

2017 ORIENTATION MANUAL

FOR THE CHRIST HOSPITAL'S
MEDICAL STAFF AND ALLIED HEALTH PROFESSIONALS



The
Christ Hospital[™]



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Mission

Improve the health of our community and create patient value by providing exceptional outcomes, affordable care and the finest experiences.

Vision

Be a national leader in clinical excellence, patient experience, and affordable care.

Model of Care

Patient and Family Centered Care: is the Model of Care that is to be practiced by all TCHHN employees. It guides the planning, delivery and evaluation of the health care provided. It is grounded in mutually beneficial partnerships among patients, their families and healthcare providers.

(Simon et Al. 1997; Culler, Titler & Drahozal 1999, Chow, 1999; DeJong & Beatty 2000; Meyers et Al. 2000, Gavaghan & Carroll, 2002)

Values – ExCELS

Excellence

Compassion

Efficiency

Leadership

Safety

Reporting to Joint Commission

Any individual who provides care, treatment or services at The Christ Hospital, who has concerns about the safety or quality of care provided may file a report with [The Joint Commission](#) by calling 1-800-994-6610. No disciplinary or punitive action will occur because of reporting of safety or quality-of-care concerns.

Environment of Care Safety & Emergency Management

The below information and more can be found in the Environment of Care and Emergency Management, Safety Manual. This manual can be found at <http://mytch.tchhn.org/Departments/mss/Pages/Medical-Staff-Member-Resources.aspx>.

Environment of Care/Safety Information

Dial 111 to report all medical emergencies. This number is answered by the hospital operator.

Dial 5-2222 for all other emergencies. This number is answered by Safety and Security.

Security Issues

Dial 5-222 to reach Safety/Security for immediate dangers, threats, or violent acts. Dial 5-4444 to report confidential information on the H.U.R.T. Line.

Safety/Security Threats

Safety threats (bomb, terrorism, etc.) are a severe disruption to the peace and comfort of patients, visitors, and staff. The person receiving a telephone threat must record as much data as possible about the call, including caller characteristics (i.e., gender, speech traits). Notify the hospital operator at once by dialing “0.”

Notify Security at 5-2222 for personal or written threats. Use local panic button where available.

VideoCom Signals: DPFA Monitors

111- Emergency/Code

Audible warble = Disaster

Fire alarms announcement: CODE RED and location



Fire Safety Plan

Remember R A C E when responding to a fire.

R = Rescue patients and visitors

A = Sound the Alarm by dialing 111 or 5-2222 and pull the fire alarm

C = Confine or contain the fire

E = Extinguish the fire

Remember PASS when using Fire Extinguishers.

P = Pull the pin

A = Aim low

S = Squeeze the lever below the handle

S = Sweep from side to side

Type of Fire Extinguishers – Use the appropriate type of extinguisher – ABC, CO2, or water – based on the type of fire.

Disaster Preparedness – Physician Response at TCH

The Medical Staff Operation Chief, appointed by the Medical Staff, will take charge of the physician assignments. The Medical House Physician will handle these duties until the Medical Staff Operations Chief arrives. Physicians will report directly to their respective treatment areas. Upon arrival:

- Contact the Medical Staff Operations Chief to acknowledge your arrival.
- Medical Residents shall immediately report to the Emergency Operations Center (Command Post) (located in Admitting), to receive assignments
- MEDICAL RESIDENT SIGN-IN - All residents are to sign-in at the Emergency Operations Center (Command Post)
- The Medical House Physician will take charge of the assignment of physicians until relieved by the Medical Staff Operations Chief on-call.

TRIAGE - The Triage identification and evaluation functions will be conducted in the lobby area of the Heart Center, C-Level.

Emergency Operations Center (Command Post-located in Admitting): 5-1532

Emergency Codes

CODE RED = Fire

CODE ADAM = Infant Abduction

CODE BLACK = Bomb/Bomb Threat

CODE GRAY = Severe Weather

CODE ORANGE = Hazardous Material Spill/Release

CODE BLUE = Medical Emergency

CODE YELLOW = Disaster

CODE VIOLET = Violent/Combative Person


CODE SILVER = Person with Weapon/Hostage Situation

CODE BROWN = Missing Patient

CODE GREEN = All Clear is the ALL CLEAR signal representing the conclusion to the emergency.

EPIC Downtime

If EPIC Production is unavailable, users will be able to access downtime reports via EPIC's BCA-Web website. Users will find the shortcut to the BCA-Web website through the hospital's employee [MyTCH] Intranet Clinical Resources, or by launching MS Internet Explorer and entering the web address: <http://tch-relay-bcaha.tch-dom.local/bcaweb/login.aspx>. When the user accesses the site, they will be prompted for the same, single password that is used for the downtime computers. The password will be kept in a sealed envelope in the unit's red downtime binder, along with other downtime information. Once



logged in, users will find a directory of folders that are receiving reports on each unit or area. Inside each folder or directory, the user can access each unit and department has paper forms to use intermittently.

The full red binder is also fully loaded within the [MyTCH] Clinical Resources; along with important phone numbers and downtime forms. You can easily access the clinical resources via MyTCH, or by entering the web address: <http://mytch.tchhn.org/downtime>.

Code of Professionalism

This Code of Professionalism represents requirements by The Christ Hospital for members of its Medical/Allied Health Professional Staff. By committing to hold practitioners accountable for their professional conduct, we will collectively create an environment that is patient centered, and ensure an atmosphere that is in alignment with the mission: to improve the health of our community and create patient value by providing exceptional outcomes, affordable care and the finest patient and family experiences.

To fulfill the mission and vision to be a national leader in clinical excellence, patient experience, and affordable care, we base our values upon ExCELS: Excellence, in which we are committed to providing the highest quality of service; Compassion, where we will work to understand and exceed the diverse expectations of those we serve; Efficiency, where we will persistently strive to provide timely and seamless services resulting in high quality outcomes; Leadership, where each of us plays an integral role in the progression of the organization and serve as examples to others; and Safety, where we will use all resources at our disposal to ensure the safety of our patients.

All members of the Medical/Allied Health Professional Staff will at all times adhere to the Medical Staff Bylaws, Rules and Regulations, and Policies and Procedures. These documents are available for complete review in the Medical Staff Services Department and online at <http://mytch.tchhn.org/Departments/mss/>. The following compact is a summary of expectations that members are presumed to follow to fulfill the ExCELS values and must be signed at each appointment cycle.

Quality and safe care requires teamwork, collegiality, mutual respect, and professional demeanor. Therefore, I will:

Behavior

- Conduct actions in a professional and ethical manner at all times toward patients, families, employees, and staff members;
- Be respectful of the rights, privacy, and cultural diversity of patients, families and others;
- Communicate respectfully with patients, families and members of the health care team;
- Address disagreements or conflicts about patient care or other issues that impact the workplace environment promptly, directly, and discretely;

Patient Centered Care

- Pledge to provide continuous care for my patients;
- Provide patient care that is compassionate and within the scope of my privileges, education and training;
- Use established and confidential medical staff and administrative channels to address patient care concerns;

Safety

- Participate in quality measures identified to improve patient safety;
- Participate in efforts to improve safety from a systems perspective by identifying and reporting potential performance initiatives;
- Participate in performance improvement activities, including ongoing and focused professional practice evaluations as deemed necessary;
- Understand and participate in safety drills and codes;

Professional Practice

- Maintain complete, timely and accurate documentation in the medical record and maintain the security and confidentiality of such information;
- Adhere to all policies regarding compliance with federal and state regulations and statutes and The Christ Hospital Code of Conduct;
- Adhere to policies regarding the acceptance of gifts and or courtesies; and
- Agree to notify the Medical Staff Services Department within five business days of any significant changes to my information or practice (e.g., changes in physical or mental health that could affect my ability to practice; action taken by another institution regarding my ability to practice; commencement of a formal investigation by any state or federal authority; notification of any non-traffic related actions by law enforcement agency, etc.).

I attest by my signature below that I have read, understand and will abide by The Christ Hospital Medical Staff/Allied Health Practitioners Code of Professionalism. If I have any questions concerning the matters set forth in the Code of Professionalism, I will seek assistance from the [Medical Staff Services Department](#).

Impairment

All people are vulnerable to illness -- illness that can result in impairment in one's personal, social or work life. Physicians, nurse practitioners, and allied health personnel are no exception -- and may even be at higher risk to certain types of illness and impairment than the general public. Studies have shown that, of all impaired health care personnel, at least one-half have problems with drug and/or alcohol abuse.

As referred to in Article 10 of the [Medical Staff Credentials Policy](#), if you or a colleague is in trouble, there are actions that you can and must take. These guidelines are intended to explain and encourage those actions, and to offer resources that can be of help regarding impairment caused by chemical dependency. Referrals can be made to the Practitioner's Aid Committee.

The Practitioners' Aid Committee shall consist of members of the Medical Staff and other appropriate professionals appointed for their knowledge about and/or expertise in impairment issues, including age impairment, substance abuse, or other health issues that might impact the ability of a practitioner to exercise privileges at the Hospital. The Committee is responsible for serving as the identified point within the Hospital for self-referral by a Practitioner and confidential referral by other organization staff with respect to potential impairments. The Committee also refers affected Practitioners to the appropriate internal or external resources for diagnosis and treatment of the condition or concern and monitors compliance with such referrals. The Committee process does maintain the confidentiality of the Practitioner seeking referral or referred for assistance, except as limited by law, ethical obligation, or when the safety of a patient is threatened.

To reach the Practitioners' Aid Committee, contact the Vice President and [Chief Clinical Officer](#) or the [President of the Medical Staff](#).

Patient Safety Goals

2014 National Patient Safety Goals

NPSG # / TCH Policy #	National Patient Safety Goal (NPSG)	TCH Policy Relating to NPSG
Improve the accuracy of patient identification		
NPSG.01.01.01 Policy 4.22.137	Use at least two patient identifiers when providing care, treatment and services	Use the patient's name and date of birth

NPSG.01.03.01 Policy 2.43.135	Eliminate transfusion errors related to patient misidentification	Check three patient identifiers with two nurses prior to blood product administration. Patient name, date of birth, and medical record number.
Improve the effectiveness of communication among caregivers		
NPSG.02.03.01 Policy 2.43.174	Report critical results of tests and diagnostic procedures on a timely basis	Report critical test results within 30 minutes to a provider who can take action and document with “read back” of the result
Improve the safety of using medications		
NPSG.03.04.01 Policy 2.34.142 Policy 2.34.144 Policy 2.43.175	Label all medications, medication containers and other solutions on and off the sterile field in perioperative and other procedural settings	If it hits the table it must be labeled
NPSG.03.05.01 Policy 2.34.177	Reduce the likelihood of patient harm associated with the use of anticoagulant therapy	Check lab results before the First Dose; Test, Monitor, Educate and Document
NPSG.03.06.01 Policy 2.43.158	Maintain and communicate accurate patient medication information	List all medications and allergies on admission, look for duplicates and omissions on transfer, reconcile at discharge and check all prescriptions, Document
Reduce the harm associated with clinical alarm systems		
NPSG.06.01.01	Improve the safety of clinical alarm systems	Form a multidisciplinary team, identify alarms by unit/area, raise awareness of all staff regarding importance of recognizing alarm fatigue
Reduce the risk of health care-associated infections		
NPSG.07.01.01 Policy 2.21.122	Comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines	Wash In Wash Out and after glove removal
NPSG.07.03.01 Policy 2.21.123	Implement evidence-based practices to prevent health care-associated infections due to multidrug-resistant organisms in acute care hospitals	Use appropriate isolation PPE
NPSG.07.04.01 Policy 1.7.139 Policy 2.43.162 Policy 2.43.202 Policy 2.43.196	Implement evidence-based practices to prevent central line-associated bloodstream infections	Follow protocols for Central Line Catheters
NPSG.7.05.01	Implement evidence-based practices for preventing surgical site infections	Follow surgical infection prevention protocols and Best Practice Guidelines

NPSG.07.06.01 Policy 2.43.183	Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTI)	Use Best Practice models for proper insertion stabilization, care and removal of indwelling catheters
Reduce the risk of patient harm resulting from falls		
NPSG.09.02.01 Policy 1.4.110	Reduce the risk of falls	Assess all patient for fall risk, implement interventions as needed
The organization identifies safety risks inherent in its patient population		
NPSG.15.01.01 Policy 2.14.105	Identify patients at risk for suicide	Assess patients with behavioral or emotional health concerns for suicide risk using SAD PERSONS scale, implement interventions as needed

Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery

UP # / TCH Policy #	Universal Protocol	TCH Policy Relating to UP
UP.01.01.01 Policy 2.43.155	Conduct a pre-procedure verification process	Use Universal Protocol to enhance safety by correctly identifying the patient, the appropriate procedure, the correct site of the procedure, and the fire risk
UP.01.02.01 Policy 2.43.155	Mark the procedure site	Marked in the pre-procedure area B LIP who will be present during the procedure to verify with the patient prior to sedation
UP.01.03.01 Policy 2.43.155	A time-out is performed before the procedure	Perform time-outs prior to entering procedure room and prior to start of procedure. STOP. Verify correct patient, correct site, correct procedure

Monitoring and Tracking

TCHHN has a process to monitor and track the following NPSG's:

1. Hospital Acquired Infections: Surgical site infections, CLABSI, CAUTI
2. Falls
3. Blood Administration Errors
4. Medication Errors
5. Wrong Site Surgeries
6. Hand Hygiene

Data is reported and followed for quality improvement.

For more information the National Patient Safety Goals are available on the Joint Commission website at <http://www.jointcommission.org/> or contact [Gregory Springer](#) at 513-585-2915 or [Laura Waddle](#), RN, BSN at 513-585-3796.

For more information on any of the aforementioned policies, click on the policy number or search for the policy on MyTCH's Forms and Policies Page: <http://mytch.tchhn.org/Forms/Pages/TCHFSearch1.aspx>.

Pain Management

Assessing Pain

Four required components in Pain Assessment at TCH (which are “starred” in EPIC): (1) Pain Location; (2) Pain Laterality / Orientation; (3) Pain Quality; and (4) Pain Intensity (0 -> 10 pain rating score).

- For Pain Intensity: clinicians choose either “**verbal**” or “**non-verbal**”.
 - For verbal patients, Pain Intensity rating score is: 0 = no pain, 10 = worst pain.
 - For non-verbal patients, Pain Intensity is assessed using a 5 item behavioral scale. Each item is scored 0 -> 2, so patient’s total Pain Intensity rating score is on a 0 -> 10 scale.

	Pain Asses
* Patient Currently in Pain	
* Pain Location	
* Pain Laterality/Orientation	
* Pain Quality	
* Pain Intensity (Verbal)	
* Pain Intensity (Non verbal)	
* Pain Intervention(s)	
Patient's Stated Pain Goal	

Review of Pain Assessment and Management in EPIC

Review nurse’s documentation of patient’s pain assessment/management on Doc Flowsheet in EPIC. This info is pulled into a report in Patient Summary called Pain Management. Access the Pain Management report by clicking on: “Patient Summary” / “Index”. Under Medications, click on “Pain Management.” Complete your own pain assessment documentation by either:

- 1) Click on Progress Notes
- 2) Click on Pain Assessment Navigator

Managing Pain

Upon Admission or After Procedure: MDs / PAs / NPs need to REORDER:

- *long acting opioid pain meds* for chronic pain (e.g., Oxycontin, Oramorph, Methadone, etc.) and
- *adjunct pain meds* (e.g., Cymbalta, Pregabalin, Gabapentin, etc.).

Patient Controlled Analgesia (PCA) & Chronic Pain Med Administration

In the PCA Order Sets, the order states no other systemic narcotics. In order for the patient to receive their chronic pain narcotic with the PCA, the MD, who has ordered the PCA, needs to approve (in verbal or written format) the chronic pain med to be given. When the Attending MD or the Resident MD is placing the order for the chronic pain narcotic, he/she needs to add in the Administration Instructions: “OK to give chronic pain opioid med with PCA per Dr. _____.”

To schedule an epidural steroid injection, then call the Pain Management Clinic at: 5-2482. Please indicate if the patient is inpatient or outpatient.

Call the **Pain Management Team** at: 5-4293 (hours: 6:30 a.m. – 3 p.m.) for:

- questions about Nerve Blocks and Regional Analgesic
- chronic pain consult

After this time, call hospital operator to contact Anesthesia on call.

ANALGESIC	EQUIANALGESIC DOSES		DURATION* (hours)	COMMENTS
	Parenteral (mg) (IV, IM, SQ)	Oral (mg)		
Morphine	10	30	3-4 hrs	Standard for comparison. Multiple routes of administration. Active metabolite M6G can accumulate with repeated dosing in renal failure.
Morphine Controlled Release Tablets	--	30	8-12 hrs	Active metabolite M6G can accumulate with repeated dosing in renal failure. Do not crush or cut controlled release morphine.
Hydromorphone	1.5	7.5	2-3 hrs	No evidence that metabolites are clinically relevant. Shorter duration than morphine.
Fentanyl	100 mcg	1000 mcg oral transdermal	1-3 hr	Short half-life, but at a steady state, slow elimination from tissues can lead to a prolonged half-life (up to 12 hrs).
Transdermal Fentanyl	--	--	72 hrs	Start opioid-naïve patients or no more than 25 mcg/hr transdermally. Transdermal fentanyl is not recommended of acute pain. 180 mg oral morphine/24 hrs = 100 mcg transdermal fentanyl/hour.
Meperidine	75	300 NR*	3-4 hrs	Not recommended for the management of acute or chronic pain due to toxicity from accumulation of metabolite (normeperidine), which has 15-20 hr half-life and is not reversed by naloxone.
Methadone	10	20	4-6 hrs	Practitioners are advised to consult with a pharmacist or a pain/palliative care specialist if they are unfamiliar with methadone prescribing.
Oxycodone	--	20	3-5 hrs	Used for moderate pain when combined with a nonopioid. Available as single entity in immediate-release and controlled-release formulations.
Oxycodone Controlled Release	--	20	12 hrs	Do not crush or cut controlled-release oxycodone.
Codeine	130	200 NR*	3-4 hrs	Used for mild to moderate pain. Known to be highly constipating. IM has unpredictable absorption and high side effect profile.
Hydrocodone	--	30 NR*	3-5 hrs	Used for mild to moderate pain. Available only in compounded formulation (ASA, APAP).
Oxymorphone	1	10 rectal	3-6 hrs	Used for moderate to severe pain. No oral formulation.
Propoxyphene	--	130	4-6 hrs	Not recommended for long-term or high dose use due to toxicity from accumulation of metabolite (norpropoxyphene). Not recommended for elderly patients.
Tramadol	--	50-100	4-7 hrs	Weak opioid receptor agonist with some anti-depressant activity. Used for mild to moderate pain. Recommended for doses of 100mg QID (max dose = 400mg/day or 300mg/day for elderly).
Nalbuphine	10	--	3-6 hrs	Agonist-Antagonist. May produce withdrawal in opioid dependent patients.

* Equianalgesic doses are drug and route conversions approximately equal to a single morphine 10mg IV or 30mg PO dose. This table is a guideline only. The equianalgesic dose is not the usual starting dose. Dosing must be individualized and titrated according to the patient's age, condition, response, and clinical situation.

* To account for incomplete cross-tolerance when converting to a new opioid, start with 50-75% of the equianalgesic dose and the new opioid and titrate to effectiveness.

* Duration: the shorter time generally refers to parenteral administration of opioids; the longer time generally refers to oral administration of immediate-release opioids.

* NR = not recommended at that dose



Anti-coagulation Therapies

Anticoagulation therapy can be used as therapeutic treatment for a number of conditions, the most common of which are atrial fibrillation, deep vein thrombosis, pulmonary embolism, and mechanical heart valve implant. However, it is important to note that anticoagulation medications are more likely than others to cause harm due to complex dosing, insufficient monitoring, and inconsistent patient compliance.

In order to ensure the safe use of anticoagulation therapy at The Christ Hospital, protocols, guidelines, and procedures for dosing and monitoring anticoagulation therapies have been developed. Pre-defined order sets exist within the computerized order entry EPIC system for warfarin, rivaroxaban, apixaban, dabigatran, UFH, LMWH, and argatroban. These order sets include automatic orders for necessary lab work for review prior to initiation of anticoagulation therapy. LMWH, warfarin, argatroban infusions, and heparin continuous infusions can only be initiated through the use of approved order sets. There are two different order sets for Heparin: Weight Based, in which the dose is initiated at 18 units/kg/hr, and Cardiac, in which the dose is initiated at 12 units/kg/hr.

Use of approved protocols will insure baseline and ongoing laboratory tests are ordered and assessed for patients as listed:

- **Warfarin** – Baseline labs consisting of a Complete Blood Count (Hgb, Hct, Platelets, WBC) and Prottime/INR are ordered by default via the warfarin order set. A default of daily monitoring of these labs is pre-selected in the order set with the option for the physician to change the frequency if desired. .
- **Rivaroxaban, apixaban, and dabigatran** – Baseline labs consisting of a Complete Blood Count (Hgb, Hct, Platelets, WBC) and Basic Metabolic Panel (EP1) are ordered by default via the order set. Options for baseline Liver Profile, Prottime/INR, PTT, and Anti-FXa monitoring are available for selection if desired. Options for daily Complete Blood Count (Hgb, Hct, Platelets, WBC), Basic Metabolic Panel (EP1), and Liver Profile are available for selection if desired.
- **Heparin** – Baseline labs consisting of a Complete Blood Count (Hgb, Hct, Platelets, WBC), Prottime/INR, PTT and Anti FXa are ordered by default via the heparin order set. A default of every 48 hour Fecal Occult Blood is pre-selected in the order set with the option for the physician to change the frequency if desired. Subsequent Anti FXa are drawn according to the heparin protocol.
- **LMWH** – Baseline labs consisting of a Complete Blood Count and Basic Metabolic Panel (EP1) are ordered by default via the LMWH order set. A default of ever 48-hour monitoring is pre-selected in the order set with the option for the physician to change to a different frequency if necessary. Options for Anti-FXa monitoring are available for selection if desired.
- **Argatroban** – Baseline labs consisting of a Complete Blood Count (Hgb, Hct, Platelets, WBC), Prottime/INR, PTT, and Liver Profile are ordered by default via the argatroban order set. A default of daily monitoring of Complete Blood Count is pre-selected on the order set. Subsequent PTT are drawn according to the argatroban protocol.

Best Practice Alerts have been created to help promote the safety of anticoagulation use within the facility. These alerts were created to assist the prescriber in choosing the appropriate order set, alerting the pharmacy in the event the order set is not chosen, monitoring for impaired renal function and the use of LMWH and monitoring LMWH use in the obese patient.



Rapid Response & e-ICU

Patient lives are saved when changes in their conditions are detected early, and addressed promptly with appropriate interventions. The challenge to all involved is to recognize signs of early change, communicate this change to the appropriate person(s), and act to prevent or correct unstable situations before critical changes require cardiopulmonary resuscitation. It is the intent of this policy to address the criteria, teamwork, and resources for activating the rapid response (STAT) team. Criteria are established to consider STAT team activation. They are:

1. Acute mental status change
2. Acute significant bleeding
3. Fall with injury
4. Heart rate more than 130/minute
5. Heart rate less than 40/minute
6. Systolic blood pressure less than 90 mm Hg
7. New seizures
8. New onset chest pain
9. Respiratory rate more than 30/minute
10. Respiratory rate less than 8/minute
11. SpO₂ less than 90% despite increasing O₂ delivery, or continuing increase in O₂ support to maintain SpO₂
12. Staff/family worried/concerned

Call 119 to activate the STAT team. Initial responders are a critical care nurse and respiratory therapist.

End-of-Life Care & Planning

Dying patients have unique needs for respectful, responsive care. All hospital staff should be sensitive to the needs of patients at the end of life. Concern for the patient's comfort and dignity should guide all aspects of care during the final stages of the patient's life. The hospital's framework for addressing issues related to the care and end of life includes:


1. Providing appropriate treatment for any primary and secondary symptoms, according to the wishes of the patient or the surrogate decision maker;
2. Managing pain aggressively and effectively;
3. Sensitively addressing issues such as autopsy and organ donation;
4. Respecting the patient's values, religion, and philosophy. Responding to the psychological, social, emotional, spiritual and cultural concerns of the patient and the family; and
5. Involving the patient and, where appropriate, the family in every aspect of care;
6. Recognizing that an adult patient who has decision-making capacity has the right to permit or refuse treatment.
7. Contacting Ethics Committee or [Palliative Care](#) as resource for recommendation. Ethics Committee and Palliative Care consultation services are available. The Ethics Committee can be reached by calling the Hospital Operator and requesting the Ethics Committee to be contacted. A Palliative Care team consult requires an order be placed in EPIC.

When providing end-of-life care at the facility, refer to the End-of-Life Care Manual on the units or the procedures listed in policy number [4.20.202](#) on the MyTCH.

Definitions

Advance Directive: Durable Power of Attorney for Healthcare (DPAHC); Living Will, Ohio Do Not Resuscitate (DNR) Order.

1. Durable Power of Attorney for Healthcare: Document signed by an adult with decision-making capacity which appoints a surrogate to make healthcare decisions for the patient when the patient cannot make decisions, according to [Ohio Revised Code, Chapter 1337](#). Only effective when the patient cannot make decisions for him/herself. General power of attorney is not sufficient according to Ohio law but the information regarding healthcare decisions can be considered.
2. Living Will: Document signed by an adult with decision-making capacity and either notarized or witnessed by two persons not related to the patient by blood, marriage or adoption which contains his/her wishes about the use of life sustaining treatment, nutrition and/or hydration,



according to [Ohio Revised Code, Chapter 2133](#). Only effective when patient is in a terminal condition or permanently unconscious state.

- a. Terminal Condition: Determination by two physicians (primary physician for patient and another physician with training/experience to make determination) that the patient suffers from an irreversible, incurable and untreatable condition caused by disease, illness or injury from which there can be no recovery and which is likely to cause death within a relatively short time if life-sustaining treatment is not administered.
 - b. Permanent Unconscious State: Determination by two physicians (see language above) that the patient is irreversibly unaware of him/herself and his/her environment and has sustained a total loss of cerebral cortical functioning, resulting in no capacity by the patient to experience pain and suffering.
3. Ohio DNR: Physician order to institute one of two protocols of care for a patient who experiences cardiac or respiratory arrest (DNRCC-Arrest) or for whom a comfort care plan is initiated when the order is written, according to [Ohio Revised Code Chapter 2133](#).

Restraint & Seclusion

Organizationally, we strive toward a restraint-free environment by continuously improving our practice to provide for patients' safety while respecting their dignity. Limited and justified use of restraints is supported with appropriate assessment planning, education, family involvement and the use of safe and effective alternatives. Restraints are never used for discipline, convenience, retaliation or coercion. It is the expectation that less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm prior to employing the use of restraints. Examples of less restrictive interventions might be:

- More frequent visual checks or moving patient closer to a nurse station (closer observation) as possible;
- Use of TV, radio, or other activity as diversion/distraction;
- Diminish external stimulation by lowering lights, sound levels, etc.;
- Offer of bedpan/assistance to the bathroom, food/fluids as appropriate;
- Use of alert devices, etc.
- Use of fall prevention plan
- Encourage family member to stay close by and assist with reorientation/redirection.
- Continuation of restraints requires an evaluation from the treating physician prior to renewal of the order.

For more information refer to policies [2.43.106](#) and [2.43.109](#) on MyTCH.

Organ & Tissue Donation

Contact LifeCenter at 513-558-5000 within one hour of the patient meeting one of the clinical triggers that indicate a potential organ or tissue donor:

1. The patient with a brain injury, on a ventilator and with a GCS of 5 or less; and/or unresponsive and missing two brain stem reflexes;
2. When families are considering the option of withdrawing ventilator or pressor support;
3. On all cardiac deaths.

LifeCenter shall coordinate all requests for organ and tissue donation with hospital staff. Conversations with the family about organ and tissue donation must be initiated by LifeCenter, who are specifically trained in the use of discretion and sensitivity to the circumstances, beliefs, and desires of the families of the potential organ, tissue, and/or eye donors.

Incomplete Medical Records

Practitioners are responsible for completing the medical record within 30 days of discharge. Failure to complete medical records in a timely and accurate fashion may result in a reduction, suspension, restriction, denial, nonrenewal or termination of clinical privileges. As set forth in Hospital Administrative Policy Number [2.26.104](#), the Medical Records Department will monitor medical records for deficiencies and delinquencies, and provide various notices to the Practitioner to ensure policy compliance. A Practitioner having medical records delinquencies that extend past 15 days from the date of patient discharge will receive a notification from the Medical Records department regarding such medical record delinquency that shall advise the Practitioner of the delinquency and also may indicate that their privileges to admit patients will be suspended or placed on “probationary hold” immediately. While on the Probationary Hold list, you may not admit patients, schedule surgeries or procedures but can continue treatment of any current inpatients and perform any previously scheduled surgeries or procedures scheduled prior to the probationary hold. If the Practitioner’s medical records are not completed within 15 days of notice, the Practitioner may also be otherwise warned, placed on probation, have privileges reduced, suspended, restricted, denied, non-renewed, or terminated, on a case-by-case basis. Should a suspension occur and last for more than 30 days, The Christ Hospital is required to report this adverse action to the National Practitioner Data Bank.

The staff in the [Medical Records Department](#) is available to assist you in completion of your records. Should you have any questions regarding this letter, please call Medical Records at 513-585-1226.

CIA Mandatory Requirements for Physicians and Allied Health Staff

Training & Education Requirements for the Medical Staff and Allied Health Professionals

1. Code of Responsible Conduct (located in your credentialing or re-appointment packets)
 - Everyone (All Medical Staff Members and Allied Health Professionals)
2. General Compliance Training (www.healthstream.com/hlc/christ)
 - Required for Employed Physicians and Practitioners
 - Strongly Encouraged for all other Medical Staff Members & Allied Health Professionals
3. Arrangements Training (<https://cc.readytalk.com/play?id=9u1mrq>)
 - Required for all Employed Physicians and Practitioners
 - Required for all Physicians that provide services on behalf of The Christ Hospital
 - Strongly Encouraged for all other Medical Staff Members & Allied Health Professionals

All required training must be completed within 30 days of becoming a covered person, and annually thereafter.

If you have questions or need assistance with these requirements, contact the [Division of Compliance & Organizational Ethics](#) at 513-585-2925.