# Table of Contents

- **Purpose and Structure of this Booklet** 6
- **Offsite Health Centers** 7
- **Administration** 9
- **Clinical Chairs** 11
- **Mission** 12
- **Vision** 12
- **Values** 13
- **Infection Control and Prevention** 15
- **Infection Control Plan** 15
- **Antimicrobial Stewardship Program** 18
- **Standard Precautions** 18
- **Provision of Care, Treatment and Services** 20
- **Patient Identification** 20
- **Assessments and Reassessments** 21
- **Consents** 22
- **Hand-Off Communication** 22
- **Fall Prevention Program** 24
- **Early Activation Response (Code 66)** 25
- **Other Emergency Codes** 25
- **Behavioral Safety** 26
- **Restraints** 27
- **Behavioral Restraints** 28
- **Debriefing** 29
- **Restraint & Seclusion Death Reporting** 29
- **Point of Care Testing** 30
- **Patient Education** 31
- **Smoking Cessation** 32
- **Discharge Planning** 33
- **Post Graduate and Resident Privileges** 34
- **Rights and Responsibilities** 35
- **Patient Grievances and Complaints** 35
- **Language Interpreters** 37
- **Patient Satisfaction** 38
- **Advance Directives/Health Care Proxy** 38
- **End of Life/Palliative Care** 39
- **Ethics Committee** 41
- **Hospital Visitation Policy** 41
- **Risk Management** 42
- **Culture of Safety Survey** 43
- **Incident Reporting** 44
- **Sentinel Events/Root Cause Analysis** 46
- **Organ and Tissue Donation** 47
- **Medication Management** 50
- **High Alert Medications** 50
- **Unacceptable Abbreviations** 53
- **Multi-dose Vials and Medications** 54
- **Hospital Quality and Safety Program** 55
- **Hospital Performance Improvement and Safety Priorities** 56
- **National Patient Safety Goals** 57
- **Performance Improvement Method** 59
- **Failure Modes and Effects Analysis (FMEA)** 59
- **Utilization Review** 60
- **Information Management** 61
- **Health Insurance Portability and Accountability Act (HIPAA)** 61
- **Safeguards for Confidentiality and Privacy** 62
- **Electronic Information** 63
- **IT Security** 63
- **Environment of Care** 64
- **EOC Management Plans** 65
- **Safety Plan** 65
- **MRI Safety** 65
- **No Smoking Policy** 66
- **Departmental Safety** 67
- **Chemical Spills** 67
- **Safety Data Sheets (SDS)** 68
- **Oxygen Shut-Off** 69
- **Electrical Outage** 69
- **Security Plan** 70
- **Active Shooter** 70
- **Forensic Patients** 72
- **Hazardous Materials Plan** 72
- **Fire Prevention Plan** 72
- **Fire Safety Alarm Response** 72
- **Fire Extinguishers** 74
- **Utilities Management Plan** 75
- **Emergency Preparedness** 76
- **Emergency Operation Plan Activation** 76
- **Disaster Privileges** 82
- **Human Resources** 82
- **Staff Rights** 82
- **Mandatory Education** 83
- **Medical Staff** 83
- **Focused Professional Practice Evaluation** 84
- **Ongoing Professional Practice Evaluation** 85
- **Compliance Program, Code of Ethics, Hot Line & Fraud Prevention** 85
Purpose and Structure of this Booklet

This booklet has been prepared to serve as a reference guide staff. It is based on CMS, the Joint Commission, NYSDOH, and Hospital Policies and Procedures. For more specific information, please refer to the following resources:

- University Hospital of Brooklyn’s Administrative Policy and Procedure Manual [http://www.downstate.edu/regulatory/]
- Infection Control Manual
- Compliance Program Information [www.downstate.edu/compliance]
- HIPAA Policies and Procedures, [www.downstate.edu/hipaa]

If you need additional information, please call the Regulatory Affairs Department at (718) 270-1136.
**Administration**
Wayne J. Riley, MD, MPH, MBA, MACP  
President, SUNY Downstate Medical Center

Carlos Pato, MD  
Dean of the College of Medicine

William P. Walsh, MBA, MSW  
Senior Vice President of Hospital Affairs & Managing Director

Patricia A. Winston, MS, RN  
Vice President, CAO, COO

Michael Lucchesi, MD  
Chief Medical Officer & Chair of Emergency Medicine

Margaret Jackson, MA, RN  
VP/Chief Nursing Officer

Renee Poncet  
Vice President, Compliance and Audit

William Gerdes  
AVP, Ancillary Services

Rachel Goldberg, JD  
AVP, Quality, Regulatory, Risk and Safety

Raymond Michelitsch  
Officer –in-charge Facilities Management and Development

Tina Riha, MPA, DPT  
AVP, Clinical Services

Joseph Testani  
AVP, Orthopedic Surgery and Rehabilitation Medicine

Bruce Feldman  
AVP, Surgical Services

---

**Clinical Chairs**

Anesthesiology  
James Cottrell, MD

Dermatology  
Edward R. Heilman, MD

Emergency Dept.  
Michael Lucchesi, MD

Family Practice  
David Stevens, MD

Medicine  
Moro Salifu, MD

Neurology  
Daniel Rosenbaum, MD

OB/GYN  
Ovadia Abulafia, MD

Ophthalmology  
John Danias, MD, PhD

Ortho Rehab  
William Urban, MD

Otolaryngology  
Richard Rosenfeld, MD

Pathology  
Jenny Libien, MD

Pediatrics  
Stephen Wadowski, MD

Psychiatry  
Ayman Fanous, MD

Radiology/Radiation  
Deborah L. Reede, MD

Oncology  
Rainer Gruessner, MD

Surgery  
Jeffrey Weiss, MD

Urology  

---

**Mission**

**SUNY Downstate Medical Center**

**Brooklyn’s Academic Medical Center**

- To provide outstanding education of physicians, scientists, nurses and other healthcare professionals.
- To advance knowledge through cutting edge research and translate it into practice.
- To care for and improve the lives of our globally diverse communities
- To foster an environment that embraces cultural diversity

**Vision**

We will be nationally recognized for improving people’s lives by providing excellent education for healthcare professionals, advancing research in biomedical science, healthcare and public health, and delivering the highest quality patient-centered care.
**Values**

**Pride**
- To take satisfaction in the work we do every day and to value our collective contributions to the Downstate community

**Professionalism**
- We commit to the highest standards of ethical behavior and exemplary performance in education, research and patient care.

**Respect**
- We value the contributions, ideas and opinions of our students, coworkers, colleagues, patients and partnering organizations.

**Innovation**
- We research and develop new and creative approaches and services for the anticipated changes in health care.

**Diversity**
- We embrace our rich diversity and commit to an inclusive and nurturing environment.

---

**Excellence**

We commit to providing the highest quality of education and service to our students, patients and community by holding ourselves, our coworkers and our leaders to high standards of performance.

---

**Teamwork**

The employee continually works to achieve individual and team goals, working with fellow employees not against them and arriving to work on time with a positive attitude.

---

**Infection Control and Prevention**

**Infection Control Plan**

UHB has made reduction of Hospital Acquired Infection a priority for 2017. The Infection Control goals include:

- Improve hand hygiene among all HCW in both inpatient and outpatient settings.

  Hand washing is the best way to prevent the spread of infections.

  To keep patients, staff and visitors safe, health care providers are required to follow these rules:

  Always wash hands **before and after** each patient contact, **before and after use of gloves**, and **frequently** during the day, as well as after using the bathroom.

  Waterless hand sanitizers can be used when hands are not visibly soiled. For C. difficile, soap and water must be used for hand hygiene.


    - UHB has implemented CLABSI and CAUTI bundles to reduce HAIs.

    - The use of 2% Chlorhexidine wipes has replaced bathing with soap and water for all ICU and step-down patients, patients in all units who have a central line or a Foley catheter, and for patients on contact isolation or who are pre-surgery or pre-procedure.

  - Increase influenza vaccine rates and compliance with mandatory masking for HCW who decline the vaccine.
• Compliance with sterilization and high-level disinfection.

Ensure patient safety and decrease risk of nosocomial transmission of microorganisms through proper handling and cleaning & disinfection of critical and semi-critical instruments.

• Improve and clarify roles and responsibilities for the cleaning and low-level disinfection of patient-care equipment in order to eliminate the risk of cross-contamination and nosocomial transmission of pathogens.

• C. difficile

Reduce hospital transmission of epidemiologically important pathogens below FY16 rates.

For C. difficile, soap and water must be used for hand hygiene.

If isolation precautions (See appendix C) would be required upon confirmation of a particular infection, then isolation precautions should be ordered and implemented as soon as that infection is suspected.

**Antimicrobial Stewardship program**

An Antimicrobial Stewardship program has also been instituted. The program includes a clinical Pharm. D. whose responsibilities are designed to promote the selection of the optimal antimicrobial drug regimen, dose, duration of therapy and route of administration. The goal of the program, which now also includes a physician who specializes in Infectious Diseases, is to achieve optimal clinical outcomes while minimizing toxicity, limiting the selection for antimicrobial resistant strains and reducing cost.

**Standard Precautions**

Standard precautions include a group of infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status, in any setting in which healthcare is delivered. These include: hand hygiene; use of gloves, gown, mask, eye protection, or face shield, depending on the anticipated exposure; and safe injection practices. Also, equipment or items in the patient environment likely to have been contaminated with infectious body fluids must be handled in a manner to prevent transmission of infectious agents (e.g. wear gloves for direct contact, contain heavily soiled equipment, properly clean and disinfect or sterilize reusable equipment before use on another patient).

Immediately report all blood/body fluid exposures to your supervisor and program director.

Report all suspected or confirmed cases of communicable diseases to Infection Control, 718-270-1940.

**Provision of Care Treatment and Services**

**Patient Identification**

Ensuring proper patient identification by at least 2 identifiers is a National Patient Safety Goal. By hospital policy, we use name (first and last) and date of birth. A careful identification process must be done at registration and before all treatments (including medications) and procedures. The steps in a proper identification process are the following:

- Identify yourself and your purpose
- Ask the patient to say and spell his/her name.
- Verify what the patient says by checking it carefully against the label on the medication or specimen tube or order for the procedure.
- Ask the patient his/her birth date.
- Verify what the patient says by checking it carefully against the label on the
medication or specimen tube or order for the procedure.

- For a patient who cannot participate, check the patient’s name and dob on the ID band against the order or medication or specimen label

**Assessments and Reassessments**

- All patients must have a completed individualized assessment within the time frame set by each discipline, e.g., Dietary, Social Work, Nursing, Physician.
- Admitted patients must have a history and physical completed within 24 hours.
- We screen all patients for abuse. Abuse can be mental, physical, neglect, or exploitation.
- We are mandated by the New York State Department of Health to report abuse, suspected child abuse and/or neglect.
- All patients are screened for pain. If a patient has pain, a complete pain assessment occurs.

**Consents**

- General consent provides the authority for routine care. For invasive and high risk procedures, an informed consent is required e.g. for surgeries, procedures and blood transfusions.
- In an informed consent, the physician explains the risks, benefits, alternatives, expected outcome, as well as the name of the physician(s) who will perform the procedure. The patient must be given an opportunity to have questions answered. If the patient agrees to the procedure, he/she signs the informed consent, which is dated and timed.

**Hand Off Communication**

The hand-off process should include the following:
- Conduct face-to-face whenever possible
- Occur at a regular time and place each day in a setting conducive to sharing patient health information and with interruptions minimized.
- Use a standardized verbal format, standardized forms, electronic tools and/or other methods all of which must be HIPAA compliant
- Provide opportunity for questions, answers, clarifications and escalation as necessary
- A structured hand-off must include at least the following:
  - Patient identifiers including name, age, location and record number
  - Identification of care providers including responsible attending and residents
  - Diagnosis of the patient and current problem list
  - Current status or condition of the patient including resuscitation status
  - Pertinent clinical information necessary for coverage for the patient (including drug allergies, medications, exam findings, lab abnormalities, imaging results, recent procedures, changes in condition, etc.)
  - A to-do list of any activities that need to be performed for the patient including pending studies or results for follow-up
  - An action plan for the next period of care along with an if/then assessment of contingencies in the event of a change in the clinical status of the patient
  - Discussion with any additional clarifications, concerns, questions addressed as well as contact information for follow-up questions and for escalations
  - Any other pertinent information relevant to the specialty, program or clinical service during the transition and for the next period of care.

The nursing staff uses SBAR methodology to communicate patient specific information when transferring care of a patient between providers. SBAR is defined as: Situation, Background, Assessment and Recommendation.

**Fall Prevention Program**

UHB has implemented a fall reduction program. All patients are assessed on admission and
reassessed every shift, upon change in patient’s condition, transfer to a new unit or after a fall. Fall reduction strategies include posting a sign outside the patient’s door, wrist bands, and special anti-slip “red” socks. UHB uses the TJC Targeted Solutions Tool (TST) to monitor and improve our Fall Prevention Program.

**Early Activation Response Criteria (Code 66)**
The hospital utilizes code 66 for the Early Activation Response Criteria for both adults and pediatrics. Criteria, including that “the clinician is very worried about the patient”, are posted on every nursing station.

**Other Emergency Codes**

- **Respiratory/Cardiac Arrest** Code 99 (Over the PA System)
- **Infant Abduction** Code Pink (On the PA System)
- **Cardiac Cath** Code H

**Behavioral Safety**
Healthcare workers face a significant risk of violence in their workplace. Risk factors include:
- working with patients and visitors who have a history of violence or who abuse drugs or alcohol;
- working alone or when understaffed (especially during mealtimes and visiting hours);
- working in neighborhoods with high crime rates;
- poor environmental design that may block employees’ vision or interfere with their escape from a violent situation;
- and inadequate security and mental health personnel on site.

UHB has initiated a series of behavioral safety meetings to consider ways to make the hospital and health care workers safer. Workgroups exist to improve de-escalation skills of staff, emergency response and patient transfer or disposition. Staff may join and contribute to this process by calling Risk Management at 718-270-3768.

**Restraints**
- Restraints should be applied only after all alternative interventions have been considered or have failed.
- The least restrictive measure is used whenever possible.
- A Licensed Independent Practitioner (LIP) /designee can write orders for restraint.
- The attending and designee must be able to demonstrate competency through orientation and in-service education thereafter.
- Orders for restraints are time limited, and must be re-ordered for medical/surgical patients every 24 hours.
- The physician must perform a face-to-face evaluation of the patient and write an order for the restraint within one hour.

**Behavioral Restraints**
The patient must have a face-to-face assessment within 30 minutes by LIP/designee.

Time Limit Orders for Behavior Management may not exceed:

<table>
<thead>
<tr>
<th>Category</th>
<th>Time Frames</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 years and older</td>
<td>4 hours</td>
</tr>
<tr>
<td>Adolescents, 9-17 years old</td>
<td>2 hours</td>
</tr>
<tr>
<td>Children under 9 years old</td>
<td>1 hour</td>
</tr>
<tr>
<td>Seclusion</td>
<td>3 hours</td>
</tr>
<tr>
<td>Psychiatry &amp; Emergency Dept. Four Point Restraint</td>
<td>4 hours</td>
</tr>
</tbody>
</table>

- When an emergency situation exists, to prevent the patient from injuring him/herself or others, restraints may be applied under the supervision of a Registered Nurse.
**Debriefing**

A debriefing with the patient and/or the family is conducted and documented when a behavioral restraint is removed.

**Restraint & Seclusion Death Reporting**

The hospital must report to CMS deaths associated with restraints and seclusion, except for 2 point restraints, where it is reasonable to assume that a patient’s death is as a result of such activity.

- Death while a patient is in restraints
- Death within 24 hours after removal of restraints
- Deaths known to the hospital that occur within 1 week after the restraint and seclusion.

Inform CMS by calling (212) 616-2205 and submitting CMS Form 10-455 within 24 hours and no later than the close of business the next business day following knowledge of the patient’s death.

---

**Point of Care Testing**

Point of Care Testing (POCT) refers to Laboratory testing activities performed at the patient’s bedside or approved outpatient settings. Testing is performed outside the physical facilities of the Clinical Laboratories.

All personnel deemed eligible to perform POCT must successfully complete a formal training program and demonstrate competency, resulting in an authorization to perform POCT for a specified period of time. Regular competency assessments are performed for all users.

Quality Controls for these tests are conducted by the person performing the test and monitored by the Department of Pathology.

Examples of POCT performed at UHB follow.

**Whole Blood Glucose:** Performed by Nursing. UHB inpatient and outpatient units, including ED; schools and Bay Ridge facilities.

**Urinalysis Dipstick:** Performed by Nursing Personnel. Location: Outpatient units and satellite facilities including Bay Ridge and schools.

**Urine HCG:** Performed by Nursing Personnel. Location: ED, satellite facilities including schools and Bay Ridge facilities.

**Fecal Occult Blood:** Performed by Physician and Nursing Personnel. Location: ED and Bayridge facility,

**i-Stat System:** Blood Gas, Electrolytes, Hematocrit, Activated Clotting Time, PT/INR testing performed by Respiratory Therapist, Perfusionist & Nursing Personnel. Location: Designated nursing stations, Cath Lab, OR and Bay Ridge Facility

**Wet Mounts & Amniotic Fluid Crystallization testing:** Physician Performed. Location: UHB Inpatient Labor & Delivery, and designated outpatient clinics. All such testing must be logged in the record next to the microscope.

---

**Patient Education**

Education is multi-disciplinary. Each direct care staff member is responsible for documenting patient education in the medical record.

---

Staff must be familiar and able to articulate the process for documenting patient education.

**Smoking Cessation**

Smoking Cessation Services are available for patients, employees and the community including counseling, referrals and free nicotine replacement products while supplies are available. Inpatients who have a recent smoking history (current smokers or quit within past year) are given smoking cessation education by the nursing staff. Any employees or community members can contact the hospital operator for the smoking cessation program number or call New York State Department of Health Quitline at 1-866-NY-QUITS or 1-866-697-8487.

Smoking cessation education provided by the nurses and/or physicians must be documented in the Education Log in HealthBridge.
**Discharge Planning**

- All patients have a right to participate in their discharge.
- Nurse and case manager must access patient for discharge needs upon admission. They will refer the patient for social work evaluation if the patient meets high risk criteria, which are part of the initial nursing assessment.

**Changes in policy:**

- Social work no longer sees every patient routinely. Instead, social work will see every patient who has been referred to them by clinical staff.
- Patient age, alone, is no longer part of the high risk criteria.
- Frequent readmission to hospital or frequent emergency room visits are now part of high risk criteria.

- Patients have a right to appeal their discharge.

**Post Graduate and Resident Privileges**

Recommendations for granting specific procedure privileges for the residents are made by Chairs/Chiefs of Service and are submitted to GME.

Privileges awarded are then entered on the **Resident Data Base (New Innovations)** to ensure up-to-date privileging information on residents. Nursing staff may access the data base available on each hospital desk top to review privileges.

**Rights and Responsibilities**

**Patient Complaints and Grievances**

**Complaints:** requests or concerns that are resolved at the time of the complaint by staff present at the time of the complaint or who can quickly be present to resolve the complaint.

**Grievance** is a formal or informal written or verbal complaint that is made to the hospital by a patient, or the patient’s representative, regarding the patient’s care, abuse or neglect issues and a Medicare beneficiary billing complaint related to rights and limitations.

When a patient care complaint cannot be resolved at the time of the complaint, is postponed for later resolution, is referred to other staff for later resolution, requires investigation, and/or requires further actions for resolution, then the complaint is a grievance. This also applies to telephone calls to the hospital after the patient has been discharged.

Employees are expected to bring patient and family complaints and/or concerns to their supervisor’s attention if they cannot be immediately resolved. If the complainant is not satisfied, he/she should be referred to the Patient Relations Department at ext. 1111.

The hospital is required to resolve all grievances as soon as possible and provide a written response to the complainant **within 7 days**. However, grievances about situations that endanger patients such as neglect or abuse are to be investigated immediately because of the seriousness of the allegation and the potential harm to the patient.

If the investigation cannot be completed within 7 days, the Patient Relations Department will inform the patient or the patient’s representative in writing that the hospital is still working to resolve the grievance and that the hospital would provide a written response as soon as possible and within a specified timeframe.
Patients also have the right to contact the NYSDOH at (1-800-804-5447) and/or The Joint Commission at (1-800-994-6610) to their concerns.

**Language Interpreters**

Patients with limited English, hearing or visual impairment have the right to receive interpreter services. This is achieved through:

- **CYRACOM International Language Service**
  - CYRACOM phones are located in all patient care areas and are available 24 hours a day, 7 days a week.

- For Sign Language Interpreters contact Patient Relations at extension 7283 during Monday – Friday, 9:00 a.m. – 5:00 p.m. To access a Sign Language interpreter for emergency purposes (evenings, weekends, holidays) please use the Deaf Talk unit stationed in the Patient Relations Office by calling the Nursing Supervisor for access.

**Family members or minors should never be used as interpreters, unless the patient insists.**

**Patient Satisfaction**

Patient satisfaction is measured through patient surveys on an ongoing basis. Patient Satisfaction studies are conducted by Press Ganey. Results are shared with all department heads and staff at all levels. If you need more information for your unit/area specific result, please ask your supervisor.

**Advance Directives/HealthCare Proxy**

Patients have the right to make their wishes known for future care. Patients can appoint someone to make decisions for them if they lose the ability to decide for themselves by filling out a **HEALTH CARE PROXY (HCP)**.

All direct care staff must know how to help a person fill out an HCP form.

- Forms are on the unit and in patient rights booklets.
- **Patient MUST HAVE CAPACITY** to appoint a health care agent. If unsure, ask the patient’s physician. **No one can create a proxy for another person.**

**End-of-Life Care/Palliative Care**

Patients who have decisional capacity have the right to accept or refuse all care.

Health care agents and other surrogates have the right to make all health care decisions, including the acceptance or refusal of all care, according to the patient’s wishes and beliefs, or if those are not reasonably known, according to the patient’s best interests.

By NYS law, physicians and nurse practitioners who have primary responsibility for a patient are required to offer palliative care information, including the right to pain and symptom management, with patients who have been diagnosed with a terminal illness (one in which death is reasonably expected to occur within 6 months).

Also by NYS law, patients who have advanced life-limiting conditions and illnesses are entitled to receive information and counseling about palliative care, including pain and symptom management, consistent with patient needs and preferences.

A consultation with the Palliative Care service is available upon the request of the patient, a surrogate, or any member of the health care team.
**Ethics Committee**
The Ethics Committee is an interdisciplinary committee, with representatives from medicine, nursing, allied health and the community. Anyone with a vested interest in the care of a patient may request an Ethics Consult. Issues that come to the Ethics Committee include disputes about medical decisions between the patient/surrogate and the clinical team or among decision-makers. An Ethics consult can also help with establishing goals of care.

Ethics Consultation is arranged by paging (917) 760-1238.

**Hospital Visitation Policy**
At UHB, visitors are welcome 24-hours a day. Upon admission, patients will be given information regarding the hospital's visiting policy. An outpatient has the right to a support person during outpatient visits. A patient’s support person does not necessarily have to be the same person as the patient’s representative who is legally responsible for making medical decisions on the patient’s behalf.

Conditions under which visitor limitation may be imposed are if:

- A patient’s attending physician restricts visiting hours for a particular patient;
- There are infection control issues;
- Visitation interferes with the care of other patients;
- The hospital is aware that there is an existing court order restricting contact;
- Visitors engage in disruptive, threatening, or violent behavior of any kind;
- The patient or patient’s roommate(s) need rest or privacy;
- The patient is undergoing care interventions.

**Risk Management**
Advice and consultation about patients’ rights, consent to and refusal of care, documentation and other medico-legal questions are available at all times. From Monday to Friday, 8:30am to 5:30pm, please contact the Director of Risk Management at 718-270-3768. During off hours, the Risk Manager can be reached through the page operator.

**Culture of Safety Survey**
UHB conducted a Culture of Safety survey in Spring 2016.

The purpose of this survey is to assess staff perception of this hospital's culture of safety. The survey identified our strengths as “organizational learning-continuous improvement” and “supervisor expectations and actions promoting safety”. In these 2 categories, Downstate was at the mean. The hospital’s perceived weaknesses were “staffing levels” and “non-punitive response to errors”. The leadership has taken several actions to address employee concerns.

After right-sizing efforts with the assistance of a consultant firm, UHB has been working hard to grow programs and volumes and to collect all of the revenue that we are entitled to. As a result, we have also been able to add 80 FTE’s, including many RN’s. In response to staff concerns about non-punitive response to errors, leadership has undertaken efforts to help staff feel safe when reporting their concerns so that our patients remain safe.

The full survey report is accessible to staff on every UHB desktop.

**Incident Reporting**
Reporting both incidents and near misses or close calls is everyone’s responsibility. A strong incident reporting process is an important part of a just culture, helping to identify problems that require attention and contributing to safer patient care.

All staff members, including residents and fellows, are encouraged to report incidents and near misses to the departments of Risk Management or Performance Improvement. These departments
work together to investigate, track and refer issues to appropriate supervisors for further action.

Incident reports are to be completed as soon as possible after an adverse event by any staff member who was involved in the event or who witnessed or learned about it. When the author of an incident report is not a physician, it is often advisable that the report be reviewed by a physician, who may document in the designated area of the form. There is no hospital requirement that an incident report be reviewed by a physician or supervisor before it is submitted.

Incident reporting forms are available in hard copy at all nursing stations and on all UHB desktops at the Incident Report icon. The form can be forwarded to Risk Management by any of the following means:

- filled out on computer, printed and forwarded via the Nursing department,
- saved on computer as a document and then sent via email to virginia.hanson@downstate.edu
- Interoffice mail to MSC #117
- faxed to # 270-8168
- Anonymous Incident Reports. An anonymous incident report may also be made by telephone to 270-1136 (voicemail); messages are retrieved each weekday. In order to follow up on the outcome of an anonymous report, write in any number or word of your choosing in the space designated for the reporter’s name and call 270-3768 a day or two after writing the report.

**Sentinel Events/Root Cause Analysis**

A sentinel event is the most serious type of adverse event because it is not primarily related to the natural course of the patient’s illness or underlying condition and results in death, permanent harm, or severe temporary harm.

When a sentinel event occurs, a root cause analysis (RCA) is conducted. UHB also occasionally conducts root cause analyses after close calls (near misses) that created the risk of serious harm even when no harm actually reached the patient. The root cause analysis involves investigation of the event and careful discussion by a multi-disciplinary team. The review is aimed at identifying the “root cause(s)” of the event by asking not just what happened, but why. The focus is on systems improvements and not individual errors and blame. Performance Improvement strategies are implemented to address all root causes identified. Certain sentinel events are reported to New York State as required by law.

**Organ/Tissue Donation**

- Patients have the right to document their wishes concerning organ and tissue donation on their Health Care Proxy.
- All deaths must be reported to LiveOnNY

- The NYODN staff is responsible for approaching the patient’s family/next-of-kin regarding organ donation.

**Tissue donation/Routine Referral**

1. Timely referrals of deaths or earliest indication of imminent deaths are to be made to LiveOnNY.

2. Within 1 hour of every patient death or earliest determination of imminent death, the Charge Nurse or designee will contact LiveOnNY at 1-800-GIFT 4 NY/1-800-443-8469 and provide pertinent clinical information.

**Donation after Cardiac Death (DCD)**

The physician will contact LiveOnNY at 1-800-GIFT 4 NY/ 1-800-443-8469 to advise them that the hospital has a potential DCD donor. The physician will also notify the admitting department that the LiveOnNY was contacted.
For more information, refer to the Organ and Tissue Donation Policy EXP-2
(http://www.downstate.edu/regulatory/pdf/policies/EXP-02.pdf)

### Medication Management

#### High Alert Medications

- Insulins
- Opiates
- Chemotherapy
- Cardioplegia
- Adrenergic Agonists, IV
- Inotropic Agents, IV
- Antithrombotics
- Thrombolytics
- Neuromuscular Blockers
- Sedatives, IV
- Electrolyte Replacement
- Concentrated Electrolytes
- Total Parenteral Nutrition
- Prostaglandin Analogs, IV
- Uterine Stimulants, IV

◊ Some safety tips:

◊ Include brand and generic names in medication orders.

◊ Be familiar with typical doses and pathways or guidelines for adjustments.

◊ Be familiar with antidotes and order them proactively for use as needed.

- Perform an independent double-check of dosage calculations for high-risk populations.
- Order and prepare medications in hospital-established standard concentrations.
- Double check the drug, dose, and route when dispensing or retrieving drugs from storage areas.

- Check the Five Rights (patient, drug, dose, route, time) when administering medications.
- Infuse intravenous preparations using smart pumps with Guardrails® drug library.
- For infusions of high-alert medications marked “Double-check required,” TWO nurses should independently check the order with medication and pump setting before starting the infusion. This includes tracing the tubing to the correct pump channel.

- Look for these reminders: HIGH ALERT, NAME ALERT, NOTE DOSAGE STRENGTH, CHEMOTHERAPY
UNACCEPTABLE ABBREVIATIONS  
“DO NOT USE”  
The following dangerous, abbreviations, Acronyms and symbols should not be used at the SUNY Downstate Medical Center:

<table>
<thead>
<tr>
<th>DO NOT USE</th>
<th>SPELL IT OUT</th>
</tr>
</thead>
<tbody>
<tr>
<td>U, u</td>
<td>Unit</td>
</tr>
<tr>
<td>IU, iu</td>
<td>International Unit</td>
</tr>
<tr>
<td>Q.D., QD, qd,</td>
<td>Every day</td>
</tr>
<tr>
<td>Q.O.D. QOD, qod</td>
<td>Every other day</td>
</tr>
<tr>
<td>Trailing zero</td>
<td>Never write a zero by itself after a decimal point (X mg), and always use a zero before a decimal point (0.X mg)</td>
</tr>
<tr>
<td>(1.0 g)</td>
<td></td>
</tr>
<tr>
<td>MS, MS04, OR MgS04</td>
<td>Morphine Sulfate or Magnesium Sulfate</td>
</tr>
</tbody>
</table>

Multi-dose Vials and Medications

All multi-dose containers of medication (such as vials, bottles, inhalers, tubes) must be stored under the manufacturer’s recommended storage requirements until the manufacturer’s expiration date or beyond-use date, whichever is sooner.

Multi-dose vials brought into the immediate patient treatment area should be used only for one patient for one procedure, and then discarded.

Multi-dose vials authorized for obtaining multiple doses for one or more patients (such as insulin) must be stored in dedicated medication preparation areas away from immediate patient treatment areas and labeled with a beyond-use date of **no more than 28 days** after first opening/puncture (not to exceed the manufacturer’s expiration date).

Multi-dose vials/injections of home medications brought in by students for use in school-based clinics should be labeled with a beyond-use date according to the manufacturers’ recommendations (which may exceed the 28-day beyond-use date for hospital provided medications). Beyond-use date shall be validated by the licensed independent practitioner at the clinic location.

Multi-dose ophthalmic products must be relabeled with a beyond-use date of no more than 28 days at the time of first opening (not to exceed the manufacturer’s expiration date), if the product will be used to administer multiple doses for more than one case.

Hospital Quality and Safety Program

QAPI (Quality Assurance Performance Improvement) refers to the continuous, data-driven study of important health care processes, which identifies changes that enhances performance and monitors performance to ensure that the improvements are sustained. PI focuses on outcomes of care, treatment, and services.

Each year, hospital leadership sets priorities and goals for quality and safety. It is important that all staff be familiar with UHB’s goals and priorities which are summarized below. Excerpts of the hospital’s annual Quality and Safety Plan, showing addition quality measures and goals, can be found in Appendix B of this booklet.

**Hospital Performance Improvement and Safety Priorities**

- Healthcare associated infection prevention
  - Reducing the use of unnecessary central lines and Foleys
  - Not using central lines for routine blood draws
  - Consistency of use of central line bundles and proper insertion techniques
  - Improvement of Foley and central line maintenance
- Readmission reduction
  - Transition of Care Clinic implemented for high risk patients at discharge
- Length-of-stay reduction
- Restructuring of Care Management Department
- Universal Precautions and Hand Hygiene rate improvement
- Increasing reporting of incidents, patient safety and care quality concerns (including near misses), especially by residents/fellows
- Patient Satisfaction (HCAHPS)
- Sepsis Management
- Hospital through-put improvement
  - Projects on medical surgical units to facilitate bed management

National Patient Safety Goals (NPSGs)
- Reduce the risk of healthcare-associated infections
- Identify safety risks inherent in its patient population
  - Identify patient suicidality risk
- Implement the Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery
- Improve the accuracy of patient identification
  - Eliminate transfusion errors
- Improve the effectiveness of communication among caregivers
  - Manage critical test results
- Improve the safety of using medications
  - Label medications appropriately
  - Manage anticoagulation therapy
  - Reconcile medications on admission and discharge and educate patients and families (orders should be reviewed on transfer)
- Reduce the harm associated with clinical alarm systems

UHB tracks outcomes in each of these areas and reports them through its Performance Improvement Structure.

Performance Improvement Method
The methodology used for PI is PDCA:

P  Plan the improvement and the data collection
D  Do the improvement and the data collection
C  Check the results of the implementation
A  Act to hold the gain and continue improvement

Failure Mode Effects Analysis (FMEA)
Failure Modes and Effects Analysis (FMEA) is a systematic, proactive method for evaluating a process to identify where and how it might fail and to assess the relative impact of different failures, in order to identify the parts of the process that are most in need of change.

UHB’s will continue the FMEA from 2016 - improving the efficiency of the Work Stations on Wheels (WOW’s). UHB is in the process of purchasing new WOWs and the FMEA will focus on the failure modes of the new models once they are selected.

Utilization Review
Hospitals are required to review the services provided to ensure quality and cost effective care. UHB has a Utilization Review plan and a committee composed of physicians, nursing, finance, operations, case management, social work and health information management. The committee meets monthly and evaluates patient through-put, length of stay, discharge planning, barriers to discharge, use of medical and hospital services and all related factors which may contribute to overall patient care through the utilization of hospital and physician services.

Clinical document improvement services are a fast-growing specialty in the healthcare industry. CDI Specialists at UHB work with providers to ensure that clinical documentation accurately reflects the patient’s medical history, current health conditions and the care rendered. This is essential to improve documentation accuracy, integrity and quality of patient data for effective communication to other providers, to regulatory bodies and to managed
care companies for optimal reimbursement reflecting the care rendered and the co-morbidities of every patient treated.

Information Management

Health Insurance Portability and Accountability Act (HIPAA)

All uses and disclosures of Protected Health Information (PHI) must be compliant with UHB’s HIPAA Privacy Policies & Procedures. UHB’s policies apply to PHI in any form, including spoken, written or electronic information. It is the responsibility of every UHB staff member and medical staff member to protect the privacy and preserve the confidentiality of all PHI and to carefully review the HIPAA Privacy guidelines & policy information provided to you during your orientation. In addition, UHB’s HIPAA Privacy policies and forms are available online at: www.downstate.edu/hipaa

Any inappropriate disclosure of PHI and/or failure to comply with the HIPAA Privacy policies & procedures will result in appropriate sanctions against the staff member, up to and including termination.

Patients are informed of their rights under HIPAA via the “Notice of Privacy Practices” (NOP), which is given to each new patient at the first point of registration. The “NOP Acknowledgement” form is signed by the patient and filed in the medical record.

Safeguards for Confidentiality/Privacy

- Staff members are required to put safeguards in place to protect patients’ information.
- Do not discuss a patient’s condition in a public place (e.g., hallways, elevators, staircases, cafeteria or the gift shop);
- Draw curtains and talk in low tones in semi-private rooms;
- Never leave test results on answering machines;
- Never leave PHI unattended and accessible to others, such as on conference room tables or at nursing stations;
- Medical records should be kept in locked/secure areas that are fire proof.
- When placing medical records in bins outside of patient rooms, the name should face the wall;
- All documents containing any PHI must be shredded.

Electronic Information

- Computer monitors should face away from the public;
- Exit patient databases before leaving a workstation;
- Never share passwords & ID’s;
- Encrypt emails containing PHI.

IT Security

- UHB provides orientation/training on the use of computers.
- Individualized training or other hardware/software programs can be obtained by contacting HIS, at 4902.

Questions regarding information and computer security should be addressed to the Downstate Security Officer at Ext. 4454.

Environment of Care

The goal of this function is to provide a safe, functional, supportive, and effective environment for patients, staff members, and other individuals in the hospital.

For Housekeeping concerns call x 2998; and for Facilities call x 1212. Another way to raise a concern is by completing the Incident Report Form, which can be found on the desktop of every UHB computer and at every nursing station, and can be filled out and sent to Risk Management.

UHB has an Environment of Care Committee (EOC) that reports up to the Medical Executive Committee (MEC) of the Hospital. The seven (7) management plans are organized for oversight into subcommittees that report to the EOC Committee.
EOC Management Plans

1. Safety Plan provides for a physical environment free from hazards and discusses staff activities to reduce the risk of injury.

MRI Safety

Magnetic Resonance Imaging (MRI) is a way of obtaining very detailed images using a powerful magnetic field. The primary danger related to MRI is that the powerful magnetic field of the MR system will attract iron-containing objects and may cause them to move suddenly and with great force. This is called the Missile Effect. This will pose a risk to the patient or anyone in an object’s flight path. Great care is taken to be certain that objects such as screwdrivers, hammers, knives, keys, IV poles, oxygen tanks or any article that may be magnetic are not brought into the MR system where the imaging table and electromagnet is located.

To maximize safety, the areas around the magnet are separated into zones.

The magnet itself is “controlled space.” It should not be entered without the knowledge of the MRI nurse or technologist.

The most important three facts to remember regarding MRI magnet safety are:

1. The magnet is always “on.” Even if there is no imaging going on and no staff is in the area, magnetic hazards exist. This remains true during power failures.
2. Never carry a metallic object into the magnet room.
3. No staff or patient should enter the magnet room without the knowledge of the nurse or technologist in the area.

No Smoking Policy

Smoking is not allowed in the building or near hospital entrances. The “No Smoking Policy” provides for disciplinary action against employees, patients, or visitors who violate the policy.

Departmental Safety

• Any equipment in the corridor should be on the same side.
• No trash, storage, carts or other equipment is allowed in stairwells, doorways, or in front of emergency exits and fire extinguishers.
• Place trash in waste containers. Do not overfill.
• Keep laundry chute locked at all times.
• Keep garbage chute locked at all times.
• Discard only infectious waste in Red Bag Containers. Follow the Infection Control policies and procedures.

Chemical Spills

First cover the spill. Block off the area, and then notify the Safety Officer at Ext. 1216. During off-tours, please notify the AOD/Nursing Supervisor.

Also refer to the (Safety Data Sheets) SDS (formerly known as Materials Safety Data Sheets MSDS) for more information. Please continue to the next section.

Safety Data Sheets

SDSs provide workers and emergency personnel with information and procedures for handling or working with substances in their workplace in a safe manner, and include information such as physical data, toxicity, health effects, first aid, reactivity, storage, disposal, protective equipment, and spill-handling procedures. The Occupational Safety and Health Administration (OSHA) require that SDS’s be available to employees for potentially harmful substances handled in the workplace.

SDS can be accessed at www.downstate.edu

1. Click on “Administration” on the left side of your screen
2. Scroll down to “Intranet”
3. Click on “Material Safety Datasheets”
4. To assist with your search, type in name of chemical and/or the manufacturer’s name, then click on the ‘Search option’
5. If no result comes up when using the name of the chemical or the manufacturer’s name, a full-text search with name of the chemical can also be done to find the available information
6. Please call Environmental Health and Safety at extension 3389 or 1216 if further assistance is needed

**Oxygen Shut-Off**
The charge nurse or designee is required to know the location of patients requiring O2 in the unit and is responsible for shutting off the oxygen in case of an emergency.

**Electrical Outage**
During an electrical outage, use only the RED electrical outlet for essential patient care equipment.

2. **Security Plan** establishes and maintains a program to protect staff, patients and visitors from harm. You must know the hospital and your area-specific security concerns.

Please wear your ID badge at all times while in hospital premises.

**Active Shooter**
The intent of most active shooters is to harm or kill as many people as quickly as possible. In order to save lives, the University Police Department will initiate an immediate response.

Upon discovery of an active shooter situation in the hospital immediately notify University Police at Extension 2626 (Internal) and (718) 270-2626 (External). If possible call 911.

University Police will make an overhead announcement of an Active Shooter and location.

**Staff in off-site locations should immediately call 911.**

---

Do the following:

1. **Evacuate (Run)**
   - Have and escape route and plan in mind
   - Leave your belonging behind
   - Keep your hands visible

2. **Hide out (Hide)**
   - Hide in an area out of the active shooter’s view
   - Block entry to your hiding place and lock the doors

3. **Take action (Fight)**
   - As a last resort and only when your life is in imminent danger
   - Attempt to incapacitate the active shooter
   - Act with physical aggression and throw items at the active shooter

---

**Forensic Patients**
When a forensic patient (prisoner) comes to the hospital, the prisoner must:

- Remain under the supervision and control of the assigned NYPD Police Officer/Correction Officer.
- Hospital Police provide the Police or Correction Officers with an orientation of the hospital’s policies on fire and safety.

---

**3. Hazardous Materials & Waste Plan** controls the handling, clean-up and removal of hazardous materials and waste in the hospital.

**4. Fire Prevention Plan** provides a safe hospital environment.

**Fire Safety Alarm Response**

A. In the event of a fire or smoke alarm activation the following will occur;
1. **An Audio-Visual Annunciation**

   SUCH AS:

   “...whooping horns and flashing strobes” followed by a voice message - “Code Red, Code Red, Hospital Building, Floor, Alarm Location.” (Repeated three times)

2. This alarm annunciation will be heard ONLY in the areas where the alarm was activated and the adjacent compartment zone(s). (i.e. an alarm that occurs on NS#42 will only be heard on the 4th Floor)

   **B.** All alarm activations in the hospital building are also annunciated at remote annunciator boxes at the Nursing station, University Police Command center and at the building entrances.

   **C.** All alarms are transmitted to the FDNY.

   **D.** In the event that you discover a fire or smoke condition follow the procedure below:

   **A** - CREATE AN ALARM
   Shout “CODE RED”
   PULL THE ALARM PULL STATION
   DIAL EXT 2626 - UNIVERSITY POLICE

   **R** - RESCUE
   REMOVE ANYONE IN IMMEDIATE DANGER

   **C** - CONFINE AND CONTAIN
   CLOSE ALL DOORS BEHIND YOU

   **E** - EVACUATE
   MOVE AWAY FROM AREA HORIZONTALLY TO THE ADJACENT COMPARTMENT

   **Fire Extinguishers**
   What type of fire extinguisher is used in your area?
   Type: “ABC”- Dry Chemical (red) - (most common)
   Type: “AC” – Water Mist - (white/blue) (MRI, L&D, OR)
   Type: “K” (Kitchen)

   **Do you know how to use a fire extinguisher?**
   Pull, Aim, Squeeze & Sweep (PASS).

   **5. Bio-Medical Equipment Plan** maintains medical equipment to promote safe and effective use. Immediately report all equipment taken out of service or equipment missing identifying tags to Bio-Medical Engineering.

   Keep “clean” equipment separate from “dirty” equipment.

   **6. Utilities Management Plan** establishes and maintains a safe and comfortable patient care environment by the maintenance of a quality hospital utility system such as heating, air conditioning, etc.

   Immediately report any system malfunctions to the Maintenance or Engineering Departments. Don’t attempt any “emergency” repairs.

   Monday to Friday 8:00 AM to 4:00 PM (dial ext. 1212). Monday to Friday after 4:00 PM and on Weekends/Holidays (dial ext. 2810)

   **7. Emergency Preparedness Plan** ensures effective response to internal and external hospital emergency events.

   **Emergency Preparedness**

   **Emergency Operation Plan Activation**

   When an emergency condition exists that requires the activation of the Emergency Operation Plan, the following announcements will be made:

   “Attention…Your attention please...The hospital’s emergency operations plan has been activated.”
Hospital staff please follow your department’s plan.” (Repeated 3 times)

The Emergency Operations Plan can be accessed online @ http://www.downstate.edu/regulatory/emergencyPrep.php

- Evacuation Preparation

“Attention... Your attention please... An emergency condition has been reported in your area. Affected areas prepare for horizontal evacuation. If asked to evacuate, walk, do not use elevator. Walk, do not use elevator.”

- Emergency Evacuation Message

“Attention... Your attention please... An emergency condition has been confirmed. Area occupants perform horizontal evacuation now. Do not use the elevators. Do not use the elevators. Walk do not run and perform horizontal evacuation now. All area occupants please perform horizontal evacuation now.” (Repeated 3 times)

Clearance to Re-Occupy the Building – All Clear

Upon investigation by the FDNY and University Police, an “All CLEAR” message will be given for Fire Alarm or Other Emergency Condition as noted:

“Attention... Your attention please... The building emergency condition has been cleared... you may return to your normal activities... the building emergency condition has been cleared... you may return to your normal activities.”

Declaration of Disaster

If a disaster is declared: Your department has a plan. Do not leave your regular post/job unless you are instructed to do so by your departmental plan or supervisor.

Do not under any circumstances speak to the news media. Refer them to the Office of Institutional Advancement.

Anyone who learns of an occurrence that might constitute a disaster should attempt to obtain the following information and contact the Senior Administrator/Administrator-on-Duty immediately. In the emergency department, the CI attending can declare a disaster, if staff is unable to contact the Senior Administrator/AOD on Duty.

What was the occurrence? What is the location of the occurrence? How many casualties are estimated? What types of injuries are there? How many people were injured?

The Command Post coordinates all resources during a declared disaster. The Disaster Cabinet and Mass Casualty Incident (MCI) Packets are in the Emergency Department Ambulance Entrance.

All patients/victims will enter through the ED ambulance entrance for primary triage. Direct all victims to that location to assure that they are evaluated and treated in order of need, given the...
best and fastest care possible and prevent hospital contamination.

Where will overflow patients at UHB be evaluated and treated?

- Adult Emergency Department Major Casualty
- Pediatric Emergency Department Peds Major Injury
- Suite A -- Minor Medical
- Suite B -- (Waiting area) Minor Trauma
- Suite D -- Peds Medical and Peds Minor Trauma
- Suite I – Behavioral Health
- Suite J – Eye Trauma

After the evaluation and treatment of minor patients is complete, they must go to the Family Reception Area to complete the proper paperwork and be discharged. The Family Reception Area is in the Cafeteria at UHB.

The Nursing Staff Resource Pool is in the Nursing Office.

Disaster Privileges

Disaster privileges may be granted when the emergency management plan has been activated and the hospital is unable to handle the immediate patient needs.

Human Resources

Staff Rights

If an employee believes that certain aspects of their job responsibilities conflict with cultural values, ethical holdings and/or religious beliefs, the employee must submit those concerns in writing to their immediate supervisor, who will, if necessary, seek the advice of the Department of Human Resources Office of Labor Relations.

In an emergency and/or life-threatening situation, the employee shall carry out direct patient care orders until other arrangements can be made. Failure to do so may be subject to disciplinary action.

Mandatory Education

All hospital-based employees, (regardless of funding source or employee type (i.e., medical faculty, staff, students, volunteers etc.), are required to complete Annual Mandatory Education training. http://www.downstate.edu/icl/ame

Medical Staff

The UHB medical staff maintains the Medical Staff Bylaws and the Medical Staff Rules and Regulations.

- Medical staff privileges do not exceed a period of two years.
- To ensure physicians practice within their scope, information on physician privileges is available in the Nursing Office and Operating Room at all times. Privileges are also available in the Medical Board Office during regular business hours.

Evaluation of a Practitioner's Professional Performance.

There are two types of Licensed Independent Practitioner Evaluations required by The Joint Commission.

Focused Professional Practice Evaluation (FPPE)

FPPE is a process whereby the organization evaluates the privilege for specific competence of the practitioner who does not have documented evidence of performing the requested privilege at the organization.

At UHB, each new physician is placed on FPPE for a period of six months. Physicians may also be placed on FPPE for cause.

Ongoing Professional Practice Evaluation (OPPE)

OPPE allows the organization to identify professional practice trends that impact on quality of care and patient safety. Ongoing professional evaluations are performed twice a year for all physicians.
Compliance Program, Code of Ethics, Hotline & Fraud Prevention

The Compliance Program is intended to define the conduct expected of employees, to provide guidance on how to resolve questions regarding legal and ethical issues, and to establish a mechanism for reporting of possible violations of law or ethical principles within UHB.

The Code of Ethics & Business Conduct outlines the basic guidelines for legal and ethical conduct. It establishes the general standards, policies and procedures with which all employees must comply. Each employee is required to read, understand, and comply fully with the standards established by the Code of Conduct. Employees are required to come forward with any information regarding an actual or possible ethical/ legal violation and cooperate fully in the investigation of any alleged violation. Reports can be made to an individual supervisor, to the Department of Human Resources or to the Office of Compliance & Audit Services at 718-270-4033. In addition, a report can be made confidentially and anonymously to DMC’s Compliance Line:

Phone Call: 1-877-349-SUNY (7869) or Web Report: Click on “Compliance Line” on the bottom of DMC’s main homepage at www.downstate.edu.

The Compliance Line is managed and operated by an independent communications firm hired by DMC to ensure the integrity and objectivity of compliance reporting. DMC’s Compliance Line is available for reporting concerns regarding violations of the law, such as possible violations related to:

- Medicare/ Medicaid fraud and abuse;
- Fraudulent billing;
- Professional and business ethics;
- Professional standards of practice;
- Patient confidentiality / Patient rights;
- Conflicts of interest;
- Bribes / Kickbacks;
- Substance abuse;
- Harassment and discrimination.

There shall be no reprisals for good faith reporting of actual or possible violations. DMC will endeavor to keep the identity of anyone reporting a violation confidential to the extent permitted by law, unless doing so prevents DMC from fully and effectively investigating an alleged violation. DMC will take appropriate disciplinary action, including dismissal when appropriate, against any employee who violates any legal requirements or organizational policies.

Please refer to DMC’s Compliance website for more information: www.downstate.edu/compliance

Maintaining high ethical standards is the responsibility of each DMC team member. If you become aware of any situation that may jeopardize the ethical integrity of DMC, it's up to you to report it.

Compliance Training

It is SUNY UHB’s policy to provide Compliance related training, as appropriate for each workforce member’s role within the organization, within a reasonable timeframe after the individual joins the workforce. Compliance training programs include, but are not limited to, HIPAA Compliance, Professional Compliance, Corporate Compliance, Prevention of False Claims/ Whistleblower Protections, Documentation Integrity, Research Conflicts of Interest & Research Misconduct and other Research Compliance programs.

The Office of Compliance & Audit Services administers the Compliance training programs. Additional information is available online at www.downstate.edu/compliance or by calling the office at 718-270-4033.
Detection & Prevention of Fraud, Waste & Abuse: Complying with the Deficit Reduction Act (DRA)

UHB is committed to preventing and detecting fraud, waste and abuse. Section 6032 of the Federal Deficit Reduction Act of 2005 (DRA) requires us to provide information to our employees regarding Federal and New York State fraud and abuse laws, whistleblower protections under these laws and our Compliance policies in preventing and detecting fraud, waste and abuse.

Part of UHB’s mission in providing excellent care includes the prevention of falsely submitted claims/reports for payment from a Federally or State funded health care program, such as Medicare or Medicaid. A false claim is a violation of Federal and State law and can have very damaging results, including civil, administrative and criminal penalties.

Examples of false claims include:
- A physician billing Medicare/ Medicaid for medical services not provided;
- A government contractor who submits false records that indicate compliance with regulatory requirements;
- A hospital that retains interim payments from Medicare/ Medicaid throughout the year and then knowingly files a false cost report at the end of the year to avoid making a refund.

Further information regarding the DRA and Compliance Program related policies are available at www.downstate.edu/compliance.

APPENDIX A
PERFORMANCE IMPROVEMENT STRUCTURE

SUNY BOARD OF TRUSTEES
Governing Body
Medical Executive Committee
Executive Performance Improvement Council (EPIC)

Medical Executive Committee
Patient Safety*
Credentials Committee
Ethics Committee
Health Information Mgmt. (HIM)
Pharmacy and Therapeutics*
O R Committee
GME Committee
- Resident Quality Council
Bylaws Committee
Environment of Care (EOC)*
Transfusion Committee*
Radioisotope Committee
Nutrition Committee*
Surgical Case Review *
Institutional Review Board
Cancer Committee*
Moderate / Deep Sedation*

Clinical / Ancillary Services Performance Improvement Committee
Surgery & Divisions
Medicine & Divisions,
Pediatrics & Divisions
Obstetrics & Gynecology
Emergency Medicine
Family Medicine
Anesthesiology, Radiology,
Neurology, Pathology, , Radiation Oncology,
Ophthalmology, Psychiatry,
Otolaryngology, Nursing,
Perioperative Services
Ambulatory Services,
Infection Control,
Patient Relations
Risk Management
Provision of Care (POC)
Root Cause Analysis, PI Projects,
Core Measures, Concerns Over
Patient Care

APPENDIX B
HOSPITAL-WIDE PERFORMANCE IMPROVEMENT AND SAFETY METRICS

Indicators and Expected Outcomes
Reduce L.O.S.
Infection Control:
Reduce Infection Rates by 5%
- CLABSI, CAUTI, SSI, C. Difficile.
- Hand Hygiene Compliance
- Ventilator Associated Events (VAE)
Increase vaccination rate for health workers
Increase hand hygiene rates

Readmission Reduction: AMI, COPD, HF, PN,
THA/TKA – all cause, all payers

Improve Case Mix Index (CMI)
Increase Culture of Safety Survey Staff Participation
Nursing Sensitive Indicators:
- Fall Reduction
- Pressure Ulcer
- Pain Management compliance
- Restraints –98-100%
- documentation compliance
- Pediatric IV Infiltration: <3 events per quarter

HCAHPS Nursing Overall score 90-100%

Medication Safety and Near Misses
Reduce medication error

Failure Mode & Effect Analysis (FMEA)
- Improve functionality of Work Stations on Wheels

AMBULATORY CARE INDICATORS

Diabetic Screening
- HbA1c
- LDL Screening/Control
- B/P Control
- Visual or ophthalmology referral
- Podiatry Screening

Colorectal Cancer screening
Cervical Cancer screening
Breast Cancer screening
Pap Smear
Chlamydia Screening

Lead Screening

Childhood Immunization
- Influenza and Pneumococcal Immunizations
- Varicella – 12 months (over 13 years/ 2 doses)
- Influenza per DOH – 6 months to annually
- TDaP – 11 years + 18 years (1dose)
- MCVU – 11 years-old – 18 Years old

Follow-up on positive TST/PPD (Chest – X-ray)
- IVP-2,4,6, 15 months last ( 4 – 6 years)
- Hep B (Pre-Vac) – DOB (2- 4 months/ 12 months)
- MMR – 12 months (4 – 6 years)
- Appropriate treatment of children with URI
- Annual dental visit

Pain Screening
- Assessment done
- Scope and rating scale usedocumented
- Treatment documented –signed/dated/timed

Mental Health: Assessment
Mental Health: Referral process (when appropriate)
Mental Health: Follow up hospitalization for mental illness: 7 & 30 days
Adult BMI Assessment
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents
APPENDIX C
ISOLATION PRECAUTIONS

CONTACT PRECAUTIONS color coded ORANGE are used for patients with draining or weeping lesion(s), or with an antibiotic resistant organism/multi-drug resistant pathogen (MDRO).

AIRBORNE/RESPIRATORY ISOLATION/PRECAUTIONS color coded BLUE is used for patients with airborne spread (droplet nuclei – 1-5 microns) diseases including TB. The N95 respirator is the mask that must be used when TB is suspected or confirmed and such patients are placed in an Airborne Infection Isolation Room (AIIR), formally referred to as negative pressure rooms or a portable HEPA Filter machine is used.

DROPLET ISOLATION/PRECAUTIONS color coded GREEN are used for patients with infections that are spread by large droplets including Influenza. A surgical mask is required unless H1N1 is suspected or diagnosed; then an N95 Respirator is required.