

# ***Patient Safety & Quality Improvement***

## ***Physician Handbook***

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# Erie County Medical Center Floor Directory

<b>Ground Floor</b>	<ul style="list-style-type: none"> <li>• Parking/Security Office</li> <li>• Medical Library</li> <li>• Pharmacy</li> </ul> <p><b>Lobby -</b> Tim Hortons', Snack Shop, Subway, Financial Planning, Foundation Offices</p> <ul style="list-style-type: none"> <li>• Human Resources</li> <li>• Medical Records</li> </ul>
<b>First Floor</b>	<ul style="list-style-type: none"> <li>• Clinical/Outpatient PHC (Primary Health Clinic) - Suite 15</li> <li>• Instacare</li> <li>• Dental</li> <li>• Ophthalmology</li> <li>• OR</li> <li>• Emergency Department</li> <li>• Radiology</li> <li>• Cath Lab/EKG</li> <li>• TICU/Burn Units</li> </ul> <ul style="list-style-type: none"> <li>• CPEP</li> </ul>
<b>Second Floor</b>	<ul style="list-style-type: none"> <li>• Cafeteria</li> <li>• Noyes Teaching Center &amp; Conference Rooms (Access from Cafeteria)</li> <li>• Staff Dining Room (Next to Cafeteria)</li> </ul> <ul style="list-style-type: none"> <li>• Chapel/Spiritual Care</li> </ul>
<b>Third Floor</b>	<ul style="list-style-type: none"> <li>• Administration</li> <li>• Smith Auditorium</li> <li>• Conference Rooms A, B, C, D &amp; Board Room</li> <li>• Medical Staff Office</li> <li>• Infection Control Offices</li> </ul>
<b>Fourth Floor</b>	<ul style="list-style-type: none"> <li>• Adult &amp; Adolescent Psychiatry</li> </ul>
<b>Fifth-Sixth Floors</b>	<ul style="list-style-type: none"> <li>• Skilled Nursing Units</li> </ul>
<b>Seventh-Eighth Floors</b>	<ul style="list-style-type: none"> <li>• Medical/Surgical Inpatient</li> <li>• 701-730 (7 North)</li> <li>• 751-780 (7 South)</li> <li>• The Jonah Center (8 Zone 2)</li> <li>• 801-830 (8 North) Rehab Medicine</li> <li>• 866-880 (8 Zone 1)</li> </ul>
<b>Ninth Floor</b>	<ul style="list-style-type: none"> <li>• Chemical Dependency Unit</li> <li>• Corrections Unit</li> <li>• 9 Zone 1 - Detox</li> <li>• 9 Zone 2</li> <li>• Zone 3 Rehab</li> <li>• Zone 4 Rehab</li> </ul>
<b>Tenth Floor</b>	<ul style="list-style-type: none"> <li>• Medical/Surgical Inpatient</li> <li>• Acute Geriatrics (Zone 1)</li> <li>• Medicine (Zone 2)</li> <li>• Hemodialysis (Zone 3)</li> </ul>
<b>Eleventh Floor</b>	<ul style="list-style-type: none"> <li>• 11-2 Geriatric Psychiatry</li> <li>• 11-1 Psychiatry Administration</li> <li>• 11-3 &amp; 4 - Psychiatry</li> </ul>
<b>Twelfth Floor</b>	<ul style="list-style-type: none"> <li>• Medical Intensive Care (MICU)</li> <li>• Cardiac Care Unit (CCU)</li> <li>• Step Down Telemetry - Zone 2 and Zone 3)</li> </ul>

# RAPID RESPONSE TEAM (RRT)

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- At ECMC, the **RAPID RESPONSE TEAM** is run by the HOSPITALIST (MED E) service. The resident teams should respond to assist and provide any needed support.
- Do not dismiss the RRT until you are sure the patient's needs have been met. Do not wait to start critical care until transfer to an ICU - be sure care is administered immediately and/or as ordered.
- Be sure the patient's condition and treatment are documented properly in the medical record. Be sure to time, date and sign your entry.
- The **RAPID RESPONSE TEAM RECORD** must be completed and included in the medical record.

# CODE BLUE ADULT MEDICAL EMERGENCY (FORMERLY CODE 5)

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- All residents are to report to Code Blue (cardiac/pulmonary arrest and offer help until the person running the code dismisses them
- Be sure all patient information is documented in the medical record
- Ensure that the patient's family has been contacted.
- Refer to the Internal Medicine Program Code Blue policy/recommendations for further information

# CMS CORE MEASURES 1

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In early 1999, the Joint Commission solicited input from a wide variety of stakeholders (e.g., clinical professionals, health care provider organizations, state hospital associations, health care consumers and convened a **Cardiovascular Conditions Clinical Advisory Panel** about the potential focus areas for core measures for hospitals. In May 2001, the Joint Commission announced four initial core measurement areas for hospitals, which included acute myocardial infarction (AMI) and heart failure (HF).

## ● **Acute Myocardial Infarction**

- AMI 1. Aspirin at arrival
- AMI 2. Aspirin prescribed at discharge
- AMI 3. ACEI/ARB for LVSD
- AMI 4. Smoking Cessation Counseling
- AMI 5. Beta-blocker at discharge
- AMI 6. Beta blocker at arrival
- AMI 7. Time to thrombolysis
- AMI 8. Time to PTCA.
- AMI 9. Inpatient mortality
- AMI-10 Lipid Profile drawn within 24 hours of arrival

## ● **Congestive Heart Failure**

- HF1. Discharge Instructions
- HF2. LVF assessment
- HF3. ACEI/ARB for LVSD
- HF4. Smoking cessation counseling

## ● **Community Acquired Pneumonia**

- CAP1. Oxygenation assessment
- CAP2. Pneumococcal screening/vaccination
- CAP 3. Blood cultures
- CAP 4. Smoking cessation counseling
- CAP5. Antibiotics within 4 hours of admission

Sometimes the recommended intervention may not be appropriate for a particular patient (i.e., blocker in asthma, ACEI in a hyperkalemic patient). In that case, the REASON WHY the intervention was not performed must be documented in the medical record.



# TELEMETRY MONITORING GUIDELINES



## Attending/Designee Notification at 16 hours

- Rule Out Myocardial Infarction / ACS
- All parameters must be met:
  - o With negative cardiac enzymes
  - o No further chest pain
  - o Normal potassium level
  - o No hypotension or ventricular arrhythmias
  - o No EKG changes (2 EKGs unchanged)

## Attending/Designee Notification at 24 hours

- Electrolyte Abnormalities
- Ventricular Ectopy
- Post Angioplasty
- Rule Out Cardiac Contusion
- Physician Request - must list indication

## Attending/Designee Notification at 48 hours

- Rule Out Myocardial Infarction with Recurrent Chest Pain
- Syncope
- Ventricular Ectopy with Ventricular Dysfunction
- ICD or Pacer placement (or awaiting placement) - until placed
- Poisoning
- New Onset Atrial Fib/Flutter - Heart Rate >60 / <100
- Heart Block (2nd or 3rd degree) - if resolved

## Attending/Designee Notification at 72 hours

- Cardiac Contusion
- Confirmed AMI
- CABG
- Open Heart Surgery

## Attending/Designee Notification at 96 hours

- Initiation of Antiarrhythmic Rx

## Indefinite - Must be d/ced by physician order

- CHF with Inotropic Rx
- Continuous Pulse Ox
- Awaiting PCI / CABG / ICD / Pacer

Attending Physician (or designee) Notification: Nursing must call attending physician (or designee) to advise them that the guideline timeframe has expired and to acquire an order to d/c or continue tele. Please be aware of arrhythmias in the last 24 hours, electrolyte abnormalities, chest pain, hypotension or other change in clinical status when calling. Please use judgment based on available telemetry beds and time of day when expiration occurs from 12:00 midnight and 7:00 a.m.

# TELEMETRY DISCONTINUATION AND ADMISSION

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## ○ **Off Tele for Tests**

In the rare circumstance that there is no telemetry trained personnel able to transport a patient on telemetry for a test (with NCCs awareness), and the attending physician (or designee) feels that it is more important to perform the test than continue telemetry, the attending physician (or designee) can order the patient be transported for the test off telemetry with telemetry to be restarted again upon return.

Please make sure the NCC is aware and no other nursing personnel are available for transport before telemetry is discontinued for any reason.

## ○ **Telemetry on Admission**

If the Attending Physician in the ED does not order telemetry and telemetry is ordered on admission, the admitting service must consult with the ED attending to be sure telemetry is really necessary.

# VERBAL ORDERS

## *Read back required*

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○ **Requirement:**

For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the order or test result “read-back” the complete order or test result.

**You must SIGN, DATE, TIME  
your phone/verbal orders  
within 48 hours.**

**Interns:**

**It is your responsibility  
to sign the verbal orders  
whether or not you are the  
ordering physician.**

# DANGEROUS ABBREVIATIONS JC Plan of Correction

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<b>NEVER USE</b>	<b>MUST WRITE</b>
QD	Daily
QOD	Every Other Day
U	Units
IU	International Units
µg	Micrograms
AU	Both Ears
AS	Left Ear
AD	Right Ear
TIW	Three times a week
MS/MSO <sub>4</sub> /MGSO <sub>4</sub>	Write out drug name

# CRITICAL VALUES REPORTING

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## ○ Requirement:

All values defined as critical by the laboratory **are reported to a responsible licensed caregiver** within time frames established by the laboratory (defined in cooperation with nursing and medical staff).

- All critical lab values are reported to the physician **and** the nurse caring for the patient. You may receive an additional call from the nursing staff to be sure you have received this urgent report.

## ○ Consults and Studies

All consults and studies ordered must include the clinical information and/or indication.

### Interesting....

**After a study of 4,074 sentinel events, it was found that communication failure was the cause of 65% of all sentinel events.**

# COMMUNICATE WITH YOUR ATTENDING

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- All patient admissions between the hours of 6:00 a.m. and 12:00 midnight are to be discussed with your attending physician.
- **Any patient deterioration should be discussed with your attending physician 24/7**
- **Communicate all test results and changes in condition with your nursing staff!**

# PROFESSIONAL CODE OF CONDUCT

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## *Definitions of inappropriate conduct*

- Verbal and/or physical conduct that interferes with patient care
- Interferes with the process of delivering quality care or the operation of the hospital
- Hostile, angry or aggressive confrontational voice or body language
- Attacks (verbal or physical) beyond bounds of professional conduct
- Inappropriate expressions of anger such as destruction of property or throwing items
- Abusive language or criticism directed in a ridiculing, humiliating, belittling way
- Criticism of staff member in front of patient or patient's family regarding other healthcare professionals or the hospital
- Writing of inappropriate, critical or litigious notes/comments in the medical record
- Negative discrimination on the basis of race, religion, etc.
- Refusal to abide by Medical/Dental staff requirements
- Sexual harassment
- **REMINDER: Paging - return all pages promptly** or instruct someone to answer the page on your behalf if you are unable to. When paging someone else, if you do not receive an answer from them, don't hesitate to page them again a few minutes later.

# ERIE COUNTY MEDICAL CENTER

## BEHAVIORAL EXPECTATIONS

*Because we are dedicated to being the medical center of choice through excellence in patient care and customer service, it is our responsibility to treat all our customers, including patients, families, physicians, co-workers and all outside contacts with courtesy, dignity, respect and professionalism*

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### **COURTESY AND RESPECT**

- Knock and ask permission before entering a patient's room.
- Greet the patient by their surname.
- If it is necessary to interrupt the patient's sleep, visit with family or another staff member, apologize for the interruption.
- Warn them before you turn on lights.
- Make eye contact; introduce yourself and tell them your role in their care.
- Explain the presence of the "whole team" when entering the patient's room on rounds.
- Politely ask visitors to step in the corridor. After they have stepped out, ask the patient if he wants anyone in the room while you discuss the care.
- Close the door or pull the curtain prior to discussions or exams. Explain what you are doing and keep patient properly draped.
- If possible, position yourself at eye level. If not, stand at the side rather than the foot of the bed.
- Listen carefully; do not interrupt; give the patient your full attention.
- Always include the patient in any teaching or conversation at the bedside.
- Respect cultural differences.
- Demonstrate a professional attitude toward co-workers and customers; use a respectful tone of voice.
- Discuss confidential or sensitive information about patients, employees, or hospital business only with those having a valid need to know, and do so privately, never in public places.

# RESPONSIVENESS, COMMUNICATION AND TEAMWORK

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- Tell patients when you expect to visit them and when you are available to speak to their family.
- If you are unable to visit them as planned, send someone in your place when possible, or call the unit.
- When your unavailability is planned, tell the patient who will be covering you and for how long.
- Provide test results as soon as available. Explain any delays.
- Inform family of change in condition, transfer to ICU, time of surgery, untoward events, expected discharge date.
- Invite questions and comments from patients and their families.
- Ensure the patient understands their care prior to leaving the room.
- Communicate with clarity and professionalism both orally and in writing.
- Keep patients informed while resolving issues or getting answers to questions.
- Participate openly, honestly share opinions; take responsibility for improving processes and systems.
- Maintain positive working relationships with co-workers and customers; perform duties in a way that makes it easier for others to perform theirs.
- NEVER disagree with other care providers in the front of the patient or family.
- Wear your name badge so that name is clearly visible at all times.
- Limit eating and drinking to designated areas.
- Do not make inappropriate or negative comments about patients or co-workers in the presence or within the hearing of any customer.

# DOCUMENTING IN THE RECORD

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- Use ball point pen
- **\*\*\*Date and time all entries\*\*\***
- Use name stamp to identify yourself only – **YOU MUST ALWAYS SIGN YOUR NAME** in addition to using your stamp – it is not a legal entry without your signature.
- No Dangerous Abbreviations
- **WRITE LEGIBLY!**
- **When you document sign your name, use your rubber name stamper (or print your name) and, ALWAYS include DATE and TIME on all entries.**

Prescriptions written for **MEDICAID** patients (both non-controlled and controlled substances):

**If written by a resident not yet licensed in New York State - must have the attending name and license or MMIS number.**

# CLINICAL DOCUMENTATION IMPROVEMENT

The purpose of the Clinical Documentation Improvement program is to create a clear picture of the patient's hospital stay to anyone who picks up the chart, to accurately code the chart, and to capture CCs and MCCs that are appropriate for your patient while they are in the hospital.

**CC – co-morbidity/complication.** Impact reimbursement on a chart, justify length of stay, impact mortality rates and increase case mix index.

**MCC – major co-morbidity.** Significantly impact reimbursement and length of stay.

Clinical Documentation Specialists (CDS) do a concurrent chart review on every inpatient in order to clarify documentation for coders. A coder has guidelines they must follow, and cannot code a diagnosis based on what's written in the chart, it must be documented as a diagnosis. For example, if the physician writes "transfuse 2 units of PRBC for low hemoglobin," a coder cannot assume this is acute blood loss anemia. This is an opportunity for a CDS to query.

**Specialists will place a query sticker in the chart such as below:**

Dear Clinician: \_\_\_\_\_ Date: \_\_\_\_\_

If you believe this patient has a systemic infection or response, please document the **specific or suspected diagnosis in the progress notes.**

Examples: Sepsis, Severe Sepsis, SIRS, Septicemia, Septic Shock

The following abnormal test appears on this patient's medial record:

Temp: _____	WBC: _____	BUNs: _____
Respiratory Rate: _____	Hypotension: _____	Heart rate: _____
Hypertemia, pO <sub>2</sub> : _____	Elevated c-reactive protein: _____	Oliguria: _____
Coarctine: _____	Hypoglycemia: _____	Edema: _____
Blood Culture: _____	Altered mental status: _____	Ilex: _____
Other: _____		

← Please respond in the progress notes  Click here if you do not agree with this query

3M  
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Systemic Infection or Response?  
DO NOT REMOVE

You can answer the query several ways – in a progress note, an order or discharge summary. **Do not answer on the sticker**, as they are not a permanent part of the medical record. If you disagree, check the disagree box on the sticker. **Do not remove** the stickers from the chart after you answer them.

# PRESENT ON ADMISSION

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The following conditions are deemed 'preventable' by Medicare. If your patient has any of these conditions on admission, it must be **documented on admission** by the physician. If they develop in the hospital, money will be taken from the hospital.

- **Catheter-associated UTI**
- **Decubitus ulcers**
- **Vascular catheter-associated infection**
- **Mediastinitis after CABG**
- **Hospital-acquired injuries**
- **Ventilator-associated pneumonia**
- **DKA**
- **PE**
- **Staph aureus septicemia**
- **Object left in during surgery**
- **Air embolism**
- **Blood incompatibility**

**Documenting on the H & P** is essential and must be done by the physician, not nursing assessment in order to be considered POA. Please be sure you are aware of these conditions and look for them upon examination and admission of the patient.

# Skin Assessment and Staging

## Lynn Kordasiewicz, MS, ANP - Wound Specialist: P-642-1985

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### Admitting Service is responsible for skin/pressure ulcer documentation

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- STAGE I

- Intact
- Non-blanchable
- Erythema
- Painful
- Temperature change



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- STAGE II

- Intact blister
- Open, pink blister



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- STAGE III

- Full thickness tissue loss
- Subcutaneous level



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- STAGE IV

- Full thickness tissue loss
- Fascia, muscle, bone, tendon
- Devitalized tissue



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- UNSTAGABLE

- Slough or eschar on the surface
- Unable to determine depth of wound
- ESCHAR
  - - dry, intact, without erythema
  - "the body's biological cover"



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- DEEP TISSUE INJURY

- Purple, maroon in color
- Blood filled blister
- Evolution



# WOUND DOCUMENTATION AND PREVENTION

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- **At least once per week**, you need to examine wound, review nursing documentation, indicate if you agree with staging and plan of wound care.
- **Prevent pressure ulcers**
  - Reposition every 1-2 hours
  - Elevate heels off bed
  - Keep skin clean and dry
  - Do not use 100% petrolatum products
  - Contain and/or divert urine/effluent
  - Nutritional consult (protein supplements)
  - Diabetes management (A1c)
  - Minimize edema
- **Document**
  - Treatment/interventions
  - Patient's response
  - Compliance
  - Noncompliant
  - Refusing interventions/treatment/care

## Specificity

- Document the reason for admission; if it's a symptom, document probable/possible cause in differential
- Document every condition impacting patient's stay, including chronic conditions
- Medications and treatments should be linked to a diagnosis
- Acute vs. chronic
- Etiology of condition
- Causative organism in infection/pneumonia
- Degree of severity of illness
- Proper staging of chronic conditions (CKD)
- Accompanying conditions (hemorrhage, coma, heart failure, CKD)
- Benign vs. malignant when neoplasm involved
- Congestive heart failure – specify if it is acute/chronic, systolic/diastolic
- Diabetes – Always specify it simply as CONTROLLED or UNCONTROLLED. Avoid qualifying terms such as “poorly controlled” as CMS considers this controlled, NOT uncontrolled.
- Specify severity of malnutrition
- Every diagnostic test and medication ordered should have a documented diagnosis
- Clinically significant diagnoses from diagnostic reports should be documented in the progress notes
- Arrow, plus signs, and many abbreviations are not sufficient documentation, must use a diagnosis

## Common MCCs

Acute diastolic heart failure	Grand mal seizure
Acute pulmonary edema	Hypovolemic shock
Acute renal failure	Pneumonia
Acute respiratory failure	Quadriplegia
Acute systolic heart failure	Respiratory arrest
AIDS	Sepsis
Anoxic brain damage	Septic Shock
Aspiration pneumonia	Septicemia
Cardiac arrest	Severe malnutrition
Cardiogenic shock	Severe protein calorie malnutrition
Decubitus ulcer stage 3 & 4 <i>present on admit</i>	SIRS
Encephalopathy	Ventricular fibrillation

## Common CCs

Acidosis	Drug dependence, continuous
Acute coronary syndrome (unstable angina)	Drug withdrawal
Acute blood loss anemia	Hemiplegia
Alcohol withdrawal	Hyperkalemia
Alkalosis	Hypernatremia
Cellulitis	Hyponatremia
Chronic diastolic heart failure	Malignancy, and site
Chronic kidney disease – Stage IV or V	Metastasis, and site
Chronic respiratory failure	Morbid obesity, BMI >40
Chronic schizophrenia	Paraplegia
Chronic systolic heart failure	Thrush
COPD, acute exacerbation	UTI

# DISCHARGE SUMMARY

***PLEASE DICTATE THE FOLLOWING:***

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- Today's Date
- Type of Report (Discharge Summary)
- Dictating Physician's Name (First and Last)
- Patient's Name (Spell Fully)
- Medical Record Number
- Admission Date
- Discharge Date
- Inpatient Attending at Discharge
- Admitting Diagnosis (Reason for Admission)
- Chief Complaint
- History of Present Illness
- Allergies
- Medications
- Past Medical History
- Family History
- Social History
- Review of Systems
- Physical Examination
- Laboratory Date (Inc. pending lab data)
- Hospital Course and Treatment
- Procedures Performed
- Condition at Discharge
- Discharge Instructions – include medications, follow-up appt. (name, date, location), diet and activity.

# DOCUMENTATION REMINDERS

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- Patient record entries should be documented at the time the treatment you describe is rendered.
- Authors of all entries should be clearly identifiable.
- Abbreviations and symbols in the patient record are permitted only when approved according to hospital and medical staff bylaws, rules and regulations.
- All entries in the patient records are permanent.
- Do not use H & P forms for consult use – use the Consult Form.
- All originals must stay with the chart.
- Do not rip forms apart.
- Patient identifiers must be on all forms.

# ORDER SETS AVAILABLE ON THE INTRANET

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ACL Reconstruction Post OP Order	ORD.087
Acute Coronary Syndrome - Emergency Care Order Set	ORD.001
Acute Coronary Syndrome Admission Order	ORD.002
Acute Medical Surgical Restriant Order Form	ORD.010
Admission Ischemic Stroke Orders	ORD.091
Admission Order	ORD.003
Adult Induced Hypothermia Status Post Cardiac Arrest Orders	ORD.097
Argatroban Protocol Order Form	ORD.096
Breast Surgery Order Form	ORD.059
Cardiothoracic Surgery 1st Day Post-Op Orders	ORD.020
Cardiothoracic Surgery Admission Order Set	ORD.070
Cardiothoracic Surgery Pre-Operative Orders	ORD.021
Cardiothoracic Surgery Transfer Orders	ORD.083
Chronic Hemodialysis Standing Orders	ORD.068
Community Acquired Pneumonia	ORD.004
Continuity of Care CKD Form	ORD.060
Deep Vein Thrombosis Prophylaxis Assessment and Physician Orders	ORD.054
Department of Psychiatry Admission	ORD.014
Diabetic Ketoacidosis Admission Order Set	ORD.085
Drotrecogin (Xigris) Order Form	ORD.082
ED - Ischemic Stroke Orders	ORD.092
Epidural Analgesia Orders	ORD.016
Erythropoietin Orders (Chronic Hemodialysis Program Only)	ORD.034
Gero - Psychiatry Medical / Surgical Restraint Order Form	ORD.062
Heparin Weight Based Therapy Information Sheet	ORD.039
Intravenous PCA Standard Order	ORD.047
Kidney/Pancreas Transplantation Pre-Operative Orders	ORD.074
Kidney/Pancreas Transplantation Post-Operative Orders	ORD.075
Knee Arthroscopy Post OP Orders	ORD.089
Major Trauma Orders (ED)	ORD.006
Non-Formulary Drug Request	ORD.072
Occupational Blood/Body Fluid Exposure Order	ORD.046
Orthopaedic Post OP / Admission Order Set	ORD.066

# ORDER SETS AVAILABLE ON THE INTRANET (CONT'D)

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Parenteral Nutrition Order	ORD.048
Peripherally Inserted Central Catheter Order	ORD.025
Physician Holding Order Form - Chemical Dependency	ORD.009
Physician Order - Acute Geriatrics Orders	ORD.026
Physician Order - Electrophysiology Post Operative Orders	ORD.018
Physician Order - Electrophysiology Pre Operative Orders	ORD.017
Physician Order - Emergency Department	ORD.007
Physician Order Form - Heart Failure (HF) Discharge	ORD.061
Physician Order Form - Pain Management	ORD.058
Physician Order Form - Pharmacy	ORD.005
Physician Order Sheet - Admission Holding Orders	ORD.013
Post Cardiac Catheterization Orders	ORD.080
Post Procedure Orders - Vascular Access Center	ORD.098
Pre Cardiac Catheterization Orders	ORD.081
Pre Procedure Orders - Vascular Access Center	ORD.099
Pressure Ulcer Orders	ORD.076
Psychiatry Seclusion / Restraint Order Form	ORD.063
Rabies Vaccination (Standing Orders)	ORD.008
Rabies Vaccination Standing Orders - # 1 - 5	ORD.050
Shoulder Arthroscopy Post OP Order	ORD.088
Single Treatment Hemodialysis Order	ORD.035
Standing Order For Administration of Alteplase (TPA) in the Hemodialysis Central Venous Catheter	ORD.030
Stress Test Order Form	ORD.086
Suspected Overdose Admission Order Set	ORD.084
Therapeutic Apheresis Orders	ORD.067
TICU Daily Orders	ORD.042
Total Hip Replacement : Post OP Order Set	ORD.064
Total Knee Replacement : Post OP Order Set	ORD.065
Transient Hemodialysis Standing Orders	ORD.032
Vancomycin Order Form	ORD.100
Venofer Orders (Outpatient Renal Program Only)	ORD.033

# MEDICATION RECONCILIATION

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- is a paper process both for inpatient and outpatient.
- is completed by creating the most complete and accurate list possible of all home medications for each patient and then comparing that list against the physician's admission, transfer, and discharge orders
- is intended to bring discrepancies to the attention of the physician so that changes may be made to the orders when appropriate
- Must be signed by the M.D.
- Medication Reconciliation is a National Patient Safety Goal
- This system leads toward future community efforts to improve home medication list management electronically.
- **Medication errors are one of the leading causes of injury to hospital patients.** and chart reviews reveal that over half of all hospital medication errors occur at the interfaces of care.
- Poor communication of medical information at transition points is responsible for as many as 50% of all medication errors in the hospital and up to 20% of adverse drug events.
- The Medication Reconciliation Form should be completed and signed by the admitting physician. Home medications are documented HERE, NOT in the H & P. By circling YES or NO in the PHYSICIAN ORDERS column and signing form, it also serves as an order for those medications being continued.

# MEDICAL RECONCILIATION FORM MED.011

## MEDICATION RECONCILIATION FORM



Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Med. Rec. #: \_\_\_\_\_ Insurance: \_\_\_\_\_  
 Visit #: \_\_\_\_\_ Service Time: \_\_\_\_\_  
 Service: \_\_\_\_\_

Allergies; Intolerances/Nature of Reaction: \_\_\_\_\_

**INSTRUCTIONS: To initiate the History and Disposition process, list below all of the patient's medications prior to admission including Over the Counter, Vitamins, and Alternative of Herbal medications. New medications or medication changes should be written on admission orders.**

DO NOT USE THESE DANGEROUS ABBREVIATIONS: U, IU µg, QD, QOD, TIW, AS, AD, AU, MS, MSO4, MgSO4, Trailing zero, Lack of leading zero.

Source of Medication list (check all used):

- |  |   |
|--|---|
| <input type="checkbox"/> Patient Medication List     | <input type="checkbox"/> Previous discharge paperwork                   |
| <input type="checkbox"/> Patient/Family Recall       | <input type="checkbox"/> Medication Administration Record from Facility |
| <input type="checkbox"/> Pharmacy _____              | <input type="checkbox"/> Medications brought in from home               |
| <input type="checkbox"/> Primary Care Physician List | <input type="checkbox"/> Other _____                                    |

CHECK HERE IF THIS IS AN ADDENDUM/REVISION OF A PREVIOUSLY COMPLETED MEDICATION LIST

							Physician Orders
	Medication Name (write legibly)	Dose (i.e., mg, mcg, mEq)	Route (i.e., PO, NG, SC, IV)	Frequency	Indication	Last Dose Date/Time	Continue on Admission
1.							Yes No
2.							Yes No
3.							Yes No
4.							Yes No
5.							Yes No
6.							Yes No
7.							Yes No
8.							Yes No
9.							Yes No
10.							Yes No
11.							Yes No

DO NOT ELECTRONICALLY TRANSMIT (fax or scan) OR TRANSCRIBE WITHOUT MD/DO/NP/PA SIGNATURE

Medication History Recorded By: \_\_\_\_\_ Date/Time Recorded: \_\_\_\_\_  
 Signature of MD/DO/NP/PA \_\_\_\_\_ Printed Name \_\_\_\_\_ Date/Time Recorded: \_\_\_\_\_  
 Signature of RN (for transcription or telephone order) \_\_\_\_\_ Date/Time Recorded: \_\_\_\_\_  
 Practitioner taking verbal order wrote and then read back content to MD for validation.  
 Physician Countersign of Telephone Order \_\_\_\_\_ Date/Time Recorded: \_\_\_\_\_

Reviewed on Transfer: By: \_\_\_\_\_ Date/Time Recorded: \_\_\_\_\_  
 Reviewed on Transfer: By: \_\_\_\_\_ Date/Time Recorded: \_\_\_\_\_  
 Reviewed on Transfer: By: \_\_\_\_\_ Date/Time Recorded: \_\_\_\_\_  
 Reviewed on Discharge: By: \_\_\_\_\_ Date/Time Recorded: \_\_\_\_\_

File under Orders portion of Chart. DO NOT THIN FROM CHART.

MED.011



# PROCEDURAL PROGRESS NOTE LGL.060

PROCEDURAL PROGRESS NOTE



Name: \_\_\_\_\_  
 Med. Rec. #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Visit #: \_\_\_\_\_ Insurance: \_\_\_\_\_  
 Service Date: \_\_\_\_\_ Service Time: \_\_\_\_\_ Room: \_\_\_\_\_

**CHECK BOXES AS INDICATED PRIOR TO BEGINNING FOR ANY PROCEDURE REQUIRING CONSENT**

PROMOTE SAFETY BY PREVENTING MEDICAL ERRORS. AVOID DANGEROUS ABBREVIATIONS : USE THESE ALTERNATIVES			
Q.D. : write daily	U : write units	AU : write both ears	MS/MS04/MgS04 : write out drug name
Q.O.D. : write every other day	IU : write international units	AD : write right ear	using trailing zero ie, 2.0 mg : write 2 mg
TIW : write 3 times weekly	ug : write micrograms	AS : write left ear	lack of leading zero ie, 2mg : write 0.2 mg

<b>Step 1</b>	<b>CONSENT</b>	<input type="checkbox"/> Obtained
<b>Step 2</b>	<b>SITE MARKING</b>	<input type="checkbox"/> Site marked with MD initials. <input type="checkbox"/> Not applicable: exceptions include interventional cases for which the catheter insertion site is not predetermined, when either the right or left side is an appropriate approach, cases at the bedside in which the individual doing the procedure is in continuous attendance from the time of decision to perform through consent and completion.
<b>Step 3</b>	<b>TIME OUT</b>	Time out using active communication verbal confirmation of the : <input type="checkbox"/> Patient <input type="checkbox"/> Site <input type="checkbox"/> Side <input type="checkbox"/> Procedure <input type="checkbox"/> Correct position <input type="checkbox"/> Necessary equipment / implants <input type="checkbox"/> Radiographic images

\_\_\_\_\_  
 PHYSICIAN/CREDENTIALLED IV NURSE SIGNATURE

\_\_\_\_\_  
 STAMPER OR PRINT NAME

\_\_\_\_\_  
 DATE/TIME

**Site Preparation**  None  Hair removal with clippers  Site scrub with \_\_\_\_\_  Other \_\_\_\_\_

**Procedure:** description of procedure, indicate anesthesia administered, # of attempts, etc.

---

**Findings/Results**  Not applicable

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**Specimens removed**  Not applicable

---

**Post Procedure Diagnosis**

---

**Condition of Patient**

---

**Post-procedural Plan/Comments**

Rev. 1/09  
 # 0622416

\_\_\_\_\_  
 PHYSICIAN/CREDENTIALLED IV NURSE SIGNATURE

\_\_\_\_\_  
 STAMPER OR PRINT NAME

\_\_\_\_\_  
 DATE/TIME

LGL.060



# Selling Soap

By STEPHEN J. DUBNER and STEVEN D. LEVITT  
The Petri-Dish Screen Saver

*In one Australian medical study, doctors self-reported their hand-washing rate at **73 percent**, whereas when these same doctors were observed, their actual rate was a paltry **9 percent.***

**Washing your hands every time you enter and exit a patient room is the single, most effective way of preventing hospital infections for you and your patients**

# ALL SURFACES IN A PATIENT ROOM ARE SUSCEPTIBLE TO CONTAMINATION!

---

## *The Inanimate Environment Can Facilitate Transmission*



~ Contaminated surfaces increase cross-transmission ~

Abstract: The Risk of Hand and Glove Contamination after Contact with a VRE (+) Patient Environment. Hayden M, ICAAC, 2001, Chicago, IL.

# SHARP INJURY PREVENTION

---

- Eliminate the use of unnecessary needles and sharps.
- Properly dispose of sharps in appropriate puncture resistant containers.
- Maintain constant communication with those in the area when sharps are used.
- Use safety devices - alter user technique to promote safety
- **If you are stuck by a contaminated needle,** housestaff are to report to Personnel Health on the ground floor 8:00 a.m. to 5:00 p.m. or the Emergency Room after hours for appropriate treatment.
- State law protects the rights of THE PATIENT. You may not have legal rights to know the status of your patient so the best protection is PREVENTION.

# ARE YOU PLANNING TO SEND A CENTRAL CATHETER TIP FOR CULTURE?

---

**Don't** send a catheter tip for culture unless a catheter-related infection is clinically suspected; in most cases you should have sent blood cultures already. Culturing a tip is NOT standard procedure if you are just removing a line because you are done with it.

Disinfect the skin around the exit site before removing the catheter. You can use an alcohol wipe for this.

Cut off a generous length of the catheter (at least 5 cm) with sterile scissors and drop it into a sterile specimen container.

## Over Attentive Families May Be Underrated

By David A. Shaywitz, M.D.

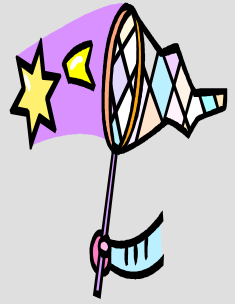
- September 19, 2006

It's every physician's fear: the patient with the "involved" family, relatives who watch over everything, question everybody and make a nuisance of themselves. Yet, in today's world of rapid-fire medicine, such relatives may be a patient's most important advocates

...The most effective families, it seems to me, are those who genuinely appreciate the efforts of frequently overwhelmed health care providers and who seek to work with them to help care for their relatives. At the same time, as a concerned family member, you may know the patient better than anyone else, and if you see something that doesn't seem right, speak up. The doctors may not thank you, but perhaps they should.

# FALL REDUCTION PROGRAM

## “CATCH A FALLING STAR”



- Patients assessed using the Hendrich II Assessment Tool
- Risk Assessment in the EMR under Care Trends (Safety Panel) – Score of 5+
- Patient assessed as a 5+ risk will be issued a **white wristband with red stars** Outpatients – star affixed to front of chart
- If ordering restraints, you must **document your assessments.**
- Please be careful with sedation medications and assess patients for fall risk accordingly.
- **Make sure you return any side rails after examining patients.**

# RISK MANAGEMENT

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**Your contact at ECMCC**

**Ann Victor-Lazarus, MS, RN,  
CPHRM  
Vice-President of Patient  
Advocacy  
Pager: 642-1454**

**Ethics Consults  
(any issues with advanced  
directives or limitation of  
treatment)  
Diane Bookhagen  
Pager - 642-7177**

# REPORT ALL INCIDENTS!

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If something adverse occurs, **we want to know about it.**

**Improvement begins with you** – report all incidents to the Hotline (4749) or ask someone to input into **Quantros** (electronic reporting system)

## **You may use the Incident Hotline 898-4749**

### ***When reporting, please include :***

- patient name
- medical record number
- date/time of event
- unit/area it occurred
- Details of event

If you are comfortable, include your name and contact information so we can get back to you.

### ***Examples of Reportable Incidents:***

- Missed orders
- Disruptive behavior
- Falls
- All patient safety events (something that did or could injure your patient)
- Any process improvement opportunities
- Adverse drug reactions
- Delays in patient care
- All medical errors

**DO THE RIGHT THING FOR ECMCC**

**WHEN YOU SUSPECT:**  
 VIOLATIONS OF LAWS, REGULATIONS, RULES  
 FRAUD OR ABUSE  
 ETHICAL OR LEGAL VIOLATIONS  
 QUESTIONABLE BILLING OR REIMBURSEMENT  
 CONFLICT OF INTEREST POLICY VIOLATIONS  
 OTHER COMPLIANCE CONCERNS

**CALL THE COMPLIANCE HOTLINE**  
**1 - 716 - 898 - 5555**  
 24 Hours / 7 Days

**ECMC**

ecmc.edu Not just a place to work... A Community of Caring

You may see these Signs around ECMC

**Your Contact for  
 Corporate Compliance Issues**

**Maryann O'Brien, MS, RHIA**

**Director of Corporate Compliance**

**898-4595**

**[mobrien@ecmc.edu](mailto:mobrien@ecmc.edu)**

**ECMCC Corporate Compliance Program  
 Located on ECMCC Intranet**

<http://home.ecmc.edu/depts/corpcom/documents/CorporateComplianceProgram.pdf>

**COMPLIANCE HOTLINE  
 898-5555**

**HIPAA**  
***CONFIDENTIALITY IS***  
***ESSENTIAL***

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**NO CAMERAS MAY  
BE USED TO  
PHOTOGRAPH PATIENTS  
OR PROCEDURES  
WITHOUT CONSENT.**

# POLICY AND PROCEDURES AND MEDICAL DENTAL STAFF WEBPAGE

## Use Internet Explorer off the Novell Screen

**ECMCC Intranet** 

Today is: Friday, November 14 | [Employee Handbook](#) | [Employee Search](#) | [ECMC Directory](#) | [Market Café Menu](#)

**Services**

- [Erie County Web](#)
- [Ethics Committee](#)
- [E-Forms](#)
- [HIPAA](#)
- [Managed Care](#)
- [Managers Survival Guide](#)
- [Medlink](#)
- [Pastoral Care](#)
- [Policies and Procedures](#)
- [Quality and Patient Safety](#)
- [Web Form - 359](#)

**Departments**

- [Corporate Compliance](#)
- [Emergency Preparedness](#)
- [Finance](#)
- [Food and Nutrition](#)
- [Health Info. Management](#)
- [Hospital Info. Systems](#)
- [Human Resources](#)
- [Infection Control](#)
- [Laboratory Medicine](#)
- [Medical / Dental Staff](#)
- [Nursing Education](#)
- [Pharmacy](#)
- [Radiology](#)
- [Renal Services](#)
- [Security - MSD'S](#)

The Erie County Medical Center Corporation is dedicated to being the medical center of choice through excellence in patient care and customer service.



We welcome your suggestions for improving the ECMC Intranet. Should you have any comments about this site's content, please click on this [Feedback Form](#) to send your ideas to the ECMC Intranet Committee. For **Telephone Directory changes** contact the **Help Desk @ 344777**.

[Comments or Suggestions?](#)

Erie County Medical Center Corporation

# NEW YORK STATE INMATE PATIENTS REMINDERS

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- Wende Correctional Facility security coverage can be contacted in the 9th floor lockup at ext. 3863 or 937-4000, ext. 5200 off hours.
- Dept of Corrections security officers must be able to maintain visual contact with their inmate patients at all times. They are bound by confidentiality rules.
- Do not advise an inmate patient of the date of a scheduled procedure; follow up visit, admission or discharge.
- Do not leave any medical tools or equipment within reach of an inmate patient. Be aware of what you have in your lab coat/shirt pockets. Inmate patients may use these items to cause injury to you or others.
- Pagers, cell phones, syringes, scissors, percussion hammers and other sharp objects are coveted items.
- Please check for your belongings after examining an inmate patient and immediately report any suspected loss to security personnel.
- Do not share any personal information with an inmate patient.
- No items are to be given to or received from an inmate unless approved by the security staff.
- Do not make personal phone calls or send emails on the behalf of an inmate.
- Medical staff may share medical information with the inmate patient's family utilizing the same privacy regulations employed when communicating with the families of non-prisoner patients.
- Inmates who are admitted to ECMC may have visitors and must be approved by the DOC security staff.

# ORDERING HOME CARE SERVICES

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- **Wound Care Orders** must be written to include site, cleansing of wound, treatment, and frequency. Also prescriptions for supplies must be written. Any BID patients that that will not be discharged by 3:00 p.m. must have their treatment done prior to leaving and will start in the morning to ensure staff safety.
- **Foley Care** - there must be a specific order for changing and/or irrigation including size of catheter and balloon, and frequency of foley change.
- **Q12H Injectable Meds** including Lovenox - order for BID if possible.
- **Diets** must be specific - simply stating “renal, diabetic, and cardiac” does not meet homecare regulations.
- **Diabetics** - order frequency of FSBS with glucometer and high and low parameters for when MD should be called. Scripts for glucometer, strips, lancets, and alcohol wipes need to be written. If 4:00 p.m. FS is needed, if patient is not discharged by 3:00 p.m., the 4:00 p.m. BS must be done prior to discharge and the agency will see the patient in the morning.
- **Insulin** - please write scripts for insulin and insulin syringes.
- **Lantus Insulin** - as per the manufacturers package insert, “Lantus may be administered at anytime during the day. It exhibits a relatively constant glucose-lowering profile over 24 hours that permits once daily dosing.” Therefore, orders for Lantus insulin should be written for daily rather than q hs to ensure staff safety.
- **IVAB/HAL** - please be sure patient has PICC line in place as peripheral IV’s are acceptable only in rare instances. Orders for drug must be written early AM so arrangements for nurse and supplies can be made. IV cases will not be accepted for start of care the same day as discharge if orders are not received by 2:00 p.m. Also please note that community pharmacies will not dispense IV meds if patient does not have insurance. If patient has Medicare only, patient is responsible for the drug which must be paid for upfront. SN, Behavior SN, PT, OT, HHA, MSW, and Dietician services are available.  
Discharge Planning can assist finding services in all counties

# MOLST

## There is a new Advance Directive form in New York State!

The **Medical Orders for Life-Sustaining Treatment (MOLST)** Program is designed to improve the translation of patient goals into medical orders that are valid for both pre-hospital and hospital professionals. MOLST helps physicians, nurses, health care facilities and emergency personnel honor patient wishes regarding life-sustaining treatments. MOLST began as a pilot program in Monroe and Onondaga Counties in 2006 following the passage of State legislation allowing EMS providers the ability to honor the MOLST form in lieu of the New York Non-Hospital DNR Form. During the pilot it became clear that the MOLST not only is a suitable replacement for the previous DNR form, but enhances patient care for the entire health care community: from prehospital, to emergency department, to hospital and skilled nursing facility care.

Fortunately, MOLST became valid statewide this summer thanks to the support of the Legislature and the Governor's office who authorized its use in the prehospital and hospital settings.

The MOLST form is a four page, 11x17" folded document with eight sections printed in **bright pink** – perfect for alerting staff of its importance. Importantly, copies and facsimiles of the MOLST form are acceptable and legal, so be sure to look for white copies in the transfer paperwork as well. Although it is recommended that the MOLST form be reviewed and renewed every 7 days in a hospital setting, every 30 days in a skilled nursing facility, or every 90 days in a nonhospital or community setting, the order remains valid and must be followed even if it has not been reviewed in this recommended time period.

Under New York State law, the MOLST should be considered valid unless it is known to have been revoked.

The six sections of the MOLST form include the following:

- Section A: Resuscitation Instructions
  - Identifies the resuscitation status for the patient in Cardiopulmonary Arrest. There are two options: DNR with no CPR, endotracheal intubation or mechanical ventilation; or full resuscitative efforts.
- Section B: Consent for DNR Status
  - Consent may be provided by the patient, a Health Care Proxy Agent, or a surrogate decision-maker in accordance with NYS Public Health law.
- Section C: Physician Signature
  - Authorizes the order in Section A. This section must be signed (no signature stamps) by a New York State licensed physician in order to be valid.

**MOLST Form with Patient/Resident/Whichever Transferred or Discharged**  
**Supplemental Documentation Form for ADULTS**  
For the Non-Resuscitative (DNR) Orders  
For MOLST Program  
Medical Orders for Life-Sustaining Treatment  
The Non-Resuscitative (DNR) and  
Other Life-Sustaining Treatments (LST)

Complete all Sections that apply.  
Section 1: Adult Patient/Resident/Whichever Lacks Capacity to Consent  
Section 2: Exempted Circumstances  
2.1: Inpatient/Outpatient  
2.2: Medical Setting and No Scenarios  
2.3: Residents of DNR and DNR/OLST Facilities  
2.4: Residents of Correctional Facilities

Section 3: Physician Signature

**Section 1**  
**Complete Steps 1-3 for adult patients/whichever who lack capacity to consent:**

**Step 1: Physician determination of lack of capacity:**  
1. I have performed a physical examination and reviewed the patient's medical history and determined that the patient lacks the ability to understand and appreciate the nature and consequences of a DNR order, including benefits and risks of such an order, and to make a free and informed decision regarding the order. (Check all that apply.)  
a. Probable duration: \_\_\_\_\_  
b. \_\_\_\_\_

**Step 2: Patient/Resident notice of the determination that he or she lacks capacity:**  
(Check one)  
a. I have provided this notice because the patient/resident lacks and gives no indication of the ability to comprehend the nature and consequences of the order and lacks the ability to make a free and informed decision.  
b. I have provided notice about lack of capacity directly to the patient/resident.

**Step 3: Physician determination of lack of ability for cardiopulmonary resuscitation:**  
This step is a **prerequisite** of consent for ACP or any health care agent.  
a. I have performed a physical examination and reviewed the patient's medical history and determined that the patient lacks the ability to understand and appreciate the nature and consequences of a DNR order, including benefits and risks of such an order, and to make a free and informed decision regarding the order. (Check all that apply.)  
b. I have examined the patient/resident and his/her medical record, and have determined to a reasonable degree of medical certainty that: (Check all that apply.)  
1. The patient/resident is terminally ill/conditioned.  
2. The patient/resident is permanently unconscious.  
3. Resuscitation would be medically futile.  
4. Resuscitation would impose an extraordinary burden on the patient/resident in light of the patient/resident's medical condition and the expected outcome of resuscitation.

# MOLST

- **Section D: Advanced Directives**  
This identifies if there are additional advanced directives available for the patient, to include a Health Care Proxy, Living Will, or other written documentation. It is strongly recommended that copies of these materials be attached to the MOLST form. However, if one of these boxes is checked, the provider may want to carefully review the accompanying stack of paper that came with the patient.
- **Section E: Orders for Other Life Sustaining Treatment and Future Hospitalization**  
This section details what types of advanced measures are requested and covers the entire second page. Treatment guidelines indicate if the patient desires comfort measures only, limited interventions, or full interventions and includes guidelines for transfer from an institution such as a skilled nursing facility. Intubation and mechanical ventilation instructions include the patient's desire for intubation as well as whether they would be willing to attempt a trial period of intubation and ventilation or BiPAP/CPAP, or if they wish intubation and long-term ventilation. Sections detailing wishes for artificial hydration and nutrition, the use of antibiotics, and a free text area are available to include other instructions not already specified.
- **Section F: Renew/Review Instructions**  
This section includes the entire third and fourth pages and offers space to indicate the date and outcome of the most recent review of the MOLST. This is an important area to review to ensure that no changes, additions, or discontinuations of the order have occurred since its initial authorization.

**The members of the Erie County Medical Center's Ethics Committee are available to assist you with any questions and concerns. Their on-call schedule is available on the Intranet or by calling the hospital operator.**

MOLST: Supplemental Documentation Form for Adults must be completed by a physician and a concurring physician only when an adult patient lacks capacity (the ability to make health care decisions) to consent for himself or herself or under exceptional circumstances. These exceptional circumstances include:

- *Therapeutic Exception* – when an individual with capacity would be harmed by a discussion of Do Not Resuscitate.
- *Medical Futility* – when CPR would be ineffective given the individual's condition and the individual has no appointed surrogate (the health care agent or proxy).  
When the individual is a resident of a care setting administered by the Office of Mental Health or Office of Mental Retardation and Developmental Disabilities facilities.
- When the individual resides in a correctional facility.

**MOLST: Supplemental Documentation Form for Minors** is completed for patients/residents under 18 years old who are not married and/or are not a parent, the Patients/residents under 18 who are married and/or are parents are treated as adults under New York State law. A lawyer should be contacted if there is any uncertainty about the situation.

Still yearning for more?

The website [www.compassionandsupport.org](http://www.compassionandsupport.org) offers providers a wealth of information on the MOLST form. The site includes two training videos offering a review of the use of the document and can result in 2 hours of AMA Category 1 CME upon successful completion of the post-test. A separate, robust training resources page offers a wealth of material including training manuals, sample documents, patient and family educational materials, FAQs, and numerous other references.

# MICU Patients

## General Considerations:

An intensive care unit provides services that include both advanced monitoring and intensive treatment. The goals of care are to provide the highest quality of care for critically ill patients and promote the desired outcomes for both individual patients and society. To this end, during times of high utilization, patients requiring intensive treatment (Priority 1) should be given priority over patients requiring monitoring (Priority 2) and terminally or critically ill patients with a poor prognosis for recovery (Priority 3). Whenever possible objective measurements of severity of illness and prognosis should be used when determining priority for admission.

**Priority 1 patients:** comprised of critically ill, unstable patients in need of intensive treatments and generally have no limits placed upon the extent of therapy they are to receive.

**Priority 2 patients:** require the advanced monitoring services of an intensive care unit. They are at risk for the need for immediate intensive treatment and therefore benefit from intensive monitoring tools. They too generally have no limits placed on the extent of therapy they are to receive.

**Priority 3 patients:** critically ill, unstable patients whose prior health status, underlying disease, or acute illness, either alone or in combination, severely reduces the likelihood of recovery and/or benefit from ICU treatment. They may receive intensive therapy to relieve acute illness but therapeutic efforts may stop short of measures such as intubation or CPR.

## The following types of patients are generally not appropriate for ICU admission:

1. Patients designated to not receive aggressive life-sustaining therapy with goals of comfort care primarily.
2. Patients in persistent vegetative state
3. Physiologically stable patients who are at statistically low risk of requiring ICU treatment

## MICU Admission Criteria

### PULMONARY DISEASE (MICU)

1. Acute respiratory failure:
  - a. Intubation and mechanical ventilation
  - b. Non-invasive ventilation >12hours/day
2. Acute decompensated gas exchange:
  - a. Expanded A-a gradient Needs  $FiO_2 > 60\%$  for  $SpO_2 \geq 90\%$
  - b. Hypercapneic acidosis  $pCO_2 \geq 55$  with  $pH \leq 7.32$
3. Dyspnea/tachypnea/hypopnea:
  - a. Cyanosis or diaphoresis
  - b.  $RR \geq 30$  or  $< 10$
  - c. Accessory muscle use/abdominal paradox
  - d. Requires frequent vital signs or pulmonary hygiene more than Q4 hourly
4. Neuromuscular weakness/disorders manifest by:
  - a. Rapidly declining FVC or acute FVC  $< 15$  ml/kg
5. Unstable airway:
  - a. Stridor/laryngospasm
  - b. Unable to protect airway
  - c. Frequent attention by staff to clearance of secretions
6. Massive hemoptysis ( $> 300$  ml/12 hours)

# MICU Patients (Cont.)

## **CARDIOVASCULAR DISEASE (MICU)**

1. Post cardiopulmonary arrest
2. Circulatory shock (any form):
  - a. SBP <90 mmHg or MAP decline by 40 mmHg
  - b. Oliguria (<0.5 ml/kg/hr)
  - c. Altered mental status
  - d. Lactate >3
  - e. Needing invasive hemodynamic monitoring
  - f. Needing vasoactive medication infusion
  - g. Need for complex fluid management
3. Accelerated or malignant hypertension:
  - a. Symptomatic (headache, seizures, encephalopathy, CHF)
  - b. Vasodilator infusion or frequent intermittent IV pushes to control
4. Acute arrhythmia requiring:
  - a. Titration of continuous infusion to manage
  - b. Temporary transcutaneous or percutaneous pacemaker
5. Acute severe aortic disease:
  - a. Dissection
  - b. Rupture

## **NEUROLOGIC DISEASE (MICU)**

1. Acute intracranial disease (CVA, SDH, ICH, SAH, etc):
  - a. Frequent “neuro” checks required ( $\geq$  Q4 hourly)
  - b. Osmotic diuresis required
  - c. ICP monitoring needed
  - d. External ventricular drain needed
  - e. Thrombolytic therapy initiated
  - f. GCS severely impaired or rapidly declining
2. Acute severe encephalopathy or delirium:
  - a. Requiring restraint
  - b. Requiring frequent IV intermittent sedatives/tranquilizers or by continuous infusion
  - c. Airway protection severely in question
3. Status epilepticus
4. Neuromuscular disease:
  - a. See Pulmonary Disease section
  - b. Frequent management of oropharyngeal secretions more than Q4 hourly
5. The brain dead patient under consideration for organ donation

## **GASTROINTESTINAL AND HEPATOBILIARY DISEASE (MICU)**

1. Acute/active bleeding evident:
  - a. Frequent monitoring of H/H required more frequently than Q6 hourly
2. Acute liver failure:
  - a. Moderate encephalopathy
  - b. Coagulopathy (INR>2) with bleeding
  - c. Oliguria despite fluid resuscitation
3. Severe pancreatitis:
  - a. Major fluid sequestration
  - b. “Acute” abdomen
  - c. Oliguria/acute kidney injury
  - d. Expanded A-a gradient
  - e. Transfusion requirement >2 units PRBC over 12 hours
4. Peritonitis/acute intra-abdominal catastrophe
  - a. Major fluid sequestration
  - b. Septic syndrome (organ dysfunction)

# MICU Patients (Cont.)

## **TOXIC – METABOLIC DISORDERS (MICU)**

1. Renal failure (acute or chronic):
  - a. Severe hyperkalemia or acidemia
  - b. Significant symptomatic fluid overload
  - c. Pericarditis or arrhythmia
  - d. Need for continuous renal replacement therapy
  - e. Peritoneal dialysis requiring frequent exchanges Q4 hourly or more (assoc. with hypertension)
2. Acute symptomatic endocrine disturbance:
  - a. Metabolic and systemic evidence of or at significant risk of organ compromise
  - b. Treatment program evolving
3. Acute severe symptomatic electrolyte disturbances:
  - a. At substantial risk for or with evident compromise of organ function
  - b. Treatment program in evolution
4. Acute symptomatic toxidrome or drug poisoning:
  - a. Either intentional/suicidal or inadvertent
5. Adverse drug reaction eg NMS, anaphylaxis
6. Use of current or future specialized medications requiring close observation because of potential side effects or adverse effects associated with their use.

## **ENVIRONMENTAL DISORDERS (MICU)**

1. Near drowning
2. Electrical injury
3. Hyperthermia
  - a. Environmental
  - b. Malignant
  - c. Drug-related
4. Accidental hypothermia
  - a. Arrhythmias
  - b. Altered sensorium
  - c. Temp <95 degrees F
5. Severe symptomatic environmental allergy

## **SPECIAL CONSIDERATIONS for the MICU**

1. DNR patients may be admitted to the ICU as interventions specific to the ICU but short of life support may be required to treat these patients.
2. The ICU shall accept borders from other ICU services according to the needs of each unit upon request when the respective ICU is over capacity. It will be assumed that the patient has met appropriate criteria for admission to that unit. Once a bed becomes available, the patient will be transferred to the "parent" ICU or if the patient meets discharge criteria there should be a prompt plan for transfer out.
3. Patients with other medical disorders not listed within the prior described categories shall be considered for admission with documentation of demonstrated need and acceptance will be the prerogative of the Chief of the ICU or hi/her designee.

# Phone Numbers

<b>AREA/UNIT MANAGER</b>	<b>PHONE</b>	<b>FAX</b>	<b>MANAGER</b>
<b>7 North - Mary Molly Shea (701-30)</b>	4844/4831	6145	3084
<b>7 South - JoAnn Wolf (751-80)</b>	4363/4364	6214	6284
<b>8 Zone 1 Sonja Melvin (866-880)</b>	3672		5730
<b>8 North - Peggy Cieri</b>	3614/3615	6144	4551
Rehab	5806/5458		
<b>9th Floor - ACC (Linda Morgan)</b>	3685		
<b>9 - Zone 1 - Ann Marie Gallineau</b>	3687/5459		5051
<b>9 - Zone 2 - Linda Morgan</b>	3621/4409		5455
<b>9 - Zone 3 - Ann Marie Gallineau</b>	3627/3650		
<b>9 - Zone 4 - Ann Marie Gallineau</b>	4206		5051
<b>10th Floor - Patricia Kiblin</b>			4376
<b>10 - Zone 1 (AGS)</b>	3605/3639	6142	
<b>10 - Zone 2</b>	3606/4361	5364	
<b>11 Zone 2 (Psych) - Laurel Carroll</b>	3592		4832
<b>11 Zone 3 - Denise Lee-Abbey</b>	4350		4901
<b>11 Zone 4</b>	3740		
<b>12th Floor</b>	3663		
<b>12 Zone 1 (CCU) - Virginia Leyh</b>	3661/3714	4864	3665
<b>12 Zone 2 (Rm 1251-65) - Beth Moses</b>	3667/4831	5062	4552
<b>12 Zone 3 (Rm 1216-30) - Sonja Melvin</b>	3672	5083	5730
<b>CPEP - Ann Marie Gallineau</b>	3465/3389		5051
<b>Critical Care Units</b>			
<b>Trauma ICU - Melinda Lawley</b>	6171/3344		5267
<b>Cardiothoracic - Lisa Hauss</b>	3354/3355		4571
<b>Burn Unit</b>	5231/5232		4378
<b>MICU - Tim Kline</b>	3673/3674		3666
<b>Operating Room - Jim Turner</b>			6211
<b>OR Reception Desk</b>	4315		
<b>OR Staff Lounge</b>	3553/3555		
<b>OR Recovery Room</b>	4101/3348		
<b>OR Scheduling</b>	4039		
<b>One Day Surgery</b>	3654/4315		
<b>OR Main Desk</b>	4315		
<b>Drs. Messages</b>	4110		
<b>OR Preadm./Tests/Surg Holds</b>	4110		
<b>Department of Medicine Education</b>			
Shirley	3897	3074	
Student/Resident Coordinator	5509		
Andrea	5210		
Lydia	4806		
Chief Medicine Resident	4924		
General Phone Numbers			
Administration	3149		
Admissions	3908/3153		
AIS/SIU	3471		
ARIS (Rehab)	4628		
Adverse Drug Reporting	4000		
Autopsy	3520		

# Phone Numbers

AREA/UNIT MANAGER	PHONE	FAX	MANAGER
Bacteriology	3532		
Biochemistry	3532/3442		
BioMed	3832		
Blood Bank	4182/4177		
Blood Gas	4184		
Cardiology Consults	5424	0 for On Call Schedule	
Niagara Frontier Heart	5424		
Cath Lab	3386		
Cleve Hill Family Health Ctr	831-8612		
Code Blue/Code Stroke	4545		
Cytology	4123		
Dent Towers (AMS)	961-9900		
Dietary	3559/3210		
Doctors Dining Rm (2nd fl caf.)	4102		
Dopplers	5238		
ECHO	3388		
EEG	3371		
EKG	3388		
Exigence Hospitalists	6995	642-7051	
GI Office	3391		
Help Desk (IT)	4477		
Hematology	4063		
Hemophilia Center	3331		
HIV Testing	4119		
Human Resources	3633/2538		
Immuno Service	4119		
Infection Control	3628		
Information (Patient)	3267		
Int. Med Clinic (Primary Health)	3334/3152		
IV Team	4273		
Library	3939		
<b>Microbiology</b>	3532		
	<i>Serology</i>	4138	
	<i>Microbiology</i>	5956	
	<i>Parasitology</i>	3535	
	<i>Virology</i>	4211	
Medicine Consult	4197	0 for On Call Schedule	
Medical Dental Staff	4656		
Medical Director - Dr. Murray	3936		
Medical Examiner	3191		
<b>Medical Records</b>	3190		
	<i>Incomplete Records</i>	5176	
	<i>Old Medical Records</i>	3917	
	<i>Transcription</i>	4811	
Morgue/Hospital	3520		
Neurology Consults	3638	0 for On Call Schedule	
Neuropsych Evals	4905		
Nuclear Medicine	3383		
Outer East Side Pharmacy - 1500 Broadway	891-2015		
Pastoral Care	3357/3356		

# Phone Numbers

AREA/UNIT MANAGER	PHONE	FAX	MANAGER
Pathology	3117/3512		
Patient Advocate - Diane Bookhagen	4155		
Personnel Health	3300		
<b>Pharmacy</b>	3925/3926		
Staff Pharm Line	3286/3282		
MetCare/Lobby	332-2866		
Pulmonary Consults	827-1616		
Radiology	3446/3416		
X-Ray Reports	4031		
CT	4040/3420		
Ultrasound	3774/5294		
Angio Reading	4046		
ED X-Ray	3433		
MRI	5999		
<b>Rapid Response Team</b>	8888		
<b>Rehabilitation</b>	3235/3217		
Physical Therapy	3904		
PT Hydro	3902		
Speech	3212		
OT	3225		
Renal Office	4803		
Respiratory	3245		
Security	3506/3505		
Serology	4138		
Skilled Nursing	3680/3583		
Social Work/DC Planning	3360		
Toxicology	3821/3442		
TV Hostess	3278		
Urinalysis	4056		
Vascular Lab	5238		
<b>Triage</b>	3458/3161	5140/5660	
<b>Med/Surg POD</b>	4166/4167		
	3401/4880		
<b>Trauma Corridor</b>	3853		
	EXT	PAGER	
<b>CASE MANAGERS</b>			
Theresa Ball - SURGERY	4262	642-9222	
Terry Makson - Med A	5848	642-9218	
Sue Montesano - Med B	3321	642-9230	
Holly Martin - Med C	5833	642-2917	
Vanessa Gray - Med D	4521	642-9229	
Judy Haynes - Med E	5841	642-2427	
Joanne Stoneman - Immuno	4387	642-9300	
Chris Krol - Ortho		642-5964	
Kitty Gazda - Director, Care Management	3834	642-4339	

