

Stamford Hospital Medical and Ancillary Staff
Education Manual

Stamford Hospital is subject to oversight by several different regulatory agencies. Physicians must be knowledgeable about regulations promulgated by these organizations The Joint Commission, OSHA, State of Connecticut, CMS, CDC, et cetera which apply to their Hospital activities. This document is a summary of pertinent information.

The Joint Commission

The Joint Commission operates an accreditation program for hospitals and other types of health care providers. The Joint Commission’s primary purposes are to improve the quality and safety of patient care and to accredit facilities as having met a comprehensive set of standards required for reimbursement under the federally-mandated entitlement programs including Medicare and Medicaid.

OSHA

The Occupational Safety and Health Administration (OSHA) has developed standards that mandate certain actions designed to protect health care workers against infectious hazards from blood and body fluids, including blood borne pathogens such as Hepatitis B and HIV. These standards can be found in the yellow Infection Control Manuals on all patient care units here at Stamford Hospital, and in an online version of this manual in the Infectious Disease folder.

I. CARE OF PATIENTS AND PATIENT RIGHTS

RESTRAINTS

There is a defined protocol for management of patients who require restraints. Restraints are avoided if at all possible as they render the patient helpless and dependent. Restraints should be removed as soon as a less restrictive method of assuring the patient's and safety of others becomes feasible.

PHILOSOPHY

The approach to restraint and seclusion at Stamford Hospital is protecting the patient's health and safety in the least restrictive environment while preserving their dignity, rights and well-being. This standard of care applies to all patients in all settings. SHS assesses, measures, and monitors all episodes of restraint use to improve hospital wide performance and compliance. The use of restraint and seclusion, therefore, is being reduced through alternative or preventive measures or by limiting use to clinically appropriate and adequately justified situations.

DEFINITION

The Joint Commission defines restraints as “the direct application of physical force, with or without the patient’s permission, to restrict his or her freedom of movement.” Any method (chemical or physical) of restricting a person’s freedom of movement, physical activity, or normal access to his or her own body is considered restraint.

The December 2006 CMS Conditions of Participation define physical restraint as any manual method of physical or mechanical device that restricts freedom of movement or normal access to one’s body, material, or equipment, attached or adjacent to the patient’s body that he or she cannot easily remove. Holding a patient in a manner that restricts his/ her movement constitutes restraint for that patient.

CMS and TJC define seclusion as the involuntary confinement of a person alone in a room or an area where the person is physically prevented from leaving.

Chemical restraints are not a standard of care at Stamford Hospital and if considered, this should be discussed with the Senior V.P. of Medical Affairs, the Senior V.P. of Patient Services, and the Director of Risk Management.

There are two sets of standards that govern restraint and seclusion: Acute Medical/Surgical restraints and Behavior Management Restraint or Seclusion.

Rationale	Acute Medical-Surgical Standard (Patient safety regarding interference with medical devices)	Behavior Management Standard- Restraint or Seclusion (Safety regarding patients exhibiting violent or self-destructive behavior)
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	Reason: To directly support medical healing.	Reason: To prevent injury due to violent, severely aggressive, combative, or destructive behavior to self or others.
	To prevent interruption of medical intervention (i.e. demonstration of a high potential for dislodging or removing or actual attempts to dislodge or remove, invasive lines, tubes, etc.)	To prevent injury due to self-destructive behavior, suicidal ideation or intent (e.g. self-mutilating or dangerous, risk taking behavior).
Orders and Time Limits	<p>A written physician's order must be obtained within 1 hour for patients requiring physical restraint The order may be by telephone, but must be countersigned, dated and timed within 24 hours.</p> <p>A note regarding the rationale for the restraint order included in the physician's Progress Notes.</p> <p>Orders must be time-limited, state a reason for use, and specify type of restraint to be used. Time limit=24 hours.</p> <p>PRN orders are never acceptable. The Restraint / Seclusion Physician Order Form is used by the physician to record and subsequently reorder patient restraints as required.</p>	<p>A physician must see the patient within 1 hour and evaluate the patient's immediate situation, the reaction to the intervention, medical and behavioral condition, and the need to continue or terminate the restraint or seclusion. After determining that restraint / seclusion are needed to manage patient behavior that might harm the patient or others, the physician or PA must provide a written order for the restraints or seclusion.</p> <p>Even if the patient is released from the restraint or seclusion within the first hour, the patient must be seen by the physician or PA.</p> <p>A note regarding the rationale for the restraint or seclusion order is included in the physician's Progress Notes.</p> <p>Orders are time-limited, state reason for use, and specify type of restraint to be used. Time limits = 4 hours for adults 2 hours for patients 9-17 years 1 hour for patients under 9 years PRN orders are never acceptable. The Restraint / Seclusion Physician Order Form is used by the physician to record and subsequently reorder patient restraints as required.</p>
Order Renewal	A new written order must be obtained every 24 hours in order to continue restraints following a face-to-face reassessment by the physician or PA.	After initial restraint / seclusion period (above), the RN may determine that continued restraint is needed. The physician is not required to perform another face-to-face assessment of the patient after 4 hours (or 2 hours or 1 hour for younger patients). While we encourage physician participation in the delivery of care and treatment, when the original order is about to expire, a nurse can telephone the physician, report the results of his / her most recent assessment, and request that the original order be renewed for another period of time (not to exceed the time limits established in the regulation.)
Order Notification	The treating / attending physician is notified of the patient's need for restraint as soon as possible if the treating / attending physician is not the physician ordering the restraint.	The treating / attending physician is notified of the patient's need for restraint or seclusion as soon as possible if the treating / attending physician is not the physician ordering the restraint/seclusion.
Education	Explain the reason for restraints to the patient and family as appropriate.	Notify and Explain the reason for restraints to the patient/and family

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Application	Apply restraint device according to manufacturer's specifications. Never fasten restraint to side rails.	Secure sufficient staff to safely apply restraints or place the patient in seclusion. Security may be called if necessary. Never fasten restraint to side rails. One Behavioral Health Unit a staff member must remain with the patient at all times. In the Emergency Department: A staff member / sitter must remain with the patient at all times.
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ADVANCE DIRECTIVES

It is the policy of Stamford Hospital to recognize and respect the wishes of patients regarding their health care as expressed through advance directives.

In Connecticut there are several types of advance directives: the living will; appointment of a health care agent; the durable power of attorney for health care decision; designation of conservator of the person for future incapacity, and document of anatomical gift.

Upon admission to the hospital the patient is asked whether he/she has an advance directive. The existence or absence of an advance directive is documented in the medical record. If the patient has an advance directive, a copy is filed with the medical record. If the patient has an advance directive but did not bring it to the hospital, nursing will follow up with patient's family to bring a copy of the advance directive from home. If the family is unable to bring the advance directive from home, or if the patient does not have an advance directive but would like more general information about it, he/she should be referred to the Department of Social Services.

The medical staff should review an existing advance directive with the patient as appropriate. The physician must write an order for DNR status. Prior to a procedure the physician performing the procedure must discuss suspending the DNR for the procedure, unless the physician and patient/legal representative agree to uphold the DNR status (see consent form). Copies of advance directives will be retained as part of the patient's medical record after discharge.

INFORMED CONSENT

Stamford Health shall insure that Informed Consent is obtained and documented as a prerequisite to any procedure or treatment for which it is appropriate. Informed Consent shall be obtained and documented for:

- All inpatient and outpatient operative and invasive procedures performed, regardless of the location where it is performed—surgical/procedural suite or bedside.
- The transfusion of all blood products
- The administration of anesthesia services
- Whenever, in the judgment of the responsible physician, the situation or nature of the procedure warrants that written consent be obtained.

Informed consent is a process, not just the signing of a form. Informed Consent is an agreement or permission accompanied by full notice about the nature of the procedure, indications, common risks and complications, intended benefits and alternatives to care, treatment or service that is the subject of the consent. A patient must be apprised of the nature, risks, benefits and alternatives of a medical procedure or treatment before the physician begins any such course.

The duty to provide informed consent rests solely with the physician who is performing the procedure or treatment. This responsibility may not be delegated to other hospital personnel. Once the informed consent discussion occurs, this discussion should be documented in the medical record. The best protection for patient and practitioner is a detailed note in the medical record. To ensure a level of uniformity, the appropriate hospital-approved Informed Consent Form for (1) Operation/Procedure, (2) Blood Transfusion, and (3) Anesthesia shall be completed and signed by the physician ordering and/or performing the procedure or treatment.

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If the determination is made that a patient requires a procedure or treatment requiring informed consent on an emergency basis, and for any reason is unable to understand or sign a Consent Form, the Health Care Representative, Next of Kin or Authorized Representative shall be required to sign the form. If any of the above parties are unavailable, but may be contacted by telephone, the physician performing the procedure or treatment shall complete page one and two of the Informed Consent Document(s).

If a Health Care Representative, Next of Kin or Authorized Representative cannot be located, and the physician has determined that the procedure or treatment is required on an emergency basis, because there is a substantial risk of death or immediate and serious harm to the patient, the physician performing the procedure or treatment is required to document in the chart the necessity of the procedure or treatment and the steps that were taken to attempt to contact the patient's Health Care Representative, Next of Kin or Authorized Representative. Additionally, the physician should complete the relevant section of the Informed Consent Document(s).

II. DISCLOSURE OF UNANTICIPATED EVENTS AND OUTCOMES OF CARE

It is the policy of Stamford Health for patients to know about their medical status, treatment and outcomes of care, including unanticipated events or outcomes of care. Unanticipated outcomes are either: 1) outcomes of care that the patient (or family) must be knowledgeable about in order to participate in current and future decisions affecting the patient's care; or 2) outcomes that differ significantly from what was anticipated to be the expected result of a treatment or procedure, including known complications. In the event of an unanticipated outcome, the attending physician (or his or her designee) and appropriate hospital personnel should communicate with each other to decide the appropriate content, manner, style and timing for informing the patient. Generally, the attending physician is expected to participate in informing the patient of the unanticipated event or outcome of care. Such disclosure should be presented in a truthful, compassionate, straightforward and non-judgmental fashion and should not ascribe fault or blame. Following the disclosure, a summary of the discussion should be documented in the medical record by the attending physician (or his or her designee). The note should identify the nature, severity and the cause (if known) of the unanticipated event or outcome of care, the date and time of the disclosure, the person(s) to whom it was made, the identity of all persons present during the disclosure discussion and any follow-up plan.

ADVERSE EVENT REPORTING

Effective October 1, 2002, the State of Connecticut instituted mandatory reporting by all hospitals and ambulatory surgery centers in Connecticut of most adverse events. Every adverse event must be reported to the Risk Management Department immediately for a determination as to whether the event meets the reporting criteria, regardless of the patient's outcome. Risk Management must report certain adverse events to the Department of Public Health. Failure to report and delays in reporting will be looked at unfavorably by the Department of Health and is against State regulations and statutes. Physicians' involvement in risk management activities is essential to comply with this law.

CONSCIOUS SEDATION (FORMERLY KNOWN AS PROCEDURAL OR MODERATE SEDATION)

It is the policy of Stamford Hospital to provide guidelines for the management of patients receiving sedation for procedures in order to maximize benefit and safety. The detailed policy can be obtained through the Medical Affairs Department's Medical Staff Office.

Conscious sedation is defined as a pharmacologically induced depression consciousness which patients respond appropriately to verbal command (note, reflex withdrawal from a painful stimulus is not considered a purposeful response) – either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. (The Joint Commission, 2008 manual). To help evaluate the potential for adverse effects, risk assessment using the American Society of Anesthesiologists (ASA) Classification of Patients is recommended. Practitioners must be specifically credentialed to administer moderate (procedural) sedation by

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achieving a passing score on the conscious sedation test **and** demonstrating airway rescue management skills. The test can be obtained from the Medical Staff Office and they can assist you in scheduling your demonstrated airway exam with a member of the Anesthesiology Department.

Patient sedation, preparation, workup, management and disposition are the responsibility of the physician and include:

- History and physical within 30 days
- Reassessment prior to the procedure
- NPO-solids (6 hours); clear liquids (2 hours) except in situations where urgent or emergent intervention is required as determined by the attending or intervening physician.
- Informed consent must be obtained per hospital policy using the Anesthesia Consent Form since a uniform standard for anesthesia services must exist throughout the institution.
- Determination of risk and ASA Class by Physician
- High-risk patients Class III, IV and V, (at the discretion of the attending physician) may require services of other specialties such as Anesthesia, Cardiology or Pulmonary Medicine.
- If anesthesiology services are required, the procedure will be performed in the main operating suite except when equipment precludes such location
- Monitors to be used and parameters to be monitored:
 - Non-invasive blood pressure
 - Cardiac monitor
 - Heart rate
 - Oxygen saturation
 - Respiratory rate

RESEARCH

All research performed at Stamford Hospital, whether a clinical drug trial, survey, chart review, or database analysis, must be submitted in advance to the Stamford Hospital Office of Research and Stamford Hospital Institutional Review Board (IRB) of record. The IRB is a committee comprised of scientific and non-scientific members, including community representatives, whose responsibility it is to protect the rights and welfare of study subjects. Stamford Hospital IRB of record may approve, request revisions, not approve, or waive IRB oversight in accordance with federal regulations and guidelines. In some instances, the IRB of record may delegate oversight to a duly convened central IRB. Stamford Hospital IRB of record also serves as the HIPAA Privacy Board for research under its purview. Stamford Hospital Office of Research Policies and application forms are available on-line at the Office of Research Department page on the Stamford Hospital Intranet. Additional information can be obtained from the Director of the Office of Research at 203-276-7866. The Office of Research is available to assist with protocol development, creation and modification of informed consent documents, budget review, and consultation regarding HIPAA and other research regulations. All studies are required to be reviewed the Office of Research prior to submission to the Stamford Hospital IRB of record or duly convened central IRB.

RESUSCITATION POLICY (DNR)

Unless a DNR order has been written pursuant to all applicable provisions of this policy, every person admitted to the Hospital shall receive CPR in the event of cardiac or respiratory arrest. For details of procedures to follow, see the Administrative Policy and Procedure Manual on any patient care unit.

The attending physician shall make all DNR orders in writing on the doctor's order sheet. Such duty may not be delegated. The attending physician in the patient's progress notes must confirm all verbal DNR orders within twelve hours. The officially approved DNR order form is preferred.

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Patients with existing DNR orders that are being transported between health care facilities, including transfer between two hospitals, are required to have a "state transfer form" filled out. Patients that have DNR orders in the hospital and are to be discharged must be offered an orange bracelet. Hospitals and health care facilities must honor both the state transfer form and an approved orange DNR bracelet.

TRANSFER POLICY

When transferring a patient to another facility (this includes a patient that is going to another facility either by ambulance or by personal transportation), the federally mandated transfer policy must be complied with.

The salient points of this policy include the following:

- Upon determination of the need for transfer, the Nursing Manager/Off Shift Coordinator will be notified to facilitate the transfer
- No patient will be transferred until the receiving facility has consented to accept the patient
- The attending of Record or designee at the receiving facility must be contacted by the responsible Attending/designee at Stamford Hospital to assure patient acceptance
- Medical stabilization must be assured to an extent, which minimizes the risks of transfer to the accepting facility. The physician must certify this in writing by signing the transfer authorization.
- A Patient Transfer Check List will be completed and a Patient Transfer Consent form will be completed and signature obtained.

III. COMMUNICATION POLICY FOR DEAF AND HARD OF HEARING PATIENTS

It is the policy of the Stamford Health System, in accordance with standards established in Consent Decree No. 395-CV-02408 (AHN), in collaboration with the State Office of Protection and Advocacy for Persons with Disabilities, to provide deaf and hard of hearing patients and their companions with appropriate auxiliary aids and services necessary for effective communication with health care providers. An initial assessment of the communication needs of all patients must be documented by the health care provider in the patients' record.

The Hospital Information Office is responsible for oversight of these services which will be provided free of charge. If you have questions regarding access to or use of auxiliary aids or services, or experience problems obtaining an interpreter or equipment, contact Human Resources at x7570 or Social Work at x4440.

Appropriate auxiliary aids and services for the hearing impaired include:

- Qualified sign language and oral interpreters
- Assistive (personal) listening devices
- Text telephones (TTYs/TDDs)
- Amplified phones
- Closed caption decoders or televisions equipped with built-in decoders
- Open and closed captioning
- Written materials and communication by writing notes
- Hearing aid compatible phones
- Note-takers
- Pictographs

Stamford Hospital has arranged for interpreters to be provided through Family Services Woodfield (FSW) of Bridgeport, CT. When an interpreter is necessary for a scheduled visit, contact FSW as soon as possible at 888-676-8554 to schedule an interpreter. For emergency or unscheduled visits, an interpreter must be requested from FSW within 15 minutes of determining that a patient/companion is in need of an interpreter. FSW has agreed to respond on site within one hour and 15 minutes from the time of request. In the event that an interpreter is not available, a list of independent interpreters is available from the Information Office or the State of

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Connecticut Commission on the Deaf and Hearing.

Stamford Hospital Emergency Department, the Switchboard, off shift Nursing Supervisors and the Tully Campus Immediate Care Center can arrange for delivery of a case containing auxiliary devices for deaf and hard of hearing individuals. This equipment can be delivered within 30 minutes of the patient's arrival.

IV. INFECTION PREVENTION AND CONTROLFACTS FOR PHYSICIANS

Consider all blood and body fluids as potentially infectious. Precautions such as barrier protection (gloves, gowns, masks, goggles, etc.) should be used for all contact with blood and body fluids to prevent the spread of blood borne pathogens. Standard Precautions apply to all patients. Transmission Based Precautions are the second tier of precautions used in addition to Standard Precautions, and replace previous forms of Isolation. These precautions are based on three of the different types of transmission: Contact, Droplet, and Airborne. There may also be combinations of precautions for some diseases.

- Contact Precautions (gown and gloves to be worn) are used for diseases transmitted by direct and indirect contact with patients and their environments (examples: MRSA, VRE, C. difficile).
- Droplet Precautions (surgical string or procedure mask to be worn) are used for diseases transmitted by droplets that are generated by coughing and sneezing, etc (examples: Meningococcal disease, Pertussis, Influenza).
- Airborne Precautions (N 95 Mask to be worn) are used for diseases transmitted by the airborne route (examples: Tuberculosis, Measles, Varicella)

MDRO and C. difficile Policy on the Intranet and Pocket guides provide specifics for Isolation and culturing patients to attempt to clear them.

Additionally, Barrier Precautions (gloves are to be worn) are used for all patient contacts in ICU, IMCU and NICU.

HAND HYGIENE

THOROUGH HAND HYGIENE IS THE MOST IMPORTANT FACTOR IN PREVENTING THE SPREAD OF INFECTIOUS DISEASES. HAND WASHING, OR HAND SANITIZING WITH ALCOHOL SANITIZER, MUST BE PERFORMED BEFORE AND AFTER EVERY SINGLE PATIENT CONTACT (even when gloves are worn, and after handling used equipment, for at least 15 seconds. Sinks are available on all patient care units, as are alcohol hand sanitizer dispensers. Soap and water are preferred when hands are soiled, or when spore-borne diseases are present, such as C. difficile).

SAFE WORK PRACTICES

Engineering and work practice controls have created a safer environment for health care workers. Needles should not be recapped or purposely broken or bent, and should be disposed of in readily identifiable sharps containers. Needleless IV systems along with other OSHA mandated needle safe devices and techniques have been adopted. Use one-handed techniques for sharps disposal, self-sheathing hollow-bore needles where possible, and increase the use of blunt tip suture needles in surgical procedures.

We promote Bundles of best practices for insertion, maintenance and removal of Devices for the purpose of reducing the risk of development of Healthcare associated infections. Daily Device Rounding is encouraged to try and get all devices out of patients as soon as they are no longer needed.

Nurse-directed Foley catheter removal is a key factor in our having very low CAUTI and Foley Catheter utilization rate. When Foley Catheters are ordered, the physician must indicate the reason for the catheter, and then daily nurses assess the patient per specific criteria to see if the catheter can be removed. If a patient meets criteria, nursing can remove the catheter per a standing order that was approved/endorsed by the Medical Executive Board.

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PERSONAL PROTECTIVE EQUIPMENT (PPE)

PPE provides barrier protection from exposure to infectious material. This includes the use of gloves, gowns, masks, face shields, goggles, etc. This equipment is located in a variety of locations on the nursing units as well as in other hospital depts. Gloves should be removed immediately after contact with infectious material, and hands should be washed/sanitized. All disposable items soiled with infectious material should be disposed of in red bio hazardous waste bags. Non-disposable items and linens should be handled by designated staff (nursing, environmental services, etc.)

Equipment cleaning/disinfection should be done after each use/patient contact. PDI Wipes (Alcohol/Quat and Bleach-based) are available on all units for ease of use in keeping equipment clean after each use

BIOHAZARDOUS WASTE

Biomedical Waste includes any items that could contain blood or body fluids such as wound drainage containers, dressings caked or saturated with blood or body fluid, urinary drainage systems, blood bags and tubing, and the like. The Biohazard Symbol is displayed and denotes infectious material.



EXPOSURE CONTROL PLAN

This plan contains the descriptions of job positions at risk, protective measures and procedures, and instructions of what to do if an exposure to potentially infected blood or body fluids occurs. OSHA Regulations including the Exposure Control Plan are located in the Infection Prevention and Control policies on the Intranet. Any exposure to blood or other potentially infectious material in eyes, on mucous membranes, skin, or through a break in the skin as in a puncture or needle stick, must be reported immediately for exposure follow-up in the Employee Health Department, or the Emergency Department at off hours. Post-exposure prophylaxis (PEP) should be administered by protocol according to the degree of risk and immunization status of the recipient. The Infectious Diseases Service should be consulted for questions.

N 95 PARTICULATE RESPIRATOR MASK

Is to be worn for contact with patients that have diseases spread by the airborne route, such as tuberculosis. These patients should be in negative pressure rooms with Airborne Precautions. Fit testing is required for staff prior to wearing this mask, and is provided by the Employee Health Department. Some personnel may not be able to wear a PR mask because of medical conditions such as asthma, or facial hair that interferes with a good seal. For such employees a Powered Air-Purifying Respirator system (PAPR) is available through the storeroom. Employee Health staff will provide training in the use of the PAPR when this is required.

TUBERCULOSIS PROTOCOL

All practitioners should have an intermediate PPD skin test performed at least annually. Health Care Workers involved in high-risk areas are to be tested every six months. Initial testing should be by a 2-step method. Individuals known to be previously positive will be evaluated on an individual basis. Health care workers exposed to a patient with active tuberculosis will be managed according to TSH protocol. This is a requirement for appointment / reappointment to the medical staff.

VACCINATIONS

Non-immune practitioners should be vaccinated for Hepatitis B, Measles, Mumps, Rubella and Varicella. These are available upon request, in addition to PPD testing, from Stamford Hospital Employee Health Services. Annual influenza vaccination is strongly encouraged and is provided free to medical staff members through the hospital's Employee Health Service. Medical Staff are advised to confirm their immunity to rubella, mumps, measles, tetanus and diphtheria according

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to the American College of Immunization Practices recommendations. Pertussis re-immunization in the form of Tdap is recommended for all practitioners with pediatric contact. The Employee Health Service can assist in providing all of these immunizations when they are needed. Other vaccinations and prophylactic medications for exposure to diseases such as meningococcal infection may be deemed necessary during emergency situations, and will be provided under the auspices of the Infectious Diseases Department and State and Local Health Departments as necessary.

ANTIBIOTIC STEWARDSHIP

Antibiotic resistance and the scarce antibiotic choices for multi-drug resistant organisms are urgent worldwide public health problems. Consequently, antibiotic stewardship has become a critical responsibility for all antibiotic prescribers. Guidelines have proliferated in attempts to assist the practitioner in making good choices, many of which are posted on the Stamford Hospital Infectious Diseases Intranet page.

PRINCIPLES OF TESTING

1. Diagnostic tests should be used wisely to avoid unnecessary antibiotic therapy or therapy that is unnecessarily broad-spectrum.
2. Use rapid diagnostic tests and biomarkers (e.g. gram stains, PCR testing, procalcitonin) to differentiate bacterial vs. non-bacterial infection to avoid use of unnecessary antibiotic therapy.
3. Bacterial cultures for identification and susceptibility testing should be collected whenever possible to identify specific bacteria causing infection and facilitate use of narrow-spectrum antibiotics.
4. Avoid diagnostic testing without an appropriate clinical indication when the results may have unintended consequences. For instance, a urine culture or *C. difficile* testing should not be performed unless the patient meets clinical indication for testing.

PRINCIPLES OF TREATMENT

1. When appropriate for the infection, source removal (e.g., drainage of abscess, removal of an implicated device) should be accomplished early in the course of treatment.
2. When multiple therapeutic options are available, use the option with the narrowest therapeutic range and least risk of promoting *C. difficile* and other adverse events.
3. Recommendations for optimal dosing of antibiotics and duration should be based on published guidelines, many of which are posted on the Stamford Hospital Infectious Diseases intranet page.
4. Always use the minimum effective duration of antibiotic therapy.
5. De-escalated from initial empiric antibiotic therapy as soon as possible using the results of bacterial cultures and diagnostic tests to discontinue or narrow unnecessarily broad-spectrum antibiotic therapy.
6. Consult with infectious diseases specialist for guidance and review all antibiotic orders daily.

V. SAFETY MANAGEMENT PROGRAM FOR PHYSICIANS

There are a number of Joint Commission requirements for physician safety programs that are incorporated into Stamford Hospital's Safety Management Program, organized into seven categories within the Environment of Care:

- Safety Management
- Emergency Management (Internal and External Disaster Plans)
- Life Safety Management (Fire prevention, drills, and response)
- Hazardous Materials Management
- Security Management
- Utilities Management
- Medical Equipment Management

Stamford Hospital's Safety Officer is Joseph Hines, the Director of Safety & Security. The Safety Officer also serves as the Chairs of the Environment of Care Committee. He can be contacted in

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any of the following ways: Office ext. 6198 or through the switchboard, please ask for "Safety Officer."

EMERGENCY PREPAREDNESS PLAN (CODE YELLOW)

"Code Yellow" paged over the public address system means that one of the Hospital's Emergency Response Plans is being implemented. If you hear "Code Yellow" paged overhead you should immediately report to the Brace Auditorium to await further instructions from Incident Command or a Hospital Administrator.

Code Yellow - External Disaster Plan - When the Hospital has been notified of some type of accidental, natural or man made disaster that might cause a large inflow of patients (plane crash, train derailment, chemical spill, bioterrorist event, etc.) , the external disaster plan is implemented. The Hospital will use its Incident Command system to provide a coordinated response to dealing with the increased patient load.

Code Yellow - Internal Disaster Plan- The Hospital's internal Disaster Response Plan can be implemented whenever circumstances arise that have the potential to impact normal Hospital operations. Examples of internal events that may warrant the activation of the Internal Disaster Plan include; water, electrical, or heating/cooling system failure; telephone system failure; internal fire or structural damage to the building; bomb threat; hazardous materials spill, etc.

Key Physician Knowledge Points:

- recognize the difference between the internal and external plans
- understand that you should report to the Brace Auditorium and await instructions if Plan D is paged
- understand that physicians may be asked to assist with patient care activities when there is a large inflow of patients into the ED. They may also be requested to assist with support activities such as considering which patients may be eligible for early discharge to create additional bed space for victims of the disaster or with other support activities depending on the nature of the incident.
- Each department's Safety Manual (and the copy in the Physicians' Lounge) contains the Emergency Preparedness (Disaster) Plan. This manual, and the Infection Control Manual, includes details of the bioterrorism response plan.

LIFE SAFETY MANAGEMENT (FIRE SAFETY AND RESPONSE)

The Life Safety Management section includes information related to organization wide fire response including how to handle a fire at its point of origin. Know R.A.C.E.

Key physician knowledge points:

- Know what to do in the event of a fire
 - R** Rescue persons in immediate danger if it is safe for you to do so
 - A** Alarm (pull the nearest fire alarm pull station and then dial extension "1-1"
 - C** Contain the fire by closing doors to stop the spread of fire and smoke
 - E** Extinguish using the nearest fire extinguishers (see below for the procedure)
- Know what you should do if you discover a fire (R.A.C.E.) Know that the Emergency assistance number from any Hospital phone is 1-1.
- Know what the Hospital no smoking policy states: patients, employees, and visitors are not permitted to smoke inside the building without exception.

HAZARDOUS MATERIALS MANAGEMENT

By federal law each employee/physician has a right to know about the hazards of chemicals they might be exposed to during work at the Hospital. Each hazardous chemical within the Hospital has a Material Safety Data Sheet (MSDS) provided by the manufacturer. This information is available to you at all times (this is an OSHA regulation). Knowledge of MSDS sheets is also helpful to you clinically in the event of patient exposure.

Key physician knowledge points:

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- MSDS (Material Safety Data Sheets) are available at all times in departments or the master libraries in the ED, Security, EMS Institute or Employee Health
- Be particularly aware of chemotherapeutic and radioactive material precautions and disposal procedures
- How to handle a hazardous materials spill...think C.L.E.A.N.
- Contain the spill if safe to do so; Leave the area immediately and do not let other staff/patients near the spill; seek/provide Emergency medical treatment as necessary while someone Alerts the switchboard by dialing 1-1 for major spills; Never put your safety in danger! Know the risks and safety procedures involved with all chemicals you work with.

SECURITY MANAGEMENT

Stamford Hospital is committed to a Security Management Program designed to maintain a safe and secure environment for all persons interacting within Stamford Hospital and to protect the physical property of the facility.

Key physician knowledge points:

Physicians should be familiar with the services provided by the Security Department:

- How to request emergency assistance: dial 1-1 from any Hospital phone; give your name, exact location and the nature of the emergency
- Transport services during weather emergencies
- Employee escort services (to cars at night, etc.)
- The Hospital's "no weapons" policy
- Reporting theft, loss or damage to property

ALWAYS wear your ID badge when in the Hospital.

UTILITIES MANAGEMENT

The Utilities Management program helps ensure the operational reliability and response to the failure of utility systems, which support Stamford Hospital's patient care environment.

Key Physician Electrical Safety Knowledge Points:

- The Hospital has a system of emergency generators in place in the event of an electrical failure
- Be familiar with the use of the Red Plugs (activate when the emergency generators start)
- Check all equipment before use; if you note a problem do not use the equipment
- Avoid the use of extension cords; only use special fused "strips" for temporary use
- To report electrical equipment problems contact Facilities Management at x7700

Key Physician Medical Gas System Knowledge Points:

- Physicians should know that in the event of a medical gas system failure portable oxygen delivery devices are available; this is the first priority of staff response
- Physicians should know that there are medical gas shut off valves on each patient care unit but recognize that ONLY respiratory therapy is permitted to use these valves
- Wherever oxygen is used or stored signs must be posted indicating that there is no smoking permitted

Key Physician Medical Vacuum System Knowledge Points:

- Physicians should recognize that in the event of a medical vacuum system failure portable suction units are available from Respiratory Therapy

Key Physician Water System Failure Knowledge Points:

- Physicians should recognize that water system emergencies are addressed (with plans) in the Emergency Preparedness Manual; hand washing, water for patient consumption and water for bathroom use are address in the plan.

Key Physician Heating, Ventilating, Air Conditioning (HVAC) Knowledge Points:

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- Physicians should know that in the event of the failure of any one or all of the HVAC systems contingency plans have been made to continue operations
- In the event of heating or air conditioning failure, portable heaters and fans are available from Facilities Management

Key Physician Elevator System Operation Knowledge Points:

- The Hospital operates seven elevators. Individual elevator failure should pose no threat to normal operation. In the event of the failure of a bank of elevators, horizontal access to alternate elevators is available at all levels of the building
- Do not use elevators in the event of a fire emergency
- Do not use the elevators for routine travel during a Disaster Plan Activation (Use the stairs)
- Should the elevator malfunction, use the emergency telephone located in each elevator to request assistance. Facilities Management or the elevator company will provide assistance.

Key Physician Telephone System Failure Knowledge Points:

- In the event of telephone failure physicians should be familiar with emergency contingency plans located in detail in the Emergency Preparedness Manual
- Physicians should know that the loss of the telephone system includes the loss of the paging system
- Depending on the type of phone system failure the red phones may become active
- Portable two-way radios will be distributed to each unit and essential support departments
- Portable cellular telephones are available for use in key areas as defined in the Emergency Preparedness Plan.

Note: Cellular telephone use is expressly prohibited in all patient care areas of the Hospital.

MEDICAL EQUIPMENT MANAGEMENT

The Medical Equipment Management Program exists to minimize the risk of using medical equipment through inspection and preventive maintenance programs as well as through the education of equipment users and maintainers. The inspection and preventive maintenance program involves a Hospital wide inventory of all medical equipment.

Key Physician Medical Equipment Knowledge Points:

- Know how to handle defective medical equipment; if you discover defective medical equipment, make certain that it will not negatively impact patient care (replace it immediately)
- Remove it from service immediately and mark it as out of service.
- Notify Clinical Engineering to request service (x7577 or x7144).

All medical equipment must have a current Clinical Engineering inspection sticker on it. If the equipment does not, remove it from service and notify Clinical Engineering.

VI. JOINT NOTICE OF PRIVACY PRACTICES

This joint notice describes how medical information about the patient (referred to as you) may be used and disclosed, and how the patient can get access to this information.

Please review it carefully.

ORGANIZED HEALTH CARE ARRANGEMENT

This joint notice applies to services provided to you by the following facilities (including all their locations) and their medical staffs:

1. Stamford Hospital
2. The Rehabilitation Center of Southwestern Connecticut, Inc.
3. Tully Surgical Center
4. Center for Continuing Care of Greater Stamford, Inc. (The William and Sally Tandet Center for Continuing Care)
5. Visiting Nurse & Hospice Care of Southwestern Connecticut, Inc.
6. Continuing Care Retirement Community of Greater Stamford, Inc. (Edgehill)

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The medical staffs of each of these facilities have elected to join in this Joint Notice of Privacy Practices and participate with the above facilities in an Organized Health Care Arrangement. The persons and facilities listed above may share your medical information as necessary to coordinate your care, to carry out the treatment, payment or health care operations of the covered entities covered by this notice and for other purposes described in this notice.

The persons and facilities listed above are independent of one another and are acting together only for the purpose of obeying the laws relating to the privacy of your medical information. Nothing in this joint notice creates a partnership, joint venture or agency relationship between or among the participating facilities and their medical staffs.

UNDERSTANDING YOUR MEDICAL RECORD

Each time you visit a hospital, doctor or other healthcare provider, a record of your visit is made. The record includes the reasons you came for treatment, the physical exam, test results, what was found, the treatment and the plan for future care. This is called your Medical Record. Your Medical Record is used in many ways:

1. It is the basis for planning your care and treatment.
2. It is a way for the health team, involved in your care, to communicate.
3. It is a legal document that describes the care you got.
4. It is a way for the health insurance payers to check to see that they are paying for the services you got.
5. It is a tool used to educate health professionals.
6. It is a source of facts for research.
7. It is a source of health facts for public health officials.
8. It is a source of data for planning and marketing.
9. It is a way that we can check on our work and improve the care that we give.

Your Medical Record has personal health information. Both state and federal law protect the privacy of this information. We hope that if you understand how this information is used and shared, it will help you to:

- Make sure the information you give us is correct.
- Better understand who, what, when, where and why your health care providers and others may see your personal health information.
- Be able to make better decisions about who can use your personal health information.

YOUR HEALTH INFORMATION RIGHTS

Your Medical Record is the property of the health care center where you went for care. But the information in the Record belongs to you. Under the Federal Privacy Rules, 45 CFR Part 164, you have the right to:

1. Get a paper copy of this notice. Or you could get an email copy if you ask for it.
2. Ask to have the use of your Medical Record restricted in some way. We will consider your request. But we are not bound by law to do as you ask.
3. Ask that we send confidential information to you at another address - or in another way.
4. Look at and get a copy of your Medical Record - unless you cannot by law. There may be a fee to get a copy of your Medical Record.
5. Ask that changes/amendments be added to your Medical Record.
6. Get a record of who saw your Medical Record after April 14, 2003 and how it was used. There may be a fee for this.

Contact information is on the last page of this notice if you want to make any of these requests.

OUR RESPONSIBILITIES

We are required by the Federal Privacy Rules to:

1. Keep your health information private.

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2. Give you notice about how we will obey the privacy laws and keep your health information private.
3. Promise to follow our responsibilities as described in this Notice. But we keep the right to:
 - Change the way we handle your health information and give a date by which these new changes will start. (These changes will affect all your health information, old and new.)
 - Change the terms of this Notice.

We will tell you if we change the way we handle your health information. In the meantime, we will use or share it only as stated in this Notice - unless you give us your permission to use it in other ways.

HOW YOUR MEDICAL RECORD WILL BE USED AND SHARED

1. We will use your health information for treatment.

For example: Information you give a nurse, doctor or other health care provider will be put in your Medical Record. They will be used to plan your treatment. Your health care team will keep a record of your care and treatment in this Record.

We may give copies of reports from your Medical Record to your primary care doctor or other provider once you leave the hospital or treatment center. We may give copies of parts of your Medical Record to your specialists. Or we may need to give them to a treatment center to which you are being transferred.

We may use information about you to call you or send you a reminder letter or phone call:

- About an appointment
- To set up a regular check-up
- To give you information about other kind of treatments
- To tell you about health products and services we can give you.

2. We will use your health information for payment.

For example: A bill may be sent to you or your health insurance plan. The information on the bill will include your personal facts (such as your name and address). It will also have medical information so the payers can see what they are paying for.

3. We will use your health information to improve our services.

We may use your health information to see that all our patients get quality care. We want to see if our staff gives the care they should. We often want to see if we need to offer more services to people, or to see if the treatments we give are working. We may also use your health information as a way to train our medical staff.

4. Business associates may see some of your health information. We have companies that work for us. Examples of these are companies that do billing, type medical reports, copy records and do patient surveys. Some of them may need to see parts of your Medical Record in order to do their work. Every company that works with us and sees parts of your Medical Record must sign a privacy contract with us.
5. A Patient directory could have some information about you. Unless you tell us not to, we may place your name, room number, general health condition and religion on our patient or client directory. There is no medical information in this directory. Except for religion, this information may be given to family members, friends or others who ask for you by name. We may give this information and religion to the clergy. If you do not want to be in this directory, please tell the Admissions department. It will not be put in - unless we have given it out before you told us.

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6. Family or friends involved in your care may get information about you. Unless you tell us not to, health care providers may give information about you to members of your family, close personal friends or other persons that you name. They will be told only as much about you as is needed for your care - or for payment for your care.
7. We may use your contact information to raise funds. We may use such information as your name, address and dates you received care, to contact you when we try to raise funds for the facility. Any fund raising letters or calls will ask if you want us to stop these contacts.

Other Ways Your Health Information May Be Used or Shared Without Your Consent

1. When required by state or federal law.
2. To any public health officials who work to prevent or control disease.
3. To government officials who check out charges of abuse, neglect and domestic violence.
4. To government officials who monitor and license health care providers and facilities.
5. When needed for a court hearing.
6. To law enforcement officials so they can
 - report on wounds or injuries caused by a crime or accident
 - find fugitives, suspects and missing persons
 - Identify a witness, victim, missing person or suspect.
7. To coroners or funeral directors to identify a deceased person or other legal duty.
8. To persons who have consented to check on organs that can be donated.
9. For research approved by a Privacy Board (IRB) of a health care institution. Each Privacy Board has a duty to protect the privacy of your health information.
10. When needed to prevent a threat to health or safety.
11. When needed for special lawful government work including the military.
12. As required by law for workers compensation programs.

RULES ABOUT RELEASE OF YOUR HEALTH INFORMATION

Federal Privacy Rules state that we must release your health information for two reasons:

1. You ask for it; and
2. The US Department of Health and Human Services (or their contractors) asks for it. They would ask for it for legal reasons or to review some special problem.

USES YOU AGREE TO

We may ask to use your personal health information in other ways as well. But we will only do it if we have your written permission/authorization. You have the right to end this permission at any time. But we have the right to use your health information until the time you tell us that you take back your consent.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions about this notice, or If you have concerns about these privacy practices, or if you believe your privacy rights have been abused, please contact:

The Privacy Officer at Stamford Hospital, One Hospital, Stamford, CT 06904, or call: (203) 276-7454. If you believe your privacy rights have been abused, you may also file a complaint with the Office of Civil Rights, U.S. Department of Health and Human Services, Government Center, J.F. Kennedy Federal Building --- Room 1875, Boston, MA 02203.

There will be no action against you if you file a complaint.

Please give requests about your medical records to:
Stamford Hospital, Release of Information Specialist, HIM Department, One Hospital Plaza,
Stamford, CT 06902, (203) 276-7453.

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Continuing Care Retirement Community of Greater Stamford, Inc., Director of Nursing, 122
Palmer's Hill Road, Stamford, CT 06902, (203) 325-5597.

STAMFORD HOSPITAL
Clinical Service Manual

Subject: MEDICAL AND ANCILLARY STAFF CODE OF CONDUCT

Policy #: MS 210

Implemented:

Reference:

Revisions:

Approval: Senior V. P. Medical Affairs; MEC

Reviewed: 11/6/2017

Department: Medical and Ancillary Staff &
Administration

Page: 1 of 6

Purpose:

The purpose of this policy is to ensure safe and high quality patient care by promoting a safe, cooperative and professional health care work environment. By encouraging a fair and just culture, the aim is to prevent and eliminate conduct that disrupts operations of the Hospital, adversely affects the ability of hospital personnel to do their jobs or creates a hostile work environment for employees or other Medical and Ancillary Staff members.

High standards of professional behavior, ethics, and integrity are expected of all members of the Stamford Hospital Medical and Ancillary Staff. This code is a statement of the ideals and guidelines for professional behavior of the Medical and Ancillary Staff, aiming for exemplary patient care and trust, integrity, and honesty in all dealings with patients, families, other health professionals, employees, students, vendors, government agencies and others. Although this policy is for members of the Medical and Ancillary Staff it also reflects the values and expectations of Stamford Hospital regarding the behavior of everyone associated with our institution.

Policy:

This policy applies to members of the Stamford Hospital Medical and Ancillary Staff – Physicians, Dentists, Podiatrists and the Ancillary Staff- Advanced Practice Nurses, Physician’s Assistants, Ph.D.’s, CRNA’s, Psychologists. This policy applies to behavior directed towards any individual associated with Stamford Hospital. The policy may also apply to behavior that occurs outside of the physical boundaries of Stamford Hospital if it is directed towards anyone directly or indirectly associated with Stamford Hospital.

I. Standard of Conduct

It is the policy of The Stamford Hospital that all persons within its facilities be treated with courtesy, respect and dignity. To that end, all Medical and Ancillary Staff members shall conduct themselves in a professional and cooperative manner. Medical and Ancillary Staff members who engage in unacceptable or disruptive conduct shall be subject to disciplinary action in accordance with the corrective action procedures set forth in The Stamford Hospital Medical Staff Bylaws. This Standard of Conduct also applies to the use of electronic and social media as set forth in the Stamford Hospital Social Media Use Policy.

A. Definitions:

“Appropriate behavior” means any reasonable conduct to advocate for patients, to recommend

improvements in patient care, to participate in the operations, leadership or activities of the organized Medical and Ancillary Staff, and to speak at their meeting or to engage in professional practice, including a practice that may be in competition with the hospital.

“Inappropriate behavior” means conduct that is unwarranted, unprofessional, or is reasonably interpreted to be demeaning or offensive to any individual or group. Persistent, repeated inappropriate behavior can become a form of harassment and thereby become disruptive, and subject to treatment as “disruptive behavior.”

“Disruptive behavior” means any conduct which interferes with the cooperative and collegial atmosphere that is required for the delivery of quality health care. Disruptive behavior may include overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities. Disruptive behavior may also include abusive conduct, including sexual or other forms of harassment, or other forms of verbal or non-verbal contact including that communicated via electronic or social media that harms or intimidates others to the extent that their ability to perform their work and deliver quality and safe patient care could be compromised.

“Harassment” means conduct toward others based on their race, religion, age, gender, gender identity, sexual orientation, nationality or ethnicity, which has the purpose or direct effect of unreasonably interfering with a person’s work performance or which creates an offensive, intimidating or otherwise hostile work environment.

“Sexual harassment” means unwelcome sexual advances, requests for sexual favors, or unwelcome conduct of a sexual nature which has the purpose or effect of unreasonably interfering with a person’s work performance or which creates an offensive intimidating or otherwise hostile work environment.

“Medical and Ancillary Staff member” means physicians and other health care professionals granted membership on the Medical and Ancillary Staff and, for purposes of this Code, includes individuals with temporary clinical privileges.

B. Types of Conduct:

1. **Appropriate Behavior** – the following are examples of appropriate behavior that in itself will not subject the individual to disciplinary action: Medical and Ancillary Staff
 - a. Criticism communicated in a confidential and reasonable manner and offered in good faith with the aim of improving patient care and safety, and the ideals of Stamford Hospital;
 - b. Encouraging clear communication in appropriate settings;
 - c. Expressions of concern about a patient’s care and safety in a productive and respectful manner to Medical and Ancillary Staff leadership, Stamford Hospital management or members of the patient’s health care team;
 - d. Expressions of dissatisfaction with policies through appropriate grievance channels or other civil non-personal means of communication;
 - e. Constructive criticism conveyed in a respectful and professional manner, without blame or shame for adverse outcomes;
 - f. Professional comments to any professional, managerial, supervisory, or administrative staff responsible for peer review, risk management or health care

- operations specific to the comments about patient care provided by others, or members of the Board of Directors about patient care provided by others;
- g. Membership on other medical and ancillary staffs.

2. Inappropriate Behavior

Inappropriate behavior by Medical and Ancillary Staff members is unacceptable.

Examples of inappropriate behavior may include, but are not limited to, the following:

- a. Belittling or berating statements;
- b. An inappropriate tone of voice or gesture;
- c. Name calling;
- d. Use of profanity or disrespectful language;
- e. Inappropriate comments written in the medical record;
- f. Failing to respond to patient care needs or staff requests;
- g. Personal sarcasm or cynicism;
- h. Deliberate lack of cooperation without good cause;
- i. Refusal to return phone calls, pages, or other messages concerning patient care or safety;
- j. Intentionally condescending language; and
- k. Intentionally degrading or demeaning comments regarding patients and their families; nurses, physicians, hospital personnel and/or the hospital.

3. Disruptive Behavior

Disruptive behavior by Medical and Ancillary Staff members is prohibited. Examples of disruptive behavior include, but are not limited to, the following:

- a. Physically threatening language directed at anyone in the hospital including physicians, nurses, other Medical and Ancillary Staff members, or any hospital employee, volunteer, resident physician or student, administrator or member of the Board of Directors;
- b. Physical contact with another individual that is threatening or intimidating;
- c. Throwing instruments, charts or other objects;
- d. Threats of violence or retribution;
- e. Sexual harassment; and,
- f. Other forms of harassment including, but not limited to, persistent inappropriate behavior and repeated threats of litigation.

II. Interventions

Interventions should initially be non-adversarial in nature, if possible, with the focus on restoring trust, placing accountability on and rehabilitating the offending Medical and Ancillary Staff member, and protecting patient care and safety. The Medical and Ancillary Staff supports tiered, non-confrontational collegial intervention strategies, starting with informal discussion of the matter with the appropriate section chief or department chairperson.

Corrective action pursuant to the Medical Staff bylaws may be activated if the behavior is or becomes disruptive. The use of summary suspension, as defined in the Bylaws, is a serious action implemented in circumstances including, but not limited to, situations in which failure to take such action may result in an imminent danger to the health of any individual. At any time, rehabilitation may be recommended. If there is reason to believe inappropriate or disruptive behavior is due to illness or impairment, the matter may be evaluated and managed confidentially according to the established procedures of the Stamford Hospital Physician Wellness Committee (or equivalent committee).

III. Procedure

Complaints about a member of the Medical or Ancillary Staff regarding allegedly inappropriate or disruptive behavior can be made to the individual's supervisor, a member of the Hospital administration or the President of the Medical Staff. If a report is not made directly to the President of the Medical Staff, the person receiving the report should advise the SVPMA/Chief Medical Officer or the President (or Vice President) of the Medical Staff of the nature of the report.

The person making the complaint should do so in writing and include, to the extent feasible, the following:

1. Date(s), time(s) and location of the inappropriate or disruptive behavior;
2. A factual description of the inappropriate or disruptive behavior;
3. Circumstances surrounding the incident;
4. Name or medical record number of any patient or patient's family member who was involved in or witnessed the incident;
5. Names of other witnesses to the incident;
6. Consequences, if any, of the inappropriate or disruptive behavior as it relates to patient care or safety, or hospital personnel or operations; and
7. Any action taken to intervene in, or remedy, the incident, including the names of those intervening.

The President of the Medical and Ancillary Staff, or appropriate designee, will inform the Senior Vice President for Medical Affairs/Chief Medical Officer and the Department Chair as soon as possible after the complaint is received either verbally or in writing. The complainant will be provided a written acknowledgement of the complaint. Complaints submitted by the Patient Safety Hotline, QASYS, or through risk management will be handled in the same way as a formal written complaint.

In all cases, the President of the Medical and Ancillary Staff and Senior Vice President for Medical Affairs/Chief Medical Officer shall initially review the complaint to determine whether an investigation is necessary.

- If the complaint is deemed to be not valid or is not an appropriate complaint pursuant to this policy, no review is necessary.
- If the complaint is deemed to be valid and is an appropriate complaint pursuant to this policy does warrant further review, the subject of the complaint shall be provided a copy of this Code of Conduct and a copy of the complaint (which should, as best as possible, not include identifying information on the reporter) in a timely fashion. The individual will be notified that attempts to confront, intimidate, or otherwise retaliate against the complainant is a violation of this Code of Conduct and may result in corrective action against him or her.
 - An ad hoc committee, none of the members of which may be economic competitors of the subject of the complaint, consisting of the President or Vice President of the Medical and Ancillary Staff, or designee, and at least two additional members of the medical executive committee, shall review as appropriate in the circumstances.
- If the individuals involved in the alleged conduct are visitors, employees or contractors of Stamford Hospital, all reviews shall be coordinated through the Senior Vice President for

Medical Affairs/Chief Medical Officer. With approval of the Senior Vice President for Medical Affairs/Chief Medical Officer, the investigation may include seeking to interview the complainant, any witnesses, and the subject of the complaint.

- The subject Medical or Ancillary Staff member shall be provided an opportunity to respond in writing to the complaint.

The Ad Hoc committee shall make one of the following recommendations to the President of the Medical Staff:

1. No further action is necessary as the review did not reveal any disruptive or inappropriate behavior. Such recommendation shall be made by written report summarizing the findings of the ad hoc committee and the basis for the recommendation. Or
2. Action is necessary because the review did reveal disruptive and/ or inappropriate behavior. Actions may include a recommendation for intervention or corrective action pursuant to the Stamford Hospital Medical Staff Bylaws. Such recommendation shall be made by written report summarizing the findings of the ad hoc committee and the basis for the recommendation.
 - a. When making a recommendation for intervention or corrective action, the Ad Hoc Committee should consider the following:
 - i. Initial Violation of the Code of Conduct
 1. In the first violation, especially if defined as Inappropriate, of the Code of Conduct the Chair of the department (or the appropriate section chief if designated by the chair) will review the matter with the subject of the review, and emphasize that the behavior is inappropriate and must cease. Further actions including an apology to the complainant may be required. The approach during this initial intervention should be collegial and helpful.
 2. If Disruptive, more actions may be recommended and required, see below.
 - b. Repeated Violations of the Code of Conduct
 - i. If the ad hoc committee determines the Medical/Ancillary Staff member has demonstrated persistent, repeated inappropriate behavior, constituting harassment (a form of disruptive behavior), or has engaged in disruptive behavior on the first offense, a letter of admonition will be sent to the subject of the complaint, and, as appropriate, a rehabilitation action plan developed by the ad hoc committee, with the advice and counsel of the medical executive committee.
 - ii. If, in spite of this admonition and intervention, disruptive behavior recurs, the ad hoc committee shall meet with and advise the individual that such behavior must immediately cease or corrective action will be initiated. This “final warning” shall be sent to the in Medical/Ancillary Staff member in writing.

5. If after the “final warning” the disruptive behavior recurs, corrective action (including suspension or termination of privileges) shall be initiated pursuant to the Medical Staff bylaws Section 13.1, and the offending Medical and Ancillary Staff member shall have all of the due process rights set forth in the Medical and Ancillary Staff bylaws.
6. If a single incident of disruptive behavior or repeated incidents of disruptive behavior constitute an imminent danger to the health of an individual or individuals or is egregious in nature, the offending Medical and Ancillary Staff member may be summarily suspended as provided in the Medical and Ancillary Staff bylaws. The Medical/ Ancillary Staff member shall have all of the due process rights set forth in the Medical Staff bylaws.
7. If no corrective action is taken pursuant to the Medical Staff bylaws, a confidential memorandum summarizing the disposition of the complaint, along with copies of any written warnings, letters of apology, and written responses from the offending Medical and Ancillary Staff member, shall be retained in the staff member’s credentials file. Informal rehabilitation, a written apology, issuance of a warning, or referral to the Wellness Committee (or equivalent committee) will not constitute corrective action.
8. At any time during this procedure the Medical/Ancillary Staff member has a right to personally retain and be represented by legal counsel. However, such right does not entitle the practitioner to have their legal counsel attend any meeting between the practitioner and the Medical and Ancillary Staff or Hospital leadership or the ad hoc investigative committee.

IV. Abuse of Process

Threats or actions directed against the complainant by the subject of the complaint will not be tolerated under any circumstance. Retaliation or attempted retaliation by Medical/Ancillary Staff members against complainants will give rise to corrective action pursuant to the Medical Staff bylaws.

Individuals who falsely submit a complaint may be subject to corrective action under the Medical and Ancillary Staff bylaws or hospital employment policies, whichever applies to the individual. Refer to the Non-retaliation policy for further information.

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Subject: New Technology/Procedure

POLICY: New technology (procedures, devices, techniques) that is not covered by an existing privilege delineation form may not be performed without prior determinations by the relevant department (and division, if applicable), the Medical Executive Committee, and the Board of Directors, that the technology would be appropriate to include among the services available to patients at this hospital. (These requirements do not apply to "clinical research," including the use of an experimental drug or device, which is covered by existing delineated privilege forms; such activities must, however, be approved by the Institutional Review Committee in accordance with applicable hospital and medical staff policies and procedures and state and federal laws.)

Criteria for delineation of clinical privileges should specify the certification or training and experience needed to be eligible for specific clinical privileges in a specialty. Criteria should be developed for all new procedures, the only exceptions being those that are clinically or procedurally similar to an existing modality.

If an applicant currently on the medical / ancillary staff requests clinical privileges for which there are no developed criteria, the practitioner should be informed that the procedure is not currently performed at the hospital, but that within a reasonable amount of time, the hospital will consider the request and will inform the practitioner whether it intends to allow that procedure to be performed, and the criteria that will be required of applicants who wish to perform it.

In making the determination whether to allow a particular procedure to be performed at the hospital, the following will be considered:

- Hospital's available resources and personnel
- Ability to appropriately monitor and review the competence of the physician to perform the procedure
- Availability of qualified physicians or other appropriate appointees to provide medical coverage for the physician in case of the applicant's illness or unavailability.
- Quality of the training programs available.

Procedures will not be scheduled until the following process is completed.

Procedure:

1. A practitioner who wishes to propose that a new technology be approved must submit the following information to the chairman of the appropriate department or, if applicable, the chief of the appropriate section:

- A description of the technology, including the indications and contraindications for it.
- A description of any new equipment or other resources that would have to be obtained, and/or any special support staff training or orientation that would have to be provided, in connection with the new technology.
- A description of the results, complications and other pertinent information reported in relevant scientific literature, with citations as appropriate.
- A description of the background and training that should be required to qualify a practitioner for privileges to perform the procedure, with reference to scientific literature and other sources of guidance as appropriate.

2. The department chairman or division director shall consider the proposal and conduct such additional inquiries or proceedings as he deems appropriate. This may include, among other options, consultation with appropriate department directors (i.e., director of perioperative services), outside experts, additional literature review, and/or presentation for general discussion at a department or section meeting. If the matter is initially considered by a division director, he shall make a recommendation to the department chairman. The department chairman shall make a written recommendation to the Credentials Committee, with relevant documentation.

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3. The Credentials Committee shall make a written recommendation to the Medical Executive Committee, with relevant documentation, including:
 - A proposed monitoring and quality review plan to assess the medical staff's overall experience with the new technology for a reasonable period or number of cases after it comes into use, taking into account anticipated results, comparative data from other institutions, and other relevant factors.
 - A proposed set of proctoring requirements to verify the competence of individual practitioners who are granted privileges to perform the new procedure, if applicable.
4. The Medical Executive Committee shall make a written recommendation to the Board of Directors, which shall make a final decision.
5. Following the Board of Directors' approval of the new technology, requests for privileges to perform it may be submitted by individual practitioners and processed in accordance with the medical-dental staff bylaws, rules and regulations, and credentialing policy.

Package: 12/28/01mfp revised1/14/03,4/03,7/03, 07/06, 12/07, 6/17, 12/17, 11/18

Stamford Health

Subject:	Interdisciplinary Clinical Communications Policy		
Policy #	[]	Implemented:	February 8, 2018
Reference(s)	HSS Communications Policy	Reviewed:	
Approval	Medical Executive Committee	Revised:	
Departments	Medical Staff, Clinical Departments	Page	1 of 4

1.0 Purpose

To assure Medical and ancillary staff members, care team members, and non-clinical staff at STAMFORD HEALTH have effective, efficient, reliable, secure and verifiable clinical communication processes to communicate about patient care; while defining which communication platforms should be utilized for different types of information.

2.0 Scope

- Establish a secure communications platform for all clinical staff to improve care for our patients, with processes that are HIPAA compliant and minimize the use of pagers, while providing a central location for call schedules with real-time updates.
- Reduce communication breakdowns which may cause delays in care by establishing a standardized clinical communication process that removes steps to find the correct physician, advanced practice practitioner or care team member, time delay of answering services, and includes manual escalation processes.
- Harness the full potential of the medical record, by effectively communicating critical, and many times actionable, information to the correct physician, advance practice practitioner or care team member in a timely manner that improves care coordination.

3.0 Policy

As indicated in this policy, STAMFORD HEALTH will use PerfectServe for inter-provider conversations related to patient care, but this does not replace the need to document all clinical activities and decision making in the patient's legal medical record. Perfect serve is the single platform that is to be used by physicians, advance practice practitioners, care team members, and non-clinical staff 24 hours a day, 7 days a week to enhance clinical collaboration and communication.

The EMR is, and will remain, the patient's legal medical record and source of truth for documentation related to the patient's care. Importantly, PerfectServe may not be used for placing orders.

Call schedules and coverage assignments will be updated and maintained within PerfectServe by all Physicians on the Active , Courtesy, and House Staff, on call to Stamford Health. Failure to do so may result in messages being sent to the wrong physician and delays in patient care. Noncompliance with this policy will be addressed via the appropriate Clinical Chair.

Medical Staff with individual user accounts on the PerfectServe Practitioner platform will access their conversations via the PerfectServe Practitioner mobile application on their Stamford Health issued or personal device, or by logging in to www.perfectserve.com.

All Active, Courtesy, and House Staff are required to use the PerfectServe mobile application to receive Hospital communications, as considered appropriate by this policy and the STAMFORD HEALTH Device Policy. It remains the Attending physicians' choice on how they would like to receive outpatient communications from calls to their own answering service.

Members of the Medical Staff who are not required to use the platform are strongly encouraged to enroll to facilitate communication between the Hospital Staff and the Medical Staff regarding outpatient critical values, patient care transitions, and general information that may be of use.

Procedure Performed by Whom

Medical and ancillary staff members, house staff, care team members, and non-clinical staff should use PerfectServe for communication regarding patient care, and when trying to reach the correct staff member on-call at any given time.

I. Procedure

- *General PerfectServe Procedures:*

As stated in the policy above, STAMFORD HEALTH staff will use PerfectServe to contact physicians, advanced practice practitioners and care team members for communication related to patient care. This includes, but is not limited to:

- a. Contacting members of the Medical Staff
- b. Contacting treatment team physicians, advanced practice practitioners and care team members regarding STAMFORD HEALTH patient care issues (i.e. pharmacist, respiratory therapist, physical therapist, case management, etc.)
- c. Requesting physician consults for STAMFORD HEALTH patients (an order in Meditech is always required for consult as well)
- d. Communication with care team members regarding patient care collaboration

- *Rapid Response:*

PAMI and Stroke Alert workflows will be initiated through PerfectServe. Staff will continue to call the operators to initiate a Rapid Response. The operators will then use PerfectServe to alert the correct team of physicians, advanced practice practitioners and care team members, and continue to use standard page until further notice from the IT Leadership Committee where the standard page is no longer needed.

II. PerfectServe Practitioner Application:

- **Care team member communication.** Each PerfectServe Practitioner account is configured according to Stamford Health guidelines per each group and/or user's preferences for call and message routing, delivery, and notification. Users must use the PerfectServe mobile application or login to www.perfectserve.com to receive and

respond to clinical communication from care team members. Users should make any changes to their communication method within the PerfectServe Practitioner account.

- **STAMFORD HEALTH consults and colleague communications.** Every user should use PerfectServe .to initiate consults, after placing an order for the consultation in Meditech. Messages delivered via the PerfectServe Practitioner account will have persistent notification of the message until the message is read (for up to 30 minutes, when not in a procedure).
- **Message priority.** PerfectServe will notify the user in a different contact method or notify at a different frequency until the message has been acknowledged. Priority and workflow rules have been established by the ITLC and approved by the MEC.
- **On-call schedules.** All on-call/coverage schedules will be maintained in the PerfectServe platform. It is the responsibility of the user and/or schedule administrator to ensure all on-call schedules are accurately maintained in PerfectServe and to expeditiously update any changes to the on-call schedules.
- **Alternative communications.** Users will not give STAMFORD HEALTH staff instructions to bypass PerfectServe as an alternate means of contact for patient care communication. If a user and/or staff member needs to change the method by which he or she is contacted – even if for a short term or temporary period, i.e., 1 hour – that change must be made within PerfectServe.
- **Troubleshooting.** Users in need of help accessing PerfectServe and/or troubleshooting should contact the PerfectServe help desk.

III Perfect Serve Clinical Team Communication

- **Care team communications.** Patient care collaboration and communication with other care team users should be initiated and received through PerfectServe via the hospital desktop icon (i.e. nurse to nurse, admitting staff to nurse, etc.).
- **Priority prompting.** At times, PerfectServe prompting will require the care team users to indicate the priority of the communication. Care team users should follow priority standards in accordance with STAMFORD HEALTH policy and with PerfectServe training received.
- **Troubleshooting.** Care team users in need of help accessing PerfectServe and/or troubleshooting should contact the STAMFORD HEALTH IT Help Desk at (2032764357) or dialing x4357

IV. Adding and Removing Users

- STAMFORD HEALTH IT Department will receive Help Desk tickets to add and/or remove PerfectServe users from the STAMFORD HEALTH directory. Staff termination requests submitted via the STAMFORD HEALTH IT Request link on the Intranet will also create a ticket for IT staff to remove user from PerfectServe.
- Medical Staff Services Department has added PerfectServe (medicalstaff@perfectserve.net) to their email distribution list. Departments that have non-prescribers on the PerfectServe Practitioner part of the platform should notify PerfectServe of new hires and terminations by emailing the above email address, or by using www.perfectserve.com/register. PerfectServe will use this information to generate new physician and advance practice practitioner accounts and program workflow as appropriate. PerfectServe will then work with users, and department leads, to help

download app, program workflow rules, and train the physician and advance practice practitioner.

V. External Callers and Non STAMFORD HEALTH Staff:

Calls to the Hospital Operator from patients or non- STAMFORD HEALTH staff will be referred to the physician's office, to speak with the physician's office staff or their after-hours service). Only STAMFORD HEALTH providers and staff are included in the PerfectServe Practitioner directory.

VI. Training

Each PerfectServe user (care team members, physicians, advance practice practitioner and administrators) have been provided the opportunity to be trained on PerfectServe. This includes training on the physician, advance practice practitioner and care team member's mobile application, care team access to PerfectServe via the Web application and phone extension, and administrator on-call schedule management training. Additionally, the PerfectServe physician, advance practice practitioner and care team mobile application includes an FAQ and Help section under Settings on the main app menu.

VII. Service issues and alerts.

- PerfectServe's Network Operations and Support Center are the first responders to any issue potentially impacting service availability. If they determine service is unavailable, they will initiate PerfectServe's internal emergency response protocol. Other alert notification may include announcements about partial limitation to service or service interruptions from carriers such as AT&T and T-Mobile.

- *Notifications*

PerfectServe will broadcast via Everbridge (everbridge.net domain) to perfectserve@StamfordHealth.com; and this email address will include the manager of the STAMFORD HEALTH operators, PerfectServe Administrators listed in Section IX of this policy, and the STAMFORD HEALTH problem manager on duty.

**STAMFORD HOSPITAL
Clinical Service Manual**

Subject: RESTRAINT / SECLUSION, USE OF

Policy #	PC 500	Implemented	6/28/04
References	TJC Hospital Accreditation Standards 2009, TJC FAQs CMS Conditions of Participation 12-06 & 2/08 Zynx Evidenced Based database	Reviewed	5/06/06, 9/4/09, 2/10/12, 9/13/12
Approval	V.P. Patient Services and CNO, Senior V.P. Medical Affairs	Revised	4/28/07, 1/30/09, 12/2012, 1/8/2014, 5/20/14, 8/25/14 7/13/15
Departments Affected	All Clinical Departments	Page	1 of 25

Purpose:

To provide safe management of the patient in restraints

Policy:

- I. **PHILOSOPHY:** The approach to Restraint or Seclusion at Stamford Hospital centers on protecting the patient’s health and safety in the least restrictive environment while preserving their dignity, rights and wellbeing. This standard of care applies to all patients in all settings. Endeavors to improve hospital wide performance of these special treatments by measuring and assessing all instances of use is intensive and continuous. The use of Restraint or Seclusion, therefore, is being reduced through alternative or preventive measures or by limiting use to clinically appropriate and adequately justified situations.
- II. Use of restraints or seclusion is limited to those situations in which there is adequate clinical justification and in which alternative methods have been deemed inappropriate or ineffective. Restraints are applied and monitored and seclusion is implemented and monitored, each with a specific physician order. Restraints or seclusion are maintained based upon a face-to-face assessment by the physician, nurse practitioner or physician’s assistant (PA) with appropriate clinical privileges. The patient’s attending physician or covering physician and unit Nurse Manager or Nursing Supervisor are to be notified of the initiation of patient restraints or seclusion.
- III. Essential elements govern the use of restraints or seclusion. These include:
 1. Attempts to first utilize safe and effective alternative methods.

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Clinical Service Manual

Subject: RESTRAINT / SECLUSION, USE OF

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2. Early identification and intervention related to behavioral changes and de-escalation of potentially violent situations in order to maintain patient safety and minimize the need for restraint.
3. Application of restraint or implementation of seclusion based strictly upon an assessment by a physician, physician's assistant or nurse practitioner, except when a registered nurse initiates in an emergency situation when a physician, physician's assistant or nurse practitioner is unavailable.
4. Concern for the preservation of patient rights, dignity and well being
5. Time limited orders and **no standing or PRN orders**.
6. Utilization of the least restrictive method of restraint or seclusion.
7. Frequent monitoring of the patient's needs and desires.
8. Frequent assessments for the requirement to continue restraint or seclusion.
9. Proper application and removal of restraints or proper implementation and discontinuation of seclusion by appropriately trained staff.
10. Appropriate documentation.
11. Explanations to patient, family or significant other, including the reason for application of restraint or the use of seclusion and the alternative(s) attempted.
12. If the restraint order is not written by the patient's attending physician, the physician, physician assistant or nurse practitioner ordering restraints must consult with the patient's attending physician regarding the patient's need for restraints.
13. Orientation and annual demonstrated competency will occur for any clinical staff implementing or caring for the patient in restraint or seclusion.
14. Clinical staff will notify their Manager or House Supervisor and Risk Management if a patient sustains any injury or dies while in restraint or seclusion with 24 hours after release from restraint or seclusion.
15. Risk Management will report adverse events related to patients in restraint or seclusion according to CMS requirements.

Definitions:

1. **Restraint:** A restraint is –

Except as provided in paragraph 3 of this section, any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely. This includes the

Subject: RESTRAINT / SECLUSION, USE OF

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restriction of patient movement through the use of a physical hold for medication administration. .

2. **A Chemical Restraint** - is a medication or drug used to control behavior or restrict the patient's freedom of movement and is **not** a standard treatment for the patient's medical or psychiatric condition. (§482.13(e)(1) and (f)(1)) (See Appendix A.)

3. A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort). [§482.13(e)(1)(i)(C)] In addition, a chemical restraint does not include the use of medication to address a medical condition, e.g. the use of Diprivan to prevent the patient from bucking while on a ventilator or to address the patient's agitation.

Explanatory Note: *The following are not typically deemed to be restraints:*

- *Surgical positioning devices.*
- *Intravenous arm boards.*
- *Temporary immobilization devices used during radiotherapy procedures.*
- *Temporary immobilization devices used for the protection of surgical and treatment sites in pediatric patients.*
- *Side rails to prevent patients from falling out of bed or off stretchers such as when they are recovering from anesthesia, being transported or experiencing involuntary movements.*
- *Picking up, redirecting, or holding an infant, toddler, or preschool-aged child to comfort the patient.*
- *Age or developmentally appropriate protective safety interventions, such as stroller safety belts, swing safety belts, high chair lap belts, raised crib rails, and crib covers, that a safety-conscious child care provider outside a health care setting would utilize to protect an infant, toddler, or preschool-aged child.*
- *Adaptive devices or mechanical supports used to achieve proper body position, balance, or alignment to allow greater freedom of mobility than would be possible without the use of such a mechanical support, such as the use of leg braces for patients who are unable to walk otherwise, or neck, head, or back braces for patients who are unable to sit upright otherwise.*

Subject: RESTRAINT / SECLUSION, USE OF

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- *The use of handcuffs or other restrictive devices applied by law enforcement officials who are not hospital employees for custody, detention, and public safety reasons.*

- A. **Seclusion** - is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior. Seclusion is only implemented on the Behavioral Health unit, the Emergency Department or on an inpatient unit with a written order for seclusion and transfer to Behavioral Health unit and awaiting bed availability.

- B. **Medical-Surgical Restraint (Least Restrictive)** – When restraints must be applied to directly support medical healing, to prevent patient injury, the restraint is considered for medical purposes.

- C. **Behavioral Management Restraint (Aggressive/Self-destructive/Violent Behavior)** – Restraint or seclusion for behavioral health purposes is used primarily to protect the patient against injury to self or others because of an emotional or behavioral disorder. The use of behavioral restraints must follow the behavioral health procedures in this policy.

- D. **Types of restraints** - Stamford Hospital prefers the use of cloth limb restraints, leather limb restraints, Net enclosure bed (refer to Appendix A, and sheet net restraint. Other forms of restraints may be used if cloth limb and leather limb restraints are unavailable or not sufficient. Physical Hold is considered a type of restraint and is used to restrict a patient’s movement for medication administration.

- E. **Patient Plan of Care**- The patient plan of care is the restraint orders, assessment(s), progress notes, notes and nursing care plan.

- F. **Licensed Independent Practitioner (LIP)** – “Any individual permitted by law and by the organization to provide care and services, without direction or supervision, within the scope of the individual’s license and consistent with individually granted clinical privileges” (The Joint Commission, 2009).

- G. **Trained Nurse** – Registered Nurse who completed the restraint education and restraint application return demonstration.

Procedure:

- I. Documentation of Purpose of Restraint:

**STAMFORD HOSPITAL
Clinical Service Manual**

Subject: Pre-Surgical Optimization Program Clinic

Policy # **Implemented** November 2017

References
Committee OR Committee, PSQC,
Approval MEC, POP Steering **Reviewed** November 2017
Committee

Approval CMO, CNO, VP Quality,
Chair of Surgery, Chair of
Orthopedics, Hospitalist
Director, Chair of **Revised** September 2018
Anesthesiology, Chair of
OB/GYN, Executive Director
of Perioperative Services

Departments Surgery, Medicine,
Affected Anesthesia, Orthopedics,
Nursing **Page 1 of 5**

I. Purpose

The Pre-Surgical Optimization Program (POP) is to provide guidance for physicians to optimize the preoperative management of elective inpatient surgery patients. Early research results on PAT/POP models and programs have shown promising results, such as reducing the need for and duplicated efforts in pre-op testing, standardization of pre-operative clearance, and decrease associated risks. Goals of POP include reducing delays or cancelled procedures, reducing complications and decreasing mortality.

II. Policy

Patients to undergo elective inpatient operations and high-risk patients undergoing outpatient operations will be referred to the POP Clinic for evaluation. Low-risk patients undergoing elective Caesarian sections are excluded.

III. Procedure

Background Information

The POP Clinic will have Medical Hospitalists and mid-level providers evaluate patients who are to undergo inpatient surgery.

The Pre-Surgical Optimization clinic/Pre-admissions testing (PAT) office will verify that all necessary records are received prior to the POP Clinic visit. These may include History and Physical, Preadmission Testing results, Consent, and when appropriate, sub-specialty consult notes. Appointments with the patient's primary care physician ideally should be scheduled 3-4 weeks prior to date of surgery.

- **Nursing Responsibilities include but are not limited to:**
 - The RN staff will oversee the scheduling of patient prior to surgical date, ideally within two weeks prior, to insure adequate time for completion and allow for review of all tests/evaluations.
 - The RN will complete the nursing pre-surgical admission evaluation, including medication reconciliation, MDRO risk and other screenings as indicated. (i.e. The Risk Assessment and Prediction Tool or also known as RAPT).
 - The RN shall work in tandem with physician in patient preparation and completion of physical exam during visit, including obtaining of vital signs, specimens and providing patient education.
 - The RN will complete a clinical review of all submitted paperwork submitted to POP@stamhealth.org as well as test results obtained at Stamford Hospital for completeness, identification of clinical issues and communicate with physician regarding need for further testing/follow up.
 - The RN will provide patient with NOX device and instructions if indicated.
 - The RN Orthopedic Educator will provide pre-operative instruction to Orthopedic patients undergoing total joint or spinal surgery (currently spine classes not offered).

- **PCP Responsibilities include but are not limited to:**
 - Attempting to schedule a pre-op office visit prior to the POP appointment once the PCP is made aware of plans for surgery by the surgeon's office.
 - Office staff to fax pertinent data and documents to the POP clinic at least one week prior to surgery.
 - Facilitate consults as indicated, to be completed at least one week prior to surgery.
 - Work collaboratively with the Hospitalists and Surgeons in optimizing patients.

- **Hospitalist Responsibilities include but are not limited to:**
 - Hospitalist will document in a newly formed "Pre-operative H and P" form that is in Meditech.
 - If the surgical procedure will need to be cancelled due to need for further medical optimization, the medical physician will directly contact the PCP's and surgeon's office.

- Abnormal test results which may impact the timing of surgery will need to be communicated directly to both the surgeon's and PCP's office.
- If any question arises regarding anesthesia, airway related questions, or if the patient has a history of complications related to anesthesia in the past, the Hospitalist are to call an official anesthesiology consultation for further guidance.
- Patients seen in the POP Clinic will be screened for cardiac risks, pulmonary risks, infection risks, and other specialized areas including sleep apnea using the STOP-BANG Apnea Questionnaire (see last page) and for the need to see a Pain Management specialist.
- A careful history of the patient's current pain medication usage should be obtained. Patients who do not have appropriate preoperative analgesic evaluations should not proceed with elective surgery. Outlined below is a guideline to assist in determining the need for referral to pain management service:
 - Complex or extensive surgery (i.e. complex revision, infected hardware etc.)
 - Any patient currently using greater than a daily total of 40 mg of morphine equivalent dose, 3 tabs daily of oxycodone/APAP 10/325 mg, 3 tabs daily of oxycodone 10 mg, 4 tabs daily of hydrocodone/APAP 10-325 mg, 8 tabs daily of Tramadol 50 mg daily.
 - Buprenorphine products (i.e. Suboxone, Subzolv, Belbuca, Butrans patch).
 - Any patient currently using long-acting (i.e. methadone) or controlled-release opioid (OxyContin, MS Contin, Opana ER, Tramadol ER, Nucynta ER).
 - Preexisting and poorly controlled chronic pain condition (i.e. trigeminal neuralgia, chronic abdominal pain, radiculopathy etc.).
 - History of poor pain control following previous surgical procedures.
 - Severe underlying medical conditions that should be noted when formulating a safe and effective analgesic plan (e.g. Moderate to severe COPD, central or obstructive sleep apnea, morbid obesity/BMI>40, renal insufficiency, significant CV disease, multiple allergies to analgesics).
 - Complex psychiatric history (i.e. poorly controlled depression and/or anxiety; Cluster B personality disorder etc.).
 - Patient wishes to receive preoperative pain consult.
 - Preexisting severe anxiety over postoperative pain.
- **Surgeon Responsibilities include but are not limited to:**
 - Educate the patient on the POP referral process.
 - Follow current booking process to schedule cases.
 - Follow current OR related infectious disease guidelines regarding preoperative antibiotic management.
 - Communicate with the patients Primary Care Provider and allow for opportunity to evaluate the patient pre-operatively.
 - If there is a patient booked at the Tully Center which may need further medical optimization, the patient should be referred to the POP Clinic to be medically evaluated and optimized.

- Identify high risk cardiac patients and arrange for cardiology consultation prior to POP visit when possible or if consult cannot be obtained, notify POP that stress test/ECHO/cardiology consult will be necessary.
- **Anesthesiologist Responsibilities include but are not limited to:**
 - Work collaboratively with the Hospitalists and Surgeons in optimizing patients.
 - Reviewing charts daily to ensure that patients are optimized after the POP visit.
 - Review all NOX (night oximetry) reports.
 - Be available for formal consultation when requested.
 - Pre-surgical anesthesia consults should be performed on the following patients:
 - a. Patients who fall outside of any established guidelines if the plan is to proceed with surgery.
 - b. Patients with any of the following:
 - Difficult airway (h/o difficult intubation, head/neck radiation or neck dissection; unable to open mouth due to surgery or connective tissue disease, significant reduction in cervical mobility; tracheostomy)
 - History (familial or self) of significant anesthesia complications requiring hospitalization
 - History of malignant hyperthermia
 - Home O2 dependence
 - Moderate-severe pulmonary hypertension
 - Severe cervical spine disease (unstable cervical spine)
 - Severe/critical valvular disease
 - Skeletal dysplasia
 - Corrected congenital heart disease

IV. Perioperative Management of the Patient with Implantable Cardioverter-Defibrillator

- When a patient with an implanted device is booked for surgery, the presence of a pacemaker or ICD should be noted in the booking form. When a patient is booked for surgery, the surgeon's office staff will inform the patient that medical clearance is needed from the patient's primary care physician and cardiologist. The POP clinic will compile and document crucial information regarding the AICD.
- Surgeon's offices are encouraged to arrange cardiology consultations prior to their POP visit if possible. If consult cannot be obtained, notify POP that Stress test/ECHO/cardiology consult will be necessary (allows time for pre-authorizations and advanced scheduling).
- Refer to AICD/Pacemaker operative management process flowchart

STOP-BANG Sleep Apnea Questionnaire

Chung F et al Anesthesiology 2008 and BJA 2012

STOP		
Do you SNORE loudly (louder than talking or loud enough to be heard through closed doors)?	Yes	No
Do you often feel TIRED , fatigued, or sleepy during daytime?	Yes	No
Has anyone OBSERVED you stop breathing during your sleep?	Yes	No
Do you have or are you being treated for high blood PRESSURE ?	Yes	No

BANG		
BMI more than 35kg/m ² ?	Yes	No
AGE over 50 years old?	Yes	No
NECK circumference > 16 inches (40cm)?	Yes	No
GENDER : Male?	Yes	No

References:

2014 ACC/AHA guideline on perioperative cardiovascular evaluation and management of patients undergoing noncardiac surgery: executive summary: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. Fleisher LA, Fleischmann KE, Auerbach AD, Barnason SA, Beckman JA, Bozkurt B, Davila-Roman VG, Gerhard-Herman MD, Holly TA, Kane GC, Marine JE, Nelson MT, Spencer CC, Thompson A, Ting HH, Uretsky BF, Wijeyesundera DN. *Circulation*. 2014;130(24):2215. Epub 2014 Aug 1.

Preoperative assessment of patients with known or suspected coronary disease. Mangano DT, Goldman L. *N Engl J Med*. 1995;333(26):1750.

Derivation and prospective validation of a simple index for prediction of cardiac risk of major noncardiac surgery. Lee TH, Marcantonio ER, Mangione CM, Thomas EJ, Polanczyk CA, Cook EF, Sugarbaker DJ, Donaldson MC, Poss R, Ho KK, Ludwig LE, Pedan A, Goldman L. *Circulation*. 1999;100(10):1043.

STAMFORD HOSPITAL
[Manual]

Subject: Use of Medical Staff Funds

References: **Implemented:** 12/2/2013

Committee Approval: Medical Executive Committee **Reviewed:** [date(s)]

VP Approval: Senior Vice President of Medical Affairs and Chief Financial Officer **Revised:** 05/01/2017

Departments Affected: Medical Executive Committee, Medical Affairs, Finance Department **Page:** 1 of 2

Purpose:

Medical Staff dues are a requirement of medical staff membership at Stamford Hospital and must be paid on an annual basis in order for a medical staff member to be considered in good standing. The purpose of this policy is to provide guidelines on the use of the funds in the medical staff dues account.

Policy:

To ensure that funds generated by medical staff dues are used appropriately in the support of medical staff activities and that the use of such funds is compliant with regulatory standards and is consistent with the Hospital's tax exempt status.

Guidelines and Procedures:

1. Per the Medical Staff Bylaws, medical staff dues are required of medical staff in the Active and Courtesy Staff categories. Affiliate, Honorary, Teleradiology, Locums, and Ancillary Staff are not required to pay dues.
2. There is no obligation by the Medical Executive Committee to grant any waiver of dues, unless such waiver is granted to all medical staff in the Active and Courtesy staff categories.
3. The medical staff dues are established by the Medical Executive Committee in the year preceding the year in which the dues are to go into effect. The MEC reserves the right to change the annual dues as needed in order to ensure that there are sufficient funds to support medical staff activities.

Subject:

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4. On or about September 15 of each calendar year, a notice for medical staff dues shall be sent by the Medical Staff Office to each member of the medical staff in the aforementioned staff categories with a due date. Any dues received after the due date shall be considered "late." A late fee may be assessed and the reappointment status of any medical staff member who is in arrears at the time of reappointment may be jeopardized.

5. Medical staff dues, upon receipt in the Medical Staff Services shall be duly recorded and deposited into the Medical Staff Checking Account.

6. Examples of acceptable uses of medical staff dues are but not limited to:
 - Food and other expenses associated with medical staff social events and meetings
 - Continuing education materials including online and print publications
 - Legal advice on issues that affect the medical staff such as medical staff bylaws and rules and regulations
 - Small gifts and awards for special life events such as retirement, births, relocation, etc. as approved by the President of the Medical Staff and/or the MEC
 - Charitable donations to the community for non-profit causes or organizations as approved by the President of the Medical Staff and/or the MEC
 - Any other uses must be approved by the President of the Medical Staff and/or the MEC

7. Examples of uses of medical staff dues that are deemed not appropriate include but not limited to:
 - Contributions to political campaigns and political lobbying
 - Activities and services that the Hospital is obligated to provide per contractual agreement with the Medical Staff
 - Activities that are not deemed to be in support of medical staff functions as determined by the President, Medical Staff and/or the MEC
 - Activities that would be deemed to be in non-compliance with the Stark Laws, and other regulatory standards as applicable

Subject:

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8. Discretionary approval of the use of funds by the President, Medical Staff shall be limited to \$5000 for any single purpose/event. Any amount over this limit requires the approval of the MEC. Approval by the MEC may be given prospectively, as necessary.
9. Signatories on the Medical Staff Account are the President, Medical Staff, President and CEO, Executive Vice President, COO and CFO.
10. All checks written on the Medical Staff Checking Account require the signature of the President, Medical Staff.
11. The President, Medical Staff shall report on a quarterly basis to the MEC at its regularly scheduled monthly meeting and to the Organized Medical Staff at its regularly scheduled quarterly meeting, an account balance to date, income and distribution in the account for the quarter preceding each report. The fiscal year is October 1 – September 30.
12. All hospital accounts including the Medical Staff account are audited annually by external auditors and the findings are reported to the Department of Finance and to the President of the Medical Staff.

**STAMFORD HOSPITAL
Clinical Service Manual**

Subject	CONSENT, INFORMED (Consent for Medical and Surgical Procedures, Consent for Anesthesia Services, Consent for Transfusion of Blood or Blood Products, Permission for Disposal of Amputated Part)		
Policy #	RI 340	Implemented	11/2/00
References	CMS §482.13(b)(2), §482.51(b)(2), . Joint Commission (JC), 2014	Revisions	6/15/07, 4/28/08, 2/21/12, 04/07/2014, 9/08/14, 11/2014, 3/2018
Approval	Medical Committee	Executive	Reviewed 4/26/06
Departments Affected	All	Page 1 of 7	

Purpose:

To identify the process for informed consent

Policy:

- I Stamford Hospital shall ensure that an Informed Consent is obtained and documented as a prerequisite to any procedure or treatment for which it is appropriate.
- II The primary purpose of the informed consent process is to ensure that the patient, or the patient's representative, is provided information necessary to enable him/her to evaluate a proposed surgery/procedure or treatment before agreeing to the surgery/procedure or treatment.
- III A patient may wish to delegate his/her right to make informed decisions to another person. The hospital must respect the patient's wishes and follow that process to the degree permitted by State law, and to the maximum extent practicable.
- IV The patient or the patient's representative should receive adequate information provided in a manner that the patient or the patient's representative can understand, to assure that the patient can effectively exercise the right to make informed decisions.
- V It is the responsibility of the physician performing the procedure, to explain to the patient or the patient's representative any proposed procedure, the common risks and complications, the intended benefits and any alternatives as well as the common risks and benefits of those alternatives.
- VI The patient has the right to request or refuse treatment. The patient's request will be addressed; however, the hospital is under no obligation to fulfill a patient's

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Subject: CONSENT, INFORMED

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request for a treatment or service that the responsible practitioner has deemed medically unnecessary or even inappropriate.

Definitions:

Authorized Representative means any person who is otherwise authorized by law to make health care decisions on behalf of a patient and provide informed consent.

Emergency situation is an immediate threat to life or limb.

Health Care Representative means an individual appointed by a patient pursuant to a proper "Appointment of a Health Care Representative" for the purpose of making health care decisions on behalf of the patient. The Health Care Representative is a person whom the patient authorizes in writing to make any and all health care decisions on their behalf including the decision whether to withhold or withdraw life support systems. A health care representative does not act unless the patient is unable to make or communicate health care decisions. The health care representative will make decisions on the patient's behalf based on the patient's wishes, as stated in a living will or as otherwise known to the health care representative. In the event the patient's wishes are not clear or a situation arises that the patient did not anticipate, the health care representative will make a decision in the patient's best interests, based upon what is known of the patient's wishes. The Health Care Representative form must be signed by the patient and witnessed by two adults.

Health Care Agent: is someone who is appointed via a document signed by a patient giving the Health Care Agent the authority to communicate certain medical decisions in the event that the patient becomes incapable of making those decisions. A Health Care Agent's authority is limited to communicating decisions about life support and comfort care measure. Therefore, the Health Care Agent's access to the patient's medical information is limited to the information needed to address these decisions. In the event no such decisions need to be made, the Health Care Agent will not be provided access to the patient's health information unless the access is otherwise authorized. Like Durable Powers of Attorney for Health Care, Health Care Agents were replaced with Health Care Representatives on October 1, 2006. Health Care Agent documents executed prior to October 1, 2006 will be honored unless the document has been revoked.

Subject: CONSENT, INFORMED

Informed Consent is an agreement or permission accompanied by full notice about nature of the procedure, indications, common risks and complications, intended benefits and alternatives to care, treatment or service that is the subject of the consent. A patient must be apprised of the nature, risk, benefits, , side effects, the likelihood of the patient achieving his or her goals, potential problems that might occur during recuperation , alternatives of a medical procedure or treatment before the physician or other health care professional begins any such course. After receiving information, the patient then either consents to or refuses such a procedure or treatment (JC 2013).

Invasive Procedure is defined as follows;

- a. Surgical entry into tissues, cavities or organs
- b. Any procedure performed in an operating room
- c. Any procedure in which moderate or deep sedation or general anesthesia is used.
- d. Any of the following, even if sedation or general anesthesia is not used:
 - i. Cardiac catheterization
 - ii. Peripheral vascular procedures
 - iii. Pacemaker insertion and replacement
 - iv. Electrophysiology studies, including AICD insertion and replacement
 - v. Cardioversion
 - vi. Endovascular procedures
 - vii. Endoscopy and bronchoscopy procedures
 - viii. Lumbar puncture
 - ix. Therapeutic Nerve Block
 - x. Central Line Insertion (including PICC lines)
 - xi. Invasive monitoring procedures
 - xii. Interventional radiology procedures
 - xiii. Biopsies and deep-tissue aspirations, including intra-cavitary and joint aspirations
 - xiv. Insertion of chest tube
 - xv. Implantation procedures (e.g. brachytherapy)
- e. Specific “minor” procedures are not invasive procedures such as the following:
 - i. Venipuncture and peripheral arterial puncture
 - ii. Peripheral IV placement and peripheral arterial line placement
 - iii. Insertion of an NG or feeding tube through the nose or mouth
 - iv. Trans-urethral urinary catheter insertion
 - v. Wound debridement and superficial wound repair
 - vi. Superficial needle biopsy

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Next of Kin means any member of the following classes of persons, in the order of priority listed (1) the patient's spouse; (2) an adult son or daughter of the patient; (3) either parent of the patient; (4) an adult brother or sister of the patient; and (5) a grandparent of the patient. For purposes of this policy, parties to a civil union shall be granted the same rights and responsibilities as spouses in a marriage.

Surgery includes any procedure that is listed as a surgical procedure in any of the various billing coding systems used by CMS or the hospital, regardless of whether Medicare pays for that surgical procedure.

Procedure:

1. An informed consent form, *Consent for Surgical and Medical Procedures*, must be obtained and placed in the patient's medical record prior to the surgery/procedure or treatment, except in the case of an emergency.
2. Informed Consent shall be obtained and documented for:
 - a. all inpatient and outpatient operative and invasive procedures performed regardless of the location where it is performed; surgical suite or bedside .
 - b. the transfusion of all blood products (see section VI)
 - c. the administration of anesthesia services.
 - d. whenever, in the judgment of the responsible physician, the situation or nature of the procedure warrants that written consent be obtained.
3. None of the above procedures shall be performed without prior completion of a "Consent for Surgical and Medical Procedures" form and, if applicable, the "Consent for Anesthesia".
4. It is the responsibility of the physician performing the procedure/treatment to explain the proposed procedure or treatment to the patient, the reasonably foreseeable risks, the possible benefits, consequences, and alternatives for care or treatment including risks, benefits, and side effects of alternatives prior to the procedure and the risk of not performing the planned procedure. This information should include potential short and longer-term risks and benefits to the patient of the proposed intervention, including the likelihood of each, based on the available clinical evidence, as informed by the responsible practitioner's professional judgment.

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- a. The above responsibilities may not be delegated to non-physicians (e.g. RNs, NPs or PAs) or to residents. In order to ensure that these responsibilities have been discharged, the physician's signs the consent form indicating that the procedure or treatment has been fully discussed with the patient or, as appropriate, his/her Health Care Representative, Next of Kin or Authorized Representative and that the appropriate Consent Forms have been or will be obtained.
5. The patient's signature on the "Consent for Surgical and Medical Procedure" form must be obtained by the practitioner performing the procedure
6. The form must be signed by the patient and witnessed prior to the time the patient is given any medication which would sedate or otherwise impair the patient's senses or in any way detract from his/her ability to understand the form. The preoperative verification of correct person, procedure, and site in the OR should also include verification that the consent form has been signed by the patient and physician.
 - a. When the form is presented to the patient for signature, it will be clearly explained to the patient that he/she is being asked to provide consent to the surgical or other procedure indicated on the form and/or administration of blood or blood products. The patient must be given as much time as required to read and reflect on the document.
7. If the patient refuses the recommended treatment, the attending physician must be immediately notified. The patient or responsible party should be asked to sign the form for *Release of from Responsibility for Actions Against Medical Advice* in accordance with the Policy regarding "Discharge and Behavior Against Medical advice." If the patient or responsible party refuses to sign the form, the circumstances related to the advice given to the patient and refusal of recommended treatment should be documented in the medical record by the attending physician.
8. It is the responsibility of the anesthesiologist or the administering physician to explain the proposed anesthesia treatment to the patient, along with the reasonably foreseeable risks, possible benefits, consequences and alternatives including risks, benefits, and side effects of alternatives to anesthesia.
9. In the event of an emergency, a physician may provide treatment without obtaining informed consent if:

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- a. The attending physician determines that the patient is unable to consent and a Health Care Representative, Next of Kin or Authorized Representative cannot be located, and emergency medical intervention is necessary,
 - b. The attending physician has determined that the procedure or treatment is required on an emergency basis because there is a substantial risk of death or immediate and serious harm to the patient; and with a reasonable degree of medical certainty, the life or health of the patient would be affected adversely by delaying treatment to obtain consent.
 - c. The “Emergency Authorization” portion on the reverse side of the “Consent for Surgery and Medical Procedures” shall also be completed prior to the procedure or treatment and signed by the treating physician.
 - d. The physician performing the procedure or treatment is required to document in the chart the necessity of the procedure or treatment and staff must document in the medical record the steps that were taken to attempt to contact the patient’s next of kin or legal representative.
10. If a blood transfusion or autologous transfusion is or may foreseeably be necessary, the physician must also explain to the patient the proposed transfusion treatment along with the reasonably foreseeable risks, possible benefits, consequences and alternatives including risks, benefits, and side effects of alternatives to transfusion.
- a. For blood transfusions associated with operative or invasive procedures, the consent is included in the Consent for Surgery and Medical Procedures form. Blood transfusions associated with operative or invasive procedures are generally warranted during the operation/procedure and/or in the immediate post-operative period. Blood transfusions required prior to surgery such as FFP for clotting disorders, packed red blood cells for pre existing anemia require a separate consent as the need for the blood products are not directly associated with the invasive or operative procedure.
 - b. For blood transfusion not associated with operative or invasive procedures, a separate Consent for Transfusion of Blood or Blood Products form is completed.
 - c. If a blood transfusion is refused, a “Refusal of Blood Transfusion” form must be completed. See *Refusal to Permit Blood Transfusions Policy* in this manual.
11. If a body part is to be amputated, the “Permission for Disposal of Amputated Part” form must be completed by the patient or the legal representative.

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12. If the determination is made that a patient requires a procedure or treatment requiring informed consent and for any reason is unable to understand or sign a Consent Form, as appropriate, the patient's Health Care Representative, Next of Kin or Authorized Representative shall be required to sign the form.
13. If a Health Care Representative, Next of Kin or Authorized Representative is physically unavailable but may be contacted by telephone, the "Telephone Permission" portion on page 2 of the "Consent for Surgery and Medical Procedures" shall also be completed by the physician performing the procedure or treatment.
14. All components of the informed consent form are completed prior to the procedure. A single consent form may be used for a series of planned treatments or procedures.
15. Consents obtained in physician's offices are delivered to the hospital in person, by mailing or fax, and are placed in the medical record before the procedure begins.
16. All completed Consent Forms shall become a permanent part of the patient's medical record.
17. For information regarding consent for minors and mentally incompetent patients, see the Consent for Procedure or Treatment – Minor or Mentally Incompetent Patient policy in this manual.
18. For information regarding consent for a conservator see the Consent for Procedure or Treatment – Appointment of Conservator policy in this manual.

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Subject: **Fair & Just Accountability Policy** Page 1 of 4

References: Henry Ford Health System,
Response to Safety Events, 2012.
Just Culture Community *Human
Resource Model Policy*, 2007. **Implemented:** 11/02/2017
Dana Farber Cancer Institute,
Principles of a Fair & Just Culture,
undated

Approval: Patient Safety & Quality Committee **Revised:** 10/23/2017

**Departments
Affected:** All including, Stamford Hospital
and SHMG

PURPOSE

Stamford Health (SH) recognizes that at times, despite the efforts of every employee and physician to deliver the best work possible, errors or unsafe acts may occur in the workplace. When such events occur, SH believes in a consistent, fair and systematic approach to understanding these events in a manner that balances a non-punitive learning environment with the equally important need to hold individuals accountable for their actions.

BACKGROUND

It is inevitable that people will make mistakes or experience an *adverse event*, defined as any variance not consistent with the desired, normal or usual operations of the organization. When events occur that cause harm or have the potential to cause harm to patients or staff members, or when those events place the organization at legal, financial, or ethical risk, Stamford Health is committed to creating a work environment that learns from these events. To that end, we seek to understand these events in a systematic manner that responds with a focus on process, prevention and process improvement measures, rather than in a manner that places blame. In addition, the lessons learned are then embedded into our systems for overall process improvement.

A Fair and Just Culture recognizes that competent professionals make mistakes, that many errors result from system or organizational errors, and that individuals should not be blamed for honest mistakes, or errors caused by system or organizational issues. We recognize the work we do is complex, rooted in systems of care and we all depend on each other and other departments to provide care to our patients. It promotes an atmosphere where staff and physicians report and discuss errors and “near misses” without the fear of reprisal, through a fair-minded assessment of events which in turn promotes system modifications and behavior changes to prevent future errors.

A Fair and Just Culture does not mean that the SH culture is non-accountable nor does it mean an avoidance of critique or assessment of competence. A Fair and Just Culture does not tolerate

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reckless behavior, gross misconduct, or willful violations. Rather, when incompetence or sub-standard performance is revealed after careful collection of facts, and/or there is reckless or willful violation of policies or negligent behavior, corrective or disciplinary action may be appropriate (See SH Corrective Action Policy). A Fair and Just Culture means living our values of Accountability and Integrity.

Stamford Health wants employees and physicians to feel safe to speak-up and speak-out about reporting adverse events, near misses, existence of hazardous conditions, and related opportunities for improvement to identify systems changes and behavior changes which have the potential to avoid future adverse events. As a reminder, Stamford Health has a non-retaliation policy that protects individuals making reports in good faith.

SCOPE/ELIGIBILITY

This policy applies to anyone working at any SH business unit or facility including, but not limited to: employees, physicians, agency staff, vendors, volunteers and contract workers.

RESPONSIBILITY

The interpretation, administration and monitoring for compliance of this policy shall be the responsibility of operational leadership in conjunction with Human Resources, Risk Management staff and other departments where necessary.

POLICY

Our organizational values define our behavioral expectations and to that end:

Employees and Physicians are obligated to:

- Avoid causing unjustified risk or harm to patients, visitors or colleagues
- Strive to achieve goals and outcomes
- Follow work rules, policies and procedures
- Report safety concerns, near misses and other events through Stamford Health's occurrence reporting system; look for risks and hazards in the work environment.
- Ask for help, seek a supervisor or check the policy when completing an assignment if they are unsure how to proceed.
- Complete all required learning obligations, such as Healthstream

Leaders are obligated to:

- Promote a learning environment and educate all team members in the concept of Fair and Just Culture.
- Foster an environment that promotes full disclosure of adverse events
- Participate in cause analysis reviews, i.e. Apparent Cause Analysis, Root Cause Analysis

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- Identify and report areas of potential harm, opportunities for improvement and adverse events
- Consistently and uniformly, utilize the Performance Management Decision Guide to evaluate events to identify system and process issues that may require change (*See Attached Appendix A*).

As part of the normal process for any event, the manager will conduct a thorough investigation to determine the type of behavior that led to the adverse event. Integrity and Accountability are critical SH values and it is expected that individuals are cooperative and truthful throughout the process. [See SH Corrective Action Policy]. As part of this investigation, the event will be assessed objectively and analyzed using a systematic approach as outlined in the attached Performance Management Decision Guide (PMDG).

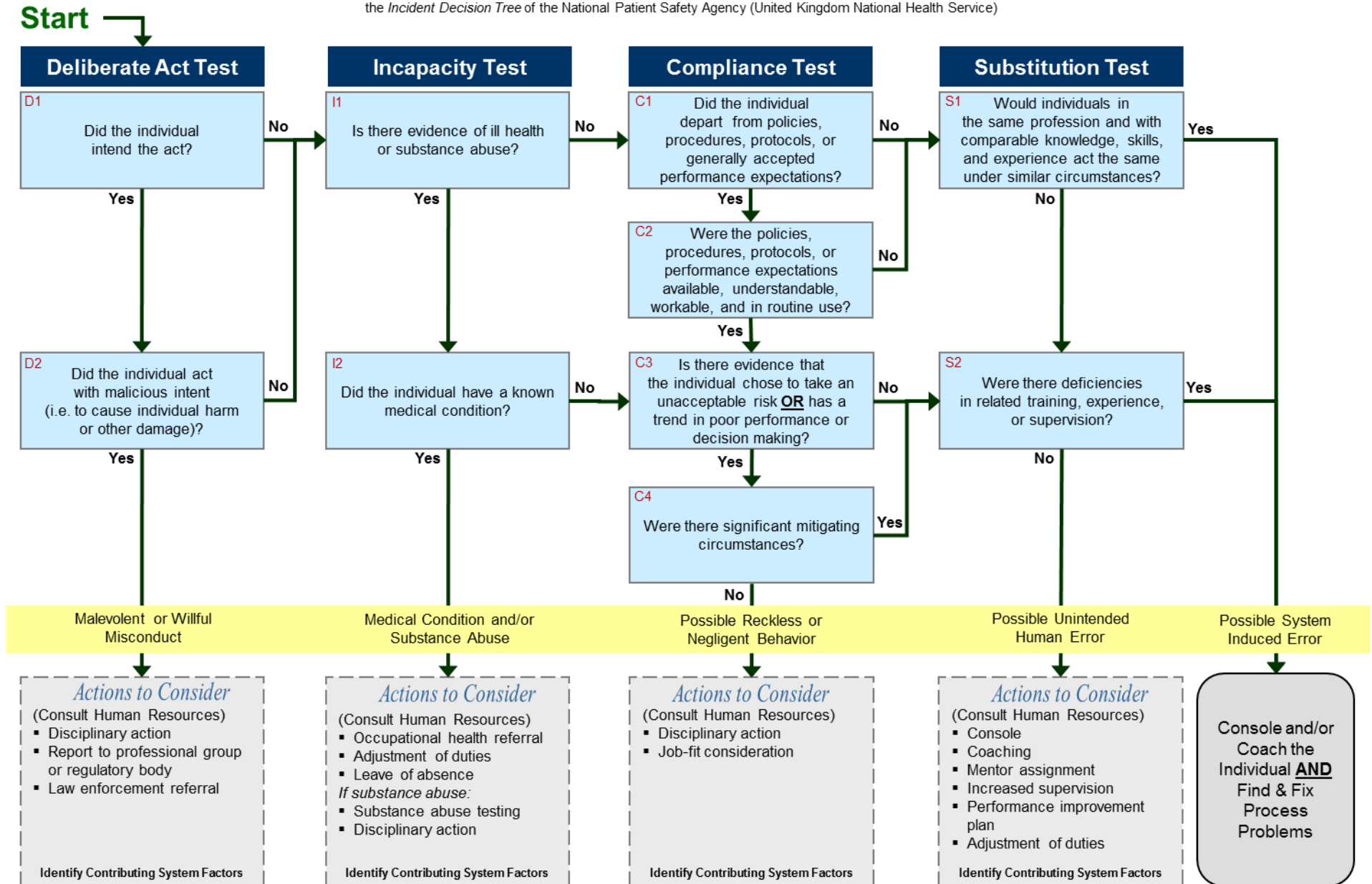
Exceptions to this approach will occur if an individual knowingly or willingly conceals a safety event, interferes with an investigation, or causes an adverse event or unsafe act that results from:

- An illegal act
- A breach of confidentiality
- A persistent issue not resolved through performance improvement.

This guide will help to determine the necessary course of action in consultation with Risk Management and Human Resources.

Performance Management Decision Guide

Adapted from James Reason's *Decision Tree for Determining the Culpability of Unsafe Acts* and the *Incident Decision Tree* of the National Patient Safety Agency (United Kingdom National Health Service)



Revision 3, April 2009

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The licensed independent practitioner who orders the use of restraint or seclusion shall make an initial determination whether the restraint or seclusion is necessary to address a medical condition or a behavioral condition. Such determination shall be clearly documented in the medical record.

II. Care Requirements:

It is important to note that patient care requirements are not specific to any treatment setting, but rather to the patient situation the restraint or seclusion is being used to address.

III. The Hospital discourages the use of chemical restraints.

Chemical restraints should only be used when a restraint is necessary and alternative means of restraint are not available. Only those practitioners, whose education and specialty includes use of chemical restraints, may order a chemical restraint.

IV. Requirements

	Medical-Surgical Restraint (Least Restrictive)	Behavior Management (Aggressive/Violent Behavior) Restraint or Seclusion
Reason	To directly support medical healing, to prevent patient injury	To manage <u>violent or self-destructive behavior</u> that jeopardizes the immediate physical safety of the patient, a staff member, or others
Overview	<p>To prevent interruption of medical intervention (i.e. demonstration of a high potential for dislodging or removing or actual attempts to dislodge or remove, invasive lines, tubes, etc.)</p> <p>Alternative to restraint must be considered prior to the application of restraint.</p> <p>A comprehensive assessment of the patient must determine that the risks associated with the use</p>	<p>To prevent injury due to self-destructive behavior, suicidal ideation or intent (e.g. self mutilating or dangerous, risk taking behavior.)</p> <p>A comprehensive assessment of the patient must determine that the risks associated with the use of the restraint are outweighed by the risk of not using it. Such assessment shall include:</p> <ul style="list-style-type: none"> • Behavior control techniques • Medical conditions, physical

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	Medical-Surgical Restraint (Least Restrictive)	Behavior Management (Aggressive/Violent Behavior) Restraint or Seclusion
	<p>of the restraint are outweighed by the risk of not using it. However, in the event of an emergency, Restraint may be applied prior to the completion of a comprehensive assessment. In the event of an emergency, the comprehensive assessment will occur as soon as possible.</p> <p>Utilize the least restrictive means that will achieve safety and security</p> <p>RN's and other qualified, trained staff members may initiate restraint pursuant to an appropriate order or in limited emergency situations.</p>	<p>disabilities that would place the patient at greater risk if restraint or seclusion were used.</p> <ul style="list-style-type: none"> • History of sexual or physical abuse that would place the patient at greater psychological risk. • Role of family for notification of Restraint or Seclusion • Advance directive for behavioral health <p>Utilize the least restrictive means that will achieve safety and security</p> <p>RN's and other qualified, trained, staff members may initiate Restraint or Seclusion pursuant to an appropriate order or in limited emergency situations.</p>
Orders and Time Limits	<p>Whenever possible, prior to application, obtain a written or telephone order from the physician/licensed independent practitioner who is responsible for the patient.</p> <p>If there is an emergency and the physician/licensed independent practitioner is unavailable, a trained registered nurse may initiate the use of restraint or seclusion but an order must be obtained as soon as possible and no later than 12 hours after the initiation of the restraint or seclusion. The</p>	<p>In an emergency situation, the RN may apply restraints or place the patient in seclusion. As soon as possible, the RN initiating restraints or seclusion in an emergency shall:</p> <ul style="list-style-type: none"> • Notify the physician/licensed independent practitioner, • Obtain an order (written or by telephone) from a physician/licensed independent practitioner, and • Consult with the physician/licensed independent practitioner about the patient's physical and psychological

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	Medical-Surgical Restraint (Least Restrictive)	Behavior Management (Aggressive/Violent Behavior) Restraint or Seclusion
	<p>physician/licensed independent practitioner must see the patient within 24 hours and enter a written order into the patient's medical record.</p> <p>If the restraint is initiated due to an unanticipated change in the patient's condition, the physician/licensed independent practitioner shall be notified immediately.</p> <p>All orders must include:</p> <ol style="list-style-type: none"> 1. The date and time the order was written. 2. The specific type of restraint to be used. 3. The specific rationale for restraint. 4. Any special precautions to safeguard the patient. 5. The physician/licensed independent practitioner's signature. 6. In the case of a telephone order, the names of the ordering physician/licensed independent practitioner and the registered nurse who received the order. 7. All orders must be time limited. At most, the maximum duration of restraint from the time the restraint was initiated is 24 hours: 8. PRN orders are <u>never</u> 	<p>condition.</p> <p>The physician/licensed independent practitioner shall conduct an in person evaluation within the following time frames after restraint or seclusion are initiated:</p> <ul style="list-style-type: none"> • 4 hours for patients age 18 and over, • 2 hours for patients age 9 to 17, and • 1 hour for patients under age 9. <p>Even if the patient is released from the restraint or seclusion within the first hour, the licensed independent practitioner must see the patient.</p> <p>All orders must include:</p> <ol style="list-style-type: none"> 1. The date and time the order was written. 2. The specific type of restraint to be used. 3. The specific rationale for restraint/seclusion. 4. Any special precautions to safeguard the patient. 5. The physician/licensed independent practitioner's signature. 6. In the case of a telephone order, the names of the ordering physician/licensed independent practitioner and the registered nurse who received the verbal

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	Medical-Surgical Restraint (Least Restrictive)	Behavior Management (Aggressive/Violent Behavior) Restraint or Seclusion
	<p>acceptable.</p> <p>The Restraint / Seclusion Physician Order Form is used by the physician to record and subsequently reorder patient restraints as required.</p>	<p>order.</p> <p>7. All orders must be time limited. At most, the maximum duration of restraint or seclusion from the time the restraint or seclusion was initiated is as follows:</p> <ul style="list-style-type: none"> • 4 hours for patients age 18 and older, • 2 hours for patients ages 9 to 17, and • 1 hour for patients under 9. <p>8. PRN orders are <u>never</u> acceptable.</p> <p>The Restraint / Seclusion Physician Order Form is used by the physician to record and subsequently reorder patient restraints as required.</p>
Order Renewals	<p>A new written order must be obtained every calendar day, but no more than every 24 hours in order to continue restraints following a face-to-face reassessment by the physician/licensed independent practitioner. Verbal orders are not acceptable if the order is a renewal.</p>	<p>Each order for restraint or seclusion must be renewed as follows:</p> <ul style="list-style-type: none"> • Every 4 hours for patients ages 18 and older, • Every 2 hours for patients ages 9 to 17, and • Every 1 hour for patients under age 9. <p>At the time an order is renewed, the patient must be evaluated by a physician/licensed independent practitioner. The physician/licensed independent practitioner must perform the in person evaluation at least every:</p>

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	Medical-Surgical Restraint (Least Restrictive)	Behavior Management (Aggressive/Violent Behavior) Restraint or Seclusion
		<ul style="list-style-type: none"> • 8 hours for patients ages 18 and older, and • 4 hours for patients under age 17. • 1 hour for patients under age 9
Order Notification	The physician/licensed independent practitioner must be notified of the patient’s need for restraint as soon as possible if the physician/licensed independent practitioner is not the physician/licensed independent practitioner ordering the restraint.	The physician/licensed independent practitioner must be notified of the patient’s need for restraint or seclusion as soon as possible if the physician/licensed independent practitioner is not the physician/licensed independent practitioner ordering the restraint.
Leadership Notification		Notify Nursing Supervisor immediately of any instance in which a patient remains in restraint or seclusion for more than 12 hours, or experiences two or more separate episodes of restraint or seclusion of any duration within 12 hours (PC.03.03.21).
Patient / Family Education	Explain the reason for restraints to the patient and family as appropriate.	Notify the patient’s family when restraint or seclusion is initiated as appropriate. Explain the hospital’s approach to the use of restraints to the patient and family as appropriate. Discuss with the patient the role of the patient’s family as appropriate.
Application	Apply restraint device according to manufacturer’s specifications. Never fasten restraint to side	Secure sufficient staff to safely apply restraints or place the patient in seclusion.

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	Medical-Surgical Restraint (Least Restrictive)	Behavior Management (Aggressive/Violent Behavior) Restraint or Seclusion
	rails	<ul style="list-style-type: none"> • Security may be called if necessary. Never fasten restraint to side rails. <p>A 1:1 staff member must remain with the patient at all times.</p> <p>Evaluate staffing levels and staff assignments.</p> <p>In the Emergency Department: A staff member/PCA must remain with the patient at all times.</p>
Patient Assessment	<p>The patient must be monitored at least every 2 hours but more frequently if necessary. The monitoring shall be conducted by a trained staff member and be documented in the medical records. The monitoring shall include:</p> <ul style="list-style-type: none"> • Proper application of restraints and adjustment of restraints as necessary, • Signs of injury caused by the restraint, • Observation of relevant vital signs, • Skin integrity and points of risk, i.e. restraint positions, weight-bearing pressure locations, etc., • Checking circulation and ROM of all extremities, • Respiratory status, • Need for nourishment and hydration, 	<p>The patient must be seen face-to-face within 1 hour after the initiation of restraint or seclusion by a physician/licensed independent practitioner or a properly trained registered nurse to evaluate:</p> <ul style="list-style-type: none"> • The patient’s immediate situation, • The patient’s reaction to the intervention, • The patient’s medical and behavioral condition; and • The need to continue or terminate the restraint or seclusion. <p>If a registered nurse conducts the face-to-face evaluation after the initiating of restraint or seclusion, the registered nurse must consult the physician/licensed independent practitioner responsible for the patient as soon as possible.</p>

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	Medical-Surgical Restraint (Least Restrictive)	Behavior Management (Aggressive/Violent Behavior) Restraint or Seclusion
	<ul style="list-style-type: none"> • Physical and psychological status and comfort • Readiness for discontinuation of restraint 	<p>The medical record shall include:</p> <ul style="list-style-type: none"> • Documentation of the face-to-face evaluation after initiation of restraint, • A description of the patient’s behavior and the intervention used, • Alternatives or other less restrictive interventions attempted, • The patient’s condition or symptoms that warranted the use of the restraint or seclusions, and • The patient’s response to the intervention used and the rationale for continued use. <p>In addition to the initial face-to-face evaluation, the patient must be continuously observed (in-person or after 1 hour by video and audio) by an appropriately trained staff member and evaluated every 15 minutes. The 15 minute evaluation shall include:</p> <ul style="list-style-type: none"> • Proper application of restraints and adjustment of restraints as necessary, • Signs of injury caused by the restraint, • Observation of relevant vital signs, • Skin integrity and points of risk, i.e. restraint positions,

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	Medical-Surgical Restraint (Least Restrictive)	Behavior Management (Aggressive/Violent Behavior) Restraint or Seclusion
		<p>weight-bearing pressure locations, etc.,</p> <ul style="list-style-type: none"> • Circulation and ROM of all restrained extremities, • Respiratory status, • Need for nourishment and hydration, • Physical and psychological status and comfort, • Address needs hygiene and elimination (offering toileting at least every 2 hours), • Realigning body or massaging extremities as needed, and • Readiness for discontinuation of restraint
Plan for Patient Care	<p>The patient plan of care shall be updated after each evaluation by the patient’s physician/licensed independent practitioner or as needed. The patient plan of care shall:</p> <ul style="list-style-type: none"> • Indicate the need for restraint or seclusion, • The assessment of the patient, • The frequency the patient should be monitored, • The goal of restraints • A description of the intervention used, • The identity of the individual who implemented the restraint 	<p>The patient plan of care shall be updated after each evaluation by the patient’s physician/licensed independent practitioner or as needed. The patient plan of care shall:</p> <ul style="list-style-type: none"> • Indicate the need for restraint or seclusion, • The assessment of the patient, • The goal of restraints or seclusion, • A description of the intervention used, • The identity of the individual who implemented the restraint or seclusion, and

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	Medical-Surgical Restraint (Least Restrictive)	Behavior Management (Aggressive/Violent Behavior) Restraint or Seclusion
	<ul style="list-style-type: none"> The Discontinuation of restraint. 	<ul style="list-style-type: none"> The Discontinuation of restraint or seclusion.
Discontinuation	<p>Restraints may be removed by staff before the end of the time specified in the licensed independent practitioner's order if the circumstances necessitating the restraint have subsided. The medical record must include the circumstances necessitating the removal of the restraint.</p> <p>Patients are released from restraints as soon as the circumstances that warranted their application no longer exist (i.e. such time as the RN assesses that the patient exhibits no behavior that will cause interruption of his / her own medical treatment.)</p>	<p>Restraints may be removed by staff before the end of the time specified in the licensed independent practitioner's order if the circumstances necessitating the restraint have subsided. The medical record must include the circumstances necessitating the removal of the restraint.</p>
Reinstitution	<p>If restraints are discontinued prior to the expiration of the original order, a new order must be obtained prior to reapplying the restraints and the requirements restart.</p>	<p>If restraints or seclusion are discontinued prior to the expiration of the original order, a new order must be obtained prior to reinitiating seclusion or reapplying the restraints and the requirements restart</p>
Post-Restraint or Seclusion		<p>Notify the Security Department immediately if a patient requiring leather restraint is transferred or no longer requires restraint.</p> <p>Staff members involved in the patient's restraint and/or seclusion will participate as soon as</p>

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	Medical-Surgical Restraint (Least Restrictive)	Behavior Management (Aggressive/Violent Behavior) Restraint or Seclusion
		<p>possible but within 24 hours in a debriefing session with the patient and, if appropriate, the patient's family.</p> <p>The debriefing session will:</p> <ul style="list-style-type: none"> • Identification of what led to the use of restraint or seclusion and what could have been done differently, • Ascertainment that the patient's physical well-being, psychological comfort, and the right to privacy were maintained, • Counseling of the patient for any physical or psychological trauma that may have resulted from the use of restraint or seclusion, and • Modification of the patient's plan of care, treatment, and services, if such modification is indicated.
Emergency Evacuations:	Emergency situations that require evacuation of patient rooms, such as a fire, require prompt release of patient restraints. The patient is then moved to a safe location and placed under constant observation by a staff member skilled in safe patient management	Emergency situations that require evacuation of patient rooms, such as a fire, require prompt release of patient restraints. The patient is then moved to a safe location and placed under constant observation by a staff member skilled in safe patient management

V. Documentation for ALL Restraint or Seclusion

Subject: RESTRAINT / SECLUSION, USE OF

- A. Record all restraint or seclusion observations and assessments on the Restraint/Seclusion Assessment. All documentation should occur on the electronic medical record whenever possible.
- B. Use of restraints must be based on a written modification to the patient's plan of care. The Nursing Care Plan must be updated when using restraints or seclusion.
- C. The licensed independent practitioner responsible for the patient shall document his or her initial assessment for each episode of restraint or seclusion. Such documentation shall include:
 - The patient's immediate situation;
 - The patient's behavior (hitting, spitting, kicking etc)
 - The patient's reaction to the intervention;
 - The patient's medical and behavioral condition; and
 - The need to continue or terminate the restraint and/or seclusion.
- D. The staff member responsible for monitoring that patient documents the following:
 - 1. The specific behavior, symptom, condition or circumstances (using concrete, objective examples) which indicate the need for restraint or seclusion to ensure the immediate physical safety of the patient, a staff member or others.
 - 2. The name, title, and credentials of staff members involved in the monitoring.
 - 3. The 1-hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior.
 - 4. A description of the type of restraint or seclusion used; including the date and time it was applied.
 - 5. Results of patient monitoring.
 - 6. Significant changes in the patient's condition.
 - 7. Alternative/least restrictive measures attempted. Documentation in the patient record should indicate a clear progression of techniques implemented with less intrusive restrictive interventions attempted or considered prior to the introduction of more restrictive measures.
 - 8. Patient/ family education
 - 9. Patient response to restraints
- E. If the patient is on the Behavioral Health Unit, the medical record must also contain the following additional information:
 - 1. That the patient and/or family was told of the Hospital's policy on restraint
 - 2. Any pre-existing medical conditions or any physical disabilities that would place the patient at greater risk during Restraint or Seclusion,
 - 3. Any history of sexual or physical abuse that would place the patient at greater psychological risk during restraint or seclusion,
 - 4. Consideration or failure of nonphysical interventions,

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5. Behavior criteria for discontinuing restraint or seclusion, and informing the patient of behavior criteria for discontinuing restraint or seclusion,
 6. 15-minute assessments of the patient's status,
 7. Assistance provided to the patient to help him or her meet the behavior criteria for discontinuing restraint or seclusion,
 8. Continuous monitoring,
 9. Debriefing of the patient with staff, and
 10. Any injuries and treatment for the injuries.
- F. The nursing supervisor shall review the restraint log at the end of each shift to ensure the use of restraints for each patient is properly logged.

VI. Staff Competency for ALL Restraint or Seclusion Scenarios

- A. Licensed independent practitioners authorized to order restraint or seclusion must have a working knowledge of the Hospital's policy regarding the use of restraint or seclusion.
- B. Restraint and seclusion education and training must be provided both as a part of the initial orientation of all clinical staff and as part of on-going in-service training at least annually. Education and training must include demonstrated, documented competency. This applies to all ED physicians, Psychiatrist, Hospitalists, residents, PA's, APRN's, RN's, LPN's, CA's, Psychiatry Techs, Respiratory Therapist, Radiology technicians, transporters, and Security.
- C. Education includes:
 1. The underlying causes of threatening behaviors exhibited by the patients.
 2. That sometimes a patient may exhibit an aggressive behavior that is related to a patient's medical condition and not related to his or her emotional condition (for example, threatening behavior that may result from delirium in fevers or other medical conditions).
 3. How staff behaviors can affect the behaviors of the patients.
 4. De-escalation, mediation, self-protection, and other techniques such as time-out.
 5. The use of nonphysical intervention skills.
 6. How to recognize signs of physical distress in patients who are being held, restrained, or secluded.
 7. The safe use of restraint, including physical holding techniques, take-down procedures, and the application and removal of mechanical restraints.

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8. The safe application and use of all types of restraint or seclusion used in the Hospital, including training in how to recognize and respond to signs of physical or psychological distress (for example, positional asphyxia).
- D. Staff members who are authorized to initiate restraint or seclusion in an emergency situation before an order can be obtained, who are authorized to perform 15-minute assessments and other monitoring of patients in restraint or seclusion, and/or who perform evaluations or reevaluations of patients in restraint or seclusion to assess their readiness for discontinuation or establish a need to secure a new order, must receive ongoing training and demonstrate competence in the following:
1. Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion.
 2. Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition.
 3. Monitoring the physical and psychological well-being of the patient who is restrained or secluded.
 4. Taking vital signs and interpreting their relevance to the physical safety of the patient in restraint or seclusion.
 5. Recognizing nutritional and hydration needs.
 6. Checking circulation and range of motion in the extremities.
 7. Addressing hygiene and elimination.
 8. Addressing physical and psychological status and comfort.
 9. Helping patients meet behavior criteria for discontinuing restraint or seclusion.
 10. Recognizing readiness for discontinuing restraint or seclusion, including clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.
 11. Recognizing signs of any incorrect application of restraints.
 12. The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.
 13. Recognizing when to contact a medically trained licensed independent practitioner or emergency medical services to evaluate and/or treat the patient's physical status.
 14. Recognizing what age, developmental considerations, gender issues, ethnicity, and history of sexual or physical abuse may affect the way in which a patient reacts to physical contact.
 15. Using behavior criteria for discontinuing restraint or seclusion and how to help patients in meeting these criteria.

VII. Performance Improvement Activities for ALL Restraint or Seclusion Scenarios

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- A. If a problem or injury occurs during the use of a restraint or seclusion, an incident report is to be completed.
- B. Data on each restraint and seclusion episodes are collected by the following:
 1. Shift,
 2. Setting/unit/location where the episode occurs,
 3. Staff who initiated the process,
 4. The length of each episode,
 5. Date and time each episode was initiated,
 6. Day of the week episode was initiated,
 7. The type of restraint used,
 8. Whether injuries were sustained by the patient or staff,
 9. Patient identifier
 10. Age of the patient, and
 11. Gender of the patient.
 12. The use of psychoactive medications as an alternative to restraint or seclusion or to enable their discontinuation
- C. The nursing department shall measure and assess the use of restraint and seclusion to identify opportunities to introduce preventive strategies, alternatives to use, and process improvements that reduce the risks associated with restraint and seclusion use. The nursing department reports restraint data and analysis to the patient safety committee.
- D. The nursing department shall collect restraint and seclusion data to monitor and improve performance of processes that involve risks or may result in sentinel events. It shall use the data to perform the following:
 - i. Ascertain that Restraint or Seclusion are used only as an emergency,
 - ii. Identify opportunities for incrementally reducing the rate and increasing the safety of restraint and seclusion use, and
 - iii. Identify any need to redesign care processes.

VIII. Reporting – Telephone Notification and Incident Reporting.

- A. All injuries or death associated with the use of restraints or seclusion shall be reported immediately to the risk manager or house supervisor. Even if the injury or death occurs after the release of the patient from restraints or seclusion, the incident must still be reported.
- B. The Hospital will report the following information to the Centers for Medicare & Medicaid Services (“CMS”):
 - Each death that occurs while a patient is in restraint or seclusion.
 - Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.

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- Each death known to the Hospital that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation.
- C. Each death referenced above will be reported to CMS by telephone or email no later than the close of business the next business day following knowledge of the patient's death.
- IV. Only the Senior Vice President for Medical Affairs, the Director of Risk Management or their designee is authorized to make these reports to CMS.
- V. Staff must document in the patient's medical record the date and time the death was reported to CMS.

Appendix A

It is the policy of Stamford Hospital to provide criteria which supports the appropriate and safe utilization of the Net Enclosure Bed (Net Bed)[™] according to regulatory and manufacturer's guidelines. The utilization of a Net Enclosure Bed[™] will be considered the least restrictive physical restraint, and as such, in addition to the procedures set forth in this Appendix A, the procedures set forth in this Policy regarding: (i) all restraints and seclusions; and (ii) the least restrictive medical-surgical restraints shall apply to the use of the Net Enclosure Bed. Stamford Hospital ensures the environment protects the rights, dignity, and physical integrity of the patient, to the fullest extent possible.

A. Criteria for Use

The utilization of the Net Enclosure Bed[™] is limited to those patients who meet one or more of the following behavioral criteria:

- Climbing out of bed
- Impulsive
- Unable to redirect
- Wandering

Monitoring and documentation requirements are the same regardless of the patient or family request for this intervention.

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Patient will not be transported in the Net Enclosure Bed to other departments for the purpose of diagnostic testing or for transfer to another unit for admission. Patient will be transported for diagnostic testing or transfer under constant observation.

B. Exclusion Criteria /Contraindications

The Net Enclosure Bed is not appropriate for and will not be utilized for the patient who exhibits:

- Highly agitated behavior
- Highly aggressive behavior
- Homicidal behavior
- Suicidal behavior
- Claustrophobia
- Burrowing behavior (i.e. persistently pushes self into the corners of the bed, other small spaces, or tries to climb under the mattress.)
- Pica eating disorder
- Patients with multiple invasive lines who try to pull out or disconnect their lines
- Patients weighing less than 46 pounds (20.865 kg) or more than 300 pounds (136.078 kg).
- Patients who are less than 45 inches (114.3 cm) in height or more than 6 feet, 4 inches (193.04 cm) in height.

C. Bed Ordering Process

Determine if the patient meets criteria to utilize the Net Enclosure Bed.

Notify the nursing supervisor or resource nurse. He/She will identify if “Just in Time” training is needed for the nursing staff on the unit.

Obtain a physician order for least restrictive restraints utilizing the Net Enclosure Bed.

The Physician will review with the patient, family and/or the health care proxy intentions for use of the Net Enclosure Bed.

Contact Vivax Medical Corporation at 1 (866) 927-7740, (set up will take approximately 2-4 hours from place of call)

The Resource Nurses will be available 24/7 to perform the “Just in Time” training and they will serve as the super users for the Net Enclosure Bed.

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D. Bed Frame Set Up and Use

- I. The Vivax medical representative will:
 1. Deliver the bed to the patient care area
 2. Verify that the mattress is an 80 inch by 35 inch wide hospital mattress
 3. Set up the Net Enclosure Bed and alert the nursing staff to the bed model type (SSE-400 Collapsible Frame or SSE-300 Full Bed)
 4. Perform a safety inspection to ensure the equipment is in proper condition and working order.

- II. Prior to placing the patient in the Net Enclosure Bed the nursing staff will:
 1. Verify that a physician order has been obtained
 2. Ensure no objects are left in the enclosure bed that the patient could use to hurt themselves, or use to damage the enclosure bed.
 3. Will zero out the bed scale with the bed in the down position, if applicable.
 4. Complete a visual inspection of the enclosure bed to ensure the netting and vinyl has no tears or holes.

- III. After placing the patient in the Net Enclosure Bed the nursing staff will:
 1. Place bed in the lowest position with bed frame supporting the mattress without suspending the canopy except when attending to the patient.
 2. Keep bed head and knee functions in the lowest possible position possible except where clinically indicated (i.e. HOB elevated 30degrees, or Semi-Fowler's position, etc...).
 3. Bed netting should be taut.
 4. When not in direct observation of the patient keep all side and end flaps closed with zipper tabs at the extreme ends to prevent patient access to back side of zipper tabs.
 5. Ensure all unused I.V. catheter ports are zipped closed. Any that are in used should be zipped as closed as possible without interfering with tubing.

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6. Both (2) side rails should be in the raised up position except when attending to the patient.
7. If using the Net Enclosure Bed SSE-400 Collapsible Frame model do not remove the head board or foot board from the hospital bed.
8. During bedside shift report the off-going RN will review all safety features of the bed with the oncoming RN, including the emergency exit procedures.

E. Patient and Family Education

Nursing will provide and review with the patient and family/agent, if appropriate, the “Patient/Family Information Sheet- Net Enclosure Bed™.”

F. Emergency Patient Evacuation

- Go to the left or right side of the Net Enclosure Bed
- Locate the zipper pull tabs on the side Access Panel.
- Unzip the zipper by pulling each zipper pull tab to the left and right uppermost corner of the Side Access Panel.
- Remove the patient through the open side of the bed.
- The off-going RN will review the emergency patient evacuation with the on-coming RN during bedside shift report.

G. Discontinuation of Bed/Use

After making a determination that discontinuation of the Net Enclosure Bed is appropriate in accordance with this Policy, the nursing staff must contact Vivax Medical Corporation at 1 (866) 927-7740.

Vivax Medical Corporation is responsible for the bed pick-up from the nursing unit after routine terminal cleaning by the Environmental Services staff.

H. Care and Maintenance

Environmental Services staff will be responsible for the routine cleaning of the bed/mattress, bolster covers and pad covers when the bed enclosure is no longer required by the patient.

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Any further cleaning of the canopy due to visible soiling will be the responsibility of the Vivax Medical Corporation.

I. Documentation

Documentation of utilization of the Net Enclosure Bed will be completed following the same requirements as set forth in Section III of this Policy. Once the bed has been discontinued as an intervention, it may not be reinstated for use until a new physician order has been obtained. Physician orders are required every twenty-four hours. The nurses will assess the patient's continued need for the Net Enclosure Bed on an ongoing basis.

J. Soma Data Tracking Sheet

All patients who have been placed into the Net Enclosure Bed program will take part in the Soma Data Tracking Program.

Upon each placement the nursing staff responsible for the care of the patient being placed in the Net Enclosure Bed™ will initiate the Soma Data Tracking form and place the form in the front of the patient's paper medical record.

The nursing staff responsible for the care of the patient at the time the enclosure bed is being discontinued will complete the Soma tracking form.

Fax the completed form to Vivax Medical @ 203-729-0489 or e-mail to datatracking@vivaxmedical.com.

Posey® *Safety Information for the Use of Posey Torso and Limb Restrictive Products*

WARNING: Monitor patients appropriately per your facility's policy!

Inappropriate and/or incorrect usage of any restrictive product may result in serious injury or death. The Posey Company recommends the following steps before any restrictive product is used:

- Identify the patient's symptoms.
- Determine and remove, if possible, the cause of the symptoms. This may include catering to individual needs and customary routines, increased rehabilitation and restorative nursing, modifying the environment, and increased supervision.
- If the cause cannot be determined and removed, attempt alternative treatments under proper medical supervision.
- A restraint should be used only when predictable alternatives have failed. The least restrictive device that will protect the patient and others should be selected and used for the shortest time while less restrictive alternatives are sought. It is critical that the appropriate restraint is selected.
- Follow the directions on the Application Sheet accompanying each product.

#1 Posey restraints are labeled: Caution: Federal law (USA) restricts this device to sale by or on order of a physician. All staff should receive proper inservice training so products are applied in accordance with the manufacturer's instructions, state and federal regulations and the facility's policies and procedures. Posters, Videos and Inservice materials are available free from the Posey Company.

#2 Restrictive products should only be used within the carefully defined and documented parameters of the patient's Individualized Care Plan (ICP) which addresses (but is not limited to) restorative nursing, patient release, and pressure sore prevention. The ICP is created after an assessment by an interdisciplinary team which may represent (but is not limited to) PT, OT, Nursing, the Physician, and Social Services.

#3 NEVER use a Posey product as a seat belt in a moving vehicle. Posey products are not designed to withstand the force of a crash.

#4 DO NOT expose any Posey Product to open fire, flame, or contact with smoking materials. Components such as fabric, webbing, thread, etc. are susceptible to ignition and burning. The facility's smoking/no smoking policy should be vigorously enforced. Flame retardant fabric is available on request.

#5 Never crisscross the straps of a Posey Vest/Jacket in back of the patient unless there is a positioning slot in the rear of the product. Any restraint applied incorrectly and/or worn backwards may cause strangulation or injury.

#6 Secure straps of restrictive products out of the patient's reach at a juncture

of the movable part of the bed frame at waist level so the device will not tighten or loosen when any section of the bed is raised or lowered. Make sure the strap will not slide in any direction, changing position of the device.

#7 After applying a restraint or self-release product; always put all side rails in the UP position. Side rail covers and gap protectors, especially with split side rails, may be required to keep the patient on top of the mattress, and avoid entrapment zones.

If the patient's body weight becomes suspended off the mattress by going under, around, over, through or between the side rails, chest compression and suffocation could result. Restraints with pelvic pieces may be necessary to reduce sliding down or pulling the restraint over their head.

#8 Hips should be held securely against the back of the chair whenever any type of restrictive product is used. The straps should be at 45 degrees over the hips and secured under the seat out of the patient's reach. Make sure straps are secured at a juncture of the frame and will not slide in any direction, changing position of the device. Use extreme caution with all cushions. If dislodged, patient injury could occur. (see #9).

#9 Monitor to make sure the patient is not able to slide down, or fall off a chair seat. If their body weight becomes suspended off the chair seat, chest compression and suffocation could result. Restraints with

pelvic pieces may be necessary to reduce sliding down or pulling the restraint over their head.

#10 Straps must always be snug, but not interfere with breathing. You should be able to slide your open hand (flat) between the device and the patient. Make sure straps do not slide in any direction, changing position of device.

#11 Always use quick-releasing ties (see drawings) or buckles to secure straps - they allow easy release in the event of accident or fire. Restraint release should be an integral part of the facility's fire/disaster evacuation drills. Straps can be cut with scissors in an emergency.

#12 Patients in restrictive products require appropriate monitoring per your facility's policy. Aggressive, agitated, restless patients and/or those in danger of aspirating their vomit require constant monitoring and a systematic review and evaluation of both physical and psychological status.

#13 Inspect before use for broken stitches or parts; torn, cut or frayed straps or fabric; or hook and loop fastener or locks that do not hold securely. These products could fail, resulting in injury or death. Destroy and discard them. Straps must be long enough to secure out of the patient's reach. DO NOT alter products.

#14 Do not use Posey products on toilets, or on any type of furniture which does not allow application as directed in the product application sheet. Posey limb and torso restraints should NOT be used at home without constant supervision of a licensed healthcare provider, physician's order and an Individualized Care Plan.

Just as patient behaviors are not 100% predictable, no product is 100% foolproof under all circumstances. A restraint is not a substitute for good nursing care. Patient safety requires regular reassessment and appropriate monitoring per your facility's policy. A product that worked successfully in the past may prove inappropriate as the patient's mental and physical health status changes. Never apply any product you feel is unsafe and consult with the proper medical authority if you feel a product is inappropriate for the patient.

How to Tie the Posey Quick Release Tie

1. Wrap the attachment strap once around the movable part of the bed frame leaving at least an 8" tail. Fold the loose end in half to create a loop and cross it over the other end. Make sure straps are secured at a juncture of the frame and will not slide in any direction, changing position of device.
2. Insert the folded strap where the straps cross over each other, as if tying a shoe or making a tourniquet knot. Pull on the loop to tighten.
3. Fold the loose end in half to create a second loop.
4. Insert the second loop into the first loop.
5. Pull on the loop to tighten.

Sizing Table for Posey Products

Always use the proper size product. Products that are too small or large compromise patient comfort and safety and should not be used.

BINDING COLOR	SIZE	WEIGHT (lb./kg)	CHEST (in./cm)
White	X-Small	50-90/27-41	28-34/71-86
Red	Small	80-120/36-54	32-39/81-99
Green	Medium	110-155/50-70	37-45/94-114
Yellow	Large	145-190/66-86	43-49/109-124
Blue	XX-Large	180-230/82-104	47-52/119-132
Black	XXX-Large	220-275/110-125	50-56/127-142
Yellow/Black	XXXX-Large	255-305/120-139	54-60/137-152
Blue/Black		295-340/134-155	58-64/147-163

Posey Belts are not color-coded, but are also sized according to this table. Flame retardant fabric is available on request. Weight and size measurements give a general indication of the proper size. Individual physical characteristics should be taken into account before the medical authority determines the correct size. Refer to label on product for specific sizing indications.

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Posey APPLICATION INSTRUCTION SHEET
POSEY® LIMB HOLDERS

Applicable Products:
2202, 2203, 2204, 2205, 2206,
2207

DESCRIPTION OF PRODUCT: Wrist/ankle restraints for use with extremely violent patients and/or patients who are potentially dangerous to themselves or others.

CAUTION: FEDERAL LAW (USA) RESTRICTS THIS DEVICE TO SALE OR USE BY OR ON ORDER OF A PHYSICIAN.

INDICATIONS:

- Patients who continually disrupt life-saving treatment (e.g., chronic tube-pulling which breaks the integrity of an IV line or self-extubation).
- When a patient's pulling lines prevents the healthcare professional from adequately monitoring the vital signs of the patient.
- When a patient's picking, pulling, scratching or peeling exacerbates a skin condition, causes self-injury, or disrupts wound site integrity.
- These products are to be used on patients assessed as being in extreme danger of injury to themselves or to others.

CONTRAINDICATIONS:

- Contraindications include, but are not limited to the following conditions:
- Do not use limb restraints on patients with dislocations, fractures or open wounds on the affected limb.
 - Do not use limb restraints if the I.V. site could be compromised.
 - Aggressive, combative, agitated, or suicidal patients should not be put into a restrictive product unless they will receive constant monitoring.

ADVERSE REACTIONS:

Severe emotional, psychological, and physical problems may occur if a patient's movement is severely limited. The patient may become agitated if the device is uncomfortable or severely limits movement. Request assistance from a qualified medical authority to try to find a less restrictive alternative product or intervention.

Do not attach the limb holder in a way that the patient may use his/her teeth to remove the device or inflict self-injury. Additional body restraint (fifth point) may be required to prevent the patient from moving the line/wound/tube site to within access of his/her hands. Refer to Posey Psychiatric and Emergency Dept. Product Book, Part No. M1031.) Always secure strap at a frame juncture which will not allow the straps to slide in any direction, changing the position of the product.

ADDITIONAL SAFETY INSTRUCTIONS ON OTHER SIDE

WARNING

A patient in a supine position who cannot sit up requires extra vigilance. Should the patient vomit, he/she could aspirate his/her vomitus and suffocate. Monitor constantly and be prepared to intervene at the first sign of danger.

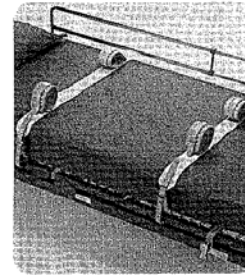
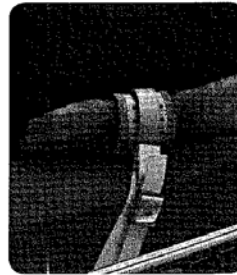
If this device is applied too tightly, circulation will be impaired; if too loose, the patient may be able to slip his/her limb from the device. Check circulation frequently and monitor for skin discoloration.

Check cuffs and straps for cracks, tears and wear. Soft leather is pliable and may allow the patient to pull the cuff off the wrist, or the straps to slide through the slots. Discard all leather products that are cracked, worn, torn or are too soft or pliable to prevent the patient from pulling the cuff off the wrist, or pulling the connecting strap through slots. If the patient is able to remove the cuff, they may do injury to themselves or others.

RECOMMENDED CLEANING: LEATHER AND SYNTHETIC LEATHER: There is no universally accepted method of sterilizing or disinfecting leather or synthetic leather products. Traditional methods of sterilization, i.e., bleach, autoclaving, steam and ETO gas sterilization, are not effective since leather is a very porous, biogenic material that will deteriorate with exposure to germicidal chemicals or high heat/moisture. Furthermore, because of the natural porosity of leather, residual disinfectant may accumulate to pose a possible risk to the caregiver and/or patient.

Synthetic Leather may be sanitized (reduction of at least 99.9% of organisms) by entirely submerging the product in 70% alcohol for 10 minutes. Be sure the product is completely dry before applying to a patient.

Since effective disinfecting and sterilizing of leather, and synthetic leather cannot be achieved, any leather or synthetic leather product contaminated with blood or bodily fluids should be discarded. A suitable alternative is the Posey T-A-T Cuff (#2790-#2799). The Posey T-A-T Cuff may be laundered according to CDC recommendations for linens soiled with blood or bodily fluid. For a durable, sterilizable restraint cuff alternative, we recommend the Posey E.D. Security Cuff (#2835).



APPLICATION INSTRUCTIONS: SINGLE CUFFS

1. Wrap the cuff around the patient's limb, leaving enough room to insert one finger, bringing the U-bar through the vertical slot and then the leather tongue through the U-bar.
 2. Pass the connecting strap through the U-bar on the cuff.
- WARNING:** If keys are needed to unlock, be sure to have keys readily available to all staff members at all times. In the event of an emergency, it would be very difficult to cut these leather cuffs off.
- WARNING:** Use extreme caution when using any type of padding. If the patient violently pulls against the padding, they may be able to compress it enough to free their hand.

LEATHER WRIST/ANKLE CUFFS:

REF 2202, Suede lined

SYNTHETIC LEATHER WRIST/ANKLE CUFFS

REF 2203

NOTE: Straps must be ordered separately. See Posey catalog, or call 800-447-6739.

APPLICATION INSTRUCTIONS: CONNECTING STRAPS FOR SINGLE CUFF

1. Wrap the strap once (or more) around the moveable frame of the bed.
2. Pass the strap through the metal U-bar and pass it through the lock or buckle, leaving no more than 1" of strap protruding through the lock. Too much excess strap may allow the patient to pull on the buckle with more than 600 pounds leverage, damaging or breaking open the lock. If more than 1" protrudes out of the lock, the strap should be positioned with the lock out of the patient's reach. Cotton and polypropylene straps may be cut with scissors to free patient in an emergency.

REF 2320, Cotton strap w/lock buckle - 18", 24", 36", 48", 60", 72"

REF 2330, Leather strap w/roller buckle - 18", 24", 36", 48"

REF 2355, Synthetic leather w/roller buckle - 18", 24", 36", 48", 60", 72"

NOTE ON CLOSING BUCKLES: If the strap does not pass easily through the locking buckle, check to see if there is an obstruction in the lock or if the strap end is bent or curled. If the strap end is relatively straight and the lock unobstructed, but the strap still does not pass easily into and through the lock, try the following remedy: With the lock in the 'open' position, gently push the strap end into the lock until it meets resistance. With the thumb of the other hand, gently push the lock latch down halfway (like you're closing it, but don't close the lock). Repeat this action several times until the strap feeds itself through the passage.

APPLICATION INSTRUCTIONS: CONNECTED CUFFS

1. Attach the long bed strap to the moveable part of the bed frame at a comfortable level for either wrist or ankle use.
 2. Lay the patient down on the bed on top of the connecting strap between the leather cuffs.
 3. Wrap the Cuff around the patient's limb, bringing the U-bar through a vertical slot. Then bring the leather strap through the metal U-bar.
- You should be able to insert 1 finger between the cuff and the patient's limb.
- WARNING:** Use extreme caution when using any type of padding. If the patient violently pulls against the padding, they may be able to compress it enough to free their hand.
- WARNING:** Make sure patients cannot reach bed connecting straps and release themselves.

SYNTHETIC LEATHER (PARACRIL® NITRILE RUBBER)

REF 2204, Connected Wrist Cuffs

REF 2205, Connected Ankle Cuffs

LEATHER

REF 2206, Connected Wrist Cuffs

REF 2207, Connected Ankle Cuffs



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STAMFORD HOSPITAL
Clinical Service Manual

Subject: RESTRAINT / SECLUSION, USE OF

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Soma Safe Enclosure Patient Data Tracking Form

Please fax the completed form to Vivax Medical: 203.729.0489, or email to: datatracking@vivaxmedical.com

Patient Admission Info:

Revised 2.5.14

ADMISSION
INPATIENT

<p>1. Name of Unit _____ 2. Room# _____</p> <p>3. Floor _____</p> <p>4. Age of Patient _____</p> <p>5. Male <input type="checkbox"/> Female <input type="checkbox"/></p> <p>6. Date of Admission _____</p>	<p>7. Patient origin: <input type="checkbox"/> Home <input type="checkbox"/> Nursing Home <input type="checkbox"/> Group Home <input type="checkbox"/> Assisted Living <input type="checkbox"/> Homeless <input type="checkbox"/> Other _____</p> <p>8. Initial fall score _____</p> <p>9. Fall scale used <input type="checkbox"/> Morse <input type="checkbox"/> Hendricks II Other _____</p> <p>10. Enclosure start date _____</p>
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<p>11: Admission Diagnosis: <i>(Number in order of importance if selecting more than one admission diagnosis)</i></p> <p>___ Alzheimer's</p> <p>___ AMI (acute myocardial infarction)</p> <p>___ AMS (altered mental status)</p> <p>___ Brain Tumor</p> <p>___ CHF (congestive heart failure)</p> <p>___ Dehydration</p> <p>___ Dementia</p> <p>___ Fracture</p> <p>___ PNA (pneumonia)</p> <p>___ Psychiatric disorder</p> <p>___ Renal Failure</p> <p>___ Seizure disorders</p> <p>___ Septicemia</p> <p>___ Strokes - CVA or TIA</p> <p>___ Subdural hematoma</p> <p>___ Substance/ETOH related mental disorders</p> <p>___ Syncope</p> <p>___ TBI</p> <p>___ UTI</p> <p>___ Withdrawal with ETOH involvement</p> <p>___ Withdrawal with substance abuse involvement</p> <p>___ Withdrawal with ETOH and substance abuse involvement</p> <p>___ Other _____</p>	<p>12: Contributing Conditions: <i>(Number in order of importance if selecting more than one condition)</i></p> <p>___ Neurological impairment due to <u>Anesthesia</u></p> <p>___ Agitation and disruptive <u>Behavior</u> requiring restraints</p> <p>___ <u>Confusional</u> state from any cause</p> <p>___ <u>Delirium</u> from any cause including drug or alcohol withdrawal, or other medical condition resulting in delirium</p> <p>___ <u>Direction</u> - Lack of comprehension to instructions</p> <p>___ <u>Psychosis</u>, hallucinations, or delusions requiring acute intervention</p> <p>___ <u>Suicidal</u> patients who otherwise would have required restraint use only when used in conjunction with a sitter</p>
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<p>13: Reason for Enclosure Use <i>(Number in order of importance if selecting more than one reason)</i></p> <p>___ Agitation</p> <p>___ Climbing out of bed</p> <p>___ Disruptive behavior</p> <p>___ Harm to self</p> <p>___ Impulsive</p> <p>___ Risk to fall</p> <p>___ Strikes others</p> <p>___ Strikes staff</p> <p>___ Wanders into others rooms</p> <p>___ Won't use call light</p>	<p>14: Likely Alternative to Enclosure: <i>(Number in order of importance if selecting more than one alternative)</i></p> <p>___ Staff: RN</p> <p>___ Staff: CNA/PCT</p> <p>___ Staff: Sitter/Observer</p> <p>___ Staff: Psych Counselor</p> <p>___ Roll Belt</p> <p>___ Vest Restraint</p> <p>___ Wrist Restraints</p> <p>___ 4 Point Restraints</p> <p>___ Increased Medication (restraint)</p> <p>___ Isolation/Seclusion</p> <p>___ Other _____</p>
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15: Patient Response to Enclosure (Select one)

<input type="checkbox"/> Positive; Had a definite calming effect	<input type="checkbox"/> Unable to determine; no obvious indications
<input type="checkbox"/> Generally positive	<input type="checkbox"/> Initially leery but chose enclosure over vest or other restraint
<input type="checkbox"/> Initially indignant but then felt safe in enclosure	<input type="checkbox"/> Patient disliked
<input type="checkbox"/> Neutral	<input type="checkbox"/> Other _____

<p>16: # of Patient Days in Enclosure _____</p> <p># of Patient Days in Hospital _____</p>	<p>17: Patient disposition:</p> <p><input type="checkbox"/> Home <input type="checkbox"/> Nursing Home <input type="checkbox"/> Assisted Living <input type="checkbox"/> Group Home Other _____</p>
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THE STAMFORD HOSPITAL
Organizational Clinical Policy

Subject: ADVANCE DIRECTIVES / APPOINTMENT OF HEALTH CARE REPRESENTATIVES

Policy #: RI 100

Implemented: 4/14/03

Reference: Title 42 of the United States Code
of Federal Regulations (C.F.R.)
§ 489.100 *et seq.*; title 42 of the United States
Code (U.S.C.) § 1395cc(f); Connecticut
General Statutes (“C.G.S.”) § 1-56r;
C.G.S. § 19a-570 *et seq.*;
C.G.S. § 19a-580 *et seq.*;
Connecticut Department of Public
Health Regulations: (“Conn. Reg.”)
§ 19a-580d-1 *et seq.*; TJC

Revisions: 03/26/08, 4/6/09, 9/24/13

Approval: Senior V.P. of Patient Services

Reviewed: 4/24/06; 03/26/08

Department: All

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Purpose:

To outline the process for respecting the wishes of patients regarding their health care as set forth in properly executed and legal Advance Directives.

Policy:

- I. It is the policy of The Stamford Hospital (the “Hospital”) to abide by all applicable federal and state laws governing Advance Directives and to recognize and respect the wishes of patients regarding their health care as expressed through Advance Directives.
- II. The Hospital may elect not to treat a person as the Health Care Representative of a patient if it has a reasonable belief that:
 - A. The patient has been or may be subjected to domestic violence, abuse or neglect by such person;
 - B. Treating such person as the personal representative could endanger the patient;
OR
 - C. It is not in the best interest of the patient to treat the person as the patient’s personal representative based upon the exercise of Stamford Hospital’s professional judgment.

Definitions:

In this Policy, the following words shall have the following meanings:

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Organizational Clinical Policy

Subject: ADVANCE DIRECTIVES / APPOINTMENT OF HEALTH CARE REPRESENTATIVES

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“Advance Directive” shall mean a written legal document in which the patient states his/her preferences about health care; Advance Directives take effect when a patient becomes incapacitated. An Advance Directive may also designate another person to express a patient's wishes or to make decisions regarding the patient's health care and act as the patient for purposes of exercising the patient's individual privacy rights in the event that the patient is unable to do so. In Connecticut, the **“Living Will,”** which sets forth a patient's directives about any aspect of health care, including, but not limited to, the withholding or withdrawal of life support systems, and, the **“Appointment of a Health Care Representative,”** by which a patient may appoint a representative to make health care decisions for the patient at times when the patient is incapacitated, and the **“Document of Anatomical Gift,”** by which a patient may provide instructions regarding the donation of hi/her organs upon death, are all examples of Advance Directives. The different types of Advance Directives may be combined together into a single document. Legally compliant Advance Directive Forms are attached to this Policy.

“Attending physician” shall mean the physician selected by, or assigned to, the patient, who has primary responsibility for the treatment and care of the patient.

“Beneficial medical treatment” includes use of medically appropriate treatment, including surgery, treatment, medication and the utilization of artificial technology to sustain life.

“Do Not Resuscitate Order” or “DNR Order” shall mean a written order by a physician that states that in the event of the respiratory or cardiac arrest of a patient, cardiopulmonary resuscitative measures (“CPR”) will not be initiated. DNR Orders should be informed by the express wishes of patients, including, without limitation, those expressed in Advance Directives. The Hospital's Policy # RI 200 regarding DNR Orders should be consulted as appropriate.

“Health Care Representative” shall mean the individual appointed by a patient pursuant to an Appointment of a Health Care Representative for the purpose of making health care decisions on behalf of the patient. Health Care Representative is a person whom the patient authorizes in writing to make any and all health care decisions on their behalf including the decision whether to withhold or withdraw life support systems. A health care representative does not act unless the patient is unable to make or communicate health care decisions. The health care representative will make decisions on the patient's behalf based on the patient's wishes, as stated in a living will or as otherwise known to the health care representative. In the event the patient's wishes are not clear or a situation arises that the patient did not anticipate, the health care representative will make a decision in the patient's best interests, based upon what is known of the patient's wishes. The Health Care Representative form must be signed by the patient and witnessed by two adults.

Health Care Agent: is someone who is appointed via a document signed by a patient giving the Health Care Agent the authority to communicate certain medical decisions in the event that the patient becomes incapable of making those decisions. A Health Care Agent's authority is limited to communicating decisions about life support and comfort care measure. Therefore, the Health Care Agent's access to the patient's medical information is limited to the information needed to address these decisions. In the event no such decisions need to be made, the Health Care Agent

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will not be provided access to the patient's health information unless the access is otherwise authorized. Like Durable Powers of Attorney for Health Care, Health Care Agents were replaced with Health Care Representatives on October 1, 2006. Health Care Agent documents executed prior to October 1, 2006 will be honored unless the document has been revoked.

“Incapacitated” shall mean being unable to understand and appreciate the nature and consequences of health care decisions, including the benefits and disadvantages of such treatment, and to reach and communicate an informed decision regarding treatment.

“Life support systems” shall mean any medical or other procedure or intervention which, when applied to a patient, does not contribute toward successful treatment of the patient's illness but only services to postpone the moment of death or maintain the individual in a state of permanent unconsciousness, including, but not limited to, mechanical or electronic devices and artificial means of providing nutrition and hydration.

“Next of kin” shall mean any member of the following classes of persons, in the order of priority listed (1) the patient's spouse; (2) an adult son or daughter of the patient; (3) either parent of the patient; (4) an adult brother or sister of the patient; and (5) a grandparent of the patient. For purposes of this policy, parties to a civil union shall be granted the same rights and responsibilities as spouses in a marriage.

“Permanently unconscious” shall mean an irreversible condition in which the individual is at no time aware of himself / herself or the environment and shows no behavioral response to the environment and includes permanent coma and persistent vegetative state.

“Terminal Condition” shall mean the final stage of an incurable or irreversible medical condition which, without the administration of a life support system, will result in death within a relatively short time period, in the opinion of the attending physician.

Procedure:

- I. Upon admission, all patients shall be given a document entitled *“Your Rights to Make Health Care Decisions”*.
 - A. This written statement regarding Advance Directives, a copy of which is attached hereto and will be revised and updated as necessary, which includes the following:
 1. An individual's rights under Connecticut law to make decisions concerning his/her health care, including the right to accept or refuse treatment and the right to give Advance Directives.
 2. The Hospital's policies respecting the implementation of the patient's rights regarding health care decisions. Among the policies detailed shall be the Hospital's policy regarding when a patient's Advance Directive

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cannot be implemented on the basis of conscience and this policy description shall include:

- i. Clarification of institutional conscience objections and those that may be raised by individual physicians;
- ii. Identification of the state legal authority permitting conscience objections; and
- iii. Identification of the range of medical conditions or procedures affected by the conscience objection.

3. The requirements of applicable federal and state law governing advance directives mention that complaints regarding the Advance Directive requirements may be filed with the Connecticut Department of Public Health.

- B. This written statement regarding Advance Directives should be explained to the patient by **Social Worker or Patient Relations Representative** and the patient should be given an opportunity to have any questions answered. After hours, nursing staff can provide an explanation and notify the Social Work department of any ongoing referral needs.
 - C. If an adult patient is incapacitated at the time of admission or at the start of care and is unable to receive the required information detailed in this Policy or articulate whether or not he/she has executed an Advance Directive, then the required information shall be given to the patient's family or representative and there shall be an opportunity to have any questions answered. Once the patient is no longer incapacitated, all the required information shall immediately be provided to the patient.
 - D. The Hospital's written information and forms regarding Advance Directives must be updated within ninety (90) days of any changes to applicable state law.
- II. Upon admission, each patient or his/her representative must be asked whether the patient has formulated written Advance Directives. The existence or absence of an Advance Directive must be clearly and conspicuously documented in the medical record. If the patient has an Advance Directive, it must be filed with the medical record. Advance Directive documents are filed in Horizon Patient Folder (HPF) under the Advance Directive tab. No presumptions may be drawn from the absence of an Advance Directive.
- A. If the patient has a written Advance Directive, but did not bring it to the Hospital, nursing will follow up with the patient/family to bring the Advance Directive from home. In the absence of the actual written Advance Directive, the substance of the Advance Directive will be documented by the physician in the patient's medical record.

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- B. When the patient has an Advance Directive on file, but does not bring a current copy at the time of admission, the Health Information Management Department will retrieve it from the medical record and send it to the proper nursing floor.
 - C. The medical staff will review an existing Advance Directive with the patient as appropriate.
 - D. The Hospital will not file Advance Directives for patients for whom an inpatient record does not exist. If such individuals mail Advance Directives to the Hospital, they will be sent back with the instruction that the directives be provided to appropriate family members, physician, clergy, etc., and that the patient should bring the Advance Directive to the Hospital if he/she is ever admitted.
- III. If the patient does not have an Advance Directive, but would like more general information about it, he/she should be referred to the Social Work Department. Sample forms will be available from the Social Work Department, and these are attached to this Policy. Patients with specific legal questions or issues will be advised to consult their own attorneys.
- IV. Components of an Enforceable and Legal Advance Directive (including Living Wills and Appointment of Health Care Representatives)
- A. Advance Directives may be executed by anyone who is at least eighteen (18) years old.
 - B. Advance Directives must be in writing, signed and dated by the maker in the presence of at least two (2) adult witnesses. In the case of an Appointment of Health Care Representative, the appointed Health Care Representative may not act as a witness to the execution of the document.
 - 1. Hospital staff involved in the care and treatment of the patient may not serve as witnesses to the signing of the patient's Advance Directives due to the potential liabilities inherent in doing so. In limited circumstances, Hospital staff not involved in the medical care and treatment of patients, such as the patient representatives or social workers, may serve as witnesses. Risk Management should be contacted whenever the use of Hospital staff as witnesses is contemplated.
 - 2. Hospital Staff may not be appointed as a Health Care Representative for any patient.
 - C. Legally compliant Advance Directive forms can be found under SHS Intranet, SharePoint Policies and Procedures.
 - D. An Advance Directive becomes operative when (1) the document is furnished to the attending physician; and (2) the patient is determined by the attending

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physician to be incapacitated. At any time after the appointment of a Health Care Representative, the attending physician shall disclose such determination of incapacity, in writing, upon the request of the person named as the Health Care Representative.

- E. Generally, the decision of a Health Care Representative will be followed when the Health Care Representative and a conservator appointed for the patient, or any other person, disagree on treatment decisions for the patient, unless a Court orders otherwise. Any such conflicts should be referred immediately to Risk Management or the Administrator on Duty for resolution.
 - F. Advance Directives executed under the laws of another state in compliance with such other laws or the laws of Connecticut, and which are not contrary to public policy, shall be deemed valid and enforceable. Hospital staff may rely and follow such Advance Directives based upon (1) an order / decision by a court of competent jurisdiction; (2) presentation of a notarized statement from the patient or person offering the Advance Directive that the Advance Directive is valid under the laws of the state in which it was made and is not contrary to the public policy of the State of Connecticut; or (3) the physician's own good faith judgment. Risk Management must be contacted where there exists a question as to the validity and enforceability of an Advance Directive.
 - G. Advance Directives properly executed under the laws of Connecticut prior to the changes in the State's Advance Directive laws, that went into effect October 1, 2006, are still enforceable. Any questions regarding such Advance Directives should be directed to Risk Management.
- V. Revocation of Living Wills
- A. A Living Will may be revoked at any time and in any manner by the patient without regard to the patient's mental or physical condition.
 - B. The patient's attending physician shall make the revocation a part of the patient's medical record.
 - C. In the absence of knowledge of the revocation of a Living Will, there is no liability for carrying out the instructions contained in a Living Will.
- VI. Revocation of Appointment of Health Care Representatives
- A. The Appointment of a patient's spouse as the patient's Health Care Representative is revoked upon the divorce or legal separation of the couple or the annulment of the marriage, unless the patient specifies otherwise.

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- B. An Appointment of Health Care Representative can be revoked only in a writing signed by two witnesses.
 - C. The revocation shall be made a part of the patient's medical record by the attending physician. Whenever a patient seeks to revoke a Health Care Representative, details about the circumstances and the patient's condition should be documented.
- VII. No patient may be discriminated against on the basis of whether or not the patient has executed an Advance Directive and the provision of care may not be conditioned on the patient executing an Advance Directive.
- VIII. Copies of Advance Directives will be retained as part of the patient's medical record after discharge.
- IX. If medical staffs, nursing staff or family question the legal validity of an Advance Directive, Risk Management or the Administrator on Duty must be notified. Advice of legal counsel will be obtained as appropriate.
- X. The attending physician or other health care provider also should record in the patient's medical record any oral communication concerning any aspect of the patient's health care, including the withholding or withdrawal of life supports systems, made directly by the patient to the physician or other health care provider or the patient's Health Care Representative, legal guardian, conservator or next of kin.
- XI. If any member of the medical staff has an objection and cannot implement an Advance Directive on the basis of conscience, a referral will be made to the Hospital's Ethics Committee and/or the care of the patient will be transferred by the physician to another appropriate provider.
- XII. Patient or family complaints concerning non-compliance with Advance Directives, or with the Hospital's Advance Directive related policies and procedures, may be filed with a Hospital Patient Representative or with the Connecticut Department of Public Health.
- XIII. In all cases, comfort care and pain alleviation shall be provided.
- XIV. All staff providing care to patients shall receive training regarding Advance Directives.
- XV. It is the policy of the Hospital to educate the community regarding Advance Directives. All such community efforts must be well-documented.
- XVI. Upon request, outpatient departments/units will refer patients to resources for assistance with formulating advance directives

**STAMFORD HOSPITAL
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Subject	CONSENT, INFORMED (Consent for Medical and Surgical Procedures, Consent for Anesthesia Services, Consent for Transfusion of Blood or Blood Products, Permission for Disposal of Amputated Part)		
Policy #	RI 340	Implemented	11/2/00
References	CMS §482.13(b)(2), §482.51(b)(2), . Joint Commission (JC), 2014	Revisions	6/15/07, 4/28/08, 2/21/12, 04/07/2014, 9/08/14, 11/2014
Approval	Medical Committee	Executive	Reviewed 4/26/06
Departments Affected	All	Page 1 of 7	

Purpose:

To identify the process for informed consent

Policy:

- I Stamford Hospital shall ensure that an Informed Consent is obtained and documented as a prerequisite to any procedure or treatment for which it is appropriate.
- II The primary purpose of the informed consent process is to ensure that the patient, or the patient's representative, is provided information necessary to enable him/her to evaluate a proposed surgery/procedure or treatment before agreeing to the surgery/procedure or treatment.
- III A patient may wish to delegate his/her right to make informed decisions to another person. The hospital must respect the patient's wishes and follow that process to the degree permitted by State law, and to the maximum extent practicable.
- IV The patient or the patient's representative should receive adequate information provided in a manner that the patient or the patient's representative can understand, to assure that the patient can effectively exercise the right to make informed decisions.
- V It is the responsibility of the the physician performing the procedure, to explain to the patient or the patient's representative any proposed procedure, the common risks and complications, the intended benefits and any alternatives as well as the common risks and benefits of those alternatives.
- VI The patient has the right to request or refuse treatment. The patient's request will be addressed, however, the hospital is under no obligation to fulfill a patient's

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request for a treatment or service that the responsible practitioner has deemed medically unnecessary or even inappropriate.

Definitions:

Authorized Representative means any person who is otherwise authorized by law to make health care decisions on behalf of a patient and provide informed consent.

Emergency situation is an immediate threat to life or limb.

Health Care Representative means an individual appointed by a patient pursuant to a proper "Appointment of a Health Care Representative" for the purpose of making health care decisions on behalf of the patient. The Health Care Representative is a person whom the patient authorizes in writing to make any and all health care decisions on their behalf including the decision whether to withhold or withdraw life support systems. A health care representative does not act unless the patient is unable to make or communicate health care decisions. The health care representative will make decisions on the patient's behalf based on the patient's wishes, as stated in a living will or as otherwise known to the health care representative. In the event the patient's wishes are not clear or a situation arises that the patient did not anticipate, the health care representative will make a decision in the patient's best interests, based upon what is known of the patient's wishes. The Health Care Representative form must be signed by the patient and witnessed by two adults.

Health Care Agent: is someone who is appointed via a document signed by a patient giving the Health Care Agent the authority to communicate certain medical decisions in the event that the patient becomes incapable of making those decisions. A Health Care Agent's authority is limited to communicating decisions about life support and comfort care measure. Therefore, the Health Care Agent's access to the patient's medical information is limited to the information needed to address these decisions. In the event no such decisions need to be made, the Health Care Agent will not be provided access to the patient's health information unless the access is otherwise authorized. Like Durable Powers of Attorney for Health Care, Health Care Agents were replaced with Health Care Representatives on October 1, 2006. Health Care Agent documents executed prior to October 1, 2006 will be honored unless the document has been revoked.

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Informed Consent is an agreement or permission accompanied by full notice about nature of the procedure, indications, common risks and complications, intended benefits and alternatives to care, treatment or service that is the subject of the consent. A patient must be apprised of the nature, risk, benefits, and alternatives of a medical procedure or treatment before the physician or other health care professional begins any such course. After receiving information, the patient then either consents to or refuses such a procedure or treatment (JC 2013).

Invasive Procedure is defined as follows;

- a. Surgical entry into tissues, cavities or organs
- b. Any procedure performed in an operating room
- c. Any procedure in which moderate or deep sedation or general anesthesia is used.
- d. Any of the following, even if sedation or general anesthesia is not used:
 - i. Cardiac catheterization
 - ii. Peripheral vascular procedures
 - iii. Pacemaker insertion and replacement
 - iv. Electrophysiology studies, including AICD insertion and replacement
 - v. Cardioversion
 - vi. Endovascular procedures
 - vii. Endoscopy and bronchoscopy procedures
 - viii. Lumbar puncture
 - ix. Therapeutic Nerve Block
 - x. Central Line Insertion (including PICC lines)
 - xi. Invasive monitoring procedures
 - xii. Interventional radiology procedures
 - xiii. Biopsies and deep-tissue aspirations, including intra-cavitary and joint aspirations
 - xiv. Insertion of chest tube
 - xv. Implantation procedures (e.g. brachytherapy)
- e. Specific “minor” procedures are not invasive procedures such as the following:
 - i. Venipuncture and peripheral arterial puncture
 - ii. Peripheral IV placement and peripheral arterial line placement
 - iii. Insertion of an NG or feeding tube through the nose or mouth
 - iv. Trans-urethral urinary catheter insertion
 - v. Wound debridement and superficial wound repair
 - vi. Superficial needle biopsy

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Next of Kin means any member of the following classes of persons, in the order of priority listed (1) the patient's spouse; (2) an adult son or daughter of the patient; (3) either parent of the patient; (4) an adult brother or sister of the patient; and (5) a grandparent of the patient. For purposes of this policy, parties to a civil union shall be granted the same rights and responsibilities as spouses in a marriage.

Surgery includes any procedure that is listed as a surgical procedure in any of the various billing coding systems used by CMS or the hospital, regardless of whether Medicare pays for that surgical procedure.

Procedure:

1. An informed consent form, *Consent for Surgical and Medical Procedures*, must be obtained and placed in the patient's medical record prior to the surgery/procedure or treatment, except in the case of an emergency.
2. Informed Consent shall be obtained and documented for:
 - a. all inpatient and outpatient operative and invasive procedures performed regardless of the location where it is performed; surgical suite or bedside .
 - b. the transfusion of all blood products (see section VI)
 - c. the administration of anesthesia services.
 - d. whenever, in the judgment of the responsible physician, the situation or nature of the procedure warrants that written consent be obtained.
3. None of the above procedures shall be performed without prior completion of a "Consent for Surgical and Medical Procedures" form and, if applicable, the "Consent for Anesthesia".
4. It is the responsibility of the physician performing the procedure/treatment to explain the proposed procedure or treatment to the patient, the reasonably foreseeable risks, the possible benefits, consequences, and alternatives for care or treatment including risks, benefits, and side effects of alternatives prior to the procedure and the risk of not performing the planned procedure. This information should include potential short and longer-term risks and benefits to the patient of the proposed intervention, including the likelihood of each, based on the available clinical evidence, as informed by the responsible practitioner's professional judgment.

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- a. The above responsibilities may not be delegated to non-physicians (e.g. RNs, NPs or PAs) or to residents. In order to ensure that these responsibilities have been discharged, the physician's signs the consent form indicating that the procedure or treatment has been fully discussed with the patient or, as appropriate, his/her Health Care Representative, Next of Kin or Authorized Representative and that the appropriate Consent Forms have been or will be obtained.
5. The patient's signature on the "Consent for Surgical and Medical Procedure" form must be obtained by the practitioner performing the procedure
6. The form must be signed by the patient and witnessed prior to the time the patient is given any medication which would sedate or otherwise impair the patient's senses or in any way detract from his/her ability to understand the form. The preoperative verification of correct person, procedure, and site in the OR should also include verification that the consent form has been signed by the patient and physician.
 - a. When the form is presented to the patient for signature, it will be clearly explained to the patient that he/she is being asked to provide consent to the surgical or other procedure indicated on the form and/or administration of blood or blood products. The patient must be given as much time as required to read and reflect on the document.
7. If the patient refuses the recommended treatment, the attending physician must be immediately notified. The patient or responsible party should be asked to sign the form for *Release of from Responsibility for Actions Against Medical Advice* in accordance with the Policy regarding "Discharge and Behavior Against Medical advice." If the patient or responsible party refuses to sign the form, the circumstances related to the advice given to the patient and refusal of recommended treatment should be documented in the medical record by the attending physician.
8. It is the responsibility of the anesthesiologist or the administering physician to explain the proposed anesthesia treatment to the patient, along with the reasonably foreseeable risks, possible benefits, consequences and alternatives including risks, benefits, and side effects of alternatives to anesthesia.
9. In the event of an emergency, a physician may provide treatment without obtaining informed consent if:

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- a. The attending physician determines that the patient is unable to consent and a Health Care Representative, Next of Kin or Authorized Representative cannot be located, and emergency medical intervention is necessary,
 - b. The attending physician has determined that the procedure or treatment is required on an emergency basis because there is a substantial risk of death or immediate and serious harm to the patient; and with a reasonable degree of medical certainty, the life or health of the patient would be affected adversely by delaying treatment to obtain consent.
 - c. The “Emergency Authorization” portion on the reverse side of the “Consent for Surgery and Medical Procedures” shall also be completed prior to the procedure or treatment and signed by the treating physician.
 - d. The physician performing the procedure or treatment is required to document in the chart the necessity of the procedure or treatment and staff must document in the medical record the steps that were taken to attempt to contact the patient’s next of kin or legal representative.
10. If a blood transfusion or autologous transfusion is or may foreseeably be necessary, the physician must also explain to the patient the proposed transfusion treatment along with the reasonably foreseeable risks, possible benefits, consequences and alternatives including risks, benefits, and side effects of alternatives to transfusion.
- a. For blood transfusions associated with operative or invasive procedures, the consent is included in the Consent for Surgery and Medical Procedures form. For blood transfusion not associated with operative or invasive procedures, a separate Consent for Transfusion of Blood or Blood Products form is completed.
 - b. If a blood transfusion is refused, a “Refusal of Blood Transfusion” form must be completed. See *Refusal to Permit Blood Transfusions Policy* in this manual.
11. If a body part is to be amputated, the “Permission for Disposal of Amputated Part” form must be completed by the patient or the legal representative.
12. If the determination is made that a patient requires a procedure or treatment requiring informed consent and for any reason is unable to understand or sign a Consent Form, as appropriate, the patient’s Health Care Representative, Next of Kin or Authorized Representative shall be required to sign the form.

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Subject: CONSENT, INFORMED

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13. If a Health Care Representative, Next of Kin or Authorized Representative is physically unavailable but may be contacted by telephone, the “Telephone Permission” portion on page 2 of the “Consent for Surgery and Medical Procedures” shall also be completed by the physician performing the procedure or treatment.
14. All components of the informed consent form are completed prior to the procedure. A single consent form may be used for a series of planned treatments or procedures.
15. Consents obtained in physician’s offices are delivered to the hospital in person, by mailing or fax, and are placed in the medical record before the procedure begins.
16. All completed Consent Forms shall become a permanent part of the patient's medical record.
17. For information regarding consent for minors and mentally incompetent patients, see the Consent for Procedure or Treatment – Minor or Mentally Incompetent Patient policy in this manual.
18. For information regarding consent for a conservator see the Consent for Procedure or Treatment – Appointment of Conservator policy in this manual.

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Subject: DISCLOSURE OF UNANTICIPATED EVENTS AND OUTCOMES OF CARE

Policy: PI

Reference:

Approval: Senior V.P. of Medical Affairs

Department: All Clinical Departments

Implemented: 9/9/02

Revisions: 9/4/12, 2/15

Reviewed: 4/26/06, 11/08; 04/15

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Purpose:

To outline the steps used to inform patients and, when appropriate, their families about unanticipated outcomes of care or events.

Definitions: The intent of this section is to define an unanticipated outcome, event and disclosure to guide the health care provider in his/her decision as to whether or not to disclose an unanticipated outcome or event.

Unanticipated Outcome:

- An outcome of care that the patient and/or family or legal guardian must be knowledgeable about in order to participate in current and future decisions affecting the patient's care.
- An outcome that differs significantly from what was anticipated to be the expected result of a treatment or procedure, including known complications.

Event: An event is an unanticipated occurrence that reached the patient, regardless of the outcome, that could have resulted in harm for which a reasonable patient and/or family would expect to know about. (Example: an unplanned, supported descent to the floor of an anesthetized patient during transfer from a stretcher to the OR table due to the OR table being unlocked. The patient was supported during the descent and no harm occurred.)

Disclosure: Disclosure is a discussion or series of discussions that take place between the patient and/or family about an event or unanticipated outcome.

Policy:

As a Planetree hospital, Stamford Hospital is committed to providing patient-centered quality health care to its patients. Despite constant and committed efforts to improve patient care, unanticipated outcomes and events may occur. We respect a patient's right to know about their medical status, treatment and outcomes and we implement policies, practices and procedures to honor that right. Consistent with this continuing commitment to appropriate communication between our healthcare providers and patients, the hospital will take all reasonable steps to insure that patients and/or families are informed about outcomes of care, including unanticipated outcomes and events.

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Procedure:

- I. Stamford Hospital recognizes that the determination of the manner, style, and timing of disclosures to be made under this Policy will involve the exercise of reasonable judgment and discretion depending on the patient's condition and other circumstances. For this reason, Stamford Hospital cannot predetermine the most appropriate manner, style, and timing for each and every disclosure that must be made under this Policy.
- II. There are, however certain procedures that should be followed in all circumstances to ensure that this Policy is implemented fully and effectively. They are as follows:
 - A. Any events that are serious, resulting in temporary or permanent patient harm, loss of function or death should be reported to the Risk Management Department.
 - B. Any "Event," regardless of outcome, requires disclosure to the patient or legally authorized representative, and when appropriate, the family, with documentation of the event in the medical record.
 - C. In the case of an event or unanticipated outcome or event, the patient's attending physician(s) and appropriate hospital personnel should:
 - Communicate with each other to decide the appropriate content, manner, style and timing for informing the patient and/or family, about the event or unanticipated outcome or event.
 - Deciding on the "manner" of communication pursuant to this Policy, including the determination of which person(s) is most appropriate to inform the patient and/or family will depend on the circumstances. Stamford Hospital expects that a patient's attending physician will normally participate in informing the patient of an unanticipated event or unanticipated outcome. If, however, the attending physician is unable or if there is a determination pursuant to this Policy that it is not in the best interest of the patient for such physician to participate, Stamford Hospital's Senior Vice President for Medical Affairs, Chief of the

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clinical service and/or other appropriate hospital representatives should participate in the disclosure.

- At least one other hospital staff person (Department Director, Patient Relations Representative, Administration representative, nursing personnel or Risk Management personnel) should be present at the initial disclosure and at subsequent planned discussions. The hospital staff designee will be determined by the severity of the adverse event.
 - The event or unanticipated outcome should be presented in a truthful, compassionate, straightforward and non-judgmental fashion.
 - All individuals who will be involved in the disclosure should identify and gather known facts, review the medical record and meet beforehand and agree on what will be communicated and by whom prior to speaking to the patient and/or family members. Following the disclosure, a summary of the discussion should be documented in the medical record by the attending or designated physician and a copy of the medical record should be made available to the patient and/or family.
 - The patient and/or family should be provided with internal and external resources for support and counseling as needed.
- D. If any person involved in a patient's care has a concern that an unanticipated outcome or event has not been disclosed to the patient in accordance with this Policy, he/she should raise that concern immediately with the Risk Management Department, Senior Vice President for Medical Services or the Chief of the clinical service.
- E. For each unanticipated event or outcome disclosure, the attending physician (or his or her designee) shall document clearly in the medical record. The note should identify the nature, severity, and the cause (if known) of the event or unanticipated outcome disclosed, the date and time of the disclosure, the person to whom it was made, the identity of all persons present during the disclosure discussion and any follow-up plan.

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- F. Event or unanticipated outcome disclosures should be made as soon as reasonably possible after the outcome is known.
- G. Event or unanticipated outcome disclosures must be made in a manner consistent with Stamford Hospital's other policies and procedures, including the Sentinel Event/Critical Incident Policy.
- H. An apology will be offered to the patient and/or family affected by the event or unanticipated outcome. An expression of apology is often appropriate and not an admission of guilt.
- I. With respect to any event or unanticipated outcome disclosure, the communication should be factual, not speculative, and the disclosure should not (and need not) ascribe fault or blame for the outcome.
- J. Event or unanticipated outcome disclosure to persons other than the patient should be made only with the patient's consent or in other circumstances permitted by state and federal laws.
- K. The decision to waive costs directly related to a serious reportable adverse event will be made on case-by-case basis by the Risk Management Department.
- L. Other disclosure guidance:
 - i. If the conversation is anticipated to be complex or difficult, the patient and/or family will be encouraged to have another person available or present for the discussion to provide support.
 - ii. Articulate the known facts about the sequence of events, consequences to the patient and why it happened, if known.
 - iii. Describe what, if anything can be done to correct the consequences of the event or unanticipated outcome.
 - iv. Pause regularly for questions and silence leaving space for conversation.
 - v. Avoid jargon. Assume no understanding of medical terminology.
 - vi. Express concern for patient and/or family both verbally (lower voice pitch) and nonverbally (eye contact).
 - vii. Assure the patient and/or family member(s) that unanswered questions will be investigated further.
 - viii. A single person from the disclosure team will act as the point of contact for any ongoing communication with the patient and/or family. The

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patient and/or family should be asked who they would prefer that person to be.

- ix. End the conversation focusing on patient and/or family needs:
 - Express continued support and concern for the family.
 - Repeat important point(s).
 - Ensure that the patient and/or family have immediate support (Social Work, friends, chaplain).
 - Leave respectfully with the patient and/or family knowing that you care.

- II. Any request for an exception to this Policy and these Procedures, due to extraordinary circumstances, must be submitted to the Vice President, Enterprise Risk Management and Corporate Compliance or the Director of Risk Management who will decide whether the requested exception is appropriate and what alternative steps, if any, should be taken.

A copy of this policy will be provided to the patient and/or family members and payers upon request.

**STAMFORD HOSPITAL
Clinical Service Manual**

Subject: EMTALA – Evaluation, Treatment and/or Transfer of Patients

Policy #	PC Centers for Medicare & Medicaid Services	Implemented	8-16-10
References	42 CFR Parts 413, 482, and 489, State Operations Manual – Appendix V	Reviewed	08-28-15
Approval	Senior VP of Patient Services	Revised	[date(s)]
Departments Affected	ED and L & D	Page 1 of 8	

PURPOSE:

To establish guidelines for the evaluation, treatment and/or transfer of patients seeking emergency medical treatment at Stamford Hospital and to assure that patients are appropriately evaluated and treated within the capabilities of the Hospital, stabilized prior to transfer to the extent appropriate, and appropriately informed of the risks and benefits of alternative means of treatment available.

POLICY:

I. All patients to whom this Policy applies shall receive an initial screening examination by Qualified Medical Personnel and appropriate treatment within the capabilities of the Hospital without regard to age, race, color, religion, national origin, sex, sexual orientation, ability to pay, payor, physical or mental condition or handicap. Any patient who cannot be appropriately treated at Stamford Hospital shall be stabilized to the extent it is medically appropriate, shall be informed of the risks and benefits of transfer or refusal of treatment to the extent practical and transferred in accordance with the provisions of this policy.

II. APPLICABILITY:

1. This Policy applies to the following persons:

- A. Any individual who presents to the Emergency Department and requests examination or treatment, or appears to need examination or treatment but is unable to make a request.
- B. Any individual who presents elsewhere on Hospital Property (defined below) and requests examination or treatment for what may be an Emergency Medical

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Condition (defined below), or appears to need examination or treatment but is unable to make a request.

- C. Any individual who is in a ground or air ambulance on Hospital Property for purposes of examination and treatment in the Emergency Department.
2. This Policy does not apply to the following persons:
- A. Any individual who has been admitted as an inpatient.
 - B. Any individual who has begun to receive outpatient services as part of an encounter, other than an encounter that the Hospital is obligated by this Policy to provide.

DEFINITIONS:

"Emergency Medical Condition" means

- a. A medical condition manifesting itself by acute symptoms (including severe pain or discomfort, psychiatric disturbances and symptoms of substance abuse) of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in:
 - 1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and/or her unborn child) in serious jeopardy,
 - 2. Serious impairment of bodily functions, or
 - 3. Serious dysfunction of any bodily organ or part.
- b. With respect to a pregnant woman who is having contractions or is in the latent or early stages of labor (unless a physician or other qualified medical personnel determines the woman is in false labor after a reasonable period of observation) and
 - 1. there is inadequate time to effect a safe transfer to another hospital before delivery, or
 - 2. transfer may pose a threat to the health or safety of the woman or unborn child.

"Hospital property" means:

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The entire main Hospital campus, including the parking lots, sidewalks and driveways and any Hospital owned property within 250 yards of the main Hospital building.

“Qualified Medical Personnel” means:

Physicians, Nurse Practitioners, Physician Assistants and Registered Nurses who have been granted appropriate clinical privileges or otherwise approved by the Senior Vice President for Patient Care Services to perform screening examinations.

"Stabilize" means:

- a. To provide such medical treatment of the Emergency Medical Condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or
- b. With respect to a pregnant woman who is in labor, to deliver the child and placenta.

"Transfer" means:

The movement (including the discharge) of an individual outside the Hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the Hospital, but does not include such a movement of an individual who (a) has been declared dead, or (b) leaves the facility without the permission of any Hospital affiliated person.

PROCEDURES:

- I. All patients to whom this Policy applies shall be offered an appropriate medical screening evaluation by Qualified Medical Personnel, within the capability of the Hospital and its Emergency Department, including clinically indicated ancillary services routinely available to the Emergency Department, to determine whether or not an Emergency Medical Condition exists.
- II. All patients coming to the Emergency Department shall be triaged as soon as possible after arrival to determine treatment priorities; however, evaluating a patient only for triage purposes shall not constitute a screening evaluation.
- III. An initial triage inquiry, medical screening examination, and any further examination and treatment required, shall not be delayed in order to inquire about the individual's method of payment, ability to pay, or insurance status. However, the usual registration process may be followed, including asking whether an individual is insured and, if so, what that insurance is, while awaiting a screening examination or further evaluation or treatment, if doing so will not result in any delay in providing the screening examination

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or treatment or would not unduly discourage the individual from remaining for a screening examination or evaluation. However, nobody may seek, or direct an individual to seek, authorization from the individual's insurance company for screening or stabilization services to be furnished by the Hospital, until after the Hospital has provided the appropriate medical screening examination and initiated any further medical examination and treatment that may be required to stabilize an Emergency Medical Condition.

- IV. After triage, all patients shall be offered a screening examination by qualified medical personnel to determine whether the patient has an Emergency Medical Condition. Qualified medical personnel shall include a physician, physician assistant, or nurse practitioner.
- V. If, after initial screening examination, it is determined that the patient does not have an Emergency Medical Condition, the patient may (in the judgment of a physician) be:
- i) discharged from the Emergency Department with appropriate discharge instructions and referral for any necessary non-emergency treatment,
 - ii) provided further non-emergency examination and treatment, including admission, or
 - iii) transferred to another facility for non-emergency evaluation and treatment.
- VI. If the patient is determined to have an Emergency Medical Condition, the patient shall be provided with either:
- i) further medical examination and treatment within the capabilities of the Hospital and staff available as required to stabilize the patient (and admit if necessary), or
 - ii) subject to the provisions of section 8 below, transfer the patient to another medical facility in accordance with this Policy.
- VII. If the emergency physician determines that a specialist is needed for consultation or treatment, or that the patient may require admission to a hospital, arrangements shall be made for the patient to be seen by the patient's private physician or a physician on call, unless an appropriate specialist is not reasonably available.
- VIII. A. No patient suffering from an Emergency Medical Condition shall be transferred to another facility unless

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- i) the patient, or a legally authorized representative of the patient, requests the transfer after being advised of the Hospital's obligations under this policy and the risks and expected benefits of transfer. This shall include situations where the patient does not have a physician with privileges at this Hospital and the patient refuses treatment at this Hospital by a physician with privileges, or
 - ii) a physician has certified on the appropriate form that the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risk to the patient or, in the case of a woman in labor, to the woman or the unborn child, from being transferred.
- B. Any patient to be transferred must be stabilized prior to transfer unless:
- i) the patient, or a legally authorized representative of the patient, requests the transfer prior to stabilization after being advised of the Hospital's obligations under this policy and the risks and expected benefits of transfer without stabilization, or
 - ii) a physician has certified on the appropriate form that the medical benefits reasonably expected from being transferred prior to stabilization outweigh the increased risk to the patient or, in the case of a woman in labor, to the woman or the unborn child, from delaying the transfer to stabilize the patient.

Under no conditions shall a patient be transferred because of the patient's inability to pay or the source of payment.

IX. In all cases where a transfer to another facility is to be made, the Hospital shall, prior to transfer:

- i) provide medical treatment within the Hospital's capacity that minimizes the risks to the patient's health and, in the case of a woman in labor, the health of the unborn child;
- ii) determine that the receiving facility has available space and qualified personnel to provide appropriate treatment of the patient;
- iii) determine that the receiving hospital, including physicians, if appropriate, has agreed to accept transfer and provide appropriate treatment;
- iv) to the extent practical, explain to the patient or patient's representative the reasons for the proposed transfer, the alternatives to the transfer and the reasonably foreseeable risks and benefits of the transfer;

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- v) except in cases of involuntary psychiatric admission, obtain the written consent of the patient or the patient's representative to the transfer, if possible; and,
 - vi) determine that a physician has signed the appropriate certifications when required by this Policy.
- X. In effecting a transfer to another medical facility, the Hospital shall, to the extent possible, provide that:
- i) medically appropriate life-support measures, as determined by a physician, are used to stabilize the patient before and during transfer;
 - ii) appropriate personnel and equipment, as determined by a physician, are provided for use in the transfer;
 - iii) copies of all medical records available shall be sent to the receiving facility at the time of transfer or as soon thereafter as possible, including:
 - the patient's history
 - physicians or nurses notes, or other observations of the patient's condition
 - preliminary diagnosis
 - results of diagnostic studies or tests
 - medications given or other treatment provided
 - written consent to transfer signed by the patient or the patient's legal representative, if consent is obtained
 - any physician's certification regarding the necessity for transfer
 - iv) If the transfer is necessary because a physician on-call did not respond on a timely basis, the receiving hospital shall be given the on-call physician's name and address. A Peminic report shall be entered and the Senior Vice President, Medical Affairs shall receive a written report outlining the delay.
- XI. Whenever a patient is transferred it shall be the responsibility of the physician and the nursing staff to complete the appropriate forms and records to document compliance with this policy. In the event a patient or representative of a patient refuses to sign any required document, such refusal shall be documented by the nursing staff. (Use **Hospital Interfacility Transfer Certification Consent and Checklist** forms)
- XII. If the patient refuses any examination, treatment or transfer recommended by a treating physician, the nursing staff shall take reasonable steps to obtain the written acknowledgment of the patient/responsible person, documenting the examination, treatment and/or services offered to the patient, the information given to the patient

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concerning the benefits of the offered services and the risks of refusal, and the patient's refusal to accept the examination, treatment or transfer recommended. (Use **Patient Discharge from Hospital Against Medical Advice** Forms). The medical records must contain a description of the examination, treatment and/or transfer that was refused by or on behalf of the patient.

XIII. The Emergency Department shall maintain the following:

- i) A list of physicians who are available on call to stabilize and/or treat an individual with an emergency medical condition after the initial examination.
- ii) For a period of five (5) years, a central log identifying each individual who came to the emergency department seeking treatment and indicating whether the individual refused treatment, or was refused treatment, or was transferred, admitted and treated, stabilized and transferred, or discharged.

XIV. Involuntary psychiatric commitments shall be handled in accordance with the Hospital's policy relating to psychiatric evaluations and commitments.

XV. It is recognized that circumstances may arise which are not covered by this policy. In such situations, the emergency physician and Emergency Department staff shall take all appropriate steps to act in the best interests of the patient and, to the extent practical, document in the patient's record the action taken, the reasons for the action and the patient's wishes. The patient's wishes shall be ascertained and complied with whenever possible.

XVI. If a patient to whom this policy applies is going to be transferred, but is unstable, the **Hospital Interfacility Transfer Certification Consent and Checklist** form shall be used as appropriate.

XVII. This policy and the accompanying forms shall be utilized to the extent practical whenever there is a transfer of a patient from anywhere in the Hospital to another acute care hospital, except discharges to nursing homes or long-term care facilities. Accordingly, the **Hospital Interfacility Transfer Certification Consent and Checklist** form will be used for all transfers, including transfers of inpatients.

XVIII. The Hospital shall post conspicuously in the Emergency Department or in a place likely to be noticed by all individuals entering the Emergency Department, as well as by all individuals waiting for examination and treatment in areas other than the Emergency Department, such as the Hospital admitting areas, a sign specifying the rights of individuals to receive examination and treatment for emergency medical conditions and women in labor.

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XIX. The obligation to perform a medical screening examination and provide appropriate treatment or transfer applies to all hospitals with an emergency department pursuant to the Emergency Medical Treatment and Active Labor Act (“EMTALA”). If a physician, physician assistant, or nurse practitioner believes that a patient has been transferred to Stamford from another hospital in an unstable medical condition in violation of EMTALA, the practitioner should report the matter immediately to the senior physician on duty in the Emergency Department, who shall confer with the Senior Vice President for Medical Affairs as soon as possible. The Senior Vice President for Medical Affairs shall consult with legal counsel to determine whether an EMTALA violation has occurred which is required to be reported. A report of an EMTALA violation may be required within 72 hours.

**STAMFORD HOSPITAL
[HIPAA]**

Subject:	Use and Disclosure of Protected Health Information		
Policy #	[H 101]	Implemented	4/14/03
References	[45 CFR 164.506,164.510,164.512, CT release of information regulations]	Reviewed	4/09,4/10
Approval	Privacy Officer CIO, VP Information Services	Revised	7/09, 12/09(combines several former policies under Use and Disclosure) ,4/10
Departments Affected	All	Page 1 of 23	

I. PURPOSE

To protect the privacy and confidentiality of personal health information; to provide guidance for release of health information, and to implement the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), including subsequent related statutes in the American Recovery and Reinvestment Act of 2009, and the Regulations promulgated by the U.S. Department of Health and Human Services, 45 CFR Parts 160 and 164 (the “Privacy Rule”).

II. DEFINITIONS

A. Protected Health Information - Protected health information (“PHI”) is all health information about a patient, including demographic information, whether maintained in the written medical, billing records, in the computer system, or spoken among two or more persons, that:

- i. is created or received by the hospital;
- ii. relates to the past, present, or future physical health or condition of a patient, the provision of health care to a patient, or the past, present, or future payment for the provision of health care to a patient; and,
- iii. Identifies the patient or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

B. Secured PHI - PHI is deemed secured if it is rendered unusable, unreadable, or indecipherable to unauthorized individuals by encryption or destruction.

C. De-Identified PHI – De-identified PHI is PHI that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. De-identified PHI is not subject to the requirements of this Policy.

III. POLICY

A. General Privacy Practices

Confidentiality of PHI - PHI is confidential and shall be protected during its collection, use, storage and destruction. PHI cannot be used within the hospital or disclosed to persons outside the hospital for any reason not authorized by a specific Hospital policy. All hospital employees, as well as other persons associated with the Hospital (including members of the Medical Staff, members of the Board of Directors, volunteers and contractors), are responsible for protecting the privacy of all PHI that is obtained or accessed in the course of their work or association with the Hospital, and safeguarding against any intentional, unintentional, or incidental use or disclosure that is in violation of hospital policy or the Privacy Rule. **PHI is strictly confidential and is not released, except as indicated in this policy.**

Incidental Use or Disclosure An incidental use or disclosure is a secondary use or disclosure that cannot reasonably be prevented, is limited in nature, and that occurs as a result of another use or disclosure that is permitted by hospital policy and the Privacy Rule. Such incidental uses and disclosures are permitted by hospital policy and the Privacy Rule, as long as reasonable precautions are taken to limit the information that might be overheard or seen. For example, a physician may discuss a patient's condition or treatment regimen with the patient in the patient's semi-private room, or a physician and nurse can discuss the treatment of a patient at a nursing station or joint treatment area, so long as reasonable efforts are made to try to keep other people from overhearing the conversation.

B. Right to Request Restriction on Use and Disclosure For Treatment, Payment or Operations

All patients and personal representatives have the right to request restriction of the uses and disclosures of *PHI* to carry out treatment, payment, or health care operations. Except as provided below, the hospital is not required to agree to a requested restriction, but is bound by the terms of any restriction agreed to. Only the Director of Health Information can agree to such a restriction of the uses and disclosures of *PHI* to carry out treatment, payment, or health care operations. Restrictions must be in writing and maintained for six (6) years from the date signed by the patient.

If a patient requests a restriction that their PHI not be disclosed to a health plan for purposes of carrying out payment, the Hospital must abide by the requested restriction if the PHI at issue pertains solely to a health care item or service for which the patient has already paid in full out of pocket.

C. Prohibition on Conditioning Authorizations

The provision to a patient of treatment may not be conditioned on the provision of an authorization for disclosure of *PHI*, except:

- i. The provision of research-related treatment may be conditioned upon the provision of an authorization for the use or disclosure of *PHI* for such research; and,
- ii. The provision of health care that is solely for the purpose of creating *PHI* for disclosure to a third party may be conditioned upon the provision of an authorization for the disclosure of the *PHI* to such third party. For example, a health care provider may condition the performance of an independent medical examination for purposes of litigation or employment on the patient providing an authorization to disclose the information obtained during the examination.

D. Notice of Privacy Practices

The Hospital has developed a document entitled “**Notice of Privacy Practices.**” A copy of this Notice will be given to anyone upon request. Except for outpatients receiving diagnostic testing only, a copy of this Notice will be given to each patient or a patient’s personal representative upon admission, including registration in the Emergency Department. Copies of the Notice will be available at several clear and prominent locations throughout the hospital for anyone to read and take with them, including the Admitting Department, the Emergency Department, and the Information Desk in the front lobby. A copy of the Notice will be made available on the Hospital’s website.

Each version of the Notice, or an electronic copy, must be maintained for six (6) years from the date each was implemented.

E. Alternative Means of Communication

Requests by patients and their personal representatives to receive communications of *PHI* from the hospital by alternative means or at alternative locations should be accommodated to the extent reasonable. For example, a patient may request that written communications from the hospital be sent to an address other than the patient’s home address. Similarly, a patient may request that written communication be sent in a closed envelope rather than a postcard.

All requests to receive communications of *PHI* by alternative means or at alternative locations must be in writing and should be referred to the Health Information Management Department. Provision of a reasonable accommodation may be conditioned on (1) when appropriate, information as to how payment, if any, will be handled; and, (2) specification of an alternative address or other method of contact. An explanation from the patient or personal representative as to the basis for the request cannot be a condition of providing communications on a confidential basis. The reasonableness of a request must be determined solely on the basis of the administrative difficulty of complying with the request and the foregoing requirements.

F. Privacy Officer

There shall be a “Privacy Officer” who shall be the hospital’s designated privacy official and who shall be responsible for the development and implementation of the hospital’s privacy policies and procedures.

The Privacy Officer is responsible for receiving complaints under this policy and is available to provide further information about matters covered by the “**Notice of Privacy Practices**”.

G. Complaints

The hospital provides a process for individuals to make complaints concerning the hospital’s privacy policies and procedures or the hospital’s compliance with such policies and procedures or the requirements of the Privacy Rule. (See Administrative Policy: Patient Complain and Grievance Policy.)

H. Intimidating and Retaliatory Acts

No individual shall be intimidated, threatened, coerced, discriminated against, or have other retaliatory action taken against them, for exercising any right under, or for participating in any process established by the Privacy Rule, including the filing of a complaint pursuant to the “Patient Grievances and Action Line Program” policy. Nor shall any such action be taken against any individual for:

- i. Filing a complaint with the Secretary of the U.S. Department of Health and Human Services pursuant to the Privacy Rule;
- ii. Testifying, assisting, or participating in an investigation, compliance review, proceeding, or hearing under Part C of Title XI; or
- iii. Opposing any act or practice made unlawful by the Privacy Rule, provided the individual or person has a good faith belief that the practice opposed is unlawful, and the manner of the opposition is reasonable and does not involve a disclosure of PHI in violation of the Privacy Rule.

I. Waiver of Rights

The hospital will not require patients to waive their rights under the Privacy Rule, including the right to file a complaint with the Secretary of the U.S. Department of Health and Human Services, as a condition of the provision of treatment.

J. Affiliated Covered Entities

The following covered entities, which are under common ownership or control of the Stamford Health Inc., are designated as a single covered entity for purposes of HIPAA and the Privacy Rule:

- i. Stamford Health System, Inc.
- ii. The Stamford Hospital
- iii. Continuing Care Retirement Community of Greater Stamford (Edgehill)
- iv. Darien Imaging Center
- v. Stamford OB/GYN Associates, P.C.
- vi. Fairfield County OB/GYN
- vii. Fairfield County Surgical Specialists, P.C.
- viii. Premier Medical Group, P.C.
- ix. Fairfield County Primary Care, P.C.
- x. Stamford Hospital Integrated Practices

K. Minimum Necessary - Hospital personnel are to use and disclose **PHI** on a need to know basis. When using or disclosing **PHI** or when requesting **PHI** from another source, reasonable efforts must be made to limit **PHI** to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

Exceptions: This requirement does not apply to:

- i. Disclosures to or requests by a health care provider for treatment. In the event there is no evidence of a patient/practitioner relationship, the Hospital may rely upon the representation of the practitioner or conduct its own investigation.
- ii. Uses and disclosures made to the patient;
- iii. Uses and disclosures made pursuant to a HIPAA compliant authorization from the patient or a *person in interest*; as Defined by the Advance Directive Policy.

- iv. Disclosures made to the Secretary of the U.S. Department of Health and Human Services during an investigation of the hospital's compliance with the Privacy Rule.
- v. Uses or disclosures that are required by law; and
- vi. Uses or disclosures that are required for compliance with the Privacy Rule.

IV. PROCEDURES

A. PERMITTED USES AND DISCLOSURES OF PHI

1. Written Authorization for Disclosure of PHI:

A written authorization may be executed by:

- i. The patient;
- ii. The parent or legally appointed guardian in cases of a minor (except requests covered in Section I - alcohol and drug abuse records, and Section J - minors treated for venereal diseases). The non-custodial parent of a minor child shall not be denied the right of access to the minor's medical, hospital, or other health records (except where confidentially protected by statute), unless otherwise ordered by the court for good cause shown;
- iii. The patient, if judged an emancipated minor by the Superior Court or who is emancipated under the common law of Connecticut, (questions regarding the definition of an emancipated minor should be referred to the Medical Record Department manager or his/her designee)
- iv. The executor or administrator of the estate of a deceased patient. If no executor or administrator has been appointed then, in order: 1. Surviving spouse; 2. Adult son or daughter; 3. Parent; 4. Adult sibling; 5. Guardian;
- v. The court-appointed conservator or guardian for an incapable patient or a mentally retarded patient;

A written authorization shall contain:

- i. A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion;
- ii. The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure;
- iii. The name or other specific identification of the person(s), or class of persons, to whom the Hospital may make the requested use or disclosure;
- iv. A description of each purpose of the requested use or disclosure. The statement "at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose;
- v. An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure ("end of research study" and "none" are acceptable if disclosure is for research purposes).
- vi. Signature of the individual (or authorized person), date, and a description of a representative's authority to act;
- vii. A statement that the individual has the right revoke the authorization and the methods by which the individual make revoke the authorization (in writing);

- viii. A statement that treatment or payment for services are not conditioned on signing the authorization;
- ix. A statement that information disclosed pursuant to the authorization may be subject to re-disclosure and no longer protected.

Revocation of Written Authorization:

An authorization may be revoked at any time provided that the revocation is in writing except to the extent that:

- i. PHI has already been disclosed in reliance on the authorization, or
- ii. The authorization was obtained as a condition of obtaining insurance coverage.

2. Use and disclosures requiring an opportunity for an individual to agree or object: Stamford Hospital will provide each patient with advance notice of his/her right to agree or object to certain uses of his/her PHI throughout the System. The advance notice will include information regarding persons/organizations that may access PHI. The individual has a right to restrict or prohibit some or all of the uses or disclosures.

- i. **Facility Directories** - Except when an objection is expressed, Stamford Hospital may use the following PHI to maintain a facility directory and disclose this information to members of the clergy or other persons who ask for a patient by name:
 - Individual's name;
 - Individual's location in Stamford Hospital;
 - Individual's condition described in general terms that does not communicate specific medical information about the individual (critical, stable, fair, good, etc.);
 - Individual's religious affiliation (may be disclosed to Clergy only);

** Refer to Section D. for patients admitted for Psychiatric Services.

In emergency situations where the opportunity to agree or object is not possible, Stamford Hospital may use or disclose some or all of the PHI listed in a. i-v. Of this section for the facility's directory. The disclosure must be consistent with prior wishes if known to Stamford Hospital, and must be in the individual's best interest. As soon as it is practicable to do so, Stamford Hospital will inform the individual and provide an opportunity to object to uses or disclosures for directory purposes.

- ii. **Individuals involved in the patient's care and for notification purposes** - Stamford Hospital may disclose to a family member, other relative, close personal friend or any other person identified by the individual, PHI directly relevant to the individual's health care treatment or payment; or to notify or assist in the notification of a family member, personal representative or other person responsible for the care of the individual, and advise of the individual's location, general condition or death provided that either:

- When a patient is present and capable of making health care decisions, Stamford Hospital will only use and disclose PHI if:
 - a) the patient agrees,
 - b) the patient has been provided with an opportunity to object to the disclosure and does not do so, or
 - c) it can be reasonably inferred from the circumstances that the patient does not object to the disclosure.
- If the individual is not present, or an opportunity to agree cannot be practically provided because of the patient's incapacity or emergency circumstances, Stamford Hospital may exercise professional judgment to determine whether the disclosure is in the best interest of the patient. Only the PHI directly relevant to the person's involvement with the individual's health care will be disclosed and made available, for example information necessary to allow someone to retrieve prescriptions or X-rays for a patient.

Individuals have the right to privacy restrictions and may ask Stamford Hospital staff to refrain from disclosing PHI to designated persons.

- iii. **Disaster Relief** – Stamford Hospital may use or disclose basic PHI to a public or private entity authorized by law to assist in disaster relief efforts.

3. Use and disclosure where an authorization, opportunity to agree or object is not required. Exceptions to the requirement for written authorization for use and disclosure of PHI are made in the instances documented below. Stamford Hospital staff should use minimum data necessary to comply with the law. Any disclosure under this part is subject to the Accounting for Disclosures rule in Section IV, Paragraph E of this Policy.

- a. **Public Health Activities** – Stamford Hospital may disclose PHI to an organization that is authorized by law to collect or receive information for:
 - i. The prevention or control of disease, injury, or disability;
 - ii. Child abuse or neglect;
 - iii. FDA regulated product or activity to collect or report adverse events, product defects, problems or biological product deviations, to track FDA regulated products, to enable product recalls, repairs, replacement, look back or to conduct post marketing surveillance;
 - iv. Notification to or about persons who may have been exposed to a communicable disease or be at risk of contracting or spreading a disease or condition;
 - v. To employers if:
 - the employer refers a patient who is a member of the employer's workforce for medical evaluation for purposes relating to medical surveillance of the workplace, evaluate work-related illness or injury or if findings reveal a work related illness or injury

- Only information related to work place illness or injury is disclosed, and
 - The patient is notified that their PHI will be shared with their employer.
- vi. State Health Department and Consumer Protection Activities: PHI may be released to State agencies without patient authorization for the following:
- Review of certain health records with respect to the licensure.
 - Review of certain health records during investigation concerning controlled substances.
 - Review of certain health records during investigation concerning reportable diseases.
 - Review of certain health records during investigation concerning child abuse.

Any requests involving access to health records by state agencies should be referred to the Director of Risk Management or the Medical Record Department Manager or their designees.

- b. **Victims of Abuse or Neglect** - Stamford Hospital may disclose PHI as required by law about an individual who is believed to be a victim of abuse or neglect to a government authority, including social service or protective services agency authorized to receive such information.

See Policy for the Identification and Management of Victims of Abuse

- i. The disclosure is required by law,
- ii. The patient consents, or
- iii. The disclosure is authorized by law and
 - a physician or other licensed health care professional determines in their professional judgment that disclosure is necessary to prevent serious harm to the patient or other potential victims, or
 - the patient is unable to agree because of incapacity and a law enforcement or other public official authorized to receive information represents that the PHI sought is not intended to be used against the patient and that an immediate enforcement activity depends on the disclosure and would be materially and adversely affected by waiting until the patient could agree,

The patient must be notified of any disclosures made pursuant to this provision unless:

- i. In the exercise of professional judgment a physician determines that informing the patient would place the patient at risk of serious harm, or
- ii. By informing the patient information would be given to someone who it is believed was responsible for the abuse, neglect or domestic violence and that informing such person would not be in the best interest of the patient.

- c. **Health Oversight Agency** – Stamford Hospital may disclose PHI to assist with audits, investigations, inspections, licensure or disciplinary actions, legal proceedings or actions for the appropriate oversight of the Stamford Hospital and any applicable government regulatory programs, provided the health oversight activity does not include an investigation of the patient and is not directly related to the receipt of health care, a claim for public benefits regarding health or qualification of public benefits/services,

Any request for PHI from a health oversight agency shall be referred to the Director of Risk Management, the Privacy Officer or the Director of Medical Records for handling.

- d. **Judicial and Administrative Proceedings** – Stamford Hospital may disclose PHI in response to a subpoena, discovery request or other lawful process in compliance with the procedures set forth in the Hospital’s Medical Records policy. Any request by Order or Subpoena shall be forward to the Director of Health Information, the Director of Risk Management, or the Privacy Officer:

- e. **Law Enforcement Officials:**

- i. **Decedents** – Stamford Hospital may disclose PHI to a law enforcement official to advise of any death believed to be a result of criminal conduct.

- ii. **Reporting of Certain Injuries/Diseases –**

- Firearm Wounds
- Burn Injuries or Injuries from Fireworks
- Child Abuse or Neglect
- Suspected abuse, neglect, exploitation and abandonment of elderly persons
- Examination and Treatment of Minors 12 years and younger for venereal diseases
- Tuberculosis

- iii. **Warrants/Subpoenas/Summons/Grand Jury** - PHI may be disclosed in compliance with a Court order, warrant, subpoena, summons issued by a judicial officer, or a grand jury subpoena;

- iv. **Administrative request**, including subpoena or summons, a civil or an authorized investigative demand provided the information sought is relevant to the inquiry; the request is reasonably specific and limited in scope; and de-identified information could not reasonably be used.

- v. **Identification and location purposes** – Stamford Hospital may disclose PHI to law enforcement officials to provide limited information for identifying or locating a suspect, fugitive, material witness, or missing person. Stamford Hospital will not disclose any PHI related to an individual’s DNA or DNA analysis, dental records, or typing, samples or analysis of body fluids or tissue. Stamford Hospital may disclose only the following information:

- Name and address;

- Date and place of birth;
 - Social security number;
 - ABO blood type and rh factor;
 - Type of injury;
 - Date and time of treatment;
 - Date and time of death, if applicable;
 - Description of distinguishing physical characteristics including height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars and tattoos.
- vi. **Crime on Premises** - Stamford Hospital may disclose PHI believed to constitute evidence of criminal conduct occurring on the premises of Stamford Hospital.
- vii. **Crime in Emergencies** - If Stamford Hospital is providing emergency health care in response to a medical emergency, other than on Stamford Hospital premises, Stamford Hospital may disclose PHI to law enforcement officials regarding:
- viii. The commission and nature of a crime;
- Location or victims of a crime;
 - Identity, description and location of the perpetrator of a crime.
- ix. **Victims of a Crime** - Stamford Hospital may disclose PHI to law enforcement officials on any individual who is or is suspected to be a victim of a crime if:
- The individual agrees;
 - Under emergency circumstances and an individual is unable to agree, law enforcement official must represent:
 - a) that the information is needed to determine whether a violation of law by another person has occurred;
 - b) the information is not intended to be used against the victim patient;
 - c) immediate law enforcement activity dependent on the disclosure would be affected by waiting for a patient to agree;
 - d) it is determined the disclosure is in the best interest of the patient.
- ix. **Verification of Dates** - The fact that a patient was treated at Stamford Hospital and the date(s) of such treatment may be given without written authorization, except in the case of patients known to have been treated for drug or alcohol abuse Section IV.D.2. of this policy.

f. **Disclosures about Decedents:**

- i. **Disclosure to a coroner or medical examiner** is permitted for purposes of identifying an individual, determining a cause of death or other duties as authorized by law.

- ii. **Funeral Director** - Stamford Hospital may disclose PHI to funeral directors according to applicable law. If necessary for funeral directors to carry out their duties, Stamford Hospital may disclose PHI prior to the individual's death.
- g. **Disclosure to organ procurement organizations or other entities** engaged in the procurement, banking or transplantation of cadaver organs, eyes, or tissue for the purpose of facilitating transplantation.
- h. **Disclosure for research purposes** - see Uses and Disclosures for Research Purposes.
- i. **Disclosures to Avert a Serious Threat to Health or Safety** - A disclosure of PHI is permitted consistent with applicable law and ethical standards if there is a good faith belief that:
 - i. the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, and
 - ii. the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat, or
 - iii. disclosure is necessary to identify or apprehend an individual because of a statement by an individual admitting participation in a violent crime that is believed to have caused serious physical harm to the victim, or it appears from all the circumstances that the individual has escaped from a correctional institution or lawful custody. Any disclosure of a statement made regarding participation in a crime shall be limited to the statement made and the information listed in section e. (Crime on Premises) above.

No disclosure may be made pursuant to this section of information obtained in the course of treatment or referral to affect the propensity to commit the criminal conduct.

- j. **PHI uses and disclosures for specialized government functions may occur:**

Under certain circumstances PHI may be disclosed for certain government functions as follows;

- i. **Military** – Stamford Hospital may use and disclose PHI of Armed Forces and Foreign Military personnel for activities deemed necessary by appropriate military command authorities. The following information must be published by notice in the Federal Register: appropriate military command authorities and the purpose for which the PHI may be used or disclosed.
- ii. **National Security and Intelligence** – PHI may be disclosed to authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities authorized by the National Security Act.
- iii. **Protective Services for the President and others** – Stamford Hospital may disclose PHI to authorized federal officials for the provision of protective services to the President or other authorized persons or to foreign heads of state or authorized investigations.

- iv. **Correctional Institutions and other Law Enforcement Custodial Situations** – Stamford Hospital may disclose PHI to those with lawful custody of an inmate or other individual, if the information is necessary to: provide continuing care for the health and safety of the individual, inmates, officers or employees, law enforcement or others at the correctional institution, individuals responsible for transporting inmates and/or for the administration and maintenance of the safety, security and good order of the correctional institution.

- k. **Worker’s Compensation** – Stamford Hospital may disclose PHI as necessary under Connecticut state guidelines, providing benefits for work-related injuries or illness without regard to fault. Information requested by employers, their attorney or insurance carriers about Worker’s Compensation cases may be released without written authorization except if covered under D (psychiatric, alcohol and drug abuse and minors treated for venereal disease) of this policy. Any requests for records containing information related to evaluation or treatment related to mental health issues, alcohol or drug abuse or minors treated for venereal disease shall be referred to the Medical Record Department Manager or his/her designee.

- l. **Disclosure for Treatment, Payment or Health Care Operations:** Stamford Hospital may disclose PHI for treatment, payment or health care operations (“TPO”), unless the Hospital has agreed with the patient to restrict the disclosure of PHI for TPO.
 - i. **Treatment** – PHI may be disclosed to a patient’s health care provider for treatment purposes. Such disclosure shall conform to the minimum necessary rule.

NOTE: If the PHI includes psychotherapy notes, such PHI shall only be disclosed to:

 - The originator of the note for treatment purposes;
 - For the Hospital’s own mental health training programs; or
 - To defend the Hospital in a legal action or other proceeding brought by the individual.

 - ii. **Payment** – PHI may be disclosed for the purpose of obtaining payment for services. Payment includes activities undertaken to obtain reimbursement for the provision of health care. Activities include:
 - Determinations of eligibility or coverage;
 - Billing, claims management, collection activities, and related health care data processing;
 - Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and
 - Utilization review activities, including precertification and preauthorization of services.

The area's designated Medicare fiscal intermediary may have access to health records without an additional patient's authorization if the patient during treatment signed the release of health information form for billing purposes.

- ii. **Health care operations** – PHI may be disclosed for health care operations. Health care operations means any of the following:
 - Conducting quality assessment and improvement activities, including outcomes evaluation, development of clinical guidelines, case management and care coordination, and contacting of health care providers and patients with information about treatment alternatives;
 - Reviewing the competence or qualifications of health care professionals, including peer review activities, credentialing and training;
 - Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
 - Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity; and
 - Business management and general administrative activities of the entity, including customer service, resolution of internal grievances; the sale, transfer, merger, or consolidation of all or part of the covered entity, and creating de-identified health information or a limited data set, and fundraising for the benefit of the covered entity.
 - In the event specific patient cases are discussed at Medical Staff conferences, such as Tumor Boards and Breast Conferences, Grand Rounds, Surgical M&M, or Trauma Conferences, the participants of the conference will take the necessary steps to ensure patient privacy by not disclosing protected health information that is not necessary for the purposes of the conference. Disclosure of PHI during a medical staff conference may not be necessary, and, therefore, such a disclosure could be a violation of the minimum necessary requirements of HIPAA.

D. SPECIAL SITUATIONS

1. Psychiatric Health Information

- i. **General** - The Health Information Management Department controls all requests for information related to patients who have received psychiatric care. Section 52-146e of the Connecticut General Statutes provide for disclosure of psychiatric information with a written authorization from the patient or his/her authorized representative provided the consent specifies "to what person or agency the information is to be disclosed and to what use it will be put." The following statement must be attached to all disclosures of information from psychiatric health records:

“The confidentiality of this record is required under Chapter 899 of the Connecticut General Statutes. This material shall not be transmitted to anyone without written authorization as provided in the aforementioned statutes.”

Written authorization for disclosure of psychiatric information is not required in certain circumstances enumerated in Connecticut General Statute § 52-146a, *et. seq.*, (a list of these allowable disclosures is available from the Hospital main Medical Record Department Manager and other designated staff).

ii. **Psychotherapy Notes** - If a record contains psychotherapy notes, a special authorization by the patient is required for the release of these records except for the following circumstances:

- Use of psychotherapy notes by the originator of the note for treatment (A special Authorization is required for use and disclosure related to payment and most healthcare operations as per Connecticut law.),
- Use by the Hospital for training purposes, or
- Use in defense of any legal action brought by the patient, or
- A use or disclosure that is required or permitted by law:
 - a) To a public health authority for the purpose of preventing or controlling disease, injury, or disability;
 - b) To a public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect;
 - c) To the U.S. Food and Drug Administration;
 - d) To a health oversight agency with respect to the oversight of the originator of the psychotherapy notes;
 - e) To a coroner, medical examiner, or funeral director; or,
 - f) To prevent or lessen a serious or imminent threat to the health or public safety of a person or the public and is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

An authorization for release of psychotherapy notes may not be combined with any other authorization.

Psychotherapy notes will be physically segregated from the remaining health record.

Any request for Psychotherapy Notes shall be forward to the Privacy Officer, Director of Medical Records or Director of Risk Management.

2. **Release of Information From Alcohol and Drug Abuse Program Records**

- i. The confidentiality of alcohol and drug abuse patient records is protected by Federal law and regulations. Generally, Stamford Hospital may not disclose to a person outside the treatment program that a patient participates in a treatment program, or disclose any information identifying a patient as an alcohol or drug abuser unless:
- The patient consents in writing;
 - The disclosure is allowed by a court order; or
- ii. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation. The Hospital may not disclose a minor patient's participation in a drug or alcohol abuse program without the minor patient's consent.

- iii. Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.
- iv. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under Connecticut law to appropriate authorities.
- v. The restriction on release of alcohol and substance abuse records only applies to records of patients who are in a formal alcohol or substance abuse program, and not to general medical/surgical records which may contain information about alcohol or substance abuse.

Any attempt to subpoena or otherwise obtain drug and alcohol use treatment records shall be referred to the Director of Risk Management, or the Director of Medical Records

3. Release Of Information From Record of a Minor Treated for Venereal Disease

- i. Sec. 19a-216 of the Connecticut Statutes prohibits release of information from the health record of a minor treated for venereal disease, including the sending of a bill for such services to any person other than the minor, without the written consent of the minor.
- ii. All requests for records containing information about venereal diseases of minor should be referred to the Risk Management.

E. ACCOUNTING FOR DISCLOSURES:

- 1. Sufficient records of disclosures of PHI must be maintained in order to satisfy the Hospital's obligation to provide an accounting of disclosures upon request by a patient. An individual has a right to receive an accounting of disclosures of protected health information made by the Hospital in the three years prior to the date on which the accounting is requested, except for disclosures:
 - i. To carry out treatment, payment and health care operations;
 - ii. To individuals of protected health information about them;
 - iii. Incident to a use or disclosure otherwise permitted or required by HIPAA;
 - iv. Pursuant to an authorization;
 - v. For the facility's directory or to persons involved in the individual's care;
 - vi. For national security or intelligence purposes;
 - vii. To correctional institutions or law enforcement officials as provided in § 164.512(k)(5) of the HIPAA regulations; or §164.528(a)(1)(v)
 - viii. As part of a limited data set in accordance with § 164.514(e) of the HIPAA regulations

2. The Hospital must provide the individual with a written accounting that meets the following requirements:
 - i. The accounting must include disclosures of protected health information that occurred during the three years (or such shorter time period at the request of the individual) prior to the date of the request for an accounting, including disclosures to or by business associates of the Hospital.
 - ii. The accounting must include for each disclosure:
 - The date of the disclosure;
 - The name of the entity or person who received the protected health information and, if known, the address of such entity or person;
 - A brief description of the protected health information disclosed; and
 - A brief statement of the purpose of the disclosure that reasonably informs the individual of the basis for the disclosure or, in lieu of such statement, a copy of a written request for a disclosure under §§ 164.502(a)(2)(ii) or 164.512, if any.
 - iv. If there are multiple disclosures of protected health information to the same person or entity for a single purpose, the accounting must also include the frequency or number of the disclosures made during the accounting period, and the date of the last such disclosure during the accounting period.
 - v. If the Hospital has made disclosures of protected health information for a particular research purpose for 50 or more individuals, the accounting may provide:
 - a) The name of the protocol or other research activity;
 - b) A description, in plain language, of the research protocol or other research activity, including the purpose of the research and the criteria for selecting particular records;
 - c) A brief description of the type of protected health information that was disclosed;
 - d) The date or period of time during which such disclosures occurred, or may have occurred, including the date of the last such disclosure during the accounting period;
 - e) The name, address, and telephone number of the entity that sponsored the research and of the researcher to whom the information was disclosed; and
 - f) A statement that the protected health information of the individual may or may not have been disclosed for a particular protocol or other research activity.

If the Hospital provides an accounting of PHI disclosed for research purposes, the Hospital shall, at the request of the individual, assist in contacting the entity that sponsored the research and the researcher.
- c. The Hospital must act on the individual's request for an accounting, no later than 60 days after receipt of such a request, as follows.
 - iv. The Hospital must provide the individual with the accounting requested; or
 - v. If the Hospital is unable to provide the accounting within 60 days, the Hospital may extend the time to provide the accounting by no more than 30 days, provided that the Hospital notifies the individual with a written statement of the reasons for the delay and the date by which the Hospital will provide the accounting.
 - vi. The first accounting to an individual in any 12 month period will be without charge. The Hospital may impose a reasonable, cost-based fee for each subsequent request for an accounting by the same individual within the 12 month period, provided that

the Hospital informs the individual in advance of the fee and provides the individual with an opportunity to withdraw or modify the request for a subsequent accounting in order to avoid or reduce the fee.

F. Business Associates

1. **Definition:** Business associate means a person or entity who is not a member of the Hospital's workforce that, on behalf of the Hospital, performs, assists in the performance of, or provides:
 - iv. A function or activity involving the use or disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and re-pricing;
 - v. Legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for the hospital, where the provision of the service involves the disclosure of individually identifiable health information from the hospital, or from another business associate of the hospital, to the person; or
 - vi. Any other function or activity regulated by the Privacy Rule.
2. **General Rule:** Disclosure of PHI may be made to a business associate, and a business associate may be allowed to create or receive PHI on behalf of the hospital, if the hospital has a written contract or agreement with the business associate, or a separate business associate agreement, that meets the requirements set forth in the Privacy Rule.
3. **Procedure:** Materials Management and the responsible Hospital Department will maintain a list of persons and entities with which the hospital has such a business associate contract or agreement. Only those persons and entities on this list are to be considered business associates of the hospital.

G. Fundraising

1. **General Rule:** The hospital may, without an authorization, use, or disclose to a business associate or to the Stamford Hospital Foundation, Inc., the following PHI for the purpose of raising funds for the hospital's own benefit:
 - i. Demographic information relating to a patient; and
 - ii. Dates of health care provided to a patient
2. **Opt Out:** All fundraising materials must include a description of how the individual may opt out of receiving any further fundraising communications, and the hospital must make reasonable efforts to ensure that individuals who decide to opt out of receiving future fundraising communications are not sent such communications.

H. Training

1. **General Rule:** All members of the hospital's workforce must be trained on the policies and procedures with respect to PHI, as necessary and appropriate for the members of the workforce to carry out their function within the hospital.

2. Procedure:

- i. Each new member of the workforce must be trained within a reasonable period of time after the person joins the workforce.
 - ii. Each member of the workforce whose functions are affected by a material change in the policies or procedures required by the Privacy Rule must be trained within a reasonable period of time after the material change becomes effective.
 - iii. Training of the workforce is an annual mandatory requirement.
- 3. Documentation:** All training must be documented. A written or electronic record of all training must be maintained for six years from the date of the training.

I. UNAUTHORIZED DISCLOSURES

1. Any individual aware of an unauthorized disclosure or potential unauthorized disclosure shall immediately report the unauthorized disclosure to the Privacy Officer. A potential unauthorized disclosure may include the loss of control of PHI data, including the inability to locate health record files, the loss or potential unauthorized access of a computer with PHI on it or the unauthorized access to PHI.
2. Employees responsible for unauthorized disclosures may be disciplined pursuant to Human Resource policies. Members of the Medical Staff responsible for unauthorized disclosures may be disciplined pursuant to the Medical Staff Bylaws, Policies and Rules & Regulations. The nature and extent of the discipline will be based upon the type of unauthorized disclosure.
3. To the extent practicable, the Hospital will mitigate any harmful effect that is known to the Hospital of a use or disclosure of PHI in violation of the hospital's policies and procedures or the requirements of the Privacy Rule, by the hospital or its business associates.

J. NOTIFICATION OF AN UNAUTHORIZED DISCLOSURE

1. In the event the Hospital is aware of an unauthorized breach of unsecured PHI, the Hospital is required to notify the individual if the disclosure poses a significant risk of harm to the individual. For purposes of this section the following definitions apply:
 - i. Unsecured PHI means protected health information that is not usable, readable or decipherable to unauthorized individuals.
 - ii. Breach means the acquisition, access, use or disclosure of PHI in a manner not permitted by this Policy and HIPAA which poses a significant risk of financial, reputational or other harm to an individual.
2. It shall be the responsibility of the Privacy Officer, in consultation with senior management, to determine whether notification is appropriate. In considering whether impermissibly disclosure poses a significant risk of harm to the individual, the Hospital shall perform a risk assessment, considering:
 - i. Who the PHI was impermissibly disclosed to;
 - ii. Whether steps to eliminate or reduce the risk of harm to the individual no longer make the disclosure a "significant risk" of harm; and
 - iii. What type of PHI was involved in the impermissibly disclosure.

3. **Timing:** The method and manner of notification depends on the scope of the breach. All notifications of a breach must be made without unreasonable delay and in no case later than 60 days after the discovery of the breach. A breach is treated as discovered on the day the breach is known to the Hospital or a business associate of the Hospital, (including any person, other than the individual committing the breach, that is an employee, officer or other agent of the entity/associate) or should reasonably have known.
4. **Manner of Notification:**
 - i. **All individuals** - Written notice to the individual (or next of kin if the individual is deceased) at the last known address of the individual (or next of kin) by first-class mail (or by electronic mail if specified by the individual).
 - ii. **Insufficient or out-of-date contact information** – If the Hospital has insufficient or out-of-date contact for the individual, substitute notice may be used if it is reasonably calculated to reach the individual. In the case in which there is insufficient or out-of-date contact information for more than 10 individuals, substitute notice must be conspicuously posted on the home page of the Hospital’s website for 90 days.
 - iii. **Imminent risk of misuse** - In cases that the entity deems urgent based on the possibility of imminent misuse of the unsecured PHI, notice by telephone or other method is permitted in addition to the above methods.
 - iv. **500 or more individuals affected** –
 - a) Notice to prominent media outlets within the State or jurisdiction;
 - b) Notice to the Secretary by covered entities immediately.
 - c) Posting by the Secretary on an HHS Web site of a list that identifies each Hospital involved in the breach.
 - ii. **Annual Reports** - In addition, to the notifying the Secretary immediately for breaches affecting 500 or more individuals, all other breaches shall be reported to the Secretary annually.
5. **The notification to the individual must include:**
 - i. A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known;
 - ii. A description of the types of unsecured PHI that were involved in the breach (such as full name, Social Security number, date of birth, home address, account number, or disability code);
 - iii. The steps individuals should take to protect themselves from potential harm resulting from the breach;
 - iv. A brief description of what the Hospital involved is doing to investigate the breach, to mitigate losses, and to protect against any further breaches; and
 - v. Contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, Web site, or postal address.

K. Organized Health Care Arrangement

Members of the Medical Staff are deemed to be part of an Organized Health Care Arrangement, as that term is defined by the Privacy Rule for purposes of HIPAA and the Privacy Rule. Members of the Medical Staff shall abide by the terms of Stamford Hospital's Privacy Notice with respect to PHI created or received by them as part of their participation in treatment, payment, and health care operations at or for Stamford Hospital. SHS will provide a copy of the Privacy Notice to patients on behalf of participants in the Organized Health Care Arrangement at each Affiliated Covered Entity sites.

L. Disclosures by Telephone or Facsimile

Disclosures of PHI made by telephone or facsimile shall be in accordance with the procedures set forth in Stamford Hospital's Medical Records Policy.

M. Disciplinary Action

No employee, Medical Staff member, agent and contractor of Stamford Hospital shall intimidate, threaten, coerce, discriminate against, or take other retaliatory action against individuals and others for exercising any rights under federal or state law relative to the privacy of their PHI.

Any violation of this policy shall be handled as follows:

- i. Violations of this policy by an employee of Stamford Hospital may be subjected to disciplinary action as described in Human Resources Corrective Action Policy.
- ii. Violation of this Policy by a member of the Medical Staff may be subjected to disciplinary action in accordance with the Medical Staff Bylaws, Rules and Regulations.

**Stamford Hospital
Credentialing Policy and Procedure**

Subject: New Procedure-Technology

new procedure.doc

- A. **POLICY:** New technology (procedures, devices, techniques) that is not covered by an existing privilege delineation form may not be performed without prior determinations by the relevant department (and section, if applicable), the Medical Executive Committee, and the Board of Directors, that the technology would be appropriate to include among the services available to patients at this hospital. (These requirements do not apply to "clinical research," including the use of an experimental drug or device, which is covered by existing delineated privilege forms; such activities must, however, be approved by the Institutional Review Committee in accordance with applicable hospital and medical staff policies and procedures and state and federal laws.)

Criteria for delineation of clinical privileges should specify the certification or training and experience needed to be eligible for specific clinical privileges in a specialty. Criteria should be developed for all new procedures, the only exceptions being those that are clinically or procedurally similar to an existing modality.

If an applicant currently on the medical / ancillary staff requests clinical privileges for which there are no developed criteria, the physician should be informed that the procedure is not currently performed at the hospital, but that within a reasonable amount of time, the hospital will consider the request and will inform the physician whether it intends to allow that procedure to be performed, and the criteria that will be required of applicants who wish to perform it.

In making the determination whether to allow a particular procedure to be performed at the hospital, the following will be considered:

- Hospital's available resources and personnel
- Ability to appropriately monitor and review the competence of the physician to perform the procedure
- Availability of qualified physicians or other appropriate appointees to provide medical coverage for the physician in case of the applicant's illness or unavailability.
- Quality of the training programs available.

Procedures will not be scheduled until the following process is completed.

Procedure:

1. A practitioner who wishes to propose that a new technology be approved must submit the following information to the chairman of the appropriate department or, if applicable, the chief of the appropriate section:
 - A description of the technology, including the indications and contraindications for it.
 - A description of any new equipment or other resources that would have to be obtained, and/or any special support staff training or orientation that would have to be provided, in connection with the new technology.

**Stamford Hospital
Credentialing Policy and Procedure**

- A description of the results, complications and other pertinent information reported in relevant scientific literature, with citations as appropriate.
 - A description of the background and training that should be required to qualify a practitioner for privileges to perform the procedure, with reference to scientific literature and other sources of guidance as appropriate.
2. The department chairman or division director shall consider the proposal and conduct such additional inquiries or proceedings as he deems appropriate. This may include, among other options, consultation with appropriate department directors (i.e., director of perioperative services), outside experts, additional literature review, and/or presentation for general discussion at a department or section meeting. If the matter is initially considered by a division director, he shall make a recommendation to the department chairman. The department chairman shall make a written recommendation to the Credentials Committee, with relevant documentation.
 3. The Credentials Committee shall make a written recommendation to the Medical Executive Committee, with relevant documentation, including:
 - A proposed monitoring and quality review plan to assess the medical staff's overall experience with the new technology for a reasonable period or number of cases after it comes into use, taking into account anticipated results, comparative data from other institutions, and other relevant factors.
 - A proposed set of proctoring requirements to verify the competence of individual practitioners who are granted privileges to perform the new procedure, if applicable.
 4. The Medical Executive Committee shall make a written recommendation to the Board of Directors, which shall make a final decision.
 5. Following the Board of Directors' approval of the new technology, requests for privileges to perform it may be submitted by individual practitioners and processed in accordance with the medical-dental staff bylaws, rules and regulations, and credentialing policy.

**STAMFORD HOSPITAL
[HIPAA]**

Subject:	Use and Disclosure of Protected Health Information		
Policy #	[H 101]	Implemented	4/14/03
References	[45 CFR 164.506,164.510,164.512, CT release of information regulations]	Reviewed	4/09,4/10
Approval	Privacy Officer CIO, VP Information Services	Revised	7/09, 12/09(combines several former policies under Use and Disclosure) ,4/10
Departments Affected	All	Page 1 of 23	

I. PURPOSE

To protect the privacy and confidentiality of personal health information; to provide guidance for release of health information, and to implement the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), including subsequent related statutes in the American Recovery and Reinvestment Act of 2009, and the Regulations promulgated by the U.S. Department of Health and Human Services, 45 CFR Parts 160 and 164 (the “Privacy Rule”).

II. DEFINITIONS

A. Protected Health Information - Protected health information (“PHI”) is all health information about a patient, including demographic information, whether maintained in the written medical, billing records, in the computer system, or spoken among two or more persons, that:

- i. is created or received by the hospital;
- ii. relates to the past, present, or future physical health or condition of a patient, the provision of health care to a patient, or the past, present, or future payment for the provision of health care to a patient; and,
- iii. Identifies the patient or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

B. Secured PHI - PHI is deemed secured if it is rendered unusable, unreadable, or indecipherable to unauthorized individuals by encryption or destruction.

C. De-Identified PHI – De-identified PHI is PHI that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. De-identified PHI is not subject to the requirements of this Policy.

III. POLICY

A. General Privacy Practices

Confidentiality of PHI - PHI is confidential and shall be protected during its collection, use, storage and destruction. PHI cannot be used within the hospital or disclosed to persons outside the hospital for any reason not authorized by a specific Hospital policy. All hospital employees, as well as other persons associated with the Hospital (including members of the Medical Staff, members of the Board of Directors, volunteers and contractors), are responsible for protecting the privacy of all PHI that is obtained or accessed in the course of their work or association with the Hospital, and safeguarding against any intentional, unintentional, or incidental use or disclosure that is in violation of hospital policy or the Privacy Rule. **PHI is strictly confidential and is not released, except as indicated in this policy.**

Incidental Use or Disclosure An incidental use or disclosure is a secondary use or disclosure that cannot reasonably be prevented, is limited in nature, and that occurs as a result of another use or disclosure that is permitted by hospital policy and the Privacy Rule. Such incidental uses and disclosures are permitted by hospital policy and the Privacy Rule, as long as reasonable precautions are taken to limit the information that might be overheard or seen. For example, a physician may discuss a patient's condition or treatment regimen with the patient in the patient's semi-private room, or a physician and nurse can discuss the treatment of a patient at a nursing station or joint treatment area, so long as reasonable efforts are made to try to keep other people from overhearing the conversation.

B. Right to Request Restriction on Use and Disclosure For Treatment, Payment or Operations

All patients and personal representatives have the right to request restriction of the uses and disclosures of *PHI* to carry out treatment, payment, or health care operations. Except as provided below, the hospital is not required to agree to a requested restriction, but is bound by the terms of any restriction agreed to. Only the Director of Health Information can agree to such a restriction of the uses and disclosures of *PHI* to carry out treatment, payment, or health care operations. Restrictions must be in writing and maintained for six (6) years from the date signed by the patient.

If a patient requests a restriction that their PHI not be disclosed to a health plan for purposes of carrying out payment, the Hospital must abide by the requested restriction if the PHI at issue pertains solely to a health care item or service for which the patient has already paid in full out of pocket.

C. Prohibition on Conditioning Authorizations

The provision to a patient of treatment may not be conditioned on the provision of an authorization for disclosure of *PHI*, except:

- i. The provision of research-related treatment may be conditioned upon the provision of an authorization for the use or disclosure of *PHI* for such research; and,
- ii. The provision of health care that is solely for the purpose of creating *PHI* for disclosure to a third party may be conditioned upon the provision of an authorization for the disclosure of the *PHI* to such third party. For example, a health care provider may condition the performance of an independent medical examination for purposes of litigation or employment on the patient providing an authorization to disclose the information obtained during the examination.

D. Notice of Privacy Practices

The Hospital has developed a document entitled “**Notice of Privacy Practices.**” A copy of this Notice will be given to anyone upon request. Except for outpatients receiving diagnostic testing only, a copy of this Notice will be given to each patient or a patient’s personal representative upon admission, including registration in the Emergency Department. Copies of the Notice will be available at several clear and prominent locations throughout the hospital for anyone to read and take with them, including the Admitting Department, the Emergency Department, and the Information Desk in the front lobby. A copy of the Notice will be made available on the Hospital’s website.

Each version of the Notice, or an electronic copy, must be maintained for six (6) years from the date each was implemented.

E. Alternative Means of Communication

Requests by patients and their personal representatives to receive communications of *PHI* from the hospital by alternative means or at alternative locations should be accommodated to the extent reasonable. For example, a patient may request that written communications from the hospital be sent to an address other than the patient’s home address. Similarly, a patient may request that written communication be sent in a closed envelope rather than a postcard.

All requests to receive communications of *PHI* by alternative means or at alternative locations must be in writing and should be referred to the Health Information Management Department. Provision of a reasonable accommodation may be conditioned on (1) when appropriate, information as to how payment, if any, will be handled; and, (2) specification of an alternative address or other method of contact. An explanation from the patient or personal representative as to the basis for the request cannot be a condition of providing communications on a confidential basis. The reasonableness of a request must be determined solely on the basis of the administrative difficulty of complying with the request and the foregoing requirements.

F. Privacy Officer

There shall be a “Privacy Officer” who shall be the hospital’s designated privacy official and who shall be responsible for the development and implementation of the hospital’s privacy policies and procedures.

The Privacy Officer is responsible for receiving complaints under this policy and is available to provide further information about matters covered by the “**Notice of Privacy Practices**”.

G. Complaints

The hospital provides a process for individuals to make complaints concerning the hospital’s privacy policies and procedures or the hospital’s compliance with such policies and procedures or the requirements of the Privacy Rule. (See Administrative Policy: Patient Complain and Grievance Policy.)

H. Intimidating and Retaliatory Acts

No individual shall be intimidated, threatened, coerced, discriminated against, or have other retaliatory action taken against them, for exercising any right under, or for participating in any process established by the Privacy Rule, including the filing of a complaint pursuant to the “Patient Grievances and Action Line Program” policy. Nor shall any such action be taken against any individual for:

- i. Filing a complaint with the Secretary of the U.S. Department of Health and Human Services pursuant to the Privacy Rule;
- ii. Testifying, assisting, or participating in an investigation, compliance review, proceeding, or hearing under Part C of Title XI; or
- iii. Opposing any act or practice made unlawful by the Privacy Rule, provided the individual or person has a good faith belief that the practice opposed is unlawful, and the manner of the opposition is reasonable and does not involve a disclosure of PHI in violation of the Privacy Rule.

I. Waiver of Rights

The hospital will not require patients to waive their rights under the Privacy Rule, including the right to file a complaint with the Secretary of the U.S. Department of Health and Human Services, as a condition of the provision of treatment.

J. Affiliated Covered Entities

The following covered entities, which are under common ownership or control of the Stamford Health Inc., are designated as a single covered entity for purposes of HIPAA and the Privacy Rule:

- i. Stamford Health System, Inc.
- ii. The Stamford Hospital
- iii. Continuing Care Retirement Community of Greater Stamford (Edgehill)
- iv. Darien Imaging Center
- v. Stamford OB/GYN Associates, P.C.
- vi. Fairfield County OB/GYN
- vii. Fairfield County Surgical Specialists, P.C.
- viii. Premier Medical Group, P.C.
- ix. Fairfield County Primary Care, P.C.
- x. Stamford Hospital Integrated Practices

K. Minimum Necessary - Hospital personnel are to use and disclose **PHI** on a need to know basis. When using or disclosing **PHI** or when requesting **PHI** from another source, reasonable efforts must be made to limit **PHI** to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

Exceptions: This requirement does not apply to:

- i. Disclosures to or requests by a health care provider for treatment. In the event there is no evidence of a patient/practitioner relationship, the Hospital may rely upon the representation of the practitioner or conduct its own investigation.
- ii. Uses and disclosures made to the patient;
- iii. Uses and disclosures made pursuant to a HIPAA compliant authorization from the patient or a *person in interest*; as Defined by the Advance Directive Policy.

- iv. Disclosures made to the Secretary of the U.S. Department of Health and Human Services during an investigation of the hospital's compliance with the Privacy Rule.
- v. Uses or disclosures that are required by law; and
- vi. Uses or disclosures that are required for compliance with the Privacy Rule.

IV. PROCEDURES

A. PERMITTED USES AND DISCLOSURES OF PHI

1. Written Authorization for Disclosure of PHI:

A written authorization may be executed by:

- i. The patient;
- ii. The parent or legally appointed guardian in cases of a minor (except requests covered in Section I - alcohol and drug abuse records, and Section J - minors treated for venereal diseases). The non-custodial parent of a minor child shall not be denied the right of access to the minor's medical, hospital, or other health records (except where confidentially protected by statute), unless otherwise ordered by the court for good cause shown;
- iii. The patient, if judged an emancipated minor by the Superior Court or who is emancipated under the common law of Connecticut, (questions regarding the definition of an emancipated minor should be referred to the Medical Record Department manager or his/her designee)
- iv. The executor or administrator of the estate of a deceased patient. If no executor or administrator has been appointed then, in order: 1. Surviving spouse; 2. Adult son or daughter; 3. Parent; 4. Adult sibling; 5. Guardian;
- v. The court-appointed conservator or guardian for an incapable patient or a mentally retarded patient;

A written authorization shall contain:

- i. A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion;
- ii. The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure;
- iii. The name or other specific identification of the person(s), or class of persons, to whom the Hospital may make the requested use or disclosure;
- iv. A description of each purpose of the requested use or disclosure. The statement "at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose;
- v. An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure ("end of research study" and "none" are acceptable if disclosure is for research purposes).
- vi. Signature of the individual (or authorized person), date, and a description of a representative's authority to act;
- vii. A statement that the individual has the right revoke the authorization and the methods by which the individual make revoke the authorization (in writing);

- viii. A statement that treatment or payment for services are not conditioned on signing the authorization;
- ix. A statement that information disclosed pursuant to the authorization may be subject to re-disclosure and no longer protected.

Revocation of Written Authorization:

An authorization may be revoked at any time provided that the revocation is in writing except to the extent that:

- i. PHI has already been disclosed in reliance on the authorization, or
- ii. The authorization was obtained as a condition of obtaining insurance coverage.

2. Use and disclosures requiring an opportunity for an individual to agree or object: Stamford Hospital will provide each patient with advance notice of his/her right to agree or object to certain uses of his/her PHI throughout the System. The advance notice will include information regarding persons/organizations that may access PHI. The individual has a right to restrict or prohibit some or all of the uses or disclosures.

- i. **Facility Directories** - Except when an objection is expressed, Stamford Hospital may use the following PHI to maintain a facility directory and disclose this information to members of the clergy or other persons who ask for a patient by name:

- Individual's name;
- Individual's location in Stamford Hospital;
- Individual's condition described in general terms that does not communicate specific medical information about the individual (critical, stable, fair, good, etc.);
- Individual's religious affiliation (may be disclosed to Clergy only);

** Refer to Section D. for patients admitted for Psychiatric Services.

In emergency situations where the opportunity to agree or object is not possible, Stamford Hospital may use or disclose some or all of the PHI listed in a. i-v. Of this section for the facility's directory. The disclosure must be consistent with prior wishes if known to Stamford Hospital, and must be in the individual's best interest. As soon as it is practicable to do so, Stamford Hospital will inform the individual and provide an opportunity to object to uses or disclosures for directory purposes.

- ii. **Individuals involved in the patient's care and for notification purposes** - Stamford Hospital may disclose to a family member, other relative, close personal friend or any other person identified by the individual, PHI directly relevant to the individual's health care treatment or payment; or to notify or assist in the notification of a family member, personal representative or other person responsible for the care of the individual, and advise of the individual's location, general condition or death provided that either:

- When a patient is present and capable of making health care decisions, Stamford Hospital will only use and disclose PHI if:
 - a) the patient agrees,
 - b) the patient has been provided with an opportunity to object to the disclosure and does not do so, or
 - c) it can be reasonably inferred from the circumstances that the patient does not object to the disclosure.
- If the individual is not present, or an opportunity to agree cannot be practically provided because of the patient's incapacity or emergency circumstances, Stamford Hospital may exercise professional judgment to determine whether the disclosure is in the best interest of the patient. Only the PHI directly relevant to the person's involvement with the individual's health care will be disclosed and made available, for example information necessary to allow someone to retrieve prescriptions or X-rays for a patient.

Individuals have the right to privacy restrictions and may ask Stamford Hospital staff to refrain from disclosing PHI to designated persons.

- iii. **Disaster Relief** – Stamford Hospital may use or disclose basic PHI to a public or private entity authorized by law to assist in disaster relief efforts.

3. Use and disclosure where an authorization, opportunity to agree or object is not required. Exceptions to the requirement for written authorization for use and disclosure of PHI are made in the instances documented below. Stamford Hospital staff should use minimum data necessary to comply with the law. Any disclosure under this part is subject to the Accounting for Disclosures rule in Section IV, Paragraph E of this Policy.

- a. **Public Health Activities** – Stamford Hospital may disclose PHI to an organization that is authorized by law to collect or receive information for:
 - i. The prevention or control of disease, injury, or disability;
 - ii. Child abuse or neglect;
 - iii. FDA regulated product or activity to collect or report adverse events, product defects, problems or biological product deviations, to track FDA regulated products, to enable product recalls, repairs, replacement, look back or to conduct post marketing surveillance;
 - iv. Notification to or about persons who may have been exposed to a communicable disease or be at risk of contracting or spreading a disease or condition;
 - v. To employers if:
 - the employer refers a patient who is a member of the employer's workforce for medical evaluation for purposes relating to medical surveillance of the workplace, evaluate work-related illness or injury or if findings reveal a work related illness or injury

- Only information related to work place illness or injury is disclosed, and
 - The patient is notified that their PHI will be shared with their employer.
- vi. State Health Department and Consumer Protection Activities: PHI may be released to State agencies without patient authorization for the following:
- Review of certain health records with respect to the licensure.
 - Review of certain health records during investigation concerning controlled substances.
 - Review of certain health records during investigation concerning reportable diseases.
 - Review of certain health records during investigation concerning child abuse.

Any requests involving access to health records by state agencies should be referred to the Director of Risk Management or the Medical Record Department Manager or their designees.

- b. **Victims of Abuse or Neglect** - Stamford Hospital may disclose PHI as required by law about an individual who is believed to be a victim of abuse or neglect to a government authority, including social service or protective services agency authorized to receive such information.

See Policy for the Identification and Management of Victims of Abuse

- i. The disclosure is required by law,
- ii. The patient consents, or
- iii. The disclosure is authorized by law and
 - a physician or other licensed health care professional determines in their professional judgment that disclosure is necessary to prevent serious harm to the patient or other potential victims, or
 - the patient is unable to agree because of incapacity and a law enforcement or other public official authorized to receive information represents that the PHI sought is not intended to be used against the patient and that an immediate enforcement activity depends on the disclosure and would be materially and adversely affected by waiting until the patient could agree,

The patient must be notified of any disclosures made pursuant to this provision unless:

- i. In the exercise of professional judgment a physician determines that informing the patient would place the patient at risk of serious harm, or
- ii. By informing the patient information would be given to someone who it is believed was responsible for the abuse, neglect or domestic violence and that informing such person would not be in the best interest of the patient.

- c. **Health Oversight Agency** – Stamford Hospital may disclose PHI to assist with audits, investigations, inspections, licensure or disciplinary actions, legal proceedings or actions for the appropriate oversight of the Stamford Hospital and any applicable government regulatory programs, provided the health oversight activity does not include an investigation of the patient and is not directly related to the receipt of health care, a claim for public benefits regarding health or qualification of public benefits/services,

Any request for PHI from a health oversight agency shall be referred to the Director of Risk Management, the Privacy Officer or the Director of Medical Records for handling.

- d. **Judicial and Administrative Proceedings** – Stamford Hospital may disclose PHI in response to a subpoena, discovery request or other lawful process in compliance with the procedures set forth in the Hospital’s Medical Records policy. Any request by Order or Subpoena shall be forward to the Director of Health Information, the Director of Risk Management, or the Privacy Officer:

- e. **Law Enforcement Officials:**

- i. **Decedents** – Stamford Hospital may disclose PHI to a law enforcement official to advise of any death believed to be a result of criminal conduct.

- ii. **Reporting of Certain Injuries/Diseases –**

- Firearm Wounds
- Burn Injuries or Injuries from Fireworks
- Child Abuse or Neglect
- Suspected abuse, neglect, exploitation and abandonment of elderly persons
- Examination and Treatment of Minors 12 years and younger for venereal diseases
- Tuberculosis

- iii. **Warrants/Subpoenas/Summons/Grand Jury** - PHI may be disclosed in compliance with a Court order, warrant, subpoena, summons issued by a judicial officer, or a grand jury subpoena;

- iv. **Administrative request**, including subpoena or summons, a civil or an authorized investigative demand provided the information sought is relevant to the inquiry; the request is reasonably specific and limited in scope; and de-identified information could not reasonably be used.

- v. **Identification and location purposes** – Stamford Hospital may disclose PHI to law enforcement officials to provide limited information for identifying or locating a suspect, fugitive, material witness, or missing person. Stamford Hospital will not disclose any PHI related to an individual’s DNA or DNA analysis, dental records, or typing, samples or analysis of body fluids or tissue. Stamford Hospital may disclose only the following information:

- Name and address;

- Date and place of birth;
 - Social security number;
 - ABO blood type and rh factor;
 - Type of injury;
 - Date and time of treatment;
 - Date and time of death, if applicable;
 - Description of distinguishing physical characteristics including height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars and tattoos.
- vi. **Crime on Premises** - Stamford Hospital may disclose PHI believed to constitute evidence of criminal conduct occurring on the premises of Stamford Hospital.
- vii. **Crime in Emergencies** - If Stamford Hospital is providing emergency health care in response to a medical emergency, other than on Stamford Hospital premises, Stamford Hospital may disclose PHI to law enforcement officials regarding:
- viii. The commission and nature of a crime;
- Location or victims of a crime;
 - Identity, description and location of the perpetrator of a crime.
- ix. **Victims of a Crime** - Stamford Hospital may disclose PHI to law enforcement officials on any individual who is or is suspected to be a victim of a crime if:
- The individual agrees;
 - Under emergency circumstances and an individual is unable to agree, law enforcement official must represent:
 - a) that the information is needed to determine whether a violation of law by another person has occurred;
 - b) the information is not intended to be used against the victim patient;
 - c) immediate law enforcement activity dependent on the disclosure would be affected by waiting for a patient to agree;
 - d) it is determined the disclosure is in the best interest of the patient.
- ix. **Verification of Dates** - The fact that a patient was treated at Stamford Hospital and the date(s) of such treatment may be given without written authorization, except in the case of patients known to have been treated for drug or alcohol abuse Section IV.D.2. of this policy.

f. **Disclosures about Decedents:**

- i. **Disclosure to a coroner or medical examiner** is permitted for purposes of identifying an individual, determining a cause of death or other duties as authorized by law.

- ii. **Funeral Director** - Stamford Hospital may disclose PHI to funeral directors according to applicable law. If necessary for funeral directors to carry out their duties, Stamford Hospital may disclose PHI prior to the individual's death.
- g. **Disclosure to organ procurement organizations or other entities** engaged in the procurement, banking or transplantation of cadaver organs, eyes, or tissue for the purpose of facilitating transplantation.
- h. **Disclosure for research purposes** - see Uses and Disclosures for Research Purposes.
- i. **Disclosures to Avert a Serious Threat to Health or Safety** - A disclosure of PHI is permitted consistent with applicable law and ethical standards if there is a good faith belief that:
 - i. the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, and
 - ii. the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat, or
 - iii. disclosure is necessary to identify or apprehend an individual because of a statement by an individual admitting participation in a violent crime that is believed to have caused serious physical harm to the victim, or it appears from all the circumstances that the individual has escaped from a correctional institution or lawful custody. Any disclosure of a statement made regarding participation in a crime shall be limited to the statement made and the information listed in section e. (Crime on Premises) above.

No disclosure may be made pursuant to this section of information obtained in the course of treatment or referral to affect the propensity to commit the criminal conduct.

- j. **PHI uses and disclosures for specialized government functions may occur:**

Under certain circumstances PHI may be disclosed for certain government functions as follows;

- i. **Military** – Stamford Hospital may use and disclose PHI of Armed Forces and Foreign Military personnel for activities deemed necessary by appropriate military command authorities. The following information must be published by notice in the Federal Register: appropriate military command authorities and the purpose for which the PHI may be used or disclosed.
- ii. **National Security and Intelligence** – PHI may be disclosed to authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities authorized by the National Security Act.
- iii. **Protective Services for the President and others** – Stamford Hospital may disclose PHI to authorized federal officials for the provision of protective services to the President or other authorized persons or to foreign heads of state or authorized investigations.

- iv. **Correctional Institutions and other Law Enforcement Custodial Situations** – Stamford Hospital may disclose PHI to those with lawful custody of an inmate or other individual, if the information is necessary to: provide continuing care for the health and safety of the individual, inmates, officers or employees, law enforcement or others at the correctional institution, individuals responsible for transporting inmates and/or for the administration and maintenance of the safety, security and good order of the correctional institution.

- k. **Worker’s Compensation** – Stamford Hospital may disclose PHI as necessary under Connecticut state guidelines, providing benefits for work-related injuries or illness without regard to fault. Information requested by employers, their attorney or insurance carriers about Worker’s Compensation cases may be released without written authorization except if covered under D (psychiatric, alcohol and drug abuse and minors treated for venereal disease) of this policy. Any requests for records containing information related to evaluation or treatment related to mental health issues, alcohol or drug abuse or minors treated for venereal disease shall be referred to the Medical Record Department Manager or his/her designee.

- l. **Disclosure for Treatment, Payment or Health Care Operations:** Stamford Hospital may disclose PHI for treatment, payment or health care operations (“TPO”), unless the Hospital has agreed with the patient to restrict the disclosure of PHI for TPO.
 - i. **Treatment** – PHI may be disclosed to a patient’s health care provider for treatment purposes. Such disclosure shall conform to the minimum necessary rule.

NOTE: If the PHI includes psychotherapy notes, such PHI shall only be disclosed to:

 - The originator of the note for treatment purposes;
 - For the Hospital’s own mental health training programs; or
 - To defend the Hospital in a legal action or other proceeding brought by the individual.

 - ii. **Payment** – PHI may be disclosed for the purpose of obtaining payment for services. Payment includes activities undertaken to obtain reimbursement for the provision of health care. Activities include:
 - Determinations of eligibility or coverage;
 - Billing, claims management, collection activities, and related health care data processing;
 - Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; and
 - Utilization review activities, including precertification and preauthorization of services.

The area's designated Medicare fiscal intermediary may have access to health records without an additional patient's authorization if the patient during treatment signed the release of health information form for billing purposes.

- ii. **Health care operations** – PHI may be disclosed for health care operations. Health care operations means any of the following:
 - Conducting quality assessment and improvement activities, including outcomes evaluation, development of clinical guidelines, case management and care coordination, and contacting of health care providers and patients with information about treatment alternatives;
 - Reviewing the competence or qualifications of health care professionals, including peer review activities, credentialing and training;
 - Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
 - Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity; and
 - Business management and general administrative activities of the entity, including customer service, resolution of internal grievances; the sale, transfer, merger, or consolidation of all or part of the covered entity, and creating de-identified health information or a limited data set, and fundraising for the benefit of the covered entity.
 - In the event specific patient cases are discussed at Medical Staff conferences, such as Tumor Boards and Breast Conferences, Grand Rounds, Surgical M&M, or Trauma Conferences, the participants of the conference will take the necessary steps to ensure patient privacy by not disclosing protected health information that is not necessary for the purposes of the conference. Disclosure of PHI during a medical staff conference may not be necessary, and, therefore, such a disclosure could be a violation of the minimum necessary requirements of HIPAA.

D. SPECIAL SITUATIONS

1. Psychiatric Health Information

- i. **General** - The Health Information Management Department controls all requests for information related to patients who have received psychiatric care. Section 52-146e of the Connecticut General Statutes provide for disclosure of psychiatric information with a written authorization from the patient or his/her authorized representative provided the consent specifies "to what person or agency the information is to be disclosed and to what use it will be put." The following statement must be attached to all disclosures of information from psychiatric health records:

“The confidentiality of this record is required under Chapter 899 of the Connecticut General Statutes. This material shall not be transmitted to anyone without written authorization as provided in the aforementioned statutes.”

Written authorization for disclosure of psychiatric information is not required in certain circumstances enumerated in Connecticut General Statute § 52-146a, *et. seq.*, (a list of these allowable disclosures is available from the Hospital main Medical Record Department Manager and other designated staff).

ii. **Psychotherapy Notes** - If a record contains psychotherapy notes, a special authorization by the patient is required for the release of these records except for the following circumstances:

- Use of psychotherapy notes by the originator of the note for treatment (A special Authorization is required for use and disclosure related to payment and most healthcare operations as per Connecticut law.),
- Use by the Hospital for training purposes, or
- Use in defense of any legal action brought by the patient, or
- A use or disclosure that is required or permitted by law:
 - a) To a public health authority for the purpose of preventing or controlling disease, injury, or disability;
 - b) To a public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect;
 - c) To the U.S. Food and Drug Administration;
 - d) To a health oversight agency with respect to the oversight of the originator of the psychotherapy notes;
 - e) To a coroner, medical examiner, or funeral director; or,
 - f) To prevent or lessen a serious or imminent threat to the health or public safety of a person or the public and is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

An authorization for release of psychotherapy notes may not be combined with any other authorization.

Psychotherapy notes will be physically segregated from the remaining health record.

Any request for Psychotherapy Notes shall be forward to the Privacy Officer, Director of Medical Records or Director of Risk Management.

2. **Release of Information From Alcohol and Drug Abuse Program Records**

- i. The confidentiality of alcohol and drug abuse patient records is protected by Federal law and regulations. Generally, Stamford Hospital may not disclose to a person outside the treatment program that a patient participates in a treatment program, or disclose any information identifying a patient as an alcohol or drug abuser unless:
- The patient consents in writing;
 - The disclosure is allowed by a court order; or
- ii. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation. The Hospital may not disclose a minor patient's participation in a drug or alcohol abuse program without the minor patient's consent.

- iii. Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.
- iv. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under Connecticut law to appropriate authorities.
- v. The restriction on release of alcohol and substance abuse records only applies to records of patients who are in a formal alcohol or substance abuse program, and not to general medical/surgical records which may contain information about alcohol or substance abuse.

Any attempt to subpoena or otherwise obtain drug and alcohol use treatment records shall be referred to the Director of Risk Management, or the Director of Medical Records

3. Release Of Information From Record of a Minor Treated for Venereal Disease

- i. Sec. 19a-216 of the Connecticut Statutes prohibits release of information from the health record of a minor treated for venereal disease, including the sending of a bill for such services to any person other than the minor, without the written consent of the minor.
- ii. All requests for records containing information about venereal diseases of minor should be referred to the Risk Management.

E. ACCOUNTING FOR DISCLOSURES:

- 1. Sufficient records of disclosures of PHI must be maintained in order to satisfy the Hospital's obligation to provide an accounting of disclosures upon request by a patient. An individual has a right to receive an accounting of disclosures of protected health information made by the Hospital in the three years prior to the date on which the accounting is requested, except for disclosures:
 - i. To carry out treatment, payment and health care operations;
 - ii. To individuals of protected health information about them;
 - iii. Incident to a use or disclosure otherwise permitted or required by HIPAA;
 - iv. Pursuant to an authorization;
 - v. For the facility's directory or to persons involved in the individual's care;
 - vi. For national security or intelligence purposes;
 - vii. To correctional institutions or law enforcement officials as provided in § 164.512(k)(5) of the HIPAA regulations; or §164.528(a)(1)(v)
 - viii. As part of a limited data set in accordance with § 164.514(e) of the HIPAA regulations

2. The Hospital must provide the individual with a written accounting that meets the following requirements:
 - i. The accounting must include disclosures of protected health information that occurred during the three years (or such shorter time period at the request of the individual) prior to the date of the request for an accounting, including disclosures to or by business associates of the Hospital.
 - ii. The accounting must include for each disclosure:
 - The date of the disclosure;
 - The name of the entity or person who received the protected health information and, if known, the address of such entity or person;
 - A brief description of the protected health information disclosed; and
 - A brief statement of the purpose of the disclosure that reasonably informs the individual of the basis for the disclosure or, in lieu of such statement, a copy of a written request for a disclosure under §§ 164.502(a)(2)(ii) or 164.512, if any.
 - iv. If there are multiple disclosures of protected health information to the same person or entity for a single purpose, the accounting must also include the frequency or number of the disclosures made during the accounting period, and the date of the last such disclosure during the accounting period.
 - v. If the Hospital has made disclosures of protected health information for a particular research purpose for 50 or more individuals, the accounting may provide:
 - a) The name of the protocol or other research activity;
 - b) A description, in plain language, of the research protocol or other research activity, including the purpose of the research and the criteria for selecting particular records;
 - c) A brief description of the type of protected health information that was disclosed;
 - d) The date or period of time during which such disclosures occurred, or may have occurred, including the date of the last such disclosure during the accounting period;
 - e) The name, address, and telephone number of the entity that sponsored the research and of the researcher to whom the information was disclosed; and
 - f) A statement that the protected health information of the individual may or may not have been disclosed for a particular protocol or other research activity.

If the Hospital provides an accounting of PHI disclosed for research purposes, the Hospital shall, at the request of the individual, assist in contacting the entity that sponsored the research and the researcher.
- c. The Hospital must act on the individual's request for an accounting, no later than 60 days after receipt of such a request, as follows.
 - iv. The Hospital must provide the individual with the accounting requested; or
 - v. If the Hospital is unable to provide the accounting within 60 days, the Hospital may extend the time to provide the accounting by no more than 30 days, provided that the Hospital notifies the individual with a written statement of the reasons for the delay and the date by which the Hospital will provide the accounting.
 - vi. The first accounting to an individual in any 12 month period will be without charge. The Hospital may impose a reasonable, cost-based fee for each subsequent request for an accounting by the same individual within the 12 month period, provided that

the Hospital informs the individual in advance of the fee and provides the individual with an opportunity to withdraw or modify the request for a subsequent accounting in order to avoid or reduce the fee.

F. Business Associates

1. **Definition:** Business associate means a person or entity who is not a member of the Hospital's workforce that, on behalf of the Hospital, performs, assists in the performance of, or provides:
 - iv. A function or activity involving the use or disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and re-pricing;
 - v. Legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for the hospital, where the provision of the service involves the disclosure of individually identifiable health information from the hospital, or from another business associate of the hospital, to the person; or
 - vi. Any other function or activity regulated by the Privacy Rule.
2. **General Rule:** Disclosure of PHI may be made to a business associate, and a business associate may be allowed to create or receive PHI on behalf of the hospital, if the hospital has a written contract or agreement with the business associate, or a separate business associate agreement, that meets the requirements set forth in the Privacy Rule.
3. **Procedure:** Materials Management and the responsible Hospital Department will maintain a list of persons and entities with which the hospital has such a business associate contract or agreement. Only those persons and entities on this list are to be considered business associates of the hospital.

G. Fundraising

1. **General Rule:** The hospital may, without an authorization, use, or disclose to a business associate or to the Stamford Hospital Foundation, Inc., the following PHI for the purpose of raising funds for the hospital's own benefit:
 - i. Demographic information relating to a patient; and
 - ii. Dates of health care provided to a patient
2. **Opt Out:** All fundraising materials must include a description of how the individual may opt out of receiving any further fundraising communications, and the hospital must make reasonable efforts to ensure that individuals who decide to opt out of receiving future fundraising communications are not sent such communications.

H. Training

1. **General Rule:** All members of the hospital's workforce must be trained on the policies and procedures with respect to PHI, as necessary and appropriate for the members of the workforce to carry out their function within the hospital.

2. Procedure:

- i. Each new member of the workforce must be trained within a reasonable period of time after the person joins the workforce.
 - ii. Each member of the workforce whose functions are affected by a material change in the policies or procedures required by the Privacy Rule must be trained within a reasonable period of time after the material change becomes effective.
 - iii. Training of the workforce is an annual mandatory requirement.
- 3. Documentation:** All training must be documented. A written or electronic record of all training must be maintained for six years from the date of the training.

I. UNAUTHORIZED DISCLOSURES

1. Any individual aware of an unauthorized disclosure or potential unauthorized disclosure shall immediately report the unauthorized disclosure to the Privacy Officer. A potential unauthorized disclosure may include the loss of control of PHI data, including the inability to locate health record files, the loss or potential unauthorized access of a computer with PHI on it or the unauthorized access to PHI.
2. Employees responsible for unauthorized disclosures may be disciplined pursuant to Human Resource policies. Members of the Medical Staff responsible for unauthorized disclosures may be disciplined pursuant to the Medical Staff Bylaws, Policies and Rules & Regulations. The nature and extent of the discipline will be based upon the type of unauthorized disclosure.
3. To the extent practicable, the Hospital will mitigate any harmful effect that is known to the Hospital of a use or disclosure of PHI in violation of the hospital's policies and procedures or the requirements of the Privacy Rule, by the hospital or its business associates.

J. NOTIFICATION OF AN UNAUTHORIZED DISCLOSURE

1. In the event the Hospital is aware of an unauthorized breach of unsecured PHI, the Hospital is required to notify the individual if the disclosure poses a significant risk of harm to the individual. For purposes of this section the following definitions apply:
 - i. Unsecured PHI means protected health information that is not usable, readable or decipherable to unauthorized individuals.
 - ii. Breach means the acquisition, access, use or disclosure of PHI in a manner not permitted by this Policy and HIPAA which poses a significant risk of financial, reputational or other harm to an individual.
2. It shall be the responsibility of the Privacy Officer, in consultation with senior management, to determine whether notification is appropriate. In considering whether impermissibly disclosure poses a significant risk of harm to the individual, the Hospital shall perform a risk assessment, considering:
 - i. Who the PHI was impermissibly disclosed to;
 - ii. Whether steps to eliminate or reduce the risk of harm to the individual no longer make the disclosure a "significant risk" of harm; and
 - iii. What type of PHI was involved in the impermissibly disclosure.

3. **Timing:** The method and manner of notification depends on the scope of the breach. All notifications of a breach must be made without unreasonable delay and in no case later than 60 days after the discovery of the breach. A breach is treated as discovered on the day the breach is known to the Hospital or a business associate of the Hospital, (including any person, other than the individual committing the breach, that is an employee, officer or other agent of the entity/associate) or should reasonably have known.
4. **Manner of Notification:**
 - i. **All individuals** - Written notice to the individual (or next of kin if the individual is deceased) at the last known address of the individual (or next of kin) by first-class mail (or by electronic mail if specified by the individual).
 - ii. **Insufficient or out-of-date contact information** – If the Hospital has insufficient or out-of-date contact for the individual, substitute notice may be used if it is reasonably calculated to reach the individual. In the case in which there is insufficient or out-of-date contact information for more than 10 individuals, substitute notice must be conspicuously posted on the home page of the Hospital’s website for 90 days.
 - iii. **Imminent risk of misuse** - In cases that the entity deems urgent based on the possibility of imminent misuse of the unsecured PHI, notice by telephone or other method is permitted in addition to the above methods.
 - iv. **500 or more individuals affected** –
 - a) Notice to prominent media outlets within the State or jurisdiction;
 - b) Notice to the Secretary by covered entities immediately.
 - c) Posting by the Secretary on an HHS Web site of a list that identifies each Hospital involved in the breach.
 - ii. **Annual Reports** - In addition, to the notifying the Secretary immediately for breaches affecting 500 or more individuals, all other breaches shall be reported to the Secretary annually.
5. **The notification to the individual must include:**
 - i. A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known;
 - ii. A description of the types of unsecured PHI that were involved in the breach (such as full name, Social Security number, date of birth, home address, account number, or disability code);
 - iii. The steps individuals should take to protect themselves from potential harm resulting from the breach;
 - iv. A brief description of what the Hospital involved is doing to investigate the breach, to mitigate losses, and to protect against any further breaches; and
 - v. Contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, Web site, or postal address.

K. Organized Health Care Arrangement

Members of the Medical Staff are deemed to be part of an Organized Health Care Arrangement, as that term is defined by the Privacy Rule for purposes of HIPAA and the Privacy Rule. Members of the Medical Staff shall abide by the terms of Stamford Hospital's Privacy Notice with respect to PHI created or received by them as part of their participation in treatment, payment, and health care operations at or for Stamford Hospital. SHS will provide a copy of the Privacy Notice to patients on behalf of participants in the Organized Health Care Arrangement at each Affiliated Covered Entity sites.

L. Disclosures by Telephone or Facsimile

Disclosures of PHI made by telephone or facsimile shall be in accordance with the procedures set forth in Stamford Hospital's Medical Records Policy.

M. Disciplinary Action

No employee, Medical Staff member, agent and contractor of Stamford Hospital shall intimidate, threaten, coerce, discriminate against, or take other retaliatory action against individuals and others for exercising any rights under federal or state law relative to the privacy of their PHI.

Any violation of this policy shall be handled as follows:

- i. Violations of this policy by an employee of Stamford Hospital may be subjected to disciplinary action as described in Human Resources Corrective Action Policy.
- ii. Violation of this Policy by a member of the Medical Staff may be subjected to disciplinary action in accordance with the Medical Staff Bylaws, Rules and Regulations.

STAMFORD HOSPITAL

Clinical Service Manual

Subject: MEDICAL AND ANCILLARY STAFF CODE OF CONDUCT

Policy #: MS 210

Implemented:

Reference:

Revisions:

Approval: Senior V. P. Medical Affairs; MEC

Reviewed: 11/6/2017

Department: Medical and Ancillary Staff &
Administration

Page: 1 of 6

Purpose:

The purpose of this policy is to ensure safe and high quality patient care by promoting a safe, cooperative and professional health care work environment. By encouraging a fair and just culture, the aim is to prevent and eliminate conduct that disrupts operations of the Hospital, adversely affects the ability of hospital personnel to do their jobs or creates a hostile work environment for employees or other Medical and Ancillary Staff members.

High standards of professional behavior, ethics, and integrity are expected of all members of the Stamford Hospital Medical and Ancillary Staff. This code is a statement of the ideals and guidelines for professional behavior of the Medical and Ancillary Staff, aiming for exemplary patient care and trust, integrity, and honesty in all dealings with patients, families, other health professionals, employees, students, vendors, government agencies and others. Although this policy is for members of the Medical and Ancillary Staff it also reflects the values and expectations of Stamford Hospital regarding the behavior of everyone associated with our institution.

Policy:

This policy applies to members of the Stamford Hospital Medical and Ancillary Staff – Physicians, Dentists, Podiatrists and the Ancillary Staff- Advanced Practice Nurses, Physician’s Assistants, Ph.D.’s, CRNA’s, Psychologists. This policy applies to behavior directed towards any individual associated with Stamford Hospital. The policy may also apply to behavior that occurs outside of the physical boundaries of Stamford Hospital if it is directed towards anyone directly or indirectly associated with Stamford Hospital.

I. Standard of Conduct

It is the policy of The Stamford Hospital that all persons within its facilities be treated with courtesy, respect and dignity. To that end, all Medical and Ancillary Staff members shall conduct themselves in a professional and cooperative manner. Medical and Ancillary Staff members who engage in unacceptable or disruptive conduct shall be subject to disciplinary action in accordance with the corrective action procedures set forth in The Stamford Hospital Medical Staff Bylaws. This Standard of Conduct also applies to the use of electronic and social media as set forth in the Stamford Hospital Social Media Use Policy.

A. Definitions:

“Appropriate behavior” means any reasonable conduct to advocate for patients, to recommend

improvements in patient care, to participate in the operations, leadership or activities of the organized Medical and Ancillary Staff, and to speak at their meeting or to engage in professional practice, including a practice that may be in competition with the hospital.

“Inappropriate behavior” means conduct that is unwarranted, unprofessional, or is reasonably interpreted to be demeaning or offensive to any individual or group. Persistent, repeated inappropriate behavior can become a form of harassment and thereby become disruptive, and subject to treatment as “disruptive behavior.”

“Disruptive behavior” means any conduct which interferes with the cooperative and collegial atmosphere that is required for the delivery of quality health care. Disruptive behavior may include overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities. Disruptive behavior may also include abusive conduct, including sexual or other forms of harassment, or other forms of verbal or non-verbal contact including that communicated via electronic or social media that harms or intimidates others to the extent that their ability to perform their work and deliver quality and safe patient care could be compromised.

“Harassment” means conduct toward others based on their race, religion, age, gender, gender identity, sexual orientation, nationality or ethnicity, which has the purpose or direct effect of unreasonably interfering with a person’s work performance or which creates an offensive, intimidating or otherwise hostile work environment.

“Sexual harassment” means unwelcome sexual advances, requests for sexual favors, or unwelcome conduct of a sexual nature which has the purpose or effect of unreasonably interfering with a person’s work performance or which creates an offensive intimidating or otherwise hostile work environment.

“Medical and Ancillary Staff member” means physicians and other health care professionals granted membership on the Medical and Ancillary Staff and, for purposes of this Code, includes individuals with temporary clinical privileges.

B. Types of Conduct:

1. **Appropriate Behavior** – the following are examples of appropriate behavior that in itself will not subject the individual to disciplinary action: Medical and Ancillary Staff
 - a. Criticism communicated in a confidential and reasonable manner and offered in good faith with the aim of improving patient care and safety, and the ideals of Stamford Hospital;
 - b. Encouraging clear communication in appropriate settings;
 - c. Expressions of concern about a patient’s care and safety in a productive and respectful manner to Medical and Ancillary Staff leadership, Stamford Hospital management or members of the patient's health care team;
 - d. Expressions of dissatisfaction with policies through appropriate grievance channels or other civil non-personal means of communication;
 - e. Constructive criticism conveyed in a respectful and professional manner, without blame or shame for adverse outcomes;
 - f. Professional comments to any professional, managerial, supervisory, or administrative staff responsible for peer review, risk management or health care

- operations specific to the comments about patient care provided by others, or members of the Board of Directors about patient care provided by others;
- g. Membership on other medical and ancillary staffs.

2. Inappropriate Behavior

Inappropriate behavior by Medical and Ancillary Staff members is unacceptable.

Examples of inappropriate behavior may include, but are not limited to, the following:

- a. Belittling or berating statements;
- b. An inappropriate tone of voice or gesture;
- c. Name calling;
- d. Use of profanity or disrespectful language;
- e. Inappropriate comments written in the medical record;
- f. Failing to respond to patient care needs or staff requests;
- g. Personal sarcasm or cynicism;
- h. Deliberate lack of cooperation without good cause;
- i. Refusal to return phone calls, pages, or other messages concerning patient care or safety;
- j. Intentionally condescending language; and
- k. Intentionally degrading or demeaning comments regarding patients and their families; nurses, physicians, hospital personnel and/or the hospital.

3. Disruptive Behavior

Disruptive behavior by Medical and Ancillary Staff members is prohibited. Examples of disruptive behavior include, but are not limited to, the following:

- a. Physically threatening language directed at anyone in the hospital including physicians, nurses, other Medical and Ancillary Staff members, or any hospital employee, volunteer, resident physician or student, administrator or member of the Board of Directors;
- b. Physical contact with another individual that is threatening or intimidating;
- c. Throwing instruments, charts or other objects;
- d. Threats of violence or retribution;
- e. Sexual harassment; and,
- f. Other forms of harassment including, but not limited to, persistent inappropriate behavior and repeated threats of litigation.

II. Interventions

Interventions should initially be non-adversarial in nature, if possible, with the focus on restoring trust, placing accountability on and rehabilitating the offending Medical and Ancillary Staff member, and protecting patient care and safety. The Medical and Ancillary Staff supports tiered, non-confrontational collegial intervention strategies, starting with informal discussion of the matter with the appropriate section chief or department chairperson.

Corrective action pursuant to the Medical Staff bylaws may be activated if the behavior is or becomes disruptive. The use of summary suspension, as defined in the Bylaws, is a serious action implemented in circumstances including, but not limited to, situations in which failure to take such action may result in an imminent danger to the health of any individual. At any time, rehabilitation may be recommended. If there is reason to believe inappropriate or disruptive behavior is due to illness or impairment, the matter may be evaluated and managed confidentially according to the established procedures of the Stamford Hospital Physician Wellness Committee (or equivalent committee).

III. Procedure

Complaints about a member of the Medical or Ancillary Staff regarding allegedly inappropriate or disruptive behavior can be made to the individual's supervisor, a member of the Hospital administration or the President of the Medical Staff. If a report is not made directly to the President of the Medical Staff, the person receiving the report should advise the SVPMA/Chief Medical Officer or the President (or Vice President) of the Medical Staff of the nature of the report.

The person making the complaint should do so in writing and include, to the extent feasible, the following:

1. Date(s), time(s) and location of the inappropriate or disruptive behavior;
2. A factual description of the inappropriate or disruptive behavior;
3. Circumstances surrounding the incident;
4. Name or medical record number of any patient or patient's family member who was involved in or witnessed the incident;
5. Names of other witnesses to the incident;
6. Consequences, if any, of the inappropriate or disruptive behavior as it relates to patient care or safety, or hospital personnel or operations; and
7. Any action taken to intervene in, or remedy, the incident, including the names of those intervening.

The President of the Medical and Ancillary Staff, or appropriate designee, will inform the Senior Vice President for Medical Affairs/Chief Medical Officer and the Department Chair as soon as possible after the complaint is received either verbally or in writing. The complainant will be provided a written acknowledgement of the complaint. Complaints submitted by the Patient Safety Hotline, QASYS, or through risk management will be handled in the same way as a formal written complaint.

In all cases, the President of the Medical and Ancillary Staff and Senior Vice President for Medical Affairs/Chief Medical Officer shall initially review the complaint to determine whether an investigation is necessary.

- If the complaint is deemed to be not valid or is not an appropriate complaint pursuant to this policy, no review is necessary.
- If the complaint is deemed to be valid and is an appropriate complaint pursuant to this policy does warrant further review, the subject of the complaint shall be provided a copy of this Code of Conduct and a copy of the complaint (which should, as best as possible, not include identifying information on the reporter) in a timely fashion. The individual will be notified that attempts to confront, intimidate, or otherwise retaliate against the complainant is a violation of this Code of Conduct and may result in corrective action against him or her.
 - An ad hoc committee, none of the members of which may be economic competitors of the subject of the complaint, consisting of the President or Vice President of the Medical and Ancillary Staff, or designee, and at least two additional members of the medical executive committee, shall review as appropriate in the circumstances.
- If the individuals involved in the alleged conduct are visitors, employees or contractors of Stamford Hospital, all reviews shall be coordinated through the Senior Vice President for

Medical Affairs/Chief Medical Officer. With approval of the Senior Vice President for Medical Affairs/Chief Medical Officer, the investigation may include seeking to interview the complainant, any witnesses, and the subject of the complaint.

- The subject Medical or Ancillary Staff member shall be provided an opportunity to respond in writing to the complaint.

The Ad Hoc committee shall make one of the following recommendations to the President of the Medical Staff:

1. No further action is necessary as the review did not reveal any disruptive or inappropriate behavior. Such recommendation shall be made by written report summarizing the findings of the ad hoc committee and the basis for the recommendation. Or
2. Action is necessary because the review did reveal disruptive and/ or inappropriate behavior. Actions may include a recommendation for intervention or corrective action pursuant to the Stamford Hospital Medical Staff Bylaws. Such recommendation shall be made by written report summarizing the findings of the ad hoc committee and the basis for the recommendation.
 - a. When making a recommendation for intervention or corrective action, the Ad Hoc Committee should consider the following:
 - i. Initial Violation of the Code of Conduct
 1. In the first violation, especially if defined as Inappropriate, of the Code of Conduct the Chair of the department (or the appropriate section chief if designated by the chair) will review the matter with the subject of the review, and emphasize that the behavior is inappropriate and must cease. Further actions including an apology to the complainant may be required. The approach during this initial intervention should be collegial and helpful.
 2. If Disruptive, more actions may be recommended and required, see below.
 - b. Repeated Violations of the Code of Conduct
 - i. If the ad hoc committee determines the Medical/Ancillary Staff member has demonstrated persistent, repeated inappropriate behavior, constituting harassment (a form of disruptive behavior), or has engaged in disruptive behavior on the first offense, a letter of admonition will be sent to the subject of the complaint, and, as appropriate, a rehabilitation action plan developed by the ad hoc committee, with the advice and counsel of the medical executive committee.
 - ii. If, in spite of this admonition and intervention, disruptive behavior recurs, the ad hoc committee shall meet with and advise the individual that such behavior must immediately cease or corrective action will be initiated. This “final warning” shall be sent to the in Medical/Ancillary Staff member in writing.

5. If after the “final warning” the disruptive behavior recurs, corrective action (including suspension or termination of privileges) shall be initiated pursuant to the Medical Staff bylaws Section 13.1, and the offending Medical and Ancillary Staff member shall have all of the due process rights set forth in the Medical and Ancillary Staff bylaws.
6. If a single incident of disruptive behavior or repeated incidents of disruptive behavior constitute an imminent danger to the health of an individual or individuals or is egregious in nature, the offending Medical and Ancillary Staff member may be summarily suspended as provided in the Medical and Ancillary Staff bylaws. The Medical/ Ancillary Staff member shall have all of the due process rights set forth in the Medical Staff bylaws.
7. If no corrective action is taken pursuant to the Medical Staff bylaws, a confidential memorandum summarizing the disposition of the complaint, along with copies of any written warnings, letters of apology, and written responses from the offending Medical and Ancillary Staff member, shall be retained in the staff member’s credentials file. Informal rehabilitation, a written apology, issuance of a warning, or referral to the Wellness Committee (or equivalent committee) will not constitute corrective action.
8. At any time during this procedure the Medical/Ancillary Staff member has a right to personally retain and be represented by legal counsel. However, such right does not entitle the practitioner to have their legal counsel attend any meeting between the practitioner and the Medical and Ancillary Staff or Hospital leadership or the ad hoc investigative committee.

IV. Abuse of Process

Threats or actions directed against the complainant by the subject of the complaint will not be tolerated under any circumstance. Retaliation or attempted retaliation by Medical/Ancillary Staff members against complainants will give rise to corrective action pursuant to the Medical Staff bylaws.

Individuals who falsely submit a complaint may be subject to corrective action under the Medical and Ancillary Staff bylaws or hospital employment policies, whichever applies to the individual. Refer to the Non-retaliation policy for further information.

**STAMFORD HOSPITAL
Clinical Service Manual**

Subject:	Delirium Prevention, Identification, and Treatment Guidelines		
Implemented:	November 2016		
Committee Approval:	Nursing Professional Practice Medical Executive committee	Reviewed:	November 2016
VP Approval:	V.P. Patient Service, Sr. V.P., Medical Affairs	Revised:	January 13, 2017
Departments Affected:	Physicians & Nursing	Page:	1 of 9

Purpose:

To enhance the recognition and management of delirium, both hypoactive and hyperactive, on the medical/surgical units.

Policy:

All at risk patients (>65 years old, post-op patients, pts with an established diagnosis of cognitive impairment/dementia, alcohol or drug withdrawal patients) will have special measures (Procedure section, starting page 3) in place to prevent/minimize the occurrence of delirium and to increase diagnosis of delirium.

Anytime a change in mental status is noted in the above population during a medical or surgical inpatient stay the nurse will perform the Short Form Confusion Assessment Method (hereafter referred to as CAM-appendix A) and relay a positive score on the assessment to the attending physician or designee as well as document the diagnosis of delirium in Meditech. In addition, any patient admitted with diagnosis or history of dementia, Alzheimer's Disease, Mild Cognitive Impairment, Lewy Body Dementia or any other cognitive impairment will have the CAM administered routinely as part of daily rounds. The Physician Reference Card for Delirium is available for diagnostic guidance.

The CAM will be administered to patients who have been identified as delirious during each shift change by the nurse and documented in Meditech. Likewise any patient with a pre-existing cognitive impairment as listed above who screens positive for delirium will also then be screened every shift by the nurse and documented in Meditech.

Definitions:

- Delirium is a syndrome characterized by a disturbance of consciousness, impaired attention and a change in cognition that develops over a short period of time and fluctuates over the course of the day; delirium is waxing and waning.
- Delirium is a diagnosis of exclusion in that other medical conditions such as infection, metabolic derangements, over or under utilization of certain medications, and cardio/cerebrovascular events must be excluded prior to officially confirming the diagnosis.
- Delirium more commonly occurs in patients who have chronic medical conditions, are older, or have some underlying cognitive impairment. Approximately 15% of all hospitalized patients develop delirium however only approximately 15%-20% of these patients are identified as such upon hospital discharge. This is more common in post-operative patients, elderly patients over the age of 80 and patients with cognitive impairment. Delirium is associated with higher rates of re-hospitalization and higher mortality rates.
- The Richmond Agitation-Sedation Scale (RASS) is a reliable assessment tool used to evaluate a patient's level of agitation or sedation to guide medical management
- The Short Form Confusion Assessment Method (CAM) is a validated screening tool for identification of Delirium (Reference: Attachment A)
- The Three A's:
 - Apraxia – inability to perform simple tasks
 - Agnosia – inability to recognize common persons or things (auditory, tactile, visual)
 - Aphasia – inability to use or understand language

Procedure:

- Preventative measures in place on the medical and surgical floors include:
 - White board for orientation of patients
 - Limited nighttime interruptions
 - Minimizing the number of lines and tethers
 - Out of bed as soon as possible

- All patients admitted to the medical or surgical floors with a *change in mental status* will be assessed for delirium

- All patients admitted to the medical or surgical floors with diagnosis or history of dementia, Alzheimer's Disease, Mild Cognitive Impairment, Lewy Body Dementia or any other cognitive impairment will have the CAM administered routinely as part of daily rounds.

- Change in mental status includes not only hyperactivity/agitation but also lethargy

- At the point of recognition of acute agitation/hyperactivity, the patient will be assessed using RASS for baseline

- Pharmacological and non-pharmacological interventions will be implemented as per the RASS scoring system for the acutely agitated patient, with a goal to utilize non-pharmacologic interventions first

- In addition to the RASS, the CAM will also be performed for agitated patients

CAM Administration:

- Nursing staff will administer the CAM to assess for delirium (**See Attachments A and B**)

- Nursing staff will have been previously trained in the administration and scoring of the CAM

- Once a patient is identified as having delirium the nursing staff will perform the CAM every shift until patient score has normalized

- When patient is assessed as having delirium the Attending Physician will be notified to discuss any work up or interventions needed

- The diagnosis of delirium will be added to the problem list in Meditech and a medical work-up to rule out organic causes will be performed outlined by an order set for delirium at the attending physician's (or designee's) discretion based on patient's condition and comorbidities.
- Non-pharmacologic interventions will be provided by the nursing staff. Non-pharmacologic interventions include:
 - a) Orientation
 - Provide visual and hearing aids
 - Reorient the patient frequently and encourage communication
 - Have familiar objects in the patients room
 - Encourage family and friends to spend time with the patient (**See Attachment D for Education**)
 - 4 R's – REPEAT, REDIRECT, REINFORCE & REASSURE
 - b) Environment
 - Promote sleep hygiene: dark room at night, quiet room, fewer interruptions; shades open and lights bright during the day
 - Provide Early Mobility-PT consult, OOB to chair, ambulate three times daily
 - Lower room temperature
 - Consider a room close to the nurse's station for frequent monitoring
 - Constant observation if necessary;
 - Remove catheters and IV's if possible
 - c) Additional Interventions
 - Spiritual support
 - Touch and massage therapy
 - Music therapy

- Pet therapy
- Volunteer support

d) Pharmacologic Interventions

- Physician may refer to **The Physician Reference Card for Delirium** for management of identified patient (maintained in the Division of Geriatric Medicine)
- For hyperactive delirium that is not responding to non-pharmacologic interventions and treatment of the underlying cause (infection, over sedation, uncontrolled pain) is not sufficient to decrease the patients hyperactive delirium low doses of medications can be administered (as per Physician Reference Card for Delirium)

e) Consult

- For patients with difficult to manage hyper or hypoactive delirium a psychiatric, geriatric or neurologic consult should be considered

f) Hospital Discharge

- Patient education materials should be provided to the family on delirium-attached
- A diagnosis of delirium should be in the patients chart and discharge summary
- Instructions to outpatient physician or rehabilitation/long term care facility on the tapering of anti-psychotics should be clear
- Ensure that appropriate post-acute discharge resources are in place. (i.e. home care, follow up instructions, outpatient services and any other resource identified for the patient)

See Additional Attachments:

- **CAM (Attachment A)**
- **CAM Meditech Screen Shot (Attachment B)**
- **Patient/Family Education (Attachment C)**

CAM – Attachment A

CONFUSION ASSESSMENT METHOD (CAM) SHORTENED VERSION WORKSHEET

EVALUATOR:

DATE:

I. ACUTE ONSET AND FLUCTUATING COURSE

a) Is there evidence of an acute change in mental status from the patient's baseline?

No _____

b) Did the (abnormal) behavior fluctuate during the day, that is tend to come and go or increase and decrease in severity?

No _____

II. INATTENTION

Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?

No _____

III. DISORGANIZED THINKING

Was the patient 's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?

No _____

IV. ALTERED LEVEL OF CONSCIOUSNESS

Overall, how would you rate the patient's level of consciousness?

-- Alert (normal)

- Vigilant (hyperalert)
- Lethargic (drowsy, easily aroused)
- Stupor (difficult to arouse)
- Coma (unarousable)

Do any checks appear in this box?

No _____

BOX 1

Yes

Yes _____

Yes _____

BOX 2

Yes

Yes _____

If all items in Box 1 are checked and at least one item in Box 2 is checked a diagnosis of delirium is suggested.

Confusion Assessment Method.© 1988, 2003, Hospital Elder Life Program. All rights reserved. Adapted from: Inouye SK et al. Ann Intern Med. 1990; 113:941-8.

CAM Tool Meditech Sample Screen Shots – Attachment B

ACUTE ONSET AND FLUCTUATING COURSE	
Evidence of acute change in mental status?	<input checked="" type="radio"/> Yes <input type="radio"/> No
Did the (abnormal) behavior fluctuate during the day?	<input checked="" type="radio"/> Yes <input type="radio"/> No
INATTENTION	
Did the patient have difficulty focusing attention?	<input checked="" type="radio"/> Yes <input type="radio"/> No
DISORGANIZED THINKING	
Was the patient's thinking disorganized or incoherent?	<input checked="" type="radio"/> Yes <input type="radio"/> No
ALTERED LEVEL OF CONSCIOUSNESS	
Overall, rate the patient's level of consciousness?	<input type="radio"/> Alert (normal) <input type="radio"/> Vigilant (hyperalert) <input checked="" type="radio"/> Lethargy (drowsy) <input type="radio"/> Stupor (difficult arouse) <input type="radio"/> Coma (unarousable)
CALCULATING POSITIVE/NEGATIVE DELIRIUM	
Positive or Negative for Delirium?	<input type="text" value="Positive"/> Confusion Assessment Method. © 1988, 2003, Hospital Elder Life Program. All rights reserved. Not to be reproduced without permission. Instructions for correct usage available at: http://www.hospitalelderlifeprogram.org

ACUTE ONSET AND FLUCTUATING COURSE	
Evidence of acute change in mental status?	<input type="radio"/> Yes <input checked="" type="radio"/> No
Did the (abnormal) behavior fluctuate during the day?	<input type="radio"/> Yes <input checked="" type="radio"/> No
INATTENTION	
Did the patient have difficulty focusing attention?	<input type="radio"/> Yes <input checked="" type="radio"/> No
DISORGANIZED THINKING	
Was the patient's thinking disorganized or incoherent?	<input type="radio"/> Yes <input checked="" type="radio"/> No
ALTERED LEVEL OF CONSCIOUSNESS	
Overall, rate the patient's level of consciousness?	<input checked="" type="radio"/> Alert (normal) <input type="radio"/> Vigilant (hyperalert) <input type="radio"/> Lethargy (drowsy) <input type="radio"/> Stupor (difficult arouse) <input type="radio"/> Coma (unarousable)
CALCULATING POSITIVE/NEGATIVE DELIRIUM	
Positive or Negative for Delirium?	<input type="text" value="Negative"/> Confusion Assessment Method. © 1988, 2003, Hospital Elder Life Program. All rights reserved. Not to be reproduced without permission. Instructions for correct usage available at: http://www.hospitalelderlifeprogram.org

Patient and Family Education– Attachment C



Delirium Education for Family, Friends and Patient

Delirium is a state of acute mental confusion, meaning a person's state of mind suddenly becomes worse than usual. The key is that it's a **sudden change** from what's normal for that individual.

The main signs of delirium usually include:

- Confused thinking.
- Difficulty focusing.
- Difficulty paying attention.
- Sudden confusion comes and goes.

Delirium can change moods:

- Increased agitation or nervousness
- Aggression and resistance to care
- Quiet or withdrawn
- Very sleepy
- Hallucinations or delusions
- At times the person may act like their usual self and then fluctuate rapidly seeming altered

Patients at highest risk for delirium include

- Older adults >age 70
- Heard of hearing/poor vision
- Stroke/brain injuries
- Underlying cognitive impairment
- Withdrawal from alcohol or certain drugs

Causes of delirium: usually caused by a medical illness

- Infection (like urinary tract infection or pneumonia)
- Dehydration/fever
- Pain
- Constipation

- Chemical imbalances-low blood sugar or sodium
- Reactions to medications: pain medications, sleep medications, steroids
- Surgery
- Lack of sleep/confusing day and night

Delirium can last for hours to WEEKS to MONTHS

What we can do to help while in the hospital:

- Familiar voices are helpful; speak calmly
- Reorient the person by letting them know where they are and the date
- Be sure to bring in glasses and/or hearing aids and to use them
- Bring in a list of the patients medications
- Encourage the patient to walk as much as possible
- Alert the nurse if the patient is in pain
- Visit at meal times to ensure they get enough nutrition
- Bring in items from home that are comforting-blanket, pillow etc
- Sometimes hiring a person to stay with the patient is helpful
- Physicians may give medications to help with delirium

What we can do when the patient is home:

- Continue to reorient your loved on to their surroundings
- Ensure they drink enough fluids and eat adequately
- Ensure they walk as much as possible
- Promote normal sleep schedules
- Follow up with their doctor and call if there is a change in status
- Ensure they take their prescriptions as directed

**STAMFORD HOSPITAL
CLINICAL SERVICE MANUAL**

Subject: Temporary Privileges Policy and Procedure

References:	Joint Commission standard MS.06.01.13 Article 7.2 - Medical staff bylaws	Implemented:	April 3, 2017
Committee Approval:	Medical Executive Committee	Reviewed:	
VP Approval:	SVP Medical Affairs & Chief Medical Officer	Revised:	
Departments Affected:	All Clinical Departments	Page:	1 of 4

PURPOSE:

Stamford Hospital has the responsibility to ensure that all members of the Medical and Ancillary staffs are qualified for the privileges they exercise in the treatment of patients.

This policy describes the procedures to be followed for the processing of requests for temporary privileges in accordance with the medical staff bylaws.

POLICY:

Temporary clinical privileges are not automatically granted and must be specifically requested. In accordance with the medical staff bylaws, temporary privileges may be granted by the Hospital Chief Executive Officer (CEO) or their designee to a qualified practitioner under the circumstances and subject to the conditions stated below.

A. Urgent Patient Care or Service Need

In appropriate circumstances, upon receipt of a written request, an appropriately licensed practitioner of documented competence, who need not be an applicant for membership or privileges, may be granted temporary privileges for up to 120 days for the care of one or more specific patients or to address an important patient care or service need, such as proctoring, education and training, which may require the exercise of clinical privileges.

The following documentation is required for temporary privileges – urgent patient care or service need:

- A written request for temporary privileges using the request form provided by the Hospital.
- A copy of the practitioners current CV
- Copy of Professional Liability Insurance in a certificate form and in amounts satisfactory to the Hospital
- Unrestricted Connecticut State license
- Unrestricted Federal DEA, if appropriate
- A statement of exactly what services will be provided, the time frame for temporary privileges and the identification of any specific patient to be treated.
- A peer recommendation that establishes current competency

STAMFORD HOSPITAL
Clinical Service Manual

Subject: Temporary Privileges Policy and Procedure

Page 2 of 4

If the individual requesting temporary privileges based on urgent patient care need is also applying for regular medical staff membership and clinical privileges, temporary privileges limited to a one or more specific patients or important patient care or service need may be granted while the application is being processed.

B. Pendency of a New Application for Membership and/or Privileges

Temporary clinical privileges may be granted to applicants seeking new medical staff membership and/or privileges, provided

- a. the application is complete and all information has been verified as required by the medical staff bylaws.
- b. there are no concerns about the applicant's qualifications or competence
- c. the applicant has no current or previously successful challenge to professional licensure or registration,
- d. the applicant has not been involuntarily terminated from medical staff membership at any other organization, and there has been no involuntary limitation, reduction, denial or loss of clinical privileges at any other organization.
- e. the applicant has submitted a request for temporary privileges using the request form provided by the Hospital.
- f. The Department Chair has recommended approval of the application and it is awaiting review and recommendation of the Credentials Committee and/or Medical Executive Committee (MEC).

DEFINITION:

Patient Care Need: Clinical needs will not be adequately met if the temporary privileges under consideration are not granted (e.g., a patient needs an urgent surgery and would not be able to undergo the surgery in a timely manner.)

Service Need: The hospital cannot adequately meet certain administrative or operational needs such as precepting for new technology or privileges.

PROCEDURE:

Processing Request for Temporary Privileges

Upon receipt of the applicant's request for temporary privileges, the Medical Staff Services Department (MSSD) will notify the Department Chair of the request by electronic mail.

The Department Chair will notify the **SVP Medical Affairs & Chief Medical Officer** or their designee of the request by electronic mail with a copy to the MSSD, requesting approval to process temporary privileges.

STAMFORD HOSPITAL
Clinical Service Manual

Subject: Temporary Privileges Policy and Procedure

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The SVP Medical Affairs & Chief Medical Officer or their designee shall advise the Department Chair and the MSSD of the decision to approve or deny the request to process.

A. For Applications for Temporary Privileges for Urgent Patient Care or Service Need

MSSD will conduct primary source verification of:

1. Current Connecticut licensure
2. National Practitioner Data Bank Query and Response
3. Office of the Inspector General List of Excluded Individuals and Entities (LEIE) status
4. System for Award Management (SAM)
5. Current competence, including verification of affiliation in good standing with at least one hospital where the applicant holds unrestricted privileges, and confirmation that the practitioner currently holds the privileges requested at another hospital

The Department Chair will review the application and all documentation and indicate on the Temporary Privileges Request form whether the Chair recommends approval of the request for temporary privileges. If the Department Chair recommends that temporary privileges be granted, the request shall then be routed to the following individuals for review and recommendation:

- The Chair of the Credentials Committee or their designee
- President, Medical Staff or their designee
- SVP Medical Affairs & Chief Medical Officer or their designee

Final approval of temporary privileges shall be by the Hospital CEO or their designee

B. For New Applicants:

MSSD shall review the application for completeness and verify information with original sources to the extent possible. When all of the information on the application has been satisfactorily verified, the credentials file is sent to the Chair of the Department in which the applicant seeks membership and/or clinical privileges.

In accordance to policy "Credentialing of Track A and Track B Appointments and Reappointments," regardless of whether a file is categorized as Track A or Track B, the credentials file of any new applicant who has a malpractice history that includes claims paid or open cases must have his/her file reviewed by the Vice President, Risk Management before the file is presented to the Department Chair for review.

The Department Chair shall review the application package; sign the application, delineation of privileges, and any other documents as required. The Department Chair shall verify the applicant's current competence and ability to perform the privileges requested. The Department Chair should indicate on the Temporary Privileges Request form by signature, his/her recommendation to approve the request for temporary privileges. The Department Chair/Division Director will specify the required Focused Professional Practice Evaluation (FPPE) for the applicant. If the Department Chair recommends that temporary privileges be granted, the request shall then be routed to the following individuals for review and recommendation:

STAMFORD HOSPITAL
Clinical Service Manual

Subject: Temporary Privileges Policy and Procedure

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- The Chair of the Credentials Committee or their designee
- President of the Medical Staff or their designee
- SVP Medical Affairs & Chief Medical Officer or their designee

Final approval of temporary privileges shall be by the Hospital CEO or their designee.

Notification Process

MSSD shall record and track who has been granted temporary privileges and for how long.

MSSD shall notify the applicant of the decision by sending a letter along with a copy of the approved privileges via first class mail. A copy of the letter should be placed in the applicant's credentials file.

MSSD shall notify the Department Chair and relevant hospital departments by electronic mail of the effective date of the applicant's temporary appointment and/or clinical privileges.

MSSD will finalize the processing of the application for medical staff membership in accordance with the medical staff bylaws.

Termination of Temporary Privileges

Temporary privileges shall automatically terminate at the end of the designated period or at such time as the particular circumstances giving rise to the temporary privileges have been resolved, unless terminated sooner. Temporary privileges may be terminated with or without cause at any time by the Hospital CEO or their designee after consideration of the recommendation of the Department Chair.

Where the life or well-being of a patient is determined to be endangered by continued treatment by a practitioner exercising temporary privileges, the termination may be effected by any person entitled to impose summary action under the medical staff bylaws. In the event of such termination, the patients of such practitioner then in Stamford Hospital shall be assigned to another practitioner by the President of the Medical Staff or their designee. Where feasible, the wishes of the patient shall be considered in choosing a substitute practitioner.

Procedural Rights of Practitioners Holding Temporary Privileges

A practitioner shall not be entitled to procedural rights because of the denial of any request for temporary privileges or termination of temporary privileges. A determination to grant temporary privileges shall not be binding or conclusive with respect to an applicant's pending request for appointment to the Medical Staff and/or clinical privileges.

Request for Temporary Privileges – Pending Approval of Application

Applicant Name: _____ Department/Division: _____

To: Department Chair

I hereby request that I be granted temporary privileges for up to 120 days while my application for medical staff membership and privileges is awaiting final approval by the Board of Directors. I understand that temporary privileges are granted at the discretion of the Hospital CEO, or designee, and I am not entitled to a hearing if my request for temporary privileges is denied, or if at any time temporary privileges are withdrawn.

 Signature of Applicant

 Date

**Temporary Privileges Checklist
 Completed by Medical Staff Services**

- Track A Track B
 _____ Completed application including all required documentation received
 _____ No current or previously successful challenge to licensure or registration
 _____ Not subject to involuntary termination of medical staff membership or privileges at any other organization
 _____ NPDB report received
 _____ Practitioner not on OIG exclusion list

 Confirmed by: _____
 Signature Printed Name Date

If Track B, malpractice history has been reviewed by the Vice President, Risk Management or designee

 Confirmed by: _____
 Signature Printed Name Date

I hereby affirm that I have personally reviewed the applicant's request for temporary privileges, along with the appointment application of the above referenced practitioner and have determined that the individual meets the criteria for the privileges for which I am recommending temporary privileges.

_____	_____
Department Chair	Date
_____	_____
Credentials Committee Chair	Date
_____	_____
Medical Staff President	Date
_____	_____
SVP Medical Affairs & Chief Medical Officer	Date

APPROVED:

 By: _____
 Signature of Hospital CEO or Designee Printed Name Date

Approval Dates: From ____/____/____ to ____/____/____

Request for Temporary Privileges – Urgent Patient Care/Service Need

Temporary Privileges Checklist
Completed by Medical Staff Services

Applicant Name: _____ Department/Division: _____

Track A Track B

- _____ Completed application including all required documentation received
- _____ No current or previously successful challenge to licensure or registration
- _____ Not subject to involuntary termination of medical staff membership or privileges at any other organization
- _____ NPDB report received
- _____ Practitioner not on OIG exclusion list

Confirmed by: _____ _____ _____
Signature Printed Name Date

If Track B, malpractice history has been reviewed by the Vice President, Risk Management or designee

Confirmed by: _____ _____ _____
Signature Printed Name Date

I hereby affirm that I have personally reviewed the initial application of the above referenced practitioner and have determined that the individual meets the criteria for the privileges for which I am recommending temporary privileges – Urgent patient care/service need.

- Applicant performs specialized procedure/services that no other practitioner on staff can perform.
- Applicant is needed in order to fulfill a patient care/service need.

_____	_____
Department Chair	Date
_____	_____
Credentials Committee Chair	Date
_____	_____
Medical Staff President	Date
_____	_____
SVP Medical Affairs & Chief Medical Officer	Date

APPROVED:

By: _____ _____ _____
Signature of Hospital CEO or Designee Printed Name Date

Approval Dates: From ____/____/____ to ____/____/____

STAMFORD HOSPITAL
[Manual]

Subject: Use of Medical Staff Funds

References: **Implemented:** 12/2/2013

Committee Approval: Medical Executive Committee **Reviewed:** [date(s)]

VP Approval: Senior Vice President of Medical Affairs and Chief Financial Officer **Revised:** 05/01/2017

Departments Affected: Medical Executive Committee, Medical Affairs, Finance Department **Page:** 1 of 2

Purpose:

Medical Staff dues are a requirement of medical staff membership at Stamford Hospital and must be paid on an annual basis in order for a medical staff member to be considered in good standing. The purpose of this policy is to provide guidelines on the use of the funds in the medical staff dues account.

Policy:

To ensure that funds generated by medical staff dues are used appropriately in the support of medical staff activities and that the use of such funds is compliant with regulatory standards and is consistent with the Hospital's tax exempt status.

Guidelines and Procedures:

1. Per the Medical Staff Bylaws, medical staff dues are required of medical staff in the Active and Courtesy Staff categories. Affiliate, Honorary, Teleradiology, Locums, and Ancillary Staff are not required to pay dues.
2. There is no obligation by the Medical Executive Committee to grant any waiver of dues, unless such waiver is granted to all medical staff in the Active and Courtesy staff categories.
3. The medical staff dues are established by the Medical Executive Committee in the year preceding the year in which the dues are to go into effect. The MEC reserves the right to change the annual dues as needed in order to ensure that there are sufficient funds to support medical staff activities.

Subject:

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4. On or about September 15 of each calendar year, a notice for medical staff dues shall be sent by the Medical Staff Office to each member of the medical staff in the aforementioned staff categories with a due date. Any dues received after the due date shall be considered "late." A late fee may be assessed and the reappointment status of any medical staff member who is in arrears at the time of reappointment may be jeopardized.

5. Medical staff dues, upon receipt in the Medical Staff Services shall be duly recorded and deposited into the Medical Staff Checking Account.

6. Examples of acceptable uses of medical staff dues are but not limited to:
 - Food and other expenses associated with medical staff social events and meetings
 - Continuing education materials including online and print publications
 - Legal advice on issues that affect the medical staff such as medical staff bylaws and rules and regulations
 - Small gifts and awards for special life events such as retirement, births, relocation, etc. as approved by the President of the Medical Staff and/or the MEC
 - Charitable donations to the community for non-profit causes or organizations as approved by the President of the Medical Staff and/or the MEC
 - Any other uses must be approved by the President of the Medical Staff and/or the MEC

7. Examples of uses of medical staff dues that are deemed not appropriate include but not limited to:
 - Contributions to political campaigns and political lobbying
 - Activities and services that the Hospital is obligated to provide per contractual agreement with the Medical Staff
 - Activities that are not deemed to be in support of medical staff functions as determined by the President, Medical Staff and/or the MEC
 - Activities that would be deemed to be in non-compliance with the Stark Laws, and other regulatory standards as applicable

Subject:

Page 3 of 3

8. Discretionary approval of the use of funds by the President, Medical Staff shall be limited to \$5000 for any single purpose/event. Any amount over this limit requires the approval of the MEC. Approval by the MEC may be given prospectively, as necessary.
9. Signatories on the Medical Staff Account are the President, Medical Staff, President and CEO, Executive Vice President, COO and CFO.
10. All checks written on the Medical Staff Checking Account require the signature of the President, Medical Staff.
11. The President, Medical Staff shall report on a quarterly basis to the MEC at its regularly scheduled monthly meeting and to the Organized Medical Staff at its regularly scheduled quarterly meeting, an account balance to date, income and distribution in the account for the quarter preceding each report. The fiscal year is October 1 – September 30.
12. All hospital accounts including the Medical Staff account are audited annually by external auditors and the findings are reported to the Department of Finance and to the President of the Medical Staff.

**STAMFORD HOSPITAL
Clinical Service Manual**

Subject: Dietitian Privileges for Writing Diet Orders and Nutrition Supplements

Policy #	NTS 100	Implemented	11/1/09
References		Reviewed	11/1/11; 8/12/14 7/10/2017
Approval	V.P. of Medical Affairs MEC, P & T committee	Revised	
Departments Affected	All Clinical Departments	Page 1 of 1	

Purpose: To provide patients with appropriate diets, nutrition supplements, and nutrition therapy.

Policy: Per CMS Guidelines and CT PA 16-66 – “An Act Concerning Various Revisions to the Public Health Statutes certified registered dietitians are authorized to write orders for patient diets, including, but not limited to, therapeutic diets for patients and nutrition supplements. In addition, a dietitian can accept a verbal order from a physician or designee, which must be cosigned by the physician or designee within 72 hours after being conveyed.”

Procedure:

A. The dietitians will complete a full nutrition assessment based on the Nutrition Standards of Care and Nutrition Department policies and:

1. Order, alter, or discontinue nutritional supplements.
2. **Modify existing diet orders based on the patient’s nutrition needs and medical condition. This does not include patients with NPO order or any liquid diet orders.**
3. Downgrade or modify a patient’s current diet order to complement patient’s nutritional needs; (*i.e. physical assessment reveals patient without teeth and states unable to tolerate milk- RD may change patient’s diet from ‘regular diet’ to ‘lactose free/mechanical soft diet’; or add kosher diet to regular diet order*).
4. Accept telephone orders for PO diets or nutrition supplements from physicians or designee. **Any verbal orders taken by a dietitian need to be co-signed by a physician or designee.**

B. The dietitians will document all relevant orders as listed above in Meditech Order section. In addition, dietitians will document in their progress notes that the orders have been entered.

References:

CMS Condition of Participation 482.28 (b)
Connecticut Certified Dietitian Nutritionist Practice Act

THE STAMFORD HOSPITAL
Department of Radiology
Department
MRI

Subject: MRI GADOLINIUM – BASED CONTRAST MEDIA: Renal function screening

Policy#: DPT-MRI-300

Reference: ACR, 2016

Approval: Radiology Chairman,

Executive Director of Radiology, MEC

Department: Radiology

Affected: All Sites

Implemented: 2001

**Revisions: 03//06, 3/09 1/12
12/13/12, 1/14/16, 2/12/16,
10/31/16**

**Reviewed: 9/06, 3/09,
7/1/14, 2/12/16, 6/6/16,
11/21/16, 8/11/2017**

Page: 1 of 2

PURPOSE: To provide guidelines and safety measures for renal function screening of patients receiving Gadolinium-based contrast media (GBCA).

POLICY: It is the policy of Stamford Hospital Radiology Department, which consists of the Main Hospital, Tully Health Center & Darien Imaging Center that all patients receive the optimal contrast agent prior to their MRI. .

BACKGROUND:

- In 2006, an association between Nephrogenic Systemic Fibrosis (NSF) and exposure to gadolinium based MRI contrast agents was identified.
- It has become clear that the condition is rare, and is seen only in patients with severe or end stage chronic kidney disease, renal failure, and/or acute kidney injury (AKI) who have received specific ‘linear’ formulations of gadolinium (ACR Type I agents). As June 2017, the American College of Radiology states that these formulations are now contraindicated for the aforementioned populations.
- Newer, ‘cyclic’ formulations of gadolinium (ACR group II agents) are not associated with NSF in any population and are rapidly becoming the standard of care in the higher risk populations. Both Type I and II agents can be safely used in patients without renal insufficiency or AKI.
- Standards are evolving rapidly, with dramatic changes in recommendations between 2016 and 2017.

THE STAMFORD HOSPITAL
Department of Radiology
Department
MRI

PROCEDURE: RENAL FUNCTION SCREENING

Inpatients:

Type II agents: Can be used in any non-allergic patients. There is no requirement for pre procedure renal function assessment/blood work and no restriction based on renal function.

Type I agents: Renal function assessment including an eGFR level should be obtained within two days of type I gadolinium contrast administration. A minimum eGFR of >30cc/min/1.73m² is required

Outpatients/ED:

Type II agents: Can be used in any non allergic patients. No requirements for eGFR testing and no restriction for patients with renal insufficiency/failure.

Type I agents: eGFR is still required for the following ‘high risk’ patient populations if they are to receive a type I MRI contrast agent:

- **History of renal disease**
 - Dialysis, Renal transplant, Single Kidney, Kidney Surgery, History of Kidney Cancer
- **History of hypertension requiring medical therapy**
- **History of diabetes mellitus**

Last known eGFR level	Age of lab	CONAST AGENT
>45 cc/min/1.7m	<6 weeks	Type I or II
30-45cc/m/1.7m	2 days	Type I or II

TYPE II ONLY PATIENTS:

Acute Kidney Injury: Examples of ‘potential AKI’ diagnoses include severe dehydration, febrile illness, sepsis, heart failure, recent hospitalization, advanced liver disease, and recent abdominal surgery Patients should be identified by ordering provider as at risk for acute kidney injury (AKI) (which may not yet be evident on serology).

Severe Renal Insufficiency and Hemodialysis: Patients with eGFR <30cc/min/1.73m², and patients on peritoneal or hemodialysis.

MRI Gadolinium – Based Contrast Media

THE STAMFORD HOSPITAL
Department of Radiology
Department
MRI

Pediatrics: Children (under the age of 18) will only receive a Type II agent

Reference: American College of Radiology, 2017; *Manual on Contrast Media*; (Nephrogenic Systemic Fibrosis (NSF)) *page 84-90*. Version 10.3 Received electronically on July 3, 2017.

Revised by JVS/IS on 1/13/12
Reviewed by IS on 1/13/12, 7/1/14

Policy Summary: Scope of Services

Purpose:

The purpose of this policy is to outline the role and responsibilities required of the medical director in Nuclear medicine.

Regularly Standards:

Joint Commission MS.03.01.01.16: For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff determines the qualifications of the radiology staff who use equipment and administer procedures. Note: Technologists who perform diagnostic computed tomography exams will, at a minimum, meet the requirements specified at HR.01.02.05 EP 19.

Executive Director of Radiology, Radiology Chairman, RSO Approval: 8/13/2015

Policy Summary: Nuclear Medicine Medical Director's Responsibilities

Purpose:

The purpose of this policy is to outline the role and responsibilities required of the medical director in Nuclear medicine.

Regularly Standards:

Joint Commission MS.03.01.01.17: For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff approves the nuclear services director's specifications for the qualifications, training, functions, and responsibilities of the nuclear medicine staff.

Executive Director of Radiology, Radiology Chairman, RSO Approval: 11/21/2016

**STAMFORD HOSPITAL
Organizational Clinical Policy**

Subject	Universal Protocol™ - Surgical and Procedural Site Verification		
Policy	SF	Implemented	11/01
References	World Health Organization, Universal Protocol- The Joint Commission AORN Position Statement on Correct Site Surgery. <i>AORN Standards, Recommended Practices, and Guidelines</i> . 2016 Edition. Denver, Colorado. Senior V.P. of Medical Affairs Nursing Coordinating Council	Reviewed	11/05, 11/08, 02/11, 05/13
Approval	Nursing Practice Council OR Committee Medical Executive Committee	Revised	7/17/06 , 03/08/09,02/11, 7/5/11, 4/11/12, 11/7/13; 1/2017
Departments Affected	All Clinical Departments	Page	1 of 8

Purpose:

To prevent wrong site/side, wrong person, wrong procedure surgery and invasive procedures

Policy:

1. All invasive procedures, with the exception of routine procedures, e.g., peripheral IV insertion, urinary catheter insertion, venipuncture, and NG tube insertion, will require a Universal Protocol Checklist.
2. This Policy and Procedure applies to all invasive and non-invasive procedures regardless of location (e.g., includes all invasive procedures that take place outside of an OR setting).
3. Separate Universal Protocol Checklists will be required for multiple or serial procedures.
4. The Universal Protocol Checklist will be documented electronically in the patient record.
5. The Bedside Universal Protocol Checklist is completed for all procedures at the patient's bedside including minor procedures and anesthesia blocks.

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6. The Universal Protocol for surgical procedures is imbedded within the perioperative nursing record including the pre-procedure check, the pre-induction check, the final pause and post procedure check. The components of each of these sections must be completed.
7. A laminated copy of the Universal Protocol Checklist will be available for surgical procedures to allow the entire team including the circulating nurse to be present at the patient's bedside.
8. Patients have the right to refuse site marking. Refusal by the patient/designee will be documented in the appropriate area of the **Universal Protocol Checklist**. Refusal does not mean the operation/procedure cannot proceed.(See Alternate site marking section)
9. The overarching goal of this policy is patient safety, so none of these precautions should be allowed to interfere with the timely care of the patient in an emergency situation (immediate threat to life or limb). In most situations in which operations or invasive procedures are performed under emergency or urgent conditions, the practitioner performing the procedure will be in continuous attendance of the patient from the point of decision to do the procedure. Under those circumstances, marking the site would not be necessary, although the "time-out" to verify the correct patient, procedure, and site would still be appropriate (unless it was an emergency such that the time out would add more risk than benefit).

Procedure

PRE-OPERATIVE VERIFICATION

- A. The nurse or professional staff member assisting with the procedure will verify: the patient's identity using the Stamford Hospital's two identifiers (name and date of birth); the procedure; the site and laterality verbally, comparing this information with the booking information and the patient's medical records. These items must concur.
- B. The presence and /or availability of all records such as H&P, signed consent, nursing assessment, pre-anesthesia assessment, ASA classification performed by proceduralist if anesthesia not present, and images, special equipment, and implants are verified while the patient is in the pre-operative area.

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SITE MARKING

A. The attending surgeon, proceduralist or anesthesiologist at time of Anesthesia Block identifies the operative or procedural site and marks the site with his/her initials using a special permanent marker. Under no circumstances will the mark be an "X" or anything other than the surgeon's/ proceduralist's initials. If an attending surgeon, proceduralist or anesthesiologist has the initials N.O., they will include their middle initial when marking the site.

1. This marking is completed with the active participation of the patient, family member, or legal guardian.
2. The mark must be placed over, or as close to the surgical/procedural site as practical, in a manner so that it will be visible after the patient is prepped and draped.
3. Multiple digits will be marked individually.
4. Sites previously marked in Radiology after needle localization are exempt.
5. Any procedure above the neck identifying laterality will be marked by placing a temporary tattoo-style site marker on the operative side. The surgeon/proceduralist will place the tattoo-style site marker on the operative side in a position where it is visible at the time of the time out. The surgeon/proceduralist will place his/her initials directly on top of the tattoo-style site marker using a surgical marking pen. Placement of the tattoo and surgeon/proceduralist initials is completed with the active participation of the patient, family member, or legal guardian.
6. In the case of laminectomy or other spinal surgery, the surgeon will mark the correct level(s) site using his/her initials prior to bringing the patient into the operating room. Thereafter, in the OR, intraoperative x-ray using markers that are fixed (e.g., spinal needles or a Penfield instrument), will be done after the patient is properly positioned to confirm the vertebral level(s) to be operated upon.
7. When more than one needle stick location will be performed for an anesthetic nerve block, each needle stick location will be marked with initials.

B. If at any time there is a discrepancy between any of the following – surgeon, patient, consent or other medical records – as to the proper identification of the patient and the operative/procedural site, the patient will not enter the operating room/procedure room until the issue is resolved.

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C. The surgeon/proceduralist also confirms the presence and availability of all required patient documents and if applicable all diagnostic studies, tools, blood or implants for the operation/procedure.

C. Alternative Process for Site Marking

If a patient, parent or guardian refused to have the site marked with the permanent marker the following process will be implemented and documented in the patient's medical record.

This verification must be documented and signed.

1. A temporary light blue paper wrist band containing the patient's name, date of birth, the intended procedure, and site is placed on the side of the procedure (Wrist or Ankle). The band must be visible after the patient is prepped and draped and for the final time out.
2. The band is removed by the circulating / procedure nurse at the completion of the procedure, prior to moving the patient from the OR / Procedure Room.
3. The banding is used as an alternative process:
 - i. patients who refuse site marking
 - ii. procedures not easily marked under the following conditions: cases in which it is technically or anatomically impossible or impractical to mark the site (mucosal surfaces, perineum)
 - iii. for minimal access procedures that intend to treat a lateralized internal organ, whether percutaneous or through a natural orifice, the intended side is indicated by a mark at or near the insertion site, and remains visible after completion of the skin prep and sterile draping
 - iv. for interventional procedure cases for which the catheter/instrument insertion site is not predetermined (for example, cardiac catheterization, pacemaker insertion)
 - v. for teeth, the operative tooth name(s) and number are indicated on documentation or the operative tooth (teeth) is marked on the dental radiographs or dental diagram. The documentation, images and /or diagrams are available in the procedure room before the start of the procedure
 - vi. for premature infants, for whom the mark may cause a permanent tattoo

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Anesthesia Block “Time Out:

- A. The “Time Out” must:**
1. Involve the active participation of the entire operative/procedural team members present, including the Anesthesiologist, RN and everyone present in the room.
 2. The time out must be completed while all other activity in the operating room (procedure room) comes to a “halt;”
 3. Result in a positive affirmation of agreement on all required elements before the anesthesia procedure can commence (vide infra).
- B. The “Time Out” includes confirming the following:**
1. The identity of the patient (using the name and date of birth);
 2. Correct side and site are marked and visible
 3. Agreement on the procedure to be done;
 4. Check for accurate signed procedure consent;
 5. The correct position;
 6. The availability of correct implants and any special equipment or special requirements anticipated to complete the procedure;
 7. Administration of antibiotics and / or fluids for irrigation purposes
 8. The presence of relevant images and results are properly labeled and appropriately displayed
 9. Safety precautions based on patient history or medication use
- C. Each member of the team present at the time of the Anesthesia Block “Time Out” shall confirm his/her concurrence with all elements of the “Time Out”. The Anesthesia procedure cannot proceed unless all are in concurrence.**
- D. Documentation of agreement by the surgical/procedural team will be made on The Universal Protocol Checklist Bedside Procedure Checklist outside the OR suite and within the Anesthetic Block section of the Operative Record.**
- E. When more than one needle stick location will be performed as part of an anesthesia block, a separate time out will occur for each stick location to ensure proper location, site marking and laterality.**

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Before Induction of Anesthesia or Administration of Moderate Sedation, Performed in the Operating Room/Procedure Room

- A. Safety strap positioned
- B. Introduction of team members
- C. Patient states identity while verified using wrist band/DOB
- D. Procedure and Laterality Stated
- E. Confirmation of Surgical Consent(s)
 - 1. Signed, dated and timed by patient
 - 2. Signed, dated and timed by attending
- F. Site marked, initialed, and visible
- G. Allergies reviewed
- H. VTE prophylaxis addressed
- I. Images displayed and reviewed by surgeon
- J. **Anesthesia safety check complete**
 - 1. O2 sat monitor functioning properly
 - 2. Any airway or aspiration issues?
 - 3. Glucose Management addressed

- K. All members of the team discuss care plan and address
- L. issues
- M. Any special equipment, devices, implants
- N. EBL (> 500 ml) discussed
- O. Adequate IV access
- P. Estimated Case length
- Q. AORN Fire Risk Assessment is completed with verbal communication to establish a safety plan in correlation with the patient's procedure and specific care needs.

“TIME OUT” Prior to Skin Incision or Scope Insertion. (Final Pause)

A. The “Time Out” must:

- 1. Involves the active participation of the entire operative/procedural team; including nurses and techs in the circulator and scrub roles, physician's assistants, anesthesiologists and proceduralists or surgeons: Everyone in the Room.

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2. To completed while all other activity in the operating room (procedure room) is at a “halt;”
3. Result in a positive affirmation of agreement on all required elements before the operation/procedure can commence (vide infra).

B. Each member of the team shall confirm his/her concurrence with all elements of the “Time Out.” The operation/procedure cannot proceed unless all are in concurrence. The scrub nurse or technician will not pass a surgical knife to the surgeon until the above conditions is met.

C. The members of the operating (procedure) team should not leave the patient’s side after the final verification

D. Team Member Roles

Circulator:

- Identified Patient
- Request of physician statement of procedure
- Confirmation of Consent(s)
- Verification of Surgical Site
- Confirmation site marking is visible when draped
- Fire Risk Assessment:
 - Head/Neck Procedures?
 - Bovie (ESU) Audible and Holstered
 - Scopes will be placed on Mayo stand
 - Prep is dry (alcohol based prep >3min)

Surgeon:

- Anticipated critical operative steps
- Intended Pathology, FS, Cultures
- Special equipment, devices, implants
- Neutral zone location

Anesthesia Provider:

- Antibiotic prophylaxis within one hour prior to incision
- Time of next Antibiotic dose written on white board
- Additional concerns

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Before Patient Leaves the Operating/Procedure Room Prior to the completion of the procedure the following will be verified:

- A. Confirmation with physician the procedure performed.
- B. Completion of sponge, sharp and instrument counts,
- C. Number of specimens identified and verification labeled per policy
- D. Wound Classification
- E. Any equipment issues to be addressed
- F. Verification Patients ID band on
- G. Key concerns for the recovery and management of this patient to be provided to the next care giver in patient hand off.

CONSENT FOR ANESTHESIA SERVICES

I, _____ (name of patient), acknowledge that my doctor has explained to me that I will have an operation, diagnostic or treatment procedure, and/or management of labor and delivery. My doctor has explained the benefits and risks of the procedure, advised me of alternative treatments and told me about the expected outcome.

It has been explained to me that all forms of anesthesia involve some risks and no guarantees or promises can be made concerning the results of my procedure or treatment. Although rare, unexpected *severe complications* with any anesthesia can occur and include the remote possibility of *drug reactions, blood clots, loss of sensation, loss of limb function, paralysis, stroke, brain damage, heart attack or death*. I understand that these risks apply to all forms of anesthesia and that additional or specific risks have been identified below as they may apply to a specific type of anesthesia.

<input type="checkbox"/> General Anesthesia	Expected Result	Total unconscious state, possible placement of a tube into the windpipe.
	Technique	Drug injected into the bloodstream, intramuscularly, or breathed into the lungs.
	Risks	Mouth or throat pain, hoarseness, injury to mouth or teeth, awareness under anesthesia, injury to blood vessels, aspiration, pneumonia.
<input type="checkbox"/> Spinal or Epidural Analgesia / Anesthesia <input type="checkbox"/> With sedation <input type="checkbox"/> Without sedation	Expected Result	Temporary decreased or loss of feeling and/or movement to lower part of the body.
	Technique	Drug injected through a needle/catheter placed either directly into the spinal canal or immediately outside the spinal canal.
	Risks	Headache, backache, buzzing in the ears, convulsions, infection, persistent weakness, numbness, residual pain, injury to blood vessels, difficulty breathing.
<input type="checkbox"/> Nerve Block <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral	Expected Result	Temporary loss of feeling and/or movement of a specific limb or area.
	Technique	Drug injected near nerves providing loss of sensation to the area of the operation.
	Risks	Infection, convulsions, weakness, persistent numbness, residual pain, injury to blood vessels.
<input type="checkbox"/> Procedural Sedation (Monitored Anesthesia Care With Sedation)	Expected Result	Reduced anxiety and pain, partial or total amnesia.
	Technique	Drug injected into the bloodstream, breathed into the lungs, or by other routes producing a semi-conscious state.
	Risks	An unconscious state, depressed breathing, injury to blood vessels.
<input type="checkbox"/> Monitored Anesthesia Care (Without Sedation)	Expected Result	Measurement of vital signs, availability of anesthesia provider for further intervention.
	Technique	None.
	Risks	Increased awareness, anxiety, and/or discomfort
<input type="checkbox"/> Other Techniques		

I hereby consent to the anesthesia service checked above and authorize that it be administered by _____ and/or his/her designated associates. I also consent to an alternative type of anesthesia, if it becomes necessary, as deemed appropriate by them. I certify and acknowledge that I have read this form or had it read to me, that I understand the risks, alternatives and expected results of the anesthesia service and that all my questions were answered to my satisfaction.

Signature of Patient or Next of Kin or Legal Representative	Printed Name if Next of Kin/ Legal Representative and Relationship	AM PM	Date
Signature of Witness	Printed Name of Witness	AM PM	Date

**THIS IS TO CERTIFY THAT I HAVE DISCUSSED THE PROPOSED ANESTHESIA SERVICES,
AS WELL AS THE RISKS, BENEFITS AND ALTERNATIVES WITH THIS PATIENT.**

Signature of Anesthesiologist or Administering MD	Printed Name of Anesthesiologist or Administering MD	AM PM	Date
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ANTIBIOTIC STEWARDSHIP PROGRAM

STAMFORD HOSPITAL INITIATIVE IN RESPONSE TO NATIONAL URGENCY FOR SAFER AND MORE EFFECTIVE USE OF ANITBIOTICS

It has been estimated that 50% of antimicrobial use in hospitals is inappropriate. Inappropriate antibiotic use has been associated with propagation of antimicrobial resistance, poor outcomes, *C. difficile* infection, other adverse effects and high costs. Appropriate use of antimicrobial agents may improve patient outcomes, reduces hospital costs and decreases adverse drug events, including hospital associated infections.

The incidence of antimicrobial resistance among health care– associated pathogens has been steadily increasing over the past 3 decades. Development of new antimicrobial agents, however, has decreased. High rates of antimicrobial resistance result in delays in initiating effective therapy, less effective and/or more toxic antimicrobial therapy. Antimicrobial-resistant infections have been associated with increased medical costs (\$18,588–\$29,069), excess hospital stay (6.4–12.7 days), and increased mortality (attributable mortality 6.5%) for infected patients (ref). For example, vancomycin-resistant *Enterococcus* bloodstream infections are associated with decreased survival (24% vs. 59%), increased LOS (34.8 vs. 16.7 days), and increased mortality as compared with infections caused by vancomycin-susceptible strains (ref). At Stamford Hospital, vancomycin susceptibility of *Enterococcus faecium* has declined from 45% to 3% in the last 20 years, and the number of ESBL-producing Gram-negative organisms has quadrupled in the last 5 years.

✓ ALL OF US MUST STRIVE TO USE ANTIBIOTICS MORE APPROPRIATELY.

Inappropriate uses include:

- Use of antibacterial agents for treatment of syndromes that are not caused by bacteria (e.g., “colds,” acute bronchitis, most sore throats, “fever”)
- Treatment for culture results that reflect colonization or contamination rather than infection (e.g., asymptomatic bacteriuria)
- Administration of an antibacterials with a broader-than-necessary spectrum of activity (e.g., failure to narrow spectrum based on culture results)
- Failure to consider likely pathogens and resistance patterns in selecting empiric antibiotic regimen
- Prescribing courses of antibacterial therapy that are longer than necessary
- Prescribing antibacterial agents at inappropriate doses (either too high or too low) or intervals and failing to adjust dosing for compromised renal function.
- Treating infectious processes with agents that do not provide activity against the causative agent(s)
- Using alternate agents (e.g., vancomycin) in patient’s without documentation of a true penicillin allergy
- Failing to de-escalate broad spectrum empiric therapy when the culture results show more susceptible pathogens

✓ CORE STRATEGIES FOR BETTER ANTIBIOTIC USE

Stamford Hospital has evolved a robust antimicrobial stewardship program over the past decade. Antimicrobial stewardship is defined as a rational, systematic approach to the use of antimicrobial agents in order to achieve optimal outcomes.

The Core Strategy of this program is formulary restriction with preauthorization and [informal] infectious diseases consultation when prescribing advanced spectrum, unusually toxic or very expensive agents, such as meropenem or daptomycin. Studies have associated antimicrobial restriction with interruption of *C. difficile* outbreaks, increased rates of clinical cure, increased antimicrobial susceptibility among gram-negative pathogens, and with substantial cost-savings. In addition, prospective audits with intervention and feedback are performed from time to time based upon consensus goals of the P&T and Infection Committees.

✓ SUPPLEMENTAL STRATEGIES FOR BETTER ANTIBIOTIC USE

Supplemental strategies at Stamford Hospital include:

- Annual education for all departments, including availability of an up-to-date antibiogram posted on the Infectious Diseases Intranet site and available as a trifold pocket guide
- Guidelines and order sets for common conditions such as pre-op surgical prophylaxis, sepsis, febrile neutropenia and pneumonia outlining preferred drug selection and dose optimization. Stamford Hospital preop surgical prophylaxis guidelines are attached to this memo.
- De-escalation (3-day “time-out”) reminders for piperacillin/tazobactam and cefepime of therapy
- Parenteral to oral conversion prompts by pharmacy
- Prescribing limitations for certain drug doses by patient weight
- Ordering indication requirement
- Restricted susceptibility reporting (cascade system thru micro lab)
- Daily Blood culture monitoring by infectious diseases service for appropriateness of Rx
- Drug:Bug Mismatch detection in microbiology lab
- Constant monitoring and flagging system for MDRO detection for determining formulary changes and guideline changes and appropriate patient isolation
- Application of rapid molecular microbiology diagnostics, e.g. PCR and other rapid methods to improve timeliness and appropriateness of antimicrobial selection
- Availability of biomarkers (e.g. procalcitonin) to identify those patients who are unlikely to benefit from antimicrobial therapy in the first place, and as an aid to early discontinuation of treatment.
- 24/7 availability of formal or informal infectious diseases consultation.

Stamford Hospital’s stewardship policies and interventions are designed to optimize outcomes for the patient (achieve clinical cure, avoid toxicity, reduce the risk of superinfection and eliminate excess cost) and for the institution (avoid emergence or propagation of antimicrobial resistance).

Reference: http://www.chpso.org/sites/main/files/file-attachments/gnyha_antimicrobial_stewardship_toolkit_finalv2_dec2011.pdf

2017 Perioperative Antimicrobial Prophylaxis Guidelines for Adults -- Inpatient and Outpatient

Surgical Category	Pre-op Antimicrobial Agent	Comments
Cardiac / Vascular		
<i>Pacemaker or AICD implant; all cardiac/aortic procedures; arterial involving a graft; groin incision; leg amputation with ischemia</i>	Cefazolin 2g IV	For severely cephalosporin or penicillin-allergic patients, or MRSA+, use Vancomycin.
Gastrointestinal - upper		
<i>PEG insertion; bariatric; small intestine, non-obstructed</i>	Cefazolin 2g IV	For severely cephalosporin or penicillin-allergic patients: Vancomycin IV plus Gentamicin 2 mg/kg IV (max 250mg)
Gastrointestinal		
<i>Biliary Tract, Appendectomy (not perforated), Colorectal</i>	Cefazolin 2g IV plus Metronidazole 500mg IV OR Cefotetan 2g IV or Cefoxitin 2g IV	For severely cephalosporin or penicillin-allergic patients: Metronidazole 500 mg IV plus Gentamicin 2mg/kg IV (max 250mg)
Head and Neck		
<i>Clean-contaminated (oral or pharyngeal mucosa is compromised), mandibular fracture repair</i>	Cefazolin 2g IV plus Metronidazole 500 mg. IV, or Unasyn 3 g IV	For severely cephalosporin or penicillin-allergic patients: Clindamycin 900mg IV plus Gentamicin 2mg/kg IV (max 250mg)
<i>Clean surgery with prosthetic material</i>	Cefazolin 2g IV	For severely cephalosporin or penicillin-allergic patients: Clindamycin 900mg IV plus Gentamicin 2mg/kg IV (max 250mg)
Neurosurgery		
<i>All cases, including spine</i>	Cefazolin 2gm IV	For cephalosporin or penicillin-allergic patients, or MRSA +, use Vancomycin.
Ob/Gyn		
<i>Cesarean delivery with active labor or premature rupture of membranes; hysterectomy; urogyn procedures with vaginal incision / prosthesis</i>	Cefazolin 2g IV or Cefotetan 2g or Cefoxitin 2g IV or Unasyn 3g IV	Give prior to skin incision, including C-section. For cephalosporin or severely penicillin-allergic patients: Clindamycin 900mg IV plus Gentamicin 2mg/kg IV (max 250mg)
Orthopedic / Podiatry		
<i>Osteotomy, arthrodesis, open fracture management</i>	Cefazolin 2g IV	For severely cephalosporin or penicillin-allergic patients, or MRSA+, use Vancomycin
Orthopedic		
<i>With prosthetic material, total joints, ORIF, spine surgery</i>	Cefazolin 2g IV	Clean procedures without prosthetic material do not require prophylaxis. For severely cephalosporin or penicillin-allergic patients, or MRSA+, use Vancomycin.
Plastic / soft tissue		
<i>Hernia repair with or without mesh; plastic surgery with risk factors (RT, cancer, implants, etc)</i>	Cefazolin 2g IV or Unasyn 3g IV	For severely cephalosporin or penicillin-allergic patients, use Clindamycin 900 mg IV or Vancomycin
Thoracic		
<i>With bronchial, lung or esophageal incision</i>	Cefazolin 2g IV or Unasyn 3g IV	For severely cephalosporin or penicillin-allergic patients, use Clindamycin 900 mg IV with Vancomycin
Urology		
<i>Cystoscopy with manipulation or upper tract instrumentation; Prostate biopsy, all approaches</i>	Ciprofloxacin 500mg PO or 400 mg. IV or TMP/SMX one DS PO; For prostate surgery, use Cefotetan 2g IV or Cefoxitin 2g IV	For severely cephalosporin or penicillin-allergic patients use Gentamicin 2mg/kg IV (max 250mg) plus Metronidazole 500mg IV in lieu of Cefotetan or Cefoxitin
<i>Penile prosthesis insertion, revision or removal, or epididymal surgery</i>	Unasyn 3 g IV or Cefazolin 2g IV plus Gentamicin 2mg/kg IV	For severely cephalosporin or penicillin-allergic patients use Gentamicin + Vancomycin.

Comments:

- For any patient known to be colonized with MRSA, or with previous MRSA colonization, vancomycin should be added. Consider broader prophylaxis for patients colonized with multi-drug resistant organisms (consult Infectious Diseases)
- Pre-op antibiotics must be started within 60 minutes of incision; for vancomycin or ciprofloxacin, within 120 minutes of incision
- Cephalosporin dose = 3gm if pt weighs >120kg; Vancomycin dose = 1000mg if pt weighs <80kg, 1500mg if pt weighs 80-120kg, 2000mg if pt weighs >120kg. Aztreonam 2gm may be used in lieu of gentamicin if renal insufficiency present. - When cefoxitin or Unasyn are used, repeat dose if procedure lasts > 3 hrs; cefazolin, > 4 hrs; ciprofloxacin or cefotetan, > 6 hrs; vancomycin, >10 hrs (adjust all for renal insufficiency).
- Post-operative doses are generally not needed. If given, they should be limited to a single dose, or less than 24 hours post-op.