore, is not warranted, the Manager/supervisor or Medical Director/Division will thank the Staff Member for his or her cooperation and return the Staff Member to work.

2. If, after assessment, OHD determines that for-cause testing is warranted, the Staff Member will be tested, sent home (via cab or with a friend/relative) and, if a Hospital employee will be suspended from employment without pay pending the results of the test. Such processes as they pertain to non-employed Medical Staff will be addressed in accordance with the Medical Staff Bylaws.

3. An employed Staff Member who tests negative for a Prohibited Substance will be reinstated with back pay for the period of the suspension. The Manager/supervisor or Medical Director/Division Chief, as applicable, will inform the employed Staff Member of the confidential and voluntary resources available through the Employee Assistance Program for additional support. Such processes as they pertain to non-employed Medical Staff will be addressed in accordance with the Medical Staff Bylaws. If any Staff Member’s behavior or performance raises a question of the Staff Member’s Fitness for Duty despite negative drug testing, Occupational Health will assess the need for a Fitness for Duty Evaluation.

4. A Staff Member who tests positive for a Prohibited Substance or who self-discloses a problem with a Prohibited Substance, will be offered the opportunity to engage in treatment for substance
abuse and return to work under a Monitoring Agreement. The Monitoring Agreement will be instituted after there is a completion of a substance abuse treatment program and a clearance to return to work by the substance abuse treatment provider. If there is evidence of Diverted drugs or any engagement in other conduct warranting termination under Hospital policy or the Medical Staff Bylaws, the Staff Member’s Monitoring Agreement is void.

5. Physicians who Test Positive may also be referred to the Pennsylvania Physician Health Program or other applicable physician health program. Members of the Medical Staff and OHD will work with the Hospital Physician Health Committee and the applicable Department Chair, Division Chief or Medical Director to determine whether such a referral is appropriate. OHD will manage the actual for-cause test and Hospital Physician Health Committee will then be the responsible for any practice implications.

D. Return to Work

1. An employee requesting to return to work following treatment for substance abuse must contact OHD and present a note from his or her substance abuse treatment provider verifying participation in a formal treatment program, identifying the substance upon which dependency occurred and clearing the employee to return to work. Professionally licensed employees must also meet the requirements of the appropriate licensing body prior to returning to work. A physician who has participated in a physician health program must provide documentation to the Occupational Health Department that he or she has satisfied and will continue to satisfy any conditions imposed by that Program.

2. Staff Members may not return to work until the OHD completes the appropriate return to work screening and notifies the Manager/supervisor or Medical Director/Division Chief that the Staff Member is cleared to return to work.

3. A Staff Member who returns to work following substance abuse treatment is required to work under a Monitoring Agreement for at least two years. The terms of this Agreement are subject to change depending on the facts and circumstances at issue for each Staff Member, including recommendations from the Staff Member’s substance treatment provider and the physician health program, as applicable.

E. Employment/Medical Staff Consequences

1. A Staff Member who Diverts drugs from the Hospital will be terminated from employment and

1 Further description can be found in Appendix B - Return to Work.
from the Medical Staff, as applicable, consistent with the Medical Staff Bylaws.

2. A Staff Member who refuses to be tested for a Prohibited Substance, who refuses treatment for substance abuse once he or she has Tested Positive for a Prohibited Substance, or who fails to comply with a treatment program or Monitoring Agreement will be terminated from employment and from the Medical Staff, as applicable, consistent with the Medical Staff Bylaws.

3. A Staff Member who returns to work on a Monitoring Agreement and Tests Positive for a Prohibited Substance, either during the duration of the Monitoring Agreement or after, will be terminated from employment and from the Medical Staff, as applicable, consistent with the Medical Staff Bylaws.

F. Legal/Regulatory Compliance and Reporting

1. The use, sale, purchase, theft or possession of an illegal drug and drug Diversion are violations of the law. The Hospital will refer such illegal drug activities to the applicable authorities, including law enforcement, regulatory, licensing and credentialing bodies as appropriate.

2. The Manager/supervisor or the Medical Director/Division Chief, in the case of a physician, will notify the applicable Vice President or, in the case of a physician, the President of the Medical Staff and the Department Chair of any use, sale, purchase, theft or possession of a Prohibited Substance or of any Drug Diversion or of any Staff Member Conviction of a local, state or federal controlled substances law. The Director of Pharmacy will report any drug loss or misuse to the appropriate authorities (other than licensing boards). Reports to professional licensing board will be handled as set forth in paragraph 3 below.

3. The Director of the Department in which the employee worked, or Division Chief/Medical Director in the case of a physician, will make reports, as appropriate, to the applicable professional licensing board for the substance-related activities of a Staff Member.

4. A Staff Member who is Convicted of a crime in connection with the violation of any local, state or federal controlled substances law must notify Human Resources or Medical Staff Affairs in the case of a non-employed Staff Member, within five calendar days of the Conviction and Human Resources or Medical Staff Affairs, as applicable, will immediately notify the Director or Division Chief/Medical Director, as applicable, and the Director of Pharmacy, who will make reports, as appropriate, to the licensing board (Director or Division Chief/Medical Director, as applicable) and/or authorities (Director of Pharmacy).

5. A non-physician Staff Member who is otherwise involved in any legal proceeding related to a Prohibited Substance (including an arrest or prosecution, i.e. DWI) is obligated to report such
involvement to Human Resources when he or she becomes aware of it. Medical Staff Members must make such notifications in accordance with the Medical Staff Bylaws.

6. The Director, Division Chief/Medical Director and the Director of Pharmacy will consult with the Office of the General Counsel before making any reports to licensing boards and/or authorities under this policy.

7. Staff Members must report all events involving clinical care that could have injured a patient, compromised patient safety and/or resulted in unanticipated injury to patient safety through the Hospital’s electronic event reporting system. Serious patient injuries should also be reported to Risk Management.

**CONSUMPTION OF ALCOHOL AT HOSPITAL-SPONSORED EVENTS**

Occasionally the Hospital may sponsor an on or off site event where Alcohol is served. The moderate consumption of Alcohol is permitted during these events. However, it does not relieve a Staff Member from meeting reasonable and acceptable standards of conduct. Under no circumstances should a Staff Member who delivers patient care consume Alcoholic beverages prior to going to work.

**ASSISTANCE PROGRAMS**

Employees may seek assistance from the Hospital’s Employee Assistance Program (EAP) in confidence. It is the responsibility of each employee to seek assistance from the EAP before Alcohol or drug problems lead to corrective action that can include termination. Once a violation of this policy occurs, subsequently using the EAP on a voluntary basis will not alter the corrective action. Information about the EAP may be found on the Benefits website on the Hospital intranet. Medical Staff Members may contact the Hospital’s Physician Health Committee, which can suggest resources for assistance with drug and Alcohol problems.

On a regular basis, the Hospital will inform Staff Members about the dangers of drug and Alcohol abuse in the workplace, its policy of maintaining a drug-free workplace, available drug and Alcohol counseling, rehabilitation and employee assistance programs and the penalties that may be imposed upon Staff Members for violations of this policy.

**RESPONSIBILITY FOR MAINTENANCE OF THIS POLICY**

PRESIDENT AND CHIEF OPERATING OFFICER
**ATTACHMENTS**

APPENDIX A: FOR CAUSE DRUG TESTING PROCEDURES

APPENDIX B: RETURN TO WORK PROCEDURES

<table>
<thead>
<tr>
<th>Supersedes</th>
<th>Approved by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/17/2011</td>
<td>Madeline Bell – President and Chief Operating Officer</td>
</tr>
</tbody>
</table>

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

ASSESSMENT AND EVALUATION FOR IMPAIRMENT

<table>
<thead>
<tr>
<th>Required Action Steps</th>
<th>Performed By</th>
<th>Supplemental Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Complete parts 1 and 2 of job aid – Observation Form.</td>
<td>Manager</td>
<td>1. Incorporate any reported observations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Consider asking another Manager to witness/confirm that the Staff Member appears impaired</td>
</tr>
<tr>
<td>2. Contact Human Resources Business Partner to discuss observations and next steps (e.g., questioning the Staff Member, whether an Occupational Health Assessment is warranted).</td>
<td>Manager</td>
<td>If unable to reach your business partner during regular business hours, contact the main Human Resources reception desk at x65337. If timely consultation is not possible, the Manager/supervisor will proceed with the procedures outlined below and notify Human Resources as soon as possible.</td>
</tr>
<tr>
<td>3. Contact Occupational Health if for cause testing is indicated.</td>
<td>Manager or Human Resources</td>
<td>1. If during normal business hours, contact Occupational Health at X41928</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. If Occupational Health is closed, contact Security at X42374</td>
</tr>
<tr>
<td></td>
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<td>3. If the Staff Member is in the nursing department, also contact the nursing supervisor at pager 10224.</td>
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<tr>
<td></td>
<td></td>
<td>4. If at an ambulatory site off hours, contact the nursing supervisor for direction.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Note:</strong> both Security and the nursing supervisor have access to off-hours pager for Occupational Health.</td>
</tr>
<tr>
<td>4. Remove the Staff Member from the work environment.</td>
<td>Manager/Supervisor</td>
<td>Provide a safe, supervised place for the Staff Member <em>(e.g. Manager’s office)</em></td>
</tr>
</tbody>
</table>
5. Tell the Staff Member you are bringing him/her to Occupational Health for an assessment for fitness for duty based on your observations or reported behavior.

| Manager/Supervisor | If after hours, security will bring the Staff Member to the OH department, or keep the Staff Member in the command center until the OH nurse or nursing supervisor arrives. |

6. If the Staff Member admits to Alcohol or drug use/abuse, acknowledge the admission and inform him or her that Occupational Health will discuss next steps.

| Manager | |

7. If the Staff Member reports a medical reason for his or her behavior, inform the Staff Member that he or she need not share such information with you but can bring it to the attention of Occupational Health during the assessment.

| Manager | Staff Member personal medical information is confidential and the Staff Member should not feel obligated to share this with a Manager. |

8. If the Staff Member refuses to undergo the assessment, inform him or her that the assessment is a condition of employment and/or appointment to the Medical Staff per the Drug-Free Workplace Policy and the Medical Staff Bylaws and refusal to participate may lead to discipline up to and including termination.

| Manager/Human Resources | Do not coerce testing; simply inform the Staff Member of the policy and consequences of refusing. |

9. Bring the Staff Member to the Occupational Health Department.

| Manager/Human Resources | If at an ambulatory site, OH will direct the Manager. If off hours, contact the nursing supervisor for direction. |

10. Notify the Physician Health Committee of any Medical Staff Member who is subject to a for cause test.

| Occupational Health Nurse | |
APPENDIX B: RETURN TO WORK PROCEDURES

A Staff Member who participates in an approved substance abuse rehabilitation program, and who complies with all prescribed care to prevent relapse, is eligible for consideration for return to work, consistent with the CHOP Family and Medical Leave of Absence Policy, 5-14 and the Medical Staff Bylaws, as applicable.

<table>
<thead>
<tr>
<th>Required Action Steps</th>
<th>Performed by</th>
<th>Supplemental Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Contact the Occupational Health Department, Manager, and Human Resources Business Partner when return to work is anticipated.</td>
<td>Staff Member</td>
<td>Prior to returning to work, the Occupational Health Department must receive at least the following information from the substance abuse treatment provider in writing: verification of participation in a formal treatment program; identification of the prohibited substances of abuse; details of the ongoing plan of care.</td>
</tr>
<tr>
<td>2. Obtain a verification of return to work in writing and plan of care from the substance abuse treatment provider.</td>
<td>Staff Member Occupational Health Nurse Physician Health Committee (for Medical Staff)</td>
<td>If the Occupational Health Nurse has any concerns regarding fitness for duty, he or she will obtain consent from the Staff Member to discuss these concerns with the treatment provider prior to initiating the return to work process.</td>
</tr>
<tr>
<td>3. Schedule a meeting with the returning Staff Member, his or her Manager, the Human Resources Business Partner, the Occupational Health Nurse and the Staff Member’s union delegate (for union Staff Members) or PHC representative (for Medical Staff).</td>
<td>Occupational Health Nurse</td>
<td>This meeting must occur prior to Staff Member returning to work.</td>
</tr>
<tr>
<td>4. Explain the conditions of return to work to all participants present.</td>
<td>Occupational Health Nurse, Human</td>
<td>If the Staff Member is a licensed healthcare worker (e.g. nurse, physician, pharmacist, RT, PT, OT), he or she must</td>
</tr>
<tr>
<td>Required Action Steps</td>
<td>Performed by</td>
<td>Supplemental Guidance</td>
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</tbody>
</table>
| required to enroll in a monitoring agreement for a minimum of 2 years.  
- The Staff Member will be randomly tested a minimum of 12 times and a maximum of 24 times during this period.  
- The Staff Member will notify the Occupational Health Nurse of any change in treatment, including any medications, and will provide documentation of compliance with the Monitoring Agreement. | Resources Business Partner and PHC representative. | meet the requirements of the applicable licensing board prior to return.  
HR and OH will work with the Staff Member’s CHOP department to assess this. |
| 5. Obtain signatures on the Monitoring Agreement from all meeting participants. | Occupational Health Nurse | The Occupational Health Nurse will instruct the Manager to leave the meeting after the Staff Member has signed the Monitoring Agreement. |
| 6. Obtain appropriate samples from the Staff Member (e.g., urine, saliva) and test for drugs and/or alcohol as applicable. | Occupational Health Nurse | Negative test results must be obtained prior to clearance for return to work.  
As health care technology changes, the methods for drug and alcohol testing change as well. The Hospital will use testing methods acceptable in the industry and permissible under the law. |
| 7. Notify the Staff Member and Manager of test results when received. Notify the HR Business Partner and PHC of positive test results. | Occupational Health Nurse | The Staff Member can return to work once negative results are documented and communicated to the Manager. |
1. **PURPOSE:**

   To define the Hospital’s policy and procedures regarding weather conditions which effect absence, late start or early dismissal.

2. **POLICY:**

   When severe weather/emergency conditions exist, due to the nature of our work, employees are expected to make every possible effort to arrive at work. During severe weather/emergency conditions, there may be occasions when the Hospital will dismiss certain employees from work early. Early dismissal due to weather conditions are judgments made only by the Senior Administration of the Hospital.

3. **COVERAGE:**

   All employees of The Children’s Hospital of Philadelphia, its ambulatory care facilities, and its other affiliated institutions.

4. **DEFINITIONS:**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe Weather Conditions</td>
<td>Including but not limited to heavy snow or ice accumulations, flooding, hurricane and/or tornado damage that significantly affect the normal operations of CHOP.</td>
</tr>
<tr>
<td>Emergency Conditions</td>
<td>States of emergency as determined by Senior Administration of the Hospital, taking into consideration states of emergency declared by the Governor(s) and/or Mayor(s) of affected areas.</td>
</tr>
<tr>
<td>Essential personnel</td>
<td>All CHOP employees are deemed essential unless or until instructed otherwise by management. During severe weather conditions, or when a state of emergency has been issued, all personnel must report to or remain at work unless instructed otherwise as noted above.</td>
</tr>
</tbody>
</table>

5. **PROCEDURES:**
I. Declaration of Weather/Emergency Conditions

The Administrator On-Call, will declare severe weather/emergency conditions when appropriate. This declaration will be announced promptly via email, voice mail, and updated on the CHOP home page on the internet. At the discretion of the Administrator On-Call, the Incident Command Center may be put into operation. Contact numbers for the emergency command center and specific directions will be included in the communications and on the internet.

For CHOP Care Network sites, declarations of severe weather/emergency conditions will be made by each site. The Practice Manager for the site in question will communicate the declaration of severe weather/emergency conditions to the Vice President of the CHOP Care Network, who will relay this information to the Administrator On-Call.

II. Department Emergency Communications Procedure

Each department head shall develop an emergency contingency plan including an emergency home telephone listing of all employees which can be referenced during weather and transportation emergencies. This listing should be updated at least twice yearly. This will help to ensure that appropriate personnel can be brought to the Hospital during such emergencies.

III. On Call/Standby

On Call and Standby guidelines are defined by HR Policy 4-3, Standard Pay Practices. The Administrator On-Call will determine and promptly communicate any applicable changes or exceptions to established on call or standby guidelines during weather/emergency conditions.

IV. Absenteeism/Unscheduled PPL

Should a weather emergency be declared and severe weather conditions prevent an employee from reporting to work, the employee will be permitted to use accrued PPL for the absence. This time will be noted as an unscheduled absence (UPPL). Exempt employees whose departments or sites are closed during the weather emergency will have the PPL time noted as scheduled (SPPL). Non-exempt employees will have the option of going unpaid or using SPPL for the day. It is the employee’s responsibility to communicate their option to their manager for timekeeping purposes.

If a manager sends an employee home prior to the end of their shift due to lack of work (low volume or site closure), exempt employees will get paid for the rest of the day, due to exempt status, and non-exempt employees will have the option of going unpaid or using SPPL for the remainder of the shift. Non-exempt employees must communicate their option directly to their manager for timekeeping purposes.

Each Department Head or designee will be responsible for informing staff regarding department or site closing decisions.

For CHOP Care Network sites, site closing decisions will be made by each site. The Practice Manager for the site in question will communicate site closing decisions to the Vice President of the CHOP Care Network, who will relay this information to the Administrator On-Call.
V. Exceptions

The Administrator On-Call may declare exception(s) to this policy based on the circumstances of the emergency in consultation with the appropriate senior management staff.

VI. Severe Weather Accommodations

CHOP may offer sleeping accommodations, at CHOP, in the event of severe weather/emergency. Employees wishing to use such accommodations must receive approval from their Department Head. Whether or not an employee elects to use such accommodations is the employee’s choice. CHOP will provide Weather Emergency pay to those staff approved to stay over as explained below. The Weather Emergency pay code will be administered as follows:

- Managers are responsible to recommend to their VP those staff members in their area who qualify for this payment; VPs will be responsible to approve these requests in advance. Both exempt and non-exempt staffs that stay over are eligible.

- Managers will use the “Weather Emergency” pay code in STAR which will pay at a rate of $2.00/hr.

- Earnings charged to Weather Emergency will not count towards overtime.

- The Weather Emergency pay code applies to non-working hours before or between shifts with manager pre-approval. Under no circumstances is the Weather Emergency pay code to be utilized concurrently with another pay code.

- Employees scheduled for On Call shifts during a severe weather/emergency event are ineligible to receive Weather Emergency pay. They may, however, be afforded overnight accommodations with Department Head approval.

- If circumstances warrant an employee to return to work while under the Weather Emergency pay code, Weather Emergency would cease and regular pay would commence at that point.

6. RESPONSIBILITY:

I. Decisions regarding the implementation of this policy shall be the responsibility of Senior Administration. Senior Administration will notify the Human Resources Department in the event of authorized excused lateness, excused unscheduled absences or early dismissal.

II. The Department Head is responsible for deciding who can be dismissed early based on work needs in accordance with the administrative decision.

III. Human Resources will communicate excused lateness, excused unscheduled absences or early dismissal notice to departments.
Policy: Employee Appearance

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

1. **PURPOSE:**

This policy exists to establish an appropriate and consistent professional employee appearance and identification standard. Employees are expected to dress in a manner that presents a professional and neat personal appearance and ensures safety. It is also expected that all employees will maintain normal and reasonable personal hygiene and grooming standards that in no manner distracts or could have an adverse effect on patient care, interaction with patients, co-workers, parents and visitors, or other work related interactions.

2. **POLICY:**

Employees’ dress, hygiene and grooming should be appropriate to the work situation. Neat and clean dressing, grooming and identification are important to good patient care, satisfaction of patients and their families and good employee-patient relations.

3. **COVERAGE:**

All employees of The Children’s Hospital of Philadelphia (the “Hospital”), and it’s other affiliated institutions unless otherwise noted.

4. **PROCEDURES:**

a. Identification and Name Badges – all employees, contractors, students, and volunteers, and any individual performing services for the Hospital are required to wear name badges while in the Hospital on duty. The badge must be worn in such a manner that the individual’s name can be visible and easily read (e.g., attached to a lanyard worn around the employee’s neck).

b. Clothing or accessories that present safety concerns, including but not limited to open toed shoes, sandals or excessive jewelry are not permitted in patient care areas. At the discretion of the manager, an employee may be asked to remove an item that poses a safety hazard to his/her work environment (e.g., acrylic nail tips).
Policy: Employee Appearance

c. Employees are permitted to wear only those items of apparel, insignia and/or other identifiable objects that are regular and customary for clothing being worn in an Institution and/or businesslike work environment.

- Reasonable accommodations will be made based on religious and/or cultural observances or practices such as, but not limited to, style of dress, head coverings, facial hair grooming requirements unless such accommodations pose an undue hardship on the operations of the Hospital. The Hospital will engage in an interactive process with the employee to discuss any requests for a religious accommodation.
- Clothing should be clean and pressed.
- Jewelry should be worn in moderation.
- Appropriate undergarments should be worn and in a manner that is not visible to others.
- Piercings, other than on the ears, and tattoos should not be visible.
- Cologne, perfume or scented oils may be prohibited or restricted if found to have an adverse effect on patients, families or co-workers.
- Clothing or accessories that contain statements of profanity refer to drug or alcohol, or other inappropriate insignia are not permitted.

d. Each department may set its own additional standards of employee appearance to fit the specific needs of their department and to address matters such as the use of electronic devices (visible personal cell phones, pagers, or other personal technology items).

e. Failure to follow the guidelines as indicated in this Appearance Policy and maintenance of the standards set by this policy will result in disciplinary actions in accordance with the CHOP Policy 5-2 - Rules of Conduct

5. RESPONSIBILITY:

a. Employees are responsible for abiding by the standards of this policy.

b. Department heads and supervisors are to review this policy with employees on a periodic basis and inform employees when they are in violation of this policy.
Job Aid for Entering Patient Related Events into Safety Net

The following steps should be taken in order to enter any type of event into Safety Net:

1) Open Internet Explorer and go to the CHOP intranet homepage (http://intranet.chop.edu/employee/jsp/home.jsp)

2) Locate the Safety Net link on the lower right-hand corner beneath the “Popular Features” section of the webpage.

3) Click on the Safety Net link and you will be taken to the login screen for Safety Net.

4) The username and password are already filled in for you so you only need to click on “Log In to STARS”
Job Aid for Entering Patient Related Events into Safety Net

5) Upon logging in you will have a new window pop up with choices for what type of event you want to enter. The choices are “Patient Safety Event” and “Issue or Concern which is Not Patient Specific”. For this we will choose “Patient Safety Event”.

6) Next you are taken to the Patient Demographics Page. If you have the patients MRN or Account Number and their last name, click on the “Patient Lookup” button.
a) Once the pop-up window opens you will need to put in at least 3 letters of the patients last name and either the MRN or Account Number in order to look up a patient. Two of the 3 fields must be filled in and the patient last name is mandatory. Once filled in click Search.

i. If a patient exists the system the screen will populate with every encounter this patient is tied to. Click on the appropriate encounter and click OK.

b) If you do not have any patient information on hand, you can fill in the blanks by hand. Only those marked with an asterisk are necessary to enter an event.
Job Aid for Entering Patient Related Events into Safety Net

7) The next page you will encounter is the Core Questions page. This page holds many questions that are relevant to the event you are reporting. The last page of this job aid explains the Event Type fields in more detail.

8) Once filled in, click “Next” on the bottom right side to move on.

---

a) You must fill in all asterisk questions in order to move on. The following fields are mandatory:

i. Date of Event – This is the date the event happened, it can be back dated

ii. Time of Event – Approximate time the event happened. If unknown, click Time Unknown

iii. CHOP Entity – High level breakout of CHOP as an institution

iv. Location where the event occurred – Specific area this event took place, this field changes depending on what you choose as a CHOP entity.

v. How was this event discovered – how you found out about this event

vi. Event Type – Major high level type of event you are entering

vii. Event Type (Level 2) – Breakdown of more specific types of event, based off Event Type

viii. Did this event reach the patient – Whether or not this event interacted with the patient at all, both adversely or not.

ix. Reporter Staff position – position you hold at CHOP

x. Reporter’s Name – this is NOT mandatory, but it is suggested that this be filled in for easier follow-up from senior staff
9) The next area you enter will change depending on the Event Type chosen in the prior page. For our purposes the Event Type “Fall” was chosen.

10) Depending on what Event Type is chosen, this page may or may not have mandatory fields on it. Once completed, click “Next” on the bottom right.

11) The final page before submission is called the Synopsis of Event page. This page is where any other information not directly filled out on any prior pages should be explained.

All fields on this page are mandatory!
Job Aid for Entering Patient Related Events into Safety Net

a) Physician Notified – Yes or No, if yes you will be prompted with a question about the name of the physician. This field would be filled in as Last Name, First Name

b) Descriptive field – This field has a 254 character limit. This means that all information here should be factual, brief and abbreviated whenever possible. 254 characters is approximately 2-3 sentences depending on how well you do the above.

c) Did the patient require treatment or intervention – Yes or No. If you choose yes you will get another field that looks identical to the descriptive field. This field has two meanings.

   a. It can be used to describe whether or not the patient actually did need any treatment or intervention because of the event being entered. This field also has a 254 character limit.

   b. It can be used to extend the explanation from the prior question regarding the description of what happened.
Explanations of the Event Type Fields:

Event Type – This field outlines the 10 major event types that you can choose from. Some of them can be somewhat cryptic and thus there is a small blue “bubble” with a question mark in it to the right. Clicking on this bubble will take you to an intranet page which has a brief crosswalk of which event types should be chosen depending on what you really want to submit. The next page of this document also contains this same crosswalk.

1) Adverse Drug Reaction
2) Blood Products / Transfusion
3) Complication of Procedure / Treatment / Test
4) Equipment, Supplies, Medical Devices
5) Errors related to Procedures, Treatments, Tests, Respiratory, Labs, Nutrition
6) Falls
7) Medications, IV, HAL, Vaccines
8) Skin Integrity *(Not IV Infiltrates)*
9) Transfer / Transport of a Patient
10) Other / Miscellaneous

Event Type (Level 2) – Depending on which of the major categories you chose for Event Type this list will drill down into more specific areas to report on. The crosswalk on the last page of this job aid can help guide you to the right event types to submit a safety event under.

Event Type (Level 3) – Some of the Level 2 events can trigger a 3rd level of information. Again, this list will be drilled down depending on what Event Type Level 2 you choose.
### Safety Net: Which Event Type to Choose?

<table>
<thead>
<tr>
<th>If you want to report a(n):</th>
<th>Event Type 1</th>
<th>Event Type 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adverse drug reaction</td>
<td>Adverse Drug Reaction</td>
<td></td>
</tr>
<tr>
<td>Alarm issue</td>
<td>Equipment/Supplies</td>
<td>Other</td>
</tr>
<tr>
<td>Anesthesia event</td>
<td>Complication of Procedure/Treatment/Test</td>
<td></td>
</tr>
<tr>
<td>Breast Milk problem</td>
<td>Error Related to Procedure/Treatment/Test</td>
<td>Dietary</td>
</tr>
<tr>
<td>Broken item(s)</td>
<td>Equipment/Supplies</td>
<td></td>
</tr>
<tr>
<td>Burn (electrical, chemical, thermal)</td>
<td>Skin Integrity</td>
<td></td>
</tr>
<tr>
<td>Cardiopulmonary arrest outside of ICU setting</td>
<td>Complication of Procedure/Treatment/Test</td>
<td></td>
</tr>
<tr>
<td>Complication following care or a procedure</td>
<td>Complication of Procedure/Treatment/Test</td>
<td></td>
</tr>
<tr>
<td>Consent missing/inadequate (blood)</td>
<td>Blood Products/Transfusion</td>
<td></td>
</tr>
<tr>
<td>Consent missing/inadequate (surgery or procedure)</td>
<td>Other / Miscellaneous</td>
<td>Other</td>
</tr>
<tr>
<td>Dietary related event</td>
<td>Error related to Procedure/Treatment/Test</td>
<td></td>
</tr>
<tr>
<td>Disconnected tubing</td>
<td>Equipment/Supplies</td>
<td></td>
</tr>
<tr>
<td>Drain related event</td>
<td>Equipment/Supplies</td>
<td></td>
</tr>
<tr>
<td>Electric shock to patient</td>
<td>Other/Miscellaneous</td>
<td></td>
</tr>
<tr>
<td>Equipment malfunction, misuse or not available</td>
<td>Equipment/ Supplies</td>
<td></td>
</tr>
<tr>
<td>Equipment safety situation</td>
<td>Equipment/Supplies</td>
<td></td>
</tr>
<tr>
<td>Event related to blood product</td>
<td>Blood Products/Transfusion</td>
<td></td>
</tr>
<tr>
<td>Extravasation of drug or radiologic contrast</td>
<td>Complication of Procedure/Treatment/Test</td>
<td></td>
</tr>
<tr>
<td>Fall</td>
<td>Fall</td>
<td></td>
</tr>
<tr>
<td>Hand off communication issue</td>
<td>Transfer/Transport of Patient</td>
<td></td>
</tr>
<tr>
<td>Inadequate pain management</td>
<td>Medication Error</td>
<td></td>
</tr>
<tr>
<td>Inadequate supplies</td>
<td>Equipment/Supplies</td>
<td></td>
</tr>
<tr>
<td>Inappropriate discharge</td>
<td>Other/Miscellaneous</td>
<td></td>
</tr>
<tr>
<td>Inappropriate mode of transport</td>
<td>Transfer/Transport of Patient</td>
<td></td>
</tr>
<tr>
<td>Infusion/ IV/Enteral</td>
<td>Equipment/ Supplies</td>
<td></td>
</tr>
<tr>
<td>IV site complication or infiltration</td>
<td>Complication of Procedure/Treatment/Test</td>
<td></td>
</tr>
<tr>
<td>Laboratory test problem</td>
<td>Error related to Procedure / Treatment / Test</td>
<td></td>
</tr>
<tr>
<td>Laceration</td>
<td>Skin Integrity</td>
<td></td>
</tr>
</tbody>
</table>
### Job Aid for Entering Patient Related Events into Safety Net

<table>
<thead>
<tr>
<th>Event Description</th>
<th>Type</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Complication</td>
<td>Complication of Procedure/Treatment/Test</td>
<td></td>
</tr>
<tr>
<td>Medical device problem</td>
<td>Equipment/Supplies</td>
<td></td>
</tr>
<tr>
<td>Medication list incorrect</td>
<td>Medication Error</td>
<td></td>
</tr>
<tr>
<td>Wrong Medication Dose</td>
<td>Medication Error</td>
<td>Wrong</td>
</tr>
<tr>
<td>Medication related event (except ADR)</td>
<td>Medication Error</td>
<td></td>
</tr>
<tr>
<td>Monitoring error (includes contraindicated drugs)</td>
<td>Medication Error</td>
<td></td>
</tr>
<tr>
<td>No identification band - lab</td>
<td>Error related to Procedure/Treatment/Test</td>
<td></td>
</tr>
<tr>
<td>No Identification Band during transport</td>
<td>Transfer/Transport of Patient</td>
<td></td>
</tr>
<tr>
<td>Not on this list?</td>
<td>Choose the most logical event type or Other</td>
<td></td>
</tr>
<tr>
<td>Onset of hypoglycemia during care</td>
<td>Complication of Procedure/Treatment/Test</td>
<td></td>
</tr>
<tr>
<td>Outdated item(s)</td>
<td>Equipment/Supplies</td>
<td></td>
</tr>
<tr>
<td>Perfusion/ECMO/Dialysis issues</td>
<td>Equipment/Supplies</td>
<td></td>
</tr>
<tr>
<td>Preventive maintenance not complete</td>
<td>Equipment/Supplies</td>
<td>Equipment Safety situation</td>
</tr>
<tr>
<td>Prescription/refill Delayed</td>
<td>Medication Error</td>
<td></td>
</tr>
<tr>
<td>Pressure ulcer</td>
<td>Skin Integrity</td>
<td></td>
</tr>
<tr>
<td>Pyxis narcotic discrepancy</td>
<td>Still need to use a paper form (for now)</td>
<td></td>
</tr>
<tr>
<td>Radiographic equipment issues</td>
<td>Equipment/Supplies</td>
<td></td>
</tr>
<tr>
<td>Radiology/imaging test problem</td>
<td>Error related to Procedure/Treatment/Test</td>
<td></td>
</tr>
<tr>
<td>Rash/Hives</td>
<td>Skin Integrity</td>
<td></td>
</tr>
<tr>
<td>Sterilization problem</td>
<td>Equipment/Supplies</td>
<td></td>
</tr>
<tr>
<td>Surgery/invasive procedure problem</td>
<td>Error related to Procedure/Treatment/Test</td>
<td></td>
</tr>
<tr>
<td>Transfer/Transport problem, delay or event</td>
<td>Transfer/Transport of Patient</td>
<td></td>
</tr>
<tr>
<td>Transport not consistent with patient needs</td>
<td>Transfer/Transport of Patient</td>
<td></td>
</tr>
<tr>
<td>Skin ulcer, abrasion, blister</td>
<td>Skin Integrity</td>
<td></td>
</tr>
<tr>
<td>Unplanned extubation</td>
<td>Error related to Procedure/Treatment/Test</td>
<td></td>
</tr>
</tbody>
</table>