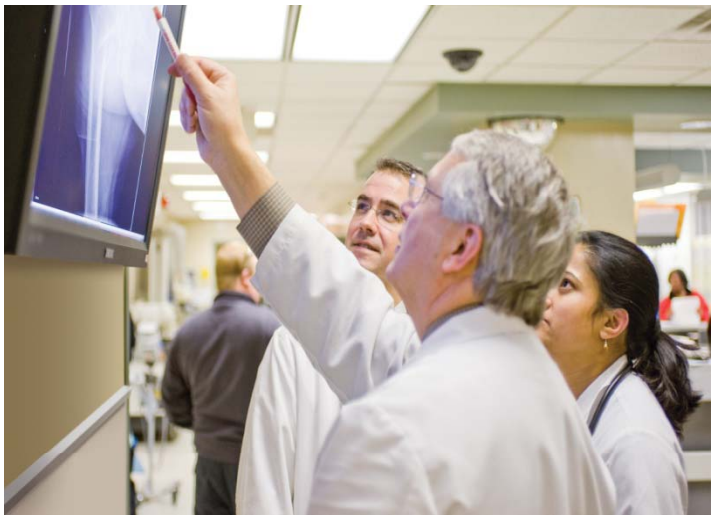
Patient Safety & Quality Improvement Physician & Resident Handbook



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Associate Professor of Internal Medicine
State University of New York at Buffalo
Department of Medicine
898-3936

2017 – 2018 ed.

ERIE COUNTY MEDICAL CENTER CORPORATION

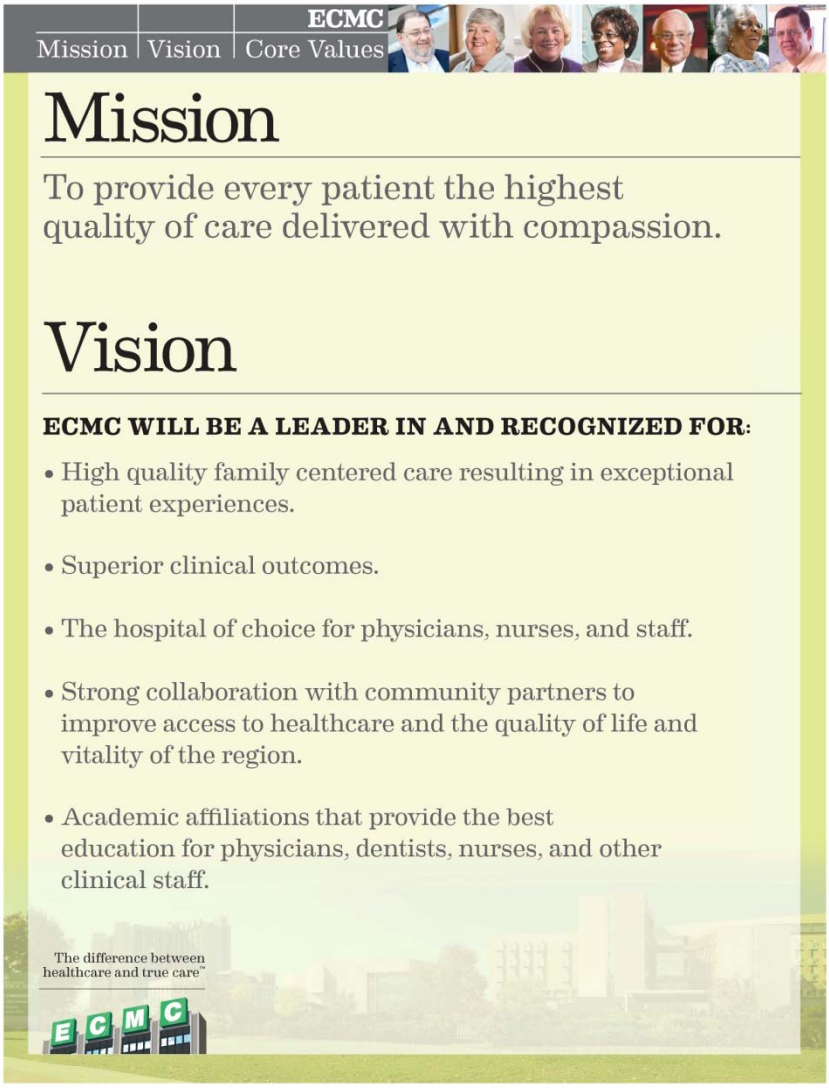
Table of Contents

Table of Contents (Con't)

I. Mission, Vision, Values

What we strive for

Erie County Medical Center
Mission, Vision and Values



Erie County Medical Center
Mission, Vision and Values

ECMC

Mission | Vision | Core Values

Core Values

ACCESS
All patients get equal care regardless of their ability to pay or source of payment. We address the healthcare needs of each patient that we can appropriately serve, without bias or pre-judgment.

EXCELLENCE
Excellence is a standard that will never be lowered; there is an expectation of excellence in all areas.

DIVERSITY
We recognize the importance and value of diversity and the enrichment that diversity can bring to ECMCC.

FULFILLING POTENTIAL
We respect the value and potential of each individual as offering a significant contribution to the good of the whole organization. Personal growth and development is important for organizational success.

DIGNITY
Each individual, no matter his or her limitations, background or situation, has intrinsic dignity and unique capabilities.

PRIVACY
We honor each person's right to privacy and confidentiality.

FAIRNESS and INTEGRITY
Equity and fairness are guidelines for all decision-making. We demand personal and institutional integrity.

COMMUNITY
In accomplishing our mission we remain mindful of the public's trust and are always responsive to the immediate surrounding community and our natural environment. This commitment represents both our organization and us as individuals. A successful future for ECMCC depends on a vibrant community and a healthy environment.

COLLABORATION
Collaboration with other organizations is beneficial within the context of our mission and is fundamental to achieving our goals.

COMPASSION
All involved with ECMCC's service delivery demonstrate caring, compassion, and understanding for patients, employees, volunteers, and families.

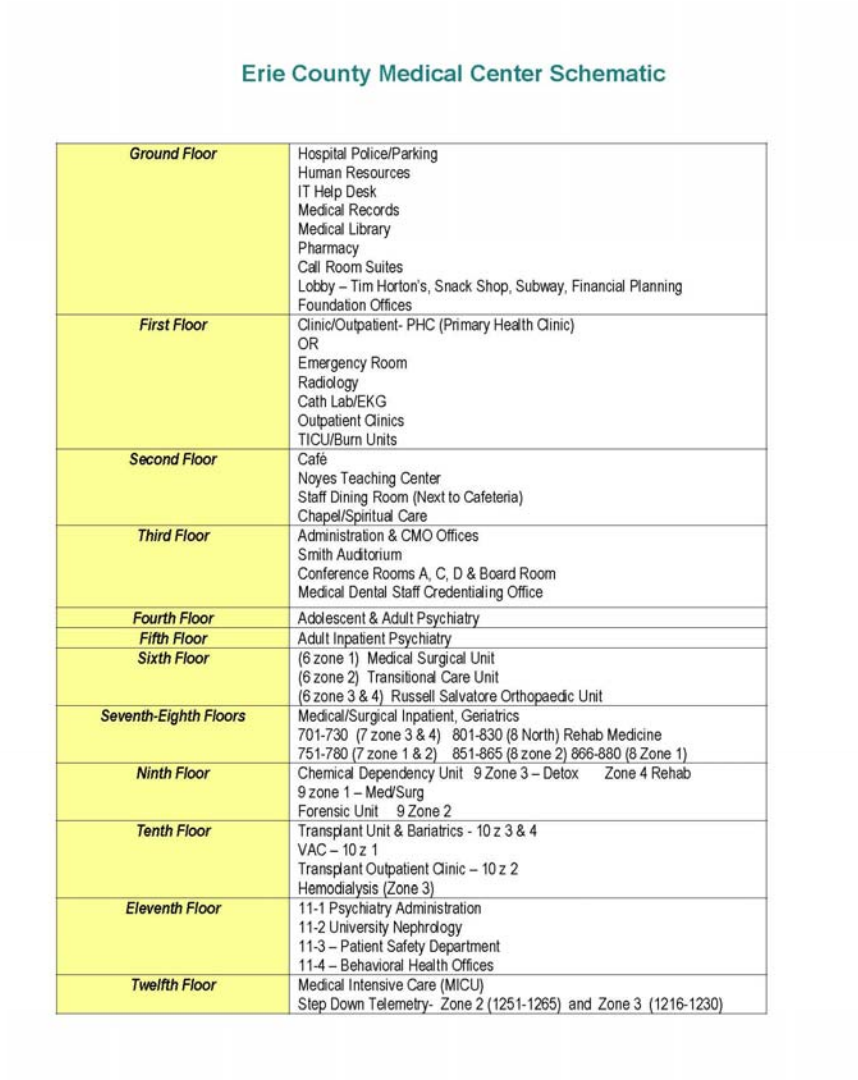
STEWARDSHIP
We can only be successful in carrying out our mission through solid financial performance and by assuring that resources provided to us are used effectively, in the way they were intended, and for the benefit of our patients and community.

The difference between healthcare and true care™

II.
Helpful Tools

Schematic, Phone Lists, Intranet & Interpreter Services

Erie County Medical Center Schematic



Erie County Medical Center Schematic

Ground Floor	Hospital Police/Parking Human Resources IT Help Desk Medical Records Medical Library Pharmacy Call Room Suites Lobby – Tim Horton's, Snack Shop, Subway, Financial Planning Foundation Offices
First Floor	Clinic/Outpatient- PHC (Primary Health Clinic) OR Emergency Room Radiology Cath Lab/EKG Outpatient Clinics TICU/Burn Units
Second Floor	Café Noyes Teaching Center Staff Dining Room (Next to Cafeteria) Chapel/Spiritual Care
Third Floor	Administration & CMO Offices Smith Auditorium Conference Rooms A, C, D & Board Room Medical Dental Staff Credentialing Office
Fourth Floor	Adolescent & Adult Psychiatry
Fifth Floor	Adult Inpatient Psychiatry
Sixth Floor	(6 zone 1) Medical Surgical Unit (6 zone 2) Transitional Care Unit (6 zone 3 & 4) Russell Salvatore Orthopaedic Unit
Seventh-Eighth Floors	Medical/Surgical Inpatient, Geriatrics 701-730 (7 zone 3 & 4) 801-830 (8 North) Rehab Medicine 751-780 (7 zone 1 & 2) 851-865 (8 zone 2) 866-880 (8 Zone 1)
Ninth Floor	Chemical Dependency Unit 9 Zone 3 – Detox Zone 4 Rehab 9 zone 1 – Med/Surg Forensic Unit 9 Zone 2
Tenth Floor	Transplant Unit & Bariatrics - 10 z 3 & 4 VAC – 10 z 1 Transplant Outpatient Clinic – 10 z 2 Hemodialysis (Zone 3)
Eleventh Floor	11-1 Psychiatry Administration 11-2 University Nephrology 11-3 – Patient Safety Department 11-4 – Behavioral Health Offices
Twelfth Floor	Medical Intensive Care (MICU) Step Down Telemetry- Zone 2 (1251-1265) and Zone 3 (1216-1230)

Helpful Phone Numbers

AREA/Unit Manager	PHONE	FAX	Manager
6 zone 1 - *Lynne Golombek*	3005		4863
6 North (Ortho) - *Judy Haynes*	3609		5397
7 Zone 2 - *Renee Delmont (751-765)*	4363		6284
7 Zone 3 - *Patricia Kiblin (716-730)*	3605	5456	4376
7 zone 4 - *(701-715) Jessica McGuigan*	1945	5456	1971
8 Zone 1 - *Jeremy Hepburn (* 866-880)	4831		3314
8 North - *Jenna DeFilippo*	3614	6144	4551
8 Zone 2 - *Lisa Hauss*	3606		4571
9th Floor - ACC Desk	3685		
6 - Zone 2 - *Santosha Gompah*	5608		5455
9 - Zone 2 - (FORENSIC) - *Nicole Cretacci*	3621/4409		5455
9 - Zone 3 (Detox) - Shonda Cleckley	3687		5892
9 - Zone 4 (Rehab)- Shonda Cleckley	4206		5892
10 - Zone 1 (Inpatient Dialysis) Jamie Repec	4644		
10 - Zone 2 (Transplant Center) Pam Riley	5001		
10 zone 3 - Inpatient Transplant - Pam Riley	6220		
10 Zone 4 - Inpatient Transplant	6220		
Transitional Care Unit (6 z 2) - *Mary Molly Shea*	3424		3084
Psychiatry Units			
4 Zone 1 - *Richard Waterstram*	3592		4743
4 Zone 2 - *Richard Waterstram*	3592		4743
4 Zone 4 (Adol. Psych) - *Laurie Carrol*	5420		4657
CPEP - *Donna Gatti*	3465/3389		3566
5 zone 3 & 4 (Beh Health)- *Denise Abbey*	5059		4901
5 South (Beh Health) - *Jillian Brown*	5728		5817
12 Zone 2 (Rm 1251-65) *Pam Riley*	3667/4831	5062	4552
12 Zone 3 (Rm 1216-30) - *Sonja Melvin*	3672	5083	5730
MICU - *Tim Kline*	3673/3674		3666
Trauma/BURN - 1st Floor			
Trauma ICU - *Melinda Lawley*	6171/3344		5267
Burn Unit - *Audrey Hoerner*	5231/5232		4378
Operating Room - *Jim Turner*	6211		6211
OR Reception Desk	4315		
OR Staff Lounge	3553/3555		
OR Recovery Room	4101/3348		
OR Scheduling	4039		
One Day Surgery	3654/4315		
OR Main Desk	4315		
Drs. Messages	4110		
OR Preadm./Tests/Surg Holds	4110		
EMERGENCY ROOM		5140/5660	
Triage	3458/3161		
Med/Surg POD	4166/4167		
Trauma Corridor	3853		

Off Hours/Holidays – Contact the Nursing Supervisor for assistance at Pager – 642-9215

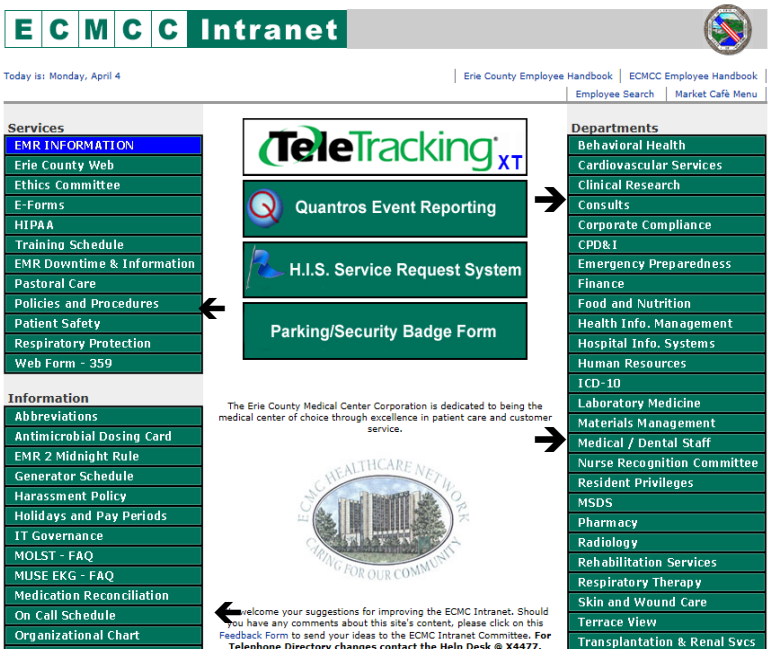
Helpful Phone Numbers

Department of Medicine	**PHONE**		
Chief Medicine Resident	4924	P: 642-1550	
UB Inpatient Geriatric Consult Service	4845	Susan Glose, NP	
General Phone Numbers			
Medical Director Office	3936	**FAX**	
Admissions	3908/3153		
AIS/SIU	3471		
ARIS (Rehab)	4628		
Adverse Drug Reporting	4000		
Autopsy	3520		
Biochemistry	3532/3442		
BioMed	3832		
Blood Bank	4182/4177		
Blood Gas	4184		
Cardiology Consults	See intranet		
Cath Lab	3386		
Code Blue/Code Stroke	4545		
Cytology	4123		
Dietary	3559/3210		
Dopplers	5238		
ECHO	3388		
EEG	3371		
EKG	3388		
Apogee Hospitalists	6995		
GI Office	3391		
Family Health Center	4449		
Help Desk (IT)	4477	x5601 for EMR Hotline	
Hematology	4063		
HIV Testing	4119		
Immuno Service	4119		
Infection Control	3628		
CALL SCHEDULES and CONSULT SERVICES			
See Intranet Tab			
CASE MANAGEMENT			
See Phone List on Intranet (Medical Dental Staff Page)			

Helpful Phone Numbers

Information (Patient)	8020		
Internal Med Clinic (Primary Health)	3334/3152		
IV Team	4273		
Library	3939		
Laboratory Administration	3114		
Hematology	3532		
Microbiology	5956		
Parasitology	3535		
Serology	4138		
Virology	4211		
Urinalysis	4056		
Medical Dental Staff (Credentialing)	3130/5270		
Medical Records	3190		
Incomplete Records	5176		
Old Medical Records	3917		
Morgue/Hospital	3520		
Neurology Consults	3638	On Call Page for Schedule	
Neuropsych Evals	5182		
Nuclear Medicine	3383		
Pastoral Care	3357/3356		
Pathology	3117/3512		
Patient Advocate	4155		
Personnel Health	3300		
Pharmacy	3925/3926		
Stat Pharm Line	3286/3282		
MetCare/Lobby	332-2866		
Pulmonary Consults	408-3075		
Radiology	3446/3468		
X-Ray Reports	3446/3468		
CT	4040/3659		
Ultrasound	3774/5294		
ED X-Ray	3433/5905		
MRI	5999 ext 1	Tech: 5577	
Rapid Response Team	8888		
Rehabilitation	3235/3217		
Physical Therapy	3904		
PT Hydro	3902		
Speech	3212		
OT	3225		
Renal Office	4803		
Respiratory	3245		
Security	3506/3505		
Skilled Nursing - Terrace View	551-7100	551-7217	
Social Work/DC Planning	3360		
Toxicology	3821/3442		
Vascular Lab	5238		

Policy and Procedures & Medical Dental Staff Webpage (when restored)



Please use the ECMC Intranet to find current **policies**, general info for all Medical Staff on the **Med/Dent Staff** page, **call schedules and contact information for Consults**. The ECMC intranet page is a primary source for communication for many of our departments so please use this as a resource.

What if my patient doesn't speak/read English?

- **Professional Medical Interpreter Services** are available at no cost to the patient. DO NOT UTILIZE A FAMILY MEMBER TO INTERPRET FOR YOU. It is essential to ensure proper medical communication and to protect the patient's confidentiality.

- **Identify Patient's Preferred Language**
  - **Language ID Card –** Cards are available throughout the hospital and has the phrase "Point to your language. An interpreter will be called. The interpreter is provided at no cost to you." translated in 90 languages and grouped by geographical regions of the world. A patient may be given an ID card with preferred language written on it as well. Stickers can be placed in the chart or on their ID bracelet.

- **Interpreter Services**
  - **Phones are available throughout the hospital.** They are easy to use and can be accessed quickly through the nursing staff.
  - **Face-to-Face Services.** Deaf Adult Services can be accessed for sign language and the International Institute for spoken language – Contact the patient advocate for assistance – 642-7177.

- **Tips**
  - **Record the interpreter's name and ID in the patient chart.**
  - **Orient the interpreter and the patient**
  - **Speak directly with the patient in the first person (Where is your pain?). Speak in short sentences**
  - **Check with the patient for understanding.**

III.
Health & Wellness

Supporting your practice and your health

ACGME Post-Graduate Work Hour Regulations

- *Some important points*

All residents and faculty should familiarize themselves with the Work Hour regulations.

These are some important points to remember.

- Maximum duty hours per work week are a maximum of 80 hours averaged over 4 weeks, inclusive of all in-house activities, clinic assignments, and moonlighting activities.
- Moonlighting – all moonlighting hours worked are included in the total weekly work hours.
- Residents must be scheduled for a minimum of 1 day in 7 free of clinical work and required education when averaged over 4 weeks. At home call cannot be assigned on these free days.
- Mandatory rest/time off between duty periods – all residents must have 8 hours, should have 10 hours free between scheduled duty periods. Intermediate level residents must have at least 14 hours free of duty after 24 hours of in-house duty.
- Maximum Duty Period Length – Different for each program year. See information on the **Medical Dental Staff Intranet Page or UB Work Hour Rules policy.**
- Maximum On Call Frequency – Every third night averaged over 4 weeks; every third night if using surgical exemption.
- Night Float Frequency – Residents must not be scheduled for more than 6 consecutive nights of night float.
- If you are required to log into the E-Value system, please ensure you are logging accurately.

ECMC
Fitness Center

The Fitness Center is open 24/7 to Employees, Residents and Physicians. You can obtain a consent to initiate your FREE access through the Human Resources Offices located on the Ground Floor.

The Medical Dental Staff maintains a Provider Wellness Committee and is a resource available for those who may require extra assistance. You may access this resource via the Chief Medical Officer's office.

Practitioner Wellness Committee

If you or a colleague are in need of help or support, the ECMC Medical Dental Staff Practitioner Wellness Committee is here to assist you. They can provide resources and/or intervene if a practitioner or resident is in need of further assistance. Please don't hesitate to reach out if you feel you need help or support – we are here to ensure your success!
You may contact committee members via links on Med/Dental Staff Intranet Page or email lisag@ecmc.edu
http://home.ecmc.local/depts/medicaldental/PractitionerHealth.htm

Flu Shot for you and your patients!

All NYS Hospital Health Workers are required to be vaccinated for flu annually (or provide evidence of contraindication) or they must wear a face mask while in the hospital. You may obtain your shot through the Teammate Health Office on the Ground floor. If you get your shot elsewhere, please bring evidence and we will give you a sticker for your badge. Please review your patient's history and if they have not acquired a flu shot or pneumonia vaccine should that be warranted, encourage them to take advantage of the vaccine while they are here either inpatient or in the clinic. Your encouragement goes a long way in improving patient compliance!

For your comfort and well being

- **Physician Lounges –**
  - The medical dental staff and administration provides a comfortable lounge located in the rear of medical records on the ground floor. This lounge is open to all members of the medical-dental staff and residents. It is available 24/7 for your use. Refreshments are served M-F and coffee and tea is available anytime. Please respect the space and leave it in the condition you found it so all who need a rest can enjoy it.
  - **Surgical Physician Lounge** – is located across from the ORs. It is available for attendings and extenders only. There is coffee, newspaper and TV available for your comfort.
  - For your convenience, the computers in both lounges are equipped with Dragon for dictation.

- **Call Rooms –**
  - Suite is available on the ground floor. Rooms are assigned by the hospital police office and are issued for 24 hours.
  - Some departments such as surgery and ED have rooms within or near the unit – see your Chief Resident or Department Manager for details.

IV. Quality & Patient Safety

Best Practices and Guidelines

CMS Measures – Best Practices

CMS has identified the following practices as "best practices". Hospitals are continuously measured on how they adhere to these guidelines. If particular guidelines cannot be followed, the reason must be clearly documented in the patient's chart.

- **ED Throughput -** ED Arrival to Departure Time & Decision to Admit to Depart Time
  *What you can do to meet the measure...*Complete your admission orders promptly and respond quickly to "ED Overcrowding" alerts by writing d/c orders early for admitted patients.

- **Immunization -** Influenza Immunization (4Q & 1Q)
  What you can do to meet the measure...Have a conversation with your patients on the importance of flu vaccination – your encouragement helps compliance!

- **Venous Thromboembolism**
  VTE Prophylaxis, ICU VTE Prophylaxis, VTE Discharge Instructions, Potentially Preventable VTE
  *What you can do to meet the measure...*Address and order VTE prophylaxis on admission – if contraindicated, document in the record.

- **Stroke**
  Thrombolytic for Ischemic Stroke
  What you can do to meet the measure: ECMCC is a NYSDOH Designated Primary Stroke Center. We have attained Gold Plus Status in The American Heart and Stroke Association's Get With the Guidelines 2016 Program.. When a stroke is suspected, call a "Stroke Code" to assure guidelines for care are met.

- **Complications** following elective hip/knee surgeries

- **Mortality Rates** for AMI, HF, PN, COPD & Ischemic Stroke
  What you can do to meet the measure: Utilize order sets for best practice guidelines and protocols.

- **Readmission Rates** for HF,PN, COPD, Ischemic Stroke & the whole hospital
  What you can do to meet the measure: Patient education is complete pertaining to their diagnosis, medication and plan of care. Work closely with discharge planning and social work to ensure a safe discharge for the patient.

Sometimes the recommended intervention may not be appropriate for a particular patient (i.e., blocker in asthma, ACEI in a hyperkalemic patient). In that case, the REASON WHY the intervention was not performed must be documented in the medical record.

CMS Measures – Best Practices
Hospital Acquired Infections

To Prevent Catheter-Associated Urinary Tract Infections (CAUTIs:)

Insert catheters only for appropriate indications
Leave catheters in place only as long as needed
Insert catheters using aseptic technique and sterile equipment (acute care setting)
Follow aseptic insertion, maintain a closed drainage system

To Prevent Central Line-Associated Bloodstream Infections (CLABSIs)

Remove unnecessary central lines
Facilitate proper insertion practices
Avoid femoral route for central venous cannulation (CVC)
Use maximal sterile barrier precautions (cap, mask, sterile gown and sterile gloves) and a sterile full-body drape while inserting CVCs, peripherally inserted central catheters, or guidewire exchange
Use appropriate agent for skin antisepsis

To Prevent Ventilator Associated Pneumonia (VAP)

Implement a continuous (24-hour) oral care protocol
Elevate the head of bed (HOB) by at least 30 degrees
Regular (at least once daily) eval of patient's readiness to wean, including at least daily sedation vacation

To Prevent *Clostridium difficile* Infections (CDI)

Contact Precautions for duration of treatment
Comply with CDC hand hygiene recommendations

To Prevent Surgical Site Infections (SSIs):

Before surgery

Administer antimicrobial prophylaxis in accordance with evidence-based standards and guidelines
Avoid hair removal at the operative site unless it will interfere with the operation; do not use razors
Use appropriate antiseptic agent and technique for skin preparation

During Surgery

Keep OR doors closed during surgery except as needed for passage of equipment, personnel, and the patient

After Surgery

Maintain immediate postoperative normothermia
Protect primary closure incisions with sterile dressing
Discontinue antibiotics according to evidence-based standards and guidelines

Rapid Response Team (RRT)

- At ECMC, the **RAPID RESPONSE TEAM** is run by the HOSPITALIST (MED H – Apogee Physicians) service. The resident teams should respond to assist and provide any needed support. A RR may be called by a nurse, provider or a **family member** who notes a significant medical change in the patient.

- Do not dismiss the RRT until you are sure the patient's needs have been met. Do not wait to start critical care until transfer into an ICU – be sure care is administered immediately and/or as ordered.

- Be sure the patient's condition and treatment are documented properly in the medical record. Be sure to time, date and sign your entry.
- Please discuss the need to contact the Health Care Agent regarding the change in patient's condition and discuss with the Attending of Record.

- The **Rapid Response Team Record** will be completed by the Rapid Response Team and is included in the medical record.

Adult Medical Emergency

- **All Internal Medicine residents as assigned by your department are to report to Adult Medical Emergency** (cardiac/pulmonary arrest) and offer help until the person running the code dismisses them. The Internal Medicine resident on call or the Chief Resident is in charge of the code.

- Be sure all patient information is documented in the medical record. If you are the team leader, you must review the Adult Medical Emergency Sheet and sign, date and time your documentation.

- If the coded patient is from your team, **ensure that the patient's family has been contacted and updated on the patient's condition and location if transferred to an ICU**.

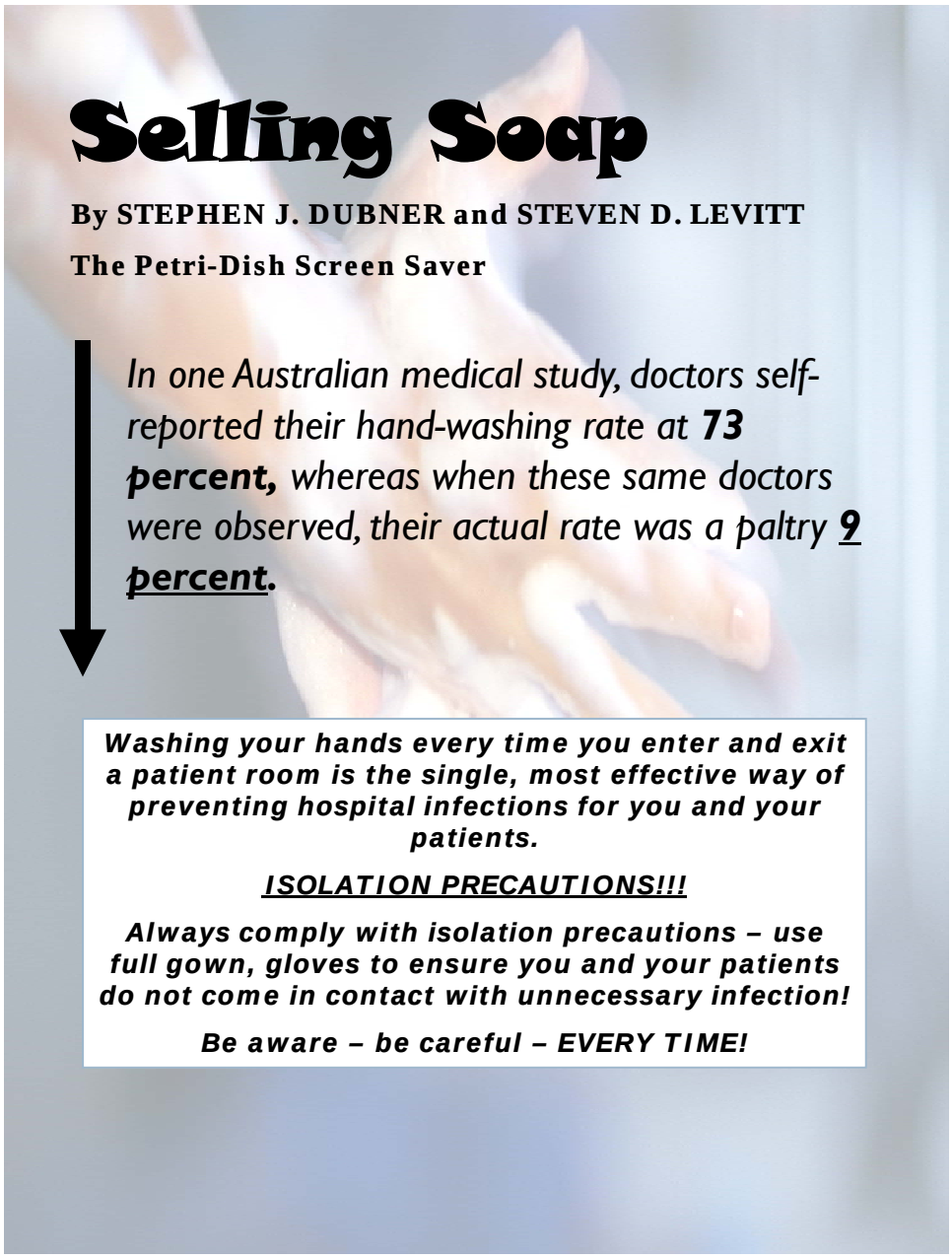
- Refer to the Internal Medicine Program Code Blue policy/ recommendations for further information.

- Ensure that the patient's Attending Physician is notified of the arrest and its outcome.
- **Please note: It is the responsibility of the PHYSICIAN (or Resident) to contact the family/health care agent.**

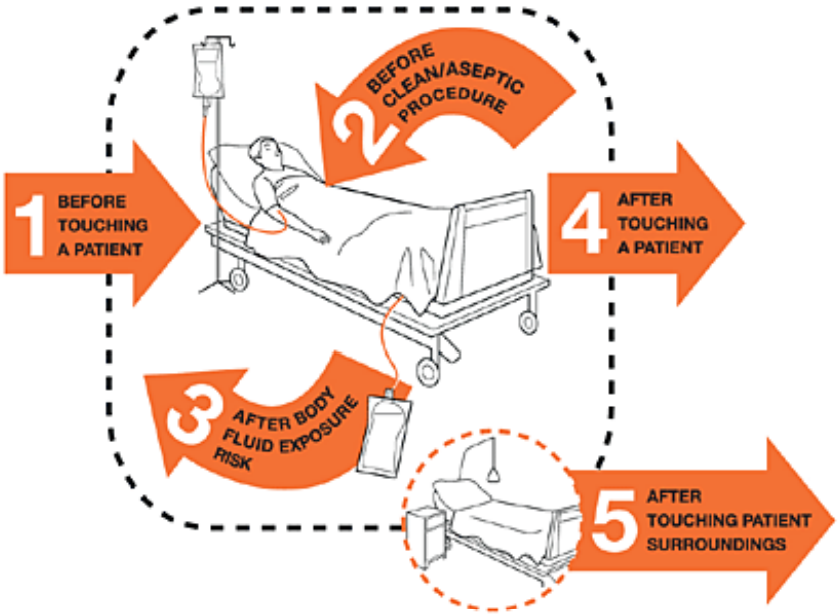
Emergency Codes
(now in plain language)

- ADULT MEDICAL EMERGENCY
- FIRE – *Fire Alarm Activation*
- BOMB THREAT
- COMMAND CENTER ACTIVATION
  - Normal, Monitoring, Partial, Full
- DANGEROUS PERSON
- EVACUATION
- HAZMAT INCIDENT
- MASS CASUALTY INCIDENT
- MISSING INFANT/CHILD/VISITOR
- PATIENT ELOPEMENT
- PEDIATRIC MEDICAL EMERGENCY
- RAPID RESPONSE TEAM
- SECURITY EVENT
- STROKE TEAM
- SUPPORT TEAM
- UTILITY OUTAGE
- WEATERH/NATURAL DISASTER WARNING

Handwashing & Infection Prevention

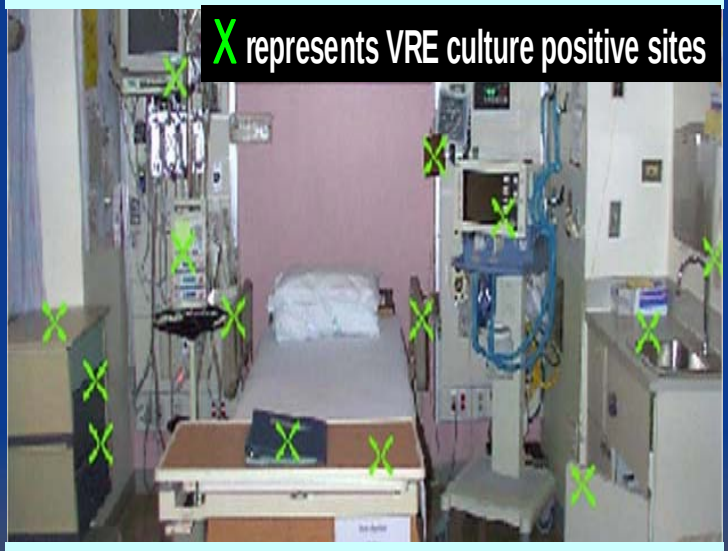


Your 5 moments for Hand Hygiene



All surfaces in a patient room are susceptible to contamination!

The Inanimate Environment Can Facilitate Transmission



~ Contaminated surfaces increase cross-transmission ~

Abstract: The Risk of Hand and Glove Contamination after Contact with a VRE (+) Patient Environment. Hayden M, ICAAC, 2001, Chicago, IL.

Sharp Injury Prevention

- Eliminate the use of unnecessary needles and sharps.
- Properly dispose of sharps in appropriate puncture resistant containers.
- Maintain constant communication with those in the area when sharps are used.
- Use safety devices - alter user technique to promote safety
- **If you are stuck by a contaminated needle,** please report to Teammate Health Office on the ground floor 7:00 a.m. to 3:00 p.m. or the Emergency Room after hours for appropriate treatment.
- State law protects the rights of THE PATIENT. You may not have legal rights to know the status of your patient so the best protection is PREVENTION. Source patients have a right to refuse an HIV test and "backdoor" tests (t-cell counts, p24 antigen, etc) are a violation of the HIV Confidentiality Law. Patients cannot be pressured to test and it is **never** appropriate for the exposed employee to approach the source of their exposure about testing.

Central Line Infection

- Avoid femoral site when possible.
- Always use Central Line Checklist and Maximum Barrier Kit which includes: chloraprep. Kits available on ALL UNITS.

If you plan to send a central catheter tip for culture…

- **Don't send a catheter tip for culture unless a catheter-related infection is clinically suspected;** in most cases you should have sent blood cultures already. Culturing a tip is NOT standard procedure if you are just removing a line because you are done with it.
- Disinfect the skin around the exit site before removing the catheter. You can use an alcohol wipe for this.
- Cut off a generous length of the catheter (at least 5 cm) with sterile scissors and drop it into a sterile specimen container.

What is an Antibiogram?

- Antibiograms are collections of information obtained from culture and sensitivity tests performed in the institution within a given time frame (annually at ECMC)
- Provides the percentage of samples for a given organism which were sensitive to certain antibiotics
- Two files: one for Gram positive organisms and one for Gram negative organisms

What is the purpose of the antibiogram?

- To guide **empiric** antibiotic therapies for suspected bacterial infections based on local susceptibility data while awaiting culture and sensitivity results
- Part of infection control measures to identify patterns of antibiotic susceptibility and track changes in susceptibility over time. Data can be utilized to:
  - -improve overall appropriate antimicrobial use
  - -guide antibiotic Formulary changes or restrictions

How is an antibiogram used?

- Numbers on tables represent the percentage of isolates susceptible to a given antibiotic
  - -When two numbers are displayed the top number indicates the percent susceptible isolates from non-ICU areas, the lower shows percent susceptible from ICU samples
- Numbers in parentheses next to the organism indicates the number of isolates tested
- Larger numbers of isolates increases the predictive value for that bug – drug combination
-

What are some limitations of the antibiogram?

- Susceptibility limited to specific institutions, not predictive of other hospitals or nursing facilities
- Does not account for specific patient history or previous infections
- Does not consider specific pharmacokinetic and pharmacodynamic properties of antimicrobials – will the drug kill the bug where the bug lives
  - -Site of infection should still be considered as well as predicted drug concentrations
  - -Rapid resistance may be seen of specific pathogens to antibiotics
    - oi.e. Fluoroquinolones and MRSA

Miscellaneous information

- Only initial isolates are included to prevent bias of data
- Fewer than 30 isolates may skew data and create statistically insignificant results
- Only clinically relevant “bug-drug” combinations are assessed
- Patient specific characteristics always outweigh the use of the antibiogram
- Antibiogram should be utilized to guide empiric therapy in conjunction with clinical judgment
- Culture and sensitivity results should guide definitive therapy
- Refer to Department of Pharmacy Therapeutic Pearls / Guidelines for additional information
  - -http://home.ecmc.edu/depts/pharmacy/Pearls.htm

Gram Positive Antibiogram

John K. Crane, Infection Prevention; Daniel Amsterdam, Laboratory Medicine; Sue Burgio, Clinical Microbiology Lab; and Christine Ruh, Pharmacy

Antimicrobial Susceptibilities of Selected Gram-Positive Bacteria, Erie County Medical Center, 2016

Gram-Positive Bacteria. Percent of Strains Susceptible. Published 2017.

Organism (Number of isolates)	Gent	Amp	Oxa	Pen	Cefaz†	Ceftri	Clinda	Erythr	Rifamp	Tetra	TMP/ SMX	Vanco	High-levl Gent	Fosfo-mycin
Staphylococcus aureus (316)	96	--	51-55	10	51	--	65 70	40	98	93	96	100	--	
Staph epi-dermidis (31)	77	--	31	--	31	--	56	--	93	80	54	100	--	
Coag (-) Staph (346)	82	--	38	5	40	--	47	30	85-92	84	54	100	--	
E. faecalis (153)	--	96	--	90	--	--	--	--	--	27	--	78	65	45¥
E. faecium (79)		4	--	0	--	--	--	--	--	17	--	23 6	89	--
Enterococcus species (50)	86	36-88	--	--	--	--	--	--	--	25	--	71	69	
Alpha & Viridans Strep. (83)		88	--	76 33	--	95	-- #	29-46	--	65 33	--	100	--	
β-hemol Strep. Grps A, B, C, F, & G (51)	--	100	--	100	--	100	47	55	--	49	--	100	--	
Strep. pneumo. (39)	--	--	--	82	--	92	--	--	--	--	--	100	--	

• Breakout data for ICU isolates are shown only when the number of isolates in the subgroup was ≥ 30 AND the % resistance differed from the non-ICU isolates. ¥: fosfomycin data is for VRE strains only. #: Clindamycin is not routinely tested. Please call the Micro. Lab and request testing if you wish to use clindamycin; otherwise, clinda is not considered reliable for alpha/ viridans Strep. This document is available for view, download, and print on the ECMCC Intranet.

Printed March 29, 2017.

Gram Negative Antibiogram

John K. Crane, Infection Prevention; Daniel Amsterdam, Laboratory Medicine; Sue Burgio, Clinical Microbiology Lab; and Christine Ruh, Pharmacy

Antimicrobial Susceptibilities of Selected Gram-Negative Bacteria, Erie County Medical Center, 2016

Gram-Negative Bacteria: Percent of Strains Susceptible. Published 2017.

Organism (number)	Amik	Tobra	Gent	Amp	Amp/sul	Pip/tazo	Ceftri	Cefep	Aztreo	Meropen	TMP/ SMX	Cipro[1]
E. coli (663)	99	88	91	46	52	92	90	97	94	99	74	70[1] 69
Klebsiella pneumoniae (194)	98	94	94	0	78	91	92	97	93	97	86	94[1]
Enterobacter cloacae (119)	100	93	92	0	0	67	61	89	66	91	85	90[1]
Serratia species (33)	98	94	96	0	0	100	92	96	57	96	77	96
Citrobacter species (25)	96	85	88	0	0	73	62	100	70	97	78	92
Proteus mirabilis (183)	100	96	94	77	92	99	98	100	98	99	79	76
Pseudomonas aeruginosa (150-327)	93 --	91 86	85 70	--	--	76 82	--	75 51	57 --	70 62	--	74 72
Acinetobacter baumannii (23)	-- --	90	65	--	69 --	52	13	54	--	84-95	43-60 79	44
Stenotrophomonas maltophilia (30)	--		--	--	--	See note[2]	--	6-25	--	--	96 100	--
Hemophilus influenzae (33)	--			59 --			100				75	100

[1] Ciprofloxacin requires ID approval except in intensive care units, Transplant, and on the Urology service.

[2] 47 % of Stenotrophomonas maltophilia strains were sensitive to ticarcillin/clavulanic acid. Ticarcillin/clavulanic acid is non-formulary.

• Breakout data for ICU isolates are shown only when the number of isolates in the subgroup was ≥ 30 AND the % resistance differed from the non-ICU isolates. Copies of this Antibiogram are Available on the ECMC Intranet under "Services→ Patient Safety-->Infection Control and also under "Departments" → Pharmacy →[Therapeutic/ Pearls] →Infectious Diseases/ Antibiograms .

Printed March 29, 2017.

SKIN AND WOUND CARE TEAM

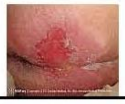
Lynn Kordasiewicz MS NP WOCN & Georgia McPartlan BSN RN WCC
office: 898-5657 pager: 642-1985

PRESSURE ULCER STAGING GUIDE 2016

Stage I

Intact skin with nonblanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surround area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons (a heralding sign of risk).

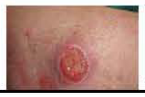
(This Pressure ulcer can be healed with quick RN intervention.)



Stage II

Partial thickness loss of dermis presenting as a shallow open ulcer with a red/pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. *** This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.** (These skin injuries need to be documented under the Wound Care & Evaluation intervention).

*Bruising indicates suspected deep tissue injury.



Stage III

Full thickness tissue loss. SQ fat may be visible but bone, tendon or muscle are *not* exposed. Slough may be present but does not obscure the depth of tissue loss. *May* include undermining and tunneling. The depth of a stage III PU varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have SQ tissue and stage III PU can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III PU. Bone/tendon is not visible or directly palpable

Stage IV

Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a stage IV PU varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have SQ tissue and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures (fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.

Deep Tissue Injury (DTI)

Purple or maroon localized area of discolored intact skin or blood filled blister d/t damage of underlying soft tissue from pressure &/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. DTI may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve & become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.

Unstagable

Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown,) &/or eschar (tan, brown or black) in the wound bed. Until enough slough &/or eschar is removed to expose the base of the wound, the true depth, & therefore stage, cannot be determined. **Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed. *Skin prep and keep heels dry.**

Wound Care Treatment Guide 2016

Product:	*Indications for use:*
Santyl (enzyme) Traid (enzyme)	Debrides devitalized tissue
MediHoney (Natural wound healing alternative)	Debrides devitalized tissue, maintains a moist wound environment
Silvadene 1% cream BID (Contains Sulfa)	Stage II & III PU, perineal excoriation with fungus, 2nd' & 3rd ' burns
Wound Vac (Change M.W.F)	Stage III & IV PU, incisions, surgical wounds
Venelex (Balsam Peru & Castor Oil)	Pressure ulcers, varicose ulcers, dehiscent (dry) ulcers
Sarna (cream)	Relieve dry, itchy skin (non steroidal)
Calmoseptine, Remedy, Zinc (Protective Barrier Cream)	Prevention, contact dermatitis, Stage I & II PU.
Triple Care Antifungal Cream	Fungal skin tinea, contact dermatitis
Kerlix, Nugauze, Iodoform (Gauze)	Wet to moist. (Wet to dry is ON 100% NECROTIC WOUNDS ONLY). Packing cavities
Algisite (Alginate)	Management of wounds with exudate (drainage).
Acticoat (Silver coated antimicrobial)	Management of infected wounds with exudate (drainage)
Skin Prep	Heels, elbows, periwound skin (any skin intact, Stage I & II PU, DTI, dry eschar/ unstageable ulcers)
SoloSite (Hydrogel)	Maintains a moist environment on viable wounds, moist packaging.
Allevyn (Foam)	Prevention, secondary dressing.

At least once per week, need to examine wound, review nursing documentation, indicate if you agree with staging and plan of wound care.

Document - Treatment/interventions, Patient's response, Compliance, Noncompliant, Refusing interventions/treatment/care

Present on Admission (POA)

The following conditions are deemed 'preventable' by Medicare. If your patient has any of these conditions on admission, it is important for the PHYSICIAN to **document these conditions on admission**. Failure to document on admission may cause the condition to be attributed to your care.

- Catheter-associated UTI
- Decubitus ulcers
- Vascular catheter-associated infection
- Mediastinitis after CABG
- Ventilator-associated pneumonia
- DKA
- PE
- Staph aureus septicemia
- Object left in during surgery
- Air embolism
- Blood incompatibility
- Latrogenic pneumothorax with venous catheterization
- Surgical site infection following certain orthopedic procedures (i.e., spine, neck, shoulder, elbow, hip, knee)
- Surgical site infection following bariatric surgery for obesity
- Surgical site infection following cardiac implantable electronic device

New --- **Falls and Trauma**
Manifestation of Poor Glycemic Control

Documenting on the H & P is essential and must be done by the physician, not by nursing in order to be considered POA. Please be sure you are aware of these conditions and look for them upon examination and admission of the patient.

Telemetry Monitoring

As telemetry tends to be over-utilized, we ask that you please evaluate patients who are placed on telemetry on a daily basis and discontinue as soon as possible. Excessive use of telemetry monitoring can lead to decompensation as it restricts patient's mobility. As soon as your medical discretion allows, please discharge patients from telemetry to avoid unwarranted monitoring. The need for continued telemetry should be discussed with the attending on daily rounds.

It is NOT appropriate to discontinue telemetry monitoring for the purpose of taking a patient off-unit for a test or study. When test or study is ordered, the following will occur:

1. **A Floor Nurse will accompany the patient if staffing allows.**
2. **If the Floor Nurse is unable to leave the unit, the charge nurse is to be contacted by the nursing staff to see if other arrangements can be made. If needed, the Charge Nurse will contact the nursing supervisor for further assistance.**
3. **In extreme circumstance where no nursing staff is available or if patient acuity warrants, the resident or extender may be required to accompany the patient for the test or study. Before doing so, please confirm nursing supervision has been contacted and is unable to provide support.**

- **Guidelines for discontinuing telemetry in patients suspected of Myocardial Infarction / ACS**

  All parameters must be met:
  - With negative cardiac enzymes
  - No further chest pain suggestive of cardiac ischemia
  - Normal potassium level
  - No hypotension or ventricular arrhythmias
  - No EKG changes (2 EKGs unchanged)

Critical Values Reporting

Critical Values Reporting – LAB

- Requirement: All values defined as critical by the laboratory **are reported to a responsible licensed caregiver** within time frames established by the laboratory (defined in cooperation with nursing and medical staff).

- All critical lab values are reported to the physician **and** the nurse caring for the patient. You may receive an additional call from the nursing staff to be sure you have received this urgent report.

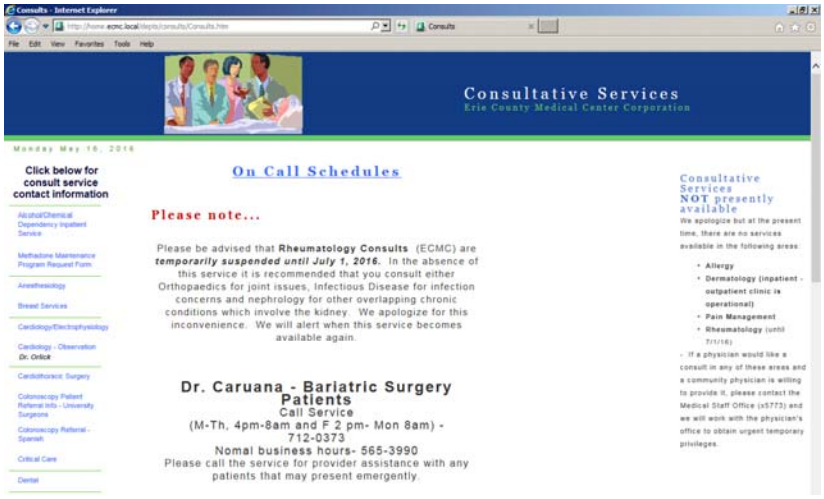
Critical Values Reporting – Radiology / Imaging

- **Radiology Critical Value Reporting-** All critical radiologic values are reported to the ATTENDING OF RECORD. A color code system is used to alert the status of the finding:
  - **Red** – patient is in imminent danger of death, significant morbidity or serious adverse consequences unless treatment is initiated immediately.
  - **Orange** – requires prompt attention, although do not reflect a potential immediate life-threatening condition.
  - **Yellow** – Significant abnormality that may threaten life – are targeted at diseases that merit rapid detection and evaluation.

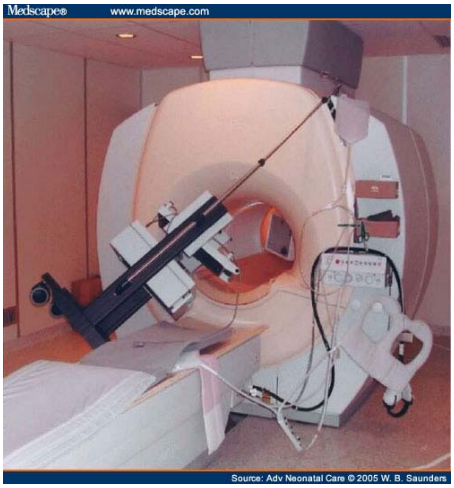
- See policy: **Radiology Critical Test/Critical Value Communication Policy (RAD-109)** - under the Radiology section of the Policy and Procedures section of the intranet.

Consults and Studies

- All consults and studies ordered must include the clinical information and/or indication.
- Request should also indicate whether you need a **consult only** or to **consult and manage** for a condition (e.g., diabetes).
- All elective consults should be ordered or approved by an Attending Physician.
- **STAT consults** – please provide an immediate contact to the attending physician ordering (such as Cell number) for the consulting service along with the major concern/diagnosis for the consult.
- All contact information for consult services are located on the intranet under “Consults”.



MRI Safety



Wheeled IV pole with infusion pumps flew into the bore of this magnet. If there had been a patient on the scanning table, the patient could have been severely injured.

Image used with permission of Moriel Ness Aiver, PhD, www.simplyphysics.com .

- **MRI Ordering** – Please make sure you complete the MRI Safety Checklist when ordering an MRI study to assure patient safety in the magnet. The checklist prints automatically when the test is entered into the Meditech system. Use caution when entering the MRI suite as the **MAGNET IS ALWAYS ON.**

Sepsis Bundle Orders

Sepsis bundle orders are available under 'Sets' in CPOE. The order set includes general information regarding goals of therapy, laboratory and microbiology orders, IV access orders, IV fluids, and antimicrobials by suspected source of infection. As with all order sets, some suggested components are pre-checked, and others are able to be included/edited in addition.

All providers are encouraged to use the Sepsis order set to initiate management of patients suspected to have sepsis/septic shock. Using the sepsis bundle orders will help streamline the ordering process to ensure all components of the sepsis bundles are met in a timely manner according to the guideline. This includes obtaining appropriate diagnostic studies, administering adequate IV fluids, and administering timely antibiotics after obtaining microbiologic cultures.

Sepsis Bundles:
TO BE COMPLETED WITHIN 3 Hours:
- Lactate level
- Blood cultures prior to antibiotics
- Broad-spectrum antibiotics
- 30 mL/kg crystalloid for hypotension or lactate ≥ 4mmol/L

TO BE COMPLETED WITHIN 6 HOURS:
- Vasopressors (hypotension not responding to initial fluid resuscitation) to maintain a MAP ≥65 mm Hg.
- Persistent arterial hypotension despite volume resuscitation (Septic Shock) or initial lactate ≥ 4mmol/L:
  - -Measure CVP (Target ≥8 mm Hg)
  - -Measure Scvo2 (Target ≥70%)

Remeasure lactate if initial lactate was elevated(Target normalization)

The Sepsis Committee will continue their efforts to monitor treatment and outcomes of septic patients, while improving compliance with requirements set forth by CMS and New York State's Sepsis Regulations.

A nursing order will also be generated to notify the RN that the sepsis orders are being initiated. **All first doses of antibiotics should be dispensed and administered as STAT orders** as indicated in the comments section of the medication label.

Sepsis bundles can be found under "STANDARD ORDER SETS", "CRITICAL CARE", "MEDICINE" and "ED CPOE". Please see next pages for a step-by-step ordering process example.

Sepsis Order Sets

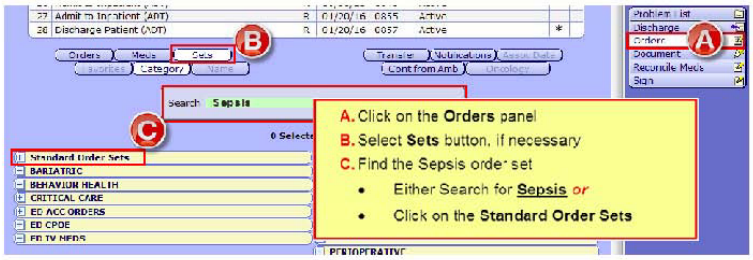
ORDERS – Sepsis Order Sets

To facilitate the ordering process when Sepsis is suspected; please use the Sepsis Order Sets found under the Standard Order Sets category

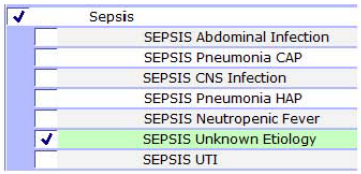
Title1

1. Locate the **Sepsis** Order Set

   NOTE: *these instructions are for inpatient units. If orders are being initiated in the ED, go to* **ED CPOE** *category and select* **ED Sepsis**



2. Click on the checkbox next to Sepsis and select the correct indication for orders:



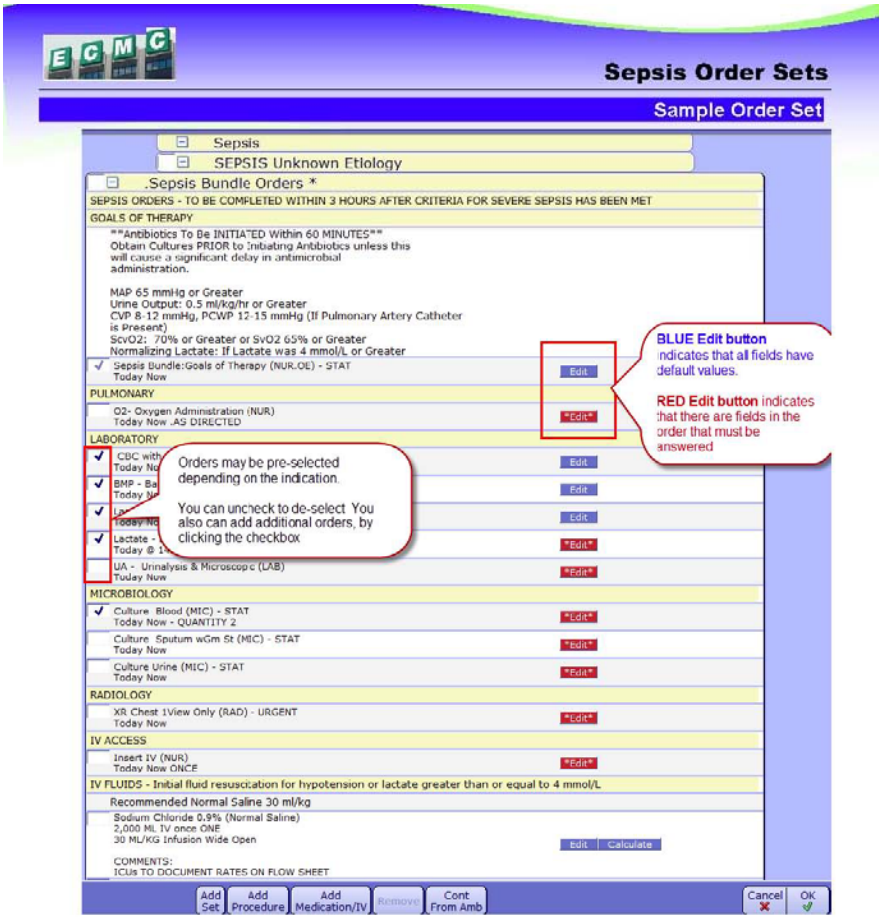
3. Click on Select at the bottom of the screen to open the order set.

4. When you have completed the order set, click on Ok at the bottom of the screen to return to the Order panel.

Last update by Dawn Rizzo, HIS Dept. April 4, 2016

1 of 2

Sepsis Sample Order



2 of 2

Pain Management Resources

Mandatory Prescriber Education

Pursuant to Public Health Law (PHL) 3309-a(3), prescribers licensed under Title Eight of the Education Law in New York to treat humans and who have a DEA registration number to prescribe controlled substances, as well as medical residents who prescribe controlled substances under a facility DEA registration number, must complete at least three (3) hours of course work or training in pain management, palliative care, and addiction. The course work or training must be completed by July 1, 2017, and once every three years thereafter.

For additional detail, a listing of approved courses and the process to file an attestation of course completion with the New York State Bureau of Narcotic Enforcement, visit their website at:

http:/www.health.ny.gov/professionals/narcotic/docs/mandatory_education_guidance.pdf

-or-

www.health.ny.gov/professional/narcotic

General Principles of Pain Management

1. Speak to the patient about the presence of pain and the effect of the prescribed medications.
2. Consider patient comfort and avoid IM administration of opioids when possible.
3. Treat persistent pain with scheduled medications. Controlled release oral preparations are typically dosed every 12 hours and therefore can eliminate the need for administration during sleeping hours.
4. Utilize only immediate release medications for PRN rescue dosing. Dose PRN medications to the pain scale being utilized for the patient (i.e., Lortab 5/500 one tablet q 4 hours as needed for pain 1-5, 2 tablets every 4 hours for pain 6-10)
5. Transdermal Fentanyl is often not recommended for the treatment of acute pain due to delayed onset of effect.

Pain Management

Dosing and Conversion Chart for Opioid Analgesics

Drug	Equianalgesic Oral Dose	Equianalgesic Parenteral Dose	Starting Dose Adults ≥ 50kg	
			Oral	Parenteral
Morphine[1]	30 mg q 3-4 h	10 mg q 3-4 h	15-30 mg 3-4 h	10 mg q 3-4 h
Codeine[2]	130 mg q 3-4 h	75 mg q 3-4 h	60 mg q 3-4 h	60 mg q 2 h IM or SQ
Fentanyl		0.1		
Hydromorphone	7.5 mg q 3-4 h	1.5 mg q 3-4 h	6 mg q 3-4 h	1.5 mg q 3-4 h
Hydrocodone	30 mg q 3-4 h	Not available	10 mg q 3-4 h	Not available
Levorphanol	4 mg q 6-8 h	2 mg q 6-8 h	4 mg q 6-8 h	0.04 mg/kg q 6-8 h
Meperidine	300 mg q 2-3 h	75 mg q 3 h	Not recommended	100 mg q 3 h
Methadone	20 mg q 6-8 h	10 mg q 6-8 h	20 mg q 6-8 h	10 mg q 6-8 h
Oxycodone	20 mg q 3-4 h	Not available	10 mg q 3-4 h	Not available
Oxymorphone	Not available	1 mg q 3-4 h	Not available	1 mg q 3-4 h

CALCULATING THE RESCUE DOSE

Calculate 10% of the provided total daily opioid dose as an immediate-release formulation.

[1] Morphine, Hydromorphone, And Oxymorphone, Rectal Administration is an alternate route for patients unable to take oral medications, but equianalgesic doses may differ from oral and parenteral doses because of pharmacokinetic differences.

[2] **Caution:** Codeine doses above 65 mg often are not appropriate, due to diminishing incremental analgesia with increasing doses but continually increasing constipation and other side effects.

(excerpt)

CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016

Recommendations & Reports/March 18, 2016 (we recommend review of entire document either on the CDC Website or on the Medical Dental Staff Intranet page)
Determining When to Initiate or Continue Opioids for Chronic Pain

1. **Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain.** Clinicians should consider opioid therapy only expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

Constant Observation

- **Constant Observation** is ordered for Medical Surgical patients who may be a danger to self or others. Constant Observation requires the patient to be in full visual contact by the assigned caregiver. Constant Observation may be assigned as a 1:1 or 1:2 staff to patient ratio as ordered/determined by the psychiatrist. The observer will document observations of the patient behavior every 15 minutes on the Patient Observation form.
- **Constant Observation may be ordered initially by the Medical Surgical Services.** The service will place an order for a routine psychiatric consult. The consult will be performed as soon as possible, but within 24 hours of the consult being ordered. The consultant psychiatrist will determine the need for ongoing Constant Observation. If the physician deems a Stat consult is needed, the physician must call CPEP and discuss the case with the attending on duty. The order for Constant Observation must be reviewed every 24 hours. In an emergent situation, the RN may initiate Constant Observation, pending the provider's assessment of the patient; if the provider is not readily available, the RN will call a Rapid Response. The provider/rapid response team will assess the need for the Constant Observation and write the initial order if indicated. The RN will notify the supervisor on call to inform them of the order for Constant Observation.
- Following the clinical assessment by a psychiatrist, the psychiatrist will determine if the patient requires the ongoing need for observation and the level of observation required: 1:1 observation or 1:2. When it is determined that the patient no longer requires CO, the order will be discontinued.
- Please see policy NUR-086 – "**Constant Observation for Medical Surgical Patients"** for the full policy and procedure. (Located on the ECMC Intranet under "Policies").

USE OF RESTRAINTS

- Physical restraints are **extremely dangerous** and should be used only in **exceptional circumstances**. They should not be used as a substitute for evaluation and treatment of the underlying cause of the patient's condition and should be used only after other less restrictive approaches have failed to control the patient's behavior or condition.
- Make a face-to-face assessment of the patient as to the cause of their behavior /condition and document this either in the space provided on the restraint order form (see attached) which is preferred or in the progress notes with a note that is dated and timed.
- Notify the patient's attending physician and document this notification (also can be done on the restraint order form).
- If restraints are applied by the nursing staff in an emergency situation the treating physician must respond as soon as possible to write the order and perform the assessment but **no later than 30 minutes.**
- For restraints applied for medical/surgical indications the order is good for up to 24 hours provided the restraints are not removed during that period. If there is a continued need for restraints beyond 24 hours then a new order and assessment is required.
- If restraints are discontinued and there is a need to reapply restraints a new order and assessment is needed even if this occurs within 24 hours of the previous order.
- **If the form of restraint is changed (e.g. 4-point to Canopy Bed) then a new order and assessment is required.**
- PLEASE NOTE: Mitts ARE a form of restraint.
- See Policy: **RESTRAINTS** – #CLIN-002.

Transfer of Internal Patients between Clinical Services (refers to policy #MS-001)

Patient Care Transfer Procedure

1. Physicians or teams desiring to transfer a patient to another service need to first have that team accept the transfer. This is preferably done at an Attending-to-Attending level but may be initiated by extenders or residents.

2. House staff or extenders should have discussed the case with their Attending before initiating a transfer. The receiving team should then consult with their Attending. **IN THE EVENT THAT THE TRANSFER IS DENIED, THE REFUSAL TO ACCEPT IS TO BE MADE ATTENDING-TO-ATTENDING ONLY.** If the patient is accepted, that can be conveyed at an extender/resident level. Transfers out of the medical or surgical ICUs cannot be declined. In the event a service feels that the transfer from an ICU is inappropriate, the Service Attending should contact the Chief Medical Officer.
3. On acceptance, the referring service should dictate a discharge summary/transfer note to summarize the patient's course to that point unless the patient has been in-house or on that service for <72 hours. Transfer orders must be written and receiving team must be notified that the patient has been transferred and is now their responsibility. In addition, <u>all transfers between different services will require a verbal provider to provider handoff. When there is a delay between transfer of service and physical transfer of patient from critical care to an inpatient floor, the transferring team must then call the receiving team to advise them the patient is being moved to a new location.</u>
4. Transfer orders must be completed electronically through CPOE (except when and where this functionality is unavailable in which case they can be written).. VERBAL/TELEPHONE ORDERS FOR TRANSFER ARE NOT ACCEPTABLE. The receiving team should then see the patient, review the transfer orders and make any changes they feel are indicated.
5. It is the responsibility of the referring service to communicate the transfer plan to the family/significant other. When possible, it should be the Attending of the referring service.

Transfers from Floor to Medical Intensive Care Unit

1. Such transfers will be initiated by requesting an ICU consult for possible transfer to the MICU service. MICU consults should be requested by paging the Hospitalist Provider on-call 642-8779, discussing the case and the specific reason for the consult. Please note, unless the patient is in extremis, house staff or extenders should discuss the patient with their Attending before requesting an ICU consult.
2. MICU service will see and assess the patient. If accepted, transferring service will be responsible for dictating a transfer summary, summarizing patient care to that point (unless patient has been in-house for <72 hours).
3. Responsibility for caring for the patient will remain with the referring service until actual transfer to the MICU bed and in most cases will require continued presence of a team member with the patient until they are transferred physically to the MICU bed when a direct face-to-face handoff can occur to the MICU service.
4. MICU service will then write the MICU admission orders.
5. If MICU service feels transfer to MICU is not indicated, THIS SHOULD BE CONVEYED BY THE MICU ATTENDING TO THE RELEVANT SERVICE ATTENDING. The exception to this is when the attempt to transfer occurs during the 11:00 pm – 7:00 am shift in which case the reason for denying transfer should be conveyed the following morning.
6. Transfers post codes: In general, medical patients who code on the floor will be admitted to the MICU. The physician who runs the code should stay with the patient until they are physically transferred to an ICU bed and then hand off face-to-face with the MICU physician/extender. MICU service will be responsible for such patients even if the only available bed is in a non-medical ICU UNIT e.g. Trauma, Burn or CTU.
7. In the case of patients on surgical services who code, they should be admitted to the Surgical ICU. If the Surgical ICU Attending feels that the patient would be more suited to be treated on the MICU service, his/her team should contact the MICU service and request a transfer as outlined above. Surgical ICU service will remain responsible for the patient until such time as patient is accepted by MICU service.
8. **It is the responsibility of the referring service to communicate the change in the patient's clinical status and the transfer to the family/significant other. When possible, it should be the Attending of the referring service.**

Transfer of Internal Patients between Clinical Services
(refers to policy #MS-001)

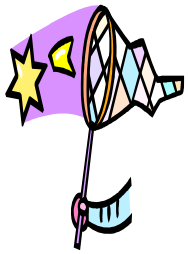
Transfers from Floor to Trauma (Surgical) Intensive Care Unit

1. In general, patients admitted to the Surgical Intensive Care Unit will come through the Emergency Department or be transferred from the Surgical Floor services. Transfers from other services will generally only occur after the patient is first seen in consultation by a surgical service or after a patient has required an operative procedure. In either case the surgical service caring for the patient will arrange for appropriate ICU admission.
2. Transfers to the Surgical Intensive Care Unit are generally arranged by contacting the ICU resident /extender. (2nd Year for Burn, 3rd year for trauma,).
3. Since these patients are either already on a surgical service or have been seen in consultation by such a service no transfer summary is generally needed.
4. Responsibility for caring for the patient will remain with the referring service until actual transfer to the Surgical Intensive Care bed and in most cases will require continued presence of a team member with the patient until they are transferred physically to the ICU bed.
5. The ICU resident/ will then write the ICU Admission Orders.
6. It is the responsibility of the referring service to communicate the change in the patient's clinical status and the transfer to the family/significant other. When possible, it should be the Attending of the referring service.
7. Inpatients initially admitted to a Medical Service who require surgery will return to the service of origin post-operatively except if they are admitted to TICU or accepted in transfer by the surgical service. Once they no longer require TICU care, transfer back to the service of origin will occur as in Section III.

New York State Forensic Patients - Reminders

- Wende Correctional Facility security coverage can be contacted in the 9th floor lockup at ext. 3863 or 937-4000, ext. 5200 off hours.
- Dept of Corrections security officers must be able to maintain visual contact with their inmate patients at all times. They are bound by confidentiality rules.
- Do not advise an inmate patient of the date of a scheduled procedure; follow up visit, admission or discharge.
- Do not leave any medical tools or equipment within reach of an inmate patient. Be aware of what you have in your lab coat/shirt pockets. Inmate patients may use these items to cause injury to you or others. Pagers, cell phones, syringes, scissors, percussion hammers and other sharp objects are coveted items. Please check for your belongings after examining an inmate patient and immediately report any suspected loss to security personnel.
- Do not share any personal information with an inmate patient.
- No items are to be given to or received from an inmate unless approved by the security staff.
- Do not make personal phone calls or send emails on the behalf of an inmate.
- Medical staff may share medical information with the inmate patient's family utilizing the same privacy regulations employed when communicating with the families of non-prisoner patients.
- Inmates who are admitted to ECMC may have visitors and must be approved by the DOC security staff.

Patient Falls & Fall Reduction Program



"Catch a Falling Star"

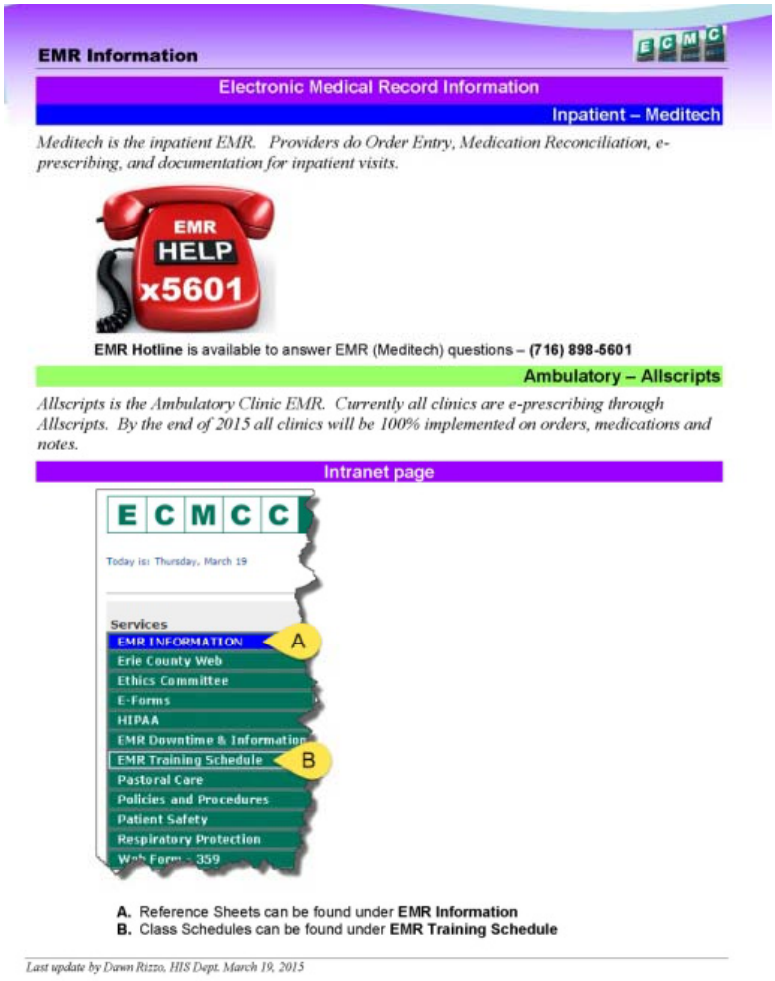
- Patients are assessed every shift using the Hendrich II Assessment Tool
- Risk Assessment in the EMR under Care Trends (Safety Panel) – Score of 5+
- Patient assessed as a 5+ risk will be issued a red **wristband** to alert staff of risk. Outpatients – star affixed to front of chart
- Please be careful with diuretics and medications that cause sedation. Assess patients for fall risk accordingly.
- **Make sure any outside rails are up after examining patients and bed is in low position.**
- Restraints are not to be ordered to prevent falls.
- For patients in acute substance withdrawal, there is an order set available that is evidence-based and recommended to treat the patient's symptoms and reduce falls.
- "Constant Observation" must be authorized by the administrator or administrator on call. Orders written for these type observations without authorization will not be accepted.
- Patient's provider will be notified of every fall.
- In the event of a fall, **the physician is to notify patient** family (if patient is cognitively impaired) promptly of condition of patient and if any injury was sustained.
- Patient fall, assessment and condition as well as family notification must be accurately documented in the progress note by the provider.

V. Documentation & Discharge Planning

Ensuring the safety of our patients with quality documentation and discharge

EMR Training

EMR – Training is required on both Meditech and AllScripts – please ensure you have attended training prior to your rotations.



Dangerous Abbreviations

Abbreviations located on the ECMCC Intranet under the Abbreviations tab, left side. http://home.ecmc.edu/abbrev.htm

Never Use	MUST WRITE
QD	Daily
QOD	Every Other Day
U	Units
IU	International Units
µg	Micrograms
AU	Both Ears
AS	Left Ear
AD	Right Ear
TIW	Three times a week
MS/MSO_4/$MgSO_4$	Write out drug name

DO NOT MAKE UP YOUR OWN ABBREVIATIONS or use Texting abbreviations. Only hospital approved abbreviations are permitted.

Clinical Documentation Improvement

The purpose of the Clinical Documentation Improvement program is to create a clear picture of the patient's hospital stay to anyone who picks up the chart, to accurately code the chart, and to capture CCs and MCCs that are appropriate for your patient while they are in the hospital.

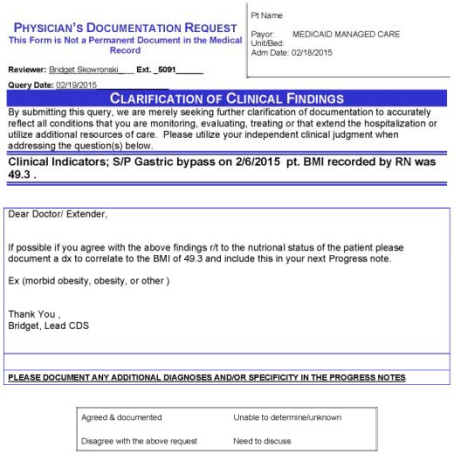
CC – co-morbidity/complication. Impact reimbursement on a chart, justify length of stay, impact mortality rates and increase case mix index.

MCC – major co-morbidity. Significantly impact reimbursement and length of stay.

Clinical Documentation Specialists (CDS) do a concurrent chart review on every inpatient in order to clarify documentation for coders. A coder has guidelines they must follow, and cannot code a diagnosis based on what's written in the chart, it must be documented as a diagnosis. For example, if the physician writes "transfuse 2 units of PRBC for low hemoglobin," for a patient with a GI bleed, a coder can only code ANEMIA but if physician lists for "Acute blood loss anemia" that code carries a higher complexity and leads to more appropriate levels of reimbursement for the hospital. This is an opportunity for a CDS to query.

Specialists will send an electronic query via Cortext (texting app):

Respond to the query in the Medical Record (Progress Note, Discharge Summary). Do not answer on Cortext as this is not part of the permanent medical record. If you disagree with the query, please let the CDS know via Cortext. They may place a query in the paper chart like the below sample.



PHYSICIAN'S DOCUMENTATION REQUEST
This Form is Not a Permanent Document in the Medical Record

Pt Name
Payor: MEDICAID MANAGED CARE
Unit/Bed:
Adm Date: 02/18/2015

Reviewer: Bridget Skowronski Ext. _5091_____
Query Date: 02/19/2015

CLARIFICATION OF CLINICAL FINDINGS

By submitting this query, we are merely seeking further clarification of documentation to accurately reflect all conditions that you are monitoring, evaluating, treating or that extend the hospitalization or utilize additional resources of care. Please utilize your independent clinical judgment when addressing the question(s) below.

Clinical Indicators; S/P Gastric bypass on 2/6/2015 pt. BMI recorded by RN was 49.3 .

Dear Doctor/ Extender,

If possible if you agree with the above findings r/t to the nutrional status of the patient please document a dx to correlate to the BMI of 49.3 and include this in your next Progress note.

Ex (morbid obesity, obesity, or other)

Thank You ,
Bridget, Lead CDS

PLEASE DOCUMENT ANY ADDITIONAL DIAGNOSES AND/OR SPECIFICITY IN THE PROGRESS NOTES

Agreed & documented	Unable to determine/unknown
Disagree with the above request	Need to discuss

Documentation Tips

Use these terms when documenting conditions listed

Specificity

- Document the reason for admission; if it's a symptom, document probable/possible cause in differential
- Document every condition impacting patient's stay, including chronic conditions
- Medications and treatments should be linked to a diagnosis
- Acute vs. chronic
- Etiology of condition
- Proper staging of chronic conditions (CKD)
- Benign vs. malignant when neoplasm involved
- Congestive heart failure – specify if it is acute/chronic, systolic/diastolic
- Diabetes – Always specify it simply as CONTROLLED or UNCONTROLLED. Avoid qualifying terms such as "poorly controlled" as CMS considers this controlled, NOT uncontrolled. Specify Type I or Type II.
- Specify severity and type of malnutrition
- Clinically significant diagnoses from diagnostic reports should be documented in the progress notes
- Arrow, plus signs, and many abbreviations are not sufficient documentation, must use a diagnosis
- For Anemia, always document the cause (i.e., due to blood loss, iron deficiency, etc.)

Common MCCs

Acute diastolic heart failure
Acute pulmonary edema
Acute respiratory failure
Acute renal failure due to acute tubular necrosis w/documented cause
Acute systolic heart failure
AIDS
Anoxic brain damage
Aspiration pneumonia
Decubitus ulcer stage 3 & 4 *present on admit*
Encephalopathy
Grand mal seizure
Hypovolemic shock
Pneumonia
Quadriplegia
Sepsis
Septic Shock
Septicemia
Severe malnutrition
Severe protein calorie malnutrition
SIRS

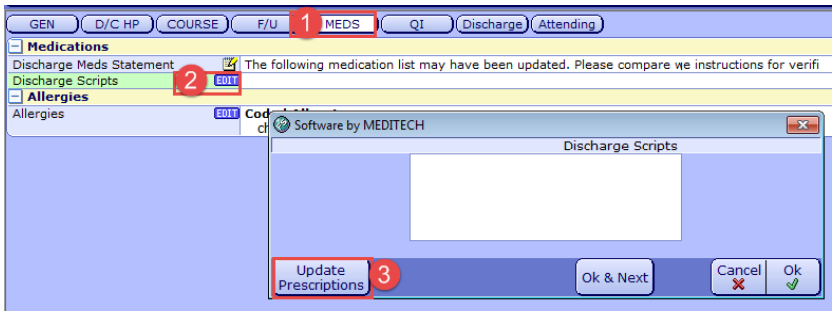
Common CCs

Acidosis
Acute coronary syndrome (unstable angina)
Acute Renal Failure
Acute blood loss anemia
Alcohol withdrawal
Alkalosis
Chronic diastolic heart failure
Chronic kidney disease – Stage IV or V
Chronic respiratory failure
Chronic schizophrenia
Chronic systolic heart failure
COPD, acute exacerbation
Drug dependence, continuous
Drug withdrawal
Hemiplegia
Hyperkalemia
Hypernatremia
Hyponatremia
Morbid obesity, BMI >40
Paraplegia
UTI

Discharge Summary

Use the Documentation Template that starts with your services name
(EX: BH – DC SUMMARY) ***:***

- All discharge documentation is done within Meditech Documentation (PDOC)
- Discharge Procedure must be completed and finalized before starting DC Summary. (This includes: Medication Reconciliation and Discharge Instructions
- In DC Summary, click on MEDS tab and update scripts. This will pull the information from your Discharge Instructions



Documentation Reminders

- **Please be very careful when using the "Cut and Paste" tool within a progress note.** As a general rule, every note must be unique and contain appropriate and pertinent information reflecting the care the patient received that day. Inappropriate use of the cut and paste will can lead to fraudulent documentation and cloning of the note and are strictly forbidden. It is important to keep in mind that the daily progress notes must reflect a timeline of the care the patient received further necessitating the requirement that daily pertinent information is included and that cutting and pasting should be avoided.
- Patient record entries should be documented at the time the treatment you describe is rendered.
- If you are called to see a patient for a change in condition after you have compiled your daily progress note, always input an additional note.
- Abbreviations and symbols in the patient record are permitted only when approved according to hospital and medical staff bylaws, rules and regulations. Avoid using any "texting" abbreviations.
- All entries in the patient record are permanent.
- All originals must stay with the chart.
- Patient identifiers must be on all forms.
- If a patient leaves **AMA**, the patient will still require discharge instructions and scripts. The patient needs to sign an AMA form and the MD needs to have a discussion with the patient of the risks of leaving AMA and document this discussion in the medical record. Please see the Elopement policy for further direction.

Death Information Management

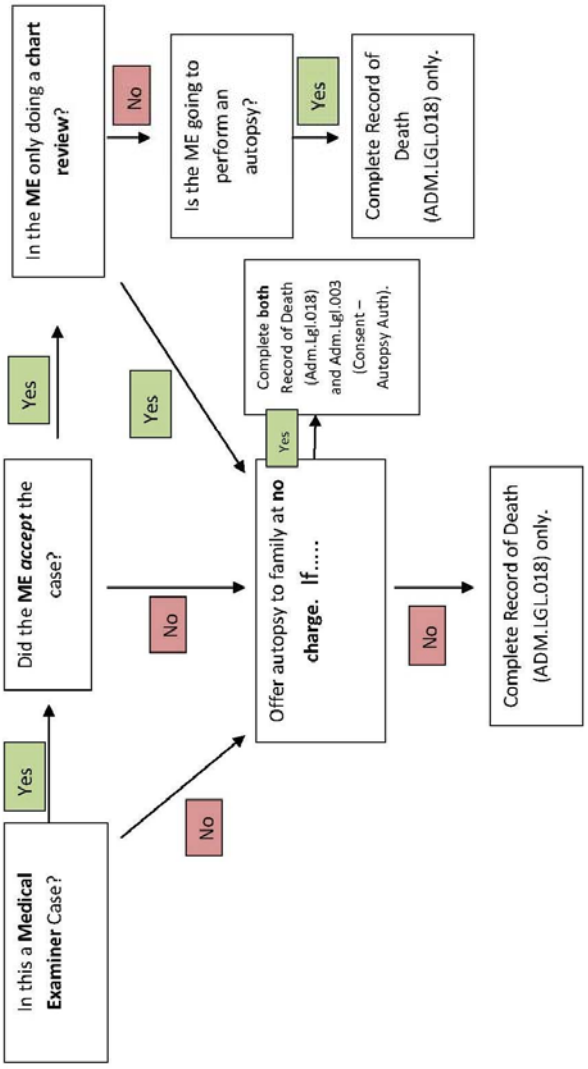
- When a patient dies, nursing staff is to notify the Nurse Manager or Nursing Care Coordinator on duty. If the Attending Physician is not present, he/she is to be notified by a physician in attendance or his/her designee.

  - **Next of Kin Notification**: If the family is not present, the attending physician or his/her designee will notify them by telephone immediately. If contact is not made within a reasonable period of time, the Social Work or Discharge Planning staff or the Nursing Care Coordinator can assist in contacting the appropriate law enforcement agency to establish contact. If next of kin is not known, immediate referral is to be made to the Clinical Patient Care Liaison(898-5769) during business hours and the Nursing Care Coordinator after business hours for due diligence efforts to find a next of kin.
  - **Medical Examiner's Referral**: The physician who pronounces the patient determines whether the death meets the criteria for a medical examiner's referral by completing the "Record of Death" form (found on e-forms). If it does, immediately contact the Medical Examiner's Office (961-7591).

Autopsy Request

- **Autopsy Request:** If the case is not accepted as an ME case, the physician should ask the family if they would like an autopsy performed which is at no cost to the family. The physician or his/her designee must obtain written consent from the deceased patient's family to perform an autopsy (ADM.LGL.003), in accordance with all applicable state and local laws. If they inquire, family members should be told that they will incur **no additional cost** for the autopsy. Bodies of persons carrying a signed, dated and notarized card indicating opposition to dissection or autopsy cannot be subject to autopsy or dissection, except as required by law.
  - The legal right to grant autopsies in NYS is vested in the following order:
  - Surviving Spouse
  - ALL children of age
  - Father and Mother. Both parents, if living and of sound mind, must sign for an unmarried child. If child is unmarried and neither parent is living, all brothers and sisters of age must sign the consent.
  - All brothers and sisters of age
  - All grandchildren of age
- **It is the sole responsibility of the attending physician to ensure that the consent form is correctly completed and attached to the Record of Death form (ADM.LGL.018)**
- **Death Certificates –** Death certificates must be completed by an attending physician within 48 hours of death. These are electronically completed through the NYS Health Commerce System.
- Please see policy **"Death Information Management: Autopsy Procedures, Death Paperwork, and Release of Human Remains" #ADM-017**, for full policy and procedure.

Death/Autopsy Algorithm



61

Medication Reconciliation

- is completed by creating the most complete and accurate list possible of all home medications for each patient and then comparing that list against the physician's admission, transfer, and discharge orders
- is intended to bring discrepancies to the attention of the physician so that changes may be made to the orders when appropriate
- Medication Reconciliation is a National Patient Safety Goal
- This system leads toward future community efforts to improve home medication list management electronically.
- ***Medication errors are one of the leading causes of injury to hospital patients,*** and chart reviews reveal that over half of all hospital medication errors occur at the interfaces of care.
- Poor communication of medical information at transition points is responsible for as many as 50% of all medication errors in the hospital and up to 20% of adverse drug events.
- Medication Reconciliation should be completed by the admitting physician/resident. Home medications are documented medication reconciliation and must be updated at the time of admission and discharge. It must be viewed as an integral part of the H & P and discharge summary.
- It is unacceptable especially upon discharge, to simply say "continue on home meds" as part of your instruction. It is essential that you reconcile all medications the patient is to take when discharged including continuation of medications they were on prior to admission. This will clarify for the patient exactly what they are to take once they are discharged.

PATIENT SAFETY –
The Universal Time Out

ERIE COUNTY MEDICAL CENTER CORPORATION

Addressograph/patient label

PROCEDURAL PROGRESS NOTE & INFORMED CONSENT FORM

UNIVERSAL TIME OUTS are a critical contribution to patient safety and must be performed and documented on the Procedural Progress Note **EVERY TIME**. The purpose is to ensure that the correct procedure is being done on the correct patient on the correct side. All those involved in the procedure should participate.

Patient Identifier
Name:
Med. Rec. #: Date of Birth:
Visit #: Age:
Service Date: Insurance:
Room: Service Time:

PROCEDURAL PROGRESS NOTE

ECMC Erie County Medical Center Corporation

Estimated Blood Loss Amount: _____
❑ No Appreciable Blood Loss

CHECK BOXES AS INDICATED *PRIOR TO BEGINNING* FOR ANY PROCEDURE REQUIRING CONSENT

PROMOTE SAFETY BY PREVENTING MEDICAL ERRORS. AVOID DANGEROUS ABBREVIATIONS : USE THESE ALTERNATIVES

Q.D. : write daily	**U** : write units	**AU** : write both ears	**MS/MS04/MgS04** : write out drug name
Q.O.D. : write every other day	**IU** : write international units	**AD** : write right ear	**using trailing zero ie, 2.0 mg** : write 2 mg
TIW : write 3 times weekly	**ug** : write micrograms	**AS** : write left ear	**lack of leading zero ie,.2mg** : write 0.2 mg

Step 1	**CONSENT**	☐ Obtained
Step 2	**SITE MARKING**	☐ Site marked with MD initials. ☐ Not applicable: exceptions include interventional cases for which the catheter insertion site is not predetermined, when either the right or left side is an appropriate approach, cases at the bedside in which the individual doing the procedure is in continuous attendance from the time of decision to perform through consent and completion.
Step 3	**TIME OUT** ___:___ **hrs**	Time out using active communication verbal confirmation of the : ☐ Patient ☐ Site ☐ Side ☐ Procedure ☐ Correct position ☐ Necessary equipment / implants ☐ Radiographic images

PHYSICIAN / EXTENDER / DESIGNEE SIGNATURE | **STAMPER OR PRINT NAME** | **DATE/TIME**

Site Preparation ☐ None ☐ Hair removal with clippers ☐ Site scrub with _____ ☐ Other _____

Procedure: description of procedure, indicate anesthesia administered.

Findings/Results ☐ Not applicable

Specimens removed ☐ Not applicable

Post Procedure Diagnosis

Condition of Patient

Post−procedural Plan/Comments

Rev. 4/16 **PHYSICIAN SIGNATURE** | **STAMPER OR PRINT NAME** | **DATE/TIME**

0622416 **PLEASE COMPLETE PROCEDURAL PROGRESS NOTE**

LGL060

Telephone/ Verbal Orders

- *Read back required*

- Requirement: For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the order or test result "read-back" the complete order or test result.
- If you are within the building and able to input your order into the patient record, please do so rather than providing a telephone order to the nurse. You may also utilize Affiliate (off site EMR access) to input your order(s) into the patient record rather than give a telephone order. Please ensure when using Affiliate you are on duty and not violating duty hour rules.

You must e-SIGN, DATE, TIME your phone/verbal orders within 48 hours.

ALC (Alternative Level of Care) Status

- ***Please note that ALC status is a billing designation only and does not change the care a patient receives.***

- All patients on ALC status must be seen **at least daily and a daily note consistent with their condition must be documented in the medical record.**

- IMPORTANT FOR RESIDENT AND ATTENDING: Should a patient suffer an adverse outcome and there was evidence that the patient had not been seen daily, the New York State Department of Health confirmed they would consider this grounds for referral to the OPMC (Office of Professional Medical Conduct).

Case Management/Discharge Planning and Social Work Assistance

- **RN Case Manager/ RN Assistant Case Manager** are geographically based on every zone. They lead the care coordination efforts and assist the multidisciplinary team with the throughput of the patient. They also serve as a resource guide for the residents and attending which contributes to strengthened physician-interdisciplinary communication. This team member also completes the utilization reviews of all patients on their zone.
- **Discharge Planners** are geographically based on every zone. They facilitate patients who are being discharge home to the community. They arrange any necessary services required after discharge including but not limited to home care services, durable medical equipment, prescription assistance and follow-up appointments discharge.
- **Social Worker** – Hospital social workers are responsible for the more complex cases within the hospital. They cover two zones. Social workers assess the psychosocial functioning, environmental and support needs of patients and families and provide support as needed. Different interventions may include connecting patients and families to necessary resources and supports in the community; providing psychotherapy, supportive counseling, or grief counseling; or helping a patient to expand and strengthen their network of social supports.

Ordering Home Care Services

- **Wound Care Orders** must be written to include site, cleansing of wound, treatment, and frequency. Also prescriptions for supplies must be written. Any BID patients that that will not be discharged by 3:00 p.m. must have their treatment done prior to leaving and will start in the morning to ensure staff safety.
- **Foley Care** – there must be a specific order for changing and/or irrigation including size of catheter and balloon, and frequency of foley change.
- **Q12H Injectable Meds** including Lovenox – order for BID if possible.
- **Diets** must be specific – simply stating "renal, diabetic, and cardiac" does not meet homecare regulations. Specify amount of calories, protein, sodium and whether low fat.
- **Diabetics** – order frequency of FSBS with glucometer and high and low parameters for when MD should be called. Scripts for glucometer, strips, lancets, and alcohol wipes need to be written. If 4:00 p.m. FS is needed, if patient is not discharged by 3:00 p.m., the 4:00 p.m. BS must be done prior to discharge and the agency will see the patient in the morning.
- **Insulin** – please issue scripts for insulin and insulin syringes.
- **Lantus Insulin** – as per the manufacturers package insert, "Lantus may be administered at anytime during the day. It exhibits a relatively constant glucose-lowering profile over 24 hours that permits once daily dosing." Therefore, orders for Lantus insulin should be written for daily rather than qhs to ensure staff safety.
- **IVAB/HAL** – please be sure patient has PICC line or a Grosberg catheter (preferred for patients with advanced CKD) in place as peripheral IV's are acceptable only in rare instances. Orders for drug must be written early AM so arrangements for nurse and supplies can be made. IV cases will not be accepted for start of care the same day as discharge if orders are not received by 2:00 p.m. Also please note that community pharmacies will not dispense IV meds if patient does not have insurance. If patient has Medicare only, patient is responsible for the drug which must be paid for upfront.
- SN, Behavior SN, PT, OT, HHA, MSW, and Dietician services are available.
- Discharge Planning can assist finding services in all counties.

VI. Professionalism

Improving the Patient and Provider Experience

Erie County Medical Center Behavioral Expectations

Because we are dedicated to being ***the medical center of choice*** *through excellence in patient care and customer service, it is our responsibility to treat all our customers, including patients, families, physicians, co-workers and all outside contacts with courtesy, dignity, respect and professionalism.*

Courtesy & Respect

- Knock and ask permission before entering a patient's room. Greet the patient by their surname but also ask the patient how they would like to be addressed. Some prefer if you call them by their first name or first and last rather than Mr. or Mrs.
- If it is necessary to interrupt the patient's sleep, visit with family or another staff member, apologize for the interruption. Warn them before you turn on lights.
- Make eye contact; introduce yourself and tell them your role in their care. If possible, **sit** while speaking with patients and families.
- Explain the presence of the "whole team" when entering the patient's room on rounds. Make sure the patient and family know the name of the "Doctor in Charge" of their care.
- Politely ask visitors to step in the corridor. After they have stepped out, ask the patient if he wants anyone in the room while you discuss the care.
- Close the door or pull the curtain prior to discussions or exams. Explain what you are doing and keep patient properly draped.
- **If possible, position yourself at eye level.** If not, stand at the side rather than the foot of the bed.
- Listen carefully; do not interrupt; give the patient your full attention.
- Always include the patient in any teaching or conversation at the bedside.
- Respect cultural differences.
- Demonstrate a professional attitude toward co-workers and customers; use a respectful tone of voice.
- Discuss confidential or sensitive information about patients, employees, or hospital business only with those having a valid need to know, and do so privately, never in public places.

Definitions of Inappropriate Conduct

- Belittling or berating statements;
- Name calling;
- Use of profanity or disrespectful language;
- Inappropriate comments written in the medical record;
- Blatant failure to respond to patient care needs or staff requests;
- Personal sarcasm or cynicism;
- Deliberate lack of cooperation without good cause;
- Deliberate refusal to return phone calls, pages, or other messages concerning patient care or safety;
- Intentionally condescending language; and
- Intentionally degrading or demeaning comments

Communicate with Your Attending, Nursing Teams and Care Management Staff

- For patients admitted between midnight and 6:00 a.m., notify attending physician if patient is critical or unstable.
- **Any change in patient condition or patient deterioration should be discussed with your attending physician 24/7.**
- **When a patient requires to be placed in restraints, communicate with nursing staff!**
- Whenever possible, check daily with patient's nurse concerning patient's condition.
- Discuss test results, changes in condition, plan of care with nursing staff – they need to know what's going on with their patient!
- ECMC is trying to **cohort** *(grouping patient's of similar status/team assignment together)* your patients to one or two zones/units to facilitate multi-disciplinary care planning.

Responsiveness, Communication and Teamwork

- Tell patients when you expect to visit them and when you are available to speak to their family.
- If you are unable to visit them as planned, send someone in your place when possible or call the unit.
- When your unavailability is planned, tell the patient who will be covering you and for how long.
- If you order X-Rays or procedures, explain them to the patient.
- Provide test results as soon as available. **Explain any delays. If delay is expected, let them know that.**
- **Inform family** of change in condition, transfer to ICU, time of surgery, untoward events, expected discharge date.
- Invite questions and comments from patients and their families.
- Ensure the patient understands their care prior to leaving the room.
- Communicate with clarity and professionalism both orally and in writing.
- Keep patients informed while resolving issues or getting answers to questions.
- Participate openly, honestly share opinions; take responsibility for improving processes and systems.
- Maintain positive working relationships with co-workers and customers; perform duties in a way that makes it easier for others to perform theirs.
- **NEVER** disagree with other care providers in front of the patient or family.
- Wear your name badge so that name is clearly visible at all times.
- Limit eating and drinking to designated areas.
- Do not make inappropriate or negative comments about patients or co-workers in the presence or within the hearing of any customer.

VII. Ethics, Risk Management, Compliance, and Transitions of Care

Healthcare decision-making,

Reporting of Incidents

Risk Management

Unsure about patient's capacity, ability to give consent, end of life issues, etc?

If in doubt, please ASK FOR HELP. We are here to support you.

Your contact at ECMCC

Amy Flaherty, Esq.
Vice-President of Patient Advocacy
X5769, x3162 or x5305

Ethics Consults

(any issues with advance directives or limitation of treatment – See Family Health Care Decision Act section for more information on the New York State law.)

Clinical Nurse Liaison
Pager - 642-7177

Report All Incidents!

- If something adverse occurs, **we want to know about it**.

- **Improvement begins with you** – report all occurrences through the *Quantros System* (electronic reporting system) – Icon located on all desktops in the hospital.

  - *When reporting, please see Quantros Direct Reporting tips which can be found on the ECMC intranet which can guide you based on the occurrence. Please include :*
  - patient name
  - medical record number
  - date/time of event
  - unit/area it occurred
  - Details of event
  - If you are comfortable, include your name and contact information so we can get back to you.

- **Examples of Reportable Occurrences:**
  - Missed orders
  - Disruptive behavior
  - Falls
  - All patient safety events (something that did or could injure your patient)
  - Any process improvement opportunities
  - Adverse drug reactions
  - Delays in patient care
  - All medical errors
  - Lost Airway

HIPAA

Confidentiality is essential.

No cameras or cell phones may be used to photograph patients, procedures or any diagnostic images without consent.

Only secure texting applications (Imprivata ®, Corext) may be used to transmit PHI and photographs for diagnostic and care process ONLY. If you will be utilizing patient information or images for educational purposes, consent MUST be obtained. If it is for research purposes, it must be a UB IRB/ECMC approved research project.

Accessing medical records is for care purposes only. Access of medical records of a friend, your own or a patient who is not under your care may be considered a HIPAA violation. If a patient or HCP asks you to review their record, you must (a) have privileges at the institution; (b) have written consent; and (c) have acknowledgement from the doctor in charge of the patient's care that you will be reviewing the record. *All your EMR views are tracked and can be searched by our Privacy Officer.*

Never discuss patients or case details in common areas such as elevators, cafeteria, lobby, etc. to avoid an unnecessary and unprofessional breach.

HIV Testing Law

- As of September 1, 2010, New York State requires that an HIV test be offered to **every individual** between the ages of 13 and 64 at least once.
- Offer should be made by providers offering primary care services. Primary care services are defined as:
  - Family Medicine
  - General Pediatrics
  - Primary Care
  - Internal Medicine
  - Primary Care Obstetrics/Gynecology
- Additional offers should be made for persons whose risk behaviors indicate need for more frequent testing.

Required Offer - Exceptions

- When the individual is being treated for a life threatening emergency
- Individual has previously been offered test or actually tested for HIV (unless otherwise indicated due to risk factor)
- Individual lacks capacity to consent and there is no other person available to provide consent.

Hep C Testing Requirements
Policy # IC-062

The requirement for the offering Hepatitis C testing applies to:
• Persons receiving inpatient services at hospitals;
• Persons receiving primary care services through hospital outpatient clinics and diagnostic and treatment centers; and
• Persons receiving primary care services from physicians, physician assistants, and nurse practitioners regardless of setting

The law does <u>not</u> require an offer of testing to be made:
• When the individual is being treated for a life-threatening emergency.
• When the individual has previously been offered or has been the subject of a hepatitis C related test (unless otherwise indicated due to on-going risk factors).
• When the individual lacks the capacity to consent* (though in these cases, the offer may also be made to an appropriate person who is available to provide consent on behalf of the patient)
*The exception as stated in the law refers to the individual lacking the capacity to accept the offer. (The reference to "capacity to consent" does not imply written, informed consent for the hepatitis C test, but rather capacity to understand the test offer)
• Emergency Departments are not required by the law to offer hepatitis C screening testing, but are encouraged to do so.

A Hepatitis C screening test will be offered to every individual born between 1945 and 1965 (Although the new law requires testing only for those born between 1945 and 1965, CDC recommends hepatitis C testing be offered to all persons at risk for hepatitis C.)
• Patients will be asked directly in writing or orally if they would like a hepatitis C test.
• A Physicians/Providers order to perform the test itself must then be obtained
• The Nurse will document on the EMR that the patient was offered this testing and if the patient refused.
• There is no separate (special) consent required for hepatitis C testing.
• The general medical consent for medical services, this would cover HCV testing. *(please see policy for "Reactive Test Result" guidance.)*

Family Healthcare Decisions Act

On June 1, 2010 New York's Family Health Care Decisions Act (FHCDA) went into effect. This new law establishes the authority of a patient's family member or close friend to make health care decisions for the patients in cases where the patient lacks decisional capacity and did not leave prior instructors **OR** appoint a health care agent. Prior to this New York had been one of the few states that prohibited family members from making health care decisions for incapacitated loved ones unless the patient had signed a health care proxy or left "clear and convincing evidence" of his or her treatment wishes.

The FHCDA does **NOT** apply to decisions for incapable patients who:

- have completed a Health Care Proxy form
- have a court appointed Legal Guardian under SCPA 1750-b, for whom decisions about life-sustaining treatment may be made
- whom treatment decisions may be made pursuant to OMH or OMRDD surrogate decision-making regulations

The statute sets forth, **IN ORDER OF PRIORITY**, the persons who may act as a surrogate decision maker for the incapable patient:

1. MHL Article 81 court-appointed legal guardian.
2. Spouse / Domestic partner
3. Adult Children
4. Parent(s)
5. Siblings
6. Close friend or other

The surrogate has the authority to make all health care decisions for the patient that the adult patient could make for himself or herself, subject to certain standards and limitations. This "surrogate" decision maker is also empowered to direct withdrawal or withholding of life-sustaining treatment when standards set forth in the statute are satisfied. The FHCDA requires the surrogate to base his or her decisions on the patient's wishes, including the patient's religious or moral beliefs. If the patient's wishes are not reasonably know and cannot with reasonable diligence be ascertained, the surrogate must base decisions on the patient's best interests.

One of the most significant features of the FHCDA is that it establishes a procedure to secure a decision to provide needed treatment for incapable patients who have NO family members or close friends that could act as the surrogate. With respect to ROUTINE medical treatment, the statute simply authorizes the attending physician to decide about such treatment for patients without surrogates. For decisions about MAJOR medical treatment, the attending physician must consult with other health care professionals directly involved with the patient's care, and a second physician must concur in the decision.

Family Healthcare Decisions Act,

continued from previous page

In contrast, decisions to withdraw or withhold life-sustaining treatment from isolated incapable patients is limited. Such decisions can be made only (1) by a court, in accordance with the FHCDA surrogate decision making standards; OR (2) if the attending physician and a second physician determines that the treatment offers the patient no medical benefit because the patient will die imminently, even if the treatment is provided, and the provision of treatment would violate accepted medical standards.

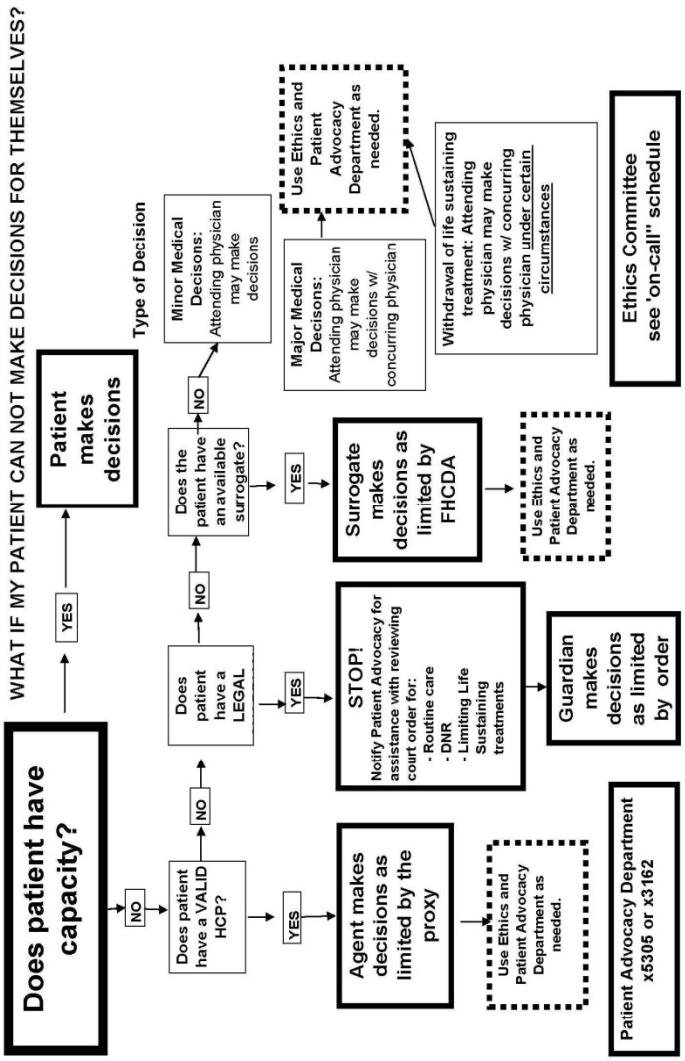
It is important to note that the FHCDA does not eliminate the need for open and honest conversations with loved ones about wishes and desires for medical care. And it does not eliminate the need for individuals to have advanced directives on file with doctors, attorneys and family member

MOLST

MOLST is generally for patients with serious health conditions. Consider the MOLST form for those who want to avoid or receive any or all life-sustaining treatment, those who reside in a long-term care facility or who require long-term care services. It is also appropriate for those patients whose health status indicates that they may die within a year. The MOLST form is signed by a New York State licensed physician and is unique in that it follows the patient as they are transferred through various facilities or levels of care. It is **bright pink** so it is easy to spot in a patient's medical file. As a reminder, we ask you to think "MOLST MONDAY" and check these orders at a minimum of each Monday.

For more information:
Source: www.compassionandsupport.org
Patricia Bomba, MD, FACP, Chair, MOLST Statewide Implementation Team

Capacity/Consent Decision-Making Flow Chart



Ethical Issues – Limitation of Treatment

Ethics Committee Activation or Ethical Concerns

If you need assistance with end of life care or decision-making issues, please do not navigate this alone. ECMCC provides Ethics Consults 24/7 – you may activate by using the On-Call schedule through the operator or on the intranet.

If you are not sure about completing a MOLST form with a patient and/or family, you may contact the clinical nurse Liaison and she will assist you at x5769 – Pager: 642-7177 or Risk Management. The MOLST form must be signed by a New York State Licensed Physician. And remember, be sure THE ATTENDING PHYSICIAN is aware of all decisions made regarding the patient at all times.

Limitation of Treatment

If you have concerns or questions about the limitation of treatment for a patient, first discuss with the ATTENDING PHYSICIAN and if additional review is needed, you may contact the Risk Management department if there are legal and/or ethical concerns.

Moral Objection

ECMCC has an approved **Moral Objection Policy (ADM-044)** which can be located on the ECMCC intranet under Policies and Procedures. Please review the process if you are in a situation that conflicts strongly with your personal beliefs to ensure that patient care will not be delayed or adversely affected in anyway.

Your Contact for Corporate Compliance Issues

Nadine Mund
Director of Corporate Compliance
898-4595
nmund@ecmc.edu

ECMCC Corporate Compliance Program
Located on ECMCC Intranet
http://home.ecmc.edu/depts/corpcom/documents/CorporateComplianceProgram.pdf

Compliance Hotline
898-5555

Avoid **Conflict of Interest** Issues

- Meals or other types of food **directly** provided or funded by Industry are prohibited at all ECMCC sponsored educational activities regardless of whether such event is held onsite or offsite. Support is permitted but must be achieved by financial donations to an ECMCC component (ECMCC Med/Dent Staff Office).

- Grants or gifts to fund meals may be received by ECMCC components but not by individual departments or divisions. Funds will be pooled to ensure that any grant or gifts will be disassociated from the receiving center and can avoid conflict of interest or the perception thereof.

- Any other gifts offered by pharmaceutical reps or other vendors is strongly discouraged.

- Please be sure to review the University at Buffalo Conflict of Interest policy as well. The ECMCC policy entitled *Exchanges between ECMCC and Industry* can be found on the ECMCC intranet policy page.

- When in doubt, feel free to contact Nadine Mund, Corporate Compliance Officer at 898-4595 for input.

VIII. Programs and Regulations

DSRIP, Patient-Centered Medical Home, I-Stop

What is DSRIP?

How will it effect how I care for my patients?

Delivery System Reform Incentive Payment (DSRIP) Program

DSRIP is an agreement (1115 waiver) dating back to April 2014 between the Center for Medicare & Medicaid (MA) Services (CMS) permitting New York State to reinvest $6.42B from previous federal savings generated by Medicaid Redesign Team (MRT) reforms. The overall intent of the 5 year DSRIP effort is to achieve the triple aim – better healthcare for individuals, better health for populations and the lowest possible cost. Specifically, DSRIP's goals are to:

•Reduce avoidable hospital admissions and emergency department use by 25 % over 5 years
•Preserve and transform NYS' fragile healthcare safety net system
•Improve public health measures consistent with NYS' prevention agenda
•Initially pay for reporting and process, ultimately pay for performance
•Ensure reforms continue beyond 5 year waiver period by leveraging managed care payment reform into value-based contracting
•DSRIP themes will not be unique to MA, and will become a way of life for future doctors for all patients:
•Putting 'system' back into healthcare *system* through collaboration, collaboration, collaboration
•Integrate medical care, behavioral health, substance abuse and other care (e.g., dental)
•Leveraging electronic health information
•Managing populations and not just individual patients
•Inclusion of the social determinants of health
•Pay for outcomes (value-based), not fee for service – quality over quantity

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What is DSRIP?

Continued….

NYS designated 25 performing provider systems (PPS) statewide. PPS are ACO-like DSRIP basic building block partnerships including safety net (and even non-safety net) hospitals, primary care (including clinics & federally qualified health centers or FQHCs), specialty care, post-acute care, long term care, home care, hospice, palliative care, health homes, social service agencies, etc. All NYS MA patients are assigned to a PPS. Each PPS selected 7 to 11 projects from a long menu. Total dollars each PPS can earn depend on a complex formula including the impact of the projects selected, the number of MA patients assigned and performance on the projects.

There are 2 PPS in the 8 counties of WNY. Millennium Collaborative Care (MCC) is ECMC's PPS in partnership with Kaleida Health, other hospitals, UB and many other providers. MCC was awarded up to $243M to plan, administrate and pay for programs, incentive partners and reimburse partners for loss of revenue. Based upon a community needs assessment, MCC selected 11 projects to serve 273,000 MA patients. They include:

- Integrating the delivery system (PCMH level 3, MU 2)
- ED Triage
- Inpatient Transfer Avoidance Program (INTERACT) for SNF
- Hospital-Home Care Collaboration
- Integration of Primary Care and Behavioral Health/Substance Abuse
- Behavioral Health Community Crisis Stabilization Services
- Cardiovascular Health
- Promote Mental, Emotional and Behavioral (MEB) Well-Being in Communities
- Increase Support Programs for Maternal & Child Health
- Reduce Premature Births
- Patient Activation Measures (PAM) – the 11th project including all uninsured

What is Patient Centered Medical Home?

How will it effect how I care for my patients?

Defining the PCMH

"Patient-centered medical homes (PCMH) are transforming primary care practices into what patients want: a focus on patients themselves and their health care needs. Medical homes are the foundation for a health care system that gives more value by achieving the "Triple Aim" of better quality, experience and cost. This is the overview to our vision for achieving that goal; it chronicles the PCMH evolution to date, the challenges that lie ahead and potential solutions to those challenges—some already underway, some yet to be developed."

"Everyone in the practice—from clinicians to front desk staff—works as a team to coordinate care from other providers and community resources. This maximizes efficiency by ensuring that highly trained clinicians are not performing tasks that can be accomplished by other staff, and helps avoid costly and preventable complications and emergencies through a focus on prevention and managing chronic conditions."

The Standards are:

- Patient Access
- Team Based Care
- Population Health Management
- Care Management and Support
- Care Coordination and Care Transitions
- Performance Measurement and Quality Improvement

Staff and Residents will be receiving additional training in each of the elements. All ECMC primary health programs are enrolled in the PCMH program in an effort to improve primary care and access for patients.

NEW YORK STATE I-STOP LEGISLATION

Effective August 27, 2013: Prescription Monitoring Program Registry (PMP)

•All practitioners who prescribe a **Schedule II, III or IV** controlled substance are required to view their patient's controlled substance history contained in the Department of Health's **Prescription Monitoring Program Registry** (PMP). The data contained within the registry is received from more than 6,000 separate reporting dispensers, including registered pharmacies throughout New York State.

•The legislation requires prescribers to check the PMP before prescribing a controlled substance. This can be prior to, but not more than 24 hours of a scheduled office visit. With increased use of the real-time PMP, prescribers can identify addiction-related behavior, including doctor-shopping. It will also allow prescribers to spot a potentially dangerous drug interaction. The law allows for certain exceptions. (APPENDIX A - below)

APPENDIX A

The duty to consult the PMP registry shall not apply to:

- veterinarians;
- a practitioner dispensing pursuant to subdivision three of Article 33 §3351 (methadone interim treatment, ordered and dispensed or administered by a practitioner, for an addict on a waiting list for admission to an authorized maintenance program);
- a practitioner administering a controlled substance;
- a practitioner prescribing or ordering a controlled substance for use on the premises of an institutional dispenser pursuant to Article 33, §3342;
- a practitioner prescribing a controlled substance in the emergency department of a general hospital, provided that the quantity of prescribed controlled substance does not exceed a five-day supply;
- a practitioner prescribing a controlled substance to a patient under the care of a hospice;
- a practitioner acting in compliance with regulations that may be promulgated as to circumstances under which consultation of the registry would result in a patient's inability to obtain a prescription in a timely manner, thereby adversely impacting the medical condition of such patient;
- a practitioner when:
  - it is not reasonably possible for the practitioner to access the registry in a timely manner;
  - no other practitioner or designee authorized to access the registry is reasonably available; and
  - the quantity of prescribed controlled substance does not exceed a five-day supply;
- a situation where the registry is not operational as determined by the department or where it cannot be accessed by the practitioner due to a temporary technological or electrical failure, as set forth in regulation;
- a practitioner who has been granted a waiver due to technological limitations that are not reasonably within the control of the practitioner, or other exceptional circumstance demonstrated by the practitioner, pursuant to a process established in regulation.

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The PMP does not need to be accessed for drugs ordered for administration on site at ECMC or at the Terrace View Nursing Home. It MUST be checked when writing prescriptions upon discharge from either facility.

Outside of the Emergency Department setting, limiting the quantity to a five day supply (3) does NOT exempt a prescriber from consulting the registry UNLESS criteria (1) and (2) of that section are also met.

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NEW YORK STATE I-STOP LEGISLATION, *continued*

• Currently, any New York State ***licensed*** prescriber who holds a valid DEA registration may access the PMP registry**.**

- **Each LICENSED prescriber MUST have an individual Health Commerce System Account (HCS) to gain access to the PMP.**
- **IF YOU DO NOT HAVE AN HCS ACCOUNT -** Instructions on how to establish an account are available at the following website:

https://hcsteamwork1.health.state.ny.us/pub/top.html
1-866-811-7957

Access to the PMP Registry for UNLICENSED PROFESSIONALS

- Licensed prescribers may give a licensed professional or an unlicensed professional permission to access the PMP Application on their behalf. The designee, if unlicensed, will need to work with the HCS coordinator from their facility or medical practice to establish their own HCS account.

- **The ECMC HCS Coordinator is the Chief Safety Officer, Charlene Ludlow 898-3435**

- **It is strongly encouraged that UB residents be granted PMP designee access through their residency program.**

Questions? Call 1-866-529-1890

Bureau of Narcotic Enforcement
Riverview Center
150 Broadway
Albany, NY
Phone: 866-811-7957
www.health.ny.gov/professionals/narcotic
E-mail: narcotic@health.state.ny.us