Credentialed Provider Mandatory Education - 2023

**All credentialed providers are expected to abide by Medical Staff Rules & Regulations, Medical Staff Bylaws, and St. Joseph's Hospital policy*

Integrity & Compliance

Trinity Health/St. Joseph's Health has established a system-wide Integrity & Compliance Program to support all who work in our health care ministry in understanding and following the laws, regulations, professional standards and ethical commitments that apply. The Trinity Health Code of Conduct describes behaviors and actions expected of all who work in Trinity Health- colleagues, physicians, suppliers, board members and others. The Code of Conduct- Supplement for Medical Staff describes those areas of the Code of Conduct that have particular application to our relationship with you as a member of St. Joseph's Medical staff. This document will be provided to you upon initial credentialing and then every two years in your re-credentialing packet. If you have any questions regarding this information, please contact your Medical Staff Office or your Integrity & Compliance Officer. The Code of Conduct – Supplement for Medical Staff is available on-line at https://sjen.sjhsyr.org/Admin/Policies/GetFile.ashx?Id=18815. The complete Code of Conduct is available on-line at https://sjen.sjhsyr.org/Admin/Policies/GetFile.ashx?Id=18814.

Consent for Procedures

Please be aware that all procedures, surgical and interventional, require informed consent from the patient or his/ her designee. All consents must be obtained by a physician or a clinical affiliate. A nurse or secretary may not obtain this consent. This must be dated and timed just prior to the procedure and reaffirmed at that time.

Consent for Blood Transfusion

Informed consent for transfusion of blood products must be obtained by a physician or clinical affiliate before a transfusion is performed. Informed consent may be obtained immediately before a transfusion, in advance for potential transfusions, or over the phone by an offsite provider with the nurse documenting on the consent form that the provider obtained consent. These forms are available on the intranet or from staff.

Active Shooter Preparedness

In this day in age, we unfortunately must be prepared for such a scenario in our institution. Not just in emergency rooms, labor and delivery or our outpatient facilities. This may occur in any area of our system. St Joseph's Health and Trinity both have an Active Shooter education series available, and you should review this and prepare yourselves for such an event. Keep yourself safe and those around you. Please review Healthstream video on active shooter preparedness.

Communicable Diseases (COVID-19, Influenza, Norovirus, RSV, Grp A Strep, etc.)

St. Joseph's Hospital recognizes the need to minimize the transmission of infectious organisms within the healthcare setting. It is also the intention of St. Joseph's to provide and maintain a safe and positive work environment that enhances the well-being of all colleagues. Medical Staff are required to self-screen before coming to work and not come to work if they are experiencing any symptoms of illness. Medical Staff who are sick or who have had a known exposure to a communicable disease should contact the Employee Health Office. Medical Staff are expected to follow all hospital policies pertaining to the mitigation of communicable diseases.

Certification and Compliance For The Emergency Medical Treatment and Labor Act (EMTALA)

The Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals with emergency departments to provide a medical screening examination to any individual who comes to the emergency department and requests such an examination, and prohibits hospitals with emergency departments from refusing to examine or treat individuals with an emergency medical condition. The term "hospital" includes critical access hospitals.

The provisions of EMTALA apply to all individuals (not just Medicare beneficiaries) who attempt to gain access to a hospital for emergency care. The regulations define "hospital with an emergency department" to mean a hospital with a dedicated emergency department.

In turn, the regulation defines "dedicated emergency department" as any department or facility of the hospital that either –

(1) is licensed by the state as an emergency department;
(2) held out to the public as providing treatment for emergency medical conditions; or
(3) on one-third of the visits to the department in the preceding calendar year actually provided treatment for emergency medical conditions on an urgent basis

Hospitals with dedicated emergency departments are required to take the following measures:

- Adopt and enforce policies and procedures to comply with the requirements of 42 CFR §489.24;
- Post signs in the dedicated ED specifying the rights of individuals with emergency medical conditions and women in labor who come to the dedicated ED for health care services, and indicate on the signs whether the hospital participates in the Medicaid program;
- Maintain medical and other records related to individuals transferred to and from the hospital for a period of five years from the date of the transfer;
- Maintain a list of physicians who are on-call to provide further evaluation and or treatment necessary to stabilize an individual with an emergency medical condition;
- Maintain a central log of individual's who come to the dedicated ED seeking treatment and indicate whether these individuals:
    - ° Refused treatment,
    - ° Were denied treatment,
    - ° Were treated, admitted, stabilized, and/or transferred or were discharged;
- Provide for an appropriate medical screening examination;
- Provide necessary stabilizing treatment for emergency medical conditions and labor within the hospital's capability and capacity;
- Provide an appropriate transfer of an unstabilized individual to another medical facility if:
    - ° The individual (or person acting on his or her behalf) after being informed of the risks and the hospital's obligations requests a transfer,
    - ° A physician has signed the certification that the benefits of the transfer of the patient to another facility outweigh the risks or
    - ° A qualified medical person (as determined by the hospital in its by-laws or rules and regulations) has signed the certification after a physician, in consultation with that qualified medical person, has made the determination that the benefits of the transfer outweigh the risks and the physician countersigns in a timely manner the certification. (This last criterion applies if the responsible physician is not physically present in the emergency department at the time the individual is transferred.
    - ° Provide treatment to minimize the risks of transfer;
    - ° Send all pertinent records to the receiving hospital;
    - ° Obtain the consent of the receiving hospital to accept the transfer,
    - ° Ensure that the transfer of an unstabilized individual is effected through qualified personnel and transportation equipment, including the use of medically appropriate life support measures;
- Medical screening examination and/or stabilizing treatment is not to be delayed in order to inquire about payment status;
- Accept appropriate transfer of individuals with an emergency medical

condition if the hospital has specialized capabilities or facilities and has the capacity to treat those individuals; and
• Not penalize or take adverse action against a physician or a qualified medical person because the physician or qualified medical person refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee who reports a violation of these requirements.

A hospital must formally determine who is qualified to perform the initial medical screening examinations, i.e., qualified medical person. While it is permissible for a hospital to designate a non-physician practitioner as the qualified medical person, the designated non-physician practitioners must be set forth in a document that is approved by the governing body of the hospital. Those health practitioners designated to perform medical screening examinations are to be identified in the hospital by-laws or in the rules and regulations governing the medical staff following governing body approval. It is not acceptable for the hospital to allow the medical director of the emergency department to make what may be informal personnel appointments that could frequently change.

A hospital is required to report to CMS or the State survey agency promptly when it suspects it may have received an improperly transferred individual. Notification should occur within 72 hours of the occurrence. Failure to report improper transfers may subject the receiving hospital to termination of its provider

Palliative Care

The goal of palliative care is to relieve suffering at all stages of disease and not just end of life – integrated model of healthcare.
WHO definition: *Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.*
Criteria to identify patients that would benefit from a palliative care consult have been proposed in a 2011 consensus statement and summarized in UptoDate:

A potentially life-limiting or life-threatening condition and...
Primary criteria

- The "surprise question": You would not be surprised if the patient died within 12 months or before adulthood
- Frequent admissions (eg, more than one admission for same condition within several months)
- Admission prompted by difficult-to-control physical or psychological symptoms (eg, moderate-to-severe symptom intensity for more than 24 to 48 hours)
- Complex care requirements (eg, functional dependency; complex home support for ventilator/antibiotics/feedings)
- Decline in function, feeding intolerance, or unintended decline in weight (eg, failure to thrive)

Secondary criteria

- Admission from long-term care facility or medical foster home
- Older patient, cognitively impaired, with acute hip fracture
- Metastatic or locally advanced incurable cancer
- Chronic home oxygen use
- Out-of-hospital cardiac arrest
- Current or past hospice program enrollee
- Limited social support (eg, family stress, chronic mental illness)
- No history of completing an advance care planning discussion/document

Adapted from National Consensus Project for Quality Palliative Care (2004). Clinical practice guidelines for quality palliative care. http://www.nationalconsensusproject.org.

Documentation

Complete, accurate, and timely documentation is critical for communication and patient care. In addition to patient care, physician/group/hospital national quality grades, patient acuity, predicted length of stay, and hospital revenue are also dependent on accurate and complete provider documentation. The Medical Staff shall be responsible for following the policy, Use of Copy/Paste Functionality in the EHR. Clinical Document Improvement (CDI) nurses may also send providers queries to clarify documentation. It is important that these queries are answered in a timely manner.

Malnutrition

Recognizing and treating patients with malnutrition is important for optimal patient care. Malnutrition is associated with increased infections, pressure ulcers, and falls. Registered Dietitian Nutritionists (RDN) evaluate patients for malnutrition following the ASPEN, *American Society Parenteral and Enteral Nutrition*, Criteria: based on weight loss, energy intake, body fat, muscle mass, fluid accumulation, and grip strength. When a patient with malnutrition is identified, the RDN completes an assessment in the nutrition flowsheet, followed by a consult note with malnutrition criteria listed. The malnutrition code documentation in the flowsheet signals a Best Practice Advisory or BPA alert for providers. This alert suggests the addition of malnutrition to the problem list and the provider can agree or disagree with this addition. If the provider agrees, they can search for, and add the appropriate malnutrition diagnosis code (noted in the BPA alert) to the problem list. The provider must include malnutrition as a problem in progress notes and discharge summary.

C-difficile

It is important to only test patients with a reasonable likelihood of having *C. diff* (see *Clinical manifestations of C diff* UpToDate). To avoid over-diagnosis and unnecessary treatment and associated consequences, patients who are on medications that may cause loose stools, such as stool softeners or laxatives, and/or patients with fewer than 3 diarrheal stools per day should not be tested for c. difficile.

Indications for Foley Catheters

- Accurate measurement (Q 1-2 hours) of urinary output in *critically ill patient*
    - Comfort/End of Life Care
    - Required/prolonged immobilization where alternative device is inappropriate.
    - Acute Urinary retention
    - Continuous bladder irrigation
    - Stage 3 or 4 Decubitus Ulcer with Incontinence
    - Select surgeries (urologic, prolonged surgery, large volume infusions and intra-op monitoring of UOP)

Urinalysis should be completed prior to urine culture and should have >10WBC/uL.

Urine cultures should only be sent if the patient is experiencing:

- Suprapubic tenderness
- Costovertebral angle pain or tenderness
- Urgency, frequency, or dysuria (only when catheter has been removed. An IUC in place could cause patient complaints of “frequency” “urgency” or “dysuria”)
- Fever >38.3^{o}F (Urine cultures have low yield for identifying fever source in the absence of other symptoms. Other sources of fever should be examined before sending a urine culture).
- Urine cultures should **NEVER** be sent due to cloudy or foul-smelling urine.

Specimens for culture should ideally be obtained after removing the Foley and obtaining a midstream urine sample or insertion of a new Foley if still indicated.

Central Lines and Central Line Associated Bacterial Infections

There are specific indications for central lines (see below) and removing them when not clinically indicated is critical. A vascular access team (VAT) provides support for intravenous access and assesses/recommends the type of line needed by the patient.

Indications for Central-Lines:

- Hemodynamic monitoring
- Administration of drugs or nutrition likely to induce phlebitis
- Provide peripheral venous access– NOT used primarily for blood draws or for medications that can be administered via another route.
- Perform ultrafiltration, hemodialysis, or other blood filtering process
- Establish temporary cardiac pacemaker
- Provide peripheral venous sheath access to place other devices –ex. Pacemaker, sheath introducer, ECOS, IABP, Impella).

A central line should not be used to draw routine blood cultures because of the risk for contamination. If blood cultures are indicated, two sets of **peripheral blood cultures** should be drawn. If peripheral blood cultures are attempted, but cannot be obtained, a central line can be used.

Antimicrobial Stewardship

To prevent complications and antimicrobial resistance, it is important to use antibiotics appropriately. Antibiotic choice should be specific and shortest duration as possible to treat the underlying disease. Patient antibiotic treatment regimens should be evaluated within 48 to 72 hours of starting antibiotics. Empiric antibiotic choice may include broad spectrum antibiotics, but once culture and sensitivity results are back, antibiotics should be adjusted to a more narrow spectrum agent to decrease the risk of resistance and other complications. Antimicrobial orders require a duration be placed into the order for it to be completed. Caution: we have seen orders entered with a duration of 7 doses when 7 days was intended. We have received multiple reports of inadvertent discontinuation of medications due to nonrenewal. Make viewing the orders tab a part of your medical record review process and take action on medication orders that are expiring.

Order Sets

Disease-specific order sets integrate best practice, save time, and streamline workflow. Important disease-specific order sets include: Sepsis, pneumonia, *C difficile*, COPD, and CHF. Other helpful order sets include: Insulin and Hypoglycemic treatment, Analgesics: Mile, Moderate or Severe pain, bowel management, fibrinolytic panel and VTE Prophylaxis.

In Basket Maintenance:

The Epic In Basket is a key tool for task-based and staff-to-staff communication.
Because some messages contain important, time-sensitive, patient care information, St. Joseph's Health and Trinity policy states that patient results, reports, and consultations in a provider's In Basket should be addressed in a timely fashion, but no later than 10 business days after the result was logged into the In Basket Compliance with completing ***(clicking done, reviewed or acting on the result with orders or communication with the patient)*** these messages in the ***Results*** and ***CC Chart*** folders within 10 business days is monitored.

Inpatient Glucose Control

Both inpatient hyperglycemia and hypoglycemia can result in increased patient morbidity and mortality. The following is recommended by the 2023 ADA Guidelines:

1. Get an A1C on all diabetic patients who have not had one in 3 months or non-diabetic patients with a glucose > 140.
2. Clearly state the type of diabetes in your note and orders (Type 1 or Type 2).
3. Request inpatient diabetic education for newly-diagnosed diabetics.
4. Hold outpatient diabetes meds upon admission and give insulin only.
5. Use the insulin order sets.
6. If a patient is NPO or has poor oral intake, give EITHER basal insulin alone OR basal plus bolus correction insulin every 4-6 hrs.
7. If a patient is eating, give basal, prandial and correction insulin (check glucose prior to meals).
8. DO NOT just give sliding scale correction insulin without basal insulin.
9. Goal inpatient glucose = 140-180

Restraints

Always choose the type of restraint based on the patient's behavior. Make sure your documentation matches the patient's behavior and the type of restraint chosen. Restraints Policy and Procedure

100% of restraints are reviewed. You may be asked to complete any documentation of the use of restraints.

Restraints for Non- Violent Behavior

Patients have the right to be free from restraint or seclusion that is used as a means of coercion, discipline, convenience or retaliation. Restraints are never used for staff convenience, as a substitute for adequate staffing or as a precaution against falls. Orders for restraints for non-violent behavior must be renewed by the provider every 24 hours with a daily progress note addressing the need for continued restraint use. Nursing assessment are completed every 30 minutes.

Restraints for Violent Behavior

Restraint or seclusion may be used if a patient is a danger to himself or others and must be discontinued at the earliest possible time. Other less restrictive measures should always be considered first. A face to face assessment must be completed within one hour of the application of restraints for violent behavior. Documentation of this assessment is in the EHR under note type called "Face to Face." This assessment includes behaviors indicating the need for ongoing restraints and possible alternative to the use of restraints. Nursing assessments are completed every 15 minutes.

The Office of Mental Health (OMH) requires that restraints for violent behavior on 3-6 and CPEP follow additional regulations around time limitations from application to order. If the provider is unable to be present at the time of restraint application, the registered nurse may obtain a verbal order. The attending physician must assess the patient and cosign the restraint order within 30 minutes of the restraint application. In addition, the face to face note documentation must be completed.

Chemical Restraints

A chemical restraint is used to manage a patient's behavior or restrict his freedom of movement and is not otherwise a standard treatment or dosage for the patient's condition. Chemical restraints, as with other restraints for violent behavior, require a specific physician's order to denote purpose as well as alternative methods used prior. They require a face to face assessment of the patient to determine efficacy within 60 minutes of administration. Nursing assessment are done every 15 minutes.

Manual Restraints (Physical Hold)

A manual restraint is the involuntary holding or pinning of the patient to restrict movement of the head, arms or body. A face to face assessment is required within 60 minutes of the use of the hold.

Patient Abuse or Neglect

It is a patient's right to be free from any act or threat of violence, abuse, neglect or harassment. This includes threatening, intimidation, physically or sexually harassing or violent behaviors whether verbal, written, or physical. Verbally report any witnessed or reported incident of violence, abuse, neglect or harassment immediately to your direct supervisor, Integrity and Compliance, or administrative coordinator.

Agitated Patients

Verbal De-escalation

With a significant increase in the number of reported assaults on physicians and staff by patients, verbal de-escalation of patients is key to ensuring the safety of yourself and your colleagues. Below are a few tools to assist in de-escalating patients.

- *Stay calm* – The patient will read your emotions; the more anxious or angry you are, the more escalated they will become.
- *Manage your own response* – Think before you speak; gauge the patient's non-verbal responses and take time to respond. Silence is OK.
- *Set limits* – Boundaries are OK. Space limits and limiting the audience will also assist you with calming the patient.
- *Handle challenging questions* – The more questions you can answer, the more satisfied the patient will be.
- *Prevent a physical confrontation* – Ensure adequate space between yourself and the patient at all times and always leave yourself between the patient and your egress.

Code Gray

When verbal de-escalation tools are not effective, the hospital has created a response team to assist in the de-escalation of these situations. Whether due to acute psychiatric needs, delirium, or substance withdrawal, calling of a **CODE GRAY (CODE G)** provides the care team with behavioral health, security and nursing resources to assist in de-escalating the situation. Call Code G as soon as it is noted that the patient's behavior is escalating to assist you in determining the appropriate treatment plan while at the same time maintaining the safety of the entire care team.

Patient Progression & Length of Stay

Physician engagement in patient progression and length of stay is critical to achieving our operational goals. **Length of stay targets have been established for the vast majority of DRG in alignment with national geometric mean length of stay for the same diagnosis: TLOS or targeted length of stay.** Prolonged length of stay without supportive evidence of increased acuity contributes to significantly higher overall cost for patient care. If patients are expected to stay beyond their targeted length of stay, documentation must be provided to support. Please review and incorporate the following guidelines into your practice to assist in impacting patient progression:

1. Know your patients target length of stay and working diagnosis by communicating regularly with the CCM assigned to your patient. Physicians are expected to attend SNAP rounds as part of regular communication with the CCM.

2. Anticipate potential weekend discharges and communicate to the CCM, especially when looking to place patients in nursing homes, inpatient rehab and/or outpatient dialysis
3. Escalate any discharge barriers/delays (i.e., OR scheduling, testing, procedures, etc.)
4. Organize your daily workflows to discharge patients first

Readmissions

Readmission reductions in high-risk patients with chronic conditions remain a focus, both nationally and here at St. Joseph's. Readmission avoidance is no longer focused purely on the patient's acute hospitalization, but on the success of the overall continuum of care. Timely follow-up appointments **within 3-5 days** with primary care physicians/specialists, appropriate access to necessary medications, transportation to follow-up care & testing, access to necessary support systems, and patient/family understanding of both their disease as well as the instructions given to care for themselves are essential to avoiding unnecessary readmissions.

Hand Hygiene

5 moments for Hand Hygiene defined by World Health Organization and CDC:

1. Before patient contact (and between contact with different sites on the same patient)
2. Before Aseptic Task (performing any invasive procedure/prior to putting on sterile gloves)
3. After Body Fluid Exposure Risk
4. After patient contact (after removing gloves)
5. After contact with patient surroundings

- Minimally, hand hygiene is required with every entry and exit of a patient's room, regardless of anticipated contact with the patient.
- Hand wash: requires15-20 seconds of friction under running water/required for all care of patients with C. difficile on Contact Precautions
- Alcohol Gel/Foam: When hands are not visibly soiled/ appropriate for same conditions listed above with exception of C. difficile patients

Hospital Acquired Infection Prevention

Central Line Associated Blood Stream Infections (CLABSI):

- Prior to insertion, review alternatives to central lines, such as peripheral IV or midline catheters
- Review line necessity daily and discontinue as soon as possible

Catheter Associated Urinary Tract Infections (CAUTI):

- Prior to insertion, review possible alternatives to bladder catheter – encourage use of bladder scanners and straight catheters and/or appropriate bedside urinals

Surgical Site Infections (SSI):

- Adherence to evidence-based interventions such as preoperative antibiotics, temperature control, blood sugar control, clean closure techniques, and evidence-based postoperative dressing and wound management
- *Perioperative Governance has reviewed and approved these protocols – adherence by medical staff is critical to improved clinical outcomes for surgical patients.*

Multidrug resistant organisms (MRSA,VRE, CRE,C. difficile, Candida auris and others):

- Hand hygiene as detailed above
- Appropriate isolation and PPE use to prevent potential spread of multi-drug resistant organisms.

Legionella

Legionella testing must consist of both a urine antigen *and* a sputum culture. Certain serogroups of *Legionella* are not detectable with urine antigen alone. Please utilize the pneumonia order set when screening these patients as it contains all necessary diagnostic testing.

OSHA Blood Borne Pathogen Standard

Blood and body fluids of all patients are to be considered potentially infectious without regard to their medical diagnosis. Wear a surgical mask and eye protection when placing a catheter, accessing or injecting material into the spinal canal or subdural space (includes lumbar punctures, intrathecal injections, etc.)

Sepsis

Incidence of sepsis is increasing. Severe sepsis and septic shock have substantial mortality. Early recognition and prompt institution of sepsis protocol can improve outcomes. Any patient who meets SIRS criteria or Sepsis should have a lactate level and antibiotics administered within 1 hour; time is critical. In accordance with CMS, the following elements should all be completed:

Within 3-hours of presentation (3 hour bundle):

1. Measure lactate level – Lactate levels > 2mmol/L with a suspected infection is indicative of *Severe Sepsis*
2. Obtain blood cultures prior to the administration of antibiotics
3. Administer broad spectrum antibiotics
4. Administer 30ml/kg crystalloid for hypotension (SBP<90mmHg or MAP<65mmHg) or lactate ≥ 4mmol/L

Within 6-hours of presentation (6 hour bundle):

5. Apply vasopressors (for hypotension that does not respond to initial fluid resuscitation) to maintain a mean arterial pressure (MAP) ≥ 65 mmHg
6. Remeasure lactate if initial value > 2mmol/L

Interpreter Services

Consistent with the American with Disabilities Act, all patients and their companions have the right to be provided meaningful access to quality healthcare services regardless *race, color, national origin, age, veteran status, disability, sex or gender identity*, including those persons who are limited English proficiency (LEP), hard of hearing, or visually impaired. For those meeting the criteria mentioned above, appropriate accommodations for communication must be made. These services are free of charge to the patient or their companion. These include, but are not limited to, translated documents (i.e., consent forms), Interpreter Phones, and Video Remote Interpretation (VRI) ipad Equipment for ASL. Documentation in the medical record must reflect use of interpretive services including, but not limited to, the refusal of offered interpreter services in lieu of a family member by the request of the patient, interpreter ID/name (this is to show that the patient understood what was said). ***Per the Interpreter Services Policy, staff cannot act as medical interpreters (3 people) but can communicate if providing direct care (2 people)***.

Medical Staff Code of Professional Behavior

In order to promote and support the mission and values of St. Joseph's Health, all members of the St. Joseph's community are expected to maintain the highest level of professional behavior, ethics, integrity and honesty, regardless of position or status. It is the policy of the Medical Staff that all credentialed medical providers shall conduct themselves in a professional and cooperative manner, and shall not engage in disruptive behavior. Disruptive behavior has a negative impact on the quality of patient care, as safety thrives in an environment that values and promotes cooperation and respect for others.
Medical Staff Supplement 2022.pdf

Ethical and Religious Directives for Catholic Health Care Services

St. Joseph's Health, as a Catholic Health care provider and regional health ministry, abides by the Ethical and Religious Directives for catholic Health Care Services. In order to support our mission, values and catholic identity, all members of the St. Joseph's community are expected to review and abide by the ERD's upon appointment to the medical staff.
https://www.usccb.org/resources/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06_0.pdf

Sexual Harassment

Sexual Harassment is a form of sex discrimination on the basis of sex, sexual orientation, gender identity or the status of being transgender, and is unlawful under federal and state law. Behavior constitutes sexual harassment if it is reasonably construed as harassing by the receiving party,

regardless of intent. Sexual harassment includes unwelcome conduct which is either of a sexual nature, or which is directed at an individual because of that individual's sex when:

- Such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an abusive, intimidating, disruptive, hostile or offensive work environment, even if the complaining individual is not the intended target of the sexual harassment;

- Such conduct makes submission to unwelcome sexual advances, submission to requests for sexual favors, or submission to other verbal or physical conduct of a sexual nature an express or implied condition of any person's continued employment or association with St. Joseph's; or
- Expressed or implied submission to, or rejection of, such conduct is used as the basis for employment decisions effecting any person.

Workplace Violence / Disruptive Behavior

It is the policy of St. Joseph's Hospital Health Center to keep the workplace free from acts or threat of violence. This includes any act of intimidation, harassment, or instance of intentional or unintentional harm or threat of harm, including domestic violence. It includes the display of any violent or threatening behavior (verbal or physical) that may result in physical or emotional injury or otherwise place one's safety and productivity at risk within the healthcare environment or other organizational spaces. Workplace violence will not be tolerated by any member of the medical staff or employee at St. Joseph's Health.

Advance Directives

Patients who are unable to produce a copy of their Advance Healthcare Directive upon admission, or within 48 hours of admission, will be asked to complete one at that time.

Competent adults and emancipated minors have the right to provide instructions about future treatment should patients lose the capacity to make health care decisions. Such instructions may be in the form of a Health Care Proxy, Living Will or other written form or verbal instructions regarding health care. Patients may with Do Not Resuscitate (DNR) order or Medical Orders for Life Sustaining Treatment (MOLST) forms completed by a physician and reflecting the patient's or authorized decision maker choices about life sustaining treatment.

Patients (or their Authorized Decision Makers) have varying preferences about the kinds of treatment desired as the end of life approaches. St. Joseph's Hospital is committed to honoring these preferences, within the bounds of medically appropriate treatment and in light of applicable laws. Patients have broad rights to refuse medical treatment, including life-sustaining treatment. If patients are incapacitated, the Authorized Decision Maker has the ethical and legal right to make decisions on the patient's behalf. The standards for such decisions are, in order of preference:

1) The patient's prior wishes;
2) Inferred from the patient's values and beliefs (substituted judgment);
3) The patient's best interests.

Refusal of medical treatment will be documented, as appropriate, by progress notes detailing the plan of care and completion of appropriate forms and Advance Directives (including MOLST forms) as described in this policy. DNR/DNI forms (and corresponding EPIC orders) will be used to document inpatient DNR/DNI orders.

All patients approaching the end of life will be offered the optimal relief of pain and other symptoms, and assistance with decisions regarding forgoing life sustaining treatments. The Palliative Care Team responds to requests by patients, families, or clinicians to assist in the provision of pain relief, symptom management, and comfort and assistance with clarifying goals of care. St. Joseph's Hospital Hospital affords all patients, including those with developmental disabilities, full and equal rights and equal protection as provided for in applicable laws.

Patient Capacity

A patient's capacity is presumed unless there is reason to suspect, by diagnosis or actions, that the patient does not understand the risks, benefits, and alternatives of the proposed treatment. Some patients may have capacity for lower level decisions but not for more complicated decisions. The initial determination of lack of capacity is made by the attending physician to a reasonable degree of medical certainty. The physician shall assess the cause and extent of the incapacity. A second licensed physician must independently assess and concur with these initial findings. All assessments and findings must be documented in the medical record. It is important to note that psych consult is not required for to determine a patient's lack of capacity.

Death Certificates

An electronic death certificate is required and can be accessed through TogetherCare. Death Certificates must be completed within 24 hours of death. At this time, Clinical Affiliates and Residents cannot complete a death certificate at SJH.

- If a medical examiner case, the medical examiner to complete within 72 hours of taking charge of the case.
- The attending physician of record or covering physician is responsible for completing the death certificate on inpatients
- The primary care provider of record should be contacted for patients arriving in the Emergency Department deceased on arrival. For patients who expire in the ED, the ED physician will complete the death certificate.

Ethics Consult

New York State requires a formal review mechanism for some medical decisions at the end of life. When disagreements arise about medical decisions at the end of life, attempts to resolve them should first be made by calling an ethics consult.

Privacy and Security of Patient Information

1. Appropriate Personal Access (ICP.23): Your access to patient information is granted in order to permit you to carry out your role responsibilities. Any personal use of the medical information contained in Trinity Health information systems is strictly prohibited. Look at and share only the minimal amount of confidential information necessary to do your job. ICP.23 Appropriate Personal Access 08.01.21.pdf
2. When entering a patient's room, ALWAYS ask the patient if it is OK for their visitor to be present for discussion about care.
    a. Limit discussing patients in hallways and other open areas by lowering your voice volume, moving away from other patients and visitors, and using minimum patient identifiers.
    b. When having discussions with patients or families minimize the chance of others overhearing by closing the door, and lowering your voice volume, and ask visitors to step out of the room.
    c. Use the designated consult rooms in surgical waiting areas to discuss the patient's status with his/her family.
3. Photographs and other media recordings of patients require patient consent unless they are taken for care and treatment purposes. Patient photos should never be shared on *any* social media such as Facebook, Instagram, Tiktok, etc.
4. Passwords must remain confidential to protect the security of our information – our systems will prompt you to change passwords every 180 days.
5. Log-off your computer when you walk away from it- even if you only step away from your computer for a few minutes.
6. Follow general guidelines for protecting portable devices, including all cell phones, tablets, and Laptops:

a. Password-protect your device – multifactor authentication (MFA) is required to access Trinity Health networks from portable devices.
b. Keep your valuables with you at all times. When traveling or at home, keep your devices with you. Additionally, devices left in an unattended and locked in vehicle is not considered a secure protection mechanism.

7. Conditions for transmission of Protected Heath Information (PHI/ePHI), or other confidential information over E-mail include but are not limited to:
    a. Only the minimum-necessary PHI may be shared.
    b. When replying to an e-mail with PHI, erase the PHI from the message if it is no longer needed.
    c. Do not include any PHI or patient identifiers in the subject line.
    d. Do not include any PHI or patient identifiers in meeting invites or calendar appointments.
    e. E-mails containing PHI may not be sent to any distribution list, recipients must be listed individually.
    f. Emails containing PHI should not be sent to patients or their families for any purpose unless specifically authorized the Director of Health Information Management, Privacy Officer, or Information Security Officer. If authorized, any replies to inquiries sent by the patient or their family should not contain PHI, if possible.
    g. Encryption is required when sending emails containing PHI outside the SJH or Trinity network. The SJH/Trinity network is currently defined as recipients with @sjhsyr.org, @sjphysicians.org, or @trinityhealth.org addresses. To force an outgoing message to be sent out securely, place the word"Secure" without the quotes anywhere in the Subject field of your email. For example, a subject of "Meeting Request Secure" will be sent out encrypted. Please keep in mind that this should only be used in cases where there is a need to send out PHI or other sensitive work related information to a user outside of our organization.
8. Know where to find privacy policies on SJEN: Policies & Procedures - St. Joseph Employee Network - St. Joseph's Hospital Health Center (sjhsyr.org). Topics include:

Privacy: Administration of Privacy Compliance	06/01/2023	System (Non-Service Specific)
Privacy: Breach Notification and Response	06/01/2023	Integrity and Compliance
Privacy: Business Associate Agreements	06/01/2023	System (Non-Service Specific)
Privacy: Disclosures to Family & Friends	06/01/2023	System (Non-Service Specific)
Privacy: Email Communications	06/01/2023	System (Non-Service Specific)
Privacy: Faxing of Protected Health Information and Sensitive Business Information	06/01/2023	System (Non-Service Specific)
Privacy: Identity Theft Prevention Program	06/01/2023	System (Non-Service Specific)
Privacy: Individual's Rights Regarding Agree/Object with Respect to Protected Health Information	06/01/2023	System (Non-Service Specific)
Privacy: Individual's Rights Regarding Records Contained in a Designated Record Set (Including Fees)	06/01/2023	System (Non-Service Specific)
Privacy: Individual's Rights Regarding Restrictions and Confidential Communications with Respect to Protected Health Information	06/01/2023	System (Non-Service Specific)
Privacy: Individual's Right to Request an Accounting of Disclosures of a Patients' Protected Health Information	06/01/2023	System (Non-Service Specific)
Privacy: Limited Data Sets and De-Identified Data	06/01/2023	Integrity and Compliance
Privacy: Minimum Necessary Use or Disclosure of PHI	06/01/2023	System (Non-Service Specific)
Privacy: Notice of Privacy Practices Related to the Use or Disclosure of Protected Health Information	06/01/2023	System (Non-Service Specific)
Privacy: Privacy and Security Incident Management and Response Involving Protected Health Information (HIPAA violation)	06/01/2023	System (Non-Service Specific)
Privacy: Recording & Image Capture (photo, video)	06/01/2023	System (Non-Service Specific)
Privacy: Refraining from Retaliatory Acts or Intimidating Acts Against Individuals (Whistleblower Protection)	06/01/2023	System (Non-Service Specific)
Privacy: Research involving Protected Health Information	06/01/2023	System (Non-Service Specific)
Privacy: Restriction on the Use or Disclosure of PHI for Fundraising Activities	06/01/2023	System (Non-Service Specific)
Privacy: Restrictions on the Use Or Disclosure of Protected Health Information for Marketing Activities	06/01/2023	System (Non-Service Specific)
Privacy: Use and Disclosure of Protected Health Information	06/01/2023	System (Non-Service Specific)
Privacy: Verification of Individuals Requesting Access or Disclosure of Protected Health Information	06/01/2023	System (Non-Service Specific)
Privacy: Verification of Individuals Seeking Medical Treatment	06/01/2023	System (Non-Service Specific)

ISO 9001: Quality Management System (QMS)

As part of our hospital accreditation with DNV, St. Joseph's is ISO 9001 certified. Through integration of CMS Hospital Conditions of Participation (CoPs) and ISO principles, an overarching quality management system has been created. ISO provides the structure to ensure the continual improvement of our key processes and achievement of our strategic goals, thus improving the care we provide. The three objectives of ISO 9001 are:

1. Consistent care
2. Customer satisfaction
3. Continual improvement

Event Reporting

Adverse events are to be reported using the MIDAS system. This is a peer review protected, confidential, electronic tool to report and collect events that involve or pose potential for harm solely for the purpose of quality assurance and patient safety. Access to event reports are not provided to patients or their representatives.

Procedure Verification/Consent

Changes to the informed consent policy were made to ensure consistent practice and patient safety between campuses and to comply with New York State DOH regulations. This applies to both adults and children The process for procedure verification and consent applies to ALL clinical settings and invasive procedures that pose more than minimal risk, including: special procedure units, endoscopy units, catheterization laboratories, interventional radiology suites, intensive care units, labor and delivery areas, emergency departments, bedside procedures, CT scans, and all clinical units.

Operative Notes

An operative report describing techniques, findings, and tissues removed or altered shall be dictated or documented, and authenticated by the physician immediately following the procedure. This must occur

prior to the patient being transferred to the next level of care (i.e., before the patient leaves the PACU). In the event that this cannot be dictated within this timeframe, a brief postoperative note is required to be documented. This shall include *all of the following elements regardless of applicability to the procedure performed*:

1. The surgeon and assistants;
2. Pre-operative and post-operative diagnosis (post-operative diagnosis of "same" is not permitted);
3. Procedure(s) performed;
4. Specimens removed;
5. Estimated blood loss;
6. Complications (if any encountered);
7. Type of anesthesia administered; and,
8. Grafts or implants (if none post-operative note should reflect "none")

For your convenience, a brief operative note template has been created and is available for use.

Operating Room Fire Safety

All perioperative team members entering the Operating Room (OR) suite will have the knowledge of how to prevent a fire in the OR, how to manage a fire in the OR should one occur, and designated individuals will possess the skills necessary to extinguish a fire should one occur. OR Fire Safety

Human Trafficking

As healthcare workers, it is important that we recognize the danger of human trafficking and are prepared to take the necessary steps when human trafficking is suspected. As required by New York State Law, St. Joseph's Hospital Health Center has established procedures and guidelines for the identification of persons who are suspected as being victims of human trafficking and in finding services for those individuals and reporting to the authorities.

The people most at risk of being the victims of human trafficking are those in vulnerable groups such as minors, foreign born persons, runaways, migrant workers and the mentally ill. In addition, human trafficking has often been found to exist in certain industries such as agricultural operations, begging/peddling, commercial food establishments, domestic work, prostitution, retail, and adult entertainment.

The leading indicators that an individual is or has been the victim of human trafficking are:

- delayed presentation for medical care;
- a discrepancy between a stated history and clinical presentation or observed pattern of injury;
- evidence of a lack of care for previously identified conditions;
- recurrent STD's;
- frequent pregnancies and multiple abortions;
- lack of identification or insurance; and
- addiction.

Factors to look for in identifying victims of human trafficking are:

- is the person accompanied by another individual who seems controlling;
- is the person rarely allowed in public except for work;
- is there physical or psychological abuse;
- is the person submissive or fearful;
- are there language barriers;
- does the patient lack identification or insurance and
- does another individual hold the patient's pay for "safe keeping".

When an individual is suspected of being the victim of human trafficking it is important that certain steps are followed in the assessment of the patient. These include:

- interview the patient privately (not in the presence of a third party);
- assess whether the patient is in immediate danger;
- arrange for a qualified interpreter if necessary;
- contact the forensic nurse program to assist;

- call an advocate (social worker or case manager) to help educate the patient about his or her rights or options;
- listen non-judgmentally;
- understand that disclosure may need to occur when the patient feels ready;
- support the patient;
- thoroughly document all findings;
- limit note-taking while in the presence of the patient; and
- be aware of any reluctance the patient may have in disclosing exploitation.

If the patient is a minor, you must follow the mandated reporting requirements when there is reasonable cause to suspect that a child is being abused. Refer to Child Abuse Policy. For adults, law enforcement may be engaged only with the patient's consent.

When human trafficking is suspected, it is important to note the resources available here in Central New York. For adults, available resources include Onondaga County Adult Protective Services (315) 435-2815 or Vera House (315)-425-0818 and the Vera House 24-Hour Crisis & Support Line (315) 468-3260. Child Protective Services is available for children under age 18, which can be reached through the State Central Registry at (800) 635-1522. In addition, there is the McMahon/Ryan Child Advocacy Site which is helpful. The point of contact there is Essence Williams and Erin Yeager. That number for McMahon/Ryan Child Advocacy is (315) 701-2985. MMR does have a referral form that is to be scanned or emailed to the site.

Also, the Syracuse Police Department (315) 435-3016, and Onondaga County Sheriff's Department (315) 435-3092 have Abused Persons Units which are helpful. The Syracuse Police Department can also be reached through its non-emergency number which is (315) 442-5111 and the Sheriff's Department can be reached through its non-emergency number at (315) 435-3044. There is also a Human trafficking Intervention Court as part of the Syracuse City Court which adjudicates issues involving Human Trafficking.

The New York State Child Abuse Hotline is (800) 342-3720. The New York State Trafficking and Exploitation Hotline is (315) 218-1966. The National Human Trafficking Resource Hotline is (888)-3737-888.

The most important thing one can do when a patient is suspected as being the victim of human trafficking is to seek help and guidance and ensure that the patient has the appropriate resources made available to them.

Emergency Codes

Code "A" ALPHA – Infant/Minor Abduction
Code "B" BRAVO – Activation of the Emergency Operations Center
Code "C" CHARLIE – OB Emergency
Code "D" DECON – Decontamination Team Activated
Code "F" FOXTROT – Facility Evacuation as directed by Incident Commander
Code "G" Gray – Behavioral Health Rapid Response
Code "I" IVAN – Surge Capacity Procedures
Code "L" Lockdown
Code "M" MIKE – Calls additional Security staff to an area
Code "P" PAPA – Emergency Patient Discharge
Code "S" SIERRA – Bomb Threat
Code "T" TANGO – Active Shooter
Code "W" – Severe Weather Warning
Code "X" XRAY – Chemical, Biological, Radiological, Nuclear, Explosive Event Response

Fire Safety – Rescue, Alarm, Confine, Extinguish (RACE)

To finish in-service please fill out the attestation and emergency contact information.