A guide for you throughout your residency. Please feel free to revisit this document as often as necessary. Any updates will be posted to the manual, which can be found on ALEX.
Table of Contents

Overview of Graduate Medical Education ......................... 4
Office of Graduate Medical Education ............................. 5
Graduate Medical Education Policy Information .................. 6
The House Staff Council ............................................. 7
Stay Connected: NYU E-Mail Accounts ............................ 8
ALEX (Advanced Learning Exchange) ............................. 14
Systems Based Practice at NYU ..................................... 15
NYU Health Sciences Library ......................................... 16
Psychiatric Consultation and Referral for Housestaff ............ 23
Committee for Physicians Health .................................. 24
Faculty and Staff Assistance Program (FASAP) .................... 25
Harassment Prevention Policy Statement ............................ 27
Do Not Resuscitate ...................................................... 28
Human Subject Research at NYU School of Medicine ......... 29
Post Exposure to Blood and Body Fluid Protocol ............... 31
THE AUTOPSY FACT SHEET ......................................... 32
Steps to Follow In The Event of a Patient Death .................. 37
Code of Conduct .......................................................... 38
The Physician-Pharmaceutical Industry Relationship .......... 39
ACGME Requirements .................................................. 40
NYU Langone Medical Center ......................................... 74
Clinical Quality and Safety for NYU Hospitals Center ....... 75
The Office of Compliance, .............................................. 78
Privacy & Internal Audit ............................................... 78
Policy Statement on Privacy, Information Security, and Confidentiality ............................................. 84
Joint Commission Survey Readiness: ................................. 86
HIM/Medical Records ................................................... 92
NYU Medical Center Insurance Department ........................ 94
Department of Social Work.................................................97
Emergency Management and Fire Safety .......................103
Bellevue Hospital Center .................................................104
NYU School of Medicine Affiliation Office .....................105
Bellevue Hospital Center Nurses Welcome You! ...........107
Bellevue Hospital Center .................................................112
Social Work Department..................................................112
What You Need to Know Before You Order Medications at Bellevue:  
The Pharmacy Survival Guide .........................................113
Bellevue Hospital Center Flow Chart of Blood Bank Sample Collection Requirements .........................121
Infection Control..............................................................122
Inter-Institutional Security Guide.................................132
Overview of Graduate Medical Education

Contact Information: Carol Bernstein, M.D.
Associate Professor of Psychiatry, Associate Dean for Graduate Medical Education.
Carol.bernstein@nyumc.org

[THE FOLLOWING IS TAKEN FROM http://WWW.ACGME.ORG]

ACGME Competencies

The residency program must require its residents to obtain competence in the six areas listed below to the level expected of a new practitioner. Programs must define the specific knowledge, skills, behaviors, and attitudes required, and provide educational experiences as needed in order for their residents to demonstrate the following:

1. **Patient care** that is compassionate, appropriate, and effective for the treatment of health programs and the promotion of health;

2. **Medical Knowledge** about established and evolving biomedical, clinical, and cognate sciences, as well as the application of this knowledge to patient care;

3. **Practice-based learning and improvement** that involves the investigation and evaluation of care for their patients, the appraisal and assimilation of scientific evidence, and improvements in patient care;

4. **Interpersonal and communication skills** that result in the effective exchange of information and collaboration with patients, their families, and other health professionals;

5. **Professionalism**, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to patients of diverse backgrounds;

6. **Systems-based practice**, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. (see http://www.med.nyu.edu/housestaff/sbp/index.html for more information).

For more information, see the Evaluation, Corrective Action, and Disciplinary Policy for Residents, or visit http://www.acgme.org.
Office of Graduate Medical Education

Contact Information: Deborah Considine, Director, Graduate Medical Education Office
Address: 333A East 29th Street, NY, NY 10016
Telephone: 212-263-5506
Fax: 212-263-7002
Website: http://gme.med.nyu.edu/

Visit the Office of Graduate Medical Education website for:

- GME Office Staff contact information
- Residency/fellowship program listing and link to their websites
- GME Policies and Forms
- Duty hour violation-related information
- Information about affordable psychotherapy for house staff
- Common program requirements
- Useful links

...and more!
Important NYU SOM Graduate Medical Education Policy Information

Contact Information:

Director: Deborah Considine, Director, Graduate Medical Education Office
Address: 333A East 29th Street, NY, NY 10016
Telephone: 212-263-5506
Fax: 212-263-7002

NYU SOM Graduate Medical Education Policy and Forms website:
Available at: http://gme.med.nyu.edu/about-gme/gme-policies-and-forms/graduate-medical-education-policies-and-procedures

Please review all policies and forms.
The House Staff Council

Contact Information: House Staff Council Committee
Neelam Vashi  neelam.vashi@nyumc.org
Sarah MacArthur  sarah.macarthur@nyumc.org
Ali Aftab Chaudhri  aliaftab.chaudhri@nyumc.org
Brijesh Malkani  brijesh.malkani@nyumc.org

While you take care of patients, who takes care of YOU?

NYU Housestaff Council

The NYU Housestaff Council represents the interests of residents and fellows in every department, at all NYU affiliated hospitals, including Tisch, Bellevue, the VA, and Joint Disease. By serving as an advisory body to the Dean of the School of Medicine, we advocate for resident concerns and help to influence policy on such topics as:

- Resident Housing
- Resident benefits
- Resident book fund
- Resident work hours
- Housestaff Mixers
- Ancillary staffing
- Safety concerns
- Technology usage

Meetings are every first Wednesday of the month at 6pm.

Interested in joining us? Have ideas about what would make your job as a resident easier? Speak with your chiefs and program administrators. Representatives from each program are selected at the beginning of the academic year.

For more information, please feel free to contact Jamie Divine-Cadavid (Jamie.Divine-Cadavid@nyumc.org) or Samantha Phillips (Samantha.Phillips@nyumc.org)
Stay Connected: NYU E-Mail Accounts

We have included in your packet a handout about your newly assigned NYULMC Kerberos ID (e.g., doe01) and temporary e-mail password. Your e-mail address is in the format of:

firstname.lastname@nyumc.org

Five important topics regarding e-mail in this section:

- If you are off campus, you can access your e-mail using Outlook Web email.
- Instructions on how to change your temporary password off campus
- If you are on campus, you can access your e-mail and the full version of MS Outlook via the secure web portal, NYU Onsite Health
- Instructions on how to change your temporary password on campus
- Instructions on how to verify your e-mail address

ACCESS YOUR E-MAIL OFF CAMPUS USING OUTLOOK WEB EMAIL

Go to NYU Langone Onsite Health:

1. Website - http://www.nyuonsitehealth.org
2. Click on the Outlook Web email link

You will be redirected to a login page. Choose the type of computer that you are using. Type your Kerberos ID as the username and your temporary password as the password that was provided in your packet sent by the Graduate Medical Education (GME) Office. If you already have an NYULMC email account, use the password you are currently using for e-mail access. Click the Login button.

You are now logged into your e-mail account. Click on the Log Off button at the right top of your screen to log out of your e-mail.

If you have any questions about your e-mail account, please contact the MCIT HelpDesk at 212-263-6868 (opened 24 hours, 7 days/week).
We encourage you to communicate with us via e-mail. However, we will only use the NYUMC E-mail address which you have been assigned to send communications and any updates on orientation information, etc. NYULMC requires that you maintain that E-mail account as a primary source of communication for all NYULMC information and you are agreeing to this when you sign your house staff training contract.

CHANGE YOUR TEMPORARY PASSWORD OFF CAMPUS

You can change your password while you are logged into Outlook Web email.

Click on Options at the top right of the screen.

2. In the Options section on the left side of the screen, click on Change Password.

You will be redirected to the “Change Password” page where you will have to enter the following information:
- Type your “temporary password” or “current password” in the Old password field
- Type your “new defined password” in the New Password and Confirm New Password fields

Once you’ve added your password information, click the Save icon on the top of the page.

A message will appear letting you know that your password has successfully been changed.

ACCESS YOUR E-MAIL ON CAMPUS USING NYU ONSITE HEALTH

If you are on campus and logged onto a workstation where you have access to other computer systems, you can access your e-mail and the full version of MS Outlook via the secure web portal, NYU Onsite Health.

Go to NYU Langone Onsite Health:
1. Website - http://www.nyuonsitehealth.org
2. Click on the Login button
3. A pop-up window will appear. Type your Kerberos ID as the username and NYULMC e-mail password as the password. Click the OK button.
4. Click on the E-mail icon on the top left of the screen. If you get prompted to save the <appname>.ica file, you do not have the Citrix software installed on your computer. Please contact the MCIT HelpDesk at 212-263-6868 and open a ticket for this request.

Type your Kerberos ID as the username and NYULMC e-mail password as the password. Click the Log In button.

Please wait while MS Outlook is being launched.

You will be automatically logged into the full version of your Outlook e-mail account.

If you have any questions about your e-mail account and policies please contact the MCIT HelpDesk at 212-263-6868 (open 24 hours, 7 days/week) or visit our Intranet “The Link” at http://www.nyumc.net/nyu/info.html
CHANGE YOUR PASSWORD ON CAMPUS

If you are on campus and logged onto a workstation where you have access to other computer systems, you can access the Password Reset site to change your password.

Website - https://apps.nyumc.org/PasswordReset/login.htm

You will be directed to a new page, “Password Reset for NYULMC Applications”. Type in your Kerberos ID in the NYULMC Username field and your temporary password or current password in the Current Password field. Type the text characters in the image, into the word verification field. Click the Login button.

The first time you are logging into the new password reset tool, you may be prompted to enter five security questions. You will have to choose five questions from a list of 24. These questions will help to identify you in the future, if you forget your password and would like to reset it using the password reset tool. Once you've completed answering these questions, hit the Submit button. You can now reset your password by clicking on Reset Your Password.

You should now see the screen below. On this page you can edit your security questions or proceed with the password reset. You will need to create a password and repeat the password. Once you hit Submit, the password will be changed and you should be able to log in to the systems that you are trying to access.

TO VERIFY YOUR E-MAIL ADDRESS ON CAMPUS

Your e-mail address will usually be in the format of: firstname.lastname@nyumc.org

If someone on campus shares the same name, your e-mail may be slightly different. For example, there are two Joe Doe on campus (first person will have an e-mail address of Joe.Doe@nyumc.org and second person will have an e-mail account of Joe.Doe2@nyumc.org). To verify your actual e-mail address you can check the Global Address List (GAL) in MS Outlook.

1. Log into your e-mail account. Click on the GAL icon on the top of the screen.
2. Type in your last name (or several letters) to search for your name in the GAL.

Once you have found your name, double click on your name and a popup window will appear.

3. Click on the E-Mail Addresses tab.

4. This window displays all of the e-mail addresses associated with your Exchange account. The e-mail address preceded by "SMTP:" (in all capitals) is the address used for account.

Based on your residency program’s use of ALEX, the site has various tools that can be used to organize program-related content and to extend learning:

- Schedules (Rotation schedules, Conference schedules, etc.)
- Announcements
- Posting important information such as syllabi, goals and objectives, and journal club material
- e-Portfolio tool
- Forum Discussions between all course participants
- Messaging to any number of course participants
- Uploading files (including interesting cases, images, PDFs, etc.)
- Access to E*Value, a site which allows you to complete evaluations
- Access to iTunes U, which allows you to download podcasts of lectures or conferences from your program
- Tests and Quizzes
- Searching medical school curriculum
- You can learn more about ALEX at the DEI's page at http://dei.med.nyu.edu/help/alex.
ALEX (Advanced Learning Exchange)

What is ALEX?

ALEX (http://alex.med.nyu.edu) is an online learning management system that can be accessed on or off campus with your Kerberos ID and password. Residency programs maintain their own site, making the ALEX site customizable and useful for all residents and faculty within a given program.

In addition to your program site, all residents have access to the GME MedEd Resources site (pictured above) and the New House Staff tab (not pictured above). This site gives residents access to important GME policies and forms, web-based modules, the House Staff guide, orientation content, patient safety curriculum, as well as other information.

Based on your residency program’s use of ALEX, the site has various tools that can be used to organize program-related content and to extend learning:

- Schedules (Rotation schedules, Conference schedules, etc.)
- Announcements
- Posting important information such as syllabi, goals and objectives, and journal club material
- e-Portfolio tool
- Forum Discussions between all participants
- Messaging to any number of participants
- Uploading files (including interesting cases, images, PDFs, etc.)
- Access to E*Value, a site which allows you to complete evaluations
- Access to iTunes U, which allows you to download podcasts of lectures or conferences from your program
- Tests and Quizzes
- Searching medical school curriculum

You can learn more about ALEX at the DEI’s page at http://dei.med.nyu.edu/help/alex.

For questions regarding the GME MedEd Resources site and/or the New House Staff tab, please contact Samantha Phillips at Samantha.Phillips@nyumc.org or (212) 263-7657, or the GME office at 212-263-5506.
Visit the NYU Systems Based Practice website (http://www.med.nyu.edu/housestaff/sbp/index.html) for Frequently Asked Questions about how to get things done at our major affiliate hospitals. If your question isn’t here, email it to us at: hs-hospital-faqs@med.nyu.edu. The module itself can be found at http://edinfo.med.nyu.edu/SBP/.

**Systems Based Practice Online Learning Module**

The SBP Online Learning Module provides an in-depth overview of the systems of care in our three primary affiliate hospitals and is designed to address the ACGME Systems Based Practice competency. It will be assigned to you by your Program Director during an appropriate point in your training.

<table>
<thead>
<tr>
<th>Topic</th>
<th>NYU Medical Center</th>
<th>Bellevue Hospital</th>
<th>VAHHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mission/History</td>
<td><img src="image" alt="NYU Medical Center" /></td>
<td><img src="image" alt="Bellevue Hospital" /></td>
<td><img src="image" alt="VAHHS" /></td>
</tr>
<tr>
<td>Administrative Structure</td>
<td><img src="image" alt="NYU Medical Center" /></td>
<td><img src="image" alt="Bellevue Hospital" /></td>
<td><img src="image" alt="VAHHS" /></td>
</tr>
<tr>
<td>Funding Sources</td>
<td><img src="image" alt="NYU Medical Center" /></td>
<td><img src="image" alt="Bellevue Hospital" /></td>
<td><img src="image" alt="VAHHS" /></td>
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<tr>
<td>Population Served</td>
<td><img src="image" alt="NYU Medical Center" /></td>
<td><img src="image" alt="Bellevue Hospital" /></td>
<td><img src="image" alt="VAHHS" /></td>
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<tr>
<td>Pharmacy Services</td>
<td><img src="image" alt="NYU Medical Center" /></td>
<td><img src="image" alt="Bellevue Hospital" /></td>
<td><img src="image" alt="VAHHS" /></td>
</tr>
</tbody>
</table>
Welcome to the NYU Ehrman Medical, Bellevue Medical and Hospital for Joint Diseases Libraries. Each provides unique services and resources. Please take a moment to learn about the vast offerings of the NYU Health Sciences Libraries!

<table>
<thead>
<tr>
<th>Ehrman Hours</th>
<th>Bellevue Hours</th>
<th>HDJ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday - Thursday</td>
<td>Monday - Thursday</td>
<td>Monday – Thursday</td>
</tr>
<tr>
<td>8:00 am - 11:00 pm</td>
<td>8:00 am – 5:00 pm</td>
<td>9:00 am – 5 pm</td>
</tr>
<tr>
<td>Friday, 8:00 am - 9:00 pm</td>
<td>Friday, 8:00 am - 4:00 pm</td>
<td>Swipe Access provides 24-hour access to medical staff and faculty with an HJD ID</td>
</tr>
<tr>
<td>Sat 10:00 - 8:00PM</td>
<td></td>
<td>(212) 562-6535</td>
</tr>
<tr>
<td>Sun 12:00 - 11:00 PM</td>
<td></td>
<td><a href="http://hsl.med.nyu.edu/berlevue/">http://hsl.med.nyu.edu/berlevue/</a></td>
</tr>
<tr>
<td>212-263-5395</td>
<td></td>
<td>(212) 598-6275</td>
</tr>
<tr>
<td><a href="http://hsl.med.nyu.edu/">http://hsl.med.nyu.edu/</a></td>
<td></td>
<td><a href="http://hsl.med.nyu.edu/location/herman-robbins-medical-library">http://hsl.med.nyu.edu/location/herman-robbins-medical-library</a></td>
</tr>
</tbody>
</table>

**NAVIGATING THE NYU Health Sciences Libraries Page**

*Links to various websites and services are easily accessible using the tabs.*

- Locate electronic resources and various services
- Keep up with the latest Library News
- Can’t find what you are looking—simply type the title here.
- Need help? There are multiple ways to get assistance! We are happy to set up individual or group consultations!
- Take advantage of the class offerings and other library sponsored events

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[Diagram showing the NYU Health Sciences Libraries page with various links and features highlighted.]
Take a few minutes to get familiar with the important resources that are provided in support of clinical care and clinical research!

**Navigating the Bellevue Medical Library**

**Bellevue Medial Library Web Site**
http://hsl.med.nyu.edu/bellevue

If you are using a Bellevue-networked computer, the HHC page will direct you to this site. If you have a kerberos id, use the NYU HSL main site with the exception of access to Up-to-Date and Micromedex.

---

**Databases / Clinical Knowledge Resources available via the NYU Health Sciences Libraries**

Some resources are network specific. Up-to-Date and Micromedix access are based on location. If you need assistance, remember the “Ask A Librarian” and Instant Messaging links!

Using the most of the biomedical databases below, let's see how well they answer the clinical question, *"is vancomycin contraindicated in morbidly obese patients?"*
• National Library of Medicine’s interface to MEDLINE.

• Use “Clinical Queries” in the right-hand frame for ease in evidence-based searching.

• Be sure to access PubMed through NYU HSLibrary pages to enable the remote access to full text, located through this icon:

• Review your results critically. Did you get all of the relevant citations? If not, consult with an NYU Health Sciences Librarian.

Notice that you retrieve 20 clinical studies on using the effects of using vancomycin in obese patients . . .

Normally, you should string two or three key concepts in the search box. To conduct an evidence-based search, click on “Clinical Queries.”

Clin-eguide

• An evidenced-based, clinical decision support resource that provides a synthesis of frequent clinical questions, in addition to drug resources, national guidelines, patient handouts, and more.

• Uses free-text searching (not a controlled vocabulary). Do not use “and” or “or” when entering keywords – simply string two or three concepts together.

• Download to your smartphone or other mobile device!
Play close attention to the results. Five stars indicate high evidence, but sometimes the results can be misleading. You must critically appraise the results.

The Medline results are far superior!

- Searchable database of topic reviews in 21 specialty areas.
- Includes patient information, “What’s new” in each of the specialty areas, and a drug interaction component.
- For evidence-based information, look for a GRADE following the information.

**Note:** This resource may only be accessed on the NYUMC network and is NOT available off campus at this time due to licensing restrictions.
• Explore the power of Micromedex 2.0!

This multi-resource tool covers books, journals, patient education, images, and so much more.

• Search Web of Science, Biological Abstracts, Medline, Inspec (for clinical computer models); analyze research results by subject, author or institution.

• Evaluate the quality of journals via Journal Citation Reports for journal impact factors, and more.

• Results can be placed into EndNote for management of information and producing your bibliography.
ACP’s PIER via Stat Ref

The Physicians’ Information and Education Resource

- Searchable evidence-based database with a focus on disease diagnosis and treatment
- This is not an effective tool for this search as there is not much evidence on the topic. It is excellent, however, for many other conditions.

Natural Standard

Evidence-based information about complementary and alternative therapies designed for clinicians to facilitate patient care decision-making.

- Provides information in the areas of “foods, herbs & supplements,” “medical conditions” and by “brand names”.
- Has a unique set of “interactive tools” to complement your information needs including a nutrition database, symptom checker and various calculators.

Ovid Featuring Medline & Embase
• For a more structured approach to searching, try the Ovid interface.
• Remove duplicates when searching multiple databases (up to five at one time!).
• Set up a personal account, and use the post-it feature to take notes about references.
• Set up automatic e-mail alerts on subjects and table of contents

Was this manual helpful? The library is in the process of creating an online manual and would appreciate your input. Click on the following link to give us feedback on how to better serve your needs: https://www.surveymonkey.com/s/HouseStaff

Thank You
Psychiatric Consultation and Referral for Housestaff and GME Programs

Dr. Lisa Goldfarb, is the GME Psychiatric consultant and a member of the GME “Wellness Committee”. Dr. Goldfarb is available to provide free short-term consultation and referral for lower-fee psychiatric and psychotherapy treatment for house-staff.

Dr. Goldfarb welcomes the opportunity to consult with program directors regarding psychiatric wellness issues for house-staff. She is also available to speak with residents and fellows in groups or individually about psychiatric and stress issues that commonly affect physicians-in-training.

Dr. Goldfarb also works with human resources staff to understand medical insurance policies at both NYU Medical Center and Bellevue Hospital Center and is able to inform the house-staff about the available insurance benefits for psychiatric treatment.

Contact information:

Lisa M. Goldfarb, MD
Greenberg Hall
545 First Avenue, SC2-179
telephone: (212) 570-4052
emergency 24-hour beeper: 917-205-8446
Lisa.Goldfarb@nyumc.org
Committee for Physicians Health

Contact Information:
865 Merrick Avenue, PO Box 9007
Westbury, NY 11590
Tel: (516) 488-6100
Fax: (516) 488-1267
E-mail: mssny@mssny.org

The mission of the Committee for Physician Health is to promote quality medical care by offering non-disciplinary confidential assistance to physicians, residents, medical students and physician assistants suffering from substance use disorder and other psychiatric disorders. The Committee monitors the treatment and compliance of program participants and provides advocacy and support as well as outreach activities, including prevention and education.

PHYSICIAN ADVOCACY

The Physician Health Program for New York State

The Committee for Physician Health, founded in 1974, is a division of the Medical Society of the State of New York. CPH provides non-disciplinary, confidential assistance to physicians, residents, medical students, and physician’s assistants experiencing problems from stress and difficult adjustment, emotional, substance abuse and other psychiatric disorders, including psychiatric problems that may arise as a result of medical illness. CPH provides support and referrals to those participating in the program, but also to those calling in with concerns about physicians including healthcare coworkers, colleagues, and family members. We recommend evaluation, treatment and/or other assistance to our participants, and monitor for progress in recovery from illness. In this way, we can also provide strong advocacy on behalf of the participant to continue their practice as a physician or physician-in-training. We provide education to the medical community as well as other communities on recognition of stress, burnout and illness in physicians, options for prevention or reduction and outreach to physician groups on our services. Importantly, we instill hope in the lives of our clients, that recognition and treatment for stress and illness is desirable, helpful, and can route the person back to optimum health as an individual and as a physician.
Faculty and Staff Assistance Program (FASAP)

What is FASAP?
Few of us go through life without experiencing some personal difficulties at one time or another. Most of the time we can work them out on our own, but sometimes these concerns become difficult to resolve alone. The Faculty And Staff Assistance Program (FASAP) is a short-term, confidential, counseling, information, and referral service with professional counselors that provides help with resolving the concerns that may affect personal relationships, emotional well-being and work performance. Professional counselors are available 24hrs/day, 7 days/week to resolve problems and concerns that may affect personal relationships, emotional well-being and work performance.

What Kinds of Concerns Can I Get Help For?
Some of the concerns professional counselors can help you with include:

- Sadness or Depression
- Grief and Loss
- Caring for Children or Elders
- Financial/Legal Worries
- Personal Problems Affecting You at Work
- Managing Stress
- Marital/Relationship and Family Concerns
- Alcohol and Drug Use

Who provides the FASAP services?
To ensure that help is provided in a confidential setting, services are provided by Corporate Counseling Associates (CCA). CCA has a staff of professional counselors conveniently located at 475 Park Avenue South at East 32nd Street. CCA also has a network of affiliate counselors available regionally and nationally to provide services closer to your home if that is something you prefer.

Who can use the services of FASAP?
All staff and compensated faculty of NYUHC, SOM and HJD and their immediate family members, including domestic partners are eligible to use the services of FASAP.

Is there a cost?
There is NO COST to you or an eligible member to use the services of FASAP. However, if a referral outside the program is required, there may be a charge for these services. CCA counselors will every
effort to work with your insurance providers.

**How to contact FASAP**

A simple phone call starts the process. To speak with a professional counselor, contact CCA at 1-800-833-8707. 24 hours a day, 7 days a week.

CCA also has an online resource center for employees and family members! The site has thousands of articles, self-searchable databases and other resources. To access information on the web go to: www.corporatecounseling.com and log-on using “fasap” as the Company Code.

**Confidentiality is a Priority!**

FASAP is committed to providing professional services in an atmosphere of privacy and confidentiality to the fullest extent permitted by law. All phone calls, counseling sessions and discussions are strictly between the individual and the counselor unless you chose to share that information.
To: All Faculty and Staff

Subject: GENERAL NOTICE: HARASSMENT PREVENTION POLICY STATEMENT

Date: November 26, 2007

It is the policy of NYU Hospitals Center and New York University School of Medicine (jointly referred to as the “NYU Langone Medical Center”) to ensure that a workplace environment free of harassment is provided for all its Faculty and Staff. It is our belief that fostering an atmosphere of respect and civility is critical to the success of our institution and harassment is contrary to these values and the mission of the Medical Center and therefore will not be tolerated.

Further, it is the responsibility of all supervisory personnel to maintain a work environment free of harassment, and it is the responsibility of our Faculty and Staff to avoid contributing to an offensive or hostile work environment, but rather to support an environment of mutual respect and tolerance for diverse persons, groups, and ideas.

Consistent with the Medical Center’s non discrimination policy statement, this Harassment Prevention policy includes cases where conduct is based on race, color, religion, sex, sexual orientation, marital or parental status, national origin, citizenship status, age, veteran status, disability or any other protected characteristic. Any employee that believes he/she is being harassed should notify his/her manager and/or Employee Relations Manager immediately. An investigation into issues brought forth will be conducted in as confidential of a manner as possible. Retaliation of any sort in response to an individual bringing forth an issue is strictly prohibited.

If you have any questions regarding this memorandum or our policy, please contact your Employee Relations Manager at (212) 404-3857 or the Vice President, Employee and Labor Relations at (212) 404-3871.

_____________________________
Nancy Sanchez
Senior Vice President and Vice Dean
Human Resources
Do Not Resuscitate
**Human Subject Research at NYU School of Medicine**

**Contact Information:**
Elan Czeisler, Director Institutional Review Board (IRB), AAHRPP Accredited Human Research Protection Program (HRPP), Regulatory Knowledge Services Core (RKSC)
Telephone: 212-263-4146
Email: elan.czeisler@nyumc.org

If you have a faculty appointment at the NYU School of Medicine and would like to conduct research you will need to submit your proposal to the NYUSOM IRB for review and approval.

**IRB Administrative Office**
The NYUSoM IRB Administrative Office facilitates the review process of human subject studies at NYUSoM and our affiliates (Bellevue Hospital, VA Medical Center, NYU College of Dentistry, NYU School of Nursing, Gouverneur Healthcare, Woodhull Hospital Center, Nathan Kline Institute and Charles B. Wang Health Center). Our staff provides professional guidance and support to the research community and helps researchers navigate the submission process. The IRB Administrative Office also serves as the Administrative office for 4 Institutional Review Boards at NYUSoM.

**Institutional Review Boards**
The IRBs at NYUSoM oversee all research involving human subjects. The IRBs have the authority, under federal regulation and institutional policy, to approve, require the modification of or disapprove research activities being conducted at NYUSoM. The IRBs also has the authority to suspend or terminate research that was previously approved in which unforeseen harm to subjects occurs, or that is not being conducted as approved by the IRB.

- Federal Regulations define research involving human subjects as follows:
  Research: a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute research for purposes of this policy, whether or not they are conducted or supported under a program which is considered research for other purposes. For example, some demonstration and service programs may include research activities.

- Human subject: a living individual about whom an investigator (whether professional or student) conducting research obtains (1) Data through intervention or interaction with the individual, or (2) Identifiable private information. Intervention includes both physical procedures by which data are gathered (for example, venipuncture) and manipulations of the subject or the subject's environment that are performed for research purposes. Interaction includes communication or interpersonal contact between investigator and subject. Private information includes information about behavior that occurs in a context in which an individual can reasonably expect that no observation or recording is taking place, and information which has been provided for specific purposes by an individual and which the individual can reasonably expect will not be made public (for example, a medical record). Private information must be individually identifiable (i.e., the identity of the subject is or may readily be ascertained by the investigator or associated with the information) in order to obtain the information to constitute research involving human subjects.
• If your research does not fall into the definitions above you may not be conducting research involving human subjects and would not have to submit your project to the IRB for review.

The IRB also functions as the Privacy Board and protects the privacy of medical information used or disclosed in research, consistent with the requirements of the federal medical Privacy Rule authorized by the Health Insurance Portability and Accountability Act (HIPAA). (Compliance with the Privacy Rule was mandatory as of April 14, 2003). The IRB is responsible for the review, prospective approval and continued oversight of all research involving human subjects that is conducted by its faculty or involves NYUSM funding or facilities.

For additional information and guidance for completing the necessary forms and understanding the procedural requirements for conducting a research study please contact the IRB office at 212-263-4110 or you can request a consultation with the IRB Director Elan Czeisler for specific guidance at 212-263-4146, email: elan.czeisler@nyumc.org

The office of the IRB is located on the 10th floor west wing in the VA Medical Center located on 1st Avenue and 23rd street.

IRB Website: http://irb.med.nyu.edu/

IRB Meeting Schedule: http://irb.med.nyu.edu/about-irb/meeting-dates-boards-a-b-c

IRB Staff: http://irb.med.nyu.edu/irb-staff
Post Exposure to Blood and Body Fluid Protocol

1. **STOP WHAT YOU ARE DOING AND TELL YOUR SUPERVISOR.**

2. Wash the site with soap and water.

3. If a splash to mouth or eye, immediately flush area with tap water- rinse eye or mouth for at least 30 seconds.

4. Your supervisor should arrange for source patient testing while you go to EHS

**Tisch Hospital/Rusk Institute**

- Mon to Fri 8AM - 5PM go to Employee Health Service (EHS) 660 1st Ave, (37th St and 1st Ave), 2nd floor  
  Tel: 212-263-5020.
- All other times go the Emergency Department, ground floor. Follow up with EHS the next working day.

**Bellevue Hospital Center**

- Mon to Fri 8AM - 4PM go to Employee Health Service  
  NB 12 E  
  Tel: 212-562-6381.
- All other times go the Emergency Department, ground floor.

**VA Medical Center**

- Mon to Fri 8AM -4PM go to Employee Health Service  
  1st flr, room 1633  
  Tel: 212-686-7500 ext. 3810.
- All other times go the Emergency Department, ground floor.

**Call the Employee Health Service Needle Stick Hotline: (212) 263-5020 for instructions.**

6. **Managing related billing/insurance issues** (for those on NYULMC payroll)

   1. Go to Employee Health the next working day and complete an **Employee Occupational Injury/Illness Report**. All treatments should be billed to workers’ comp.
**THE AUTOPSY FACT SHEET**

**The Autopsy Service:**

The autopsy service is a consultation service whose primary purpose is to provide a thorough postmortem examination including clinico-pathologic correlation for the clinician and satisfaction to the next of kin who signed the permission. It is the responsibility of the Pathology department to see that this is done in a timely manner (within the 30 day limit imposed by the College of American Pathologists Laboratory Accreditation Program requirements) but with care and scholarly attention to detail. A preliminary autopsy report is to be made available within 48 hours of performing the autopsy. This autopsy service is available 24 hours a day through the Department of Pathology. An attending pathologist and resident are on-call during these hours.

Following a death, the medical team needs to pronounce the patient and fill out a Death Notice and write a death note in the patient’s chart. The date, time and circumstances of death should be documented in the decedent’s medical chart. The designated ward nurse will complete the ‘Organ Donation’ portion of the death notice.

The process of performing an autopsy begins with verifying that the decedent’s death does not fall under the jurisdiction of the Office of the Chief Medical Examiner of New York City. If this is verified and the case is determined not to be a medico legal case then the autopsy process can proceed by gaining consent by the next of kin. A list of OCME case situations is listed under “reportable ME cases”. This list should be consulted before proceeding. If the case is designated by the OCME as a “NO CASE”, this information and the OCME investigators name should be listed on the Death Notice. The next of kin is a term to describe the decedent’s closest living relative. In New York, the next of kin order is designated as below.

**Next of kin:**
For patients under the age of 18:
Both parent signatures are needed for children.
Only the mother’s permission required for an intrauterine demise.

For adults:
Spouse (Legal domestic partner status can be considered on an individual basis)
Son or daughter, over 18 years of age.
Either parent.
Brother or sister, over 18 years of age.
Legal guardian at time of death.
Grandchildren of the decedent, over 18 years of age.
Grandparents.
Great grandparents, uncles, aunts, over 18 years of age.

A named Health care proxy is not able to consent unless the named is next of kin or is the person responsible for the decedents burial.

After 48 hours following death and a reasonably exhaustive search is made for locating the next of kin and none is found, the Hospital Medical Director can authorize an autopsy on the decedent and an Executive Director’s order for Autopsy needs to be completed.
Questions regarding Next of Kin status can be directed to pathology 212-562-3415 or Decedent affairs 212-562-4367.

**Requesting Consent - Sample conversation:**
If you have not offered the option of autopsy prior to your patient's death, do so when you notify the family of the death:

I am ________, the doctor caring for your ________. I am sorry to have to tell you that he/she has died. His/her other doctors and I think that the cause of death was _________. It is your privilege to have an autopsy performed on your ________________, if you choose. This is a service that the hospital provides, free of charge, to help us answer any questions that you or the doctors might have about his/her disease or the care he/she received.

It is important to help us learn more about [this disease] for the sake of patients in the future. The autopsy need not delay your funeral preparations, and even a complete autopsy will not disfigure the body, should you want a viewing.

Would you like us to perform an autopsy? (Offer a problem directed/limited autopsy if this is more acceptable).

**Signing Consent:**
Witnessed telephone consent is legal at your hospital. A notarized faxed consent or telegram is also legal.

Help the family fill out the consent form completely, including the witness signature(s).

Thank them and assure them that the autopsy will be useful to them, the hospital and to future patients.

With proper identification, they may obtain a copy of the Final Autopsy report from Medical records at Bellevue Hospital.

**Reportable ME Deaths (OCME New York City 212-447-2030):**

- All forms of criminal violence or from an unlawful act or criminal neglect
- All accidents (motor vehicle, falls, industrial)
- All suicides
- All deaths caused or contributed to by drug/chemical overdose or poisoning
- Sudden death of a person in apparent good health
- Death unattended by a physician
- Deaths of all persons in legal/court ordered detention
- Deaths during or due to complications of diagnostic or therapeutic procedures
- Deaths related to employment
- Deaths which occur in any suspicious or unusual manner
- Fetus born dead due to maternal trauma or drug abuse or in the absence of a physician/midwife

Any death that is not due to 100% natural disease must be reported to the OCME, even if that injury takes years to result in the fatality.

There is no 24 hour rule in NYC; Natural deaths in patients who survived less than 24 hours in the hospital need not be reported to the OCME.
**Religion and the Autopsy:**

Many religions/belief systems have various dictums or policies regarding the performance of an autopsy. The chart below lists selected religions/belief systems and their reported policy on autopsy. Be advised, that each individual and their next of kin, may not necessarily follow the practice listed below and each case can be treated independently.

<table>
<thead>
<tr>
<th>Religion/Belief system</th>
<th>Autopsy</th>
<th>Tissue Retention</th>
<th>Body disposal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atheism</td>
<td>No prohibition</td>
<td>No prohibition</td>
<td>Burial or cremation</td>
</tr>
<tr>
<td>Baha’i</td>
<td>No prohibition</td>
<td>No prohibition</td>
<td>Burial w/1hr journey of place of</td>
</tr>
<tr>
<td>Buddhism</td>
<td>No prohibition</td>
<td>No prohibition</td>
<td>Cremation, usual</td>
</tr>
<tr>
<td>Christianity</td>
<td>No prohibition</td>
<td>No prohibition</td>
<td>Burial or cremation</td>
</tr>
<tr>
<td>Christian scientist</td>
<td>No prohibition, but usually unacceptable</td>
<td>No prohibition, but usually unacceptable</td>
<td>Burial or cremation</td>
</tr>
<tr>
<td>Church of Jesus Christ and Later day Saints</td>
<td>No prohibition</td>
<td>No prohibition</td>
<td>Burial</td>
</tr>
<tr>
<td>Hinduism</td>
<td>No prohibition</td>
<td>No prohibition</td>
<td>Cremation, w/o unnecessary delay</td>
</tr>
<tr>
<td>Islam</td>
<td>Usually only if required by law</td>
<td>Returned to the body or if released after funeral, buried</td>
<td>Burial, ideally w/ 24 hrs of death</td>
</tr>
<tr>
<td>Jainism</td>
<td>No prohibition</td>
<td>No prohibition</td>
<td>Cremation</td>
</tr>
<tr>
<td>Jehovah Witness</td>
<td>No prohibition, but usually unacceptable</td>
<td>No prohibition, but usually unacceptable</td>
<td>Burial or Cremation</td>
</tr>
<tr>
<td>Judaism</td>
<td>Usually only if required by law</td>
<td>Returned to the body or if released after funeral, buried</td>
<td>Burial or Cremation</td>
</tr>
<tr>
<td>Rastafarianism</td>
<td>Only if required by law</td>
<td>Only if required by law</td>
<td>Burial, ideally w/ 24 hrs of death</td>
</tr>
<tr>
<td>Shintoism</td>
<td>No prohibition</td>
<td>No prohibition</td>
<td>Cremation is usual</td>
</tr>
<tr>
<td>Sikhism</td>
<td>No prohibition</td>
<td>No prohibition</td>
<td>Cremation w/o unnecessary delay</td>
</tr>
<tr>
<td>Taoism</td>
<td>No prohibition</td>
<td>No prohibition</td>
<td>Burial or cremation</td>
</tr>
</tbody>
</table>

*Where there is no prohibition, there may be cultural, secular or personal objections.*

**Death Certificate and Pronouncement:**

After consent is obtained, Decedent affairs and the nursing staff should be notified. Organ donation should not preclude the performance of an autopsy. The pronouncement of death portion of the death certificate can be filed on-line at the electronic death registry system (EDRs) at [https://a816-healthportal.nyc.gov](https://a816-healthportal.nyc.gov). Registration for EDRS can be done at Decedent Affairs (Bellevue Hospital only).
Decedent affairs will contact the autopsy resident on-call when the autopsy consent is received by them.

If the clinical team has a specific question regarding the death or disease process of the decedent, it is advisable to contact the autopsy service and discuss these concerns. The clinical team is encouraged to view and/or participate in the autopsy. The autopsy takes place in Bellevue, H building, room 4W16.

**Autopsy Policy and Procedures:**

The College of American Pathologists recommends that a request be made for autopsy on every death. Deaths in which an autopsy should be encouraged include:

- Deaths in which autopsy may help to explain unknown and unanticipated medical complications to the attending physician.
- All deaths in which the cause of death or a major diagnosis is not known with reasonable certainty on clinical grounds.
- Cases in which autopsy may help to allay concerns of the family and/or the public regarding the death, and to provide reassurance to them regarding same.
- Unexpected or unexplained deaths occurring during or following any dental, medical or surgical diagnostic procedures and/or therapies.
- Deaths of patients who have participated in clinical trials (protocols) approved by institutional review boards.
- Unexpected or unexplained deaths which are apparently natural and not subject to a forensic medical jurisdiction.
- Natural deaths which are subject to, but waived by, a forensic medical jurisdiction such as a) persons dead on arrival at hospitals; b) deaths occurring in hospitals within 24 hours of admission; and c) deaths in which the patient sustained or apparently sustained an injury while hospitalized.
- Deaths resulting from high-risk infectious and contagious diseases.
- All obstetric deaths.
- All perinatal and pediatric deaths.
- Deaths at any age in which it is believed that autopsy would disclose a known or suspected illness which also may have a bearing on survivors or recipients of transplant organs.
- Deaths known or suspected to have resulted from environmental or occupational hazards.

Here are some facts concerning the policy and performance of the autopsy:

- Organs are retained for up to 3 months after the final autopsy report is filed
- Paraffin block, reports and slides are retained for 10 years after the autopsy
• Partial/restricted, Kosher, biopsy based, aspiration based autopsy can be performed upon request
• Cultures are standard and taken on all autopsies
• Tissues can be processed and stained with H &E, immunohistochemistry, FISH, cytogenetics and other molecular techniques (i.e. PCR)

General Procedure may differ for pediatric and intra-uterine demise patients; the general autopsy procedure is as follows:
• External inspection/photographs, as applicable
• Usually remove the organ block from epiglottis to rectum
• Brain is removed via a bi-mastoidal incision with scalp retraction
• Organ block dissected
• Organs weighed and examined
• Portions of organs prepared to have slides made
• Portions of organs retained in a formalin stock jar
• Some organs are returned to the body cavity in a biohazard bag and handled by the funeral home according to their procedures
• Certain organs removed and retained under special circumstances
• Chest and abdomen incisions are sewn up and the body placed in refrigerator until funeral home picks it up
• Relevant, representative sections of organs are made into slides
• Appropriate tissue and fluids can be obtained (i.e. vitreous, synovial fluid)
• The eyes, face and limbs are usually not dissected, unless special consent is obtained

References:

Clinical, educational, and epidemiological value of autopsy

**Steps to Follow In The Event of a Patient Death**

[] Pronouncement of death

[] Note time of death

[] Notify nurse/clerk (they will notify decedent affairs office)

[] Notify next of kin *
- Healthcare proxy has no legal rights following death unless next of kin; medical executor can make decisions following death (can make decisions over next of kin)

[] Determine if death qualifies for medical examiner (ME) notification **
  [] IF YES → call ME office (212-447-2030), GET CASE #
  (will need this for death certificate)
  [] IF NO (determined not to be ME case) → GET INVESTIGATOR’S NAME (will need this for death notice)

[] If case to go to ME, discuss this with next of kin

[] If case not to go to ME, ask next of kin for an autopsy ***

[] Documentation of death:
  1. Brief MYSIS “Other” or “Event” Note documenting:
     ▪ Time of death; clinical circumstances; which next of kin notified or inability to notify; if consent for autopsy given
  2. Pink Paper Death Notice
     ▪ Ask clerk for this and once completed give back to clerk
  3. Discharge Summary (MYSIS)
     ▪ Mandatory responsibility of primary team

[] Complete Death Certificate (must be completed)
- Go to decedent affairs office (same place as admitting office)
- Complete EVRS online death certificate, including fingerprint signature

** Next Of Kin Priority
1. Spouse
2. Son/daughter > 18y/o
3. Either parent
4. Brother/sister > 18y/o
5. Legal guardian
6. Grandchildren > 18y/o
7. Grandparents
8. Great grandparents, uncles/aunts > 18y/o

* Questions about next of kin status? Pathology (562.3415) or Decedent Affairs (562-4367)

** Reportable Deaths
1. Criminal violence/neglect, unlawful act
2. All accidents (i.e. MVA)
3. All suicides
4. Caused/contributed by drug overdose/poisoning
5. Sudden death following apparent good health
6. Death unattended by physician
7. Patient in legal/court ordered detention
8. Death during or due to complication of procedure
9. Related to employment
10. Occurs in suspicious or

*** Making Arrangements for Autopsy
1. Next-of-kin present: request consent for autopsy. Offer fact sheet “A Gift to the Living” (ask clerk for this). If next-of-kin agrees, complete Authorization for Autopsy (ask clerk) and have next-of-kin sign – THIS CONSENT MUST BE SENT TO DECEDED AFFAIRS WHO WILL THEN NOTIFY PATHOLOGY
2. Next-of-kin not present: ask him/her to come to hospital to discuss the case. If unable to come, witnessed telephone and notarized faxed consents acceptable
3. If no next-of-kin identified, complete Executive Director’s Order for Autopsy (ask clerk), signing your name on top signature line. This will allow autopsy to be performed if hospital unable to identify next-of-kin as of 48 hours after death.
NYULMC’s Code of Conduct can be found here:  

Be sure to review this policy. You will be required to complete the Code of Conduct module as part of your credentialing process.
The Physician-Pharmaceutical Industry Relationship

A. **Contact Information**: Laura S. Boylan, MD  
   Clinical Associate Professor  
   Department of Neurology  
   laura.boylan@med.nyu.edu  
   No Free Lunch ([http://www.nofreelunch.org/aboutus.htm](http://www.nofreelunch.org/aboutus.htm))

The physician-pharmaceutical industry relationship has many potential ethical pitfalls. The AMA, American College of Physician's – American Society of Internal Medicine have guidelines which you should know. Their guidelines allow some limited acceptance of gifts. I do not think any gifts should be accepted and will herein outline existing policies and the evidence which has come to bear on issues at hand.

A concomitant issue is the need to become a critical consumer of the medical literature. Two major items on the agenda 1) policies exist 2) if you think you are not biased by promotional materials and items you are wrong.

Who is “No Free Lunch”?

**We** are physicians and other health care providers who aim to encourage health care practitioners to provide high quality care based on unbiased evidence rather than on biased pharmaceutical promotion. I am a member.
ACGME Requirements
Common Program Requirements
http://www.acgme.org/acWebsite/dutyHours/dh_dutyhoursCommonPR07012007.pdf

Effective: July 1, 2007

I Institutions..........................................................................................................................  1
   A. Sponsoring Institution..................................................................................................... 1
   B. Participating Sites.......................................................................................................... 1

I Program Personnel and Resources .................................................................................... 2
   A. Program Director ........................................................................................................... 2
   B. Faculty........................................................................................................................... 5
   C. Other Program Personnel ............................................................................................. 6
   D. Resources ....................................................................................................................... 6
   E. Medical Information Access .......................................................................................... 6

II Resident Appointments .................................................................................................. 6
   A. Eligibility Criteria ........................................................................................................... 6
   B. Number of Residents .................................................................................................... 6
   C. Resident Transfers ......................................................................................................... 7
   D. Appointment of Fellows and Other Learners ................................................................. 7

IV Educational Program .................................................................................................. 7
   A. The Curriculum ............................................................................................................. 7
   B. Residents' Scholarly Activities ...................................................................................... 11

Evaluation .......................................................................................................................... 11
   A. Resident Evaluation ....................................................................................................... 11
   B. Faculty Evaluation ......................................................................................................... 12
   C. Program Evaluation and Improvement ......................................................................... 12

VI Resident Duty Hours in the Learning and Working Environment ................................ 13
   A. Principles ....................................................................................................................... 13
   B. Supervision of Residents ............................................................................................. 13
   C. Fatigue .......................................................................................................................... 13
   D. Duty Hours .................................................................................................................... 13
   E. On-call Activities .......................................................................................................... 14
   F. Moonlighting .................................................................................................................. 15
   G. Duty Hours Exceptions ................................................................................................. 15

VII Experimentation and Innovation .................................................................................... 15
Institutions

Sponsoring Institution

One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to resident assignments at all participating sites.

The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his or her educational and administrative responsibilities to the program.

Participating Sites

There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years.

The PLA should:

- Identify the faculty who will assume both educational and supervisory responsibilities for residents;
- Specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;
- Specify the duration and content of the educational experience; and,
- State the policies and procedures that will govern resident education during the assignment.

The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS).

[As further specified by the Review Committee]
Program Personnel and Resources

II. Program Director

A. Program Director

There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMEC must approve a change in program director. After approval, the program director must submit this change to the ACGME via the ADS.

[As further specified by the Review Committee]

The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability.

Qualifications of the program director must include:

Requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;

Current certification in the specialty by the American Board of ________, or specialty qualifications that are acceptable to the Review Committee; and,

Current medical licensure and appropriate medical staff appointment.

[As further specified by the Review Committee]

The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. The program director must:

Oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;

Approve a local director at each participating site who is accountable for resident education;

Approve the selection of program faculty as appropriate;

Evaluate program faculty and approve the continued participation of program faculty based on evaluation;

Common Program Requirements 2
Effective July 1, 2007
e) Monitor resident supervision at all participating sites;

Prepare and submit all information required and requested by the ACGME, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete;

Provide each resident with documented semiannual evaluation of performance with feedback;

Ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;

Provide verification of residency education for all residents, including those who leave the program prior to completion;

Implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, and, to that end, must:

Distribute these policies and procedures to the residents and faculty;

Monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;

Adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,

If applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.

Monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;

Comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents;
Be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;

Obtain review and approval of the sponsoring institution's GMEC/DIO before submitting to the ACGME information or requests for the following:

- All applications for ACGME accreditation of new programs;
- Changes in resident complement;
- Major changes in program structure or length of training;
- Progress reports requested by the Review Committee;
- Responses to all proposed adverse actions;
- Requests for increases or any change to resident duty hours;
- Voluntary withdrawals of ACGME-accredited programs;
- Requests for appeal of an adverse action;
- Appeal presentations to a Board of Appeal or the ACGME; and,
- Proposals to ACGME for approval of innovative educational approaches.

Obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:

- Program citations, and/or
  1) Request for changes in the program that would have significant impact, including financial, on the program or institution.
  2) [As further specified by the Review Committee].

Common Program Requirements 4
Effective July 1, 2007
B. Faculty

At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all residents at that location.

The faculty must:

Devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of residents, and

Administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas.

The physician faculty must have current certification in the specialty by the American Board of ________, or possess qualifications acceptable to the Review Committee.

[As further specified by the Review Committee]

The physician faculty must possess current medical licensure and appropriate medical staff appointment.

The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.

The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.

The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.

Some members of the faculty should also demonstrate scholarship by one or more of the following:

Peer-reviewed funding;

1) Publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;

2) Publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,
Participation in national committees or educational organizations.

Faculty should encourage and support residents in scholarly activities.

[As further specified by the Review Committee]

Other Program Personnel

The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program.

[As further specified by the Review Committee]

Resources

The institution and the program must jointly ensure the availability of adequate resources for resident education, as defined in the specialty program requirements.

[As further specified by the Review Committee]

Medical Information Access

Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available.

Resident Appointments

II. Eligibility Criteria

The program director must comply with the criteria for resident eligibility as specified in the Institutional Requirements.

[As further specified by the Review Committee]

Number of Residents

The program director may not appoint more residents than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. The program’s educational resources must be adequate to support the number of residents appointed to the program.

Common Program Requirements 6
Effective July 1, 2007
Resident Transfers

C. Before accepting a resident who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring resident.

A program director must provide timely verification of residency education and summative performance evaluations for residents who leave the program prior to completion.

Appointment of Fellows and Other Learners

The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed residents' education. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines.

Educational Program

V. The curriculum must contain the following educational components:

A. Overall educational goals for the program, which the program must distribute to residents and faculty annually;

Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty annually, in either written or electronic form.

These should be reviewed by the resident at the start of each rotation;

Regularly scheduled didactic sessions;

Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and supervision of residents over the continuum of the program; and,

Common Program Requirements 7
Effective July 1, 2007
ACGME Competencies

5.

The program must integrate the following ACGME competencies into the curriculum:

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:

[As further specified by the Review Committee]

Medical Knowledge

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Residents:

[As further specified by the Review Committee]

Practice-based Learning and Improvement

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning.

Residents are expected to develop skills and habits to be able to meet the following goals:

1) Identify strengths, deficiencies, and limits in one’s knowledge and expertise;
2) Set learning and improvement goals;
3) Identify and perform appropriate learning activities;
4) Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;
5) Incorporate formative evaluation feedback into daily practice;

Common Program Requirements 8
Effective July 1, 2007
Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;

Use information technology to optimize learning; and,

Participate in the education of patients, families, students, residents and other health professionals.

[As further specified by the Review Committee]

Interpersonal and Communication Skills

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents are expected to:

Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;

Communicate effectively with physicians, other health professionals, and health related agencies;

Work effectively as a member or leader of a health care team or other professional group;

Act in a consultative role to other physicians and health professionals; and,

Maintain comprehensive, timely, and legible medical records, if applicable.

[As further specified by the Review Committee]

Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:

Compassion, integrity, and respect for others;

Responsiveness to patient needs that supersedes self-interest;
Respect for patient privacy and autonomy;

(3) Accountability to patients, society and the profession; and,

4) Sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

[As further specified by the Review Committee]

Systems-based Practice

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

Residents are expected to:

1) Work effectively in various health care delivery settings and systems relevant to their clinical specialty;

2) Coordinate patient care within the health care system relevant to their clinical specialty;

3) Incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;

4) Advocate for quality patient care and optimal patient care systems;

5) Work in inter-professional teams to enhance patient safety and improve patient care quality; and,

6) Participate in identifying system errors and implementing potential systems solutions.

[As further specified by the Review Committee]
Residents’ Scholarly Activities

B.

The curriculum must advance residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.

Residents should participate in scholarly activity.

[As further specified by the Review Committee]

The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.

[As further specified by the Review Committee]

Evaluation

A. Resident Evaluation

1. Formative Evaluation

The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.

The program must:

1) Provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;

2) Use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);

3) Document progressive resident performance improvement appropriate to educational level; and,

4) Provide each resident with documented semiannual evaluation of performance with feedback.

The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.
Summative Evaluation

2. The program director must provide a summative evaluation for each resident upon completion of the program. This evaluation must become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy. This evaluation must:

   Document the resident's performance during the final period of education, and

   Verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.

Faculty Evaluation

At least annually, the program must evaluate faculty performance as it relates to the educational program.

These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.

This evaluation must include at least annual written confidential evaluations by the residents.

Program Evaluation and Improvement

The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:

   Resident performance;

   Faculty development;

   Graduate performance, including performance of program graduates on the certification examination; and,

   Program quality. Specifically:

   Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and
The program must use the results of residents' assessments of the program together with other program evaluation results to improve the program.

If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.

Resident Duty Hours in the Learning and Working Environment

I. Principles

A. The program must be committed to and be responsible for promoting patient safety and resident well-being and to providing a supportive educational environment.

B. The learning objectives of the program must not be compromised by excessive reliance on residents to fulfill service obligations.

C. Didactic and clinical education must have priority in the allotment of residents' time and energy.

D. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

Supervision of Residents

The program must ensure that qualified faculty provide appropriate supervision of residents in patient care activities.

Fatigue

Faculty and residents must be educated to recognize the signs of fatigue and sleep deprivation and must adopt and apply policies to prevent and counteract its potential negative effects on patient care and learning.

Duty Hours (the terms in this section are defined in the ACGME Glossary and apply to all programs)

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

Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.

Residents must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call.

Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.

On-call Activities

In-house call must occur no more frequently than every third night, averaged over a four-week period.

Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.

No new patients may be accepted after 24 hours of continuous duty.

At-home call (or pager call)

The frequency of at-home call is not subject to the every third-night, or 24+6 limitation. However at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident.

Residents taking at-home call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.

When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.
Moonlighting

F. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

Internal moonlighting must be considered part of the 80-hour weekly limit on duty hours.

Duty Hours Exceptions

A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale.

In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.

Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.

Experimentation and Innovation

II. Requests for experimentation or innovative projects that may deviate from the institutional, common and/or specialty specific program requirements must be approved in advance by the Review Committee. In preparing requests, the program director must follow Procedures for Approving Proposals for Experimentation or Innovative Projects located in the ACGME Manual on Policies and Procedures. Once a Review Committee approves a project, the sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project.

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ACGME: February 2007 Effective: July 1, 2007
I  INSTITUTIONAL ORGANIZATION AND RESPONSIBILITIES................. 1
   Sponsoring Institution .......................................................................................... 1
   Commitment to Graduate Medical Education (GME)........................................... 1
   Institutional Agreements..................................................................................... 3
   Accreditation for Patient Care in Sponsoring and Major Participating
   Sites that Are Hospitals..................................................................................... 3

II  INSTITUTIONAL RESPONSIBILITIES FOR RESIDENTS ...................... 4
   Eligibility and Selection of Residents .................................................................. 4
   Financial Support for Residents........................................................................... 5
   Benefits and Conditions of Appointment............................................................ 5
   Agreement of Appointment.................................................................................. 5
   Resident Participation in Educational and Professional Activities................... 9
   Resident Educational and Work Environment.................................................... 9

III GRADUATE MEDICAL EDUCATION COMMITTEE (GMEC)............. 10
   GMEC Composition and Meetings ..................................................................... 10
   GMEC Responsibilities....................................................................................... 10

IV  INTERNAL REVIEW................................................................................. 13
   Process ................................................................................................................... 13
   Internal Review Report......................................................................................... 15
INSTITUTIONAL ORGANIZATION AND RESPONSIBILITIES

A. Sponsoring Institution

Residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) must operate under the authority and control of one Sponsoring Institution. Institutional responsibility extends to resident assignments at all participating sites.

A Sponsoring Institution must be in substantial compliance with the ACGME Institutional Requirements and must ensure that its ACGME-accredited programs* are in substantial compliance with the Institutional, Common and specialty-specific Program Requirements, and the ACGME Policies and Procedures.

A Sponsoring Institution's failure to maintain accreditation will jeopardize the accreditation of all its sponsored programs.

Commitment to Graduate Medical Education (GME)

The Sponsoring Institution must provide graduate medical education (GME) that facilitates residents' professional, ethical, and personal development. The Sponsoring Institution and its GME programs, through curricula, evaluation, and resident supervision, must support safe and appropriate patient care.

A written statement must document the Sponsoring Institution's commitment to provide the necessary educational, financial, and human resources to support GME. It must be reviewed, dated, and signed by representatives of the Sponsoring Institution's governing body, administration, and GME leadership within at least one year prior to the institutional site visit.

An organized administrative system, led by a Designated Institutional Official (DIO) in collaboration with a Graduate Medical Education Committee (GMEC), must oversee all ACGME-accredited programs of the Sponsoring Institution.

The DIO and GMEC must have authority and responsibility for the oversight and administration of the Sponsoring Institution's programs and responsibility for assuring compliance with ACGME Common, specialty/subspecialty-specific Program, and Institutional Requirements.
The DIO must establish and implement procedures to ensure that s/he, or a designee in the absence of the DIO, reviews and cosigns all program information forms and any documents or correspondence submitted to the ACGME by program directors (See III.B.10.a-k).

The DIO and/or the Chair of the GMEC must present an annual report to the Organized Medical Staff(s) (OMS) and the governing body(s) of the Sponsoring Institution. This report must also be given to the OMS and governing body of major participating sites that do not sponsor GME programs. This annual report will review the activities of the GMEC during the past year with attention to, at a minimum, resident supervision, resident responsibilities, resident evaluation, compliance with duty-hour standards, and resident participation in patient safety and quality of care education.

The Sponsoring Institution must provide sufficient institutional resources to ensure the effective implementation and support of its programs in compliance with the Institutional, Common, and specialty/subspecialty-specific Program Requirements.

The Sponsoring Institution must ensure that the DIO has sufficient financial support and protected time to effectively carry out his/her educational and administrative responsibilities to the Sponsoring Institution.

The Sponsoring Institution must ensure that program directors have sufficient financial support and protected time to effectively carry out their educational and administrative responsibilities to their respective programs.

The Sponsoring Institution and the program must ensure sufficient salary support and resources (e.g., time, space, technology, supplies) to allow for effective administration of the GME Office and all of its programs.

Faculty and residents must have ready access to adequate communication resources and technological support.

Residents must have ready access to specialty/subspecialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available.

Institutional Requirements 2
Effective: July 1, 2007
The Sponsoring Institution must have a policy that addresses administrative support for GME programs and residents in the event of a disaster or interruption in patient care. This policy should include assistance for continuation of resident assignments.

Institutional Agreements

The Sponsoring Institution retains responsibility for the quality of GME, including when resident education occurs in other sites.

Current master affiliation agreements must be renewed every five years and must exist between the Sponsoring Institution and all of its major participating sites. (See ACGME Glossary for definitions.)

The Sponsoring Institution must assure that each of its programs has established program letters of agreement with its participating sites in compliance with the Common Program Requirements.

Accreditation for Patient Care in Sponsoring and Major Participating Sites that Are Hospitals

Sponsoring Institutions and/or Major Participating Sites that are hospitals should be accredited by The Joint Commission; accredited by another entity with reasonably equivalent standards as determined by the Institutional Review Committee (IRC); or recognized by another entity with reasonably equivalent standards as determined by the IRC.

When a Sponsoring Institution or Major Participating Sites that is a hospital and is not so accredited or recognized, the Sponsoring Institution must provide an explanation satisfactory to the IRC of why neither has been granted or sought.

When a Sponsoring Institution or a Major Participating Sites that is a hospital loses its accreditation or recognition, the Sponsoring Institution must notify and provide a plan of response to the IRC within 30 days of such loss. Based on the particular circumstances, the IRC may request the ACGME to invoke its "egregious or catastrophic" policy.
INSTITUTIONAL RESPONSIBILITIES FOR RESIDENTS

Eligibility and Selection of Residents: The Sponsoring Institution must have written policies and procedures for resident recruitment and appointment and must monitor each program for compliance. These eligibility requirements must address the following:

Resident eligibility: Applicants with one of the following qualifications are eligible for appointment to programs:

1. Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME).
2. Graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA).
3. Graduates of medical schools outside the United States and Canada who meet one of the following qualifications:
   1) Have received a currently valid certificate from the Educational Commission for Foreign Medical Graduates prior to appointment, or,
   2) Have a full and unrestricted license to practice medicine in a US licensing jurisdiction in which they are training.
4. Graduates of medical schools outside the United States who have completed a Fifth Pathway** program provided by an LCME-accredited medical school.

Resident selection

The Sponsoring Institution must ensure that its ACGME-accredited programs select from among eligible applicants on the basis of residency program-related criteria such as their preparedness, ability, aptitude, academic credentials, communication skills, and personal qualities such as motivation and integrity. ACGME-accredited programs must not discriminate with regard to sex, race, age, religion, color, national origin, disability, or any other applicable legally protected status.

Institutional Requirements 4
Effective: July 1, 2007
In selecting from among qualified applicants, it is strongly suggested that the Sponsoring Institution and all of its programs participate in an organized matching program, such as the National Resident Matching Program (NRMP), where such is available.

Financial Support for Residents: Sponsoring and participating sites must provide all residents with appropriate financial support and benefits to ensure that they are able to fulfill the responsibilities of their educational programs.

Benefits and Conditions of Appointment: Candidates for programs (applicants who are invited for an interview) must be informed, in writing or by electronic means, of the terms, conditions, and benefits of their appointment, including financial support; vacations; parental, sick, and other leaves of absence; professional liability, hospitalization, health, disability and other insurance provided for the residents and their families; and the conditions under which the Sponsoring Institution provides call rooms, meals, laundry services, or their equivalents.

Agreement of Appointment

The Sponsoring Institution and program directors must assure that residents are provided with a written agreement of appointment/contract outlining the terms and conditions of their appointment to a program.

The Sponsoring Institution must monitor programs with regard to implementation of terms and conditions of appointment by program directors.

The Sponsoring Institution and program directors must ensure that residents are informed of and adhere to established educational and clinical practices, policies, and procedures in all sites to which residents are assigned.

The resident agreement/contract must contain or provide a reference to at least the following institutional policies:

- Residents' responsibilities;
- Duration of appointment;
- Financial support; and,
- Conditions for reappointment

Institutional Requirements 5
Effective: July 1, 2007
Non-renewal of appointment or non-promotion: In instances where a resident's agreement will not be renewed, or when a resident will not be promoted to the next level of training, the Sponsoring Institution must ensure that its programs provide the resident(s) with a written notice of intent no later than four months prior to the end of the resident's current agreement.

If the primary reason(s) for the non-renewal or non-promotion occurs within the four months prior to the end of the agreement, the Sponsoring Institution must ensure that its programs provide the resident(s) with as much written notice of the intent not to renew or not to promote as circumstances will reasonably allow, prior to the end of the agreement.

Residents must be allowed to implement the institution's grievance procedures if they receive a written notice either of intent not to renew their agreement(s) or of intent to renew their agreement(s) but not to promote them to the next level of training.

Grievance procedures and due process: The Sponsoring Institution must provide residents with fair, reasonable, and readily available written institutional policies and procedures for grievance and due process. These policies and procedures must minimize conflict of interest by adjudicating parties in addressing:

1) Academic or other disciplinary actions taken against residents that could result in dismissal, non-renewal of a resident's agreement, non-promotion of a resident to the next level of training, or other actions that could significantly threaten a resident's intended career development; and,

2) Adjudication of resident complaints and grievances related to the work environment or issues related to the program or faculty.

Professional liability insurance

The Sponsoring Institution must provide residents with professional liability coverage and with a summary of pertinent information regarding this coverage.
(2) Liability coverage must include legal defense and protection against awards from claims reported or filed after the completion of the program(s) if the alleged acts or omissions of the residents are within the scope of the program(s).

Health and disability insurance: The Sponsoring Institution must provide hospital and health insurance benefits for the residents and their families. Coverage for such benefits should begin upon the first recognized day of their respective programs, unless statute or regulation requires a later date to begin coverage. The Sponsoring Institution must also provide access to insurance to all residents for disabilities resulting from activities that are part of the educational program.

Leaves of absence

The Sponsoring Institution must provide written institutional policies on residents’ vacation and other leaves of absence (with or without pay) to include parental and sick leave; these policies must comply with applicable laws.

The Sponsoring Institution must ensure that each program provides its residents with:

2) A written policy in compliance with its Program Requirements concerning the effect of leaves of absence, for any reason, on satisfying the criteria for completion of the residency program, and;

   Information relating to access to eligibility for certification by the relevant certifying board.

Duty Hours: The Sponsoring Institution must have formal written policies and procedures governing resident duty hours. (See Common Program Requirements, VI)

Moonlighting

The Sponsoring Institution must have a written policy that addresses moonlighting. The policy must:
Specify that residents must not be required to engage in moonlighting;

(a) Require a prospective, written statement of permission from the program director that is included in the resident's file; and,

(b) State that the residents' performance will be monitored for the effect of these activities and that adverse effects may lead to withdrawal of permission.

Sponsoring Institutions and program directors must closely monitor all moonlighting activities.

2) Counseling services: The Sponsoring Institution should facilitate residents' access to confidential counseling, medical, and psychological support services.

Physician impairment: The Sponsoring Institution must have written policies that describe how it will address physician impairment, including that due to substance abuse.

Harassment: The Sponsoring Institution must have written policies covering sexual and other forms of harassment.

Accommodation for disabilities: The Sponsoring Institution must have a written policy regarding accommodation, which would apply to residents with disabilities. This policy need not be GME-specific.

Closures and Reductions: The Sponsoring Institution must have a written policy that addresses a reduction in size or closure of a residency program or closure of the Institution. The policy must include the following:

The Sponsoring Institution must inform the GMEC, the DIO, and the residents as soon as possible when it intends to reduce the size of or close one or more programs, or when the Sponsoring Institution intends to close; and,

The Sponsoring Institution must either allow residents already in the program(s) to complete their education or assist the residents in enrolling in an ACGME-accredited program(s) in which they can continue their education.

Institutional Requirements 8
Effective: July 1, 2007
Restrictive Covenants: Neither the Sponsoring Institution nor its programs may require residents to sign a non-competition guarantee.

Resident Participation in Educational and Professional Activities

The Sponsoring Institution must ensure that each program provides effective educational experiences for residents that lead to measurable achievement of educational outcomes in the ACGME competencies as outlined in the Common and specialty/subspecialty-specific Program Requirements.

The Sponsoring Institution must ensure that residents:

- Participate on committees and councils whose actions affect their education and/or patient care; and,
- Participate in an educational program regarding physician impairment, including substance abuse and sleep deprivation.

Resident Educational and Work Environment

The Sponsoring Institution and its programs must provide an educational and work environment in which residents may raise and resolve issues without fear of intimidation or retaliation. Mechanisms to ensure this environment must include:

- An organization or other forum for residents to communicate and exchange information on their educational and work environment, their programs, and other resident issues.
- A process by which individual residents can address concerns in a confidential and protected manner.

The Sponsoring Institution must provide services and develop health care delivery systems to minimize residents' work that is extraneous to their GME programs' educational goals and objectives. These services and systems must include:

- Patient support services: Peripheral intravenous access placement, phlebotomy, and laboratory and transporter services must be provided in a manner appropriate to and consistent with educational objectives and quality patient care.
Laboratory/pathology/radiology services: Laboratory, pathology, and radiology services must be in place to support timely and quality patient care.

Medical records: A medical records system that documents the course of each patient's illness and care must be available at all times and must be adequate to support quality patient care, residents' education, quality assurance activities, and provide a resource for scholarly activity.

The Sponsoring Institution must ensure a healthy and safe work environment that provides for:

Food services: Residents must have access to appropriate food services 24 hours a day while on duty in all institutions.

Call rooms: Residents on call must be provided with adequate and appropriate sleeping quarters that are safe, quiet, and private.

Security/safety: Appropriate security and personal safety measures must be provided to residents at all locations including but not limited to:

- parking facilities, on-call quarters, hospital and institutional grounds, and related facilities.

GRADUATE MEDICAL EDUCATION COMMITTEE (GMEC)

A. GMEC Composition and Meetings

The Sponsoring Institution must have a GMEC.

Voting membership on the committee must include the DIO, residents nominated by their peers, representative program directors, and administrators. It may also include other members of the faculty or other members as determined.

The GMEC must meet at least quarterly and maintain written minutes.

GMEC Responsibilities: The GMEC must establish and implement policies and procedures regarding the quality of education and the work environment for the residents in all programs. These policies and procedures must include:
1. Stipends and position allocation: Annual review and recommendations to the Sponsoring Institution regarding resident stipends, benefits, and funding for resident positions.

Communication with program directors: The GMEC must:

- Ensure that communication mechanisms exist between the GMEC and all program directors within the institution.
- Ensure that program directors maintain effective communication mechanisms with the site directors at each participating site for their respective programs to maintain proper oversight at all clinical sites.

2. Resident duty hours: The GMEC must:

- Develop and implement written policies and procedures regarding resident duty hours to ensure compliance with the Institutional, Common, and specialty/subspecialty-specific Program Requirements.
- Consider for approval requests from program directors prior to submission to an RRC for exceptions in the weekly limit on duty hours up to 10 percent or up to a maximum of 88 hours in compliance with ACGME Policies and Procedures for duty hour exceptions.

3. Resident supervision: Monitor programs’ supervision of residents and ensure that supervision is consistent with:

- Provision of safe and effective patient care;
- Educational needs of residents;
- Progressive responsibility appropriate to residents’ level of education, competence, and experience; and,
- Other applicable Common and specialty/subspecialty-specific Program Requirements.

Communication with Medical Staff: Communication between leadership of the medical staff regarding the safety and quality of patient care that includes:

a) The annual report to the OMS;
Description of resident participation in patient safety and quality of care education; and,

The accreditation status of programs and any citations regarding patient care issues

Curriculum and evaluation: Assurance that each program provides a curriculum and an evaluation system that enables residents to demonstrate achievement of the ACGME general competencies as defined in the Common and specialty/subspecialty-specific Program Requirements.

Resident status: Selection, evaluation, promotion, transfer, discipline, and/or dismissal of residents in compliance with the Institutional and Common Program Requirements.

Oversight of program accreditation: Review of all ACGME program accreditation letters of notification and monitoring of action plans for correction of citations and areas of noncompliance.

Management of institutional accreditation: Review of the Sponsoring Institution's ACGME letter of notification from the IRC and monitoring of action plans for correction of citations and areas of noncompliance.

Oversight of program changes: Review of the following for approval, prior to submission to the ACGME by program directors:

- All applications for ACGME accreditation of new programs;
- Changes in resident complement;
- Major changes in program structure or length of training;
- Additions and deletions of participating sites;
- Appointments of new program directors;
- Progress reports requested by any Review Committee;
- Responses to all proposed adverse actions;
- Requests for exceptions of resident duty hours;
- Voluntary withdrawal of program accreditation;

Institutional Requirements 12
Effective: July 1, 2007
Requests for an appeal of an adverse action; and,

j) Appeal presentations to a Board of Appeal or the ACGME.

1. Experimentation and innovation: Oversight of all phases of educational experiments and innovations that may deviate from Institutional, Common, and specialty/subspecialty-specific Program Requirements, including:

   Approval prior to submission to the ACGME and/or respective Review Committee;

   Adherence to Procedures for "Approving Proposals for Experimentation or Innovative Projects" in ACGME Policies and Procedures; and,

   Monitoring quality of education provided to residents for the duration of such a project.

2. Oversight of reductions and closures: Oversight of all processes related to reductions and/or closures of:

   a) Individual programs;

   b) Major participating sites; and,

   c) The Sponsoring Institution.

3. Vendor interactions: Provision of a statement or institutional policy (not necessarily GME-specific) that addresses interactions between vendor representatives/corporations and residents/GME programs.

INTERNAL REVIEW

A. Process

   The GMEC must develop, implement, and oversee an internal review process as follows:

   An internal review committee(s) for each program must include at least one faculty member and at least one resident from within the Sponsoring Institution but not from within GME programs being reviewed. Additional internal or external reviewers may be included on the internal review committee as determined by the GMEC. Administrators from outside the program may also be included.
A written protocol approved by the GMEC that incorporates, at a
minimum, the requirements in this Section IV of the Institutional
Requirements.

Internal reviews must be in process and documented in the GMEC minutes
by approximately the midpoint of the accreditation cycle. The accreditation cycle
is calculated from the date of the meeting at which the final accreditation action
was taken to the time of the next site visit. (See ACGME Policies and
Procedures, II.B.4)

When a program has no residents enrolled at the mid-point of the review
cycle, the following circumstances apply:

The GMEC must demonstrate continued oversight of those programs
through a modified internal review that ensures the program has
maintained adequate faculty and staff resources, clinical volume, and
other necessary curricular elements required to be in substantial
compliance with the Institutional, Common and specialty-specific
Program Requirements prior to the program enrolling a resident.

After enrolling a resident, an internal review must be completed within
the second six-month period of the resident's first year in the program.

The internal review should assess each program's:

- Compliance with the Common, specialty/subspecialty- specific
  Program, and Institutional Requirements;
- Educational objectives and effectiveness in meeting those objectives;
- Educational and financial resources;
- Effectiveness in addressing areas of non-compliance and concerns in
  previous ACGME accreditation letters of notification and previous internal
  reviews;
- Effectiveness of educational outcomes in the ACGME general
  competencies;
- Effectiveness in using evaluation tools and outcome measures to
  assess a resident's level of competence in each of the ACGME general
  competencies; and,
Annual program improvement efforts in:

g) Resident performance using aggregated resident data;

1) Faculty development;

2) Graduate performance including performance of program graduates on the certification examination; and,

3) Program quality. (see Common Program Requirements, V.C.)

Materials and data to be used in the review process must include:

The ACGME Common, specialty/subspecialty-specific program, and Institutional Requirements in effect at the time of the review;

Accreditation letters of notification from previous ACGME reviews and progress reports sent to the respective RRC;

Reports from previous internal reviews of the program;

Previous annual program evaluations; and,

Results from internal or external resident surveys, if available.

The internal review committee must conduct interviews with the program director, key faculty members, at least one peer-selected resident from each level of training in the program, and other individuals deemed appropriate by the committee.

Internal Review Report

The written report of the internal review for each program must contain, at a minimum:

The name of the program reviewed;

The date of the assigned midpoint and the status of the GMEC's oversight of the internal review at that midpoint;
The names and titles of the internal review committee members;

A brief description of how the internal review process was conducted, including the list of the groups/individuals interviewed and the documents reviewed;

Sufficient documentation to demonstrate that a comprehensive review followed the GMEC's internal review protocol;

A list of the citations and areas of non-compliance or any concerns or comments from the previous ACGME accreditation letter of notification with a summary of how the program and/or institution subsequently addressed each item.

The DIO and the GMEC must monitor the response by the program to actions recommended by the GMEC in the internal review process.

The Sponsoring Institution must submit the most recent internal review report for each training program as a part of the Institutional Review Document (IRD). If the institutional site visitor simultaneously conducts individual program reviews at the same time as the institutional review, the internal review reports for those programs must not be shared with the site visitor.

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Footnote for I.A.2

* Further use in this document of the term "program(s)" will refer to "ACGME-accredited program(s)."

Footnote for II.A.1.d

A Fifth Pathway program is an academic year of supervised clinical education provided by an LCME-accredited medical school to students who meet the following conditions: (1) have completed, in an accredited college or university in the United States, undergraduate premedical education of the quality acceptable for matriculation in an accredited United States medical school; (2) have studied at a medical school outside the United States and Canada but listed in the World Health Organization Directory of Medical Schools; (3) have completed all of the formal requirements of the foreign medical school except internship and/or social service; (4) have attained a score satisfactory to the sponsoring medical school on a screening examination; and (5) have passed either the Foreign Medical Graduate Examination in the Medical Sciences, Parts I and II of the examination of the National Board of Medical Examiners, or Steps 1 and 2 of the United States Medical Licensing Examination (USMLE).
NYU Langone Medical Center
Clinical Quality and Safety for NYU Hospitals Center

Information for House Staff

Assuring that our patients receive the highest quality, safest care possible is central to the mission of the NYU Langone Medical Center and its clinical care venues: Tisch Hospital, Rusk Institute, and Hospital for Joint Diseases. The NYUHC 2009 quality and safety goals are:

- **Minimize the risk of hospital-acquired infections.**
  - Central line-associated bloodstream infections.
  - Infections associated with invasive/surgical procedures.
  - Clostridium difficile-associated disease.
  - Achieve excellent compliance with hand hygiene and contact precautions guidelines by all staff.

- **Achieve and maintain excellent performance on all nationally-reported quality performance measures:**
  - Medicine: heart attack, heart failure, pneumonia.
  - Surgery: prevent infectious, thromboembolic, and cardiac complications.

- **Foster communication among caregivers and patients:**
  - Understand and respect patients’ care preferences.
  - Medication reconciliation.
  - Procedure verification.
  - Team training.

Unit-based, service-based, and organization-wide teams are organized to achieve these goals. We welcome housestaff involvement on any and all improvement teams. Some teams that housestaff might be interested to participate, where your input may be particularly helpful:

- Development of standard documentation for a variety of clinical situations: admission, progress notes, discharge summaries, etc. This is an opportunity to leverage our electronic medical record to support clinical quality and safety.
- Central line-associated bloodstream infection prevention.
- Prevention of wound infection. This is an opportunity for physicians to develop intra- and inter-department consensus guidelines.
- Medical Response Team (MRT) oversight.
- Oversight for specialized response teams: surgical airway team, pediatric response team, obstetrics response team, STEMI acute reperfusion team, stroke team, acute pulmonary embolus team.
- National measures improvement oversight team. There is opportunity to participate for both medicine and surgery physicians.
- Skin care team, to prevent hospital-acquired pressure ulcers.
Progress toward goals is tracked by centralized quality performance measurement that is posted on the NYUHC intranet: http://intranet1.nyumc.org/nyu/include.jsp?nav=ps&url=/patient_safety/index.html.

All clinical quality and safety activities are overseen by the Department of Clinical Quality and Effectiveness and the Office of Patient Safety. We welcome your ideas, involvement, feedback, questions, and suggestions.

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<tr>
<th>Martha Radford, MD</th>
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<tr>
<td>Chief Quality Officer</td>
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<td><a href="mailto:Martha.radford@nyumc.org">Martha.radford@nyumc.org</a></td>
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<td>Senior Nurse Analyst</td>
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<td>Project Manager</td>
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<td>Quality Improvement Proj. Mgr.</td>
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<td>Samantha Lincoln</td>
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<td>Christina Sillery</td>
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Greenberg Hall, 545 First Avenue, SC-1-47
212-263-8199
The Office of Compliance, Privacy & Internal Audit

The Office of Compliance, Privacy & Internal Audit was established to support the Medical Center's commitment to the highest standards of conduct, honesty and reliability in our business practices. Compliance is all about doing the right things for the right reasons. The Office of Compliance, Privacy & Internal Audit is here to help the organization uphold our continued commitment to making proper and ethical decisions.

The Compliance Program applies to the entire Medical Center, the Hospital, the School of Medicine, all trustees, employees, medical staff, faculty members, volunteers and students. It includes detailed standards of conduct, training and education programs, monitoring systems, sanctions for noncompliance and a compliance helpline for reporting concerns regarding potential ethical or legal issues. Here are the major compliance risk areas:

- Federal and State False Claims Act and Whistleblower Protection
- The Referral Statutes: The Physician Self-Referral Law (Stark Law) and Federal Anti-Kickback Statute
- Payments to Reduce or Limit Services
- Emergency Medical Treatment and Labor Act (EMTALA)
- Substandard Care
- Relationship with Federal Health Care Beneficiaries
- HIPAA Privacy and Security Rules
- Billing Medicare or Medicaid Substantially in Excess of Usual Charge

To read more about these laws and the Medical Center's policies relating to them, please visit the Compliance website.

Our Compliance Program requires the commitment of everyone at the Medical Center--the Boards of Trustees, each department, and every employee and staff member. Program success is everyone's responsibility. Program oversight, leadership, and guidance are obtained through the support of several Compliance Committees, including the Audit & Compliance Committee of the Boards of Trustees and several Compliance Oversight Committees and Operational Compliance Committees.

The Medical Center has promulgated standards of conduct, embodied in the NYULMC Code of Conduct. The Code requires all individuals associated with the Medical Center to conduct the Medical Center's business in accordance with federal, state, and local laws;
professional standards; applicable federally funded health care program regulations and policies; and with honesty, fairness, and integrity. Employees should perform their duties in good faith, in a manner that they reasonably believe to be in the best interest of the Medical Center and its patients and with the same care that a reasonably prudent person in the same position would use under similar circumstances.

Nancy Dean is the designated Compliance Officer for the Medical Center. She is the Vice President of the Office of Compliance, Privacy & Internal Audit. She is also the Medical Center’s HIPAA Privacy Officer. Nancy reports to senior leadership, the Boards of Trustees and the Compliance Oversight Committees. She is responsible for the daily monitoring and implementation of our Compliance Plan. As Privacy Officer, Nancy is also responsible for the development, implementation and monitoring of the Medical Center’s HIPAA compliance initiatives. If you have any compliance or HIPAA questions or concerns, you can call Nancy and her staff directly. For contact information, please visit the Compliance website. An organizational chart for the Office of Compliance, Privacy & Internal Audit is included in your materials.

Resolving Compliance and Privacy Issues: Compliance & HIPAA Helplines

http://compliance.med.nyu.edu/node/474The Medical Center culture promotes conduct that conforms to Federal and State laws as well as to our own ethical and business policies. A significant focus of our Compliance Program is to help prevent inappropriate conduct. If you suspect or detect an exception to our desired conduct that cannot be reasonably resolved through established procedures, then it is your responsibility to let us know about it. Call the Medical Center Compliance Helpline. You may remain anonymous. 1-866-NYU-1212 (Toll Free, Multilingual 24 Hours a Day-7 Days a Week).

Examples of Helpline calls include, but are not limited to: employees with lapsed licenses, false documentation on reports to government agencies, fictitious vendors, mistakes in coding, scientific misconduct, and offers of items of value in exchange for referrals. These are only a few examples of compliance issues. If you are unsure whether there is a violation, report it!

http://compliance.med.nyu.edu/node/520If you discover a breach of protected health information (PHI), regardless of who was responsible for the breach, you must report the breach within 24 hours of the event to 1-877- PHI-LOSS or to the Privacy Office, at 212-404-4079, during normal business hours. The HIPAA Helpline is available 24 hours a day, 7 days a week.

You cannot be fired for reporting a breach of PHI or for reporting a HIPAA concern. After you make a report, the Privacy Office will work with you to investigate the breach and handle patient notification as required. You should not contact any patients that may have been affected by the possible breach. If patient notification is required, the Privacy Office will make the notice in order to ensure full compliance with all regulatory requirements.

Examples of electronic breaches that must be reported include a lost or stolen laptop, PDA, or flash drive that is used to store PHI. Examples of paper breaches that must be reported include faxing PHI to an incorrect number or person, mailing PHI to the wrong address or person, or failing to shred paper medical records or patient billing
records prior to disposal. Breaches that happen by word of mouth include releasing PHI over the telephone or in person to an unauthorized individual. These are only a few examples of possible breaches of PHI. If you are unsure whether a breach has occurred, report it! For more information about HIPAA compliance, please visit the Compliance website.

Compliance and Privacy Badge Buddies
The badge buddy (pictured) features the Compliance Helpline on one side and the HIPAA Helpline on the other. It is an easy and convenient tool. As long as you have your badge, you will also have these important phone numbers with you at all times. You should have received your badge buddy during Orientation. If you did not, please click here to request one.

Physician Compliance
The focus of the School of Medicine and Faculty Group Practice Compliance Office is to provide physicians and administrative staff with compliance oversight and support with respect to physician billing practices. The goal is to eliminate any coding and billing errors in order to reduce the risk of any possible allegation of fraud, to create more accurate accounts receivable, and to identify systems that can be added or changed to improve physician billing practices.

Accurate and thorough medical record documentation is the key to physician billing compliance and facilitates:

- Communication and continuity of care among physicians and others involved in the patient's care
- Accurate and timely claims review and payment
- Appropriate utilization review and quality of care evaluations
- Collection of data that may be used for research and education
7 Principles of Accurate Documentation

These 7 principles of accurate documentation are applicable to all types of medical and surgical services in all settings. For Evaluation and Management (E/M) services, the nature and amount of a physician’s work and documentation in a medical record varies by the type of service, the place of service and the patient's status.

1. The medical record should be complete and legible.
2. The documentation of each patient encounter should include:
   - reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;
   - assessment, clinical impression or diagnosis;
   - plan for care; and
   - date and legible identity of the observer.
3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
4. Past and present diagnoses should be accessible to the treating and/or consulting physician.
5. Appropriate health risk factors should be identified.
6. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.
7. The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

In order to maintain an accurate medical record, services should be documented during the encounter or as soon as practicable after the encounter. For more information, go to the Evaluation and Management Services Guide published by the Centers for Medicare & Medicaid Services (CMS).

A Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse assists physicians in understanding how to comply with applicable Federal laws by identifying "red flags" that could lead to potential liability in law enforcement and administrative actions. The information is organized around three types of relationships that physicians frequently encounter in their careers: relationships with payers, fellow physicians and other providers and with vendors.

Guidelines for Teaching Physicians, Interns, and Residents provides teaching physicians, interns, and residents information about the payment for physician services in teaching settings.

Research Compliance

The Office of Research Compliance (ORC) helps ensure that the Medical Center community is in compliance with the complex array of regulatory requirements that govern research. The ORC collaborates with departments under the Office of Science & Research to create an integrated research compliance program. In a continued effort to be proactive, the ORC also provides training and information on new research-related regulations.
Research compliance involves a many different areas but some areas are particularly vulnerable to risk either because of complex regulations or volume. Here are some of the more common risks in research compliance

GRANTS: conflicts of interest, time & effort reporting, cost transfers, cost sharing, NIH salary cap, direct costs, and F&A rate.

HUMAN SUBJECT PROTECTIONS: definition of research, PHI, informed consent process, vulnerable populations, risk/benefits analysis, adverse event reporting, and Good Clinical Practice.

ANIMAL PROTECTIONS: pain categories, USDA covered species, hazardous materials, and survival surgery.

LAB SAFETY: select agents, MSDAs, shipping & receiving biologics, infectious agents, recombinant DNA, and radio-isotopes.

RESPONSIBLE CONDUCT OF RESEARCH: scientific misconduct, authorship guidelines, plagiarism, fabrication and falsification.

Research Resources

Office of Science and Research
Office of Research Compliance
Sponsored Program Administration
212-263-8822

Office of Clinical Trials
212-263-4210

Institutional Review Board
212-263-4110

Institutional Animal Care and Use Committee
212-263-8441

Office of Industrial Liaison
212-263-8178

Division of Laboratory Animal Resources
212-263-5308
**Compliance Training & Education Requirements**

You are required to do initial compliance education during your credentialing process as a Level 2 requirement, but your compliance training obligations do not end there. Periodically, the Office of Compliance, Privacy & Internal Audit requires the medical Center community, including house staff, to participate in training as mandated by law and/or as required to allow you to carry out your responsibilities in compliance with the law. Continuing training and education of faculty and staff at all levels is a significant element of our Compliance Program.

When new courses are available, you will receive a broadcast email with the course requirements and log in instructions. There is a “Connect to Training” button in the right navigation bar on every page of the Compliance Website.

You can visit the Compliance website periodically to check for updates to the Compliance Curriculum.

You will be able to print a certificate of completion at the conclusion of your course work. It is important for you to retain a copy of your certificate(s) for your records so that you can establish your own compliance with the law when you wish to pursue opportunities at other medical institutions. You can always return to the learning tool at anytime to reprint your own certificate in the event you misplace your original.

**Compliance Contacts**

**Office of Compliance Privacy & Internal Audit**  
212-404-4078

[compliance.med.nyu.edu](mailto:compliance.med.nyu.edu)

**Compliance Helpline**  
1-866-NYU-1212

**HIPAA Helpline**  
1-877-PHI-LOSS

[Compliance.help@nyumc.org](mailto:Compliance.help@nyumc.org)
NYU Medical Center, which includes both NYU School of Medicine and NYU Hospitals Center, places a high priority on maintaining the confidentiality of its records, documents, agreements, and all other sensitive information.

In the course of your duties, you may be given access to confidential information about patients (including people who choose to participate in our research), employees, students, other individuals, or the institution itself. The institution's confidential information includes policies, business practices, financial information, and technology such as ideas and inventions (whether this information belongs to NYU Medical Center or was shared with us in confidence by a third party).

By signing this statement, you acknowledge that your access to confidential information is for the purpose of performing your responsibilities within this institution, and for no other purpose.

1. I will look at and use only the information I need to care for my patients or do my job. I will not look at patient records or seek other confidential information that I do not need to perform my job. I understand that my institution has the ability to determine whether I have followed this rule.

2. I understand that patient information or any other confidential information is not to be shared with anyone who does not have an official need to know. I will be especially careful not to share this information with others in casual conversation.

3. I will handle all records—both paper and electronic— with care to prevent unauthorized use or disclosure of confidential information. I understand that I am not permitted to remove confidential information from my work area. I also understand that I may not copy medical records or remove them from the patient floors or the Medical Records Department.

4. Because electronic messages may be intercepted by other people, I will not use
email to send individually identifiable health information outside NYUMC unless it is sent via an approved secure system. I understand that use of email to transmit such information within the NYUMC secure network is permitted.

5. If I no longer need confidential information, I will dispose of it in a way that ensures that others will not see it. I recognize that the appropriate disposal method will depend upon the type of information in question (i.e., paper versus electronic).

6. If I am involved in research, any research utilizing identifiable patient information will be performed in accordance with Federal and State regulations and local Institutional Review Board (IRB) policies.

7. If my responsibilities include sharing my institution’s confidential information with outside parties such as ambulance drivers, home care providers, insurance companies, or research sponsors, I will use only processes and procedures approved by my institution.

8. Any passwords, verification codes, or electronic signature codes assigned to me are equivalent to my personal signature:
   - They are intended for my use only.
   - I will not share them with anyone or let anyone else use them.
   - I will not attempt to learn or use the passwords, verification codes, or electronic signature codes of others.

9. If I find that someone else has been using my passwords or codes, or if I learn that someone else is using passwords or codes improperly, I will immediately notify my manager or the Compliance Officer at my institution. I understand that if I allow another person to use my codes, I will be held accountable.

10. I will not abuse my rights to use my institution’s computers, information systems, Intranet, and the Internet. They are intended to be used specifically in performing my assigned job responsibilities.

11. I will not attempt to bypass security software (i.e., anti-virus software) or intentionally cause a security incident on NYUMC workstations, applications, or accounts.

12. I will not copy or download software that is not approved by my institution.

13. I will handle all confidential information stored on a computer or downloaded to diskettes or CDs with care to prevent unauthorized access to, disclosure of, or loss of this information.

14. I understand that the confidential information and software I use for my job are not to be used for personal benefit or to benefit another unauthorized institution. I also understand that my institution may inspect the computers it owns, as well as personal PCs used for work, to ensure that its data and software are used according to its policies and procedures.
Joint Commission Survey Readiness:

What House Staff Need to Know

The Joint Commission is an independent, not-for-profit organization, which evaluates and accredits more than 16,000 health care organizations in the United States. The mission of TJC is to continuously improve the safety and quality of health care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations.

To earn and maintain accreditation, an organization must undergo an unannounced on-site survey by a TJC survey team at least every three years. Surveyors look at policies, records, tour facilities extensively, and query employees to determine if they have been properly trained. While an accreditation period may be up to 36 months, an accreditation survey visit may occur as early as 19 months in the continuum. All surveys by The Joint Commission are unannounced. These include the triennial survey, validation surveys or surveys “for cause”. The current survey window for the NYU Hospitals Center is May 21, 2011 through November 30, 2012.

Joint Commission Standards

House staff are expected to be familiar with the requirements of The Joint Commission and to demonstrate compliance with Hospital policies and procedures focused on meeting the intent of the standards. In order to assist you in becoming familiar with key components, a brief summary is presented below. It is also suggested that you periodically review information about regulatory requirements which is available through various publications and communications across the Hospitals. There are more than 1,700 Joint Commission elements of performance with which the hospital must comply. The Joint Commission standards may be found on the Link under Hospital Administration – Regulatory Compliance–Joint Commission (http://nyumc.net/nyu/include.jsp?nav=es&url=/env_services/jcaho/jcaho.html).

For your learning convenience, the following is a summary of some key hospital policies that are critical to compliance with the Joint Commission and other regulatory agencies.

Medication Reconciliation – the physician or nurse practitioner must complete and document medication reconciliation on admission, discharge, and whenever a patient is transferred to a different level of care or different provider. The prescriber must indicate which medications are to be continued or discontinued. The list of medications includes herbals and vitamins. This reconciliation is to be performed for every medication. In the inpatient setting, the reconciliation is documented in ICIS. As we are in transition our electronic health record during 2011-2012, the medication reconciliation module for ambulatory patients may be found in ICIS, EPIC or on paper, dependent on the clinical area.

Documentation

- Do not use abbreviations – The Joint Commission prohibits the use of certain dangerous abbreviations. A list of the Do Not Use abbreviations can be found in every patient chart in the History and Physical Section. These abbreviations, if confused, can result in serious medication errors.
### Improve the Effectiveness of Communication

**"Do Not Use" Abbreviations**

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<th>USE</th>
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<tr>
<td>Q.D./Q.O.D.</td>
<td>Write “daily”/“every other day”</td>
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<tr>
<td>.5mg</td>
<td>Use a “Leading Zero” 0.5mg</td>
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<tr>
<td>MgSO₄</td>
<td>Write “Magnesium Sulfate”</td>
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<tr>
<td>1.0mg</td>
<td>Omit a “Trailing Zero” 1mg</td>
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<tr>
<td>U/IU</td>
<td>Write “Unit”/“International Unit”</td>
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<tr>
<td>MSO₄/MS</td>
<td>Write “Morphine Sulfate”</td>
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**NYU Langone Medical Center**

- **Error Correction** – in the event you enter incorrect or inaccurate information in a patient’s medical record, there is a prescribed format for making a correction. If you have electronically documented in ICIS, please use the “correction pathway”. If you are using a paper record, you are required to draw a single line through the incorrect entry, date, time and write error. Then enter the correct information.
- **Telephone orders** – Telephone orders are discouraged. Residents are asked to log into ICIS and enter the order. If off site, residents can log in through OnSite Health. In the event a telephone order is issued, the written order must be countersigned within 24 hours. **When issuing a** telephone order, the prescriber must wait for the person taking the order to write it down and **read it back** (no face to face verbal orders may be given except in an emergency).
- **History and Physicals** – A complete history and physical must be signed within 24 hours of admission. If the history and physical has been completed by a resident, the attending physician must countersign within 24 hours of admission.
- **Authentication** - **All** entries in the medical record must be signed, dated and timed.
- **Legibility** - All documentation in the medical record must be legible.
- **Coordination of care** - Daily progress notes by the resident and by the attending physicians should reflect knowledge of clinical observations and treatment plan previously documented by residents, physician assistants, and nurse practitioners.
- **Consultations** – in addition to calling the physician or service to request a consultation, a Consult Order must be entered into ICIS.
- **Supervision** - Resident supervision must be clearly documented by the attending or the resident in the progress notes. A supportive note /countersignature by the attending is necessary to document supervision.

- **Post op notes** - A brief post op note must be entered in the chart immediately after surgery and the operative report must be dictated within 24 hours.

**Patient Rights**
- All employees and medical staff must be cognizant of patient privacy issues. Bed curtains should be used in patient rooms and patient information should not be discussed in public places.

- Informed consent must be obtained for all invasive procedures and must include documentation of the risks, benefits, and alternatives. Consents must be signed, dated, timed and witnessed.

- Patient’s have a right to know who is caring for them. It is expected that you will wear your I.D. badge above your waist and make certain that your name is showing.

**Restraints and Seclusion**
- The avoidance of restraints and/or seclusion is encouraged.
- Physicians must write orders for every episode of restraints and renew every 24 hours on the general nursing units and every four hours on the psychiatric unit (for patients 18 and over). On the psychiatric unit, orders are limited to 2 hours for patients ages 9-17 and 1 hour for children under 9.

- In the acute care setting, the LIP must be notified within 12 hours of the initiation of restraints. A written order, based on the examination of a patient by an LIP, must be entered into the patient’s record within 24 hours. In psychiatry, the patient must be evaluated face to face within one hour of initiation of restraints.

- Physicians must document the rationale for the use of restraints, type of restraint and the specific time period for their use.

**Patient Safety**
- It is important that residents know the Joint Commission National Patient Safety Goals. These goals are important to the safe care of patients and will also be discussed with you during a survey.

**2011 National Patient Safety Goals**
- No new goals for 2011
- All requirements for Goal 8 are not in effect at this time: medication reconciliation

**Goal 1- 01.01.01**
Improve accuracy of patient identification
✓ two patient identifiers: Name & DOB

Goal 2- 02.03.01
Improve effectiveness of communication

Goal 3-03.04.01
Improve the safety of using medications
✓ verify all medications or solutions both verbally & visually

  done by two qualified individuals
✓ all medications & solutions, both on & off the sterile field are

  reviewed by entering & exiting staff

Goal 3- 03.05.01
Reduce the likelihood of harm associated with the use of anticoagulant therapy

Approved protocols for initiation & maintenance of anticoagulation therapy
✓ provide education to prescribers, staff, patients and families

✓ the importance of follow up monitoring compliance

  drug-food interactions
  potential for adverse drug reactions & interactions

Goal 3- 03.06.01 (Old Goal #8- Medication reconciliation)
Maintain & communicate accurate patient medication information
✓ Medications patient currently is taking on admission or in outpatient setting
  Scheduled times and as needed basis
✓ Define medication information collected in non-24hour settings

  ED, Outpatient Radiology, Ambulatory surgery, Diagnostic settings
✓ Compare medication information brought to hospital with those ordered
  Discrepancies reviewed by qualified individual
✓ Provide patient with written information on discharge or end of outpatient encounters
  Name, dose, route, frequency
✓ Explain managing medications to patient on discharge or at end of encounter

  When medications are discontinued, dose changes or new medication

Goal 7- 07.01.01
Reduce the risk of healthcare-associated infections (HAIs)
✓ Hand Hygiene

Goal 7- 07.03.01
Prevent HAI due to multidrug resistant organisms
✓ staff education on hire an annually on prevention strategies
✓ educate patient & families
✓ implement policies & procedures aimed at reducing risk of transmitting (MDROs)

Goal 7- 07.04.01
Implement evidence-based practices to prevent central line-associated bloodstream infections
✓ provide education to LIPs & staff who are involved in managing central lines about central-line-associated bloodstream infections
✓ educate patients & families about central-line-associated bloodstream infection prevention
✓ implement policies & procedures aimed at reducing risk of central-line-associated bloodstream infections
✓ use catheter checklist for central venous catheter insertion
✓ perform hand hygiene prior to insertion & manipulation
✓ do not use femoral vein unless other sites are unavailable
✓ standardized supply cart
✓ standardized protocol for sterile barrier precautions
✓ use antiseptic for skin preparation
✓ use standard protocol to disinfect catheter hubs
✓ evaluate central venous catheters routinely

Goal 7- 07.05.01
Implement evidence-based practices to prevent surgical site infections
✓ educate to LIPs & staff who are involved in surgical procedures about surgical site infections
✓ educate patients & families having surgical procedures about surgical site infections
✓ implement policies & procedures aimed at reducing surgical site infections
✓ administer antimicrobial agents prophylaxis for a particular procedure or disease
✓ hair removal method cited in literature

Goal 15 – 15.01.01.01
The hospital identifies safety risks inherent in its patient population
✓ conduct a risk assessment that identifies characteristics & environment features that may increase or decrease risks
✓ address patient’s immediate safety needs
✓ when patient leaves the hospital, provide suicide prevention information

Universal Protocol
Prevent wrong-person, wrong-site, and wrong-procedure surgery
UP 01.01.01
Conduct a preprocedure verification process
UP 01.02.01
Mark the site
✓ identify procedures that require site marking
✓ mark the site prior to procedure
✓ procedure is mark by LIP accountable for procedure

UP 01.03.01
Time-out is performed before the procedure

✓ document the time out
Survey Process

When the Joint Commission surveys a hospital they use an approach that is referred to as the tracer methodology. The surveyors selects a patient record and then "trace" the patient's care throughout the organization. For example, they may start on an inpatient unit by reviewing a medical record discussing the care with the nurse who is taking care of the patient. Then they proceed to visit all of the areas that the patient encountered during their stay (e.g. operating rooms, radiology, etc.). The surveyor may also review the credentialing file of the physician in charge of the patient's care or the employee files of staff they speak with during the tracer. Any areas of concern are noted and further reviewed. It is imperative that you can: (1) clearly discuss the care of patients covered by your team; (2) know who you would contact if you had a patient care concern; (3) understand the scope of what you are permitted to do under both direct and indirect supervision; and (4) how you would respond to an emergency situation whether it be a patient related or facility issue.
HIM/Medical Records

Health Information Management Department (Medical Records) of Tisch Hospital and Rusk Institute of Rehabilitation Medicine

A. Gabriela Grygus, MBA, RHIA, Senior Director of Health Information Management

B. Department Contact Information:

<table>
<thead>
<tr>
<th>Name/Service</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gabriela Grygus, Senior Director of HIM</td>
<td>(212) 263-5495</td>
</tr>
<tr>
<td>Nina Gore, Assistant Director of Operations, HIM</td>
<td>(212) 263-5881</td>
</tr>
<tr>
<td>Chart Completion Area</td>
<td>(212) 263-0252, X 74301</td>
</tr>
<tr>
<td>Dictation Numbers/Status/Assistance</td>
<td>(212) 263-5493</td>
</tr>
<tr>
<td>Main Number (Chart Requests &amp; Death Certificates)</td>
<td>(212) 263-5497</td>
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<td>X 32201</td>
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<td>House staff dictation ID is 1111</td>
<td></td>
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<tr>
<td><em>(Name of the Attending must be dictated)</em></td>
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<tr>
<td>Dictaphone dictation phone number</td>
<td>(877) 424-2781</td>
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<tr>
<td><em>(when dictate from offsite)</em></td>
<td>Site ID 294</td>
</tr>
<tr>
<td>Dictation Work types</td>
<td>10- Operative Report</td>
</tr>
<tr>
<td></td>
<td>11- Discharge Summary</td>
</tr>
</tbody>
</table>

 ► Medical Record Documentation Requirements at NYULMC

Please note: Only Attending physicians are assigned to complete deficiencies.

- Medical Records must be completed as soon as possible after discharge.
- All entries must be dated, timed and signed.
- History & Physical examination must be performed within 24 hours of admission. If the H&P is not performed by Admitting Attending, the H&P documentation must be reviewed and co-
signed, dated and timed by Admitting Attending within 24 hours of admission but prior to any procedure. If History & Physical examination performed 1 to 30 days prior to admission/arrival the H&P documentation must be reviewed, an examination to update any changes in the patient’s health status must be performed, and any additions or changes documented, dated and signed within 24 hours of admission but prior to any procedure.

- Verbal orders must be signed within 24 hours.
- All pre-operative diagnoses are recorded before surgery/procedure.
- A brief operative note must be entered in ICIS immediately following surgery/procedure.
- An operative report is to be dictated immediately following surgery/procedure.
- A discharge summary may be entered in ICIS at the time of discharge for all inpatients or dictated in Dictaphone.
Malpractice Statistics
Medical errors kill between 44,000 and 98,000 people a year. More than the number of people who die on the road (43,450), from breast cancer (42,300), or from AIDS (16,500).

Legal Definition
Medical malpractice is the handling of a case by a physician, surgeon, or other professional in a manner that fails to meet the standards of conduct for duties relating to the medical profession and results in an injury to the patient. These standards are based on what a reasonable person with requisite knowledge and skills would or would not do. Keep in mind that a bad result from a treatment or procedure does not automatically mean bad medicine. Example: a heart surgeon may do everything right during surgery and still lose the patient during surgery.

In a medical malpractice action, in order for the plaintiff to prevail, the plaintiff’s attorney must prove the following:

1. There is a standard of care in the community which applied to the physician’s conduct
2. The physician departed from this standard of care
3. The departure directly injured the patient

Once a doctor enters into a physician-patient relationship, he or she has a duty to provide care at a level that compares to what other competent doctors would have provided in the same situation.
Steps Leading to a Malpractice Action

1. The patient meets with a plaintiff’s attorney to discuss the care in question. A determination is then made as to whether the filing of an action at this time would be within the statute of limitations which is 2 ½ years from the act or omission complained of or from the end of a continuous treatment during which this act or omission took place. The exceptions to this time period are:
   a. within 1 year from the date upon which the foreign object was discovered or should reasonably have been discovered.
   b. Infants: 10 years
   c. Wrongful Death: 2 years from the date of death

2. The patient signs an authorization for the release of their medical records to the attorney.

3. The attorney has the records reviewed by a physician who gives an opinion as to whether or not malpractice has occurred. If the physician reviewer believes that it has, the attorney will sign a certificate of merit, which will accompany the Summons & Complaint when it is served.

4. The attorney prepares the Summons which is then served on the physician or someone authorized to accept service for that physician. This starts a civil action and gives jurisdiction over a party. It can be either a Summons & Complaint or a Summons with Notice.
   a. Summons with Notice: gives formal notification to the party that has been sued in civil case of the fact that the lawsuit has been filed. The Summons also tells you the type of court in which the case will be heard, usually Supreme Court, and it will tell you the venue (location) which is one of the Counties, usually the one in which the care took place.
   b. Summons and Complaint: This Summons tells you the above information and the Complaint tells the court what the plaintiff wants and vaguely describes the allegations of malpractice.

Defendant’s Response
The individual who is sued is the defendant and he can be served with legal papers in a number of ways:

1. Personal Service: The papers are given directly to the physician. With this type of service, the defendant has 20 days (exclusive of the day of service) in which to have his attorney put in an Answer. The Answer is the document in which the attorney denies all allegations and demands a Bill of Particulars that lists the allegations in very specific detail.

2. Substitute Service: The papers are given to some other person of standing, i.e. office manager, secretary in Dean’s Office. With this type of service, the defendant has 30 days in which to have his attorney put in an Answer.

3. Mail: This can be sent to the physician’s address along with 2 copies of “statement of service by mail and acknowledgement of receipt.” With this type of service, the defendant has 30 days to return the receipt and 20 days from the return of the receipt to have his attorney put in an Answer for him.
A failure to Answer or serve a Notice of Appearance results in a default judgment against the physician for the relief demanded in the Complaint. Legal papers must be dealt with properly and promptly.

**Other Legal Papers**
The other legal papers that you may see are called *Subpoenas*. These documents can be either be a request for an examination before trial (EBT), trial testimony, or for the production of records in your possession (Subpoena Duces Tecum).

**What To Do If You Receive Legal Papers**
If a process server attempts to serve you with papers, accept them. Do not try to deny who you are or try to “get away”. More often than not, service will be accepted for you in our Office of Legal Counsel who will send you a copy of the papers. In addition, a copy of the papers is sent to the NYU Insurance Department. Whenever you receive legal papers, no matter how you receive them, you must call the NYU Insurance Department and speak with either Patricia Lascarides (646) 501-3046 or Michael Browdy (646) 501-3045. Instructions and reassurance will be provided. Do not discuss the matter with anyone other the above mentioned people and your assigned attorney. Do not attempt to review the medical records. That will be done at a later date with your attorney. You will be guided closely and skillfully through the legal process.
Department of Social Work

A. Department Contact Information:

Director:  
Thomas Sedgwick 212-263-5077 or 212-263-5018 (Main Number)

Department Office Hours:  
Monday thru Friday 9:00-5:00pm

In-House Social Work Coverage - There is social work coverage on all of the hospital units, the PUC give covering social worker contact).

In addition, there is Sunday thru Saturday (excluding Wednesdays) coverage, 8am-9pm, pager 1299

ED Hours:  
Su/M/Tu 8:00am-11:30pm pagers 3663/1662/3662  
W/Th/F 8:30am-11:30pm pagers 1662/3662  
Sa 10:30am-10:30pm pager 1662

Saturday In-House Social Worker:  
9:00 – 5:00pm pagers 1903 & 2108 (pager 1299 from 5pm to 9pm)

Weekend on Call CM/SW Manager:  
Long Range Beeper 917-812-5325 -24 hrs.

Equipment Liaison (Medstar):  
212-263-8249

Transportation:  
212-263-8252

(The hospital has a charity care policy for patients who need financial assistance with their bill. Patients and families can call 1-866-486-9847 if they need information.)

On-Site Home Care Vendors:

Visiting Nurse Service of New York  
212-263-8959

Revival Home Care:  
212-263-6681

Domestic Violence:  the Department of Social Work has designated staff to assess and refer patients for services. Call 212-263-5018.

Department of Social Work  is part of an interdisciplinary team, responsible for counseling and referrals for post hospital care. This includes home care, hospice nursing homes, and rehabilitation facilities. The social worker works with an RN Care Social Work is available to provide supportive counseling to patients and families.

Manager to arrange safe transition from the hospital.
The RN Care Managers in the department are responsible for coordinating all high-tech home infusion cases (Call 212-263-6601, 9-5 M-F)

Child Protection:

NY State Social Service Law, Sections 412 and 413, and New York State Family Court Act, Section 1012 require the reporting of cases of suspected child abuse and neglect to the New York Statewide Central Register for Child Abuse and Maltreatment (SCR) 1-800-635-1522, for investigation by the local child protective services.

The Hospitals Center staff has the responsibility of intervening in any situation of suspected child abuse or maltreatment to protect the child from further abuse or maltreatment. The key to recognition of the problems is a constant awareness of the possibility of its existence through ongoing education of Hospital staff, and administrative organization to facilitate reporting of suspected cases. Implementation of this policy is carried out by the Chairperson of the Child Protection Committee and Child Protection Coordinator.

SUPPORTIVE DATA
1. Child abuse and neglect, or the suspicion of such abuse or maltreatment, mandates that all health care professionals report this to the NY State Central Registry (SCR). Further, if any child is/are before them in their professional or official capacity, and state(s), from personal knowledge, facts, conditions or circumstances which, if correct, would render the child as an abused or maltreated child additionally requires that the professional report the parent(s) or person(s) legally responsible to the authorities as well.
2. In furtherance of this mandate, the parenting responsibilities of all adult patients (including psychiatric patients) with minors in their homes must be considered as part of the initial assessment and ongoing treatment plan.

DEFINITION OF TERMS & CONDITIONS
1. Child Abuse
An “abused child” is a child less than eighteen years of age whose parent(s) or other person(s) legally responsible for his/her care, by other than accidental means:
   a. Inflict(s), or allow(s) to be inflicted upon the child, serious physical injury, or
   b. Create(s), or allow(s) to be inflicted a substantial risk or physical injury, or
   c. Commit(s), or allow(s) to be committed against the child, a sexual offense as defined in the penal law.

2. Child Neglect
A “neglected child” is a child less than eighteen years of age whose physical, mental or emotional condition has been impaired, or is impaired, as a result of the failure of his parents(s) or other person(s) legally responsible for his/her care to exercise a minimum degree of care:
   a. In supplying the child with adequate food, clothing, shelter, education, medical or surgical care, though financially able to do so, or offered financial or other reasonable means to do so, or
   b. In providing the child with proper supervision or guardianship, or
   c. By using a drug or drugs, or
   d. By using alcoholic beverages to the extent that (s)he loses self-control of his/her actions, or
   e. By any other acts of a similarly serious nature requiring the aid of the Family Court, or
   f. Abandonment.
3. Child Maltreatment
A “maltreated child” is a child less than eighteen years of age who is either:
a. “Neglected”, as defined above, or
b. Has had serious physical injury inflicted upon him by other than accidental means.

4. Access to Medical Records
When a child is reported to the State Central Registry (SCR) for suspected child abuse or maltreatment, a representative from the Administration for Children’s Services (ACS), detectives from the Special Victims Squad (SVS) or the police may come to the Medical Center as part of their investigative process.
   a. Patient Information is to be kept confidential at all times. These representatives are not entitled to any more than what is contained in the SCR report. If there are questions as to the relevance of some of the information presented on the SCR report they should be directed to a medical person (preferably the attending physician) who can explain why the findings reported may indicate abuse/maltreatment.
   b. ACS may have access to whatever pertinent medical information is in SCR report provided to them; however, ACS, SVS, or the police should not be given access to the patient's medical record beyond that pertinent medical information that is part of the report provided (neither supervised review, nor a copy). If they insist on having this access, ACS and/or the police can bring an action for declaratory judgment or issue a subpoena for the information required.
   c. If the hospital has not made a report to SCR, release of information, a HIPAA consent or subpoena is required to obtain any information.

5. Child Protection Consultant
The Child Protection Consultant chairs the Child Protection Committee, which is made up of multidisciplinary staff at NYU Hospitals Center; its role is to review cases and to assist the staff in the decision to report a case to the SCR.
   a. Serving as the primary consultant, the Child Protection Consultant may also advise the staff about other medical tests or procedures that can be done to help with the assessment in suspected situations.
   b. On the request of the Child Protection Consultant (a specially trained pediatrician, the committee is notified about a suspected case of child abuse/maltreatment.

6. Child Protection Coordinator(s)
The Child Protection Coordinators at each site (Tisch/Rusk and HJD) are members of their respective Social Work Department at NYU Hospitals and communicate regularly with each other.
   a. The Coordinator(s) are a liaison with the Administration of Children’s Services (ACS) and facilitates the exchange of information between the Hospitals Center staff and this child protection agency in the community when needed.
   b. The Coordinator(s) works with the respective health care team of the site to review cases and help with the decision that there is reasonable cause to suspect abuse/maltreatment and to call the State Central Registry (SCR).
   c. The Coordinators communicate their activities ultimately to the Child Protection Committee and to the Pediatric Quality Improvement Committee that report to the Medical Board.
7. Failure to Report
Any mandated reporter who willfully fails to make a report may be guilty of a Class A Misdemeanor. Furthermore, any mandated reporter who knowingly and willfully fails to do so may be civilly liable for damages caused by the failure to report.

8. Immunity of the Reporter
To encourage prompt and complete reporting of suspected child abuse and maltreatment, the Social Services Law of NYS affords mandated reporters certain legal protections from liability. Any mandated reporter who in good faith makes a report, photographs and/or takes protective custody, has immunity from any liability, civil, or criminal action that might be a result of such actions.

9. Mandated Reporters
Mandated reporters are those individuals who:

a. Must report, or cause a report to be made, whenever they have reasonable cause to suspect that a child coming before them in their professional (includes licensed personnel in NY State) or official capacity is abused or maltreated, or
b. When they have reasonable cause to suspect that a child is an abused or maltreated child where the parent, guardian or custodian or the person legally responsible for the child comes before them in their professional or official capacity and states from personal knowledge, facts, conditions, or circumstance which, if correct, would render the child an abused or maltreated child.

c. Hospital personnel engaged in the admission, examination, care, or treatment of persons are considered to be Mandated Reporters of child abuse or maltreatment.
d. Other hospital staff, who are not legally mandated reporters, such as escort, building services, and ancillary clinical staff are advised to contact their supervisor if they have any concerns about a child who may be suspected to be a victim of abuse or maltreatment.

Certain mandated reporters must take all appropriate measures to protect a child’s life and health including, when appropriate, taking protective custody of a child without the consent of a parent or guardian if such mandated reporter has reasonable cause to believe that the circumstances and condition of the child are such that for the child’s care presents an imminent danger to the child’s life or health.

a. Hospital Administrators have the authority and responsibility to take a child into protective custody when contacted by the clinical team who is treating the child since the team is comprised of mandated reporters. The child is to be admitted to the hospital pending further investigation. This action can be done without a Court Order and without the consent of parent(s) or other legally responsible person(s) as directed by the Social Services Law until the child can be transferred to an authorized protective services agency. However, a call to the NY State Central Registry – Mandated Hotline needs to be made. Hospital Security may be required in the event the parent(s) attempt(s) to remove the child from the premises against the advice of the medical, nursing and social work staff.
Child Protection Consultation Team

The Child Protection Consultation (CPC) Team provides education and consultation regarding the complex issues surrounding child maltreatment via the availability of an interdisciplinary team of health care professionals (physicians, social workers, nurses, etc.) with specialized education in both applied child abuse and the psychosocial evaluation process. The Chairperson of the Child Protection Committee is a pediatrician who has expertise/training in child abuse pediatrics. The Chairperson is the child protection consultant for all cases, and is responsible for a call-schedule of other pediatric child protection physicians who are his/her designee. All referrals for Child Protection Consultation or educational in-services are sent through the CPC chairperson, CPC coordinator or Social Work Department where they are reviewed and assigned appropriate team members. In the case of suspected child abuse or maltreatment, as in the case of acute life-threatening emergencies, the hospital may bypass the usual requirements for consent of the patient or parent/guardian for treatment or admission, following the appropriate guidelines as defined in the NYS Social Services Law and NYU policy.

Child protection consultation requests may include, but are not limited to, the following case types:
1. Concerns of possible child abuse, neglect or maltreatment which arise in the clinical care of children and their families;
2. Concerns related to laboratory or imaging findings which may indicate suspected child abuse or neglect;
3. Communication and cultural practices impacting patient medical care;
4. Family dynamics impacting patient medical care;
5. Disagreements among healthcare team members and/or families regarding suspected child abuse or neglect;
6. Refusal of medically indicated treatment;
7. Unexpected deaths, especially those reported to the office of the medical examiner;

Contact Lists, Hours, Titles

Tisch:
Social Work Department:
Monday through Friday:
9 AM – 5 PM: 212-263-2018

Monday through Friday:
Emergency Department Social Work: 9:30 AM – 10:30 PM. 212-263-6969 or
in-house beeper 1662 or 3662 0r 3663

Saturday and Sunday:
Emergency Department Social Work: 10:30 AM – 10:30 PM 212-263-6969 or
in-house beeper 1662

Saturday and Sunday:
Tisch Hospital Social Work: 9 AM – 5 PM beeper 1903 and beeper 2108
* All other times: by telephone through the Communications Department x37411 if
needed. Social Work Management staff carries a long-range beeper on a rotating
basis for evening, night and holiday coverage and available for consultation; they
will attempt to arrange for a social worker to come to the Medical Center to assist with the patient/family assessment if agreed upon by all the treatment team members that this is necessary and the situation cannot be managed by the ED staff or over the telephone.

**Child Protection Consultation Service:**
Monday - Friday
Dr. Vincent Palusci, MD
Office: 212-562-6073
Pager: 917-313-0310
*After hours Consultation Service coverage can be obtained through the ED at extension 35550 or through the Social Work Management Staff On Call via the Page Operator 37411 who have access to the afterhours on call schedule.

**Child Protection Coordinator:**
Monday - Friday
Dennis Sklenar, LCSW
Extension: 35018 or 30885
Beeper: 1674
Blackberry: 646-315-0692
*After hours Social Work consultation can be obtained through the Page Operator 37411.

**Emergency Department:**
Jessica C. Foltin, MD,* Director, Pediatric Emergency Medicine Extension 30080
Cell: 917-439-0928
*Dr. Foltin should be notified of suspected child abuse/maltreatment and DOA cases that present in the ED at any hour

Please refer to the corresponding Patient Care Standards:

**Interdisciplinary Structure Standards:**
Child Abuse & Maltreatment
Child Protection Consultation Team

**Interdisciplinary Process Standards:**
Identification & Management of Suspected Child Abuse & Neglect
Taking of Photographs of Suspected or Actual Abuse Victims

These Patient Care Structure Standards are available on the Medical Center’s Intranet under Patient Care and Nursing Standards

The Medical Center’s Child Protection Policy is located in the Rules and Regulations of the Medical and Dental Staff accessed through the Medical Center’s Administrative Policy and Procedure Manual via the medical center’s intranet.
Emergency Management and Fire Safety

Contact Information:

For NON-EMERGENCIES: For information on Emergency Management (during non-emergencies only), contact: Kristin Stevens, Assistant Director, Emergency Management, 212-263-2628, kristin.stevens@nyumc.org

Employee Emergency Information Hotline: 212.263.2002
Note: This number will only be activated during an actual emergency.

NYUMC Emergency Management information is available on the NYU Intranet at:
http://nyumc.net/nyu/include.jsp?nav=em&url=/emergency_info/command_center_info.htm

Internal/External Disaster "Code 1000"

Upon hearing the announcement of "Code 1000" what should you do?
Wait for instructions from leadership in your assigned area. If you are not in your assigned work area when the Code 1000 is called, you should return there.

Fire Safety “Code 00”

The announcement Code 00 means that there is a fire situation.

What would you do if you discovered a fire?

Follow the R.A.C.E. plan
• Rescue anyone from immediate danger
• Alarm - pull alarm at the closest alarm pull station then dial 74400 for the communications operator (give your name and exact location of the fire)
• Confine or contain - close the doors to the room where the fire is as well as all doors to patient rooms
• Extinguish or Evacuate - Extinguish fire if possible with extinguisher. Evacuate if directed by the fire department or leadership

How do you operate the fire extinguisher?
• Pull out the pin
• Aim at the base of the fire
• Squeeze the handle
• Spray or sweep across the base of the fire

*** Please visit the Emergency Management website at the above-listed web address for newly posted information. ***
Bellevue Hospital Center
The NYU School of Medicine Affiliation Office manages the Affiliation Agreements between the School of Medicine and three of the NYC HHC (Health and Hospitals Corporation) facilities - Bellevue Hospital Center, Gouverneur Healthcare Services and Woodhull Hospital. These affiliation agreements are multi-million dollar professional contracts for providing physicians, midlevel providers and technical staff to the affiliated hospitals. The agreements also cover a portion of the costs of residency training directors, coordinators and other expenses related to the teaching and training functions.

The Affiliation between Bellevue and the School of Medicine has a long and historical past. As a resident you will have the privilege of taking care of patients who will value your expertise more than you can imagine and you will work alongside staff who daily take on the challenges of providing top quality care in a public hospital, many of whom have devoted their careers to this selfless effort.

We are proud of our ability to provide services to the patients of Bellevue and expect all who enter Bellevue’s doors wearing an NYU badge to show the utmost in respect and compassion for this most venerable of medical institutions, its patients and staff.

While the majority of the activities of the Affiliation Office revolve around faculty and staff, there are some areas that pertain to House Staff and you need to be familiar with these.

Our contract has multiple Performance Indicators. These are measurable indicators of performance such as timely discharge of patients, timely dictation of operative reports etc. Below is a list of indicators that are a part of our contract with Bellevue. As you can see, these are logical and laudable goals. It is incumbent upon you to comply with these indicators. The Affiliation Office will contact you and your Department if you are non-compliant. Please assist us in achieving and maintaining our compliance goals.

**Efficiency**
- Timeliness of start time for operating room

**Documentation**
- Operative reports dictated within 24 hours
- Ambulatory care note verified within 24 hours
- Medical records completed within 30 days of discharge
- Use of standardized JCAHO-approved abbreviations

**Quality Indicators**
- Screening of Pneumonia patients for pneumococcal vaccine status & vaccinated prior to discharge
- Reduction in Diabetes HbA1C
- Annual colonoscopy screenings
- Pneumococcal vaccine screening for patients 65 and older
- Breast cancer screening: mammogram for women 40-69 within the past 2 years
In addition to the above, you will be required to do several on-line training modules pertaining to HIPAA and Fraud Awareness and Compliance (coding and billing procedures). These courses are also mandatory and governed by Federal regulations. Some of the training completed at Bellevue will also give you credit at Tisch Hospital. (BUT NOT THE OTHER WAY AROUND!).

The web sites for HIPAA and Compliance are as follows:

HIPAA (this may consist of multiple modules offered at different times): 
http://hipaacbt.nychhc.org. By accessing this web site you will automatically be able to see what modules you have completed and what modules are outstanding.

Fraud Awareness & Compliance (http://compliancecbt.nychhc.org) which is designed to ensure compliance with the requirements of Compliance Regulations, including, without limitation, adherence to proper coding and billing procedures.

Enjoy your time at Bellevue and never hesitate to contact the Affiliation Office with any concerns you have regarding issues at Bellevue. We will troubleshoot issues for you, direct you to the most appropriate office to address your concerns, as well as advocate for you as necessary.

Maria Ivanova  
Affiliation Administrator

Elizabeth Deleon-Perez  
Executive Assistant

(212) 263-6264 phone  
(917) 829-2051 fax
Bellevue Hospital Center Nurses Welcome You!

- Welcome to Bellevue Hospital Center, we have an interdisciplinary approach with our patients.
- Nursing monitors and reports on the following: 2009 National Patient Safety Goals to various committees.
- It is very important that you be aware of the following National Patient Safety Goals (NPSG):

**Goal 1: Improve the accuracy of patient identification:**
- Use two identifiers before administering medication, performing a procedure and treatment by:
- Asking the name of the patient and check the Medical Record number with the ID band
  OR
- Ask the name of the patient and check the date of birth (CLINICS ONLY)
- All specimens collected must be labeled in front of the patient.
- You must use patient identifiers when providing treatment or procedures.
- Patient identifiers are used when administering medication, blood or blood components.

**Goal 2: Improve the effectiveness of communication among caregivers.**
- There is a LIST of abbreviations that we CANNOT use; check the computer the list is available for your viewing.
- This is monitored weekly and the name and Title of the staff using inappropriate abbreviations will be reported in hospital wide committee's.
- We use the SBAR format for handoff communication:
  - **S**-Situation, **B**- Background, **A**- assessment, **R**- recommendation
  - TICKET TO RIDE is in MYSIS being piloted and is used as a handoff when sending patients for diagnostic tests for the next caregiver.

**Goal 3: Improve the safety of using medication**
- Concentrated electrolytes are not available on the units.
- **High Alert medications such as:** Insulin, Heparin, Morphine, Fentanyl, Dilauded, are required to be verified by two Nurses: the drug, dosage, and signatures in the Medication Administration Record.
- There is a list of **LOOK ALIKE SOUND ALIKE** (LASA) medication and the list is reviewed and
posted annually.

- Use only **APPROVED ABBREVIATIONS** for medication and your progress notes.
- All unlabeled medication need to be labeled: syringes, cups, and basins.

**Goal 7: Reduce the risk of health care associated infections:**

- **HANDWASHING**, adherence to aseptic techniques, prevent VAP(Ventilator Acquired Pneumonia) by using protocol, adherence CLABSI protocol (Central Line Associated Blood Infections), SSI (Surgical Site Infections), and MDRO(Multi-Drug Resistant organism)
- You must wash or use the hand gel in-between patients.
- We are monitoring compliance with all disciplines regarding this process and it is reported monthly.

**Goal 8: Accurately and completely reconcile medications across the continuum of care:**

- A medication list is generated upon admission, it is then reconciled during the length of their hospital stay and once again upon discharge.
- This medication list will be provided to the patient, next caregiver, or designated family member.
- Medication is only reconciled the Physician, it is Physician generated.

**Goal 9: Reduce the risk of harm resulting from falls:**

- The following IHI(Institute for Health Care Improvement) fall and injury prevention strategies were implemented:
- The use of skid proof shoes, furniture with sharp edges are removed, bathroom and shower grab rails were installed, wet floor signs are re-in forced, environmental rounds 30 minutes are done to anticipate patient needs, wheel chairs with anti-tippers, bathroom use is offered prior to medication administration, high risk patients are placed closer to the Nurses Station, beds are placed on the lowest position, **YELLOW** falling star is placed at the bedside.
- We approach the patient as a TEAM to prevent falls with injury.

**Goal 10: Reduce the risk of influenza and pneumoccocal disease in institutionalized older adults:**

- Educate and encourage your patients to accept the flu and pneumonia vaccine.
- This is a team effort we must increase our compliance.

**Goal 11: Reduce the risk of surgical fires**

- Controlling the heat source such as lasers and electrocautery.
- Users will activate the unit only when the tip is in view; deactivate the unit not in use.
- Surgeon will inform the anesthesiologist when to stop the supplemental oxygen at least for a minute before the use of the laser. Lasers should be on standby when not actively in use.
- Post sign outside the door to indicate the laser is being used during a procedure.

**Goal 13: Encourage patient’s active involvement in their own care as a patient safety strategy**
- There is the “SPEAK UP,” campaign wherein the patients are encouraged to report their complaints about safety.
- They are also encouraged to ask their caregivers to wash their hands.

**Goal 14: Prevent health care associated pressure ulcers (decubitus ulcers)**
- Skin assessment is done for all Nursing admissions using the Braden scale.
- We turn the patient every 2 hours based on the skin care protocol.
- We have a wound care team and weekly interdisciplinary rounds are done.
- Pictures are taken of the pressure ulcer once identified upon admission and placed in the chart.

**Goal 15: The organization identifies safety risks inherent in its patient population.**
- In the Nursing Admission we ask if they have a history of suicide, we assess the mood and assess their appearance.
- If they are suicidal the Nurse will notify the Physician and place the patient on 1:1 suicide precautions. This entails a staff member monitoring the suicidal patient at arm’s length at all times including when the patient is in the bathroom or showering.
- An order must be obtained **immediately.**
- The order has to be re-newed EVERY 24 hours.
- When a patient is on 1:1 suicide precautions the staff member assigned is with the patient at all times arm’s length.
- **A Psychiatric consultation will be done by the Physician immediately for the suicidal patient.**
- In Psychiatry the process is much more stringent. There are specific protocols to follow most importantly- THE UNIT DOORS ARE LOCKED AT ALL TIMES, when you enter a Psychiatric unit ensure that no one has followed you in or out the unit. Consult the Psychiatric Department Staff.
- Always inform the Head Nurse or ask the Charge Nurse if you any questions regarding the patient’s safety risks.

**Goal 16: Improve recognition and response to change’s in patients’ condition:**
- We have an **RAPID RESPONSE TEAM (RRT)** that responds to the units for any changes in the patients’ condition.
- How to activate the **RRT**: Call **4311** and provide the unit, and room number

**RERAINTS:**

**MEDICAL INDICATION:** 1) **Vital medical device/s in place. If removed inadvertently will threaten patients’ life and limb** 2) **Patient attempting to pull medical device/s or drains** 3) **Patient has succeeded in removing medical device/s or drains.**

- A face to face evaluation will be done by the Physician for every initiation and for every episode.
- A restraint order has to be done every 24 hours.
- It must be indicated in the care plan and the progress why the patient is in restraints.
- A Registered Nurse may initiate the restraint but an order must be obtained **within 1 HOUR.**
- When patient is discharged or has expired you must discontinue the restraint order.
- There is a **RESTRAINT ORDER FORM** that has to be filled up appropriately when a patient is in restraints. This is monitored closely by NURSING and all deficiencies will be reported according to department.

**BEHAVIORAL INDICATIONS:** 1) **Imminent danger to self and 2) Imminent danger to others**

- When a patient is acting out behaviorally that causes them to be an imminent danger to self and others the seclusion/ restraint flow sheet for Behavioral indications must be done.
- A face to face evaluation will be done by the Physician for every initiation and for every episode.
- Time limit for Behavioral Restraints: 2 hours for Adults, 2 hours for ages 10-17 years old, and 1 hour for ages 9 and below.
- There is no such thing as a renewal, every episode is a new episode the seclusion/ restraint order form must be done.
- It must be indicated in the care plan and the progress why the patient is in restraints.
- The patient must be entered into the Violence Reduction Program.
- There is a log where all restraints and seclusions are being logged it is a requirement by Office of Mental Health; this is being done by Nursing QM.
- A Registered Nurse may initiate the restraint but an order must be obtained **within 1 HOUR.**
- There is a **RESTRAINT/ SECLUSION ORDER FORM** that has to be filled up appropriately when a patient is in seclusion or restraints. This is monitored closely by NURSING and all deficiencies will be reported according to the department.

**NURSING ORGANIZATIONAL CHART:**

- Nursing Deputy Executive Director
  - The Deputy Executive Director oversees all Departments of Nursing at Bellevue Hospital Center.
- Associate Executive Director
- Senior Directors of Nursing
- Director of Nursing
- Associate Director of Nursing
- Assistant Director of Nursing
- Nursing Supervisors
- Head Nurses
  - They are unit based, and are in charge of their specific units.
- Charge Nurse/ Staff Nurse
  - The Charge Nurse is the designated Nurse in charge of the unit when the Head Nurse is not on duty or during Tour 1 and Tour 3.
Bellevue Hospital Center
Social Work Department

Contact Information:

Irene Torres, LCSW
Sr. Assoc. Executive Director
212-562-6881

Alma Pamadanan, R.N.
Director/Care Management
212-562-3129

Ines Suarez, LCSW
Director/Social Work
212-562-4201

Natalie Kramer
Associate Director/Social Work
212-562-4659

<table>
<thead>
<tr>
<th>Services</th>
<th>Telephone</th>
</tr>
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<tbody>
<tr>
<td>Main Reception</td>
<td>212-562-4166</td>
</tr>
<tr>
<td>Psychiatry Division</td>
<td>212-562-4656</td>
</tr>
<tr>
<td>Emergency Department (24hrs/7days)</td>
<td>212-562-4730/7715</td>
</tr>
<tr>
<td>CPEP (Psychiatric Emergency 24 hrs/7 days)</td>
<td>212-562-7665/7666</td>
</tr>
<tr>
<td>Child Protection</td>
<td>212-562-6045/6046</td>
</tr>
<tr>
<td>Child Protection Coordinator-Kimberly Fitzpatrick</td>
<td>212-562-5762</td>
</tr>
<tr>
<td>Crime Victims Program Reception</td>
<td>212-562-3755</td>
</tr>
<tr>
<td>Domestic Violence Coordinator-Christina Janick</td>
<td>212-562-4693</td>
</tr>
<tr>
<td>Sexual Assault/Rape Crisis Coordinator-Carla Brekke</td>
<td>212-562-3435</td>
</tr>
<tr>
<td>Chaplaincy</td>
<td>212-562-4440/7944/7203</td>
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What You Need to Know Before You Order Medications at Bellevue: The Pharmacy Survival Guide

By Elias G. Sakalis, MD, Chairman, Pharmacy and Therapeutics Committee

1. Important Contacts

Dr. Elias G. Sakalis, Chairman,
Pharmacy and Therapeutics Committee.................... 917-884-2637

Michael Blumenfeld, Director of Pharmacy ............... ext.6504

Kim Tran, Associate Director of Pharmacy .................. ext.7788

Vacant, Assistant Director for OPD/Purchasing .............. ext.4276

Main Pharmacy, 14th Floor South.............................. ext.6502

Adult Outpatient Pharmacy, Ground Floor.................. ext.2289, 7733
9:30am – 5:30pm, M-F

Discharge Prescriptions........................................Fax = 6908

Pharmacy and Therapeutics Committee Physician Members

Elias G. Sakalis, M.D. Chairperson, Medicine
Joseph Carter, MD Surgery
Harminder Chawla, M.D. Nephrology
David Chong, M.D Critical Care
Miriam Cremer, M.D. OB/GYN
Benard Dreyer, M.D. Pediatrics
Robert Hoffman, M.D Adult Emergency Services
Harold Horowitz, M.D Med/Infectious Diseases
Andrea Kondracke, MD Psychiatry and Medicine
Eric Manheimer, MD Medical Director
David Roccaforte, M.D Anesthesiology
Miguel Sanchez, M.D Dermatology
Ron Simon, M.D Trauma and Surgery
Michael Tanner, M.D Ambulatory Care, Medicine
Michael Tunik, M.D Pediatric Emergency Services
Andrew Wallach, M.D Medicine
Marcelle Levy-Santoro, M.S. Director, Pharmacy
2. Why do we have a medication formulary?

Section 405.17 of the NYS Health Code and JCAHO requires each hospital in New York to establish a list of medications (Formulary) that are to be used to treat patients. Only the medications on this list, selected by the Pharmacy and Therapeutics Committee, are to be prescribed and dispensed by all health care providers in the hospital. Medications are selected to the formulary based on efficacy, safety and cost. The hospital formulary is found on the Bellevue Hospital intranet and is updated on a monthly basis. Patients admitted to the hospital, who are on medications as outpatients not listed in the formulary should be prescribed the formulary therapeutic equivalence (e.g. monopril for lisinopril).

3. What is the role of the Pharmacy and Therapeutics Committee?

Physician members (as listed above) representing each medical discipline, make up the majority of the committee. Each member is a leader in his or her own department and has been chosen by the chief of service based on academic and clinical excellence. The committee meets once a month and one of its major duties is to decide what medications, based on safety, efficacy and cost, are included in Bellevue’s formulary. The committee is also responsible for reviewing all clinical pharmacy issues in the hospital. This includes reviewing formulary requests, medical literature, medication errors, medication utilization, and treatment guidelines. The committee regularly updates the formulary to comply with treatment standards and reviews updated pharmacy operating policies and procedures.

4. What is an appropriate non-formulary request?

A non-formulary request is a medication that is requested that is not on Bellevue’s Formulary. Non-formulary requests represent a tremendous financial and administrative burden for the hospital. Because of higher costs in obtaining these medications and because hospital staff may be less experienced in using them (possibly leading to medication errors), medications not listed on Bellevue’s formulary will not be dispensed without appropriate approval (see below).

The Pharmacy and Therapeutics Committee however, does recognize that situations do occur that require the use of an FDA-approved drug that is not on formulary and for which a formulary substitution is not possible. This would include inpatient treatment of a life threatening condition (e.g. heparin induced thrombocytopenia) or continuation of an outpatient medication in a hospitalized patient for which there is no substitute on formulary, and for which its withholding may be life threatening to the patient (e.g. Cellcept for organ transplantation).

Please remember that the non-formulary medication requested may not be stocked in pharmacy and therefore, the pharmacy department may require 24-48 business hours to purchase the medication.

Non-formulary requests for outpatients are generally not honored and every attempt should be made to use the medications listed on our formulary.
5. How do I obtain a non-formulary medication?

The physician responsible for the patients care should obtain (from pharmacy-14S) and fill out a non-formulary request form. Once filled out, the non-formulary request form should be left with the pharmacy secretary on 14S. All requests will be reviewed within the day by Dr. Sakalis, the pharmacy director or supervisor. After hours, please contact the main pharmacy at ext.6502, and speak with a pharmacist. In many cases, pharmacy will dispense the medication (if in stock) until the following working day when the request can be formally reviewed.

6. Why are some medications restricted?

Drugs which are listed in the Bellevue Hospital Formulary, but which require special approval to be prescribed are said to be restricted medications. Reasons for restriction include drug toxicity, high purchasing cost, or the potential for poor outcomes due to inappropriate use. An example of restricted medications include broad-spectrum antibiotics - they will be made available from pharmacy only on approval by infectious diseases. The hospital formulary, located on the Bellevue Hospital Intranet will state if a given drug is restricted.

7. Can I administrate medications to patients?

In order to protect patients and staff, physicians should not administer medications to patients unless in an emergency situation (cardiac arrest, active seizure, etc). The administering physician is responsible for insuring that the medication he or she obtains is correct in both substance and dosage, and should view the label and dilution before administering. Remember, that when you are physically administering a drug to a patient, you are completely responsible for any errors that may occur (in dosage, strength, route, rate of infusion, etc.) during its administration. Again, for everyone’s safety, avoid administering medications unless in emergency conditions.

8. What do I do when admitted patients bring their own medications to the hospital?

It is a violation of hospital policy for anyone to administer medications that have not been dispensed from Bellevue’s pharmacy. The only exception to this policy is if the medication is non-formulary and not available in pharmacy, and the patient has his own supply with him. If the treating physician decides it is necessary to continue the medication, a non-formulary request form must still be filled out. Drugs used in this manner must be brought to the main pharmacy on the 14th floor (along with the non-formulary form), identified, ensured that the medication has not been adulterated (which will require that the pharmacist cannot proceed with liquid medications or medications in which improper storage could lead to strongly unfavorable results) and re-labeled before dispensed to patients on a nursing unit. In this case, the patient’s supply is used until the pharmacy is able to obtain the drug.
9. What is the policy on drug samples and other gifts from pharmaceutical companies?

It is against hospital policy for sample drugs to be distributed within hospital grounds by pharmaceutical representatives or to patients by physicians. This is necessary in order to ensure the proper receipt, storage, and documentation of all medications dispensed to patients in the hospital.

It is also against hospital policy for any staff physician at Bellevue to accept from a pharmaceutical company any compensation, stipend, gratuity or gift in any form, including but not limited to loans, travel, entertainment, meals, tickets to sporting events, theater tickets, or any other thing of value offered by or on behalf of the company. In addition, physicians are not allowed to attend any meetings in restaurants underwritten by a pharmaceutical company where CME credits are directly provided by the company. Educational (CME) meetings that are conducted by a hospital, medical school, or any medical society are allowed as long as an academic lecture is given, even if a pharmaceutical company is providing some sponsorship.

10. Why are some medications on hold by pharmacy?

A medication will be placed on hold by pharmacy if the drug, dose, route and timing are deemed by the pharmacist to be either incorrect or not safe for the patient. When a medication is held, the pharmacist will make every attempt by phone to reach the prescribing physician as noted on the QuadraMed® face sheet for clarification. Other reasons why medications may be held include the ordering of restricted or non-formulary medications without prior approval.

*Remember, it is imperative for the patient face sheet on QuadraMed® to be updated and filled out correctly with the appropriate physician contact numbers so that pharmacy can contact the prescribing physician when questions arise.*

11. What abbreviations should I never use at Bellevue?

In order to ensure the safety of patients throughout Bellevue, the following list of 12 abbreviations should never be used (see next page). These abbreviations have caused numerous errors in the past that have lead to bad outcomes, including death, in many patients throughout the nation. These abbreviations should never be used when writing medication orders or progress notes, and should never appear in any part of a patient’s chart.
<table>
<thead>
<tr>
<th>Abbreviation/Dose Expression</th>
<th>Intended Meaning</th>
<th>Misinterpretation</th>
<th>Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>IU</td>
<td>International Unit</td>
<td>Mistaken as IV or 10</td>
<td>Write “international unit”</td>
</tr>
<tr>
<td>U or u</td>
<td>Unit</td>
<td>Read as a zero (0) or a four (4), causing a 10 fold overdose or greater (4U seen as “40” or 4u seen as 44).</td>
<td>Use “unit”</td>
</tr>
<tr>
<td>MSO4</td>
<td>Morphine sulfate</td>
<td>Confused for one another – Can mean morphine sulfate or magnesium sulfate</td>
<td>Write “morphine sulfate” or “magnesium sulfate”</td>
</tr>
<tr>
<td>MgSO4</td>
<td>Magnesium sulfate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>QD or q.d.</td>
<td>Every day</td>
<td>Mistaken as q.i.d., especially if the period after the “q” or the tail of the “q” is misunderstood as an “i”.</td>
<td>Use “daily”</td>
</tr>
<tr>
<td>QOD or q.o.d.</td>
<td>Every other day</td>
<td>Misinterpreted as “q.d.” (daily) or “q.i.d” (four times daily) if the “o” is poorly written.</td>
<td>Use “every other day”</td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------</td>
<td>----------------------------------------------------------------------------------------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Zero after decimal point (1.0)</td>
<td>1 mg</td>
<td>Misread as 10 mg if the decimal point is not seen</td>
<td>Do not use terminal zeros for doses expressed in whole numbers.</td>
</tr>
<tr>
<td>No zero before decimal point (.5)</td>
<td>0.5 mg</td>
<td>Misread as 5 mg.</td>
<td>Always use zero before a decimal when the dose is less than a whole unit.</td>
</tr>
</tbody>
</table>

12. How do I get discharge prescriptions for my patients?

Inpatients who are being discharged from the hospital and who do not have prescription insurance coverage (such as Medicaid) will have up to a one-month supply of medication dispensed from the pharmacy. Patients who have prescription coverage should have their prescriptions filled at an outside pharmacy. In order to expedite the discharge process, discharge prescriptions can either be delivered to the 14th floor pharmacy or faxed to 2260 preferably the day prior to discharge. This will allow pharmacy ample time to fill all prescriptions and have them available early the following day for discharge without delay.

On the day of discharge, patients will go to the 14th floor pharmacy window and pick up all of their medications. Patients who are non-ambulatory, including patients on the physical rehabilitation service, and psychiatric patients, will have their discharge prescriptions
delivered to their respective nursing units (if requested).

13. What is a medication error and how do I report one?

A medication error is defined as any preventable event that can potentially cause inappropriate medication use or patient harm, while the medication is in control of a health care professional or patient. Errors can occur in the prescribing, documentation, dispensing, administering or monitoring of a medication. These lead to errors in dose, duration, frequency, route of administration, and type of drug used.

Pharmacy's role is to investigate each medication error and place safeguards into practice that will eliminate its reoccurrence. This can include safety improvements in the ordering, dispensing, and administration of medications that have great potential to cause harm if misused. However, in order for the entire medication system to be improved and made as safe as possible, all health care providers, including physicians, need to report any medication error by filling out a medication even occurrence form located on each nursing unit. Without this reporting, the current medication system cannot be upgraded and made as safe as possible for our patients. Please also note that Bellevue's policy on medication errors states that all reporting will result in non-punitive action.

14. What if my patient smokes?

Bellevue Hospital has made smoking cessation a priority for all our patients. Every patient seen in the Hospital, whether as an inpatient or outpatient, should be asked about smoking and offered smoking cessation therapy. An outpatient smoking cessation clinic has been set up to offer counseling and free smoking cessation medication. In order to extend our reach to smokers who are hospitalized, nicotine patches are unrestricted for inpatient use and should be offered to all inpatients who wish to stop smoking. Upon discharge from the hospital, patients should be referred to smoking cessation clinic.

15. When are inpatient medications administered and how do I order a medication to be given immediately?

The schedule listed below indicates the expected nursing administration time for all medications prescribed. If a physician prefers a different time schedule, it should be specified in the medication order. Please note that when you are ordering a medication (like an antibiotic) and its important for the patient to receive the first dose right away, you need to write 2 orders: a now order for one dose only, and then a dosing order for continued doses - Q12, Q8, BID etc. Attempts to combine both these orders into one are dangerous and have lead to errors of omission.

**Order When Administered to the Patient**

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Once daily</td>
<td>10 AM</td>
</tr>
<tr>
<td>BID</td>
<td>10 AM and 6 PM</td>
</tr>
<tr>
<td>Three times daily</td>
<td>10 AM, 2 PM, and 6 PM</td>
</tr>
<tr>
<td>QID</td>
<td>10 AM, 2 PM, 6 PM, and 10 PM</td>
</tr>
<tr>
<td>Q6 hours</td>
<td>4-10-4-10 or 6-12-6-12 (stated night or day)</td>
</tr>
<tr>
<td>Q8 hours</td>
<td>2-10-6 (started night or day)</td>
</tr>
<tr>
<td>Q12 hour's</td>
<td>10 AM and 10 PM Now</td>
</tr>
<tr>
<td></td>
<td>Within 30-60 minutes</td>
</tr>
<tr>
<td></td>
<td>Stat At once in emergency situations</td>
</tr>
</tbody>
</table>
1. Order desired test(s) (e.g. Type & Screen) in Misys

2. If the patient does not already have an ABO Rh test result in Misys (under the Blood Bank Results section), a second sample must be ordered in Misys and drawn for ABO Rh Confirmation. This second sample must either be:
   A) Drawn by a second person or
   B) Drawn by the same person performing a second needle stick and patient identification >10 minutes after the first stick.

3. Print bar coded Misys label(s) containing patient’s full name, medical record number, location, and date and time specimen drawn

4. At the patient’s bedside, ask the patient to identify himself or herself by name and DOB

5. Transfusion related samples can only be drawn by a MD, RN, PA, or a phlebotomist

6. Check patient’s ID to verify that the patient’s full name and medical record number match the patient from which sample is to be collected. You must match-up the information on the Misys bar coded sample label(s) with the information on the patient’s ID band.

7. At patient’s bedside, apply bar coded Mysis label and Securline Wristband label to the Blood Bank 6ml (EDTA) special pink top tube

8. The person drawing the sample(s) must sign/initial the Misys label.

   **INITIALS**

   Note: Signing/Initialing sample tube(s) that you did not personally draw is fraud and is grounds for disciplinary action

9. If the printed time on the Misys label is not the correct draw time, handwrite the actual draw time on the Misys label

10. Send or deliver sample(s) to Blood Bank 11N26 for testing

Version 2, 1/2009
Infection Control

HAND HYGIENE

Hand hygiene is the single most effective means of preventing the spread of organisms and diseases in the healthcare setting. Hand hygiene is defined as cleansing hands with either soap and water or alcohol-based hand rubs.

Hand Hygiene is indicated at the following times:

• Before patient contact
• After patient contact
• After touching any object in the patient’s environment – for example: the bedside table, the monitor in the ICU, or the privacy curtain around the bed. Everything around the patient is potentially contaminated.
• After removing gloves
• After contact with blood or potentially infectious body fluids, regardless of whether gloves were worn
• Before an invasive procedure – for example: before putting on a gown and glove prior to inserting a central venous catheter

ALCOHOL-BASED HAND RUBS are effective, cause less drying to skin and take less time to use than soap and water, easy to locate throughout the healthcare setting, and convenient to use. Rubs are recommended by the Centers for Disease Control and Prevention for most routine hand cleansing. There are several exceptions to this general rule:

• Hands must be washed with soap and water when visibly soiled, and
• Hands should be washed with soap and water when caring for a patient with C. difficile diarrhea or Bacillus anthracis (anthrax) if a sink is available – alcohol does not kill C. difficile or B. anthracis spores.

To properly apply hand rub:

• Squirt an adequate amount of hand-rub to cover all surfaces of hands into the palm of one hand
• Rub hands together spreading the alcohol rub on all surfaces of hands including around fingernails and between fingers and allow to dry
• Be sure hands are completely dry before touching anything or before putting on gloves.
• If hands are wet when you apply alcohol-based products, the alcohol will penetrate deeper into the dermal layers and may cause irritation. Avoid using alcohol gels when hands are still wet/damp from soap and water washing.

HAND WASHING is defined as using either anti-microbial or plain soap and water to clean hands and remove pathogens using surfactant and friction.

• Turn on WARM water (hot or cold water is irritating to skin)
• Wet hands and apply soap
• Rub hands together vigorously for at least 15 seconds (sing Happy Birthday)
• Be sure to wash all surfaces of hands including nail beds and areas between fingers
• WASH hands (as opposed to using alcohol products) whenever hands are visibly soiled, when they feel sticky from lotions, or when caring for patients with *C. difficile* diarrhea or anthrax.

NYU Hospitals Center and Bellevue Hospital Center (BHC) are serious about staff and patient safety. For your safety, perform hand hygiene often and sanitize equipment easily contaminated by frequent touching – such as pagers and stethoscopes. Hand lotion is available in dispensers at the Nurses’ stations and is compatible with the soaps that we use in patient care areas. Use this lotion rather than your own personal lotion to protect skin while at work.

NYU Langone Medical Center and BHC encourage patients and families to ask all healthcare providers whether they have washed/sanitized their hands before they begin providing care. Don’t be surprised if patients ask you about hand hygiene. The correct answer is either, “Thanks for reminding me” or “Thanks, I just used the alcohol gel before coming in”. This contributes to safe care and improved patient satisfaction. The best approach: Use the alcohol rub or wash your hands as you enter the patient’s room. *Patients really DO notice this!!!!*

**FINGERNAILS**

Fingernails may be no more than 1/4 inch longer than fingertips. Intact fingernail polish (not chipped) is permissible. *No artificial fingernails, tips, wraps, silks or nail jewelry may be worn.* Artificial nails and long natural nails worn by staff have been associated with outbreaks of Gram negative bacterial infections amongst critically ill patients. Staff members with artificial nails will be asked to leave work until they have them removed.

**JEWELRY**

Rings and bracelets should be kept to a minimum so that hand hygiene is easily and effectively accomplished. Wearing rings makes it harder to remove bacteria and other pathogens from all surfaces of hands when washing. In addition, rings with intricate patterns or stones provide nooks and crannies that can easily harbor pathogens. There are additional restrictions on wearing of rings and jewelry in OR areas.

**EMPLOYEE HEALTH SERVICES and HAND HYGIENE**

Employee health services (EHS) must be consulted if you have any health condition that impedes your ability to perform hand hygiene. This includes use of braces, casts or other appliances on hands and arms, irritant dermatitis, and other conditions that result in irritated or non-intact skin on hands and/or
forearms. In addition, systemic reactions to hand hygiene products should be reported to EHS. EHS can recommend alternate hand hygiene products that may be more tolerable for staff members with allergies or local reactions to standard products.

**EXPOSURE TO BLOOD OR BODY FLUIDS**

If you are exposed to blood or other body fluids that could put you at risk for blood borne pathogens such as HIV, or Hepatitis B or C:

1. Wash the area with soap and water
2. Promptly inform your supervisor of the incident so that coverage can be arranged while you get exposure follow-up.
3. Report to Employee Health Service as soon as possible. When the Employee Service is closed, report to the Emergency Department as soon as possible after the exposure.
4. To arrange for Source Patient Testing:
   a. at NYU, EHS will assist with source testing during regular business hours; after hours a physician or nurse practitioner colleague may ask the source patient for permission to obtain an HIV test. Follow directions in ICIS for obtaining appropriate consents and specimens by typing “blood/body fluid exposure” into the order worksheet.
   b. at BHC, EHS pages the HIV counseling service during business hours. HIV counselors obtain consents from 9am –9 pm on weekdays, and 10am-6pm on weekends. Contact number: 917-884-6679. For more detail and for what to do during times other than those listed above go onto the BHC intranet and scroll to “Occupational Exposure, Needlestick, Sharp Injury...What to do?” and click. A flow diagram and other downloadable forms can be found here.
5. If you are evaluated at by an Emergency Services Department, report the exposure to the Employee’s Health Service the following day.

**INFECTION CONTROL PRECAUTIONS**

**STANDARD PRECAUTIONS**

Standard precautions are the protective measures we routinely use to prevent spread of pathogens. Standard precautions are used with all patients and require anticipation of the type of contact and the potential for exposure to pathogens. All secretions and excretions are considered to contain infectious agents, except sweat.

- Standard precautions protect both the staff member and patient, because the barriers prevent transmission of pathogens in both directions.
- Standard precautions must be used for EVERY PATIENT and EVERY ENCOUNTER to be effective.
- Standard precautions require hand hygiene at all times, and the appropriate use of gloves, fluid-resistant gowns and face and eye protection, depending on the nature of the interaction with the patient. Gloves gowns and masks are known as personal protective equipment (PPE).
GLOVES: Wear gloves when contact with secretions (other than sweat), excretions, mucous membranes, and non-intact skin is anticipated.

GOWN: Wear fluid-resistant gown when splashes or contact with body fluids that could contaminate uniforms is anticipated. Examples are performing surgery, bathing a patient, dressing an extensive wound.

FACE and EYE PROTECTION: Use face masks and eye protection when splashes to the eyes or mucous membranes of nose and mouth are anticipated. Examples are surgical operations and extensive wound dressings.

TRANSMISSION BASED PRECAUTIONS

Transmission based precautions are used in addition to Standard Precautions for diseases of epidemiologic importance, or diseases with known modes of transmission. Patients on transmission based precautions have signs on their doors and/or charts that indicate the type of protection needed. Follow the directions on the signs and be sure to comply. Transmission based precautions include:

• Airborne Precautions (for tuberculosis, measles, SARS and other emerging pathogens). Patients are housed in specially ventilated rooms which have high air flow and negative air pressure relative to the corridor. Wear an N-95 respirators whenever you are in an Airborne Precautions rooms. YOU MUST BE FIT-TESTED for the N-95 RESPIRATOR!

• Droplet Precautions (for influenza, pertussis, bacterial meningitis, and pediatric viral respiratory illnesses). A private room is used but the room need not have negative pressure. At Tisch and BHC wear a surgical mask when within 3 feet of the patient.

• Contact Precautions (for C. difficile, Multi- drug- resistant organisms [MDRO], and pediatric respiratory or diarrheal diseases of unknown origin) this is the most common of the transmission-based precautions. Wear GOWN and GLOVES for all contact with the patient and/or patient’s environment.

INFECTION CONTROL SIGNAGE

A list of the signage for each type of transmission based precautions used at NYU and BHC follow on the next pages. A picture of the signage used in the hospital is shown with a description of the precautions needed and typical diseases for which each is used. For a complete listing of diseases and precautions, refer to the facility infection control manual.

Signage at NYU
ISOLATION PRECAUTIONS REVIEW

Contact Precautions – Yellow Sign
- Yellow sign for all Contact Precautions patients (except if patient has C. difficile)
- Wear gowns and gloves for all contact with patient & environment
- Terminal cleaning with curtain change at discharge or transfer to a different unit
- Clean all pt care equipment before use with another patient
- Use single-patient supplies (e.g., disposable BP cuff) whenever possible
- Clean hands with soap & water or Purell
- Room door may remain open
- Patient should wear an isolation gown when leaving the room
- MRSA, VRE, drug resistant Klebsiella pneumoniae, some uncommon multi-drug resistant bacteria, & RSV are diseases that require Contact Precautions

Contact Precautions – Red Sign
- Red sign must be used for patients with C. difficile
- Wear gowns and gloves for all contact with patient & environment
- Terminal cleaning with curtain change at discharge or transfer to a different unit
- Clean all pt care equipment before use with another patient
- Use single-patient supplies (e.g., disposable BP cuff) whenever possible
- Clean hands with soap & water only (don’t use Purell)
- For patients who need both signs, just use the Red one
- Room door may remain open
- Patient should wear an isolation gown when leaving the room
- C. difficile − suspected or proven requires Contact Precautions – Red sign

Droplet Precautions
- Green sign for all Droplet Precautions patients
- Wear regular surgical mask only when close (about 3 feet) to patient
- Use gown/glove in accord with Standard Precautions
- Patient wears regular surgical mask when leaving the room
- Room door may remain open
- Clean hands with soap & water or Purell
- Influenza, mumps, pertussis, & meningitis are diseases that require Droplet Precautions

Airborne Precautions
- Blue sign for all Airborne Precautions patients
- Wear N95 respirator when entering room; always keep on until you leave the room
- Visitors wear N95 respirator as well when entering the room
- Patient wears regular surgical mask when leaving the room
- Room door must remain closed
- Clean hands with soap & water or Purell
- Tuberculosis, Avian Influenza, SARS, & Chickenpox (also use Contact for these last 3 diseases) are diseases that require Airborne Precautions

For questions or concerns, please contact your unit’s Infection Prevention & Control staff member or the department at 3-5454 (NYUMC) or 8-6767 (HJD).

Infection Prevention & Control Department

NYU Medical Center
Signage at Bellevue

Bellevue Hospital Center
Infection Control Department

**ISOLATION PRECAUTIONS REVIEW**

<table>
<thead>
<tr>
<th>Yellow Sign</th>
<th>Contact Precautions – Yellow Sign</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Yellow sign for all Contact Precautions patients (except if patient has a spore forming bacteria such as <em>C. difficile</em>)</td>
<td></td>
</tr>
<tr>
<td>- Wear gowns and gloves for all contact with patient and environment</td>
<td></td>
</tr>
<tr>
<td>- Clean all patient care equipment before use with another patient</td>
<td></td>
</tr>
<tr>
<td>- Use dedicated or disposable equipment whenever possible</td>
<td></td>
</tr>
<tr>
<td>- Clean hands with soap and water or alcohol-based foam</td>
<td></td>
</tr>
<tr>
<td>- Room door may remain open</td>
<td></td>
</tr>
<tr>
<td>- Patients with draining wounds or other portals of exits with MRSA, VRE, drug resistant <em>Klebsiella pneumoniae</em>, or other multi-drug resistant bacteria, and patients with RSV require Contact Precautions</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Red Sign</th>
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<tbody>
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<td></td>
</tr>
<tr>
<td>- Room door may remain open</td>
<td></td>
</tr>
<tr>
<td>- <em>C. difficile</em> – suspected or proven requires Contact Precautions – Red sign</td>
<td></td>
</tr>
<tr>
<td>- For patients needing Red and Yellow precaution signs, the Red sign alone is sufficient</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Green Sign</th>
<th>Droplet Precautions – Green Sign</th>
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<table>
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<td></td>
</tr>
</tbody>
</table>

For questions or concerns, please contact your unit’s Infection Control Practitioner or the IC department at x 6888.
DIFFERENCES IN PRECAUTIONS:

At BHC, for Contact Precautions, curtains are changed on a schedule or when visibly soiled.

At BHC, physicians write the orders for precautions, but in the absence of a written order, nurses are authorized to initiate the appropriate precautions to avoid unnecessary exposure and to permit timely application of preventive measures.

MULTI-DRUG RESISTANT ORGANISMS (MDROS):

MDROs are organisms which are resistant to more than one of the primary antibiotics of choice and have epidemiological importance in our hospitals. The major route of transmission of MDROs is through the hands of healthcare workers and via contact with contaminated equipment and environment.

**MDRO Definition at BHC for gram-positive organisms:**
- *Staphylococcus aureus* - Resistant to Penicillinase-resistant Penicillins: (MRSA)
  - Methicillin, Oxacillin, Nafcillin
- Intermediate in sensitivity or resistant to Vancomycin (VISA, VRSA)
- *Vancomycin Resistant Enterococci*
  - *E. faecalis, E. faecium, E. durans*

**MDRO Definition at BHC for Gram negative organisms:**
- *Acinetobacter calcoaceticus baumanni complex* - Resistant to any one of:
  - Amikacin, Ampicillin-Sulbactam, Imipenem

- *Other GNRs (Pseudomonads, Klebsiella, E. coli, etc.*) - Resistant to any one of:
  - Cefepime, Imipenem or Meropenem, Amikacin OR are identified as ESBL (Extended Spectrum Beta-Lactamase) or Carbapenemase producers

- *Clostridium difficile (C. diff)* is also included in our MDRO definition

The following recommendations can help reduce the risk of HAIs due to multi-drug-resistant organisms.

- **Use of Transmission-Based Precautions when indicated**
  Patients who are infected with MDROs and have a portal of exit (ie: draining wounds, Foley catheters, tracheostomies requiring frequent suctioning) are placed on Contact Precautions and are isolated in a private room and a yellow sign is posted on the outside of their door. Gloves and gown are worn when caring for the patient, and in certain instances a mask and/or eye shield is worn depending upon the task being performed.

- **Appropriate glove use when indicated**
  Make sure gloves are changed and hands are washed in between patients.

- **Hand Hygiene**
Hand washing along with appropriate glove use is crucial for preventing the spread of infections. Improved hand hygiene using alcohol-based hand sanitizers has been effective in reducing the transmission of multi-drug-resistant organisms.

**CDC’S 12 STEPS TO PREVENT ANTIMICROBIAL RESISTANCE**

12. Contain your contagion  
11. Isolate the pathogen  
10. Stop treatment when cured  
  9. Know when to say “no” to Vanco  
  8. Treat infection, not colonization  
  7. Treat infection, not contamination  
  6. Access the experts  
  5. Use local data  
  4. Practice antimicrobial control  
  3. Target the pathogen  
  2. Get the catheters out  
  1. Vaccinate

**Prevent**  
**Transmission**

**Use Antibiotics**  
**Wisely**

**Diagnose &**  
**Treat Effectively**

**Prevent**  
**Infections**

**CLOSTRIDIUM DIFFICILE**

*Clostridim difficile*, also known as “C. diff” is a spore forming bacterium that can cause diarrhea. Most cases of C. diff infection occur in patients taking antibiotics. At BHC, a patient has a C. diff infection if he or she has diarrhea (more than one liquid stool over a period greater than 12 hours), and a C. diff toxin A and/or B test positive.

**To prevent C. diff infections:**
- Wash hands with soap and water before and after caring for every patient
- Carefully clean hospital rooms (with bleach) and equipment that have been used for patients with C. diff
- Use Contact Precautions (RED sign posted on the outside of the patient’s door) to prevent C. diff from spreading to other patients
- Only give antibiotics when it is necessary
DEVICE ASSOCIATED INFECTIONS

Central Line Associated Bloodstream Infections (CLABs)

Devices inserted into the cardiovascular system bypass the body’s normal defense mechanisms and provide an opportunity for microorganisms to invade and cause infection. In order to minimize the risk, BHC uses a CLABS Bundle:

- Hand hygiene
- Maximal sterile barrier precautions
- Chlorhexidine antisepsis
- Optimal catheter site selection (subclavian preferred for non-tunneled catheters)
- Antibiotic-impregnated catheters
- Biopatch dressing
- Insertion and daily maintenance check list.

Catheter Associated Urinary Tract Infections (caUTIs)

Catheter Associated Urinary Tract Infection Prevention Bundle: CAUTION

- Closed system / Catheter selection
- Aseptic management
- Use standard precautions
- Tie / Secure catheter and Foley bag
- Indications - catheterize only when necessary
- Obstruction free / obtain specimens from sampling port
- No looping of catheter tubing

VENTILATOR ASSOCIATED PNEUMONIA (VAP)

Ventilator-associated pneumonia (VAP) refers to pneumonia that develops in a mechanically ventilated patient after intubation.

Ventilator Bundle: ZAP THE VAP!

- Patient positioning – elevation of the head of the bead 30-45 degrees
- Ventilator weaning – daily “sedation vacations” and daily assessment of readiness to extubate
- Peptic ulcer disease (PUD) prophylaxis – medications that reduce gastric acidity have been shown to protect patients from the development of PUD and GI bleeding
- Deep vein thrombosis (DVT) prophylaxis – preventing blood clots for all sedentary patients is an appropriate intervention
SURGICAL SITE INFECTIONS (SSIS)

Surgical procedures result in breaches in the skin and create an increased risk of infection.

SSI Prevention:

- Hand hygiene is the key to stopping the spread of infection
- Pre-operative patient showering
- Hair removal
  - a) Outside the OR
  - b) Only when necessary
  - c) Use clippers, NOT a razor
- Surgical skin antisepsis with chlorhexidine
- Timely antibiotic prophylaxis when indicated
- Aseptic technique, limited traffic, proper use of surgical attire
- Avoidance of flash sterilization
- Optimal surgical technique
- Sterile dressing placement and limited post-operative dressing manipulation
Inter-Institutional Security Guide

FOLLOWING IS A GUIDE TO THE VARIOUS SECURITY ISSUES AND REGULATIONS THAT YOU WILL MEET AT THE BELLEVUE HOSPITAL CENTER, NYU LANGONE MEDICAL CENTER AND THE VETERANS ADMINISTRATION HOSPITAL. THE SECURITY AND POLICE STAFF AT THE THREE FACILITIES ARE AT YOUR SERVICE AND DEDICATED TO PROVIDING A SAFE AND SECURE WORK ENVIRONMENT FOR YOU.
## Contents

- SECURITY CONTACTS ................................................................. 134
- ENTRY INTO FACILITY .................................................................. 136
- SECURITY AND/OR POLICE .......................................................... 137
- IDENTIFICATION CARDS: ............................................................. 138
- ACCESS CARDS: ........................................................................ 139
- TRANSPORTATION BETWEEN SITES .......................................... 140
- PACKAGE CHECKS ........................................................................ 140
- PARKING ....................................................................................... 141
- OFF HOURS SECURITY ................................................................. 142
- LOST AND FOUND ........................................................................ 142
- SMOKING ..................................................................................... 143
- ALCOHOL .................................................................................... 143
- FIREARMS ................................................................................... 144
- FIRE ALARMS ............................................................................ 145
- SECURITY CODES ......................................................................... 145
- TIPS FOR INTERACTION WITH POLICE/SECURITY .................... 146
SECURITY CONTACTS

Bellevue Hospital Center

Bellevue security is available 24hrs 7 days a week with supervision on site or on call at all times. The chain of command is as follows:

(Vacant)
Director of Security
(212) 562-5203

Victor Hart
Assistant Director of Security
(212) 562-8135

Ramon Welsh
Assistant Director of Security
(212) 562-7483

Operations Hospital Police
(212) 562-6191

In the operations office there are supervisors available at all times. The chain of command is as follows:

Captain
Lieutenant
Sergeant

NYU Langone Medical Center

A representative of the Security Management Team is present in the Medical Center 24 hours a day, 7 days a week. They may be reached by asking the Security Officer assigned to the Operations Center to contact one via telephone. Useful numbers of the Security Department are listed:

24 Hour Security Operations Center (212) 263-5120
Security Administration (Business Hours) (212) 263-5038

Robert Zick
Director of Security (212) 263-5038

Robert Pickett
Associate Director (212) 263-5038

David Sweet
Operations Manager (212) 263-0940
George Domanski  
Loss Prevention/Investigations Manager  (212) 263-0929

Rafael Ortiz  
Training Manager  (212) 263-6593

Security Supervisors  (212)-263-5038

Michele Meller  
Office Manager  (212) 263-0930

**NYU Hospital for Joint Diseases**

*NYU Hospital for Joint Diseases security is available 24hrs 7 days a week with supervision on site or on call at all times.*

Thomas Fascianella  
Director of Security  (212) 598-6675

Javier Crespo  
Day Supervisor  (212) 598-6202

John Cuffy  
Evening Asst: Supervisor  (212) 598-6202

William Ocasio  
Night Supervisor  (212) 598-6202

**V.A. Hospital**

For additional information please contact your Clinical Service Chief. The following VA NYHHS employees can also assist or provide guidance.

**Brooklyn Campus:**  
Chief Frank Corselli -  718-836-6600 x2974  
Captain Raymond Behan -  718-836-6600 x4281

**New York Campus:**  
Captain Nelson Reyes -  212-686-7500 x3201  
Lieutenant Willie Parker -  212-686-7500 x3711

**St. Albans Campus:**  
Lieutenant Martin Richards -  718-526-1000 x8501
ENTRY INTO FACILITY

Bellevue Hospital

Entry into the facility is controlled by Bellevue Hospital Police (“HP”). When entering the facility, you are required to show your Identification Card to the HP staffing the entrance.

NYU Langone Medical Center

Entry into the facility is controlled by NYU Langone Medical Center Security Officers. Standards established by the Joint Commission, New York State Department of Health and the Medical Center require that the identification of all medical center staff, including faculty, students, contractors and volunteers be accomplished through the use of identification badges which are clearly visible and worn at all times above the waist, “face-side” out while on the premises. While entering the facility you will be expected and required to show your Identification Badge. Your cooperation with the Security Officer is required and you may be refused entry into the facility if you are not properly identified.

NYU Hospital for Joint Diseases

Entry into the NYU Hospital for Joint Diseases facility is controlled by the Loss Prevention Department, Security Officers creating a visible front line of defense for the facility. Loss Prevention is also responsible for the Patient Information desk and the Visitor Management System; which screens all visitors and patients entering the facility. Individuals entering the facility will be expected and required to show an Identification Badge. Identification Badges is required to be worn by all employees, patients, visitors, contractors, vendors and volunteers. Self-expiring badges with the wearer’s captured photo and signature is issued to each visitor; showing the area they are authorized to visit. Identification Badges are to be worn at all times while on the premises. Employees are required to have their Identification Badges readily visible; worn above the waist with the “face-side” out. If you do not have your badge with you, you will be asked to go to the Loss Prevention Security office to sign in and receive a temporary identification badge. Your cooperation with the Security Officer and this policy is required; non cooperation may result in your entry into the facility being refused.

V.A. Hospital

Following September 11, 2001, VA NYHHS implemented many security measures to provide additional safeguards for veteran patients, visitors, staff and volunteers and VA NYHHS facilities. Increased security measures include magnetometer screening of all individuals and x-ray scanning of all bags and packages entering our campuses. Additionally, all individuals entering VA NYHHS facilities must show proper identification.

Most VA NYHHS campus exits have been designated for emergency use only or closed to normal day-to-day pedestrian traffic to improve security. Utilizing emergency exits or propping open doors to enter and exit it is a breech of security. All VA NYHHS staff, volunteers and veteran patients have a responsibly to maintain security at all facilities.
SECURITY AND/OR POLICE

Bellevue Hospital Center

Bellevue security consists of New York City Health and Hospitals Hospital Police ("HP") and Watchpersons. Watchpersons’ duties are similar to HP except that they do not have the power to arrest. HP is governed by the New York State Penal Law and perform all law enforcement duties on HHC owned and controlled property. HP staff several stationary posts and patrols, and are authorized to arrest for violations of law or issue summonses for disorderly conduct, smoking parking violations', and similar activity.

NYU Langone Medical Center

NYU Langone Medical Center is patrolled and protected by Security Officers. All Security Officers are licensed and regulated by the Security Guard Act of 1992, which is enforced by the New York State Department of State.

Security Officers do not have police powers but can make arrests just as any civilian can and then must turn over the prisoner to the New York City Police Department or other governmental enforcement agency.

Security Officers may not issue summonses and at NYULMC none of the security personnel are permitted to carry firearms.

NYU Hospital for Joint Diseases

NYU Hospital for Joint Diseases is patrolled and protected by the Loss Prevention Department, Security Officers. All Security Officers are licensed and regulated by the Security Guard Act of 1992, which is enforced by the New York State Department of State.

Security Officers do not have police powers but can make arrests just as any civilian can and then must turn over the prisoner to the New York City Police Department or other governmental enforcement agency.

Security Officers may not issue summonses and at NYU HJD none of the security personnel are permitted to carry firearms.

V.A. Hospital

VA Police Officers are federal law enforcement officers that have the same law enforcement powers and authority as state and municipal police officers including arrest authority. VA Police Officers are empowered under Title 38 of the United States Code (Section 902) to perform all law enforcement duties on VA owned and controlled property through the enforcement of federal, state and local laws, as well as VA rules and regulations.

VA NYHHS facilities are under the "exclusive or proprietary" jurisdiction of the United States Government. New York City Police do not patrol the grounds or buildings and do not exercise law enforcement authority while on federal grounds. However, full cooperation is afforded to local law
enforcement agencies when necessary to apprehend criminal suspects or serve criminal and civil processes.

VA Police Officers enforce posted rules and regulations to include speed limits and parking regulations primarily through the use of Courtesy Violation Notices, U.S. District Court Violation Notice or physical arrest enforcement actions. Individuals found guilty of violating VA rules and regulations while on VA NYHHS property may be subject to fines.

IDENTIFICATION CARDS:

Bellevue Hospital Center

All employees are issued photo identification cards by HP and are required to wear them face up and above the waistline or on the outer clothing at all time while on Bellevue Hospital grounds. HP and Watchpersons acknowledge NYU and Veterans Administration Identification for entry into the facility. Lost cards may be replaced with the consent of your immediate supervisor for a $10.00 fee. Worn cards are replaced free of charge. All Identification cards remain the property of Bellevue Hospital Center and must be returned upon termination or resignation.

NYU Langone Medical Center

All employees are issued current validated photo identification badges by the Security Department and are required to wear them face up, above the waist on outer clothing at all times while on NYU Langone Medical Center property. Lost badges may be replaced by bringing a note from your supervisor to any of the Hospitals Center or School of Medicine cashiers, paying the fee and presenting the receipt to the Security Department. Worn badges are replaced free of charge. Identification badges remain the property of the Medical Center and must be returned to your supervisor by your last day of work. Identification Badges are also used to unlock certain areas of the Medical Center via their security system. It is important to immediately report lost/missing ID/access cards to security.

NYU Hospital for Joint Diseases

All employees are issued current validated photo identification badges by the Loss Prevention Department and are required to wear them face up, above the waist on outer clothing at all times while on NYU Hospital for Joint Diseases property. Lost/missing badges must be reported immediately to your supervisor/department head and the Loss Prevention Department. Loss badges may be replaced by paying a fee at the cashiers and presenting the receipt to the Loss Prevention Department. Worn badges are replaced free of charge. Identification badges remain the property of the NYU Hospital for Joint Diseases and must be returned to your supervisor by your last day of work. Identification Badges are used to unlock certain areas of NYUHJD via their security system they are also used to swipe in and out at designated time clocks when entering and leaving Hospital during employees shifts. It is important to immediately report lost/missing ID/access cards to security.
**V.A. Hospital**

Proper identification includes VA Identification Card or up to date NYUMC Identification. VA NYHHS will replace employee VA Identification Card when lost or damaged. During clinical rotations and residencies, NYU and SUNY-Downstate medical students and residents are expected to obtain and wear a VA Identification Card while on VA NYHHS campuses. VA Identification Cards are obtained in the Human Resources Service at the beginning of the training period and require the completion of appropriate forms, including a National Agency Check Inquiry, and electronic finger print scanning. This is a requirement of all VA employees, volunteers, medical residents and trainees.

**ACCESS CARDS:**

**Bellevue Hospital Center**

Bellevue Identification cards can be used to access restricted areas, such as the ED, 8th floor PICU, 10th floor ICU, the 14th floor Pharmacy, and the AmCare pavilion. Such access is limited to authorized personnel. To get access, you must request it through your department head who will in turn apply through HP. Access will be granted either through programming a Bellevue ID card or through the placement of a programmable disc on the sleeve that holds the NYU ID card.

**V.A. Hospital**

All access cards to secure areas must be authorized by Service Chief.

**NYU Langone Medical Center**

Your Identification Badge is also a access card. Access to authorized areas will require a written request from the department head in charge of that area to the Security Department. It is important that lost/missing access cards get reported to security immediately so it can be deleted from the system.

**NYU HOSPITAL FOR JOINT DISEASES**

A computerized card-access system has been installed to facilitate entry into specific areas of NYUHJD (i.e., 8th Floor Pediatrics, Medical Library, 18th Street Employee Entrance, etc.). This system is integrated with our existing identification badge to enhance the security of these designated areas. Employees given approved access to these areas are not to share or lend their ID/Access card with anyone at any time. Lost, stolen and or misplaced ID/access cards must be reported to the Loss Prevention Department as soon as possible so it can be deleted from the system database immediately. This prevents any unauthorized persons from using them.
TRANSPORTATION BETWEEN SITES

V.A. Hospital

Doctors requiring transportation from the VA to either NYU or Bellevue Hospital will go to Police Operations, 1st Floor, Room 1043W, and request that car service be ordered. The Police will then telephone Delancy Car Service at (212) 228-3301 for transportation. The VA maintains an account with this vendor. There are only two authorized destinations, NYU or Bellevue Hospital.

NYU Langone Medical Center

During the hours of 11:30pm to 7:30 am, daily, NYU Langone Security staff can provide an escort in-between sites. This service can be arranged by calling 212-263-5120. When calling please note the lobby you wish to be met at, and leave some time for this service to be arranged.

NYU HOSPITAL FOR JOINT DISEASES

NYU Hospital for Joint Diseases has a van which is used for pick-up and deliveries, and transportation of staff to and from our off site locations. Departments can schedule use of the van after requesting and receiving approval from their department head and Loss Prevention.

PACKAGE CHECKS

Bellevue Hospital Center

Bellevue Hospital conducts random package inspection of all sizeable packages entering and leaving the facility. Employees who have been authorized to remove Bellevue Hospital property must have a properly obtained Relinquishment Voucher, which can be obtained at HP offices, approved by HP and the employee’s immediate supervisor.

V.A. Hospital

Upon entering the facility all packages must be placed on the x-ray machine for examination.

A VA Property Pass is required to remove clinical related documentation or diagnostic materials from any VA NYHHS Campus. VA Property Passes should be obtained from Clinical Service Chiefs.

NYU Langone Medical Center

As a precaution taken for the safety of your property, as well as that of NYU Langone Medical Center and our patients, the Security Department is authorized to examine the contents of any package or bag, which is being carried into or out of the Medical Center. Staff who have permission to remove Medical
Center property must have a package pass. Compliance with such inspections is required. Failure to cooperate with a package check can lead to disciplinary action up to and including termination.

NYU HOSPITAL FOR JOINT DISEASES

The Loss Prevention Department is authorized to examine the contents of any package or bag, which is being carried in or out of the facility. This precaution is taken for the safety of your property, as well as that of NYU Hospital for Joint Disease and our patients. Employees who have permission to remove Hospital property must have a properly obtained Package Pass. A Package Pass must be given to the Loss Prevention Security Guard to check for a proper signature by a supervisor authorizing the property to be removed from the facility. Compliance with such inspections is required. Failure to cooperate with a package check can lead to disciplinary action up to and including termination.

PARKING

Bellevue Hospital Center

There is no free parking at Bellevue Hospital. Three parking lots operate on a first come-first served basis; when the lots are full, no other parking spaces will be available. The lots are open to the public; the rate is $14 per 12-hour period. Employee rates, which are available to Bellevue employees and NYU staff working at Bellevue, are $7.00 per 12-hour period and $140.00 for monthly parking. If you are an employee and need monthly parking, you should fill out an application at Hospital Police located at Room GD-14 on the 1st Level to the right of the rotunda. All vehicles parked in unauthorized areas will be summonsed and towed at the owner’s expense.

V.A. Hospital

Parking at the New York campus is extremely limited and must be approved by the screening committee. At the Brooklyn and St. Albans campuses, the VA Police will issue parking permits.

NYU Langone Medical Center

There is no free parking at NYU Medical Center. If you need parking you should make an application to Real Estate.

NYU HOSPITAL FOR JOINT DISEASES

There is parking for employees at NYU Hospital for Joint Diseases at an outside garage located on 21st street between 1st and 2nd Avenue. Employees can park there on a monthly basis at a Hospital rate. Employees must come to the Loss Prevention Department to sign up for parking to get the monthly Hospital rate.
OFF HOURS SECURITY

Bellevue Hospital Center

When working during off hours, an employee should notify HP by calling x6191. HP are available to provide escorts to and from secluded areas of the campus. Scores of phones are equipped with duress alarms, also known as “panic buttons”, which ring at the HP Control Center.

NYU Langone Medical Center

A Security Van is operated daily from 11:30pm to 7:30am. This van is at your service to drive you to or from NYU Medical Center, Bellevue Hospital and the VA Hospital. As an extended service we will also drive to the local train stations, bus stops or any reasonable destination within the area. For this service if you are inside the Medical Center dial extension 7-3000. From outside the Medical Center please dial (212) 263-5120.

LOST AND FOUND

Bellevue Hospital Center

Bellevue Hospital does not have a lost and found section. All inquiries regarding lost property should be referred to the Patient Property office or the cashier.

V.A. HOSPITAL

At the New York campus, Lost and Found is located on the 9th floor, Room 9C. At the Brooklyn campus, Lost and Found is located on the 1st Floor, Telephone Operators Room. At the St. Albans campus, Lost and Found is located on the ground floor reception area.

NYU Langone Medical Center

The Lost and Found Department is maintained by the NYULMC Security Department. Found property should be given to any Security Officer. Inquiries regarding lost property should be made at the Security Department Administrative Offices located in Alumni Hall, Room G-100.

NYU HOSPITAL FOR JOINT DISEASES

The Lost and Found Department is maintained by the NYUHJD Loss Prevention Department. Found property should be given to any Security Officer. Inquiries regarding lost property should be made at the Loss Prevention Department Administrative Offices located on First floor, room 133.
SMOKING

Bellevue Hospital Center

Bellevue Hospital is a smoke-free facility. There is one designated smoking area in the Sobriety Garden located by the South lot parking lot. If employees or visitors are found smoking outside of this area, they will be issued an Environmental Control Board summons with a penalty of up to $250.00. Employees are also referred to Human Resources for appropriate discipline.

V.A. Hospital

The VA New York Harbor Healthcare System is a smoke free environment.

NYU Langone Medical Center

NYU Langone Medical Center is a smoke free environment. There is no smoking anywhere inside of the facility. For those who do wish to smoke, there is a smoking area on the perimeter of the facility on 30th street. The ban on smoking extends to NYULMC operated vehicles.

NYU Hospital for Joint Diseases

NYU Hospital for Joint Disease is a smoke free environment. The only area where smoking is permitted is across the street from the hospital in the park. Smoking is prohibited in front of the hospital building to include the 18th Street employee entrance, the 17th Street front entrance ramp way, and the 17th Street entrance by Immediate Care. This smoking ban also extends to all NYUHJD owned vehicles.

ALCOHOL

Bellevue Hospital Center

Any employee suspected of being under the influence of illicit drugs or alcohol will be referred to Emergency Health Service for medical evaluation. Any employee who refuses to be medically evaluated may be subjected to disciplinary action up to and including termination of employment.

NYU Langone Medical Center

This policy is established with the goal of ensuring a safe and productive work environment for the faculty and staff of the Medical Center. The policy establishes rules and procedures for drug and alcohol testing in the event there is reasonable cause to believe that a Medical Center employee is using
alcohol or illegal drugs in the workplace, is abusing controlled substances in the workplace, or is performing official duties while under the influence of alcohol, illegal drugs, or controlled substances.

As a rule, possession, use or distribution of drugs or alcohol on Medical Center premises is prohibited. On those occasions of Medical Center sponsored events the consumption of alcohol in moderation is permissible but is prohibited within patient care areas and the research environment. Employees on duty or working immediately after attending a sponsored event cannot consume alcohol or they will be deemed unfit for duty and subject to discipline. Medical Center sponsored events, on campus, may only serve alcohol provided by the Catering Department of the Food Service Department in order to ensure compliance with the institutions liquor license.

Should you have any questions concerning this policy please contact the Employee Relations Department at 404-3857.

NYU HOSPITAL FOR JOINT DISEASES

If there is reasonable cause to suspected any NYU Hospital for Joint Diseases employee of using alcohol or illegal drugs in the workplace, of abusing controlled substances in the workplace, or is performing official duties while under the influence of alcohol, illegal drugs, or controlled substances; this employee will not be allowed to work and may be subject to a drug and alcohol testing conducted by the NYU Employee Health Service. Any employee who refuses to be medically evaluated may be subject to disciplinary action up to and including termination of employment.

As a rule, possession, use or distribution of drugs or alcohol on NYUHJD premises is prohibited. On those occasions of NYUHJD sponsored events the consumption of alcohol in moderation is permissible but is prohibited within patient care areas and the research environment. Employees on duty or working immediately after attending a sponsored event cannot consume alcohol or they will be deemed unfit for duty and subject to discipline.

FIREARMS

Bellevue Hospital Center

No firearms are allowed in the facility except NYPD, DOC and law enforcement officers in performance of their duties. There are some areas where carrying loaded firearms is prohibited. In those areas, there are Unloading Stations available.

NYU Langone Medical Center

No firearm is permitted on medical center property. If you are a licensed pistol permit holder you are still NOT permitted to carry a firearm on NYULMC Property or in any of its vehicles.
NYU HOSPITAL FOR JOINT DISEASES

No firearms are allowed in the NYU Hospital for Joint Diseases facility; except personnel from Federal, State, County, and City law enforcement agencies that are on official business and authorized to be armed are allowed to retain their firearms while in NYUHJD. Other armed personnel unless cleared by Hospital or Security Administration, will be directed and escorted to the Loss Prevention Department.

FIRE ALARMS

Bellevue Hospital Center

It is the policy of Bellevue Hospital that a fire alarm is to be pulled upon discovery of a smoke condition or fire. When the fire alarm sounds, every employee is to implement the fire protocol: (RACE) Rescue, Alarm, Contain, Extinguish.

NYU Langone Medical Center

It is the policy of the Medical Center that upon discovery of smoke or fire the fire alarm is to be pulled. Because of the potential for underestimating the seriousness of a fire condition, there is no exception to this policy.

When a fire alarm sounds, every employee is expected to implement fire protocol appropriate to his or her work area. There is no code to indicate if an alarm signifies a drill or a real fire; therefore, every alarm should be treated as a potentially serious fire.

NYU HOSPITAL FOR JOINT DISEASES

It is the policy of NYU Hospital for Joint Disease that when a fire alarm sounds, every employee is expected to implement fire protocol appropriate to his or her work area. There is no code to indicate if an alarm signifies a drill or a real fire; therefore, every alarm should be treated as a real fire. When the fire alarm sounds, every employee is to implement the fire protocol: (RACE) Rescue, Alarm, Confine, and Extinguish.

SECURITY CODES

Bellevue Hospital

Code Pink: In the event of a child or infant abduction you will hear an overhead announcement of Code Pink. The Hospital will commence a lockdown condition and no one will be allowed to leave until all packages are checked. All Bellevue employees are expected to assist in the lockdown process by looking for anyone carrying large or oversized bags and identifying anyone who looks suspicious or is trying to exit the hospital with an infant or small child.
**Code 777:** In the event of an internal or external disaster, you will hear a series of bells followed by an announcement of Code 777. In the event of a Code 777, you should report to your work area unless otherwise instructed by your supervisor.

**NYU Langone Medical Center**

**Code Pink:** In the event of a child or infant abduction you will hear an overhead announcement of, “Code Pink”. In the event of a Code Pink the Medical Center may go into a lock-down condition and no one will be allowed to leave until all his or her packages have been checked. Due to the seriousness of a child being abducted all staff is expected to look for anyone carrying or walking with a child or infant or attempting to exit the medical center undetected. Any suspicious activity of this nature should be reported immediately to the Security Department @ 73000.

**Code 1000:** In the event of a disaster that requires a response you will hear an overhead announcement of, “Code 1000”. In the event of a Code 1000 you should report to your work area unless you have been previously designated to report to somewhere else.

**NYU Hospital for Joint Diseases**

**Code Pink:** In the event of a child or infant abduction you will hear an overhead announcement of, “Code Pink”. In the event of a Code Pink the Hospital will be going into a lock-down condition and no one will be allowed to leave until all his or her packages have been checked. Due to the seriousness of a child being abducted all employees are expected to look for anyone carrying or walking with a child or infant or attempting to exit the Hospital undetected. Any suspicious activity of this nature should be reported immediately to the Loss Prevention Department.

**Code 1000:** In the event of an internal or external disaster that requires a response you will hear an overhead announcement of, “Code 1000”. In the event of a Code 1000 you should report to your work area or designated area.

**Code Hazmat:** In the event that a Code Hazmat is called all assign personal must report to security office and take direction from Decon Team Leader.

**Code Orange:** Security/Loss Prevention personnel will follow departmental procedures, including (but not limited to) calling 911 for NYPD assistance if the situation warrants, and/or responding directly to the location if it is determined that it is safe for Security/Loss Prevention personnel to do so. Departments will maintain implementation of Code Orange procedures until the “All Clear” has been given.

**TIPS FOR INTERACTION WITH POLICE/SECURITY**

*Bellevue Hospital Center, VA Hospital, NYU Langone Medical Center*
Although the VA Hospital has federal police, Bellevue has NYC Hospital Police and NYULMC has security officers, these tips will help you interact with all of them.

1. **Clearly display & wear your ID.** It lets the officer know immediately who you are and that you’re on the premises legally.

2. **Package Inspections.** All three hospitals maintain a right to inspect all incoming and outgoing packages. Please cooperate with the officers at the door. Arguing with them won’t change their minds.

3. **Disagreements.** Don’t let a disagreement become a confrontation. If you feel an officer is being unreasonable, ask to speak to his supervisor.

4. **Emergencies.** In an emergency you may be told to leave immediately or go out another exit or any one of a dozen orders that you may not like. This is not a good time to engage in a debate. Usually if an officer is forcefully telling you to do something, there is a very good reason. Please cooperate with them.

5. **Cooperation.** All of the hospital and medical center personnel are important in the maintaining of a safe and secure environment. The easiest way for all of us to work together is in the spirit of cooperation. There are times when you will not agree with an officer and you are free to express that but please don’t let it become a confrontation.

6. **Arrest Powers.** The VA Hospital and Bellevue Hospital maintain a staff of police officers that have the power to arrest and/or issue summonses. Being disorderly can result in your being arrested. At NYULMC security officers are employed and they too have the power to arrest you if you commit a crime against the institution or any of its occupants. In the rare event that you find yourself being arrested, please do not resist. If a matter gets to that point then the place to resolve it is in a court of law.