Patient Safety & Quality Improvement Physician & Resident Handbook

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ERIE COUNTY MEDICAL CENTER CORPORATION

Table of Contents

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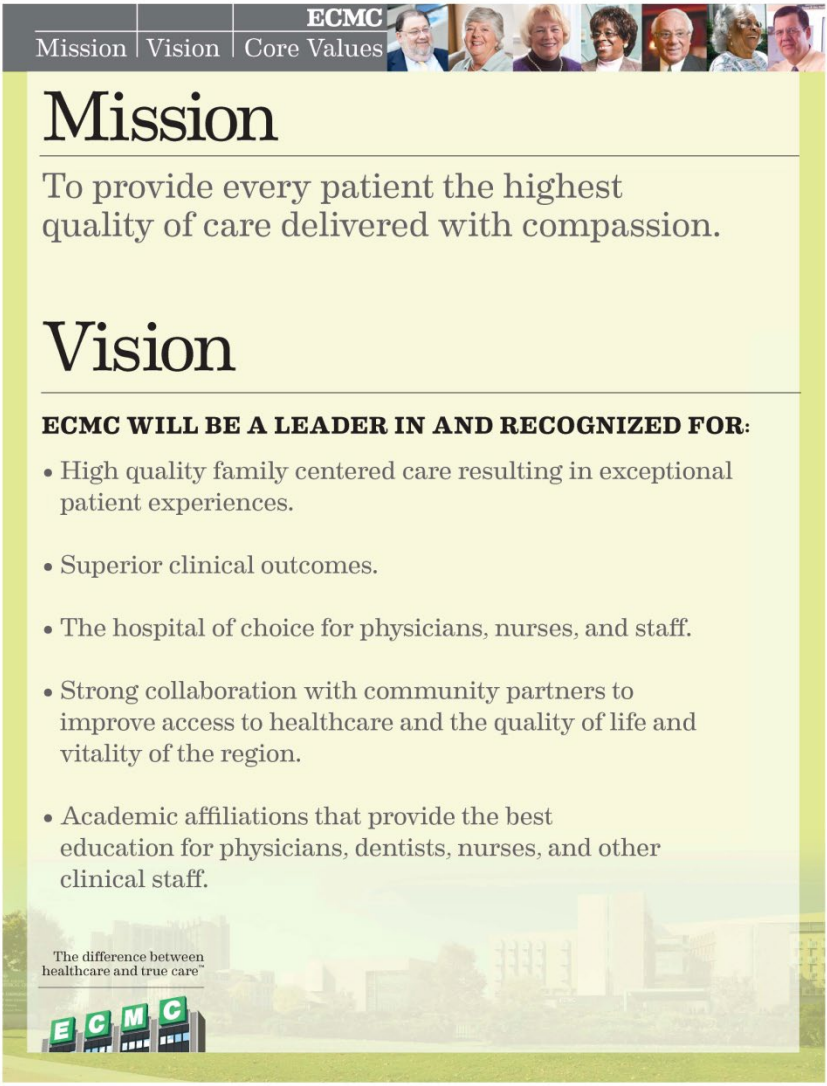
I. Mission, Vision, Values

What we strive for

Erie County Medical Center Mission, Vision and Values



Erie County Medical Center Mission, Vision and 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

Ground Floor	Call Room Suites Fitness Center Hospital Police/Parking Human Resources IT Help Desk Medical Records Medical Library Parking Ramp Entrance Pharmacy Physician/Resident Lounger Lobby – Time Horton's, Snack Shop, Subway Foundation Offices
First Floor	Clinic/Outpatient- PHC (Primary Health Clinic) Observation Unit OR Radiology Cath Lab/EKG Outpatient Clinics TICU/Burn Units
Second Floor	Café Whitehead Teaching Center Dr. Joseph Zizzi Conference Center Chapel/Spiritual Care
Third Floor	Administration & CMO Offices Smith Auditorium Conference Rooms A, C & Board Room Noyes Medical Education Center (formerly Conf Rm D) Medical Central Staff Credentialing Office
Fourth Floor	Adult Psychiatry (4 Zone 1, 2 and 3) Adolescent Psychiatry (4 Zone 4)
Fifth Floor	Geriatrics (5 Zone 1) Adult Inpatient Psychiatry (5 Zone 2, 3 and 4)
Sixth Floor*	(6 zone 1) Medical Surgical Unit (6 zone 2) Med/Surg/Palliative Care (6 zone 3 & 4) Russell Salvatore Orthopedic Unit
Seventh-Eighth Floors	Medical/Surgical Inpatient 701-730 (7 zone 3 & 4) 801-815 (8 Zone 4) Rehab Medicine 816-830 (8 Zone 3) 751-780 (7 zone 1 & 2) 851-865 (8 Zone 2) 866-880 (8 zone 1)
Ninth Floor	Chemical Dependency Unit (9 Zone 3 & 4) Detox (9 zone 1 ALC) Forensic Unit (9 zone 2)
Tenth Floor*	Transplant Unit & Bariatrics (10 zone 3 & 4) VAC (10 zone 1) Transplant Outpatient Clinic (10 zone 2) Hemodialysis Inpatient (Zone 1)
Eleventh Floor	(11 zone 1) Psychiatry Administration (11 zone 2) University Nephrology (11 zone 3) Risk Management & Palliative Care (11 zone 4) Behavioral Health Offices
Twelfth Floor*	Medical Intensive Care MICU (Zone 1 & 2) Medical 1251-1265 (12 zone 2) and MICU stepdown 1216-1230 (12 zone 3)

Helpful Phone Numbers

AREA/Unit Manager	PHONE	FAX	Manager
6 zone 1 - Tara Gregorio	3005		5844
6 North (Ortho) - *Renee Delmont*	3609		6284
6 - Zone 2 - *Santosha Gompah*	5608		5455
7 Zone 2 - *(751-765) Alecia Kurek*	4363		6284
7 Zone 1- *Jennifer Maloney (766-780)*	3605	5456	4376
7 Zone 3 - (716-730) LaToya Brooks	4333		4324
7 zone 4 - *(701-715) Jessica McGuigan*	1945	5456	1971
8 Zone 1 - (866-880) Lindsey West	4831		6318
8 Zone 3 - Mindy Brennan	6499	6144	6554
8 Zone 2 - *Ben Stanford*	3606		4571
8 zone 4 - *Dana Balito-Clark* (MRU)	4551		6442
9th Floor - ACC Desk	3685		
9 Zone 1 - ALC Unit - Jillian Sauer	4908		6554
9 - Zone 2 - (FORENSIC) - *Nicole Cretacci*	3621/4409		5455
9 - Zone 3 (Detox) - *Shaunda Wright*	3687		5892
9 - Zone 4 (Detox)- *Shaunda Wright*	4206		5892
10 - Zone 1 (Inpatient Dialysis) Jamie LaBelle	4644		
10 - Zone 2 (Transplant Center) Clinic	5001		
10 North - (1001-1030) **Inpatient Transplant and Medical -** Alex Mitchell	6220		
12 Zone 2 (Rm 1251-65) *Shawntres Currin*	3667/4831	5062	4552
12 Zone 3 Step down MICU(Rm 1216-30) - *Melissa Perkins*	3672	5083	5730
MICU - *Markita Mack* **MICU South** - Jenine Rudyk	3673/3674		3666
Psychiatry Units			
4 Zone 1 - Kristine Nowak	3592		4743
4 Zone 2 - *Kristine Nowak*	3592		4743
4 Zone 3 - Intensive Unit Psychiatry - Larry Blair			
4 Zone 4 (Adol. Psych) - *Larry Blair*	5420		4657
CPEP - Taywanda Bolden	3465/3389		3566
5 zone 3 & 4 (Beh Health)- *Jennifer Carroll*	5059		4901
5 South (Beh Health) - *Karen Kimble*	5728		5817
Trauma/BURN - 1st Floor			
Trauma ICU - *Melinda Lawley*	6171/3344		5267
Burn Unit - *Audrey Hoerner*	5231/5232		4378
Observation Unit - John Rizzo	6595		
Operating Room - *Marc LaBelle*	3593		3593
OR Reception Desk	4315		
OR Staff Lounge	3553/3555		
OR Recovery Room PACU	4101/3348		
OR Scheduling	4039		
One Day Surgery - Karen Schurr	3654/4315		
OR Main Desk	4315		
OR Preadm./Tests/Surg Holds	4110		
EMERGENCY ROOM		5140/5660	
Triage	3161/6734		
Trauma Corridor	6250/6741		
ED Command Center 716-277-1471			

Off Hours/Holidays – Contact the Nursing Supervisor for assistance at Pager – 716-225-7769

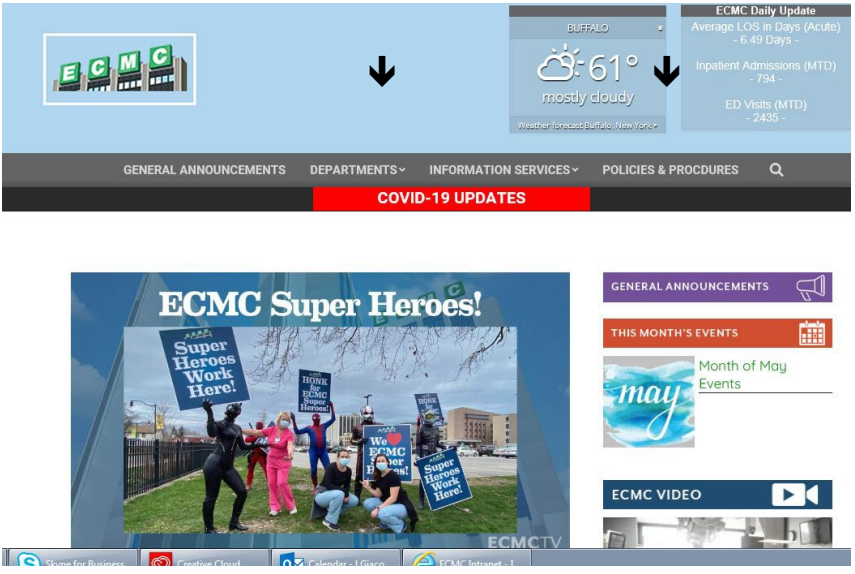
Helpful Phone Numbers

	EXT	PAGER	
CASE MANAGERS			
See Call schedule on the intranet			
Department of Medicine	**PHONE**		
Chief Medicine Resident	4924	P: 642-1550	
General Phone Numbers			
Medical Director Office	5888		
Admissions	3908/3153		
AIS/SIU	3471		
Adverse Drug Reporting	4000		
Autopsy	3520		
Biochemistry	3532/3442		
BioMed	3832		
Blood Bank	4182/4177		
Blood Gas	4184		
Cardiology Consults	See Hypercare		
Cath Lab	3386		
CODE - Adult Medical Emergency	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 Hypercare			
CASE MANAGEMENT			
See Hypercare			

Helpful Phone Numbers

Information (Patient)	0		
Internal Med Clinic (Primary Health)	3334/3152		
IV Team	4273		
Library	3939		
Laboratory Administration	3114		
Hematology	3532		
Microbiology	5956		
Serology	4138		
Urinalysis	4056		
Medical Dental Staff (Credentialing)	3130/5270		
Medical Records	3190		
Incomplete Records	5176	4811	
Old Medical Records	3917		
Morgue/Hospital	3520		
Neurology Consults	3638		
Neuropsych Evals	4857		
Nuclear Medicine	3383		
Pastoral Care	3357/3356		
Pathology	3117/3512		
Patient Advocate	4155		
Personnel Health - COEM	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	7777	
Skilled Nursing - Terrace View	551-7100	551-7217	
Social Work/DC Planning	3360		
Toxicology	3821/3442		
USI Vascular Lab	5238		

Policy and Procedures & Medical Dental Staff Webpage



Please use the ECMC Intranet to find current **policies**, general info for all Medical Staff on the **Med/Dent Staff** page (under departments), **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. As a Medical Provider, you can communicate with a patient in the language they prefer, but you cannot translate for other Medical providers.

- **Identify Patient's Preferred Language**
  - **Once you have identified the patient's language needed, there are options to obtaining an interpreter. Each unit and departments in the organization have a VOYCE iPad. VOYCE provides LIVE video interpretation including American Sign Language.**

  - **To Access an Interpreter via telephone:**

    Dial: 1-716-456-8944 – no client ID needed

- **Interpreter Services**
  - **iPad and Phones are available throughout the hospital.** They are easy to use and can be accessed quickly through the nursing staff.
- **Tips**
  - **Allow the interpreter to greet you and to provide an interpreter ID number.**
  - **Provide the interpreter with a brief explanation of the call**
  - **Speak directly to your patient and make eye contact**
  - **Speak to the first person and use short and complete phrases. Avoid slang, jargon, and metaphors**
  - **Allow the interpreter to clarify linguistic and cultural issues**
  - **Remember that everything is kept confidential. Tech Support (716) 714-4370**

Face-to-Face Services. Deaf Adult Services can be accessed for sign language and the International Institute for spoken language.

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 5:00 am – 9:00 pm daily and has a capacity of 15 to meet social distancing guidelines. You must sign a consent to be given access to the gym. You may find the link to participate on the ECMC Intranet under the ***Human Resources tab****. You must be fully vaccinated for COVID and for flu to utilize the gym.*

Professional Development and Wellness Committee

If you or a colleague are in need of help or support, the ECMC Medical Dental Staff Professional Development and 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. Residents can also find support through their programs and the University Resident Wellness Program. 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 email or our Chair
Dr. Matthew Ruggieri at mruggieri@buffalo.edu

Vaccination for you and your patients!

Influenza vaccination for all hospital workers is required annually and we ask you to please encourage your patients to obtain a flu vaccine as well. 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 next to the Medical Library on the ground floor. We have two massage chairs in the lounge available for your comfort and relaxation. This lounge is open to all members of the medical-dental staff and residents. It is available 24/7 for your use and coffee / tea are available. 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

Emergency Codes

- **Adult Medical Emergency (see p. 20 for more info)**
- Immediate medical assistance for all inpatients 18 years of age or greater requiring Basic Life Support (BLS) and Advanced Cardiac Life Support (ACLS)
- Activated by calling extension 4545 and stating *Adult Medical Emergency*
- ***Code Triage***
- Declared by the NCC or AOC when there is an External or Internal Disaster such as a Severe Weather Event, a Mass Casualty Incident (i.e. a Plane Crash or Mass Shooting) a Hazardous Materials release or the need to evacuate patients. All staff will remain on-duty at there respective workspace until relieved.
- **Pediatric Medical Emergency**
- Immediate medical assistance for all inpatients and outpatients less than 18 years of age.
- Activated by calling 4545 and stating *Pediatric Medical Emergency*
- **Medical Response Team(see p. 20 for more info)**
- Immediate medical assistance for all visitors and staff members 18 years of age or greater
- Activated by calling extension 4545 and stating *Medical Response Team*
- **Fire** *Fire Alarm Activation*
- **Rapid Response Team (see p. 21 for more info)**
- **Stroke Team** – activates the stroke team to the bedside to evaluate the patient.
- *Other Codes:*
    - BOMB THREAT
    - COMMAND CENTER ACTIVATION - Normal, Monitoring, Partial, Full
    - DANGEROUS PERSON
    - EVACUATION
    - HAZMAT INCIDENT
    - MASS CASUALTY INCIDENT
    - MISSING INFANT/CHILD/VISITOR
    - PATIENT ELOPEMENT
    - SECURITY EVENT
    - SUPPORT TEAM
    - UTILITY OUTAGE
    - WEATHER/NATURAL DISASTER WARNING

Adult Medical Emergency –
see policy CLIN-028

- **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.**

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.

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: We have attained Gold Plus Status in The American Heart and Stroke Association's Get With the Guidelines 2018 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.

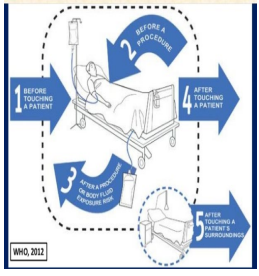
Sometimes the recommended intervention may not be appropriate for a particular patient (i.e., blocker in asthma, ACEI in a hyperkalemic patient). In that case, the ***REASON WHY*** *the intervention was not performed must be documented in the medical record.*

Hand Hygiene & Infection Prevention

Handwashing is the single most important means of preventing the spread of infection." CDC

- Alcohol-based hand sanitizers are the most effective products for reducing the number of germs on the hands of healthcare providers.
- Alcohol-based hand sanitizers are the preferred method of hand hygiene in most clinical situations.
- Wash your hands with soap and water whenever hands are visibly soiled.

- **Hand Hygiene performed with soap & water --- *scrub for at least 20 seconds.***
- **Purell - alcohol based hand gel ---- *cover all surfaces, rub hands until dry***
- **No artificial nails**
  - **Includes but not limited to: bindings, tips, wraps, tapes, gels, sculptured or acrylic**
  - **Policy includes SPD, Prep & Pack, Dentistry, Environmental Services, Medical Staff, Anesthesia, Surgery, Nursing, Respiratory therapy, Rehab staff, Transporters, Radiology, Dietary, Pharmacy.**



- *Immediately before touching a patient*
- *Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices*
- *Before moving from work on a soiled body site to a clean body site on the same patient*
- *After touching a patient or the patient's immediate environment*
- *After contact with blood, body fluids or contaminated surfaces*
- *Immediately after glove removal*

In our continued efforts to protect our patients from the harm of acquiring a Hospital Associated Infection ECMC /Great Lakes Health has initiated the

"HIGH FIVE for HAND HYGIENE" PROGRAM.

Waving or saying 'High Five'

is a means to gain awareness across our health system to use the same non-verbal/verbal cue to coach a fellow staff member to perform Hand Hygiene.

Isolation Precautions

Standard Precautions includes

Hand Hygiene, Proper use of PPE, Respiratory Etiquette, Sharps Safety, Safe Injection Practices, Proper Waste Disposal, Environmental Cleaning, Patient Placement, Cleaning and Disinfection of Patient Equipment.

When Standard Precautions alone cannot prevent transmission, they are supplemented with

Transmission-Based Precautions.

Use appropriate PPE (*personal protective equipment*) pertinent to the type of precautions necessary

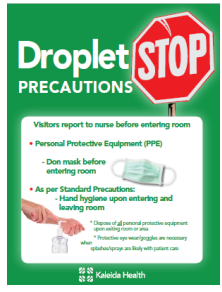
COVID patients require specific PPE *(DROPLET & CONTACT PRECAUTIONS)*

Please see the nurse manager of the unit should you need any additional PPE.

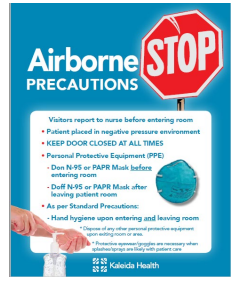
You will see the following signs posted for these types of isolation - each depicts the correct PPE for the type of precautions.

Please use proper donning and doffing technique.

Gown and Gloves
required upon entering patient room, applies whether or not contact with the patient or the patient environment is anticipated
C-Diff patients –bleach wipes will be used for environmental cleaning
For known or suspected C-Diff patients –an X will be placed in the box



Mask & Eye Protection
procedure mask and eye protection must be worn upon entering room



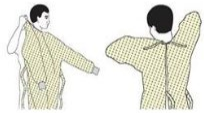
N95 Respirator or PAPR
must be worn upon entering room
Negative Pressure Room with Door Closed

SEQUENCE FOR PUTTING ON PERSONAL PROTECTIVE EQUIPMENT (PPE)

The type of PPE used will vary based on the level of precautions required, such as standard and contact, droplet or airborne infection isolation precautions. The procedure for putting on and removing PPE should be tailored to the specific type of PPE.

1. GOWN

- Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
- Fasten in back of neck and waist



2. MASK OR RESPIRATOR

- Secure ties or elastic bands at middle of head and neck
- Fit flexible band to nose bridge
- Fit snug to face and below chin
- Fit-check respirator

3. GOGGLES OR FACE SHIELD

- Place over face and eyes and adjust to fit

4. GLOVES

- Extend to cover wrist of isolation gown

USE SAFE WORK PRACTICES TO PROTECT YOURSELF AND LIMIT THE SPREAD OF CONTAMINATION

- Keep hands away from face
- Limit surfaces touched
- Change gloves when torn or heavily conta
- Perform hand hygiene

HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 1

There are a variety of ways to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. Here is one example. **Remove all PPE before exiting the patient room** except a respirator, if worn. Remove the respirator **after** leaving the patient room and closing the door. Remove PPE in the following sequence:

1. GLOVES

- Outside of gloves are contaminated!
- If your hands get contaminated during glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Using a gloved hand, grasp the palm area of the other gloved hand and peel off first glove
- Hold removed glove in gloved hand
- Slide fingers of ungloved hand under remaining glove at wrist and peel off second glove over first glove
- Discard gloves in a waste container

2. GOGGLES OR FACE SHIELD

- Outside of goggles or face shield are contaminated!
- If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Remove goggles or face shield from the back by lifting head band or ear pieces
- If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container

3. GOWN

- Gown front and sleeves are contaminated!
- If your hands get contaminated during gown removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Unfasten gown ties, taking care that sleeves don't contact your body when reaching for ties
- Pull gown away from neck and shoulders, touching inside of gown only
- Turn gown inside out
- Fold or roll into a bundle and discard in a waste container

4. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — DO NOT TOUCH!
- If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
- Discard in a waste container

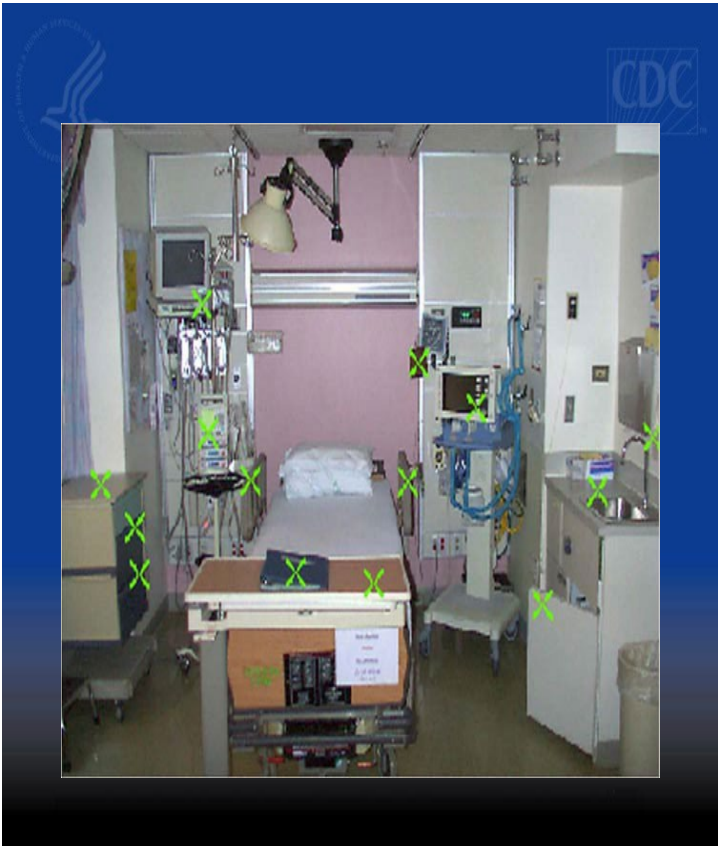
5. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE

PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE

The Inanimate Environment Can Facilitate Transmission

All surfaces in a patient room are susceptible to contamination! Hand Washing is essential even if you have not touched the patient!

X represents VRE culture positive sites



~ 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.
- **If you are stuck by a contaminated needle, or any other exposure incident:**
  - **Wash / flush the area immediately**
  - **Report the incident immediately**

Report to the Center for Occupational Health (COEM) or the Emergency Room after hours for appropriate treatment and follow up.

- 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.

Prevention Measures for Catheter Associate Urinary Tract Infections (CAUTIs)

- Insert catheters only for appropriate indications
- Leave catheters in place only as long as needed
- Document daily on continued need rationale
- Insert catheters using aseptic technique and sterile equipment (acute care setting)
- Follow aseptic insertion, maintain a closed drainage system
- Urethral catheterization requires a physician/provider written order which includes appropriate reason for catheter use. When the physician/provider orders the Foley Catheter insertion in Meditech, two reflex orders will automatically be entered:

  (1) the Nurse Driven Catheter Removal Protocol and
  (2) Post Removal Protocol

  - The physician/provider may opt out by "unchecking" the reflex orders.
  - When the physician/provider orders the protocol, it allows for removal of the catheter without obtaining an additional physician/provider order if the indication for urinary catheter continuation is no longer present. This is decided with specific criteria by an RN.
  - (See "Catheterization, Urethral – Policy #NUR-24)

External Urinary Collection Device

- This should be considered for males and females
- For patients who may benefit from the use of non-invasive urinary collection devices/systems.
- The use of non-invasive devices to collect urine, assists in the management of urinary incontinence and prevention of incontinence associated dermatitis and aims to minimize the unnecessary utilization of indwelling catheters that pose an increased risk of associated urinary tract infections.
- See "External Urinary Collection Device"- Policy NUR-089

Reportable CAUTI is defined by:

- Catheter for >2d & present at time of culture or removed the day before or day of AND $>10^5$ cfu/ml organisms AND
- Any one sign/symptom: T>38.0C, suprapubic tenderness, costovertebral angle pain or tenderness (urgency, frequency, dysuria only if catheter is out). CAUTIs are reported to State and Federal agencies.

Target urine cultures for patients with possible infection & urinary symptoms:

- "Soft" neurologic/behavioral signs do not correlate with UTI in adults.
- Even if there is another probable source of infection, a (+) urine culture may still generate a reportable CAUTI.
- Avoid "routine" urine cultures, including when removing a catheter; consider a UA first.

Pyuria does not confirm the diagnosis of (CA)UTI

- By itself, pyuria is NOT an indication to Rx bacteriuria
- Avoid Rx of asymptomatic bacteriuria or candiduria EXCEPT in pregnant women or pre-urologic procedure with anticipated mucosal bleeding.
- Please utilize the UTI order set for treatment orders.

Hospital Acquired Infections

Prevention of Central Line-Associated Bloodstream Infections (CLABSIs)

Central line-associated bloodstream infections (CLABSIs) result in thousands of deaths each year and billions of dollars in added costs to the U.S. healthcare system, yet these infections are preventable.

To Prevent Central Line-Associated Bloodstream Infections (CLABSIs)

*Determine **appropriate** level of IV access – peripheral, midline or central line*

- *Remove unnecessary central lines asap.*
- *Document daily on continued need rationale.*
- *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 (and Chg if not contraindicated), peripherally inserted central catheters, or guidewire exchange. Always use Central Line Checklist and Maximum Barrier Kit which includes: chlorapres. **Kits available on ALL UNTS**.

- Catheter tip cultures are not used to determine whether a patient has a CLABSI. Culture tips are not recommended to be sent due to risk of contamination.
- Blood specimens drawn through central lines have a higher rate of contamination than specimens collected through peripheral venipuncture

Prevent Hospital Acquired Infections – VAP and SSIs

To Prevent Ventilator Associated Pneumonia (VAP)

Implement the Institute for Healthcare Improvement (IHI) VAP Bundle in the care of ventilated patients can markedly reduce the incidence of VAP.

- *Elevation of the head of the bed at least 30 degrees*
- *Implement a continuous oral care regimen*
- *Daily "sedation vacations" and assessment of readiness to extubate*
- *Peoptic ulcer disease prophylaxis*
- *Deep vein thrombosis prophylaxis*

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

Prevent C.difficile Infections

We follow CDC recommendations to help prevent C.diff infections:

Prescribe and use antibiotics carefully.

- Discontinue unnecessary antibiotics especially those with increased risk of CDI Penicillins/ cephalosporins, clindamycin, fluoroquinolones, carbapenems
- If antibiotics are necessary, use the narrowest spectrum antibiotics possible
- Test for C.diff when patients develop diarrhea while on antibiotics or within several months of taking them, if there is no other known potential cause for the diarrhea
    - If patient is on laxatives and does not appear ill, these should be discontinued and a C.diff test sent only if diarrhea persists off laxatives.
    - Order stool/fecal C.difficile on loose, watery, unformed stool
    - (There is no indication to rest asymptomatic patients or patients with formed stool).
    - If a patient is being admitted, ensure that test is sent within the first 2 days of admission to prevent hospital onset status and diagnose early
    - Order a single test. Multiple test are not required.
    - There is no indication for "test for cure"
    - Immediately place patients with **possible or known C. diff on Contact Precautions.**
        - Utilize appropriate Personal Protective Equipment and perform Hand Hygiene
        - Wear gloves and gown when treating patients with C.diff, even during short visits.
    - Notify the new facility before transferring a patient with a C.diff infection.
    - Patient room surfaces will be thoroughly cleaned with a hospital approved bleach product or another EPA-approved, spore-killing disinfectant.

Refer to the **ECMC Intranet Pharmacy site for Guidelines for Management of Suspected Antibiotic Associated diarrhea**

- Utilize the CDI Order Set for treatment orders

Prevent C.*difficile* Infections

We follow CDC recommendations to help prevent C. diff infections:

- Prescribe and use antibiotics carefully.
    - Discontinue unnecessary antibiotics especially those with increased risk of CDI
      Penicillins/ cephalosporins, clindamycin, fluoroquinolones, carbapenems
    - If antibiotics are necessary use the narrowest spectrum antibiotics possible
- Test for C. diff when patients develop diarrhea while on antibiotics or within several months of taking them, if there is no other known cause for the diarrhea.
    - Order stool/ fecal *C. difficile* on loose, watery, unformed stool
    - (There is no indication to test asymptomatic patients or patients with formed stool).
    - If a patient is being admitted, ensure that test is sent within the first 2 days of admission to prevent hospital onset status
    - Discontinue bowel regimens (antidiarrheals and laxatives)
    - Order a single test. Multiple test are not required.
    - There is no indication for "test for cure"
- Immediately place patients with **possible or known C. diff on Contact Precautions.**
    - Utilize appropriate Personal Protective Equipment and perform Hand Hygiene
    - Wear gloves and gown when treating patients with C. diff, even during short visits.
- Notify the new facility before transferring a patient with a C. diff infection.
- Patient room surfaces will be thoroughly cleaned with a hospital approved bleach product or another EPA-approved, spore-killing disinfectant.

Refer to the **ECMC Intranet Pharmacy site for Guidelines for Management of Suspected Antibiotic Associated Diarrhea**

- Utilize the CDI Order Set for treatment orders

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
    - i.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

Antimicrobial Susceptibilities of Selected Gram-Negative Bacteria, ECMC, 2023

Gram-Negative Bacteria: Percent of Strains Susceptible. Published 2024.

Organism	Amp/ Sul	Ceftriax	Cefep.	Pip/Tazo	Aztreo	Mero	TMP/SMX	Amik.	Genta.	Tobra.	Cipro[1]	Misc.
Acinetobacter baumannii (65)	78	11	49	48	--	62	78	--	86	91	46	Mino-Cycline 68 %
Enterobacter cloacae (195)	--	75	99	--	78	99	85	100	100	96	94	--
Escherichia coli (953)	61	82	96	96	90	100	72	99	91	92	71	Nitrofur. 94, fosfo 100
Haemophilus influenzae (35)	94	100	--	--	--	100	66	--	--	--	--	Ampi 63 %
Klebsiella oxytoca (89)	57	70	100	--	90	99	98	100	100	100	91	Nitrofur 93
Klebsiella pneumoniae (449)	65	76	90	85	78	100	71	99	86	83	74	--
Proteus mirabilis (241)	89	92	98	100	98	100	81	100	95	95	79	--
Pseudomonas aeruginosa (566)	--	--	87	96	76	84	--	100	53	98	84	Ceftaz. 78 %
Serratia marcescens (90)	--	91	100	--	99	98	98	100	99	92	90	--
Stenotrophomonas maltophilia (49)	--	--	--	--	--	--	95	--	--	--	--	Mino-cycline[2] 97

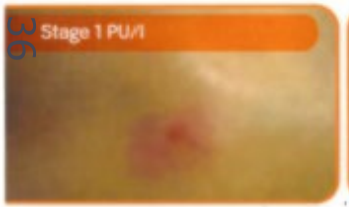
[1] Ciprofloxacin requires ID approval except in intensive care units, Transplant, and on the Urology service. [2] Kaleida Microbiology Lab is 716-626-7965. Call the Kaleida Micro Lab if you wish to request testing for minocycline or other any non-standard antibiotic such as ceftazidime/avibactam, ceftolozane/tazobactam, meropenem/vaborbactam, polymyxin B, colistin, or fosfomycin. Copies of this Antibiogram can be downloaded and printed from the ECMC IntraNet. printed February 6, 24

Gram-Positive Bacteria. Percent of Strains Susceptible. Published 2024.

Organism (Number of isolates)	Amp	Amp/ Sul-bac	Pen	Oxa	Cefaz	Ceftri	Clinda	Rifamp	Tetra	TMP/ SMX	Vanco	Gent	High-levl Gent	Misc
Staphylococcus aureus (775)	--	57	--	57	57	--	70	99	94	96	100	98	--	
Staph epi-dermidis (240)	--	39	--	39	40	--	50	96	79	56	100	89	--	
Coag (-) Staph (393)	--	39	--	40	39	--	52	94	79	58	100	87	--	
E. faecalis (390)	100	100	99	--	--	--	--	--	26	--	87	--	79	Fosfo, 71; nitrofur 100
E. faecium (209)	5	7	4	--	--	--	--	--	11	--	33	--	98	Linezolid 100
Enterococcus species (41)	78	100	78	--	--	--	--	--	60	--	68	--	89	Linezolid 100
Alpha & Viridans Strep. (18; 2021 data)	83	--	70	--	--	90	50 #	--	40	--	100	--	--	Linezolid 100
ß-hemol Strep. Grps A, B, C, F, & G (54)	100	--	100	--	--	100	57 #	--	14-60	--	100	--	--	
Strep. pneumo. (27)	--	--	96	--	--	85¥-100	79	--	--	--	100	--	--	--

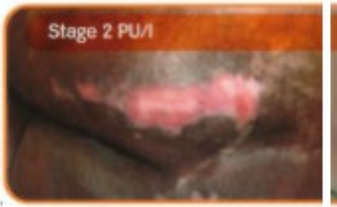
#, Clindamycin is not routinely tested. Please call the Kaleida Micro. Lab, 716-626-7965, and request testing if you wish to use clindamycin; otherwise, clinda is **not considered reliable** for alpha-hemolytic ("viridans") Strep or for ß-hemolytic Strep. ¥, Strep. pneumo., for meningitis, 85% suscept; 100 % for non-meningeal sites. This document is available for view, download, and print on the ECMC Intranet. Printed February 6, 2024

Pressure Ulcer/Injury Staging



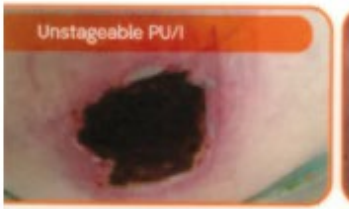
Stage 1 pressure ulcer/injury

Intact skin with a localized area of non-blanchable erythema. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede the visual changes.



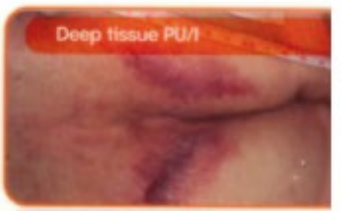
Stage 2 pressure ulcer/injury

Partial thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister.



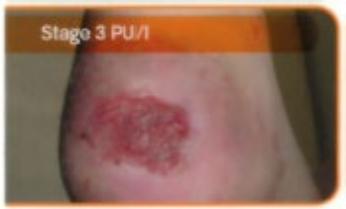
Unstageable pressure ulcer/injury

Full thickness skin and tissue loss in which the extent of tissue damage cannot be confirmed because it is obscured by slough or eschar.



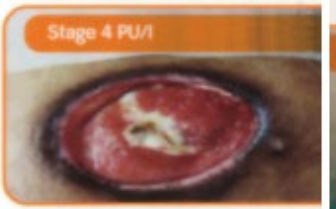
Deep tissue pressure ulcer/injury

Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister.



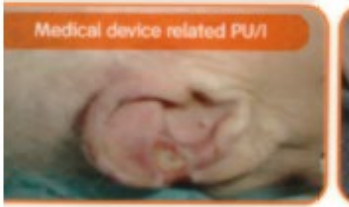
Stage 3 pressure ulcer/injury

Full thickness loss of skin, in which adipose (fat) is visible but fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed.



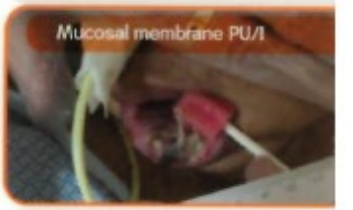
Stage 4 pressure ulcer/injury

Full thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer/injury.



Medical device related pressure ulcer/injury

Related to the use of devices and generally conform to the pattern or shape of the device. The ulcer/injury should be staged.



Mucosal membrane pressure ulcer/injury

Found on mucous membranes with a history of a medical device in use at the location of the ulcer/injury. Due to the anatomy of the tissue, these ulcers/injuries cannot be staged.

Wound Treatment Guide 2024

Select a cleansing agent:	
0.9% Sodium Chloride	Cleanses
Sterile water	Cleanses
Dakins 0.25%	Cleanses contaminated, odorous surfaces
Acetic acid 0.25%	Cleanses contaminated, odorous surfaces with green drainage
Hydrogen peroxide (1/2 strength)	Cleanses contaminated surfaces
Vashe	Cleanses contaminated, odorous surfaces
Dressing care options:	
Alginate dressing	Absorbs drainage, packs cavities
Foam dressing	Protects skin, primary or secondary dressing
Hydrogel dressing	Enhances moist wound healing, packs cavities
Kerlix Nugauze Iodoform	Packs cavities
Acticoat flex 3 dressing (silver)	Antimicrobial, absorbs drainage, packs cavities
Transparent film	Protects wound surface
Hydrocolloid	Protects wound surface, moist environment
Topical treatments:	
Skin prep (barrier film)	Prevention, stage 1, intact blisters, deep tissue, and unstageable pressure injuries
BAZA Calmoseptine Zinc oxide Venelex (protective barrier creams)	Prevention, stage 1 and 2 pressure injuries, partial thickness wounds, DTIs, dermatitis
Triple Care Antifungal Cream	Contact dermatitis, antifungal
Silvadene 1% cream (silver sulfadiazine) *contains Silver – NOT MRI compatible*	Stages 1 and 2 pressure injuries, fungal rash, dermatitis, partial thickness wounds / burns *contains Sulfa* *not indicated in Stevens-Johnsons*
Calamine	Pruritus
Ammonium Lactate lotion	Pruritus, Xerosis
Permethrin (topical cream or lotion)	Body lice
Miconazole powder	Antifungal
Debriding options:	
Medihoney	Debrides, heals
Triad (paste)	Debrides, heals, dermatitis
Santyl (enzymatic collagenase)	Debrides, heals
Wet to dry gauze	Debrides
Advanced Treatments	
Wound VAC (negative pressure)	Stages 3 and 4 pressure injuries, surgical incisions, full thickness wounds, change 3 x per week
Ultrasonic Mist (request PT Wound Care)	Gently debrides biofilm and moist slough
E-stim (request PT Wound Care)	Enhances perfusion
Profore compression wrap	Multilayered, with Vascular team recommendations

When admitting patients with burns or other exfoliative skin disorders, document the % of body-wide cutaneous injury present in the H&P. According to the Agency for Healthcare Research and Quality Guidelines with the DOH July 2019, if a patient is admitted with > or = 20% of cutaneous injuries, ECMC is exempt from reporting future cutaneous injuries during hospitalization.

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
- Pressure ulcers
- Vascular catheter-associated infection
- Mediastinitis after CABG
- Ventilator-associated pneumonia
- DKA
- PE
- Sepsis
- 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
- Surgical site infection following cardiac implantable electronic device
- ***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 evalutae patients who are placed on telemetry on a daily basis the need to continue. Overuse can lead to ED gridlock, alarm fatigue and longer lengths of stay.

Telemetry tracks heart rhythm, not vital signs, mental status, or respiratory status. Overreliance of telemetry may mean patients are not getting the clinical monitoring they need.

Utilizing the RN telemetry discontinue protocol following AHA guidelines, ensures that telemetry will be assess in a time period ordered by you.

Class	Indications	Time Frames that May be Used
1	ICU only, continuous monitoring while on and off unit, including transport	*Not a candidate for telemetry protocol
2a	Tachycardic > 110 or Bradycardic <60 Non chronic arrhythmias, <8 Beats SVT sustained	24, 48, or 72 hours
2b	Intermittent telemetry monitoring that may be suspended for short distances such as showering, off-unit testing, and procedures. May include acute issues that arise during inpatient stay	24 hours
3	Observation only	*If patient flips to inpatient, the provider needs a new telemetry order for either 2a or 2b.

*ICU protocol under review, subject to change

The conditions that are assessed for continued used by RN are the following:

If NO: Reason to Continue		
	☐ Abnormal Arrhythmia	☐ Awaits cardiac procedure
	☐ QTC greater than 500	☐ Positive Troponin
	☐ HR greater than 120	☐ HR less than 50
	☐ K+ greater/equal to 5.2	☐ K+ less than/equal to 2.9
	☐ Mg less than/equal to 1.5	☐ Pending Neurosurgery

Telemetry will only be renewed for 24 hours at a time until patient issue resolves or intervention to correct ididcation for continued use is completed. Provider will be notified to place renewel order.

**If critera is met by patient, RN will discontinue telemetry and no notification to provider is needed.

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.
- **COVID19 Results** – For inpatients, these are reported to the nurse caring for the patient who then will contact the appropriate provider.

o *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 – Requesting Services

1. Ordering Consults – Requesting Services

Consults can be ordered through CPOE and MUST include clinical information and/or indication.

The request should also indicate whether the requesting physician requires:

1) Consult only – consult service is to provide recommendations only

2) Consult and Manage – consult service may write orders

3) Whether consult is routine or STAT.

   Routine consults should be completed within 24 hours by the consulting service.

   STAT consults should be done as soon as possible. They require a direct communication (pager, phone , Cortext) to the consultant to ensure the consultant is aware of the stat consult. Generally Stat consults should be confined to serious, potentially life threatening conditions but may also be required for patients on Observation so as to facilitate their disposition.

   Consult orders are processed by hospital staff and sent to the location outlined by the consulting service. Since some of these locations (e.g fax machines) are not staffed 24/7, the requesting services are encouraged to also Cortext the consultant when placing a consultation request with patient name, date of birth, room number and indication.

Consults – Performing Consults

Routine consults need to be completed and signed by the attending within 24 hours of the order being transmitted to the service.

Stat consults should be performed as soon as is practical and prioritized ahead of routine consultations. Consult services are encouraged to notify the requesting service that the consult is completed by Cortext.

Consult requests may be:

1. **Consult only** – consult service is to provide recommendations only.
2. **Consult and Manage** – If recommendations are just for additional diagnostic studies, the consult service is expected to write orders for those studies.

If the consult service has significant therapeutic recommendations, e.g initiation of new drug therapy, operative or other procedure, etc. those should be communicated directly to the requesting service (by pager, phone or cortext) . Therapeutic orders can then be written by either service by mutual consent.

Certain specialty specific orders MUST be written by the consulting service including:

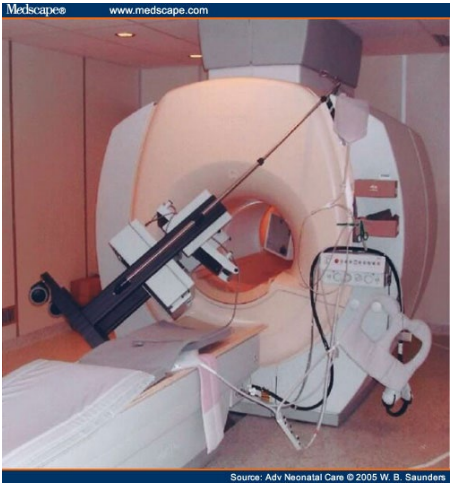
- Hemodialysis or plasmapheresis (Renal)
- Chemotherapy (Oncology)
- Specialty specific Biologics.

If not ordering themselves, the consultant should leave specific instructions with regard to dosing/ frequency.

Consults requested by Behavioral Health

For consults performed on the behavioral health floor, the consult services should write orders for both diagnostic and therapeutic recommendations.

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

In same patients e.g. those with CHF, fluid administration may be contraindicated. In that case document the reason in your note.

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:

-After IVF, document "**Repeat Focus Exam** (Includes VS, cardiopulmonary exam, capillary refill, peripheral pulse, AND skin examination)

- 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

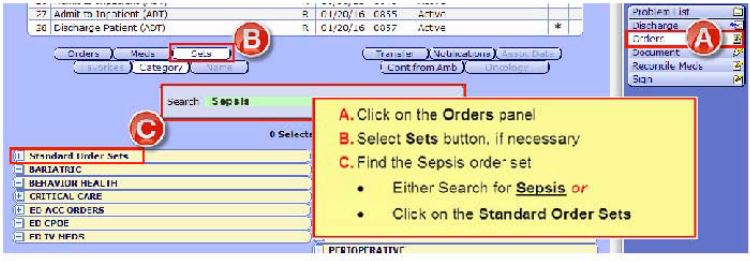
ORDERS – Sepsis Order Sets

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

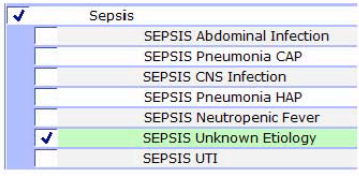
Title1

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:



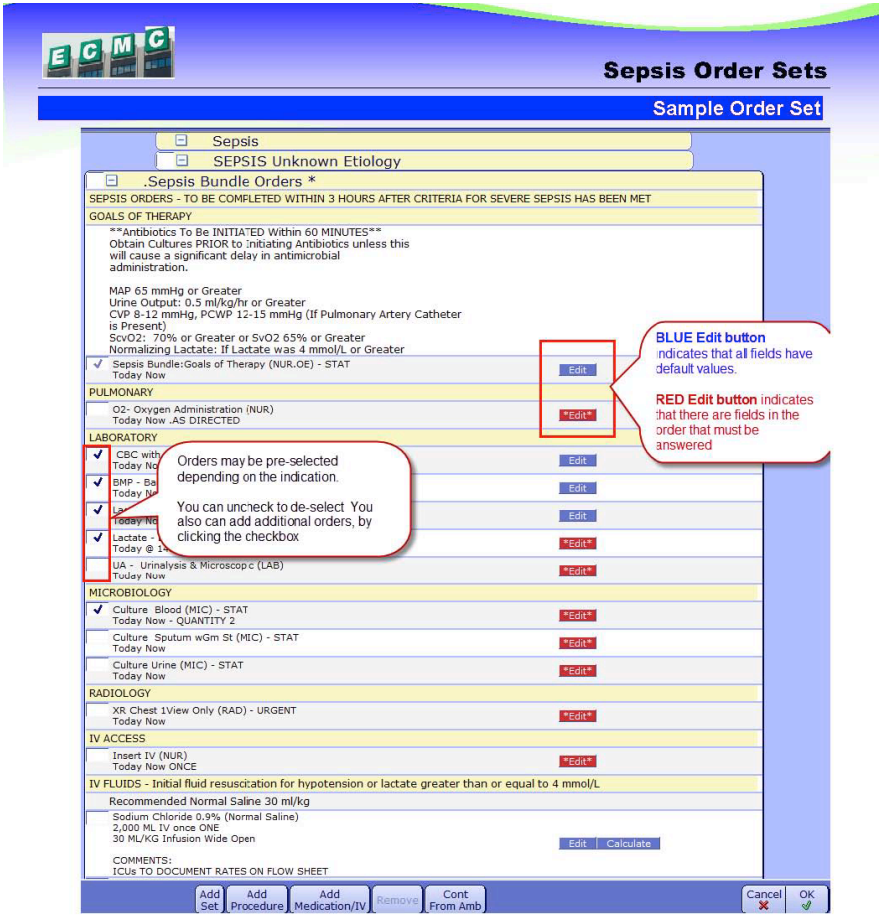
3. Click on 

at the bottom of the screen to open the order set.

4. When you have completed the order set, click on 

at the bottom of the screen to return to the Order panel.

Sepsis Sample Order



Acute Pain Management Guideline

Principles of Pain Management

Establish realistic pain goals

Will vary depending on patient and type of pain – goal of zero may not be feasible

↓

Educate patient/caregivers on pain management goals and regimen

↓

Consider Pharmacologic and non-pharmacologic treatment options and initiate therapy

↓

Continually reassess patient's pain and monitor for medication efficacy and side effects

- Use same scale to reassess pain
- Use scale that is age and cognitively appropriate
- If no improvement, adjust regimen

Opioid Cross-Sensitivities

Phenanthrenes (related to morphine): morphine, codeine, oxycodone, hydrocodone, hydromorphone

Phenylpiperidines (related to meperidine): Meperidine and fentanyl

Risk of cross-sensitivity in patients with allergies is greater when medications from the same opioid family are administered

Pain Management Considerations

- Type of Pain: Nociceptive, neuropathic, and inflammatory
- Acute vs Chronic vs Acute on chronic pain exacerbation
- Pain medication History: OTC, Rx, and herbal
- Patient factors: Genetics, culture, age,

Treatment Options

- Pharmacotherapy: Systemic, topical, transdermal – nerve blocks
- Non-Pharmacologic treatment modalities: Splinting, distraction, hot/cold therapy, exercise, massage, and imagery
- Refer to pain, palliative or other specialists for advanced treatment

General Principles for Opioid Therapy:

1. Always consider other modalities of pain relief (NSAIDs, APAP, Topical Anesthetics and adjuvant therapy) prior to or in addition to prescribing opioids as multimodal therapy can reduce IV opioid requirements
2. Early intervention, with prompt adjustments in the regimen for inadequately controlled pain
3. A reasonable approach to parenteral opioid management involves using lower doses initially and titrating to higher doses as needed**
4. At higher doses, opioids cause respiratory depression.
5. Patients who are administered higher doses of opioids should have their respiratory status monitored. Frequent re-assessment and evaluation for development of opioid-related adverse effects should take place in 20 to 30-minute intervals
6. Work with patient to establish goals of therapy and adjust medications based on those goals
7. Switch to oral therapy when possible
8. Facilitate recovery from underlying disease or injury

Analgesic Ladder and Treatment Basics

Step 1: Mild Pain

Non-Opioid Analgesics (APAP, NSAIDs, COX-2 Inhibitors) +/- Local/Topical Anesthetics

↓

Step 2: Moderate Pain

Step 1 Strategy + Intermittent Dose of Opioid Analgesics (PO, IV) +/- Interventional (Blocks & Procedures)

↓

Step 3: Severe Pain

Step 1 and Step 2 Strategies +/- Scheduled Opioid Analgesics

Ladder Basics

1. Use oral route when possible
2. Give analgesics at regular intervals
3. Prescribe according to pain intensity
4. Dosing must be adapted to individual
5. Analgesic plan must be refined and communicated with patient and staff

Disclaimer: Use of these general guidelines is not intended to supersede clinical judgment of the prescriber.

Opioid and Non-Opioid Dosing and Pain Medications

Opioid Dosing Equivalency and Dosing

Opioid Agent	Dosing Equivalents		Interval/Duration (Hours)	Onset	Initial Dosing Recommendations		Comments
	IV	PO			IV	PO	
Morphine	10 mg	30 mg	4 – 6	IV: 5-10 min Oral: 30-60 min	2-10mg IV or SQ q4-6hr PRN	10-30mg PO q4-6hr PRN	- Caution with renal dysfunction (eGFR < 30 ml/min)
Hydromorphone (Dilaudid)	1.5 mg	7.5 mg	3 – 4	IV: 5 – 10 min Oral: 15-30 min	0.5-1.5mg IV or SQ q2-3hr PRN	2-4mg PO q4-6hr PRN	- May have a more rapid onset and shorter duration of effect than morphine
Hydrocodone/APAP (Lortab)	--	30 mg	4 - 6	PO: 30-60 min	--	5-10mg PO q4-6hr PRN	- Max dose of acetaminophen from all sources = 3000 mg
Oxycodone (Roxicodone)	--	20-30 mg	4 - 6	PO: 10-15 min	--	5-10mg PO q4-6hr PRN	- Available in combination with acetaminophen
Tramadol (Ultram)	--	300 mg	3 – 6	PO: 60 min	--	50-100mg PO q8hr PRN	- Weak analgesic
Meperidine (Demerol)	100 mg	300 mg	3 - 4	IV: ~ 5 min IM/SQ: 10 – 15 min	50 to 100mg IM, SQ or IV q3-4hr PRN	--	- Do not use in patients with renal dysfunction (eGFR <50mL/min). - Not for chronic use (< 48 hrs of use) - May increase seizure risk
Fentanyl (Sublimaze) Most potent – Last line	100 **micrograms**	--	0.5 -1	IV: immediate Transdermal: 12-24HR	25 to 50 mcg IV q1-2hr PRN	Transdermal patch** 12-25mcg mcg/hr Q72hr	- Severe pain management in an appropriately monitored setting only - 0.35 to 0.5 mcg/kg (weight based, recommended max dose of 50 mcg)

Non-Opioid Analgesics

Acetaminophen (Tylenol)	325-650 mg PO q4-6hr Max: 3000 mg/d
Celecoxib (Celebrex)*	100-200 mg PO daily to q12hr Max: 400 mg/d
Ibuprofen (Motrin)*	400-800mg PO q6-8hr Max: 3200 mg/d
Ketorolac (Toradol)*^	15-30mg IV/IM q6hr Max: 120 mg/d x 5 days
Naproxen (Naprosyn)*	250-500 mg PO q8 -12hr Max 1500 mg/d
Meloxicam (Mobic)*	7.5 – 15mg PO daily Max: 15 mg/d

*NSAIDs: Doses can be scheduled or PRN. Avoid NSAIDs in renal dysfunction, CHF, PUD and with caution in elderly
^Dose adjustment per policy based on renal function, age and weight.

Neuropathic Pain Medications

Generic (Brand)	Beginning dose	Max Dose
Gabapentin (Neurontin)*	300 mg PO HS to q8hr	3600 mg/day
Pregabalin (Lyrica)*	50 mg PO q8hr	300 mg/day
SNRIs: Duloxetine (Cymbalta)* Venlafaxine (Effexor)*	30 mg PO daily 37.5mg PO daily	60 mg/day 225 mg/day
TCAs: Amitriptyline (Elavil) Nortriptyline (Pamelor)	25 mg PO HS 25 mg PO HS	200 mg/day 150 mg/day

*Required dose adjustment based on renal function

Muscle Relaxer Pain Medications

Generic (Brand)	Beginning Dose	Max Dose
Baclofen (Lioresal)	5 mg PO q8hr	80 mg/day
Cyclobenzaprine (Flexeril)	5 mg PO q8hr	30 mg/day
Methocarbamol (Robaxin)	1 g PO q8 to q6hr x 48 -72hr, then 500 – 750mg PO q8 to q6hr	8 g/day
Diazepam (Valium)	2-10 mg PO q8 to q6hr; 5-10mg IV/IM	40 mg/day

Disclaimer: Use of these general guidelines is not intended to supersede clinical judgment of the prescriber.

Keeping patients safe from self-harm and harm of others – Lethality Assessment and Constant Observation

- In an effort to identify patients at risk for lethality in our patient population, ECMC will conduct **patient lethality risk assessments**. Patients identified to be at risk will be screened using a standardized tool. ECMC's accepted screening tool is the Columbia Suicide Severity Rating Scale (C-SSRS). The accepted tool in Ambulatory Care – Primary Care is the PHQ-2 screen.
- **Dedicated Space:** At ECMC, our Psychiatric Care units are designated as "dedicated spaces." This is a hospital space which is dedicated to the treatment of the suicidal patient. Psychiatric Care units need to mitigate ligature risks in the clinical patient care areas to maintain an environment of care that is "ligature resistant".
- **Non-dedicated Space:** At ECMC, all other clinical patient care areas and units are considered "non-dedicated spaces." In these areas, an environmental ligature risk assessment has been completed. This assessment has guided mitigation of such risks.
- Necessary items for patient treatment that are a potential risk are recognized and noted on the risk assessment, and attention to maintaining safety of the patient at risk to harm themselves/others is performed. All unnecessary items that pose a risk will be removed from their environment.
- Any patient admitted to the hospital who has attempted suicide, who has revealed suicidal ideation (risk of harm to self/others), or who has been determined to be at risk for suicide, will be placed on Constant Observation/Level III Observation (ECMC Nursing Policy NUR-086 "Constant Observation for Patients in Non-Dedicated Spaces"/ ECMC Psychiatry Policy PSY-036 "Levels of Patient Observation in Psychiatry) until it is determined by a physician/provider that the patient is no longer considered a danger to himself/herself or others. As clinically indicated, the RN will initiate Constant Observation/Level III, pending the provider's assessment of the patient. The 1:1 observation may be provided by an RN, LPN, Hospital Aide, ED tech, or other qualified employee.

Constant Observation

- Constant Observation is ordered for Patients in Non-Dedicated Areas (all non-Psychiatric Care units, refer to policy ADM-004) who may be a danger to self or others. Constant Observation requires the patient to be in full visual contact within arms-reach of (by) the assigned caregiver, or as ordered by the Physician/Provider. Visualization of the patient's head must remain unobstructed from the Observer's view. Constant Observation is assigned as a 1:1. 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 Physician/Provider team caring for the patient. 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 registered nurse 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 order for Constant Observation. Following the clinical assessment by a psychiatrist, the psychiatrist will determine if the patient requires the ongoing need for observation. If it is determined that the patient no longer requires Constant Observation, the order will be discontinued.
- Constant observation is ordered by the provider, this order has two reflex orders attached- Psychiatric Consult and a Safe tray order.

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 in the progress notes with a note that is dated and timed.
- Notify the patient's attending physician and document this notification.
- 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, 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.

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. For patients who deteriorate acutely on the floor either a rapid response or adult emergency should be called, whichever is appropriate. If after the rapid response or adult emergency the team feels the patient requires immediate transfer to the ICU, they should contact the MICU APP to institute immediate co-management while the appropriate attendings are notified of the patient's condition.
2. Requests for transfer or consultation on all other patients should be initiated by the service attending contacting the MICU Attending on call.. to discuss the case and the specific reason for the consult.
3. 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).
4. 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.
5. MICU service will then write the MICU admission orders.
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

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 incarcerated patients at all times. They are bound by confidentiality rules.
- Do not advise an incarcerated 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 incarcerated patient. Be aware of what you have in your lab coat/shirt pockets. Incarcerated 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 incarcerated patient and immediately report any suspected loss to security personnel.
- Do not share any personal information with an incarcerated patient.
- No items are to be given to or received from an incarcerated patient unless approved by the security staff.
- Do not make personal phone calls or send emails on the behalf of an incarcerated patient.
- Medical staff may share medical information with the incarcerated patient's family utilizing the same privacy regulations employed when communicating with the families of non-incarcerated patients.
- Incarcerated individuals who are admitted to ECMC may have visitors and must be approved by the DOC security staff.

Patient Falls & Fall Reduction Program

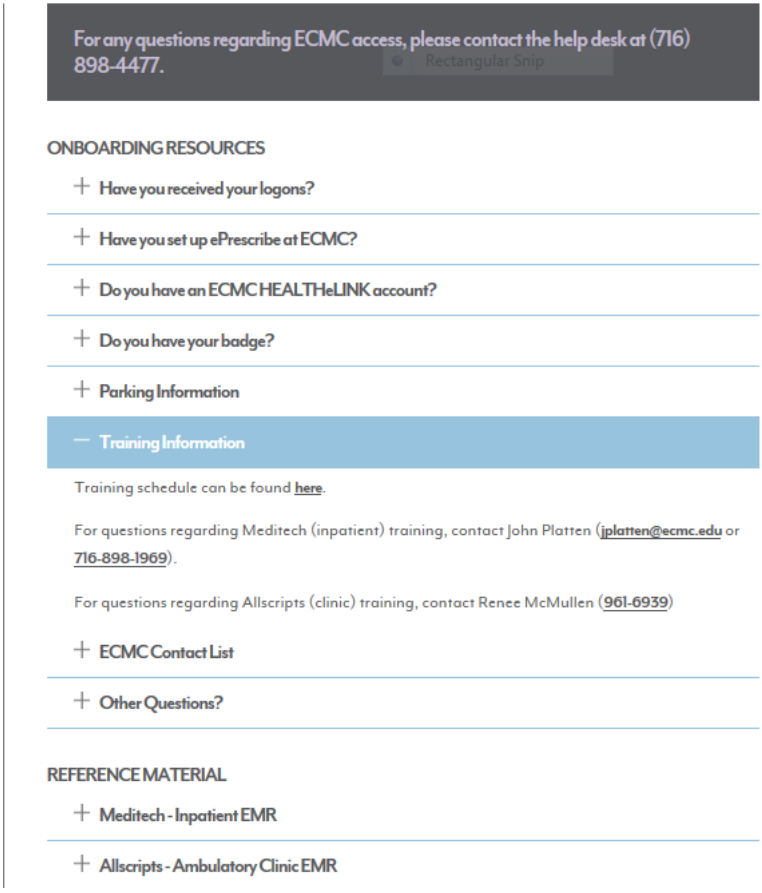
- Patients are assessed daily using the Hendrich II assessment tool
- Risk assessment is located in the EMR Under care activity (fall risk assessment)
- Patient assessed greater than 5 are at high risk for a fall and are to be issued a yellow wristband, a yellow star outside their doors and yellow socks
- Please be cautious ordering medications that could put patients at risk for falls (for example diuretics, narcotics and sedatives to name a few)
- Make sure bed is in low position after examining patients and side rails up when appropriate
- 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.
- 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 participated in training prior to your rotations. You can find this information and scheduling on the www.ecmc.edu website, "about ecmc", "onboarding" menu.



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 capture a clear picture of the patient's hospital stay to anyone who accesses the chart. Documentation accuracy allows the ability for coders to capture CCs and MCCs that are appropriate for the patient from admission to discharge. It also makes it possible to capture the highest severity of illness & risk of mortality for each patient

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 chart review on every inpatient to clarify documentation for coders. A coder then has guidelines they must follow and cannot code a diagnosis based on assumption of what the doctor means by what is written in the chart. Each diagnosis must be documented by the physician and then clinically supported. 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 the GI bleed. If the same statement reads "transfuse 2 units of PRBC for anemia secondary to a GI bleed, a coder can now capture the diagnosis of ANEMIA along with the GI bleed. However, if the physician lists the specificity for the anemia as "Acute blood loss anemia" that code carries a higher complexity and leads to more appropriate levels of reimbursement for the hospital as well as being clinically supported with the low Hgb, cause, & treatment. This missing specificity is an opportunity for a CDS to query.

Query Process - Queries will show up in the EMR in the Other Reports labeled CDI Query Report.

Specialists will send an electronic query via Cortext (texting app) notifying you that a query has been placed in the medical record:

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. This will allow the CDS to know to close the query as it has been answered.

The query will remain in open status in the EMR until the CDS sees new documentation in the record in response to the query or receives a cortext notifying he or she you disagree. Only at that point will the status be changed to closed.

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; by D/C if no definitive reason try to go with most likely reason
- 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, 1.5, or Type II.
- Specify severity and type of protein calorie malnutrition (mild, moderate, severe)
- Clinically significant diagnoses from diagnostic reports should be documented in the progress notes
- Many abbreviations are not sufficient documentation, spell out the diagnosis
- For Anemia, always document the cause (i.e., due to blood loss, iron deficiency, etc.)

Common MCCs

Acute diastolic heart failure
Acute Endocarditis or Myorcarditis
Acute Pancreatitis
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*
Toxic or Metabolic Encephalopathy
Grand mal seizure
Hypovolemic shock
Pneumonia
Quadriplegia, Functioning Quadriplegic
Sepsis
Septic Shock
Septicemia
Severe protein calorie malnutrition

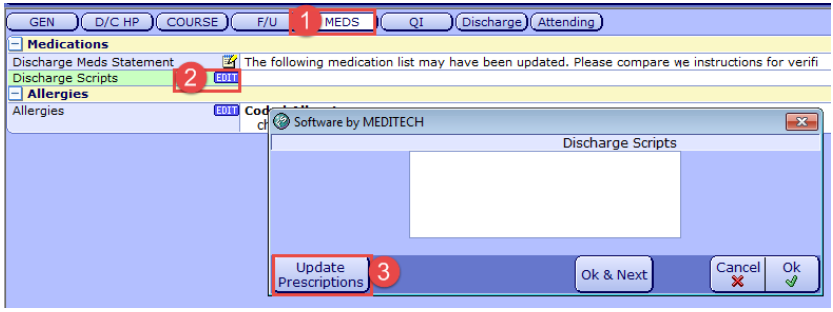
Common CCs

Acidosis
Acute coronary syndrome (unstable angina)
Acute Renal Failure
Acute blood loss anemia
Alcohol withdrawal
Chronic diastolic/systolic heart failure
Chronic kidney disease – Stage IV or V
Chronic Pancreatitis
Chronic respiratory failure
Chronic schizophrenia
Chronic systolic heart failure
COPD with acute exacerbation
Opiate, Cocaine, Heroin dependence, continuous
Drug withdrawal
Hemiplegia
Hyperkalemia/Hypernatremia
Ileus
Morbid obesity, BMI >40
Osteomyelitis, Acute or Chronic
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.

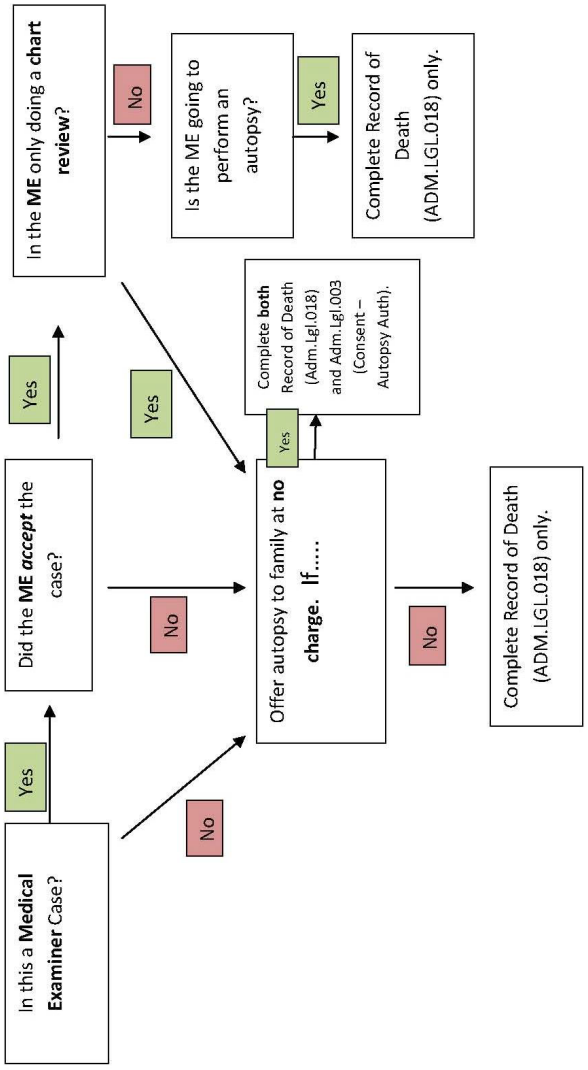
Death Information Management

- 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).
  - **All death certificates are registered through the NYS Electronic Death Registry**. Attending physicians/AHPs must login to the system via their own Health Commerce Account (HCS). All new providers must be linked to ECMC via our HCS Coordinator in Administration.

Autopsy Request

- **Autopsy Request:** If the case is not accepted as an ME case, the physician may 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. Please note we cannot provide autopsy for patients who die COVID19+.
  - 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 and signed by an attending physician within 48 hours of death.
- 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



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.

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. #:
Visit #:
Service Date:
Room:
Date of Birth:
Age:
Insurance:
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

LGL000

Please ensure bedside procedures follow the same time out and consent protocol for patient safety. EACH procedure requires its own consent and must be explained to the patient. Please ensure all forms are signed, dated and timed.

Verbal/Telephone 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 remote access (off site EMR access) to input your order(s) into the patient record rather than give a telephone order. Please ensure when using your remote access, you are on duty and not violating duty hour rules.

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

You can NOT send orders via text messaging

ALC (Alternative Level of Care) Status

- ALC status is reserved for patients no longer in need of acute patient inpatient care but for whom a suitable discharge disposition has not yet been found. We recommend that when a patient is placed on ALC a discharge summary should be done as the patient should be ready for discharge. This can be updated at the time of actual discharge.
  Such patients do not need to be seen daily but should be seen and a visit note documented at least every 7 days and anytime there is a change in status. If the patient's condition changes while on ALC to the point they are again in need of acute inpatient care, THE CHANGE OF STATUS ORDER MUST BE USED TO SWITCH THE patient back to acute STATUS.

- 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 discharged 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 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

Risk Management

The mission of the ECMCC Risk Management Department is support ECMCC's mission to promote a safe, secure, caring, healthy working and learning environment for the protection of patients, staff, visitors and volunteers through the identification of risks and the development of programs to manage, control and minimize loss.

Event Reporting

Risk Management uses several systems to identify risk. Our main system is ECMCC's event reporting system: Riskonnect (events entered in Riskonnect are referred to as "**CASE** calls", which stands for **C**are **A**nd **S**afety **E**vent)

How to Report an Event:

Reporting a CASE Call using the Riskonnect reporting system is easy and required by ECMCC's Occurrence Policy

Attend to the patient, visitor, or occurrence first. Notify supervisors as appropriate and document in the medical record per practice.

Enter CASE Calls in *Riskonnect* after the situation is stable and controlled.

What Should be Reported?

Report an event which is not consistent with the routine care of the patient or operation of the hospital.

Examples: Falls, Provider Communication Issue, Elopement, Equipment Problem, Delay in Care, Medication Error, etc.

Access Riskonnect Online:

•URL: https://riskonnectecmc.my.salesforce-sites.com/SelectEvent/
•Shortcut is also on all Desktops
•Follow the Prompts to Report a CASE Call
•Anonymous Reporting is Permitted

Risk Management (Continued)

After the report:

•After an event is reported in the Riskonnect/CASE Call system, the event is assigned to a manager to be investigated and any corrective action taken.

•Some events will be further escalated including a review at a Root Cause Analysis.

•Some events are required to be reported to a regulatory agency like the Department of Health.

Risk Management as a Resource

After hours and weekends please be sure the ***NCC*** is notified of all patient care complaints and concerns. The ***NCC*** will seek assistance from the ***Administrator on Call*** who can page Risk Management, as needed.

Subpoenas

Risk Management triages subpoenas for the entire ECMCC system.

Any staff who receives a subpoena at home related to hospital business should report the subpoena to Risk Management.

Report all subpoenas related to hospital business to Risk Management for processing and

appropriate response.

All inquiries for records, evidence, video, or testimony of employees from law enforcement or insurance agencies should be reported to Risk Management and HR.

Amy Archer Flaherty Director of Risk Management Ext. 3162

HIPAA

Confidentiality is essential.

Privacy Officer-Laura Fleming
lfleming@ecmc.edu
716-898-5880 Office

Compliance & HIPAA Anonymous Hotline: 1-855-222-0758

No cameras or cell phones may be used to photograph patients, procedures, or any diagnostic images *without the patient's consent*.

Only secure testing applications (Imprivata®, Hypercare) may be used to transmit protected health information (PHI) and photographs for diagnostic and/or care processes ONLY.

If you will be utilizing patient information or images for educational purposes, patient consent MUST be obtained. If it is for research purposes, it must be approved by the UB IRB and ECMCC Research Committee.

Accessing medical records is for care purposes only. Access of medical records of a friend, relative, your own or a patient who is not under your care may be considered a HIPAA violation. If a patient or a patient's health care proxy (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 electronic medical record (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 unnecessary and unprofessional breach of confidential information.

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 not 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 over the age of 18 (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.)*

Advance Directives

All adult individuals in New York State have the right to self-determination in Health Care and the right to express their preferences regarding health care treatment, including decisions to continue or refuse routine or major medical treatment, as well as life-sustaining treatment without which the individual is expected to die. Advance directives such as health care proxies (HCP), living wills and consents to Do Not Resuscitate (DNR) orders allow an adult to express his/her healthcare treatment preferences and wishes, in order to be prepared for those situations in which that individual may be unable to communicate for themselves.

For patients who are already incapacitated with no proxy, it is a goal to identify the surrogate decision maker(s), as per the Family Health Care Decisions Act as early as possible and actively engage them in the care of those patients.

Health Care Proxy (HCP): an adult to whom authority to make health care decisions is delegated under a health care proxy form. A competent adult may appoint a health care proxy/agent and every adult shall be presumed competent to appoint a health care proxy/agent unless such adult has been adjudged by a court to be incompetent or determined by an attending practitioner not competent to appoint a health care proxy/agent, or unless a committee or guardian of the person has already been appointed for the adult pursuant to law.

For additional information related to the procedure to complete or execute a Health Care Proxy please refer to the Advance Directive Policy found on the intranet.

Living Will: a document completed by an individual that Indicates types of treatment he/she wishes to receive or forgo under specific circumstances.

Power of Attorney (POA): written document by which a person (the "patient") with capacity designates another person (the "proxy/agent") to act on his or her behalf. A proxy/agent acting under a power of attorney has a fiduciary relationship with the patient which is different from a health care proxy/agent by proxy or a health care surrogate relationship. The Power of Attorney proxy/agent acts on behalf of the patient with respect to banking, financial, real estate, business transactions and the like. The power of attorney's authority does not include authorization to make medical or health care decisions for the patient. The proxy/agent may have access to the patient's health care records to make decisions regarding the payment for health care services, health care benefits or insurance coverage

Family Health Care Decisions Act

Family Health Care Decisions Act (FHCDA)

This 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 instructions OR appoint a Health Care Proxy. 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

Prior to relying upon a decision by a surrogate, the attending physician or someone acting on his or her behalf shall make reasonable efforts to determine if the patient has appointed a health care agent by signing a Health Care Proxy. If so, the agent has priority over anyone else to make decisions for a patient who has lost decision-making capacity.

One person from the following list, who is in the highest priority class, who is reasonably available, willing, and competent to serve as surrogate:

1. A guardian authorized to make decisions pertaining to health care pursuant to Mental Hygiene Law Article 81 (review court order for any limitations in authority);
2. The spouse, if not legally separated from the patient, or the domestic partner (see definition);
3. A son or daughter 18 years of age or older.
4. A parent;
5. A brother or sister 18 years of age or older; or
6. A close friend (see definition).

Any person who is highest on the list may designate someone else on the list to be surrogate, as long as no one who is higher on the list than the person designated objects.

Family Health Care Decisions Act (continued)

Family Health Care Decisions Act (FHCDA) **continued…**

If a patient requires treatment decisions, lacks capacity and does NOT have a Health Care Agent OR Surrogate available to make decisions for them, the FHCDA authorizes Physicians to make routine and major medical treatment for a patients. All decisions shall be based on the following standards:

1.The patient's wishes, including the patient's religious and moral beliefs.

2.If the patient's wishes are not reasonably known and cannot with reasonable diligence be ascertained, in accordance with the patient's best interests. In assessing the patient's best interests, physicians shall consider the dignity and uniqueness of every person; the possibility and extent of preserving the patient's life, the preservation, improvement, or restoration of the patient's health or functioning; the relief of the patient's suffering; and other values that a reasonable person in the patient's circumstances would wish to consider.

3.In assessing the patient's wishes and best interests, physicians shall make a decision that is patient-centered and made on an individualized basis to be consistent with the patient's values, including religious and moral beliefs, to the extent reasonably possible.

4.Under no circumstances, shall any decision be based on the financial interests of the hospital or any health care professional.

Decisions to withdraw or withhold life-sustaining treatment from isolated incapable patients is limited. Such decisions can be made only (1) 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, OR (2) by a court, in accordance with the FHCDA surrogate decision-making 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.

For additional information related to the procedure to make treatment decisions based on the Family Healthcare Decisions Act please refer to the appropriate policy found on the intranet.:

Treatment Decisions for Adult Patients Who Lack Capacity, DO NOT have a Health Care Proxy/Agent and Have a Surrogate Available, or;

Treatment Decisions for Adult Patients Who Lack Capacity and DO NOT have a Health Care Agent OR Surrogate Available to Decide for Them, or:

Treatment Decisions for Adult Patients Who Lack Capacity, Do Not Have a Health Care Proxy/Agent and Have a Developmental Disability

Medical Orders for Life Sustaining Treatment

Medical Orders for Life Sustaining Treatment (MOLST)

Health care professionals should discuss MOLST with their patients who have advanced progressive chronic illness, are terminally ill or are interested in further defining their care preferences. Specifically, health care professionals should discuss MOLST if the patient:

- Wants all appropriate treatments including cardiopulmonary resuscitation (CPR).
- Wants to avoid all life-sustaining treatments.
- Chooses to limit life-sustaining treatments.
- Wants to avoid cardiopulmonary resuscitation (CPR) by requesting a "Do Not Resuscitate Order" (DNR order).
- Might die within the next year.
- Resides in a long-term care facility.
- Resides in the community and are eligible for long-term care

If you are unsure on how to complete a MOLST form, the Department of Health (DOH) has developed legal requirements checklists. The checklists are intended to assist providers in satisfying the complex legal requirements associated with decisions concerning life-sustaining treatment for patients. You will find these tools on the ECMC intranet page under hotlinks (MOLST-FAQ)

Molst - FAQ

MOLST Checklists

MOLST General Instructions and Glossary Adults

#1 Adult Patient With Capacity

#2 Adult Patient with HCP

#3 Adult Patient with FHCDA Surrogate

#4 Adult Patient without FHCDA Surrogate - includes Hospice

#5 MOLST Legal Requirements Checklist For Individuals With Developmental Disabilities

#6 MINOR Patients

The Physician, PA, or NP must review the MOLST form every 7 (seven) days in hospitalized patients receiving acute care or more often if there is a significant change in patient's condition from time to time as the law requires, and;
-If the patient moves from one location to another to receive care; or
-If the patient has a major change in health status (for better or worse); or
-If the patient or other surrogate decision-maker changes his or her mind about treatment.

Palliative Care, Hospital Ethics, Moral Objection

Palliative Care

Palliative care is specialized medical care for people living with serious illness that provides relief from the symptoms and stress of the illness throughout the continuum of care while incorporating psychosocial and spiritual care according to the patient/ family's needs, values, beliefs, and cultures. The goal is to anticipate, prevent, and reduce suffering; promote coping; and improve quality of life for the patient/ family/caregiver.

Palliative care is provided by specialty trained clinicians in a multi-disciplinary setting and may include physicians, advanced practice providers, nurses, dietitians, social workers, clergy, and pharmacists; and addresses all aspects of a person's needs including physical, spiritual, social- emotional, and financial.

Referrals to ECMC palliative care are made through physician EHR orders/consult to the palliative care team. The consult team will visit with the patient, provide a comprehensive assessment, and follow up with the consulting/referring physician during the hospital admission.

Hospital Ethics Committee

The hospital's Ethics Committee exists to provide 24-hour, seven day a week access to any patient, patient's family, physicians, and staff who have ethical concerns regarding a patient's care and treatment. It respects the patient's right to make choices based on the patient's perception of what is in his/her best interest. To this end it functions as a mechanism for conflict resolution regarding ethical issues between patient, family, and staff. Therefore, it addresses such issues as withholding of treatment including resuscitative services, limitation of treatment, advance directives, access to care, confidentiality, and other personal value issues.

Any member of the medical or hospital staff, patient, or their significant others (including same sex-partner) may request a consultation or a case review by the Committee.

The person requesting a consult calls the hospital operator, or uses the team consult schedule to identify the consult team on call.

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.

Compliance Issues or Concerns

Contact:
Nadine Mund
Director of Corporate Compliance
nmund@ecmc.edu
716-898-4595 Office
or

Compliance & HIPAA Anonymous Hotline:
1-855-222-0758

ECMCC's Corporate Compliance Program, policies and standards of practice supports the ***prevention and detection of false claims and statements and impermissible financial transactions which result in health care fraud and abuse***. They include, but are not limited to the **Code of Conduct**, **Corporate Compliance Coding and Billing policy**, and **Conflict of Interest**.

- ***Detecting FRAUD, WASTE, AND ABUSE (FWA) is the responsibility of everyone.***
- ***Our Code of Conduct clearly outlines the expectations of behavior and compliance with all rules and regulations.***
- ***Zero tolerance for any form of intimidation or retaliation against a whistleblower.***
- ***Corporate Compliance Program and Policies are listed on the ECMCC Homepage of the Intranet:***
  - ***Hotlinks: Compliance Resources***

Avoid Conflict of Interest Issues

- Meals or other types of food directly funded by Industry/Vendors are prohibited at all ECMCC sponsored educational activities regardless of whether such event is held onsite or offsite. Support is permitted by must be achieved by financial donations to an ECMCC component (ECMCC Medical Dental Staff Office).
- Any other gifts offered by pharmaceutical reps or other vendors is strongly discouraged.
- Please review the ECMCC's policy (located on the intranet): Exchanges between Industry; and the University at Buffalo's Conflict of Interest policy.

VIII. Programs and Regulations

Patient-Centered Medical Home, I-Stop

What is the Safe Act?
(see Policy "Safe Act Reporting" for more information

The SAFE Act became effective on 03/16/2013. Mental Hygiene Law 9.46 is part of the SAFE Act and requires a mental health professional to report a person who, in the mental health professional's exercise of reasonable professional judgement, is likely to engage in conduct that would result in serious harm to self or others. Physicians, psychologists, registered nurses and licensed clinical social workers are considered mental health professionals for purposes of SAFE Act reporting. Reports are made to the director of community services (or the director's designee) through the Office of Mental Health's Integrated SAFE Act Reporting System (ISARS). Reports are to be made as soon as practicable.

SAFE Act reporting requirements apply to inpatients and outpatients. SAFE Act reporting requirements apply to patients of medicine services and behavioral health services.

A mental health professional is not required to report a person when, in the exercise of reasonable professional judgment, the report would endanger the mental health professional or increase the danger to a potential victim or victims.

It is not necessary for the mental health professional to determine that the person has a gun or other firearm before making a report.

The patient does not have to be told that a report was made pursuant to the SAFE Act.

"Frequently Asked Questions...next page"

Safe Act?

FAQs

- ***What does "likely to engage in conduct that would result in serious harm" mean?***

The standard 'likely to engage in conduct that would result in serious harm' means threats of, or attempts at, suicide/serious bodily harm to self, or homicidal/violent behavior towards others. If the clinician determines that the person is likely to engage in conduct that could seriously harm themselves or others, a MHL 9.46 report should be filed. It is NOT necessary to determine if the person has a gun before making determination.

- ***Who is reported?***

Any person who is receiving mental health services, **in any healthcare setting**, that is deemed to meet criteria, MUST be reported. Possessing a firearm is not a precursor to reporting. There is NO age restriction or limitation for reporting individuals. The reporting requirement applies to inpatients and outpatients of both behavioral health and medical services.

If mental health services are provided in an OASAS certified program, information disclosed cannot include information regarding substance use disorder treatment.

MHL 9.46 does **NOT** apply in an OASAS certified program when a mental health professional is solely providing substance abuse services to the person.

- ***When NOT to report?***

A report is not required when, in the mental health professional's reasonable professional judgement, a report would endanger him/her or increase danger to potential victim(s).

A reporter is NOT required to notify the person that they have filed a report.

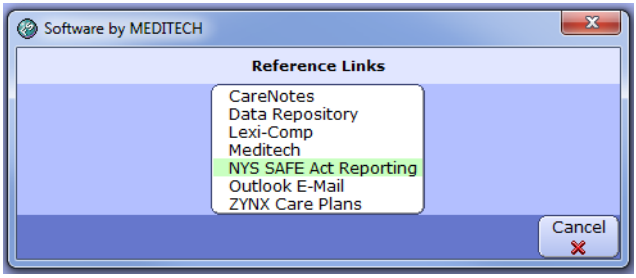
- ***Immunity Standard***

- MHL 9.46 provides that if a mental health professional uses "reasonable professional judgement" and acts in "good faith" when making a determination, this decision cannot be the basis for any civil or criminal liability on the part of that professional.

Safe Act Reporting

- *How to Report*

A report can be made by accessing the Safe Act application on the desktop or click on the external links button in Meditech (Click on the globe at the bottom of the screen and chose NYS Safe Act Reporting). Enter all of the fields and submit the application to the OMH.



When report is confirmed, obtain the ISARS confirmation number for verification. For inpatients, once a report is made, no further separate reports are required.

- *Where does the report go?*

The report is sent to the Director of Community Services who, in turn, makes a further report to the division of criminal justice services if the Director agrees that the person is likely to engage in such conduct. The division of criminal justice services may use the information, among other things, to determine whether a firearm license should be suspended or revoked.

Medical Dental Staff Practice Improvement Process

With the ultimate goal of making ECMCC the best place to practice, the Medical and Dental Staff have moved from traditional peer review to the constructive and educational process of Practice Improvement. The benefits of the newly defined Practice Improvement Program are intended to:

- Empower staff to effect change
- Increase satisfaction
- Decrease burnout
- Improve quality and efficiency of patient care
- Provide a mechanism for coordinating multidisciplinary care
- Build a program that is proactive rather than reactive.

The Practice Improvement Program is built on the **FIVE PILLARS OF CLINICAL QUALITY:**

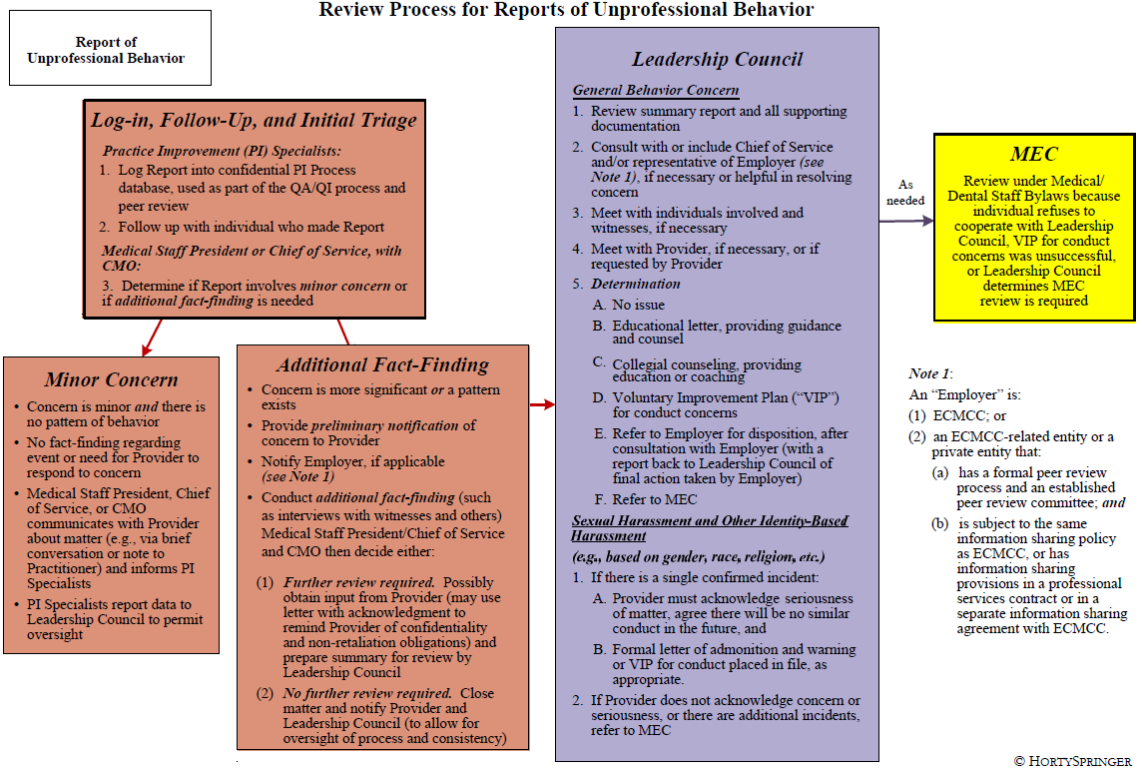
1. Medical Dental Staff: Bylaws, Rules & Regulations, Credentials Policies
2. Professionalism
3. Practitioner Health & Wellness:
4. Ongoing Professional Practice Evaluation (OPPE) & Focused Professional Practice Evaluation (FPPE)
5. Utilization Management/Medical Necessity

The policies governing the Pillars of Clinical Quality can be found on ECMCC's Intranet Page, under Policies and Procedures. Credentialed Members of the Medical and Dental Staff are expected to know, understand and participate in the program.
Specific Policies for review include the Professionalism Policy (ADM-026) and the Practitioner Health & Wellness (MS-06). The full text of those policies can be found on ECMCC's intranet site, under policies and procedures. The workflow and function of these policies are as illustrated on the following page.

Practice Improvement Process

Appendix B

Erie County Medical Center Corporation
Practice Improvement Process
Review Process for Reports of Unprofessional Behavior



Conducting Clinical Research at ECMC

If you are interested in conducting clinical research at ECMCC, please review ECMCC Clinical Research Policies.

Once IRB approval is obtained, a research request must go through to the ECMC Clinical Research Committee directed by Dr. Mandip Panesar.

The ECMC Clinical Research Committee performs the final approval and directs the ECMCC Reporting team as to the priority, method and what data is to be provided for each research request.

When on the ECMCC intranet, go the following website for more information for **Clinical Research** at the following link: http://home.ecmc.edu/depts/ClinResearch/index.html. You will find the following:

- CLINICAL RESEARCH AT ECMC POLICY
- PROCEDURES FOR CONDUCT OF QUALITY ASSESSMENT/QUALITY IMPROVEMENT (QA/QI) RESEARCH POLICY
- If you are conducting **clinical research** at ECMC, please complete **the Clinical Research Application**
- **PROCESS GUIDE FOR PRICING, BILLING & RECONCILIATION OF CLINICAL RESEARCH STUDIES FOR CLIENT ACCOUNTS**
- New Client Request/ECMC Resources Form

The Risk Office, directed by Amy Flaherty, ECMC Risk Officer, aflaherty1@ecmc.edu, oversees the ECMC Clinical Research Committee activities.