

Yale New Haven Health System

Medical Staff Education

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VISION, MISSION AND VALUES



YaleNewHaven**Health**

Purpose

This education module is designed to: support the delivery of quality patient care, satisfy regulatory mandates; and inform you about other matters that are important for you to understand as a Medical Staff Member or Affiliated member at one or more Yale New Haven Health System Affiliated Hospital.

We recognize that not all aspects of this training are applicable to all individuals.

Following your review of this material, please complete and return the self-test at the end. A score of at least 80% is necessary to pass the test at the time of initial and reappointment to the Medical or Affiliate Staff. The test confirms a basic understanding of the concepts presented.

Yale Continuing Medical Education is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. The Yale School of Medicine designates this internet activity for **1.0 AMA PRA Category 1 Credit™**. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

In accordance with CME accreditation requirements for this course, you will be required to take a course evaluation before downloading your certificate of completion.

Presentation Outline

- I. Continuing Medical Education (CME) Requirements
- II. Standards of Appearance
- III. Physician/Affiliated Health Care Professionals Health
- IV. Patient Safety
- V. Special Patient Care Considerations
- VI. Safety
- VII. Infection Prevention & Control
- VIII. The Joint Commission (TJC) National Patient Safety Goals
- IX. High Reliability Organization (HRO) Information
- X. Standards of Professional Behavior
- XI. Privacy and Corporate Compliance
- XII. Library Resources
- XIII. Legal compliance: fraud & abuse, private inurement and excess benefit transactions
- XIV. Antimicrobial Stewardship
- XV. Attestation & Post Test

I. CONTINUING MEDICAL EDUCATION (CME) REQUIREMENTS

CME State Requirements (CT and RI)

The State of Connecticut and State of Rhode Island require physicians to participate in CME as a condition of continued licensure.

The [State of Connecticut](#) requires a minimum of fifty (50) contact hours of qualifying continuing medical education within the preceding twenty-four (24) period.

Continuing Medical Education shall be in an area of the physician's practice, reflect the professional needs of the licensee in order to meet the healthcare needs of the public and during the first renewal period in which continuing medical education is required and not less than once every six (6) years thereafter, include at least one contact hour of training or education in each of the following topics:

- Infectious diseases (Including, but not limited to acquired immune deficiency syndrome (AIDS) and human immunodeficiency virus (HIV).)
- Risk management (Including, but not limited to, prescribing controlled substances and pain management.)
- Sexual assault
- Domestic violence
- Cultural competency
- Behavioral health (Including, but not limited to, topics of mental health conditions common to veterans and family members of veterans, including:
 - Determining whether a patient is a veteran or family member of a veteran
 - Screening for conditions such as post-traumatic stress disorder, risk of suicide, depression and grief
 - Suicide prevention training.
- Yale Continuing Medical Education department offers CME online courses in these topics mentioned above. You can view these courses at <https://yale.cloud-cme.com/>. The courses are located under "Online Courses". They are available to all Medical Staff members, however, may require payment depending on your staffing location.
- At the time of each re-appointment, supply copies of certificates or attest to having them on file and available if requested

CME Requirements (continued)

Physicians in the [State of Rhode Island](#) are required to document to the Board of Medical Licensure and Discipline that they have earned a minimum of forty (40) hours of American Medical Association, Physician Recognition Award or American Osteopathic Association (AOA Category 1a) continuing medical education credits.

At least four (4) hours of continuing medical education shall be earned on topics of current concern as determined by the director of the Rhode Island Department of Health.

Current topics include:

- Ethics
- Risk Management
- Opioid pain management/chronic pain management
- End of life/palliative care
- Antimicrobial Stewardship

II. STANDARDS OF APPEARANCE

Standards of Appearance

Members and Affiliate members of the Medical Staff are expected to adhere to professional dress standards when attending to the patients in the hospital. Compliance with the applicable facility policy on this subject is expected.

Except in emergency situations, your cooperation in avoiding use of the following items is appreciated:

- Exercise clothing – including shorts, sweatpants, yoga pants, sweatshirts and t-shirts
- Jeans

Please also:

- Be sure to cover midribs and offensive tattoos
- Follow Infection Control Policies surrounding fingernails
 - No artificial nails
 - Nails must be kept to ¼ inch or shorter

For more information, the hospital policies regarding professional appearance can be found via the “Policies” tab on each hospital’s Intranet home page.

- Bridgeport, Greenwich & Yale New Haven Hospital’s – Standards of Appearance
- Lawrence + Memorial Hospital - Dress Code
- Westerly Hospital - Dress Code

III. PHYSICIAN/AFFILIATED HEALTH CARE PROFESSIONALS HEALTH

Physician/Affiliated Health Care Professionals Health

The Medical Staff's at each YNHHS Delivery Network have a committee in place for addressing the health of its respective Physician and Affiliated Health Care Professionals. The goal of these committees is to:

- Educate Medical Staff about physical, psychological and substance abuse issues that may affect a practitioner's ability to safely deliver care
- Encourage self-referral of medical staff with health problems
- Remediate and rehabilitate physicians with health problems as quickly and to the extent possible
- Establish a mechanism for the identification and referral of medical staff with health problems
- Evaluate referred or self-referred concerns with appropriate confidentiality

To read more about each committee, please refer to:

- Bridgeport Hospital – Physician Health Committee
- Greenwich Hospital – Practitioner Health Issues
- Lawrence + Memorial Hospital – Medical Staff Bylaws, Article VII (Collegial Intervention, Corrective Action; Automatic and Summary Suspension; Physician's Health Matters; Disruptive Behavior) Section 5 (Physician Health)
- Westerly Hospital – Medical Staff Bylaws, Article XII (Medical) Staff Committees) Section 10 (Committees of the MEC - Medical Staff Health Committee
- Yale New Haven Hospital – Medical Staff Bylaws, Article XVI (Medical Executive Committee) Section G (Committees – Medical Staff Health)

Physician/Affiliated Health Care Professionals Health (continued)

Signs of Potential Practitioner Impairment:

- Odd behavior/personality changes
- Making rounds at unusual/inappropriate times
- Lack of availability or inappropriate responses to phone calls
- Social withdrawal
- Increased problems in quality
- Changes in personal hygiene and grooming
- Inability to focus and follow conversations

Practitioners considered “At-Risk”:

Impaired practitioners may be found in all specialty areas, but are reportedly most often in:

- Anesthesiology
- Psychiatry
- Emergency Medicine

Per the State of Connecticut Department of Health, any health care professional or hospital shall file a petition if that hospital or health care professional has any information that appears to show that a health care professional is, or may be, unable to practice his or her profession with reasonable skill or safety.

Physician/Affiliated Health Care Professionals Health (continued)

Self-referrals or reports of suspected impairment should be brought to the attention of one of the following:

- **Bridgeport Hospital**
 - Ryan O’Connell, MD, Interim Chief Medical Officer/Interim Chair, Physician Health Committee
ryan.o'connell@bpthosp.org or (203) 384-3760
- **Greenwich Hospital**
 - Spike Lipschutz, MD, Chief Quality Officer
spike.lipschutz@greenwichhospital.org or (203) 863-3904
- **Lawrence + Memorial Hospital**
 - Oliver Mayorga, MD, Chief Medical Officer
oliver.mayorga@lmhosp.org or (860) 442-0711, ext 4370
- **Westerly Hospital**
 - William Conlin, MD, Associate Chief Medical Officer
william.conlin@westerlyhospital.org or (401) 348-3325
 - **or**
 - Oliver Mayorga, MD, Chief Medical Officer
oliver.mayorga@lmhosp.org or (860) 442-0711, ext 4370
- **Yale New Haven Hospital**
 - William Sledge, MD, Chair, Medical Staff Health Committee
william.sledge@ynhh.org or (203) 688-9711
 - **or**
 - Thomas Balcezak, MD, Chief Medical Officer
thomas.balcezak@ynhh.org or (203) 688-1343

Additionally, self-referrals or reports of suspected impairment can be brought to YNHHS Legal & Risk Services Department at (203) 688-2291 or off hours via page operator (203) 3111.

IV. PATIENT SAFETY

Patient Safety

- I. **Patient Safety Reporting**
- II. **CLEAR Program**

Patient Safety

I. Patient Safety Reporting

Under the **Connecticut Department of Public Health** and the **Rhode Island Department of Health** statutes, hospitals are required to report certain adverse patient safety events within seven (7) days of awareness.

If you become aware of an adverse patient safety event, please report that event via one of the following methods:

- The online event reporting system (RL Solutions) located on the Hospital Intranet Home Page.
- The YNHHS Department of Legal & Risk Services at (203) 688-2291.

Examples of reportable events:

Surgical or Invasive Procedure Related:

- Surgery performed on the wrong body part, wrong patient or wrong procedure performed
- Unintended retention of a foreign object in a patient after surgery or other procedure
- Intraoperative or immediate (w/in 24 hours of surgery) death in an ASA Class I or II patient
- Patient death or serious disability as a result of surgery including hemorrhage greater than 30% of circulating blood volume
- Perforation during open, laparoscopic and/or endoscopic procedure resulting in death or serious disability

Care Management Related:

- Patient death or serious disability associated with a medication error (wrong drug, dose, route, patient, rate or time) or medication reaction
- Patient death or serious disability associated with a hemolytic reaction due to administration of incompatible blood or blood products
- Lab or radiology test results not reported to the treating practitioner or reported incorrectly which result in death or serious disability due to incorrect or missed diagnosis in the emergency department
- Death or serious disability associated with hypoglycemia when onset occurs in the hospital
- Death or serious disability associated with failure to identify and treat hyperbilirubinemia in neonates

Patient Safety (continued)

I. Patient Safety Reporting (continued)

Examples of reportable events (continued):

Environment Related:

- Patient death or serious disability associated with a burn incurred from any source while in the hospital
- Patient death or serious disability associated with a fall in the hospital

Obstetrics Related:

- Obstetrical events resulting in death or serious disability to the neonate
- Maternal death or serious disability associated with labor and delivery in a low-risk patient

Product or Device Related:

- Patient death or serious disability related to the use of contaminated drugs, devices or biologics provided by the hospital
- Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than intended
- Patient death or serious disability associated with intravascular air embolism that occurs in the hospital

Patient Safety (continued)

II. CLEAR Program

Communication Leads to Early Resolution (CLEAR)

- The CLEAR program is a communication and resolution program that encourages disclosures of unanticipated care outcomes to affected patients.
- The CLEAR program proactively seeks resolutions by:
 - Offering of apology
 - Explanation of what occurred
 - Reimbursement/compensation where appropriate
- Encourages a culture of:
 - Transparency
 - Early reporting
 - Patient Safety
 - Provider integrity
 - Peer support

CLEAR Committee

- YNHHS implemented the CLEAR Committee throughout all network delivery systems in FY2018.
- Goals of the YNHHS CLEAR Committee:
 - To operationalize awareness, access and delivery of CLEAR into all YNHHS Delivery Networks.
 - To increase the frequency of CLEAR process activation for Serious Safety Events (SSEs).
 - To assess the number of SSEs that use CLEAR Coach for disclosure.
 - To provide education process for staff, medical staff and coaches.
 - To develop a Peer Support process.

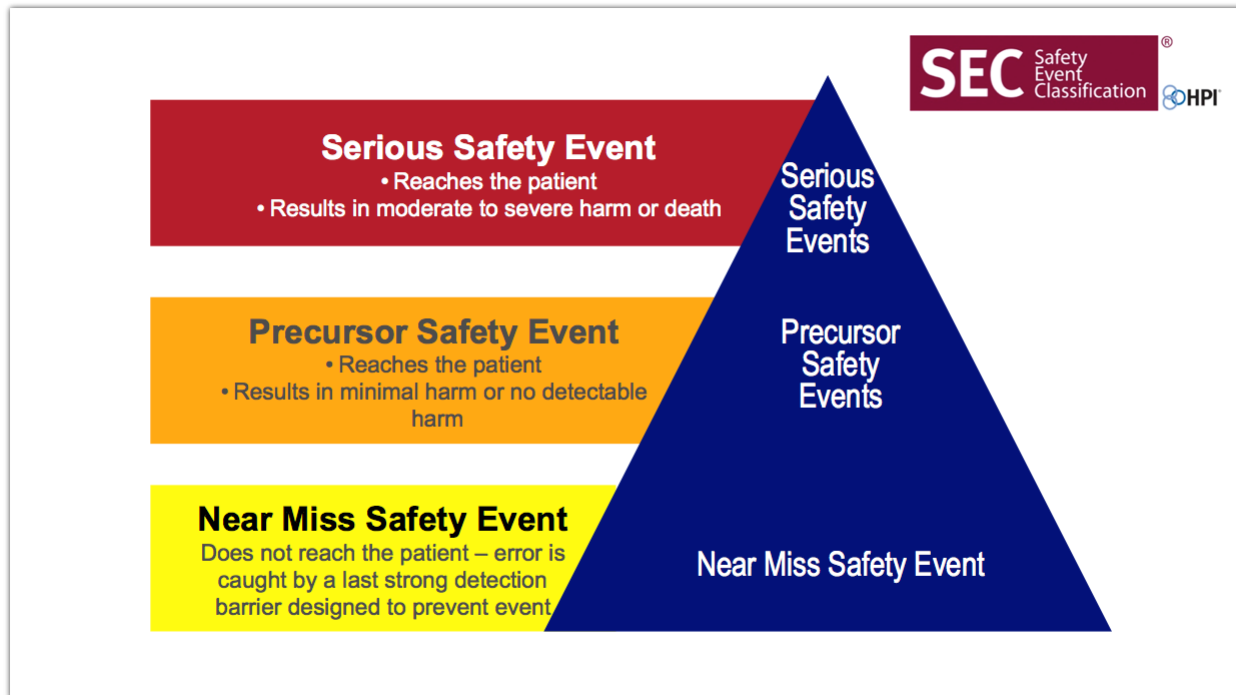
CLEAR: It's the right thing to do!

Patient Safety (continued)

II. CLEAR Program (continued)

Serious Safety Event Classifications

- All Serious Safety Events must be disclosed.



V. SPECIAL PATIENT CARE CONSIDERATIONS

Special Patient Care Considerations

- I. **Pain Management**
- II. **Use of Restraints**
- III. **Organ Donation**
- IV. **Patient Rights**
- V. **Interpreter Services**
- VI. **Mandatory Reporting**

Special Patient Care Considerations (continued)

I. Pain Management

Pain is expected to be assessed using objective criteria with regular reassessment and appropriate analgesia prescribed appropriately to manage pain. This includes:

- Using and/or understanding the objective scale appropriate for your population of patients (i.e., 1-10 numeric pain scale, etc.)
- Writing medication orders that define parameters for administration that match the appropriate scale for use (e.g. X medication Y mg PO PRN for Pain Score 8-10)
- Assessing and reassessing the patients and documenting these assessments using this scale
- Considering non-pharmacologic interventions
- Considering an appropriate plan for ongoing pain control after discharge.

For more information, the hospital policies regarding pain management can be found via the “Policies” tab on each hospital’s Intranet home page.

- Bridgeport Hospital – Pain Assessment & Management Policy
- Greenwich Hospital – Pain Assessment Management Policy
- Lawrence + Memorial Hospital – Pain Management Policy
- Westerly Hospital – Pain Management Policy
- Yale New Haven Hospital – Clinical Practice Manual

Special Patient Care Considerations (continued)

II. Restraints

Yale New Haven Health System is committed to prevent, reduce and eliminate the use of restraints and seclusion whenever clinically feasible and to promote the rights, dignity and physical integrity of the patient to the fullest extent possible.

Restraints for violent/self-destructive reasons:

- MD/DO/APRN/PA/RN must conduct and document a Face-to-Face assessment within one hour of the restraint being applied and/or seclusion initiated
- If an RN applies a restraint, a MD/DO/APRN/PA must be notified within one hour after application to obtain an order. The MD/DO/APRN/PA responsible for the patient must review the physical and psychological status of the patient, determining if the restraint should be continued and help with identifying ways to help the patient regain control so the restraint/seclusion can be discontinued
- If the restraint remains, a MD/DO/APRN/PA must conduct an initial face-to-face assessment within 4 hours (>18 years old) or 2 hours (<17 years old).
- A debrief with the patient and staff must occur and be documented within 24 hours of the restraint/seclusion

Restraints for non-violent behavior reasons:

- MD/DO/APRN/PA/RN must write an order each calendar day
- MD/DO/APRN/PA/RN must complete an assessment within 24 hours of each order and documented this in the medical record

For more information, please review the YNHHS Restraint and Seclusion Policy, which can be found via the “Policies” tab on each hospital’s Intranet home page.

Special Patient Care Considerations (continued)

III. Organ Donation

Nationwide, as well as within Yale New Haven Health System, hundreds of patients are awaiting life- saving heart, liver, kidney and pancreas transplants and many die waiting for the organ that they will never receive. Transplant can become a reality for many of these patients **IF** the guidelines below are followed:

Policy:

- YNHHS encourages discretion and sensitivity with respect to circumstances, views and beliefs of families of potential donors.
- YNHHS will maintain compliance with relevant Connecticut, Rhode Island and federal law, and provide documentation of that compliance.
- YNHHS encourages organ and tissue donation by donors and their families whenever donation may be appropriate. In these situations, referral to the local procurement organization (OPO) is made as early as possible to determine if donation is clinically appropriate.

Hospital and medical staff who routinely care for or provide consultation to patients who have illness or injuries compatible with progression to brain death shall use the following four clinical triggers (GIVE):

- G** – Glasgow Coma Scale (GCS) is low, indicating cerebral insult from a catastrophic or irreversible condition
- I** – Intubated, unable to maintain patent airway independently
- V** – Ventilatory support required due to absence of, or ineffective, spontaneous respiratory effort
- E** – End of life discussion anticipated with potential for discussion re: brain death or comfort measures only

For more information, please review the YNHHS Organ and Tissue Donation Policy, which can be found via the “Policies” tab on each hospital’s Intranet home page.

Special Patient Care Considerations (continued)

IV. Patient Rights

YNHHS must and does respect, protect and promote individual's rights as a patient, recognizing that each patient is an individual with unique health care needs. Because of the importance of respecting each patient's personal dignity, the hospital strives to provide considerate, respectful care focused upon each patient's individual needs. It is YNHHS's obligation and privilege to inform patients of and explain (in the patient's preferred language), the rights and responsibilities of patients and assist in exercising these rights.

Informed Consent

All patients must be properly and completely consented for procedures that will be performed.

Disclosure

Patients, and when appropriate their families, must be informed of outcomes, especially those causing significant harm, whether or not an error occurred. Please refer to the Patient Safety section for information regarding the YNHHS CLEAR Program.

For more information, the hospital policies regarding patient rights can be found via the "Policies" tab on each hospital's Intranet home page.

- Bridgeport, Greenwich and Yale New Haven Hospitals – YNHHS Patient Rights and Responsibilities Policy
- Lawrence + Memorial Hospital – L+M Patient Rights and Responsibilities Policy
- Westerly Hospital – Rights and Responsibilities of Patients

Special Patient Care Considerations (continued)

V. Interpreter Services

Healthcare providers are required by State and Federal law and The Joint Commission to use appropriate interpreters to communicate with limited English proficient (LEP) patients and their families/caregivers. YNHHS will provide interpretation services free of charge to LEP patients/companions who what indicated their preferred language to medical personnel for effective communication in the delivery, planning, instruction and understanding of medical case. Patients/companions will not be turned away, rescheduled or not seen due to staff refusal to use available interpreter services.

Patient family members, friends or other non-Hospital personnel present with the patient are NOT considered appropriate interpreters.

Please call (203) 688-7523

(enter this number in your cell phone)

- Interpreters of over 150 spoken languages available
- American Sign Language interpreters
- 24 hours / 7 days a week

For more information, please review the YNHHS Language Services Policy, which can be found via the “Policies” tab on each hospital’s Intranet home page.

Special Patient Care Considerations (continued)

VI. Mandatory Reporting

State of Connecticut

Licensed health care providers are legislatively mandated reporters of suspected abuse, neglect or exploitation of certain groups of people.

Children

- Pursuant to Section 17a-101 of the Connecticut General Statutes, certain health professionals regulated by the Department of Public Health are mandated to report suspected child abuse or neglect to the Department of Children and Families' (DCF) Child Abuse and Neglect Careline or a law enforcement agency.
- Reports must be made within twelve hours of the moment the practitioner suspects the abuse/neglect has occurred. Suspected child maltreatment of any kind, regardless of the identity of the alleged perpetrator must be reported. The Careline can answer questions regarding these laws.
- It is important that health care practitioners become familiar with Connecticut's reporting laws as failure to meet reporting responsibilities may subject the practitioner to criminal prosecution and possible action against the practitioner's license or certificate.

Special Patient Care Considerations (continued)

VI. Mandatory Reporting (continued)

State of Connecticut (continued)

Persons with Disabilities

- Pursuant to Section 46a-11b of the Connecticut General Statutes, any physician licensed under the provisions of chapter 370, any resident physician or intern in any hospital in this state, any registered nurse, any person paid for caring for persons in any facility and any licensed practical nurse, medical examiner, dental hygienist, dentist, occupational therapist, optometrist, chiropractor, psychologist, podiatrist, social worker, school teacher, school principal, school guidance counselor, school paraprofessional, mental health professional, physician assistant, licensed or certified substance abuse counselor, licensed marital and family therapist, speech pathologist, clergyman, police officer, pharmacist, physical therapist or sexual assault counselor or battered women's counselor as defined in section 52-146k who has reasonable cause to suspect or believe that any person with intellectual disability has been abused or neglected shall, within five calendar days, report such information or cause a report to be made in any reasonable manner to the director of the Office of Protection and Advocacy for Persons with Disabilities or to persons the director designates to receive such reports. Such report shall be followed up by a written report within five additional calendar days. Any person required to report who fails to make such report shall be fined not more than five hundred dollars.

Special Patient Care Considerations (continued)

VI. Mandatory Reporting (continued)

State of Connecticut (continued)

Residents of Long-Term Care Facilities

- Pursuant to Sec. 17b-407 of the Connecticut General Statutes, any physician or surgeon licensed under the provisions of chapter 370, any resident physician or intern in any hospital in this state, any registered nurse, licensed practical nurse, medical examiner, dentist, optometrist, chiropractor, podiatrist, social worker, clergyman, police officer, pharmacist, physical therapist, long-term care facility administrator, nurse's aide or orderly in a long-term care facility, any person paid for caring for a patient in a long-term care facility, any staff person employed by a long-term care facility and any person who is a sexual assault counselor or a battered women's counselor as defined in section 52-146k who has reasonable cause to suspect or believe that a resident in a long-term care facility has been abused, neglected, exploited or abandoned, or is in a condition that is the result of such abuse, neglect, exploitation or abandonment, shall within five calendar days report such information or cause a report to be made in any reasonable manner to the Commissioner of Social Services pursuant to chapter 319dd. Any person required to report under the provision who fails to make such report within the prescribed time period shall be fined not more than five hundred dollars.

Special Patient Care Considerations (continued)

VI. Mandatory Reporting (continued)

State of Connecticut (continued)

The Elderly

- Pursuant to Section 17b-451 of the Connecticut General Statutes, any physician or surgeon licensed under the provisions of chapter 370, any resident physician or intern in any hospital in this state, any registered nurse, any nursing home administrator, nurse's aide or orderly in a nursing home facility, any person paid for caring for a patient in a nursing home facility, any staff person employed by a nursing home facility, any patients' advocate and any licensed practical nurse, medical examiner, dentist, optometrist, chiropractor, podiatrist, social worker, clergyman, police officer, pharmacist, psychologist or physical therapist, who has reasonable cause to suspect or believe that any elderly person has been abused, neglected, exploited or abandoned, or is in a condition which is the result of such abuse, neglect, exploitation or abandonment, or who is in need of protective services, shall within five calendar days report such information or cause a report to be made in any reasonable manner to the Commissioner of Social Services or to the person or persons designated by the commissioner to receive such reports. Any person required to report who fails to make such report shall be fined not more than five hundred dollars.

Special Patient Care Considerations (continued)

VI. Mandatory Reporting (continued)

State of Rhode Island

Rhode Island law requires any person to report child abuse or elder abuse to the Department of Children, Youth and Families or the Department of Elderly Affairs.

The following statutes include definitions of abuse and injury, reporting procedures, and any exceptions to mandatory reporting obligations. Additionally, physicians must report to law enforcement injuries caused by firearms.

- Child Abuse – RI Gen. Laws 40-11-3
- Elder Abuse – RI Gen. Laws 42-66-8
- Firearm Injury – RI Gen. Laws 11-47-48

VI. SAFETY

Safety

- I. **General Safety**
- II. **Emergency Management**
- III. **Fire Safety**
- IV. **Emergency/Life Safety Codes**

Safety (continued)

I. General Safety

- Your identification badge must be displayed at all times while on hospital property.
- YNHHS Hospitals have been designated as a smoke-free facilities.
- Be aware of your surroundings and if you identify a specific problem that relates to safety risks in the hospital environment, it is important to report this through the patient service or other relevant manager and/or electronic event reporting application on the Clinical Workstation to resolve the care risk for your safety and the safety of our patients.

For more information, the hospital policies regarding badging can be found via the “Policies” tab on each hospital’s Intranet home page.

- Bridgeport, Greenwich and Yale New Haven Hospitals – Employee Identification Badge Policy
- Lawrence + Memorial Hospital and Westerly Hospital – Badging and Identification Policy

Safety (continued)

I. General Safety (continued)

Handling Medical Waste

- Safe handling of hazardous materials is important. Please refer to the manager of the area if you use, store, transport or need to dispose of a hazardous material, for Material Safety Data Sheet sheets (MSDS) and/or other key instructions.
- Dispose of regulated* medical waste appropriately in a leak-proof biohazard container/bag.

*Includes blood, blood products, pleural fluid, amniotic fluid, semen, CSF, peritoneal fluid, synovial fluid, vaginal secretions, pericardial fluid

Material Safety Data Sheets “MSDS Program

Safety Data Sheets are informational tools that tell us the hazards of a chemical or product and how to properly protect yourself when using, as well as much other emergency response information.

Safety Data Sheets can be located on each individual delivery network’s intranet.

Additionally, OSHA provides a free guide to Safety Data Sheets at:

<https://www.osha.gov/Publications/OSHA3493QuickCardSafetyDataSheet.pdf>

Safety (continued)

I. General Safety (continued)

Hazard Communication

It is important to understand how to identify potential hazards.

- **Physical Hazards –**
 - Related to the way that a chemical interacts with other substances or the environment. A chemical that is physically hazardous can harm you by:
 - Exploding
 - Igniting
 - Reacting violently with other substances.
 - Examples of these hazards are:
 - TNT/dynamite
 - Compressed gas in a cylinder
 - Isopropanol and other alcohols that can catch fire if exposed to heat or sparks.

Safety (continued)

I. General Safety (continued)

Hazard Communication (continued)

- **Health Hazards**
 - Related to the way that a chemical interacts with your body.
 - If you are exposed to a chemical hazardous to human health, you could suffer:
 - Long-term damage
 - Short-term injury or illness
 - Death
 - Routes of exposure for health hazards include:
 - Eyes
 - Skin
 - Inhalation
 - Ingestion
 - Injection
 - Examples of these hazards are:
 - Lead
 - Mercury
 - Formalin
 - Glutaraldehyde

Safety (continued)

I. General Safety (continued)

Hazard Communication (continued)

- **Health Hazards – Types of Damage**
 - Toxic chemicals can have local and or/systemic health effects.
 - A local effect occurs when the chemical causes damage at the point where it first contacts the body:
 - Eyes
 - Skin
 - Nose
 - A systemic effect occurs when the chemical enters the bloodstream and travels throughout the body. The organs most commonly harmed include:
 - Liver
 - Kidneys
 - Heart
 - Brain
 - Reproductive Organs

Safety (continued)

I. General Safety (continued)

Hazard Communication (continued)

• Forms of Hazardous Chemicals

- Hazardous chemicals come in the forms of:
 - Solid
 - Liquid
 - Gas
- Solids are not usually hazardous because solid materials are not readily absorbed into the body. Certain forms of solids, however, can be highly hazardous because they are readily absorbed into the body. These include:
 - Dust (Consists of very small particles suspended in the air that can be inhaled.)
 - Fume (Consists of very small, fine particles suspended in the air when solid chemicals are heated to very high temperatures. Fume is easily inhaled and can be highly toxic.)
 - Fibers (Long, thin solid particle that can be inhaled. Small fibers can lodge in the lungs and cause damage.)
- Liquids are hazardous chemical at normal temperatures and pressures that can damage the skin, enter the body through the skin or evaporate, forming a toxic gas that can be inhaled.
- Gases that are hazardous can be difficult to detect. Many do not have a distinctive color or odor, but can be flammable, explosive or toxic.

Safety (continued)

I. General Safety (continued)

Oxygen Safety

- Store oxygen with the valve closed.
- Separate full and empty oxygen cylinders
- Oxygen cylinders must never be left lying down.
- Access to emergency oxygen shut off valves with gurneys, wheelchairs, etc. must never be blocked.
- During a medical emergency code, ventilators must be turned off before defibrillating or using other electrical equipment. Otherwise, concentrated oxygen will continue to be supplied to the area.
- Intentional O₂ shut-offs are only indicated when there is a major fire emergency or leak in the system. Respiratory Therapists and/or Plant Engineers are the only staff authorized to shut off O₂ after assessing the consequences to patient care.

Safety (continued)

I. General Safety (continued)

Radiation Safety

- Key safety elements regarding radiation exposure:
 - TIME—minimize time spent in room with patient who is being treated with radionuclide therapy
 - DISTANCE—maintain at least 6 feet away from patients during exposure and treatment
 - SHIELDING—wear appropriate protective shielding such as a lead apron and thyroid collar
- Sources of radiation include x-ray machines, therapeutic radiology equipment and radionuclides.

Contact the Radiation Safety Officer at your facility with questions:

- Bridgeport Hospital – Roderick (Rick) Richardson (203-336-7814)
- Greenwich Hospital – Michael Mink (203-863-3050)
- Lawrence + Memorial Hospital – Michael Lairmore (201-693-2277)
- Westerly Hospital - Michael Lairmore (201-693-2277)
- YNHH - Michael Bohan (203-688-2950)

Safety (continued)

II. Emergency Management

- Report any emergency to the patient service manager in the area or call the hospital emergency number.
- If you hear an alarm, see the manager in the area for more information and possible instructions which may include: assisting patients, following evacuation routes, using a fire extinguisher or accessing a fire alarm pull station.
- During a declared disaster, you may be asked to supervise other practitioners who have been granted disaster privileges. Directions regarding this would be coordinated through Medical Staff Administration.

For more information, please review the YNHHS Emergency Operations Plan, which can be found via the “Policies” tab on each hospital’s Intranet home page.

Safety (continued)

III. Fire Safety

In the event of a fire, follow the RACE protocol:

- Rescue others at risk from the fire,
- Sound the Alarm,
- Close all doors/chutes/windows/etc.,
- Extinguish the fire using the PASS method
 - Pull
 - Aim
 - Squeeze
 - Sweep

Safety (continued)

IV. Emergency/Life Safety Codes

Yale New Haven Health uses “Plain Language Codes” throughout the Health System.

Alert / Condition	Plain Language Code
Adult Code	Medical Alert + Code Blue
Pediatric Code	Medical Alert + Code White
Birth Outside the Delivery Room (Bridgeport Only)	Medical Alert + Code Pink
Infectious Disease (Westerly Only)	Medical Alert + Code Purple
Trauma (Westerly Only)	Medical Alert + Code Yellow

Safety (continued)

IV. Emergency/Life Safety Codes

Alert / Condition	Plain Language Code
Disaster	Facility Alert + The hospital's Emergency Operations Plan has been activated for + Description of Emergency
Decontamination	Facility Alert + Decontamination + Location + Directions
Evacuation/Relocation	Facility Alert + Evacuation + Location + Directions
Fire	Facility Alert + Fire Alarm Activation + Location
Hazardous Material Release	Facility Alert + Threat + Location + Avoid the area
Mass Casualty	Facility Alert + Mass Casualty + Location + Directions
Utility/Technology Interruption	Facility Alert + Utility/Technology Interruption + Location + Directions
Weather Event	Facility Alert+ Event Type (e.g. Weather Alert Tornado Warning in effect until 2000)

Safety (continued)

IV. Emergency/Life Safety Codes (continued)

Alert / Condition	New Plain Language Code
Active Shooter / Active Assailant	Security Alert + Armed Intruder + Location + Description
Bomb Threat	Security Alert + Bomb Threat + Location + Directions
Combative Patient	Security Alert + Assistance Requested + Behavioral Intervention + Location
Missing Child	Security Alert + Missing Child / Infant + Description + Last Location
Suspicious Package	Security Alert + Suspicious Package + Location + Directions

VII. INFECTION PREVENTION & CONTROL

Infection Prevention & Control

- I. **Overview**
- II. **Hand Hygiene**
- III. **Standard & Contact Precautions**

Infection Prevention & Control

I. Overview

The use of **STANDARD PRECAUTIONS** is **mandatory**:

- Perform Hand Hygiene:
 - Before entering a patient room
 - Before leaving a patient room
 - Before every patient contact
 - After every patient contact
 - Immediately after skin exposure to blood or other potentially infectious material
- Wear gloves when there is a risk of exposure to blood or other potentially infectious materials from all patients. Gloves must be removed and hands washed immediately after the task.

Wearing gloves is not a substitute for hand washing.

- Use goggles/glasses with side shields or masks with face shield to protect mucous membranes from accidental exposure when a procedure might result in splashing, spraying, or aerosolization of blood and other body fluids.
- Discard sharps in the appropriate puncture resistant containers provided in treatment areas. Sharps should be discarded without breaking, bending, or recapping.
- Promptly clean up all spills of blood or other potentially infectious material in an appropriate manner with decontamination of the site with approved disinfectant.
- Handle soiled linens, medical waste and laboratory specimens in a safe manner.

Other precautions are used in situations that are designed to reduce transmission of epidemiologically significant organisms by direct or indirect contact. This may include **CONTACT PRECAUTIONS**:

- Wash hands with soap and water or alcohol based sanitizer before entering or leaving a patient room and before or after contact with a patient or his/her environment. NOTE: **If the patient is known to have C. Difficile, soap and water must be used to wash hands.**
- Use appropriate gloves and gowns.
- Clean and disinfect equipment/supplies before removal from the room.

Infection Prevention & Control (continued)

II. Hand Hygiene

Proper Performance of Hand Hygiene

Using Soap and Water

- Turn on faucet, wet hands, apply soap
- Rub hands together to form a lather for at least **15** seconds making sure to cleanse thumbs, areas in between fingers, and under fingernails
- Thoroughly rinse lather from hands
- Pat dry with clean paper towel
- Use paper towel to turn off faucet
- Dispose of paper towel in appropriate receptacle

Using Alcohol-based Hand Rub

- Push the dispenser once and coat all surfaces of your hands including:
 - between fingers
 - under fingernails
 - back of hands and wrists
- Rub hands together briskly until dry (No rinsing needed)

Other Considerations

- Artificial nails, nail art or nail jewelry is not permitted
- Gloves are not a substitute for hand hygiene
- Perform hand hygiene *before* putting on gloves
- Remove gloves after patient care and immediately perform hand hygiene
- Wear a new, clean pair of gloves for each patient encounter and never wash, disinfect or sterilize gloves for re-use

Infection Prevention & Control (continued)

II. Hand Hygiene (continued)

Proper Performance of Hand Hygiene (continued)

When should and alcohol-based hand rub not be used?

- When hands are visibly soiled or dirty
- When hands have been in direct contact with blood or body fluids
- After contact with a patient, or their environment, who has *C. difficile*

In the above cases, hand hygiene should be performed using soap and water instead of an alcohol-based hand rub.



For more information, please review the YNHHS Hand Hygiene Policy, which can be found via the “Policies” tab on each hospital’s Intranet home page.

Infection Prevention & Control (continued)

III. Standard and Contact Precautions

Standard Precautions

- Used for patients known or suspected to be colonized and/or infected with epidemiologically significant organisms (e.g., MDROs)
- MDROs are most commonly transmitted via contact:
 - Direct contact transmission: organisms are transferred from one person to another
 - Indirect contact transmission: transfer of an organism through a contaminated intermediate object or person (e.g., unwashed hands, improperly cleaned patient care devices, instruments, equipment, environment)

Contact Precautions

- Contact Precautions are intended to prevent transmission of organisms (such as MDROs) that are spread by direct or indirect contact with a patient or a patient's environment.
- Require putting on gown and gloves
 - *Prior* to entering a patient room even if...“I’m not going to touch anything.”
 - Perform hand hygiene *before* putting on gloves so gloves are not contaminated. This protects the patient and you.
 - Tie gown at the waist and neck to keep it from opening and/or slipping off the shoulders to prevent contamination of your clothing.
- Remove gown and gloves before leaving the room.
- Perform hand hygiene immediately after removal of gown and gloves, before touching anything or anyone.

VIII. TJC NATIONAL PATIENT SAFETY GOALS

TJC National Patient Safety Goals

- I. **Goals**
- II. **Anticoagulation**
- III. **Hospital Acquired Infections**
- IV. **Multi-Drug Resistant Organisms (MDRO)**
- V. **Central Line Associated Blood Stream Infections (CLABSI)**
- VI. **Catheter Associated Urinary Tract Infections (CAUTI)**
- VII. **Surgical Site Infections (SSI)**
- VIII. **Falls**

TJC National Patient Safety Goals (continued)

I. Goals

The purpose of the National Patient Safety Goals is to improve Patient Safety.

The NPSGs were established by The Joint Commission to help accredited organizations address specific areas of concern with regard to patient safety such as:

- Identifying patient correctly
- Improving staff communication
- Using medicines safely
- Using alarms safely
- Preventing infection
- Identifying patient safety risks
- Preventing mistakes in surgery

TJC National Patient Safety Goals (continued)

II. Anticoagulation

Education:

- Patients who receive anticoagulant therapy must be educated regarding:
 - the importance of follow-up monitoring after discharge
 - compliance with the medication they are prescribed
 - food-drug interactions
 - potential adverse drug reactions/interactions
 - Who they should contact and what they should do if they experience bleeding signs and symptoms or other described reactions/interactions
- Education process:
 - Pharmacist identifies patients on warfarin and/or therapeutic doses of dalteparin (inpatients)
 - Patients who will be discharged soon are educated first if not already educated by the nurse
 - Documentation of education is located in patient education flowsheet

RN Driven UFH (unfractionated heparin) Dosing Protocol:

- Unpredictable pharmacodynamic profile
 - Can lead to delays in achieving therapeutic PTT goal
- Literature supports rapid anticoagulation to achieve a therapeutic PTT
 - Local data shows patients reach PTT goal sooner when on protocol
- Exceeding the therapeutic threshold reduces mortality compared to patients who never met therapeutic threshold
- **PTT goal of 55-95 for UFH**
 - UFH is monitored by the aPTT
 - aPTT used as a surrogate measurement for anti-Xa activity
 - Therapeutic range for heparin is an anti-Xa activity level between 0.3 and 0.7 units/ml
 - Corresponds to a therapeutic aPTT range of 55- 95 seconds
 - This range will change based on type of reagent and lot #

TJC National Patient Safety Goals (continued)

II. Anticoagulation (continued)

Why use LMWH (low molecular weight heparin):

- More predictable anticoagulant response
- Doesn't require routine monitoring
- Administered once or twice daily as a subcutaneous injection
- Level IA recommendation from CHEST guidelines for VTE, bridge therapy, AFib and ACS
- LMWHs are more cost-effective, when considering the overall cost of care

Contraindications for LMWH:

- **Concomitant epidural or spinal anesthesia or planned LP**
 - Active bleeding
 - Hepatic failure
 - Major surgery/procedure in past 24-hrs or planned within 24-hrs
 - Bacterial endocarditis
 - Uncontrolled HTN
 - Coagulopathy (PT>16 or Plts <50K)
- **Special Considerations**
 - CrCl<30
 - Requires routine monitoring of anti-Xa levels
 - May require dose adjustment

TJC National Patient Safety Goals (continued)

III. Hospital Acquired Infections

Hospital Acquired Infections (HAIs) are an important issue for all hospitals.

The areas of current focus are:

- Multidrug-Resistant Organisms (MDROs)
- Central Line Associated Blood Stream Infections (CLABSIs)
- Surgical Site Infections (SSIs)
- Catheter-Associated Urinary Tract Infections (CAUTIs)

TJC National Patient Safety Goals (continued)

III. Hospital Acquired Infections (continued)

Multi-Drug Resistant Organisms (MDRO): Prevention and Control

Background:

- HAIs are more likely to be caused by multi-drug resistant organisms (MDRO) than community acquired infections.
 - MDROs are bacteria resistant to first-line therapies.
 - MDROs are often difficult to treat due to their innate or acquired resistance to multiple classes of antimicrobial agents.
 - In some cases, there are few, if any, options for patient treatment.
 - Examples of MDROs:
 - Vancomycin resistant enterococcus (VRE)
 - Methicillin resistant *Staphylococcus aureus* (MRSA)
 - Gram negative bacteria (e.g., *E. coli*, *Pseudomonas*, *Klebsiella*, *Enterobacter*, *Acinetobacter*) resistant to first-line antibiotic agents and/or carrying certain resistance traits (e.g., ESBL = extended spectrum beta-lactamase; KPC = *Klebsiella pneumoniae* carbapenemase)
- MDRO infections are particularly difficult and problematic to treat in certain patient populations such as:
 - Immunosuppression
 - Prosthetic devices
 - Device-related infections (e.g., central line infection, Foley catheter related infection, ventilator associated pneumonia)
- Although *C. difficile* (*C. diff*) is not technically an MDRO, it poses similar challenges for prevention of transmission and treatment.
 - Outbreaks of a particularly virulent strain of *C. diff* are being increasingly reported across the US.

TJC National Patient Safety Goals (continued)

IV. Multi-Drug Resistant Organisms (MDRO): Prevention and Control

Scope:

- The CDC estimates that healthcare-associated infections (HAI) account for an estimated 1.7 million infections and 99,000 associated deaths each year in the US.
 - Cost: \$17 - 29 billion a year.
 - One of the top ten leading causes of death.
- HAIs are infections that patients acquire during the course of receiving treatment for other conditions within a healthcare setting.
 - HAIs are not present or incubating at the time of admission.
 - HAIs lead to:
 - increased length of stay
 - more diagnostic tests
 - more treatment
 - more antibiotics
 - more antibiotic resistance

TJC National Patient Safety Goals (continued)

V. Central Line Associated Blood Stream Infections (CLABSI)

Background:

- A CVC or Central Venous Access Device (CVAD) is an intravenous catheter whose tip ends in the central venous system
- Common sites of insertion include internal jugular vein, subclavian vein, femoral vein, and as well as the cephalic & basilic veins (PICC: peripherally inserted central catheter)
- Indications:
 - Hemodynamic monitoring
 - IV fluids, medications, vasopressors, blood products, chemotherapy, total parenteral nutrition
 - Hemodialysis

Scope:

- 18 million ICU days (11% of total hospital days).
- 9.7 million catheter-days in ICUs (54% of ICU days).
- 48,600 patients in the ICUs have a CLABSI (catheter-related bloodstream infection (5 BSI/1000 catheter days)).
- 17,000 deaths attributable to CLABSIs in the ICU.
- Although the catheter utilization rate is lower outside of the ICU setting, as many or more CLABSIs occur outside the ICU setting.²

1. Wenzel RP & Edmond MB: NEJM 355(26):2781-83 (2006)

2. Marschall J et al. Infection Control & Hospital Epidemiology 28(8):905-9 (2007)

TJC National Patient Safety Goals (continued)

V. Central Line Associated Blood Stream Infections (CLABSI) (continued)

Efforts to Reduce CLABSI:

- **Central line insertion checklist and CVAD policy:**
 - Elements of the checklist are reviewed in detail in the following slides.
 - Checklist hard copies available under “C” in the clinical workstation.
 - Completed copies should be returned to nursing leadership on each unit.
 - Completion of training required for all who insert CVADs is required upon hire and annually per the National Patient Safety Goals.
- **Patient and Family Education**
 - Education should occur at time of consent if possible using educational materials that have been developed for this purpose regarding CVAD devices in general and information related to CLABSI.
- **Maintenance:**
 - Maintenance policy in place requiring orders for maintaining the CVAD
 - Monitoring and prompt removal of unnecessary CVAD is essential component of reduction of CLABSI
 - Assess CVAD daily with prompt removal when appropriate and other lines can be used (i.e., peripheral IV)

TJC National Patient Safety Goals (continued)

V. Central Line Associated Blood Stream Infections (CLABSI) (continued)

Risk Factors:

- Duration of catheterization (CVAD duration > 3 -4 days)
- Increased diameter and number of ports on catheter
- Location (femoral > internal jugular > subclavian)
- Type of catheter:
 - Tunneled catheters lower risk than non-tunneled
 - Antimicrobial/Antiseptic coated catheters are lower risk than non-coated
- Thrombosis at the site of the CVAD
- TPN or other lipid rich infusate
- Impaired skin integrity (burns, dermatologic disease)

TJC National Patient Safety Goals (continued)

VI. Catheter Associated Urinary Tract Infections (CAUTI)

Background:

- In 2012, The Joint Commission required that hospitals fully implement best practices to prevent indwelling catheter-associated urinary tract infections

Scope:

- **Implementation of Evidence Based Guidelines:**
 - **Limit use and duration** to situations necessary for patient care
 - Use aseptic technique for site preparation, equipment and supplies
 - Consider alternatives to indwelling catheters (i.e., texas catheter for men) and bladder scanning retention

TJC National Patient Safety Goals (continued)

VII. Surgical Site Infections (SSI)

Background:

- In spite of advances in infection prevention practices, surgical site infections (SSIs) remain a substantial cause of morbidity and mortality among patients.
- A systematic approach must be applied with the awareness that SSI risk is influenced by characteristics of the patient, operation, personnel, and healthcare setting.

Scope:

- Estimated 24 million surgical procedures/year
- 2 to 5% of operations are complicated by an SSI
- SSIs account for 24% of all Hospital Acquired Infections (HAI)
 - Third most frequent HAI
 - Most costly HAI
- SSIs prolong hospital stay an average of 7-10 days
- Patients with an SSI have a 2-11 times higher risk of death compared with operative patients without an SSI
- Total cost may exceed \$10 billion/yr
 - Attributable costs vary: \$3000-\$29,000

¹Anderson, Kaye, Classen et al. Strategies to Prevent Surgical Site Infections in Acute Care Hospitals. Infect control Hosp Epidemiol 2008;29:S51-S61.

TJC National Patient Safety Goals (continued)

VII. Surgical Site Infections (SSI)

Prevention Strategies:

- Preoperative Antibiotics: *“Timing is everything”*

<u>Antibiotic given</u>	<u>SSI rate</u>
Early (2-24 hours before incision)	3.8%
Within 2 hours before incision	0.6%
Within 3 hours after incision	1.4%
Post-op	3.3%
- Minimize patient microbial burden
 - Surgical site disinfection before incision
 - Pre-operative antibiotic prophylaxis
 - Smoking cessation
- Optimize wound condition
- Optimize patient immune defenses
 - Control blood glucose in diabetics

TJC National Patient Safety Goals (continued)

VII. Surgical Site Infections (SSI) (continued)

Risk Factors:

<u>Wound Classification</u>	<u>Infection Rate</u>
Clean	<2%
Clean contaminated	<10%
Contaminated	20%
Dirty	30 to 40%

Endogenous

- Diabetes mellitus
- Advanced age
- Obesity
- Malnutrition, recent weight loss
- Cancer
- Immunosuppressed (e.g., steroid use)
- Other remote site of infection

Exogenous

- Prolonged preoperative stay
- Preoperative hair removal by shaving
- Length of operation
- Maintenance of body temperature
- Surgical technique
- Incorrect use of prophylactic antibiotics

TJC National Patient Safety Goals (continued)

VII. Surgical Site Infections (SSI) (continued)

Efforts to Reduce SSI

- Patient and Family Education
 - All surgical patients must be educated regarding measures to prevent SSIs.
 - Educational materials that have been developed specifically for patients should be used.
- Whiteboard
 - Pre-operative antibiotic choice (if indicated), timing, duration; follow evidence based guidelines
 - Hair removal – no shaving: razors removed from OR
 - Normothermia
 - Glucose control
- Monitor compliance with best practices or evidence based guidelines
 - ALL staff members empowered to **stop** a procedure if there has been a breach in sterile technique or any non-adherence with checklists/protocol.

TJC National Patient Safety Goals (continued)

vii. Surgical Site Infections (SSI) (continued)

Surgical Care Improvement Project (SCIP)

- **SCIP tracks all of the following at YNH**
 - Antibiotics received *within 1 hour prior to incision* for those procedures where antibiotics are indicated
 - For quinolones and vancomycin a 2 hour time frame is acceptable
 - Antibiotic selection
 - CABG, other cardiac and vascular -> cefazolin, cefuroxime, or vancomycin*
 - Hysterectomy -> cefotetan, cefazolin, cefoxitin, cefuroxime, or ampicillin/sulbactam
 - Hip/knee arthroplasty -> cefazolin, cefuroxime, vancomycin*
 - Colon operations -> cefotetan, cefoxitin, ampicillin/sulbactam, ertapenam, or cefazolin, cefuroxime and metronidazole
 - For beta-lactam allergic patients alternative recommendations are available
 - **Reason for use of vancomycin must be documented by physician/APRN/PA if patient not beta-lactam allergic*
 - Antibiotic discontinuation
 - Antibiotics must be stopped within 24 hours of surgery end time for elective surgical cases
 - For cardiac surgery antibiotics must be stopped within 48 hours of surgery end time
 - Cardiac surgery patients must have blood glucose <200 mg/dl at 6AM on post-operative day #1 and day #2.
 - Hair removal must be with clippers or depilatory only (no shaving), only if necessary and performed immediately prior to incision.
 - Colorectal surgery patients must have a temperature $\geq 96.8^{\circ}\text{F}$ within 15 minutes of leaving the operating room.

TJC National Patient Safety Goals (continued)

VIII. Falls

Purpose:

- Policies have been put in place to provide guidance for the care of patients across all YNHHS Delivery Networks who are at risk for falling or who has experienced a fall while in the hospital.

For more information, the system policies regarding fall prevention can be found via the “Policies” tab on each hospital’s Intranet home page:

- Adult Fall Prevention and Management (Inpatient and Emergency Services)
- Fall Prevention and Management (Adult Outpatient Service Areas)
- Newborn Drop or Fall Prevention

IX. HIGH RELIABILITY ORGANIZATION (HRO) INFORMATION

High Reliability Organization (HRO) Information

Overview HRO/“CHAMP” Behaviors

High Reliability Organizations (HRO) operate under very challenging conditions all the time yet manage to have fewer serious safety events by focusing on an established set of principles and practices.

HRO focuses on Safety, Quality, Experience and Finances to achieve Excellence.

We need your commitment on this journey!

The high reliability organization journey requires a continuing commitment to behavioral change and education. YNHH has created a training video that builds on the initial training all staff received on CHAMP safety behaviors:

Communicate Clearly

Handoff Effectively

Attention to Detail

Mentor each other for 200% accountability

Ppractice and accept a questioning attitude

The video, “HRO: Tools in Action” is available on the following link: <https://vimeo.com/207518855>.

High Reliability Organization (HRO) Information (continued)

CHAMP Behaviors Guidelines

C

Communicate Clearly

- Repeat Backs/Read Backs with Clarifying Questions
- Phonetic and Numeric Clarifications

H

Handoff Effectively

- Situation, Background, Assessment, Recommendation (SBAR)

A

Attention to Detail

- Self-check using Stop, Think, Act, Review (STAR)

M

Mentor Each Other – 200% Accountability

- Cross-Check and Coach Teammates
- Speak Up for Safety: “I Have a Concern”

P

Practice and Accept a Questioning Attitude

- Repeat Backs/Read Backs with Clarifying Questions
- Phonetic and Numeric Clarifications

High Reliability Organization (HRO) Information (continued)

HRO Training

- Yale New Haven Health System is a High Reliability Organization (HRO). All newly appointed Medical Staff Members are required to attend an HRO training session within ninety (90) days of initial appointment. You do not need to wait until you are appointed in order to attend HRO training and are, in fact, encouraged to do so during the time your application is being processed. Additionally, if you have already attended HRO training at any YNHHS hospital you have fulfilled this requirement. Please inform your Credentialing Specialist.
- Please visit www.ynhh.org> select “Providers” at the bottom of the page> Under “Resources” select “Medical Staff Bulletin”> Open the most recent issue> Select “HRO training schedule for new credentialed practitioners”> Register by following the instructions indicated. If you have any questions regarding HRO training, please contact Kathleen Quinn at (203) 688-5242 (Kathleen.Quinn@YNHH.ORG).

X. STANDARDS OF PROFESSIONAL BEHAVIOR

Standards Of Professional Behavior

Standards of Professional Behavior

Patient-Centered Care – Put Patients and families first

- Keep patients safe and use high reliability practices
- Deliver the highest quality of coordinated care and service
- Make patients and families part of the team

Respect – Value all people

- Protect others' privacy and dignity
- Introduce yourself and your role
- Be curious, ask questions and listen without interruption
- Support, recognize and appreciate others

Compassion – Be empathetic

- Smile, make eye contact and offer a warm greeting
- Offer thoughtful gestures of courtesy, comfort and kindness
- Identify and respond to feelings, concerns and requests
- Communicate with courtesy and respect

Integrity – Do the right thing

- Be on time and prepared
- Promote diversity and be inclusive
- Work as a team and speak well of others
- Value different ideas, perspectives and feedback

Accountability – Be responsible and take action

- Own your work and follow through with commitments
- Explain what you are doing and why
- Present a professional image
- Acknowledge when wrong, apologize and take action

XI. PRIVACY AND CORPORATE COMPLIANCE

XI. CORPORATE COMPLIANCE & HIPAA PRIVACY

- I. Key Laws and Regulations**
- II. YNHHS Policies & Procedures**

Corporate Compliance

False Claims Act:

A false claim is an incorrect bill sent intentionally or recklessly to the government payers for payment.

To prevent false claims, follow these standards:

- Bill only for services actually performed, using the appropriate codes
- Ensure documentation supports medical necessity
- Document patient records completely and accurately to support patient care
- Report any concerns regardless of the concern or issue. The Compliance Department will investigate and take appropriate action.

If you suspect that erroneous claims are being produced, report your concerns through one of the following methods:

- Your proper chain of command
- Directly to Compliance at 203.688.8416 or compliance@ynhh.org
- Corporate Compliance Hotline 888.688.7744

EMTALA (Emergency Medical Treatment and Labor Act):

Ensure public access to emergency services regardless of ability to pay

Requires that all patients who come to the Emergency Department receive a medical screening examination to determine whether or not an Emergency Medical Condition (EMC) exists

A patient who has an EMC be stabilized before being transferred to another acute care facility or being discharged.

HIPAA PRIVACY

I. Key Laws and Regulations (continued)

HIPPA (Health Information Portability and Accountability Act):

- Federal law that establishes basic privacy rights for patients while allowing the flow of information needed to provide high quality care and ensures security of electronic patient information. All protected health information (PHI) in any form (paper, electronic, verbal) must be handled with care to avoid inappropriate disclosures.

Important YNHHS policies:

- Without a formal request from the patient's treating clinician or designee, it is generally prohibited to access a patient's medical record, regardless of your credentials or licensure.
- Requests made by friends or family members asking the opinion of a medical professional that is not directly involved in the plan of care must follow the procedure below:
 - The patient's written request and authorization for the provider to access the medical record must be **filed in the medical record prior to or within 24 hours of access to the record.** Such request must include:
 - *The patient's full name (first and last name), address, and date of birth.*
 - *The request must list the name and relationship of the provider whom they are authorizing to access their medical record.*
 - Or a formal consultation request from the patient's current clinician
 - Email documentation to HIMDocMgmt@ynhh.org
- AS A GUIDING PRINCIPLE, DO NOT ACCESS MEDICAL RECORDS FOR REASONS OUTSIDE OF TREATMENT, PAYMENT, AND/OR OPERATIONS
- In general, guests of the clinical staff are not permitted in the operating room without appropriate approval

Interactions with Vendors/ Conflicts of Interest

- YNHHS has strict policies regarding interactions with vendors, corporations, and non-YNHHS entities:
 - If you would like a vendor representative to meet with you at any YNHHS location, the vendor must be registered with Vendormate and wear appropriate identification prior to each visit
 - Food & Beverage provided by vendors are generally prohibited at any YNHHS location
 - In general, attendance at events sponsored by non-profits or professional societies are permissible
 - Contact the Compliance Office(compliance@ynhh.org):
 - Before agreeing to any financial relationship with non-YNHHS entities
 - Prior to attending any industry sponsored event including but not limited to speaker programs, satellite symposia, educational meals, etc

XII. LIBRARY RESOURCES

Library Resources

Mission:

The System Health Sciences Libraries of Bridgeport, Greenwich, L+M and Westerly Hospitals provide evidence-based resources and services to support patient safety, patient care, clinical research, education for multidisciplinary teams and lifelong learning.

To learn more about the library resources that are available, please contact:

Bridgeport Hospital

- Todd Lane, Chief, Library & Multimedia Services
- 203-384-3615
- Todd.Lane@bpthosp.org

Greenwich Hospital

- Donna Belcinski, Content Management Librarian
- 203-863-3284
- Donna.Belcinski@greenwichhospital.org

L+M + Westerly Hospitals

- Anne-Marie Kaminsky, Library Manager
- 860-442-0711 ext 2238
- Anne-Marie.Kaminsky@LMHOSP.ORG

YNHH

- Access the current Medical Staff Portal via www.ynhhconnect.org and click on the left column that says “Epic Login/Cushing Medical Library” to access the Yale University Harvey Cushing Medical Library,

XIII. LEGAL COMPLIANCE: FRAUD & ABUSE, PRIVATE INUREMENT AND EXCESS BENEFIT TRANSACTIONS

XIII. Legal Compliance: Fraud & Abuse, Private Inurement and Excess Benefit Transactions

- I. Stark & Anti-Kickback Law**
- II. Private Inurement & Intermediate Sanctions**
- III. Risk & Penalties**

XIII. Legal Compliance: Fraud & Abuse, Private Inurement and Excess Benefit Transactions

I. Stark & Anti-Kickback Law

- Stark and Anti-Kickback Statutes restrict *financial relationships* with persons or entities that make, receive, or influence referrals of patients or services to or from hospitals.
- Financial relationships include the exchange of anything of value (e.g., cash, services, support).
- Anti-Kickback Statute imposes civil and criminal liability for those who knowingly and willfully offer or pay *any* remuneration, in cash or in kind, to any person as an inducement for referrals.
- Subject to meeting certain exceptions, Stark and Anti-Kickback prohibit referrals when the physician and the hospital have a *financial relationship*. To be permissible, relationships must generally be in writing, signed by both parties, at fair market value and commercially reasonable.
- Yale New Haven Health Policy requires that, prior to entering into any financial relationship with a physician or other who is in a position to refer patients, the Health System's Legal & Risk Services Department must be contacted to review the proposed arrangement and to prepare a signed written contract that complies with the law.

XIII. Legal Compliance: Fraud & Abuse, Private Inurement and Excess Benefit Transactions

II. Private Inurement & Intermediate Sanctions

PRIVATE INUREMENT

- The hospital is a tax-exempt healthcare organization. As such, the hospital's income and assets may not be used for non-charitable purposes to benefit any individual who has a significant relationship with the hospital (this individual is known as an "Insider").

INTERMEDIATE SANCTIONS - EXCESS BENEFIT TRANSACTIONS

- A hospital may not provide a benefit to a "Disqualified Person" that exceeds the value received by the hospital (e.g., when the hospital pays compensation that's not reasonable).
- A "Disqualified Person" is (a) any person who is currently or was in the prior 5 years in a position of substantial influence over the hospital's affairs, and (b) a family member or entity controlled 35% or more by a person described in (a).
- Persons with substantial influence include voting trustees, certain officers, and others with the ability to exercise substantial influence.

Financial relationships between a hospital and an Insider or Disqualified Person must be reasonable and fair market value, and must be approved *in advance* by the Health System's Legal & Risk Services Department, as well as by the hospital's Board of Trustees based on market comparability data that supports the appropriateness of the proposed arrangement.

XIII. Legal Compliance: Fraud & Abuse, Private Inurement and Excess Benefit Transactions

III. Risk & Penalties

Stark penalties can be severe

- Denial/Refund of claims for referred services
- Up to \$15,000 per service monetary penalty
- Exclusion from government health care programs

Anti-Kickback violation is a felony offense

- Criminal fines and imprisonment for up to 5 years
- Up to \$50,000 per service monetary penalty *plus* potential fine of up to three times the penalty amount
- Exclusion from government health care programs

Private Inurement & Excess Benefit Transaction

- Private Inurement can result in revocation of a hospital's tax-exempt status.
- Significant penalty taxes may be imposed on individuals who engage in impermissible transactions (including on the "Disqualified Person" and on the manager who approved the transaction). The hospital may also be subject to penalty taxes.
- Excess benefit transactions must be corrected when discovered.

XIV. ANTIMICROBIAL STEWARDSHIP

XIV. Antimicrobial Stewardship

- All acute care hospitals are required by The Joint Commission to have an antimicrobial stewardship program (ASP)
- Antimicrobial stewardship is every health care provider's responsibility and involves a multi-modal process that is a coordinated effort to mitigate unnecessary or inappropriate antimicrobial usage to improve patient care and decrease patient harm and antimicrobial resistance
- Yale New Haven Health System has an Antimicrobial Stewardship Committee that develops and monitors system-level antimicrobial use and looks for opportunities for improvement in antimicrobial therapy management
- Certain antimicrobials require pre-authorization or approval by ID and/or pharmacy prior to use as part of the ASP
- Additional components of the ASP include a Pharmacist Driven IV to Enteral Protocol and Renal Dose Adjustment Protocol

XV. ATTESTATION & POST TEST

Post Test and CME Course Evaluation

Please Complete the Following for this CME Course:

1. Post-test (score of at least 80% is required to pass)
2. CME Course Evaluation
3. Download your CME Certificate
4. Send your certificate to your credentialing representative as instructed (Not the Yale CME office)

Click [HERE](#) to Start!

*Note: You will be required to sign into your Yale CME Profile.
If you do not have a profile, you will be asked to register.*

View all CME Offerings at the Yale CME Website:

<https://yale.cloud-cme.com>

For questions regarding the Yale CME Website, please email us at cme@yale.edu

For questions regarding your Staff Recredentialing Requirements, please visit the [Medical Staff Administration Website](#) or contact them at 203-688-2615.

Additional Resources

- The video, “YNHHS Standards of Professional Behavior is available via the following link:
<https://vimeo.com/ynhh/review/187379332/3c9b5dc336>
- The video, “HRO: Tools in Action” is available on the following link: <https://vimeo.com/207518855>