

The Mount Sinai Services Elmhurst Hospital House Staff Manual

OFFICE FOR GRADUATE MEDICAL EDUCATION
MOUNT SINAI SERVICES
MOUNT SINAI SCHOOL OF MEDICINE
79-01 BROADWAY
ELMHURST, NEW YORK 11373

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Foreword

It is our hope that your training at Mount Sinai Services will enable you to develop the skills necessary to become a practitioner in your specialty and to foster the development of a personal program of learning that allows continued professional growth. As a House Staff Officer at Mount Sinai Services, you will be participating in safe, effective, and compassionate patient care under the clinical supervision of faculty. You will also be given the opportunity to participate, as appropriate, in other related activities.

As you fulfill these responsibilities, it is important that you remain aware of the practices, procedures, and policies of the institution. This Manual is designed to familiarize you with Medical Center policies and to help you carry out your administrative and patient care responsibilities as a House Staff Officer. The Hospital retains the right to make changes to this Manual without notice in accordance with applicable law.

Although this Manual attempts to be comprehensive, if you have a question or problem that is not covered, please feel free to contact your chief resident, program director, or our offices for guidance. If in the future you would like to see additional information included in this Manual, please let us know.

We all share the common goal of providing the finest quality care to our patients. During your training at Mount Sinai Services, your primary consideration should always be the patients in your charge.

We wish you success as a House Staff Officer and throughout your career. We look forward to meeting with you during your appointment at Mount Sinai Services.

Kenneth L. Davis, M.D.

President and CEO

The Mount Sinai Services Medical Center

Dean

Mount Sinai Services School of Medicine

Barry Stimmel, M.D.

Dean for Graduate Medical Education

Mount Sinai Services School of Medicine

Section One: Welcome

MISSION STATEMENT

Preamble: The Boards of Trustees commit the art and science of medicine through clinical excellence. This central mission consists of high-quality patient care and teaching conducted in an atmosphere of social concern and scholarly inquiry into the nature, causation, prevention, and therapy of human disease.

Article I: Patient Care: In this academic medical center, the responsibility to teach and conduct research in the laboratory, at the bedside and in the community enhances the fundamental goal of entirely personal, compassionate patient care. Mount Sinai Services will strive to provide superlative patient care, considered to be the requisite model for learning.

Article II: Education: The educational process will aim to graduate individuals who will be committed to a lifetime of continuing education while they are contributing in many and varied ways to the health needs of people. Mount Sinai Services will be responsible for the certification of physicians at the undergraduate, graduate, and postgraduate levels, as well as the certification of biomedical scientists at the graduate level and, as appropriate, will undertake the education of other health and allied professionals.

Article III: Research: Since medicine is a derivative science and must draw upon at least the biological, social, and physical sciences, no discipline will intentionally be excluded as irrelevant. Fundamental and applied research will be primarily centered in geographic proximity to clinical facilities. Mount Sinai Services will encourage, support, and evaluate innovative ideas and programs in health services delivery.

Article IV: Dissemination of Knowledge: Mount Sinai will participate as a national and international resource in the gathering, analysis, and dissemination of information pertaining to the prevention, diagnosis, and treatment of disease.

Article V: Concern for the Community: Mount Sinai will be ever sensitive to the social and health care needs of the many different communities it serves. Mount Sinai Services will be a participant in efforts to define and solve health problems in population groups and communities through its capability in developing scientific knowledge, education, and service.

Article VI: Organization: In a framework of free participation, Mount Sinai Services will strive to create a stable, evolving working environment conducive to individual creativity.

Consortium for Graduate Medical Education

The Mount Sinai Services School of Medicine Consortium for Graduate Medical Education is dedicated to centralizing, enhancing, and monitoring the quality of the education provided to House Staff in all programs at all participating institutions. The Graduate Medical Education Office works with affiliated institutions in the Consortium to meet the new demands and responsibilities inherent in maintaining quality residency education. The Consortium consists of 13 institutions in New York and New Jersey, sponsors more than 135 residency programs in virtually all medical specialties, and enrolls in the aggregate more than 2,250 House Staff. Activities and services provided to all House Staff, regardless of home institution or specialty, include:

- A two-day Core Curriculum for all entering House Staff
- An opportunity for clinical assessment using standardized patients in the School of Medicine's Morchand Center for Clinical Competence
- A two-day Retreat for all incoming chief residents
- Internal Reviews of residency programs to assure quality of resident education in all sponsored programs
- House Staff representation on all Consortium committees
- Opportunities for career placement through the utilization of the <http://fusion.mssm.edu/gme/view/> website

The hospitals currently participating in the Consortium are:

- [James J. Peters VA Medical Center](#)
- [Cabrini Medical Center](#)
- [Elmhurst Hospital Center](#)
- [Englewood Hospital and Medical Center](#)
- [Jamaica Hospital Medical Center \(Family Practice Program\)](#)
- [Jersey City Medical Center](#)
- [Maimonides Medical Center](#)
- [The Mount Sinai Hospital](#)
- [Newark Beth Israel Medical Center](#)
- [North General Hospital](#)
- [Queens Hospital Center](#)
- [Saint Barnabas Medical Center](#)
- [St. Joseph's Regional Medical Center](#)

Core Competencies

Residency programs must require their residents to obtain competency in the six areas below to the level expected of a new practitioner. Toward this end, programs must define the specific knowledge, skills, and attitudes required and provide educational experiences as needed in order for their residents to demonstrate:

- I. *Patient Care* that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.
- II. *Medical Knowledge* about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.
- III. *Practice-Based Learning and Improvement* that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care.
- IV. *Interpersonal and Communication Skills* that result in effective information exchange and teaming with patients, their families, and other health professionals.
- V. *Professionalism*, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.
- VI. *Systems-Based Practice*, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

Commitment to Diversity

The School of Medicine is committed to promoting and supporting diversity at all levels in the working and learning environments and to meeting the needs of the diverse body of students, House Staff Officers, faculty, staff, and communities we serve.

Diversity in the health professions workforce benefits every aspect of health care. Addressing the needs of our increasingly multicultural and ethnically diverse patient population at Mount Sinai Services makes it essential that patients have increased access to physicians who share their ethnic heritage. Further, interacting with a diverse peer group is important for students, House Staff, and faculty for effectively managing cross-cultural patient presentations and for having a beneficial impact on health outcomes.

Section Two: Employment at Mount Sinai Services

HOUSE STAFF ELIGIBILITY AND PROCESSING

Employment Eligibility Verification

In compliance with federal regulations, The Mount Sinai Services Hospital must verify documentation of a House Staff Officer's identity and employment eligibility.

A House Staff Officer is required to provide proof of his or her identity and employment eligibility per United States Citizenship and Immigration Service (USCIS), Form I-9, Employment Eligibility Verification.

All U.S. employers are responsible for completion and retention of Form I-9 for each individual they hire for employment in the U.S. This includes citizens and non-citizens. On the form, the employer must verify employment eligibility and documents presented by the employee and record the document information on Form I-9. Original documents must be provided for verification.

International medical graduates (IMG's) may not begin their training until they have obtained an appropriate visa. If an appropriate visa is not obtained in a timely fashion, IMG's will not be permitted to begin training until the process is complete. Employers must keep a copy of the current visa on file.

Medical Licensure

Hospital policy requires that all graduates of U.S. (including Puerto Rico) and Canadian medical schools appointed to the House Staff must have a New York State limited permit or license to practice medicine. The only exceptions to this requirement are House Staff in their first postgraduate year (PGY-1's). IMG's are also exempt from this regulation, but must be certified by the Educational Commission for Foreign Medical Graduates (ECFMG) and must present a valid copy of their Certificates.

Graduates of U.S., Puerto Rican, and Canadian medical schools must apply for a New York State limited permit or license after their PG-1 year. If an eligible House Staff Officer does not show proof of registration for a New York State license or limited permit by the time s/he is to be reappointed to the PG-3 year, his or her salary will not be increased to the next PGY level. In effect, PGY-2s must have either a New York State limited permit or license by the middle of their PG-2 year.

IMG's must apply for a New York State limited permit or license after their PG-3 year. Eligible IMG's must show proof of a limited permit or license by the middle of the PG-4 year to be eligible for reappointment to the PG-5 year.

All fellows and clinical fellows must have a New York State limited permit or license before they may be appointed. All Dentistry House Staff must have a New York State license or limited permit.

Any exceptions to the above licensing requirements must be approved by the Medical Board.

Requirements for Licensure

First-time applicants for a New York State medical license need to be certified in Child Abuse Recognition and Infection Control.

Child Abuse Recognition certification is a one-time requirement. The course does not have to be retaken before renewal of the license. In addition to being a requirement for licensure, an Infection Control course is also a State and Hospital requirement for all House Staff. This course must be taken periodically for renewal of your New York State license.

All entering first-year residents are expected to attend the Core Curriculum, which includes both of the mandatory certifications discussed above. The training sessions are held during Orientation in late June. Other House Staff available at this time are also invited to attend to receive certification.

You may take either of these courses at any location as long as a certificate of completion is provided. Mount Sinai Services offers both courses on campus for the convenience of House Staff. For information regarding Child Abuse Recognition courses at Mount Sinai Services call (212) 731-7950; for Infection Control courses at Mount Sinai Services call (212) 659-9450.

For information about the required United States Medical Licensing Examination (USMLE), you may call the New York State Education Department's Office of the Professions at (518) 474-3839, visit the www.nysed.gov, or write to:

The New York State Education Department
Division of Professional Licensing Services
89 Washington Avenue
Albany, NY 12234

Equal Opportunity Employer

The Mount Sinai Services Hospital and the Mount Sinai Services School of Medicine are equal opportunity, affirmative action employers. Personnel are chosen on the basis of ability and qualifications, without regard to race, color, creed, religion, cultural background, sex, age, national origin, marital status, sexual orientation or affectional preference, disability, or veteran status, in compliance with federal, State, and municipal laws.

CPR Qualifications

Basic Cardiac Life Support (BCLS) (Initial Course) is required for all House Staff with patient care responsibilities. Recertification is required every two years.

Advanced Cardiac Life Support (ACLS) is required every two years for:

- Internal Medicine House Staff
- Emergency Medicine House Staff
- Anesthesiology House Staff

- Surgery House Staff and Critical Care Fellows
- Pulmonary / Critical Care Fellows
- Pediatrics House Staff
- Psychiatry House Staff (initial course only)
- Interventional Radiology Fellows (initial course only)
- Obstetrics and Gynecology House Staff (initial course only)
- All House Staff performing sedation or analgesia (regardless of specialty)

Pediatric Advanced Life Support (PALS) is required every two years for:

- Emergency Medicine House Staff
- Pediatrics House Staff

Neonatal Resuscitation Program (NRP) is required every two years for Pediatrics House Staff.

Automated External Defibrillator (AED) Training is required every two years for selected physicians in Psychiatry.

For further information please contact Nursing Education at x212-241-7050.

Criminal Background Check

A criminal background check will be completed on all new House Staff in order to evaluate whether any individuals might constitute an unreasonable risk to Medical Center property or to the safety or welfare of patients or others.

- I. Prior to issuance of any identification card, all new House Staff will be fingerprinted.
- II. All fingerprint cards are forwarded to the State of New York Division of Criminal Justice Services.
- III. The results of the background check will be reviewed by the Labor Relations Office, and will be screened against pertinent documents.

Physical Examination

In keeping with the policies of Mount Sinai Services/Elmhurst Hospital, the New York State Department of Health, the Joint Commission on Accreditation of Healthcare Organizations, and the U.S. Public Health Service, all House Staff Officers are required to submit to the Occupational Health Service (OHS) documentation of a recent physical examination prior to commencing graduate medical education.

In addition to completing the standard history and physical examination forms enclosed in the hiring packet, the following studies are required:

- I. *Toxicology Screening*: Appropriate forms and instructions are included in the hiring packet.

- II. *Tuberculosis Screening:* A 5-TU (tuberculin units) PPD must be done within three months of commencing employment. The PPD screening form provided to House Staff should be forwarded to EHS. For those with a history of positive tuberculosis skin testing, a report of chest PA and lateral films, done within the previous six months, must be provided along with documentation for follow-up.
- III. *Laboratory Reports:* Reports must be submitted for the following tests conducted within the last five years:
 - A. Measles titer.
 - B. Mumps titer.
 - C. Rubella titer.
 - D. Hepatitis B surface antigen/antibody titers.
 - E. Varicella titer (if no history of disease).

For susceptible titers, documentation of booster vaccinations must be received.

All of the above, with the exception of toxicology screens, may be performed at EHS. Appointments must be scheduled well in advance of the beginning of training.

OHS is located at 78-07 41st Ave, first floor and operates Monday through Friday, 8:00am-4:00pm. The phone number is 718- 334-3030, and the confidential fax number is 718- 334-5763.

All House Staff Officers are required to complete an annual health assessment questionnaire. The questionnaires are included in the officers' OHS records. House Staff who previously had negative PPDs must also be retested *every 12 months*.

Security Processing

All House Staff Officers must be photographed. Hospital Police maintains a copy of the identification photograph and pre-employment data.

Toxicology Screening

Mount Sinai Services/Elmhurst Hospital has always attempted to ensure that the work environment remains free from hazards to patients, employees, and visitors. Taking into account the recommendations of the New York State Department of Health, the Joint Commission on Accreditation of Healthcare Organizations, and the Drug-Free Workplace Act, the Hospital conducts a urine toxicology screening program for all new employees, incoming House Staff, and incoming medical students. All House Staff rotating from other institutions must also be screened and submit evidence of a negative test result with their application. No paperwork will be processed if this documentation is not presented.

Mount Sinai Service's protocol includes screening for amphetamines, barbiturates, benzodiazepines, cannabinoids, cocaine, opiates, and phencyclidine. All initial positive specimens are confirmed by gas

chromatography and then reviewed by a Certified Medical Review Officer. The typical limits of sensitivity tested are as follows:*

Drug Name	Screen Cut-Off	Confirmation Cut-Off
Amphetamines	1,000ng/ml	500ng/ml
Barbiturates	300ng/ml	300ng/ml
Benzodiazepines	300ng/ml	150ng/ml
Cannabinoids	100ng/ml	15ng/ml
Cocaine	300ng/ml	150ng/ml
Opiates	300ng/ml	300ng/ml
Phencyclidine	25ng/ml	25ng/ml

The results of any information relating to drug screening are confidential, and a strict chain of custody is followed.

** These values may vary by laboratory.*

COMPENSATION AND BENEFITS

Compensation

The appointment of a House Staff Officer with the title of Resident shall be based on his or her appropriate postgraduate year (PGY) in his or her particular training program, which shall be determined as follows:

- I. A House Staff Officer who has not completed at least one year of service in an ACGME- or ADA-approved training program shall be placed at the PGY-1 level.
- II. A House Staff Officer who has completed one or more years of service in a specific ACGME- or ADA-approved training program shall be placed at the PGY level that equals the number of such years of service in that training program plus one (e.g., House Staff who have completed two years in such a training program shall be placed at the PGY-3 level). House Staff required to spend a prerequisite period of service in an ACGME- or ADA-approved training program in a specialty other than that in which they are serving shall be classified on the basis of the required prerequisite. In the event that a House Staff Officer changes his or her specialty, s/he shall receive a maximum credit of one year (in his or her salary level) for prior service in such other ACGME- or ADA-approved training program at the discretion and approval of the Department Chair. For compensation of fellows, please see Section Three, "House Staff Titles."

Paychecks

Paychecks are issued biweekly and distributed every other Friday. All House Staff should contact their Department Administrator to find out where their checks may be claimed.

Health and Related Benefits

Mount Sinai Services provides House Staff Officers many benefits, including:

- Health Insurance
- Dental Insurance
- Optical Insurance
- Prescription Drug Coverage
- Life Insurance
- Workers' Compensation
- Short-Term Disability
- Long-Term Disability
- Nursery Care

Mount Sinai Services will provide certificates of insurance and/or explanatory booklets to each House Staff Officer at the time s/he commences employment at Mount Sinai Services. Further information is available from the Benefits Administration Office.

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), effective January 1, 1987, House Staff

Officers may continue their group health insurance after leaving The Mount Sinai Services. Contact the Human Resources Benefits Administration Office at x44848 for further information.

Occupational Health Service

The Employee Health Service (OHS) is an ambulatory care unit located at 78-07 41st Ave, 1st Floor. It operates Monday through Friday, 8:00am-4:00pm. The EHS staff also administers and reviews mandated annual employee health assessment questionnaires.

Services provided directly to employees include state-mandated OSHA tests and immunizations (measles, rubella and hepatitis B), administration of influenza vaccine, and return-to-work clearance (only in cases involving Workers' Compensation).

Mandated, routine, and periodic screening for tuberculosis (involving skin-testing and/or chest X-rays) is performed on all employees. Employees requiring tuberculosis prophylaxis are placed on a treatment and surveillance program managed by EHS staff.

On-the-job accidents, injuries, and exposures are evaluated, treated, and reported to the appropriate agencies. These include blood and body fluid exposures (see Appendix), animal bites, neuroskeletal injuries, falls, excoriations, and simple lacerations.

Employees must go to the Emergency Department for follow-up of these occurrences at times when EHS is closed.

For follow-up of all other illnesses and medical conditions, House Staff Officers should see their primary care providers.

Resident Mental Health Service

Dr. Kathy Berkman of the Department of Psychiatry is available for an initial consultation at no cost to House Staff Officers in need of mental health services. A referral will be made if it is considered to be necessary. The cost of continuing therapy will be arranged between the therapist and the House Staff Officer. Dr. Berkman can be reached at (212) 579-6670.

Malpractice Insurance

All members of the House Staff are covered by the Hospital for medical professional liability insurance under a group policy for work performed within the scope of their employment by the Hospital. In case of unanticipated and/or serious sequel to any diagnostic or therapeutic procedure, a report of the incident is to be made promptly by telephone to the Office of Risk Management at x43696.

Should any patient or family member express dissatisfaction regarding the quality of patient care that has the potential to become a professional liability matter, it should be reported promptly to Risk Management.

Vacation

Vacation for House Staff Officers is 20 paid days per annum (July 1 through June 30).

Any deviation from the above is granted at the discretion of the involved Chief of Service and with the approval of the Director of the Department.

Vacation must be taken each year and may not accrue from year to year. House Staff Officers are not compensated for vacation time not taken.

Leave Time

House Staff Officers will receive 12 days of paid sick leave per year, cumulative to a maximum of 60 days.

A House Staff Officer will receive three condolence days in the event of the death of his or her parent, spouse, child, brother, sister or grandparent. These three days must be taken consecutively within a reasonable time of the day of death or day of the funeral and may not be split or postponed.

Time off with pay for specialty examinations will not be unreasonably denied; however, it is at the discretion of the Department Chair.

Educational leave time will be granted at the discretion of the Department Chair and in accordance with appropriate departmental policy.

In the event that a House Staff Officer needs to interrupt his or her training (i) due to the birth, adoption, care for a newborn, or placement of a child; (ii) in order to care for a child, parent, or spouse with a serious health condition; or (iii) because of the House Staff Officer's own serious health condition, 12 weeks of leave time may be available. When the need for leave is foreseeable, House Staff Officers must provide at least 30 days written notice explaining the reason for the leave and the leave's anticipated duration. When leave is not foreseeable, notice must be given within two working days of learning of the need for leave, except in extraordinary circumstances. Accrued vacation, holidays, free days, and sick time will be used during this leave. Health care coverage will be maintained provided the House Staff Officer pays his or her cost share. The Family and Medical Leave Policy may be read in its entirety in the Human Resources Policy Manual on the Mount Sinai Services Intranet.

The length of the leave will be determined by the Department Chair, who will take into consideration New York State and federal laws as well as attendance requirements of the appropriate Specialty Board with reference to minimal, contiguous time that must be spent in a training program. Short-term disability will be paid in accordance with New York Disability Law. One parental day will be allowed at the discretion of the Department Chair.

Accommodations for Disabled Employees

In compliance with the Americans with Disabilities Act, the Medical Center will attempt to make reasonable accommodations for qualified disabled individuals. A committee consisting of representatives from Human Resources, Engineering Services, Facilities Design and Construction, Rehabilitation Medicine, and the

department employing the individual, will explore and recommend appropriate accommodations for the School of Medicine and the Hospital.

Dependent Care Reimbursement Account

The Dependent Care Reimbursement Account (DCRA) allows eligible House Staff to deduct funds from their paychecks before taxes to be used to pay for the care of children, a disabled spouse or child, or an aging parent. Plan participants may set aside up to \$5,000 per year for use in meeting the costs of dependent care. If you are interested in obtaining more information or in enrolling in the plan, call the Human Resources Benefits Administration Office at (212) 241-7045.

FACILITIES

Housing

Mount Sinai Hospital owns several apartment buildings used for professional housing in the vicinity of the Medical Center. Size of household is a factor in determining housing assignments. Accommodations include furnished bedrooms in shared suites in the Residence Hall, studios, and one- and two-bedroom apartments. Occupancy is subject to availability. Applications for housing are available from the Department of Real Estate at x212-241-9630, or may be picked up at 1240 Park Avenue, Mondays through Fridays, 10:00am-11:45am or 3:00pm-5:00pm.

Food Service

Elmhurst Hospital Center does not have a cafeteria on site. House Staff are required to supply their own meals. At each departments own discretion, lunch may be provided during conferences.

Health Sciences Library

Elmhurst Hospital

Location and Contact Information

Location: Third floor of the D-wing, Room D3-52A
Telephone: 718-334-2040
Fax: 718-334-5690
E-mail: ehc-library@nychhc.org

*Library Hours**

Monday through Friday	9:00 AM to 10:00 PM**
Saturday	9:00 AM to 12:00 PM, 1:00 PM-5:00 PM
Sunday	12:00 PM to 5:00 PM

* In the case of an emergency when the library is closed, patrons can ask hospital police to open up the library. The police officer will wait while the library material is copied.

** Patrons must have their ID to swipe into the library after 5:30 PM every weekday, and on the weekends.

Electronic journals and databases

House Staff has remote access to many databases and electronic journals through Mount Sinai's Library, Levy Library's (www.mssm.edu/library) with their username, which can be found at <http://develop1.mssm.edu/userlogin.epl>, and password (life number), which can be found at Mount Sinai's Human Resources at 4-4848. EHC's Library staff can be contacted for help in accessing this log-in information.

If an article is not available in full-text from Levy Library, House Staff can either request the article through ILLiad, Levy Library's electronic Interlibrary Loan system, or request an Interlibrary Loan through EHC's Library. Interlibrary loans for articles usually take a week; if the article is necessary for urgent patient care, please contact the library.

EHC's Library staff provides instruction in the use of the library and its resources, including Medline, PsycInfo, and Web of Science, in one-to-one or small-group settings.

Literature searching by EHC Library Staff

EHC's Library staff provides comprehensive literature searching for clinical, teaching, research, and presentation purposes for House Staff. The searches come complete with select relevant citations and full-text articles.

Borrowing Items

The library has many up-to-date handbooks, board reviews, textbooks, and other primarily clinically oriented texts, DVDs and VHS tapes to borrow. House Staff fill out a simple registration form when they initially borrow items, and only need their hospital ID for each subsequent borrowing.

House Staff can borrow a total of five items from the library, with a limit of three audiovisuals, DVDs or Clinics (a series of concise reviews on various topics). Books can be borrowed for two weeks, and can be renewed once for another two weeks; audiovisuals and Clinics can be borrowed for one week at a time.

If an item is not available in EHC's Library, House Staff can either request it through ILLiad, Levy Library's electronic Interlibrary Loan system, or through EHC's Library. House Staff are invited to suggest books and other items that the library should own; these recommendations are given serious consideration. Interlibrary loans for books take a minimum of ten days.

Photocopying and Printing

Free photocopying and printing for school- and hospital-related purposes, but staff may be asked to use their department copy machine and printer if the copying is not kept to a reasonable amount.

Other Amenities

- DVD Player and VCR
- Telephone
- Internet and Microsoft Office applications
- Computer to Access Patient Records
- Monthly book sales
- List of staff publications

Mount Sinai School of Medicine - Gustave L. and Janet W. Levy Library

The Gustave L. and Janet W. Levy Library is located on the 10th and 11th floors of the Annenberg Building. Enter through the passenger elevator lobby on the 11th floor of Annenberg. Mobility-impaired persons who

would like access to the 10th floor of the Levy Library may make arrangements with the Library Circulation staff at x212-241-7791.

The library accommodates more than 300 users at tables, carrels, and individual and group study rooms. Internet and e-mail access, computer applications such as Microsoft Office Suite and digitally formatted educational materials are available from over 75 computer workstations. In addition, wireless access and an abundance of laptop jacks are available throughout the Library.

Resources

The Levy Library offers access to over 3,000 online biomedical journal titles, 1,400 full-text electronic books, and 80 databases through its website. Mount Sinai Services House Staff may access most online resources from off-campus. House Staff at affiliated institutions should consult with the librarian at their home institution to learn more about the online and print resources available to them.

The Library also houses over 34,000 print books, over 900 current print journal titles, and approximately 1,000 audiovisual materials in the biomedical sciences. The Levy Library Catalog provides information about the availability and location of books, journals, audiovisual resources, and software. Mount Sinai Services House Staff may obtain materials not in the collection via ILLiad, the online interlibrary loan system. House Staff at affiliated institutions should consult with the librarian at their home institution to learn more about interlibrary loan services available to them. Visit the mssm.edu/library for extensive information on programs and services.

Hours

Monday–Thursday	8:00am–11:50pm
Friday	8:00am–7:50pm
Saturday	9:00am–7:50pm
Sunday	12:00pm–11:50pm

Media Resource Center

Monday–Thursday	9:00am–10:50pm
Friday	9:00am–7:50pm
Saturday	9:00am–4:50pm
Sunday	12:00pm–7:50pm

Further information about Library hours is available at x47791.

Circulation Policy and Library Cards

Circulation Policy: Circulation periods for various categories of materials vary by type of material. Materials may be renewed twice online, by telephone, or in person, provided they have not been requested by other Library patrons. A schedule of fines for overdue material is posted at the Circulation Desk.

Library Cards: House Staff may register to borrow Library materials at the Circulation Desk. A barcode will be affixed to your identification card, which must be presented to check out materials.

Printing, Photocopying, and Scanning

Library computers are networked to black-and-white printers. In addition, the Library offers one color printer and one poster printer. There are six photocopy machines (including one color copier). To operate most Library copiers and printers, patrons must purchase a reusable copy card for a one-dollar fee. The cost of copies must be added to the card; black-and-white copies are ten cents per page. Credit copy cards allow copies to be charged to departmental budgets, grants, or funds.

Reference and Instruction

Reference librarians provide support in literature searching and in identifying and using appropriate print and online journals, books, databases, and Internet resources. Reference services are provided from Monday through Friday, 9:00am–5:00pm, at the Reference Desk, by telephone (x47793), and via AOL's *Instant Messenger* service (Screen Name *mssmref*). E-mail reference is available through the "Ask a Librarian" at mssm.edu/library service.

Reference librarians offer a variety of classes on the use of the Library's databases and applications. Librarians also provide individual consultations, group training sessions, and Library tours and orientations upon request.

Media Resource Center

The Media Resource Center (MRC), located on the 10th floor of the Annenberg Building (access from the 11th Floor), contains educational materials in a variety of formats as well as computers, a high-speed scanner, and a flatbed scanner for general use. There is also a large-format printer that may be used for a fee to prepare posters (24" x 60"). An additional fourteen computers are located adjacent to the MRC in a classroom that is used to teach courses on accessing computer-based information.

Electronic Mail

Mount Sinai Services House Staff e-mail accounts are available through the Library. E-mail can be accessed from computers in the Library, from the hospital computers, or from home. Accounts are created in the MRC. A Mount Sinai Services House Staff e-mail list enables communication among the group.

House Staff at affiliated institutions may obtain Mount Sinai Services e-mail accounts by requesting them through the librarian at the home institution.

Archives

The Archives Division of the Library is charged with identifying, collecting, preserving, and making available the documentary evidence relating to Mount Sinai Services and its component parts. The collection includes paper records, oral histories, video recordings, photographs, artifacts, and memorabilia dating from 1852 to the present. If you have any questions about Mount Sinai Hospital's history or are in need of information or images for a project, please contact the Archives at x212-241-7239.

General Policies

Beverages in covered containers are permitted in the Library. Eating is strictly prohibited in the Library in order to preserve Library materials and maintain a pleasant, clean environment in which to work or study.

On-Call Rooms

On-call rooms are available for members of the House Staff whose Clinical Departments require them to be on call at night. Cooking or keeping food in on-call rooms is not permitted in compliance with fire and sanitation safeguards. Each House Staff member is expected to regard the House Staff on-call room as he/she would his/her own home and is to follow accepted rules of conduct. See your Department Administrator for additional information.

Telephone and Paging Systems

The Hospital has a public address page system and a dial access radio receiver system. Many physicians and other key hospital personnel can be reached by dialing 41908, then the pager ID, followed by the # sign. You will hear the current status of the person you are paging. If the person is available for paging, the system will ask you to enter your call back number.

Pagers are assigned to new House Staff by the departments during orientation. The number assigned is stamped on the case. If an incoming message is unclear, dial 41401, and the page operator will repeat the message.

Handle with Care: The pocket pager is a valuable instrument, costing approximately \$300.00, and requires careful handling to work properly. The best precaution against damage is to carry it clipped to a belt or inside pocket. The Hospital expects pagers to be guarded against carelessness and abuse. An individual will be held responsible for loss or damage through negligence. If the pager is lost or stolen the House Staff Officer must pay \$75.

Pager Coverage: There should not be a place within the confines of the Medical Center, including yard areas, where one cannot receive a page. But remember – **DO NOT PLACE THE PAGING UNIT ON OR NEAR METAL DESKS OR METAL EQUIPMENT;** this impedes reception.

Batteries are distributed in the telecommunication office.

Safety

Mount Sinai Services is committed to providing a safe environment for the people it serves: patients, staff, employees, students, and visitors. To meet these needs, the medical center has a comprehensive safety program consisting of:

- Safety Education and Training
- Employee Accident Management
- Hazardous Materials Management
- Emergency Preparedness
- Life Safety Management
- Equipment Management
- Utility Management

Certain departments, such as Chemical Safety, Radiation Safety, and Fire Safety, also deal with specific safety issues.

An interdisciplinary Center Safety Committee oversees the operations of the overall safety programs of the Medical Center.

Individual departments have specific safety policies and procedures that are available for reference and review.

If a House Staff Officer sees or is concerned about a safety problem, please call ext. 43434.

Security

Identification Cards

Mount Sinai Services/Elmhurst Hospital identification cards are issued during initial processing. Policy requires that identification cards be presented for access to the Mount Sinai Services/Elmhurst Hospital and that employees wear identification cards while on the premises.

Escorts

Security escorts are available within the Elmhurst Hospital Center as well as to parking lots and residences immediately adjacent to the Hospital. Please call Security at ext. 41945 ten minutes prior to departure to arrange for an escort.

Property Passes

Property and equipment removed from the Mount Sinai Services/Elmhurst Hospital must be accompanied by a property pass. Passes for personal or Hospital property can be obtained from the Hospital Police and should be signed by the appropriate Department Administrator.

Shuttle Service

Shuttle Service is available at no charge to House Staff on rotations to Elmhurst Hospital and Queens Hospital.

Parking

Parking is available for Mount Sinai staff on a monthly basis, at reasonable rates, in the Hospital-owned parking located on 78th Street and 41st Avenue. A parking application must be obtained at Support Services Office, Annex "O", 6th floor. Once the monthly fee is paid, a parking access card will be issued. An employee must have his/her car with him/her and present a driver's license, car registration, EHC ID, and proof of residence to the Parking Supervisor at the garage, who will issue an access card.

Mailroom

The Mailroom is located in the basement, BE-11. Hours of operation are 8:00 A.M. to 6:00 P.M., Monday through Friday. The Mailroom is responsible for handling outgoing, incoming, interoffice, and incoming express mail. It also handles certain incoming UPS packages. It does not pickup or deliver mail or packages. Mail is picked up by the U.S. Post Office daily at 10 A.M.

Other services include:

- Patient mail: Delivered to nursing stations in the late afternoon, Monday through Friday.
- Priority mail: Registered, certified or express mail is processed daily from 9:00 A.M. to 12:00 noon. Priority mail must be hand carried to the Mailroom for processing.
- Express couriers: Mount Sinai vendors for outgoing and incoming express service are Airborne Domestic, Airborne International, and UPS. The Mailroom only receives mail from Federal Express.

Mailing address should appear as follows:

House Staff Officer's Name

Clinical Service Department Name

Elmhurst Hospital Center

79-01 Broadway

Elmhurst, NY 11373

Personal mail, including magazines, should be mailed to your home address.

Uniforms and Laundry

Uniforms are furnished without charge at Mount Sinai Services/Elmhurst Hospital. Subject to certain exceptions, House Staff Officers may select any combination of lab coats, trousers/skirts, and shirts/blouses up to eight (8) pieces as long as no more than four (4) of any one item are chosen. Fellows and Anesthesia Residents receive up to four (4) lab coats only. Pediatric residents have the option of uniforms or not. First-year Psychiatry residents receive uniforms; however, other Psychiatry residents and fellows do not.

INTERNET RESOURCES

Residency Management Software

New Innovations Residency Management Suite (RMS) is a web-based software program that serves House Staff, program administration, and hospital administration. It is important for House Staff to review their demographic information as posted in the system for accuracy. The Residency Coordinator should be notified of any errors or changes. It is especially important to maintain a current e-mail address (a personal e-mail address is acceptable) because important information relevant to the residency or fellowship will be transmitted through this software. A logon/password for New Innovations RMS may be obtained from the Residency Coordinator.

While the Consortium for Graduate Medical Education is in the process of implementing this software in all residency programs, some programs have not yet implemented it. However, it is anticipated that all programs will be online by 2007.

The use of the various functions available in the New Innovations RMS will vary from program to program. The New Innovations RMS offers the following functions: demographic data, rotation schedule, event calendar, procedure log, duty hours log, viewing evaluations written on the House Staff Officer, and completing evaluations of faculty, rotations, and program.

Privileging Website

A “privilege” is the permission to perform a procedure without the supervision of an attending physician. Privileges are earned by accumulating the required number of repetitions of a procedure (which vary from procedure to procedure) under the supervision of an attending physician who will then evaluate competence.

Privileges that have been granted may be viewed on the [Resident and Fellows Privileges Granted Website](#), available to the clinical staff in any of the member hospitals in the Consortium. House Staff are encouraged to review their posted list of privileges from time to time with the assistance of their Residency Coordinator.

Job Placement Website

The Consortium for Graduate Medical Education’s Job Placement for Residents website has been developed to assist House Staff Officers completing their training in looking for career opportunities. Visit the [Job Placement for Residents](#) site for more information.

While specific information is requested concerning the identity of physicians or organizations posting positions, the accuracy of posts cannot be verified. It is incumbent on each House Staff Officer to carefully evaluate the postings and the descriptions of these positions.

Comments and suggestions for the website should be addressed to Monique Sylvester, GME Coordinator, at monique.sylvester@mssm.edu.

National Practitioner Data Bank

The National Practitioner Data Bank was created in accordance with federal law and serves as a national clearinghouse for information concerning physicians, dentists and other health care providers.

For House Staff, the Hospital must consider reporting to the Data Bank instances where the license to practice medicine or dentistry has been revoked or limited. Malpractice insurers including the Hospital (for its self-pay portion) must also report to the Data Bank any payments made on behalf of a House Staff Officer.

Hospitals are required to query the Data Bank when performing credentialing and privileging functions. This requirement does not generally apply to House Staff; however, if a House Staff Officer moonlights for the Hospital in another capacity (i.e., in the Emergency Room), the Data Bank is queried.

Under the law, a House Staff Officer may have access to his or her own Data Bank File. Requests for information should be directed through the [National Practitioner Data Bank website](#).

ACTIVITIES AND SERVICES

The Mount Sinai Alumni

The Mount Sinai Alumni, founded more than 100 years ago, is an organization comprised of graduates from the School of Medicine, the Graduate School of Biological Sciences, and physicians who completed training at The Mount Sinai Services Hospital and its affiliates.

The Mount Sinai Services Alumni is concerned with the present and future of the School and its affiliated hospitals, the quality of their education and research, and the quality of resident and student life. It is a vigorous organization devoted to fostering enduring relationships among its members, promoting the educational and charitable purposes of The Mount Sinai Medical Center, and recognizing medical excellence in clinical care and academic endeavors.

Programs supported by The Mount Sinai Alumni include:

- Each Saturday throughout the year, the Alumni hosts a communal Saturday Night Dinner for House Staff on call.
- A Career Planning Seminar is held each fall. Topics include financial, legal, and other important issues for House Staff as they begin their job search. Seminars are held at Mount Sinai Services and at an affiliated institution in New Jersey.
- Scholarships and debt relief assistance.
- Levy Library facilities, services and instructional programs.
- Alumni publications and website.
- Annual Alumni Reunion Week.
- Student and House Staff events, publications, and activities.
- Student and House Staff orientations and graduation celebrations.
- Alumni reunions.
- Expansion and renovation of Mount Sinai's teaching and research facilities.
- The Mount Sinai Alumni recognition, humanitarian, and service awards.

For more information, call (212) 241-6116 or 1-877-MSSM-EDU (toll-free), or e-mail at alumni@mssm.edu. Please also visit [The Mount Sinai Alumni website](#) for more information.

Employee Assistance Program

The Employee Assistance Program (EAP) is a free, short-term counseling and referral service available to employees and their families. An individual may consult with a member of the EAP counseling staff concerning such issues as family and marital difficulties, emotional problems, illness and stress, alcohol or drug abuse, financial or legal worries, and difficulties in getting along with co-workers.

If an employee appears to be having problems, a supervisor or physician may suggest calling the EAP at 212-241-8937. However, the service is strictly voluntary and confidential, and no reference will be made in personnel records. EAP is located at 19 East 98th Street, Room 3A.

Recreation

The Recreation and Consumer Services Office offers a wide range of services, such as discounted tickets for many Broadway and Off-Broadway shows, concerts at Lincoln Center and Carnegie Hall, dance programs, operas, children's entertainment, and family shows.

Many sports tickets are also available, including baseball, basketball, hockey, and tennis. Employees may also purchase tickets for movies, major amusement parks, ski resorts, comedy clubs, and attractions including the Bronx Zoo. Discounts are available on travel, car rentals, hotels, restaurants, buying clubs, invitations, and more. The office is open to all staff, students, volunteers, retirees, and patients and their families.

The Recreation Office is located at 19 East 98th Street, Room 1E, and can be reached at 212-241-6660. Days and hours of operation are Monday, Tuesday, and Friday, 12pm-5:15pm, and Wednesday and Thursday, 8:00am-9:00am.

For ticket information, please call the "future" tape at 212-241-7257 or the "current week" tape at x49531. You may access the Recreation Office via the Mount Sinai Services Intranet by selecting "Employee Services," then proceeding to "Organizational Development and Learning (ODL)."

Personal Check Cashing

Upon presentation of a Mount Sinai identification card, personal checks not exceeding \$50.00 may be cashed at the Main Cashier's Office (Guggenheim Pavilion, First Floor):

Monday–Friday	9:00am–3:00pm
Saturday–Sunday; Holidays	9:00am–12:30pm; 1:00pm–5:00pm

Third-party checks will not be cashed. A fee of \$10.00 will be charged for checks returned by the bank. A fee of \$1.00 will be charged for cashing personal checks. There is a limit of one check per day.

Medical Society of the State of New York

The Medical Society of the State of New York (MSSNY) has a Resident Physician Section offering a forum to address common concerns and a mechanism to bring them to the AMA, to Residency Review Committees, and to other appropriate agencies.

For more information about membership, visit the [MSSNY website](#) or call (516) 488-6100.

Mount Sinai Journal of Medicine

Established in 1934, the Mount Sinai Services Journal of Medicine is a peer-reviewed general medical journal indexed in Index Medicus, Current Contents, and other major sources. It has an international circulation and is published six times per year. Mount Sinai Services House Staff and medical students are encouraged to submit their original manuscripts to the *Journal* for publication. Throughout the training years, medical students and

House Staff automatically receive complimentary copies of the *Journal*. For further information, contact the Managing Editor at (212) 731-7790.

Section Three: Policies and Procedures

House Staff Titles

The Medical Board has adopted the following titles, definitions, and conditions applicable to House Staff positions in accredited residency programs or other type appointments made principally for educational purposes. The Accreditation Council for Graduate Medical Education (ACGME) considers all physicians in ACGME-approved programs to be residents.

Resident (PGY-1 through PGY-8)

Definition: Title assigned to qualified physicians or dentists accepted for enrollment in accredited residency training programs as part of the requirement to qualify for specialty certification from an American Specialty Board.

Condition: Appointments will be made at the appropriate postgraduate year (PGY) of training in a particular program. Salary (compensation) level will be as approved by the Compensation Committee.

Fellow

Definition: Title assigned to qualified physicians or dentists appointed for approved training in either ACGME-approved specialty programs or non-ACGME-approved programs that have received institutional approval.

Condition: Fellow appointments to ACGME-approved programs will have a salary level commensurate with their PGY. Fellow appointments to non-ACGME-approved positions will carry no fixed salary (compensation) level. A compensation rate for each appointment shall be established pursuant to funds available to the training program director and confirmed to the appointee in a letter/contract of appointment. Fringe benefits are available comparable to those provided House Staff Officers.

Contracts

- I. Each House Staff Officer shall, prior to his or her employment, receive a written contract which shall set forth Mount Sinai Services' commitment to the House Staff Officer and the House Staff Officer's responsibilities to the Hospital.
- II. House Staff Officers who have July 1 appointments will be notified by November 15 (December 15 for Internal Medicine and Anesthesiology) if their contracts are not to be renewed for the next year of a given residency program. This notification will include the reason(s) for non-renewal of the contract. Contract non-renewals are subject to the hearing rights specified below in "Section Four: Disciplinary Action: I-V."
- III. Contracts must be returned to the Medical Staff Office within two (2) weeks of the time a House Staff Officer receives the contract. Failure to return a contract will result in a suspension of privileges.

House Staff Evaluation

All House Staff are regularly evaluated by faculty and the program director. Formal feedback concerning a

House Staff Officer's performance by the program director occurs at periodic intervals that may vary with the specific program, but occurs no less than semiannually. The criteria for promotion will be provided on a departmental basis to all House Staff.

The program director or his or her designee will meet with each House Staff Officer at least twice a year to review his or her performance.

All House Staff are to be provided access to their evaluations upon request.

House Staff Officers must also have the ability to submit to their program director an anonymous written evaluation of both faculty and clinical rotations at least on an annual basis.

Interventions based on evaluations may include academic advisement or disciplinary action. An academic advisement (or academic alert) is undertaken when a House Staff Officer's academic performance does not meet departmental standards but is not sufficiently below standards to warrant disciplinary action. Disciplinary actions may include, but are not limited to, written warnings, probation, suspension, or termination. See "Disciplinary Action" below for more information.

Departments are encouraged to implement electronic evaluations in New Innovations RMS. House Staff may view evaluations of their performance and evaluate faculty, rotations, and the program on the New Innovations RMS site. New Innovations RMS also covers evaluations of procedures. House Staff may obtain their logon and password from the Residency Coordinator.

Note: Not all programs have implemented New Innovations RMS as of publication, but it is anticipated that all programs will be online by December 2007.

House Staff Representation

Medical Board and Executive Committee of the Medical Board

The Medical Board and the Executive Committee of the Medical Board include in their regular voting membership representatives of the House Staff. These representatives are elected at the Chief Residents Retreat.

House Staff Affairs Committee

When a request for a hearing has been made by a House Staff Officer, the President of the Medical Board shall appoint an *ad hoc* committee to serve as the House Staff Affairs Committee. The House Staff Affairs Committee shall consist of two members of the House Staff elected by the House Staff Chief Residents Forum, five members of the Medical Staff, and the President of the Medical Board. No one from the same department as the House Staff Officer requesting the hearing shall be appointed as a member of the Committee. The President of the Medical Board (or designee) shall serve as the Chair of the Committee.

Graduate Medical Education Committees

The Consortium for Graduate Medical Education (GME) has a coordinating GME Committee, which meets monthly, and subcommittees addressing House Staff recruitment, internal reviews and size of House Staff. House Staff representation exists on all committees, with some representatives elected annually at the Chief Residents Retreat. Other resident representatives, such as those in Internal Medicine and Pediatrics, are selected by peers in their residency programs. The GME Committee's objectives include enhancing the quality of education provided, addressing all issues pertaining to GME, and assessing the current and future distribution of House Staff and programs within the Consortium. Resident representatives are encouraged to bring any questions concerning GME to the Committee. In addition to the Consortium-wide GME Committee, individual institutions and departments may have their own committees addressing GME. These committees also encourage resident participation.

Departmental Committees

Each program has established a mechanism for House Staff Officers to exchange information concerning their education and work environment. If a satisfactory resolution cannot be obtained on a departmental level or a House Staff Officer wishes confidentiality, the issue should be brought to the Dean for Graduate Medical Education or discussed with the Internal Review Committee during its confidential meeting with House Staff Officers as part of the quality assurance process.

Privileging

The New York State Health Code (Section 405: The Bell Commission Report) contains several provisions that apply to postgraduate trainees in New York State. This includes a credentialing requirement for postgraduate trainees, stipulating that trainees may not perform treatments or procedures without direct visual supervision by an authorized physician until they have been granted authorization (i.e., "privileged") to perform these procedures under general supervision.

Each department has its own House Staff privileging process with a list of treatments and procedures that are specific to each PGY level. All House Staff Officers should know what procedures they are privileged to perform under general supervision and which procedures require direct visual supervision.

For more information, see "Privileging Website" in Section II.

Work Hours

Section 405 of the New York State Health Code also establishes guidelines for working hours of House Staff Officers.

In addition, effective July 1, 2003, the Accreditation Council for Graduate Medical Education (ACGME) approved similar standards relative to supervision, on-call activities, and moonlighting.

Postgraduate trainees may not have work schedules that exceed 80 hours per week, averaged over a four-week period, inclusive of all work activities. However, on an individual basis a program may apply to the appropriate Residency Review Committee (RRC) for a 10 percent exception to the 80-hour limit based on a sound educational rationale, and only with prior approval from the Graduate Medical Education Committee.

Postgraduate trainees may not be scheduled to work more than 24 consecutive hours and must have at least one 24-hour period of nonworking time each week as well as at least ten hours between all daily duty periods, and after in-house call; postgraduate trainees must not be assigned in-house call more frequently than every third night, averaged over a four-week period. Work in the Emergency Room is limited to no more than 12 consecutive hours per assignment.

All 7,800 residency programs in the United States must comply with the ACGME's Duty Hours Standards, which limit House Staff duty hours to a maximum of 80 hours a week and set other restrictions. These standards, which apply to House Staff in all specialties, are meant to balance the needs of patient care, resident well-being, and academic and clinical education. Programs that fail to comply with the new standards will face adverse accreditation action, including loss of accreditation.

The ACGME monitors compliance with work hours standards through multiple methods, including confidential resident surveys; interviews with program directors, staff, and residents during accreditation site visits; and ACGME Monitoring Committee assessment of the performance of Residency Review Committees for all specialties in applying and enforcing the accreditation standards. The ACGME communicates with all residents in accredited programs, informing them that it takes the new standards seriously and plans on rigorous monitoring and enforcement. RRCs will keep resident complaints about duty hours violations, like all resident complaints, confidential. Programs that violate duty hours standards must correct the problem within 8 to 12 weeks, and ACGME field staff will conduct follow-up site visits to some of those programs to ensure compliance.

“Moonlighting”

House Staff Officers are never required to engage in moonlighting activities. Should House Staff Officers wish to engage in such activities, they must notify their respective Directors of their intent to work additional hours as physicians providing professional patient care services, and they must have a New York State license. Regulations on maximum work hours have been set forth in Section 405.4 of the New York State Health Code and the ACGME Duty Hours Standards. The time spent on moonlighting activities must be counted toward the limits imposed by these standards. The House Staff Officers have the sole responsibility of guaranteeing that they are in compliance with these hours. For more information regarding Section 405.4 of the New York State Health Code, see the above section, “Work Hours.”

Mount Sinai Services/Elmhurst Hospital House Staff may not moonlight if the work entails care for inpatients at Mount Sinai Hospital. They may moonlight in an outpatient department or in the Emergency Department at Mount Sinai Hospital if i) they complete a moonlighting agreement; ii) they are appropriately credentialed via the medical staff office; and iii) they have approval from their program director to moonlight.

House staff may also moonlight at another institution if i) they receive approval from the Director of Services; ii) they are credentialed at the other institution; and iii) they have their own malpractice insurance coverage that covers them at the institution where they will moonlight.

It is the obligation of the House Staff Officer seeking dual employment to gain written permission from his or her Director. A copy of the Director’s letter of permission must be placed in the House Staff Officer’s file. It is at the discretion of the individual Director to place further constraints on “moonlighting” for House Staff Officers as s/he deems appropriate. In addition, the House Staff Officer’s performance in the residency will be monitored to determine the effects of these extra hours. Any adverse effects on performance of duties as a House Staff Officer may result in a withdrawal of permission to moonlight.

Disciplinary Action

- I. *Disciplinary Action:* The Chief of Service, the Program Director, or the Medical Director may take disciplinary action, including termination for cause, against any House Staff Officer who:
 - A. Fails to demonstrate an acceptable level of professional competence, clinical judgment in the treatment of patients, or professionalism.
 - B. Commits an act that constitutes professional misconduct under the New York State Education Law or a breach of professional ethics.
 - C. Fails to abide by the By-laws, Rules and Regulations, or policies of the Hospital or the Medical Staff.
 - D. Engages in any activities that are a threat to the welfare or safety of patients, employees, other physicians, or the Hospital. The Chief of Service or Hospital Director shall send the House Staff Officer written notice of the disciplinary action together with a statement of the reasons therefore. If no request for a hearing is made by the House Staff Officer pursuant to Section II below, the

disciplinary action shall become effective and final.

- II. *Notice:* Notice of disciplinary action shall be in writing and shall include the action taken and the basis therefore.
- III. *Right to a Hearing:* Any House Staff Officer who has received notice of proposed disciplinary action may request, in writing, a hearing before the House Staff Affairs Committee of the Medical Board within ten days from receipt of such notice. Requests should be directed to the President of the Medical Board in care of the House Staff Office at Room A1-27C. Should you have any questions, call x42127. The non-renewal of a contract is subject to a hearing by the House Staff Affairs Committee of the Medical Board.
- IV. *Hearing*
 - A. The House Staff Affairs Committee shall hold a hearing no sooner than 15, and no later than 45 days, from the date the written request for the hearing is received. The House Staff Officer shall be entitled to be present at the hearing, to present relevant evidence and witnesses on his or her behalf, and to question witnesses appearing in support of the charges made.

The scope of the hearing shall be limited to determining whether there is sufficient evidence to demonstrate that the adverse action taken by the Department was not arbitrary and capricious. All testimony at the hearing shall be under oath, and a transcript of the hearing shall be made. The rules of evidence shall not apply, and the decision shall be based on a preponderance of the evidence.

At the hearing, the staff member or applicant may be represented by an attorney or other person of his or her choice. The role of this representative or department's attorney shall be limited to: (1) providing advice and counsel to the Staff Member or applicant; and (2) addressing the members of the Hearing Committee. The role of the representative shall not include the presentation of evidence or the examination or cross-examination of witnesses. The Hearing Committee may, in its discretion, further define, expand or limit the role of any such representative.

A majority of members of the House Staff Affairs Committee shall constitute a quorum. The House Staff Affairs Committee shall make such additional rules as it deems necessary to assure prompt, fair, and expeditious handling of the matter. The House Staff Affairs Committee may take whatever action, consistent with Hospital policy, it considers appropriate.

- B. Within 30 days of the conclusion of the hearing, the House Staff Affairs Committee shall make a written report of its findings and decision to the Director of the Hospital, the Chief of Service and the House Staff Officer.
- V. *Appeal:* The decision of the House Staff Affairs Committee may be appealed by the House Staff Officer, the Chief of Service or Hospital Director to the Executive Committee of the Medical Board within 15 days of receipt of notice of the decision of the House Staff Affairs Committee. If no request for an appeal is made, the decision of the House Staff Affairs Committee shall be final. The appeal shall be limited to the record of the proceedings before the House Staff Affairs Committee, and the scope of review shall be limited to determining whether there is a reasonable basis on which to support

the findings and conclusions of the House Staff Affairs Committee. Within 30 days after the conclusion of the appeal, the Executive Committee shall send notice of its decision to the House Staff Officer, the Chief of Service, and the Hospital Director. The decision of the Executive Committee shall be final.

- VI. *Summary Suspension:* A House Staff Officer may be summarily suspended from his or her duties and responsibilities without a hearing where his or her continued presence is deemed a risk to the Hospital or its patients. Following such action either by the Chief of Service or by the Hospital Director with the concurrence of the Chief of Service, the House Staff Officer shall have the right to an immediate appeal to the House Staff Affairs Committee. A summary suspension of a House Staff Officer pending termination shall be a suspension without pay. If the House Staff Officer requests a hearing before the House Staff Affairs Committee, and is subsequently reinstated, he or she may be entitled to full or limited back pay at the discretion of the House Staff Affairs Committee.

Professional Misconduct

New York State law defines the parameters of misconduct. The following is a summary of the most significant types of professional misconduct that must be reported. The complete text of this act can be found in Article 131-A (Definitions of Professional Misconduct Applicable to Physicians, Physician Assistants, and Specialist Assistants) of New York State Law.

- Obtaining the license fraudulently
- Practicing the profession fraudulently or beyond its authorized scope
- Practicing the profession with negligence on more than one occasion
- Practicing the profession with gross negligence on a particular occasion
- Practicing the profession with incompetence on more than one occasion
- Practicing the profession with gross incompetence
- Practicing the profession while impaired by alcohol, drugs, physical disability or mental disability
- Being a habitual abuser of alcohol, or being dependent on or a habitual user of narcotics, barbiturates, amphetamines, hallucinogens, or other drugs having similar effects, except for a licensee who is maintained on an approved therapeutic regimen which does not impair the ability to practice, or having a psychiatric condition which impairs the licensee's ability to practice
- Being convicted of committing an act constituting a crime
- Being found guilty of improper professional practice or professional misconduct by a duly authorized professional disciplinary agency of another state where the conduct upon which the finding was made would, if committed in New York State, constitute professional misconduct under New York State law
- Accepting and performing professional responsibilities that the practitioner knows s/he is not competent to perform
- Delegating professional responsibilities to a person when the practitioner knows or has reason to know such person is not qualified to perform them
- Performing professional services that have not been duly authorized by the patient or his or her representative
- Altering or falsifying medical records in such a way that needed information for patient care is omitted or falsified
- Fee splitting

In addition to the requirement that a physician be reported for conduct described above, any licensed health care professional and any physician in training must be reported if the following should occur:

- I. The suspension, restriction, termination, or curtailment of the training, employment, association, or professional privileges of a licensed health care practitioner, or medical resident, related in any way to:
 - A. alleged mental or physical impairment;
 - B. incompetence;
 - C. malpractice;
 - D. misconduct; or
 - E. impairment of patient welfare.
- II. The denial of certification or completion of training of any individual for reasons related in any way to I.A-E above.
- III. The voluntary or involuntary resignation or withdrawal of association, or of privileges, to avoid the imposition of disciplinary measures.
- IV. The receipt of information that indicates that any licensed health care professional or medical resident has been convicted of a crime.
- V. The denial of staff privileges to a physician if the reasons for such denial are related to I.A-E above.

Job Retention

- I. A House Staff Officer may be terminated from his or her residency program for failure to abide by the By-laws, Rules, and Regulations, or policies of the Medical Center or of the medical staff; for falsification of any Medical Center document; for any activity that may threaten the safety or welfare of a patient, employee, or other physician; or for any action that may be detrimental to Medical Center operations.

As stated above in "Disciplinary Action," a House Staff Officer may be disciplined up to, and including, termination of his or her residency program for failure to abide by the House Staff Manual, By-Laws, Rules and Regulations, or policies of the Medical Center; for falsification of any medical center document; any conduct that may threaten the safety or welfare of a patient, employee, other physician, or visitor; or any other conduct that maybe detrimental to medical center operations.

- II. Mount Sinai Services will notify each affected House Staff Officer immediately:
 - A. Of a decision to discontinue any training program for any reason; and/or

- B. Upon receipt from the Accreditation Council for Graduate Medical Education or the American Dental Association of any notification regarding non-accreditation or probationary status of any training program.

Program Closure or Reduction

If a decision is made to significantly reduce the size of a residency program or to close a specific program, the House Staff Officers will be informed in writing of this decision as soon as possible. In such a case, institutions will allow House Staff Officers already in the program to complete their education when possible or will assist the House Staff Officers in enrolling in ACGME-accredited programs either within the Consortium or at other institutions.

Certificates

A certificate will be granted to each House Staff Officer upon satisfactory completion of the training program. Certificates may not be ready on the date the House Staff Officer completes his or her training. Therefore, the House Staff Officer must be sure to provide his or her Department Administrator with a forwarding address. A certificate cannot be issued until the House Staff Officer has completed his or her medical records, returned any borrowed books to the Levy Library, completed the checkout procedure at the termination of his or her appointment, and fulfilled all Medical Board requirements.

Drug-Free Workplace

The Drug-Free Workplace Act of 1988 requires Mount Sinai Services, as a federal grant recipient and contractor, to certify that it will provide a drug-free workplace. To accomplish this, each employee engaged in a federal grant or contract is provided with the Medical Center's Drug-Free Workplace Policy and Statement and is expected to be familiar with its contents.

As a condition of employment under such a grant or contract, employees will abide by the terms of this Statement, and notify the Vice President of Human Resources and Labor Relations or his or her designee of any criminal drug statute conviction for a violation occurring in the workplace no later than five (5) days after such conviction.

In addition, the health screening program for all new employees, incoming residents, and medical students includes urine toxicology testing (see "Toxicology Screening" in Section II of this Manual). This policy includes all House Staff rotating from other institutions.

A Drug-Free Awareness Program has been established to inform all employees about the dangers of drug abuse in the workplace; the Medical Center's policy of maintaining a drug-free workplace; the available drug counseling, rehabilitation, and employee assistance programs; and the potential penalties for drug-abuse violations.

Although the adverse effects of the excessive use of alcohol and the use of nicotine and other mood-altering substances are well described as part of the School of Medicine curriculum, see Table 1 for a summary of the effects of the commonly abused drugs.

Statement to Employees

The following statement describes Mount Sinai Services/Elmhurst Hospital policy regarding substance abuse for all employees, including faculty, House Staff, and bargaining and non-bargaining unit employees:

Mount Sinai Services/Elmhurst Hospital has a significant interest in ensuring that the work environment is free from the hazards to patients, employees, and visitors that are created due to the unauthorized use of alcohol, drugs, or controlled substances.

The illegal sale, manufacture, distribution, or unauthorized use or possession of drugs or controlled substances by employees on Mount Sinai Services/Elmhurst Hospital premises, or in the course of Mount Sinai Services/Elmhurst Hospital business, are prohibited and may be grounds for immediate dismissal.

Mount Sinai Services/Elmhurst Hospital may, at its discretion, take any other appropriate disciplinary action short of termination against employees who have violated the above rules.

Physicians Wellness Committee

The Physicians Wellness Committee addresses the need to identify, treat, and monitor physicians who are mentally impaired, are substance abusers, or have physical handicaps that impede their ability to carry out their patient care responsibilities. For further information, contact the Director of Risk Management at (212) 241-5853.

Table 1. Common Drugs and Symptoms of Abuse

Drug/Group	Drug Name	Street Names*	Method of Use	Signs and Symptoms	Hazards of Use
Marijuana Hashish	Tetrahydrocannabinol (THC)	Pot, Grass, Reefer, Pasto, Weed, Colombian, Hash, Hash Oil, Sinsemilla, Joint, Chiba, Herb, Spliff, Smoke	Most often smoked; can also be swallowed in solid form.	Sweet burnt odor, red eyes, lethargy, lack of coordination. Chronic heavy use may lead to loss of interest and motivation, possible weight change.	Impaired memory perception, interference with psychological maturation. Possible damage to lungs, heart, reproductive and immune systems. Psychological dependence.
Stimulants Includes look-alike drugs that contain caffeine, phenylpropanolamine (PBA) and ephedrine.	Amphetamine Dextroamphetamine, Methamphetamine, Biphentamine	Speed, Uppers, Pep Pills, Bennies, Ice, Dexies, Moth, Crank, Crystal, Black Beauties	Smoked or swallowed in pill or capsule form; also injected.	Excess activity, irritability, restlessness, nervousness and mood swings. Dilated pupils.	Loss of appetite, weight loss. Hallucinations; paranoia.
	Nicotine	Coffin Nail, Butt, Smoke, Cigarettes, Cigars, Chew, Snuff	Smoked, inhaled or chewed.	Smell of tobacco, stained teeth and yellow fingers. High carbon monoxide levels.	Cancers of the lung, throat, mouth, esophagus. Heart disease, emphysema.
	Cocaine	Coke, Snow, Toot, White Lady, Blow Rock, Crack, Girl, Uptown, Perico	Most often smoked or inhaled; also injected in powder, pill or rock form.	Restlessness, irritability, anxiety, talkativeness. Dilated pupils, sniffing. Intense, short-term high followed by depression. Hallucination and paranoia with prolonged use.	Intense psychological dependency; sleeplessness; anxiety; nasal passage damage; lung damage; liver toxicity, cardiovascular effects and death from overdose.
Alcohol Sedatives Hypnotics	Benzodiazepines: Valium, Xanax, Halicion	Tranks, Sleepers, Vs, or Veas	Swallowed in pill form or injected.	Drowsiness, confusion, impaired judgment, slurred speech, needle marks, constricted pupils.	Infection, addiction with severe withdrawal symptoms, loss of appetite, nausea, death from overdose.
	Barbiturates: Pentobarbital, Secobarbital, Amobarbital	Barbs, Goof Balls, Downers, Yellow Jackets, Nembies, Red Devils, Blue Devils	Swallowed in pill form or injected.	Impaired judgment and performance; also drowsiness, slurred speech.	Death from overdose, injury or car accident; synergistic effects with alcohol.
	Alcohol: Includes Beer, Wine, Wine Coolers, Distilled Spirits	Booze, Hooch, Juice, Brew, Taste, Sauce	Swallowed in liquid form.	Impaired muscle coordination and judgment. Slurred speech. Blackouts.	Heart and liver damage with prolonged excessive use. Death from overdose, accidents. Addiction.

Table 1. Common Drugs and Symptoms of Abuse (*cont'd.*)

Drug/Group	Drug Name	Street Names*	Method of Use	Signs and Symptoms	Hazards of Use
Narcotics (Opioids)	Dilaudid, Percodan, Demerol, Methadone, Vicodin, Percocet, Darvocet		Swallowed in pill or liquid form, injected.	Drowsiness, lethargy. Constricted pupils, slurred speech.	Addiction with withdrawal symptoms. Loss of appetite, death from overdose.
	Agonists	Codeine	School boy, Licorice	Swallowed in pill or liquid form.	
	Morphine, Heroin	Dope, Smack, Boy, Scug	Injected, smoked or snorted.		
Antagonists	Buprenex, Butorphanol, Buprenorphine, Nalpuhine, Pentazocine		Injected.	Similar to agonists.	Similar to agonists. Can precipitate withdrawal if person is already on an agonist.
Hallucinogens	PCP (Phencyclidine)	Angel Dust, Killer Hog, Weed, Super-grass, PeaCeePill	Most often smoked, can also be inhaled (snorted) injected or swallowed in tablets.	Slurred speech, blurred vision, incoordination. Confusion, agitation, aggression.	Anxiety, depression, impaired memory and perception. Uncontrolled aggression. Death from accidents or overdose.
Inhalants	Gasoline, Airplane Glue, Paint Thinner, Dry Cleaner Fluid		Inhaled or sniffed, often with use of paper or plastic bag or rag.	Poor motor coordination, impaired vision, memory and thought.	High risk of sudden death. Drastic weight loss. Brain, liver and bone marrow damage.
	Nitrous Oxide	Laughing Gas, Whippets	Inhaled or sniffed by mask or balloons.	Slowed thought, headache.	Death by anoxia. Neuropathy, muscle weakness.
	Amyl Nitrite, Butyl Nitrite	Poppers, Snappers, Rush, Locker Room	Inhaled or sniffed from gauze or ampules.	Abusive violent behavior, lightheadedness.	Anemia, death by anoxia.
May vary from one geographic location to another. Adapted from "F.Y.I.: Common Drugs/Symptoms of Abuse," distributed by New York State Office of Alcoholism and Substance Abuse Services.					

Harassment

Harassment has become an increasingly prominent national concern in the workplace and in academic institutions. The School of Medicine regards any behavior that is harassing, discriminatory, or abusive as a violation of the standards of conduct required of all persons associated with the academic mission of the institution. An ideal of U.S. medical, graduate, and postgraduate education is to create an environment that

nurtures respect and collegiality between educator and student. In the teacher-student relationship, each party has certain legitimate expectations of the other. For example, the student can expect that the teacher will provide instruction, guidance, inspiration, and leadership in learning. The teacher expects the student to make an appropriate professional investment of energy and intellect to acquire the knowledge and skills necessary to become an effective physician or scientist. The social relationships required in the achievement of this academic ideal—mentor, peer, professional, staff—require the active trust of partnership, not the dependence of authoritarian dominance and submission.

The School of Medicine is responsible for providing a work and academic environment free of sexual and other forms of harassment. The institution may pursue any complaint of harassment known to it in order to achieve this goal. The Harassment Grievance Board was established in 1992 to serve as an educational resource to the School of Medicine community on issues relevant to harassment and to address complaints of sexual harassment and other forms of harassment and abuse as defined below. Complaints about implementation of school policies concerning appointment, promotion, and distribution of resources, including notification requirements associated with these policies, will not be addressed by this Grievance Board unless they involve, in addition to those complaints, an allegation of harassment or abuse as defined below. The responsibility of the Board in handling complaints of harassment and abuse extends to complaints brought by any faculty member, medical or graduate student, House Staff, or postdoctoral fellow against any other such member of the school community, concurrent with Human Resources involvement. Complaints by and against other employees of the School of Medicine will be handled by other appropriate existing grievance mechanisms (i.e., Human Resources). The operation of this Grievance Board can occur, at the Board's discretion, in addition to or concurrently with any other action an individual may take to exercise his or her rights both within and outside the institution.

The Board will attempt, whenever possible, to emphasize mediation and conciliation. It will rely on discreet inquiry and trust in dealing with complaints that are brought for its consideration. Confidentiality will be maintained to the maximum extent possible consistent with the need to investigate complaints and with the requirements of the law. Full cooperation with the Grievance Board is expected of all members of the community.

To ensure an environment in which education, work, research, and discussion are not corrupted by abuse, discrimination, and harassment, the following statement has been created to educate members of the academic community about the internal mechanism for the receipt, consideration, and resolution of complaints of such alleged acts.

Definition of Unacceptable Behavior

Certain behaviors are inherently destructive to the relationships that are required in a community organized to provide medical education. Behaviors such as violence, sexual and other harassment, abuses of power, and discrimination (based on race, color, religion, national origin, gender, sexual orientation, veteran status, age, disability, citizenship, marital status, genetic predisposition, or any other characteristic protected by law) will not be tolerated.

- I. *Sexual Harassment* is defined as unwelcome sexual advances, requests for sexual favors, and/or other verbal or physical conduct of a sexual nature when:

- A. Submission to such conduct is made either explicitly or implicitly as a term or condition of an individual's employment or academic success.
- B. Submission to or rejection of such conduct by an individual is used as a basis for employment or academic decisions affecting such an individual.
- C. Such conduct has the purpose or effect of unreasonably interfering with an individual's work or academic performance or creating an intimidating, hostile, or offensive work or academic environment. Sexual harassment is a violation of institutional policy and of City, State, and federal laws. Sexual harassment need not be intentional to violate this policy.

Examples of sexual harassment include, but are not limited to:

1. sexual assault.
2. inappropriate sexual advances, propositions, or demands.
3. unwelcome physical contact.
4. inappropriate persistent public statements or displays of sexually explicit or offensive material which is not legitimately related to employment duties, course content, or research.
5. threats or insinuations, which lead the victim to believe that acceptance or refusal of sexual favors will affect his or her reputation, education, employment, or advancement.
6. derogatory comments relating to gender or sexual orientation.

In general, though not always, sexual harassment occurs in circumstances where the harasser has some form of power or authority over the life of the harassed. As such, sexual harassment does not fall within the range of personal private relationships. Although a variety of consensual sexual relationships are possible between medical supervisors and trainees, such relationships raise ethical concerns because of inherent inequalities in the status and power that supervisors wield in relation to trainees. Despite the consensual nature of the relationship, the potential for sexual exploitation exists. Even if no professional relationship currently exists between a supervisor and a trainee, the future possibility that the supervisor may unexpectedly assume a position of responsibility for the trainee must be considered.

- II. *Discrimination* is defined as actions on the part of an individual, group or institution that treats another individual or group differently because of race, color, national origin, gender, sexual orientation, religion, veteran status, age, disability, citizenship, marital status, genetic predisposition or any other characteristic protected by law. Discrimination or harassment on the basis of these characteristics violates federal, state, and city laws and is prohibited and covered by this policy.
- III. *Abuse* is defined, for purposes of this policy, as behavior that is viewed by society and by the academic community as exploitative or punishing without appropriate cause. It is particularly objectionable

when it involves the abuse of authority.

Examples of behavior which may be abusive include, but are not limited to:

1. habitual conduct or speech that creates an intimidating, demeaning, degrading, hostile, or otherwise seriously offensive working or educational environment.
2. physical punishment.
3. repeated episodes of verbal punishment (e.g. public humiliation, threats, and intimidation).
4. removal of privileges without appropriate cause.
5. grading or evaluations used to punish rather than to evaluate objective performance.
6. assigning tasks solely for punishment rather than educational purposes.
7. repeated demands to perform personal services outside job description.
8. intentional neglect or intentional lack of communication.
9. requirements of individuals to perform unpleasant tasks that are entirely irrelevant to their education and employment that others are not also asked to perform.

Constructive criticism, as part of the learning process, does not constitute harassment. To be most effective, negative feedback should be delivered in a private setting that fosters free discussion and behavioral change.

Harassment Grievance Board

- I. *Purview:* The Harassment Grievance Board is charged with addressing any complaint of harassment or abuse brought by any member of the faculty, medical or graduate student, House Staff Officer, or postdoctoral research fellow against any other such member of the school community.
- II. *Composition of the Board:* The Board will consist of 20 members. Among these will be two with counseling experience, two medical students, two graduate students, two House Staff, two faculty with administrative appointments, and two research postdoctoral fellows. Faculty members of the Board will be representative of both basic science and clinical, junior and senior faculty. Every effort will be made to have the Board reflect the full diversity of the medical school population. The Chairperson shall be a faculty member with experience in counseling who does not have an administrative appointment. All members of the Board, including the Chairperson, will be appointed by the Dean after consultation with relevant groups in the School. Faculty will serve staggered three-year renewable terms; students, postdoctoral fellows, and House Officers will serve renewable one-year terms.

Protection from Retaliation

All individuals involved in registering a complaint, serving as representatives for the complainant or respondent, as witnesses, or on the Board will be free from any and all retaliation or reprisal of threats thereof. This principle applies with equal force after a complaint has been adjudicated. Upon submission of a complaint or threat of retaliation, the Board will review the facts and recommend appropriate action.

Reevaluation of Procedures

The Board will review the grievance procedures periodically. Proposed changes, approved by a majority of the Board, must be reviewed and approved by the Office of the General Counsel before being implemented.

Conflicts of Interest and Related Matters

The purpose of the Policy on Conflicts of Interest and Related Matters is to ensure that all institutional decisions are made solely to promote the best interests of Mount Sinai Services and its patients without favor or preference based on personal considerations, and to provide for the highest ethical conduct with respect to the actions and business relationships of all trustees, House Staff, employees, and voluntary staff. All House Staff must review these policies and disclose any potential conflicts as provided by the policies. House Staff should also review the Mount Sinai Services Code of Conduct and Business Ethics, which details guidelines for relationships with vendors (e.g., pharmaceutical companies). Violations of the Code of Conduct and Business Ethics can be reported confidentially by calling the Mount Sinai Services Compliance Hotline at (800) 853-9212. Copies of the publications are available through the Office of Corporate Compliance.

Intellectual Property: Ownership and Commercial Development

All employees of Mount Sinai Services, including members of the faculty and House Staff, are required to abide by institutional policies on Intellectual Property: Ownership and Commercial Development.

Dress Code

It is incumbent upon the medical community to set standards of professionalism, of which manner of dress is one tangible component. As such, the Medical Board has addressed this issue and has voted to adopt the dress code outlined below. It is intended to provide a standard to follow while acting in the capacity of House Staff Officer and representative of the Hospital.

Men:

- Dress shirt and tie
- Trousers (no blue or faded jeans)
- White pants (provided)
- White coat (provided)
- Clean, white sneakers are acceptable (no open-toed shoes)

- No “greens” or booties beyond sterile environment unless properly covered
- Identification badges are to be worn at all times while on Medical Center premises

Women:

- Dresses, skirts, blouses, slacks (no blue or faded jeans)
- White skirt or pants (provided)
- White coat (provided)
- Clean, white sneakers are acceptable (no open-toed shoes)
- No “greens” or booties beyond sterile environment unless properly covered
- ID badges are to be worn at all times while on Medical Center premises

A white coat is optional for Pediatrics and Psychiatry House Staff.

Protective attire, including scrub suits, must not be worn beyond restricted areas. Gowns used as covering must be tied securely in back. Long lab coats used as a cover-up must be buttoned. *At no times are scrub suits to be worn outside Elmhurst Hospital Center.*

Press Relations

House Staff should refer all media inquiries directly to External Affairs ext. 45919.

No news media or promotional audio or video recording, filming, or still photography may be conducted within EHC without authorization and advance arrangement through Public Affairs, which will advise Security of all such arrangements. Since EHC procedures provide that Security will prevent any photographer or camera crew arriving unexpectedly from entering EHC, Public Affairs should be advised in advance whenever an outside camera crew or photographer will be coming to the campus for any purpose. Please refer to the following link, [MEDREC18.PDF](#)

Section Four: Patient Care

PATIENT CARE GUIDELINES

Admissions and Discharges

Patient Access Services

Patient Access Services is a 24/7, 365-day operation where all emergency, inter-hospital transfers, intra-hospital transfers, PACU, and direct admissions are processed for bed procurement.

Central bed listing is located in the admitting department, B1-10 (Main Building). In house bed management is centralized, excluding Psychiatry and Obstetrics services.

The admitting department consists of central bed listing, patient information, elective admission, scheduling personnel and hospital care investigators from the patient accounts department. Please refer to the following link, [ADM04.PDF](#)

Utilization Review Guidelines

Admission and Continued Stay: Federal and State regulations require hospitals to have Utilization Review (UR) programs to qualify for reimbursement for medical care rendered during hospitalization. Documentation in the patient's record is reviewed concurrently by a Hospital case manager for medical justification of admission and continued stay. Review includes the completeness of notes, legibility, and the presence of signatures with code, date, and time of note.

When the medical justification is not evident through chart review, the case manager will refer the case to a Physician Advisor (PA) for a decision. The PA may contact a House Staff Officer when there is a question regarding care. Adverse determinations rendered as a result of this activity can result in loss of reimbursement to the Hospital, if reviewed by a third-party payer.

The Peer Review Organization (PRO), Island Peer Review Organization (IPRO), Blue Cross agencies, and commercial insurance providers conduct retrospective and current review of records to determine medical necessity of admission and continued hospital stay. Adverse determinations from these reviews will result in fiscal penalties to the Hospital. The physician may be asked to assist in appeals to these denials.

House Staff Role in Length of Stay

Elmhurst Hospital recognizes the importance of managing the length of stay (LOS) of patients admitted to the inpatient service. Not only does reducing the LOS increase the efficiency of medical care and improve the quality of care provided, it also assures revenue availability to the Hospital for program development. Throughout the Hospital, mechanisms are in place to reduce LOS. All Hospital personnel must be cognizant of this pressing issue. Case managers and social workers are actively involved in discharge planning and are routinely available on the patient floors for consultation with the medical staff. House Staff are encouraged to interact with these individuals and, wherever possible, bring to administration's attention any areas where intervention could play a part in reducing LOS.

Discharge Planning

Discharge Planning as an integral component of all patient care is mandated by Federal and State regulations, and is an essential element of Case Management. Optimally, such planning is begun at the time of admission, with the goal of enabling the patient to complete his/her care in the hospital and to return home or to transfer to another facility with arrangements for the continuing care he/she may require.

It is the responsibility of the patient care team to work together to establish a target LOS for the patient, and to work with the patient/ family to establish an appropriate discharge plan working toward this goal.

The physician is responsible for thinking about the discharge plan and probable date of discharge as soon as the patient is admitted, and for communicating alterations in that plan and date to other health care team members. He/she is also responsible for the final discharge determination and writing of the discharge orders. It is essential that physicians communicate with other team members regarding the patient's needs and readiness for discharge.

The Department of Social Work Services is responsible for coordinating discharge planning for patients having complex needs for post-hospital care. To identify such patients, social workers employ a high-risk screening program when patients are admitted as well as collaborate with other health professionals during patient hospital stays.

Early referral by physicians of patients with complicated psychosocial or health care needs is a further impetus to early initiation of planning efforts. Current application procedures and eligibility criteria for all services, whether institutional or home-based, are quite complicated. The social work staff members will explain these to the physician as they affect individual situations and will expect cooperation in completing necessary applications and summaries.

Temporary Departure from the Hospital

A patient may leave the Hospital temporarily only upon the written order of a physician on the staff in emergency situations, and/or for purposes of a court hearing, and/or for therapeutic indications in psychiatry.

1. The nurse must sign the Pass Form (Form A-1-A-10 5M 11/78 ABG) and note the date/hour of departure. The form is placed in the patient's record. *NOTE: This data must be accurately recorded for insurance/ reimbursement purposes.*
2. When considering passes for patients, bear in mind that third-party payers may not cover the cost of pass days. Inform the patient that such costs must and will be passed on to the patient, if not absorbed by third-party payers.
3. Depending on the patient's insurance coverage, the following will apply:
 - A. Psychiatric patients:
 1. Medicaid
 - a. Psychiatric patients who are covered by Medicaid must be in the hospital for 15 consecutive days before a pass is issued.
 - b. Therapeutic passes (limited to 2 days per pass) are honored and are limited to 18 days for any 12 month period.
 - c. Therapeutic need and the goal of the leave must be a part of the patient's medical record pursuant to the physician's treatment plan.
 - d. Therapeutic passes must be cleared through the Psychiatry Administrative Office.
 2. Commercial insurance plans, including Blue Cross and Medicare
 1. Rules and regulations, as outlined for medical/surgical patients (section B, 1-4), pertain.

B. Medical/Surgical patients:

1. Pass days are discouraged and should be used only in an emergency (e.g., death in the family) or for presence at a court hearing to determine patient capacity.
 2. Patient must return by midnight on the day of departure.
 3. Approval and payment for the pass day(s) rest solely with the third-party payer. Inform the patient that he/she may be responsible for the payment of the pass day(s).
 4. The emergency nature of the pass must be documented.
4. If there are any questions relating to the provision of insurance coverage, phone the Patient Accounts Department at (212) 731-3961.
 5. The physician issuing the pass must complete the Approval of Temporary Leave Form (Form A-1-A-10), including the length of leave and specific reason for the leave, and sign, noting the date.
 6. The patient and/or responsible party/guardian must sign the form prior to leaving the hospital. The nurse must sign and date the form and place it in the medical record.

In psychiatry, the form is forwarded to the Psychiatric Administrative Office, from which it is forwarded to the Patients Accounts Department

Consultations

In general, the decision to request a consultation should be made with the knowledge of the patient or family and the attending physician. Please refer to the following link,

http://qhmintranet.qhнад.nyehc.org/documents/POL_PDF/PTS19.PDF

Diagnosis-Related Groups

Hospital stays in New York State are paid under a prospective payment system. The basis for payment under this system is the Diagnosis-Related Group (DRG). The DRG is a method for classifying patient hospitalizations by diagnosis and procedure on the assumption that similar costs are expended by patients with similar intensity of resources (e.g., hours of nursing care, laboratory tests, Operating Room (OR) time, medications). Patients are initially divided into medical or surgical subgroups, depending on whether or not an OR procedure was performed. DRGs are then assigned based on the following:

- Principal diagnosis;
- Principal OR procedure;
- Complication or co-morbid condition (cc);
- Patient's age (either under or over 18);
- Discharge status (e.g., expired, transferred, discharged home with help); and
- Newborn's birth weight.

The driving factor is the principal diagnosis, defined at the time of discharge as that which is determined to have caused the admission. It is not the most resource-intensive diagnosis. Certain managed care contracts negotiate special agreements such as a per diem rate or pass-through of charges for specific high cost items used.

DRG payment is calculated by multiplying the specific DRG weight by the Hospital's current Medicare, Medicaid, or negotiated payer rate per case. The main component in the payment for each patient is the DRG's

relative weight. The federal and State governments have developed indices of relative weights that reflect the intensity of resources consumed for each DRG. A relative weight of 1.00 reflects the average resources consumed for treating a patient. Any weight greater than 1.00 is considered to consume more resources than average and thus be more costly. Higher relative weights, therefore, reflect medical or surgical conditions requiring more intense hospital resource consumption and lead to higher reimbursement. In addition to case mix, Medicare and Medicaid payment rates for hospitals are adjusted for medical education and capital costs. Medicare also provides additional reimbursement called disproportionate care for hospitals that treat a high percentage of Medicaid and disabled patients.

Coding practices have not always kept up with emerging technologies, resulting in certain situations where a procedure may be severely under- or overcompensated. It may take time to redress these inequalities.

The geometric mean length of stay (LOS) is intended as a guide reflecting the average LOS for the typical patient with a given illness or disorder. Outliers are patients with atypically long LOS or high costs. Medicare provides additional reimbursement for acute patients that are deemed to be high-cost. Medicare sets a high cost threshold for each DRG. If the cost for a case exceeds this threshold, then the Hospital receives 80% or its costs above this amount. Medicaid provides additional reimbursement for acute patients who are deemed to be high-cost or long-stay outliers. Medicaid sets a high cost threshold and a high trim LOS for each DRG. If the cost for a case threshold is exceeded, then the Hospital receives a percentage of its costs above this amount. If the high trim point is exceeded, the Hospital receives incremental per diem reimbursement. Additionally, Medicaid provides low trim points for each DRG. If the patient's LOS is below the low trim point, Medicaid provides reduced reimbursement through a per diem payment rather than the full DRG payment. Cost per case is determined by the Hospital's historical ratio of cost to charges (RCC) for both Medicare and Medicaid.

Emergencies: Medical and Surgical

Emergency Preparedness: Emergency Management (Plan E)

The hospital's Emergency Management plan is aimed at prompt and efficient handling of any community or hospital emergency. The plan is designed as an "all hazards plan." The hospital uses an incident management system command center which defines chain of command and operations objectives. The incident management system command center is the site from which response efforts are coordinated by an Incident Commander. Exercises are performed and evaluated throughout the year. This provides staff the opportunity to reinforce their knowledge of the plan and it provides the hospital the opportunity to make improvements to the plan, if necessary. Participation is mandatory if the drill involves your departments.

If the Disaster plan is activated, it will be announced by overhead loudspeaker, or you may receive a page by the Hospital operator, or your department. After ensuring your own and your hospital patients' safety, you should contact your direct supervisor for further instructions. Do not attempt to respond to the scene of the incident or the Emergency Department unless directed to do so by your supervisor or it is your responsibility in the disaster plan. A copy of the current Plan can be found in the Nursing Units, in Departmental Administrator's Offices, and on the [OHN](#) Intranet.

Please make sure your department has current contact information, in order that the professional staff availability may be assessed for such unforeseeable catastrophes.

Team 700: In-Hospital Resuscitation

Occasionally unforeseen problems arise that constitute an immediate threat to the life of a patient. Cardiac arrest, respiratory tract obstruction, and other emergencies must be treated quickly. To help meet these emergencies, there are Team 700 carts located at strategic areas throughout the Hospital. At all times there is a team of physicians, consisting of an anesthesiologist, an internist, and a cardiologist, available for assistance.

To Get Assistance: Dial 911 and tell the operator where the emergency team is needed. Do not call the operator to page individuals, as this will only delay arrival of the team.

Emergency Equipment: All Nursing Units contain a Team 700 Cart. This cart has pertinent cardiac and respiratory stimulants as recommended by the Medical Board. Monitors and defibrillators for use in Team 7000 are available on the carts.

For information and specific help concerning any emergency, call the following:

CARDIAC AND/OR RESPIRATORY ARREST
Team 700 (Cardio-Respiratory Emergency Team) Ext. 45017

EXTERNAL CARDIAC PACEMAKER OR ELECTRICAL DEFIBRILLATOR
Cardiology Resident through Department of Cardiology during routine hours Ext. 45017

Following a Cardiac Emergency, a note must be put in the patient's chart.

Please refer to the following link, http://qhnintranet.qhnad.nychhc.org/documents/POL_PDF/ADM28.PDF

Ethics: Clinical Dilemmas

The Ethics Committee of the Medical Board of Mount Sinai Services is available for consultation and guidance on ethical issues concerning patient care and treatment. For further information call the Patient Advocate at ext. 3690. Please refer to the following link,

http://qhnintranet.qhnad.nychhc.org/documents/POL_PDF/PTS12.PDF

Patient Safety Policy

Please see the attached link for information on Patient Safety

Patient Safety Policies

qhnintranet.qhnad.nychhc.org/documents/POL_PDF/PTS50.PDF

FINGERNAILS, HAND ANTISEPSIS AND HANDWASHING

qhnintranet.qhnad.nychhc.org/documents/POL_PDF/PTS54.PDF

HAND-OFF COMMUNICATION OF PATIENT INFORMATION

qhnintranet.qhnad.nychhc.org/documents/POL_PDF/PTS56.PDF

HIPPA Guideline, E-mail and Protected Health Information

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was passed to improve the efficiency and effectiveness of the healthcare system while preventing fraud and abuse.

The Mount Sinai School of Medicine and its affiliate institutions have always placed a high priority on maintaining the confidentiality of its records, documents, agreements, and other sensitive information. However, the passage of the HIPAA privacy regulations has made it essential that House Staff understand that access to confidential information is solely for the purpose of performing your responsibilities as a House Staff Officer within the Hospital or ambulatory care settings.

The HIPAA privacy regulations establish a stringent and complex set of standards that governs all uses and disclosures of what is considered protected health information. It is essential to be aware that lack of compliance with these regulations may lead to personal, criminal, and civil penalties. Any Medical Center employee who fails to follow these standards is subject to disciplinary action, up to and including termination.

Protected health information is any clinical, financial, or demographic information that is created or received by a health care provider, and relates to the past, present, or future physical or mental health condition of an individual, the provision of health care to an individual for the past, present or future regarding payment for the provision of health care to an individual, or identifies the individual in any way and with such information maintained or transmitted electronically or in oral or written form. It includes specific diagnostic and treatment-related information about an individual and may include the mere fact that an individual is a patient in a Hospital or its ambulatory care centers, or if the patient opts out of the Hospital Directory.

Although these regulations are very complex with respect to disclosure, House Staff should also be aware of the following guidelines:

- I. House Staff should view only information needed to care for patients or to fulfill the responsibilities of House Staff Officers. Patient records or other confidential information not needed to perform work responsibilities should never be accessed.
- II. Any patient information or other confidential information may not be shared with anyone who does not have an official need to know. That includes not sharing such information with others in casual conversations.
- III. All records, both paper and electronic, must be handled with care to prevent unauthorized use or disclosure of confidential information.
- IV. Confidential information must not be removed from the immediate work area, nor may copies be made of medical records, or may records be removed from the patient floors or the medical records department.
- V. Electronic messages containing individually identifiable health information to patients cannot be sent unless authorized by the patient.
- VI. All confidential information in one's possession that is no longer needed must be disposed in the confidential bins located throughout the hospital or shredded.
- VII. Any passwords, MISYS keys, or dictation codes or electronic signature codes assigned to a specific House Staff Officer are equivalent to a personal signature and are intended for the individual's use only and are not to be shared with any other individual.
- VIII. All Medical Center computers, information systems, Intranet, and Internet are to be solely for performing assigned job responsibilities. Software that is not approved by the Medical Center should not be copied or downloaded, nor should such confidential information and software be used to function in the residency to be used for personal benefit or to benefit another unauthorized institution.

E-mail and Protected Health Information

Please note that the "Consent to Communication via E-mail" (MR-240) form is available on the Mount Sinai Intranet under Core Administrative Services: HIPAA: Forms.

- I. When choosing to use e-mail, certain of its characteristics need to be appreciated to assure that privacy is maintained. Specifically, there is potential for misdirection and interception of e-mail in our unencrypted environment. Each department should develop procedures for the use of e-mail containing PHI that are consistent with institutional policies.
- II. The minimum necessary amount of Protected Health Information (PHI) should be disclosed via e-mail, even for treatment purposes.

- III. PHI that is specially protected by law (i.e., related to mental health, substance abuse, HIV, genetic testing) must be handled in accordance with applicable law and institutional policies.
- IV. The “To” field must be checked carefully and the contents of any earlier message strings reviewed and deleted, if appropriate, before sending an e-mail message containing PHI, to ensure that the message is sent to the correct person and earlier messages are not forwarded in error.
- V. E-mail containing PHI should be printed for secure filing immediately, if appropriate, then deleted; it should not be maintained in an electronic archive (including mail archives, inbox, and sent items). If it is treatment- or payment-related, it should be made part of the Designated Record Set in accordance with institutional policy. Exercise care to insure that communication is printed out in an area that is not accessible to the public.

- VI. All staff with access to confidential patient information communicated via e-mail must be instructed that such information is confidential patient information and must not be shared with any third parties not involved in the patient’s care. A footer regarding confidentiality should be attached. For example:

This e-mail and any attachments may contain confidential information and are intended for use solely by the addressee(s). If you are not the intended recipient of this e-mail, please be aware that any dissemination, distribution, copying, or other use of the e-mail in whole or in part, is strictly prohibited. If you have received this e-mail in error, please notify the sender and permanently delete the original and all copies of the e-mail, attachments, and any printouts. Thank you.

- VII. Anyone using e-mail (including members of a physician’s office staff) must use his or her own logon and password and not share items with anyone.
- VIII. If an e-mail containing PHI is misdirected, an incident report should be documented in the appropriate Accounting of Disclosures. (See H-6)

- IX. Depending on the nature of the e-mail communication, the following additional standards apply:

A. Physician-Physician Communication

- 1. Wherever appropriate for patient care, the institution’s e-mail system may be used to transmit PHI. Users should be aware of other more secure mechanism of obtaining clinical information (e.g., EDR).
- 2. Employees of ancillary areas are considered extensions of physicians when they are e-mailing test results to or on behalf of physicians.

B. Staff-Staff Communication: If it is essential to transmit PHI via e-mail between Mount Sinai staff in order to provide proper care or to perform one’s job function, three options are available:

- 1. Use the medical record number without the patient’s name.

2. If a single patient is the subject of the e-mail and it is clear who is being referenced, put the PHI in one e-mail and the patient's name in a second, non-linked e-mail.
 3. For routine interactions use pre-defined contact lists.
 4. E-mail should not be used to communicate PHI with non-Mount Sinai staff not involved in patient care unless it is encrypted or transmitted in a password-protected zip file.
- C. Provider-Patient Communication: If a patient wishes to communicate with his or her provider via e-mail regarding his or her care, the provider must obtain the patient's consent. Exceptions to the standards set forth below should be addressed specifically in the patient consent.
1. The patient's e-mail address should be verified unless s/he initiated the contact. Each provider should establish a turn-around time e-mail replies as appropriate to his or her practice. Patients should be advised of same. E-mail should not be used for urgent communication.
 - a. Incoming e-mails should be acknowledged upon receipt and include an expected response time. (Outlook utilities may be utilized.)
 - b. The response should include a telephone number to call if immediate medical attention is needed.
 2. Patients should be instructed as part of the consent process that:
 - a. They may escalate any communication to a phone call or visit if:
 - 1) The use of e-mail is not addressing their needs.
 - 2) There are network problems.
 - b. The subject of the message should be labeled appropriately (appointment, prescription, instructions, test or billing questions, etc.).
 - c. The message should include the patient's name and a second identifier (e.g., date of birth) to prevent confusion regarding patients with the same name.

Medication Practices

Drug Enforcement Agency Number

In order to prescribe and administer controlled substances to Hospital inpatients or outpatients, it is necessary to use the Hospital Drug Enforcement Administration (DEA) number with an assigned suffix (if a physician does not have his or her own DEA number).

Department of Pharmacy

The Pharmacy Department is in the Main Building, Basement Level BD-22; several pharmacy satellites are located in patient care areas. The pharmacist on duty can be reached 24 hours a day, 7 days a week, at x42377. Only a registered pharmacist (or authorized pharmacy personnel under the direction and supervision of a registered pharmacist) may prepare, dispense, or make label changes on medication, or transfer medication from one container to another.

Adverse Drug Reaction Reporting

- An Adverse Drug Reaction Report Form Card must be completed if an adverse drug reaction is suspected. The form is available on all Nursing Units and Pharmacy Satellites.
- The reaction should be reported to the physician responsible for the patient’s care and recorded in the patient’s medical record.
- Completed Drug Reaction Report Forms should be forwarded to the Pharmacy Department, Director of Pharmacy, Room BD-22 or phoned directly to the ADR hotline at ext. 4-ADRS

Antibiotic Control Program

Refer to the EHC Drug Formulary posted on the QHN intranet for an alphabetical listing of all formulary medication. Antibiotics not listed are non-formulary and approval from Infectious Diseases must be obtained before they can be used in a particular patient. In addition, a non formulary request form must be filled out and signed by the chief of service and the P & T chairman.

- Page the ID Service prior to ordering a non-formulary antibiotic between 9:00 A.M. and 8:00 P.M.
- During off hours (4:00 P.M. to A.M. the N/F request form can be signed by the Bell Attending. The form should be forwarded to the C4-14 satellite pharmacy (open 24 hours)

8:00pm - 11:30pm	send to the Satellite Pharmacy
11:30pm - 7:30am	send to the Inpatient Pharmacy, ext. 47714
7:30am - 9:00am	send to the Satellite Pharmacy

The Pharmacy and Therapeutics Committee recommends surgical prophylaxis be limited to 48 hours in surgical patients and 72 hours for cardiothoracic cases. First doses should be administered 15-60 minutes prior to surgery

Prescribing Restricted Drugs

Restricted drugs are medications that have been approved by the Pharmacy and Therapeutics Committee for use only by specific services, for specific indications, or for a combination of both.

Restricted to a Particular Service or Specialty: A drug may be dispensed only when prescribed or approved by a physician (attending or fellow) from that service, a Chief of Service, or the Chair of the Pharmacy and Therapeutics Committee (or designees).

Automatic Stop Orders

The Medical Board has approved an automatic stop order for all medications not specifically prescribed as to duration and dosage. It is the responsibility of the prescriber to be alert to this termination date and reorder the medication if so desired.

- Orders for controlled drugs with a including p.r.n. (as needed) must be rewritten every 3 days if therapy is to continue on a specified schedule. A p.r.n. order for a controlled substance without a specific frequency is valid for a single administration only within a 72-hour period.
- Other medications not specifically prescribed as to duration and dosage will be discontinued after seven days.
- Should the physician elect to order medication for a specified period, the automatic stop order will not apply except for controlled drugs.
- All drug orders for patients undergoing surgery are automatically discontinued.

Bedside Medication

No drugs are to be kept on the bedside.

Investigational Drugs

Investigational drugs are those drugs not approved by the Food and Drug Administration (FDA) and/or drugs approved by the FDA but used in doses, routes of administration, or indications for which no acceptable precedent exists in the medical literature.

Order Writing

To maintain uniformity, provide clarity, and avoid errors, the House Staff must familiarize themselves with drug and treatment ordering procedures.

- All orders should be generated via MISYS.
- All medication orders entered into the MISYS hospital computer system will be transmitted electronically to the Pharmacy Department.
- All orders shall include the following:
 - Patient's full name;
 - Unit and MRN;
 - Patient location;
 - Date and time written;
 - Generic name of drug;
 - Dose, route and frequency of administration;
 - Prescriber's signature and dictation control number.

NOTE: a) The metric system must be used for all drug orders (except when dosage is commonly expressed as drops or units); and b) All orders indicating a trade name product will be filled with the generic brand in stock.

- All orders should be specific. An order reading "50 mg – 100 mg Q 3-4 h p.r.n." is not acceptable. An exact dose and dosing interval must be indicated, e.g., 50 mg q4h p.r.n.
- Admission orders, including all information outlined above, as well as diagnosis, drug allergies, and patient's weight, should be forwarded to the Pharmacy Department as part of all patients' initial drug orders.
- All medications prescribed for inpatients should be approved drugs listed in the EHC Formulary. Investigational agents must be approved by the Hospital's Institutional Review Board or the Committee on Pharmacy and Therapeutics. The EHC Drug Formulary is available on the QHC intranet.

Only approved abbreviations listed in the QHN intranet will be honored. When required, "p.r.n." orders must indicate the minimum interval between doses and the indication for use, e.g., acetaminophen 650

mg p.o. q6h daily, p.r.n. for pain. NOTE: An order indicating a change of drug or amount will discontinue a previous "p.r.n." order for that drug

NOTE: Daily orders are administered at 10:00 A.M.. Daily orders written after this time should be ordered "stat" and daily thereafter.

Mount Sinai Clinic patients should be directed to the Outpatient Pharmacy or to a local pharmacy for prescription filling.

Prescriptions for patients seen in a EHC Clinic must generated on a Outpatient Prescription Blank.

Controlled drugs must be written on the NYS official prescription blank, which must be obtained from the Pharmacy Department

Each prescription must contain the following:

- Patient name, age and address (contained on each patient's clinic card);
 - Date prescription written;
 - Name, strength, quantity of prescribed drug and directions for use;
 - Prescriber's signature and dictation control number;
 - Prescriber's imprinted or stamped name (your embossing plate should be used for this purpose);
 - Prescriber's profession (M.D., D.D.S., etc.);
 - New York State License Number;
 - A DEA Number must be included for all controlled substance prescriptions, schedules II-V. House Staff members may use their four-digit suffix as assigned along with the Hospital DEA Number.
-
- Please note the following guidelines pertaining to prescription writing:
 - Stamped or pre-printed prescriber's signatures are not allowed;
 - Stamped or pre-printed prescriptions are not allowed;
 - Drug name abbreviations are not acceptable;
 - Schedule II-V controlled substances can be prescribed for up to 30-day quantities;
 - The EHC OPD Pharmacy does not honor refills on controlled substance prescriptions.
 - The following guidelines pertain to Medicaid prescriptions only:
 - Medicaid prescriptions are valid within only 14 days from issue;
 - Drugs for acute illness should be limited in quantity, while no more than a 30-day supply should be prescribed for maintenance drugs;
 - Drugs should be prescribed as generic equivalents even if a brand name is used. The full name of the drug must be written;

Abbreviations Not Permitted

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has expanded the National Patient Safety Goal regarding unapproved abbreviations. All institutions must have a list of abbreviations that are not permitted (a "Do Not Use" list). Most of the abbreviations chosen for this list are prohibited by JCAHO, and the rest were selected by the institution. These abbreviations are not permitted in medication orders or any medication-related documentations (e.g., medication administration records, H&P). It is important to note that this requirement applies to all inpatient records and outpatient clinic records, as well as the employee pharmacy. It does not apply to practitioners' private practices.

Non-Formulary Drugs

A drug not included in the EHC Drug Formulary is considered a non-formulary drug and will only be dispensed for a specific patient upon proper request and justification. The following are hospital guidelines:

- House Staff physicians cannot request non-formulary medications.
- Attending Physicians should consult with the pharmacist regarding the specific patient, indications, and drug requested. The pharmacist will discuss which available formulary agents are therapeutically similar and may be used for the specified indication.
- If a non-formulary agent is needed a non formulary form must be filled out and signed by the attending and the P&T chairman. The Attending Physician may approve it only for a designated patient for a specific reason.

Non-formulary agents may not be available for 24-48 hours.

Reconciliation of Medications

- I. *Introduction:* Medical errors and adverse drug events in hospitals are known to be due to poor communication of medical information at transition points across the continuum of care. To promote safety and reduce the potential for medication errors, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) mandated implementation of their medication reconciliation National Patient Safety Goal initiative, effective January 2006.
- II. *Purpose:* The purpose of medication reconciliation is to provide a process for obtaining and documenting the most accurate lists of patients' medications prior to admission, and matching these lists with the medications that the Hospital will provide during the inpatient stay. This process is repeated at discharge. Medication reconciliation helps avoid transcription errors and omissions and prevents duplication of therapy, drug interaction, and drug-disease interaction.
- III. *Definitions:* Medication is defined as any prescription medication, herbal remedies, over-the-counter medication, sample medication, vitamins, nutraceuticals, diagnostic or contrast agent, radioactive medication, blood derivative, parenteral nutrition, intravenous solution, vaccine, and/or product determined by the Food and Drug Administration as a drug.
- IV. *Procedure*
Click on the link: ghnintranet.ghnad.nychhc.org/documents/POL_PDF/PTS57.PDF

Telephone and Verbal Order Policy

Verbal orders shall be carried out only in the case of an emergency.

The order must be written on the Doctor's Order Sheet exactly as stated verbally or via the telephone. The order must indicate the following:

- Drug name, dose, route and frequency of administration;
- Prescriber's name;
- Time the order was taken;
- Name of the professional taking the order.
- The prescriber shall countersign the order within 24 hours.
- Oral orders for Schedule II controlled drugs are valid for an initial dose only unless countersigned.
- Telephone and verbal orders received in the Narcotics Rehabilitation Center shall be countersigned as follows:
 - Verbal orders received Monday through Friday shall be countersigned within 24 hours;
 - Verbal orders received on the weekend are to be countersigned within 72 hours.
- Telephone and verbal orders for medications are accepted in the Employee Pharmacy.

Needlestick or Sharp Injury Procedure

In order to ensure immediate and appropriate management following needlestick/sharp injuries and other blood/body fluid exposures, please follow these steps.

1. Any area exposed must be washed with soap and water or mucous membrane flushed with water immediately, or as soon as feasible following exposure.
2. The incident is to be reported to your supervisor or supervisor of area where incident occurred.
3. Supervisor will contact the Needlestick Coordinator, Beeper 917-467-3478, Monday through Friday, from 9:00 A.M. to 5:00 P.M. or the Nursing Administrator through the page operator at other times. Supervisor will complete Risk Alert Form.
4. Complete Employee Accident/Injury Report Form.
5. Needlestick Coordinator or Nursing Administrator will refer you to Employee Health Service, Emergency Room, or Jack Martin Fund Clinic.

For more detailed information regarding the above, as well as procedures to follow if exposures to other persons, including visitors and patients, occur, refer to the Infection Control Manual located on the Queens Health Network Intranet, policies and manual section.

Patient Demise

Anatomical Gifts

Requests for donation must be made for all deaths to the New York Organ Donor Network (“the Donor Network”) in accordance with the Public Health Service Act, Section 372 (Routine Referral Law).

Consent to donate anatomical gifts will be requested from the next of kin or guardian for all patients who are suitable candidates for tissue/ organ donation at the time of death by the Donor Network staff. Based on acceptable medical standards for screening potential donors, a designated representative will speak with the family/guardian unless there is actual notice of contrary intentions by the decedent, actual notice of opposition by any of the persons listed in hierarchy of consent, or that an anatomical gift is contrary to the decedent’s religious or moral beliefs.

Note: According to NYS law, only an individual trained and certified to counsel and request organs from families may initiate the discussion of donation with a family member. The Donor Network has trained counselors who will come to the hospital to work with families. Please refer to the following link,

qhnintranet.qhnad.nychhc.org/documents/POL_PDF/MEDREC16.PDF

Autopsy Consent

Permission to perform an autopsy must be requested from the Next-of-Kin of all patients who expire at The Mount Sinai Services Medical Center (Permission Sheet #17: Request for Post-Mortem Examination). Members of the medical staff are expected to exhaust all reasonable efforts to obtain post-mortem permission. If help is needed, House Staff must request assistance from the attending on the case. The Next-of-Kin may not be aware of the possibility of an autopsy unless it is addressed.

- If permission for autopsy is not granted, this fact and the reason for it must be documented in the patient’s medical record on the bottom of the consent form itself and on the Death Certificate.

- For cases where the Medical Examiner assumes jurisdiction, the Next-of-Kin does not need to be asked for permission for autopsy.
- In cases declined by the Medical Examiner, requests for autopsy must be made of the Next-of-Kin.
- Consent for autopsy must be obtained from legal Next-of-Kin as defined by the New York City Health Code. (See below.)
- All autopsies are performed either by members of the Pathology staff of The Mount Sinai Services Medical Center and /or by the Office of Chief Medical Examiner for the City of New York.

Definition of "Next of Kin": New York City Health Code Article 205, Section 205.1 (Definition) Paragraph D states that 'Next of Kin' means person or persons, in the following order of priority, who are available within the applicable limits of time as provided in the article to receive communications and give communications and give instruction regarding the disposal of a decedent's remains either personally, by telephone, telegraph, mail, or other usual means.

- I. Spouse or registered domestic partner
- II. Children over 21 years of age or older
- III. Grandchildren and other descendants 21 years of age or older
- IV. Parents or surviving parent
- V. Brothers and sisters of the decedent 21 years of age or older
- VI. Grandparents
- VII. Great-grandparents, uncles, and aunts 21 years of age or older
- VIII. Other persons 21 years of age or older entitled to share in the estate

The New York City Health Code *does not recognize* common law relationships in determinations of Next-of-Kin. A health care proxy is not acceptable for purposes of Next-of-Kin. All of the above apply only if there is no anatomical gift declaration prior to death.

When there is a controversy among members of a group of equal kinship over permission for autopsy, it is suggested that it is unwise to accept consent from only one individual. The kin should be advised to come to a group agreement concerning whether or not to proceed with an autopsy.

Note: Grandchildren have priority over parents or siblings in the New York City Health Code.

According to NY Public Health Code (4214): In no case shall an autopsy or dissection be performed upon any body within 48 hours after death unless a **written consent or directive** therefor has been received from the person or persons legally entitled to consent to or order such autopsy or dissection.

(In other words, written consent must be obtained within 48 hours of the death of an individual. This can be achieved by having the Next-of-Kin come to the Hospital to sign the form or by faxing a copy of the consent form to them and then having them fax it back after signing it.)

After 48 hours of the death of an individual, one may obtain consent for autopsy via the telephone; however, the Hospital operator must serve as a witness to the conversation.

Birth, Spontaneous Termination of Pregnancy, and Induced Termination of Pregnancy Certificates

The preparation of Birth Certificates is the responsibility of the House Staff Officer and/or the attending physician. The following information must be completed on all Birth Certificates:

- I. Signature of the “certifier” (Cynthia McKie-Addy).
- II. Numbers 16 to 40 in the “Confidential Medical Report” section of the certificate.

In the case of an infant born alive, (heartbeat after birth or voluntary muscle movement), but dying within a few moments after delivery, both a Birth Certificate and a Death Certificate must be completed.

A Certificate of Spontaneous Termination must be completed for any terminated pregnancy that does not result in a live birth, regardless of the period of gestation. This applies in the case of a stillborn fetus or where fetal tissues are recovered at curettage. Abortions are to be reported on Induced Termination Certificates. These forms are available at the treatment areas.

The completed certificate (either Birth or Spontaneous Termination) is to be left in the Birth Certificate dropbox on K2 or with the Operating Room supervisor. (The Birth Certificate Office must be informed if the Operating Room supervisor completes the form.) An abstract of the Birth Certificate will be inserted in the chart after processing by the Birth Certificate Office.

Birth Certificates should be sent to the Birth Certificate Office. Spontaneous and Induced Termination Certificates are processed by Natalie Weinstein on KP-9. Certificates must be completed immediately after delivery, as the time limit for filing with the Health Department is 48 hours after birth.

Death Certificates

It is the responsibility of the House Staff Officer to complete the Death Certificate for deaths that occur on his or her service. This is to be done promptly after the patient has been pronounced dead. Prior to certificate completion, the pronouncing physician must consider whether the case needs to be referred to the Office of the Chief Medical Examiner. In addition, the House Staff Officer must notify the attending physician of the death. At that time, the House Staff Officer and the attending should determine who will contact the Next-of-Kin of the death and who will request autopsy permission from the Next-of-Kin. Information concerning Medical Examiner referral, pronouncement of death and the request for autopsy permission must be indicated in a note in the patient’s chart (i.e., “note at the time of death”). A deceased individual may not be removed from the Hospital by a funeral director until an appropriately completed Death Certificate has been provided by the physician. Delays in completing certificates can impact a family’s ability to proceed with timely funeral arrangements.

A House Staff Officer may be asked to complete a Death Certificate for a patient s/he is only covering for, or on a patient that s/he has never seen or cared for. In this sense, the House Staff Officer acts as a representative of the Hospital with regard to completion of a Death Certificate. By signing the certificate, one is merely stating that the information contained therein is correct “to the best of your immediate information,” as ascertained from the patient’s medical record or discussion with the attending of record. In other words, information written in a Cause of Death Statement on a Death Certificate is the House Staff Officer’s best opinion based on available information. Please refer to the following link,

ghninet.ghnad.nychhc.org/documents/POL_PDF/PTS21.PDF

Note: The House Staff Officer completing the Death Certificate need not: a) have ever seen the patient alive; b) have pronounced the patient dead; or c) have been on duty when the patient died.

All certificates must be completed in *black ink*. Felt tip pens are unacceptable, even if in black ink.

Definition of Death: Criteria and techniques for determination of death should be determined in accordance with Medical Board criteria. Questions concerning the pronouncement of death should be discussed with the appropriate Chief Resident and /or attending physician.

General Guidelines for Completion of Death Certificate: To avoid errors when completing Death Certificates, please follow the procedures below.

- A. Death Certificates are completed by the pronouncing physician, the admitting department staff coordinates with the physician to ensure completion of death certificates. The mortuary department staff is responsible for all other related functions.
- B. Permission to perform the autopsy is to be noted on the Death Certificate. (Check yes or no.) If left incomplete, the Death Certificate will be returned to the physician.

Accuracy is imperative in the completion of Death Certificates, since the certificate becomes a matter of permanent and official record. Erasures and/or deletions make the certificate UNACCEPTABLE to the Bureau of Vital Records of the Department of Health. Diagnoses with question marks are not acceptable.

The completed Certificate is to be attached to the chart of the deceased and retained in the admitting department for mortuary department pick up.

Completing the Cause of Death

Use the following guidelines in completing the cause of death:

ghninet.ghnad.nychhc.org/documents/POL_PDF/PTS21.PDF

Completed Death Certificates

- C. Death Certificates are completed by the pronouncing physician, the admitting department staff coordinates with the physician to ensure completion of death certificates. The mortuary department staff is responsible for all other related functions.
- D. Permission to perform the autopsy is to be noted on the Death Certificate. (Check yes or no.) If left incomplete, the Death Certificate will be returned to the physician.

Accuracy is imperative in the completion of Death Certificates, since the certificate becomes a matter of permanent and official record. Erasures and / or deletions make the certificate UNACCEPTABLE to the Bureau of Vital Records of the Department of Health. Diagnoses with question marks are not acceptable.

The completed Certificate is to be attached to the chart of the deceased and retained in the admitting department for mortuary department pick up. Please refer to the following link,

ghninet.net.ghnad.nychhc.org/documents/POL_PDF/PTS10.PDF

Medical Examiner's Cases

In all Medical Examiner's (ME) cases, the ME should be notified by the physician only.

Permission for autopsy must never be asked for in the above cases.

Any information with regard to the family's wishes "for or against" an autopsy should be conveyed to the ME, including religious objection.

Permission for Autopsy in Certain Medical Examiner's Cases: The only types of Medical Examiner's cases on which the Hospital may request autopsy permission, with the advance approval first of the ME, are as follows:

1. Cases of chronic alcoholism without manifestations of trauma, but with such manifestations as beriberi, nutritional edema, Korsakoff Syndrome, etc.
2. Accidental burns that are not the result of homicidal attacks, criminal negligence, or arson.
3. Deaths or sudden deaths associated with necessary therapeutic or diagnostic procedures in acute or chronically ill persons.
4. Anesthetic deaths in which the Hospital or the anesthesiologist is not negligently involved.
5. Fractures of the femur in elderly persons resulting from simple falls at home or elsewhere when there is no question of negligence.
6. Agranulocytosis, aplastic anemia, or acute yellow atrophy of the liver believed to be the result of therapeutic administration of drugs, e.g., arsphenamine, amidopyrine, cinchophen, etc.

All of the above are Medical Examiner's cases and must be promptly reported to the Medical Examiner's Office before permission for autopsy is obtained. Such permission must be with the consent of the ME. These cases will remain under the jurisdiction of the ME who is responsible for the performance of such autopsies and for issuing the Death Certificate. Therefore, in such cases the ME will perform or supervise the autopsy.

Deaths from natural causes in which a definite diagnosis can be made, despite the fact that the patient survived less than 24 hours in the hospital, need not be reported to the Medical Examiner's Office.

Deaths where the patient is admitted without medical history, in a coma, with convulsive seizures, or with gastroenteric disturbances, and the diagnosis is uncertain or cannot be made, must be promptly reported to the Medical Examiner's Office, regardless of the length of sojourn in the hospital. If there is any doubt in a particular case, advice may be obtained by telephone from the Medical Examiner's Office at (212) 447-2030.

Procedures to Follow in Medical Examiner's Cases: When it is decided that a death is under the jurisdiction of the Medical Examiner's Office:

1. No Death Certificate is issued by the Hospital.
2. In lieu of a Death Certificate the House Staff Officer will furnish complete data of each case on the Medical Examiner's Hospital Report Form. This form must contain accurate and adequate information concerning each case. As it is an official city document that is often referred to in criminal and civil proceedings, care must be taken to avoid misleading or inaccurate information and to include all pertinent and relevant data. A duplicate copy of the Medical Examiner's Report Form is made part of the patient's record. It should be filled out promptly, preferably by the House Staff Officer who is most familiar with the case.

If there is doubt whether a case is within the realm of the Medical Examiner's Office, the Administrator on duty should be consulted. Please refer to the following link,

qhnintranet.qhnad.nychhc.org/documents/POL_PDF/PTS22.PDF

Procedures to Follow in Medical Examiner's Cases: When it is decided that a death is under the jurisdiction of the Medical Examiner's Office:

- I. No Death Certificate is issued by the Hospital.
- II. In lieu of a Death Certificate, the House Staff Officer will furnish complete data of each case on the Medical Examiner's Hospital Report Form. This form must contain accurate and adequate information concerning each case. As it is an official city document that is often referred to in criminal and civil proceedings, care must be taken to avoid misleading or inaccurate information and to include all pertinent and relevant data. A duplicate copy of the Medical Examiner's Report Form is made part of the patient's record. It should be filled out promptly, preferably by the House Staff Officer who is most familiar with the case.

If there is doubt whether a case falls within the jurisdiction of the Medical Examiner's Office, the Administrator on duty should be consulted. Alternatively, the Morgue staff or Autopsy Director (Pat Lento, M.D., at x49157) may be consulted. Please refer to the following link,

qhnintranet.qhnad.nychhc.org/documents/POL_PDF/PTS22.PDF

Post-Mortem Reports

If, in the process of securing post-mortem consent, the House Staff Officer promises a report on the findings to the family, he/she should arrange for this report in one of two ways.

1. If the deceased and/or the family has a private physician, the family should be informed that the physician will be sent the complete report. The House Staff Officer should advise the pathologist of this by written note accompanying the post-mortem consent, giving the family physician's name and address.
2. If the deceased has no private physician (clinic patient, self referred, and so on), the House Staff Officer promising the report should arrange to contact or be contacted by the family, within a reasonable time, and he/she is to give a brief verbal report of the major findings to the family.

Please refer to the Q Drive

Unclaimed Bodies

If a body is still unclaimed after 48 hours of a bona fide inquiry to locate a relative, or if no objection is made by next of kin within 24 hours after notice of death, the Hospital Administrator, may order an autopsy.

Under New York City Health Code (section 205.19), the Hospital Administrator is to notify the Department of Health by telephone of such an unclaimed body and of intent to perform an autopsy pursuant to Section 4214.1 of the Public Health Law. Please refer to the following link, ghninet.ghnad.nychhc.org/documents/POL_PDF/PTS23.PDF

Patient Rights and Responsibilities

Informed Consent

The following guidelines establish procedures for obtaining consent for treatment at The Mount Sinai Services Hospital. Consent is a process of communication between physician and patient in which the patient grants permission for the proposed treatment based on a realistic expectation of the potential risks and benefits. These guidelines are designed to facilitate that communication without encumbering or interfering with patient care. The guidelines describe who must give consent, how consent should be obtained, and when written forms are necessary to document the consent process.

If any question or problem arises that is not discussed below, the appropriate Care Center Director should be notified.

I. What Is Consent?

An individual must consent, either orally or in writing, to all procedures, treatment, or operations performed upon him or her. The requirement of an “informed consent” means that a patient is entitled to know all the information that may be relevant in deciding whether or not to undergo the proposed treatment. Patients are presumed to have the capacity to consent.

A. *Disclosure by Physician:* Disclosures by the patient’s physician must include, at a minimum, the nature, purposes, risks of, and alternatives to the proposed treatment. The patient should be told the information that a reasonable physician would tell his or her patient to make a knowledgeable evaluation. The information must be presented in a manner that the patient can be reasonably expected to understand. The physician, relying upon his or her professional judgment, may withhold discussion of risks if s/he reasonably believes his or her disclosure would have a substantial, adverse effect upon the patient’s condition. In such situations, the health care proxy or surrogate should be notified and asked to grant additional consent. Information may not be withheld from the patient out of fear that disclosure would cause the patient to refuse to undergo treatment deemed necessary by the physician.

B. Types of Consent

1. *Express Consent:* Express consent is a patient’s stated decision, either orally or in writing, to undergo proposed treatment. Those treatments for which written consent is appropriate are discussed throughout this section.
2. *Implied Consent:* For routine and non-hazardous procedures and treatments, a patient may be

deemed to have given consent by presenting himself or herself for treatment at the Hospital.

3. *Emergencies:* Consent may also be implied in emergency situations where an attempt to obtain express consent would result in a delay of treatment detrimental to the health of the patient. Relatives of the patient, or the health care agent (if the patient has designated one pursuant to the Health Care Agents and Proxy Law) must be notified of any action taken as soon as possible.

II. Who Must Give Consent?

A patient must give consent for himself or herself if s/he is 18 years of age or over. The patient must be capable of understanding that s/he is granting consent, must understand what is being consented to, and must be capable of making a rational decision. If the physician has any question as to whether a patient is mentally capable to grant consent, s/he should obtain a consultation from a psychiatrist, neurologist, or other physician, as appropriate, and the reasons for the determination should be carefully documented in the patient's chart.

If the patient is 18 years of age or older and has become incapacitated, as determined by the attending physician, a health care agent may give consent if a valid health care proxy exists. The agent's authority commences when the attending physician determines, to a reasonable degree of medical certainty, that the patient lacks capacity to make health care decisions (defined as the ability to understand and appreciate the nature and consequences of health care decisions, including the benefits and risks of, and alternatives to, any proposed treatment, and to reach an informed decision).

The attending physician must make a note in the patient's medical record that includes a finding as to the patient's capacity and, in the event the patient is found to lack capacity, the cause, nature, extent, and probable duration of the incapacity.

When the patient is under 18 years of age or mentally incapable of granting consent, and has no health care proxy, the following persons (if themselves capable of giving consent) may give consent on behalf of the patient in the following order: guardian, spouse, adult child, parent, sibling, aunt or uncle, and cousin. If a patient has more than one person in the relevant category, the consent of one is sufficient unless the others object. If no one is available to grant consent for the patient, the appropriate Care Center Clinical Director should be notified. For disputes between family members, see "Special Consent Problems" below. Where a patient is under 18, a parent or legal guardian may give consent. A patient under 18 years of age may grant consent on his or her own behalf if s/he is a) a parent, b) married, or c) self-supporting and living away from his or her parents. In addition, minors who are fully able to understand and evaluate the nature, risks, and benefits of the proposed treatment may consent to abortions and receive birth control examinations, information, and devices (including treatment for any complications related thereto and treatment for venereal disease without parental consent). Any failure to recognize a minor's right to consent to abortion, birth control examination, information, or treatment, as stated here, is a violation of that minor's rights. Do not notify parents or guardians unless the minor so wishes. Consent forms are written in English and Spanish. Be sure to apprise the patient of Spanish translation to ensure full comprehension where needed.

III. How Should Consent Be Obtained?

- A. *General:* It is the obligation of the physician to obtain the patient's consent to medical treatment. The physician's discussion of the elements of consent should, if possible, take place at least 12 hours before the operation or procedure, and the patient should be given the opportunity to ask questions. When a written consent form is used, the patient should be given adequate time to read the form. Both the patient and physician should sign the form at the end of the discussion, and the form should be attached to the patient's chart. Each clinical service should develop written outlines for high-risk procedures that list relevant information to be discussed with the patient. The physician should follow this outline in making his or her presentation to the patient, modifying it as s/he sees fit to suit the individual situation of the patient.
- B. *Witnesses:* The purpose of a witness is to substantiate that the physician/patient communication has occurred and consent has been given. The witness should therefore be present when the physician speaks to the patient. In general, use of a witness is optional. However, the consent for participation in research projects, consent to sterilization (DSS 3134), and consent for novel procedures or drugs (Permission Sheet #3) must be witnessed. In addition, it is recommended that consent to hazardous treatment be witnessed. The witness should be a member of the patient's family. If no family member is available, Hospital employees may serve as witnesses.

IV. Procedures Requiring Written Consent

The purpose of the consent form (Permission Sheet) is to document that the consent process has taken place. The following list indicates the procedures for which written consent must be obtained and the form to be used in each instance:

- A. Surgical procedures and other hazardous treatment procedures, including anesthesia (use Permission Sheet #1).
- B. Diagnostic procedures (use Permission Sheet #1), including, but not limited to:
 - 1. Diagnostic or X-ray studies with injection of contrast media, including but not limited to arteriography, myelography, myelencephalography, pneumoencephalography, IVP (adults only) and brain scan.
 - 2. Laparoscopy.
 - 3. Endoscopy with biopsy, such as bronchoscopy, esophagoscopy, cystoscopy, sigmoidoscopy, colonoscopy.
 - 4. Needle biopsy.
 - 5. Amniocentesis and chorionic villi biopsy.
 - 6. Paracentesis, thoracentesis.
- C. Novel procedures or drugs (use Permission Sheet #3)
- D. Catheterization and angiography (use Permission Sheet #4)

- E. Kidney transplant (use Permission Sheet #5)
- F. Electroshock treatment or electroconvulsive therapy (use Permission Sheet #6)
- G. Radiation therapy (use Permission Sheet #7)
- H. Abortion (use Permission Sheet #8)
- I. Sterilization (use DSS 3134)
- J. IUD placement (use Permission Sheet #10)
- K. Videotaping, photographing, recording (use Permission Sheet #11)
- L. Unauthorized departure (use Permission Sheet #12)
- M. Refusal to consent to recommended treatment (use Permission Sheet #13)
- N. Off-premises activities (use Permission Sheet #12)
- O. Disposal of amputated member (use Permission Sheet #15)
- P. Ritual circumcision (use Permission Sheet #16)
- Q. Post-mortem examination (use Permission Sheet #17)
- R. Consent for removal of organs (use Permission Sheet titled Consent for Removal of Organs, Form #2047G/JS)

NOTE: This list is not exhaustive. Written consent should be obtained for all other potentially hazardous diagnostic procedures. Written consent is not necessary for non-hazardous procedures such as routine venipuncture or routine lumbar punctures (use Permission Sheet #2). Permission Sheets can be found on all Nursing Units and Operating Services.

V. Research

Federal and State laws require special procedures and forms for experimental and research-oriented procedures and/or treatments. Further information and copies of the relevant documents are available in the Institutional Review Board office. Permission Sheet #3 should be used for novel or unusual treatment that is not part of a research protocol.

VI. For How Long Is Consent Valid?

A patient's consent to a particular treatment may be obtained prior to the patient's admission and remains valid so long as there has been no change in the patient's condition that affects the risks or consequences of, or the alternatives to, the proposed treatment, and so long as there are no intervening circumstances indicating the patient has withdrawn his or her consent. As a general guideline in the

case of procedures requiring written consent, a new permission sheet should be signed by the patient if the permission sheet has been signed more than three weeks prior to the procedure.

Consent may be obtained once for a series of similar procedures or treatments if it is so indicated on the consent form and the patient is fully aware of the proposed course of treatment.

VII. Right to Refuse Treatment

A mentally competent adult patient has the right to refuse treatment for himself or herself no matter how detrimental to his or her health such a refusal may be. The physician should document a patient's refusal to be treated by using Permission Sheet #13 and by carefully documenting in the patient's chart the circumstances surrounding the refusal and the patient's competence to make the refusal. As indicated above, if there is any question as to the patient's mental capacity, a consultation should be obtained from a psychiatrist, neurologist, or other appropriate physician, and the reasons for the determination should be carefully documented in the chart. In all cases where such refusal seriously endangers the patient's health, the appropriate Care Center Clinical Director should be notified.

VIII. Special Consent Problems

A. *Parent's or Relative's Refusal to Consent to Needed Treatment for Child or Incompetent:* When a parent's refusal to consent to treatment for his or her child, or a family member's refusal to consent to treatment for a relative presents a risk to the patient's health or life, the Care Center Director should be notified.

NOTE: A parent or other relative may not prevent a patient from receiving urgent and critical medical care for religious or other reasons.

B. *Parental or Relative Disagreement Over Treatment for Child or Mentally Incapacitated Patient:* After obtaining consent from one parent, consent need not be obtained from the other. However, in the situation where the physician is aware of a disagreement, the appropriate Care Center Director should be notified. Similarly, if siblings or other relatives with equal authority to consent are in disagreement, the appropriate Care Center Director should be notified.

C. *Implied Consent under Anesthesia:* Although the physician has the obligation to disclose to the patient prior to surgery the reasonably foreseeable risks and complications, s/he may treat an unanticipated condition discovered after the patient has been anesthetized if it presents a serious risk to the patient and requires immediate attention; or if it is good medical practice to treat the condition, and the physician has no reason to believe the patient would object to the treatment. Whenever possible, a close relative should be notified before proceeding.

D. *Discovery of Lack of Consent after Administration of Preoperative Sedation or Anesthesia:* Since informed consent must be based on a knowing and rational decision, consent should not be obtained after a patient has been sedated for surgery. Except in emergencies, a patient should not be admitted to the Operating Room without a signed consent form attached to his or her chart.

E. *Consent by Telephone:* When the patient is unable to consent to treatment and no appropriate relative is available to give consent in person, consent by telephone is acceptable. A second person,

such as the operator, should listen to the conversation, and the physician should immediately confirm in the patient's chart the time and content of the conversation and the name and title or identity of the witness. A Spanish-speaking operator or witness may be requested if needed. It should then be noted in the patient's chart that the witness and person requesting the consent conducted the discussion in Spanish.

- F. *Consent for Prescription Drugs:* The duty of the physician to disclose reasonable alternatives, risks, and benefits extends to the prescription of drugs. While written forms may be impractical, the physician should discuss with the patient the nature and risks of the prescribed drugs. When prescribing drugs involving a high degree of risk, it is appropriate to use Permission Sheet #1 to document the consent process or to note in the patient's chart that the elements of informed consent have been fully discussed. For experimental drugs, see Section V: Research (page 93).
- G. *Consent to Sterilization and Hysterectomy:* New York City requires a special form and procedure for consent to sterilization, and additional federal and State requirements apply to both sterilizations and hysterectomies for Medicaid patients.
- H. *Psychiatry Patients:* Consent by Psychiatry patients is not covered by this policy statement, but is subject to special State regulations. The appropriate Care Center Director should be contacted if there are any questions.

Please refer to the following link, ghninet.nychhc.org/documents/POL_PDF/MEDREC04.PDF

Advance Directives, Health Care Agents, and Proxy Law

Under federal and New York State laws, competent adults have the right to appoint someone they trust as their health care agent. The health care agent makes decisions about their medical care in the event that they become unable to make these decisions for themselves.

It is the responsibility of each department to educate its staff with respect to this policy and any methodologies established by the department necessary for the implementation of this policy. For instructions, see Elmhurst Hospital Administrative Policy and Procedure Manual, on the Intranet, ghninet.nychhc.org/documents/POL_PDF/PTS06.PDF

Patient Representative Department

Patient Relations provide individual service to patients and their families, working interdepartmentally to resolve problems/complaints, facilitate care, and address unmet needs. The Department supplies information and assistance regarding patients' rights. It also arranges for special services, such as sign and foreign language interpretation and notarization of patient documents. Patient Representatives are available to help medical staff resolve difficult situations concerning patients and families, assist with issues of patient compliance, and explain Hospital Policies and Procedures. They can be reached at ext. 43690. Please refer to the following link, ghnintranet.ghnad.nychhc.org/documents/POL_PDF/PTS11.PDF

Patient Bill of Rights

The New York State Department of Health mandates that information about the Patient's Bill of Rights and the Health Care Proxy Law be given to patients upon admission to the Hospital or registration in the Clinics. It also requires that all staff be knowledgeable about their provisions and will question individual staff members during state review of implementation. In addition to providing patients with a booklet containing material on these laws, the Hospital has posted the Patient's Bill of Rights on Nursing Units and in Clinic areas. If a Proxy has been executed, it is placed in the patient's medical record. The Patient Representative Department (ext. 5690) will address issues regarding patients' rights and the Proxy Law.

Patients with Financial Problems

House Staff Officers should not attempt to handle any financial questions raised by patients. All such questions should be referred to the Admitting Department when an impending admission is planned; or the patient should be directed to H Building, 3rd Floor. Those patients in the Hospital raising financial questions should be instructed to call Patients' Accounts at 718-334-4700.

Medically indigent service patients may be eligible for medical assistance under the Medicaid program. Other service patients may be covered by Medicare, Blue Cross, or other hospitalization insurance plans. Regardless of the method of reimbursement, members of the House Staff are charged with the responsibility for managing the care of the patient and determining the appropriateness of diagnostic tests, drugs, and other therapeutic/diagnostic procedures. To the extent that the Hospital is accountable to various governmental and reimbursement agencies, as well as to the community, the Hospital strongly urges members of the House Staff to avoid ordering unnecessary tests and diagnostic procedures. This measure will help to minimize incidents that may deprive the patient of maximum third-party coverage.

Hearing/Speech-Impaired and Non-English-Speaking Patients

Mount Sinai Services is committed to providing effective communication for hearing- and speech-impaired and non-English-speaking patients. Hearing-impaired should be identified with a special symbol or sign placed on the medical record and, with permission, on the wall behind the bed. Telephone amplifiers and teletypewriters can be obtained from the Communications Department. "Communi-Card," a device that assists patients in nonverbal communication with their health care providers, interpreter services in foreign and sign languages are available through the Cultural Diversity Department (ext. 1500). Advance notice is necessary for sign-language interpreters. In addition, hospital staff has access to a 24-hour translation service, the Sprint Language Line, which provides interpretation in more than 140 languages. Instructions for its uses are available on each Nursing Unit. QHN Interpreter Hotline 1500. Please refer to the following link, ghnintranet.ghnad.nychhc.org/documents/POL_PDF/ADM30.PDF

Quality Improvement

The Performance Improvement/Patient Safety Committee (PIPSC) is a standing committee of the Medical Board and serves to facilitate quality improvement activities within the Institution. Primary functions of this

committee include the review, evaluation and integration of the quality improvement activities of Departments and Patient Care Areas, and assuring that patients receive appropriate, high-quality care in an efficient manner.

As a body, PIPS serves to demonstrate to the Medical Board and to third-party payers that:

- Opportunities to improve care are identified and acted upon;
- Care is medically necessary and resources are utilized efficiently; and
- Patient care is delivered in conformity with established criteria for medical practice and in accordance with the By-laws and Rules and Regulations of the Medical Staff.

Please refer to the following link, qhnintranet.qhnad.nychhc.org/documents/POL_PDF/ADM13.PDF

Reporting Occurrences

Unusual events, such as accidental falls, burns, or other iatrogenic injuries or events, must be recorded in the patient's record immediately, and the printed form for Occurrence Reports must be completed at the time of the injury. If a serious injury occurs in the Hospital, the Clinical Nurse Manager for the area should be informed immediately as should the Department of Risk Management at ext. 43693.

Since 1985, the New York State Department of Health has required hospitals to report patient incidents that are not thought to be part of the natural history of the patient's disease or usually expected treatment. The Department of Risk Management, Regulatory and Medical Affairs, is obligated to investigate such occurrences and, as appropriate, to report to the Department of Health within specified time periods. The physician may be asked to assist with information relative to such an investigation, at which time full cooperation is required. It is the House Staff Officer's obligation to cooperate fully with any quality assurance, risk management, or peer review investigation undertaken by the Hospital. For detailed information refer to the Hospital's policy for "Incident Reporting," available on the QHN Intranet. Only clinical aspects of the patient's treatment plan should be discussed with the patient or his/her relatives. Non-relevant conversations relative to the occurrence itself should be avoided.

NOTE: Risk Management provides assistance 24-hours a day through the page operator.

Restraints and Seclusion

The EHC promotes a restraint-free environment to the greatest extent possible. Use of restraints and seclusion is limited to clinically justified situations to prevent harm to patients or others. The importance of this has been emphasized by the recent publication of the Federal Government concerning the use of restraints for acute medical and surgical care in Medicare and Medicaid patients. These regulations state:

Federal Regulations on the Use of Restraints for Acute Medical and Surgical Care

- 1 The patient has the right to be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff.
- 2 A restraint can only be used, if needed, to improve the patient's well-being and less restrictive interventions have been determined to be ineffective.
- 3 The use of restraints must be in accordance with the order of a physician or other licensed independent practitioner.
- 4 The condition of the restrained patient must be continually assessed, monitored and reevaluated.

Source: Health Care Financing Administration: Department of Health and Human Services. Medicare and Medicaid programs: hospital conditions of participation, patients' rights. Fed Regist 1998; 64: 36070-89

To reduce the risks associated with restraints, least restrictive alternatives are implemented first. When these measures are ineffective in maintaining a safe environment, restraints may be used. Restraints include any device that immobilizes the patient; this includes therapeutic holding and excludes therapeutic comforting of children. Types of restraints include, but are not limited to, wrist/ankle restraints, mittens, vests, siderails, and tabletop chairs.

Medications are also considered a restraint when the primary reason for the drug is to restrict and confine movement. Situations when medications are not considered a restraint include:

- Sedation used to facilitate the treatment plan (i.e., mechanical ventilation)
- Conditions such as brain injury, anoxia, tumor or stroke often require use of PRN medications such as, but not limited to, benzodiazepines, to enable the patient to participate in therapy
- Common PRN medications to reduce anxiety and agitation when indicated by predictable responses to illness or medical diagnosis
- Psychotropics as the standard treatment to decrease agitation in the treatment of dementia and delirium

A registered professional nurse may apply or supervise trained personnel in the application of restraints in an emergency situation, when least restrictive alternatives are not an option or are ineffective. After ensuring the patient's safety, the nurse notifies the physician/ NP/ PA (physician only in psychiatry). A face-to-face assessment of the patient and entry of orders in the patient record must be completed by the physician/ NP/ PA within one hour of initiation of restraints for non psychiatric patients and thirty minutes for psychiatric patients. Documentation in the patient record must include the less restrictive alternatives attempted, the behavior warranting restraint, the type of restraint implemented, and a brief follow-up plan.

Restraint devices such as adaptive devices (e.g., tabletop chairs), devices for positioning extremities related to procedures (e.g., IV armboard, safety devices, and lap belts) do not require a medical order. A registered professional nurse has the authority to determine the need to apply and to discontinue these devices based on the NYS Nursing Practice Act and professional nursing license.

- 24 hours - one point, two point mittens, and vest restraints (nonpsychiatry patients only)
- 2 hours - four point, five point, seclusion (all adult patients, 18 and older), vest, (psychiatry only)
- 1 hours - any restraint or seclusion for psychiatry patients age 9-17 years
- 1 hour - any restraint or seclusion for psychiatry patients under age 9

When patients in restraints must be transported to a diagnostic test or procedure, a physician or registered professional nurse must accompany the patient for the duration of the procedure to ensure appropriate assessment and positioning of restraints. This excludes areas such as cardiac catheterization lab, cystoscopy, etc., where a registered professional nurse is continuously observing and monitoring the patient during the procedure.

For additional policy and care information, refer to EHC Policies.

Suicidal Patients

A psychiatric consultation must be called if it is thought that a patient has suicidal tendencies. In addition, the Departmental Director where the patient is located should be notified in the case of an attempted suicide.

Transfusions: Requests for Blood and Blood Products

Specimens for blood transfusion may be drawn by House Staff, physicians, phlebotomy team members, and nursing personnel. ALL labeling and requests MUST be filled out and signed by the individual who draws the specimen. At the time of phlebotomy, the patient MUST be correctly identified and the specimen drawn into a labeled tube. The patient identification and label should be checked before leaving the patient. This double check MUST be validated by the signature of the Housestaff, Nurse or attending. phlebotomist on the specimen and the Requisition Form.

The circular of information for the use of blood and blood components can be obtained from the Blood Bank. In addition, ALL questions regarding blood product use and transfusion reactions should also be directed to the Blood Bank Laboratory, Ext. 46101

DEPARTMENTAL INFORMATION

Ambulatory Care Services

Emergency Department

No patient will be denied evaluation in the Emergency Department. Rapidity of evaluation will depend upon the severity of the complaint. Failure to comply may result in legal action.

All patients presenting to the Emergency Department will be evaluated by House Staff and/or attendings following nursing triage. Patients:

- judged seriously ill without improvement in status while under treatment;
- with extensive deterioration of a chronic condition; or
- in whom a potentially serious diagnosis is entertained will be admitted to the appropriate service by the House Staff or attendings according to Hospital Guidelines.

All questions regarding disposition must be brought to the attendings or senior Residents who are responsible to Department Heads (medicine, surgery, pediatrics, psychiatry) for all professional matters and the Director of the Hospital for administrative matters.

If the decision is made not to admit a patient referred by a private physician, the Emergency Department attendings must attempt to contact that physician. The referring physician should also be notified of admissions so that continuity of care is maintained.

All patients to be admitted must be listed with Bed Board Management. Actual bed locations will be determined by Bed Board.

All transfers shall be made in accordance with federal and state laws and the Hospital's Transfer Policy. All transfer forms are available in the Emergency Department Administration office.

All referrals to the clinics must be arranged by the ED staff. In addition, during regular business hours the ED staff must call the clinic to verify that a patient can be referred directly to them. During off hours, patients should be given the number of the clinic call center and be informed to call for an appointment.

PGY-1 and -2s will be oriented to the function of the Emergency Department by their respective supervisors and will be supervised by PGY-3s and attendings. Emergency Department attendings will adjudicate all matters of disagreement regarding admission decisions.

Ambulatory Care Practices

Generally, the Ambulatory Care Practices operate Monday through Friday, 8:00am-5:00pm, and selected evenings for some Primary Care Practices. Schedules and hours of operation of the Practices are available at all Nursing Stations and in the Emergency Room.

During operating hours, the Practices should be called directly when referring Emergency Room patients for primary care follow-up or a specialty consultation appointment. During off hours, patients should be given a referral form with the name and the telephone number of the Practice so that they may make an appointment. If a referral is being made to a Specialty Practice, it may be necessary to obtain prior approval from the physician in charge of the Practice or the patient's primary care provider.

When referring patients upon discharge to a Practice for follow-up, the name and telephone number of the Practice should be noted on the discharge orders.

If a patient requires an immediate follow-up or has an unusual problem, a telephone call to the physician in charge of the Practice is always appreciated. Call the Practice directly and ask to speak with the physician in charge.

Documentation in the Medical Record: All outpatient medical records should be problem oriented and contain information pertinent to the care of the patient. The following guidelines should be followed:

- I. A physician, nurse practitioner, midwife, or physician assistant must document a complete medical history and comprehensive physical examination at the time of the initial visit.
- II. A physician, nurse practitioner, midwife, or physician assistant must document a noted and focused physical examination at the time of a subsequent visit.
 - A. An attending physician/preceptor must countersign notes written by House Staff and physician assistants.
 - B. A note written by the attending, nurse practitioner, midwife or physician assistant must accompany notes written by students (including medical students).
- III. At the time of each visit the provider must update the patient's problem and medication lists.
- IV. The progress notes should include a notation that lab results have been reviewed.
- V. When specific practice guidelines warrant a nursing assessment (including vital signs), this nursing assessment must be documented in the ambulatory record.
- VI. The health care team assesses pain according to unit specific policies.
- VII. New York State Health Code Section 405.11 requires an identifiable signature for every entry in the medical record. Signatures at Elmhurst Hospital Center are identifiable by the dictation code number. It is recommended that this code number accompany every signature.

Home Health Care Services

The Mount Sinai Hospital has a preferred provider relationship with the Visiting Nurse Service of New York, which is a certified home health agency. There are many such agencies in the New York area and patients should be given a choice of agency for referral. All home health agencies provide a wide range of home health services to qualified patients, including skilled nursing, physical, occupational and speech therapies, social work, home health aides, medical supplies and equipment, laboratory services, and IV therapy. Home health services are covered by most insurances and most agencies have a small allotment for charity care. There are criteria which a patient must meet in order to qualify for service which the on-site home care coordinator from NYC HHC-Health Care Intake number 646-458-6411 can review. In all referrals a physician must certify that the services requested are necessary. The Intake number and the main VNSNY office number is (212) 290-3800. The social workers on the units maintain a list of all certified agencies for patient choice

Clinical Laboratories

Clinical laboratories at Elmhurst Hospital are organized under the Ancillary Division; the administrative office is located in the Main Building (Room A1-06). Specimens pass through Central Accessioning (D3) to the Automated Core Labs and other areas.

Chemistry/ Endocrinology/ Immunology/ Toxicology	E3-18
Hematology	C5-11
Cellular Immunology	D3-25
Microbiology	D5-01
TB	C3-11
Histology	E3-7
Cytology	Queens Hospital
Cytogenetic/Tumor Cytogenetic	Quest Sendout
Central Accessioning	E3-21

STAT bloods from the ER/SICU/Delivery Room are sent by chute directly to Hematology and/or Chemistry

Alternatively: STAT's are brought by messenger directly to Chemistry and Hematology

Alternatively: Micro specimens brought by messenger directly to Central Accessioning

All tests are listed in the MYSIS CPR system. If Questions regarding available tests and their respective requirements can be addressed by calling Accessioning at exts: 43490, 43473 or 43482

Infection Control

The Infection Control Program is a multifaceted program aimed at the prevention of infection in the Hospital environment. The Infection Control Manual is available on the Queens Health Network Intranet (see Policies and Manuals) and is comprised of guidelines necessary for controlling Hospital-acquired infection.

Indications for Airborne Precautions

- A. Confirmed, active *M. tuberculosis* respiratory tract disease: Positive culture from upper or lower respiratory tract (e.g., sputum, bronchoalveolar lavage, transbronchial, open lung or laryngeal biopsy).
- B. Suspected active *M. tuberculosis* respiratory tract disease:
 - 1. Positive AFB smear from upper or lower respiratory tract (e.g., sputum, bronchoalveolar lavage, transbronchial, open lung or laryngoscopy).
 - 2. *M. tuberculosis* disease should also be suspected in the following clinical situations and isolation considered:
 - a. Non-HIV positive patients (and/or without risk factors for HIV infection), with:
 - i. A subacute or chronic presentation, and
 - ii. Chest x-ray findings:
 - upper lobe infiltrates (with or without cavitation)
 - cavitation
 - other locations of infiltrates with hilar/mediastinal adenopathy or other supporting clinical evidence as below:
 - history of tuberculosis
 - history of exposure to tuberculosis
 - history of positive PPD
 - hemoptysis
 - persistent productive cough
 - night sweats
 - anorexia
 - weight loss
 - fever
 - pleural effusion
 - any infiltrate determined unresponsive to nonantituberculous antimicrobial therapy
 - b. HIV-positive patients (and/or with risk factors for HIV infection), as above in 1-B-2-a-ii, with cough or fever in addition to the following:
 - i. Chest x-ray findings (in addition to 1-B-2-a-i):
 - Interstitial infiltrates
 - Increased interstitial markings
 - Nodule(s)
 - Hilar/mediastinal adenopathy
 - Pleural effusion
 - ii. Unexplained productive cough >5 days duration regardless of CXR findings (including negative chest x-ray)

Clearance for Discontinuation of Airborne Precautions

- A. Patients treated with antituberculous therapy:
 - 1. Known/suspected isolate sensitive to antituberculous agent(s):
 - a. After 14 days of effective therapy;
 - b. Clinical response to therapy (i.e., resolution/significant diminution of cough and fever); and
 - c. Decreased number of organisms on AFB smear (if specimen available).
 - 2. Known/suspected isolate resistant to antituberculous agent(s):
 - a. After 14 days of effective therapy; **and**
 - b. Clinical response to therapy (i.e., resolution/significant diminution of cough and fever); **and**
 - c. Decreased number of organisms on AFB smears (if specimen available).
- B. Patients not thought to have tuberculosis and not treated with antituberculous therapy:

1. Other (non-*M. tuberculosis*) confirmed etiology (i.e., *S. pneumonia* isolated from blood, PCP identified in BAL):
 - a. Clinical response (i.e., improvement in respiratory/ pulmonary status and resolution/ diminution of fever) without other clinical parameters to suggest concurrent tuberculosis and AFB smear(s), if available, are negative.
 - b. Isolation may also be discontinued on a case by case basis without a clinical response if above criteria 2-B-1-a are satisfied.
2. Other (non-*M. tuberculosis*) presumed/ unconfirmed etiology:
 - a. Clinical response (improvement in respiratory/ pulmonary status and resolution/ diminution of fever); **and**
 - b. Clinical parameters (including chest x-ray) completely consistent with confirmed diagnosis (e.g., without persistent productive cough, without hilar/ mediastinal adenopathy or cavitation, if diagnosis presumed PCP) and AFB smear(s), if available, are negative.
3. Clearance for Discontinuation of Isolation
 - a. Decisions regarding clearance for discontinuation of isolation will be reviewed on a case by case basis by Infection Control. Clearance for discontinuation of isolation must be approved by Infection Control or as indicated below.
 - b. Infectious Diseases and Pulmonary attending physicians(s) may approve discontinuation of isolation under the following circumstances:
 1. When acting in the role of responsible attending physician on an individual case.
 2. When acting in the role of responsible attending physician for a service patient or as the service consult attending.
 - c. Clearance for discontinuation of isolation on nights and weekends may also be made by the Infectious Diseases Fellow.
 - d. Infection Control must be informed prior to discontinuation of isolation and will monitor implementation of the above guidelines. The physician in charge of Infection Control maintains the authority to veto any decision that is inconsistent with the above guidelines.

Nutrition Services

The Department of Clinical Nutrition encourages House Staff to become active participants in the nutritional care of patients. Research has shown that even today malnutrition exists in hospitals and is associated with an increase in morbidity and mortality rates, longer lengths of hospital stays, increased patient complications and an increase in the cost of health care. Early and appropriate nutrition intervention is associated with a shortened recovery period and enhanced quality of life for the patient.

With your effort we can strive to improve the nutritional status of our patients. On the care centers, every unit is covered by a Registered Dietitian who will gladly work with you to ensure optimal nutritional care. You may refer a patient to the Registered Dietitians for nutrition assessment or counseling. They can be reached by beeper or by initiating a nutrition consult in HIS. For continued education after discharge, you may refer the patient to Ambulatory Care for an appointment with a dietician in a specialized clinic.

The American Dietitians Association Nutrition Care Manual is a comprehensive guide to diet prescriptions as well as a quick reference regarding appropriate diet restrictions. In addition, Enteral nutrition products on formulary are described in the Diet Manual. The manual can be assessed through the QHN intranet under quick links.

Our staff of Registered Dietitians are dedicated to provide quality nutritional care to our patients. Clinical nutrition intervention includes:

- Comprehensive Nutrition Assessment, including Anthropometric and Biochemical markers
- Detection of Malnutrition Risk Factors
- Nutrition Care Plan, including recommendations for Enteral and Parenteral Nutrition Support
- Education/Counseling regarding therapeutic diets and meal planning

Please review the Dietitians Nutritional Assessment for a detailed account of the patient's needs and the interventions recommended to improve patient outcomes.

For a listing of dietitians and beeper numbers, or any nutrition related questions, please contact the food and nutrition clinical division.

Nursing Department

Philosophy and Organization

Interdisciplinary collaboration, effective communication, and collegial partnerships among nurses, physicians, and other health professionals, ensure the provision of high quality patient care.

Each inpatient has a nurse from admission to discharge who is accountable to plan, coordinate, deliver, and evaluate care for the patient and family. Professional nurses have clinical autonomy to determine care interventions within the scope of nursing practice, to advocate for patient rights, to ensure continuity of care, and to promote communication within the interdisciplinary team.

Clinical Nurse Managers have 24-hour accountability for the delivery of patient care within designated clinical areas and programs. To promote excellence in patient care, the Clinical Nurse Manager creates a therapeutic environment for caregiving that supports the nurse-patient relationship and the implementation of evidence-based practice. Advanced practice nurses, such as nurse practitioners, nurse clinicians, clinical coordinators, and education specialists, provide support to the clinical nurses in the management of complex patients. The Department of Nursing Education provides initial and ongoing education to all nurses to ensure and sustain

excellence in patientcare. Through the Nursing Practice Committee clinical nurses determine and advance standards of nursing care that meet the changing needs of patients.

All care centers have a Director who is responsible for nursing practice across a number of patient care units. The Chief Nursing Officer (CNO) is accountable for nursing services throughout the hospital and ensures that standards are implemented and evaluated.

Private Duty Nurses or Companions

When a patient or family wishes to obtain private duty nurses or companions, they are referred to the Nursing Office, Room A1-25. Please refer to this link,

ghnintranet.ghnad.nychhc.org/documents/NursingAdmin/AP2.pdf

Intravenous (IV) Therapy and Blood Work

Intravenous Therapy and Blood Work: RN or LPN nurses competent in IV therapy techniques are available to initiate, restart, and discontinue peripheral IV therapy catheters. In the absence of a registered nurse, the physician must initiate, restart, or discontinue peripheral IVs.

Medications

Registered professional nurses administer medications by all routes based on unit competencies. All medications require a valid medical order with the drug name, dose (concentration and flow rate for IV administration), frequency, and route, in accordance with the current *Mount Sinai Drug Formulary*. Only drugs approved by the Formulary Committee may be administered to patients.

Please refer to the *EHC Drug Formulary* for information regarding the administration of investigational drugs.

Verbal/telephone orders are only accepted in an emergency and must be authenticated/cosigned by the prescriber as soon as possible and not to exceed 24 hours, in accordance with the Rules and Regulations of the Medical Staff of The Mount Sinai Hospital.

When a physician administers a medication, it must be entered in the medical orders and the drug name, dose, route, and time administered is entered in the patient record. If a medication is administered in error (i.e., wrong dose, extra dose), an occurrence report must be completed by the involved nursing and medical staff. This form must be completed immediately after discovery and forwarded to the responsible Clinical Nurse Manager.

Use of Therapeutic Mattresses and Specialty Beds

When a patient is at significant risk for skin breakdown, a pressure relieving mattress or bed may be required. Use of these beds must be approved by the AED, who will process the request for the device then forward it to the Bio Med department. When the patient is no longer at risk or the pressure ulcer is healed, the device should be discontinued.

Operating Room

Pre-Operative Testing

Chest x-rays are required for all surgical patients 70 years of age and over scheduled for general anesthesia; chest x-rays may be ordered for other surgical patients when appropriate. It is the responsibility of the House Staff member managing the patient's medical care to ascertain that this procedure is completed. Prior to admission, an Admission Test Order Sheet, which can be obtained from the Admitting Office, should be completed.

All ambulatory surgery and same day surgery adult patients scheduled for surgery requiring general/spinal anesthesia are evaluated in the Perioperative Care Center (PCC) by an anesthesiologist or internist who will determine the appropriate lab test, x rays, EKG and other diagnostic testing are performed based on patient assessments, patient history and clinical needs.

*Elmhurst Hospital Center
Operating Room Policies & Procedures – 2006 Listing*

Please review the following link for Operating Room Policies and Procedures
qhnintranet.qhnad.nychhc.org/documents/OR/ORP&PIndexListing06.pdf

Attire

- All personnel entering the surgical suites are to wear appropriate attire. (See Infection Control Manual: Infection Control Guidelines for OR's/Surgical Scrub Procedure Special Instructions, section 1.)
- OR attire is not to be worn outside of the OR unless covered by a clean lab coat or gown. Scrubs are not to be worn in the street. Masks, hats, and shoe coverings should be removed before leaving the OR area.
- Street clothes are not to be worn in restricted or semi-restricted areas.

Surgical Scheduling

The scheduling of elective surgery for all services is to be done via the Surgical Admission. All information concerning patients should be made available at the time of scheduling surgery, including exact location of surgery. Procedures scheduled after the schedule has been finalized may be placed on a wait list and will be accommodated as quickly as possible.

Procedures are to be scheduled realistically with a full appreciation for the need for accurate information by the Operating Room staff. Operations should be listed in the order in which they are to be performed. For Anesthesiology Consultation on problem cases, call ext. 42138, or page the Anesthesiology Resident on call for evenings or weekends.

The printed preliminary OR schedule is available for distribution from 4:00 P.M. to 5:00 P.M.. Copies are faxed to the office of Directors of Service and Nursing Units. delivered by the Transportation and Information Department to each Nursing Station and are available at the OR Control Desk for Residents of each surgical service. A late-edition, final schedule is available and distributed after 9:00 P.M.

Changes to the printed schedule should be communicated immediately to the OR Scheduling Office, ext. 46283, to permit utilization of all OR time. This includes cancellations, changes in order of procedure or changes in type of procedure.

Changes to the schedule can be made up until 8:30 P.M.

Preoperative orders are to be written only for those patients appearing on the OR schedule, with the exception of emergencies. Orders for the preoperative preparation of the skin are to be written as early as possible to allow personnel time to carry out orders before 11:00 P.M. all "on call" orders should note destination, e.g., "on call to OR" (refer also to OR Nursing Policy #40 on "Scheduling Patients for Surgery").

Arrival Time before Surgery

Surgical House Staff should arrive in the Operating Room 30 minutes prior to the scheduled time of the operation. They should be present in time to observe the induction of anesthesia and to assist in any way possible, such as positioning of the patient.

Blood Availability for Elective Surgery

Requests to reserve blood for elective surgical cases are filled by the Blood Bank according to the Maximal Blood Ordering for Surgery (MBOS) guidelines. To reserve in excess of these guidelines, the attending physician MUST speak with a Blood Bank Supervisor. For further information, call the Blood Bank at ext. 42014. Please refer to the following link,

Operative Procedures Not in the Operating Room

Except for an acute emergency or in those situations where it is impossible to transport the patient, operative procedures are to be done in the Operating Room proper. Incisions of abscesses, endoscopic examinations with biopsies, and similar procedures are best done in the Operating Suite where proper protection for the patient and the staff is possible. Requests for exceptions must be discussed with the appropriate Clinical Director and have the prior approval of the responsible attending physician.

Operative Reports

Operative Reports are to be dictated as soon as possible following the surgical procedure. Telephone extensions are available for this purpose in the main Operating Suites. It is imperative that complete identification of the patient (full name and unit number) precede each Operative Report and that the physician identify him/herself at the end of each report.

An outline for dictation of Operative Reports is posted in the main Operating Suites. The dictator is urged to become familiar with this process in order to minimize errors in transcription. Poorly dictated reports may not be transcribable or may be typed unacceptably.

Dictation can be done using any hospital telephone.

Surgical Specimen Care and Requisition for Pathological Examination

1. All tissue removed from every patient during surgery is to be appropriately and accurately identified and sent to Surgical Pathology for histological examination.
2. After each specimen is obtained, the scrub nurse will verify anatomical identification for the specimen, the type of solution media and the pathological examination desired with the surgeon.
3. The surgeon or Resident will complete the Pathology Form at the completion of the operative procedure and give the completed form to the circulating nurse.
4. Any specimen that is removed from the Surgical Suites by the surgeon or Resident is to be signed out in the Operating Room Log Book by the responsible physician.

Biopsy for Frozen Section: A biopsy removed for frozen section is handled immediately by the nursing personnel. The nurse-in-charge sends the specimen over to the laboratory with the Identifying Pathology Slip completely filled out. This specimen goes over exactly as removed and is not placed in any solution.

Radiology Services

The Radiology Department includes diagnostic radiology, ultrasonography, computerized tomography (CT), interventional radiology, nuclear medicine, magnetic resonance imaging (MRI) and mammography. The Department provides services to inpatients and emergency patients 24 hours per day and services to outpatients approximately 9 hours per day, Monday through Friday, and on a limited schedule on weekends. The range of services includes diagnostic procedures and interventional special procedures, utilizing ionizing and nonionizing radiation, with and without the use of contrast media.

Voice Reports, Electronic Reports, and Transcriptions

Dictated results of x-rays are immediately accessible on MISYS CPR.

Electronic Reports are available via MISYS 1 on terminals via the hospital intranet. Login IDs and passwords are obtained from Radiology at 718-334-2082

PACS: Picture archiving Communication System is available throughout the facility for viewing images. Support for services is available Monday thru Friday 8:00 am thru 12:00 midnight, and can be reached through the help desk at 42082.

Diagnostic Radiology Services - Film File Room

COPIES: Can be requested in office room E1-18P, Monday thru Friday 8:00 am through 4:00 pm. Authorizations from patients are required, along with 2 picture ID's. Charges for copies may be applicable; details will be given in office E1-18P. Copies for patients being transferred will be made at time of transfer, after approval from administration, and may be transferred electronically.

File Room: Open Monday through Friday 8:00 am thru 11:30 am and 1:00 pm thru 3:30 pm for mammographic exam folders only. All requests for folders must be submitted 24 hours in advance.

Social Work Services

Social Work Services provides the patient and families are more effectively served when personal and family problems influencing health care treatment and recovery are treated simultaneously and in close relationship with the diagnosis and treatment of illness. The services are given by the staff of the Department of Social Work Services made up of professionally trained personnel.

Based on the recognition that social and emotional factors are fundamental concerns in illness and can be disruptive to health and medical care, the Department of Social Work Services is prepared to help patients and their families in meeting these related problems. Social workers also provide consultation and technical assistance related to behavioral health issues. The following are areas with which patients and staff frequently have need for assistance:

1. Discharge planning for care needed following hospitalization (e.g., assessment of needs; adjustment of patient/family to changes in function; connection to resources for effective aftercare).
2. Emotional, social, family, economic, and vocational problems interfering with the patient's ability to use medical care prescribed by the doctor or to derive optimum benefits from health care services.
3. The patient's and his/her family's reactions, whether related to the illness or not, that hamper the health care (e.g., because of fear, preconceived attitudes, misunderstandings, difficulty in accepting limitations due to illness).
4. Practical day-to-day living affected temporarily or long term by the limiting and handicapping restrictions involved in the illness (e.g., household responsibilities, care of children, job consideration, poor housing, financial stresses).
5. Special health or social needs necessary to ensure benefits of treatment (e.g., nursing care, homemaker service, appliances, vocational, educational adjustments).
6. Family problems created or aggravated by illness or handicap (e.g., marital difficulties, faulty parent-child relationships).
7. Unexplained reasons for the illness, particularly in children or the elderly.
8. Where abuse is suspected (e.g., child abuse, elder abuse, domestic violence, etc.).
9. The unvisited patient, or one reacting to the illness and hospital situation with withdrawal, belligerence, or aggression.
10. Use of health care services that are unsubstantiated by physical illness.

Please refer to the following link, qhnintranet.qhnad.nychhc.org/documents/SocialWork/POL1-01A.pdf

Preparing Patients and Families for Referral: Social workers use high-risk criteria to determine whether to initiate intervention with patients. When physicians refer to the Department of Social Work, it is very helpful if they discuss with the patient/family the reason for referral in relation to the medical treatment plan. Interpretation of the importance of getting assistance with emotional and social problems, as part of comprehensive health care, can be most helpful.

Adoption Policy

It is the policy of Mount Sinai Services that neither employee, nor any physician with privileges may participate in making legal adoption arrangements for private adoptions. The Department of Social Work Services is available to assist prospective parents who wish to place a baby for adoption in obtaining the services of licensed adoption agencies. Patients requesting information on planning a private adoption may not be referred to attorneys but should be referred to the Department of Social Work Services.

Use of Medical Records by House Staff

The rules governing the use of charts are established by the Medical Board and are enforced by the HIM (Health Information Management). A House Staff Officer may call the following numbers for any problems or questions with regard to HIM:

Chart Retrieval/Release of Information:	
Assistant Director	Ext. 43138
General Issues:	
Director	Ext. 43127
Chart Completion or Dictation:	
Chart Completion Manager	Ext. 43131
Electronic Signature:	
HIS Help Desk	Ext. 41318

1. HIM serve many critical functions
 - Education and scientific research
 - Peer review
 - Quality Management
 - Risk Management
 - Fullfills billing requirements
 - Ensures compliance with Federal, State and accrediting mandates
 - Chronological documentation of the care rendered
 - Treatment planning and evaluation
 - Communication tool among the patient’s physician(s) and other health care providers.
 - Continuity of care
 - Legal document: Legally admissible as evidence in court of law
2. To ensure availability for transfer to HIM, charts should not be taken from the Clinics or Nursing Stations. Discharged charts are picked up by HIM staff from the Nursing Station beginning at 10:00 A.M. and from the Clinics beginning at 3:00 P.M.
3. Hospital staff members have access to the hand copy and computerized medical record, as required to carry out their assigned roles and responsibilities relative to treatment, payment and health care operations.
4. Generally, Federal and State laws requires the patient’s written authorization for release of information to outside parties.

5. Charts requested other than the patient care must be approved by the Service Director. The HIM Department requires 72 hours notice and will hold the chart in reserve for 1 week before returning to file.
6. Charts are not to be removed from the HIM Department without specific authorization, and under no circumstances are charts to be taken from Hospital premises

Confidentiality

1. HIM, radiology films, and pathology slides are kept for the *benefit* of the *patient*, but are the *legal property* of the *Hospital*.
 - a. The original medical record may not be taken off-site. In the event of a court order or subpoena the Legal Department is immediately contacted.
 - b. Original slides may be released for outside consultation only with patient authorization and approval of HHC legal.
 - c. Radiology films may be released with patient authorization.
 - d. Authorization of the patient, surrogate, or legal guardian is required for release of copies off-site except:
 - To comply with a regulation
 - In response to a subpoena or court order
 - To enable continued patient care in the event of:
 - Direct transfer
 - Diagnostic interpretations or second opinions (only if a contract exists with consultant)
 - Case conference (if care is taken to eliminate identifying material appropriately).
 - e. Providers may look at information belonging to patients whose care they were involved in for these episodes and preceding episodes leading up to those episodes only.
 - f. Records may be reviewed for educational purposes as long as:
 - Patient identification is removed from each page if a copy is made
 - Names and identifying information are not used during case presentation
 - Patients are not identified by name or initials in committee minutes
 - g. The record may be used for IRB-Approved Research if:
 - Patient names are blocked out on any photocopies made
 - Cases are assigned numbers, with a number key maintained under lock and key.
2. Confidential Patient Information
 - a. Includes all:
 - Clinical and psychosocial information gathered during the diagnostic/therapeutic process.
 - Financial information related to a patient's or employee's personal financial status, credit, and insurance information.
 - Any demographic information, including the fact of treatment, regarding a patient receiving psychiatric or substance abuse-related treatment.
 - b. May exist in:
 - A patient record (either hard copy or electronic format).
 - Logs (either hard copy or electronic)
 - Lab
 - Radiology
 - HIM/Finance
 - SAP Scheduling
 - Outpatient Scheduling
 - Pathology
 - Published Schedules (OR, Procedure, and so on)
 - Data Repositories

- QA Reports
 - Registries
 - Requests from Third Party Payors
 - Research Records
 - Clinical Trial Case Reports
- c. Protected records require special releases and handling; they include:
- Psychiatric records
 - Substance abuse records
 - HIV-related records
3. Responsibility
- a. Passwords should never be shared
 - b. All research, even if it is limited to chart review, requires IRB approval
 - c. Confidential information should never be discussed or shared in any public or unsecured environment, including:
 - Cafeteria
 - Elevators
 - Unencrypted e-mail
 - Publicly accessed laptop
4. Disposal
- a. Non-permanent material, including copies of paper records, computer printouts, and microfiche, must be disposed of by:
 - Shredding
 - Confidential security bins are located throughout the Hospital
 - b. Information accessed online must be cleared from the terminal and the session logged out prior to leaving the work station.
 - c. Floppy disks containing confidential information must be secured.
5. To obtain a network login ID, contact your department's administrator. Additional assistance for this and other computer related issues is available through the HIS Help Desk at ext. 41315.

Patient Medical Information

In order to protect patient confidentiality and comply with legal restrictions concerning the release of information, all requests for medical information of a non-emergent nature from outside the Hospital are to be submitted in writing to the Correspondence Unit of the HIM Department. Information deemed urgent is to be transmitted with the utmost discretion when consistent with legal requirements. If you have any questions, call the HIM assistant director at ext. 43138.

HIV Confidentiality Law: The New York State HIV Confidentiality Law requires that all health care professionals who have access to HIV related information be informed of, and comply with, the various aspects of the law. The major sections of concern are:

Disclosure of HIV-Related Information: Any information related to the HIV status (be it positive or negative) of a patient may not be released without written consent from the patient to do so. Any time information is released, it must be accompanied by a statement prohibiting redisclosure and informing the recipient of the confidential nature of the materials.

HIV Test Results: HIV test results and related material must be maintained directly in the patient's medical record.

A copy of the law can be obtained from the AIDS Center at ext. 41897 or the Legal Department at ext. 48105

Unit Number for Patient Identification

The Hospital presently uses a unit-number system for both inpatient and outpatient identification.

This seven-digit number is prominently marked on the chart and is assigned to the patient for life. Patients who repeatedly use EHC services usually have a card on which the unit number is marked. Care should be taken to record this number correctly when entering information in the chart, dictating reports, ordering medications, or otherwise directing patient care.

Central Dictating System

The Hospital has a direct dial dictating system that operates through the telephone. The system is presently restricted to the preparation of Operative Reports.

The direct dial system is available 24 hours per day. Questions or assistance can be obtained by calling ext. 45280, Monday through Friday, 8:00 A.M. to 11:00 P.M., or ext. 43140, Saturday and Sunday, 8:00 A.M. to 11:00 P.M.

All dictated operative reports are uploaded to the MISYS electronic medical record. Attending physicians electronically sign these reports. For information and training contact the HIS help desk at ext. 41315.

Dictating Instructions

At Elmhurst Speed Dial : 45061

Otherwise Dial: 800-801-0714

Doctor ID# _____

When prompted, key in your I.D. number followed by the # key

When prompted, key in 1-digit Work Type Number followed by # Key.

1 = ENT

2 = NEURO-SURGERY

3 = OB/GYN

4 = OPHTHAMOLOGY

5 = ORAL SURGERY

6 = ORTHO

7 = SURGERY

8 = UROLOGY

When prompted, key in patients Medical Record Number followed by # Key.

You are now ready to dictate. At the prompt, press 2 to begin recording. If you hear a tone while speaking, you are not recording. Press 2 to resume recording.

Telephone keypad Functions

2 Dictate or resume recording Pause

8 Complete current report and start next report without redialing into the system. When dictating multiple reports in one telephone call, you must press 8 between each dictation.

Disconnect from the system

Short review and playback

Full rewind to beginning of report

Fast forward to end of report

To note the Job # of the report you are dictating, press the # Key twice anytime while dictating and then press 2 to resume dictating.

MedRec Resources. LLC 609-693-9471

Please call ext. 45280 for information and/or assistance.

All dictated Reports are sent to a Transcription Service outside the Hospital. Inpatient/Ambulatory Surgery operative reports are returned within 24 hours. All physicians are required to use the direct dial dictating system, thereby expediting the chart completion process and improving documentation.

Operative reports are to be dictated as soon as possible after surgery. Discharge summaries are to be completed immediately following discharge. If the House Staff Officer has not completed his/her HIM at the time of the patient's discharge, he/she may obtain the record for completion in the chart completion area of the HIM Department (Room BE-4).

When a House Staff Officer is on rotation at an affiliate hospital, it is his/her responsibility to complete all of his/her medical charts before rotating to another affiliate or returning to Mount Sinai.

House Staff will be notified by The Chief of Service of chart deficiencies. Charts not completed within 30 days (including signatures) are deemed delinquent. Department Directors at Elmhurst Hospital Center and Mount Sinai affiliate office will be notified of any delinquent records.

The Medical Board has approved suspension of admitting and operating privileges of physicians with delinquent HIM, and has agreed to the following additional sanctions for house staff:

A notation shall be placed in the House Staff Officer's file, noting their failure to meet the required timeframe or to respond to warnings about chart completion.

The annual salary increase commensurate with promotion to the next PGY level will not be awarded unless all HIM have been completed.

The House Staff Officer's diploma/certification will not be awarded upon residency completion unless all HIM have been completed.

Medical Record Content

Admitting Diagnosis

Each patient must have a presumptive diagnosis recorded upon admission to the hospital. This is particularly important for hospital and medical insurance purposes, as well as to justify the need for hospitalization. It also facilitates patient care plans and discharge planning.

History and Physical Examination

A complete history and physical examination must be dated, timed, and recorded within 24 hours of admission, regardless of the service to which the patient is admitted.

The following will be included:

1. Date of admission
2. Identification: patient's age, sex, and occupation
3. Chief complaint
4. Present illness
5. Past history: general health, childhood diseases, adult illnesses, trauma, and operations
6. System review
7. Habits
8. Marital and social history
9. Family history
10. Record of complete physical examination prefaced by temperature, pulse, respiration, blood pressure and pelvic exam for female patients over 21 years of age.
11. Assessment and treatment plan
12. Signature and stamp of author
13. Doctor's dictation code

In addition to the standard elements, House Staff must become familiar with any specific items of a complete history and physical examination required by the department in which he/she is serving.

Progress Notes

Progress Notes insure continuity of care between shifts and disciplines, justify care to third-party payers and regulatory agencies, and help defend quality in a legal action. Entries are made by all disciplines involved in a patient's care and should be made as often as the patient's condition warrants, but not less than once a day. Notes should be objective and deal primarily with the patient's care; editorializing should be avoided. They should be legible, dated (month, day, and year), and timed, and the signature and dictation code should be included.

1. As a rule, the first Progress Note should contain any significant history or physical findings not previously recorded, diagnostic impressions, and any further suggestions that are pertinent.
2. Subsequent Notes should contain statements relative to *all* significant findings, changes in diagnosis, condition, or therapeutic program. All lab and ancillary test results should be documented.
3. Prior to surgery, a Note should indicate the preoperative diagnosis and reason for surgery. Immediately following surgery, a brief Note should be completed.
4. Consultant findings should be acknowledged in the progress notes.
5. The final Progress Note prior to discharge should contain the principal diagnosis (that which is determined upon discharge to have caused the admission), complications and comorbidities.
6. When changing services, a final "off service" Note should be placed in the chart, including the major diagnoses, so far as they are known, as well as the therapeutic program.

Discharge Summary

The increasing demands for and uses of the medical record (e.g., billing, mandatory reporting, regulatory requirements, and so on), require unfailing physician cooperation in completing the record. Therefore, immediately prior to the discharge of a patient a Discharge Summary should be completed by the Attending or the House Staff member (see ghninet.ghnad.nychhc.org/documents/POL_PDF/PTS25.PDF). The House Staff member enters the Discharge Summary into the MISYS HIS system and the attending physician electronically signs this document.

When a patient is discharged, the covering resident at the time of discharge shall be responsible for completion of discharge summary.

Signatures

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and New York State Health Code (section 405.11) require an identifiable signature for every entry in the medical record. Signatures at Mount Sinai Services are identifiable by the dictation code number. *Please use this code number whenever signing any portion of the chart.*

Error Correction

To correct an error: Place one line through it, label it “error” and date, time, and initial the correction. Never white-out, scribble out, write over, tear out a page, or squeeze in an entry. To correct an electronic error in MISYS, the document can be edited

Incomplete Medical Records

Operative reports are to be dictated as soon as possible after surgery. Discharge summaries are to be completed immediately following discharge. If the House Staff Officer has not completed his or her medical records at the time of the patient’s discharge, s/he may obtain the record for completion in the chart completion area of the Medical Records Department , Main Building, Basement.

When a House Staff Officer is on rotation at an affiliate hospital, it is his or her responsibility to complete dictation of all of his or her medical charts before rotating to another affiliated institution or returning to Mount Sinai Services.

House Staff will be notified by mail of chart deficiencies. Charts not completed within 30 days (including signatures) are deemed delinquent. Department chairs at Mount Sinai Services and its affiliates will be notified of any delinquent records.