Carroll Hospital Center
Carroll Hospital Center has designed this computer based training (CBT) to educate our Medical Staff on hospital standards, policies and procedures. The Joint Commission requires hospitals to regularly inform licensed independent practitioners about important hospital, quality and patient safety standards.
About our Hospital . . .

• Established in 1961
• Private, nonprofit 195-bed hospital
• Governed by a community board of directors whose primary goal is to provide high quality, comprehensive medical services in Carroll County
• Today has over 1,750 individuals; second largest employer in Carroll County
• Has an annual budget in excess of $249 million
• Annually serves more than 310,000 individuals with direct medical care, outreach/community programs, diagnostic, outpatient services and health screenings
• Service is provided to all people without regard to their disease, race, color, national/ethnic origin, age, sex, religion, mental or physical handicap, or ability to pay for care, in compliance with all Federal, State and local laws and regulations.
Our Mission, Vision and Values

**Mission:** Our Communities expect and deserve excellent medical treatment, compassionate care and expert guidance in maintaining their health and well-being. At Carroll Hospital Center, we offer an uncompromising commitment to the highest quality health care experience for people in all stages of life. We are the heart of health care in our communities.

**Vision:** Founded by and for our communities, Carroll Hospital Center will help people maintain the highest attainable level of good health throughout their lives. We strive to be the best place to work, practice medicine and receive care. Our commitment is to be the hospital of choice.

**Our Actions & Decisions are Guided by these Values:**

**S**ERVICE ... exceed customer expectations.

**P**ERFORMANCE ... deliver efficient, high quality service & achieve excellence in all we do.

**I**NNOVATION ... take the initiative to make it better.

**R**ESPECT ... honor the dignity and worth of all.

**I**NTEGRITY ... uphold the highest standards of ethics and honest.

**T**EAMWORK ... work together, win together.
The Executive Team

John Sernulka
President & Chief Executive Officer

Leslie Simmons
Executive Vice President & Chief Operating Officer

Kevin Kelbly
Chief Financial Officer and Senior Vice President Corporate & Fiscal Affairs

Joyce Romans
Vice President & Chief Risk and Compliance Officer

Tracey Ellison
Vice President Human Resources

Ellen Finnerty Myers
Chief Development Officer & Vice President of Marketing and Community Affairs

David Louder, MD
Vice President of Physician Partnerships

Chief Medical and Quality Officer & Senior Vice President of Medical Affairs

vacant
About our Medical Staff . . .

- Carroll Hospital Center has more than 530 members on the medical staff
- There are over 460 physicians
- 90% of our physicians are Board certified
- There are over 70 allied health professionals
- There are 10 departments
- Representing over 35 medical specialties
Medical Staff Key Leaders

Syed Hosain, M.D., President of the Medical Staff
Sohaila Ali, M.D., Vice President of the Medical Staff
Tariq Mahmood, M.D., Secretary/Treasurer
John A. Steers, M.D., Member-at-Large
Binu Chacko, M.D., Member-at-Large

Departmental Chiefs

Andrew Green, M.D. – Anesthesiology
Valeriano Fugoso, M.D. – Diagnostic Imaging
Timothy Hsu, M.D. – Emergency Medicine
Daniel Aukerman, M.D. – Family Medicine
Natvarlal Rajpara, M.D. – Medicine
Michael Vietz, M.D. – Obstetrics & Gynecology
Christopher Grove, M.D. – Pathology
Michael Beardsley, M.D. – Pediatrics
Miguel Macaoay, M.D. – Psychiatry
Jed S. Rosen, M.D. – Surgery
Regulatory Agencies

Carroll Hospital Center is a Joint Commission accredited facility.
- Proxy for CMS
- They survey the hospital every 3 years (give or take a few months)
- We must maintain compliance constantly due to the unannounced nature of their visits
- Physician participation and cooperation is expected
- Regulatory Compliance Manager on staff

Centers for Medicare-Medicaid Services (CMS)/ Maryland Department of Health and Mental Hygiene (DHMH)
- Unannounced visit(s) as well
- Similar standards to the Joint Commission
- CMS and DHMH regulation determine many hospital policies and procedures
- Regulatory Compliance Manager on staff
Medical Staff Expectations
and
Responsibilities
Medical Staff Code of Conduct

It is the policy of Carroll Hospital Center to treat all individuals within its facilities with courtesy, respect and dignity. To that end, the Board requires that all members of the Medical Staff conduct themselves in a professional and cooperative manner in the hospital.

The objective of the policy is to ensure optimum patient care by promoting a safe cooperative, and professional healthcare environment, and to prevent or eliminate (to the extent possible) conduct that:

- disrupts the operation of the hospital
- affects the ability of others to do their jobs
- creates a hostile work environment for hospital employees or other medical staff members
- interferes with an individuals ability to practice competently
- adversely affects or impacts the community’s confidence in the hospital’s ability to provide quality patient care

Incidents of disruptive conduct or inappropriate behavior shall result in an investigation, efforts to improve poor performance and possible corrective action with early resolution or formal action by the MEC as defined in the Medical Staff Bylaws.
Medical Staff Health Policy (Impaired Physician)

The Medical Staff, Administration and Board of Directors have an obligation to protect patients, fellow physicians, Associates and other persons present in the hospital from harm. It is also their responsibility to ensure that members of the Medical Staff are physically and mentally competent to perform their designated responsibilities.

The Medical Staff Health Policy provides a means to identify impaired members and facilitate their treatment. It is not the purpose of the policy to be punitive, but to aid members in retaining and regaining optimal professional functioning that is consistent with protection of patients. The policy provides for confidential investigation of the member seeking referral, or referred for assistance, except as limited by law, ethical obligation or when the health and safety of a patient is threatened.

The AMA defines: “An impaired physician is one whose ability to practice medicine with reasonable skill and safety, is impaired because of a physical or mental illness, including deterioration through the aging process or loss of motor skill, or excessive use or abuse of drugs including alcohol”.

Allegations of impairment will be investigated in accordance with the Medical Staff Health Policy.
Medical Staff References:

Useful references available on the Medical Staff Resource page include:

- Medical Staff Code of Conduct [click here to view]
- Medical Staff Health Policy [click here to view]
- Medical Staff Bylaws [click here to view]
- Medical Staff Quality Policy [click here to view]
Medical Staff References:

Other useful references can be located on the Hospital’s Intranet page. To include:

• Medical Affairs
• Medical Library
• Clinical Practice Protocols
• Policies
• Core Measures
The Carroll Hospital Center Medical Library provides access to health care information to the Medical Staff and Associates. The library contains books and journals in medicine and the health sciences. In addition to print resources, users have onsite access to electronic journals and books as well as databases such as MD Consult and UpToDate.

The library is staffed Monday through Friday from 8:30 am to 5:00 pm. The library staff can provide research services and obtain copies of articles from other libraries. Access to the library is available 24 hours a day, 7 days a week by using the ID badge reader outside the door of the library. Access to the Medical Library’s website is available via Carroll Hospital Center’s Intranet.
Continuing Medical Education (CME)

The Continuing Medical Education (CME) Program of Carroll Hospital Center provides educational programs that lead to continuous advances in professional knowledge and skill. CME programs are carefully planned and utilize fully qualified presenters, primarily from nearby centers of healthcare delivery and research. CME programs are designed to offer education regarding current diagnostic and therapeutic modalities, the application of new technologies as well as standards of high quality patient care.

Carroll Hospital Center is accredited by MedChi, the Maryland State Medical Society, to provide continuing medical education for physicians. Carroll Hospital Center designates these live activities for *AMA PRA Category 1 Credit(s)™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity. Refer to the Medical Library’s website on the intranet for a list of available programs.
Health Information Management (HIM)
(Slides 17 – 33)
CHC uses an electronic medical record. PORTAL is the system which allows providers to view patient information and to complete chart deficiencies electronically. CPOE (Computerized Provider Order Entry) is used for the majority of orders at the hospital.

Training is required. To schedule an individualized training session:

Contact Steve Goyette for Portal training  
at 410-871-6537

and

Contact Michelle Rivers for CPOE training  
at 410-871-7087
When electronic medical records are not available, our procedure is:

- A unit patient roster is printed and distributed to managers and patient care coordinators.
- Lab values, radiology results and transcriptions are printed and available on each patient’s paper medical record.
- Nurses have a hard copy of each patient’s VS, I&O’s and medications on the clipboards they carry.
Medical Record Entries

• There must be an order to admit a patient
• **Date, time and sign** (authenticate) every entry in the medical record, including verbal orders
• Authenticate verbal orders within 48 hours
• If providing written orders, print your name or ID number on every entry
• Use hospital protocols and order sets when applicable
• All entries must be legible in the medical record!
• If your handwriting is difficult to read by clinical/non-clinical staff, you will be expected to dictate your notes.
Documentation Required in Medical Record

- Reasons for admission & treatment
- Initial diagnosis & impressions
- Assessment findings
- Allergies
- Conclusions drawn from history
- Diagnosis
- Consultations
- Patient response to care/treatment
- Progress notes
- Orders including medications, and restraint/seclusion
- Treatment goals and plan of care
- Results of diagnostic tests/procedures
- Discharge diagnosis
- Discharge plan and evaluation
History and Physical

- H&Ps must be completed within 24 hours of admission and prior to surgery. The surgical H&P must include a preoperative diagnosis.

- The H&P may be completed within 30 days prior to a scheduled surgery/procedure and updated within 24 hours prior to the surgery.

- If the H&P is completed by physician not on staff at Carroll Hospital Center, the attending (or designee) must also write an attending physician’s note within 24 hours after the admission of the patient.

- An H&P must be completed for the following types of procedures performed in:
  - The Operating Room
  - Endoscopy Suite
  - Under Conscious Sedation
  - Any procedure that places a patient at risk
  - All Angiography procedures
All dictated history and physical reports must include:

- **Type of Report, Dictating Physician Name, Patient Name, Medical Record Number, Date of Admission, List of physicians for sending Copies**
- **Chief Complaint**
- **Present Illness**
- **Past History** (Past medical history, Surgical history, Family History and Social History)
- **Allergies**
- **Current Medications**
- **Review of Systems** (ROS) (Systemic inventory of subjective symptoms described by patient)
- **Physical Examination** (must include: pelvic, breast, and rectal examinations or reason why deferred)
- **Treatment Plan** (Plan of Care)
- **Impression or Admitting/Provisional Diagnosis(es)**
History and Physical for patients readmitted within 30 days

- For patients readmitted within 30 days for the same or closely related condition, an “interval” H&P reflecting any changes may be used.

- The original physical exam must be readily available

- An admission note is to be completed and authenticated by the attending physician and shall include:
  - Present complaint
  - Update of family, social, or personal history
  - Summary of changes since last history and examination
  - Current physical findings
Consultation Report

All dictated consultation reports must include:

• Type of Report, Dictating Physician Name, Patient Name, Medical Record Number, Date of Admission, Date of Consultation, List of physicians for sending copies

• **Reason for Consultation**

• **Requesting Physician**

• **Current History**

• **Past Medical History**

• **Review of Systems**

• **Physical Examination**

• **Pertinent Laboratory/Radiology findings and/or Studies**

• **Treatment Plan**

• **Impression/Conclusion**
Operative Progress Note

Due to transcription delays, an operative progress note (use the hospital form) must be entered in the medical record immediately after the procedure and prior to transfer to another level of care.

The operative progress note should include:

- Name of the primary surgeon and assistants
- Procedures performed and a description of each procedure finding
- Estimated blood loss
- Specimens removed
- Post operative diagnosis
An operative report must be written or dictated immediately after an operative or high risk procedure.

All dictated operative reports must include:

- Type of Report (Operative Report), Dictating Physician Name, Patient Name, Medical Record Number, Date of Operation, List of physicians for sending Copies
- Preoperative Diagnosis
- Postoperative Diagnosis
- Surgeon
- Assistant(s) **(if none, state none)**
- Type of Anesthesia
- Operation(s)/Procedure(s) performed **(do not use abbreviations)**
- Findings
- Description of Procedure **(sutures/drains - if none, state none)**
- Specimens Removed **(if none, state none)**
- Estimated Blood Loss **(if none, state none)**
- Complications (Describe)
- Condition at conclusion of procedure
Discharge Summary

• A dictated discharge summary is required for:
  • All patients with a length of stay ≥ to 48 hours
  • All expired patients, regardless of length of stay
  • All nursing home transfers

• A final progress note or completion of the discharge summary form can be substituted for patients with problems of a minor nature who have equal to or less than a 48hr LOS, and in the case of normal newborn infants and uncomplicated obstetric deliveries

• The physician who has written the discharge instructions and final discharge disposition will be responsible for completing the discharge summary
Discharge Summaries

All dictated discharge summaries must include:

- Type of Report, Dictating Physician Name, Patient Name, Medical Record Number, Date of Admission, Date of Discharge, List of physicians for sending Copies
- **Admitting Diagnosis and History** (Reason for Hospitalization)
- **Hospital Course** (Including Procedures Performed, Significant Findings and Treatment Rendered)
- **Principle Diagnosis** (condition found after study to be chiefly responsible for admission)
- **Additional Diagnoses** (those conditions identified, evaluated, treated or that required additional resources or extended the length of stay)
- **Discharge Instructions** (including **Activity**, **Diet** and **Discharge Medications**)
- **Condition on Discharge**
- **Disposition** (if transferred, state what level of care the receiving facility will provide [such as rehabilitation or acute care])
- **Plan for follow-up care**
Patient Records are required to be completed within 30 days. Records are considered delinquent after 30 days.

This includes the following:

- Discharge summary
  - Must include final diagnosis
- History and Physical not completed within 24hrs of admission (per policy)
- Consult not documented
- Operative report not dictated immediately following procedure
- Verbal orders not authenticated in accordance with the verbal order policy
Notification of Suspension for Delinquent Records

A letter will be faxed to the physician’s office by the Health Information Management department 10 days prior to the suspension date.

The physician’s office will receive a phone call 1-2 days prior to suspension as a reminder to complete delinquent records.
Practicing While On Suspension

- Suspensions for delinquent records, a physician will not admit any new patients or post new operating room cases.

- A physician may continue to follow patient(s) currently under their care and perform surgery on patient(s) posted prior to the date of suspension.

- A physician may also perform “emergent” surgical cases if they are the sole provider within the designated response time.

- Responsibilities of a physician on call to the ED to admit and treat ED patients supersede any requirements of the medical records suspension and the physician must fulfill the requirements for being on call to the ED.
Physicians identified as having been on the suspension list in excess of 60 days will be deemed to voluntarily relinquish their medical staff privileges.

Physicians identified as having been suspended more than two (2) times within a calendar year will incur a $200 fine per additional occurrence.
Dictation

• Dial 1-877-430-0643 or in house extension 4040
• Enter Physician ID number, press #
• Press 1 to dictate or 3 to listen
• Enter worktype number then press #
• Worktypes:
  • Discharge Summary: 1
  • Operative Report: 2
  • History and Physical: 3
  • Consult: 4
  • STAT(any type): 5
  • Progress Notes: 80
• Enter patient medical record number, press #
• Listen for tone and begin Dictation

The Job # given at the end of the dictated note needs to be documented on the paper Progress Note
Quality, Risk and Compliance Principles
(Slides 35 – 59)

The Medical Staff of Carroll Hospital Center is committed to a patient-centered philosophy and fully supports the hospital’s goals of continuous performance improvement, high quality health care and patient safety.
Just Culture

- This is Carroll Hospital’s approach to addressing a mistake, medical error or inappropriate behavior

- It balances a non-punitive response and holding individuals accountable for their actions if they knowingly violate safety procedures or policy

- “Just Culture” requires an atmosphere of trust in which people are encouraged, even rewarded, for providing essential safety-related information, and in which they are also clear about where the line must be drawn between acceptable and unacceptable behavior

- There are certain steps to take depending on the type of behavior that caused the mistake, medical error or inappropriate behavior
Just Culture

Single Human Error (caused by poor system design that predisposes provider to fatigue, distraction, knowledge deficit, unsafe conditions, etc)
  • Console provider
  • Conduct Human Error Investigation (education, training, support)

At-Risk Behavior (caused by unintentional risk-taking; taking short-cuts)
  • Coach and educate provider
  • Conduct At-Risk Behavior Investigation

Reckless Behavior (caused by intentional risk-taking; not following policies)
  • Counsel provider
  • Use remedial action to change behavior for first offense
  • Use disciplinary action to change behavior thereafter

Repetitive Errors or At-Risk Behaviors
  • Investigate to determine source of repetitive errors or at-risk behaviors
  • If source resides in system, change the system
  • If the provider caused the error, consider remedial and then punitive action to address risky behavior
Potentially Litigious Situations

CHC encourages a cooperative relationship with our medical staff:

• Call Risk management to discuss/notify
• We can involve the Patient Representative (410-871-7099) in some cases to smooth/resolve issues
• History of working cooperatively with the medical staff members during a suit process, on through to the decision of the court or a settlement if such is the case

You have a right to a copy of the medical record pertinent to the issues

• RM can facilitate receipt of the record if any difficulties are encountered

Prevention is best and good, frequent, compassionate communication with the patient and family are the best defenses.

• Apology:
  • Required by regulation to notify patient/family of untoward event
  • We advocate apology
    ✓ Risk manager can help, facilitate, etc. as needed
    ✓ Documentation can be guided by Risk manager too

Risk Manager Access:

• During business hours – 410-871-6523 or through assistant at 6600
• After hours – through the Shift Coordinator at 410-871-6938
Informed Consent

The physician is accountable for consent by the appropriate decision maker – the patient, unless patient is unable or has assigned or deferred to someone else.

• Patient unable: Determine if the patient has someone assigned via an Advance Directive – get consent for treatment from that person. If there is no advance directive, then you and another physician must complete Physician Certifications – Part 1, to declare the patient incapable of making medical decisions (not *incompetent* – that is done by a court). If the patient is then declared incapable, the state of Maryland defines who can now be the surrogate decision maker. Nursing staff or case management staff can help with this information.

• Patient has assigned someone: Read and know the content of the advance directive
  • Is it effective immediately as soon as it was signed?
  • Does it require you and another physician to declare the patient incapable of making medical decisions?
  • Does it assign only one person or several to make the decisions
  • Are there any other restrictions?
  • Is it really a valid document to which we are bound by state law to follow or is there something missing that makes it an invalid document – call risk management if unsure.
**Informed Consent**

- You must explain the risks, benefits, and alternative treatments available to the patient and document your conversation.

- Nursing staff will check for informed consent and may question the physician. Nursing may also be a witness to the patient/decision maker’s signature but cannot answer questions that are intended for the physician.

- The signed consent form cannot be any older than 30 days.

- If you have a specific consent form that you wish to use in your practice at CHC, please present a copy to the Director of Health Information Management to get that form through the form approval process.
Advance Directives

Critical to ascertain existence and content as soon after arrival as possible as consent and decisions must be made through the patient or valid decision maker once the emergency situation is past, even if no procedures or surgery is involved.

- Verbal advance directive:
  If you have a conversation with a patient who tells you that they don’t want life support or do want life support:
  - That is an advance directive and should be memorialized in the chart.
  - It must be witnessed by someone else as well and that witness noted in the chart too.
  - If the verbal discussion occurred in your office and you have it documented along with notation of a witness to the conversation, send a copy of that office note to be included in the hospital record and that directive is as valid as any written directive – the most recent valid directive is the one that rules.
  - We are bound by law to abide by a valid directive, so seek guidance if you are unsure of the content, the intent, the actions needed, etc.
Transfusion Administration

All transfusions, other than emergency transfusions, require a signed consent.

A transfusion specific consent is available for your use and contains the risks and benefits and alternative treatments to facilitate documentation of the communication of this information as part of your consent process.

You may also document the content of the informed consent discussion in your progress notes if that works better for you.

If you are giving blood/ blood products related to a surgical procedure, the consent for that blood is covered by the surgical consent. If however, the transfusion is to treat something else or something that is fairly far removed from the procedure, consent is best obtained and documented.
Transfusion Refusal

All patients/valid decision makers have the right to refuse a transfusion or any aspect of care.

We do have a Refusal of Transfusion form that is on the back of the Transfusion Consent form.

Emergency Transfusions

Document the need and if any discussion was had with patient/decision maker in your progress notes, but no written consent form is required.
Effective July 1, 2013, a new State Law will go into effect which includes a statewide standard Medical Orders of Life Sustaining Treatments (MOLST) form.

- The form will replace all current DNR EMS forms.
- It is not an advanced directive, but a current order regarding Life Sustaining Treatments; therefore, it must be addressed when a patient is admitted to CHC.
- Patients who arrive with a current MOLST form must have it reviewed upon admission by nursing.
- ED patients who have limits placed on life sustaining treatments and are transferred back to a nursing home, assisted living facility or Hospice must have a MOLST form filled out.
- MOLST does not expire.
- MOLST completed by physicians or nurse practitioners who do not have privileges at CHC are valid.
- MOLST must be completed of all patients regardless of age or type of admission.
- MOLST does not need to be witnessed because it is not an Advance Directive.
- MOLST stays with active orders while the patient is admitted.
- A copy of MOLST must be provided to the patient upon discharge or within 48 hours of completion.
- MOLST must be signed and dated by a physician or nurse practitioner to be valid.
Withholding or Withdrawing of Life-Sustaining Treatment

By Maryland law, two physicians must certify patient in terminal or end-stage condition prior to discontinuing life sustaining treatment

- Physician Certification – Part 2 (back of the document signed to declare patient incapable of making medical decisions)
- Be sure not in violation of advance directive
- Be sure you get the decision from valid decision maker
- Not just related to discontinuing ventilator – *ALSO DEALS WITH STOPPING ANTIBIOTICS, FOOD, PRESSORS, ETC. IF THOSE ITEMS ARE “SUSTAINING” LIFE IN THE PATIENT.*
- Not necessarily required of the attending physician but best for him/her to be knowledgeable of the decision – can be consultant, hospitalist, covering physician, etc.
Futile Care

What if you think all else is futile and the patient doesn’t or the decision maker doesn’t?

• Person who is the valid decision maker (patient or someone else) is always the director of the care – if that person refuses to stop all care, then all care does not stop
• BUT you are supported by Maryland law as to not being forced to provide any more care than you believe is appropriate
• You must care for the patient until:
  • Another physician takes the patient
  • The patient is transferred to another facility under the care of another physician who accepts the patient, or
  • The decision maker decides to cease life sustaining treatment that aligns with your recommendation
• Call Risk manager for guidance if needed
Organ Donation

At the end of life, and by Maryland regulations, the transplant agency (Living Legacy) must be notified.

- When the patient dies, if not anticipated earlier
- When patient meets specific criteria
- When patient is declared brain dead or anticipation of declaration of brain death has occurred.

Hospital staff will make the call and are NOT required to notify the attending, but will do so at some point as part of continuation of care and communication among all team members.

NO Hospital staff or Medical staff members are PERMITTED TO APPROACH PATIENT OR FAMILY ABOUT THE POTENTIAL OF DONATION! Living Legacy must do so by Maryland regulation.

If donation is to be done, CHC has procedures defined to guide care until harvest is accomplished.
Autopsies

Expected to be sought in appropriate situations.

Criteria to help guide your decision is posted in various places – ask if you do not see it anywhere.

Medical Examiner Cases

When in doubt, notify the Medical Examiner. The physician or the shift coordinator or nurse may make the call.

The hospital cooperates with the Medical Examiner to provide any information requested.
Incident Reporting

It is a reporting tool for trending and improvement efforts as well as notification of the risk management staff as to a potentially litigious event.

Incident reporting is not and should not be done as retaliation for any actions.

Electronically, by phone to Safety Hotline, by email to risk manager or patient safety coordinator, or by phone to risk manager or patient safety coordinator:

- **Electronically:**
  - Hospital Intranet page: Blue Hot Button “Incident Reporting” – follow the prompts – quick and easy, can be anonymous
  - Safety Hotline: ext. 6909- monitored daily by the patient safety coordinator – can also be anonymous
  - Email: mak@carrollhospitalcenter.org or lrock@carrollhospitalcenter.org

- **Phone:** Mary Ann Kowalczyk: 410-871-6523 or Lisa Rock: 410-871-6591

Confidential and protected: Maryland law so far protects this information as risk management work product, but is being challenged more and more every year.
Improvement Mechanisms

Root Cause Analysis:

Done for significant events in a very structured, multidisciplinary manner – all confidential and protected by law – usually conducted by the risk manager if a significant event

Also done for less significant events that have good potential for identifying and correcting system issues

Please participate if asked to do so – your input and opinion is welcomed and many times sought and necessary
Confidentiality

Taken very seriously at CHC!

Violations have resulted in medical staff disciplinary action such as suspension and termination of privileges.

Avoidance of problems:
- Watch where you speak about patient issues and who might be able to hear
- Do not access information that you do not need to see or read
- Do not give patient private information to anyone not authorized by the patient or by job role in the hospital as being permitted to have the information
- Do not share your computer sign-on and password with anyone, including your office staff. Office staff should seek their own username and passwords through the IS Department of the hospital (Helpline – 410-871-6909)
- Do not access your own medical record or that of anyone you know without their specific written permission and through hospital approved processed to gain access to that information. Call HIM Release of Information for guidance (410-871-6873)

Behavioral Health (Psychiatric patients) – additional protections in that we do not acknowledge their presence in the hospital to anyone not part of the treatment team or authorized by the patient to receive information on their care.
Confidentiality Compliance

• All Jump Drives (USB, Thumb drives, Flash drives, Memory sticks, etc) must be cleared through IS (Information Systems) before used by Physicians or outside speakers.

• You MUST minimize or sign off a computer when there is the potential for others to see information. Keep all patient information (computerized or print) out of public view.

• Share confidential patient information only with authorized individuals.

• For practitioners who have a private practice, contact IS so that your staff may receive individual access. They may not use your ID/passwords to access any hospital electronic system.

• Everyone has the responsibility to protect PHI (Patient Health Information). This can be verbal, electronic or written. Never use this as scrap paper. Be aware of how you dispose of any paper with PHI on it!!

• Do NOT access any information, especially a patient’s chart, unless you have a work-related reason to do so.

• Armbands indicating HIPAA/OPT-OUT privacy issue will be clear with “PRIVACY” written in black.
Protection of Your Patient’s Confidentiality

Some patients prefer to remain anonymous while in the hospital for fear that he/she may be discovered by family or friends. You may call for help in getting the patient registered under an alias name when the patient is admitted.

If patient comes in through Emergency Room, staff may take steps to get alias name immediately if need is identified.
Transfers

Transfer of Service to another physician on staff:
- Notification of the new physician must be physician to physician
- Must be ordered in CPOE

Transfer of Patient to another hospital: EMTALA Regulations
- Physician must obtain the acceptance of patient by a specific physician at the other facility
  - EMTALA transfer form with all mandated documentation and action items is available and requires approval by the patient/decision maker, and description of the risks and benefits of the transfer
  - Not required for discharge to another facility such as a rehab facility
Consultations

Notification must be through physician to physician communication – hospital staff may not be the conduit. Also, place a consult order in CPOE.

Consult must be completed within 24 hours of the order.
Patient Complaints

Our aim is to resolve any patient/family concerns as soon as possible and while the patient is still in the hospital.

Monday – Friday during business hours, the Patient Representative is in-house to assist in the resolutions (410-871-7099). Call for help if needed.

Concerns expressed by patients/families after discharge can be referred to the same person or to the risk management office.

Federal and state regulations exist that define how quickly resolution is expected and how the resolution is to be relayed to the complainant. Seek Patient Rep or Risk management assistance if any issues.

Grievances (those complaints of serious nature or filed after discharge) are reviewed quarterly by a team and reported through the hospital performance improvement process and through the Medical Executive Committee.

If concern involves a physician in any way, the physician and the chief of his/her department will be notified and input sought to assist in the resolution.
Leaving Against Medical Advice (AMA)

Every patient who is capable of making their own medical decisions may decide to leave the hospital against medical advice and cannot be prevented from leaving unless valid certification for involuntary admission have been completed by two physicians.

An AMA form is available and signing by patient is desired but not always possible. Document the risk and benefits of AMA.

We do have an obligation to:
• Notify the attending of the intended or completed action
• Assure that the patient has any needed follow-up information and prescriptions to be as safe as possible upon departure.
Institutional Review Board (IRB)

At times, physicians and other professionals may wish to participate in multi-site research projects. A review process is required to assure adequate informed consent to subjects and to otherwise protect their interests. Drug companies, medical device manufacturers, and other research initiators fulfill this legal and ethical obligation by consulting an Institutional Review Board (IRB). This may be done through an independent third party (a hired consultant) or through the initiator's organization (e.g., a teaching hospital's own IRB).

While projects under consideration for Carroll Hospital Center would be required to already have an outside IRB's approval, a mechanism is still needed to consider the local impact of the proposal. There is an obligation upon the hospital to consider the needs of its community, both externally and internally. For instance, research projects may have an effect on patient or provider finances, length of stay, staffing requirements or follow up care. These are the types of issues intended for review by the hospital’s IRB.

To request participation with a study for hospital patients, contact the Performance Improvement office (410-871-6600).
Medical Staff Peer Review Process

- Overseen by Medical Staff leadership
- Facilitated by Director of Quality Outcomes Management
- Established review indicators plus option of a risk referral review of untoward event related to provision of care
- Case assigned to physician reviewer (assignments are spread across the medical staff); if physician reviewer indicates appropriate care, case closed; if physician reviewer has a concern about the care, then on to the Medical Staff Quality Committee after the treating physician’s input is obtained
- Physician input is time sensitive in order to provide prompt resolution of the issue – the time frames are explained in the request for input
OPPE and FPPE

The Medical Staff is also responsible for the ongoing evaluation of the competency of practitioners and providing leadership in performance improvement activities within the organization. Refer to the Medical Staff Quality Policy for details.

Ongoing Professional Practice Evaluation (OPPE):
OPPE is the process used to continuously evaluate a practitioner’s performance, requiring ongoing evaluation of each practitioner’s professional performance to identify practice trends that may impact quality of care and patient safety. This process is designed to resolve potential problems with performance as soon as possible as well as to foster an evidence-based privilege renewal process.

Focused Professional Practice Evaluations (FPPE):
This is the establishment of current competency when the Medical Staff lacks information regarding the performance of physicians who hold or are requesting clinical privileges. This generally occurs under three circumstances:

• Initially requested privileges of new Medical Staff or Allied Health members
• For current Medical Staff or Allied Health members requesting new privileges/procedures (the practitioner has not yet performed the procedure for which he or she seeks privileges)
• For current Medical Staff or Allied Health members with identified competency concerns generated from peer review or OPPE (there is a concern regarding an existing privileged practitioner’s current competency that may affect their ability to provide safe, high-quality patient care).
Patient Satisfaction
HCAHPS
Our Culture of Always
(Slides 61 – 66)
HCAHPS Measures...

- The perception of frequency versus degree of satisfaction

- Patients rate:
  - Always
  - Usually
  - Sometimes
  - Never

- Measured as percent always
Our Goals

• Implement an action plan to increase consistency and improve performance

• To maximize Medicare reimbursement under Value Based Purchasing by raising our mean “always” scores to 70% or greater
Survey Questions

- Nurse Communication
- Doctor Communication
  - How often did doctors treat you with courtesy and respect?
  - How often did doctors listen carefully to you?
  - How often did doctors explain things in a way that you could understand?
- Responsiveness of Hospital Staff
- Pain Management
- Communication about Medications
- Discharge Information
- Noise at Night
- Room/Bathroom Cleanliness
- Likelihood of Recommending
- Overall Hospital Rating
Ways to Improve Communication

AIDET: 5 Fundamentals of Patient Communication
AIDET

A = Acknowledge: Knock before entering room, ask if you can come in. Good eye contact with patient and then family.

I = Introduce: “I am Dr. Smith and I will be taking care of you in the hospital. What brings you to the hospital today?”

D = Duration: Give time frame for when you expect test results or improvement in the patient’s condition.

E = Explanation: Take this time to explain what will happen to the patient while they are in the hospital.

T = Thank You: “Please let me know if there is anything else I can do for you.” “We always want you to be very satisfied with the care provided when you come to Carroll Hospital Center.”
AIDET’s Purpose

- Decreases patient anxiety
- Builds trust
- Increases compliance
- Reduces complaints
National Patient Safety Goals
(Slides 68 – 77)
Joint Commission

In 2002, Joint Commission established National Patient Safety Goals (NPSG) to help educate Healthcare personnel on Medical Errors. The Joint Commission developed Standards of Practice that must be consistently met.

Each Patient Safety Goal comes from a Nationally Reported Sentinel Event. A Sentinel Event is when a patient is severely harmed or dies.

Concerns about safety or quality issues should be reported to the Patient Safety Coordinator at ext. 6591. If you continue to have concerns about safety or quality issues after reporting them as above, you can contact The Joint Commission without retaliation from the hospital. The Joint Commission can be contacted at 1-800-994-6610 or via website at www.jointcommission.org.
Patient Identification

- Use two patient identifiers (patient’s name and birth date) when doing a treatment, procedure, collecting specimens or administering a medication
- Use two people to verify blood products
- Label specimens in front of the patient
Effective Communication

Critical Results must be communicated among caregivers. Critical Results are those that if left untreated, can be life threatening or place the patient at serious risk. Critical Results will be reported to the Attending Physician within 60 minutes after identification.

- We use the WBC process for verbal orders and critical lab values
  
  Write it down, read Back, & Confirm

- Confirm that orders or lab values read back to you are accurate
- Do not use abbreviations on the “do not use” list
- Be aware that nurses and other caregivers use the SBAR (situation, background, assessment, recommendation) format for communication
Medication Safety

Labeling medications, medication containers and solutions is essential. Medications and solutions are labeled even if only one is being used. Labeling occurs when the medication is taken from the original package to another container.

- Label all medications, containers and solutions used for any procedure with:
  - Name
  - Strength
  - Diluent and volume
  - Expiration date
  - Expiration time if < 24 hours

- Discard unlabeled medications

- For anticoagulants:
  - Use the protocols
  - Use unit-dose or premixed products
  - Check the baseline INR before giving Warfarin and recheck to adjust therapy
  - Initiate a dietary consult for patients on Warfarin as needed.
Reducing Infections

Wash your hands before entering and when leaving patient rooms.

• Be aware of multi-drug resistant organisms seen in the hospital and community
• Use the central line checklist when inserting central lines
• Only insert a central line in the femoral vein when there is no other access
• Remove non-essential central lines
• Administer prophylactic antimicrobial agents for procedures as indicated by best practice
• Use clippers for hair removal
Reducing Infections (Con’t)

- Use Standard Precautions (assume all blood and body fluids are infectious)
- Wear Personal Protective Equipment as appropriate
- Comply with the posted signs for Standard, Contact, Enhanced Contact, Air-borne and Droplet Precautions
- If you are doing a surgical procedure follow the SCIP standards
- Remove foley catheters as soon as possible to prevent infections
- Patients and families should be educated pre-op about preventing surgical site infection
- Contact our Infection Preventionist; Libby Fuss (x6832) for any questions
Medication Reconciliation

- Review the list of home medications on admission and transfer
- On transfer, review the current medication and home lists and write orders for those medications you want continued
- On discharge, provide the patient and next provider of care with a list of current medications
Changing Conditions of Patients

Encourage patients and families to ask for assistance when their condition gets worse. CHC uses the Critical Outreach Team (COT) as a form of rapid response team for patients or families to contact. By calling a COT, patients receive a quick response from a Critical Care Physician, Critical Care Nurse, and Respiratory Care Provider.

To call a COT
dial
4444.
Universal Protocol

Universal Protocol focuses on safety for all surgical & non-surgical invasive procedures. It prevents wrong patient, wrong site, and wrong side surgery. Must be documented in the medical record!

- Participate in the pre-procedure verification process
- When you perform a procedure mark the site using the hospital consistent format
- Participate in the time-out process immediately before starting the invasive procedure
- Perform a time-out for each procedure if more than one is performed
- Perform a time-out immediately prior to all invasive procedures
- Time-out identifies correct:
  - Patient
  - Site
  - Procedure
Pain Management

Freedom from pain is a patient right. Pain is extremely subjective, hence, the patient is the best judge of the intensity and relief. Assessment tools used to evaluate the patient’s perception of pain include the Wong face’s and when patients are unable to report their pain, the Functional Pain Scale or the Scale for Assessment in Nonverbal Patients.
You are instrumental in keeping our hospital safe! Whenever you see an unsafe condition, report it to the Safety Hotline at x6909.

Don’t wait for someone to get hurt!
Pillars of Excellence

The “Pillars of Excellence” is our quality dashboard and can be found on the Ground Floor near the cafeteria, the Physician Lounge, and on the intranet.

All of the hospital quality indicators are on display.
Medication Management
(Slides 81 – 89)
Adverse Drug Events

Any error or unplanned response is considered an adverse drug event or an adverse drug reaction and must be reported and tracked.

- Incident reporting process
- Safety Hotline (ext 6909)
High alert medications are identified by the **CHICKEN** acronym:

- **C**oumadin
- **H**eparin
- **I**nsulin
- **C**hemotherapy
- **K**CL
- **E**noxaparin
- **N**arcotics
• Keep prescription pads secure!
• Licensed independent practitioners (LIP) cannot bring sample medications in for a patient
• Try to minimize verbal and telephone orders
• Report adverse drug reactions and medication errors to the Safety Hotline at 410-871-6909
Pharmacists:

- Automatic renal dose adjustment service
- Monitor and write orders for all patients on aminoglycosides and vancomycin; co-signature is not required
- Automatic IV to oral conversion service for 7 drugs
- In conjunction with a dietician, pharmacists order and monitor TPN and PPN
- Review orders by 2 pm
- Follow the hospital’s therapeutic interchange policy for specified medications
• Non-formulary drugs
  • It may take up to 48 hours to obtain a non-formulary medication
  • The Formulary list can be found on the Intranet under the Pharmacy link
• Paper order forms are used for TPN/PPN, PCA/PCEA, and Chemotherapy
• Blanket reinstatement order for previously ordered medications are **not acceptable**
### These abbreviations are prohibited in any patient record!

<table>
<thead>
<tr>
<th>Unsafe/Prohibited</th>
<th>Potential Problem</th>
<th>What to use instead</th>
</tr>
</thead>
<tbody>
<tr>
<td>U (for unit)</td>
<td>Can be mistaken as zero, four or cc.</td>
<td>Write “unit”</td>
</tr>
<tr>
<td>IU (for international unit)</td>
<td>Can be mistaken as IV (for intravenous or as 10 (ten)</td>
<td>Write “international units”</td>
</tr>
<tr>
<td>Q.D. (for once daily)</td>
<td>Can be mistaken for each other.</td>
<td>Write “daily” or “q day”</td>
</tr>
<tr>
<td>Q.O.D. (for every other day)</td>
<td>The period after the Q can be mistaken for the letter “i” and the O can be mistaken for an “i”</td>
<td>Write “every other day”</td>
</tr>
<tr>
<td>Trailing Zero (lead don’t trail)</td>
<td>The decimal point can get missed. Never write a zero by itself after a decimal point (X.0mg)</td>
<td>Write a zero before a decimal point (0.Xmg)</td>
</tr>
<tr>
<td>Lack of a Leading Zero (lead don’t trail)</td>
<td>The decimal point can get missed. Never write a zero by itself after a decimal point (X.0mg)</td>
<td>E.g. write “5mg”, not 5.0mg</td>
</tr>
<tr>
<td>MS</td>
<td>Can be confused to mean another drug</td>
<td>Write out the drug name “morphine sulfate” or “morphine”</td>
</tr>
<tr>
<td>MSO4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MgSO4</td>
<td>Can be confused to mean another drug</td>
<td>Write out the drug name “magnesium sulfate” or “magnesium”</td>
</tr>
</tbody>
</table>

(Carroll Hospital Center Prohibited Abbreviations (Nov. 2003)
Documented diagnosis, condition, or indication for use for each medication ordered

Lab or other supporting data can serve as the indication.

• **For example:** K+ of 6.5 for Kayexalate. The indication does not have to be part of the order, only accessible in the record.
Verbal Orders

- Should only be used when absolutely necessary
- Ask the listener to **READ** back the order
- Pronounce each digit of numbers separately, especially for numbers in the teens and multiples of ten
  - *For Example:* “One-four units” not “14 units” (fourteen)
- Prescribers must confirm whether the order read back to them was correct
Dilaudid Safety

- Initial I.V. Dilaudid dose for an opiate-naïve patient should be 0.2 mg – 0.6 mg
- Remember:
  - 2 mg of Dilaudid is equal to 14 mg-20 mg of morphine!
  - 4 mg of Dilaudid is equal to 28 mg-40 mg of morphine!
Case Management
(Slides 91 – 93)
Case Management and Physician Interface

- Discharge Planning
- Physician Advisor
- Expedited Appeals
- Family Meetings
- ED Case Management
- Observation Placement Assistance
- Level of Care (LOC) Recommendations for ED Patients
- Appropriate LOC discussions
- Assuring plans are made and ready on discharge/transfer
- Paperwork/Forms
Case Management Services

- Screen each admission for medical necessity
- Perform UR certification activities
- Concurrent review of patient progress
- Monitor for risk management and quality issues
- Appropriate care, place, cost and time

- Discharge planning-continuum of care issues
- Psychosocial needs associated with illness, lifestyle changes, etc.
- Liaison with payors, community resources, patients, physicians
- Patient Advocates
- Interpreter Services
- Transportation
How to reach Case Management:

• Office hours: 410-871-7922
  • Monday - Friday, 0700-1630
  • Saturday
    • 0800-1600
    • Two staff members in house for discharge planning issue
• ED Coverage Monday-Saturday, 0930-2200
• On call after hours
  • Access through Shift Coordinator
Emergency Management
(Slides 95 – 105)
EMERGENCY MANAGEMENT

Call x4444 to activate any code

In the event of an actual emergency, Medical Staff members should report to the Doctor’s Lounge. Specialty specific instructions will be posted.

See the yellow Quick Reference Guide posted in the Doctor’s lounge for more information.
In the event of a Code Red:

Dial 4444

RACE

- R escue endangered patients
- A ctivate the alarm system
- C ontain the fire
- E vacuate as appropriate

- Know the location of fire alarms and extinguishers
- The hospital is a series of “compartments” designed to prevent the spread of smoke and fire.
- You may be needed to help transfer patients to an adjacent smoke compartment.
Hazardous Materials

- Material Safety Data Sheets (MSDS) are found on the hospital intranet page → Quick Links → MSDS on-line

- Wear Personal Protective Equipment

- Call x6756 if you don’t know the proper disposal of chemicals

- Require labels on all chemicals you use
Code Emergency Response ensures that any practitioner, staff member, visitor or out-patient on the hospital campus needing emergency care receives care.
Utility Systems

• The hospital’s generators will “kick-in” in less than 10 seconds

• You may be needed to assist patients whose equipment has failed

• Refer to the yellow Quick Reference Guide for specific actions for different systems failures
Security on our Campus

• Wear your ID badge at all times while on campus
• Register vehicles: **Click on the Security link** on the intranet to register your vehicle on-line.
• Lock your vehicle and secure your belongings
• Please obey all traffic signs!
• Don’t leave valuables in plain sight
• Pay attention to your surroundings
• Park in appropriate areas
Medical Equipment

• Sequester any medical equipment you suspect or know was involved in an incident

• Notify immediately:
  • Biomed 410-871-6755
  • Risk Management 410-871-6523

• Do not use any medical equipment on a patient unless it is checked by Biomed

• OR equipment (even trial equipment from vendors) must be checked by Biomed prior to usage
Medical Restraints

- Used for nonviolent/non-self destructive patients
- Medical staff order must be obtained within 1 hour of application
- Initial order expires at 24 hrs
- Face to face exam/reassessment must occur every 24 hours
Behavioral Restraints

• Used for violent/self destructive patients, and includes any time that hands or physical/chemical restraints are placed on the patient for that behavior

• Medical staff order must be obtained ASAP; no longer than 1 hour after application

• Use the restraint order sheet

• Orders must be renewed
  • Adults= every 4hrs
  • 9-17 yo= every 2hrs
  • <9 yo= every 1hr
Seclusion

* Normally done only in the ED and on 4West (the inpatient BHS unit), but
* Patient is considered in Seclusion, with a requirement for an order of same, when a patient is locked in a room or not permitted to leave an area or room, so
* You may be asked for a Seclusion order for areas other than ED and 4 West.
Smoking

Smoking on hospital campus is prohibited! Please remember to order nicotine replacement therapy for your patients to alleviate their withdraw symptoms.

As Healthcare professionals we must set the standard to make our Community healthier!
Congratulations
You have completed the online Medical Staff CBT.

Click here
to print out the Certificate of Completion.
Return the signed certificate to the Medical Affairs Office as follows:

Mail:
Carroll Hospital Center
Medical Affairs
200 Memorial Avenue
Westminster, MD 21157

or

Fax:
410=871-6526
If you have any questions about any information included in this presentation, you may contact:

Terri Wilson, Director of Medical Affairs: 410-871-6899