East Jefferson General Hospital

Medical Staff Orientation Manual
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MISSION STATEMENT

East Jefferson General Hospital, community owned, provides the highest quality, compassionate healthcare to the people we serve.

VISION STATEMENT

East Jefferson General Hospital will be the region’s healthcare leader, providing the highest quality care through innovation and collaboration with our team members, medical staff, and community.

VALUES

Quality
We commit to quality in everything that we do, through achievement and innovation, always contributing to excellent care and patient satisfaction.

Integrity
We uphold the highest standards of behavior encompassing fairness, trust, respect, and ethical practices.

Collaboration
Teamwork is the key to our success. Working together, we ensure everyone benefits from our collective wisdom.

Continual Improvement
We embrace and encourage creativity and innovation, as well as ongoing self-evaluation of our processes and outcomes.

Compassion
By our thoughts, words, and deeds, we create and maintain a caring, compassionate environment.

Stewardship
We are accountable to make wise use of time, skills, and resources.

Service Statement
Providing care and comfort is our highest mission.
We pledge to our guests and each other:
The finest in personal service
Courtesy and respect
A satisfying experience
GOVERNING BYLAWS

A copy of the East Jefferson General Hospital Medical Staff Bylaws is available for download from the East Jefferson General Hospital MD Portal at https://ejmd.ejgh.org/ or by calling Medical Staff Services at 504-454-5641.

MEDICAL STAFF EXPECTATIONS AND RESPONSIBILITIES

STANDARDS OF BEHAVIOR FOR MEDICAL STAFF
A copy of the East Jefferson General Hospital Standards of Behavior for Medical Staff is available for download from the East Jefferson General Hospital MD Portal at https://ejmd.ejgh.org/ or by calling Medical Staff Services at 504-454-5641.

HEALTH INFORMATION MANAGEMENT

Every medical record entry must be dated, timed, authenticated, and must be legible.

History and Physical Documentation
- An H&P must be dictated by the attending practitioner no more than 30 days prior to, or within 24 hours after, registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services.
- An H&P Addendum is required to document any changes in the patient's condition within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services if a medical history and physical examination was completed within 30 days prior to registration or inpatient admission.

Operative Report Documentation
- All operative/invasive procedure reports must be dictated within 24 hours of the procedure, surgery suspension is applied at 48 hours.

Consent Documentation
- Informed consents should be filled out completely prior to the procedure and include the date and time of completion.

Verbal Orders
- Verbal orders should only be used in emergent cases and must be authenticated within 48 hours from the date the order was given.

Abbreviations
- Do NOT Use Abbreviations per The Joint Commission are not acceptable abbreviations to use in EJGH medical records: qd, qod, u, IU, .65mg (leading decimal), 1.0mg (trailing zero), MS, MSO4, MgSO4.
- Jablonski’s Dictionary of Medical Acronyms & Abbreviations has been approved as the official list of abbreviations, which may be used for medical record documentation. Please refer to policy Doc-28, Charting Abbreviations.

Suspension Process
- An 8-14 day letter is sent out to all physicians, by the Health Information Management Director, with delinquencies between 8-14 days from discharge date.
- A preliminary letter is sent out to all physicians, by the Medical Director, with delinquencies between 15-21 days from discharge date.
- Automatic suspension is applied at day 22, without additional notification.

HIM Inbox
- For any orders that are placed in your inbox incorrectly, please forward them to the HIM Inbox with the reason why you are rejecting the order.
Unbilled Charts

- Unbilled charts are those that cannot be coded and billed due to missing documentation. If you receive notification, either by phone or letter, that you have unbilled charts, please make sure to complete this documentation as soon as possible.

Transcription/Dictation

- Please refer to the dictation instructions. The back-up line may be used when in-house dictation is unavailable.
- Enter entire FIN if possible. If not possible, dictate as much identifying information as possible (name, dates, etc.).
- If you are dictating an H&P before the patient has been registered, please contact the HIM Department to send a copy of the final report to scheduling. An H&P is needed in order to schedule, but the report cannot be placed into the encounter until it has been created by scheduling.
- To record the dictation from a dictation phone, hold down the “D” on the side of the handset.
- Please do not use cell phones for dictation; voice quality is not as clear.
- Identify yourself at the beginning of every dictation.
- Spell out hyper/hypo, new drugs, or sound alike medications.
- Modifications can be made to a report from your inbox before authenticating the report.

Teaming for Documentation Integrity (TDI)

- Clinical documentation specialists review the chart for supporting documentation for treatment being provided.
- Queries are left on the chart and/or faxed to the office for the physician if additional documentation is needed.
- Please document your response to queries on the progress note provided and not on the query itself as it is not part of the permanent medical record.
- Please call the nurse if you have any questions.

Help Desk/Passwords

- If you need any passwords reset, please call the Help Desk at 454-4847, or 4847 (in-house). You may need to give them your dictating ID number for verification.

NOTICE OF PRIVACY PRACTICE

East Jefferson General Hospital will make its Notice of Privacy Practices (N OPP) available to patients. The hospital will inform patients of their rights and the hospital’s duties regarding the use and disclosure of Protected Health Information (PHI) and document the patient's receipt of the notice.

- The notice will be provided at the first service delivery subsequent to the effective date of the Privacy Standards, April 14, 2003 or if the patient’s condition prevents, as soon thereafter as reasonably possible. A copy does not need to be provided again unless there has been a material change since a previous documented receipt. The Privacy Officer will maintain a copy of the changes to the Notice of Privacy Practices.

- The notice describes the hospital’s privacy practices and those of:
  a. any health care professional authorized to enter information into the hospital/EJPN office chart
  b. all departments and units of the hospital
  c. any member of our volunteer services
  d. all team members and associated workforce members

How can you make a difference?

- Sign out of computers when not in use.
- Place confidential patient information in designated places.

See Administrative Policy & Procedure Policy No. HIP-13

DISCHARGE PLANNING

Discharge planning is an interdisciplinary process involving the patient/family, medical and nursing staff, ancillary staff, care management/social workers, and others as deemed appropriate. The interdisciplinary team, facilitated by the care management staff, develops a plan that is discussed with and supported by the patient or family. The plan is reassessed as factors that may affect
continuing care needs are identified. Communication about the plan may occur verbally or in writing, and in a manner that the patient and/or the patient’s family or caregiver can understand and shall be documented in the patient’s medical record.

To coordinate care across the continuum, the care management staff utilizes McKesson’s Interqual criteria (a synthesis of evidence-based standards of care) as an objective tool for determining whether a patient’s condition is severe enough, or the services provided are intense enough, to be admitted to a specific level of care. In Interqual, the care manager sets up a review by selecting from one of several service types (acute adult, rehab, subacute, etc.) and levels of service (observation, acute care, critical care or intermediate care). They then compare documentation present in the patient’s record to criteria in the screening tool.

Once the review is opened, there is a tree structure of criteria for both "severity of illness (SI)" and "intensity of service (IS)". The criteria are organized by body system: general, cardio/respiratory, CNS, GI, metabolic, obstetrics, and surgery/trauma. The IS criteria include such things as assessments and monitoring, medications, blood products and IV fluids, and psych crisis intervention. Both SI and IS criteria must be met to support the medical necessity for admission, observation or another service.

If acute inpatient care is no longer needed, the following post-hospital resources should be considered:

- Cardiac Rehab OP program (2wk, 4wk, 6wk)
- Diabetic Education follow up
- Home Health Care (Nurse, PT, OT, ST, HH aide, IV therapy)
- Home Medical Equipment (beds, wheelchairs, walkers, oxygen, nebs, etc.)
- Hospice (inpatient, home or nursing home)
- Mental Health and Counseling Services
- Nursing Home Placement
- OP Services (therapies, whirlpool, IV meds, etc.)
- Pulmonary Rehab
- Substance Abuse Services
- Wound Care Center
- Skilled Nursing Facility (SNF)
- Long Term Acute Care
- Rehab

Criteria for post-acute or long-term acute services:

**SNF:**

Must meet 3-day acute length of stay. Must need at least daily services which cannot be provided as out patient or at home, for example:

- IV antibiotics when not appropriate for home or outpatient, IV steroids or other IV meds that can safely be given in the Post-acute setting,
- Complex wound care (i.e.; stage iv decub)
- Radiation therapy and unable to receive as out patient due to medical condition

**OR**

- Management of prolonged or chronic conditions, which have resulted in debilitation and require reconditioning (PT, OT)

**OR**

- Must need continued PT, OT and/or ST for CVA, FXs, etc
- Must not need care that would exceed approx 14 days

If care required will likely exceed 2 weeks, it is better to consider a longer term SNF situation such as SNF in a nursing home.

**REHAB:**

Must meet Diagnosis for Rehab i.e. CVA, FXs/Replacements of 2 joints, Head Injury, Amputations
Must have need for at least 2 of 3 therapies (PT, OT, ST)
Must be able to tolerate at least 3 hours of therapy
Must have Rehab potential

LONG TERM ACUTE CARE:

Must require acute level care that will be required for greater than 2 weeks. This may include, for example, IV medications, complex wound care, ventilated patient with tracheostomy and weaning.

QUALITY IMPROVEMENT

The EJGH Board of Directors has ultimate responsibility for the quality and appropriateness of patient care services. To meet this responsibility, the Board of Directors delegates the quality assessment process through the following committees:

- Utilization Review Committee
- Medical Staff Appropriateness of Care (MSAOC)
- Quality Council

UTILIZATION REVIEW

The mission of utilization management at East Jefferson General Hospital is to support the hospital’s goals through collection and review of data to assess appropriate allocation of hospital resources, make recommendations for improvement, and monitor and assess effectiveness of improvement efforts. Membership is composed of:

- Six representatives of the Department of Medicine
- Six representatives of the Department of Surgery

MEDICAL STAFF APPROPRIATENESS OF CARE

The Medical Staff Appropriateness of Care (MSAOC) implements the Quality Management Plan as it relates to the Medical Staff. The plan assigns responsibility to the Quality Management (QM) Department to perform the initial screening and reviews necessary for peer review. The annual Scope of Review is approved by MSAOC and Medical Executive Committees of the Medical Staff and dictates the types of reviews and indicators to be screened by the Quality Management Department.

As a member of the medical staff you may be selected by MSAOC to review cases for peers. The QM Department Staff will contact you in advance and guide you through this process as well as the documentation requirements, the forms and the definitions for each peer review score designation. Peer review must be completed with 10 working days following case assignment to the reviewer. At re-appointment, completed peer review cases associated with an individual are aggregated and forwarded to the physician for review. Any questions related to this process can be forwarded to the Quality Management Department located on the first floor of the hospital or by calling 456-8449.

QUALITY COUNCIL

Quality Council oversees the quality program and monitors and prioritizes hospital-wide improvements. Membership is composed of a diverse interdepartmental mixture that includes:

- Seven physicians
- Executives
- Nursing administration
- Department leaders
- Performance improvement team leaders

Communication of quality information, improvements, or need for improvement is accomplished through various hospital and medical staff committees, publications, and presentations.

PATIENT SAFETY

Administering an effective, integrated, organization-wide performance improvement program creates a best practice strategy for ensuring patient safety. Physicians are critical members of our patient safety program and are routinely requested to participate in event reviews of patient safety related issues and/or proposed improvement strategies.

Here are some tips on how you can play an active and vital role in promoting patient safety:

- Be aware of the high-risk work processes that could be hazardous to a patient or cause an error in care.
• Look actively for potential patient safety issues. Correct them if you can. Report them immediately to the appropriate party.
• Follow policy and procedure. Avoid taking short cuts.
• Use protocols/order sets based on evidenced-based medicine.
• Use equipment according to manufacturer specifications and/or policy. Follow appropriate precautions when using equipment in patient care.
• Play an active role in promoting hand hygiene practices.
• Use good hand off communication.
• Encourage use of SBAR.
• Maintain a non-punitive approach to error investigation.
• Promote a Culture of Safety.

SENTINEL EVENT
A sentinel event is defined as an unexpected occurrence involving death or serious physical injury or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or risk thereof" includes any process variation for which the recurrence would carry a significant chance of a serious adverse outcome. Sentinel events are to be reported immediately.

When a sentinel event occurs, an RCA (Root Cause Analysis) is conducted within 14 days of the event. Participation in the RCA includes those involved in the incident, Administration, Physicians, and Quality/Risk Management. Together, physicians and team members develop action plans to mitigate future risk.

NATIONAL PATIENT SAFETY GOALS (NPSGs)
The Joint Commission NPSGs were established to help accredited organizations address specific areas of concern in regards to patient safety. Each year the goals are updated. A complete listing of the current goals can be found on the East Jefferson General Hospital intranet at Team Talk >Joint Commission > National Patient Safety Goals.

UNIVERSAL PROTOCOL – For all invasive procedures in all areas of the hospital
• Use preoperative check list.
• Mark site – an unambiguous mark (initials by the practitioner who is credentialed and privileged to perform the procedure and will be participating in the procedure.
• Conduct “TIME OUT” immediately prior to procedure to verify correct: patient, procedure, side/site, and position, availability of correct implants or special equipment/requirements.

SBAR
Communication has been identified as a major risk factor to patient safety and SBAR is a tool that provides a framework for concise communication between members of the health care team about a patient’s condition. SBAR is the acronym for:

   Situation: What is going on with the patient?
   Background: What is the clinical background or context?
   Assessment: What is the current status of the patient?
   Recommendation: What do I think needs to be done for the patient?

SBAR helps to organize, standardize, and direct meaningful communication, which is essential for developing teamwork and fostering a culture of patient safety.

Benefits of SBAR:
• Helps create a shared understanding of what is happening
• Avoids natural tendency to speak indirectly
• Promotes critical thinking
• Similar to SOAP model-familiar to physicians
The Joint Commission Survey

This section contains key information related to The Joint Commission survey process. Most of this information is presented in a question and answer format. If you have any questions, please contact a representative of the Clinical Excellence and Outcomes Management Division at 504-883-6854.

The Joint Commission (TJC) is a national non-profit organization that accredits approximately 70% of hospitals and other healthcare organizations to ensure that processes and teamwork support safe patient care. Accreditation by TJC means that they periodically survey us. The Louisiana Department of Health & Hospitals (DHH) may choose to survey and review licensure compliance. TJC also surveys the Conditions of Participation (COP) to the Medicare program. Compliance to the standards is required for eligibility for Medicare and Medicaid reimbursement.
Why is this important to the hospital?

- Commitment to patient care
- To meet and excel nationally recognized standards of care and safety
- Participation in federal government insurance programs, Medicare and Medicaid

**BE PROUD OF THE GOOD WORK YOU DO**

Talk about what has been done over the past year to improve care or increase patient safety. Your ability to demonstrate that our hospital complies with regulations and accreditation standards will be the key to our success.

**RIGHTS, ETHICS, & RESPONSIBILITIES**

**Topics Covered**

- Patient Rights & Responsibilities
- Advance Directives
- Informed Consent
- Ethics
- Patient Complaints & Grievances

**PATIENT RIGHTS & RESPONSIBILITIES**

*What rights does a patient have?*

Patients have a wide variety of rights. The hospital has a policy on patient rights. Some of these rights include:

- Confidentiality and privacy of patient information
- Effective management of pain
- To refuse care
- To receive information about their care

*What responsibility does a patient have?*

Patients have the responsibility to:

- Provide information about their condition
- Follow hospital policies
- Inform staff of changes in their condition

*How are patients informed about their rights and responsibilities?*

Patients receive written information upon admission. Rights and responsibilities are also included in the patient handbook.

**ADVANCE DIRECTIVES**

*What is an advance directive?*

An advance directive is either a written or verbal statement by a patient or their authorized designee regarding care issues. Types of advance directives include:

- Living Wills
- Durable Power of Attorney for Healthcare
- Advance Directive

*How are patients assessed for an advance directive?*

Patients are asked if they have an advance directive when they are admitted to the hospital. If the patient does not have an advanced directive, he/she is asked if they would like more information and the materials can be provided.
What do you do if the patient has an advance directive?
If the directive is with them, place a copy in the medical record. If the copy is not available, ask the patient to have it brought to the hospital. This should be documented in the Medical Record.

Can a patient change their directive during their hospitalization?
Yes…a directive can be changed at any time. This can either be done verbally or in writing. If a patient wishes to change their directive, the physician is notified, the directive updated and placed in chart.

INFORMED CONSENT
Who is authorized to provide informed consent?
In Louisiana, the physician is required to provide informed consent for operative or invasive procedures. The consent must occur before the procedure begins. Staff is responsible for witnessing the patient’s signature on the consent form. Patient should not be taken to Operating Room or undergo any invasive procedure if physician has not signed/dated/timed the Informed Consent prior to procedure. It is important to fill out all sections of the consent, including dating and timing of all signatures (physician, patient, witness).

ETHICS
What type of assistance is available in resolving ethical dilemmas?
The hospital has a Hospital Ethics Committee (HEC), which can provide information, guidelines and advice to patients, family, medical staff and hospital personnel relative to the area or ethics.

How do you access the Ethics Committee?
The Hospital Ethics Committee is accessed through Administration during normal work hours and by the House Supervisor after hours and weekends.

PATIENT COMPLAINTS AND GRIEVANCES
Do patients have the right to file a complaint or grievance?
Yes…both policy and law give patients the right to file a complaint or grievance.

What is the process for filing a complaint or grievance?
If a team member or doctor becomes aware of a complaint, the following actions should be taken:
- Report the complaint to the immediate supervisor or director of the work area.
- The complaint or grievance is investigated by the hospital.
- The patient is informed in writing of the results of the investigation and any actions taken.
- If the patient wants to file a formal complaint with any regulatory agencies, they may do so.

If anyone (staff or patient) has a complaint about quality of care, they are encouraged to talk with the supervisor or Administration. It is always our hope that we can resolve the issue; however any person can file a complaint about quality of care with the Joint Commission or DHH.

PROVISION OF CARE
Topics Covered
- Assessment & Reassessment of Patients
- Assessment & Management of Pain
- Victims of Abuse
- Care Planning
- Patient / Family Education
- Use of Restraints
- Procedural (Conscious) Sedation
- Use of Interpreters
ASSESSMENT & REASSESSMENT OF PATIENTS:
When do patients receive an initial assessment?

Patients receive an initial assessment upon admission or when presenting for care. The time frame for completing the initial assessment may vary depending upon the care setting.

What is included in an initial assessment?
The initial assessment includes the following:
- Physical assessment
- Psycho-social assessment
- Victims of abuse assessment
- Pain screen
- Nutrition screen
- Functional screen
- Cultural needs
- Spiritual needs
- Discharge planning screen
- Medications
- Suicide assessment (if applicable)

How do other disciplines become involved in the patient’s care and conduct their initial assessments?
Other disciplines (PT, OT, Speech, Respiratory Therapy, Case Management, Clinical Dietitian, Pharmacy, etc) become involved in the patient’s care in one of three ways:
1. By physician order
2. Based on referral criteria as the result of the initial nursing assessment
3. Reconciliation of medications

When do patients receive a reassessment?
The frequency of reassessment varies depending on the care setting and the needs of the patient. In general, a patient is reassessed:
- For nursing, at least upon change in nurse caregiver.
- When there is a significant change in condition
- When the patient is transferred to a different level of care
- To evaluate response to care/treatment and service

ASSESSMENT & MANAGEMENT OF PAIN
How do we objectively measure pain?
- Pain is recognized as the 5th vital sign.
- We use a pain scale (0-10) to assess the level of pain.

When are patients assessed for pain?
Each patient is screened for the presence of pain upon admission, presentation for care, or visit. If the patient reports pain, then they receive a more comprehensive assessment. Patients are also screened for pain:
- After treatments and procedures
- Routinely during care when vital signs are taken

What happens if a patient has pain?
If a patient reports pain, they receive an assessment that addresses:
- Location, severity, and duration of pain
- What precipitates the pain?
- What alleviates pain?
- What has been ordered by the MD for pain?
- How effective is the pain medication ordered in relieving the pain?
How is pain managed?
We employ a variety of treatment modalities to combat pain:
• Medication
• Patient Controlled Analgesia (PCA)
• Relaxation techniques/music
• Application of heat and cold

Are patients educated about pain management?
Yes…patients (and, when appropriate, their families) are educated about their role in pain management. This includes the following:
• Importance of reporting pain
• The type of pain treatment they are receiving
• Techniques for managing pain
• Pain scale used for evaluating pain

Key Points
Pain management will be highly scrutinized during the survey. Make sure that documentation of the following is complete in each medical record:
• Initial screen / assessment of pain
• Ongoing assessments/reassessments of pain
• Pain interventions (i.e. medications given)
• Response to pain interventions
• Notation on the patient’s plan of care

VICTIMS OF ABUSE

Are patients assessed for potential abuse?
Yes…patients are assessed upon admission to the hospital or upon presenting for care. The assessment is conducted by qualified staff (usually the physician or nurse). The assessment is based upon objective criteria.

How has staff been trained in recognizing abuse?
Patient care staff are trained on recognizing specific types of abuse. In addition, all staff are trained on state mandated reporting requirements upon hire and annual update. A social worker is to be notified of any suspected abuse case.

All cases of possible abuse or neglect are reported to the appropriate agencies by Social Services.

CARE PLANNING

How does patient care planning occur in the organization?
Care planning is interdisciplinary in nature. Each discipline identifies and prioritizes care problems as the result of their assessment activities.

How are patient care needs prioritized?
Needs are prioritized based upon criteria accepted by all the clinical disciplines. The criteria (in order of priority) are:
• Life threatening conditions
• Patient safety issues
• Care needs to enable the patient to be discharged
• Patient education needs
• Other issues identified

Make sure that all identified patient care problems are documented on the plan of care

How do disciplines communicate patient care needs to each other?
Care needs are communicated among the various disciplines through hands off communication.
PATIENT / FAMILY EDUCATION

What types of patient education needs are assessed?
Patients are assessed for education needs on admission or entry into care. Patient Needs include: knowledge of disease, medication use, equipment use, rehabilitative techniques, diet, access to community resources and how to activate a Rapid Response Team (posted in patient rooms).

What kinds of barriers to learning are there?
Barriers to learning include language, education level, speech or hearing difficulties, cultural influences, and a patient’s readiness to learn.

What resources have been allocated to support patient education?
We have developed patient education programs, education materials, education videos, and community education classes. Education material is also available through Lexi-Comp online. The link is located within COMPAS.

USE OF RESTRAINT

What is the hospital’s philosophy regarding restraint use?
We believe that the use of restraint is a last resort only after other clinical interventions have been considered or attempted. Restraint use must be limited to clinically justifiable situations only. Restraints are never used for convenience, punishment, or coercion.

Does the hospital use chemical restraint?
No…we do not use chemical restraints. Medications used as part of a standard treatment plan for a patient’s underlying medical or psychiatric condition are not chemical restraints.

Are PRN orders for restraint allowed?
No… PRN orders are NEVER allowed. If such an order is written, order clarification obtained/new order written.

How long is a restraint order good for?
Initial orders for restraints are good for 24 hours and then must be renewed each calendar day.

PROCEDURAL (CONSCIOUS) SEDATION

How does the hospital assure that patients receive procedural sedation in a safe environment?

• All persons administering sedation and analgesia are responsible for maintaining proficient skills and current validated competency per policy.
• Procedural sedation may be performed only in designated areas of the facility with qualified staff in attendance.
• An informed consent is necessary.
• Single standard of care used throughout the facility.
• Patient selection and ordering of the drugs is the responsibility of the physician.
• Documentation of a pre-procedural assessment is the responsibility of the person monitoring the patient.
• Age-specific emergency equipment is immediately available.
• “Time Out” is used just prior to the procedure (when the healthcare team, including MD, is present) to verify patient identification, procedure and site (if applicable). Time out elements are documented in the medical record.
• Patient meets established discharge criteria prior discharge home or another unit.
• Patients are discharged with a responsible adult.
USE OF INTERPRETER SERVICES

Does the hospital make interpreter services available to patients?
Yes…interpreter services are available to patients who need them. Guest Services or an Administrative Representative can arrange the service.

Does hospital staff serve as interpreters?
Only if they are competent do so. Hospital staff must be competent by virtue of education and training to competently translate medical information. Staff may translate non-clinical information (i.e. visiting hours, directions, etc.).

Can the family serve as interpreters?
A patient may choose to use a family member or friend as an interpreter after being informed of the availability of free interpreter services unless the effectiveness of services is compromised or the limited English proficient person’s confidentiality is violated. Family/friend interpreters must be at least 18 years old.

Are outside translation services available to patients?
Yes…Certified Language International can be utilized to provide translation services in a wide variety of languages. Guest Services or an Administrative Representative can arrange the service. Patients are not charged for this service and the services are available 24 hours per day, seven days per week. The Deaf Action Center provides sign language interpreter services. Guest Services or an Administrative Representative can arrange the service.

MEDICATION USE

Topics Covered
- Medication Shortages
- Use of Investigational Medications
- Storing of Medications
- Security of Medications
- Control of Controlled Substances
- High Risk Medications
- Concentrated Electrolytes
- Medication Administration
- IV Admixture Outside of Pharmacy

MEDICATION SHORTAGES

How are staff members notified of medication shortages or outages?
The Pharmacy Department sends a notice to all affected areas each time a shortage or outage occurs. The notice provides instructions as to alternative medications available.

USE OF INVESTIGATIONAL MEDICATIONS

How are investigational medications managed?
The hospital’s Institutional Review Board approves all investigational medications for use in the facility. A copy of the investigational protocol governing the medication is placed in the patient’s medical record. Staff are oriented to any requirements regarding the medication.

STORING OF MEDICATIONS

How do you assure that medications are appropriately stored?
We have developed specific policies to assure that medications are appropriately stored. These policies require that:
• Internal and external medications are stored in separate locations.
• Medications requiring refrigeration are stored in refrigerators. The temperature is monitored each day to ensure that proper temperature is maintained.
• Medications are protected from light as required.
• Medications are made available in the most “ready to use” form as possible.
• Medications are provided in unit dose form whenever possible.
• Pharmacy staff make routine inspections of medication storage areas to ensure compliance with policy.
• “Look-alike” and “sound alike” medications are stored with special precautions.
• Outdated medications are returned to Pharmacy for appropriate disposal.

SECURITY OF MEDICATIONS

How do you keep medications secured?
We have developed specific policies to assure that medications are appropriately secured. These policies require that:
• Medication rooms and carts are locked unless under visual observation of authorized staff.
• Only authorized staff are permitted access to medication areas.
• Emergency medication carts and tackle boxes are checked regularly. Tags are controlled by pharmacy.
• No medications are kept on top of medication carts or in patient rooms.
• Staff is not allowed access into the main pharmacy.

CONTROL OF CONTROLLED SUBSTANCES

How do you keep controlled substances secure and reconciled?
We have developed specific policies to ensure that controlled substances are appropriately controlled. These policies require that:
• Only licensed authorized staff will have access to controlled substances.
• Discrepancies of controlled substances are reconciled each shift. If the count cannot be reconciled, an investigation is conducted involving pharmacy and an Occurrence Report.
• Any wastage of controlled substances is witnessed by two licensed personnel.

HIGH RISK MEDICATIONS

What steps do you take to protect patients from risks of errors in care when dealing with high-risk medications?
We have taken steps to manage high-risk medications such as:
• Specific policies have been developed to manage high-risk medications such as insulin, heparin, and chemotherapy.
• Special warning labels and precautions statements are placed on high-risk medications such as those that look alike or sound alike.
• Special precautions have been taken to reduce the risk of administration errors such as requiring two licensed nurses to verify identified high risk medications.

CONCENTRATED ELECTROLYTES

Is there any concentrated potassium or hypertonic saline stored in the various patient care areas?
No…concentrated potassium and hypertonic saline are stored under the control of pharmacy. They are not stored in patient care areas.

ADVERSE DRUG REACTION (ADR)

How are adverse drug reactions reported?
Staff document suspected Adverse Drug Events through Compas POWERCHART message sender. Clinical pharmacist researches potential and actual ADR. Results are analyzed and reported to Pharmacy & Therapeutics Committee. The staff also completes an Occurrence Report.
MEDICATIONS BROUGHT FROM HOME

Are patients allowed to take medications from home?
Patients are encouraged to send all medications home. When this is not feasible, medications are retrieved and inventoried by nursing. Only under specific circumstances can the patient’s medications be used while in the hospital. See Clinical Guidelines: Med-05 Administration of Medications Brought From Home for ordering guidelines.

MEDICATION ORDERING- RANGE ORDERS

Are range orders permitted?
An example of a range order is Morphine 2 - 4mg IV every 4 to 6 hours (PRN pain). EJGH orders require medication orders be specific with regard to dose and frequency. Example: the above order would be written to include dose and frequency ordered for different pain levels. This allows nursing to be consistent in dosing among caregivers.

MEDICATION ADMINISTRATION

How do you ensure that you administer medications to a patient safely and effectively?
We have developed specific policies to guide staff in administering medication. Key steps to safely administering medication include:
- Wash your hands.
- Correctly identify the patient using two patient identifiers: using the patient’s armband and the medication administration record.
- Verify that you have the correct medication / dose / route against both the drug label and the medication order.
- Check the expiration date on the drug to make sure it is still good. Do not use if the drug has expired.
- As appropriate, visualize the medication for stability (i.e., color, clarity, presence of particulate matter). Do not use if the medication appears compromised.
- Check the patient’s medical record to make sure there are no contra-indications to giving the medication.
- Verify that you are giving the medication at the proper time.
- Advise the patient of the purpose of the medication, and, as appropriate, of any potential adverse reactions or side effects.
- If you have any questions or concerns regarding the medication, discuss them in advance with the physician or call the pharmacist for assistance.

IV ADMIXTURE OUTSIDE OF PHARMACY

Can Nursing admix IV’s outside of pharmacy?
Only under emergency conditions. Otherwise, all IV admixtures are done in Pharmacy. If Nursing must admix a medication, special training and precautions are taken.

LEADERSHIP, PERFORMANCE IMPROVEMENT, HUMAN RESOURCES, & MANAGEMENT OF INFORMATION

Topics Covered
- Performance Improvement
- Performance Improvement Tools
- Privacy and Confidentiality of Patient Information
PERFORMANCE IMPROVEMENT

WHAT IS PERFORMANCE IMPROVEMENT (PI)?
Performance improvement is an approach used to improve existing processes and outcomes and then to sustain the improved performance. Our Board of Directors is responsible to ensure EJGH has a performance improvement plan and a reporting process. The hospital Quality Council oversees the PI plan and prioritizes hospital-wide PI initiatives using a prioritization grid.

What is the performance improvement model?
We use the PDCA performance improvement model:

- **P** = Plan
- **D** = Do
- **C** = Check
- **A** = Act

**Plan**: Identify what process or outcome you want to assess and improve. Review the process; consider flow diagramming, and measure current performance.

**Do**: Determine the action you will take and implement it.

**Check**: Collect and analyze data on your implemented changes to evaluate the impact and results of your action. Determine if the results indicate whether or not a process modification is needed.

**Act**: Communicate results and the actions that need to be taken to sustain the improvement as determined by check phase.

How are you involved in performance improvement?
Physicians and team members are involved in performance improvement in the following ways:
- Bringing ideas or suggestions for improvement to the attention of leadership
- Implementing performance improvement action plans
- Being educated and familiar with performance improvement activities
- Core Measures
- Patient Safety Monitoring
- Patient Satisfaction
- Being educated and familiar with departmental performance improvement activities

**CORE MEASURES:**
The monitoring results of Core Measures are reported to the Joint Commission and CMS quarterly. These results are also reported to appropriate Medical Staff Departments/Committees/ and Governing Board. A listing of the current Core Measures and results can be found on East Jefferson General Hospital website at [https://www.ejgh.org](https://www.ejgh.org)

**DEPARTMENTAL PERFORMANCE IMPROVEMENT ACTIVITIES**
All Nursing units monitor the following for improvement opportunities:
- Medication errors
- Pressure ulcers
- Falls and falls with injury
- Restraint use
- Infection rates
- Blood culture contamination rates
- Patient satisfaction
PERFORMANCE IMPROVEMENT TOOLS

**Root Cause Analysis (RCA)** is a tool for identifying prevention strategies after an event has occurred. In an RCA, contributing factors and root causes are discovered in a process similar to diagnosis of disease – with the goal always in mind of preventing recurrence. It is required by THE JOINT COMMISSION for any sentinel event. The goal of an RCA is to find out 1) what happened 2) why did it happen 3) what you can do to prevent it from happening again.

**Failure Mode Effect Analysis (FMEA)** – a proactive analysis that identifies a procedure (high risk, high volume, problem prone) from THE JOINT COMMISSION sentinel events, risk management, or incident reports. The process / procedure is diagrammed out step-by-step to identify weak points, how likely those weak points are to fail, and how bad it would be if those weak points failed. Process changes are then implemented to make the weak points stronger thus reducing risk and improving patient safety. THE JOINT COMMISSION requires hospitals to do one proactive FMEA every 18 months.

PRIVACY AND CONFIDENTIALITY OF PATIENT INFORMATION

How does the hospital protect the privacy and confidentiality of patient information?

Actions that staff can take in this area include:

- Do not discuss patient information in public places or with individuals who are not involved in caring for the patient.
- Keep medical records secure. Do not leave the record out in public areas.
- Dispose of any paper waste containing patient information into the secure shredding bins. Do not throw into the normal trash.
- Do not leave patient identifiable information in ways that can be seen by visitors or unauthorized personnel. For example: computer screens, hospital lists/charts.
- Be aware of patients that have requested “no information” or “limited information” to be divulged to others.
- Secure your computer workstation before leaving by selecting Control + Alt + Delete.

ENVIRONMENT OF CARE & INFECTION CONTROL

**Topics Covered**

- Safety Management
- Security Management
- Management of Hazardous Materials & Waste
- Life Safety
- Medical Equipment
- Utilities
- Emergency Preparedness
- Emergency Codes
- Infection Control

SAFETY MANAGEMENT

What are potential hazards in the work environment?

Typical hazards found in patient care areas include:

- Exposure to infectious diseases and medical waste
- Exposure to chemicals such as medications, cleaning solutions, and chemotherapy
- Hazards associated with lifting and moving patients – i.e. injury
- Hazards associated with the use of complex medical equipment
- Potential for violence in the workplace in high-risk areas such as the Emergency Department

SECURITY MANAGEMENT

How do you provide for a secure environment for staff and patients?

Staff participates in this program in the following ways:

- Know the location of the emergency procedures manual in the work area. It contains response procedures to the most common security issues we face.
• Report any suspicious individuals or activity to the immediate supervisor or to Security (ext. 4059).
• Keep personal articles and valuables secure. Do not bring personal items of value to work with you.
• Lock desks or doors to offices when not in use.
• Secure hospital equipment in their appropriate area(s).
• If you have any questions or concerns about security issues in the work area, contact the immediate supervisor for assistance.

HAZARDOUS MATERIALS

How do you get information about chemicals used in the work area?

Material Safety Data Sheets (MSDS) are provided for staff on chemicals found in the work area. The MSDS give basic information about the chemical and how to use it safely. MSDS books can be found on each department. MSDS information is available at all times by accessing the MAXCOM System, through Team Talk to view MSDS for any chemical used in the hospital or department.

What do you do if there is a chemical spill?

The following procedure should be utilized managing a chemical spill:

• Contain the spill and evacuate the area if necessary.
• Obtain a copy of the Material Safety Data Sheet (MSDS) on the chemical or material in question.
• Obtain the necessary clean up supplies and personal protective equipment.
• Clean the spill per instructions on the clean up kit and/or MSDS.
• If large spill, evacuate and notify Stat Line 4111 and immediate supervisor.

LIFE SAFETY

What is the procedure to respond to a fire in the work area?

The formal procedure for a fire is called “Code Red”. If a fire occurs in the work area, you should do the following:

RACE:
- FIRE - the patient, person
- ALARM – activate the alarm
- CONTAIN – shut all doors
- EXTINGUISH –the fire

PASS:
- Pull the pin
- Aim at the base of the fire
- Squeeze the handle
- Sweep the flames

What would you do if the fire occurs elsewhere in the hospital?

The following actions should be taken:

• Clear hallways of equipment.
• Close doors to rooms.
• Reassure patients.
• Prepare for possible evacuation.
• Continue normal care activities and await instructions.

What is a smoke compartment?

A smoke compartment is a structural feature of the building that prevents smoke from being spread from one area to another. This is accomplished when the fire doors are closed.

How do you assure a fire safe environment?

Take the following actions:

• Know where the fire alarm pull stations are located in the work area. In general, these are located near the exits and the elevators.
• Know where the exits are from the work area. There are two exits from each department. You should be familiar with both locations.
• Know the location of fire extinguishers in the work area.
• Know where your smoke compartment starts and ends.
• You can help keep the work area fire safe by taking the following actions:
  o Store equipment to keep hallways clear.
MEDICAL EQUIPMENT

How do you know that a piece of equipment is safe to use?
Engineering conducts an electrical safety check when equipment is first purchased. In addition, the Biomedical Department routinely checks and maintains all medical equipment. Each piece of equipment has a sticker that tells staff when the equipment was maintained.

What is SMDA?
SMDA stands for “Safe Medical Device Act”. It is a federal law that requires hospitals to report incidences of equipment failure that result in harm to the patient.

What do you do to ensure that equipment is used safely and effectively?
The following actions should be taken when medical equipment is utilized:
- Use equipment only for its intended purpose.
- Follow manufacturer instructions and/or our procedures when using equipment.
- Inspect the equipment prior to use. Look for obvious break down or disrepair such as frayed cables, broken dials, cracked housing, etc. if there is any question as to the safety of the equipment, do not use it. Pull it from service and notify Biomedical Engineering.
- Check to see if the equipment has been electrically safety checked and maintained. Each piece of equipment has a sticker that tells you whether or not it was checked / maintained. If you are unsure, contact Biomed before you use the equipment.
- Do not use equipment that you have not been trained to use or are not competent to use. See your supervisor if you require additional training.

What do you do if a piece of equipment fails?
- Know what actions to take before the equipment fails. Be familiar with the response procedures.
- Make sure you have the standby supplies and equipment you need in case of failure. For example, have an ambu-bag readily available for all patients on a ventilator.
- Support the patient and provide for immediate care needs.
- Pull the equipment, mark it as “out of service” and notify Biomed.

UTILITIES MANAGEMENT

What is the procedure to shut off medical gases in an emergency?
- Each gas valve is labeled with the area it controls.
- Staff should not shut off gases without permission.
- Engineering, Respiratory Therapy, and the House Supervisor will coordinate shutting off of medical gases.
EMERGENCY PREPAREDNESS

How is the hospital organized around emergency preparedness?
We have adopted the N.I.M.S. (National Incident Management System), H.I.C.S. emergency response system, and have developed an "all hazards" response plan. HICS stands for:

- Hospital
- Incident
- Command
- System

What is your role in the event of a disaster?
The "Disaster Preparedness" manual outlines the "all hazards" plan as well as each department's specific response procedure. In general, physicians should contact the Medical Staff Office for further instructions.

EMERGENCY CODES

What are the emergency codes in our facility and what do they mean?
The following is a list of the emergency codes:

- **CODE RED**
  - Fire
- **CODE BLUE**
  - Cardiopulmonary Arrest
- **CODE PINK**
  - Infant/Child Abduction
- **CODE WHITE**
  - Security Alert
- **CODE BLACK**
  - Bomb Threat
- **CODE YELLOW**
  - Surge – Mass Causality
- **CODE YELLOW DECON**
  - Surge – Mass Causality Decontamination Required
- **CODE ORANGE**
  - Hazardous Materials Incident or Spill
- **CODE ORANGE DECON**
  - Hazardous Materials Incident or Spill Decontamination Required
- **CODE GRAY**
  - Severe Weather (High Winds, Tornado, Hurricane)
- **CODE GREEN**
  - Internal Flood
- **CODE SILVER**
  - Weapon in Facility

INFECTION CONTROL

How do you prevent the spread of infection?
Everyone can prevent the spread of infection by taking these simple steps:

- Wash hands before and after each patient contact.
- Wash hands after using the restroom and before touching food.
- Follow universal precautions.
- Wear personal protective equipment as required.

HAND HYGIENE

Hand washing is the most important way to prevent patients and yourself from acquiring and spreading infection. Soap and water hand washing is required after using restroom, before touching food, after care of patient with C difficile or any acute diarrhea or anytime hands are physically dirty. Hand sanitizers should be used before and after contact with the patient or his/her environment, before aseptic procedures and after removal of gloves.

ISOLATION PRECAUTIONS:
The Center for Disease Control Guidelines are utilized for type and duration of isolation. The Infection Control Department should be contacted with any questions or concerns. Additional information may also be found on the Infection Control Department website at Team Talk>Department>Infection Control.

The following are the types of isolation precautions:

- **Airborne precautions** – For patients known or suspected to be infected with microorganisms transmitted by airborne (small particle residue that remain suspended in air), i.e. cases of TB.
  - Requires monitored negative pressure private room
  - N-95 mask by all entering
Contact precautions – For patients known or suspected of being infected or colonized with highly transmissible or epidemiologically important microorganisms that can be transmitted by direct contact with the patient or direct contact with environmental surfaces or patient care items.

Some examples would include:
- Wound drainage not contained by a dressing
- Diarrhea
- Incontinence
- C. difficile

Droplet precautions – For patients known or suspected of being infected with microorganisms transmitted by droplets (large particles that drop to floor and do not remain suspended in air). All entering need to wear a regular paper mask. Some examples would include: Influenza, Adenovirus, Pertussis, Meningitis, etc.

MULTIDRUG RESISTANT ORGANISMS (MDROs):
Surveillance of all resistant organisms is done to help us develop plans for prevention and control. Microbiology notifies the nursing unit directly of all patient culture positive for resistant organisms (MRSA, VRE, ESBL, Resistant Acinetobacter, C difficile) so Contact Precautions can be implemented timely.

MRSA has increased both in hospitals and in the community and eliminating the transmission of MRSA in our hospital will help save lives and also reduce healthcare cost. Targeted active surveillance will help us identify patients infected or colonized so that they can be placed on Contact Precautions to reduce transmission.

How to prevent the transmission of MDROs:
- Clean hands before and after caring for every patient.
- Follow Contact Precautions when caring for patients infected or colonized with MDROs.
- Carefully clean their personal medical equipment.
- Work with hospital staff to ensure that all vendor instruments/equipment is adequately processed before use.
- Communicate patient MDRO history to hospital staff and consultants before admission.
- Inform patients and their families about the MDRO and control measures.
- Support facility screening and control programs.
- Practice antibiotic stewardship to minimize development of antibiotic resistance.

Hospital Associated Infections (HAIs) - implementing best practices in preventing device related infections has led to the adoption of the Institute for Healthcare Improvement (IHI) bundle for management of the following devices:

Ventilator associated pneumonia (VAP)
1. Elevation of head of bed 30 to 45 degrees
2. Daily sedation vacation and assessment of readiness to extubate
3. Peptic ulcer disease prophylaxis
4. Deep venous thrombosis prophylaxis

Central line associated bloodstream infections (CABSI)
1. Hand hygiene
2. Maximal barrier precautions on insertion
3. Chlorhexidine skin antiseptics
4. Optimal catheter site selection (subclavian preferred for non tunneled)
5. Daily review of line necessity

Foley catheter associated urinary tract infections (CAUTI)
1. Avoid unnecessary catheterization
2. Proper catheter insertion technique
3. Use of silver coated catheters for most patients
4. Secure device to prevent pulling (Statlock)
5. Removal after appropriate use (removal criteria for removal after 72 hrs or Post Operative day 1 or Post operative day 2 for surgical patients).
IMPORTANT INFORMATION

EA PROGRAM

As a result of the difficulty with specialties taking unreferred emergency calls, hospital administration implemented a program that pays physicians (on the unreferred emergency call schedule) for the services they provide to an unreferred, self-pay or Medicaid patient that presents to the emergency room. That program is referred to as EA, which is the name of the third party company that processes your requests for payment. The EJGH Program Liaison works in the Medical Staff office and can assist and answer any questions you may have regarding this program. The Program Liaison can be reached at 504-454-4431. If you are interested in participating, you must request a contract from EA via their website: www.eahealthcorp.com.

CONTINUING MEDICAL EDUCATION

The Continuing Medical Education (CME) Program at East Jefferson General Hospital is established to enhance the quality of health care provided as well as support the educational needs of its physicians and other health care professionals. The Continuing Medical Education Committee is assigned the responsibility of developing educational activities for the East Jefferson General Hospital (EJGH) Medical Staff, which are responsive to their current needs.

CME offerings can be found on the physician website: https://ejmd.ejgh.org/

ORDER SETS

Order Sets have been developed for the treatment of many conditions and diagnoses. The formulation of the order set helps to build consensus among physicians and utilization of the order set:
- Incorporates evidence-based findings into practice and reduces variation in clinical practice
- Facilitates the comprehensive management of all aspects of the disease/disorder

Available order sets can be found by accessing Lagniappe.

PHARMACY SERVICES

Inpatient pharmacy services are provided by pharmacists and pharmacy technicians 24 hours a day, 7 days a week. The pharmacists at East Jefferson are decentralized from 07:00 until 23:00 on weekdays, located on key units to provide face-to-face assistance to all the disciplines working on the various units. Inpatient medication distribution is done primarily through automated dispensing devices (Pyxis) on all nursing units.

Pharmacy Department location:
- 1st floor of the hospital behind the main elevators, near the security office

Contact numbers incase you have questions:
- Staff pharmacists are available in the central inpatient pharmacy (454-4864 prompt #1) 24 hours a day, 7 days a week.
- Decentralized staff pharmacists are assigned to patient care units. Assignments are posted on the units and include their mobile phone numbers.
- Clinical pharmacists are assigned to multiple care units and they can be reached by calling the clinical pharmacy office (located on the 3rd floor outside of ICU1) at 454-4012 or the clinical consult pager at 560-8598

Other services provide by the pharmacists 24/7:
1. Drug information
2. Initial pharmacokinetic dosing
3. Renal dosing adjustments
4. Therapeutic interchange
5. Clozaril initial registration
The following Consult services are provided 7 days a week from 6am - 8pm:
1. Parenteral nutrition consults
2. Follow-up pharmacokinetic monitoring and dosing (aminoglycosides, vancomycin, digoxin, antiepileptics)
3. Anticoagulation consults (lowenox dosing, anti Xa level monitoring, warfarin dosing and monitoring)
4. Consults that require lengthy research (adverse drug event chart review, drug interaction review and dose adjustments, literature research on specific drug topics etc.)

Nonformulary Medications

- Medications that have not been added to the pharmacy’s formulary by the Pharmacy and Therapeutics committee.
- (Coming Soon – September 2010) To determine if a medication is on the approved formulary look on any computer in the hospital for the Lexi-Comp drug information icon. Enter the drug you are inquiring about and it will tell you if it is formulary or non-formulary.
- If you choose to write for a nonformulary medication, pharmacy will request that you fill out a non-formulary form and provide an explicit, evidence based reason as to why this drug is needed for your patient over the options available on the formulary. The non-formulary request can take 24-72 hour to process.
- If you would like a drug added to the formulary here at EJGH, please call the pharmacy department at 454-4855 and request a formulary addition form. Fill out the form and return it to the Pharmacy Department. It is required that you come to the next Pharmacy and Therapeutics Committee meeting to present your request for addition of this item to the hospital’s formulary.

“Patient’s Own” medications:

- Permitted: non-formulary agents, extremely high expense patient specific medications, research protocol medications;
- Not permitted: dietary supplements, controlled substances, medications that can not be identified, formulary medications;
- If you wish to have your patient take their own medication (as permitted above), a complete order stating that the patient may take their own home medication must be written, including: generic drug name, dose, schedule, and route of administration.

Sample Medications:

- Samples may not be used for patients while they are in the hospital.

Herbal/Nutritional Supplements (Nutraceutical Products):

- EJGH recommends that’s physicians include, as part of the admission process, any pertinent history of herbal/nutritional supplement use.
- Due to little drug-drug and drug-disease interaction documentation in the medical literature, use of these products may make it difficult to monitor and care for the patient.
- The Pharmacy will not obtain any nutraceutical products that are not listed in the formulary.

Tips to Remember when Ordering TPNs (Total Parenteral Nutrition):

- Albumin &/or lipids will not be added to TPN’s. If there is a legitimate indication for either of these, it shall be given as a separate infusion;
- The use of a standard formula along with standard rates is offered, with the ability for the physician to customize the formula as needed;
- The cut-off time for accepting TPN orders is 14:00 daily;
- Due the complex compounding issues involved, TPN shall not be provided STAT.
- When new TPNs are ordered after 14:00, a standard mixture for the route employed will be administered until the following day. (Central mixture = 5% amino acids & 20% Dextrose w/o electrolytes, Peripheral Standard Mixture = 4.25% amino acids & 5% Dextrose w/o electrolytes);
- All TPN’s will adhere to the same “Introduction Rate Schedule”, 30ml/hr x 6 hours, 60ml/hr x 6 hours, then advance to target rate. If target rate is < 75ml/hr, 30 ml/hr x 6 hours, then advance to target rate.
DICTATION INSTRUCTIONS

Step I. Call 454-4088
Step II. Enter 4-digit Physician ID# ________
Step III. Enter 2-digit Work Type #

Work Type
01 H&P
02 Consult Report
03 Transfer Summary
04 Operative/Procedure Report
05 Discharge Summary
06 Generic

Step IV. Enter Patient’s 11-digits FIN#
Step V. Begin Dictation.

Dictate TIPS for quality reports:
- Identify yourself (esp. if you are dictating for a physician).
- Provide patient demographic information, all pertinent dates, and MRN if FIN# was not manually entered in.
- Emphasize or spell out (hyper vs. hypo, regular vs. irregular, 15 vs. 50).
- Due to multiple surnames, please provide first and last names of physician.

Step VI. Touch “9” to disconnect or
Touch “5” to end dictation then Enter new Work Type

NOTE: How to obtain your job# when dictating from an outside line?
When finished with dictation, Touch “9” then “1”. It will then give you your job#.

OPERATING TONE CONTROLS ON THE TELEPHONE PAD:

1………..Listen
2………..Dictate
3………..Reverse a few words
4………..Pause
5………..Start a new report
6………..Go to end of dictation
7………..Fast Forward
8………..Reverse to the beginning
*………..To correct I.D. number
# & 0…..Assistance

MEDQUIST BACK-UP DICTATION LINE INSTRUCTIONS:
(For use when in-house dictation is unavailable)

Dial: 1-866-505-9199
Enter in 100170# for your Client Location Code.
Enter in 9999# for your user ID. (Please dictate your first and last name and verbally give your dictating ID #.)
Enter in the 2-digit work type followed by a # sign.
For the subject code, enter in the patient’s 11-digit FIN number followed by the # sign.
After the beep, you may begin dictating.

The keypad functions are different. Please see below:
1 - Incremental Rewind
2 - Pause / Resume
22 - Record End
3 - Incremental Fast Forward
5 - Play from beginning
8 - Play
## - End Job

When finished with dictation, press #. It will then give you your job #.

DIRECTORY

Listing by Departments

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<thead>
<tr>
<th>Floor</th>
<th>Listing</th>
<th>Number</th>
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</thead>
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<tr>
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<td>PBX</td>
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<td>Endoscopy</td>
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# Nursing Units by Floor

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<th>Floor</th>
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<tr>
<td>2nd Floor: Nurses Station 2 East</td>
<td>Main</td>
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<td>2nd Floor: Nurses Station Coronary Care Unit</td>
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<td>3rd Floor: Nurses Station 3 East</td>
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<td>3rd Floor: Nurses Station Intensive Care Unit</td>
<td>ICU I (Blue)</td>
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<td>ICU III (Teal)</td>
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<tr>
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<td>Labor and Delivery/4 West</td>
<td>(454)-4099/4496</td>
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<tr>
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<td>Main</td>
<td>(454)-4500</td>
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<tr>
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<td>Debbie Schmitz - Cancer Navigator</td>
<td>(883)-8950</td>
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<tr>
<td>5th Floor: Nurses Station 5 South - Select Specialties</td>
<td>Main</td>
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<td>6th Floor: Diabetes Management Center</td>
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<tr>
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<td>6th Floor: Nurses Station West - Skilled Nursing</td>
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<td>7th Floor: Traction Room</td>
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<td>(456)-8078</td>
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<td>9th Floor: Nurses Station 9 West - Rehabilitation Unit</td>
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