Staten Island University Hospital

Annual Physician/Practitioner Orientation & Mandatory Training Program

Physician Training on Safety

Patients' Bill of Rights

Advance Directives & Organ Donation

Incident Report Policy & Procedure

2803-e Hospital Reporting Responsibilities

Performance Improvement Plan

Physician's Annual Training

Staten Island University Hospital's Mission Statement

Staten Island University Hospital is dedicated to providing our community with the best possible quality care through continuous Quality Improvement efforts. We consider our employees to be our greatest resource. We continually examine the way we do our work in order to make improvements and prevent errors. Exceeding the needs and expectations of our customers is the basis for all that we do.

Patient Rights

Confidentiality and privacy, respectful and considerate care, and resolution of complaints. When patients are in the Hospital they have the right to be well informed about their illness, possible treatments and their outcome, and to discuss this information with their physician; consent or refuse treatment as permitted by law, throughout their hospital stay. If they refuse a recommended treatment, they will receive their needed available care. An advance directive, such as a living will or health care proxy. These express patients' choices about their future care or name someone to decide if they cannot speak for themselves.

Hospital resources such as patient representatives 8851(N) 2010(S) and the ethics committee can help resolve problems about patients' stay and care. Never discuss a patient in the hallways, elevators or cafeteria. All patient information must be treated in a confidential manner.

I.D. Badges

All medical staff must wear their I.D. Badges at their lapel above the waist so as to be noticeable and readable.

Emergency Codes

All physicians must be familiar with the following emergency codes:

CODE RED
Smoke and fires are reported by pulling the fire alarm and dialing 47, report location and type of fire. Smoke doors will automatically close when the fire alarm system is activated. To respond rapidly and effectively, follow the "RACE" procedure.

"RACE" Procedure
Close all doors and windows. Code RED codes (posted next to fire alarms).
Always evacuate horizontally first away from the fire.
R – Rescue
A – Alarm
C – Contain
E - Evacuate

Types of Fires Extinguishers at SIUH

TYPE A Ordinary Combustible
TYPE B Flammable liquids/electrical
TYPE C Electrical
TYPE ABC All of the Above

PASS – Procedure (use of fire extinguishers)
P – Pull the retaining pin, breaking the nylon seal
A – Aim the hose at the base of the fire
S – Squeeze the extinguisher's handles together releasing the extinguisher medium
S – Sweep from side to side

CODE BLUE
Any person who is not breathing or whose heart has stopped beating **DIAL – 47**

CODE HEICS
Internal and External Disaster
Internal – An event which causes or threatens to cause physical damage or injury to hospital personnel and patients within the facility. Examples: loss of water, electric, telephone services and emergency supplies due to a fire, explosions, riots or natural disasters.
External – An event which requires the hospital to receive and care for a large number of casualties from a disaster such as a plane crash, or vehicle accident with multiple injuries.

Hazard Communications

Right to Know
Each department maintains a manual of their chemical inventory. Each department is responsible for updating the chemical inventory on an annual basis. MSDS (Material Safety Data Sheet) must be available in the department for all chemicals used. All chemical containers must be labeled with the classifications for flammability, health hazard, reactivity and other. Patient Support Services maintains a master list in alphabetical order by trade name of MSDA for hazardous materials used in the hospital.

Incident Reporting

If a physician experiences an injury or an accident while at Staten Island University Hospital, the Director of Service is notified, a Managers Incident Accident/Illness Report is completed and the physician is seen in Employee Health Service or the Emergency Department as needed.

Security

Perceived Threat: The following steps are to be followed if confronted by a violent or potentially violent threatening situation:
P – Protect yourself
A – Sound the alarm, dial 47, alert the operator to the situation. The operator will notify security and send help.
L – Listen to the instructions provided by security.

Patients' Bill of Rights

As a patient in a hospital in New York State, you have the right, consistent with law, to:

(1) Understand and use these rights. If for any reason you do not understand or you need help, the hospital MUST provide assistance, including an interpreter.

(2) Receive treatment without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation or source of payment.

(3) Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.

(4) Receive emergency care if you need it.

(5) Be informed of the name and position of the doctor who will be in charge of your care in the hospital.

(6) Know the names, positions and functions of any hospital staff involved in your care and refuse their treatment, examination or observation.

(7) A no smoking room.

(8) Receive complete information about your diagnosis, treatment and prognosis.

(9) Receive all the information that you need to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.

(10) Receive all the information you need to give informed consent for an order not to resuscitate. You also have the right to designate an individual to give this consent for you if you are too ill to do so. If you would like additional information, please ask for a copy of the pamphlet "Do Not Resuscitate Orders — A Guide for Patients and Families."

(11) Refuse treatment and be told what effect this may have on your health.

(12) Refuse to take part in research. In deciding whether or not to participate, you have the right to a full explanation.

(13) Privacy while in the hospital and confidentiality of all information and records regarding your care.

(14) Participate in all decisions about your treatment and discharge from the hospital. The hospital must provide you with a written discharge plan and written description of how you can appeal your discharge.

(15) Review your medical record without charge. Obtain a copy of your medical record for which the hospital can charge a reasonable fee. You cannot be denied a copy solely because you cannot afford to pay.

(16) Receive an itemized bill and explanation of all charges.

(17) Complain without fear of reprisals about the care and services you are receiving and to have the hospital respond to you and if you request it, a written response. If you are not satisfied with the hospital's response, you can complain to the New York State Health Department. The hospital must provide you with the Health Department telephone number.

(18) Authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors.

(19) Make known your wishes in regard to anatomical gifts. You may document your wishes in your health care proxy or on a donor card, available from the hospital.

9/97

STATEN ISLAND UNIVERSITY HOSPITAL

PATIENT CARE MANUAL

SUBJECT: Advance Directives	**MANUAL CODE:** PCM – V – A – 5.0 **Replaces:** ADM – III- B-1.0
EFFECTIVE DATE: August 2014 Page 1 of 4	**SUPERSEDES:** September 2011

GENERAL STATEMENT OF PURPOSE

The purpose of this policy is to provide an atmosphere of respect and caring, and to ensure that each patient's ability and right in medical decision making is maximized and not compromised as a result of admission for care at Staten Island University Hospital "Hospital".
The Hospital will also ensure compliance with Federal, State, and Local Laws including the Federal Patient Self-Determination Act (PSDA), and the Family Health Care Decisions Act ("FHCDA") concerning patients who made a prior decision, ("Advance Directives"), and will provide patients with information regarding their rights to formulate Health Care Proxies and other Advance Directives. PHL Articles 29-B, 29-C and 2994

POLICY:

It is the policy at Staten Island University Hospital that the rights of all adult patients, in all settings will be honored and respected to make voluntary, informed decisions concerning their medical care and to execute an Advance Directive(s) in the event the patient losses the capacity to make his/her own healthcare decisions. Rights are communicated to the person served in a way that is understandable. Patients will be encouraged and assisted to be active participants in the decision making process regarding their care through education, inquiry and assistance as requested. The existence of an Advance Directive, or lack thereof, will not impact the patient's access to care, treatment and services.

Definitions:

Adult: any person who is 18 years of age or older.
Advance Directives: a patient's prior decision documented in an oral or written instruction relating to the provision
of health care when an adult becomes incapacitated, such as a Health Care Proxy, consent to DNR/DNI order, MOLST, or a Living Will.
Emancipated Minor – A minor who is less than 16 years of age whom is married or the parent of a child.
Health Care Proxy: a document delegating health care decision-making authority in accordance with New York's health care proxy law (PHL Article 29-C).
Health Care: any treatment, service, or procedure to diagnose or treat an individual's physical or mental condition
Capacity to make health care decisions: the ability to understand and appreciate the nature and consequences of health care decisions, including the benefits and risks of and alternatives to any proposed health care, and to make an informed decision.

Health Care Agent(s): adult(s) to whom health care decision-making authority has been delegated under a health care proxy.

Health Care Decision: any decision to consent or refuse consent to health care.

Health Care Provider: any person, hospice, home health agencies, etc., licensed, certified or otherwise authorized or permitted by law to administer health care in the ordinary course of business or professional practice.

Living Will: a document which contains specific instructions concerning an adult's wishes about the type of health care choices and treatments that an adult does or does not want to receive, but which does not designate an agent to make health care decisions. A living will must be supported by affidavits demonstrating clear and convincing evidence of a patients wishes by immediate family members.

PROCEDURE:

1. Upon admission or registration each adult patient or, if the patient lacks capacity, a Surrogate, family member or other adult who represents the patient must be given a copy of the following:
   a. For outpatients:
      "Planning in Advance for Your Medical Treatment" which summarizes the rights of an adult to accept or refuse medical treatment, consent to a DNR order, designate a health care proxy, or formulate an Advance Directive in accordance with state and federal law.
      Note: for Outpatients who receive care on a recurring basis this document will be provided only once.
   b. For inpatients:
      "Your Rights as a Hospital Patient" booklet

2. Provider's Obligations:
   a. At the time of the patient's initial contact (admission or registration) information regarding the patient's wishes "Advance Directives" is entered into the Electronic Medical Record (EMR) in the Horizon Health Summary (HHS) Admission profile or on the Patient Notification Record of Advance Directives Form (38568)). This form provides documentation indicating whether the patient has signed a health care proxy or has provided other written or oral advance instructions about treatment to hospital staff responsible for the patient's care.
   b. The health care provider (e.g. nurse, counselor, social worker, physician, etc.)
      Must:
      - Document whether the patient has made oral or written provisions regarding advance instructions for treatment in the Patient Profile.

STATEN ISLAND UNIVERSITY HOSPITAL

PATIENT CARE MANUAL

SUBJECT: Advance Directives	**MANUAL CODE:** NSG – V – A – 5.0
EFFECTIVE DATE: August 2014 Page 3 of 4	**SUPERSEDES:** September 2011

- Document whether the patient has a Living Will, DNR/DNI, MOLST, or Health Care Proxy. If there is a Health Care Proxy, the name of the agent and how to contact the agent must be documented in the patient Profile.
- A copy of any written document the patient has should be placed in the medical record immediately and the patient/designated agent should be given the original.

c. If a patient or family member requests further information about Advance Directives, they should be referred to the Department of Patient Representation. The RN should place a nurse referral order for Patient Representation in HEO.

3. To ensure the continuity of patient's rights across the continuum, and eliminate duplication of effort, the following will occur:
   a. Patients who currently have a valid Advanced Directive in the medical record, and are being discharged from an acute care unit to a Prospective Payment System (PPS) exempt unit (Comprehensive Inpatient Rehabilitation or Inpatient Psychiatry), the Advanced Directive may be forwarded, and placed on the exempt unit medical record.
   b. The same process applies when patient's are readmitted from a PPS exempt unit (Comprehensive Inpatient Rehabilitation or Inpatient Psychiatry) to an acute care setting.

4. If a copy of the Advanced Directive is not available the following should occur:
   a. The healthcare provider must indicate the type of directive the patient has on the Patient Notification Record of Advance Directives Form (38568) or in the Patient Profile of the EMR.
   b. If the patient does not wish to execute an Advance Directive on this admission, the healthcare provider will document this in the medical record.
   c. If the Health Care Proxy or Surrogate is not present, the intent of the Advance Directive should be documented on the Patient Notification Record of Advance Directives form section IV or in the Patient Profile of the EMR: the name of the Health Care Agent, the Surrogate, the relationship to the patient, and how to contact that individual.
   d. The patient/family/significant other should be instructed to bring in a copy of the Health Care Proxy within 24 hours. A consult to Patient Representation should be made by the RN at this time. This is accomplished by placing a protocol order for Patient Representation in Horizon Expert Orders (HEO)
   e. Actions taken toward securing the presence of an Advance Directive on the medical record will be documented on the Patient Profile in the EMR or on the Patient Care Flowsheet (38161). Notification to the Patient Representative will also be noted on the Patient Profile or progress note.

Notification of Record of Advance Directives form or in the HHS Admission Profile..

f. The Patient Representative will document actions taken thereafter on the patient

5. The hospital must assess Advance Directives other than Health Care Proxies and consents to DNR orders that have been made in accordance with New York State Law. A copy of any such document, including Health Care Proxies from any other state, should be immediately referred to the Department of Patient Representation and/or the Office of Legal Affairs to determine the validity of the document.

6. The Department of Patient Representation must provide in-service education to staff, including medical staff, involved in the provision of care regarding the hospital's policies and procedures concerning Advance Directives.

7. The hospital, hospital staff and medical staff cannot discriminate against any patient in the provision of care based on whether or not the patient has an advance directive.

8. The hospital will post, in appropriate public places, the rights, duties and obligations of these laws, rules and regulations.

REFERENCE:
(OBRA 1990 amendments-Patient Self Determination Act 42 U.S.C.A. 1395cc) N.Y. PHL Article 29-B and Article 29-C and NYS DOH regulations (10 NYCRR400.21 and 700.5, add FHCDA)

SIGNATURES:

Reviewed by:	Title:	Date:
______________	Associate Executive Director/NE	________ Month/Year
______________	Medical Director	________ Month/Year
______________	Sr. Director, Patient Experience and Patient Relations	________ Month/Year
______________	Associate Executive Director Quality/Risk Management .	________ Month/Year

North Shore – LIJ Health System, Inc.
Staten Island University Hospital

POLICY TITLE: Donation After Cardiac Death	ADMINISTRATIVE POLICY AND PROCEDURE MANUAL
POLICY #: ADM III B 42.1 System # 700.07	CATEGORY: Administration
System Approval Date: 1/23/14 Site Implementation Date:3/1/14	Effective Date: December, 2002 Last Revised: March, 2011
Prepared by: Dana Lustbader MD, FCCM, FCCP North Shore University Hospital Section Head, Palliative Medicine Intensivist, Critical Care Medicine	Superseded Policy(s)/#: n/a

GENERAL STATEMENT of PURPOSE

The purpose of this policy is to describe the process which enables patients receiving mechanical ventilation or their surrogates to exercise their right to withdraw all life sustaining treatments and to request organ donation after death has been declared on the basis of cardio-pulmonary criteria. This policy defines the protocol for Donation after Cardiac Death (DCD) in these patients.

POLICY

Organ donation after cardiac death (DCD) refers to organ donation from a deceased donor who has been declared dead on the basis of traditional cardio-pulmonary criteria (permanent cessation of circulatory and respiratory function) rather than brain death criteria (permanent cessation of brain function). It is the policy of The North Shore LIJ Health System to identify and facilitate DCD in collaboration with the New York Organ Donor Network to offer the opportunity for organ donation after cardiac death in a manner that is compassionate and reflects best practice.

SCOPE

This policy applies to all members of the North Shore – LIJ Health System workforce including, but not limited to, employees, medical staff, volunteers, students, physician office staff, and other persons performing work for or at North Shore – LIJ Health System.

DEFINITIONS

1. Cardiac death – Death which is determined by traditional cardio-pulmonary criteria including apnea, absent circulation and unresponsiveness.

2. Brain death – The total and permanent cessation of brain function.

3. DCD - Donation after Cardiac Death (DCD) refers to organ donation after the withdrawal of mechanical ventilation and cardiac death declaration. This is in contrast to organ donation following the declaration of brain death which does not involve the withdrawal of mechanical ventilation and declaration of cardiac death.

4. DNR – A Do Not Resuscitate (DNR) order means that no resuscitative measure will be used if the patient has a cardiopulmonary arrest. A DNR order does not mean other treatments pre-arrest are withheld or withdrawn.

PROCEDURE/GUIDELINES

Patient Eligibility

1. The patient is receiving mechanical ventilation.
2. All life sustaining therapies are being withdrawn. This decision is made independently from any consideration regarding organ donation.
3. The patient or person with decision making authority has consented to the withdrawal of life sustaining therapy.
4. A DNR order is in place.
5. A potential donor is generally between the ages of 0 and 60 years of age.
6. Only the New York Organ Donor Network (NYODN) can determine donation suitability.
7. Cardiac death is expected to occur in less than 60 minutes after extubation.

Notification of Organ Procurement Organization

1. The New York Organ Donor Network (NYODN) 1-800-443-8469 will be notified as a patient is being evaluated for withdrawal of life sustaining therapy.

Consent for Organ Donation

1. Discussion regarding organ donation will occur after the patient or person with decision making authority has consented to withdrawal of life sustaining therapy.
2. Only members of the NYODN may discuss and obtain consent for organ donation.
3. The NYODN consent form will be used and a copy will be placed included in the medical record.
4. The medical decision maker should be fully informed about:

   - The possibility of procedures, testing and medication administration (including heparin) prior to withdrawal of life support, intended to determine donation suitability and facilitate organ retrieval.
   - The possibility that cardiopulmonary arrest will not occur within the time frame that will allow for organ donation. In this case, the patient would

remain under the care of the attending physician or his/her designee and be returned to an appropriate location for continued palliative care.

5. In the absence of written authorization by the patient to be a donor, the order of priority for persons making the decision for organ and tissue donation as stated in The New York State Public Health Law – Section 4301 is as follows:

   - Decedent's Health Care Agent
   - Decedent's Agent for disposition of remains (Burial Agent)
   - Spouse, if not legally separated, or domestic partner
   - Adult Children (18 years or old)
   - Either Parent
   - Adult Siblings (18 years or older)
   - Guardian at the time of the decedent's death
   - Any other person authorized or under the obligation to dispose of the body

Withdrawal of Life Sustaining Therapy

1. Withdrawal of life support shall be done by a physician or his/her designee knowledgeable in the use of analgesics and anxiolytics.
2. Ventilator withdrawal generally takes place in the operating room.
3. All members of the surgical recovery team are prohibited from participating in the withdrawal of life sustaining therapies or treatment of the patient.
4. Comfort medications to relieve suffering should be administered to the patient prior to and after ventilator withdrawal as prescribed by the patient's health care team.
5. Heparin is generally administered before ventilator withdrawal. Heparin is a critical component of DCD. The administration of heparin at the time of withdrawal of life-sustaining treatment is the current standard of care and a key component of best practice.
6. A protracted period of warm ischemia may affect the viability of organs for transplant and therefore preclude organ procurement.
7. The NYODN will be responsible for deciding when to discontinue the organ procurement process.
8. If discontinuation is necessary the patient will be transferred out of the operating room to an appropriate location in the hospital where palliative care will be provided.
9. Appropriate emotional and spiritual support will be provided to the family throughout the process.

Declaration of Death

1. An attending physician or his/her designee will make the declaration of death and complete the death certificate.
2. Once respirations stop, the determination of death requires two minutes of both of the following:
   a. Pulselessness

   b. Electrocardiographic changes such as asystole or pulseless electrical activity (PEA) that indicates the absence of heart function
3. No organ or tissue may be removed until death has been formally declared and documented.
4. The surgical recovery team may begin procuring organs and tissues after death has been declared.
5. Physicians involved in death declaration may not be involved in organ procurement.

Patients Found Ineligible

1. A protracted period of warm ischemia may affect the viability of organs for transplant and therefore preclude organ procurement.
2. The NYODN and the surgical recovery team will be responsible for deciding when to forgo organ procurement.
3. If discontinuation of the organ donor process is necessary, the patient will be transferred to an appropriate location in the hospital where palliative care will continue.

Disposition of the Body

When organ procurement procedures are completed, the body shall receive post-mortem care and be transferred to the morgue.

Responsibility for Costs

The NYODN will be financially responsible for all expenses directly associated with the evaluation and procurement of organs. In cases where the cardiopulmonary function continues and the patient does not die after ventilator withdrawal and efforts for organ donation cease, patient care expenses following attempted donation remain the responsibility of the patient.

REFERENCES to REGULATIONS and/or OTHER RELATED POLICIES

Refer to Administration Policy and Procedure 100.28, Patient Advance Directives, 100.25, Health Care Agents and Proxies and 700.03, Consent to Anatomical Gift and Organ.

A Position Paper by The Society of Critical Care Medicine. Recommendations for non heart beating organ donation. Critical Care Medicine 2001; 29(9): 1826-1831.

R. Steinbrook. Organ donation after cardiac death. NEJM 2007; 357(3): 209-212.

Donation After Cardiac Death: Analysis and Recommendations from the New York State Task Force on Life and the Law. April 17, 2007

CLINICAL REFERENCES
n/a

FORMS
n/a

APPROVAL:	
System Administrative P&P Committee	3/08/11; 12/19/13
System PICG Committee/Clinical Operations Committee	3/24/11; 1/23/14
SIUH MEC	5/2/11; 2/3/14

Versioning History:
April 2008;
March 2011

STATEN ISLAND UNIVERSITY HOSPITAL

ORGAN DONATION

It is the intent of Staten Island University Hospital to encourage organ and tissue donation and to assure that patients and the families of each potential organ donor know of the option to donate organs and/or tissues. Discretion and sensitivity shall be utilized with respect to the circumstances involved in the patient's hospitalization and consideration will be given to the views and beliefs of the families of potential donors.

A. All patients are presented the opportunity to express their interest in anatomical donation.

B. When the death of a patient has occurred or is imminent, a representative of the Hospital shall contact the New York Organ Donor Network (800-GIFT-4-NY), in order to make a preliminary determination of the suitability of the patient for organ donation. The New York Organ Donor Network is the federally designated organ procurement organization for Southern New York. **SIUH DOES NOT HAVE DESIGNATED REQUESTORS.** Only a representative from the New York Organ Donor Network may approach the family about possible anatomical donation.

C. If consent for an Anatomical Gift is obtained, page 3 of the death packet must also be completed.

D. Anatomical donations shall not be requested when any one of the following conditions are present:

- actual notice of contrary intentions by the decedent;
- actual notice of opposition by a member of the highest priority class available (as specified above); or
- other reasons to believe that an anatomical gift is contrary to the decedent's religious or moral beliefs.
- the medical record shall document the evidence that served as the basis for the "reason to believe."

Incident Report Policy and Procedure Summary

GENERAL STATEMENT OF PURPOSE
To insure adequate documentation, notification to the appropriate persons, and that the proper action is taken when an incident involving a patient, visitor, volunteer, employee or property or an unusual event which may potentially interrupt services necessary to the continued safe operation of the health facility has occurred. To comply with the JCAHO and federal regulations and (Ed Law 6527) and (PHL §2805 j.l.m.) and 10 NYCRR 405.8.

POLICY
All incident reports must be completed immediately after the incident has been discovered or reported and, if necessary, the required assistance rendered. It is the responsibility of all staff that provides care at Staten Island University Hospital to identify unusual incidents. The reports should answer the "who, what, where and how" of the incident.

PROCEDURE
I. Incidents are to be reported as follows:

A. Unusual incidents (see Administrative Policy ADM I 13.0 for complete list)

B. Patient Incidents: The incident reports should be investigated and completed by the employee who has best knowledge of the incident, usually the individual who first learned of the incident (nurse, physician, or technician). The physician attending that patient should be immediately notified and asked to assess the patient. Once completed, the incident report should be sent to appropriate persons for review. Any Patient's death will also be reported to the NYS Commission on Quality of Care. All incidents of a serious nature should be reviewed by the appropriate Director(s) of Service. The examining physician should document his/her findings on the report, date and sign name. Incidents should be fully documented in the patient's medical record by both the nursing staff and the physician who examined the patient. However, no reference should be made in the patient's medical record with regard to preparing an incident report.

C. Behavioral Sciences: In addition to hospital reporting of incidents the Department of Behavioral Sciences must report specific incidents to outside regulatory agencies. The procedure to be followed is found in the Behavioral Science Policy and Procedure Manual.

D. State Reportable Incidents: All significant incidents which indicate circumstances other than those related to the natural course of illness, disease or proper treatment, in accordance with generally accepted medical standards, or which disrupt the provision of patient care services, or cause harm to patients or staff, MUST BE REPORTED IMMEDIATELY to the following persons by phone or in person: Quality /Risk Management Department - from 8:00a.m. to 5:00p.m., Monday through Friday, Call (226-9162 or 9514). At all other times, these individuals are to be notified by long distance beeper (dial the operator).

The following categories of incidents, by law, must be reported to the State (10 N.Y.C.R.R. 405.8). Below each category is a list of specific incidents, which the Department of Health has identified as reportable. The lists are not all inclusive and, therefore, other types of incidents not specifically listed may also be reportable. (see appendix A/B-NYPORTS Includes/Excludes Incident List).

1. Patient deaths in circumstances other than those related to the natural course of illness, disease or proper treatment in accordance with generally accepted medical standards.

2. Injuries and impairments of bodily functions in circumstances other than those related to the natural course of illness, disease or proper treatment in accordance with generally accepted medical standards and that necessitates additional or more complicated treatment/regimens or which result in a significant change in patient status.

Types of State Reportable Incidents under these categories which must be reported include but are not limited to the following: (see appendix A - NYPORTS Includes/Excludes List, for other incidents that must be reported.)

- Anesthesia incidents resulting in coma, permanent disabilities or death.
- Patient arrest during surgery due to improper intubation.
- Medication error resulting in coma, permanent disabilities, allergic reactions and death

- Adverse medication reaction resulting in anaphylactic shock
- Patient falls or other in-house (or outpatient) injuries resulting in fractures or lacerations requiring sutures
- Rapes, molestation or assaults to patient (including child abuse) that occur in the hospital
- Suicides which occur in the hospital
- Attempted suicides which occur in the hospital and result in harm to the patient
- Pneumothoraces requiring chest tube insertion
- Surgical procedures wherein a foreign body is retained and a second procedure is required to remove it
- A wrong procedure performed on a patient
- Aspirations resulting in pneumonia, coma or death
- SIDS occurring in in-patients
- Unplanned returns to the O.R.
- Any new neurological deficit.
- All unplanned conversions to an open procedure secondary to an injury.

E. Fires or Internal Disasters in the facility which disrupt the provision of patient care services or cause harm to patients or personnel. (see Administrative Policy ADM I 13.0 for complete list)

F. Equipment malfunction or Equipment User Error during treatment or diagnosis of a patient, which did or could have adversely affected a patient or personnel. The term "equipment user error" refers to the inappropriate or improper use of mechanical patient care or diagnostic equipment by the individual using the equipment if the inappropriate or improper use could or did adversely affect the patient or the user. (see Administrative Policy ADM I 13.0 for complete list)

G. Poisoning occurring within the facility. (see Administrative Policy ADM I 13.0 for complete list)

H. Reportable Infections This category includes increased incidence of infections including nosocomial infection outbreaks, emerging pathogens of epidemiological significance; single cases of nosocomial acquired reportable communicable diseases; infections unrelated to the natural course of illness, disease or treatment in accordance with generally accepted medical standards that necessitate additional or more complicated treatment or that result in a significant change in the patient's status. This must be reported to the Director of Infection Control.

I. Patient Elopements and Kidnappings A reportable elopement occurs when the hospital is unable to account for the whereabouts of any in-patient following a thorough and diligent search and following the efforts to contact the patient's family/representative in an effort to locate the mission patient (see Administrative Policy ADM I 9.0, "Patient Elopements").

J. Disasters or other Emergency situations external to the hospital environment which affect facility operations. This category includes:
   - External events which affect the hospital's ability to meet patient care needs such as snow emergencies, chemical spill/exposure, contamination of water supply, major fires/explosions, floods and bomb threats.

K. Unscheduled termination of any services vital to the continued safe operation of the facility or to the health and safety of its patients and personnel. Incidents reportable under this category are:
   - Termination of telephone, electric, gas, fuel, water, heat, air-conditioning, rodent or pest control, laundry services, food, or contracted services.

By LAW, notification to the New York State Department of Health must be made within 24 hours of the incident or of the time when the hospital has reasonable cause to believe such an incident has occurred. Prior to the reporting, each incident is reviewed by Quality /Risk Management, Administration, and the respective Director of Service, as necessary.

The Department of Health maintains the authority to investigate incidents at any time.

The Quality/Risk Management Department maintains files for patient, visitor and volunteer incident reports and maintains statistics of said incident. From these statistics, the Quality/Risk Management Department will evaluate trends and patterns for significance. These statistics will be reported quarterly to Medical Staff Performance Improvement, Performance Improvement Coordinating Group. The Quality/Risk Management Department forwards copies of all incident reports to the appropriate investigation, insurance and/or law firms, as required.

ADM I 13.0
ATTAchment

Memo to Quality Assurance Subcommittee
(Ed Law § 6527)
(PHL §2805 j,l,m)

Hospital No. 0135562359
Hospital Name STATEN ISLAND UNIVERSITY HOSPITAL NORTH DIVISION
Bldg. ____
Floor ____ Room ____
Subject's Name: ____
Admitting Dx.: ____

☐ Inpt. ☐ Outpt. ☐ Visitor ☐ Employee ☐ Other Birthdate ☐☐ ☐☐ ☐☐☐☐ Sex: ☐ Male ☐ Femal

OCCURRENCE DATA
Date __|__|__ Time __|__ ☐AM ☐PM

FOR RM USE ONLY
Severity Index: ☐ Level I ☐ Level II ☐ Level III ☐ Level IV

Reportable to: DOH ☐ YES ☐ NO
MEDWATCH ☐ YES ☐ NO
Product/Drug Lot No.: ____

OCCURRENCE LOCATION
☐ Amb. Surgery ☐ Cardiac Cath. ☐ Clinic ☐ Critical Care ☐ Dentistry
☐ Detoxification ☐ Dialysis ☐ Emergency Dept. ☐ Extended Care ☐ Gen. Med./Surg.
☐ Grounds/Parking Lot ☐ Home Care ☐ Labor & Delivery ☐ Laboratory ☐ Lobby/Common Area ☐ Medicine
☐ Nuclear Medicine ☐ Nursery ☐ OB/GYN ☐ Operating Room ☐ PACU ☐ Pediatrics
☐ Physical Therapy ☐ Psychiatry ☐ Radiation Therapy ☐ Radiology ☐ Rehabilitation ☐ Satellite Site
☐ Step Down Unit ☐ Surgery ☐ Telemetry ☐ Transport ☐ Other ____

OCCURRENCE CATEGORY

Select one category (Oval) only. Under the Falls category, select one box in each section. For all other categories, you may select up to 2 boxes by marking them with numbers 1 and 2, indicating the primary and secondary nature of the occurrence.

FALLS ◯

OBSERVED ☐ YES ☐ NO
ASSISTED ☐ YES ☐ NO

LOCATION
☐ Patient's Bathroom
☐ Patient's Room
☐ Unit Hallway
☐ Other ____

ACTIVITY PRIOR TO FALL
☐ In Bed
☐ On Commode/Toilet
☐ In Chair/Wheelchair
☐ Standing/Walking
☐ In Tub/Shower
☐ On Stretcher/Table/Equipment
☐ Unknown
☐ Other ____

CAUSE
☐ Slipped/Tripped
☐ Weakness/Collapse
☐ Unknown
☐ Other ____

CONDITION OF FLOOR
☐ Wet ☐ Dry

SIDERAILS UP
☐1 ☐2 ☐3 ☐4 ☐None ☐N/A

PROCEDURE ◯ *or* **TEST** ◯ *or* **TREATMENT** ◯

☐ Allergic/Adverse reaction
☐ Break in sterile technique
☐ Cancellation
☐ Contamination
☐ Delay/Failure to review results
☐ Delay in performance/Results
☐ Error in performance/Results
☐ Delay/Error in reporting results
☐ Equipment failure/Malfunction
☐ Foreign body
☐ Implant failure
☐ Improper/Lack of consent
☐ Incorrect OR count
☐ Intolerance
☐ Lack of adequate monitoring
☐ Lost/Mishandled specimen
☐ Not ordered
☐ Ordered, not done
☐ Patient refusal
☐ Trauma from/Complication of
☐ Wrong patient/Site
☐ Wrong procedure/Test/Treatment
☐ Other ____

MEDICATION ◯ *or* **BLOOD** ◯ *or* **IV** ◯

☐ Allergic/Adverse reaction
☐ Contaminated/Outdated
☐ Delay in administration
☐ Discontinued
☐ Discontinued by patient
☐ Duplicated
☐ Equipment failure/Malfunction
☐ Improper/Lack of consent
☐ Incorrect narcotic count
☐ Infiltration
☐ Mislabeled
☐ Omission
☐ Patient refusal
☐ Wrong dose
☐ Wrong flow rate
☐ Wrong medication
☐ Wrong patient
☐ Wrong route
☐ Wrong solution
☐ Wrong time
☐ Other ____

Was a transcription error involved? ☐ YES ☐ N

MISCELLANEOUS ◯

☐ Assault/Altercation
☐ Attempted suicide/Suicide
☐ Burns
☐ Elopement
☐ Fire
☐ Food/Beverage related
☐ Left AMA
☐ LBT/LWCT
☐ Needlestick
☐ Power failure
☐ Pt./Family/Visitor complair
☐ Patient interference
☐ Property loss/Damage
☐ Self-extubation
☐ Self-inflicted injury
☐ Spill/Leak
☐ Unauthorized drugs/Smok
☐ Other ____

ACCOUNT OF OCCURRENCE (Print) ____

Signature ____ Printed Name ____ Title ____ Ext. ____ Date ____

OUTCOME
☐ Abrasion/Blister/Skin tear
☐ Aggr. pre-exist. condition
☐ Aspiration/Anoxia
☐ Bruise/Ecchymosis/Hematoma
☐ Burn
☐ Code/Arrest
☐ Death
☐ Dental injury
☐ Fracture/Dislocation
☐ Infection
☐ Laceration
☐ Neurologic injury
☐ No injury
☐ Ocular injury
☐ Reaction/Toxic effect
☐ Reddened
☐ Sprain/Strain
☐ Swelling/Phlebitis
☐ Other ____

CHANGE IN DISPOSITION
☐ None/Unknown
☐ Extended hospital stay
☐ Unplanned returned to OR
☐ Transferred to higher level of care
☐ Transferred to tertiary care facility

Diagnosis ____ Radiologic Study Ordered: ☐ YES ☐ N
Treatment ____
Physician/Supervisor Name ____ Signature ____ Date ____

MANAGEMENT INVESTIGATION OF EMPLOYEE ACCIDENT/INCIDENT

Name (Last, First)			Department/Job Title	
Status Full/Time Part Time	BW Hours	Incident Date	Day of the Week	Time _______AM _______PM
Part/s of body affected		Report Date	Side/s of body affected (circle) left right	

A) PROVIDE A BRIEF DESCRIPTION OF THE ALLEGED INCIDENT/ACCIDENT

IMMEDIATE ACTION TAKEN:

B) INVESTIGATION OF THE ALLEGED INCIDENT/ACCIDENT INCLUDING CONTRIBUTING FACTORS AND CORRECTIVE ACTION/S TO PREVENT REOCCURENCE. PLEASE INDICATE WHETHER FURTHER INVESTIGATING OR FOLLOW UP IS NECESSARY. WHEN SUBMITTING, PLEASE BE SURE TO ATTACH THE "EMPLOYEE ACCOUNT OF INCIDENT" FORM, AND ANY WITNESS STATEMENTS.

WHO:

WHAT:

WHEN:

WHERE:

WHY:

HOW:

CORRECTIVE ACTION TAKEN:

INSTRUCTIONS: CHECK ANY UNSAFE ACT OR CONDITION THAT APPLIES.

C) UNSAFE ACT: PRESENT DURING A VIOLATION OF AN ACCEPTED SAFE PROCEDURE/PRACTICE THAT WERE DIRECTLY RESPONSIBLE FOR THE INCIDENT/ACCIDENT.

☐ Operating without authority	☐ Horseplay	☐ Disregard for standard posture ergonomics
☐ Failure to use appropriate PPE/equipment	☐ Improper use of tools/equipment	☐ Driving error on Hospital grounds
☐ Failure to secure against unexpected motion	☐ Inattention to footing or surroundings	☐ Creating a fire/explosive hazard
☐ Failure to warn of hazard	☐ Making safety devices inoperative	☐ Using unsafe/defective equipment (not PPE)
☐ Other (Explain):		

D) UNSAFE CONDITION: IDENTIFY THE PHYSICAL LOCATION OR PROCEDURE/CIRCUMSTANCES THAT WERE DIRECTLY RESPONSIBLE FOR THE INCIDENT/ACCIDENT. LOCATION:____________________ SITE: NORTH_____ SOUTH_____ POUCH_____ OTHER___________

☐ Unsafe or defective equipment	☐ Disregard of instructions	☐ Physical impairment
☐ Lack of appropriate clothing or PPE/equipment	☐ Lack of knowledge or skills	☐ Inadequate space clearance
☐ Improperly placed/labeled items	☐ Lack of proper hazardous warning	☐ Failure to report observation to Mnmgt
☐ Other (explain):		

Accident Type: Identifies the event that directly caused the injury		
☐ Struck against	☐ Fall from elevation	☐ Ergonomics
☐ Needlestick	☐ Fall from same level	☐ Over exertion
☐ Struck by	☐ Caught in, under/bet	☐ Lifting object
☐ Lifting a patient	☐ Rubbed or abraded	☐ Contact
☐ Other		

Nature of Injury			
☐ Amputation	☐ Concussion	☐ Laceration/bruise	☐ Splash
☐ Asphyxia	☐ Infectious Disease	☐ Puncture	
☐ Burn	☐ Contusion	☐ Dermatitis	
☐ Electric shock	☐ Fracture	☐ Freezing	
☐ Hearing loss	☐ Heat exhaustion	☐ Hernia	
☐ Inflammation	☐ Radiation	☐ Abrasion	
☐ Sprain/Fracture	☐ Crushing	☐ Other (explain):	

Medical Disposition

Was medical care provided Yes No

If Yes, When Date of care ____/____/______

Type of care First Aid____________ EHS/ED____________

Did employee refuse care Yes No

Is employee losing time Yes No

If yes, what is the last day of work ________________________

Disposition Hospitalized_________ Deceased _________

Returned to work ___________ Unable to return ____________

INSTRUCTIONS FOR COMPLETION

1) This form must be completed by a Supervisor or Manager.

2) Attach the signed Employee Account of Incident form and any witness statements of incident/accident.

3) Make sure all appropriate signatures and extension are completed.

4) Fax completed Management and Employee Incident/Accident report forms and any witness statements within 24 hours of the incident to Occupational Health at ext 2450.

Supervisor/Manager Signature ___________________________Print Name_____________________ Extension __________________

Department Head/Administrator Signature ____________________Print Name___________________ Extension __________________

North Shore LIJ Staten Island University Hospital

North Shore-Long Island Jewish Health System

EMPLOYEE'S ACCOUNT OF ACCIDENT/INCIDENT REPORT FORM

Employee's Name: ______________________ **Title:** ____________ **Phone:** ________________________

Manager's Name: ______________________ **Department** ________ **Extension:** ______________________

Date of Incident: _________ **Tme of Incident:** ______ **Time shift began:** _____________________________

Did you notify your manager regarding your incident? Yes_ No__if yes date: _________________________

If no, whom did you notify: Name ______________________ **Date:** ______________________________

Where did the incident occur? ____

Witness to incident? Yes_____No_______if yes, name of witness ___________________________________

Body parts affected: ____

How did the injury occur:

____

____

____

____

____

____

____

____

____

____

____

EMPLOYEE'S SIGNATURE **(NOT VALID UNLESS SIGNED BY THE EMPLOYEE)**

PRINT NAME: ________________________________

SIGNATURE: ____ DATE: ________________

RETAIN A COPY FOR YOUR RECORDS.

1) **RETURN THE ORIGINAL OF THIS FORM TO THE MANAGER COMPLETING THE "MANAGEMENT INVESTIGATION OF EMPLOYEE ACCIDENT/INCIDENT" FORM AND FAX TO THE OCCUPATIONAL HEALTH DEPARTMENT AT EXTENSION 2450.**

STATEN ISLAND UNIVERSITY HOSPITAL

HOSPITAL REPORTING RESPONSIBILITIES PURSUANT TO SECTION 2803-e OF THE PHYSICIAN HEALTH LIST FOR ALLEGED PROFESSIONAL MISCONDUCT

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renumbered § 2803–

Historical and Statutory Notes

Effective Date. Section effective on the 180th day after Aug. 11, 1977, pursuant to L.1977, c. 902, § 2.

Cross References

Pharmacists, see Education Law § 6800 et seq.
Schedules of controlled substances, see Public Health Law § 3306.

Library References

American Digest System

Drugs and druggists: conduct of business, see Drugs and Narcotics ⟹16.
Drugs and druggists: state regulation in general, see Drugs and Narcotics ⟹11.
Regulation and supervision of asylums, see Asylums ⟹3.

Encyclopedia

Conduct of business of druggists and pharmacists, see C.J.S. Drugs and Narcotics § 43.
Regulation and supervision of asylums and institutional care facilities, see C.J.S. Asylums and Institutional Care Facilities § 5.
Regulation of drug stores and pharmacists in general, see C.J.S. Drugs and Narcotics § 27 et seq.

WESTLAW Research

Asylums cases: 43k[add key number].
Drugs and narcotics cases: 138k[add key number].

§ 2803–e. Reporting incidents of possible professional misconduct [See, also, § 2803–c ante.]

1. (a) Hospitals and other facilities approved pursuant to this article shall make a report or cause a report to be made within thirty days of the occurrence of any of the following: the suspension, restriction, termination or curtailment of the training, employment, association or professional privileges or the denial of the certification of completion of training of an individual licensed pursuant to the provisions of title eight of the education law or of a medical resident with such facility for reasons related in any way to alleged mental or physical impairment, incompetence, malpractice or misconduct or impairment of patient safety or welfare; the voluntary or involuntary resignation or withdrawal of association or of privileges with such facility to avoid the imposition of disciplinary measures; or the receipt of information which indicates that any professional licensee or medical resident has been convicted of a crime; the denial of staff privileges to a physician if the reasons stated for such denial are related to alleged mental or physical impairment, incompetence, malpractice, misconduct or impairment of patient safety or welfare.

(b) Hospitals and other facilities approved pursuant to this ar[...] shall make a report or cause a report to be made within sixty day[...] obtaining knowledge of any information which reasonably appear[...] show that a physician is guilty of professional misconduct as defi[...] in section sixty-five hundred thirty or sixty-five hundred thirty-on[...] the education law. A violation of this subparagraph shall no[...] subject to the provisions of section twelve-b of this chapter.

2. Reports of possible professional misconduct made pursuant [...] this section shall be made in writing to the education departm[...] with respect to all individuals licensed pursuant to title eight of [...] education law except that such reports shall be made to the dep[...]ment of health in the case of physicians, physician's assistants [...] specialist's assistants. Written reports shall include the follow[...] information: name, address, profession and license number of [...] individual, a description of the action taken by the hospital includi[...] the reason for the action and the date thereof, or the nature of th[...] action or conduct which led to the resignation or withdrawal, a[...] the date thereof, any criminal conviction of which the hospital h[...] knowledge, and such other information as the education departme[...] or the department of health shall require.

3. (a) Any report or information furnished to the education de[...]partment or department of health in accordance with the provisio[...] of this section shall be deemed a confidential communication and shall not be subject to inspection or disclosure in any manner except upon formal written request by a duly authorized public agency o[...] pursuant to a judicial subpoena issued in a pending action or proceeding.

(b) Any person, facility or corporation which makes a report pur[...]suant to this section in good faith and without malice shall have immunity from any liability, civil or criminal, for having made such a report. For the purpose of any proceeding, civil or criminal, the good faith of any person required to make a report shall be pre[...]sumed.

(Added L.1980, c. 866, § 15; amended L.1984, c. 1005, §§ 10, 11; L.1985, c. 294, § 2; L.1991, c. 606, § 17.)

Historical and Statutory Notes

1991 Amendments. L.1991, c. 606, § 17, substituted reference to Education Law §§ 6530 and 6531 for reference to Education Law § 6509. See Effective Date of Amendment by L.1991, c. 606 note below.

1985 Amendments. Subd. 1, par. (a). L.1985, c. 294, § 2, eff. July 1, 1985, inserted "or of a medical resident" following "the education law" and "or medical resident" following "any professional licensee".

1984 Amendments. [...] L.1984, c. 1005, § 10, [...] designated existing tex[...] par. (a) as designated [...] days" for "sixty days" [...] pension, restriction,", [...] denial of the certifica[...] of training", "reasons [...] to", "mental or physi[...] competence,", "or im[...] safety or welfare", "vo[...]tary" and "; the deni[...] to a physician if the [...] such denial are relate[...] or physical impairm[...] malpractice, miscond[...] of patient safety or we[...]

Subd. 1, par. (b). [...] § 10, eff. Jun. 20, 19[...]

Subd. 3, par. (a). [...] § 11, eff. Jan. 20, 198[...] partment of health".

Effective Date of [...] L.1991, c. 606; Appl[...] ment effective July 26, [...] applicable to cases in [...] of charges had been [...] date pursuant to par. [...] § 230, unless the part[...]

Defense and inde[...] Law § 17.
Definitions of pro[...] 6531.
Disclosure in—
Civil actions, [...]
Criminal act[...]
Freedom of info[...]
Personal privacy [...]
Physicians, see E[...]
Physician's and [...]
State manageme[...]
Subpoena duces [...]
Subpoena of hos[...] municipal [...]
Subpoenas gene[...]
The professions, [...]
Wilful violation [...]

L.1991, c. 606: [...]
ney's 199[...]

S.I.U.H. PERFORMANCE IMPROVEMENT PLAN

Leadership Commitment to Quality

The Staten Island University Hospital performance improvement program is designed to support collaborative processes in care delivery. The program relies on objective measurements regarding performance that result in service specific PI initiatives. The Board of Trustees, at the summit of the organizational structure, shall be ultimately responsible for maintaining the Hospital-wide Performance Improvement Program. The Board shall assure the implementation of a mechanism designed to insure the uniform performance of patient care processes throughout the organization. It shall delegate to the President and Chief Executive Officer, and his direct representatives, the responsibility for the implementation of the program. The President and Chief Executive Officer will assure the Trustees that a process exists for setting priorities for performance improvement through leadership personnel the vehicle being the Joint Conference Professional Affairs Committee. Leadership sets expectations for performance improvement (include resource utilization); provides resources and training for performance improvement activities; and, promotes communication and coordination. The President and CEO shall enact such measures through the Vice President of Quality Management, the Medical Board and the various Performance Improvement Coordinating Group's. Authority has been delegated to the Vice President of Quality Management by the President and CEO, and the Chairman of the Board, to coordinate and integrate all aspects of the Program. This includes performance improvement for the Hospital, its

components, the North, South Site, and Doctor's Hospital (under management agreement) and practitioner sites. S.I.U.H. shall regularly communicate performance information to each Component and Practitioner site through the Medical Leadership Group, respective Performance Improvement Coordinating Group's, the Joint Conference/Professional Affairs Committees and, through them to the Board of Trustees. The Administrator, the Nurse Executive, the PICG's and the Vice President for Quality Management shall be empowered to coordinate and assure that all activities are performed. In building a common clinical culture across a large integrated delivery system, senior organizational leaders shall work together to coordinate Hospitalwide quality management processes. It is through this structure that genuine coordination of services shall be achieved. Together with the QM Program of the NS-LIJ Health System, genuine Bench Marking and system initiatives are developed.

Joint Conference / Professional Affairs Committee

- Creates the stage for medical boards of culturally diverse institutions to work together
- Reviews Scope of Care for all facilities
- Acts as a Liaison between the Board of Trustees, Administration and Medical Staff
- Assumes responsibility for medical care charged to the Board of Trustees
- Assures implementation and makes recommendations for organizational performance improvement
- Considers issues that concern operation of services throughout the continuum
- Evaluate the delivery of patient care
- Identify risk management/quality management issues *(sentinel events conducting a root cause analysis)*
- Evaluates competency and orientation of staff
- Develops benchmarking measurements