

The Englewood Hospital & Medical Center

House Staff Manual

OFFICE FOR GRADUATE MEDICAL EDUCATION
ENGLEWOOD HOSPITAL & MEDICAL CENTER
350 ENGLE STREET
ENGLEWOOD, NEW JERSEY 07631

Revised March, 2007

Contents

FOREWORD	VI
SECTION ONE: WELCOME	
Vision Statement	1
Consortium for Graduate Medical Education	1
Core Competencies	2
Commitment to Diversity	3
SECTION TWO: EMPLOYMENT AT ENGLEWOOD HOSPITAL & MEDICAL CENTER	
House Staff Eligibility and Processing	
Employment Eligibility Verification	4
<i>Medical Licensure</i>	4
<i>Requirements for Licensure</i>	5
Equal Opportunity Employer	5
CPR Qualifications	5
Criminal Background Check	5
Physical Examination	6
Toxicology Screening	6
Security Processing	7
Compensation and Benefits	
Compensation	7
Paychecks	8
Health and Related Benefits	8
<i>Employee Health Service</i>	8
Malpractice Insurance	9
Vacation	9
Leave Time	9
Accommodations for Disabled Employees	10
Flexible Spending Accounts	11
Facilities	
Housing	11
Food Service	11
Englewood Hospital and Medical Center	12
Health Sciences Library	

Gustave L. and Janet W. Levy Library	12
On-Call Rooms	12
Telephone and Paging Systems	12
Safety	13
Security	14
<i>Identification Cards</i>	14
<i>Escorts</i>	14
<i>Shuttle Service</i>	14
Parking	14
Uniforms and Laundry	14

Internet Resources

Residency Management Software	15
Privileging Website	15
Job Placement Website	15
National Practitioner Data Bank	15

Activities and Services

Employee Assistance Program	16
Professional Assistance Program of NJ (PAPNJ)	16

SECTION THREE: POLICIES AND PROCEDURES

House Staff Titles	17
<i>Resident (PGY-1 through PGY-8)</i>	17
<i>Fellow</i>	17
Contracts	17
House Staff Evaluation	18
House Staff Representation	18
<i>Englewood Hospital Committees</i>	18
<i>Graduate Medical Education Committees at Mt. Sinai</i>	19
Work Hours	19
“Moonlighting”	20
Disciplinary Action & Grievance Procedure	20
Harassment	21
<i>Definition of Unacceptable Behavior</i>	22
<i>Protection from Retaliation</i>	24
Conflicts of Interest and Related Matters	24
Dress Code	25
Press Relations	28

SECTION FOUR: PATIENT CARE

Patient Care Guidelines	29
<i>House Staff Role in Length of Stay</i>	29
<i>Discharge Planning</i>	29
Consultations	30

Diagnosis-Related Groups	30
Emergencies: Medical and Surgical	31
<i>Emergency Preparedness and Management</i>	31
<i>Code Blue: In-Hospital Resuscitation</i>	32
Ethics: Clinical Dilemmas	32
<i>Capacity Assessment</i>	32
Department of Pharmacy	33
<i>Order Writing</i>	35
<i>Telephone and Verbal Order Policy</i>	37
<i>Unapproved Abbreviations</i>	39
<i>Prescribing Restricted Drugs</i>	40
<i>Automatic Stop Orders</i>	40
<i>Prescribing Errors</i>	43
<i>Adverse Drug Reaction Reporting</i>	44
<i>Pharmacy on the Intranet</i>	46
Patient Demise	46
<i>Patient Expiration</i>	46
<i>Medical Examiner's Cases</i>	48
<i>Reportable Deaths</i>	48
<i>Expiration Checklist</i>	50
<i>Sharing Network Referral Form</i>	51
<i>Anatomical Gifts</i>	54
<i>Organ & Tissue Donation</i>	54
<i>Organ & Tissue Donation after Cardiac Arrest</i>	59
<i>Autopsy Consent</i>	66
Patient Issues, Rights and Responsibilities	70
<i>Informed Consent</i>	70
<i>Advanced Directives, Health Care</i>	
<i>Agents, and Proxy Law</i>	73
<i>Patient Bill of Rights</i>	75
Reporting Occurrences	79
Restraints and Seclusion	83
Suicidal Patients	83
Departmental Information	
Ambulatory Care Services	84
<i>Emergency Department</i>	85
<i>Ambulatory Care Practices</i>	86
<i>Home Health Care Services</i>	87
Clinical Laboratories	87
Infection Control	87
Nutrition Services	91
Nursing Department	91
Radiology Services	94
<i>Request for Exams</i>	94
Social Work Services	95
Medical Records	
Use of Medical Records by House Staff	97

<i>Progress Notes</i>	97
<i>Discharge Summary</i>	97
<i>Signatures</i>	98
<i>Error Correction</i>	98
Incomplete Medical Records	98

THE MEDICAL CENTER'S ACTIONS MAY VARY FROM WRITTEN POLICY. AS SUCH, THE CONTENTS OF THIS MANUAL DO NOT CONSTITUTE A CONTRACT OF EMPLOYMENT. NOTHING CONTAINED IN THIS MANUAL SHOULD BE CONSTRUED AS A GUARANTEE OF CONTINUED EMPLOYMENT. RATHER, EMPLOYMENT WITH THE MEDICAL CENTER IS ON AN "AT WILL" BASIS.

Foreword

It is our hope that your training at Englewood Hospital & Medical Center (EHMC) 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 EHMC, 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 EHMC, 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 EHMC.

Douglas Duchak *President/CEO EHMC*

Lawrence R Krakoff MD *Chief of Medicine*

Barry Stimmel, M.D.
*Dean for Graduate Medical Education
Mount Sinai School of Medicine*

Alex Hyatt MD *Chair Medical Education Committee*

Section One:

Welcome

Englewood Hospital & Medical Center is a non-profit and non-sectarian community hospital. The Board of EHMC is committed to the following Vision and Mission Statements:

Vision Statement:

Englewood Hospital and Medical Center will be the regional leader in providing state-of-the-art compassionate care in a humanistic environment.

The Mission of Englewood Hospital and Medical Center is to:

Provide comprehensive, state-of-the-art patient services. Emphasize caring and other human values in the treatment of patients and in relations among employees, medical staff and community.

Be a center of education and research, as demonstrated by its affiliation with The Mount Sinai School of Medicine.

Provide employees and medical staff with maximum opportunities to achieve their personal and professional goals.

Consortium for Graduate Medical Education

EHMC participates in the Mount Sinai School of Medicine Consortium for Graduate Medical Education that 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 [Job Placement for Residents website](#)

The hospitals currently participating in the Consortium are:

- [Bronx Veterans Affairs 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

EHMC shares the commitment of the Mount Sinai School of Medicine 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 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 Englewood Hospital & Medical Center

HOUSE STAFF ELIGIBILITY AND PROCESSING

Employment Eligibility Verification

In compliance with federal regulations, Englewood Hospital & Medical Center 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 (IMGs) may not begin their training until they have obtained an appropriate visa. If an appropriate visa is not obtained in a timely fashion, IMGs will not be permitted to begin training and their contract will become null.

Medical Licensure

Medical Center policy requires that all graduates of US and International, medical schools appointed to the House Staff must become registered with the New Jersey State Board of Medical Examiners for their PGY I year. PGY II year residents are required to apply for a NJ State Board Permit, which will allow them to continue training in the State of NJ until they complete their residency. All House Staff are required to pass USMLE III prior to graduation.

The Medical Board must approve any exceptions to the above licensing requirements.

Requirements for Licensure

Due to Mt. Sinai Hospital's affiliation with Englewood Hospital & Medical Center's Residency program, as part of our orientation, all entering first-year residents are expected to attend the Mt. Sinai Hospitals orientation, which includes courses in Child Abuse Recognition and Infection Control, for which certificates are issued. The training sessions are held during Orientation in late June.

Equal Opportunity Employer

Englewood Hospital & Medical Center is an equal opportunity, affirmative action employer. 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

The following trainings are **mandatory** during Englewood Hospital & Medical Center's orientation for all House staff with patient-care responsibilities. Recertification is required every two years.

Basic Cardiac Life Support (BCLS) (Initial Course)

Advanced Cardiac Life Support (ACLS)

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.

Prior to issuance of any identification card all new House Staff will have a criminal background check performed by a qualified agency for Englewood Hospital & Medical Center. Multiple states may be searched to capture places lived, worked, and schooled in the past seven years.

The Human Resources department will review the results of the background checks. In addition, foreign nationals, as part of their Immigrant Visa application, will have presented police certificates from Local Authorities in foreign countries for months prior to obtaining their visa.

Because security clearances are required by the USCIS and the consulates issue immigrant visas, the Medical Center will continue to rely on their background checks.

Physical Examination

In keeping with the policies of Englewood Hospital & Medical Center, the New Jersey 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 a health screening conducted by the Employee Health Services (EHS) department of Englewood Hospital & Medical Center prior to commencement of employment.

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.

Englewood Hospital & Medical Center 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 Jersey 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.

Englewood Hospital & Medical Center'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 results of any information relating to drug screening are confidential, and a strict chain of custody is followed.

- 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.

EHS is located on the 5th floor of our Main Building and operates Monday, Tuesday, and Thursday 8am - 4pm. The phone number is 201-894-3111 and their confidential fax number is 201-541-3400.

All House Staff Officers are required to complete an annual health assessment questionnaire. The questionnaires are included in the House Staff's EHS records.

House Staff who previously had negative PPDs must also be retested *every 12 months*.

Security Processing

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

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 Thursday. All House Staff should contact their Department Administrator to find out where their checks may be claimed. Paycheck cashing is available on Hospital premises. We encourage you to take advantage of Direct Deposit. For information about Direct Deposit, call x3025.

Health and Related Benefits

Englewood Hospital & Medical Center provides House Staff Officers many benefits, including:

- Health Insurance
- Prescription Drug Coverage
- Dental Insurance
- Vision Insurance
- Life Insurance
- Short-Term Disability
- Long-Term Disability
- Workers' Compensation
- Flexible Spending Accounts (Medical & Dependant Care)

- Multiple Voluntary Benefits such as group auto Insurance and legal Insurance

Englewood Hospital & Medical Center will provide certificates of insurance and/or explanatory booklets to each House Staff Officer at the time s/he commences employment at Englewood Hospital & Medical Center. Further information is available from the Human Resources office.

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), effective January 1, 1987, House Staff Officers may continue their group health insurance after leaving Englewood Hospital & Medical Center. Contact the Human Resources Benefits Administration Office at x3025 for further information.

Employee Health Service

The Employee Health Service (EHS) is located on the 5th floor of our Main Building. It operates Monday Tuesday, and Thursday, 8:00am-4:00pm, solely for the care of Englewood Hospital & Medical Center employees and applicants for employment and volunteer positions. 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.

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 sequelae 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 x47987.

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.

Englewood Healthcare system currently purchases Professional Liability Insurance for scheduled employed physicians of the Medical Center. Coverage is provided for currently employed and previously employed physicians. The policies provide coverage on a claims made basis retroactive to the physician's date of hire or 01/01/1988, whichever is later. The hospital renews the policies annually. As long as the policies remain in

force, it is not necessary to purchase a separate tail for individual physicians if and when they leave their employment with the Englewood Healthcare System.

Vacation

House Staff Officers are entitled to 192 hours of vacation each year. Vacation time may be carried over from year to year.

Leave Time

House Staff Officers are entitled to 96 hours of sick time each year. Sick time may be carried over from year to year.

House Staff Officers who requests time off as a result of the death of his/her spouse, child, brother, sister, parent, domestic partner, or grandchild may be granted up to three working days off with pay. Such days will be taken consecutively within a reasonable period of time of the day of death or the day of the funeral and may not be split or postponed. This also applies to any relative who was living (at the time of death) in the household of the employee as a permanent member of the family unit.

House Staff Officers who requests time off as a result of the death of his/her grandparent, mother-in-law or father-in-law may be granted the day of the funeral off with pay.

For the purpose of this policy, "Step" relationships are included as applied to the relatives listed above.

Documentation may be requested.

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 as soon as is reasonably possible. Accrued vacation, holidays, and sick time will be used during this leave if it is a paid 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.

All employees are eligible to apply for New Jersey Temporary Disability Benefits (TBD) if they are out of work due to an illness or injury not related to their job.

The benefit is equal to 2/3 of your weekly salary to a maximum benefit of \$502.00 per week. The first seven days is considered the "waiting week". Benefits are payable on the eighth day of disability if you are out of work less than 21 calendar days. If you are out of work longer than 21 calendar days, the "waiting week" is then paid. Forms can be obtained from Human Resources so your physician may complete the medical

certification. The form is returned to us and we complete the wage and salary information and forward the form to the state for you.

An extended leave of absence of a medical or other reasons may extend a house officer's training to meet ACGME requirements. Internal medicine house staff are required to complete 33 month of training in order to be eligible for graduation and ABIM certification.

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.

Flexible Spending Accounts

Flexible Spending Accounts are an IRS approved program that allow you to put aside a portion of your pay on a pre-tax (before Federal, Social Security, and in most cases state and local taxes are withheld) basis to help pay for many health care and dependant care related expenses each year. The amount you put aside is based on reasonably anticipated expenses for the year so you should give careful consideration to this amount. You have to use the money in your account toward services received from January 1st of each year through March 15th of the next year and claims have to be filed no later than June 30th of the following year. You can elect to participate in either a Medical Reimbursement Account or a Dependant Care Reimbursement Account, or both. Your participation in the FSA program is always voluntary but you must sign up each year to take advantage of the program from year to year.

Use your FSA(s) to pay for hundreds of products and services not otherwise covered through the benefits program. A small sample of eligible expenses includes co-pays and deductibles, allergy medicine, over the counter medications, dental and vision expenses, day care, before and after school programs, and elder care.

Repayment options include a Debit Card (Medical FSA only) with which you can eligible purchases that will be paid directly form your account, as well as Pay Online (Medical & Dependant FSA's) which allows you to use online tools to pay your providers directly from your FSA account. For both account types, you can also file a claim for reimbursement from your account.

If you are interested in participating In a Flexible Spending Account, please be sure to familiarize yourself with all of the details of these plans, as well as the rules and regulations before pledging an annual contribution. This information, including a complete list of eligible expenses, is available by visiting the FSA administrators website or contacting the Human Resources department.

FACILITIES

Housing

Englewood does not provide housing for house staff. Individuals may contact the Department of Medicine for assistance locating apartments prior to moving to Englewood.

Food Service

Retail food service is available at reasonable rates on campus as follows:

The Garden Café

(Daily Menu Information at x(6368)

Weekdays 6:30am–7:30pm

Weekends, Holidays 7:00am–9:00am, 11:00am–3:00pm

Vending machines are available 24 hours each day in the Cafeteria and in various locations throughout the Medical Center.

Kosher meals are available daily and are prepared in the Kosher Kitchen under the supervision of the Orthodox Union.

Englewood Hospital Health Sciences Library

The Englewood Hospital Health Sciences Library is located on the first floor of the Medical Center of Learning. Information on the services provided by the references librarians, hours of operation, and available computer facilities is available on the website at www.EnglewoodHospital.com/library. In addition, multiple computers throughout the hospital have access to UpToDate.

Gustave L. and Janet W. Levy Library

Englewood House Staff have privileges at the Levy Library and may use the library when rotating at Mount Sinai Medical Center. Please see the Mount Sinai website for a full description of the library services at <http://www.mssm.edu/library/>. Senior (PGY3) Internal Medicine House Staff have teaching appointments through Mount Sinai School of Medicine and are therefore able to receive full online resources through the library website.

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 Officer is expected to regard the House Staff on-call room as s/he would his or her own home and to follow accepted rules of conduct. See your Department Administrator for additional information.

Telephone and Paging Systems

The Hospital maintains an internal dialing system for interoffice calls. All house staff are provided with key telephone numbers during orientation. Certain telephones have direct outside lines that may be reached by dialing “9” and waiting for a dial tone. These lines only accept calls within the area code 201. For calls outside the area, contact the hospital operator for assistance placing the call.

The Hospital has a public address page system and a dial-access radio receiver system. Many physicians and

other key hospital personnel may be reached by dialing x3501, then the pager identification number, followed by "#". 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.

The overhead voice page can generally be heard throughout the Dean wings of the hospital. To place a public address page or request information on a dial-access radio page or receiver, dial x3311

Pagers are assigned to new House Staff by the departments during Orientation. The number assigned is stamped on the case.

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.

Pager Coverage: There should not be a place within the confines of the Medical Center, including yard areas, where one cannot receive a page. House Staff should not place the paging unit on or near metal desks or metal equipment, as this impedes reception. If reception is poor, the Telephone Services Supervisor should be notified promptly.

Safety

Englewood Hospital and Medical Center 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

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 observes a safety problem, s/he should call X2222.

Security

Identification Cards

Medical Center identification cards are issued during initial orientation. Identification cards must be presented for access to the Medical Center and employees must wear identification cards while on the premises.

Escorts

Security escorts are available within the Medical Center as well as to parking lots on the hospital property. 10 minutes before departure, please call Security at x3225 to arrange for an escort.

Shuttle Service

Shuttle service is available at no charge to House Staff on rotations to the Mount Sinai Medical Center. The schedule of shuttles to and from Mount Sinai is as follows. In addition, an earlier pick-up at 4:15pm during Geriatric block may be arranged by calling Security at x3225.

Weekday Schedule:

Departs EHMC from in front of the clinic at 5:15am, 6:30am, 8:15am, 12:00pm, 5:00pm, and 6:30pm.

Departs MSSM from in front of Aaron Hall at 6:00am, 7:00am, 9:00am, 12:45pm, 5:30pm, and 7:00pm.

Weekend and Holiday Schedule:

Departs EHMC from in front of the clinic at 8:00am and 9:45am.

Departs MSSM from in front of Aaron Hall at 8:30am and 10:15am.

Arrival times are 20-30 minutes following departure depending on weather and traffic conditions.

Parking

Parking is available to all Englewood Hospital staff at no cost. Parking lots are accessed by swiping security badges.

Uniforms and Laundry

Three White Lab Coats are provided each year to House Staff. Green scrubs are available in the ER radiology department and the ICU storage area. Uniforms are furnished without charge. Subject to certain exceptions, House Staff Officers may select any combination of lab coats, trousers/skirts, and shirts/blouses. Laundry service is provided free for Hospital uniforms only. The Uniform Room, located in the LLO Level, is open from Monday to Friday, 8:00am-11:00am, and 12:00pm-2:00pm. During these times, soiled uniforms may be brought in for cleaning and clean uniforms may be picked up.

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 will be transmitted through this software. A logon/password for New Innovations RMS may be obtained from the Residency Coordinator. Rotation and call schedules are provided via the Internet at www.amion.com. Passwords for accessing the site are provided and change yearly.

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.

House Staff currently track procedures in a pocket ABIM procedure log. On-line tracking of procedures will be added through New Innovations sometime during the 2006-2007 academic year.

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](#).

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 800-531-0200. However, the service is strictly voluntary and confidential, and no reference will be made in personnel records.

Discount Programs

Englewood Hospital and Medical Center offers a variety of discount programs. Contact Human Resources at extension 3025 for a listing.

Professional Assistance Program of New Jersey (PAPNJ)

The professional Assistance Program of New Jersey provides services to protect the public safety and welfare of the citizens of New Jersey through education, identification, evaluation, treatment planning, and advocacy for licensed healthcare and other professionals in recovery from impairing medical conditions and illnesses. PAPNJ also provides assistance to resident physicians and can be reached at (609) 919-1660.

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 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 Englewood's 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 December 15th 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 nonrenewal of the contract. Contract nonrenewals are subject to the hearing rights specified below in "Disciplinary Action."
- III. Contracts must be returned 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 & Promotion

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 or his/her designee occurs at periodic intervals that may vary with the specific program, but occurs no less than semiannually.

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.

Promotion criteria to the next PGY level are based on mastery of the six core competencies at each level of training. See your departmental curriculum for specific descriptions of the core competencies by PGY level. In the Department of Medicine, the Clinical Evaluation Committee meets quarterly and reviews the progress of all house staff. House Staff are evaluated on a scale of 1-5 with 3 being satisfactory progress in competency based training. Performance at a level below 3 may result in academic advisement/probation as described above. If a house officer completes the academic year at a level below satisfactory, he/she may be asked to repeat all or part of the current year of training. Severe deficiencies in one or more of the core competencies may result in termination from the program. ABIM core competency based evaluations are completed yearly and are incorporated into the promotion process.

House Staff Representation

Englewood Hospital Committees

Each program has established a mechanism for House Staff Officers to exchange information concerning their education and work environment. Internal Medicine (IM) residents are encouraged to participate in the Resident Faculty Forums that meet 6-7 times yearly to serve this need. In addition, 1-2 IM residents are chosen each year to represent Englewood at the Mount Sinai GMEC monthly meetings (see below). 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 Chief Residents, the Program Director or discussed with the Medical Education Committee during its confidential meetings as part of the quality assurance process.

Graduate Medical Education Committees at Mount Sinai

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.

Work Hours

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.

House Staff may not have work schedules that exceed 80 hours per week, averaged over a four-week period, inclusive of all work activities. House Staff may not be scheduled to work more than 24 consecutive hours plus no more than 6 additional hours to transition patient care. They 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; house staff 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 Chairs of their intent to work additional hours as physicians providing professional patient care services, and they must have a New Jersey training permit or license. House Staff must have already taken all three of the USMLE exams prior to moonlighting and must be in good academic with his/her department. The time spent on moonlighting activities must be counted toward the limits imposed by the standards of the ACGME described above. The House Staff Officers have the sole responsibility of guaranteeing that they are in compliance with these hours.

Englewood House Staff may moonlight on the non-teaching medicine service or in other capacities as approved by their program director if i) they are appropriately credentialed via the medical staff office; and ii) they have approval from their program director to moonlight.

Englewood IM house officers are not eligible to moonlight at other outside institutions. House officers training on a J1 visa are not eligible for moonlighting due to visa restrictions. The House Staff'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 may result in a withdrawal of permission to moonlight.

Disciplinary Action & Grievance Procedure

- I. *Disciplinary Action:* The Chief of Medicine, the Program Director, or the Hospital's Human Resources 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 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 House Staff Officer will be sent written notice of the disciplinary action together with a statement of the reasons therefore. If no request for a grievance procedure (see below) is made by the House Staff Officer, the disciplinary action shall become effective and final.
- II. *Grievance Procedure.* A grievance shall be defined as a dispute regarding (a) the written interpretation or application of the terms of the individual contract or its conditions; or (b) a question regarding the non-renewal of the appointment of a House Staff Officer or (c) application or interpretation of Hospital policies and procedures. A grievance may be brought by an individual House Staff and should follow the following grievance procedure:
 - A. Within 10 calendar days of the occurrence giving rise to the grievance, the House Staff Officer with the grievance may present the grievance in writing and discuss the grievance with the Program Director. The Program Director will Issue a written decision within 10 calendar days of the grievance meeting.
 - B. If the grievance is not resolved satisfactorily in Step A, the grievant may, within 15 calendar days after notification of the decision of the Program Director, present the grievance in writing to the Medical Education Committee for evaluation and determination. The Medical Education Committee will issue a written decision within 15 days of the grievance or grievance hearing.
 - C. Submissions of grievances in above steps must be in writing. The time limits set forth above will be strictly applied. Failure on the part of the grievant to process the grievance within the above time limits will be deemed to establish agreement with the resolution in the prior steps or waiver of the grievance.

Harassment

Englewood Hospital and Medical Center is committed to maintaining a work environment that is free of discrimination. In keeping with this commitment, the harassment of employees by anyone, including any supervisor, co-worker, vendor, client, customer, or anyone else affiliated with the Medical Center will not be tolerated.

DEFINITION

Generally, harassment consists of unwelcome conduct, whether verbal, physical, or visual, that is based upon a person's protected status, such as sex, color, race, ancestry, religion, national origin, age, physical handicap, medical condition, disability, marital status, veteran status, citizenship status, sexual orientation or other protected group status which affects tangible job benefits, interferes unreasonably with an individual's work performance, or creates an intimidating, hostile, or offensive working environment.

This general anti-harassment policy includes a prohibition against sexual harassment. Unwelcome sexual advances, requests for sexual favors, and other physical, verbal, or visual conduct based on sex constitute sexual harassment when:

- (1) submission to the conduct is an explicit or implicit term or condition of employment,
- (2) submission to or rejection of the conduct is used as the basis for an employment decision, or
- (3) the conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile, or offensive working environment.

Sexual harassment may include unwelcome sexual advances, requests for sexual favors, explicit sexual propositions, sexual innuendo, suggestive comments, sexually oriented "kidding" or "teasing", "practical jokes", jokes about gender-specific traits, foul or obscene language or gestures, displays of foul or obscene printed or visual material, and physical contact, such as patting, pinching, or brushing against another's body.

PROCEDURE

All members of House Staff are responsible for helping to assure that harassment is avoided. If you believe that you have experienced or witnessed harassment, you are to immediately notify your Program Director, or the Employee Relations Manager in the Human Resources Department.

All complaints or reports of harassment will be promptly investigated and kept on a confidential basis to the extent possible. Anyone found to have engaged in conduct is subject to appropriate disciplinary action, up to and including termination from employment.

Retaliation against anyone who has reported or complained of harassment is strictly forbidden.

Harassment has become an increasingly prominent national concern in the workplace and in academic institutions. Englewood Hospital and Medical Center 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.

Englewood Hospital and Medical Center 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.

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.

Protection from Retaliation

All individuals involved in registering a complaint, serving as representatives for the complainant or respondent, as witnesses, 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.

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 Englewood Hospital and Medical Center 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 Englewood Hospital and Medical Center 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

Englewood Hospital and Medical Center Compliance Hotline at (800) 597-3227. Copies of the publications are available through the Office of Corporate Compliance.

All House Staff employees, for the benefit of Englewood Healthcare System, must exercise their utmost good faith in all activities that touch on their duties and responsibilities on behalf of the Healthcare System. This is necessary, as even the appearance of a conflict or wrongdoing can be damaging to the Healthcare System. Accordingly, such situations must be avoided.

The policy of the Healthcare System, with respect to conflicts of interest, requires that all employees avoid conflict between their own interests (including interest of family or friends) and the interest of the Healthcare System in dealing with suppliers, customers and any other organization or individual doing business or otherwise engaged in transactions with the Healthcare System.

House Staff members must not use their position or knowledge gained from their position to create a conflict between the interests of the Healthcare System and themselves. House Staff members must also avoid any conflict between their own interests and the interests of the Healthcare System in the conduct of their personal affairs.

A conflict of interest / violation of the policy will exist when a House Staff member engages in the acceptance of gifts, gratuities, entertainment or other favors from a vendor, contractor, individual or company that does, or is seeking to do business with the Healthcare system which would thereby create a situation that could be perceived as influence of a Healthcare System. This also applies to any relationship with a competitor of Englewood Healthcare System.

This does not preclude accepting items of nominal value that are not intended to influence decisions and would not be perceived by others as doing so. If an item or situation is unclear as to whether or not it may present, or perceive to present, a conflict, it should be brought to the attention of a Compliance Officer.

Outside business relationships must also not be a conflict with the interest of the Healthcare System or the individual's responsibility.

Additional information may be requested in order to make full determination if any conflict currently exists. It will be the employee's obligation to update his /her Program Director with any changes as they occur.

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.

The Medical Center's image is reflected in its employees. Well-dressed employees improve the image of the Medical Center because the public often formulates its' first impression of the Medical Center by such things as employees' appearance. Medical residents, volunteers, students and any other representatives impact the image of the Medical Center by their appearance in the same manner and are expected to abide by the rules listed below.

It is for this reason that every endeavor is made to present Englewood Hospital and Medical Center to our visitors and patients as a medical center that is modern, progressive, concerned, clean and well kept.

In addition, the Occupational Safety and Health Act and other health codes mandate certain dress requirements.

1. Employees are required to wear Englewood Hospital and Medical Center's official name/photo ID badges at all times while on duty. The badge must be prominently displayed and worn facing forward so as to be visible and readable by an approaching individual.
2. Medical Center personnel should present a business-like appearance. Attire must be neat and appropriate to a professional setting.
3. Clothing should be clean and should fit properly. See-through or revealing clothing is not allowed. Shirts should be fully buttoned (except for top button when appropriate) or have conservative necklines.
4. Shoes and hose appropriate for the position are to be worn at all times (with the exception that hose is optional during the months of June, July and August). Low-cut all white or all black athletic footwear will be acceptable (in other than business offices and when not in conflict with specific department rules) where the position requires constant standing or walking. Hosiery and shoes must be clean, in good repair, and meet safety and noise abatement needs of the Medical Center environment.
5. Suits, pants and coordinated pant outfits must be appropriate and in good taste. Skirts and dress lengths should be appropriate for business wear. Trousers, which drag on the floor, are not permitted. Clothing which is made of traditional blue jean or denim fabric is inappropriate.
6. Some additional examples of acceptable attire include: blouses, shirts, sweaters, business skirts and dresses, business suits, pant suits, dress shoes, Polo or oxford shirts with collars, blazers or sport coats, slacks, business suits, loafers worn with socks.
7. Some additional examples of unacceptable attire include: halter tops, halter dresses, sundresses, tank tops, leggings, Capri pants, shorts of any kind, any clothing made from sweatshirt material, visible thongs, clinging fabrics, jogging or warm-up suits, spandex clothing, clothing that reveals undergarments or displays a bare midriff, clothing with holes, baseball caps, or beach, athletic, or other casual type sandals.
8. Employees who are required to wear uniforms must keep them clean and neat. The uniforms must comply with requirements. T-shirts with decals or other insignia are not permitted to be worn if visible underneath uniform. Scrub suits are considered to be uniforms and may only be worn when authorized.
9. The wearing of pins, buttons, insignia or any other non-Medical Center issued items in immediate patient areas is prohibited, except items which constitute part of the employee's Medical Center authorized uniform or are otherwise authorized by our Medical Center such as Medical Center service pins, school pins and professional registration insignia. Immediate patient care areas include, but not limited to, patient rooms, operating rooms, diagnostic and treatment rooms; corridors adjacent to the aforementioned areas; and sitting and waiting rooms on patient floors and in diagnostic and treatment areas that are used by patients.
10. Employees who have direct patient contact, or work with food, dangerous machinery, chemicals or infectious materials must have short hair, or if long, must have it pulled back or secured in a hair net. Beards, moustaches and sideburns must be clean and neatly trimmed

at all times. Fingernail length should not interfere with one's ability to perform all the job tasks nor present any safety hazards.

11. To help prevent the spread of infection, artificial nails or extenders are not to be worn by any personnel having direct patient contact.
12. Personal cleanliness and good body hygiene are a must in the Medical Center environment. Heavily scented soaps, colognes, perfumes or after-shave lotions should not be used.
13. For safety and sanitary reasons, no dangling earrings or excessive jewelry should be worn near patients, in hazardous work areas or in sterile processing or storage areas. In all areas, jewelry should not be excessive in size or amount. No more than three small earrings per ear and no other visible piercings are permissible. Visible tattoos must not be distracting in size or amount. A department manager may require an employee to conceal the tattoo(s) while on duty.

Existing safety, health, and infection control codes and rules and regulations will cover all other aspects of personal appearance.

Individual departments may have a dress code that contains additional regulations specific to that department and its operations.

Supervisors and Department Heads are immediately responsible for their department's compliance. Any individual not appropriately dressed for work, should be sent home as unprepared. When feasible, that individual should be allowed to return as soon as he/she is prepared. Subsequent occurrence should be dealt with through the use of the Medical Center's progressive disciplinary policy.

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 the Medical Center.*

Press Relations

While the Medical Center does not restrict the right of House Staff to communicate with the media as individuals, such contacts carry the potential for misrepresentation, dissemination of incorrect information, disclosure of confidential matters, violation of privacy, and the misinterpretation of the comments of an individual as being representative of the policy or viewpoint of the entire Medical Center. Therefore, House Staff should refer all media inquiries directly to Press Relations at (201) 894-3524.

No news media or promotional audio or video recording, filming, or still photography may be conducted within the Medical Center without authorization and advance arrangement through Press Relations, which will advise the Security Office of all such arrangements. Since Medical Center procedures provide that the Security Office will prevent any photographer or camera crew arriving unexpectedly from entering the Medical Center, Press Relations should be advised in advance whenever an outside camera crew or photographer will be coming to the campus for any purpose.

Section Four:

Patient Care

PATIENT CARE GUIDELINES

House Staff Role in Length of Stay

Englewood 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. Care coordinators 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.

Orders on the Teaching Service

Admission orders and daily changes are to be written by the medical residents. Suggestions for changes should be stated in the Attending's admission note or Progress notes. Whenever possible, these suggestions should be discussed with the residents. The residents should review charts at regular intervals during the day and their sign out to pick up and read your notes and suggestions. Attendings may write orders when a resident is not immediately available. However, the resident should be called or located for discussion and explanation. The policy for order writing by residents applies to consultants as well as the primary attending.

Discharge Planning

An integral component of all patient care, Discharge Planning is mandated by federal and State regulations, and is an essential element of Utilization Management. Optimally, such planning begins at the time of admission. The goal of Discharge Planning is to enable the patient to complete his or her care in the Hospital and to return home or to transfer to another facility with arrangements for the continuing care s/he 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 and 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. S/he 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 and collaborate with other health professionals during Hospital stays.

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

Consultations

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

The House Staff Officer should discuss the role of consults from other services with the patient's primary attending. Either the House Staff Officer or the attending of record may contact the consulting service. It should be noted that the House Staff Officer of the teaching service rather than the consulting service has the responsibility for ordering routine tests. All tests performed on patients must have a corresponding order dated and signed by the requesting physician on the patient's order sheet.

Diagnosis-Related Groups

Hospital stays in New Jersey 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

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 the Hospital Emergency Incident Command System, which defines chain of command and operations objectives. The Emergency Operations Center is the site from which response efforts are coordinated by an Incident Commander. Drills are performed and evaluated throughout the year. This provides staff the opportunity to reinforce their knowledge of the plan while providing the Hospital an opportunity to make improvements to the plan. Participation is mandatory for all employees in departments involved in a drill.

If the Emergency Management Plan is activated, it will be announced by overhead loudspeaker. House Staff may receive a page from Hospital operators or their departments. After the House Staff Officer ensures his or her safety and that of his or her patients, s/he should contact a direct supervisor for further instructions. House Staff should not attempt to respond to the scene of the incident or the Emergency Department unless directed to do so by a supervisor, or unless it is the responsibility of the House Staff Officer under the Emergency Management Plan. A copy of the Plan can be found in the Nursing Units, in Department Administrators' Offices, and on the Mount Sinai Intranet.

House Staff should make sure that their departments have their current contact information so that professional staff availability may be assessed in emergencies.

Code Blue: 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 crash carts strategically located throughout the Hospital. The Cardiology Senior resident is responsible for running codes with the assistance of anesthesiologists, respiratory therapists, and nursing supervisors.

To Get Assistance: Dial x3311 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 Code Cart. This cart has pertinent cardiac and respiratory stimulants as recommended by the Medical Board. Monitors and defibrillators for use by code teams are available on the carts.

Following a cardiac emergency, a timed and dated note must be put in the patient's chart.

Ethics: Clinical Dilemmas

The Ethics Committee of the Medical Board of Englewood Hospital and Medical Center is available for consultation and guidance on ethical issues concerning patient care and treatment. To contact the Ethics Committee, call extension 3198 to request a consultation.

Jeff Matican, M.D., Chair

Sharon Roche, PhD.

Information on clinical ethical dilemmas, capacity assessment, and decision-making (Figure 1) is provided below.

Capacity Assessment

The more significant the consequences of refusal, the more certain House Staff should be that the patient has decisional capacity. They should assess whether the patient:

- *Understands and appreciates* the diagnosis, prognosis, likelihood of risks and benefits, and the treatment alternatives.
- *Makes and communicates* a choice.
- *Articulates a reason* for the refusal that is consistent with patient's values.

House Staff should elicit the patient's reasons for refusal:

- "Help me understand why you decided to refuse _____."
- "Tell me what makes _____ seem worse than the alternatives."
- "What do you believe will happen if you don't have _____?"

It should also be determined whether the patient has a related mood or other distortion of judgment (e.g., depression, fear, or anxiety). When a patient lacks decisional capacity, a surrogate (e.g., health care proxy, or guardian, or next of kin) may make decisions on behalf of the patient.

Department of Pharmacy

ENGLEWOOD HOSPITAL AND MEDICAL CENTER
PHARMACY DEPARTMENT

Pharmacy services are provided by licensed pharmacists to patients of all ages admitted to the Medical Center. The Pharmacy provides the following services in accordance with legal, regulatory and professional practice standards:

- A unit dose system of medication distribution for inpatients. Thus, medications are contained in single unit packages, dispensed in as ready-to-administer form as possible and not more than 24-hour supply of doses is delivered to or available at the patient care area at any time.
- A comprehensive IV admixture service to all inpatient care units. This service consists of the preparation of large and small volume parenteral solutions, continuous or intermittent admixture, parenteral nutrition, antineoplastic agents and irrigation solutions. Exceptions to this policy will only be made by the Pharmacy and Therapeutics Committee after careful review of patient care.
- Outpatient prescription services for registered clinic patients who are treated by staff members of the institution in their respective clinics, employees and their dependents.
- Drug information for health care professionals.
- Patient education to improve therapeutic outcomes by maximizing proper use of medications. Pharmacist-conducted patient education is available to inpatients upon request, all outpatients whose prescriptions are filled in the Outpatient Pharmacy and the community at large as needed.
- Purchasing, distribution and control of all medications used in the Medical Center.

The Pharmacy Department is located on the Lower Level O (LLO) and open 24 hours a day, 7 days a week. The Pharmacy may be reached at extension 3375.

This section includes the following policies and procedures:

- Medical Orders
- Orders for Medications
- Standard Medication Administration Times
- Unapproved Abbreviations
- Restricted Drugs
- Automatic Stop Orders
- Therapeutic Alternates/Substitution
- Prescribing Errors
- Adverse Drug Reaction Reporting
- Pharmacy on the Intranet

Medical Orders

POLICY:

Order Writing on Teaching Service

For patients on the Teaching Services, all orders are to be written by the house staff officer with appropriate supervision by the attending physician. In an emergency or other unusual circumstance when an order on a house staff's patient is written by the attending or subspecialist, he/she must communicate with the house staff in a timely manner.

Physician's Orders:

All orders for treatment, medication, and restraints shall be written on the appropriate physician order forms. All medical orders must be dated and signed by a licensed physician or other authorized prescribers pursuant to Medical Staff Rules and Regulations. Signatures must be clearly legible to allow for authentication, or prescribers must print their name after their signature.

Orders Written by an Unlicensed House Staff Officer:

All prescriptions and orders for inpatients issued by an unlicensed house staff officer (i.e., intern or PGY-1) must be countersigned by either a PGYII or PGYIII ("permit holder") or a licensed physician. All orders shall be countersigned as soon as possible or within 48 hours.

Individuals Authorized to take Verbal and Telephone Orders:

The following personnel may take verbal and telephone orders within their scope of practice:

- Physical Therapist – orders for rehab services, activity levels and weight bearing status.
- Respiratory Therapist – orders for lab tests and medications pertaining to respiratory care.
- Registered Dietitian – orders for lab tests, diet, parenteral nutrition and medications added to parenteral nutrition, enteral nutrition, calorie count, weights, intake and output and metabolic cart study.
- Licensed Pharmacist – orders for medications and lab tests pertaining to pharmaceutical care.
 - Registered Nurse – any medical order pertaining to patient care, e.g., lab tests, medications, diet, treatment, activity, etc.

Orders Written by Other Licensed Health Practitioners:

	<u>Countersignature</u>	<u>Controlled</u>	<u>Other</u>
	<u>Required</u>	<u>Substances</u>	<u>Medications</u>
Nurse Practitioners	No	Yes	Yes
Physician Assistants	No	Yes	Yes
Nurse Midwives	No	Yes	Yes
Certified Registered Nurse Anesthetists	Yes	Yes	Yes

Orders for Medications

For the purpose of this policy, medication includes prescription medications sample medications, herbal remedies, vitamins, nutraceuticals, over-the-counter drugs, vaccines, diagnostic and contrast agents used on or administered to persons to diagnose, treat or prevent disease or other abnormal conditions; radioactive medications; respiratory therapy treatments; parenteral nutrition; blood derivatives, intravenous solutions (plain, with electrolytes and/or drugs); and any product designated by the Food and Drug Administration (FDA) as a drug. The definition of medication does not include enteral nutrition solutions (which are considered food products), oxygen and other medical gases.

Elements of a Complete Order:

The written order must specify:

1. Medication: brand or generic name is acceptable.
2. Dose
 - 2.1 For neonatal and pediatric (age < 12y) patients, dose shall include the patient's weight and the "dose/Kg/day", eg, ampicillin 125mg IV Q6h (100mg/Kg/day, weight 5Kg)
 - 2.2 For chemotherapeutic agents, order shall include the patient's height and weight
3. Route

4. Frequency of administration
 - 4.1 Initial dose for certain drugs will be designated by the P&T/Medical Executive Committees to be given within 1 hour even if not ordered "stat" and if not already given to the patient
 - 4.2 Initial dose of anti-infective agents, if not already given to the patient, shall be administered within 1 hour even if not ordered "stat".
 - 4.3 Initial dose for drugs ordered once daily shall be started on the day the order was written if not already given to the patient.
 - 4.4 The nurse shall enter a "stat" order in the computer to obtain the initial dose and chart the stat dose as given
5. Indication for use
 - 5.1 For certain drugs below with sound-alike or look-alike names, both brand and generic names or indication for use is required:
 - Insulin glargine (Lantus)
 - Zetia for cholesterol lowering
 Pharmacy shall continue to monitor drugs with sound-alike and look-alike names and recommend actions to be taken to prevent medication errors.
 - 5.2 For all other medications, the indication for use shall be found in the patient's medical record for each medication ordered
6. Date and time of the order
7. Prescriber's printed name and/or legible signature
8. Dangerous abbreviations (Policy 100.32 – Abbreviation List) shall not be used.
9. Advanced Practice Nurses (APN) may initiate an order for a controlled substance provided the APN has a joint protocol with a collaborating physician.
10. Effective 9/17/05, Physician Assistants (PA) may prescribe controlled substances to continue/renew/adjust the dose of the controlled substance order written by the supervising physician. PAs may initiate an order for a controlled substance provided there is prior consultation with the supervising physician or as part of a treatment plan for a patient with terminal illness as determined by the supervising physician. All orders for controlled substances must state "as per protocol" or "as per Dr. ____ direction".

Additional elements required for the following types of orders that are deemed acceptable for use:

1. Standing routine orders – no additional elements required
2. "As needed" (prn) orders - shall require an indication for use
3. Automatic stop order and hold orders – see Policy 100.21 Stop Order Policy – Medication Order Renewals.
 - 3.1 Blanket reinstatement of previous orders ie. resume orders is not acceptable
4. Titrating orders – shall include patient outcome parameters such as RASS score for pain, blood pressure, etc. Orders to "titrate" without parameters are not acceptable.
5. Taper orders – shall include the number of doses for each tapered dose
 - Range orders – are not acceptable and must be clarified by the pharmacist and /or nurse prior to dispensing and /or administration of the medication respectively. For example, Percocet 1-2 tablets every 4-6H PRN pain may be written as Percocet 1 tablet PO every 6H PRN for mild pain and Percocet 2 tablets PO every 6H PRN for moderate pain.
7. Orders for compounded drugs or drug mixtures not commercially available – shall include ingredient and amount of each ingredient
8. Orders for medication-related devices such as nebulizers or catheters – no additional elements required
9. Orders for investigational medications – no additional elements required. Also see Policy 100.12 Use of Investigational, Experimental or Research Drugs or Devices for Treatment of Patients
10. Orders for herbal products – are discouraged due to limited safety and efficacy data, potential drug-herb interactions and adverse reactions, and lack of guarantees of purity, quality or consistency. However, if the patient insists and considering patient's rights, the physician may write an order for product continuation from the patient's own supply.
11. Orders for medications at discharge – no additional elements required.

Illegible or Incomplete Orders:

If the medication order is illegible or incomplete, the Nurse or Pharmacist must contact the prescriber for clarification.

Verbal and Telephone Orders:

Both verbal and telephone orders are prescription or medication orders that are transmitted as oral, spoken communications between senders and receivers face to face, by telephone, or by other auditory device (The National Coordinating Council for Medication Error Reporting and Prevention; Feb. 20, 2001). In the interest of patient safety, the following distinctions apply:

1. **Telephone orders are generally restricted to situations** where immediate written or electronic communication is not feasible, or the prescriber/ other licensed health practitioner is unavailable. All orders shall be countersigned as soon as possible or within 48 hours.
2. **Verbal orders are generally restricted to emergent situations** where the prescriber is present but unable to write the order due to immediate patient care needs or where sterility might restrict the practitioner from writing the order. All orders shall be countersigned as soon as possible or within 48 hours.

A. Procedures for Verbal and Telephone Orders:

1. Read Back Procedure for Telephone Orders:

- A. Authorized personnel taking a telephone order must perform the following “read-back” procedure in the sequence listed below for each order:
- B. Write down the complete order
- C. Read-back the order
- D. Receive confirmation from the individual who gave the order
- E. Enter the order into a computer system if required.
- F. Document performance of the Read-Back procedure on the MD Order Sheet by writing “RB” adjacent to the telephone order.

2. Repeat Back Procedure for Verbal Orders:

The “repeat back” procedure is only to be used in emergency situations when writing down the order prior to reading back is not feasible such as during an emergent situation such as a cardiac arrest (Code), or other similar situations.

B. Additional Procedures for Verbal and Telephone Orders

1. Questions about verbal or telephone orders shall be resolved prior to the preparation, dispensing, or administration of the medication.
2. All verbal and telephone orders should follow the policies, and include the items required for prescription writing as previously identified in this policy, and include the name of the individual transmitting the order, if different from the prescriber.
3. The content of the verbal order shall be clearly and effectively communicated.
4. Spelling, and / or providing both the brand and generic names of the medication should be used to confirm the name of the drug.
5. Instructions for use shall be provided without abbreviations. Example, “1 tab tid “ shall be communicated as “Take/Give one tablet 3 times daily.” To avoid confusion with spoken numbers, a dose such as 50mg shall be dictated as “fifty milligrams... five zero milligrams” to distinguish from “fifteen milligrams... one five milligrams”.

C. Restrictions to Verbal and Telephone Orders:

Orders for antineoplastic agents for Oncology use are not permitted under any circumstances to be taken verbally or by telephone. These medications are not administered in emergency or urgent situations, and they have a narrow margin of safety. However, when necessary, modifications of antineoplastic orders may be taken verbally or by telephone by a nurse or a pharmacist.

Standard Medication Administration Times

Daily	---	---	10a	---	---	---	---
BID	---	---	10a	---	6p	---	---
TID	---	---	10a	2p	6p	---	---
QID	---	---	10a	2p	6p	10p	---

HS	---	---	---	---	---	10p
Q4h	2a	6a	10a	2p	6p	10p
Q6h	-- 4a	--	10a	-- 4p	--	10p
Q8h	---	6a	---	2p	---	10p
Q12h	---	---	10a	---	---	10p
AC	---	-- 8a	-- 12p	-- 4p	--	---
PC	---	---	10a	2p	6p	---

Unapproved Abbreviations

POLICY:

When medication orders are handwritten and abbreviations are used by prescribers, any attempt to standardize them will not sufficiently address the problems of illegibility and misinterpretation which are recognized causes of prescription errors. To minimize these situations, prescribers are strongly encouraged to enter medication orders directly into the Medical Center's computer system. This automated method of communicating drug orders greatly reduces the possibility of incorrect transcription and any delay involved in picking up the orders.

To comply with JCAHO requirement, the following list of prohibited (dangerous) abbreviations (Attachment A) are not to be used in all orders and medication-related documents.

PROCEDURE:

1. The Dangerous Abbreviation list shall be approved by the Pharmacy and Therapeutics Committee. These abbreviations are those that are often misunderstood and have contributed to patient injury and death (see Attachment A).
2. If the handwritten order contains the above abbreviations, the prescriber shall be contacted by nursing personnel prior to medication order entry, to clarify in writing the prescriber's intended meaning and prevent misinterpretation. This will be documented on a physician order sheet as a clarification order.
 - 2.1 Any of the listed abbreviations used in approved preprinted order sets need not be clarified since there is no problem of illegibility. These order sets shall be revised to remove unapproved abbreviations.

Prohibited (Dangerous) Abbreviations

To comply with JCAHO requirement, the following list of prohibited (dangerous) abbreviations are not to be used in all orders and medication-related documents.

Abbreviation	Intended Meaning	Common Error	Should be Written As
MS MSO ₄ MgSO ₄	Morphine sulfate or Magnesium sulfate	Confused for one another.	morphine sulfate or magnesium sulfate
Trailing zero Lack of leading zero	X.0 mg .X mg	Decimal point is missed	Never write a zero by itself after a decimal point (X mg), and always use a zero before a decimal point (0.X mg)
U	Unit	Mistaken as a zero or a four (4), resulting in overdose. Also mistaken for "cc" (cubic centimeters) when poorly written.	unit
IU	International unit	Mistaken as IV (intravenous) or 10 (ten)	international unit

Q.D.	Latin abbreviation for every day	The period after the "Q" has sometimes been mistaken for an "I", and the drug has been given "QID" (four times daily) rather than daily.	daily
Q.O.D.	Latin abbreviation for every other day	Misinterpreted as "QD" (daily) or "QID" (four times daily). If the "O" is poorly written, it looks like a period or "I".	every other day

Restricted Drugs

POLICY: The Medical Executive Committee and the Pharmacy and Therapeutics Committee identified prescribers approved to use specific formulary drugs or drug classes to ensure that medications are used appropriately, safely and effectively.

PROCEDURE:

1. Upon receipt of an order for a medication listed in Attachment A, the Pharmacist shall ensure that the order was written by an approved prescriber.
2. If the order for the medication was written by an unapproved prescriber, the Pharmacist shall contact the ordering prescriber and inform him/her of the prescribers that may order the medication.
3. The Pharmacist shall process and dispense the medication upon approval/signature of the approved prescriber.

Medications on Restricted Use

Drug Class	Drug	Approved Prescribers
Anesthetics	Inhaled	Anesthesiologists Certified Registered Nurse Anesthetists (CRNA)
	Propofol (Diprivan)	Anesthesiologists Critical Care Certified Registered Nurse Anesthetists (CRNA)
Antibiotics	Caspofungin (Cancidas)	Infectious Disease
	Daptomycin (Cubicin)	Infectious Disease
	Drotrecogin (Xigris)	Joint Infectious Disease and Critical Care
	Linezolid (Zyvox)	Infectious Disease
	Quinupristin/ dalfopristin (Synercid)	Infectious Disease
	Tigecycline (Tygacil)	Infectious Disease
	Voriconazole (Vfend)	Infectious Disease
Antineoplastic agents for chemotherapy for cancer	All except disease modifying drugs for non-malignant diseases	Hematology/Oncology Gynecological Oncologist Surgical Oncologist
Cardiac drugs	Dofetilide (Tikosyn)	Cardiologists
	Nesiritide (Natrecor)	Cardiologists Emergency Department Critical Care

	Glycoprotein IIb/IIIa inhibitors	Cardiologists Emergency Department after consultation with the Cardiologist
Hemostatics	Factor VIIa (NovoSeven)	Anesthesiologists Critical Care Hematology/Oncology Neurologists
Neuromuscular blocking agents	All	Anesthesiologists Certified Registered Nurse Anesthetists (CRNA) Emergency Department Critical Care
Thrombolytic agents	Alteplase (Activase) for acute myocardial infarction, pulmonary embolism, stroke	Cardiologists Neurologists Emergency Department Critical Care Pulmonary

Stop Order

POLICY:

It is the policy of the Medical Center that medication orders for all patients (inpatient and outpatient) will have specific renewal periods (unless otherwise specified by the prescriber) which are determined by the Pharmacy and Therapeutics Committee and approved by the Medical Executive Committee. The purpose of this policy is to maintain current and accurate records of the patient's medication needs. To allow for continuity of administration, the last dose of the drug will be the morning dose following the day of automatic cancellation, unless renewed.

PROCEDURE: Reorder dates shall be observed as follows:

1. Reorder albumin every 24 hours.
2. Reorder I.V. proton pump inhibitors every 72 hours.
3. Reorder IV anticoagulants every 72 hours.
4. Reorder all controlled drugs (Schedule II-V) every 96 hours.
5. Reorder oxytocics, respiratory nebulizers and IV solutions every 96 hours.
6. Reorder total parenteral nutrition (TPN) every 48 hours, except for ICU patients whereby TPN is ordered daily.
7. Reorder antibiotics every 5 days.
8. Reorder oral antineoplastics every 7 days for inpatients.
9. Reorder epoetin (Procrit) every 7 days.
10. Reorder all other medications every 14 days.
11. All medication orders will automatically be discontinued and must be rewritten in their entirety when a patient goes to the operating room and when transferred to and from the intensive care units. The order "renew all pre-op orders" is not acceptable.
12. Orders written to "hold medication" with no specific time frame recorded will be considered to be orders to discontinue the medication. These orders must be rewritten in their entirety when it is desired to resume the medication.
 - 12.1 When a "hold medication" order with a specified time frame is written, the administration of the medication will resume at the end of the specified time.
13. With the drug manufacturer's warning on the use of ketorolac (Toradol), it should not be reordered after 5 days of therapy.

Therapeutic Alternates/Substitution

The purpose of this document is to describe the procedure by which the medical staff, functioning through the Pharmacy & Therapeutics Committee and upon approval of the Medical Executive Committee, designates medications as therapeutic alternates and when therapeutic substitution is allowed. Therapeutic alternates and therapeutic substitution is defined as follows:

- **Therapeutic alternates** are drug products with different chemical structures but which are of the same pharmacological and/or therapeutic class, and usually can be expected to have similar therapeutic effects and adverse reaction profiles when administered to patients in therapeutically equivalent doses.
- **Therapeutic substitution** is the act of dispensing a therapeutic alternate for the drug product prescribed without prior authorization of the prescriber.

(Adopted from The American Medical Association Board of Trustees Report I-93-45)

PROCEDURE:

1. Periodic reviews of the hospital formulary by pharmacologic and/or therapeutic class is performed by the Pharmacy Department for the Pharmacy & Therapeutics Committee to minimize duplication and cost.
 - 1.1 The Pharmacy prepares a comparison of drug products with similar therapeutic effects, adverse reaction profiles and therapeutically equivalent doses are compared by efficacy, safety and cost.
 - 1.2 The Pharmacy and Therapeutics Committee reviews the comparative report and votes on having the drugs as therapeutically equivalent. Depending on the financial advantage to the hospital, the P&T Committee chooses the preferred product and approves a change order form which will be sent by the Pharmacy whenever the other therapeutic alternates are prescribed.
 - 1.3 These recommendations are sent to the Medical Executive Committee for approval.
 - 1.4 After approval by the Medical Executive Committee, the medical and nursing staff are notified in writing prior to implementation.

2. After at least 6 months of successful implementation of the therapeutic alternate policy, the P&T Committee shall consider whether the therapeutic alternates should be considered therapeutically equivalent.
 - 2.1 This recommendation is sent to the Medical Executive Committee for approval.
 - 2.2 After approval by the Medical Executive Committee, the medical and nursing staff are notified in writing prior to implementation.
 - 2.3 The change order form notification shall not be sent by the Pharmacy.

THERAPEUTIC ALTERNATE DRUGS
CHANGED TO
THERAPEUTIC EQUIVALENTS

As of November 2006

Beclomethasone (Beconase AQ) to Fluticasone (Flonase)
 IV Cefazolin (Kefzol) Q6H to Q8H
 Cefotetan (Cefotan) to Cefoxitin (Mefoxin) 11/06
 IV Cefoxitin (Mefoxin) Q6H to Q8H 11/06
 Cephadrine (Velosef) to Cephalexin (Keflex)
 Ciprofloxacin (Ciloxan) and ofloxacin (Ocuflox) to levofloxacin (Quixin)
 Citalopram (Celexa) to escitalopram (Lexapro)
 Dolasetron (Anzemet) to Ondansetron (Zofran) 11/06
 Esomeprazole (Nexium) to Pantoprazole (Protonix)
 Flurazepam (Dalmane) to Temazepam (Restoril)
 Hydrocortisone cream 1% to 2.5% (adults only)
 Insulin lispro (Humalog) to Insulin Aspart (Novolog)
 IV Metronidazole (Flagyl) Q6H to Q8H
 IV Ranitidine (Zantac) to IV Famotidine (Pepcid)
 Ketorolac (Toradol) PO to Ibuprofen (Motrin) PO
 Lansoprazole (Prevacid) to Pantoprazole (Protonix)
 Nizatidine (Axid) to PO Famotidine (Pepcid)
 Omeprazole (Prilosec) to Pantoprazole (Protonix)

Paroxetine: Paxil CR to Paxil
Ofloxacin (Floxin) to Levofloxacin (Levaquin)
Propafenone (Rhythmol) SR to IR
Rabeprazole (Aciphex) to Pantoprazole (Protonix)
Terazosin (Hytrin) to Doxazosin (Cardura)
Triamcinolone (Nasacort) to Fluticasone (Flonase)

THERAPEUTIC ALTERNATES

Fluvastatin (Lescol) to Simvastatin (Zocor)
Lovastatin (Mevacor) to Simvastatin (Zocor)
Pravastatin (Pravachol) to Simvastatin (Zocor)
Rosuvastatin (Crestor) to Simvastatin (Zocor)

Insulin regular (Novulin R) to insulin aspart (Novolog) 4/06
Insulin NPH (Novulin N) to Insulin Glargine (Lantus) 4/06

Prescribing Errors

PURPOSE:

To establish a policy and procedure for the review of medication errors affecting the delivery of health care to patients in the Medical Center and to assist in identifying and eliminating causes of errors and prevention of their recurrence. Implementation of this program shall be a multidisciplinary effort involving the medical staff, pharmacy, nursing, risk management and hospital administration and shall be part of the hospital-wide process improvement program.

DEFINITION:

A medication error is "any preventable event that may cause or lead to inappropriate medication use or patient harm, while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems including: prescribing; order communication; product labeling, packaging and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use." (National Coordinating Council for Medication Error Reporting and Prevention).

TYPES OF MEDICATION OCCURRENCES:

For purposes of this policy and procedure, the following are the types of medication errors:

1. Prescribing error – incorrect drug selection (based on indications, contraindications, known drug allergies, existing drug therapy and other factors), dose, route, rate of administration;
2. Dispensing error – Mistakes made by pharmacy staff when dispensing medications to patient care areas or directly to patients in the ambulatory care pharmacy, e.g., incorrect profile entry, selection (picking), reconstitution, preparation, labeling;
3. Medication administration error – Incidents that are drug administration related, e.g., omission, improper dose, unordered drug, wrong dosage form, wrong drug preparation or administration technique.
4. Monitoring error - Failure to review a prescribed regimen for appropriateness and detection of problems, or failure to use appropriate clinical or laboratory data for adequate assessment of patient response to prescribed therapy.
5. Transcription Error: Reported error is transcription error only. Did not reach patient.

6. Adverse Reaction

Medication error severity shall be rated in accordance with the following categories recommended by the National Coordinating Council for Medication Error Reporting and Prevention (the Council).

The DUE Committee shall review prescribing errors. The review will be conducted by drug to identify opportunities for improving medication use. Trends relating to individual prescribers will be communicated by the DUE Chairman to the section chief(s).

Adverse Drug Reaction Reporting

The medical staff's pharmacy and therapeutics monitoring function, as mandated by JCAHO, includes the definition and review of all significant adverse drug reactions (ADRs). The review of significant ADRs is a means of assisting the prescriber and the patient who may receive such drugs in the future, and of alerting the hospital staff to the need for detection and reporting such reactions (*Accreditation Manual for Hospitals, 1992*).

An ADR reporting and monitoring system is helpful in providing quality improvement in patient care through identification of preventable ADRs and the anticipatory surveillance of high-risk drugs or patients. Over time, an active ADR reporting program can result in important modifications in the use of involved drug(s), educate health professionals on drug effects and increase their level of awareness of ADRs, thus resulting in early detection and treatment of ADRs and a decrease in occurrence of preventable ADRs.

The hospital's adverse drug reaction reporting and monitoring program shall be a responsibility of the Pharmacy and Therapeutics Committee. However, all hospital professional personnel are encouraged and are responsible for reporting suspected ADRs by *completing the Hospital's Occurrence Report form* after providing the immediate supportive care of the patient, and send *the form to Quality Management*.

A feature of this hospital-wide program is the prospective monitoring for ADRs whereby physicians and nurses take note and document the patient's drug allergy history. Physicians shall include, among the admitting orders, a notation on the patient's allergies. Nurses shall ascertain the patient's allergies during their initial patient history, and nursing personnel shall note the patient's drug allergy on the Allergy section of the Doctor's Order Sheet. Pharmacists shall enter the patient's drug allergy information as part of the patient's drug profile, and shall screen each initial drug order to prevent dispensing of a drug that the patient is allergic to.

1. DEFINITIONS

For purposes of this policy, the following definitions shall be adopted:

- 1.1 An adverse drug reaction is any response to a drug which is noxious and unintended and which occurs at doses used in man for prophylaxis, diagnosis, or therapy, excluding therapeutic failures. The following shall be considered as adverse drug reactions:
 - a) Idiosyncratic reactions, e.g., anaphylaxis, skin manifestations, fever, serum sickness syndrome, angioneurotic edema.
 - b) Blood dyscrasias, e.g., thrombocytopenia, agranulocytosis, aplastic anemia, hemolytic anemia.
 - c) Cardiac disorders, e.g., arrhythmias, cardiomyopathy, hypertension.
 - d) Various types of dermatitis.
 - e) Gastrointestinal disorders, e.g., diarrhea, constipation, anorexia, nausea, intestinal obstruction.
 - f) Hepatic disorders, e.g., jaundice, hepatitis.
 - g) Neurological disorders, e.g., seizures, syncope, headache, dyskinesias, peripheral neuropathies.
 - h) Renal disorders, e.g., creatinine elevation, renal impairment, renal failure, glomerulonephritis.
- 1.2 A significant ADR is one with a severe or serious severity in accordance with the following severity classification:
 - Minor Awareness of sign or symptom, but easily tolerated. No treatment is given for adverse experience.
 - Mild Transient symptomatology responding to treatment within 24-48 hours without residual effects.

- Moderate Discomfort enough to cause interference with usual activity. Treatment is given for residual effect(s) of adverse experience.
- Severe Incapacitating with inability to do usual activity. Treatment is given for residual effect(s) of adverse experience.
- Serious (*FDA definition*) When patient outcome is death, life-threatening (real risk of dying), disability (significant, persistent or permanent), required intervention to prevent permanent impairment or damage.

2. REPORTING OF ADVERSE DRUG REACTIONS

Suspected ADRs in inpatients shall be reported on an ongoing and concurrent basis by nurses, pharmacists, physicians, and other health professionals.

- 2.1 When a physician (attending or housestaff) detects an adverse drug reaction, he shall notify the nurse caregiver who shall initiate the Hospital's Occurrence Report form after providing the immediate supportive care of the patient, and send the form to Quality Management.
 - 2.1.1 Afterwards, the physician shall initiate updating of the patient's allergy history by writing an order in the Doctor's Order Sheet: "*Note the patient allergic/sensitive to _____(drug).*"
- 2.2 If a nurse discovers an adverse drug reaction she shall promptly report it to a physician. Following the immediate supportive care of the patient, she shall complete the Hospital's Occurrence Report form and send the form to Quality Management.
 - 2.2.1 At the earliest opportunity, the nurse/physician shall provide patient instruction on his/her new drug allergy/sensitivity and document this interaction.
- 2.3 When processing orders for immediate ("stat") doses of antihistamines, epinephrine and corticosteroids, the pharmacist shall check for possible adverse drug reactions.
 - 2.3.1 If a pharmacist discovers an adverse drug reaction, he/she shall immediately report it to a physician and the nurse taking care of the patient.
- 2.4 The Medical Records Department shall provide the Pharmacy with a list of patients with suspected ADRs based on their final DRG diagnosis.
- 2.5 Any health professional can report suspected ADRs by calling the ADR Hotline, telephone extension 4304.

3. ASSESSMENT OF ADRS

After receipt of any suspected ADR report or the Medical Records Department list of suspected ADRs, the Pharmacy shall obtain the following information from the patient's chart:

- Patient's medical and medication history;
- Description of suspected ADR;
- Drug(s) suspected of causing ADR, using the FDA algorithm to establish causal relationship (Attachment A);
- Any remedial treatment given;
- Classification of severity; and
- Sequelae or outcome of ADR.

Any question about the evaluation of the suspected ADR shall be referred by the Pharmacy to the patient's physician and/or a designated physician member of the Pharmacy and Therapeutics Committee.

4. REVIEW OF ADRS

The Pharmacy and Therapeutics Committee shall review all significant adverse reactions.

- 4.1 The attending physician shall be notified in writing of any findings or recommendations to improve the use of the involved drug(s).
- 4.2 The Pharmacy department shall prepare a quarterly report for the Pharmacy and Therapeutics Committee of the number of suspected ADRs reported, the number verified, and the number classified as significant.

Pharmacy on the Intranet

The following information may be found on the EHMC Intranet, Departments, Pharmacy:

- Hospital Formulary
- Drug Usage Guidelines
- Clinical Pearles

Patient Demise

Patient Expiration 100.16

1. The responsibility to pronounce a patient as expired rests with the Attending Physician.

In the absence of the Attending, the House Physician/Resident/ED Physician may pronounce the patient.

The House Physician/Resident or ED Physician is responsible for notifying the Attending Physician of the patient's demise.

The physician pronouncing the patient as expired shall document all pertinent information in the Physician Progress Notes and the Expiration Checklist

- Whether Cardiac Arrest Code (CAC) is called/time begun/ended
 - Circumstances surrounding the demise
 - Time
 - MD notified (if house MD/Resident/ED MD pronouncing the patient)
2. The Nurse in attendance will ensure that the Primary Physician, Patient Care Director/Supervisor and the Admitting Department have been notified. The Nurse in attendance is responsible to document all pertinent information received from the Physician in the Nursing Progress Record and on the Expiration Checklist (See Page 5).
 3. The attending physician is required to notify the family/next of kin of the patient's demise within 60 minutes. If unable to reach the family within 60 minutes, the MD should notify the nurse. The nurse will contact the supervisor/manager who will in turn contact the police of the town of residence of the patient. The nursing supervisor will be responsible at that point for assessing that notification has occurred.

The attending MD should also identify, if known, if the family will be coming to view the body.

- If the family does not come to the Unit within 2 hours of the patient's demise, the body is to be transferred to the morgue, and the nurse/nursing supervisor can arrange for late viewing by the family in the appropriate morgue area.
- In situations wherein the House Physician/Resident notifies the Attending Physician of the patient expiration, the Attending Physician will determine which consultant(s) the House Physician/Resident should notify.

4. The Nurse/Unit Secretary shall update all appropriate patient information, including changing the patient status in the ADT system, and notify Admitting within two hours of the expiration.
- Transport of the patient's body to the morgue and transfer of the Medical Record with completed Expiration Checklist to the Admitting Department is to be arranged and completed within two hours of the expiration. Any body released from the morgue or Patient Care Unit to a funeral home is to come from the Admitting Office.
5. The Admitting Department will ensure receipt of the Medical Record and Expiration Checklist, review the Expiration Checklist, and any pertinent sections of the Medical Record to confirm that the Attending Physician and the family/next-of-kin have been contacted. If any discrepancy is noted, the Admitting Department will contact the nurse in charge. If notification of next-of-kin and/or Attending Physician has not taken place, the Admitting Department will contact the attending physician.
- The Attending shall complete the Death Certificate within 24 hours. In certain instances, wherein the Death Certificate has not been signed, the Attending Physician may give verbal authorization to release the body to the funeral home (no autopsy/non-Medical Examiners case) and such authorization will be documented in the Expiration Checklist and Admitting Expiration Flowsheet.
- Burial of Limb – Sometimes a person who has a limb amputated wishes to have the limb in the plot that he/she will eventually be interred in. When the situation presents, notification is to be given to the Admitting Department. The Medical Center release form, P. 8 is to be signed by the patient and witnessed and then forwarded to the Admitting Department. The Attending is to complete the Death Certificate within 24 hours for burial of the limb.
6. In cases of fetal/neonatal death in Labor and Delivery, the record of fetal/neonatal death will be completed and sent to Admitting. The obstetrician will sign the death certificate unless an Attending Pediatrician is present/assigned in cases of live birth. The Attending Pediatrician will then sign the death certificate in these cases. In those cases of 20 weeks gestation (or less than 500 gms) or less, the patient has the option of burial or hospital disposal.
7. The Nurse in attendance will be responsible and ensure that all existing lines, tubes, catheters and any medical equipment be removed prior to transferring body to morgue. (This includes cases the Medical Examiner (M.E.) has declined.)
8. The pronouncing MD shall complete the Communicable Disease Alert Form as per State Regulations (See Page 7).

SPECIAL NOTES:

1. According to the Uniform Anatomical Gift Act, all patients who have died at Englewood Hospital and Medical Center shall be referred to the New Jersey Organ and Tissue Sharing Network at telephone number 1-800-541-0075. The referral will be documented on the Expiration Checklist (See Page 5).

MEDICAL EXAMINER PHONE: 201/599-6097

The Medical Examiner Notification form (Release Sheet) (see Page 8) shall be completed by Attending Physician/House Physician/Resident/ED Staff calling the M.E. The Medical Examiner may elect not to review the case, and in turn release the body to the funeral home. If the M.E elects to examine the body, the M.E will provide transportation from the hospital to the Bergen County Medical Examiners Office.

2. The Attending Physician should inquire of the next-of-kin/family if an autopsy (postmortem) examination is permissible and obtain appropriate consent (refer to "Autopsies" / Administrative Manual Section #100.25).
3. Please refer to individual departmental Policy and Procedure Manuals (Nursing, Pathology, and

Admitting) for detailed instructions concerning the expiration of patients.

4. The Medical Examiner (M.E.) shall be notified by the Attending/Pathologist/House Physician/Resident/ED/OR Staff of the patient(s) death if the expiration was due to :
 - a) Death from violence of any kind.
 - b) Death from any disease in which an external force acts as a contributory factor.
 - c) Cases of homicide or suspected homicide.
 - d) Cases of suicide or suspected suicide.
 - e) Cases of death occurring as a result of or following an accident, regardless of the nature of the accident, or the time between the accident and death, if any relationship between the accident and death can be assumed. The decision as to whether or not a traumatic factor is contributory to the death rests with the Medical Examiner.
 - f) Any death of a woman caused by a criminal or self-induced abortion or an attempted or suspected criminal or self-induced abortion.
 - g) Any stillbirth, particularly those unattended by a physician.
 - h) Any death due to poisoning or suspected poisoning.
 - i) Any death occurring in a patient hospitalized less than 24 hours.
 - j) Any death occurring in jail or prison or resulting from an illness or injury originating while in jail or prison or death in hospital of any prisoner who is hospitalized for active medical care.
 - k) Any death which may be related to, or the result of, or associated with, the decedent's occupation.
 - l) Any death caused or contributed to by electricity, heat, cold, the elements or radiation injury.
 - m) Any death due to acute alcoholism.
 - n) Any drug overdose or suspected drug overdose.
 - o) Any death due to neglect.
 - p) Any death in which the underlying cause of death is uncertain or unknown.
 - q) Deaths in custodial or psychiatric institutions without recent medical attendance.
 - r) When any suspicion arises during the course of an autopsy in case not originally believed to be a Medical Examiner case, the autopsy should be stopped at once, and the case reported to the Medical Examiner immediately.
 - s) Any death in which there is doubt as to whether or not it is a Medical Examiner's case.
 - t) Maternal deaths associated with delivery or abortion.
 - u) Deaths unattended during the course of illness by a physician (Dead-on-Arrival).
 - v) Deaths in any unusual, peculiar or suspicious manner.
 - w) Sudden death of a child, adolescent or young adult, with no apparent reasons.
 - x) Deaths associated with therapeutic or diagnostic procedures.
 - y) Deaths occurring in the Operating Room or Recovery Room prior to the patient's full recovery from the effects of anesthesia ("Table Deaths").
 - z) Deaths associated with anesthesia.
 - aa) Unexpected deaths where a definite diagnosis is uncertain shall be reported regardless of the length of hospitalization.

Source

Admitting, Nursing &
Medical Executive Committee

Approved by:

DOUGLAS A. DUCHAK, PRESIDENT & CEO

SHARING NETWORK REFERRAL(Mandatory referral to the Sharing Network for all patients 1-800-541-0075)

Sharing Network Verification (name of representative):

*Medical Suitability? YES NO

If yes, Option of Donation offered to family by:

(*Medical suitability will be determined by the Network)

Consent? N/A NO YES, Given By: _____ Relationship to decedent: _____**MEDICAL EXAMINER NOTIFICATION**

(To be completed by Housestaff or Emergency Department Nursing Staff)

REQUIRED DATA

PATIENT NAME:

DATE & TIME OF EXPIRATION:

ADMISSION DIAGNOSIS:

MEDICAL EXAMINERS OFFICE TELEPHONE: (201) 599-6097

1. DATE & TIME CALLED:

2. NAME & TITLE OF M.E. STAFF:

3. M.E. PHYSICIAN:

4. BODY RELEASED: YES NO --- BODY TO BE PICKED UP BY M.E. AT _____ AM / PM

CALL COMPLETED BY:

OPTIONAL DATA

D.O.B./AGE

SOCIAL SECURITY #:

RACE:

OCCUPATION:

MARITAL STATUS:

MEDICAL HISTORY:

MEDICATIONS:

NARRATIVE OF EVENTS PRIOR TO DEATH:

WHO DISCOVERED THE BODY:

WHERE WAS THE BODY FOUND:

LAST SEEN ALIVE: DATE: _____ TIME: _____ AM / PM AND BY WHOM: _____

METHOD OF TRANSPORT TO HOSPITAL:

HOSPICE CASE: YES NO

New Jersey Department of Health and Senior Services

PO Box 367

Trenton, New Jersey 08625-0367

COMMUNICABLE DISEASES ALERT FORM

<http://www.state.nj.us/health/forms/lcs-4.pdf>

Englewood Hospital & Medical Center

RELEASE FORM

Patient Name: _____ Room# _____ MR# _____

I certify that I am authorized by law to direct disposition of the deceased patient

_____ my _____
Name Relationship

and, for the advancement of medical science, I hereby authorize the performance of a post-mortem examination upon the said patient, which may include the removal of specimens, tissues and organs, which may be preserved or contributed for such diagnostic, therapeutic or other scientific purposes, as the responsible physicians deem proper.

Restrictions: _____

Date: _____ Signed: _____

Address: _____

_____ Witness Countersigned – Hospital Administrator

I, the undersigned do desire burial for the possession of the _____
separated from the body of my _____ by means of a surgical operation,
Relationship
performed at the Englewood Hospital & Medical Center on the _____ day of _____, 20____.

Signed: _____ Date: _____

Witness: _____

I, the undersigned do not desire burial for the possession of the _____
separated from the body of my _____ by means of a surgical operation,
Relationship
performed at the Englewood Hospital & Medical Center on the _____ day of _____, 20____.

Signed: _____ Date: _____

Witness: _____

Anatomical Gifts

In accordance with New Jersey's Uniform Anatomical Gift Act as amended, and Federal Medicare Regulations, all acute care hospitals are required to develop policies and procedures to ensure the routine referral of all deaths and impending brain deaths to their regional organ procurement organization (OPO) for the determination of medical suitability for organ and tissue donation. The New Jersey Organ and Tissue Sharing Network (The Sharing Network) is the Federally designated, State certified, organ procurement organization for this Medical Center.

This Policy assures that all potential organ and tissue donors are identified, and families are provided the option of donation in compliance with the law. This Policy provides a mechanism for Englewood Hospital & Medical Center (EHMC) to document each referral in accordance with Federal and State Regulations and guidelines promulgated by the Health Care Financing Administration, the New Jersey Department of Health and Senior Services, and the Joint Commission for Accreditation of Health Care Organizations. Adherence to this Policy also provides a permanent record for the purpose of quality assurance and quality improvement.

Please refer to the following Policies and Procedures:

Organ and Tissue Donation: 300.83

I. POLICY STATEMENT

In accordance with New Jersey's Uniform Anatomical Gift Act as amended, and Federal Medicare Regulations, all acute care hospitals are required to develop policies and procedures to ensure the routine referral of all deaths and impending brain deaths to their regional organ procurement organization (OPO) for the determination of medical suitability for organ and tissue donation. The New Jersey Organ and Tissue Sharing Network (The Sharing Network) is the Federally designated, State certified, organ procurement organization for this Medical Center.

II. PURPOSE

This Policy assures that all potential organ and tissue donors are identified, and families are provided the option of donation in compliance with the law. This Policy provides a mechanism for Englewood Hospital & Medical Center (EHMC) to document each referral in accordance with Federal and State Regulations and guidelines promulgated by the Health Care Financing Administration, the New Jersey Department of Health and Senior Services, and the Joint Commission for Accreditation of Health Care Organizations. Adherence to this Policy also provides a permanent record for the purpose of quality assurance and quality improvement.

III. DEFINITIONS

- A. Organ Donation - Refers to the donation of solid vascular organs: kidneys, heart liver, pancreas
lungs and small bowel
- B. Tissue Donation – Refers to cartilage, bone, tendons, ligaments and soft tissue i.e., skin, fascia, dura, heart valves and saphenous valves. Tissue donation requires donor death to be determined by neurological or cardiopulmonary criteria.
- C. Eye Donation – Refers to corneas and/or whole eyes. Eye donation requires donor death to be determined by neurological or cardiopulmonary criteria.
- D. Neurological (brain) death – Irreversible cessation of all function of the entire brain, including the brain stem. The criteria and procedures whereby death can be determined and certified in accordance with neurological criteria is set forth in Administrative Policy # 100.24.
- E. “Imminent death” is when a patient, on neurological exam, has the absence of (2) or more brain stem reflexes with minimal or absence of respiration, and/or a Glasgow Coma Scale (GCS) of ≤ 5 .
- F. Designated Requestor – An individual employed by the NJ Sharing Network or an EHMC staff member who has received training by the NJ Sharing Network to approach family members for organ/tissue donation.

IV. REFERRAL

- A. The Medical Center shall notify The Sharing Network of each Medical Center patient whose death is imminent. The triggers for referral to the NJ Sharing Network are:
1. Glasgow Coma Scale (GCS) \leq 5
 2. Two of the following reflexes are absent:
 - > cough/gag
 - > corneal
 - > pupillary response to light
 - > response to pain
 3. Before the first clinical exam indicating death by neurological criteria.

Referral to the NJ Sharing Network is to be made within (2) hours of the above identified triggers.

- B. In the event of cardiac death, referral should be made within two (2) hours of declaration of death.
- C. The following should be provided to the Sharing Network upon referral:

1. Patient's name and identification number.
2. Age.
3. Cause of death or anticipated cause of death.
4. Past medical history.
5. Other pertinent medical information as requested by OPO.
6. Referral of a patient *does not* constitute a commitment on the part of the family or Medical Center.

- D. Any Staff Member may call in the referral to the Sharing Network telephone #:

1-800-541-0075

(Donor Referral "Hot Line" – 24 Hours A Day , 7 Days A Week)

It should be noted that the NJ Sharing Network is HIPPA exempt. Any information requested to promote and or assure the safety of an organ donation or transplant is permitted.

E. Medical suitability for Organ Donation: The Sharing Network has sole responsibility to determine medical suitability for donation.

F. Medical Examiner's Case: In the event that the death falls under the jurisdiction of the Medical Examiner, in addition to the consent of the next-of-kin, it will be necessary to obtain consent from the Medical Examiner's Office for the removal of specified organs and tissues. Obtaining such consent will be the responsibility of The NJ Sharing Network or the Tissue Bank Recovery Team. The hospital is responsible for notification to the Medical Examiner's according to Englewood Hospital and Medical Center's policy and procedure

G. A note must be placed in the patient's medical record regarding the potential donor's medical suitability as determined by the NJ Sharing Network. If the patient is determined to be an unsuitable candidate for donation, an explanatory note shall be made part of the patient's medical record. This standardized note will be placed in the patient's medical record by the coordinator who performs the on site evaluation.

V. PRONOUNCEMENT OF BRAIN DEATH

- A. Pronouncement of brain death must be determined according to steps outlined in Brain Death Policy (Administrative Policy #100.24)
- B. The legal declaration of brain death occurs when a licensed physician places a dated and timed note declaring the patient dead in the patient's medical record. It will be noted on the Death by neurological criteria checklist as well as the physician's progress record.
- C. The organ transplant or organ recovery surgeon may not be involved in the pronouncement of brain death.

VI. CONSENT

- A. If the patient has a validly executed donor card, Will, other document of gift, drivers license or identification card evidencing an anatomical gift, The Sharing Network representative or the Designated Requestor shall attempt to notify an appropriate person as described below of his or her gift. If there is no documentation of gift available, The NJ Sharing Network representative or Designated Requestor, shall ask persons in the following order of priority:
 - 1. Spouse or Registered Domestic Partner or legal equivalent in accordance with N.J.S.A. 26:8A-3 and 26:8A-6.
 - 2. Adult Children
 - 3. Parents (if no adult children)
 - 4. Adult Siblings
 - 5. Legal guardian
 - 6. Any person authorized or under the obligation to dispose of the body. N.J.S.A. 26:6-58.1 defines this category to include but is not limited to a hospital administrator, a designated health care representative or a person named in the person's will.
- B. The consent process is complete when the person in the highest category available consents or declines to donate, and there is no known contrary to that request from anyone in the same or higher category.
- C. Ideally, consent should be in written form but may be a witnessed facsimile or tape-recorded facsimile or in the form of a tape-recorded telephonic message. The NJ Sharing Network will provide all appropriate consent forms.
- D. Approaching the Family
 - 1. Only individuals employed by The NJ Sharing Network or EHMC Staff trained by The NJ Sharing Network as a Designated Requestor may approach families for organ donation. EHMC has decided to identify the Sharing Network as the Designated Requestor. Since the approach to the family must be collaborative, The NJ Sharing Network will work in concert with the Health Care Team at EHMC.
 - 2. To ensure that request for donation is made in a sensitive manner, it is critical that donation not be introduced to the family until they understand that their loved one is brain dead.
- E. A notation shall be made in a deceased person's medical record indicating whether or not consent for organ or tissue donation was granted. The notation shall include the following information:
 - 1. Whether consent was granted or refused;
 - 2. The name of the person granting or refusing consent;
 - 3. That person's relationship to the decedent; and
 - 4. Documentation of telephone contact with The Sharing Network.

VII. ORGAN RECOVERY

If consent is granted, the surgical recovery of organ(s) will take place in EHMC's operating room. Only qualified, trained individuals shall be permitted to serve on surgical recovery teams coordinated by the NJ Sharing Network. The NJ Sharing Network is responsible for assuring the competency and licensure of all physicians and team members. Only surgeons from approved UNOS transplant programs may recover organ in EHMC.

VIII. TISSUE RECOVERY

- A. All expired patients will be considered by NJ Sharing Network for tissue donation.
- B. The recovery of tissues will be accomplished by professional surgical recovery specialists trained by the Sharing Network. Tissue recovery may occur at the EHMC or at another approved site. Arrangements will be made by NJ Sharing Network recovery specialists to have the body transported, if necessary. The NJ Sharing Network will obtain approval from the family and medical examiner before transporting the body to another location. The NJ Sharing Network approved livery service will be utilized for this purpose. If a funeral director has been chosen by the family, the NJ Sharing Network staff will contact them and provide information related to the timing of the case and where the body can be recovered.
- C. Should the deceased be suitable for eye donation alone the NJ Sharing Network will place the referral with the affiliated Eye Bank designated in the affiliation agreement.

IX. OPERATIVE RECOVERY

- A. The Transplant Coordinator will contact the Operating Room (Peri-Operative) Administrator or her/his designee to coordinate times for organ and/or tissue recovery. The NJ Sharing Network will supply the names, license numbers, and any other required information deemed necessary by the Administrator or her/his designee prior to surgical recovery.
- B. In general, The Sharing Network will require assistance from the following personnel:
 - 1. Anesthesiologist.
 - 2. Nursing Services: It will be necessary to have one (1) Circulating Nurse and one (1) Scrub Nurse.
 - 3. The Recovery Surgeon will document operative findings.
 - 4. Normal post-mortem will be given to the patient and the body will be transferred to the morgue.
- C. For tissue donation of bone, heart valves, saphenous veins, eyes, etc., The NJ Sharing Network will require the use of an Operating Room. The Recovery Team is self-sufficient and will provide their own instruments and equipment

X. REIMBURSEMENT

- A. The NJ Sharing Network agrees to reimburse EHMC for all charges incurred from the time that death has been declared and which are directly related to organ and tissue procurement. Physician's fees shall also be covered by The NJ Sharing Network, provided that they are incurred after the declaration of death, and that the services provided were related specifically to donor evaluation, maintenance and/or surgical recovery of organs. All expenses should be sent to the:

New Jersey Tissue and Organ Sharing Network
841 Mountain Avenue
Springfield, New Jersey 07081

- B. Under no circumstances should any cost directly related to the recovery of organs

and tissues be passed on to the family or to the deceased's insurance company. The Business Office should be notified by the Peri-Operative Service Manager and/or her/his designee, the next business day.

XI. QUALITY IMPROVEMENT

- A. Medical Record reviews will be conducted by The NJ Sharing Network to ensure early referral of all potential organ donors. A periodic review of all death charts will be conducted by The NJ Sharing Network to ensure the timely notification of all Medical Center deaths. Charts will be reviewed for documentation of the referrals to The Sharing Network.
- B. The Sharing Network will provide to EHMC a quarterly report. The report will include all patients referred to The Sharing Network with outcomes.
- C. All reports policies and correspondences by the NJ Sharing Network will be kept in a binder provided to the hospital by the NJ Sharing Network. An identical copy of the binder is kept in the NJ Sharing Network office. The binder will serve as documentation of CMS compliance.

SOURCE:

-Bioethics Committee – 11/06
Sharon Roche, DNSc, APNc, CCRN
-Anatomical Gift Act/Donor Enhancement Act - 11/95
-NJ State Department of Health, Licensing Standards
NJAC B:34 G-5
-Conditions for Participation for Organ/Tissue
Procurement 42 CFR 482.45
JACHO Accreditation Manual for Hospitals 1998 RI2 –
Patients' Rights and Organizational Ethics
-Critical Care Committee 11/06

APPROVED BY:

Douglas A. Duchak, President/CEO

Organ and Tissue Donation after Cardiac Death: 300.83A

BACKGROUND

Most deaths are declared by an absence of cardio-respiratory function. As a unifying concept, all deaths occur when there is a permanent loss of the entire brain function. Thus, if there is no circulation to the brain for a sustained period, injury to the brain is permanent. The absence of a heartbeat during that period can be simultaneously used to declare death by traditional criteria of death, but also as a sign there is no blood flow to the brain.

Englewood Hospital & Medical Center strives to provide an ethically justifiable policy that respects the rights of patients to have life support withdrawn and to donate organs upon their death, according to Withdrawal/Withholding of Life Support Treatment. Patients or their surrogates can (within certain parameters) decide to forego life-sustaining treatment. These guidelines authorize comfort measures for patients wishing to forego such treatments. Furthermore, all patients have the right to elect organ donation in the event of death. While the vast majority of organ donors have been persons declared dead by brain death criteria, this institution believes it is ethically appropriate to allow patients who die after withdrawal of life support, to proceed with organ donation, even though such donation will necessitate declaration of death based on traditional cardio-pulmonary criteria and not brain death.

PURPOSE

The purpose of this policy is to outline the steps necessary to ensure that all patients or their surrogates to exercise their right to have life support withdrawn and to elect organ donation in the event of death. Donation following withdrawal of life support necessitates that declaration of death be based on traditional cardiopulmonary criteria (cessation of circulatory and respiratory function), rather than on neurological criteria (cessation of functions of the entire brain), also known as "brain death".

DEFINITIONS

Cardiac Death - Cardiopulmonary criteria for determining death - persistent cessation of circulatory and respiratory function during an appropriate period of observation, upon the basis of which a physician or other authorized person may declare death.

Brain Death - Death as determined by neurological criteria - cessation of functions of the entire brain, including the brain stem, a finding of which (when reached by a protocol stipulated in New Jersey regulations) is basis upon which a physician may declare death.

Healthcare Decisions - A decision to accept or refuse medical treatment, diagnostic procedures, hospital admissions, etc.

Decision-Making Capacity- The ability to make and communicate healthcare decisions. More than merely saying "yes" or "no", this capacity entails the ability to:

- Understand one's medical condition
- Appreciate the consequences of the decision, including benefits and burdens
- Take into account the likelihood of effectiveness
- Weigh alternatives to the procedure being considered, and
- Reach an informed choice

Advance Directive - Legally binding, written directions prepared by a person to guide medical care during a period when that person lacks decision-making capacity. Policy # 300.94 "Advance Directives and Healthcare Proxy".

Surrogate - Person recognized as having authority to make healthcare decisions on behalf of a patient who lacks decision-making capacity. The appropriate surrogate is the person in the following order of priority that is available, willing and able to assume this responsibility:

1. a healthcare representative (proxy) appointed by the patient in an Advance Directive or other legal document
2. a court-appointed guardian
3. the patient's spouse
4. the patient's adult child
5. the patient's parent
6. the patient's sibling
7. another close family member

Do Not Resuscitate (DNR) Order - A physician's written order directing the treatment team not to attempt CPR in the event of cardiac and/or respiratory arrest.

Comfort - Only Plan of Care - a decision to pursue patient comfort, dignity and quality of life as the aims of care, foregoing interventions, the primary purpose of which is to prevent death.

The Sharing Network - The New Jersey Organ and Tissue Donation Services. A non-profit agency, which has agreements with Englewood Hospital & Medical Center authorizing it with appropriate consent, to recover organs and tissues from patients who have died.

Ethics Consultation - Assistance regarding healthcare decisions to health professionals and/or patients and families, by or under oversight of the hospital's Bioethics Committee. Ethics consultation should be considered when there are conflicts, uncertainties or other concerns on the part of any person with responsibility for the patient's care.

Bereavement/Psychosocial Support - Assistance to patients and families coping with the stresses of grief and loss, provided routinely by all Englewood Hospital & Medical Center hospital professionals and, upon referral, by specialists.

PRINCIPLES

1. Englewood Hospital & Medical Center supports the social goal of encouraging and facilitating organ donations by surrogates of patients who have died. Englewood Hospital & Medical Center is further committed to respect the wishes of patients and families, to informed decision-making and to complete openness about policies and procedures.
2. All adults have the right to make informed choices regarding medical treatment. This right remains even when a patient no longer has decision-making capacity and may be exercised by an appropriate surrogate on the patient's behalf.
 - a. Patients or their surrogates have the right to forego life-sustaining medical treatment in most circumstances.
 - b. Patients or their surrogates have a right to elect organ donation in the event of death.
3. In New Jersey, decisions to withdraw life-sustaining medical treatment from patients with no reasonable hope of recovery may be made by surrogates without recourse to the courts.
4. Appropriate candidates for organ donation after cardiac death are those patients on life-sustaining treatment in whom withdrawal of that therapy is likely to result in death within a short period of time (e.g., patients who are ventilator-dependent and, preferably apneic),
5. Decisions about the appropriateness of withdrawal of life support will be made independently of the patient's donor status.
6. The healthcare professional responsible for a patient's care must also be responsible for organ recovery or subsequent transplantation. Such healthcare professionals have the sole responsibility to optimize the patient's care. The process of removing life support must be done in the manner that will promote patient comfort and respect the patient's autonomy. It is an important objective of this policy that the interest in recovering organs does not interfere with optimal patient care.
7. Patient comfort is the primary indication for using medications; doses of the medications should be carefully titrated to this purpose. With approval of the surrogate, other medications which are intended to enhance organ viability and which are neither beneficial nor harmful to the patient may be given.
8. Any intervention primarily intended to shorten the patient's life is expressly prohibited. Active euthanasia in any form is contrary to law, professional codes and hospital policy.
9. If any member of the healthcare team perceives an ethical conflict, he or she is encouraged to request a consultation by the Bioethics Committee. See hospital policy "Bioethics Consultation Service" (Policy # 100.5).
10. Healthcare professionals are not required to participate in the procedures described herein if such participation would violate their personal, ethical or religious beliefs.

PATIENT CRITERIA

This policy is to be applied with respect to any patient who satisfies ALL of the following prerequisite criteria:

- 1 A decision has been reached to withdraw life support, consistent with Englewood Hospital & Medical Center Policy Withdrawal/ Withholding of Life Support Treatment (Policy #100.11)
 - a Discussion/ decision concerning withdrawal of mechanical support and/or medications must be made separately from and prior to, discussions related to organ donation.
- 2 A decision must be reached by patient (or surrogate) and physician to issue a Do Not Resuscitate (DNR) order to adopt a plan of care to address the treatment goal of comfort (Policy # 100.29).
- 3 The patient, the patient's advance directive, or the patient's surrogate has indicated that organ donation is desired. Englewood Hospital & Medical Center policy "Organ/Tissue Donation (Policy # 300.83).
 - a. The Uniform Anatomical Gift Act establishes the following order of priority for consent: (1) spouse; (2) adult son or daughter; (3) either parent; (4) adult brother or sister; (5) guardian of the person of the decedent; (6) any other person authorized under obligation to dispose of the body. Donor Enhancement Act of 1995 and the Uniform Anatomical Gift Act, P.L. 1969 N.J.S.A. 26:6-etseq
 - b. decisionally incapacitated patient without a surrogate shall not be considered for organ donation after cardiac death unless (1) the patient's advance directive specifically designates both withdrawal of life-support and organ donation or (2) the patient's advance directive authorizes withdrawal of life-support and there is a legal document of a gift.
4. The patient must be ventilator-dependent and not expected to sustain his or her own spontaneous ventilation.
5. The patient must have been deemed medically acceptable by the New Jersey Organ and Tissue Sharing Network (The Sharing Network) for the donation of at least one vascular organ.

PROCEDURE

1. The patient must have a DNR order written and the decision for the withdrawal of the ventilator must be reached. See policy for "Withholding or Withdrawing Life-Sustaining Medical Treatment"
 - a. Discussions with the patient or surrogate leading to the decision to withdraw life-sustaining therapy must be appropriately documented in the medical record.
 - b. Discussion of organ donation shall be deferred until after the decision to withdraw life-support has been reached. It is then that The Sharing Network is notified of a potential donation after cardiac death. 1-800-541-0075. See policy "Organ/Tissue Donation" (Policy # 300.83)
 - i Medical suitability of a potential organ donor can be determined only by The Sharing Network
 - ii The Sharing Network Coordinator as the designated requestor, in collaboration with the hospital staff, shall initiate discussions with the patient or surrogate regarding donation and will present the option of donation, if appropriate
 - c. If the patient or surrogate initiates the discussion of potential organ or tissue donation, The Sharing Network shall be promptly notified to determine medical suitability prior to cessation of mechanical ventilation.
 - d. Organ recovery may proceed only if the patient or surrogate agrees to organ recovery upon death of the patient and signs the appropriate Sharing Network consent forms (appended)
 - i. Consent for donation can be withdrawn at any time
 - ii. The surrogate must also be specifically advised that medications which are neither beneficial nor harmful to the patient (i.e. heparin) may be administered. (This information is also specifically set forth in The Sharing Network consent form).

OPERATING ROOM (OR) REQUIREMENTS

1. The location for withdrawal of life-support shall be the operating room.
2. Notify the OR Nurse Manager of Supervisor whenever a patient who is on life-support is being considered as a possible organ donor.
3. The Sharing Network Coordinator will facilitate the OR Recovery Process.
4. Cannulation of the femoral artery and vein will take place prior to the removal of the ventilator and after appropriate consent is obtained.
5. Appropriate psychosocial and spiritual support will be provided for the family. Pastoral care shall be provided as requested. Arrangements should be made for family members to be present in the OR for extubation and pronouncement, if that is their wish.

Nursing responsibilities: See OR Procedure Manual.

6. Nursing responsibilities: See OR Procedure Manual.
7. Anesthesia Requirements: To assist ventilator support or patient monitoring.

VERIFICATION AND CERTIFICATION OF DEATH BY CARDIO-RESPIRATORY CRITERIA

1. After the patient is extubated and meets the criteria for death outlined below, the declaration of death will be made by the attending physician [anesthesiologist] (or his/her designee, who must be another fully-licensed physician with admitting privileges). Englewood Hospital & Medical Center policy "Expiration Protocol (Policy # 100.16)
2. The physician certifying death must not be involved either in recovering organs or the care of any of the transplant recipients. Completion of the death certificate and death summary in the medical record is the responsibility of the attending physician or his/her designee. Englewood Hospital & Medical Center "Expiration Protocol (Policy #100.16)
3. The surgical staff responsible for organ recovery shall not participate in any aspect of the prospective donor's care.
4. If narcotics or a sedative are administered, these drugs must be titrated to the patient's need for comfort. Medications must be justified by their effectiveness in the care of the patient. No medications will be used for the purpose of preserving a more usable transplant (with the exception of heparin and corticosteroids) or in regulating the time of death.
5. If organ ischemia is prolonged, it may not be possible to utilize organs designated for donation and recovery may not be performed. The decision to cancel organ recovery because of prolonged ischemia rests with the responsible transplantation surgeon. (If this occurs, the patient will be returned to an appropriate bed for hospice-type care. The patient's surrogate and attending physician will be promptly notified).
6. No organs may be procured until death has been certified. To keep warm ischemia time to a minimum, all other appropriate preparations for the procurement operation (such as cleansing of the skin, draping of the field and cannulation of the artery and vein) may take place prior to extubation (with appropriate consent). However, no incision will be made until the patient has been pronounced dead.
7. For certification of death, the prompt and accurate diagnosis of cardiac arrest is extremely important. Recovery of organs cannot begin until the patient meets the cardiopulmonary criteria for death that is the persistent and irreversible cessation of functions during an appropriate period of observation".
8. Because of obvious concerns regarding conflict of interest, the criteria to be used in this policy are, therefore, more stringent than the standard clinical practice for declaring death in patients who are receiving "comfort measures only", but who are not candidates for organ donation.
9. The diagnosis of death by traditional cardio-pulmonary criteria requires confirmation of correct EKG lead placement and confirmation of absent pulse via a femoral artery catheter. The pulse pressure must be zero or by definition, the heart is beating. In addition to pulselessness, the patient must be apneic and unresponsive to verbal stimuli.
 - a. Once pulselessness is confirmed by the above means, **any one** of the following electrocardiographic criteria will be sufficient for certification of death.

- Five minutes of ventricular fibrillation
- Five minutes of electrical asystole (i.e., agonal baseline drift only); or
- Five minutes of pulseless electrical activity (PEA),

b. The verifying physician shall record date and time of death in the Progress Notes.

10. Immediately after certification of death, organ recovery will proceed in accordance with procedures of The Sharing Network.

NOTIFICATION OF DEATH

1. If not present in the OR, the family shall be notified promptly by the declaring physician or his/her designee that death has occurred and that organ recovery is under way.
 - a. The Nursing Office and/or Administrative Nurse Manager and the Admitting Office will be notified by the OR nurse in charge.
 - b. The primary physician or his/her designee will be notified of the death if he/she did not declare death in the OR. See hospital policy "Expiration Protocol" (Policy #100.16)

MEDICAL RECORDS

1. Documentation of outcome of procedure will be noted by The Sharing Network in the Progress Notes.
2. The medical record shall be transported from the OR to the Admitting Office in a timely manner

DISPOSITION OF THE BODY

1. When recovery procedures are completed, the body shall be given post-mortem care to the Englewood Hospital & Medical Center procedure. The Sharing Network will assist with post-mortem care.
2. The body shall then be transferred to the morgue.

COSTS AND CHARGES

1. The donor's estate shall be responsible for those charges incurred for;
 - a. Diagnosis and treatment of the donor's primary illness,
 - b. Consultation relative to pronouncement of death,
 - c. Disposition of the body after the removal of organs for transplantation
2. The Sharing Network shall be responsible for all charges incurred for;
 - a. Donor evaluation (not relative to the pronouncement of death) and donor management.
 - b. Operating room use for organ retrieval.

SURGICAL PRIVILEGES

1. The affiliation agreement between Englewood Hospital & Medical Center and The Sharing Network assures that all physicians involved in the recovery are properly credentialed.
2. In cases of tissue procurement, the Donor Enhancement Act allows a certified Surgical Recovery Specialist to procure tissue without a physician in attendance.

REFERENCES

Donor Enhancement Act of 1995 and the Uniform Anatomical Gift Act, P.L. 1969 N.J.S.A. 26:6-et seq

JCAHO, Accreditation Manual for Hospitals, 2003, RI2, Patient Rights and Organization Ethics NJDOH Licensing Standards
NJAC 8:34G5

Institute of Medicine Report - Committee on Non-Heart Beating Transplantation II: The Scientific and Ethical Basis for Practice and Protocols. Non-Heart Beating Organ Transplantation: Practice and Protocols. National Academy Press: Washington, DC: 2000.

Institute of Medicine Report - Non-Heart Beating Organ Transplantation: Medical and Ethical Issues in Procurement. National Academy Press: Washington, DC, 1997

Englewood Hospital & Medical Center Policy "Determination and Certification of Death by Neurological Criteria" (Policy # 100.24)

Englewood Hospital & Medical Center Policy "Advance Directives and Health Care Proxy" (Policy #300.94)

Englewood Hospital & Medical Center Policy "Bioethics Consultation Service" (Policy # 100.5)

Englewood Hospital & Medical Center Policy "Consent for Surgical, Diagnostic and Other Procedures" (Policy # 100.8)

Englewood Hospital & Medical Center Policy "Do Not Resuscitate (No Code) Order" (Policy # 100.29)

Englewood Hospital & Medical Center Policy "Special Medical Guardianship" (Policy # 400.20)

Englewood Hospital & Medical Center Policy "Withholding or Withdrawing Life-Sustaining Medical Treatment" (Policy* 100.11)

Englewood Hospital & Medical Center Policy "Organ/Tissue Donation" (Policy # 300.83) Englewood Hospital & Medical Center Policy "Expiration Protocol" (Policy #100.16) Englewood Hospital & Medical Center Policy "Bereavement" (Policy # 300.57)

SOURCE:

NJ Tissue and Organ Sharing Network

Autopsies: 100.25

POLICY:

It is the policy of the Medical Center that autopsies shall be performed only with the consent of the patients family or guardian in accordance with N.J.S.A. 26:6-50 and NJ Department of Health Standards 8:43G-25.1 – 5.

N.J.S.A. 26:6-50 specifically states that an autopsy may be performed by an authorized licensed physician in the state of New Jersey after "...he first obtains the consent in writing of any of the following persons who shall have assumed responsibility and custody of the body for purposes of the burial: surviving spouse, adult child, parent, or other next of kin, of the deceased person. In the absence of any of the foregoing named persons any other person charged by law with and who shall have assumed responsibility and custody of the body for the burial may give such consent. Where two or more of the above mentioned have assumed such responsibility and custody of the body for purposes of burial, the consent of one of such persons shall be sufficient."

NJ DOH Hospital Licensing standards 8:43G-25.2 specifically states that "The physician who routinely performs or supervises the performance of autopsies shall be Board Certified in Pathology".

Procedure:

1. It is the responsibility of the physician in charge of the case to:

- A. Obtain *written* consent for autopsy (copy of form attached) from the next-of-kin in accordance with the above-stated New Jersey Statute and EHMC policies and procedures on Consents (100.8) and Patient Expiration (100.16). The latter policy defines specific circumstances requiring notification of the Medical Examiners office of any patient's death.
 - B. Obtain *written* approval from the Executive Office for performance of the autopsy. In the absence of a Medical Center Executive, a nursing supervisor is authorized to give executive approval for the autopsy following completion of the consent procedure.
2. **If the next-of-kin is unable to come to the Medical Center to sign the consent form for autopsy due to distance or physical disability, then a phone consent shall be obtained by the physician along with a witness to the phone conversation.**
 3. The Bergen County Medical Examiner must be notified immediately by the Attending/Pathologist/House Physician/Resident/ED/OR Staff, after the death of a patient, if the expiration was due to any one of a number of causes as listed in EHMC policy and procedure on Patient Expiration (100.16).

This includes, but is not limited to:

- A. Medical Center death 24 hours or less from the time of admission, deaths following surgery or any diagnostic or therapeutic procedure.
 - B. Accidents, criminal or self-induced abortions, overdoses, neglect, and acute alcoholism.
 - C. Maternal deaths associated with delivery or abortion.
 - D. Violence of any kind including homicide or suicide.
 - E. Death due to uncertain or unknown causes.
4. When the deceased is a Medical Examiner case and the Attending Physician desires an autopsy he/she must contact the Medical Examiner to be certain that the autopsy is to be performed. Autopsies on patients dead on arrival, or who die in the Emergency Department, should be performed by the Medical Examiner. **Consent is not required for Medical Examiner cases.**
 5. When denied by the Medical Examiner, the Medical Center will perform autopsies without charge only when the medical staff determines the need for an autopsy and obtains appropriate consent in cases of unusual deaths, deaths from unknown causes and cases of medicolegal and educational interest, unless otherwise provided for by law.
 6. Relatives or Guardians desiring an autopsy that *is not* requested by a physician may utilize a private pathology service who may perform the autopsy at their own facility, or at the funeral home. A list of private pathology services is maintained by the Patient Access Services Department.
 7. Autopsies may be performed by the Department of Pathology here at the Medical Center or by other facilities under contract with the Medical Center.
 8. In the event of an autopsy the consent form and medical center chart are forwarded to Patient Access Services. Laboratory and Patient Access Services procedures in their respective departmental policy and procedure manuals shall be complied with.

Provisional Autopsy results and Final Autopsy results will be sent to the office of Clinical Effectiveness upon completion for review and reporting through the Medical Centers Process Improvement process.

SOURCE:

N.J.S.A. 26: 6-50

- Executive Offices
- Laboratory / Pathology
- Patient Access Services

APPROVED BY:

Douglas Duchak, President & CEO

ENGLEWOOD HOSPITAL AND MEDICAL CENTER
350 Engle Street, Englewood, NJ, 07631

CONSENT FOR AUTOPSY / BURIAL

Patient Name _____ **Room #** _____ **MR#** _____

This autopsy has been requested by Dr. _____. Englewood Hospital & Medical Center will assume cost of autopsy.

The post mortem will be performed by pathologists at _____ that has an Agreement with Englewood Hospital and Medical Center to perform post-mortem (autopsy) examinations. If the institution named above is unable to perform the post-mortem it will be performed at another subcontracted facility licensed to perform post-mortem examinations, or at Englewood Hospital and Medical Center.

Autopsy requested by undersigned family or guardian who will make arrangements for the autopsy, burial, and assume all costs.

Post-mortem: I certify that I am authorized by law to direct disposition of the deceased patient identified above and, in the interest of determining cause of death and the advancement of medical science, I hereby authorize the performance of a post-mortem (autopsy) examination upon the said patient, which may include the removal of specimens, tissues and organs which may be preserved or contributed for such diagnostic, therapeutic or other scientific purposes as the responsible physicians deem proper.

Restrictions: all of the parts of the deceased may be incised, excised, or removed except:

_____ Date: ____/____/____
Signature of Health Care Representative or other Responsible Person Relationship to Patient

Witness: _____ Date: ____/____/____

Physician (required for phone consents): _____ Date: ____/____/____

Countersigned: _____ Date: ____/____/____
Medical Center Executive or Nursing Supervisor

Burial (body part or fetus): I hereby grant permission to _____

(Undertaker)

at (address) _____ for the burial of the _____
separated from my body by means of a surgical operation performed at Englewood Hospital and

Medical Center on the _____ day of _____, in the year 200 __.

_____ Date: ____/____/____
Signature of Patient Date Witness to Signature

_____ Date: ____/____/____
Signature of Health Care Representative or other Responsible Person Relationship to Patient

(0406) Rev. 12/02

Patient Rights and Responsibilities

See policy and procedure #100.8 - Consent

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.

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 which must be documented in detail in the medical record. 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.

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 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. Two physicians must fill out a determination of lack of capacity form when an advance directive exists.

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 Patient Care 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) seeking care for psychiatric or substance abuse treatment. 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. Every effort should be made to find out why the minor does not want the parents to be notified and support/services should be offered as appropriate. Consent forms are written in English and Spanish as well as many other languages. Be sure to apprise the patient that a translator can be provided upon request 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 take place 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 and consent for novel procedures or drugs must be witnessed. In addition, it is recommended that consent to hazardous treatment be witnessed. The witness should be a person over 18 years of age. Hospital employees may serve as witnesses.

IV. 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.

V. 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.

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.

VI. 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. Such refusals must be documented in detail in the medical record.

VII. 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 Patient Care Director or Administrator on duty should be notified.
- 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 Patient Care Director should be notified. Similarly, if siblings or other relatives with equal authority to consent are in disagreement, the appropriate Patient Care 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 an immediate threat and is required to save the life of the patient and requires immediate attention; 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 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.

Advance Directives, Health Care Agents, and Proxy Law

Under federal and 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 policy of The Englewood Hospital and Medical Center to provide all patients with information concerning the Health Care Proxy Law to assist those who wish to execute a health care proxy, and to honor decisions made by health care agents pursuant to validly executed health care proxies. If the patient has

executed a proxy, this document is placed in the medical record.

An individual designates an agent by completing a health care proxy. A health care proxy can make health care decisions only once the patient has been found to lack capacity to make those decisions. Unless the patient limits the powers, an agent may make all health care decisions the competent adult may make, including decisions to withhold or withdraw life-sustaining treatment, such as CPR or artificial respiration. Treatment decisions must always be made in accordance with the patient's wishes, if they are known. The law requires the agent to have specific knowledge of the patient's wishes concerning artificial hydration and nutrition.

An agent's authority begins when a physician determines that the patient has lost the capacity to decide about treatment. It is the physician's obligation to inform the agent and to give the agent all pertinent information about the patient's condition, prognosis and suggested therapies. Health care providers are obligated to comply with decisions made by a duly appointed agent.

Do Not Resuscitate (DNR) Order:

Refer to Medical Center policies: #100.29, Do Not Resuscitate and 100.8 Consent

There is a presumption in favor of cardiopulmonary resuscitation for patients who suffer an arrest while in the Hospital. Nonetheless, the application of cardiopulmonary resuscitation (CPR) to all patients who suffer an arrest is not always appropriate.

Thus, in order to prevent inappropriate resuscitative measures, it is very important that, when arrests seem likely, the appropriateness of CPR in the event of an arrest be communicated to appropriate members of the health care team. Prior discussion with the patient or designated surrogate with respect to the appropriateness of resuscitation, and communication of the results of such deliberation is the responsibility of the attending physician. The decision to initiate or forgo CPR is fundamentally like all other treatment decisions, and, consequently, it should be made in accordance with the principles embodied in the Medical Center's (Informed) Consent policy (#100.8) and DNR policy (100.29).

The attending physician must discuss the implications of a DNR Order with the patient or the designated surrogate. The patient or designated surrogate makes the decision regarding the DNR Order. A physician may issue a DNR Order in the absence of a designated surrogate in limited circumstances. If the decision is reached that CPR would not be appropriate, it is the responsibility of the attending physician to ensure that the appropriate DNR documentation and forms are completed, and that the DNR Order is written on both the order sheet and in the progress notes in the patient's chart and that any discussion in which consent was obtained is documented. Moreover, the attending physician has not adequately discharged his or her responsibility to either Englewood Hospital and Medical Center, the patient, or the patient's family unless and until the DNR decision has been communicated to appropriate members of the health care team involved in the care and treatment of the patient.

Under the DNR law the attending physician is the physician selected by or assigned to a patient who has primary responsibility for the treatment and care of the patient. When more than one physician shares this responsibility, any such physician can be considered the attending physician. In these circumstances senior House Staff can be considered the attending physician for DNR order purposes.

If a patient has appointed a health care agent, the agent has priority to decide about CPR and not the person appointed under the DNR Law, unless the patient's written proxy or surrogate appointment states otherwise.

The agent's decision takes priority over any other surrogate decision-maker. Just as in the case of a consent (or refusal to consent), generally a DNR Order remains valid so long as there has been no relevant change in the patient's condition and so long as there are no intervening circumstances indicating the patient or surrogate has changed his or her mind. It is the responsibility of the attending physician to reevaluate the appropriateness of the DNR Order as may be required by the patient's condition, or if the patient changes his or her mind about DNR. In the event there is a change in status of the Order, the physician must communicate such a change to appropriate members of the health care team. *A DNR Order may be rescinded at any time.*

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 Mount Sinai Administrative Policy Manual, Section A3 116, on the Intranet. DNR documentation sheets are available at the Nursing station.

Policy # 400.03 PATIENTS RIGHTS & RESPONSIBILITIES

The Medical Center is committed to educating patients and their families on their rights under the Laws of New Jersey. Patients are our primary concern, and therefore it is the responsibility for each staff member to be aware of the rights and responsibilities of all patients of the Medical Center. Patients are given copies of their rights upon admission. Copies are also posted on each patient care unit and in all waiting areas. As a patient at Englewood Hospital and Medical Center, all patients have the following rights and responsibilities:

MEDICAL CARE

- To receive the care and health services that the Medical Center is required by law to provide.
- To receive an understandable explanation from the physician of the patient's complete medical condition, recommended treatment, expected results, risks involved and reasonable medical alternatives. If the physician believes that some of this information would be detrimental to the patient's health or beyond the patient's ability to understand, the explanation must be given to the patient's next of kin or guardian.
- To give informed, written consent prior to the start of specified, non-emergency medical procedures or treatments. The physician should explain to the patient, in words that the patient understands, specific details about the recommended procedure, treatment, any risks involved, time required for recovery and any reasonable medical alternatives.
- To refuse medication and treatment to the extent permitted by law after possible consequences of this decision have been explained to the patient. Patients may also request treatment.
- To be included in experimental research only if given informed, written consent. The patient has the right to refuse to participate.
- To complete an Advance Directive outlining the patient's wishes related to health care should the patient become incapacitated and to have the medical team comply with the patient's wishes.

PAIN MANAGEMENT

- To receive information about pain and pain relief measures from concerned staff who are committed to pain prevention.
- To health professionals who respond quickly to reports of pain and practice state-of-the-art pain management.

COMMUNICATION AND INFORMATION

- To be informed of the names and functions of all health care professionals providing the patient with personal care.

- To receive, as soon as possible, the services of an interpreter if the patient needs one to help the patient communicate with the medical team.
- To be informed of the names and functions of any outside health care and educational institutions involved in the patient's treatment. The patient may refuse to allow their participation.
- To receive, upon request, the Medical Center's written policies and procedures regarding life-saving methods and the use or withdrawal of life support.
- To receive, upon request, information about how to gain access to and participate in the ethical resolution process surrounding the patient's care.
- To be advised in writing of the Medical Center's rules regarding the conduct of patients and visitors.
- To receive a summary of patient rights that includes the name and telephone number of the staff member to whom the patient can direct questions or complaints about possible violations of patient rights.

COST OF HOSPITAL CARE

- To receive a copy of the Medical Center payment rates. If the patient requests an itemized bill, the Medical Center must provide one and explain any questions the patient may have. The patient has the right to appeal any charges.
- To be informed by the Medical Center if part or the entire bill will not be covered by insurance. The Medical Center is required to help the patient obtain public assistance and private health care benefits to which the patient may be entitled.
- To obtain a copy of the patient's medical record, at a reasonable fee, within 30 days after a written request to the Medical Center.

DISCHARGE PLANNING

- To receive information and assistance from the patient's attending physician and other health care providers if the patient needs to arrange for continuing health care after the patient's discharge from the Medical Center.
- To receive sufficient time before discharge to arrange for continuing health care needs.
- To be informed by the Medical Center about any appeal process to which the patient is entitled by law if the patient disagrees with their discharge.

TRANSFERS

- To be transferred to another facility only when the patient or the patient's family has made the request, if the patient is mentally incapacitated, or in instances where the transferring hospital is unable to provide the patient with the care the patient needs.
- To receive an advanced explanation from a physician of the reasons for the transfer and possible alternatives.

PERSONAL NEEDS

- To be treated with courtesy, consideration and respect for the patient's dignity and individuality.
- To have access to storage space in the patient's room for private use. The Medical Center has a system to safeguard the patient's personal property (See Administrative Policy # 300.18-B).

- To contract directly with a New Jersey licensed registered professional nurse of the patient's choosing for private professional nursing care during the patient's hospitalization.

FREEDOM FROM ABUSE AND RESTRAINTS

- To freedom from physical and mental abuse and harassment.

The Medical Center is committed to providing a safe environment free from abuse, neglect or exploitation from anyone, including staff, students, volunteers, other patients, visitors, or family members. Patients are educated about their rights upon admission, through signage throughout the Medical Center, and through actual one-on-one visitations to their rooms from Patient Relations where they are given a number to call if they have any questions or concerns. In cases of real or perceived abuse, the Medical Center has a zero tolerance policy. The Department Supervisor should be notified immediately. The Supervisor initially investigates the extent of the abuse, based on the facts collected at the time, and notifies Security and/or the Administrator on call, as deemed appropriate. All such incidents shall be documented in accordance with Administrative Occurrence Reporting Policy #300.15A and/or Security Policy E.C.1.2.b.1. At any time, patients may file a grievance with the Patient Representative at extension 3368 and an additional investigation will be conducted according to the Patient Complaint and Grievance Policy #300.98.

- To freedom from restraints, unless they are authorized by a physician for a limited period of time to protect the safety of the patient and others, and other less restrictive measures have been taken. Seclusion and restraints may only be used in combination in an emergency situation to ensure the patient's physical safety and must be monitored regularly.
- To access protective services in cases of abuse or neglect. Refer to Policy & Procedure 200.36-A for detailed information.

PRIVACY AND CONFIDENTIALITY

- To have physical privacy during medical treatment and personal hygiene functions, unless the patient needs assistance.
- To confidential treatment of information about the patient. Information in the patient's records will not be released to anyone outside the Medical Center without the patient's approval, unless required by law.

LEGAL RIGHTS

- To treatment and medical services without discrimination based on age, race, religion, national origin, sex, sexual preferences, handicap, diagnosis, ability to pay, or source of payment.
- To exercise all of the patient's constitutional, civil and legal rights.
- To exercise spiritual beliefs and cultural practices as long as these do not interfere with treatments or harm others.

QUESTIONS AND COMPLAINTS/GRIEVANCES

- To present questions or grievances to a designated Medical Center staff member and to receive a response in a reasonable period of time. The patient may contact a Patient Representative by dialing extension 3368 or from outside the Medical Center at (201) 894-3368. The Medical Center must provide the patient with an address and telephone number of the New Jersey Department of Health agency that handles questions and complaints. The patient may contact the New Jersey Department of Health Complaint Hotline by calling 1-800-792-9770.

- This is an abbreviated summary of current New Jersey laws and regulations governing the rights of Medical Center patients as well as Medicare patients' rights. For more complete information, the patient may consult the New Jersey Department of Health Regulations at N.J.A.C.8:43G-4 or Public Law 1989-Chapter 170, available through the Medical Center's Patient Representative.

RESTRICTION OF PATIENT RIGHTS

It may be necessary for the Medical Center to restrict certain patient rights due to medical requirements as prescribed by a physician or as required by law. For example, it may be necessary to restrict a patient's visitors, mail, telephone calls, or other forms of communication as a component of a patient's care and medical treatment in such cases as to prevent injury or deterioration in the patient, damage to the environment, or infringement on the rights of others. The patient and family are included in any such decision, unless it would be thought to cause harm to the patient, and Patient Relations is notified of this action. These restrictions are explained in a language the patient understands

PATIENT RESPONSIBILITIES

As a patient at Englewood Hospital and Medical Center, it is the patient's responsibility:

- To provide accurate and complete information about the patient's present complaints, past illnesses, treatments, medications, hospitalizations and other matters relating to the patient's health.
- To report any changes in the patient's condition to the patient's healthcare provider.
- To make it known whether the patient understands a course of action and what is expected of the patient.
- To accept responsibility for refusing to accept a treatment or failing to follow the physician's advice.
- To ask the patient's physician or nurse what to expect regarding pain and pain management.
- To discuss pain relief options with the patient's doctor or nurse.
- To work with the patient's doctor and nurse to develop a pain management plan.
- To ask for pain relief when pain first begins.
- To help the doctor and nurse measure the patient's pain.
- To tell the doctor or nurse if patient's pain is not relieved.
- To arrive on time and to keep appointments or to notify the Medical Center in advance if the patient is unable to keep appointments.
- To assure that the patient's financial obligations to the Medical Center are met in a timely manner.
- To follow all Medical Center rules and regulations relating to patient care and conduct.
- To be considerate of the rights of other patients
- To be courteous and respectful to all Medical Center staff members.

Patient Relations: (201) 894-3368

Beeper #1304 (For Staff Use Only): 9:00 AM – 5:00 PM

Voice Mail on the evenings and weekends

OCCURRENCE REPORTING

Please see the following policies:

- # 300.15A Occurrence Reporting
- # 300.15B Significant Occurrences
- # 300.15C DOH Reporting

It is the policy of Englewood Hospital and Medical Center to report and document all unusual occurrences, injuries and misplaced items that involve patients, visitors, staff, volunteers, or others who are on the Hospital premises

Definition:

An occurrence is any event that happens in the hospital or on the hospital premises that is not consistent with routine patient care or with the routine operation of the facility. An occurrence has the potential to adversely affect or threaten the health, life or comfort of a patient, visitor, staff, volunteer or other.

TYPES / CATEGORIES OF REPORTABLE OCCURRENCES - Please note, this is not to be an all-inclusive list, but should serve as a guide for issues that need to be reported.

1. SURGICALLY RELATED OCCURRENCES

- wrong limb operated on and /or removed*
- wrong patient operated on*
- wrong procedure performed*
- incorrect instrument or sponge count
- burn caused by instrument or equipment
- malfunctioning instrument or equipment (with or without injury to patient)
- discovered retained instrument/ sponge

2. TREATMENT / PROCEDURE RELATED OCCURRENCES

- reaction to contrast material used in a diagnostic procedure
- inappropriate exposure to x-rays
- burns resulting from improper use of equipment
- malfunctioning equipment (with or without injury to patient)
- wrong procedure prepped for and /or performed
- wrong solution used in treatment

3. BLOOD RELATED OCCURRENCES

- wrong blood given to patient
- blood given to wrong patient
- blood or blood product.

4. INTRAVENOUS RELATED OCCURRENCES

- wrong solution administered
- infiltration of solution
- inappropriate infusion rate

5. MEDICATION RELATED OCCURRENCES

- wrong medication
- wrong dosages
- wrong time
- wrong patient
- wrong route of administration
- wrong drug dispensed
- reaction to medication (Adverse Drug Reaction)
- missing controlled drugs (See Medication Occ. Policy 300.92)
- unavailable drugs

6. FALLS

- with or without injury to patient
- place of fall: room, bathroom, hall, hospital property
- from bed, chair, stretcher, exam table

7. LOST, DAMAGED, MISSING OR MISPLACED PERSONAL ITEMS

- teeth, hearing aid, glasses, clothing, jewelry, wallet, etc.

8. OTHER REPORTABLE OCCURRENCES

- infant abduction or discharge to incorrect person*
- AMA and/or elopement
- suicides, or attempts*
- assault involving any person on hospital premises
- omission of treatment/procedure
- maternity related occurrences: incorrect identification, etc.
- assault on patient, visitor, staff

Examples or occurrences to report by clinical area include: ct reaction

OPERATING ROOM/RECOVERY ROOM

1. Wrong patient/wrong procedure performed*
2. Lack of consent/or improper consent
3. Unplanned removal of organ/body part not covered in consent
4. Burn resulting from equipment
5. Incorrect count: sponge, needle, instrument, etc.
6. Return to OR: organ or body part damaged/injured in surgery
7. Adverse results of anesthesia
8. Injury resulting from intubation
9. Death

EMERGENCY ROOM

1. Patient discharged or admitted to hospital without being seen by MD
2. DOA: seen in ER or hospitalized within past 7 days
3. Dies in ER within 24 hours
4. Patient leaves AMA
5. Discrepancy between initial and final x-ray interpretation (follow-up care could not be done)
6. Patient/visitor fall resulting in injury
7. Treatment/procedure errors
8. Lack of proper consent
9. Patient with head trauma discharged with altered state of consciousness

MATERNAL/CHILD HEALTH

1. Maternal or infant death
2. Apgar: less than 6 at one minute; 8 at 5 minutes
3. Infant injury
4. Newborn resuscitation
5. Delivery unattended by MD with OB privileges
6. Maternal hemorrhage
7. Mother's unplanned return to delivery or surgery
8. Maternal injury or complications
9. Discharge of infant to wrong person
10. Infant abduction*

CRITICAL CARE AREA

1. Equipment malfunction resulting in patient injury
2. ICU incurred trauma
3. Injured in transport to or from ICU
4. Lack of timely response by healthcare professional to a deteriorating condition

HOME CARE

1. Falls, burns, accident causing hazards in the home
2. Abuse of patients/ child abuse
3. Care giver barred from home
4. Mishaps due to faulty equipment or misuse of equipment
5. Patient charges alleged theft
6. Disagreement between patient and home care staff
7. Breakage or damage to personal property of patient or family

Please note, this list is not all inclusive and is a guide as to issues that need to be reported.

- Denotes potential Significance Occurrence (See Significance Occurrences Policy © 300.15-B)

Procedure:

1. Staff person involved in, or in the discovery of an unusual occurrence, documents such on the appropriate portion of the Occurrence Report Form.
2. If a physician is required to see/examine the person involved, he/she is notified to do so and to document on the Physician's portion of the report.
3. The incident is reported to the staff person's immediate manager by means of this report. The Manager is responsible to review the report and so indicate by his/her signature.
4. Occurrences indicated by an asterisk (*) on the Types/Categories above must be reported to the VP, Clinical Effectiveness or designee immediately as well as the report being documented. (ADRs are to be reported immediately to the Pharmacy.)
5. The report shall be documented and completed within 24 hours. The form is brought to the Nursing Office where a drop-off box for occurrence reports is available.
6. The VP, Clinical Effectiveness or designee will review, forward and/or copy all Occurrence Reports. Reports that are forwarded should be responded to, or reported on, through the Department's Process Improvement program.
7. Investigation and follow-up of significant issues will be coordinated through the office of VP, Clinical Effectiveness (See Significant Occurrence Policy).
8. If necessary, a Risk File will be established and/or the Insurance Broker/Carrier will be notified.

Restraint Management

Please refer to the entire Restraint Management Policy #300.90 (23 pages):

The administrative Restraint Management Policy is made up of two distinct parts:

- 1) The Medical-Surgical Restraint Policy governs the care of patients who require restraints for non-behavioral care reasons for the prevention of disruption in their medical-surgical treatment (i.e., line disruption and/or fall prevention).
- 2) The Behavioral Health Care Restraint/Seclusion Policy governs the care of patients in restraint due to an emotional/behavioral problem or agitated behavior regardless of setting.

PURPOSE:

To outline for physicians, nurses and other medical center personnel the circumstances under which patients may be restrained, the safety precautions that must be followed to protect patients, and the considerations to be observed in order to protect patients' rights, dignity and well being.

PHILOSOPHY:

It is the philosophy of EHMC that patients have the right to be restraint free. Early identification of the potential risk of dangerous patient behavior and prevention, reduction or elimination of restraint use when possible is our goal. In addition, the prevention of emergencies that have the potential to lead to restraints is also our goal.

Patients are placed in restraints to prevent injury to themselves or others, to prevent the disruption of medical treatment, to ensure a safe environment and to prevent destruction of physical environment. This is done while maintaining patients' rights, dignity, and well being. The least restrictive method of restraint that meets the patient's needs is applied. Non physical interventions are preferred. Restraints are never used as a punishment or for the convenience of staff. (Neither shall Psychotropic medications, when used as part of the patient's treatment plan, be used as a method of discipline, or for the convenience of staff). A multidisciplinary team provides care for restrained patients.

Utilizing a restraint intervention is a collaborative function of the MD or other independent licensed health provider and RN in response to an assessed patient need. Restraint intervention is utilized only after less restrictive and non-physical intervention strategies have failed. Every effort is made to maintain a patient's **safety**, privacy and dignity while in restraints. Restraints are discontinued as soon as possible, and staff are to facilitate this occurrence.

Suicidal Patients

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

DEPARTMENTAL INFORMATION

Ambulatory Care Services

Generally, the Ambulatory Care Practices operate Monday through Friday, 8:00am-5:00pm. 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.

Emergency Department

Please refer to policy # 400.23 TRIAGE, EMERGENCY MEDICAL SCREENING, TREATMENT, TRANSFER AND ON-CALL POLICY

The Medical Center complies fully with the Emergency Medical Treatment and Labor Act (EMTALA) as per the regulations found in 42 CFR part 489 for any individual who attempts to gain access to the Medical Center for emergency medical care.

All patients presenting to the Emergency Department will be evaluated by House Staff, Emergency Room physicians, and /or attending physicians following nursing triage.

No patient will be denied evaluation in the Emergency Department. Rapidity of evaluation will depend upon the severity of the complaint.

Medical Center Obligations Under EMTALA:

- A Medical Center must provide to any person who comes seeking emergency services, an appropriate medical screening examination sufficient to determine whether he or she has an emergency medical condition, as defined by statute.
- If it is determined that an emergency medical condition exists, the Medical Center is required to stabilize the medical condition of the individual prior to discharge or transfer.
- If the patient's medical condition cannot be stabilized before a transfer requested by the patient, or determined to be in the patient's best interest by the responsible medical personnel, the Medical Center is required to follow very specific statutory requirements designed to facilitate a safe transfer to another facility.
- A Medical Center may not delay the provision of triage, an appropriate medical screening examination, or further medical examination and stabilizing medical treatment, in order to inquire about the individual's method of payment or insurance status.
- It's The Law: Medical Centers must conspicuously post signs in any Emergency Department (E.D.), and /or in places likely to be noticed by persons entering the Emergency Department, as well as those individuals waiting for examination and treatment (e.g. entrance, admitting area, waiting room, treatment area). The signs must advise all individuals who have a medical emergency, or who are in labor, of their right to receive a medical screening exam, stabilizing treatment, and an appropriate transfer to another facility if medically necessary, all of which is regardless of the person's ability to pay. The sign must also state whether or not the Medical Center participates in the Medicaid Program under a State plan approved under Title XIX. Signs must

be in simple understandable language, and posted in the most common languages of the community. Copies of the Englewood Hospital & Medical Center (EHMC) signs are attached (see attachments #1).

- Recipient hospital responsibilities: A participating hospital that has specialized capabilities or facilities (including but not limited to, facilities such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers) may not refuse to accept from a referring hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual.

Patients will be admitted to the appropriate service by the House Staff or attendings according to Hospital Guidelines if:

- judged seriously ill without improvement in status while under treatment;
- extensive deterioration of a chronic condition is noted; or
- a potentially serious diagnosis is entertained.

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.

Ambulatory Care Practices

Generally, the Ambulatory Care Practices operate Monday through Friday, 8:00am-5:00pm. 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.

Clinical Laboratories

Clinical laboratories at Mount Sinai are organized under the Department of Laboratory and Pathology located in the Dean Building, Lower Level 2. Inpatient and ED specimens are delivered via the pneumatic tube system to the accessioning area. Outpatient specimens are either tubed or hand delivered to the Lab Office depending upon the draw location.

Laboratory results are all entered into the labs Mysis Laboratory Information System and made available throughout the Medical Center through the hospitals Eclipsys clinical information system (CIS) as well as printed on the specific unit in which the patient is located. House Staff access to the system is determined by a unique login ID and password which is provided at the time the resident joins the medical center and which should never be shared. Questions regarding available tests and their requirements may be directed to the laboratory at x3430.

Assistance with terminal and access problems can be obtained by calling the IT Help Desk at x3483.

In accordance with the institution's confidentiality regulations, all Laboratory testing information, including HIV testing, may be viewed on the CIS computer systems. As per HIPAA regulations an audit trail may be performed for all personnel viewing clinical information.

Infection Control

Bloodborne Pathogen Policy

Policy: If a health-care worker has an exposure incident (an exposure incident is defined as a specific eye, mouth or other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious matter, i.e. sharp object injury) the health-care worker will notify his or her supervisor immediately to complete an Accident Report. The Accident Report must include:

- Job classification
- Type of object causing exposure
- Route (s) of exposure
- Circumstances surrounding the incident
- Source Patient name and Medical Record number
- Source Patient location and Attending Physician

The Accident Report will accompany the health-care worker for immediate follow-up. The health-care worker will report to:

Employee Health Service
Emergency Room

Monday, Tuesday & Friday, 8am-4pm
all other times

ALL HEALTH-CARE WORKERS SEEN IN THE EMERGENCY ROOM MUST BE REFERRED TO EMPLOYEE HEALTH SERVICE FOR FOLLOW-UP COUNSELLING.

EXPOSURE INCIDENT EVALUATION:

- I. Source Patient Evaluation: If the source patient (the patient whose blood or body fluids have come in contact with the health-care worker) is known, it is the responsibility of the Supervisor/Patient Care Director to assure that the required blood work and consent are obtained and sent as follows. **This is the most important consideration in an exposure incident and must be done immediately at the time of the exposure.**

Blods are to be drawn on the patient using Blood Exposure Protocol in TDS. Blods are to be drawn as follows:

1. Hepatitis B surface antigen.
2. Heptatitis C surface antibody.
3. HIV Screening (original consent must go with blood specimen to the lab) This must be ordered "STAT" and the lab office notified it has been drawn. (ext. 3430)

While there is no legal requirement to obtain written consent for HIV testing in the State of New Jersey, there is an obligation to fully inform the patient or the patient's guardian of the Federal standard which states that if consent is not obtained and the source patient's blood is available, it shall be tested and the results documented. **Every effort must be made to obtain written, informed consent from the source patient.** The attempt to obtain consent will be the responsibility of the health care professional assigned to the source patient. The health care professional obtaining the consent shall further assure that the attending physician is notified of the testing. If the patient refuses to consent, he/she must initial the bottom of the consent form. If consent cannot be obtained, the attending physician must document why consent could not be obtained and initial the box.

I. Health-Care Worker Evaluation:

Initial Procedure:

For all exposure incidents the wound should be cleaned with an appropriate antiseptic. If necessary a dry sterile dressing or bandaid may be applied. If the health-care worker has not had a tetanus toxoid in the past ten years, the ED physician will offer 0.5cc of Tetanus toxoid. **The offer of this injection is not related to the exposure incident. It is a means of keeping the health-care worker up to date with tetanus prophylaxis.** Mucosal splashes should be immediately flushed with copious quantities of water or saline.

Uncontaminated exposures need only the above procedure.

Contaminated exposures require:

Bloods to be drawn as follows:

Health-care worker has completed Hepatitis B Vaccine series:

- a. Hepatitis B surface antibody
- b. HIV hold
1. Health-care worker's history unknown or denies Hepatitis B Vaccine
 - a. Hepatitis B core antibody
 - b. Hepatitis B surface antibody
 - c. Hepatitis B surface antigen
 - d. HIV hold
2. If the source patient is known positive HCV, health-care worker must have baseline Hepatitis C surface antibody testing done at this time.

3. HIV TESTING FOR THE HEALTH-CARE WORKER WILL BE DONE THROUGH EMPLOYEE HEALTH SERVICE ONLY.

The laboratory will hold the specimen for up to 90 days or until the health-care worker signs an HIV consent in EHS and is given a coded name to protect the confidentiality of the test.

5. If the exposure involved a known or suspected HIV positive patient the Post-Exposure Prophylaxis policy should be consulted for guidance.
6. If the exposure involved an unknown source patient, the exposure will be evaluated for type of exposure and source material. If it is determined that the exposure was significant, baseline testing for Hepatitis B, Hepatitis C and HIV will be performed on the health-care worker. The health-care worker will be advised to return for repeat Hepatitis C testing in 6 months and repeat HIV testing at 3- and 6-month intervals.

Health-Care Worker Incident Follow – Up

All Health-Care Worker Exposures will be followed up through Employee Health Service: (except in the case of outside agency non-EHMC workers, who shall be followed by their own employer's Employee Health Service.)

Initial blood work will be ordered and drawn in the Emergency Dept. when Employee Health Service is closed. The blood exposure screen should be activated on TDS.

1. If the patient is known carrier of Hepatitis B and the health-care worker is unvaccinated or a known non-responder to the vaccine (has had 2 complete series and is negative on post-testing):
 - a. HBIG x 1 dose, plus vaccination (within 72 hours) complete vaccine series on regular schedule or
 - b. HBIG baseline and 30 days post exposure
2. If the health-care worker has completed 3 doses of Hepatitis B vaccine:
 - A. and the healthcare worker is a known responder to the vaccine, no further follow-up is needed.
 - B. or the health-care worker's initial response to the vaccine is unknown: await the source patient's Hepatitis B results, then
 - a. if source patient is HbsAg negative, no follow-up needed.
 - b. if source patient is HbsAg positive,
 1. if worker is HbsAB positive, no further follow-up needed.
 2. If health-care worker is HbsAB negative, give HBIG x 1 dose, plus complete second three dose series. Test 8 weeks after completion of series.
3. The result of the source patient's Hepatitis C antibody test will be made known to the healthcare worker. If the source patient is Hepatitis C positive or if the clinical picture indicates possible HCV infection, the healthcare worker will be advised to return to Employee Health Service for baseline Hepatitis C antibody testing. If this baseline test is negative, the health care worker will be counseled regarding potential signs and symptoms of acute HCV infection and asked to report back immediately should any occur. In addition, the health care worker will be advised to return in 4-5 weeks when a Hepatitis C viral RNA (by PCR) test and ALT test will be performed. If this testing is still negative, the health care worker will be advised to return at 6 months for anti-HCV testing. Result reported as repeated reactive by enzyme immunoassay (ELISA) must be confirmed by supplemental anti-HCV testing. If the health care worker tests positive for anti-HCV at baseline, the employee will be counseled about the need to practice strict aseptic technique, and referred to their private physician. No further follow-up is required in this case. If either follow-up test (4 weeks or 6 months) is positive, the health care worker will be referred to an Infectious Disease physician for evaluation and follow-up. If both follow-up tests are negative, no further work-up is required.

4. Results of the source individual's test will be made available to the exposed health care worker, who will be told that he may not further disclose these results.
5. HIV Screening- The health care worker will be:
 - a. advised about his/her right to be tested confidentially (a coded system is used)
 - b. counseled with regard to the right to consent at any time up to 90 days post exposure to testing of the baseline sample
 - c. advised to report all acute viral illnesses for three months post exposure
6. If the source patient's HIV screening result is negative, only baseline testing will be performed on the worker. If the source patient's HIV screen result is confirmed positive, repeat testing on the worker will be conducted at 6 weeks, 3 and 6 months post exposure. If the source patient is found on testing to be HIV positive, or is known HIV/AIDS positive or with acute retroviral illness, please refer to the September 30, 2005 issue of Morbidity and Mortality Weekly Report, for the Public Health Service Recommendations for Post Exposure Prophylaxis and the EHMC Policy for Bloodborne Pathogens: Post-Exposure Prophylaxis and Employee Testing.
7. The health care worker who has been exposed to an HIV positive source patient shall be advised to use precautions (e.g. avoid blood or tissue donations, breastfeeding, or pregnancy) to prevent secondary transmission, especially during the first 6-12 weeks post-exposure.
8. The health care worker will be provided with a copy of the completed Accident Report and the Health Care Provider's Written Opinion within 15 days of the completion of the evaluation.
9. All exposure incident records will be released only with the written consent of the health care worker. The incident records will be maintained in Employee Health Service, in a separate and confidential file for the duration of employment. Thereafter, the records of the incident will be kept for 30 years
10. A log of all Bloodborne Pathogen exposure injuries shall be maintained. Documentation of each exposure injury shall include an explanation of the incident, the type and brand of device used, and where the injury occurred. The confidentiality of the injured health care worker shall be strictly protected in the maintenance of the Exposure Injury Log.

Source: NJAC 8:43G-20.2

OSHA Bloodborne Pathogens Standard
MMWR, September 30, 2005

Nutrition Services

The Department of Food & Nutrition Services 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.

Every patient care unit is covered by a Registered Dietitian who will work with House Staff to ensure optimal nutritional care. House Staff Officers may refer patients to the Registered Dietitians for nutrition assessment or counseling. They may be reached by beeper or by initiating a nutrition consult in TDS. For continued education after discharge, you may refer the patient to the Out Patient Registered Dietitian at 201-894-3673.

The EHMC Diet Manual on every nursing unit 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 and are available on the hospital intranet.

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

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

The dietitians may be reached by beeper or via the Dietary Office:

- Beepers: 1281, 1284, 1014, 2073, 1280.
- Chief Clinical Dietician: Joanne Lewandoski 1696
- Dietary Office x3097

Nursing Department

Philosophy and Organization

The Englewood Hospital and Medical Center (EHMC) nursing department's philosophy integrates Jean Watson's Caring theory and the humanistic values as stated in the medical center's mission statement. EHMC Nurses work collaboratively with physicians, and other members of the health care team to assure optimal patient outcomes.

The integrated practice model is the basis of professional nursing care at EHMC. An integrated practice model takes the education, experience, and competence of each care giver and matches it to the patient and families needs. This model gives the RN the authority and accountability for patient care management. Nursing care is built on evidence based standards that are pre-defined terms for patient care based on diagnosis. Standards of care and continuous performance improvement are assured through nursing representation on Nursing Councils, the Nursing Research Committee, the Nursing Practice Committee and the Ethics Committee.

The following roles are defined within our nursing structure:

Senior Vice President for Patient Care Services: Reports directly to the President of the Medical Center. The Senior VP possesses the authority and responsibility to influence all nursing care and nursing practice throughout the institution. He/she acts as a formal and informal liaison with the Medical Staff regarding nursing and administrative issues.

Vice President of Inpatient Services, Vice President of Perioperative Services; Inpatient services and perioperative services have a Vice President who is responsible for nursing practice in a number of patient care units cohorted by clinical specialization.

Vice President of Clinical Effectiveness: Is responsible for nursing practice in the Emergency Department. This person is also responsible for the Care Coordination Department, Risk Management, and the Advance Practice Nurses.

Patient care director (PCD): Are the first line managers on the unit. The PCD has 24/7 administrative and clinical accountability for the functioning of the unit.

Care Manager: Is a BSN prepared nurse whose focus is the more complex patients and families in the unit

Staff RN: The staff nurse is Diploma, Associate Degree, BSN or Master's prepared, who provides care for individuals and their significant others.

Patient Care Associate (PCA)/Patient Care Technician (PCT): The PCA/PCT is a support position for the nurse. The PCA/PCT provides direct patient care under the supervision of an RN. Depending on the area of the institution the role may be a PCT level which includes EKG and phlebotomy functions

Care support/ Clinical Roles: Those in support/clinical roles include masters and doctorate prepared Advance Practice Nurses (Clinical Nurse Specialists and Nurse Practitioners). Advanced Practice Nurses provide consultation for complex levels of patient care that require greater integration and decision making across diverse settings and the care continuum.

Care Coordinators: Are nurses who collaborate with the health care team to assure the patient gets the services they need in a timely manner and to plan a safe discharge.

Nursing Administrative Supervisors (NAS): provide clinical and managerial support to the nursing staff and assume maintenance responsibility for the operation of all departments in the absence of department head and hospital administration.

Private Duty Nurses or Companions

A list of agencies that provide private duty nurses or companions can be obtained from the Central Nursing Office (extension 3192)

Nurse and House Staff Responsibilities for Administration of Intravenous Therapy, Medications, and Blood Work

Intravenous (IV) Therapy and Blood Work: Registered professional nurses competent in IV therapy techniques are available to initiate, restart, and discontinue peripheral IV therapy catheters. If the nurse encounters difficulty in starting an IV she/he may request the physician's assistance. Phlebotomists draw blood in the patient care units. Patient Care Associate Technicians are also available in the Emergency Department to complete orders for phlebotomy. Patients requiring a peripherally inserted central catheter (PICC) are referred to Interventional Radiology for its placement.

Medications:

Only registered nurses may administer medications ordered by a physician in accordance with EHMC policies (*Administrative Policy & Procedure Manual, #100.47*) and medication administration procedures (EHMC *Generic Structure Manual, section IV*). Administration of certain medications (i.e. vasopressors, chemotherapy) and route of administration (i.e. IV push) is based on specific unit policies and the nurse's competencies. Patients may self-administer prescribed medications under proper supervision who have received appropriate training (*Administrative Policy and Procedure Manual, policy #100.47*) All medications require a medical order with drug name, dose (concentration and flow rate for intravenous administration), frequency, and route in accordance with *Englewood Hospital and Medical Center Formulary*. Only JCAHO approved abbreviations are permitted. All medications administered must be approved by the EHMC Formulary Committee.

Information regarding the administration of investigational drugs can be found in the *Englewood Hospital Administrative Policy & Procedure Manual* available on the hospital internet.

All medical orders must be dated and signed by a licensed physician or other authorized prescriber pursuant to *Medical Staff Rules and Regulations*. Signatures must be clearly legible to allow for authentication or the prescriber must print their name after their signature (*Administrative Policy & Procedure Manual, policy #100.02*).

All prescriptions and orders for inpatients issued by an unlicensed house staff officer (i.e. intern or PGY-1) must be countersigned by either a PGYII or PCYIII ("permit holder") or a licensed physician. All orders shall be counter-signed as soon as possible or within 48 hours (*Administrative Policy & Procedure Manual, policy #100.2*).

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

Medication Errors

If a medication is administered in error (i.e., wrong dose, extra dose, wrong medication) an occurrence report must be completed by the involved Nursing and medical staff. This form must be completed immediately after discovery and forwarded Patient Care Director or Nursing Administrative Supervisor.

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.

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 endostomal clinical nurse specialist or in her absence the PCD or NAS. When the patient is no longer at risk or the pressure ulcer is healed, the device should be discontinued.

Radiology Services

Diagnostic Radiology and Imaging Services

The Radiology Department includes diagnostic radiology, ultrasonography, computerized tomography (CT), interventional radiology, nuclear medicine, positron emission tomography (PET), magnetic resonance imaging (MRI), mammography, and early detection screening CT. The Department provides services to inpatients and emergency patients 24 hours per day and services to outpatients approximately 12 hours per day, Monday through Friday, and on a limited schedule on weekends. The range of services includes diagnostic imaging and special interventional or therapeutic procedures, utilizing ionizing and non-ionizing radiation, with and without the use of contrast media. The Vascular Laboratory and Echocardiography provide routine and emergency testing.

Request for Exams

All requests for imaging studies or interventional procedures must be electronically ordered through the Hospital Order Entry System (Eclipsys) on an appropriate Radiology Request Form or submitted through the HIS order entry system by members of the medical staff. Final reports are uploaded to the hospital information system and can be viewed online. A hard copy prints on the unit and is placed in the patient's chart.

Social Work Services

Social work services are provided at Englewood Hospital and Medical Center. Patients 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. Professionally trained and licensed social workers of the Care Coordination Department provide this needed service.

Based on the recognition that social and emotional factors are fundamental concerns in illness and can be disruptive to health and medical care, the Care Coordination Department is prepared to help patients and their families deal and cope with these related problems. Social workers can also provide consultation and technical assistance related to behavioral health issues. The referral guidelines below were developed to assist physicians and other professional staff in identifying patients or families in need of social work intervention at any point during the course of treatment. The Care Coordination Department should be contacted if any of the following situations exist:

- I. Patient/family safety issues interferes with continuity of care, including:
 - A. Patient with evidence of lack of sufficient care in the community.
 - B. Suspicion of abuse, neglect or domestic violence.
 - C. Lack of family and/or community support system adequate for care plan.
 - D. Inadequate insurance or other resources for recommended levels of care.
 - E. Evidence of substance abuse and/or psychiatric disorder impeding care.

- II. Potential exists for extended or long-term care needs, including:
 - A. Need for sub acute or long-term placement.
 - B. Need for hospice care.
 - C. Need for supervised living arrangements/foster care.
 - D. Frail elder with multiple admissions and/or failure to thrive.
 - E. Homelessness.
 - F. Concern that patient's condition will alter his or her ability to continue present living arrangements.
 - G. Need for Medicaid related home care services.
- III. There is evidence of patient/family coping and/or compliance issues, including:
 - A. Complex patient/family dynamics interfering with medical treatment plan; history of refusing needed skilled or support services at home.
 - B. History of AMA discharge or current AMA.
 - C. Non-adherence to medical regime.
 - D. Lack of follow-through with efforts to plan hospital discharge.
 - E. Need for bereavement counseling.
 - F. Psychosocial issues related to adjustment/adaptation to illness or medical condition.
 - G. Mental health issues impacting medical management.
- IV. There are legal/regulatory issues, including:
 - A. Inability to make decisions regarding safe discharge alternatives and no surrogate decision maker.
 - B. Inability to access financial assets for continuing care needs.
 - C. Immigration issues.
 - D. Need for involvement of Division of Youth and Family Services [DYFS].
- V. There are immediate resource concerns, for example:
 - A. All medically necessary transportation arrangements.
 - B. Financial assistance with discharge needs including prescriptions.

Social workers use high-risk criteria to determine whether to initiate intervention with patients. When physicians refer to the Care Coordination Department 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.

MEDICAL RECORDS

Use of Medical Records by House Staff

Progress Notes

Progress notes insure continuity of care between shifts and disciplines, justify care to third-party payers and regulatory agencies, and help to 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.

- I. As a rule, the first progress note should contain the attending physician's name, any significant history or physical findings not previously recorded, diagnostic impressions, and any further suggestions.
- II. Subsequent notes should contain statements relative to all significant findings, changes in diagnosis, condition, or therapeutic program. All laboratory and ancillary test results should be documented.
- III. Prior to surgery, a note should indicate the preoperative diagnosis and reason for surgery. Immediately following surgery, a brief note should be completed.
- IV. If a physician chooses not to follow a consultant's recommendations, s/he should document his or her reasoning.
- V. The final progress note prior to discharge should contain the principal diagnosis (that which is determined upon discharge to have caused the admission), complications, comorbidities and therapeutic recommendations of the attending physician.
- VI. 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.
- VII. Prior to the discharge of the patient, all Division cases (direct or indirect referrals) must be assigned by the Chief Resident to the house physician responsible for completion of the Operative Report and Summary. Please make this assignment in the orders or the last progress note.

Discharge Summary

The increasing demands for and uses of the medical record (e.g., billing, mandatory reporting, regulatory requirements) require unfailing physician cooperation in completing the record. Therefore, immediately prior to the discharge of a patient, the discharge diagnoses should be entered on the Attending Physician Attestation Form, and a Discharge Summary should be dictated by the Attending or the House Staff Officer (see Section IV, "Admissions and Discharges"). A handwritten Discharge Summary may be completed in lieu of a dictation. Transcribed dictations are available for review on EDR or TDS from terminals on each unit.

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 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 TDS, an addendum must be dictated separately.

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 (GP-2, Room 211).

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.

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 and its affiliates will be notified of any delinquent records.

The Medical Board has approved suspension of admitting and operating privileges of physicians with delinquent medical records, and has agreed to the following additional sanctions for House Staff:

- I. A notation shall be placed in the House Staff Officer's file, noting their failure to meet the required time frame or to respond to warnings about chart completion.
- II. The annual salary increase commensurate with promotion to the next postgraduate year will not be awarded unless all medical records have been completed.
- III. The House Staff Officer's diploma/certification will not be awarded upon residency completion unless all medical records have been completed.

Comments Requested

This document was based on the Mount Sinai Medical Center's House Staff manual and used with permission from the GMEC committee at Mount Sinai. Additions or corrections to this document to better adapt it to the needs of Englewood Hospital & Medical Center are welcomed. Please contact Alexa Gottdiener, MD at ext 3312 or via email: alexandra.gottdiener@ehmc.com with comments.