



House Staff Manual

Academic Year 2015-2016

This document is effective for the academic year noted and replaces any and all previous Manuals. Information regarding benefits, policies and procedures quoted in this Manual are subject to change without prior notice.

Howard University Hospital is an Equal Opportunity/Affirmative Action/Drug Free Environment Employer and does not discriminate with regard to sex, race, religion, color, national origin, disability, or any other applicable legally protected status.

A Special Note to Residents and Fellows

This manual contains information relative to the graduate medical education enterprise sponsored by Howard University Hospital and should not be construed as a contract. Herein, you will find information regarding the administrative organization of the hospital as well as general information regarding eligibility and selection criteria for trainees. In addition, information regarding your professional responsibilities and the work environment are included for your reference. Policies and protocols which are germane to your professional activities and designed to support the Hospital's mission of education, service and research are included for reference as well. While the basic outlines of appropriate behavior are provided herein, we ask that you allow your good judgment, trained thought and compassion for the patient be part of your guiding principles. As well, we ask that you seek consultation from the appropriate supervisor when in doubt. It is expected that, with the use of the information contained herein, you will find the proper channels to accomplish your professional goals relative to your training.

All of us in Graduate Medical Education express appreciation for all the effort you will undertake to learn and provide competent treatment to the patient population for which the Hospital provides care.

Please keep in mind during your training that the Office of Graduate Medical Education is available to assist you in your professional endeavors.

Peter L. Sealy, M.D., FACP
Associate Dean for Graduate Medical Education
Chair, Graduate Medical Education Committee
Designated Institutional Official (DIO)

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Institutional Statement of Commitment to Graduate Medical Education

Howard University is a comprehensive, research-oriented, historically Black private university providing an educational experience of exceptional quality to students of high academic potential with particular emphasis upon the provision of educational opportunities to promising minority students. For more than 140 years, Howard University Hospital, a 482 bed award winning university and teaching hospital, has proudly served the global community with a commitment to innovative patient care, teaching and research. Howard University and Howard University Hospital are committed to the education and training of individuals with high academic potential, regardless of age, race, sex, creed, religion or national origin, for service to the nation and global community.

Howard University and Howard University Hospital, including the board, executive management and medical staff, are committed to providing graduate medical education programs that facilitate residents' professional, ethical and personal development in the provision of safe and appropriate patient care. To ensure this development, the graduate medical education programs, through curricula, supervision and evaluation, provide the necessary means by which to accomplish these ends as well as through research in support of excellence in patient care. Howard University and Howard University Hospital both value scholarship and life-long learning; professionalism; academic and clinical discipline; and, the ethical and humanistic treatment of patients. It is expected that our teachers will model these values and that our learners will incorporate them.

The Howard University Board of Trustees, administration and faculty unequivocally reaffirm the institution's commitment to graduate medical education (GME) and to providing the educational, financial, communication, and human resources necessary to meet or exceed the institutional and program requirements of the Accreditation Council of Graduate Medical Education (ACGME). This includes forming and maintaining alliances with other hospitals and organizations, based on educational criteria, to provide appropriate patient care experiences for residents, as well as, attracting and retaining faculty and administrative support staff with the necessary breadth of knowledge and skills and facilitating their ongoing professional development. It also includes supporting and maintaining an organized administrative system, led by a Designated Institutional Official in collaboration with a Graduate Medical Education Committee which oversees all residency programs and assures compliance with all institutional, common and specialty/subspecialty-specific requirements. Further, it includes provision of administrative support for GME programs and residents in the event of disaster or interruption in patient care as related to the continuation of resident assignments.

Howard University and Howard University Hospital as a whole are committed to the goal of developing outstanding health care professionals and demonstrating excellence in patient care, professionalism, scholarly activity, and leadership.

HOWARD UNIVERSITY HOSPITAL'S GME VISION

To be recognized as America's premier educational institution known nationally and internationally for highly competitive graduate medical education programs with a reputation for innovative education, research and outcome oriented curricula. To this end, this unique educational experience will produce culturally competent leaders who will direct and mobilize the global community to eliminate health care disparities.

GME MISSION

The mission of the Howard University Hospital Graduate Medical Education Program is to provide a unique and outstanding educational experience for its post graduate trainees, with emphasis on teaching them to be compassionate, provide the highest quality care and be committed to serving the African-American and other historically disenfranchised groups in the community while providing educational opportunities to a diverse group of physicians, who will not only be distinguished in service, teaching and research, but will also seek solutions to human and social problems, addressing disparities in the health care delivery system in the United States and throughout the world.

GME CORE VALUES

The unique experience provided to post graduates will produce committed health care practitioners, espousing the core competencies of compassionate patient care, outstanding medical knowledge, professionalism, excellent interpersonal and communication skills, and who continue to develop and improve

in practice based learning and systems based practice as defined by the Accreditation Council for GME. These core values govern all HUH sponsored graduate medical education programs.

PATIENT CARE

Residents must be able to provide patient care that is compassionate, appropriate and effective for the treatment of health problems and the promotion of health. Residents are expected to:

- communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families
- gather essential and accurate information about their patients
- make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence and clinical judgment
- develop and carry out patient management plans
- counsel and educate patients and their families
- use information technology to support patient care decisions and patient education
- perform competently all medical and invasive procedures considered essential for the area of practice
- provide health care services aimed at preventing health problems or maintaining health
- work with health care professionals, including those from other disciplines, to provide patient-focused care

MEDICAL KNOWLEDGE

Residents must demonstrate knowledge about established and evolving biomedical, clinical and cognate (e.g., epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. Residents are expected to:

- demonstrate an investigatory and analytic thinking approach to clinical situations
- know and apply the basic and clinically supportive sciences which are appropriate to their discipline

PRACTICE-BASED LEARNING AND IMPROVEMENT

Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence and improve their patient care practices. Residents are expected to:

- analyze practice experience and perform practice-based improvement activities using a systematic methodology
- locate, appraise and assimilate evidence from scientific studies related to their patients' health problems
- obtain and use information about their own population of patients and the larger population from which their patients are drawn
- apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness
- use information technology to manage information, access on-line medical information and support their own education
- facilitate the learning of students and other health care professionals

INTERPERSONAL AND COMMUNICATION SKILLS

Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients' families and professional associates. Residents are expected to:

- create and sustain a therapeutic and ethically sound relationship with patients
- use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills
- work effectively with others as a member or leader of a health care team or other professional group

PROFESSIONALISM

Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to a diverse patient population. Residents are expected to:

- demonstrate respect, compassion and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society and the profession; and a commitment to excellence and on-going professional development
- demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices
- demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities

SYSTEM-BASED PRACTICE

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. Residents are expected to:

- understand how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements of the system affect their own practice
- know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources
- practice cost-effective health care and resource allocation that does not compromise quality of care

- advocate for quality patient care and assist patients in dealing with system complexities
- know how to partner with health care managers and health care providers to assess, coordinate and improve health care and know how these activities can affect system performance

THE HOSPITAL

Howard University was founded in 1865 and is known worldwide for academic excellence and community service. Howard University Hospital (HUH) opened in the fall of 1975, replacing the Freedman's Hospital circa 1862. The legacy of community services established by its predecessor – The Freedmen's Hospital – is mirrored through a myriad of primary and specialty care services currently provided at HUH. These include, but are not limited to, a Cancer Center, a Sickle Cell Center, a Diabetes Treatment Center, a kidney transplant program, the Perinatal Diagnostic and Ultrasound Center and neonatal care units. On an annual basis, approximately 12,000 patients are admitted, with more than 100,000 out-patient visits being made to HUH. As a major teaching resource, "the symbiotic relationship" between HUH and the Howard University Health Science Colleges is obvious in that together they are responsible for training more than 20 percent of this nation's African American health professionals. In fact, HUH continues to be a valuable medical resource by maintaining teaching programs in 20 specialties. The drive to fulfill its heritage and tradition of being the center for service, education and research will not only ensure its longevity, but will sustain its legacy in the 21st Century.

The Hospital sponsors the following training programs:

Residencies – clinical pharmacy, dermatology, family medicine, general dentistry, general surgery, internal medicine, neurology, obstetrics/gynecology, ophthalmology, oral surgery, orthopedic surgery, pathology, podiatry, preliminary medicine, and psychiatry.

Fellowships – cardiology, endocrinology, gastroenterology, hematology and medical oncology, infectious diseases, and pulmonary disease.

Residents/Fellows are assigned to training in specialty services which are approved by either the Accreditation Council for Graduate Medical Education (ACGME), the American Dental Association, the American Society of Health Systems Pharmacists, or the American Podiatric Association. Programs are approved for one to five years of training with an established number of residents regulated by the accrediting body for each training program.

HUH Values: CARES

The C.A.R.E.S. Campaign represents an initiative by the Hospital to enhance institutional quality through the communication of expected “Standards of Behavior” for all hospital employees. The C.A.R.E.S. acronym stands for Collaboration, Accountability, Respect, Excellence and Service. Each word conveys the following set of expectations:

COLLABORATION

- Work together to achieve our mission and goals
- We are a team! If you don’t know, ask. Share information with others; together everyone achieves more.
- Never doubt that blending your talents with others’ can lead to powerful change.
- Admit your mistakes; they are an opportunity for improvement and others can learn from them.

ACCOUNTABILITY

- Ask yourself. Would you want a member of your family to be treated the way that you are treating one another or the customer?
- Take responsibility. It **IS** your department/job; do it with a smile.
- Maintain professionalism and ethical standards.).
- Acknowledge that serving the needs of our customers is our #1 reason for being here; help create an outstanding experience for our customers.
- Be mindful of ways to improve our organization and environment.

RESPECT

- Be respectful toward co-workers and patients in the performance of your job duties. .
- Maintain the confidentiality of the Hospital’s proprietary information and protected patient information. .

EXCELLENCE

- Proudly share information about our University.
- Explore opportunities to create positive experiences for our customers.
- Maintain a professional appearance that is appropriate in a hospital setting (*neatly groomed, clean shaven, clean nails, appropriate clothing*).
- Know/learn the expectations of your job and *exceed* them.

SERVICE

- Be helpful and professional to coworkers, visitors, patients, students, and community members.
- Demonstrate excellent customer service by promptly, warmly and professionally acknowledging the existence of others with eye contact and a smile.
- Remain focused on customer needs.
- Be a solution provider.

THE COMMUNITY

Howard University Hospital is a six-story brick and glass structure standing on the campus of Howard University. On the grounds immediately adjacent to the hospital is the Cancer Center and Ambulatory Care Building. Howard University's campus has an impressive array of schools, colleges, institutes, and centers which embody a tradition of academic excellence and address a number of national concerns, as well as those of the immediate Washington area.

Washington, DC is an internationally oriented center of multicultural diversity and a city of internationally recognized political power, prestige, and influence. The city's attractions range from its imposing national monuments, museums, zoos, and parks to its unique educational resources and exciting night life. Its cultural offerings include the National Gallery of Art, Ford's Theater, National Spy Museum, Corcoran Gallery of Art, and more.

Home of the United States Capitol, the three branches of the government and diplomats from all over the world, Washington, D.C. is firmly established as a uniquely endowed and historical city. While the DC metropolitan area also encompasses parts of Maryland and Virginia, the downtown area is its heart. Key Neighborhoods that reflect some part of the city's history and culture are LeDroit Park, Adam's Morgan, Dupont Circle, Woodley Park, Cleveland Park, Foggy Bottom, Georgetown and Chinatown, and last but not least, Capitol Hill. Just across the Potomac River from the Capitol, along the Capitol Beltway, Northern Virginia abounds in historic sites and is a Mecca for shopping enthusiasts. The suburban Maryland communities are bustling centers of business and established communities.

Each year, millions of people visit the monuments and memorials honoring those who have affected the course of U.S. history. Of course, the best known of these are the Washington Monument, Jefferson Memorial, Lincoln Memorial, Theodore Roosevelt Memorial, and more recently, the Vietnam Veterans Memorial. Other extraordinary city sights are the U.S. Capitol, White House, Congressional Buildings, Arlington National Cemetery, Bureau of Engraving and Printing, Library of Congress, the National Aquarium, the Spy Museum, and so on.

Washington is also the home of the Redskins, Nationals and Wizards. The local area is serviced by three major airports. Less than an hour away by car is Annapolis, the capital city of Maryland. Fronting the Chesapeake Bay, a major inland waterway, Annapolis is known as the sail boating capital of the world. Howard University residents, staff, and alumni are active participants in this community of interests.

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Hematology/Oncology	Gladys Onojobi, M.D. gonojobi@aol.com	(202)865-4688
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865-6613

Podiatry; Orthopedic Surgery
865-1656

Pharmacy
865-4360

Pathology
806-6306

Cardiology
865-6792

General Dentistry; Oral Surgery
865-1361

Family Medicine
865-1452

Obstetrics/Gynecology
865-7081

General Surgery
865-1642

865-4608

Internal Medicine *and* Fellowships
865-1920

Ophthalmology
865-6425

Internal Medicine *and* Fellowships
865-1924

Dermatology
865-1680

HOUSE STAFF ASSOCIATION OFFICERS (2015-2016 Academic Year)

Officers: President – Chad Hines M.D. (Internal Medicine)

Vice Presidents – Mohammed Achhal El Kadmiri, M.D. (Endocrinology)
Abiodun Otolorin, M.D. (Family Medicine)

Secretary - Jericho de Mata, M.D. (Family Medicine)

Treasurer – Brittany Brooks, M.D. (Family Medicine)

Public Relations Officer – Jessica Berry, M.D. (Internal Medicine)

I. ORGANIZATION

Office of the Senior Vice President for Health Sciences: The Health Sciences of Howard University include Howard University Hospital and affiliations, the College of Medicine, the College of Dentistry, the College of Pharmacy, Nursing and Allied Health Sciences, the Health Sciences Library, the School Health Center, related programs and activities. The Senior Vice President for Health Sciences is responsible for strategic and capital planning, all satellite facilities and services and review of all Health Sciences Enterprise budgets.

Office of the Executive Director of the Hospital: The Executive Director of the Hospital is responsible for the overall management of the facility ensuring compliance with established administrative standard practices throughout the hospital.

Office of Graduate Medical Education: The Office of Graduate Medical Education reports to the Associate Dean for Graduate Medical Education/Designated Institutional Official and is responsible for the oversight of a broad range of clinical, educational, research, and administrative activities. These activities are attendant to the full complement of Graduate Medical Education programs inclusive of ACGME-approved postgraduate physician residency/fellowship training as well as training in specialty services which are approved by the American Dental Association, American Society of Health Systems Pharmacists or American Podiatric Association. The Office of Graduate Medical Education assists clinical departments with postgraduate training programs in maintaining the accreditation of their respective training programs by working with the respective department chairpersons and program directors. General oversight of the GME enterprise is managed by the Designated Institutional Official (DIO) with assistance from a professional staff which includes a GME Administrator/Development Manager, Manager for Special Projects, Project Coordinator and Administrative Coordinator. The DIO reports to the Executive Director of HUH and the Dean of the College of Medicine and also serves as the Chair of the Graduate Medical Education Committee (GMEC).

Role of the Designated Institutional Official (DIO): The DIO is the administrative official who, in collaboration with the Graduate Medical Education Committee (GMEC), oversees all postgraduate training programs. He/she has the authority and responsibility for the oversight and administration of graduate medical education programs to assure compliance with the education and training requirements of the appropriate accrediting bodies. The DIO presents an annual report on all GME activities to the Organized Medical Staff and the governing bodies of the major participating institutions.

The Chief Medical Officer: The Chief Medical Officer is responsible for ensuring the quality of patient care and employee health, in the hospital. The Chief Medical Officer reports to the Executive Director of the Hospital.

The Medical Staff:

The Medical Staff consists of the Faculty Attending, Senior Faculty Attending, Courtesy Attending, Senior Courtesy Attending (collectively referred to as the Active Attending Staff), Retired Attending, Affiliate and Referring Medical Staff.

The Faculty Attending Staff - members of the Faculty Attending Staff must have a faculty appointment at Howard University through the College of Medicine, College of Dentistry, or the College of Pharmacy, Nursing and Allied Health Sciences. Members of the Faculty Attending Staff must also have a current Federal DEA license and District of Columbia registrations to dispense controlled substances, if applicable. Members of the Faculty Attending Staff may have patient care responsibilities consistent with clinical privileges granted, and shall have educational responsibilities as defined by the Faculty Handbook, departmental policies and procedures, and the requirements of their respective Colleges or Schools. Members of the Faculty Attending Staff are eligible to vote and hold office on the Medical Staff, and must pay Medical Staff dues. Each patient's general medical condition shall be the responsibility of his or her respective attending staff member.

The Senior Faculty Attending Staff – in order to be granted Senior Faculty Attending status, at the time of application, a practitioner must be a member of the Faculty Attending Staff and/or have been a member of the Medical Staff in good standing within the preceding 120 days and must be recommended for Senior Faculty Attending Status by the Chairperson of his or her clinical department and the Chief Medical Officer. No member of the Faculty Attending Staff may be recommended for Senior status unless he or she is age 65 or older, and has been a member of the Medical Staff of Howard University Hospital for at least ten (10) years. Members of the Senior Faculty Attending Staff may exercise clinical privileges consistent with those in their Delineation of Privileges Statements, provided that they satisfy the requirements for reappointment. Senior Faculty Attending Staff members may hold office and have a right to vote on Medical Staff matters. All members of the Senior Faculty Attending Staff shall be exempt from the payment of Medical Staff dues.

The Courtesy Attending Staff – members of the Courtesy Attending Staff shall not be required to have a faculty appointment at Howard University. A member of the Courtesy Attending Staff may be given the opportunity, however, to become a member of the Faculty Attending Staff by applying for a Howard University faculty appointment and being approved for such an appointment on the basis of individual qualifications and educational needs of Howard University. Members of the Courtesy Attending Staff must also have a current Federal DEA license and District of Columbia registrations to dispense controlled substances, if applicable. Members of the Courtesy Attending Staff may have patient care responsibilities consistent with clinical privileges granted. Members of the Courtesy Attending Staff are eligible to vote and hold office on the Medical Staff, and must pay Medical Staff dues. Each patient's general medical condition shall be the responsibility of his or her respective attending staff member.

The Senior Courtesy Staff – in order to be granted Senior Courtesy Attending status, at the time of application, a practitioner must be a member of the Courtesy Attending Staff and/or have been a member of the Medical Staff in good standing within the preceding

120 days and must be recommended for Senior Courtesy Attending status by the Chairperson of his or her clinical department and the Chief Medical Officer. No member of the Courtesy Attending Staff may be recommended for Senior Courtesy Attending status unless he or she is age 65 or older, and has been a member of the Medical Staff of Howard University Hospital for at least ten (10) years. Members of the Senior Courtesy Attending Staff may exercise clinical privileges consistent with those in their Delineation of Privileges Statements. Senior Courtesy Attending Staff members may hold office and have a right to vote on Medical Staff matters. All members of the Senior Courtesy Attending Staff shall be exempt for the payment of Medical Staff dues.

The Retired Attending Staff – a Faculty Attending, Senior Faculty Attending, Courtesy Attending or Senior Courtesy Attending Staff member who elects not to exercise clinical privileges or who does not satisfy the requirements for reappointment are eligible for Retired Attending Status. Retired Attending Staff members shall not have a right to hold office or to vote on Medical Staff matters. Retired Attending Staff members may participate in Medical Staff Committees as non-voting members at the discretion of the President of the Medical Staff. All members of the Retired Attending Staff shall be exempt from Medical Staff dues.

The Affiliate Staff – Members of this classification are non-physicians who are licensed or certified practitioners, including physician assistants, who provide patient care services at the Hospital. They shall be under the supervision of a physician credentialed by the Medical Staff at the Hospital, unless otherwise permitted by law. They are responsible to the appropriate Clinical Department chairperson and to the Medical Staff for their actions and interactions in patient care. Their patient care activities shall be strictly confined to their delineation of privileges. Members of the Affiliate Staff may neither vote nor hold office, but may be asked to provide expertise on various committees of the Medical Staff and/or Hospital. Members of the Affiliate Staff may have a faculty appointment at Howard University through the College of Medicine, College of Dentistry, or College of Pharmacy, Nursing and Allied Health Sciences. Each member of the Affiliate Staff will be assigned to an appropriate clinical department and shall carry out his or her professional activities, subject to departmental policies and procedures and in a manner consistent with the Bylaws and Rules and Regulation of the Medical Staff. The Affiliate Staff shall not form a separate organizational entity.

HOWARD UNIVERSITY HOSPITAL HOUSE STAFF ASSOCIATION

The HUH House Staff Association is an organized group of post graduate physicians, podiatrists, dentists and pharmacists currently in training at HUH. Representation from this body is provided on the Graduate Medical Education Committee, and most committees of the Medical Staff including the Executive Committee. The members of the house staff are represented by a roster of officers which are elected by their peers. Residents are encouraged to voice concerns, make recommendations and otherwise seek assistance or correction concerning house staff training, environment, or well-being. Requests in support of the house staff or house staff members may be made through the

house staff organization or individually. The Designated Institutional Official has the immediate responsibility to assist the house staff organization or members in this regard and further represent the house staff and house staff issues to the Chief Executive Officer.

GME COMMITTEES

The Graduate Medical Education Committee (GMEC): The GMEC and its subcommittees are comprised of program directors, department chairs, faculty, residents, health science administrators and GME administrative staff at the Hospital and affiliated institutions.

The functions of the GMEC are as follows:

To advise and monitor any changes in the policies and procedures of the GME program;

To establish policies and procedures related to eligibility and selection, supervision and appropriate treatment, evaluation, promotion, dismissal, appeal of adverse actions, duty hours, and moonlighting of trainees;

To review and monitor working conditions, trainee supervision, duty hours standards compliance, ancillary support, trainee participation in departmental scholarly activity as set forth in the ACGME Institutional, Common and applicable specialty Program Requirements;

To assure that each Program provides a curriculum and an evaluation system to ensure that all trainees demonstrate achievement of the six general competencies:

1. Patient Care
2. Medical Knowledge
3. Interpersonal and communication skills
4. Professionalism
5. Practice-based learning and improvement
6. Systems-based practice;

To regularly review Institutional, Program specific accreditation letters, internal review citations and monitor action plans for correction of concerns and areas of non-compliance;

To coordinate and conduct accreditation cycle mid-point internal reviews of all residency programs to ensure compliance with accreditation requirements, review and approve internal review reports, and monitor action plans for correction of areas of non-compliance;

To establish and maintain appropriate oversight to assure that Program Directors maintain proper oversight of and liaison with appropriate personnel of other institutions participating in the respective training programs;

To review and approve the annual proposal for salary ranges and benefits for all trainees; and,

To review and approve any proposal to substantially alter the working conditions (e.g., program reduction or closure) before they are enacted.

There are four standing subcommittees as follows:

a. Resident Affairs Subcommittee – This GMEC subcommittee is charged with the reviewing and making recommendations regarding residents' compensation and benefits annually and as needed. The committee also reviews results from the End-of-Year Survey of residents' educational and clinical experiences. The committee makes recommendations to GMEC regarding violations and/or opportunities for improvement.

b. Clinical Learning Environment Review Subcommittee - This GMEC Subcommittee is charged to advise the GMEC on matters affecting the clinical learning environment for training programs within the institution. Matters to be addressed by this committee will involve violations of policy and/or protocol that impact a trainee's ability to practice medicine in a safe and convivial learning environment. Issues to be discussed would include, but are not limited to:

- Patient Safety
- Quality Improvement
- Supervision by Faculty
- Competency Assessments
- Hand-offs of Care
- Fatigue/Well-being

c. Professionalism Subcommittee – This GMEC subcommittee focus is to ensure an optimum learning environment. The GMEC Professionalism Subcommittee is responsible for overseeing this feedback system and working through the Program Directors to address possible lapses in professional behavior by residents/fellows.

d. Annual Institutional Review Subcommittee – This subcommittee reviews all residency training programs in relation to their compliance with institutional policies. In addition the subcommittee reviews the summary reports to ensure that all programs are in ACGME/Accrediting Body compliance and makes recommendations to the program via the GMEC to aid in successful ACGME-RRR/Accrediting Body site visits.

Ad hoc subcommittees are formed as needed and serve until the task assigned is completed and a final report made to the GMEC for action.

The GMEC meets monthly (2nd Friday) and also holds quarterly meetings during the academic year.

Institutional Grievance Committee

The Institutional Grievance Committee is an *ad hoc* committee that is the reviewing body for disciplinary matters involving residents and a department or division, and also for matters of resident ethics, morals and general conduct. The Committee, appointed by the Designated Institutional Official consists of three (3) attending faculty members from different departments of the Hospital, the Designated Institutional Official or designee (who shall serve as chairperson), the President of the House Staff Association or his/her designee, and two (2) other members of the house staff.

HEALTH SCIENCES, HOSPITAL AND MEDICAL STAFF COMMITTEES

HUH have several committees that are a part of the institution and the medical staff that are essential to the quality and safety operations of the health enterprise. Resident membership and participation on these committees is encouraged. A listing of these committees appears below. Residents who are interested in becoming a member of one of these committees should indicate their intention to the President of the House Staff Association.

Health Sciences Committees:

- Academic Evaluation & Assessment
- Customer Experience and Engagement
- Ethics
- Patient, Student and Workforce Safety
- Quality Improvement Council

Hospital Committees:

- Forms
- Ethics
- Physician EHR (Electronic Health Record) Implementation
- Quality Management
- Regulatory

Medical Staff Standing Committees:

- | | |
|-------------------------------------|---|
| • Medical Executive | • Medical Devices |
| • Bylaws and Legal Affairs | • Cancer |
| • Credentials and Grievance | • Operating Room |
| • Nominating | • Utilization Review |
| • Health Information Management C | • Surveillance, Prevention and Control of Infection |
| • Pharmacy and Therapeutic Services | • Practitioner Health |
| • Blood Utilization | • Practitioner Peer Review |
| • Tissue (Surgical Review) | • Joint Conference |

II. HOUSE STAFF ELIGIBILITY AND SELECTION FOR POSTGRADUATE TRAINING

Essential Abilities, Requirements and Technical Standards – In the selection of trainees and in their progress through the curriculum of a training program, the attending and supervising faculty is guided by institutional policies and the requirements of the respective accrediting bodies. Consequently, all candidates for any graduate medical education program offered by the clinical departments of Howard University Hospital must meet the identified criteria necessary to successfully complete that respective program. Furthermore, the faculty is cognizant of its responsibilities to patients who will be a part of the education and training process and therefore consider carefully the scholastic achievement, personal and emotional characteristics, motivation, industry, maturity, resourcefulness, and personal health appropriate to the competent and effective health care provider.

To achieve the optimal educational experience and to maintain patient safety, trainees are required to participate in all phases of their training program. A specific minimum set of observation, communication, motor, intellectual/conceptual, integrative and quantitative abilities, behavioral and social attributes, and ethical and legal standards are needed to be a successful trainee. To be successful, the resident/fellow must progress with increasing independence throughout the training program and by the time of program completion must be capable of competent and independent practice in his/her specialty. Essential abilities and characteristics required for the completion of a training program consist of certain minimum physical and cognitive abilities and sufficient mental and emotional stability to complete the entire training program.

Candidates for any graduate medical education training program must be able to satisfy all of the technical standards listed below, which in conjunction with individual program qualification criteria, constitute the training program. These technical standards serve to delineate the necessary physical, emotional and behavioral qualifications all candidates must meet but are not intended to deter any candidate for whom reasonable accommodation will allow for the completion of the training program. Individual training programs may require more stringent or more extensive abilities as appropriate to the specific requirements for training in that clinical specialty. In certain clinical specialties one or more of the technical standards may be more or less essential. Overall, Howard University Hospital recognizes that certain disabilities can be accommodated, without compromising the requirements of the respective accrediting bodies or the fundamental integrity of its training programs.

1. **Observation:** A trainee must be able to
 - observe materials presented in the learning environment including, but not limited to, audiovisual presentations, written documents, tissues and gross organs in the normal and pathologic state and diagnostic images, and
 - accurately and completely observe patients both at a distance and directly and assess findings and perceive non-verbal communication (including facial expressing, body language and affect).

2. **Communication:** A trainee must be able to
 - speak to and hear patients and their family members in a sensitive and respectful manner to elicit information in order to obtain a medical history and respond appropriately to emotions communicated verbally and non – verbally,
 - interact efficiently and effectively with all members of the health care team,
 - synthesize accurately and quickly large volumes of medical information from different types of written and electronic formats, and
 - record information accurately and clearly in English in a variety of handwritten and computerized record systems.
3. **Motor Function:** A trainee must be able to
 - elicit information from patients by palpation, auscultation, percussion, and other diagnostic maneuvers,
 - execute motor movements reasonably required to provide general care and emergency treatment to patients,
 - carry out diagnostic maneuvers required by the specialty,
 - adhere to universal precaution measures and meet safety standards applicable to inpatient and outpatient settings and other clinical activities, and
 - manipulate equipment and instruments to perform basic laboratory tests and procedures as required to attain specialty goals.
4. **Intellectual-Conceptual, Integrative and Quantitative Abilities:** A trainee must be able to
 - comprehend factual knowledge from readings and didactic presentations,
 - apply knowledge and reasoning to solve problems,
 - recognize, comprehend and draw conclusions about three dimensional spatial relationships as well as logical, sequential relationships among events,
 - formulate and test hypotheses which enable timely and effective problem solving in diagnosis and treatment of patients in a variety of clinical modalities;
 - develop habits for lifelong learning,
 - collect, organize, prioritize, analyze, synthesize, and assimilate large amounts of technically detailed and complex information in a timely fashion and with progressive independence,
 - apply such information in problem solving and decision making in the clinical situation in a timely manner, and
 - perform calculations necessary to solve quantitative problems as required by patient care and testing needs.
5. **Behavioral and Social Attributes:** A trainee must be able to
 - demonstrate the possession of maturity and emotional health required for full utilization of his/her intellectual abilities,

- exercise good judgment in the prompt completion of all responsibilities attendant to the diagnosis and care of patients,
- develop a mature, sensitive and effective relationship with patients and colleagues,
- tolerate physically taxing workloads and function effectively under stress,
- display flexibility and adaptability to changing environments during training and patient care including call,
- be punctual and present at all assignments,
- remain awake and alert for assigned duty periods and teaching activities,
- function in the face of uncertainties and ambiguities inherent in the clinical problems of patients,
- adhere to the Hospital's code of professional conduct as well as the code of ethics and/or conduct of your accrediting institutions
- exhibit sufficient interpersonal skills to interact positively and sensitively with people from different racial, ethnic, religious and socio-economic backgrounds,
- cooperate with others and work collaboratively as a healthcare team member,
- seek the guidance and assistance of colleagues when appropriate,
- complete work including documentation and dictations in a timely manner,
- acknowledge conflicts of interests, mistakes and adverse outcomes and cooperate in the resolution of such, and
- demonstrate insight into personal strengths and weaknesses.

6. Ethical Standards: A trainee must be able to

- Adhere to ethical standards established by accrediting bodies and the Hospital;
- Conduct yourself in an ethical manner in all dealings with peers, co-workers, patients and their families, and customers; and
- meet the legal standards to obtain a Postgraduate Physician Training Enrollment form from the District of Columbia Board of Medicine

Candidates with disabilities and with questions regarding technical standards are encouraged to contact the Office of Graduate Medical Education or the specific training programs of interest to begin to address what types of reasonable accommodations may be considered for development to achieve the aforementioned standards.

A “qualified candidate with a disability” is an individual with a disability who meets the academic and technical standards requisite to admission and participation in graduate medical education programs, with or without reasonable accommodations. An accommodation is considered not to be reasonable if it poses a direct threat to the health and safety of patients, the candidate and/or others, and if making it requires a substantial modification in an essential element of a training program, if it lowers graduate medical education standards, or imposes an undue administrative or financial burden by the program or institution.

Admitted candidates with a disability will be reviewed individually, on a case-by-case basis, with a complete and careful consideration of all the attributes of each candidate to determine whether he/she can satisfy the standards with or without any reasonable accommodations. It will be the responsibility of a candidate with a disability to provide sufficient and current information documenting the general nature and extent of his/her disability and the functional limitations proposed to be accommodated. If necessary, appropriate consultation with a specialist may be obtained to help the candidate and/or the training program determine what kind of reasonable accommodations, if any, are necessary. The Office of Graduate Medical Education reserves the right to request new or additional information.

When a candidate with a disability is selected and admitted to a training program it is expected that all necessary accommodations will be detailed and agreed to by the program before he/she begins training.

Should a postgraduate trainee develop a documented disability subsequent to admission to the program or if the trainee's accommodation needs change, the trainee should contact the Office of Graduate Medical Education.

Subsequently, a complete and careful reconsideration of any condition that may pose a direct threat to patients, the trainee or others will be performed and reasonable accommodations will be made and may require a medical evaluation.

RESIDENT ELIGIBILITY

All candidates must pass a background check, physical examination and pre-employment drug screen prior to beginning a residency/fellowship training program.

1. Physicians

A candidate must pass USLME Step 1 and Step 2 inclusive of the clinical skills exam prior to beginning his/her residency or COMLEX Step and Step 2, as applicable. Applicants with one of the following qualifications are eligible for appointment to one of HUH sponsored ACGME accredited residency programs:

- Graduate of a medical school in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME);
- Graduate of a college of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA); or
- Graduate of a medical school outside the United States and Canada who meets one of the following qualifications-
 - Has received a currently valid certificate from the Educational Commission for Foreign Medical Graduates, or

- Has a full and unrestricted license to practice medicine in a US Licensing jurisdiction or has completed a Fifth Pathway Program provided by an LCME-accredited medical school.

(**Note:** H1B visa applicants will have passed all three steps of the USMLE)

In addition, a candidate must meet regulations of the District of Columbia Board of Medicine regarding either medical training licensure or regular licensure. Any candidate possessing a license to practice medicine in a US licensing jurisdiction must apply for and receive a license to practice medicine in the District of Columbia prior to beginning residency/fellowship.

2. Dentists

A candidate must:

- Have been awarded either a DDS or DMD degree from an accredited U.S. or Canadian dental school;
- Have passed Part I and take Part II of the National Dental Boards; and
- Meet the District of Columbia regulations regarding licensure.

A candidate entering the Oral and Maxillofacial Surgery Program must have passed must have passed Part I and II of the National Board Examination for Oral and Maxillofacial Surgery Residency.

3. Pharmacists

A candidate must:

- Meet all requirements for acceptance as specified by the American Society of Health System Pharmacists;
- Have been awarded a Doctor of Pharmacy degree from a pharmacy school accredited by the Accreditation Council on Pharmacy Education;
- Have passed the NAPLEX or MPJE; and
- Meet the District of Columbia regulations regarding pharmacist licensure.

4. Podiatrists

A candidate must:

- Have graduated from a College of Podiatric Medicine that is accredited by The Council on Podiatric Medical Education;
- Have successfully passed both Parts I and Part II of The National Board of Podiatric Medical Examiners exam; and
- Meet the District of Columbia regulations regarding licensure.

RESIDENT SELECTION

1. Each program will ensure that the program selects from among eligible applicants on the basis of their preparedness, ability, aptitude, academic credentials, communication skills, and personal qualities such as motivation and integrity. Programs must not discriminate with regard to sex, race, age, religion, color, national origin, disability, or veteran status.
2. In selecting from among qualified applicants, sponsored programs participate in an organized matching program, such as the National Resident Matching Program (NRMP), the Postdoctoral Application Support Service (PASS), the ASHP-affiliated Residency Matching Program, or the Central Application Service for Podiatric Residencies (CASPR) where such is available.
3. The enrollment of non-eligible residents is a cause for withdrawal of accreditation of the involved program.

Applicants for each postgraduate year must meet the requirements of having completed each previous postgraduate year or/and the postgraduate requirement for admission to the next advance year or subspecialty program as required by the program.

In situations in which an applicant transfers from another program if selected, a competency based written evaluation must be obtained from the program director of the program from which the resident is transferring.

III. SALARIES

Salaries for the 2015-2016 academic year, by PGY level, are as follows:

PGY-1	\$48,758.00
PGY-2	\$49,980.00
PGY-3	\$52,080.00
PGY-4	\$54,652.00
PGY-5	\$57,331.00
PGY-6	\$60,224.00
PGY-7	\$63,010.00

Salaries – Salaries are appropriate to the training level of the resident and are reviewed annually. Residents are paid every two weeks.

Resident physicians at the same PGY-level receive the same salary regardless of specialty. A salary review is conducted by the Resident Affairs Subcommittee of the Graduate Medical Education Committee each year and adjustments made as economic circumstances allow.

Direct Deposit – Under direct deposit, the resident authorizes Howard University Hospital to make the paycheck deposit electronically. A complete record of pay and

deductions will be confidentially distributed by mail while the next pay will be automatically deposited in the resident's bank on payday and will appear as a deposit on the resident's bank statement. The direct deposit authorization is processed by the Payroll Office.

If the resident wishes to stop direct deposit or request a change in direct deposit – to a different bank and/or account – the resident should contact the Payroll Office for assistance.

Social Security – Deductions for Social Security, as required by federal law, are withheld from paychecks. A valid Social Security number is a prerequisite for appointment.

No Personnel Action Form (PAF) can be processed and no paycheck can be issued to a resident who is not holding a valid Social Security number.

Verification of Employment – The Office of Graduate Medical Education will provide the verification necessary for deferment of educational loans. Deferment forms can be submitted to the Office of Graduate Medical Education by the Residency Program Coordinator if the signature of a GME official is needed and will forms will be co-signed by the Designated Institutional Official or his/her designee and returned to the resident's department for subsequent mailing.

Change of Address – It is essential that the Office of Graduate Medical Education maintain accurate personal information on residents. Any change in home address, telephone number, etc., should be promptly reported. Addresses are considered confidential employment information and are not released to outside agencies without prior consent of the resident.

IV. HOUSE STAFF BENEFITS

The following benefits are provided to all residents employed by the Hospital:

A. HEALTH INSURANCE

Howard University Hospital benefits program is designed to help protect the resident and his/her family against the high cost of medical care, or loss of income if he/she becomes disabled. This program also offers the resident's survivors a measure of financial security in case of his/her death, and his/her personal retirement benefits can help him/her prepare for his/her future financial needs.

The benefit programs that Howard University Hospital offers are comprehensive and the Hospital constantly strives to maintain the quality of such programs by managing cost and flexibility for the resident to choose the benefits that best meet the needs of him/her and his/her family. Benefits constitute a substantial portion of the total compensation. Understanding and using these benefits wisely allows the resident to make the most of what Howard University Hospital offers.

Key features of HUH Residents' Benefits Plan:

Residents can choose from two different medical plans:

- CIGNA Open Access Plus In Network
- CIGNA Open Access Plus 90/70 Plan

Each Plan offers quality medical, vision and prescription services.

1. Prescription

The Program includes three categories of prescription drugs – generic, preferred brand and non-preferred brand – that allows the resident to choose drugs that are effective and affordable.

2. Vision

A resident can choose in-network or out-of-network providers. By using HUH Vision Care Center a resident will pay the lowest out-of-pocket cost.

3. Dental

- Delta Dental

(A resident can enroll in the dental plan separately, without the medical plan)

The plan offers preventive care (exam, cleaning, X-rays and fluoride treatment), basic services (fillings, extractions, root canals, and oral surgery), and major services (crowns, dentures, and bridgework). In network and out-of-network providers are available, although out-of-pocket costs are lower when an in-network provider is selected. If a HUH Dental Suite provider is chosen, the resident pays the lowest out-of pocket costs.

B. LIFE INSURANCE

1. Basic Life

The amount of coverage is equal to 1 times the resident's basic annual earnings with a minimum of \$50,000.00 which is paid 100% by the Employer. Any salary over \$50,000.00 is 1 times the salary.

2. Supplemental Life

A resident may elect Supplemental life insurance coverage equal to 1, 2, 3, 4, or 5 times his/her basic annual earnings to a maximum of \$500,000.00.

C. DISABILITY INSURANCE

- 1. Short-Term Disability:** (STD) coverage provides a resident with income replacement after he/she have been disabled at least (30) thirty-days due to illness or a non-job related injury. STD pays 50% of a resident's base salary up \$500.00/week over a maximum period of 6 months (180 days).
- 2. Long Term Disability (RESIDENTS ONLY)**

If a resident is disabled for (90) days, he/she may be eligible for Long-term Disability (LTD) through Standard Insurance Company at 60% of his/her base salary.

For more information about the Howard University Hospital benefit plan, please contact a benefits representative at (202) 865-6897 or (202)865-3631.

D. PROFESSIONAL LIABILITY INSURANCE

Professional liability coverage is provided to the resident for program activities through the Howard University Self-Insurance Trust Fund, without cost. Coverage for residents will be included while on duty at the Hospital or on any assignment to any affiliated hospital, affiliated program or affiliated clinic under the direction of the Hospital's training program and personnel, unless otherwise provided by the affiliated hospital on its behalf. **Any resident shall immediately inform the Office of Graduate Medical Education and the Office of General Counsel when he/she is named or is threatened to be named in any malpractice claims, including all suits resulting from professional activities and other suits not associated with the educational program.**

E. LEAVE

Leave is integrally conditioned by each training program's participation requirements for Board eligibility in terms of minimum time spent in a training program. Approval of leave requests may be influenced by Residency Review Committee regulations as well as Specialty Board leave policies for training certification. Attendance records for each resident are maintained by the respective Program. Annual and other non-emergency leave must be scheduled in joint agreement between the resident and the Program Director. Before a resident takes leave, he/she must first check with his/her program director to schedule the appropriate time of leave, arrange for adequate coverage while off duty, and check his/her leave balance to determine the amount of leave which he/she has earned. A leave slip, which can be obtained from each Program Office, must be completed in advance for all leave requests, excluding emergency sick leave. Annual leave or other non-emergency leave should be requested at the beginning of the contract year and no less than 30 days before the scheduled leave. Failure to follow these instructions may subject the resident to leave without pay or a more severe penalty as the circumstances warrant.

In the event that a resident spends more time away from the program than is allowed for board certification, time must be made up at the end of the training period in order to achieve certification. There will be **no compensation for this made up time**, except in the case in which leave taken during the contract year was leave without pay.

1. Annual Leave

Each resident shall have three (3) weeks' annual leave per year. Unused annual leave is not carried over from one academic year to another. Residents may not voluntarily give up leave. Other than cases of personal hardship, annual leave will not be approved for the last two weeks of the training year.

Annual leave shall be scheduled by mutual joint agreement between the resident and the Program Director. Each Department sets its own rules regarding vacation requests; e.g.

the Department may pre-schedule house staff annual leave or disallow annual leave during certain times of the year. If annual leave is not pre-scheduled by the Department, it is recommended that the resident plan his/her annual leave according to Departmental policy and submit requests at the beginning of the training year.

2. Sick Leave

Sick leave shall accrue at the rate of (6) hours per pay period. Unused sick leave may be carried to the next academic year but shall be forfeited at the completion of training without compensation.

In the case of illness, the Program Director and the Chief Resident must be notified. For illness developing while on day duty in the Hospital, the resident shall report to the Employee Health Unit where he/she shall be evaluated and/or referred to a physician. During night duty, the resident shall report to the Emergency Department. For all illnesses extending beyond three (3) days, a "fitness for duty" statement signed by a licensed physician (indicating the nature of the illness, the date the resident will be able to return to duty, and any special limitations preventing full activity on return to duty), or other evidence acceptable to Employee Health, must be submitted to the Program Director's Office and Employee Health Unit prior to reporting to work. Depending on the nature of the illness, the resident shall be evaluated, or referred for evaluation, by the Employee Health Unit to determine when he/she may safely resume activities in the program. The physician completing the return-to-duty certificate cannot be a resident or related to the involved resident.

3. Administrative Leave

Administrative leave is excused absence from duty, authorized or approved by the DIO for the purpose of attending meetings, etc., from which information would be obtained or shared for the benefit of the hospital in its functions or programs. Such leave does not result in any charge to annual leave or loss of pay.

The Program Director should request approval of the DIO for administrative leave for residents under his/her jurisdiction four (4) weeks prior to meetings outside of the District of Columbia, and at least two (2) weeks prior to meetings held in the District of Columbia. This request should be forwarded to the Office of the Graduate Medical Education for signature by the DIO.

4. Leave Without Pay

Any leave other than annual, sick or administrative leave shall be classified as leave without pay (LWOP). Leave without pay requires approval by the DIO upon recommendation by the Program Director. Residents should utilize all annual and sick leave before being placed on leave without pay. During any period of LWOP, the resident is financially responsible for health insurance premiums.

5. Family and Medical Leave (DCFMLA)

Family and Medical Leave provides up to 16 weeks of unpaid family or medical leave during a twenty-four (24) month period. This applies to employees who have worked for 12 months without a break in service and worked 1000 hours during the past 12 months. The resident must notify the Program Director of his/her need for medical leave either thirty (30) days prior to the commencement of the leave or “as soon as possible prior to the date on which the resident wishes the leave to begin” when the leave was not foreseeable. Under Family and Medical Leave, the resident is entitled to be reinstated to the same PGY-level at the end of protected family and medical leave. If the resident takes more than sixteen weeks of protected leave or is unable to return to work after sixteen weeks of leave, there is no obligation under the DCFMLA to reinstate the resident.

After consultation with the DIO, the Program Director shall contact the Hospital’s Human Resources Department regarding the appropriate documentation required.

Family leave may be taken for one or more of the following reasons:

- a) the birth of a child and in order to care for the child;
- b) the adoption or placement of a child for foster care or other permanent care;
- c) serious health condition of person related by blood, legal custody or marriage, sharing a mutual residence, or committed relationship;
- d) serious health condition of a child who lives with an resident and for whom the resident assumes and discharges parental responsibility;

Medical leave may be taken for the reason:

- a) to recover from a serious illness rendering the resident unable to work

F. EMPLOYEE ASSISTANCE PROGRAM (EAP)

The Employee Assistance Program assists house staff with personal problems that can affect job performance. These problems may include marital difficulties, financial or legal problems, emotional difficulties or problems caused by alcohol or drug abuse. House Staff will have the option of obtaining help from in-house or outside consultants through referral by Employee Health staff or the Director, Graduate Medical Education. All consultations are confidential to the extent permitted by law. Appointment may be made by calling ComPsych Guidance Resources Program at 1-866-519-8354; online: guidanceresources.com. The company’s ID is EAP4HU.

G. WORKER’S COMPENSATION

While on duty, the Hospital provides worker's compensation insurance for all house staff unless otherwise provided by the affiliate hospital or on its behalf. House Staff should report all injuries (including needle sticks) to his/her supervisor as soon as possible following the occurrence. Guidelines for management in Employee Health and the ECA for house staff exposed to blood borne pathogens are outlined in the Information Booklet on OSHA Occupational Exposure Plan.

H. PARKING

Free parking shall be provided for all residents while on duty at the Hospital. Reimbursement will be made for parking elsewhere, as required while on duty.

I. UNIFORMS

Each resident shall be provided three (3) white coats without cost during the first training year. One (1) additional white coat will be provided per year thereafter, without cost. Scrub suits are available from the Laundry for residents on duty in the operating room, labor and delivery suites, nursery, and Emergency Care area. Scrub suits are required to be returned to the laundry after use and should not be worn or laundered outside of the Hospital. There is no charge to residents for the laundering of uniforms by the Hospital.

J. CONTINUING MEDICAL EDUCATION

The Hospital provides an educational stipend for allowable travel expenses for educational purposes during the senior residency or senior fellowship year. The Program Director must first approve the review course, conference or scientific publication. An administrative leave slip, Travel Authorization Form and copy of the registration information must be submitted to the Office of Graduate Medical Education prior to travel. **All travel receipts must be submitted within two weeks of travel and prior to June 30 of the academic year for reimbursement.**

GENERAL INFORMATION

A. ATTIRE

Unacceptable attire while on duty includes, but is not limited to, see-through or mesh clothing (worn alone), abbreviated tops (e.g. halters, tank tops), shorts, sun dresses, curlers in the hair, unsafe footwear or bare feet, and spandex tops or bottoms. Each department shall set its own additional rules regarding professional attire and grooming. Clean and neat clothing must be worn at all times.

B. CARDIOPULMONARY RESUSCITATION

Cardiopulmonary resuscitation certification is required of all residents. Some programs require advanced Cardiac Life Support or Pediatric Advanced Life Support training. The Hospital provides free classes for residents. Residents needing training in either of these disciplines should see their chief resident or program director.

C. HOUSE STAFF LOUNGE AND GYM

A recreation room for house staff is located on 4 South. The room is equipped with a television, telephone and lounge chairs. The house staff gym is located on the third floor of the Towers Building, room 3600. The facility has weight equipment, exercise bikes, treadmills, lockers, bathrooms, television, and more.

D. LOCKERS

The GME office will issue to each resident/fellow a locker for his/her personal use to store personal items. Locker assignments will be done at orientation. Issues related to lockers can be addressed at the GME office Monday thru Friday from 7:30AM to 5:30PM. Residents/Fellows are responsible for securing the locker issued to them and the Hospital is not liable for lost or stolen items from the resident lockers.

E. MEDICAL LIBRARY

Medical texts, journals and databases are available in departmental offices and at the Louis Stokes Health Sciences Library. The hours of operation are 8:30am - 2:00am

Monday through Thursday; 8:30am – 12midnight Friday; 9:00am to 12midnight Saturday; Noon – 12 midnight Sunday. Computers are available in all departments for research, to review lab data, and for other appropriate use. Residents are given sign on codes to Howard University website to facilitate off-site usage of library databases.

F. PRESCRIPTION MEDICATIONS

House staff may not write prescriptions for themselves, family members or Hospital employees, who are not officially under the resident's care. Moreover, the HUH Pharmacy Department shall not accept such prescriptions. Violation of this policy could result in discipline up to and including termination.

G. SECURITY

The Security Department is located in room BC-44 on the basement level of the Hospital and is operational 24 hours daily. Assistance and/or service from the Security Department may be obtained by reporting to the Security Office or by dialing 202-865-1103.

Security of valuables: To reduce the likelihood of theft of valuables, residents are encouraged to refrain from bringing large sums of cash or high priced valuables to work. If in possession of such items, residents should retain them on their person or place them in locked, secured containers. To ensure security of resident rooms, house staff should make certain that access doors to the 4 South corridor are kept locked at all times and should refrain from sharing their pass codes, badges, propping doors open or exposing valuables. Residents will not be reimbursed for stolen items.

Security escort service: During hours of darkness, escorts to or from vehicles are provided by the Security Department. Residents who desire an escort to their vehicle may obtain this service by calling ext. 5-1103 at least fifteen (15) minutes prior to the time the escort service is desired.

H. TELEPHONE SERVICES

Telephones have been placed throughout the hospital and in the resident's on-call room for the sole purpose of conducting official Hospital business. The telephone operator must be notified when any of the following occur:

1. of any temporary changes in schedule;
2. when the resident is on leave (annual, sick, or administrative) in order that his/her calls may be referred to the covering resident; and
3. immediately upon change of the resident's home telephone number.

V. GENERAL RESPONSIBILITIES OF HOUSE STAFF

Each member of the house staff must agree to:

- develop and utilize a personal program of self-study and professional growth with guidance from the teaching staff;

- fulfill the educational requirements of the graduate-training program as outlined by the respective department, the accrediting body for the specialty, and certifying board/specialty and licensing bodies;
- demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of that knowledge to patient care;
- accept the obligation to provide safe, effective and compassionate patient care that is appropriate and effective for the promotion health, prevention of illness, treatment of disease, and at the end of life, under supervision, which is commensurate with his/her level of training;
- use scientific evidence and methods to investigate, evaluate and improve patient care practices;
- comply with the rules, regulations, and policies of the institution to which he/she is assigned;
- make legible entry to medical records, patient instructions and prescriptions;
- complete all medical records within the time frame established by the HUH GME Medical Record Policy, and applicable federal and local law and Hospital policy and procedure;
- teach junior residents, medical students, and other health professional students under the supervision of the attending staff;
- apply appropriate cost-containment measures in all aspects of patient care;
- Adhere to the Hospital's professional code of conduct and the ethical standards established by the Hospital and accrediting bodies. ;
- participate in all patient care, academic and administrative activities assigned to the resident by the Department or by the Office of Graduate Medical Education; and,
- participate in departmental and hospital committees and councils whose actions affect resident education and/or patient care. The resident will be expected to participate in the evaluation of the quality of education provided by the residency program and in the evaluation of teaching faculty;
- participate in an educational program regarding impairment, including substance abuse and sleep deprivation; and,
- exhibit congenial, cooperative, and respectful relationships with colleagues peers, support staff, and patients in the performance of your job duties.

ARTICLE ____ PROFESSIONAL CODE OF CONDUCT

Professionalism is one of the six educational competencies promoted by the ACGME and adopted by the HUH GMEC as one of its Core Values. House Staff members must refrain from any act of violence on Hospital property; illegally indecent conduct on Hospital property; hostile treatment toward co-workers, patients, and visitors in the performance of job duties; and actions that would constitute hate crimes under applicable law

Section 1. House Staff Professional Code of Conduct

Professionalism is one of the six educational competencies promoted by the ACGME and adopted by the Hospital AGMEC as one of its Core Values. House Staff members must ascribe to a level of professional conduct which prohibits public behaviors that reflect poorly on the Hospital, such as any act of violence on Hospital property; immoral or indecent conduct on Hospital property; flagrant discourteous treatment of employees, patients, visitors, or other outside contacts of the Hospital; actions that demean another individual or group of individuals on the basis of his/her personal attributes, including but not limited to jokes, slurs, disparaging or derogatory remarks that are racist, ethnical, sexist, or related to sexual orientation, age, or disabilities. A member of the house staff shall not attempt to discipline any patient or employee. House staff shall adhere to the ethical and moral standards set forth by the individual clinical departments at the Hospital and affiliated institutions. Standards of conduct are outlined in the *Howard University Hospital Compliance Program, By-laws, Rules and Regulations of the Medical Staff of Howard University Hospital and Howard University Hospital's Administrative Standard Practice Manual*. Copies of these manuals are located in each Department.

Section 2. Howard University College of Medicine – Professional Code of Conduct

The Code of Honor, Professionalism and Ethics, hereafter referred to as the Code, demands that community members tell the truth, live honestly, advance on individual merit, and demonstrate respect for others in the academic, clinical and research communities. The central purpose of the Code is to sustain and protect an environment of mutual respect and trust in which the faculty, house staff and students have the freedom necessary to develop their intellectual and personal potential. To support the community of trust, students and faculty must accept individual responsibility and apply themselves to developing a collegial atmosphere. The intent of the Code is not merely to prevent students from engaging in dishonest behaviors, or to punish those who violate its principles. Rather, participation in such a Code assures The College of Medicine community that the integrity of its members is unquestioned, and accepted as fact by those in the academic, clinical and research communities. Participation in the Code confers upon faculty, staff, house staff and most importantly, students, the responsibility to respect and protect the values of the Howard University College of Medicine (COM).

Section 3. Howard University Hospital - Professional Code of Conduct

The Hospital is committed to supporting a culture that values excellence, honesty, and fair dealing in all its operations with the goal of promoting a safe, caring environment for patients, their families and all employees.

The purpose of this policy is to ensure optimum patient care by promoting a safe, cooperative and professional healthcare environment.

Collaboration and communication are essential for the provision of safe and competent patient care. Thus, all medical and non-medical employees working in the Hospital must treat each other with equal respect and courtesy regardless of age, gender, gender-identity, religious disposition, job description, nationality or ethnicity. They are required to always conduct themselves in a professional and cooperative manner. Enforcing a code of conduct requires consequences for breaking the code that are clearly defined and applied when employees exhibit inappropriate behavior.

Section 4. Definitions

Appropriate Behavior—includes conduct that advocates for patients or activities that foster patient care and safety. It also includes conduct that promotes a streamlined, safe, efficient and fulfilling work environment.

Inappropriate Behavior – includes conduct that is reasonably interpreted to include that which is contrary to professional ethics standards and/or otherwise unsafe, reckless, fraudulent, and criminal. Persistent or repeated inappropriate behavior could become disruptive to routine Hospital or employee function, and thus subject to disciplinary action.

Harassment – includes persistent offensive conduct towards other based on their race, religion, gender, gender identity, sexual orientation, nationality or ethnicity, which has the effect of unreasonably interfering with a person's work performance and/or creates a hostile work environment.

Sexual Harassment –includes unwelcome sexual advances, requests for sexual activity which is made an explicit or implicit condition of current or future employment and related decisions; 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.

Section 5. Inappropriate Behaviors

Behaviors listed below warrant disciplinary action. These behaviors will be listed according to levels with the highest level having the most severe consequences. The levels would be from I- IV. All consequences would be enacted after investigation that the punishment was fair.

Level I

- Ignoring patients/employees for non-Hospital related activities while working:
 - Personal conversations, phone calls or web browsing
- Interrupting, delaying or obstructing patient care (such as- providing medications, discussing pertinent information, use of computers, evaluating patient, checking vitals or labs on computer) for non-Hospital related activities:
 - Personal conversations, phone calls or web browsing
- Eye Rolling at patients/employees
- Hanging up on patients/ employees while on the phone
- Dismissing patients/employees while they are talking
- Excessively loud music or personal telephone conversations
- Use of abusive language directed at patients
- Yelling or raising one's voice during conversation with patients
- Not treating co-workers respectfully and professionally

Level II

- >3 Level I offenses
- Malicious gossip, spreading rumors intended to, or reasonably likely to, cause reputational harm or emotional distress to a co-worker or patient.
- Degrading or demeaning comments regarding patients or hospital co-workers
- Unwelcome harassment of patients and employees

Level III

- Bullying co-workers or patients
- Threats directed at other employees and patients
- Unwanted touching
- Drug or alcohol abuse or on-the-job intoxication
- Theft
- Failure to properly waste narcotic medications in accordance with Hospital procedures

Level IV (ZERO TOLERANCE)

- Physical assault
- Sexual harassment
- Threats of physical harm or death
- Using, carrying or brandishing a weapon while on Hospital premises or engaged in Hospital business
- Damaging Hospital property intentionally
- Rape or sexual assault
- Obscene phone calls (Explicit sexual content)
- Stalking
- Illegal drug use on Hospital property

Professional Standards: Use and Policies Regarding Social Media

1. As a comprehensive research university, Howard University recognizes the importance of participating in online conversations and activities. Howard encourages responsible and respectful online activity by students, faculty and staff and maintains a commitment to academic freedom on social media platforms. It is expected that the following university core values will govern the online choices Howard University communicators make: Truth, Service, Leadership, and Excellence.
2. Guidelines have been developed to provide and outline how the above core values should be demonstrated in official communications in social media spaces. The Guidelines apply to material that Howard departments, offices and related units publish on Howard-hosted websites and related Howard social media sites. Any questions about these Guidelines should be directed to the Office of University Communications by sending an email to ouc@howard.edu.

Specific details and requirements of the Guidelines and the complete policy can be found at:

<http://www.howard.edu/secretary/documents/POLICY700-001SocialMedia.pdf>

Processing Complaints and Due Process

All are encouraged to promptly report any forms of misconduct so that appropriate action can be taken. The complaint procedures are designed to ensure the rights of the complainant while at the same time affording due process to both parties.

Complaints can be accepted orally or in writing. Anonymous complaints will be accepted and investigated to the extent possible. Confidentiality will be maintained throughout the entire investigatory process to the extent practicable and appropriate under the circumstances to protect the privacy of persons involved. The persons charged with investigating the complaint must discuss the complaint or the underlying behavior only with persons involved in the case who have a need to know the information, which must include the complainant and the respondent.

Immigration Status

House staff who are physicians are required to submit evidence of their professional degree, prior to postgraduate training, a passing score on United States Medical Licensing Examination Steps 1, and 2 or (NBME, FLEX, NBOME), and eligibility for employment (i.e., U.S. Citizenship, Permanent Residency, or a valid work permit) as a condition of acceptance for training.

Residents who are international medical graduates and not US citizens or permanent residents are required to maintain legal immigration status while in training. A post graduate physician, who is a foreign citizen and does not have a valid permit to work in the United States, will be immediately terminated from the residency program. Permission to work in one hospital training program may not be transferable to another. For more information, contact The Educational Commission for Foreign Medical Graduates, 3624 Market Street, Philadelphia, PA 19104-2685; telephone number: 215/386-5900 and/or Dr.

Wilma Hosten, Petitioner for Howard University and Howard University Hospital, 2244 10th Street, NW, 4th Floor, Rm. 437, Washington, D.C. 20059; telephone number: 202/806-1279.

National Provider Identifier (NPI) Number

Each physician resident must apply for a NPI Number within 30 days of starting their residency training. The application is made online at <https://nppes.cms.hhs.gov/NPPES>. The number must be reported to the residency coordinator when it is received.

Identification

House staff shall introduce themselves by name, title and role to patients on initial contact and to other Hospital employees or patient visitors upon inquiry. When on duty, Hospital-issued identification badges are to be worn at all times. In the event the identification badge is lost, a replacement badge may be obtained through the Hospital Office of Human Resources located on the Second Floor, Room 2105. A fee will be charged to obtain a replacement identification badge.

Medical Training License/Licensure

Postgraduate Physicians:

- Medical Training License (MTL)

All M.D./D.O. residents and fellows who are not licensed and are not required to be licensed in the District of Columbia are required to complete a Medical Training License Application (inclusive of required supporting documentation on initial application) annually. The initial MTL application package should be completed and turned in to the GME Administrator for Office of Graduate Medical Education attestation review and approval for submission to the DC Board of Medicine. All MTL applications must be subsequently submitted to the DC Department of Health. The MTL must be renewed online every year thereafter during residency or fellowship training. The application and instructions can be found on the D.C. Government Department of Health website, <http://doh.dc.gov/service/bomed-medical-training-license-and-registrant-application>

- USMLE Step 3

It is the policy of HUH that all physician residents are to complete and pass the USMLE, Step 3/COMLEX, Level 3, as applicable, within eighteen (18) months of starting a training program. Failure to pass the Step 3/Level 3 examination within this timeframe will result in non-promotion of the resident to the next year of training. In other words, residents cannot advance to the next PGY-level of training without passing the USMLE, Step 3/COMLEX, Level 3.

- Full Licensure

The District of Columbia Board of Medicine requires that a postgraduate physician obtain an unrestricted license to practice medicine in the District of Columbia after five (5) years or if they have secured a license in another jurisdiction after the completion of clinical training program. In addition, if a postgraduate physician has a license in any other jurisdiction in the United States, that physician must have a D.C. medical license in order to participate in a HUH residency program.

The medical licensure in the District of Columbia is related to the United States Medical Licensing Examination (USMLE) and COMLEX. Postgraduate physicians must successfully pass USMLE 1, 2, and 3 before obtaining a full D.C. medical license. Postgraduate physicians (U.S. grads) must complete at least one year of postgraduate training in an approved program in order to be eligible for a full license in the District of Columbia; international medical graduates need three years of approved postgraduate training in the United States to be eligible for a full license in the District of Columbia.

There is a maximum of seven years to complete all three Steps of the licensing examination (USMLE or COMLEX). The seven-year maximum begins with passing Step 1. If a physician fails Step 3 three (3) times, the physician must complete another year of ACGME- approved postgraduate training before being eligible to retake Step 3.

INSTITUTIONAL GME DUTY HOURS POLICY

PURPOSE: To provide residents and fellows with a sound academic and clinical education that is carefully planned and balanced in order to enhance patient safety and resident well-being and ensures that the learning objectives of the program are not compromised by excessive reliance on residents/fellows to fulfill service obligations. Duty hour assignments recognize that didactic and clinical education has priority in the allotment of residents'/fellows' time and energies and that faculty and residents/fellows collectively have responsibility for the safety and welfare of patients.

Definitions:

Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading, studying and preparation time spent away from the duty site.

In-house call is defined as those duty hours beyond the normal work day when residents are required to be immediately available in the assigned institution.

At-home call is defined as call taken from outside the assigned institution.

Moonlighting is defined as any clinical activity that is optional and separately paid, including work not requiring a physician's license.

POLICY STATEMENT: Consistent with the ACGME duty hours standard outlined in the Common Program Requirements, graduate medical education programs sponsored by Howard University Hospital must meet the following requirements:

Duty Hours:

1. Maximum Hours of Work per Week: Duty hours are limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting.

2. Mandatory Time Free of Duty: Residents/Fellows should be scheduled for a minimum of one day free every week from all educational and clinical responsibilities, averaged over a 4-week period. At-home call cannot be assigned on these free days. One day free is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.

3. Maximum Duty Period Length:

- Duty periods for PGY-1 residents must not exceed 16 hours in duration.
- Duty periods for PGY-2 residents and above may be scheduled for a maximum of 24 hours of continuous duty in the hospital.
 - Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.
 - Residents/fellows must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty. Residents/fellows may be allowed to remain on-site in order to accomplish effective transitions in care; however, this period of time must not exceed four hours.
 - In unusual circumstances, residents/fellows, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a **single** patient. Justifications for such extensions of duty are limited to reasons of required continuity of care for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family. Under such circumstances, the resident/fellow must appropriately hand over the care of all other patients to the team responsible for their continuing care; and, document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director within 24 hours of occurrence.

4. Minimum Time Off between Scheduled Duty Periods:

- PGY-1 residents should have 10 hours, and must have 8 hours, free of duty between scheduled duty periods.
- Intermediate-level residents/fellows should have 10 hours free of duty, and must have 8 hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.

- Residents/fellows in the final year of education must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. This preparation must occur within the context of the 80-hour, maximum duty length, and one day off in seven standards. While it is desirable that residents/fellows in their final year of education have eight hours free of duty between scheduled duty periods, there may be circumstances, as defined by a program's RRC, when these resident must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty. Such circumstances must be monitored by the program director and be appropriately documented.
5. **Maximum Frequency of In-House Night Float:** Residents must not be scheduled for more than six consecutive nights of night float.
 6. **Maximum In-House On-Call Frequency:** PGY-2 residents and above must be scheduled for in-house call no more frequently than every third night, when averaged over a four-week period.
 7. **At-Home Call:** Time spent in the hospital by residents/fellows on at-home call must count towards the 80-hour maximum weekly hour limit.
 - The frequency of at-home call is not subject to the every third night limitation, but must satisfy the requirement for one day in seven free of duty, when averaged over four weeks.
 - At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident/fellow.
 - Residents/Fellows are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period".

Duty Hour Violations

1. Residents are required to honestly and accurately report the hours spent on duty on a monthly basis. The following actions will be taken when a resident fails to report duty hours.
 - a. First occurrence – The resident will present his/her reason(s) for failing to report duty hours to the GMEC
 - b. Second occurrence - The resident will present his/her reason(s) for failing to report duty hours to the GMEC and a letter of warning will be placed in his/her training record.
 - c. Third occurrence – The resident will be suspended without pay for one day or until his/her duty hours are entered into the on-line system,

whichever is **greater**. In addition, a letter of non-compliance will be placed in the resident's file.

2. A resident who is found to have violated a duty hour standard or who reports a violation of the duty hour policy will be asked to present the reason why the violation occurred. (This rule was created to enable residents to report violations secondary to problematic rotations, faculty or senior residents.)

The affected resident will present his/her reason(s) to the chief resident in his/her department. The chief resident will also speak with the senior most resident on the rotation who was on-call on the day the violation occurred to determine whether the violation was a result of a problem with signing out from duties.

If it is determined that the affected resident spent extra time as a result of an inability to complete his/her clinical duties on a post-call day then the chief resident will communicate with the attending in-charge. The chief resident must also talk to the Program Director who may opt to talk to the department chairperson about the circumstance.

The respective chief resident will subsequently present his/her finding to the GMEC for each resident found to have a duty hour violation. An affected resident shall have the option of attending the GMEC meeting if he/she wished to do so. An affected resident shall also have the option of presenting his/her reason for a violation directly to either the Program Director, the Office of Graduate

Medical Education or to House Staff Association Executive Council members without going to the chief resident. In such situations either the Program Director, Office of Graduate Medical Education or the House Staff Association Executive Council will present findings to the GMEC.

3. If the violation occurred because the resident refused to leave at the end of his/her scheduled shift, the resident will receive a letter of warning for the first occurrence. A subsequent violation will result in a one-day suspension without pay and a letter of non-compliance placed in the resident's file.
4. Any resident who does not report duty hour violations and is later discovered to be in violation, will receive a one-day suspension without pay and a letter of non-compliance will be placed in his/her file.

Duty Hours Exceptions: Howard University Hospital does not permit exceptions to the standard duty hour requirements.

Moonlighting: Residents/fellows are not required or encouraged to moonlight. In those instances in which permission by the program director is given to moonlight, such activity must not interfere with the ability of the resident/fellow to achieve the goals and objectives of the educational program. Time spent by residents/fellows in Internal and

External Moonlighting must be counted towards the 80-hour maximum weekly hour limit. PGY-1 residents are not permitted to moonlight. (see Institutional Moonlighting Policy)

Fatigue Mitigation: Programs must educate all faculty members and residents/fellows to recognize the signs of fatigue and sleep deprivation; educate all faculty and residents/fellows in alertness management and fatigue mitigation processes; and, adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules. All residents and fellows are required to complete an online module (LIFE – Learning to Address Impairment and Fatigue to Enhance Patient Safety- curriculum) which will fulfill the training requirement for house staff. Programs may provide additional training to house staff, and must identify proper training methods for their faculty.

Program Policies and Oversight: Each residency and fellowship training program must develop and maintain a policy on resident/fellow duty hours. Program duty hour policy must meet the educational goals and objectives and patient care responsibilities of the training programs, and must comply with the duty hour limits according to the specialty-specific Program Requirements, the Common Program Requirements, and the Institutional Duty Hours Policy. In addition a program's policy should also address:

1. How the program will monitor duty hours to ensure compliance with ACGME requirements;
2. How the program will monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue, if applicable;
3. How the program will monitor fatigue and engage in alertness management and fatigue mitigation should circumstances dictate, and how the program will adjust schedules as necessary to ameliorate such situations when presented;
4. How the program will monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;
5. Whether or not the program allows moonlighting, the process that must be followed to obtain approval from the program director, and the circumstances which will lead to withdrawal of approval;
6. How the program will track episodes of additional duty when the resident/fellow, through his/her own initiative, remains beyond the scheduled period of duty to continue to provide care to a **single** patient; and,
7. Mechanisms the program will use to ensure residents and fellows honestly and accurately report their duty hours and compliance with all duty hour standards in the E-Value* Residency Management Software system in a timely manner.

NOTE: Each resident/fellow will be asked to sign an acknowledgement of receipt of the duty hour policy at the beginning of the academic year.

Formal Documentation of Additional Clinical Hours

Note: In unusual circumstances, a resident/fellow, of his/her own initiative, may remain beyond his/her scheduled period of duty to continue to provide care to a single patient. In such instances, this form is to be used by the resident/fellow to document the circumstances for remaining on duty beyond the scheduled period. **This form must be submitted to the Program Director within twenty-four (24) hours of such an occurrence.**

Resident/Fellow Name: _____

Program: _____

Rotation: _____

Date of Occurrence: _____

To the Program Director:

This form is submitted to inform you that I, of my own initiative, remained beyond my scheduled duty period to care for a single patient. My decision to remain beyond my scheduled duty period to provide such required continuity of care was for the following reason(s):

- ☐ The patient was severely ill or unstable
- ☐ The events transpiring were of academic importance
- ☐ I needed to provide attention to the needs of the patient
- ☐ I needed to provide attention to the needs of the patient's family

I handed over the care of all my other patients to the team responsible for their care.

Resident/Fellow Signature

Date

Acknowledgment by Program Director/Signature

Date

NOTE: As required by the ACGME, a copy of this form will be kept in the resident's/fellow's file.

INSTITUTIONAL GME MOONLIGHTING POLICY

Purpose: To describe the parameters for clinical activities that occur outside the context of a resident's/fellow's graduate medical education program and for which there is separate remuneration.

Definition: Moonlighting is defined as any clinical activity that is optional and separately paid, including work not requiring a physician's license. This definition pertains even if the work is supervised by attending physicians and even if the work is identical to activities that are part of the residency or fellowship program.

POLICY STATEMENT: PGY-1 residents may not moonlight and upper level residents/fellows are not required or encouraged to engage in moonlighting. Prior to engaging in any moonlighting activities, an upper level resident or a fellow must obtain approval from his/her program director. This is to be accomplished through formal request to the program director which lists the institution(s) for moonlighting activities, the scope of the proposed activities and the maximum number of hours of proposed moonlighting. In turn, the program director must provide written verification that he/she has approved the resident's/fellow's request to moonlight. Written verification of approval of the resident's moonlighting request will be placed in the resident's/fellow's file.

Once approval for moonlighting has been granted, it will be the responsibility of the program director to monitor the resident's/fellow's performance for the effect of moonlighting upon his/her academic and clinical performance. If adverse effects are detected, the program director may withdraw permission to moonlight.

Residents who engage in moonlighting must be licensed for unsupervised medical practice in the state where the moonlighting occurs. Howard University Hospital (HUH) is not responsible for determining a resident's/fellow's licensure status for the purpose of moonlighting at another institution. In addition, Howard University Hospital does not provide professional liability coverage to residents for moonlighting activities. Howard University and Howard University Hospital are not in any way responsible or liable for the acts or omissions of residents/fellows while moonlighting at another institution.

The hiring institution is responsible for determining:

- a. proper licensure for the moonlighting resident
- b. adequacy of liability coverage for the resident
- c. whether the resident has appropriate training and skills to do the assigned duty.

All moonlighting hours, whether it is internal or external to HUH, are to be counted toward the 80-hour weekly average. In programs in which moonlighting is allowed, residents/fellows are required to sign an acknowledgement of receipt of this policy. The signed acknowledgement is to be kept in the resident's file.

FORMAL REQUEST TO MOONLIGHT

Name of Resident/Fellow: _____

Program: _____

I hereby request permission to engage in clinical activities outside the scope of the residency/fellowship training program (i.e., moonlighting). I will limit the hours of moonlighting to no more than _____ hours per month, and will not allow my duty hours (i.e., the total sum of time spent in the training program **plus** time moonlighting) to exceed the 80-hourly weekly average set by the ACGME and the program's Residency Review Committee (RRC).

I shall be working at the following health care facility (ies):

1. _____
2. _____
3. _____
4. _____

A brief description of the activities in which I will engage is as follows:

I acknowledge that Howard University Hospital does not provide professional liability coverage to residents/fellows for moonlighting activities. I also acknowledge that Howard University and Howard University Hospital are not in any way responsible or liable for the acts or omissions of residents/fellows while moonlighting.

I recognize that the residency/fellowship program is my main professional priority and I will not let additional professional activities interfere with this. I also understand that the program director will monitor my academic and clinical performance, and if he/she determines that there is an adverse effect from the moonlighting activity, he/she may withdraw permission to moonlight. I have read and understand the Institutional Moonlighting Policy and will abide by it.

Signature of Requestor

Date

Approved by Program Director/Signature

Date

GMEC Monitoring and Oversight of Duty Hours

The GMEC will also monitor duty hours monthly at its regularly scheduled meeting. The GMEC will look for trends in violations and determine whether the cause of the violation is program, faculty or resident dependent.

SCHOLARLY ACTIVITY

Publications and Issuance of Information

Contributions to scholarly, scientific, and professional periodicals or journals must be with the written consent of the applicable Program Director. Disclosing the Hospital's proprietary and confidential information and/or protected patient information is prohibited.

Use of official University or Hospital stationery for personal or partisan political activity is prohibited.

Research

Each resident is expected to become involved in research activity. This activity is coordinated by the program director and may be in collaboration with faculty and attending staff. Annual resident and faculty research forums are held during Alumni Week each May. Oral presentations or poster presentations are rewarded by competitive prizes to the resident. Entry for presentation in May should be made by December each year.

Publications and Issuance of Information

Contributions to scholarly, scientific, and professional periodicals or journals must be with the written consent of the applicable Program Director. Disclosing the Hospital's proprietary and confidential information and/or protected patient information is prohibited.

Use of official University or Hospital stationery for personal or partisan political activity is prohibited.

FINAL CLEARANCE/CERTIFICATE OF TRAINING

A final clearance form must be completed during the last month of training in order to receive a final paycheck and certificate of training. Verification that the resident has no obligations to the University is obtained by signatures from officials in Medical Records, Student Loans Office, Laundry, Security, Telecommunications, Health Sciences Library and the Program Director. Forms can be obtained from each Program Office. Residents will be required to complete an exit survey prior to clearance form sign off by the Office Graduate Medical Education. Clearance forms should be submitted to the Payroll Office upon completion.

Upon the recommendation of the program director, a certificate of training will be awarded to house staff at the end of the final year of training provided that the resident's performance was satisfactory and he/she is not indebted to the Hospital. The certificate will bear the date indicating when the resident fulfilled all requirements of the program.

VI. HOSPITAL RESPONSIBILITIES

The hospital agrees to:

- provide an educational program that meets the standards of the accrediting bodies and specialty boards of the residents' training program;
- maintain staff and facilities in accordance with the standards of the respective training program accrediting body, and the Hospital;
- provide professional liability insurance coverage for each house officer for patient care activities associated with the hospital educational program, including all affiliated teaching facilities to which the house officer is assigned, unless such coverage is provided by the affiliated facility;
- provide fair and equitable scheduling of duty time for all house staff, including the provision of adequate off-duty hours as required by the accrediting body;
- provide meals and sleeping accommodations for all house staff while on night duty at the Hospital;
- notify residents of any changes in the accreditation status of their respective training program; and,
- make reasonable effort to provide continued fulfillment of contractual agreement or placement for training in the event of a Hospital or affiliated hospital merger, closure or downsizing.

SUPERVISION

Howard University Hospital (HUH) ensures that its GME programs provide appropriate supervision for all residents that is consistent with proper care, the educational needs of residents and the applicable program requirements. There is sufficient oversight by HUH to ensure the residents are appropriately supervised in the following manner:

All patient care will be supervised by qualified faculty. The program director ensures, directs, and documents adequate supervision of residents at all times. Supervision by teaching staff occurs in such a way that the residents assume progressive, increasing responsibility according to their level of training, ability and experience. Residents are provided with rapid, reliable systems for communicating with supervising faculty.

On-call schedules for teaching faculty are structured to ensure that supervision is readily available to residents on duty.

POLICY STATEMENT: The program director will direct, manage and document faculty supervision of residents and/or fellows to ensure that these trainees are provided with a prompt and reliable system for communicating with supervising faculty. In addition, the program director of each residency and/or fellowship will ensure that all program faculty and trainees: 1) are educated to recognize the signs of fatigue and sleep deprivation; 2) are educated in alertness management and fatigue mitigation processes; and, 3) adopt fatigue mitigation processes to manage the negative effects on patient

care and learning.

Below are listed general guidelines relative to the institutional expectations regarding faculty supervision and senior residents/fellows supervision of trainees.

Definition: Supervision is an intervention provided by a supervising practitioner to a resident. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the resident while monitoring the quality of professional services delivered. Supervision is exercised through observation, consultation, directing the learning of the resident, and role modeling. **NOTE:** This definition is adapted from Bernard, J. M., & Goodyear, R. D., *Fundamentals of Clinical Supervision* (2nd ed.), Needham Heights, MA:Allyn & Bacon 1998.

Roles and Responsibilities: Resident and fellowship training occur in the context of different disciplines and in a variety of appropriately structured clinical settings, including inpatient, outpatient, long-term care, and community settings. As such the following functions are implemented:

1. Residency/Fellowship Program Director: The residency/fellowship program director is responsible for the quality of the overall education and training program in a given discipline and for ensuring that the program is in compliance with the policies of the respective accrediting body. The residency/fellowship director, in conjunction with program faculty members, defines the levels of responsibilities for each year of training by criterion-based descriptions of the types of clinical activities trainees may perform at each training level.
2. Supervising Faculty: The supervising faculty member is responsible for, and must be personally involved in, the care provided to individual patients in inpatient and outpatient settings as well as long-term care and community settings. When a resident/fellow is involved in the care of the patient, the responsible supervising faculty member must continue to maintain a personal involvement in the care of the patient. A supervising faculty member must provide an appropriate level of supervision as described below:
 - a. Direct supervision – the supervising faculty is physically present with the patient and resident;
 - b. Indirect supervision:
 - with direct supervision immediately available – the supervising physician is physically within the hospital or other site patient care, and is immediately available to provide direct supervision;
 - with direct supervision available – the supervising physician is not physically present within the hospital or other site patient care, but is immediately available by mean of telephonic and/or electronic modalities, and is available to provide direct supervision.

- c. Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

NOTE: PGY-1 physician residents should be supervised either directly or indirectly with direct supervision immediately available as required by the ACGME.

Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident/fellow and delegate to him/her the appropriate level of patient care authority and responsibility.

Guidelines must be established for circumstances and events in which residents/fellows must communicate with appropriate supervising faculty members, such as transfer of a patient to an ICU, or end-of-life decisions.

3. Senior Residents/Fellows: Senior residents and/or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. Senior residents and fellows are still considered to be in training and must be supervised by a faculty member via one of the levels previously described.

Documentation of Supervision of Residents/Fellows: In general the medical record must clearly demonstrate the involvement of the supervising faculty in each type of resident/fellow-patient encounter as described:

1. Progress note or other entry in the medical record by the supervising faculty member;
2. Addendum to the resident/fellow progress note by the supervising faculty member;
3. Co-signature of the progress note or other medical record entry by the supervising faculty member.

NOTE: The supervising faculty member's signature signifies that he/she has reviewed the resident/fellow note, and absent an addendum to the contrary, concurs with the content of the resident/fellow note or entry;

4. Resident/fellow progress note or other medical record entry documenting the name of the supervising faculty member with whom the case was discussed and a statement of the supervising faculty member's responsibility with respect to the assessment or diagnosis and/or the plan for evaluation and/or treatment.

NOTE: Items 1 through 4 are for documentation of level of supervision and may not be appropriate for clinical documentation and billing purposes.

Monitoring Procedure:

To ensure that supervision occurs at an appropriate level for all residents/fellows, the residency/fellowship program director will report annually to the GMEC and update or changes in roles, responsibilities and patient care activities of the participants in the respective graduate medical education program, or report if there is no change from the previous year. There will be particular reference to changes in job descriptions,

procedure grids, progressive involvement and independence in specific patient care activities. In addition, residents will be periodically surveyed to assess the perceived nature and level of supervision provided by faculty as well as senior residents/fellows. Finally, adequacy of supervision will also be assessed by review of the ACGME resident survey (physicians in training only), findings during the annual review of program effectiveness and during the internal review process.

ANNUAL PHYSICAL EXAMINATION

The Hospital has a continuing responsibility to ensure that its employees and trainees are healthy as monitored by the Employee Health unit. Hospital and District of Columbia regulations require annual physical examinations of house staff. Conditions found not to be consistent with house staff or patient safety during training must be addressed as indicated. The Hospital may deny acceptance to the training program of any prospective trainee with an infectious disease or any other health condition, which may place patients in the hospital or employees at risk.

- a) Pre-Employment Physical Exams are scheduled by the GME Office in conjunction with the Employee Health Unit. A complete physical examination will be performed on all residents. The examination will include:
 - a. VDRL (Venereal Disease Research Lab test for syphilis)
 - b. Tuberculin (PPD) testing or Chest X-ray on those with reactive PPD
 - c. Hepatitis B profile
 - d. Rubella titers
- b) Immunization of Employees - Prophylactic therapy is provided to resident under certain circumstances, such as gamma globulin and HBIG when indicated following needle punctures and certain vaccines for non-immune employees. The employee health vaccination program includes:
 - a. Tetanus-Diphtheria (TD) is provided upon request of employees who have not received booster injections of tetanus toxoid with a ten-year period.
 - b. Rubella – Those employees who are found to have no protection against the Rubella virus are notified by Employee Health. Rubella vaccine is mandatory for all employees who do not have adequate protection against Rubella who work in high risk areas, e.g., ECA, Pediatrics, and OB/GYN. Other employees may receive the vaccine on an elective basis.
 - c. Hepatitis B vaccine is offered free of cost to all HUH employees
 - d. Influenza vaccine is offered to all HUH employees
 - e. Rabies vaccine is offered to HUH employees who are exposed to potentially rabid animals as a part of their employment.
- c) Human Immunodeficiency Virus prophylaxis is offered to employees as a part of the needle stick protocol or who have been potentially exposed to the virus as a part of their employment.
- d) Fit Testing

Management of Occupational Exposures to Bloodborne Pathogens/Needle Stick

In the event of an injury by a needle stick, scalpel, dental care tool, or other sharp object which results in breakage of the skin or exposure of blood to a mucous membrane, the

individual should report the incident to their supervisor and go immediately to the appropriate venue for evaluation – TIME IS OF THE ESSENCE.

Where to go for evaluation

	M-F, 8am - 3:30pm, report to:	All other times, report to:
Employees, Volunteers, and HUH Residents	Employee Health Department – Medical Arts Bldg, 2 nd floor 202-865-1481	Emergency Department, with subsequent follow-up in Employee Health

The Healthcare Provider will document in the clinical record the specific type of injury, the location where the injury occurred, how the injury occurred, and any significant medical information on the particular patient involved. The provider should review the exposed individual's records to ascertain his/her hepatitis B, tetanus, and other pertinent vaccination statuses.

DEA Number

The Drug Enforcement Agency issues a DEA number to the hospital for the purpose of dispensing controlled drugs. The GME Office will assign each resident a hospital signifier that is to be attached to the hospital's DEA number when writing prescriptions.

Electronic Mail/Mail/Internet Access

Each resident will be assigned a Howard University email address. This address will be used to communicate with the resident during the duration of his/her training at HUH. It is imperative that the resident use this address only as it also serves as the sign in for off campus use of the Louis Stokes Health Sciences library. In addition, each department provides an area for house staff mail. Each program provides computers for internet access. In addition, computers/printers are available in the Computer Resource Lab on the fourth floor of the Hospital.

Meals

The GME Office issues a meal card to each house officer at the beginning of every month that he/she is assigned to duty in the Hospital for the purchase of meals in the cafeteria during normal operating hours. Meal cards are not transferable. A detected transferred meal card will be confiscated. If the meal card is confiscated or lost, no additional meal allowance will be provided for that month, and a twenty-five dollar (\$25) card replacement fee shall be charged. Meals are delivered to 4 South for residents who are assigned to night call. There is a monthly meal allowance for residents who are assigned to outside rotations.

Pagers

Pagers are assigned to each house officer to allow communications within the Hospital and off the premises. If a pager is lost, the house officer shall be charged a replacement fee. In addition to pagers, several services carry cell phones to facilitate consultation.

Sleeping Accommodations

Sleeping accommodations are provided to residents without cost while on night duty. A listing of HUH on-call rooms assigned to each resident is maintained in the Office of GME. Residents shall report needed repairs or housekeeping concerns to the Departments of Engineering (ext. 5-1251) or Environmental and Linen Services (ext. 5-1101) respectively, or to the Office of GME. Unusual delays in corrective action should be reported to the Office of GME.

The resident/fellow call rooms are located on 4 South Corridor – Residents’ Quarters (4th floor). The call rooms are assigned daily to residents within specific programs, who take In-House Call. The call room assignments are distributed every day at 1:00pm. However, there are a few unassigned call rooms, open to residents on a sign-up basis for Home Call and Fatigue. The descriptions are outlined below.

In House Call – Programs whose house staff remain in-house overnight are assigned call rooms on a daily basis. These include sleep space (bunk beds), shower and toilet facilities, lockers, and a pc in each call room.

Home Call – Programs whose house staff takes home call may have times that they remain in the hospital without returning home. In these instances, there are some “hotel” call rooms that can be used on an as-needed basis.

Fatigue – In the event that a resident is too fatigued to safely return home, he/she should utilize the on-call sleep space to nap until such time as they are safe to drive. Another option would be to contact their primary training office, or the GME office to find someone who will safely transport the resident home or provide a travel voucher.

In the event a resident takes Home Call or is fatigued, they are asked to contact the GME Administrator to schedule a room reservation for that day.

All call rooms are the property of Howard University Hospital and house staff are expected to be good stewards of this space. The rooms are serviced every day to provide house staff with the paramount cleanliness and comfort. Any problems with these rooms (linens, cleanliness, pest control, burnt out lights, broken furniture, etc.) should be reported to Ms. Alonda Thompson, MA in GME at alothompson@howard.edu, 202.865.7151 or 202.689.5399.

INSTITUTIONAL GME DISASTER POLICY

In the event of a disaster or interruption in patient care in which the training environment is unable to support a quality clinical education/training experience, the Designated Institutional Official (DIO) working with the program directors and residency training coordinators will:

1. Assess all programs to determine what training, if any, can occur in the institution.

2. Determine how many resident/fellows need temporary or permanent transfer to another training program.
3. The DIO will call or e-mail the ACGME Institutional Review Committee Executive Director with regard to the nature of the disaster and the need for assistance, if any. Similarly, the program directors will call or e-mail their respective Residency Review Committee Executive Director to supply necessary information.
4. The program directors with the assistance of the residency coordinators will prepare documentation necessary to effect temporary or permanent transfer of affected residents. Each resident/fellow will be given an estimate of the minimum amount of time of his/her transfer. If permanent transfer is required affected residents/fellows will be so notified.
5. The DIO will work with HUH leadership to ensure that financial and administrative support of all programs and residents will occur through the duration of the disaster.
6. If relocation of GME administration is necessary, such relocation will be communicated to the residents by the HUH and HU website. In addition, Howard University's radio and television stations may be utilized through public service announcements to communicate to residents and fellows.
7. If it is determined that the program will close permanently, the ACGME will be notified and the GMEC policy for program closure will be followed.

This ACGME requirement shall be applicable to all HUH sponsored graduate medical education programs.

TRAINING PROGRAM REDUCTION/CLOSURE

If a HUH sponsored postgraduate medical education training program reduces its size or ceases to exist, the residents in the program will be notified as soon as possible by the Program Director of the affected program.

In the event of program reduction or closure, every reasonable effort will be made to allow an affected resident currently in the program to complete his/her education if satisfactory progression has been demonstrated.

If a resident is displaced because of program reduction or closure, the Program Director will make every effort to assist the affected resident in enrolling in a similarly accredited program in which he/she can continue his/her education.

POLICY ON NON-COMPETITION

SECTION 1. - SCOPE OF POLICY

1. The Accreditation Council for Graduate Medical Education (ACGME) specifically prohibits the use of restrictive covenants in trainee agreements and requires the Sponsoring Institution to maintain a policy that prohibits programs from requiring a Resident/Fellow to sign a non-competition guarantee or restrictive covenant.

1.2. This policy applies to all ACGME-accredited Residency and Fellowship programs at Howard University Hospital and ensures appropriate institutional oversight as required by the ACGME Institutional Requirements.

SECTION 2. - POLICY

It is a policy that Howard University Hospital Residency Programs may not require Residents and Fellows to sign a non-competition guarantee (restrictive covenant)

SECTION 3. - POLICY OVERSIGHT

The Office of Graduate Medical Education shall be charged with monitoring the Programs to ensure compliance with this policy.

VII. RESPONSIBILITIES FOR PATIENT CARE

Members of the house staff shall render service in the outpatient clinics and Emergency Department as well as on the inpatient units. Patient care in the ambulatory areas will be evaluated based on the same standards of care as in the inpatient areas. All house staff shall prescribe and treat patients under direction of the Attending or Courtesy Staff with the exception of an emergency or an attempt to save a life.

INSTITUTIONAL GME POLICY ON PATIENT HANDOFFS/TRANSITIONS OF CARE

Purpose: To define a structured process to convey important information about a patient's care when transferring care responsibility from one caregiver to another in order to assure continuity of care and patient safety.

Definition: The working definition for a **patient handoff** is as follows: "The process of transferring primary authority and responsibility for providing clinical care to a patient from one departing caregiver to one oncoming caregiver". Caregivers include attending physicians, resident physicians, physician assistants, nurse practitioners, registered nurses, and licensed practitioner nurses. The goal of the handoff is to provide timely, accurate information about a patient's care plan, treatment, current condition and any recent or anticipated changes.

Policy Statement:

Proper patient hand-offs should prevent the occurrence of errors due to failure to communicate changes in the status of a patient that have occurred during the shift. The information communicated during a hand-off must be complete and accurate to ensure safe and effective continuity of care. Thus, each residency training program that provides in-patient care shall be responsible for creating a template patient checklist and be expected to have a documented process in place to assure complete and

accurate resident-to-resident patient transitions. At a minimum, key elements of the template must include:

- Patient name
- Age
- Room number
- ID number
- Name and contact number of responsible resident and attending physician
- Pertinent diagnoses
- Important prior medical history
- Medications, fluids, diet
- Allergies
- Important current labs, vitals, cultures and any pending laboratory and X-rays,
- Overnight care issues with a “to do” list including follow up on laboratory and X-rays
- Resuscitation status and advance directives
- Other items may be added depending upon the specialty

Each residency program must identify the particular circumstances that would warrant a handoff procedure (e.g., shift to shift, ER to floor, floor to ICU, ICU to floor, preoperative to peri-operative, peri-operative to post-operative, post-operative to floor, temporary relief of coverage and discharge).

The handoff must be a structured face-to-face exchange that occurs with each patient transition, include at a minimum a senior resident or attending physician, and allow sufficient time for interactive questions for verification of the received information, including repeat-back or read back, as appropriate. Interruptions during handoffs should be limited in order to minimize the possibility that information would fail to be conveyed or would be forgotten. Telephonic or electronic handoff is not acceptable.

Each training program shall be responsible for the timely input of its call schedule into the New Innovations (NI) Scheduler system so that the entire health care team (attending physicians, residents, medical students, and nurses) knows how to immediately reach the resident and attending physician responsible for an individual patient’s care. Any adjustments to the original call schedule should be made in the AMION system at the time the adjustment is made.

Each training program shall be responsible for assuring its residents are competent in communicating with all caregivers involved in the transitions of patient care. This includes members of interprofessional teams that are appropriate to the delivery of care as defined by its specialty residency review committee. Methods to achieve competency shall be determined by the program director and program faculty. It will be expected that there be a formal periodic observation by a program faculty member to assess the competence of each resident to perform a “high quality” handoff during each

training year which shall be documented and included as part of the assessment of each resident's performance.

1. Inpatient Units

Residents shall immediately visit each new patient admitted to their service upon being notified and shall take a history and physical examination and apply such measures as are in accord with the specific regulations of the service. A complete H&P shall be recorded immediately. A detailed problem list, differential diagnosis, and treatment plan including consultation and diagnostic tests requested will be recorded. On the day of admission, the resident shall discuss his/her H&P with the senior resident and Attending who will amend and endorse the medical record and treatment plan and/or give his/her own history, physical and treatment plan.

Detailed, informative progress notes are to be recorded at least daily. Progress notes should include an update of each unresolved clinical or social problem, notation of new problems, results of diagnostic tests, summaries of consultation reports and changes in the treatment plan. Cases should be discussed daily with the Attending and a mutually agreed upon treatment plan formulated. The resident will complete his/her portion of the record within 24 hours after discharge.

2. Change in Patient Condition

The resident shall report immediately to the senior resident and attending when any patient's condition is regarded as "serious" or "critical". The family shall be informed immediately. (If the family is not available, the resident should leave a recorded message asking that he/she be contacted. Information regarding the patient's condition should not be left on the recorded message. The resident must provide medical assistance in keeping with his/her level of training, except in those instances of emergency in which the procedure addresses an immediate threat to the patient's life or physical well-being.

3. Writing Orders for Restraint or Seclusion

Three requirements must be met for a resident to order restraint or seclusion:

- a) The resident meets the state's requirements to practice medicine within the auspices of the training program;
- b) The resident has successfully completed the first year of post-graduate medical education;
- c) The graduate medical education program allows the resident to perform this activity.
- d) The resident must comply with HUH's policy on restraint and seclusion.

4. Medical and Surgical Procedures

A resident may perform procedures on patients only under the direct supervision of a member of the Attending Staff unless the resident is certified by the applicable program to perform the procedure without direct supervision or is supervised by a certified senior house officer. Certification will be ascertained through the Delineation of Clinical Privileges form submitted by the individual programs. Copies of these forms are located on each nursing unit, in the Emergency Department and in the Operating Room. Informed consent

in all cases must be obtained prior to performing procedures. These forms are updated twice annually.

5. Consultations

Consultations should be obtained when diagnostic or treatment questions concerning the best course of medical care to pursue arise. Requests should be directed to the specialty or sub-specialty, which will provide the medical advice. Where practical, the attending physician should be consulted as to the specific consultant requested. The resident should clearly specify the problem he/she would like the consultant to address.

ALL consultation requests MUST be written on the Doctor's Orders form and an attempt to reach the consultant by telephone or pager made. The specific reason for consultation should be recorded on the consult sheet and given directly to the consultant or left on the front of the medical record. Consults should be initiated within one hour for stat requests and within eighteen hours for routine requests. All consultations MUST be answered within 24 hours with at least a preliminary report.

6. Rounds

The interaction between the attending staff, residents and students is basic to medical education. In order for the resident to obtain the maximum learning from every hospitalized patient, a team approach is implemented to provide the opportunity for each member of the house staff to evaluate each case assigned to him/her and react through dialogue within the team. Following this exchange, the admitting resident or any member of the team will present their findings during admitting rounds. When the case has been more completely worked up, any member of the team should be prepared to present the case when called upon during ward rounds or even grand rounds.

The format and frequency of rounds will vary between departments, but generally will include four types of rounds:

- **Work Rounds**

Each morning, the house staff team should examine and speak with each patient, discuss events of the previous night, review new entries to the medical record, amend the treatment plan and plan the day's activities.

- **Admitting Rounds/Morning Report**

Admitting rounds, made each morning upon all new patients by the Attending or Chief of Service, provide an excellent learning session for the house staff to relate the problem list and plans for further evaluation and initial therapy.

- **Teaching Attending Rounds**

The house staff team members accompany the Attending Physician on visits to his/her patients and discuss each patient's history, physical, differential diagnosis, rationale for diagnostic tests ordered, treatment, disposition and discharge plans. Frequently, demonstrations of physical findings are conducted at the bedside.

7. Conferences

Residents are required to attend meetings of their clinical department including grand rounds, morbidity/mortality conferences, quality improvement meetings, journal club and pathology conferences. Schedules of such meetings are displayed in the office of each department or division.

Each department and division schedules various conferences during the week for continuous teaching of students and residents. These conferences are mandatory. Some conferences may be interdepartmental. Notice of these conferences may be posted on the bulletin boards in the elevator corridors or in the department office. Residents should involve themselves with the formulation, presentation, and discussion of cases in these conferences.

8. Maintenance of Patient Care Logs

Residents will maintain a log of all patient care activities in accordance with the requirements of the applicable accrediting body. These logs will be submitted according to program policy to the Residency Program Office for review.

9. The Medical Record

The **Face Sheet** is considered administrative data and includes the admitting diagnosis, socioeconomic information, clinical information and financial information which are gathered upon admission of the patient to the facility. All medical records must contain identification data. The Face Sheet is the front page of a patient's chart.

History and Physical Examination. A History and Examination (H&P) contains the minimum elements required and documented in the medical record within twenty-four hours after an inpatient admission and/or prior to any operative or high risk procedure and/or prior to any outpatient procedure requiring general or regional anesthesia, whichever occurs first. The history and physical examination and its related documentation shall meet the following requirements:

It is the responsibility of the first year postgraduate physician to complete and document a comprehensive admission history, physician examination, and plan for the evaluation and treatment of each patient.

The senior resident after reading the H&P of the first year resident, probes and inquires further to document an admission note with his or her own provisional diagnosis. It is the responsibility of the Attending to critique, correct, validate H&Ps and complete the appropriate Physician at Teaching Hospital (P.A.T.H.) statement.

The resident notifies the private physician of the admission of his/her patient and is given guidance. When the resident believes that certain rare and expensive laboratory tests are indicated, the reasons for ordering them should be clearly documented in the Progress Notes. Authorization from the private physician or Attending is necessary before ordering. The chief or senior resident may provide the authorization for the proposed studies if the Attending or private physician is not available.

Timing

An H&P and the related documentation **completed more than 30 days prior to** an inpatient admission, an operative or high risk procedure or an outpatient procedure requiring general or regional anesthesia **does not meet** the time requirements established by the medical staff at Howard University Hospital.

An H&P and the related documentation **completed less than 24 hours prior to** an inpatient admission, an operative or high risk procedure or an outpatient procedure requiring general or regional anesthesia **does meet** the time requirements established by the medical staff at Howard University Hospital. A H&P and the related documentation **completed less than 30 days but more than 24 hours prior to** an inpatient admission, an operative or high risk procedure or an outpatient procedure requiring general or regional anesthesia **does not meet** the time requirements established by the medical staff at Howard University Hospital **but requires an Interval Update**, as defined below.

Exceptions to These Requirements:

Emergency situations may preclude performance of a complete H&P according to the requirements established by the medical staff at Howard University Hospital. In such emergency situations, a clinically pertinent note (such as an emergency medical screening note, an Emergency Department physician's note or a progress note) is acceptable. However, under these circumstances, the full and complete H&P shall be documented in the medical record as soon as is practical after the emergency situation has stabilized but always within 24 hours of the inpatient admission, operative or high risk procedure or procedure requiring general or regional anesthesia.

The prenatal record, in its entirety, may be used as a H&P for normal vaginal deliveries, provided that there is an Interval Update assessment and annotation of the patient's current condition documented in the record upon admission.

Interval Update:

An update or interval note (also known as the "Interval Update") shall be entered into the medical record whenever the H&P was **completed less than 30 days but more than 24 hours prior to** the inpatient admission, the operative or high risk procedure or the outpatient procedure requiring general or regional anesthesia.

This Interval Update shall be documented in the medical record within 24 hours of the inpatient admission and prior to any operative or high risk procedure or outpatient procedure requiring general or regional anesthesia, whichever occurs first.

This Interval Update note shall document any significant changes reported by or observed in the patient since the prior complete H&P was performed.

In the event that no significant changes are reported by or observed in the patient since the prior complete H&P was performed, the Interval Update note shall specifically document the absence of any changes.

This Interval Update note shall be dated and signed by the Practitioner performing the Interval update examination.

A Nursing Assessment in the preoperative holding area, a pre-anesthesia evaluation performed by an anesthesiologist or a CRNA or a pre-procedure assessment performed by the Attending Practitioner may all be considered as appropriate Interval Updates, **on condition that the practitioner performing the assessment documents any significant changes (or lack of them), as reported or observed since the prior complete H&P, on the medical record.**

In the event that the Interval Update is not completed by the Attending Practitioner, the Interval Update must be countersigned by the Attending Practitioner prior to any operative or high risk procedure and / or prior to any outpatient procedure requiring general or regional anesthesia, whichever occurs first.

Elements of H&P:

A valid H&P, as defined by medical staff policy, includes, but is not limited to, the following elements:

Those elements of the H&P that are immediately pertinent to the chief complaint or presenting problem;

The history of present illness; relevant past medical history and major medical conditions; significant prior operative or invasive procedures; medications; and known allergies;

Review and examination of mental status and appearance, cardiovascular system, pulmonary system and all other systems pertinent to the chief complaint or presenting problem;

Additional elements as necessary for the safe and effective treatment of the patient.

Qualifications to Perform an H&P:

The privilege to perform an H&P is delineated for members of the medical staff in the Bylaws.

Privileges to perform history and physical examinations may be awarded to non-medical staff members in accordance with the Bylaws and Hospital policy.

An H&P performed by a non-medical staff member - under the supervision of, in collaboration with or through appropriate delegation by a member of the medical staff - needs only be countersigned if so required by the medical staff Bylaws and Hospital policy. However, under all circumstances, the supervising or Attending Practitioner shall retain accountability for the accuracy and appropriateness of the documented H&P, as denoted by his / her countersignature.

The Hospital may accept a H&P performed by a practitioner who is not on the medical staff and / or does not hold privileges at the Hospital as long as all elements related to time and content of the H&P meet the requirements of this policy and that a practitioner who is a member of the medical staff and who does hold current privileges at the Hospital endorses the findings and enters an Interval Note within 24 hours of the inpatient admission and / or prior to any operative or high risk procedure or outpatient procedure requiring general or regional anesthesia, whichever occurs first.

How to Document the H&P: H&Ps must be dictated using the hospital dictation system or other means of electronic documentation approved by the facility and includes a provisional diagnosis. Hand-written H&Ps are only to be used during system downtime and will be scanned into the electronic legal health record. All dictations, including H&Ps must be electronically signed by the dictating physician prior to authentication by the supervising Attending physician.

Discharge Summary. Discharge Summaries provide succinct information regarding a patient's hospital course and are essential for efficient and accurate communication with providers who will be engaged in on-going care of the patient. All hospital admissions except those stays of 48 hours or less for normal newborns or normal deliveries require a Discharge Summary.

Timing

A Discharge Summary **completed more than 30 days prior to** an inpatient discharge **does not meet** the time requirements established by the medical staff at Howard University Hospital.

Ideally, Discharge Summaries should be dictated at the time of discharge. If the dictation cannot be done at the time of discharge, it should be completed within 1-3 days of discharge. Residents should not delay dictations until after the monthly schedule is complete. Fourteen (14) days post-discharge, Discharge Summaries are considered delinquent. Note that weekly a report is sent to Graduate Medical Education (GME) leadership and all Program Chairs listing all Residents with incomplete dictations/documentation. GME takes action to ensure that those Residents identified complete their delinquent records.

The Attending of record is ultimately responsible for all dictations/chart completion and failure to complete all dictations/charts may result in the inactivation of clinical privileges for the Attending of record in addition to discipline up to and including termination.

Elements of Discharge Summary:

A valid Discharge Summary, as defined by this medical staff policy, includes, but is not limited to, the following elements:

Those elements of the Discharge Summary immediately pertinent to the chief complaint or presenting problem;

The admission date; discharge date; history of present illness; significant findings including: past medical history, allergies, habits, review of systems, laboratory tests, current medications, family history, physical examination, x-rays; impression; hospital course including principal diagnosis and secondary diagnoses; discharge condition; discharge instructions; disposition

Review and examination of mental status and appearance, cardiovascular system, pulmonary system and all other systems pertinent to the chief complaint or presenting problem;

Additional elements as necessary for the safe and effective treatment of the patient.

Qualifications to Document a Discharge Summary:

The privilege to document a Discharge Summary is delineated for members of the medical staff in the Bylaws.

How to Document the Discharge Summary

Discharge Summaries must be dictated using the hospital dictation system or other means of electronic documentation approved by the facility. Hand-written Discharge Summaries are only to be used during system downtime and will be scanned into the electronic legal health record.

It is the responsibility of the Attending to critique, correct, validate Discharge Summaries and complete the appropriate Physician at Teaching Hospital (P.A.T.H.) statement.

Operative Report. The Operative Report must be dictated immediately after an operation or other high risk procedure. There needs to be enough information in the record immediately after surgery in order to manage the patient throughout the postoperative period.

This information could be entered as the Operative Report or as a hand-written operative progress note.

If the Operative Report is not placed in the medical record immediately after surgery due to transcription or filing delay, then an operative progress note should be entered in the medical record immediately after surgery to provide pertinent information for anyone required to attend to the patient. This operative progress note should contain, at a minimum, comparable Operative Report information. These elements include;

- the name of the primary surgeon and assistants
- procedures performed and description of each procedure findings
- estimated blood loss
- specimens removed
- post- operative diagnosis.

Timing

Operative Report must be dictated immediately after surgery. Immediately is defined as "upon completion of surgery, before the patient is transferred to the next level of care". This is to ensure that pertinent information is available to the next caregiver. In addition if the surgeon accompanies the patient from the operating room to the next unit or area of care, the operative note or progress note can be documented in that unit or area of care. Failure to timely dictate an Operative Report is cause for discipline up to and including termination.

Elements of Operative Report

A valid Operative Report, as defined by this medical staff policy, includes, but is not limited to, the following elements:

The date of surgery; surgeon; assistant(s); anesthesiologist; pre-operative diagnosis; post-operative diagnosis; procedure performed; anesthesia; description of the procedure to include the following: description of the findings, detailed account of the techniques used, blood loss, complications and tissues removed, condition on discharge from the operating room

Qualification to Document Operative Report

The privilege to document a Discharge Summary is delineated for members of the medical staff in the Bylaws.

Privileges to document Discharge Summaries may be awarded to non-medical staff members in accordance with the Bylaws and Hospital policy.

How to Document Operative Report

Operative Reports must be dictated using the hospital dictation system or other means of electronic documentation approved by the facility. Hand-written Operative Reports are only to be used during system downtime and will be scanned into the electronic legal health record.

It is the responsibility of the Attending to critique, correct, validate Operative Reports and complete the appropriate Physician at Teaching Hospital (P.A.T.H.) statement.

Progress Note. The purpose of progress notes is to provide a daily account of your patients and their illnesses, and of developments in their diagnosis and treatment, for all of those who share in their care. They should be written in the problem-oriented, SOAP format, as follows:

- "Subjective" should include information from the patient about their symptoms and wishes, and from family and from other caregivers (eg. "nurse reports the patient had a sleepless night.")

- “Objective” should only include new information. Information that is readily available to others can be briefly summarized, or include only abnormal or changing results. This section should include the following kinds of information:
 - vital signs and physical examination (ie. results of an appropriate, focused exam)
 - lab data
 - imaging data
 - Assessment and plans should be summarized BY PROBLEM. Problems may be diagnosed diseases or syndromes, or symptoms, symptom complexes, or abnormalities from the exam, labs or imaging. Although sometimes a problem may be best expressed by reference to an organ system, eg. “pulmonary abnormalities,” generally the problem list is not simply a list of organ systems (some diseases or problems involve several organ systems; some organ systems may have more than one discrete problem)
 - the assessment is the MOST important part. It can be brief, but should include the working differential diagnosis or established diagnosis, the severity or the prognosis when appropriate, and the “status” of the problem, i.e. whether the patient is improved, has worsened, or has developed additional problems. It is where one interprets the changes in the patient’s subjective status, the new diagnostic test results, summarizes input from consultants, and articulates an opinion re: the unfolding of the patient’s diagnosis and treatment.
 - the plan is what is next; it may be divided between diagnostic (or monitoring) plans and therapeutic plans
- The required “last problem” (analogous to concluding ambulatory problem lists with “health maintenance”) should be “disposition” or “discharge planning” and should always include discharge planning or needs.
- A “Formulation” or “Impression” is not required for every progress note, and should not simply be a recapitulation of the patient’s past or present diagnoses or findings. A brief overall assessment may be provided when it is helpful to have summary assessment of the patient’s status or progress, or his or her cumulative morbidity, or the interaction of various separate problems. Progress notes can and should be relatively brief, focusing on developments since the previous note, and recapitulating only relevant, ongoing, active problems.
Cutting and pasting from previous notes without editing or updating is not permitted, and outdated and redundant information should be eliminated from notes.
- Date and time all notes.

- Include a brief title for all medical record entries; identify yourself and your role (eg. Intern Progress Note).
- Avoid abbreviations.
- Cutting and pasting from previous notes without editing and updating is not permitted; using another provider's observations or assessments is unethical and unprofessional.
- If writing in the paper record, use blue or black ink only; for errors, draw a line through the erroneous entry and initial.
- In addition to signing notes, be sure to print your name legibly and include your pager number.

How to Document Progress Notes: Progress Notes must be on official Howard University Hospital Progress Note forms.

- All Progress Notes must be legible, signed, dated and timed.

The patient's medical record is the official record recognized by the courts as the legal document of the patient's experience during hospitalization. Howard University Hospital is transitioning to an electronic health record and during this time has a "hybrid" medical record, that is part is paper and part is electronic. Protected patient information (which includes patient's medical records) are confidential. Only upon Subpoena Duces Tecum or a court order and approval by the Sr. Director of Revenue Cycle Health Information Services, may a medical record be removed from Howard University Hospital.. All requests for access to and or copies of patient health records are to be referred to the Health Information Management Department.

10. Faculty Involvement Protocol

Residents are encouraged to communicate with supervising faculty any time they feel the need to discuss any matter relating to patient care.

The following are circumstances and events where residents must communicate with supervising faculty (PGY-1-PGY-7/8):

- ICU transfers, DNR or other end of life decisions
- Encounters with any patient in emergency rooms
- All new patient encounters in intensive care or critical care units or inpatient units
- If requested to do so by other faculty attendings in any primary or specialty program
- If specifically requested to do so by patients or family
- If any error or unexpected serious adverse event is encountered at any time
- If the resident is uncomfortable with carrying out any aspect of patient care for any reason

11. Function of Health Information Management Department

The purpose of the Health Information Management Department is to provide a central file for medical records which documents the course of the patient's illness and file for medical records which documents the course of the patient's illness and treatment

during a particular episode as an inpatient or outpatient. An adequate record serves as a basis for planning patient care, evaluating care and providing physician and other professional groups in contributing to the patient's care. A secondary purpose is to protect the legal interest of the hospital and the physicians and to provide clinical data of interest to those who may wish to do research in a particular field.

The contents of the medical records shall be in accordance with The Joint Commission, District of Columbia Regulation, and Howard University Hospitals Rules and Regulations.

The primary responsibility of the Health Information Management Department is to assure that an adequate medical record is maintained for every patient in our hospital.

- The patient's medical record shall include all significant clinical information pertaining to the patient, in order that the purpose stated above may be fulfilled.
- All entries in the record are to be dated, timed and authenticated.

Each medical record must contain sufficient information to identify the patient, to justify the diagnosis, to delineate the plan of treatment and to documents the results accurately.

- The medical record must be appropriately documented to meet the standards of licensing and surveying agencies, as well as the hospital bylaws, rules, and regulations.
- The medical records of the hospital are held confidential and information may be released only in accordance with the law.
- There must be approved methods for processing, analyzing, indexing and filing of all records.
- Diagnosis shall be recorded in the standard nomenclature of International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM).
- The Health Information Management Department must maintain a close working relationship with the medical and hospital staff.

GME Medical Records Completion Procedure

1. Program Directors will receive notification by medical records of residents with incomplete charts which have aged 3 days or more. Residents will be notified of the incomplete charts at that time.
2. Program Directors will receive notification by medical records of residents with delinquent charts on the first business of the month. Residents will be notified if their name appears on the delinquent list.
3. The applicable resident will be relieved of clinical duty to go to the medical records department until the records are complete.
4. Medical records will provide a completion notice to the resident to be taken to his/her program director once all records have been completed.

5. The resident will be returned to clinical duty once the medical record completion notice has been received.
6. If the resident has to be relieved of clinical duty for delinquent medical records more than once in six months, then he/she will have a letter placed in his/her permanent file stating the same.
7. Documentation of a history of untimely completion of medical records will be recorded on reference forms when the program and/or GME office is queried for references.
8. A resident will be suspended without pay until all records are complete if the resident is relieved of clinical duty for failure to complete medical records a third time within a 12 month period.

Each resident will sign an acknowledgement of receipt of this procedure at the beginning of the academic year.

11. Accidents, Reportable Deaths and Unusual Occurrences

Residents shall report to the Chief Resident, who in turn shall report this information immediately to the Office of the Chief Medical Officer or his designee any facts coming to his/her attention before or after the death of any patient under the following circumstances:

- a) Death within 24 hours of admission
- b) Violent death
- c) Sudden death not caused by recognizable disease
- d) Death under suspicion
- e) Death of persons to be cremated or dissected
- f) Death related to diseases, which are a threat to public health
- g) Postoperative death

In addition, house officers shall immediately report all accidents, unusual incidents and complaints occurring in the confines of the hospital to the Chief Resident, who in turn shall report this information immediately to the Office of the Chief Medical Officer or his/her designee. In the case of accidents or injuries to visitors, patients or employees, which are witnessed or may have occurred in an area to which assigned, the following procedure will be carried out:

Investigate immediately and obtain all pertinent facts as to the time, persons involved, all who witnessed the condition of the area, any factors which may have been contributory, what steps were taken to prevent the incident, and if there was an opportunity to prevent the incident. A Patient Safety Net® (PSN) report will be completed and electronically submitted to the Office of Risk Services.

It is imperative that this directive be strictly adhered to so that all persons concerned will be well informed prior to inquiries from governmental agencies, private agencies, attorneys or

newspapers. Clinical assessment and treatment relating to such occurrences must be documented in the medical record, but reference should not be made to the "incident report."

Guidance on the Use of Email Containing PHI

Email is our most common tool used to communicate or share information with one another, and many times the data we share or talk about are protected patient information (PPI) or protected health information (PHI). When using email as a tool to share PHI, one must NOT send that information in unsecured ways nor should PHI ever be sent to individuals who are not contracted with Howard University/Howard University Hospital as a Business Associate.

Below are email requirements all employees MUST follow when it comes to sharing protected health information via email:

1. Howard University, which includes the Hospital, Faculty Practice Plans, and Health Sciences employees are NOT permitted to send PHI to personal email accounts such as Gmail, Hotmail, AOL, yahoo, etc. These accounts are not secure and can compromise PHI.
2. Sending patient data in an email to another Howard email address (howard.edu/huhosp.org) is secure because the data never go out to the internet before they get to these internal addresses.
3. Patient information should NOT be placed in a subject line going to any email address (internal or external) and if only being sent internally, still limited in information within the body of an email. This helps protect exposure of the information from an accidental forward or copy to someone who did not need to be exposed to the data.
4. Medical Diagnosis information or clinical information should NOT be sent in email as a hardwired practice unless you are using a secure messaging tool specific for this purpose.
5. Files with patient information in them, such as names, medical record numbers, social security numbers and the like, should NOT be sent unless they are encrypted and secured from access with passwords.
6. When sending files that are password protected and encrypted, you should send passwords in a different email or you should require an individual to call you for the password or access to further protect from accidental permissions.
7. Files should NOT be sent to a vendor or individual unless they are contracted with Howard University, Hospital, FPP or Health Sciences, as a Business Associate with a formal Business Associate Agreement (BAA).
8. Secure FTP or file transfer of files is a technical way we share large files or data with existing Business Associates. Inquire with IT about these capabilities if you have the need to share larger files with specific vendors. This prevents data from have to be sent via email.
9. Always advocate protection of PHI and sharing in secure ways. It is not uncommon that a vendor or Business Associate might say "just email the information to me". Stop and respond by only sharing the data in a secure way. Demonstrate our leadership in protecting PHI.

10. When our PHA data move from Howard to another person or organization, it is then up to them to insure it is protected. Be sure to advocate with our Business Associates these same expectations of their behaviors to further protect our PHI.

VIII. PERFORMANCE EVALUATION & DISCIPLINARY ACTION

PERFORMANCE EVALUATION

The performance of a resident is periodically evaluated and based upon the resident's performance in the six major competencies: 1) patient care, 2) medical knowledge, 3) communication and interpersonal skills, 4) practice based learning and improvement, 5) professionalism, and 6) systems based practice. The supervising Attending(s) at the end of each rotation completes a written evaluation and the resident is given the opportunity to review the written evaluation. The Resident is also afforded the opportunity to include a brief written statement with regard to the contents of a written evaluation, if he/she deems it necessary.

The Clinical Competency Committee (CCC) will evaluate resident performance at least semi-annually. This evaluation will be based upon several evaluation tools submitted to the program as per the program's policies and procedures. Assessments by Hospital employees, patients, other faculty, residents and medical students may be taken into consideration. If the evaluation is below average or unsatisfactory, an opportunity for improvement of resident performance exists. Opportunities for improvement occur in two steps. During Step I - the resident shall meet with the program director or his/her designee to identify the resident's needs for improvement. This process is designed to be collaborative in nature, giving the resident an opportunity to self-evaluate and assist in the creation of a self-improvement plan. The self-improvement plan will contain resident specific assignments with deadlines for completion and an end date for re-evaluation. The resident will sign a copy of the self-improvement plan and the resident's progress will be monitored. Implementation of the self-improvement plan is not dependent upon the resident's approval or acceptance of the plan.

If during the re-evaluation it is determined that the resident did not meet the outcomes outlined in the Step I self-improvement plan, a Step II self-improvement plan may be created. Efforts will be made to develop this plan in a collaborative manner and will focus on outcomes not achieved in the first plan and any new improvement opportunities that may have been identified subsequent to the development of the Step I plan. Again, all requirements in the plan will be resident specific with outcome deadlines and a pre-determined re-evaluation date will be set. If on re-evaluation the resident does not meet the expectations of the Step II improvement plan, the program will decide on a further course of action. This action could be a decision to require the resident to repeat the year of training, or the program may decide to dismiss the resident from the program..

Under circumstances where a resident's performance, behavior, acts or omissions pose a substantial risk to the health and/ or safety of a patient, employee, or any other person, the resident may be immediately relieved from duty and subsequently dismissed from the program without undergoing the self-improvement process described above. In addition, this policy can be superseded by adverse actions

mandated by the Accrediting Body, if applicable. All adverse actions are subject to appeal as outlined in the Complaints, Grievances and Adverse Action section of this manual.

As self-improvement plans are NOT considered adverse actions, they are not subject to appeal. However, if the resident is unable to reach an agreement on the terms of the self-improvement plan or the amount of time needed to accomplish the objectives of the self-improvement plan, the resident may discuss their dissatisfaction with the Department Chair or DIO. It is anticipated that such discussions will be very rare, as the self-improvement plan is designed to be a collaborative process between the Program Director and the resident. Finally, residents may request that an assessment of the outcomes of the self-improvement plan occur earlier than originally scheduled if the resident feels that he/she has accomplished the objectives outlined in the plan.

PROMOTION NOTIFICATION

Notification of decisions concerning promotion or renewal of appointment in the training program shall be provided in writing **prior to the 15th of January**. In situations where the reason for a decision not to advance or non-renewal of contract was not known prior to January 15th, the resident will be informed of the decision not to advance as soon as practical. In cases where the resident's academic year is off the traditional cycle, the decisions should be made at least four months prior to the end of that resident's contract year. Any adverse actions taken under these scenarios will be subject to due process procedures as outlined by this manual. Residents are reminded that they must pass Step 3 of the licensing examination by December 31st of the second year of training to be promoted to the PGY-3 year of training.

NOTIFICATION OF VOLUNTARY WITHDRAWAL

A resident who does not plan to continue in the succeeding year of his/her residency/fellowship program must notify the Program Director in writing of his/her intent by January 15th of the current contract year.

ACCESS TO EVALUATION FILES AND SIGNATURE

An evaluation file for each resident is maintained in the Program Office. In addition, recent evaluations may be found on line through the Residency Management Software system. Residents may review their files upon request during normal business hours. Residents may view their on-line evaluations at any time simply by signing into the Residency Management Software system. Residents must sign and date each evaluation form or correspondence pertaining to clinical/behavioral performance contained within the file after reviewing the information.

ADVERSE ACTION

Unsatisfactory performance will be handled in accordance with the procedure outlined in the Performance Evaluation section above. Misconduct and violation of ethical standards may result in disciplinary action against a resident. Adverse actions may include warning, probation, suspension, or other limitations of resident activities in the program up to and including termination. The nature and seriousness of a resident's conduct shall determine which action the program deems appropriate. The resident shall receive notice of the type of adverse action being taken. At the end of the disciplinary period, the resident will be

informed of his/her new status. Again, adverse actions are subject to appeal as outlined in the Complaint/Grievance/Due Process Protocol section of this manual.

JEOPARDIZING SAFETY OR CRIMINAL ACTIVITY

If the program director determines that a resident's conduct jeopardizes patient or staff safety or well-being, or when the Program Director or Department Chair reasonably believes that the resident may have committed a criminal act at any time during the training program, the Program Director, with the approval of the DIO, may immediately place the resident on administrative leave with pay and relieve the resident of all patient care duties until such time as the department can conduct an investigation of the matter. If the investigation reveals that the resident's conduct either jeopardized patient or staff safety, well-being or was criminal, the resident may be disciplined, including, but not limited to, non-renewal of his/her contract or immediate termination. An arrest or criminal conviction is not necessary for a resident's action to be deemed criminal. The Program Director shall notify the DIO prior to any action being taken under this provision. Adverse actions are subject to appeal as outlined in the Complaints, Grievances and Adverse Action section of this Manual.

EVALUATION OF THE FACULTY

At least annually, residents shall offer constructive criticism of each faculty member. Evaluation forms are supplied by the Program Office through the Residency Management Software system. Evaluations are completed confidentially and forwarded via computer to the Program Director and the Department Chair with no identifying data attached. These evaluations are considered during the faculty member's annual performance evaluation by the Chair of the Department.

EVALUATION OF THE PROGRAM

Annually, residents shall offer constructive criticism of the training program. The program evaluation is performed by filling out the applicable form in the Residency Management Software system. Evaluations are completed confidentially and forwarded via computer to the Program Director with no identifying data attached. These evaluations are used as a part of the program's annual self-evaluation for educational effectiveness.

POLICY FORMULATION

Residents have the opportunity to participate in the formulation of policies related to education and patient care by participating in meetings of the Department, Graduate Medical Education Committee (GMEC), and Medical Staff.

IX. COMPLAINT/GRIEVANCE PROCEDURES/DUE PROCESS PROTOCOL

COMPLAINT PROCEDURE

Should a resident have a complaint with any aspect of the residency program, faculty, work environment or the hospital, he/she should submit the complaint to his/her

Program Director. If the complaint is not resolved to his/her satisfaction, the resident may bring the matter before his/her Department Chair. If the matter is still not resolved to his/her satisfaction, he/she may refer the matter to the Designated Institutional Official or his/her designee. Complaints addressed under these procedures include, but are not limited to, inability to agree on a timeline or substance/terms of the self-improvement plan, working conditions, benefits and failure of HUH to fill its obligations under the terms of his/her residency contract. Complaints regarding matters related to compliance may be referred to the Compliance Office. Complaints regarding matters of discrimination or harassment of any nature may be referred to the above or to the EEOC office in Human Resources.

Any resident who has reasonable concern about discussing a matter with the Program Director or the Department Chair has the option of bringing the concern(s) directly to the Designated Institutional Official or his/her designee.

GRIEVANCE PROCEDURE FOR HOUSE STAFF

A resident has the right to ask for reconsideration of academic or other disciplinary actions taken against him/her that could result in dismissal, non-renewal of a resident's agreement or other actions that could significantly threaten a resident's intended career development. The following procedures have been developed to establish the mechanism by which such reconsideration may take place.

1. Evaluations and Disposition

Residents will be given access to the entire contents of their file. Residents have the right to challenge the accuracy of information within their files. If a resident disagrees with an evaluation contained within his/her file, the house officer must write "I disagree" directly on the evaluation and immediately inform the Program Director, in writing, of this disagreement. Within thirty (30) days of the resident complaint, the Program Director will meet with the resident to determine the validity of the evaluation and, if applicable, develop and institute a plan of action. The decision as to whether to institute a plan of action for matters which do not constitute an adverse action are within the discretion of the Program Director.

2. Reconsideration of Adverse Action

The following shall be observed if the resident wishes to appeal an adverse action:

Departmental Review

If the resident wishes to appeal the adverse action, the resident shall provide the Program Director with a written request for reconsideration within two (2) weeks of receiving written notification of the Program Director's/Education Committee's decision, otherwise he/she waives the right to appeal.

The Program Director will schedule a Departmental Review hearing by the Education Committee to be held within thirty (30) days of receiving the request from the resident. The resident shall be given at least one (1) week's advance notice of the date, time and place at which the Education Committee will meet to discuss the resident's request. The resident shall also be notified of the names of the

Education Committee members. The Departmental Review is an informal procedure and is conducted without benefit of legal counsel. The resident may **not** have legal counsel at the Departmental Review hearing, but a union representative may be present upon request of the employee.

The Education Committee shall send its final decision to the resident within one (1) week of the completion of the hearing process. The resident will also receive a copy of the minutes of the Education Committee's deliberations.

Pending a final decision of the Education Committee, the resident shall be permitted to continue in the training program except in the case where patient or staff safety and/or well-being would be jeopardized.

Institutional Grievance Committee Review

If the resident is dissatisfied with the outcome of the Departmental Review, a review by the Institutional Grievance Committee may be initiated at the request of the resident when made in writing to the Designated Institutional Official within seven (7) days of receipt of the Departmental Review Committee's decision. It is recognized that the program director has the ultimate fiduciary responsibility to ensure that all residents who finish the training program are able to practice competently, independently and professionally. Therefore, the purpose of this appeal is not to provide for a new hearing at a higher level. This appeal process provides for a review of the evidence for the adverse action taken by the program.

The academic and professional judgment of the Departmental Review Committee shall be afforded a presumption of correctness. Therefore, the resident shall have the burden to show that the decision of the Departmental Review Committee was clearly erroneous in one or more material ways.

Except as provided below, statements or evidence that were not presented prior to the adverse action being taken, or at the Departmental Review Hearing will not be considered by the Institutional Grievance Committee. The Institutional Grievance Committee's decision will be one of the following:

1. **Program's decision upheld** – this decision will be made if the institutional committee finds that the program had evidence to warrant adverse action and the Department gave the resident an opportunity to correct the issues that led to that adverse action or give the resident the opportunity to be heard such that the resident explains their perspective of the issue that led to the adverse action. **The institutional committee cannot modify the program's action,**
2. **Program's decision rescinded** – this decision will be made if the institutional committee finds that the program did not have evidence to warrant adverse action and the Education Committee's decision was clearly erroneous or the Department did not give the resident an opportunity to

correct the issues that led to the adverse action or give the resident the opportunity to be heard such that the resident explains their perspective of the issue that led to the adverse action. **The Institutional Grievance Committee shall not make its decision on the basis of disagreement with the decision of the Departmental Review Committee.**

The Designated Institutional Official or his/her designee will schedule an Institutional Grievance Committee review to be held within thirty (30) days of receiving the request for appeal. The resident and Program Director will be given at least one week's advance notice of the date, time and place of the review, as well as the names of the Committee members. Grievance procedures for the conduct of the Institutional Grievance Committee hearing are set forth below.

Pending a final decision of the Committee, the resident shall be permitted to continue in the training program except in the case where patient or staff safety and/or well-being would be jeopardized.

Institutional Grievance Committee Hearing Procedures

1. Pursuant to a Resident's appeal of the Departmental Review Committee's recommendation to uphold the program's decision to discipline the Resident, the Designated Institutional Official or his/her designee shall provide seven (7) days written notice of a hearing to the Institutional Grievance Committee.
2. At the appointed time and place of the hearing, the Chairperson of the Institutional Grievance Committee will call the meeting to order.
3. The Program Director or, in cases of prolonged absence his/her designee shall be present at the Institutional Grievance Committee meeting to provide an account of the adverse action.
4. At the beginning of the Hearing, both the Program Director and the Resident may make opening remarks that summarize their respective positions. Each will be given five (5) minutes to accomplish this.
5. The Program Director and the Resident will be given an opportunity to rebut statements made by the other party. However, neither party shall be subject to cross-examination by the other. Each will be given ten (10) minutes to accomplish this.
6. At the conclusion of the hearing, the Chairperson of the Institutional Grievance Committee may afford the Program Director and the Resident an opportunity to make closing remarks. Each will be given three (3) minutes to accomplish this.
7. The Chairperson shall ensure that any documents submitted to the Committee for its review and inclusion were available at the time the adverse action was taken and were presented at the Departmental Review Hearing. Minutes of the

Departmental Review Hearing will also be made available to the Institutional Grievance Committee.

8. After the receipt of statements and the compilation of relevant documents, the Committee shall deliberate outside the presence of the parties. The Institutional Grievance Committee will make a decision on the disposition within seven (7) days of the completion of the hearing process. The decision shall be forwarded to the resident in writing.
9. Pursuant to the House Staff Manual, the Chairperson of the Institutional Grievance Committee shall decide all other procedural issues that arise during the course of the Hearing.
10. The resident may be accompanied by counsel at the hearing or union representative. If counsel and/or union representative accompanies the resident, he/she must notify the Designated Institutional Official or his/her designee at least three (3) business days in advance of the meeting. The role of the resident's counsel at the hearing is to serve only as an advisor and the resident's counsel is not entitled to address the committee or ask questions of any attendee. Counsel may also be present to advise the Program Director and/or the Chairperson of the Department's Education Committee.
11. At the discretion of the Chairperson of the Institutional Grievance Committee, counsel may be appointed to advise the Institutional Grievance Committee regarding all procedural issues.
12. The Chairperson of the Institutional Grievance Committee shall provide written notice of the Committee's decision to the Designated Institutional Official or his/her designee, who in turn, shall forward the decision to the resident, Program Director, and Chief Executive Officer within seven (7) days of the completion of the hearing process.
13. The decision of the Institutional Grievance Committee is the final decision in the grievance process.

COMPOSITION OF THE COMMITTEES PARTICIPATING IN THE GRIEVANCE PROCESS

Education Committee

Each Program Director, with the concurrence of the department Chairperson, shall appoint an Education Committee to assist in evaluating the House Staff. The Program Director or designee shall serve as the Chairperson of the Committee. This standing Committee shall have a minimum of three members, at least one of whom shall be a resident. If a conflict of interest with the resident member arises with respect to a matter to be presented to the Committee, a new representative will be appointed.

Departmental Review Committee

The Education Committee shall act as the Departmental Review Committee and review house staff grievances. All Committee members shall have equal voting rights.

Institutional Grievance Review Committee

The Committee shall be composed of three (3) attending physicians, three (3) members of the house staff and the Designated Institutional Official or his/her designee who shall serve as the Chairperson of the Committee. The Committee members shall not be from the Department against which the resident has filed a grievance. All members shall have equal voting rights.

X. INSTITUTIONAL GME POLICY ON HOUSE STAFF IMPAIRMENT

Purpose: To help assure house staff member well-being and patient safety in the learning and working environment; to set expectations relative to fitness for duty on the part of the house staff member; and to set forth consequences of an impairment.

Definitions: **Fit for duty** or **fitness for duty** refers to the physical and mental health status that facilitates the performance of essential job duties in an effective manner and protects the health and safety of oneself and others as well as property.

An **impaired house staff member** is one who is not **fit for duty** because of an **impairment**.

Impairment is a mental or physical condition including but not limited to mental illness, alcoholism, inappropriate drug use or physical injury or illness, stress, fatigue, sleep deprivation or illness.

Chemical substance abuse is the use of illegal drugs or use or abuse of any chemical substance (controlled substance, or over the counter) which results in an impairment such that the house staff member is not fit for duty.

Alcohol use is prohibited for house staff members while on duty, whether it causes impairment or not. House staff members may not be under the influence of alcohol whenever they are or may be called in for duty and will be cause for immediate removal.

Supervising physician refers to the individual (faculty, senior resident, or fellow) to whom the house staff member has a reporting responsibility relative to the provision of patient care.

Policy Statement:

It is the expectation of Howard University Hospital that all members of the health care team monitor their own and one another's fitness for duty.

House Staff Member Responsibilities:

1. to appear for duty appropriately rested as well as physically and mentally able to provide the services required by his/her patients in a safe, productive, and effective manner such that safe and appropriate quality patient- and family-centered care can be achieved;
2. to manage his/her time and health before, during and after clinical assignments to meet professional expectations;
3. to notify the appropriate supervising physician and/or Program Director when he/she is not fit for duty (i.e., self-referral); and,
4. to notify the appropriate supervising faculty and/or program director and/or supervising resident/fellow when he/she observes any other member of the health care team act in a manner that indicates s/he may not be fit for duty.

Supervising Physician and Program Director responsibilities:

1. to observe the attendance, performance and behavior of the house staff members they supervise;
2. to address expressions of concern regarding house staff member impairment received from any source, including house members' family/household members, co-workers, faculty and other hospital staff, as well as patients and their relatives; and,
3. to follow the procedures delineated in this policy when presented with circumstances or knowledge that indicate that a house staff member may be impaired.

Employee Health Department Responsibilities:

1. to monitor the health status of all house staff and the effect of the working conditions and physical work environment on the health and safety of house staff members;
2. to evaluate (or refer for evaluation and treatment) any house staff member who is suspected or confirmed to be impaired for the purpose of determining his/her fitness for duty;
3. to notify the Program Director and Human Resources Department of each house officer's fitness for duty; and,
4. to recommend reasonable accommodations, when appropriate, such as modification of work hours, work duties, or work environment.

Delineated Levels of Impairment Notification

1. Self-referral

When the house staff member recognizes his/her **impairment** as indicated by one or more of the above descriptors, he/she should make the appropriate notification (described above) and should seek, as appropriate, professional help through a personal physician. Alternatively, the house staff member may seek help through the Employee Assistance Program. In cases of stress, fatigue, sleep deprivation, or sudden illness, immediate notification should be made to the supervising physician.

2. Action By Program Director

When the impairment of a house staff member is suspected and the Program Director does not find it completely unfounded, the house staff member shall be informed by the supervising physician and/or Program Director that an expression of concern regarding possible impairment has been made about him/her and the Program Director will relieve the house staff member of all patient care duties.

a. In The Case Of Voluntary Acknowledgement and Treatment

When the Program Director concludes there is a reasonable basis to conclude the house staff member is **impaired**, the Program Director may require that the house staff member obtain treatment, professional help through a personal physician, treatment program or the Employee Assistance Program as dictated by the nature of the suspected impairment. The house staff member will be allowed to resume patient care duties when the Program Director concludes the member is **fit for duty**.

b. Contested Impairment

When the affected house staff member denies **impairment**, the Program Director shall refer the house staff member to the Employee Health Unit for an evaluation. If **impairment** is confirmed, the Program Director shall counsel the house staff member and recommend that he/she seek professional help through a personal physician or the Employee Assistance Program. Appropriate steps to safeguard patient care will be instituted. If after an appropriate evaluation, the Program Director concludes the house staff member is **fit for duty**, the house staff member will be allowed to resume his/her activities.

c. Refusal of Evaluation or Treatment

If the affected house staff member denies suspected **impairment** and refuses evaluation, or is in non-compliance with a required therapy or treatment plan, he/she shall be immediately relieved of patient care duties and subject to additional discipline, including, but not limited to, termination from the training program. Notification should be made to the Program Director and Designated Institutional Official if such action occurs.

Procedure for Managing Impairment:

In circumstances involving impairment due to fatigue, sleep deprivation and/or illness, any house staff members who is not alert enough to drive safely will be instructed not to drive without first taking a nap or a taxi cab voucher will be given to any resident who usually drives home if a nap is not feasible or sufficient to allow safe driving. In cases of sudden illness, in addition to releasing the house staff officer from duty, and depending on the severity of the sudden illness, the supervising physician will refer the house staff officer to the Emergency Department or to his/her personal physician.

In circumstances which involve impairment caused by a psychological or physical condition, the house staff member may NOT return to work until cleared by Employee

Health. The house staff member shall provide to Employee Health a “fitness for duty” evaluation from his/her treating physician or the Employee Assistance Program, as applicable, indicating the resident is fit for duty, along with any accommodations needed for safe performance of duties. The Program Director will determine, with input from Employee Health and Human Resources, whether any requested accommodation is reasonable.

The supervising physician shall immediately notify the Program Director of the decision to release a house staff member from duty due to **impairment** and place him/her on sick leave. A documentation form must be completed by the supervising physician and submitted to the Program Director within 24 hours of occurrence. The form will be retained in the affected house staff member’s resident file. Appropriate notification should be made to the Office of Graduate Medical Education within 48 hours of occurrence.

For all instances of **impairment** in which the affected house staff member is relieved of duty, arrangements shall be made by the supervising physician and/or Program Director to ensure continuity of patient care. Any assignments missed due to release from duty because of **impairment** which exceed the requirements for completion of training must be made up in order to meet Residency Review Committee guidelines.

Any severe or persistent **impairment** which prevents a house staff member from performing his/her duties may be considered grounds for dismissal from the program.

/form/

Documentation of Release from Duty due to Reported Impairment

Resident/Fellow Name: _____

Program: _____

Rotation: _____

Date of Occurrence: _____

The above-named House Staff member reported for duty but subsequently . . .

- ☐ Self-reported that he/she was unable to continue on duty due to:

☐ sleep deprivation ☐ other

☐ substantial fatigue

☐ debilitating illness

☐ stress

- ☐ Was reported by an observer to be impaired based on:

☐ physical symptoms:

☐ concerns regarding judgment or concentration:

☐ other:

Action taken:

☐ release from duty with recommendation to see personal physician or seek assistance from Employee Assistance Program; Fitness for Duty report required for resumption of duties.

☐ release from duty with referral to Employee Health Department for initial evaluation; Fitness for Duty report required for resumption of duties.

☐ release from duty with permission to return to duty on _____
(date).

Signature of House Staff Officer

Date

Signature of Supervising Physician

Date

Acknowledgment of Program Director/Signature

Date

NOTE: A copy of this form will be kept in the resident's/fellow's file and a copy will be provided to the Office of Graduate Medical Education.

ARTICLE ---- ANTI- HARASSMENT AND NON-DISCRIMINATION

Section 1. Workplace Atmosphere: We strive to maintain a friendly, congenial and professional atmosphere free from all forms of discrimination and harassment. Employees are expected to contribute to an atmosphere that is healthy, productive, and safe for all employees, our patients, and our customers.

The Hospital will not tolerate employee conduct that creates an intimidating, offensive, or hostile working environment. An employee who, in violation of these Workplace Conduct Guidelines, intimidates, is hostile to, or is offensive to another employee, a patient, a customer, or prospective customer of the Hospital will be subject to disciplinary action, up to and including termination of employment.

Section 2. Anti-Discrimination & Anti-Harassment Policy & Policy against Sexual Harassment: The Hospital is committed to providing a workplace that is free of discrimination of any kind. In keeping with this commitment, the Hospital will not tolerate discrimination or harassment of any employee by any person, including any manager, co-worker, customer, client, vendor, or any other third party. Harassment consists of unwelcome conduct, whether verbal, physical, or visual, that is based upon a person's protected status, such as gender, color, race, religion, national origin, age, physical or mental disability, sexual orientation, genetic information, marital status, or any other protected status.

The Hospital will not tolerate harassing conduct that affects tangible job benefits, that interferes unreasonably with a person's work performance, or that creates an intimidating, hostile or offensive working environment. Prohibited harassment includes, but is not limited to, jokes, kidding, teasing or pranks directed at a person based on his/her protected status.

Sexual harassment deserves special mention. Sexual harassment is conduct based on gender, whether directed toward a person of the opposite or same gender, and may include explicit sexual propositions, sexual innuendo, suggestive comments, sexually oriented "kidding" or "teasing," "practical jokes," obscene printed or visual material, and physical contact such as patting, pinching, or brushing against another person's body.

The Hospital expressly prohibits sexual harassment or sexual misconduct of any kind.

Unwelcome sexual advances, requests for sexual favors, and other physical, verbal, or visual conduct based on gender, constitutes sexual harassment if:

- Submission to the conduct is an explicit or implicit term or condition of employment.
- Submission to or rejection of the conduct is used as the basis for an employment decision.
- The conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile, or offensive working environment.

Section 3. How to Report Harassment: All employees of the Hospital are responsible to help ensure that a workplace free of discrimination and harassment is maintained. An employee who believes that he or she has experienced or witnessed any type of discrimination or harassment may immediately notify their immediate supervisor or the Office of Human Resources. The Hospital's policy prohibits retaliation against anyone for reporting harassment, assisting in making a harassment complaint, or cooperating in a harassment investigation. An employee, who believes that he/she has been retaliated against, can immediately notify their immediate supervisor or the Office of Human Resources. It is the Hospital's policy to investigate, immediately, promptly and thoroughly, all complaints of harassment and to ensure to the fullest extent practicable, that complaints and the terms of any resolution are kept confidential.

If an investigation confirms that a violation of this policy has occurred, appropriate corrective action will be taken, including disciplinary action, up to and including immediate termination of employment.

Section 4. Workplace Violence: The Hospital attempts to provide a safe workplace for all employees. To ensure a safe workplace and to reduce the risk of violence, all employees should review and understand all provisions of this policy.

a. Prohibited Conduct

We do not tolerate any type of workplace violence committed by or against employees. Employees are prohibited from making threats or engaging in violent activities. This list of behaviors, while not all inclusive, provides examples of conduct that is prohibited:

- i. Causing physical injury to another person
- ii. Making threatening remarks;
- iii. Aggressive or hostile behavior that creates a reasonable fear of injury to another employee, patient, or customer or that which subjects such individuals to emotional distress;
- iv. Damaging company property or property of another employee;
- v. Possession of a weapon while on company property or while on company business; and
- vi. Committing acts motivated by, or related to, harassment or domestic violence.

b. Reporting Procedures

Any potentially dangerous situations must be reported immediately to a Manager or the Office of Human Resources. Reports can be made anonymously and all reported incidents will be investigated. Reports or incidents warranting confidentiality will be handled appropriately and information will be disclosed to others only on a need-to-know basis. All parties involved in a situation will be counseled and the results of investigations will be discussed with them. The Hospital will actively intervene at any indication of a possibly hostile or violent situation.

XII. CODE OF ETHICS

The principal objective of the resident is to render service to humanity with full respect for the dignity of the individual. The resident shall merit the confidence of patients entrusted to their care, and render to each a full measure of service and devotion.

1. The resident shall practice a method of healing founded on a scientific basis and shall not voluntarily associate professionally with anyone who violates this principle.
2. The resident shall protect themselves and the public from health care practitioners who are deficient in moral character or in professional competence. The resident shall observe all laws, uphold the dignity and honor of their profession, and accept the self-imposed discipline of health care practitioner. They shall expose, without hesitation, illegal or unethical conduct of fellow members of the profession.
3. A resident shall not discriminate in the delivery of health care based on the patient's race, religion, sex, marital status, creed, color, national or ethnic origin, sexual orientation or handicap, etc.
4. A resident shall not provide services under conditions that interfere with or impair the free and complete exercise of professional judgment and skill, that tend to cause a deterioration of the quality of care provided.
5. Residents shall not request, demand or accept from any patient or any person, any fee or any monetary gift for services rendered or about to be rendered in the Hospital.

The honor ideals of the health care professions imply that the responsibilities of the practitioner extend to participation in activities, which have the purpose of improving both the health and the well-being of the individual and community.

A copy of the Code of Ethics and Conduct is located in Appendix B.

XIII. DIVISION OF NURSING

The Division of Nursing extends a warm welcome to you as you continue your clinical experience at Howard University Hospital. We are pleased to provide the assistance that will support your training activities. We in the Division of Nursing view ourselves as facilitators in your training endeavors and will assist you in the hands on care of patients. We also see ourselves as collaborators in the care and management of our patients. To this end, the following is key information that you may find useful during your clinical experience.

PHILOSOPHY OF NURSING

A brief overview of our philosophy: We believe that the patient is the central focus for the practice of nursing and the family and significant others share an important part in the patient's care; Patient-centered care is driven by the needs of the client, and incorporates the concept of interdisciplinary collaboration and shared leadership, including the client and family, for the purposes of maintaining or promoting health, active intervention to assist in recovery and rehabilitation, or counseling assistance in coping with and achieving a peaceful death if life cannot be maintained.

NURSING MANAGEMENT STAFF

The nursing management staff is led by the Chief Nursing Officer. The hospital is staffed with 24 hour coverage by Clinical Service Managers for each patient care unit during business hours and by Nurse Managers who are house supervisors during the evening and night shifts and on weekends and holidays. See the attached listing of the Nursing Management Team.

NURSING DOCUMENTATION

Nursing staff document care provided on several documents. The following are the key pieces of documentation that you may refer to on occasion.

- **Nurses Notes:** The Focus Format is utilized which focuses upon pertinent aspects of patient care using DAR. D= Data: includes subjective or objective assessment information relating to a particular patient concern. A= Action: The actions implemented to deal with the patient concern (what was or will be done) R=The response of the patient to the actions implemented.
- **Patient Care Kardex:** Used to document physician's orders including routine procedures.
- **Medication Administration Record:** Referred to as the MAR is a record of all routine, prn and single doses of medications that are ordered.
- **Flow Sheets:** Various flow sheets are utilized to record vital signs, skin condition and other routine patient care activities.

PATIENT SAFETY

As you are aware nothing is more important than patient safety. The following are 3 major patient safety initiatives that nursing staff will seek your assistance with:

- **Using the Read Back Process for Communicating Critical Test Results and Physicians Orders:** In an effort to insure effectiveness of communication when receiving critical test results or physician's verbal or telephone orders, a read back process is required. Nursing staff will record panic values on the Critical Lab Values Sheet and will read back the report to lab staff member. The nurse will provide a copy of the Critical Test results to the physician. When receiving verbal or telephone orders from physicians the nurse is required to read back the orders verbatim to the

physician and will wait for verbal confirmation from the physician prior to carrying out the order.

- **Physician's Orders:** All physician medication orders must be printed, dated, timed and signed with the physician's name printed clearly. Include the indication for use when appropriate. All orders must be written using the appropriate abbreviations, acronyms and symbols and must be prescribed in the metric system except for medications administered by drops. Volumes must be expressed in milliliters. A zero must be written before a decimal point if quantity is less than one unit. Never use a trailing zero after a decimal point. Present medication orders to the licensed nurse in a timely manner so that all orders may be forwarded to pharmacy within one hour. This is very important when ordering Stat or Now/As Soon As Possible orders. *If physician's orders include abbreviations that are prohibited, are not complete, or are not legible, the staff member transcribing the order must obtain correction from the physician who wrote the order prior to transcribing or executing the order.*
- **Patient Identification:** Prior to taking blood samples, administering medications or blood products and prior to initiating diagnostic studies the caregiver must check the patient's identification bracelet against an imprint of the patient's addressograph plate. The patient's name and medical record number are the two identifiers that will be used to insure accuracy of patient identification.

XIV. OFFICE OF RISK MANAGEMENT

Risk management is the process of identifying and evaluating the risk to patients and other customers in order to minimize the exposure to liability inherent in providing health care. The Office of Risk Services conducts the risk management process. The Office of Risk Services depends on various early warning systems to provide notification that an adverse event has occurred. Information obtained can be used to plan for potential defenses should litigation occur and claim resolution.

TIMELY REPORTING OF EVENTS

The occurrence of an adverse event or threat of a lawsuit requires a report to Risk Services. The report should be made online utilizing the HUH intranet. A Patient Safety Net® (PSN) report will be completed. There is no password or login in required to submit a report to the system. Reports may also be made in person or via telephone to Risk Services staff.

Early reporting of events is an effective method of addressing concerns and permits risk services staff the ability to preserve evidence, investigate the event, and advise hospital staff as to how to minimize exposure to individuals and the organization.

The Office of Insurance and Risk Services is located in Room 2007 on the second floor of the main hospital. The office may be contacted at 202-865-5801 with voicemail

available 24 hours a day. The office hours are 8:30 am. to 5 p.m. Monday through Friday. Additionally, Risk Services staff is available for consultation after office hours at any time by contacting the hospital operator.

REQUIREMENTS FOR REPORTING INCIDENTS

All untoward incidents occurring in the hospital or during external rotations involving patient care are to be reported to Risk Services within 24 Hours. Examples of the types of events that must be reported are as follows:

1. Unexpected deaths, including but not limited to: suicides, sudden cardiopulmonary arrest.
2. Unanticipated neurological, sensory and systemic deficits, including but not limited to brain damage, permanent paralysis including paraplegia and quadriplegia, partial or complete loss of sight or hearing, kidney failure or sepsis.
3. Birth related injuries, including but limited to maternal or fetal death, anesthesia related injuries, Apgar scores below 5 at 5 minutes, any infant resuscitation, fractures or discoloration.
4. Severe Burns, including but not limited to thermal, chemical radiological, electrical.
5. Severe internal injuries, including but not limited to: laceration of an organ, infectious process, foreign body retention, and sensory or reproductive organ injury.
6. Substantial disability including but not limited to fractures, amputation, and disfigurement.
7. Any professional claim or suit, which is evaluated to have potential damages in excess of \$100,000.00.

EVENT DEFINITIONS

EVENT	DEFINITION
Unexpected Cardiac/Respiratory Arrest	Patient not presently treated in an ICU; not a DO NOT Resuscitate; not at known risk (cardiac/respiratory arrest).
Unexpected Death	Death occurring in a patient at little/no risk based on prognosis after an initial admission evaluation and work-up.
Unexpected Hemorrhage (Requiring Transfusion)	An instance in which although blood loss is recognized as a risk of a procedure or medical intervention, excessive bleeding occurs, requiring a transfusion and/or return to the operating room.
Unexpected Surgical Procedure Outcome	Outcome was not expected.

EVENT	DEFINITION
Unexpected Anesthetic Outcome	Outcome was not expected.
Unexpected Atelectasis/ Pneumothorax/Aspiration (Requiring Treatment)	Instance in which atelectasis, pneumothorax, or aspiration occurred when it was to consider to be a risk of a medical/ surgical intervention, as if a chest tube is placed, or patient receives empirical treatment.
Unexpected Neurological Deficit not present on admission	Instance when a patient is discharged with a neuralgic deficit that was not present on admission and is not considered an expected consequence or the prescribed medical/surgical intervention.
Unexpected Blood Transfusion Reaction	Life-threatening or potentially life-threatening (in future treatment) response to a blood transfusion.
Reaction to Contrast/Dye	Life-threatening or potentially life-threatening (in future treatment) response to a contrast medium / dye used for diagnostic purposes.
Wound Dehiscence	Separation of the layers of a surgical wound, requiring re-operation/repair.
Nonscheduled return to operating room/hospital/clinic area	Patient presenting to site requiring further unexpected treatment related to previous visit.
Deep Vein Thrombosis/phlebitis	Not identified on admission, verified per physician evaluation and/or Doppler, requiring treatment such as anticoagulants.
Skin Breakdown	Skin degeneration that arises during hospitalization, requiring wound packing, dressing changes, surgical intervention, or antibiotic management.
Left without service/Elopement/ Discharge Against Medical Advice (AMA)	Patient chooses to leave prior to assessment and/or initiation of treatment.
Problems related to Inter-Unit Patient Transfer	This may include early discharge from ICU, miscommunication, inadequate communications, etc.
Equipment/Supply Malfunction/ Inadequate Stock	Situation that adversely affects/delays patient care.
Injury to Patient or Visitor	Includes suicide attempt, self-inflicted injury, or mishap resulting in injury to someone other than employee.
Incomplete/Incorrect/Missing Consent	Lack of consent for a procedure/treatment. Required consent in non-emergency situations.
Adverse Drug Experience	Included both allergic reactions and adverse drug reactions.
Wrong site, person or procedure	Surgery or invasive procedure that is performed on a body part that is not consistent with the documented informed consent, performed on a patient other than that

EVENT	DEFINITION
	identified by the informed consent, or not consistent with the surgery or procedure documented on the informed consent.

Risk Services staff work in conjunction with the HU Office of the General Counsel, which represents and provides legal services to the Hospital and the University. Risk Services, also works with physicians and employees to:

1. Identify potential risk exposure situations or conditions.
2. Recommend changes to reduce potential occurrences.
3. Provide education regarding potential risk and methods of prevention.
4. Advise physicians/employees of appropriate actions when claims are asserted or suits filed.
5. Settle claims before they become lawsuits.
6. Serve as liaison for physicians/employees when depositions are scheduled.

MEDICAL RECORDS - Entries in the Patient's Chart

Good documentation is essential! The ability to defend a case is dependent upon good, clear, legible documentation. Under no circumstances should the medical record be ALTERED. Altering a record to avoid liability is a serious and potentially criminal offense.

Always follow the basic rules of documentation:

1. Document entries in BLACK INK.
2. Time, date and sign each entry including your pager number.
3. Make certain all entries are legible.
4. Use only hospital-approved abbreviations.
5. Document all information and interactions (with the patient and/or surrogate decision makers) that impact the patient's condition, care and/or treatment plan.
6. Document in the medical record: all x-ray results, laboratory results, diagnostic test results, and explanation of procedures, treatments and surgical procedures. When you are seeking the patient's approval and a signature is being requested on a consent form include in the medical record a progress note that documents all procedure's risk and known complications discussed with the patient at the time informed consent was provided.
7. When an error is made, draw a single line through the entry. Write the word "Error", date and initial the entry. Then write the correct information.
8. When information has been omitted an "Addendum" entry may be made in the medical record. The entry should be titled as an "Addendum" and dated and timed for when you are writing the addendum entry. Contact the Risk Management office if you are uncertain if an addendum entry is appropriate.

XV. PHARMACY SERVICES

POLICY NAME: MEDICATION ADMINISTRATION

PURPOSE

To establish a policy for the safe practice of prescribing, administering, dispensing, documenting, and monitoring medications.

SCOPE

All hospital personnel responsible for prescribing, administering, dispensing, documenting, and monitoring medications.

POLICY

I. PRESCRIBING MEDICATION

A. Authority

The following personnel are authorized to write medication orders:

- Physicians
- Dentists
- Podiatrists
- Physician Assistants (under the direct supervision of a licensed physician)
- Nurse Practitioners (as denoted by Scope of Service and/or HUH Medical Staff By-Laws)

B. Prescription Requirements

All medication orders must:

- Be reviewed by the pharmacist before dispensing, removal from floor stock, or removal from the Omnicell system unless a licensed independent practitioner controls the ordering, preparation and administration, or in urgent situations in which the patient experiences a sudden change in clinical status. Each patient care area will maintain an Override List in cases when medications must be administered without prior review. (See HUH policy PHA -008-10, Omnicell Override).
- Be printed, dated, timed and signed with the MD name printed clearly. The appropriate professional degree and pager number must be included.
- Include the patient's diagnosis and/ or indication for use.
- Be written using the appropriate abbreviations, acronyms and symbols. (See Abbreviations, Acronyms and Symbols: Not To Be Used, Department of Pharmacy Services Policy, Procedure and Safety Manual.)

- Be complete: include specified dose, route and frequency of medications to be administered. Orders written with a range of dosages or a range of time frame are not acceptable. (For example, give 1 or 2 tablets every 3 – 4 hours). These types of orders are not specific and cannot be transcribed or executed.
- Indicate the requested drug name by trade or generic name, dosage, route and frequency of administration. The order will indicate when the first dose is to be given if it deviates from the standard administration time.
- Be prescribed in the metric system except for medications administered by drops. Volumes should be expressed in milliliters. **A zero (0) should appear before the decimal if quantity is less than one unit. Never use a trailing zero after a decimal point.**
- Be written on the form entitled “**ANTIBIOTIC ORDER SHEET**” if antibiotic medications are being prescribed.
- Be written by a provider when changes are made to a medication order previously written by the provider and reviewed by the pharmacy. **Medication orders may not be changed by making marks or cross-outs on the original order.**
- Be presented to the licensed nurse in a timely manner so that all orders may be forwarded to Pharmacy within one (1) hour.

*If the physician's orders include abbreviations that are prohibited, are not complete, or not legible, the staff member transcribing the order must obtain corrections from the physician who wrote the order **prior to** transcribing or executing the order.*

II. TYPES OF MEDICATION ORDERS

A. STAT Orders

All orders for “stat” must receive immediate attention. The physician will inform the nursing staff of the presence of the stat order, the pharmacy must be notified and the pharmacy copy of the order must be sent immediately for review. When the medication is prepared, the pharmacy will call the nursing station for pickup. The medication must be administered within thirty (30) minutes. Non- formulary medications will not be ordered on a “stat” basis.

B. NPO Orders

In order to ensure that medications are properly administered or withheld whenever a patient is NPO, the NPO order must include directions to either: withhold all oral medications, or change the route of the medication. The order must also include when to re-administer routine medications. NPO orders that do not include specific directions, as cited above, are invalid and cannot be executed. If the NPO order is not written as stated above, the physician must be notified and a complete order will be requested. For patients who are receiving diabetes medication, the NPO order must include specific orders that will ensure appropriate blood glucose levels.

C. Now Orders

“Now” orders must be administered within one (1) hour. Non-formulary medications will not be ordered on a “Now” basis.

D. Range Orders

Range orders are not acceptable. Specific doses and time frames must be indicated for all medication orders.

E. Titration Orders

Titration orders must be written to include specific dose ranges in response to the patient’s status.

F. Taper Orders

Orders for tapering medications must include dose, time of administration, duration and specific directions for administration. The medication orders must be written individually in each instance that the dose, time frame or duration is adjusted.

G. PRN Orders

PRN orders will be prescribed for patients requiring medications on an as needed basis. All PRN orders will include a specific dose and specific time frame and will include the route and indication for use.

H. Standing Orders

All standing medical orders/protocols will be approved by the Pharmacy and Therapeutics Committee.

I. Pre-Printed Orders

All pre-printed orders are approved by the Medical Executive Committee. Pre-printed orders should be utilized when indicated.

J. Telephone Orders

Registered nurses and licensed practical nurses may accept telephone orders. Telephone orders that are accepted will:

- Be recorded on the physician’s order form as a telephone order from the physician giving the order. The nurse will request that the physician spell the medications and state dosages in digits separately (for example state one-five instead of fifteen to avoid confusion with fifty); state the frequency and route including quantity and duration; state the purpose or indication of medication or treatment; and provide specific instructions when indicated. The physician’s name and pager number must be clearly printed on the order.
- Be **read back** (enunciating clearly) to the ordering physician for verification **prior to executing** the order.

- Be signed by the respective nurse and be transcribed by the nurse or unit secretary.
- Be countersigned by the respective physician or other physician member of the patient care team **within 24 hours**. Nursing staff will remind physicians to countersign orders.

K. Verbal Orders

Registered nurses and licensed practical nurses may accept verbal orders. The use of verbal orders is limited to patient care circumstances that require **emergency intervention**. When verbal orders are unavoidable, the following is required:

1. The nurse receiving the order must write the order (preferably) directly onto the patient's physician's order sheet if possible. **Exception: During CPR procedures, and other extreme emergencies.**
2. The nurse will ensure the verbal order includes the patient's name, age and weight when appropriate; the name of the medication; dosage, frequency, route and duration; purpose or indication; and specific instructions when indicated. The name of the ordering physician along with pager/telephone number will also be included.
3. The nurse will **read back** the verbal order verbatim to the physician and will wait for verbal confirmation **prior** to carrying out the order.
4. The physician will sign and date the order as soon as possible within 24 hours.

- L. Adherence to Medical Order Protocols and Procedures: Failure to adhere to medical order protocols and procedures described above in paragraphs A-K is cause for discipline up to and including termination.

III. DISPENSING MEDICATIONS

A. Formulary Medications

Only licensed pharmacists are authorized to dispense medications. The pharmacy will dispense products on the approved HUH formulary list and will substitute equivalent brands as needed and approved.

B. Non Formulary Medications

When prescribing non-formulary medications, a Non-Formulary Request (form HUH #343) must be completed by the ordering physician. The physician's order must be sent along with the Non-Formulary Request form to the Pharmacy. The physician will be promptly notified by the pharmacist if an alternative formulary medication is available, or if a delay in obtaining the medication is anticipated. If the patient brings medication from home which is not on the HUH formulary and not readily available from the pharmacy, the patient's own medication may be used. The physician must complete the Non-Formulary Request form and write an order:

“MAY USE PATIENTS’ OWN MEDICATION UNTIL PHARMACY OBTAINS THE MEDICATION”. The order should specify the name of the drug, strength, route and frequency. The patient’s personal medication(s) must be identified/verified and signed off by a staff pharmacist prior to use. The pharmacist will label the medication and place in the patient’s bin for dispensing by the pharmacy.

C. Compounded Medications

Medication orders for compounded drugs or drug mixtures that are not commercially available must list the name of each component along with the dose, route, frequency, indication and specific directions for use. Compounded medications will be prepared by the pharmacy.

D. Combining /Reconstituting Medications

The pharmacist and/or Drug Information Center, and other references will be consulted for mixture compatibility prior to combining the medications. At the time of reconstitution, all medications will be labeled with the amount of diluents used, the date and time, the amount of drug per ml, the name of the individual who mixed the medication, and the expiration date.

E. Multi-dose Vials

All multiple dose vials will expire on the manufacturer’s expiration date printed on the vial. Multiple dose vials may be discarded earlier at the discretion of the user. Insulin vials expire within 28 days of opening.

F. Restricted Antibiotics

Orders for restricted antibiotics must be approved for continued use by the Infectious Diseases Department. Approval must be called in to the Pharmacy by the infectious disease physician. The Pharmacy will dispense a 24 hour supply of the restricted antibiotic until approval is received. (See Pharmacy policy #3-44 Restricted Antibiotics)

G. Medication at Patient’s Bedside

Medications will only be left at patients’ bedside if:

- There is a written physician’s order to do so.
- The patient is being taught self-administration techniques as per plan- of-care.
- The medications are topical treatments such as creams or lotions, installation medications such as ear drops and eye drops.

Exception: Medications will not be left at the bedside of pediatric or psychiatric patients.

H. Medications to be Returned to Pharmacy

Medications will be returned to the pharmacy under the following circumstances:

- Expired medications.
- Drugs with torn, missing, incorrect, or illegible labels.
- Any medication which reflects a change in color, odor, or consistency, or is in a damaged package or container.
- All patient's medications when discontinued or when the patient is discharged.

I. Sample Medications

No sample medications are to be kept in any patient care areas of the hospital. (See Pharmacy Policy # 2.8.0).

J. Renewal of Medication Orders

- Unless a stop date is indicated, medication orders have no expiration dates with the exception of Antibiotic order which must be rewritten (if the order is to continue) every 5 days (as indicated on the Antibiotic order sheet).
- Large volume parenterals and those containing additives are renewed every 24 hours. This includes total parenteral nutrition infusions.
- PCA orders should be renewed every 72 hours, however, PCA infusion bags must be changed every 24 hours.
- The pharmacy staff will provide a daily report to assist nurses and practitioners in identifying Antibiotic and PCA orders that are to be renewed. This notification will be sent 48 hours in advance of the expiration date and provides the opportunity for the practitioner to ensure timely order renewal and to prevent automatic cancellation of the orders.
- If medications have been cancelled for any reason, or held for 24 hours, the physician must re-write specific medication orders to continue the medication regimen. Blanket orders written to "resume" all medications are not acceptable.

K. Automatic Cancellation of Medication Orders

Medications will be automatically cancelled under the following circumstances:

- If the patient has surgery or is post-delivery or if the patient is transferred to another clinical service (example patient is transferred from Medicine to Surgery service), or if the level of care is changed (e.g., from 5N to MICU).
- When a new medication order is written for a previously ordered medication.
- When a medication that has been placed on hold has been on hold for 24 hours.

Exception: Transfer orders are not needed if patient is transferred to another unit but within the same service (e.g., transferred from 4N Medicine to 6P Medicine).

L. Patient's Personal Medications

Personal medications brought to the hospital by patients should be sent home by family member/friend once the medications have been reviewed by the physician or nurse during the admission process. If there is no relative or friend to send the medications home with, the nursing staff will send the medication to the pharmacy for storage until the patient is discharged. (*Exception: See Non-Formulary section of this policy*). Nursing staff will place the medications in a plastic bag and will label the bag with the patient's name before sending to the pharmacy. Upon discharge, the nursing staff will retrieve the patient's medication from the pharmacy and return to the patient.

- M. Failure to adhere to the protocols and procedures concerning dispensing of medications as described in any of the provisions in paragraphs II (A) through (L) above can result in discipline up to and including termination.

IV. ADMINISTRATION OF MEDICATION

A. Authority

The following personnel are authorized to administer medication as defined in their scope of practice and the HUH Medical Staff Bylaws.

- Physicians, Dentists, Podiatrists
- Registered Nurses
- Licensed Practical Nurses
- Dialysis Therapists (under the supervision of the registered nurse or physician)
- Physician Assistants
- Nurse Practitioners
- Licensed Respiratory Therapists
- Radiology Technologists
- Students (under direct supervision of a licensed instructor).

B. Responsibilities of Personnel Administering Medications

All personnel administering medications will:

- Demonstrate basic competence required for safe performance of medication administration, including knowledge of the drug action, side and adverse effects, contraindications, interactions and food-drug interactions.
- Participate in competence assessment programs involving medication administration, dosage calculation and pharmacology updates during orientation and periodically as required.

- Assess the indicated physiological parameters prior to administration of certain medications (e.g. antibiotics, steroids, digoxin, morphine, insulin electrolytes, etc.).
- Ensure accurate patient identification by using the two patient identifiers: for inpatients, Emergency Department, Oncology Clinic and Ambulatory Surgery: the **medical record number** and **patient's name** will be used; for patients in the Outpatient Clinics, the **patient's name** and **birth date** will be used; and for the Outpatient Hemodialysis unit, the **patient's name** and **photograph** will be used to verify identification prior to administering medications. The two identifiers will be checked **against** the information available to the individual administering the medication such as the Medication Administration Record or any part of the medical record with the two identifiers.
- Observe the 5 rights of medication administration by ensuring that the right patient, right medication, right time, right dose and the right route has been verified.
- Check the medication 3 times when: when removing the container from the container/drawer/shelf, before pouring/opening the container, and before returning it to the drawer/shelf.
- Monitor each patient's response to medications both routine and newly prescribed, based on review of laboratory results, physiological parameters and the patient's self-report.
- Document in the medical record the patient's response to the prescribed medications and any actual or potential medication-related problems.

C. Patient Safety

To ensure patient safety special care will be taken when prescribing and administering medications. If the Hospital determines that an employee's prescription or administration of medication compromised, or reasonably could have compromised, patient safety, the employee can be subject to discipline up to and including termination.

D. Administration of Medications by the Preparer

Other than medication admixtures or manufactured products dispensed by the pharmacy, medications will only be administered by the individual who prepared them except in emergency and operative situations where medication syringes are prepared and provided to practitioners for administration. In such situations, it is

the responsibility of the practitioner who prepared the medication to repeat to the practitioner who will administer the medication the name and dosage of the medication.

E. Locking of Medication Carts

Medication carts will be locked when unattended. Medication preparation rooms must also be locked when unoccupied. During the administration of medication, carts will remain within the eyesight of the nurse. The cart must be pushed into the patient's room (except isolation rooms) while the nurse is administering medications. Failure to properly lock medication cards can lead to discipline up to and including termination.

F. Verification of Patient Medication Allergies and Weight

Prior to ordering, dispensing or administering medications, patient allergy and weight status must be obtained and documented.

- As a component of the initial assessment, the nurse will verify allergy information. Known allergies will be indicated on the Patient Data Base, the Medication Administration Record, the Plan for Care I and in the Invision order entry system. A red allergy alert ID bracelet will also be placed on the patient's wrist.
- When allergy information is obtained after the admission process, the change in allergy status will be discussed with the physician and will be documented on the Physicians Order form as a verbal order to change the allergy status. A copy of the order will be sent to the pharmacy. The nurse will transcribe the order and follow the procedure to indicate allergies as described above.
- Pharmacists must verify all allergy information prior to dispensing any medication. If allergy information is not available, the pharmacist must call the nurse to obtain the allergy information. If conflicting allergy information exists, for example, what is written in the medical record is different than what is on the pharmacy medication profile, the physician will be notified to resolve any conflict of allergy information. The pharmacist will document the date, time and name of the physician notified. Failure to follow these procedures is grounds for discipline up to and including termination.
- On admission to the hospital, nursing staff will weigh all patients and enter the information in the computer system. All patients will be weighed routinely to ensure the most accurate weights are being used to calculate medication doses when indicated.

G. Self-Administration of Medications

Patients will be permitted to self-administer medications only when there is a documented physician's order to do so. Patients that will be self-administering medications must be under the direct supervision of the licensed nurse. Medications that will be self-administered must be maintained in the patient's medication bin of the medication cart.

H. High Alert Medications

High Alert medications are those drugs that are involved in a high percentage of medication errors and/or sentinel events and medications that carry a higher risk for abuse, errors, or other adverse outcomes. (See HUH policy PHA-011-10, High Alert Medications). The following are safety precautions during prescribing, dispensing and administration of high alert medications that must be followed. Failure to take these precautions can result in discipline up to and including termination:

- Pharmacy must maintain segregated, clearly labeled storage locations for all high alert medications stored in the pharmacy and patient care areas with distinct high-alert medication warning label visibly placed on the storage bin.
- High alert medications stocked in the Omnicell cabinets must be stored in individual drawers. High Alert stickers must be placed inside of the drawers to alert staff.
- High Alert intravenous infusions must be clearly labeled as "High Alert" to notify staff to use appropriate precautions when administering the infusion.

I. Adverse Drug Reaction (ADR)

If a patient develops any noxious, harmful or unintended reaction to a medication, the ADR policy must be followed. Failure to follow the ADR policy can result in discipline up to and including termination.

ADR requires that the nurse must discontinue the medication immediately and contact the physician. The remaining medication must be bagged by nursing personnel and sent to the pharmacy. The individual who first observes the reaction must generate an Adverse Drug Reaction (ADR) Report form (HUH #0087) or call the ADR voicemail at 5-7322 (5-REAC) for follow-up by the pharmacy department. Additionally a Safety Risk Report must be completed. A description of the drug reaction, including manifestations and interventions provided, must be written in the Progress notes and the Nurses Focus notes. If the ADR is considered an allergic reaction, the procedure for documenting allergies will be followed.

J. Look A-Like Sound A-Like Medications

Special care must be taken when prescribing and administering look-alike, sound a-like medications. These medications will be identified by the pharmacy and a list will be circulated throughout the hospital for reference on an annual basis. (See HUH policy, PHA-012-10, Look A-Like Sound Alike Medications). A copy of the look-alike, sound-alike list will be placed in each medical record.

K. Insulin Administration

Prior to administering insulin via subcutaneous, IV push or IV infusion, **the dose and route must be verified and the insulin vial and medication syringe visually checked by a second licensed practitioner. Subcutaneous insulin doses must be verified by two (2) RNs or an RN and LPN prior to administration. IV push and IV infusions of insulin must be verified by two (2) RNs.** The two nurses are required to initial the appropriate space on the medication administration record. Any other practitioner who is authorized to administer insulin is required to follow the same verification process. (See HUH policy, NUR-016-10, IV Insulin Protocol). Pre-filled insulin pens will be used to administer insulin. Exceptions include: mixing insulins and use of insulin not available in pens. (See Insulin Pen Protocol.) Failure to adhere to these steps can result in discipline up to and including termination.

L. Heparin Administration

When administering IV push or bolus heparin, two (2) registered nurses are required to verify the correct dose and visually check the heparin vial and medication syringe prior to administration. The two (2) nurses are required to initial the appropriate space on the MAR. IV push heparin doses will not exceed 10,000 units. (See HUH policy PHA-005-10, Anticoagulant Management Protocol.) Failure to adhere to these steps can result in discipline up to and including termination.

M. Patient's Use of Personal Medications

Generally patients will not be permitted to use personal medications except if the patient is on a non-formulary medication. (Refer to the Non-Formulary section of this policy and Pharmacy Policy # 2.31, Patient's Use of Personal Medications.)

N. Herbal Products

HUH pharmacy will not stock any herbal/alternative products since these products are not subject to FDA review. In the event a patient desires to continue use herbal products while hospitalized, the patient will be required to sign a waiver. Once the waiver has been

signed, the physician will write the order for the product to be administered including the dose, route, time and directions for use. The patient's personal herbal/alternative product will be administered.

O. Pediatric Doses

In most circumstances pediatric doses are prepared in the pharmacy. However, short stability medications that cannot be prepared in the pharmacy will be verified by two (2) licensed members of the health care team, (e.g. (2) RNs, LPN and RN, or RN/LPN and Physician). All pediatric medication orders must include the patient's current weight and the mg/kg per dose.

To ensure safety in preparing pediatric medications the following is required:

- All neonatal and pediatric weight-based doses must be calculated and verified by two (2) pharmacists.
- The current weight of the patient must be obtained prior to calculating medication doses.
- All labels and medications in syringes/bottles must be checked by two (2) pharmacists.
- Medications delivered to the pediatric and nursery units must be placed directly into the patient's bin or refrigerator, and not left at the nurse's station or on top of medication carts.

Failure to adhere to these procedures for preparing pediatric medications can result in discipline up to and including termination.

P. Intravenous Administration of Medication

Physicians, Physicians Assistants, Registered Nurses, Licensed Practical Nurses, and Radiology Technologists, may administer medications by intravenous infusions. Physicians, Physicians Assistants, Registered Nurses and Dialysis Technicians are permitted to administer medications by direct IV push. Dialysis Technicians may only push the identified drugs pertaining to dialysis, and are not permitted to administer any other medication by this method. (Refer to Departmental Operational Guidelines for IV push medications that RNs may administer.) Failure to adhere to these procedures for intravenous administration of medications can result in discipline up to and including termination

Q. Patient Controlled Analgesia

Physicians and Registered Nurses must be trained to properly prescribe, administer and monitor narcotics administered using the Patient Controlled Analgesia (PCA) pump. Competence is accomplished through an approved program of instruction. (Refer

to PCA Pump Policy #100.7 in the Division of Nursing Policy Manual).

R. Investigational Medications

Investigational medications are prescribed by the principal investigator and designated attending physician. The following procedure for the use of investigational medications must be followed prior to implementation:

- A copy of the protocol will be submitted to the pharmacy by the physician.
- The IRB and the Director of Pharmacy Services must be notified and provide written approval. (See HUH Policy CMO-001-10, Investigational Drugs).

Failure to adhere to these procedures for the use of investigational medications can result in discipline up to and including termination

S. Moderate Sedation

1. Individuals providing moderate sedation must be trained via a competency based course of instruction approved by the Chairman of the Department of Anesthesiology. This competency based program will prepare the practitioner to: administer pharmacological agents to predictably achieve desired levels of sedation; monitor patients in order to maintain the desired level of sedation; rescue a patient in the event the patient progresses to deep sedation; manage a compromised airway and provide oxygenation and ventilation. Practitioners are re-credentialed every two (2) years via a formal program of competency demonstration. Practitioners who work full time in areas providing moderate sedation on a daily basis may be re-credentialed based on direct observation by the Department Chair, Division Director or designee.
2. All patients receiving moderate sedation will have written orders by the physician performing the procedure. The minimum number of available personnel for moderate sedation will be two (2), the physician and a physician or nurse who will serve as the monitor. Sedation must be carried out in such a manner that will insure patient safety and provide for optimal conditions during the performance of therapeutic, diagnostic, invasive and surgical procedures. Failure to do so can result in discipline up to and including termination. (See HUH policy ANE-001-10, Moderate Sedation).

T. Standing Medication Administration Times

The standing administration times for medication administration are as follows:

<u>Description</u>	<u>Abbreviation</u>	<u>Standard Times</u>
Once a day	Daily (no abbreviation)	10am
Two times a day	bid	10am – 6pm
Three times a day	TID	10am – 2pm – 6pm
Four times a day	QID	10am – 2pm – 6pm – 10pm
Five times a day		6am-10am-2pm-6pm-10pm
Six times a day		2am-6am-10am-2pm-6pm- 10pm
Every 12 hours	q12hr	10am-10pm
Every 8 hours	q8hr	6am-2pm-10pm
Every 6 hrs	q6hr	6am-12n-6pm-12mn
Every 4 hours	q4hr	2am-6am-10am-2pm-6pm-10pm
Every 3 hours	q3hr	3am-6am-9am-12n-3pm-6pm-9pm12mn
<u>Description</u>	<u>Abbreviation</u>	<u>Standard Times</u>
Every 2 hours	q 2 hr	every hour on the even hour; starting at 2am
Every hour	q hr	every hour on the hour; starting at 1am
Before meals	ac	7:30am-11:30am-4:30pm
After meals	pc	10am-2pm-6pm
Bedtime	hs	10pm
Every other Day	Every other day(no abbreviation)	use even or odd dates

Certain classifications of medications are required to be evenly spaced throughout a 24 hour period in order to maintain therapeutic levels. The following categories of drugs that must be evenly spaced are:

- Antiarrhythmics
- Antibiotics
- Anticoagulants
- Anticonvulsants
- Antihypertensives
- Sedatives
- Tranquilizers

When orders are written for the above named categories of medications the time schedule for administration will be as follows:

BID	10am-10pm
Q12h	10am-10pm
TID	6am-2pm-10pm
Q8h	6am-2pm-10pm
QID	6am-12n-6pm-12mn
Q6h	6am-12n-6pm-12mn

U. Standardizing Medication Administration Times

All medications will be administered within a range of one (1) hour before and one (1) hour after the standard time. Unless otherwise ordered, initial dose of medications will be administered at the standard administration time, but not earlier than the one-half time

interval. Exceptions are Intensive Care, Labor and Delivery and Pediatric units.

Example: *A Medication order is written stat and every 12hours. It is first administered at 3pm. The standard administration times are 10am and 10pm. Therefore, the next scheduled dose will be at 10pm, since there is more than one-half the time interval remaining (7 remaining hours). However, if the drug was administered at 5pm, then the next scheduled dose would be 10am, since the time period between 5pm and 10pm is less than one-half the time interval remaining, (5 hours).*

V. Patient Transfers

To ensure continuity in care the following will be done when patients are transferred to another unit:

- When patients are transferred from one unit to another, all medications will accompany the patient to the new unit. Once new medication orders are written for the patient, the receiving unit will return all medications that were not reordered to the pharmacy for credit.
- To avoid delays in treatment, nurses may administer medications from the previous unit's supply if the medication has been reordered following transfer. The nursing staff will ensure that there are no interruptions in medication administration when patients are transferred between units.
- If a bed is not readily available to receive a transfer patient and the transfer orders have been written, it is the responsibility of the nurse on the transferring unit to contact the physician for further direction concerning the execution of the transfer orders. Orders for a medication to be administered prior to transfer must be written separately from the transfer orders.

Repeated failures to properly transfer patients can result in discipline up to and including termination.

W. Documentation of Medication Administration

1. The **Computer-generated Medication Administration Record (C-MAR)** is the official record of medication administration except in emergency and operative/postoperative situations. Practitioners administering medications must record all medications immediately after administration. The effects of routine medications will be documented in the nurse's focus notes when indicated and the effect of PRN medications will be noted on the MAR.
2. Certain medications require that the actual administration and blood sampling times be documented in order to make useful interpretation of laboratory results. Aminoglycosides have narrow therapeutic indices, e.g. therapeutic concentration is close to that of

toxicity and must be monitored to prevent serious adverse effects. Failure to accurately document actual administration times and actual blood sampling times may result in incorrect dosing and toxicity. Blood sampling times for medications requiring blood levels will be documented in the medical record.

3. Wasting of Narcotics (see Addendum to Medication Administration Policy).

V. PATIENT/FAMILY EDUCATION

Patient /Family education is a multidisciplinary activity that is documented on the Patient Family Health Education Record and in the progress notes. All disciplines directly involved in the process of medication administration are required to provide patient/family education and document such. Health care providers will provide education on medications during hospitalization pertaining to any potential clinically significant adverse reaction or other concerns relating to administration of routine and all new medications. Nursing staff will be responsible for providing education on medications prescribed at discharge. Printed materials in English and Spanish are available in the pharmacy department. Pharmacy staff will provide additional and specific patient/family education related to medications in the following situations:

- When the patient is discharged on 5 or more medications
- When there is a need to review the medications for potential drug/drug and drug/food interactions, contraindications, appropriate dosage and drug allergies
- When a patient experiences an adverse drug reaction
- When a patient is discharged on anticoagulant therapy.

VI. MEDICATION INCIDENTS AND TRACKING SYSTEM

A. Failure to administer the prescribed medication, IV fluid or diagnostic agent at the specified time and or in the manner as ordered constitutes a reportable error. (See HUH policy PHA-009-10, Adverse Drug Event Reduction Plan). The following are categories of reportable medication errors:

- **Omission:** Dose not given at the prescribed time or dose not recorded as being given at the prescribed time.
- **Wrong Dose:** Any dose greater or lesser than the prescribed dose.
- **Extra Dose Given:** Any dose given in excess of the total number of times indicated by the physician's order.
- **Unordered Drug Given:** The administration of any medication/IV fluid/diagnostic agent not prescribed for that patient by an authorized practitioner.
- **Wrong Route:** Any medication that is not given via the route as ordered.

- B. In the event that a medication error has occurred, the procedure for reporting an Adverse Drug Reaction must be followed. Document in the focus or progress note the unordered drug administered to the patient including the dosage, route date and time the drug was administered. Indicate the interventions taken and the time the physician was notified. In case of omission the nurse will initial and circle the appropriate box indicating that the medication was not given on the Medication Administration Record, and will complete the section on the MAR that states the reason for the omission and when the physician was notified. Any additional information regarding interventions or adverse effects will be written in the focus notes.
- C. Repeated medication errors can result in discipline up to and including termination.

VII. EVALUATION

The Pharmacy Department and the Pharmacy and Therapeutics Committee, a multidisciplinary committee representing all disciplines involved in medication administration, are responsible for reviewing Risk Management Safety and Adverse Drug Reaction reports for the purpose of identifying trends and issues relating to medication management. Results of analysis of these data are reported to the Hospital Performance Improvement Committee and the Division of Nursing Performance Improvement Committee for development of appropriate action plans.

ADDENDUM TO MEDICATION ADMINISTRATION POLICY

Under Documentation of Medication Administration

- D. Wasting of Narcotics
 - All partial and full dose medication wastes must be documented in the automated system or on the green narcotic sheets (see Automated Dispensing System Policy PHA-004 in the Administrative Policy Manual).
 - **Wasting of narcotic drugs must be documented at the time of occurrence. Two nurses (RNs or LPNs) must visually witness narcotic wastage and both must indicate such on the appropriate record.**
 - **Excess narcotic medications must not be saved for later use.**
 - Narcotics should not be removed from the system/cabinet until the medication is due to be given.
 - **Narcotics must not be given to any individual to whom they are not prescribed.**
 - **Absent documented medical necessity, narcotics must not be consumed by employees while on working time;**
 - Failure to adhere to this policy concerning usage of an wasting of narcotics can result in discipline up to and including termination.

ABBREVIATIONS!! ABBREVIATIONS!!

DO NOT USE



The Joint Commission Official “Do Not Use” List¹

<u>Do Not Use</u>	<u>Potential Problem</u>	<u>Use Instead</u>
U (unit)	Mistaken for “0” (zero), the number “4” (four) or “cc”	Write “unit”
IU (international unit) Unit	Mistaken for IV (intravenous)	Write “International
Q.D., QD, q.d., qd (daily) Q.O.D., QOD,, q.o.d, qod (every other day)	Mistaken for each other Period after the Q mistaken for “I” and the “O” mistaken for “I”	Write “daily” Write “every other day”
Trailing zero (X.0)mg)* Lack of leading zero (.Xmg)	Decimal point is missing	Write X mg Write 0.X mg
MS sulfate” MSO ₄ and MgSO ₄	Can mean morphine sulfate or Magnesium sulfate Confused for one another	Write “morphine sulfate” Write “magnesium

¹Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms

*Exception: A “trailing zero” may be used only where required to demonstrate the level of precision of the value being reported, such as laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

POLICY ON SOUND ALIKE LOOK ALIKE DRUGS (SALA) MEDICATIONS

- Purpose:** The purpose of this policy is to delineate guidelines for procuring, storing, ordering, dispensing, and administration of drugs that are easily confused to minimize the potential for adverse drug events.
- Scope:** This policy applies to all personnel in all areas of the hospital authorized to handle medications. All personnel who procure, store, order, dispense, and administer medications are responsible for complying with this policy.
- Policy:** The Medication Error Adverse Drug Event (MEADE) Council, presently known as the Adverse Drug Reaction Committee (ADR), will annually review a list of look-alike and sound-alike medications used in the organization and take action to prevent errors involving the interchange of these drugs.

The hospital may establish policies for procuring, storing, ordering, dispensing, and administering specific medications that look-alike or sound-alike.

1.1 PURCHASING:

- 1.1.1 McKesson serves as the Primary Wholesaler for pharmaceuticals purchased by Howard University Hospital.
- 1.1.2 All healthcare practitioners are encouraged to notify the ADR Committee, of look-alike products (or notify the Pharmacy Department directly). For example, two look-alike drugs in adjacent compartments in Operating Room Anesthesia Omnicell® Carts can be problematic.
- 1.1.3 The Department's Formulary Manager and Drug Purchasing Agent will attempt to identify an alternative product.
- 1.1.4 A more expensive product may be purchased if necessary.
- 1.1.5 These actions are recorded in the ADR Committee Meeting minutes.

1.2 STORAGE AND DRUG SELECTION:

- 1.2.1 Potential for error in drug selection is minimized by following:
 - Drug product nomenclature on product labels is generic.
 - Drug storage labels are designed to match the product labels.
 - If two products are identified as representing a sound-alike hazard (hydralazine/hydroxyzine), both product shelf/bin labels are labeled with "SALA Alert" stickers.
 - Two adjacent products representing a product "look-alike" hazard, e.g., two bottles from the same manufacturer are separated. If the products are not adjacent, select products are labeled with "SALA Alert" stickers.
 - The Medication Safety Officer maintains the list of products targeted for "SALA Alert" stickers.
 - The Technician Support Coordinator for Medication Area Inspections is responsible for placing the stickers on shelves or bins.
- 1.2.2 The pharmacy department will vertically segregate select SALA medications.
- 1.2.3 Medication that is alphabetically first, in pharmacy satellites, will remain in the designated place. The medication that is alphabetically second will be located after the letter "Z". A medication bin will be located in the alphabetical spot, but will be turned upside-down with labeling which reads "SALA: epinephrine is located after "Z". Do not restock this bin."
- 1.2.4 See Addendum A 08-10 for the list of SALA medications targeted for SALA stickers and vertical segregation.

- 1.2.5 The hospital is in the process of converting to Insulin Pens. Patient specific insulin pens are stored in the patient specific medication storage box and are removed from the nursing unit upon discharge. Formulary Insulin products are as follows: NovoLOG Flexpen, LanTUS (Glargine) Solostar Pen, and NovoLOG 70/30 Mix Flexpen,
- 1.2.6 NovoLIN R (Regular) and NovoLIN N will continue to be available in the ICU, ED, L&D and Pediatrics.

1.3 ORDERING:

- 1.3.1 Generic prescribing is encouraged to reduce confusion between two brand name products, the source of most sound alike errors.
- 1.3.2 The design of HUH's Computerized Prescriber Medication Order Entry is generic name-driven. Documents produced by Siemens® order entry are generic only, including medication labels and Medication Administration (MARs).
- 1.3.3 Enhanced lettering (TALL MAN) is used for select SALA drugs to prevent prescribing errors.

1.4 ORDER ENTRY:

- 1.4.1 The Medication Safety Officer and Formulary Manager are responsible for identifying products that represent a risk for misreading.
- 1.4.2 The Medication Safety Officer maintains a list of these products. The Medication Safety Officer requests that the Drug File Pharmacist update the drug file nomenclature to include enhanced lettering for select SALA drugs.
- 1.4.3 The pharmacist contacts the prescriber if the intent is in doubt.

1.5 ADMINISTRATION:

- 1.5.1 SALA alerts are included on the Medication Administration Record, serving as a reminder for the nurse to check the medication for high-risk nomenclature. For example, the note on the MAR reads:
"SALA ALERT" PLEASE DOUBLE-CHECK MED.
- 1.5.2 For select SALA drugs, the brand name always appears on the MAR in addition to the generic name. These drugs include: Oxycontin® (oxycodone extended release), MS Contin® (morphine extended release), and Dilaudid® (hydromorphone).

1.6 SELECTION, ORDER ENTRY, PRODUCT SELECTION, AND ADMINISTRATION

- 1.6.1 HUH formulary products are entered into Siemens® in

Enhanced letter format. Therefore, “hydroxine” appears as “hydrOXYine” and “hydralazine” appears as “hydrALAZINE”.

- 1.6.2 The Medication Safety Officer works with the Formulary Manager to identify new formulary products with SALA drug names. The Medication Safety Officer provides the list to the Drug File Pharmacist.
- 1.6.3 “Enhanced” nomenclature appears on all Siemens computer Screens and all Siemens®-generated documents (Labels, MARs, Automatic Stop Order Reports). Enhanced Nomenclature also appears on the Unit-based Cabinet (Omnicell®) screen.

Addendum A:

List of SALA Drug Combinations Targeted for SALA stickers and Vertical Segregation within Pharmacy:

- 1. CARBOplatin and CISplatin
- 2. ClonazePAM and CloniDINE
- 3. DOBUTamine and DOPamine
- 4. ePHEDrine and EPINEPHrine
- 5. HydralAZINE and HydroOXYzine
- 6. LamiVUDine and LamoTRIgine
- 7. OxyCODONE and OxyCONTIN
- 8. ZANTAC® ranitidine and XANAX® alprazolam
- 9. VinBLASTine and VinCRISTine
- 10. CISplatin (PLATINOL®) and CARBOplatin (PARAplatin®)
- 11. CEREbyx®, CeleBREX® and CELEXA®
- 12. metFORMIN® and metroNIDAZOLE

Addendum B:

List of SALA Drug Combinations Taken from the Joint Commission List. These drugs are targeted for enhanced lettering, label alerts, and EMAR alerts.

- 1. ePHEDrine and EPINEPHrine

2. HYDROmorphine injection and Morphine injection
3. Insulin products:
 - HumaLOG® and HumuLIN
 - NovoLOG® and NovoLIN
 - HumuLIN and NovoLIN
 - HumaLOG® and NovoLOG®
4. MetFORMIN and MetroNIDAZOLE
5. HydralAZINE and HydrOXYzine
6. OxyCONTIN® and OxyCODONE
7. VinBLAstine and VinCRISStine
8. CeleBREX® (celecoxib), CELEXA® (citalopram hydrobromide) and CEREByx® (fosphenytoin)
9. CloniDINE and Klonopin® (clonazepam)
10. LamiVUDine and LamTRIgine

XVI. PATIENT RELATIONS

A. ROLE OF THE DEPARTMENT OF PATIENT RELATIONS

The Department of Patient Relations provides a specific channel through which patients can present their problems, concerns and unmet needs for investigation and resolution. The Patient Relations Program has been designed to strengthen, personalize and enhance the relationship between the patient and Howard University Hospital service providers. The Department of Patient Relations resolves complaints, channels compliments and tracks applicable data. Data collected is reported to Executive Management and designated committees to foster customer delight and continuous performance improvement.

B. POLICY ON PATIENT COMPLAINT/GRIEVANCE RESOLUTION (CMR-002-10)

Purpose: To establish a formal mechanism for ensuring that patient complaints and grievances receive appropriate response and resolution. This policy delineates the process by which patient complaints and grievances will be communicated and addressed. Patient complaints will be handled at the point of service whenever possible.

Scope:

- A. All Hospital service providers are expected to adhere to the policy for resolving patient complaints. Any provider who receives an initial complaint has a responsibility to assist in addressing and resolving the complaint. Complaints should always be resolved at the point of service via the established protocol. Documentation of the complaint and corrective action should be forwarded to the Department of Patient Relations for record keeping purposes. Responses to patient complaints and records of all complaints will be coordinated and maintained by the Department of Patient Relations. The Department of Patient Relations functions under the direction of the Office of the Chief Operating Officer.
- B. In instances where the complaint cannot be resolved at the point of service, or if the patient would rather not resolve the complaint at that level, the provider should forward the complaint to the Department of Patient Relations. The Department of Patient Relations will make every reasonable effort to facilitate an equitable and timely resolution.
- C. Responses to written patient complaints/grievances and records of all complaints will be coordinated and maintained by the Department of Patient Relations.
- D. Patients are informed of the complaint process via the Patient Bill of Rights posting and brochure.
- E. HUH service providers are informed of the complaint process through the following:
 - 1. Patient Bill of Rights posting and brochure.
 - 2. House Staff Manual or Administrative Standard Practice Manual
 - 3. New hire orientation, in-service training programs, and/or credentialing processes.

POLICY: Complaints referred to the Department of Patient Relations for handling as well as complaints that are escalated to grievance status will be addressed collaboratively with hospital supervisors, managers, administrators, clinic chairs, department heads, Executive Leadership Team and/or Risk Management, Legal Counsel and Quality Assurance departments to ensure resolution and identify areas for continued performance improvement. Feedback will be provided to patients to ensure their satisfaction with the hospital's response to their concerns and to promote positive patient relations. The specific groups affected by this policy are:

A. Patients:

- 1. Inpatients/Outpatients
- 2. Patients' Family Members
- 3. Patients' Representatives

B. Howard University Hospital (HUH) Service Providers:

- 1. Howard University Hospital Staff
- 2. HUH Physicians/Staff Physicians/Community Physicians

3. Howard University Hospital Contractors
4. Howard University Faculty and Staff

PROCEDURE: Procedure on handling a Patient Grievance:

1. Hospital Service Provider: Following receipt of a patient grievance, the provider should forward the concern to the appropriate department head as well as the Department of Patient Relations.
2. Point of Service Staff/Department Head: The point of service staff/department head should attempt to resolve the patient grievance using the following steps:
 - a. Review the grievance and begin an investigation by speaking with the involve service providers.
 - b. Gather and review pertinent information and performance standards to determine an appropriate response.
 - c. Determine and implement a corrective action plan and/or performance improvement plan to address the concern and prevent reoccurrence.
 - d. Draft an email or complete a Complaint Follow-up Form to submit to the Department of Patient Relations indicating the findings and outcome of the review. The email/form should include corrective action or measures taken to ensure performance improvement.
 - e. Submit the email or Complaint Follow-up Form indicating the outcome to the review to the Department of Patient Relations within (3) business days.
 - f. If additional time is required to complete the investigation, request an extension and provide an explanation and a date that the written response will be submitted to the Department of Patient Relations.
 - g. Conduct the necessary follow-up to ensure performance improvement.
3. Department of Patient Relations:
Upon receipt of a patient grievance, The Department of Patient Relations will:
 - a. Ensure that the concern has been forwarded to the appropriate department head(s) for investigation and response within two (2) business days from the date the concern is received.
 - b. Send an acknowledgment letter to the patient within two (2) business days from the date the concern is received.
 - c. Ensure that the email or Complaint Follow-up Form indicating the outcome of the investigation is received from the applicable department head(s) within three (3) business days from the date that the complaint was forwarded to the department.
 - d. Coordinate responses when there is more than one department involved.
 - e. Send the final correspondence to the patient within seven (7) business days of the date the complaint was received.
4. Referral of Complaints Outside of the Department of Patient Relations
There are instances where complaints may be referred to the Faculty Practice Plan, Office of Risk Management Office of the Chief Compliance Officer, hospital/university counsel or another area for further handling. In such instances, the Department of Patient Relations will send correspondence to the

patient indicating that the matter has been referred to the applicable area for further handling.

5. Unresolved Patient Complaint/Grievance:

If the patient is not satisfied with the outcome of the review, or would rather not discuss the complaint/grievance at the Hospital level, the patient has the right, under the CMS Conditions of Participation (CoPs), to contact the DC Department of Health to review the complaint. Contact information for the DC Department of Health is included in the Patient Bill of Rights posting and brochure. Contact information for the Joint Commission is also listed within these documents for patients and their representatives to communicate concerns.

6. Reporting Mechanisms:

The Department of Patient Relations will provide written reports of all patient complaints and their outcomes to managers, administrators, executive leadership, chairs and other applicable staff. The Department will provide written reports to other committees/individuals as instructed by the Director of the Division of Community Relations.

Contacting the Department of Patient Relations:

For assistance in addressing a complaint at the point of service, please contact the Department of Patient Relations during regular business hours at 202-865-6823. Any provider calling the Department of Patient Relations and receiving the voicemail may leave a detailed message and a member of the Patient Relations staff will follow-up as soon as possible. Any provider calling to request assistance in addressing an urgent patient complaint and receiving the voicemail between 8:30am – 5:00pm Monday thru Friday, except during holidays, may contact the operator at 202-865-6100 to request that he/she locate the Director of Patient Relations. Any provider calling to request assistance in addressing a patient complaint between 5:00pm – 8:30am Monday thru Friday, or during holidays and weekends, may contact the operator at 202-865-6100 to request the operator locate the House Supervisor or the Administrator-On-Call.

1. Visit the Department of Patient Relations: 2nd floor, room 2049; call 202-865-6823; fax documents to 202-865-6542; or send email to patientrelations@huhosp.org.
2. Contact the Operator at 202-865-6100.

DEFINITION(S): Definition of a Patient Grievance: The Centers of Medicare and Medicaid Services (CMS) defines a “patient grievance” as a verbal complaint (when the complaint about patient care is not resolved at the time of the complaint by staff present or a written complaint by a patient, or the patient’s representative, regarding the patient’s care, abuse or neglect, issues relate to the hospital’s compliance with the CMS Hospital Conditions of Participation (CoP), or a Medicare beneficiary billing complaint related to rights and limitations provided by 42 CFR §489. However, Howard University Hospital will handle any written complaint as a patient grievance in order to prevent ambiguity and ensure consistency in implementation. For exclusions, please see “Section III. C: Referral of Complaints Outside of the Department of Patient Relations”.

Patient Rights and Responsibilities

HUH's Responsibilities to Our Patients

- To provide patients' or patients' representatives (as allowed under State law), information about their rights, prior to beginning or discontinuing patient care whenever possible.
- To provide patients with information about their responsibilities initially and as needed thereafter while they receive care, treatment, and services.
- To provide patients with the name of the physician or other practitioner primarily responsible for their care, treatment, and services, and the name of the physician or other practitioner who will provide their care, treatment, and services.
- To promptly contact family members/representatives of the patients' choice and their personal physicians to notify them when they are admitted to the hospital.
- To permit patients or patients' representatives (as allowed under State law) to make informed decisions regarding their care, treatment and services, and to obtain their informed consent or respect their right to refuse care, treatment or services in accordance with law and regulation.
- To ensure that the treatment or services we provide are deemed medically necessary and appropriate.
- To inform patients and, when appropriate, their family, about the outcomes of care, treatment, and services that have been provided, including unanticipated outcomes.
- To assess patients' pain and provide them with appropriate pain management.
- To ensure that patients are free from all forms of abuse or harassment.
- To provide patients with care in a safe setting and an environment that preserves their dignity and contributes to a positive self-image.
- To ensure that restraint or seclusion, of any form, is imposed safely by trained staff only to ensure the immediate physical safety of patients, our staff, or others, and to discontinue the restraint or seclusion at the earliest possible time.
- To address patients' wishes relating to end-of-life decisions to include their right to prepare advance directives and to have hospital staff and practitioners comply with these directives.
- To respect patients' right to and need for effective communication both within the hospital and externally.
- To respect patients' need for confidentiality and privacy.
- To ensure the confidentiality of patients' clinical records and provide them with access to information contained in their clinical records within a reasonable time frame.
- To protect and respect patients' rights during research, investigation, and clinical trials for which they have consented to be a research subject.
- To obtain patients' consent for recording or filming made for the purposes other than identifying, diagnosing, or treating them.
- To promote patients' right to access protective and advocacy services.
- To promptly address complaints from patients and their family and provide appropriate information for purposes of filing a grievance or referring a concern regarding quality of care or premature discharge.
- To ensure patients have the right to designate visitors who shall receive the same visitation privileges as the patient's immediate family members, regardless of whether the visitors are legally related to the patient. Centers for Medicare and Medicaid Services (CMS) participating hospitals may not deny visitation privileges on the basis of race, color, national origin, religion, sex, sexual orientation, gender identity, or disability.

Our Patients' Responsibilities

- To share accurate information about their health to help us better serve them.
- To inform their physician of all medications they are taking including herbal and non-prescription medications
- To follow the care, treatment and service plan recommended by their treatment team, including not taking drugs or medications unless prescribed by their physicians and provided by hospital staff.
- To ask questions when they or, as appropriate, their family do not understand their care, treatment, services or what they are expected to do.
- To report unexpected changes in their condition.
- To adhere to the hospital's rules and regulations affecting patient care and conduct, and be considerate of the hospital's staff and property, as well as other patients and their property.
- To report safety concerns to their physician, nurse, department/unit manager or the Patient Relations Department.
- To adhere to the hospital's **No Smoking** policy.
- To keep appointments or to notify HUH when they have to cancel.
- To pay their bills promptly or request assistance from a financial counselor, regardless of payment source.

XVII. ADMISSION AND DISCHARGE REGULATIONS

The Admission Officer and Emergency Department are responsible for the physical admission of all patients to the hospital with the Admitting Office exercising control of all beds. However, the responsibility for establishing the patient's medical eligibility rests with the medical staff.

RESERVATIONS

The physician will arrange for non-operative admissions by calling (202) 865-1201 or faxing (202) 865-1360 the Admitting Office and giving the following:

- Patient's name
- Age
- Telephone Number
- Diagnosis
- Insurance Information
- Desired date of Admission
- Authorization number for HMO's

If an operative admission is involved, call the OR Posting Clerk and provide the same information. If the patient is in the hospital at the time the reservation is being placed, direct the patient to the Surgery Center to schedule an appointment for pre-testing. If this is not convenient, the patient is contacted by telephone at a later date. The actual admission time will be scheduled by the Admitting Office and completed between the hours of 10:00am and 3:00pm on the requested date of admission.

EMERGENCY ADMISSION

All emergency admissions shall be admitted to the hospital immediately without reference to eligibility (provided a bed is available) or insurance status. No patient is to be admitted to the nursing unit, however, unless cleared and approved by the Admitting Office. Emergency Admission transfers from other institutions must be requested during business hours. Otherwise, such transfers must be authorized by the CEO.

FINANCIAL ELIGIBILITY FOR ADMISSION

Financial arrangements must be made for all elective cases prior to admission to the Hospital. These arrangements entail the assignment of financial responsibility to the patient, an insurance company, a government agency or some other responsible organization or person and screening for eligibility for financial assistance.

TRANSFER OF PATIENTS

Once a patient has been assigned an inpatient bed, he/she shall not be moved without prior authorization from the Admitting Office. Routine requests (e.g., request for a private room) will be processed between the hours of 8:00am and 4:00pm. Transfer request for other reasons (e.g., to intensive care, isolation, and administrative) will be honored at any time. Request for hospital services change and/or doctor change must also be submitted through the Admitting Office.

PATIENT PASSES

The administration of the hospital does not generally endorse granting passes to patients, however, in emergency cases, passes are issued which will not exceed 12 hours. Patients on the Psychiatry Services may be granted leave for therapeutic purposes for a period not to exceed 24 hours. The Chief Medical Officer will approve passes.

DISCHARGE OF PATIENTS

The discharge time for all inpatients is 10:00am. The physician shall write patient discharge orders on the day prior to discharge and the patient advised that he may go home on the next day. The physician shall inform the patient of the discharge time on the day prior to discharge, allowing ample time for patient to make arrangements. The physician shall also advise the nurse-in-charge who shall immediately notify the Admitting Office and prepare a Pre-Discharge Notice. NOTE: Patients who leave the hospital after the 10:00am discharge hour will be assessed a late charge.

NOTICE OF DEATH

It is the responsibility of the physician who pronounces the death of a patient to (1) Complete a Notice of Death, (2) request the nurse to immediately notify the Admitting Office, (3) If necessary, notify the attending physician. The Notice of Death must be delivered to the Admitting Office within fifteen (15) minutes of the patient's death.

MEDICAL EXAMINER'S CASES

It is understood by DC law that violent deaths, death within 24 hours of admission, sudden deaths not caused by recognizable diseases, death under suspicion, death of persons to be cremated or dissected, death related to diseases which are a threat to public health, and postoperative deaths be reported to the Medical Examiner's Office (202) 724-4330.

AUTOPSY PERMITS

Autopsies should be performed when possible. If the case is of no interest to the Medical Examiner, the closest surviving relative grants written permission, and an administrative authority (Director of Admission, Administrator On Call), approves the autopsy. Signature of the closest surviving relatives must be secured in the following order: spouse, child of legal age, parent, grandparents, and aunts/uncles.

STILLBIRTHS AND OTHER PRODUCTS OF GESTATION

A "Notice of Death" (Exhibit IV – 6) must be completed by the physician pronouncing the patient at the time of death. The physician and Charge Nurse are responsible for the proper execution of this form.

1. Immediately after a patient expires on any unit, the Charge Nurse or designee shall notify the Admitting Office of the patient's death.
2. The physician and Charge Nurse shall properly execute the "Notice of Death."
3. The designated person on the unit shall prepare the chart for discharge; attach the completed "Notice of Death."
4. The chart shall be immediately transmitted to the Admitting Office.
5. The admitting personnel shall review the "Notice of Death" upon receipt of the discharge chart.
6. All items on the "Notice of Death" must be completed and accurate before admitting personnel can accept the chart.

DEATHS

Death cases are handled as explained below according to when, where, and how the death occurred.

CORONER CASES

The DC Medical Examiner's Office must be notified when a patient death occurs, as follows:

- Patient dies in ECA
- Patient is dead on arrival to hospital
- Patient dies in operating room
- Patient dies in X-ray
- Patient is an inpatient for 24 hours or less
- Patient is inpatient diagnosed as having a traumatic injury as follows:
 - Head Injuries
 - Subdural Hematoma-Etiology unknown;
 - Stab wound
 - Gunshot wound

- Fractures
- Automobile accident
- Drug overdose
- Burns

The DC Medical Examiner's Office is responsible for determining who will perform the autopsy on these types of cases and/or whether they may be released for burial. The contact phone number for the DC Medical Examiner's Office is (202) 698-9000.

1. Any incomplete items will result in the admitting personnel immediately notifying the Charge Nurse on the unit and requesting immediate correction.
2. The patient information shall be recorded in the "Death Register":
 - Date of death
 - Deceased
 - Unit
 - Medical record number
 - Physician who pronounced patient; and
 - Time patient expired

DEATH CERTIFICATES

It is the responsibility of the attending physician to promptly sign the Certificate of Death for patients under his/her care. Admitting personnel for each patient who expires at Howard University Hospital with the exception of coroner cases not released to Howard University Hospital must complete a Certificate of Death..

There are two types of death certificates utilized in Admissions. The "Certificate of Stillbirths" and the "Certificate of Death"

1. Certificate of Stillbirth: The certificate is completed when there is fetal death.
2. Certificate of Death: This certificate shall be completed when:
 - a. A baby is born live but expires prior to discharge from the hospital; and
 - b. The baby's death is not classified as a Coroner's Case.

The Physician Must Sign with a Black Ballpoint Pen.

There are two formats for completing the certificate, as indicated by the categories above.

STILLBIRTHS AND OTHER PRODUCTS OF GESTATION

A product of human gestation of twenty weeks or more (10 inches or 300 grams if the gestation period is unknown) must be reported on the Certificate of Stillbirth and signed by the licensed physician responsible for the delivery. The physician must also complete an authority of autopsy and disposal, have it signed by the parents, and delivered to the Admitting Office.

AUTOPSY PERMITS

Autopsies should be performed, if the case is of no interest to the Medical Examiner, the closest relative grants written permission, and an Administrative Authority approves the permission for autopsy.

B. AUTHORIZATION FOR AUTOPSY WILL BE ACCEPTED AS FOLLOWS

The nearest relative must sign for the autopsy. Determination of nearest relative in successive order:

1. Spouse of decedent
2. Oldest child and second oldest child of decedent if they have reached the legal age of majority:
3. Parents of decedent; or
4. Sister or brother of decedent
5. Grandparents
6. Aunt/Uncle

XVIII. CLINICAL NUTRITION SERVICES

Administrative Office: Room 2056
Telephone Number: 202- 865-6761

MISSION

The mission of the Department, Clinical Nutrition Services is to identify patients at nutritional risk, and to provide safe, effective and timely individualized nutritional care which is evidence based and incorporates their medical, social, cultural and religious needs and preferences.

SERVICES PROVIDED:

Nutrition Risk Screening
Comprehensive Nutrition Assessment and Design of Individualized Care Plan
Consultation for recommendations on appropriate Medical Nutrition Therapy
Follow-up monitoring and re-assessment of Care Plans
Nutrient Intake Analysis (Calorie Count)
Nutrition education and diet counseling

ACCESS PROCESS

Consultation may be requested at any point during the patient's stay by writing a Physician's Order, which will be communicated to Nutrition Services via the Hospital Information System.

Consultations for the Multidisciplinary Nutrition Support Service must be written on a Consultation form and delivered to 4B15.

To speak with a Dietitian, identify the dietitian assigned to floor and page. Names and pager numbers may be obtained from the Nursing station or the Department's Administrative Office on extension 5-6761.

HOURS OF OPERATION

Monday – Friday:	7:00 a.m. to 6:00 p.m.
Weekends and Holidays	8:30 a.m. to 5:00 p.m.

Randomized clinical trials and case studies have found that the prevention of malnutrition, or the aggressive management of acute and chronic malnutrition, when present, may decrease morbidity and mortality and reduce hospitalization costs through shortened length-of-stay.

High quality medical care at minimal cost, therefore, can be assured through the recognition of the critical role of proper nutrition, and the inclusion of timely and appropriate Medical Nutrition Therapy as a component of the medical plan.

To facilitate early detection and treatment of malnourished states, Physicians are urged to evaluate all patients during physical examination, for the presence of nutritional risk factors and clinical signs and symptoms of malnutrition. Findings should be documented as a part of the History and Physical.

When patients are found to have indices that suggest the presence or potential for malnutrition, the diagnosis of malnutrition should be documented on the problem list and a treatment plan implemented. If necessary, a consultation by the clinical dietitian, for nutritional assessment and recommendations may be ordered through the computerized system.

Patient progress must be documented in the physician's Progress Notes and the outcome included in the discharge summary. To facilitate accurate coding for maximum reimbursement, in those DRG cases that allow for malnutrition as a co-morbid condition, malnutrition must be included in the list of final diagnoses.

Registered Dietitians are available to provide the following services:

- Nutritional Assessment and design of Individualized Care Plans
- Consultation for recommendations on appropriate Medical Nutrition Therapy
- Follow-up monitoring and re-assessment of care plans
- Nutrient Intake Analysis (Calorie Count)
- Patient/Family Education and Diet Counseling

Clinical nutrition services are available Monday through Friday, 7:00 a.m. - 6:00 p.m., and 8:30 a.m. - 5:00 p.m. on weekends and holidays.

NUTRITION INTERVENTION

At the time of admission to a unit, Nursing screens all patients for the presence or potential risk for malnutrition. Patients identified as being at nutritional risk should be referred to the dietitian for a Comprehensive Nutritional Assessment. Once a referral is received, via the Hospital Information System, the assessment is usually documented in the patient's medical record within 48 hours. Earlier intervention may be obtained for any patient, through a physician's written order for a nutritional assessment, or other consultation request.

To facilitate the timely completion of nutritional assessments, physicians must write orders for a Comprehensive Metabolic Panel, Prealbumin and Transferrin, to provide the nutrition-related laboratory data needed for the assessment. Consult requests are usually answered within 24 hours after receipt in the Department. Findings and recommendations are documented on the *Nutritional Assessment Form*, which is inserted into the “Doctor’s Progress Notes” section of the patient’s medical record.

PROCEDURES FOR WRITING DIET ORDERS

A written diet order is required for all newly admitted patients and for any subsequent changes in the dietary prescription. No patient shall receive food or nutrition products without a prescription from an authorized medical staff member. When it is necessary to make a verbal order, the order must be given to authorized nursing personnel for entry into the patient’s medical record. **The prescribing or ordering physician must countersign verbal orders within 24 hours of making the order. Dietitians are not authorized to accept verbal diet orders.** Diet orders should be reviewed, at least weekly, to ensure that the patient’s current nutritional requirements are being met, or to make changes in the dietary prescription when indicated.

Standard Diets

Diet and nutrition care orders must be written in accordance with the approved Nutrition Care Manual. Currently, the electronic *American Dietetic Association Nutrition Care Manual (NCM)* has been approved for use at HUH and is accessible to all interdisciplinary team members through the Dash Board. If further assistance is needed when writing orders, the dietitian assigned to the unit should be contacted. Nursing personnel can assist you in finding the name and pager number of the dietitian or you may contact the Department’s Administrative Office on extension 5-6761.

Modified Diets

Prescriptions for modified diets must specify the level of restriction for each nutrient that must be modified (see examples below).

“2 gm Sodium” vs. “Low Sodium”

“2000 Calorie, Consistent Carbohydrate Diet” vs. “Diabetic Diet”

“1500 Calorie, 2 gm Sodium” vs. “Diabetic Low Sodium”

“70 gm Protein, 45 meq K+, 2 gm sodium, 1000 ml fluid” vs. “Renal Diet”

“300 mg Cholesterol” vs. “Low Cholesterol”

Non-specific orders will be interpreted according to established policy, until such time that a specific order can be obtained from the physician.

Diet Changes

After meal service has begun, the only changes in dietary prescriptions which will be honored at that meal, are those requiring a **change from liquid to solid foods or vice versa**. All other changes will be honored at the next meal. Individual cases, which require deviation from this policy, should be discussed with the dietitian or Food Services supervisor.

NUTRITION SUPPORT

Supplemental Oral Feedings

Occasionally, patients with increased nutrient needs or depressed appetite may require supplemental oral feedings to assure an adequate nutrient intake. Please refer to the approved **Enteral Nutrition Formulary** before writing orders for medical nutritional products. Physicians are strongly encouraged to order only those products that appear on the Formulary.

Enteral Tube-Feedings (EN)

In the presence of a functional gastrointestinal (GI) tract, feeding via the enteral route (EN) is preferred over Total Parenteral Nutrition (TPN) for critically ill patients.

When patients are unable to tolerate gastric feedings or are experiencing problems with high residuals, regurgitation, intractable vomiting or at increased risk of aspiration, enteral feeding via the duodenal or jejunal route should be considered.

Orders for enteral feedings must be written on the ***Physician's Order – Enteral Nutrition Form*** (HUH-0452). A new form is required for new orders, each time orders are rewritten or when there is a change in product or route of administration. Upon completion, forms must be authenticated with signature, date and time. **If the form is not used for writing orders, physicians will be asked to return to the unit to rewrite the order on the form. Orders will not be processed until such time that the order form is completed.**

Parenteral Nutrition (PN)

Peripheral Parenteral Nutrition may be indicated for patients who require short-term nutrition support or may need supplemental nutrition even in the presence of a functional gastrointestinal tract.

Total Parenteral Nutrition (TPN) should be reserved for patients with a non-functional gastrointestinal tract, or conditions that require complete bowel rest. Candidates for PN must be referred to the Nutrition Support Service for initial evaluation and recommendations.

Forms HUH 0441 - ***Physician's Parenteral Nutrition Order Form*** and HUH 0448 – ***Total Parenteral Nutrition General Orders*** must be used when writing orders for Parenteral Nutrition Support.

Consultation requests for such Specialized Nutrition Support should be sent to Room 4B15.

Forms for use in writing orders for Enteral or Parenteral Nutrition are available at all Nursing Stations.

Discharge Instructions

During hospitalization, patients on modified diets will usually be counseled on his/her prescribed diet and provided with a copy of the diet for use after discharge. Patients

who require further counseling on his/her diet, or on drug-nutrient interactions, at the time of discharge, must have a written order specifying the instructions required.

Evaluation for required diet instructions/nutrition education should be part of the discharge planning process, so that orders can be written as early as possible, but no later than 24 – 48 hours prior to the anticipated date of discharge.

Ambulatory Care Services

Nutrition education is available, **by appointment ONLY**, for patients attending Ambulatory Care Clinics at HUH. Patients must be provided with a written referral specifying the diet prescription or request for consultation which includes his/her diagnosis(es) height and current weight, results of recent nutrition-related laboratory studies and Medical Record Number and instructed to call 202-865-6761 for an appointment.

PATIENT FOOD SERVICES

A Physician's written diet order must be recorded on the "Doctor's Orders" sheet and transmitted electronically to the **Department of Food Services** before food service will be initiated. After writing an order for "NPO", a complete diet order must be written to resume feeding of the patient. Orders written as "Resume Diet", "Diet as Tolerated" or other unspecified diet will be questioned for clarification.

Feeding Status Categories

Assignment to a feeding status category is required, as a part of the diet order, to identify the level of assistance needed by patients, in order to eat at mealtime.

- | | | |
|----------------|---|--|
| "Self-Feeder" | - | Requires no assistance. |
| "Feeder" | - | Requires total assistance. Service is provided by nursing personnel. |
| "Tube-Feeding" | - | Requires total assistance. Service is provided by nursing personnel. |

Hours of Service

Meal services for patients are available through the Department of Food Services from 7:00 a.m.-7:00 p.m. daily. Orders for patients admitted in the evening, must be written and transmitted to the kitchen prior to 7:00 p.m., if a meal is expected prior to breakfast on the following day. Limited meal service for patients who are admitted after 7:00 p.m. and require a meal, may be obtained, with a written physician's order, through the office of the evening nursing administrator.

Service to Emergency Care Department

Patients in the Emergency Care Department, under observation for longer than eight (8) hours, or those awaiting admission to the Hospital, may receive food services through a physician's written order. Orders may be transmitted electronically, via the Hospital Information System, or a copy of the written order must be delivered, to the kitchen before service will be provided to the patient.

Food Service Personnel are not authorized to accept verbal orders for any patient.

XIX. SOCIAL WORK SERVICES

PURPOSE

To establish that patients are expected to have individualized discharge plans initiated upon admission and reviewed and /or revised during hospitalization.

SCOPE

The discharge planning process at Howard University Hospital is expected to be multidisciplinary with social workers assuming leadership in identifying patient discharge needs.

RESPONSIBILITY

All Social Work Service Staff

1. Identification of Patients for Discharge Planning. All patients are screened within two working days of admission. (See social work high-risk screening criteria.) Admission sheets are received daily and reviewed by social workers to determine risk factors, which may impede discharge. Priority is given to those deemed high risk, the elderly, nursing home admission, trauma cases and patients identified during rounds and conferences with members of the health care team.
2. Assessment of Resources. Based on the assessment standard (see policy 1003.7 on "Screening and Assessment"), data is collected to reflect the patient's situation prior to admission, resources available and level of care anticipated post-hospitalization. This information is documented on the "Discharge Planning Assessment" form and placed on the chart in the Discharge Planning section.
3. Development of Plan. Taking into consideration medical recommendations, patients' resources, needs and preferences, a plan of care is developed. The discharge planning standards (see attached) can be used as a guideline to make sure all points have been addressed. The discharge plan is reviewed and /or revised as the situation dictates. These reviews and/or revisions are to be documented as they occur on the Social Work Consultation Note or in the Comments Section of the Discharge Planning Assessment form.
4. Implementation of Plan. With the concurrence of patient/family and the interdisciplinary health care team, the social worker sets in motion the developed plan. If the original plan cannot be implemented, the problem is identified and referred to the appropriate discipline for assistance in developing a new plan. The final discharge plan should be documented on the Social Work Screening form or Progress Notes and Nursing Discharge Instruction form.

XX. MEDIA RELATIONS AND MEDIA CONSENT

POLICY

The Director of Marketing and Communications, or his/her authorized designee, will act as the official voice and primary spokesperson for the Hospital. Therefore, requests for Hospital statements must be referred to the Marketing and Communications Department.

Individuals not authorized to speak on behalf of the Hospital may not do so. Making unauthorized statements to the media on behalf of the Hospital or purporting to speak to the media on behalf of the Hospital can result in discipline up to and including termination.

PROCEDURE

The Director of Marketing and Communications will issue press releases, publicize news conferences, publish op-ed pieces, etc. to aggressively promote and market the hospital, its programs, services and people. When appropriate, s/he will secure necessary signatures from patients who will complete a Howard University Media Consent Form.

Calls from the media seeking an official statement or report from the Hospital should be directed to the Director of Marketing and Communications.

The staff of the Marketing and Communications Department will schedule and provide the training to the appropriate individuals whom the Hospital has authorized to speak on its behalf. The Marketing and Communications Department maintains lists of local and national media contacts. If the Hospital's image is distorted in news media coverage, Director of Marketing and Communications, in conjunction with the Office of University Communications, will determine the Hospital's response.

XXI. OFFICE OF QUALITY IMPROVEMENT, UTILIZATION REVIEW AND INFECTION CONTROL

Organizationally, the Office of Quality Improvement, Utilization Review and Infection Control reports to the Office of the Chief Medical Officer, and is the focal point for all quality improvement/utilization review and infection control activities. All medical and administrative endeavors related to the day-to-day operations of the program are coordinated through this office.

Specifically, the Office is responsible for the following:

1. To advise the Medical Staff, the Administrative Staff, the Quality Improvement Committees and UR Committee regarding the availability of data to aid required monitoring and evaluation activities.
2. To design standardized information gathering, display, and storage systems.

3. To prepare reports and perform other staff functions including tabulation of findings and preparation for analysis by the medical and/or other professional technical staffs.
4. To gather data required to monitor compliance and effectiveness with actions, recommendations and directives.
5. To maintain appropriate documentation of quality improvement/utilization review and infection control activities including cumulative profiles of findings.
6. To prepare reports for the annual review of the quality improvement, utilization review and infection control plan.
7. To establish systems to ensure the confidentiality of all data and related information.
8. To provide liaison with Health Information Management (formerly known as the Medical Records Department) to facilitate data gathering.
9. To provide liaison with external agencies requesting information on quality improvement, utilization review and infection control activities.
10. To coordinate activities relating to regulatory surveys and inspections.

QUALITY IMPROVEMENT COUNCIL (QIC)

The Quality Improvement Council (QIC) is the oversight body responsible for the creation, implementation and outcome of the Performance Improvement Plan. The QIC sets priorities for improvement initiatives and ensures that key processes are measured through appropriate data collection and statistical analysis techniques. The Council establishes or ensures benchmarks are established for performance and assesses outcome data to note accomplishment of established objectives or the need for further intervention. The QIC reports its findings to the Board of Governors on a quarterly basis or as otherwise required. The Quality Improvement Council meets monthly.

Standing committees of the QIC meet on a regular basis to ensure regular oversight of specific organizational priorities within their domain. The committees include the Academic Assessment and Evaluation Committee, Clinical Practice Committee, Customer Experience and Engagement Committee, Knowledge Management Committee, Provider Compliance Committee, Quality Management Committee, and the Settlement Committee.

Membership/Key Leaders of the QIC include:

- Senior Vice President Health Sciences, Council Chair
- Associate SVP Clinical Affairs and Quality, Council Vice Chair
- Chief Executive Officer
- Senior Director, Quality and Process Improvement
- Chief Medical Officer
- Chief Administrative Officer, FPP
- Health Sciences Chief Financial Officer
- Chief Nursing Officer
- Dean, College of Medicine

Dean, College of Dentistry
Dean, College of Pharmacy, Nursing and Allied Health
Director of Insurance and Risk Services
President – Medical Staff
Chair of Quality Management Committee
Chair of the Regulatory Team
Patient Safety Officer
Two Faculty Representatives
Two Student Representatives
One Resident Representative

Purpose:

1. Ensures and oversees the integration of Performance Improvement throughout the Health Sciences Enterprise
2. Annually reviews, revises and makes recommendations to approve the Performance Improvement Plan to the Board of Governors and Medical Affairs Committee
3. Makes recommendations on priorities for data collection, frequency of data collection, and priorities for PI and safety activities to the Board of Governors and Medical Affairs Committee
4. Ensures the alignment of people and projects with organizational safety and quality goals
5. Annually reviews, and where necessary, makes recommendations for the revision of the Patient Safety Plan
6. Ensures needed resources, inclusive of equipment, training and people are identified and made available for quality improvement activities
7. Evaluates trends in adverse clinical outcomes or variations in processes for quality improvement
8. Gathers recommendations and sets priorities for training

A. Academic Assessment & Evaluation Committee:

The Academic Assessment & Evaluation Committee is charged with reviewing the indicators of accreditation for the various colleges, schools and programs within the Health Sciences. Analyzed data (results) will be collected from the College of Medicine, College of Dentistry, College of Pharmacy, Nursing and Allied Health, the Graduate Medical Education Department and Library.

- Create Academic Accreditation Dashboard
- Review academic indicators and ensure resultant plans for improvement are data driven
- Ensure compliance with accreditation standards

The following teams report to the Academic Assessment and Evaluation Committee: Dental, Medical and College of Pharmacy, Nursing and Allied

Health Academic Assessment and Evaluation Teams, the Graduate Medical Education Team (Committee), and the Continuing Education Team

B. Customer Experience and Engagement Committee:

The Customer Experience and Engagement Committee uses the broadest definition of “customer” to include internal and external customers. Therefore this team monitors patient, student, faculty, workforce and community satisfaction and engagement by:

- Creating a plan for improving customer experience
- Creating behavior standards for the Health Sciences
- Determining the mechanism whereby the maximum numbers of patients, students and staff are engaged in and impacted by the customer experience plan
- Monitor satisfaction surveys and address opportunities for improvement with data driven actions

C. Knowledge Management Committee:

The Howard University Health Sciences enterprise maintains appropriate databases to collect, track and manage information that is required to measure and display the quality of organizational services. The systems allow data to be processed into usable information within the organization.

Performance improvement data are obtained from at least the following sources:

- Ongoing customer surveys
- Medical record reviews
- Comparative databases locally, regionally and nationally
- Projects and studies
- Direct ongoing reviews and observations
- Reports from various sources, including clinical management, financial management and internal and external surveys

The Knowledge Management Committee is responsible for

- Reviewing the analysis of all quality reports and ensuring that conclusions derived are accurate
- Formatting the quality dashboard to maximize transparency and understanding of analyzed data
- Ensuring all significant findings are sun shined and actions are taken to implement correction
- Creating and implementing an educational plan that improves the appropriate use of data for performance improvement

D. Provider Compliance Committee:

The purpose of this committee is to provide guidance to the Office of the Chief Compliance Officer on all significant issues relating to compliance with applicable laws, regulations, policies, and the implementation of the HUHS Compliance Program. The Committee is established to help promote a culture of compliance within the Health Sciences community by increasing the awareness and appreciation for the importance of complying with state and federal health care laws and regulations. The Committee is established to ensure that the Compliance Office is informed of the needs and perspective of its Provider customers.

E. Quality Management Committee (QMC):

The Quality Management Committee, led by a designated clinical faculty member or a Director of Nursing and the Senior Director of Quality and Process Improvement, is charged with analyzing the aggregate data from clinical and non-clinical departments to assure that quality of care is at an acceptable level, that opportunities for improvement are pursued and that problems are solved throughout the organization. Additionally, this committee will focus on tracking the outcomes of sentinel event plans, CORE (ORYX) Measures, SCIP, Press Ganey and any other data collected and displayed on public websites. Where needed, the committee will identify opportunities for further improvement and oversee their implementation and outcome. Committee membership will consist of representatives from clinical departments, nursing, pharmacy, hospital administration, house staff and other hospital support services staff. Six teams report to the QMC. In addition to reporting to the QIC the QMC will report its findings to the Medical Staff Executive Committee on a monthly basis.

E.1. Regulatory Team:

The Regulatory Team, led by the Senior Director of Quality and Process Improvement and a Director of Nursing focuses on assessing performance of important patient-centered and organizational functions that support the safety and quality of patient care. This assessment is accomplished through evaluating the organization's compliance with applicable standards utilizing mock surveys and/or evaluation tools. The committee will be chaired by the Sr. Director of Quality and Process Improvement and membership will include representatives from clinical departments, hospital administration, nursing, house staff, students and other hospital support services staff. Information to be covered includes, but is not limited to:

Joint Commission, DC Licensure, OSHA, Radiation Safety, CLIA, FDA, other regulatory functions

E.2. Serious & Sentinel Event Analysis Team:

The Serious & Sentinel Event Team, led by the Chief Medical Officer is charged with addressing adverse or unexpected occurrences resulting in death, serious physical or psychological injury, or risk thereof. This committee will develop a root cause analysis (RCA) and associated action

plan which will identify strategies intended to reduce future risk or similar events. In addition, the committee will review RCA outcomes for organizational trends or gaps in care. The trending information will be reported bi-annually to the QIC in order to be considered in the annual prioritization of quality initiatives. Committee membership will consist of representatives from the Office of the General Counsel, the Hospital Medical Director, Chief Operating Officer, Chief Nursing Officer, Senior Director of Quality and Process Improvement, and Clinical Faculty (as appropriate).

E.3. Patient, Student and Workforce Safety Team

The Patient, Student and Workforce Safety Team, led by the Patient Safety and Hospital Safety Officers is charged with improvement of patient, staff, volunteers, and visitor safety and risk reduction through the establishment of a climate whereby the reporting of errors, near misses, and unsafe conditions is encouraged. The Quality Management staff will collect, aggregate, analyze and report occurrence data utilizing appropriate data management systems. Outcomes will be reported to the QMC which will provide oversight of the integrated patient and workforce safety program. Team membership will consist of representatives from administration, clinical departments, quality improvement, nursing, house staff, security, employee health and other support services staff. In addition, under the direction of the Patient Safety Officer, the team will monitor the staff's performance on The Joint Commission Patient Safety Goals and provide outcome data to the Joint Commission/Regulatory Team.

E.4. Infection Control Team

The Team shall be responsible for developing and implementing an effective hospital-wide infection control program. It shall examine both nosocomial and community infections and establish and maintain a system of records concerning nosocomial infections as a basis for evaluating the effectiveness of standards and procedures for prevention and control. The committee shall develop and implement programs necessary to ensure the effective control and prevention of infections within the Hospital. This committee will also report monthly to the Medical Staff Executive Committee.

E.5. Pharmacy and Therapeutics Team

The duties of the Team shall include the formulation and recommendation to the Medical Staff and Hospital of policies and procedures for the evaluation, selection, procurement, distribution, use, safe practice and other matters pertaining to drugs and equipment, and other therapeutic devices, as well as the provision of information regarding medications and pharmaceutical practices to health care practitioners at the Hospital. This committee will also report quarterly to the Medical Staff Executive Committee.

E.6. Utilization Review/Case Management Team

This team reviews and makes recommendation for monitoring the use and delivery of health care services for appropriateness and length of stay in order to maximize value to the patient and cost containment for the

institution. Where length of stay is found to consistently exceed published benchmarks, quality improvement teams will be launched to review processes and make recommendations to shorten stay while ensuring patient safety. This committee will also report monthly to the Medical Staff Executive Committee.

E.7. Clinical Practice Committee

The Clinical Practice Committee is a forum by which members of the Medical Staff, Faculty Practice Plan and the College of Dentistry practice can identify clinical issues and make recommendations for change to the Quality Management Committee and/or QIC/

F. Settlement Committee

The Settlement Committee provides a report and recommendations for action to the QIC based on trends that are gleaned from malpractice and/or asserted matters that are reviewed by the Claims Review Team.

THE APPROACH TO PERFORMANCE IMPROVEMENT

The leaders of Howard University Health Sciences utilize the Baldrige Criteria for Performance Excellence as a framework to organize and guide quality activities. The purpose of the framework is two-fold:

1. Provides an integrated management framework for excelling in quality initiatives.
2. Offers a broad perspective on organizational improvement through systematic exploration of all facets of the organization.

In other words, Quality is not something we do; it is a management philosophy and the way we approach day to day operations.

The benefit of the Criteria is that it places emphasis on:

1. Organization sustainability through the delivery of ever improving value to our customers
2. Improving organizational effectiveness and capabilities
3. Improving organizational development and personal learning
4. Achieving a total quality system that promotes continuous improvement for our customers which results in
 - a. Increased patient satisfaction
 - b. Increased student achievement
 - c. Increased retention of employees and staff
 - d. Increased satisfaction of all other customers

The criteria focus on seven key areas:

1. Leadership
2. Strategic planning
3. Customer focus
4. Measurement, analysis and knowledge management
5. Workforce focus
6. Process management
7. Results

METHODOLOGY OF PERFORMANCE IMPROVEMENT

A. Establishing Priorities for Improving Performance

The leadership of Howard University Health Sciences, through the QIC, is committed to continuously improving patient and educational outcomes and the health and welfare of the community served. Therefore, performance improvement prioritization is imperative. Priorities are consistent with the mission, vision and values of the organization. QIC, through its authority, will lead the organization in the establishment of priorities for process design or redesign. Criteria for prioritization will include at least the following:

- The planned process design or redesign is consistent with the strategic direction, mission, vision, and values of the organization.
- Customer experience data significantly indicates that a process design or redesign is essential to the improvement of services for patients, students or the community served.
- The planned process design or redesign will prevent the likelihood of a sentinel or serious event, thereby enhancing patient and workforce safety.
- The process design or redesign is consistent with new or improved technologies for the delivery of care and services.
- The process design or redesign is critical to the economic viability of a service provided to patients, students and the community.
- The process design or redesign is required for the enhancement of health science services that are determined through community assessment.

Occasionally, there is a need to reprioritize performance initiatives, as data become available to the organization. Criteria for the reprioritization of projects will include at least the following:

- Reprioritization is necessary to respond to the root cause analysis of an organizationally based sentinel or serious event, or the likelihood that an event in another organization could potentially occur at Howard University.
- There is an internal disaster, creating a need to reallocate resources to restore patient care or student educational areas, supplies and equipment so that services can be continuous and efficient.
- There are data from Customer Satisfaction databases that indicate a need for the immediate design or redesign of an existing service.
- There is a recognized change in normative practice patterns or the state of care technology.

B. MODELS FOR PERFORMANCE IMPROVEMENT

The HUHSE uses one of two methodologies to examine processes targeted for potential redesign or improvement.

1. Lean Six Sigma

Lean Six Sigma is a process for problem solving that consists of a set of tools that assist with problem identification, data analysis and process redesign. Lean methodology is designed to reduce delay and non-value added activities, while Six Sigma emphasizes the reduction of errors, defects and process variation. The entire process simulates the eyes of the customer in process evaluation and design and, therefore is ideal for a health sciences enterprise quality improvement program.

DMAIC Model

DMAIC is a problem solving methodology that uses the five phases of Six Sigma improvement: Define, Measure, Analyze, Improve, Control to bring about process improvement.

- Define phase focuses on exactly what is to be improved by defining, prioritizing and selecting the process to improve.
- Measure phase focuses on identifying measuring key characteristics that impact the process to assess the current state.
- Analyze phase focuses on identifying causes impacting the critical inputs and outputs related to the desired outcome.
- Improve phase focuses on the implementation of selected solutions to determine which contribute to the desired outcome.
- Control phase occurs when the project is complete and is handed off to the process owner with a map for continuing the gains achieved during the improvement process.

2. FOCUS PDCA Model

Howard University Hospital also uses the FOCUS PDCA methodology for the implementation of improvement initiatives. This methodology although in some respects simpler than Lean Six Sigma, actually mirrors its phases as illustrated below:

- F Find a Process to improve
- O Organize a team that knows the process
- C Clarify the current process, using reference, benchmarking and other data sources
- U Understand the performance expectation or the cause of variation, if applicable
- S Select the process improvement, ensuring that it is consistent with the strategic goals, the mission and the established performance expectations of Howard University and the QIC
- P Plan the improvement of the new or existing process, determining what needs to be done, and develop a plan for achieving it
- D Do the data collection needed, benchmark key processes and implement the modified or new process
- C Check data for improvement through the new or modified function
- A Act to sustain the improvement

XXII. POLICIES, RULES AND REGULATIONS GOVERNING BUILDING AND GROUNDS

These rules and regulations shall apply to all persons employed, or entering in, or on facilities and grounds under the charge and control of Howard University and Howard University Hospital.

PRESERVATION OF PROPERTY

The injury, abuse, or damage in any way whatsoever of any public building or part thereof, including signs, regulations, decorations or other facility or equipment, or of any tree, shrub, flower or other planting material is prohibited.

NUISANCES

Unlawful nuisances, unlawful loitering, unlawful assembly, littering, defacing of the Hospital's property, prurient prying, the commission of any unlawful act is prohibited and grounds for discipline including but not limited to termination. This prohibition is intended to protect the Hospital and its property from illegal activity and not intended to infringe on its employees' rights to engage in concerted activity that is protected by the National Labor Relations Act.

GAMBLING

Participating in games for money or property, or the operation of gambling devices, or the selling or purchasing of numbers tickets is prohibited.

SOLICITING AND VENDING

The soliciting of alms and contributions for private gain, commercial soliciting and vending of all kinds, the display or distribution of commercial advertising, or the collecting of private debts is prohibited unless authorized in connection with the facility operation.

USE OF LIQUORS, ETC.

Entering a facility or the driving of a motor vehicle in or on the property by a person visibly under the influence of an intoxicating liquor or narcotic drug is prohibited and is grounds for termination or removal of the program..

PHOTOGRAPHY

Taking photographs of patients and in patient care areas without authorization is prohibited. This provision is intended to protect the privacy of the Hospital's patients and not intended to prohibit employees from, during non-work time, photographing matters concerning their terms and conditions of employment.

DOGS AND OTHER ANIMALS

Bringing a dog or other animal, except Seeing Eye dogs, into a building is prohibited unless prior permission is obtained.

AUTOMOBILE TRAFFIC

Drivers of all motor vehicles within the buildings and grounds shall drive in a careful and safe manner at all times and shall comply with the directions of all posted signs. Failure to adhere to traffic signage, traffic controllers, or traffic lights which causes, or reasonably could have caused, an accident on the Hospital's property; or, which posed, or reasonably could have posed, a risk to the health and safety of the Hospital's employees and patients on the Hospital's property is cause for discipline up to and including termination.

OFFICE TELEPHONES

All employees are reminded that use of office telephones is restricted to the transaction of official Hospital business and that the telephones are not to be used for personal purposes except in cases of extreme emergency. Outgoing personal long distance and international calls are strictly prohibited and incoming personal calls should be limited to not more than one (1) minute. Making prohibited personal phone calls and/or abusing phone codes to make unauthorized long distance calls can result in discipline up to and including termination.

VISITORS IN QUARTERS

No resident shall have friends stay over-night in the Hospital.

SMOKING

To provide maximum comfort to our patients, and adherence to existing fire regulations, it is imperative that hospital personnel, visitors, and patients are aware that the Hospital maintains a smoke free environment. Therefore, smoking is prohibited in all Hospital facilities. To ensure compliance with this regulation, all personnel should be aware of their responsibility in this regard and be alert to correct deficiencies as they occur. Failure to adhere to the Hospital's no smoking policy can result in discipline up to and including termination.

VISITING HOURS

Visiting hours shall remain as published in the hospital regulations, with the exception that where special visiting hours will have a therapeutic value for the patient. The senior nurse on duty will have knowledge of the patients who are to receive visitors at other times.

XXIII. INTERNAL DISASTER AND FIRE EVALUATION PLAN

All personnel are instructed that safety to life should always be first and that they should do nothing to create a fire hazard or dangerous condition. Remember that the greatest danger during a hospital fire is panic, caused by fear, unpreparedness and thoughtlessness. Therefore, if a fire should occur, all should be calm. Proceed with special assignments quietly and expeditiously.

Floor Wardens will be designated to the floors to see that all occupants have been evacuated after an alarm has been sounded and to search all areas.

In case of fire, the following steps are to be taken in this order:

1. Move patients who are in close proximity to fire or smoke, to safety.
2. Immediately afterwards, sound the interior alarm.
3. Notify the Switchboard Operator.
4. Close all doors and windows if open. Turn off all electrical and ventilating systems.
5. Fight the fire with the available firefighting equipment, if possible. Use wet blankets and towels, if helpful.

All fire wardens are to report to the fire scene immediately after receiving the alarm. They are to:

1. See that all fire doors *remain* closed.
2. Help in extinguishing the fire and the evacuation of patients.
3. Stand by for instructions from the Fire Marshal.
4. Assist in the clean up after the fire.
5. Return expanded fire extinguishers to the Engineering Shop (if applicable) and secure all other firefighting equipment.

If evacuation is imperative, remember that 'horizontal evacuation' is preferable. This means removing patients from one side of the building to the other on the same floor level. "Vertical evacuation" is another method used when horizontal evacuation becomes impossible. It consists of moving patients from the upper to lower floors, away from the scene of the fire.

NEVER MOVE PATIENTS TO FLOORS ABOVE THE FIRE!

House staff may refer to the *Howard University Hospital Disaster Plan* for additional information.