Credentialed Provider Mandatory Education - 2019
*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.

**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


**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. Nutritionists evaluate patients for malnutrition following the 2012 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 nutritionist completes a consult note and orders for the provider to cosign. The provider must include malnutrition as a problem in progress notes and discharge summary.

**C-Diff**
It is important to only test patients with a reasonable likelihood of having C. diff (see *Clinical manifestations of C diff* UpToDate). *C. difficile* testing is currently done with a very sensitive PCR assay and because of the high colonization rate of *C diff* in hospitalized patients, 20-30%, the positive predictive value (likelihood of disease given positive test) for *C diff* testing by PCR is only 44% - so over half of patients that test positive for *C diff* actually do not have the disease. To avoid over-diagnosis and unnecessary treatment and associated consequences, avoid testing for *C. diff* in patients who are on medications that may cause loose stools, such as stool softeners or laxatives, and patient with fewer than 3 stools per day.

**Foley Catheters and Catheter Associated Urinary Tract Infections (CAUTI)**
Foley catheters are indicated in specific situations (see below). A nurse-driven protocol to remove Foley catheters when patients no longer need a Foley is active; however, continued evaluation of the necessity of a Foley catheter by the physician and removal when not indicated is critical. In addition, cloudy or foul smelling urine are not clearly associated with UTI and should not be the sole reason for assessment. Patients with a CAUTI generally have evidence of infection: fever, localizing symptoms, or nonspecific systemic symptoms including new-onset delirium. Also, a specimen for culture should
ideally be obtained after removing the Foley and obtaining a midstream urine sample or insertion of a new Foley if indicated.

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

**Central Lines and Central Line Associated Bacterial Infections**
There are specific indications for central lines, and removing them when not indicated is critical. A vascular access team (VAT) provides support for intravenous access and assesses/recommends the type of line needed by the patient.

A central line should not be used to draw blood cultures because of the risk for contamination. Two sets of peripheral blood cultures should be drawn when indicated. To evaluate for a central line infection, an additional two sets of blood cultures should be drawn: one from the central line and one peripherally of equal blood volume.

**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. Empirc 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.

**Disease-specific Order Sets**
Order sets integrate best practice and should be used when appropriate. Important disease-specific order sets include: Sepsis, pneumonia, *C difficile*, COPD, and CHF.

**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.

**Glycemia**
The rate of hyperglycemia in patients treated with insulin at St Joseph’s is high – approximated 35% of patient insulin days have an average daily glucose > 200 mg/dL. Hyperglycemia is associated with increased morbidity and LOS, and it is important that we quickly achieve a target glucose of 100-180 mg/dL.

Using Total Daily Dose (TDD) principles is best practice. TDD is essentially the sum of patient’s daily insulin requirements of which generally 50% is basal insulin (Lantus) and 50% is nutritional insulin divided between 3 meals (Humalog). Instructions for prescribing insulin based on TDD principles is detailed in the subcutaneous insulin order set.
Restraint
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.

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 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.
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: requires 15-20 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 and others):
- Hand hygiene as detailed above
- Appropriate isolation to prevent potential spread of bacteria

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 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 the international Surviving Sepsis Campaign, the following elements should all be completed:

**Within 3-hours of presentation (3 hour bundle):**
1. Measure lactate level – Lactate levels > 2 mmol/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 30 ml/kg crystalloid for hypotension (SBP < 90 mmHg or MAP < 65 mmHg) or lactate ≥ 4 mmol/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. In the event of persistent hypotension after initial fluid administration or initial lactate ≥ 4 mmol/L, reassess volume status and tissue perfusion and document findings (use smartphrase/dot phrase .SEPSISREEVALUATION).
7. Remeasure lactate if initial value > 2 mmol/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 of race, religion, ethnicity, or national origin, 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), CyraCom Interpreter Phones, and CyraCom Video Remote Interpretation 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. Per the Interpreter Services Policy, staff cannot act as medical interpreters.

Just Culture

We support one another in the creation of a safe environment for our patients and our community at-large. The concepts of human beings being inherently fallible and the systems within which we work being imperfect are central to creating this culture of safety. Just Culture encourages supporting, consoling and coaching a colleague prior to discipline in order to ensure understanding and improvement of system contributors to patient safety.

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.

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.  

Sexual Harassment
St. Joseph’s Health has a zero tolerance for harassment in any form, and does not tolerate offensive or inappropriate behavior. All members and affiliates of the Medical Staff are responsible for assuring that the workplace is free from sexual harassment. The hospital strongly disapproves of offensive or inappropriate sexual behavior at work. It is expected that all members and affiliates of the Medical Staff will avoid any action or conduct that could be viewed as sexual harassment.

Workplace Violence / Disruptive Behavior
Workplace violence will not be tolerated by any member of the medical staff or employee at St. Joseph’s Health. Whether real or perceived, workplace violence is defined as threatening, intimidating, abusive, physically/sexually harassing or violent behaviors occurring in the work setting. These behaviors can be in the form of verbal, including yelling or use of profanity, written, or physical towards others, including patients, visitors, coworkers.

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.

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 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
Death Certificates must be completed and made available to the funeral director within 72 hours of receipt of the body. An electronic death certificate is required and can be accessed through EPIC EHR.

- 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
- A resident may complete a death certificate if licensed
- 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.
- Conflicts arising related to who will complete the death certificate will be elevated to the VPMA.
- Healthstream training on eDeathCertificate is available

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. Your access to patient information is granted in order to permit you to carry out your role responsibilities. Look at and share only the minimal amount of confidential information necessary to do your job.

2. When entering a patient’s room, ALWAYS ask the patient if it is OK for his or her visitor to be present for discussion about care.

3. 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.

4. 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.

5. Use the designated consult rooms in surgical waiting areas to discuss the patient’s status with his/her family.

6. If you are not a member of the care and treatment team for a specific patient, you may not access information without the Attending Physician’s consent.

7. Photographs and other media recordings of patients require patient consent unless they are taken for care and treatment purposes.

8. Passwords must remain confidential to protect the security of our information.

9. Log-off your computer when you walk away from it; even if you only step away from your computer for a few minutes.

10. Follow general guidelines for protecting portable devices, including iOS devices, Blackberries, and Laptops:
   a. Password-protect your device - Make sure that you have to enter a password to log into your mobile device;
   b. Keep your valuables with you at all times - When traveling or at home, keep your device with you. Additionally, device left in unattended and locked vehicles is not considered a secure protection mechanism;

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 QATF 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, their representatives or third parties

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.

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.