CODE CALLS and EMERGENCY NUMBERS
(complete safety training books are available in the Safety Office)

Code Calls

- **Code 5** - Cardiac/Respiratory Arrest
- **Code 99** – disaster plan in action, disaster drill (report to your patient floor/clinic and wait for instructions)
- **Code Red** - actual fire condition, fire alarm activated or fire drill
- **Code Orange** – bomb threats
- **Code Green** – hostage situation

Emergency Phone Numbers

- **Police and Security** - IF EMERGENCY: x2375.
- **Police and Security** - Non-emergency: x6225 or 6226
- **Fire Emergency**: x2000
- **Call a code**: x2633 (CODE)
- **Needlestick**: x6824(OUCH) or x5888
- **Radiation Safety**: x6009
- **Infection Control**: x2916/3393/4000
- **Biomed Engineering**: x5829
- **Chief of Staff**: x6623/5859; *after hours, contact VA operator (“0” or 823-5800)*
CERTIFICATION OF RECEIPT OF PVAMC ORIENTATION CD-ROM/HANDBOOK/WEBLINK AND ETHICS TRAINING

The VA resident handbook (on-line, hard copy, or CD-ROM version) serves as your VA hospital orientation. VA Ethics Training (on pages 73-77) is required for trainees and contained in the handbook. The handbook contents should be reviewed and this form must be completed and returned on an annual basis.

Printed name: ____________________________________________________

Please select one:

☐ 1. FELLOW
☐ 2. RESIDENT
☐ 3. INTERN
☐ 4. MEDICAL STUDENT
☐ 5. OTHER ____________________

Department: _____________________________________________________

Division/Subspeciality (if applicable): _________________________________

X I have received a copy (hardcopy or CD-ROM) and/or been given access to the intranet version of the PVAMC Resident Handbook which contains important policy information and Ethics Training. I have reviewed and understand its contents. All questions have been asked and answered.

Signature: _________________________________________________

Date: _____________________________________________________

Please return this form to your VA Resident Coordinator or Ms. Renata Hunter in the VA Education Office (VA intra-office mail address: MS111).
Welcome to the Philadelphia VA Medical Center. As part of our strong affiliation with the University of Pennsylvania School of Medicine, we have a long, respected tradition of excellence in clinical training.

We believe you will find your educational experience and training at this Medical Center stimulating and rewarding. Our goal is to provide excellent preparation for your ultimate career in medicine, as well as an opportunity to care for some of the most unique and special patients – America’s veterans.

The Philadelphia VA Medical Center family of employees is ready to support you with the goal of making this a memorable rotation. You will experience state-of-the-art technology, the most advanced computerized patient record system, as well as many of the other exceptional services with which we provide care to our veterans.

We have much to be proud of at the Philadelphia VA Medical Center and having the opportunity to play a role in your clinical training is an honor for us. As a member of our Medical Center family, you will join us as we embrace the initiative of “Affirming the Commitment.” As employees of the Department of Veterans Affairs, we are not about profits or balance sheets or shareholder returns. We are about service of the noblest type. We serve those who have lived a commitment to protect our nation. This is an awesome responsibility and privilege.

Every American owes our veterans an incredible debt of gratitude. At the Philadelphia VA Medical Center, we are fortunate to have been chosen to help America repay that debt. We welcome you as we affirm our commitment to the veterans we so proudly serve.
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Resident Parking and Escorts

Parking options for residents working at the VA during off hours:

1) Residents MAY park in the VA patient lot evenings, weekends, nights (residents must show their VA or Penn ID and must move their car by 7am the next work day).

2) Residents who anticipate working late into the evening M-F may move their car from the Penn campus onto VA grounds after 4pm.

3) VA Federal Police Officers cannot leave the VA grounds to escort trainees except in extreme emergencies. Trainees are encouraged to utilize one of the escort options below offered Penn’s Division of Public Safety.

Safety and security services offered by Penn’s Division of Public Safety and the University City District:

- Walking Escorts: 215/898.WALK
  (Walking Escort boundaries extend from 30th Street - 50th Street, Spring Garden Street to Woodland Avenue)

- Penn Transit: 215/898.RIDE
  http://www.upenn.edu/transportation
  6pm-3am
  *On-call for emergencies, 3am-7am
  (Penn Transit boundaries are: 50th Street - 20th Street and Spring Garden Street to Woodland Avenue)

- UPPD Detective Unit: 215/898.4485

On Call Meals

Breakfast and Dinner are available for on-call teams in Food Services which located in the basement of the old building. Residents make pick up ‘doc trays’ and ‘doc bags’ (with dinner) between 7 and 8:30am and between 5 and 7pm.
Trainees must be aware of the public affairs policy at the VA. Please refer to the full Medical Center Memorandum (#00-10) at http://vaww.va.gov/philadelphia/mcm.html for more details

**Here are the important points:**

- Radio, television, magazines, trade journals, public speeches, public reports, displays, publications, videos and films are all considered publicity media. Approval to release information to the media is obtained from the VP, External Affairs and then forwarded to the Director and/or Chief Operating Officer for approval.

- Unescorted reporters and/or photographers who appear (planned or unannounced) at the Medical Center or CBOC should be reported or referred to the VP, External Affairs (during business hours) or the evening/night nursing supervisor (during nights, weekends, holidays).

- The Public Affairs Officer may be contacted at Office: (215) 823-5913.

- Patient confidentiality must be maintained in accordance with the Privacy Act of 1974. The Director, Business Office is responsible for securing and releasing any patient information and for consulting with the VP, External Affairs regarding patient information to be released to the media.

- Any interviews or photographs by the media of patients, volunteers, or employees (including trainees) must be coordinated through the VP, External Affairs. A consent form must be completed for each patient photographed, videotaped or voice recorded. Employees and volunteers are not required to complete a consent form to be photographed, videotaped or voice recorded.

- **Serious or Unusual Occurrences (i.e., suicides, homicides or fatal accidents):** The Office of the Director will be notified immediately of any serious or unusual events. In the event of the Director’s unavailability, Chief Operating Officer and the VP, External Affairs, or during irregular duty hours those listed in paragraph 4a (2), will be notified. Release of authorized information concerning patients will be in accordance with MP-1, Part I, Chapter 4 and Title 38, U.S. Code, Section 3305. The VP, External Affairs is responsible for notifying the VISN Office, and/or the Office of Public Affairs in VA Central Office in the event of a crisis situation or sensitive media matters.
FREQUENTLY USED PHONE NUMBERS

VA operator/Main number ................................................................. 823-5800 (or "0" inside VA)
To dial OUT of VA .............................................................................. 8-1-area code-number
To dial while INSIDE VA ................................................................. enter 4-digit extension
HUP main number ............................................................................. 8-1-215-662-4000
Presby main number .......................................................................... 8-1-215-662-8000
VA Chief of Staff Office .................................................................... 6623; 5859
HUP pagers ........................................................................................... (8-1-215- #)
VA 3-digit pagers .............................................................................. (73 (tone)3 digit #(tone)
Computer Help ..................................................................................... 4357 (HELP)
Multiple sign-on release .................................................................... 5802; after hours: page 841

DIALING INTO THE VA FROM OUTSIDE

If the extension you are calling is listed below, you must dial 215-823-5800 and then enter the extension.
- 2000 - 2999
- 3000 - 3999
- 4700 - 4999
- 5000 - 5099
- 5200 - 5799
- 6100 - 6259
- 6280 - 6299
- 6400 - 6999
- 7000 - 7799

HOW TO USE 3-DIGIT VA PAGING SYSTEM

1. Dial 73, wait for voice prompt (in-house only).
2. Prompt - "Please enter User Number." Enter the person’s pager number.
3. Prompt - "Please enter four digit message." Enter the extension where you want the person to call. If successful, the system will say "Your paging request is accepted," followed by a high pitch tone.
4. The page has been sent, and you can return the telephone receiver to its cradle.
**Misc. Offices**

Admissions office .......................................................... 6200/5941; evenings 5802
Transfers (Lisa Montana) ............................................... 581-7922/4181
Transfer Office (alternate #) ..................................... 4591/4613/4572
Transfers after hours (admissions) ......................... 5801/5802
VA NH (to arrange a bed, Kathy Rossetti) ................. pager 73-797
Dialysis ................................................................................ 6500
Emergency room ............................................................... 6003/6004
Home O2 (Jerome Beverly) ........................................ 5147/pager (215) 894-9995
Medical Records ............................................................... 6279/2164
Medical Records (to pull charts for dictation) ...... 6277/4434 (night 5802/6702)
Medical Records (Release of Information) .............. 4434/2722/6267
Supplies (LP trays, trach trays, etc) ................. 6222

**Consultants/Clinics**

Behavioral Health ...................................................... 6233/4313/4314
Cardiology clinic .............................................................. 4105
Cardiology NP (Joyce McGrory) .............................. 812-7469/4292
Dental ................................................................................. 5822
Dermatology ........................................................................ 4263/4015
Dialysis ................................................................................ 4082/4076
ENT appointments .......................................................... 4327
ENT (doctor’s office) ....................................................... 2588
Eye Clinic ............................................................................. 4141
GI clinic .................................................................................. 5122/3525/5966
GI clinic (schedule colonoscopy) ................................. 6444
GI NP (Barbara Rensman) ............................................. 2288/581-1956
Heme-Oncology clinic .................................................. 5999/6198/6455
Heme-Oncology NP (Maureen Rogers) ................. 306-3311/5999/4361 (NP)
Infectious Disease ......................................................... 6346/4000
Neurology clinic ............................................................. 4331
Neurology consult ........................................................... 5850
## Phone Numbers

Neurology EEG (Kelli Grant) .................................................... 2148/2149  
Neurosurgery PA (Bill Schultz) ............................................. (215) 308-7644  
Nutrition .................................................................................... 2073/2367  
Occupational Therapy .............................................................. 5921/6550  
Ophthalmology .......................................................................... 4141  
Palliative Care Services ............................................................... 4142  
Physical Therapy (in/outpatient) ............................................ 4132/4700/6552  
Prosthetics .................................................................................. 4230/2339  
Psychiatry (daytime consults) .................................................. 581-7476  
Psychiatry (nights and weekends) .......................................... VA pg 725/pgr 215-894-4511  
Pulmonary clinic .......................................................................... 6400  
Rehab Dr. consult ........................................................................ 5851  
Renal clinic................................................................................. 5848  
Rheumatology clinic .................................................................. 5966  
Smoking cessation ...................................................................... 4366  
Speech and swallow .................................................................... 4667/4008/4009  
Surgery clinic ............................................................................... 4334  
Urology clinic .............................................................................. 6707/6711/6706  
Vascular Lab ................................................................................. 6666  

**Floors**

**5S Nurses Station** ................................................................. 6480  
**5W Nurses Station** ................................................................. 6721, 2610, 5579  
**5E Nurses Station** ................................................................. 3497, 3498, 3487  
**6W Nurses Station** ................................................................. 6797, 6798, 6789, 3192  
**7W Nurses Station** ................................................................. 4087, 660, 6990  
**7S Nurses Station** ................................................................. 4107, 6613  
**MICU – Nurses Station** ......................................................... 6476, 6820, 6477, 4467  
**SICU – Nurses Station** ......................................................... 6664, 6650
Housekeeping

William Rucker (Housekeeping Aid Officer) .......... 5806/pager 647
James Kauffman (Weekend supervisor) ............... pager 788, 0 if no response

Area #1  Pagar
Supervisor ......................Gregory Elliot .............. 619
Work Leader ....................Vernon Scott ............... 629
All of the Building #1, A/E Building and Linen Room, Mon. - Fri., 6:00 a.m. - 2:30 p.m.

Area #2  Pager
Supervisor ......................Anthony Jenkins ........... 827
Work Leader ....................Anthony Cramer ........... 819
All of the Building #2 and Building 21, Mon. - Fri., 6:00 a.m. - 2:30 p.m.

Area #3  Pager
Supervisor ......................Edgar Bush ................. 905
Work Leader ....................Lois Lacey ................. 624
All Nursing Home Care Unit, Buildings #’s 7, 3, 5, 15, 31, 6, Mon - Fri, 6:00 a.m - 2:30 p.m.

Area #4  Pager
Supervisor ......................Vacant ......................... 788
Work Leader ....................Cardell Stevenson .......... 977
Weekend Coverage - Entire Medical Center, NHCU and all Outside Buildings
Saturday and Sunday 6:00 a.m. - 10:00 p.m.

Area #5  Pager
Supervisor ......................Vacant ......................... 625
Work Leader ....................Bill Jones ..................... 637
All of Building #2 and Building #21 - Mon - Fri., 2:30 - 11:00 p.m.

Area #6  Pager
Supervisor ......................Warren Herbin .............. 959
Work Leader ....................Douglass Merritt ............ 534
All of Building #1, A/E Building, NHCU and All outside buildings

Area #7  Pager
Supervisor ......................Margaret Cook .............. 625
Work Leader ....................Perry McCord ............... 548
Entire Medical Center, NHCU and All Outside Building, Sun-Thurs - 10:00 p.m. - 6:00 a.m.

Weekend Coverage  Pager
Housekeeping Aid ........... Cardell Stevenson .......... 788
Entire Medical Center, NHCU and All Outside Building, Fri. - Sat. - 10:00 p.m. - 6:00 a.m.
Inpatient Nurse Managers
(5S/6W) Tammy McCollum .................................................. 4465, 883-6272
(MICU) Sandy Shlifer ............................................................... 812-0466, x5904
(5 East/West) Dorothy McDonough ........................................ 883-6263, x5923
(SICU) Editha Carino ................................................................. 883-6273, x6664
Behavioral Health Inpat. Catherine Bowen ...................... 215-557-3823, x6901
Behavioral Health Outpatient ................................................ 4106
(Dialysis) Tammy McCollum .................................................. 883-6272/ x6500
Director of Nursing, Medicine .............................................. Vacant
Annette Nelson (Director of Nursing, Surg) ....................... 215-581-7562/ x4444
Ann Farrell (Director of Nursing, NHCU) ......................... 215-899-6262/x4502
Rose Hollis (Director of Nursing, BH) ............................... 215-812-1902/ x5123
Nights and weekend supervisor ........................................... pager 73-841

Laboratory  Main Number ............................................... 2341
Blood Bank (24 hour) ................................................................. 6305/6306
Blood culture team ................................................................. 2341
Chem/Blood Gas (24 hour) ....................................................... 6307/2362/2464
Hema/Coag (24 hour) ............................................................... 6294/6295
To request HIV test (Molly McLaughlin) ......................... 4006
HIV results (M-F days only) .................................................. 3911 (Results available in CPRS)
Immunology/Serology (M-F dayshift only) ....................... 3911
Microbiology (7 days dayshift only) ................................. 6289/6290
Toxicology for GC/MS confirms ........................................ 6303
Urinalysis .......................................................... 2788
Cytology (M-F days only) ....................................................... 6284/6300/6299
Pathology main # (was specimen rec’d, etc) .................. 6300/6299
Pathology reports (M-F days only) ................................. 6284
**Nuclear Medicine**
Main number (results, scheduling) ........................................... 5865
Technician (for STAT orders) .................................................. 6372
Chief Technician ....................................................................... 6585
Fellow (office and reading room) ............................................. 6368
Stress thallium ......................................................................... 6442/6443
Nuc Med dictation reports line (See page # for dictation report)

**Pharmacy**
Inpatient .................................................................................... 6364/6365/6366
Outpatient ................................................................................... 6361
*Note: If a pharmacist is needed for code or emergency, please call 6365.*

**Safety**
Please advise your supervisor or one of the personnel listed below if you believe there is
an unsafe or unhealthful condition in your work area.
Joe Copes, Safety Manager ................................................... 6109, Beeper 402
John Ingram, Industrial Hygienist ........................................ 4104, Beeper 405
Greg Tate, Gems Coordinator ................................................. 6097, Beeper 425
Daniel Rowcroft, Safety Specialist ....................................... 5909, Beeper 404

**Social Work**
7W, 7S, HOMELESS ........................................................... Hicks, Rebecca .......... 6559
ADC / HAA ................................................................. Slentz, Edward J. .............. 4012
ARU / DDX ........................................................................... Okore, Cynthia ...... 3518
ARU / DDX ........................................................................... Wiles, Deborah .... 6841
CHIEF .................................................................................... O'Kane, Patricia .... 4096
COM, NURS HOME/PMF ............................................. Goodnow, Leah ............ 5785
CRC / CNH ............................................................................. Strayline, Charles .... 4621
DIALYSIS / MED ...................................................... Carpenter, Asora ........... 5787
GERIATRICS ........................................................................ Powell, Mia .......... 6383
HOMELESS OUTREACH ............................................ Clevenger, Richard ...... 6492
INPT MED .............................................................................. Blose, Stefanie ....... 4397
INPT MED .............................................................................. Carlock, Dawn ......... 4260
### Phone Numbers

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<tr>
<th>Department</th>
<th>Name</th>
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<td>INPT MED</td>
<td>Duckson, Reginald</td>
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<td>INPT PSYCH</td>
<td>Lugo, Andy</td>
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<td>MHC</td>
<td>Schoppet, Elinor</td>
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<tr>
<td>MHC / CIU</td>
<td>Davis, Najma</td>
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<td>Chapman, Andrea B.</td>
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<td>Roundtree, Iris Y.</td>
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<td>Verner, Aretha A.</td>
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<td>Newkirk, Waltina L.</td>
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<td>SURGERY</td>
<td>Rucker, Leslye</td>
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### Studies

CT, MRI, Dexa, Ultrasound, Mammography, fluoroscopy or other radiological study scheduling .....6313

Stat/Emergency CT..................................................2155

All other STAT/Emergency Radiology studies ...........6313

Interventional Radiology scheduling........................6328

Film library and duplication of images ..................6313

Radiology after hours (to arrange a general x-ray)........ Pager 943 or 946
Phone Numbers

ECG (Heart station/old ECG's) ................................................................. 6421
Echo tech .............................................................................................. 6417/6422
Echo scheduling .................................................................................. 4105
Echo results (VA) .................................................................................. 4105 (also on computer under “procedures”)
Echo results (HUP) (rarely sent there) .................................................. 662-6291
EEG ........................................................................................................ 2148/2149
EMG ....................................................................................................... 5851/6519
Pulmonary function lab ................................................................. 6407
Vascular lab ....................................................................................... 6666
Medication Orders and Prescriptions

Inpatient Orders

(1) Take time to renew all of your patient’s orders when starting on-service. This will cause the computer to send all alerts to you and not to the previous team members. Review patient’s med lists daily and check expiration dates regularly. You will receive a view alert 24 hours before the order expires. It’s also a good idea to renew orders at least once per week to prevent an order from expiring on evenings/weekends disrupting treatment.

- Most medication orders are active for 8 days.
- Narcotics, Fingersticks and IVF for 72 hours.
- PCA and TPN/PPN for 24 hours.

(2) Verbal orders are accepted in cases of emergency. Verbal orders for medication must be given directly to the pharmacist (215-823-6365). You will receive a “view alert” to electronically sign the order the next time you sign onto the computer system. Please do so.

(3) Take administration times into account when ordering medication. The next scheduled dose will appear in the lower right hand corner of the ordering box in CPRS. If you want the patient to receive a dose before that time, click “FIRST DOSE NOW” to place a “now” order.

(4) Some medications have specific administration times:

- Digoxin & warfarin = 6PM
- Antidiabetic meds = 7AM, 5PM
- Statins = 10PM
- Antibiotics = around the clock

(5) TPN/PPN orders need to be approved by the Nutrition Service prior to initiation (73-664 or 73-934). The orders must be written on the pre-printed form (2 copies—one for the nurse and one for the pharmacist) and sent to the pharmacy by 1PM. Late orders will not be honored. Patients receiving TPN/PPN must also have an order for sliding scale insulin four times daily as long as they receive TPN/PPN.

(6) The hospital uses the Alaris Guardrails safety pump system. Standard dilutions are
programmed into the pump. The pharmacy will change “guardrails” infusions such as fentanyl, dopamine and amiodarone infusions to the standard so that the pump can be set up to run properly.

(7) All infusions must have a starting rate including boluses. (ex. NSS @ 999ml/hr over 30 minutes).

(8) It is hospital policy that a patient on PCA may not have a second narcotic order with the exception of methadone maintenance. If your patient is on PCA, write the order with a PRN dose instead of writing a second order for breakthrough medication such as Percocet or Dilaudid.

(9) To change the rate of a titratable drip (ex. Heparin) use the “CHANGE RATE” function instead of creating a new order. The new order will make it difficult for the nurse to chart the infusion in BCMA. Also put the rate in units in the “provider comment” section of the order to prevent medication errors. Ex. 1000 units/hr

(10) Text orders cannot be used for pharmacy orders including IV rate changes or for discontinuing an IV infusion. These orders never go to the pharmacy or to BCMA to be acted upon.

(11) IV Push Medications on the Floor – RN who have demonstrated competency may administer the following medications by direct IV push:

- Prochlorperazine (Compazine) 5-10 mg slow IV, < 5mg/min.
- Metoclopramine (Reglan) 10-20mg over 1-2 minutes
- Furosemide (Lasix) IV if dose < 100mg
- Bumetanide (Bumex) 0.5 – 1mg over 1-2 min. up to 10mg.
- D50W – one amp
- Diphenhydramine (Benadryl) 12.5-25mg over 2 min, may repeat x 1 up to 50 mg.
- Naloxone (Narcan) 0.1-0.2 mg over 1-2 min. up to 2.4 mg
- Haloperidol (Haldol) 2-5 mg over 1-2 min.
- Dexamethadone (Decadron) 1-4mg. IV over 1-2 min.
- Benztropine (Cogentin) 1-4 mg. over 1-2 min.
- Morphine Sulfate 1-2 mg over 1-2 min for acute chest pain only.
Outpatient Orders (Prescriptions)

(1) Restrictions/required labs are in the “I” information box. Please be sure to read them and order any necessary consults/lab work to prevent a delay in processing the prescription.

(2) Take a look at the ordering units. You may need to type in “30” for “30 gm” instead of “1” for one tube of ointment.

(3) Nutritional products (ex. Ensure, Glucerna) are available only for tube feeders, AIDS patients, and Radiation Oncology patients upon recommendation by Nutrition Service. Consult Nutrition Service through the computer.

(4) Tell the patient that he/she must see the pharmacist to get the prescription(s) processed. This will prevent the patient from coming to the pharmacy pick up window expecting his medication and then having to wait to see the pharmacist to process the prescriptions.

(5) Non-formulary drugs will be processed for mail. See Section II for more detail.

(6) Outpatient IV therapy is provided via a contract service. Contact the Case Manager or Social Worker to set up delivery of service.

(7) Procedure for Reporting Adverse Drug Reactions (ADR).
   - On the left side of your main GUI order entry screen, there will be a selection titled “ADR”. Selecting it brings you to an ADR Report screen.
   - The patient’s social security number, date of birth and weight default to the screen.
   - Provider fills in the medication name and the nature of the event as free text.
   - Click on the box adjacent to the Date of Event to bring up a calendar to select the date. The date of event is no a required field.
   - When completed, select OK and sign the consult. The pharmacists will be notified of a pending ADR. Pharmacy will complete the report based on medical records review and will contact the reporting individual if necessary.
Understanding VA Criteria for Use
How will I know if guidelines/criteria for use exist for a certain drug? Where can I find them?

(1) CPRS
1. Select patient for example: Test, User
2. Select medication tab.
3. Go to Action tab on top of page.
4. Select New Medication.
5. Choose a drug, may see NF status, IBOX, Blue box-criteria for use etc.

(2) PBM Website – National Formulary
1. There are links to downloadable National Formulary and recent updates.
2. There are also many Criteria for Use/Guidelines/Monographs available for review.
4. Thru CPRS, go to Tools bar click National Formulary.

Non-Formulary versus Formulary Restricted Drugs
Non-Formulary: Requires NF consult prior to approval of medication and dispensing to patient (these agents are NF at the National level). Max allowed is 30 days with 5 refills.

Formulary Restricted: May Require a consult. It is on VA Formulary with Criteria for Use developed by VISN/local or National level requiring review and documentation in patient record of how patient met criteria prior to approval and dispensing to the patient. Examples include rosiglitazone, clopidogrel, memantine, ARBs all require consult. Other agents may be restricted to a service or diagnosis and may not require consult.

The Following are restricted to a diagnosis only: (document under Problem List in CPRS)
- Metoprolol - CHF, heart failure, cardiomyopathy
- Vardenafil - Erectile dysfunction
- Loratidine - allergic rhinitis
Understanding Consults

Entering Consults

(1) Thru CPRS, go to Orders tab, click “non form. “

a) Templated Drug Consults
   Non-Formulary Restricted
   Tamsulosin Clopidogrel
   Fluticasone/Salmeterol Memantine
   Insulin Glargine ARBs (Angiotensin Receptor Blocker)
   Escitalopram Rosiglitazone
   Generic NF/ restricted drug consult (for everything else)

b) Be aware of restrictions/guidelines when they are posted. IBOX, blue box will guide thru published criteria/guidelines.

c) Be complete! Incomplete completion of a consult will delay approval of meds.

Disapproved Consults

i. If a request is disapproved, pharmacy will ask notify provider via telephone, email and/or by requesting receipt acknowledgement on the completed consult progress note. Patients will be sent letters from pharmacy informing them of the decision.

ii. It is the provider’s responsibility to discuss other available therapeutic alternatives.

iii. NF medication denials can be appealed via email thru exchange at vhaphi pharmacy non form appeal or thru VISTA at g.pharmacy non form appeal.

iv. The appeal group consists of 3 physician members of P&T including the Chair of P&T, Dr. Edna Schwab.
The scheduled time for discharge in the Medical Center is 11 am. This means that discharge orders must be entered before 9am on the day of discharge. Patients being discharged to the VA Nursing Home must have a discharge order signed by 9am.

1. PVAMC uses scheduled “discharge appointments.” Write an order for ANTICIPATED DISCHARGE DATE as soon as you anticipate discharge (24-48 hours in advance). The ward clerk will actually enter the discharge appointment in the computer; this tool allows services like Lab, Pharmacy, etc. to prioritize discharges.

2. Complete discharge prescriptions. Discharge medications are done electronically in CPRS. If the medication is an active inpatient medication that needs to be continued upon discharge do the following:
   a. Highlight the order your want to continue (if there is more than one, hold down the CTRL key on the keyboard and select the items).
   b. Click on ACTION on the toolbar and select TRANSFER TO OUTPATIENT from the drop down menu.
   c. When the dialog screen appears, check the dosing and schedule. Make sure the number of days supply is what is needed. Check the number of tablets/pills/etc. and the number of refills. Finally, select the pickup method of CLINIC if the patient is taking the medication home with him/her. The WINDOW option will allow the patient to pick up the medication in the next 2-5 days and the MAIL option will send the patient the medication in 7-10 days from the time Pharmacy verifies the order.
   d. If the discharge medication is new, then go to the ORDERS tab and select OUTPATIENT MEDICATIONS from the left hand column.

Controlled substances:

Prescriptions for Narcotics need to be written on a paper VA script and taken to the Inpatient pharmacy (just outside of the elevators on the 2nd floor in the old building). Pads are available at the Pharmacy. You have an assigned VA 6-digit provider number (ex: 102123) which serves as the equivalent of your license number in the VA system. Schedule 3-5 controlled substances (Tylenol #3, benzodiazepines) may be ordered electronically.

Timing of prescriptions:
   a. Monday through Friday: must be entered 24 hours prior to discharge
Section II: Practical Information

Discharging Patients

b. Saturdays: scripts entered by 11am will be filled by 3:30pm

c. Sundays: there is no discharge prescription service on Sundays

d. Holidays: prescriptions should be brought to the pharmacy the
preceding business day (eg. for Monday holidays, this means Friday)

e. Emergency discharge Rx may be done on the same day, but will take a MINI-
mum of 4 hours. Please contact Inpatient Pharmacy directly

Prescriptions are not necessary for patients transferred to another VA or the VA NH.

3. Arrive Follow-up Appointments
You may WRITE AN ORDER for follow-up appointments within the VA from the
inpatient order screen. The clerk will retrieve the order and schedule the patient.
Make sure you double check the computer (look on the cover sheet) to make sure
the appointment is not scheduled too far in advance for your patient. It is a good
idea to order appointments as soon as you anticipate discharge.
NOTE: patients transferred from other VA's generally will NOT need primary care appoint-
ments here as they are enrolled for primary care at their referring site.

4. Complete Discharge Instruction Sheet (In Computer)
a. Order discharge medications and get outpatient appointments scheduled BE-
FORE you do the discharge instruction form so this information will automati-
cally appear in the discharge instruction form
b. Create a new note titled: “discharge instructions”
c. Complete appropriate check boxes
d. Edit the templated note –
   1) all areas that have blanks (____) must be completed or you will not be able
to sign the note
   2) Edit any information (especially meds) that was imported incorrectly.
**REMEMBER: patients use this list to know which medications they should
be taking, so it MUST be accurate!! (the med list that defaults OFTEN must
be edited)
e. Sign note to release to system and nursing.

5. Make Other Home Arrangements
At least two days prior to discharge, make appropriate arrangements:
a. Hospital beds and other durable medical equipment are ordered via prosthetic
consult. Please check with PT/OT regarding equipment they may have
ordered. Prosthetics equipment can also be ordered STAT.
b. The social worker or case manager should be contacted regarding in home
   services, i.e. PT, home nursing, home health aide, etc.
c. Under transportation-patients will need to meet the VA Travel transportation
guidelines for transportation to home. Special arrangements may be able to
   be made on a case by case basis. Discuss this with the Social Worker if needed.
   Transportation to facilities, i.e. nursing homes hospitals, rehabs, etc who does
   not meet criteria may be able to be negotiated with VA travel. Discuss this with
   the Social Worker if needed.
d. If transportation home is required, you need to fill out a TRANSPORTATION
   Form and take it to the transportation office near the Module A clinic on
   the first floor (Ward Clerks may assist you in this). NOTE: During the 2007-2008
   academic year, it is anticipated that the travel form will become an electronic order.
   Shuttle arrangements can be made by contacting the Transfer office (PTO) at x4591/
   4613 as soon as Discharge is planned.

   Shuttle Schedules:
   Lebanon: leaves PVAMC – 10:15 am, M-F
   Coatesville: leaves PVAMC – 10:15 am, M,T,T,F
   Wilmington: leaves PVAMC- 11:45 am, and approx. 2:30 pm, M-F
   Wilkes Barre: schedule varies, contact PTO for schedule.

   Patients may ride shuttle transportation if they are alert, oriented and ambulatory
Patient must have the appropriate outerwear, including shoes to ride. For those
patients that require a wheelchair or other medical needs such as 02, a transporta-
tion request with medical justification will be needed.

   Note: The clothing room may be contacted at x6195,2340 for those patients
   without proper outerwear.

e. Complete PROTHESESIS REQUEST (wheelchair, cane, glucometer, etc.) – write a
   consult in the computer

f. Call or email patient’s PCP to make them aware of the discharge

5. Complete discharge summary (see next page).
6. Write discharge to home order.
Discharge Summaries
ALL admissions require a D/C Summary (EVEN those admissions less than 24-48 hours!). Discharge summaries may be dictated OR typed directly using the discharge summary tab at the bottom of the screen in the VA computer system. See page 28 for dictation instructions.

Minimal Requirements
- Patient’s full SSN
- Date of admission and date of discharge
- Dictated by: Your Last Name, First Name (with spelling)
- Attending Name; Last, First (with spelling)
- Chart and follow-up information as follows:
  a) Discharge Diagnosis (diagnoses)
  b) Brief Hospital Coursing, including:
      - Reason for hospitalization
      - Significant findings
      - Summary of procedures
      - Treatment given
  d) Discharge Medications
  e) Follow-up appointment
### Sample Simple Discharge Summary

This is a discharge summary on John Vet.

| Social Security Number: 123-45-6789 |
| Date of admission: 12/29/02 | Date of discharge: 1/2/03 |
| Dictated by: Joe Resident (spell out) | Attending Name: Jane Attending |

#### Discharge Diagnoses:
- 1) acute pancreatitis
- 2) hypertension

#### Brief Hospital Course:
Mr. Vet has a history of hypertension, pancreatitis and a distant history of alcoholism who presented with 4 days of nausea, vomiting, and abdominal pain. His amylase and lipase were significantly elevated on admission at 600 and 500, respectively. Other laboratory data was unremarkable. No imaging studies were performed. He was made npo and given IV fluids and IV pain medication. After 3 days he was switched to a po pain regimen and was tolerating clears.

#### Discharge Medications:
- Dilaudid 2 mg 1 po Q4h prn for severe pain for 3 days,
- thiamine 100 mg QD, Atenolol 50 mg QD

#### FU apts:
- Dr. Outpatient, Module A, Wed 1/7/00, 10:00am

#### FU instructions:
- the patient was told to return if the pain recurred, fever developed, or if unable to take po's
Transfers

1. Transfers to another VA or community Hospital (Acute level care)
   1. Patients transferred from other VA spoke hospitals require a Physician to Physician report prior to transfer back to home facility. Please contact the transfer coordinator for assistance.
   2. Form 10-1000 must be completed for spoke hospital transfers, please see unit ward clerks for form.
   3. For patients emergently or urgently transferred to HUP or other Community Hospitals for services not provided at PVAMC, authorization will need to be provided. Please refer to section on 10-7078 Authorization at the end of this section.
   4. Once mutual agreement has been reached by the referring and accepting physicians regarding the safety of a patient transfer, a transfer summary shall be completed to include the following information.
      1. Date and time of transfer.
      2. Documentation that the patient is stable at the time of transfer.
      3. Documentation of the patient’s informed consent to transfer (or appropriate surrogate).
      4. The mode of transportation, appropriate level of care and equipment needed: ACLS vs. BCLS, Medication infusions, ventilator, etc.
      5. Identification of transferring and receiving physicians.
      6. Documentation of significant assessment parameters to include labs, radiology and procedure results.
      7. Documentation of the patient’s advance directive if made prior to transfer.

2. Transfers to VA Nursing Home
   1. Call Social Worker as soon as placement becomes an issue
   2. Complete form Geriatric Medicine Nursing Home evaluation form and return to Social Worker, who will fax to VANH.
   3. VANH reviews forms weekly to determine eligibility.
   4. If patient is accepted, SW will notify you of what unit patient will be going to.
   5. Call the unit Nurse Practitioner and give report the day before discharge.
   6. Write order for patient to be D/C to NHCU. (Order must be written by 9am so
that they can be transported by 11 am as the NH does not accept patients after 12noon)
7. Complete transportation form for those patients requiring an ambulance. PVAMC escort can take ambulatory and Wheelchair bound patients.

3. Transfers to Community Nursing Home
1. Call Social Worker as soon as placement becomes an issue.
2. Complete discharge summary to initiate process of NHP.
3. Write “awaiting NH placement in progress notes daily.
   a. Please do not use the name of nursing homes in physician progress notes or the reasons why a veteran may have been rejected by a nursing home for placement.
   b. There is no need to request that charts be coded and copied. The Social Worker will prepare a discharge packet including the discharge instructions, written orders, and other pertinent medical information.
   c. Also physicians should be careful if they are copying and pasting information from a previous note. If the information is old, i.e. stating a patient needs 1:1 supervision, when they do not, the discharge could be delayed.
4. Day prior to D/C write an order for the chart to be copied and coded.
5. Dictate ADDENDEM (or create in GUI) on the day of D/C which details what, if anything, happened in the patient’s course since you dictated D/C summary.
6. Complete Discharge instruction Form on-line.
7. Complete written transfer form which will be provided by Social Worker. For Long term placement a MA-51 form will need to be completed. (** Forms will need to include Attending signature and have MD license #.
8. Complete TRANSPORTATION form.
9. Write “D/C to Nursing Home” in order.

4. Transfers from Outside Hospitals
- Residents, upon approval from their attending, may deny or defer transfer requests when there is reasonable doubt about the safe transfer of the patient, or if there is no documented need for hospital level care.
- Direct transfers to the hospital will not be routinely screened in the ER. In these cases, the assessment of stability for transfer is the responsibility of the accepting Service/Section Staff Physician. Doc to Doc report is expected.
5. Transfers To Hup For Services

VA patients who receive care at the Philadelphia VAMC (PVAMC) and are sent or transferred to the University of Pennsylvania Hospital for procedures must be sent with a completed **VA Form 10-7078, Authorization and Invoice for Medical and Hospital Services.** The medical information on this form and location of the procedure at HUP must be completed by the primary housestaff. The ward clerk will complete the remainder of the form and will take the form for the required signature from the VA Chief of Staff.

Price is obtained by calling the Resource Management (Fiscal) case manager at ext. 4086, 7:30 a.m. – 4:00 p.m., Monday – Friday. For off hours, write the statement “Payment no to exceed DRG”. A travel form must also be completed.

Exception: Certain services (ex: most Cardiology Services) are performed under VA-HUP contract and do NOT require a 7078 form.

Please contact the specialty service performing the procedure if there is a question.

Please note that VA patients sent to HUP are NOT eligible to be recruited for any University of Pennsylvania RESEARCH PROTOCOL unless the protocol has been previously approved by the Philadelphia VA IRB. These patients are still under the care and jurisdiction of the VA as the primary provider. As such, the Philadelphia VAMC IRB must remain the primary advocate protecting the rights and welfare of all Philadelphia VAMC patients in research protocols. If you have any questions, call the PVAMC R&D office at 215-823-7847.
Medical Records Dictation Instructions*  Effective May 2005

Dictate

Dial:  1-877-413-3113
Enter:  6 Digit ID number followed by #
Enter:  Patient’s full 9-digit Social Security #
Enter:  Work Type (see below) followed by #

Immediately after hearing tone begin dictation
Please dictate and spell the name of the patient. Dictate full Social Security number.

Work Types:

01  Discharge Summary
02  Addendum To Discharge Summary
03  Operative Reports (Include The Case Number)
04  C&P (Include The Case Number)
06  Nursing Home Placement
07  Transfer Summary

Key Pad Codes:

1.  Pause (after pausing, enter 2 to resume, you will hear a tone to continue to dictate).
2.  Dictate.
3.  Rewind (rewinds for approximately 3 seconds, press multiple times for additional rewinds, at tone continue to dictate).
5.  Disconnect.
7.  Rewind to beginning.
8.  Next dictation (you can begin a new dictation).
   •  After dictation is complete, enter ##.
   •  A voice prompt will provide your verification number, the information you entered and the length of your dictation or you may simply hang up.

*Dictation system is used for op reports and as an alternative to typing DC summaries in CPRS.
Listen to Radiology Reports

(Used only when the usual Radiology voice recognition system is down.)

Listen User ID Number is 59999 for any provider to Listen to any patient’s dictation.

- **Dial:** 1-877-413-3113
- **Enter:** 59999 followed by # (menu of options offered listed below)
- **Enter 1:** listen by Job #
- **Enter 2:** listen by Author/Provider ID
- **Enter 3:** listen by Subject number (Social Security #)
- **Enter 4:** listen by WorkType #
- **Enter 5:** listen by Department #
- **Enter 6:** listen by Location #
- **Enter 8:** skip to previous dictation on the same patient
- **Enter:** Patient’s full 9-digit SSN followed by #

You may skip to each previous dictation by pressing 8 until you come to the one you wish to hear.

Please call DINA at x6277, Monday through Friday, 8am-4pm, for either a concurrent or discharged listing of your patients not yet completed.
**What housestaff can expect from the ward clerks**

1. Professional and courteous interactions with patients, guests, and staff.
2. Schedule post-discharge appointments as ordered by providers. If clinic is booked for the date requested, clerk notifies their supervisor for processing of the order.
3. When patients are to go to a non-VA facility for a test or procedure, the ward clerk prepares the VAF 7078, ensures that the form has appropriate signatures and ensures that a completed VAF 7078 accompanies the patient (except for Cardiology patients, as Cardiology takes care of that). The provider will provide the following information: name of test or procedure, reason for procedure, date, time, locality of procedure, and sign when appropriate.
4. Will make necessary travel arrangements for patients going to non-VA facilities for procedures, or for transfers to other VA facilities. Based on the travel order entered, the clerk will assist the housestaff in completing a Special Mode Transportation Request for the providers’ signature and deliver the form to the Transportation Office.
5. Ensure that there are sufficient amounts of forms available on the ward for the clinical staff to do their work; provide specific forms to staff when requested.
6. Answer the ward’s phone calls; relay messages to housestaff/nursing staff as appropriate.
7. Coordinate patient movements to/from tests and/or procedures within the facility.
8. Available to assist the provider and nursing staff with any questions they may have.
9. The clerk will collaborate with the charge nurse to assign admissions and transfers to the appropriate bed type and notify Environmental Management Services when beds need to be cleaned.

**What the ward clerks can expect from housestaff**

1. Professional and courteous interactions with patients, guests, and staff.
2. Write free text orders for necessary patient services performed by ward clerks (ex: making discharge appointments) and print a hardcopy of the orders and present to ward clerk directly or place in designated clipboard/box in ward clerk area.
3. When patients are to go to a non-VA facility for a test/procedure, the ward clerk prepares the VAF 7078. The provider will provide the following information: name of test/procedure, reason for procedure, date, time, locality of procedure, and sign...
when appropriate. Housestaff should print a copy of the orders and present to ward clerk directly or place in designated clipboard/box in ward clerk area.

4. For patients going to non-VA facilities for procedures, or for transfers to other VA facilities, and for discharges when needed, providers must enter a free text order about what travel arrangements need to be made and inform the ward clerks of the order. (Housestaff should print a hardcopy of the orders and present to ward clerk directly or place in designated clipboard/box in ward clerk area.)

5. Answer pages to the nurses’ station in a timely manner.

6. Inform the ward clerk of planned discharges each morning.

### Evening & Night Shift Ward Clerk Beeper Numbers*

(dial 73 to access the pager system)

**4:00pm-Midnight (rotating assignments; schedule available by calling x5802/6702)**
- Barbara Morrison  #593
- Lester Carter  #480
- Joyce Coleman  #484
- Ruth Pressley  #482
- Constance Ratliff  #481

**3:00pm-11:00pm (rotating assignments; schedule available by calling x5802/6702)**
- Adrianne Feribee  #483

**11:00pm-7:00am (rotating assignments; schedule available by calling x5802/6702)**
- Patrice Ray  #486
- Ivana Willis  #992

**Midnight-8:00am (rotating assignments; schedule available by calling x5802/6702)**
- Ellen Salmond  #485

**Supervisor, Ward Administration Service**
- Mia Duckett  #299

*Subject to change
Resident Handbook 2007-2008

Section II: Practical Information

Laboratory Information

Lab Draws
- Routine lab draws: 6am, 11:00am, 1:30pm, 7pm daily.
- Cut-off times for orders are 2:30am, 10:30 am, 1:00pm, 6:30pm, respectively.
- STAT labs and blood culture draws may be done by phlebotomy staff (except for between the hours of midnight-6 am)- they must be called. x2341 (Main Lab #)
- Blood bank requests require a SPECIFIC AND DETAILED PROTOCOL (see “BLOOD BANK” next page). Phlebotomy is available to help with type and screen drawing upon request. (Seek their assistance the first time you draw a type and cross/screen)
- If drawing blood cultures, 2 sets should be drawn.
- To order an HIV test you must have the patient sign a consent and file in the chart prior to ordering the test. You MUST keep track of all HIV tests you order and should contact patient re: results even if they are discharged.
- Blood Gases must be placed on ice immediately upon collection & delivered to 3B138.
- Each nursing unit should have a Laboratory Ward manual which outlines each test, requirements, and other information. It is a light blue binder.
- STAT labs drawn by the house staff must be taken to the 3B138 on the third floor with the appropriate slips. All specimens must be labeled properly at bedside to contain the full name and full social security number. If the name on the slips does not match the name on the specimen, the specimens will be discarded by the lab. Please make sure you date the slip with the time of draw (there is no tube system).

Transfusions
- Type and cross, type and screen and transfusion orders MUST be handwritten on the appropriate form.(SF-518)
- Please be aware that there is a SPECIFIC PROTOCOL for DRAWING type and cross/screen specimens at the VA (see below). For assistance, you may call the Blood Bank at x 6305 OR inquire with staff nurses.
- Phlebotomy may be available to draw urgent type and cross and help with the protocol (X2341).
- Nursing instructions and pre- or post-transfusion meds MUST BE DONE ON THE COMPUTER (write a nursing free text order with transfusion instructions i.e. infuse 2
units or prbs over 2 hours each; medics must be ordered as usual timing = “on call”)

- NOTE: There are NO PRN pre- or post-transfusion orders.
- Providers MUST make sure there is a signed Transfusion Consent prior to writing an order for transfusion.

**VA Medical Center Transfusion Service**

**Collection of Blood Bank Specimens**

*Note:* If the patient does not have a Hospital I.D. Band attached to their arm or leg, **DO NOT** proceed with this procedure.

*Note:* Phlebotomy is available to draw blood bank specimens 6am to midnight.

**Step I: Obtain the needed supplies**

- SF 518 Request Form - completely & correctly filled out
- Hollister Recipient Label Sheet and Pink Plastic I.D. Bracelet
- Pink Blood Bank Hemogard Vacutainer Tube

**Step II: Patient Identification**

- Check that the patient’s name and Social Security Number on the SF 518 form is an EXACT match to patient’s Hospital I.D. Band. This includes middle initials and Jr/Sr.
- Ask the patient to state their Name & Social Security Number as it appears on the SF 518 and Hospital I.D. Band. Also have them sign their name on the SF 518 (exactly as it appears on the SF 518) if they are capable. If a patient is unable to clearly I.D. themselves and sign their name, you must get a witness (RN or MD) to confirm the patient’s identity. This witness must sign the SF 518 in the “Remarks” section prior to collecting the specimen.
- Stamp or write/print the patient’s Name & Social Security Number on the Hollister Recipient I.D. wristband label & Hollister Tube Label. These must be legible and an EXACT match to the SF 518 and patient’s Hospital I.D. Band.

**Step III: Collect the specimen**

**Step IV: Post specimen collection**

1. **Immediately** label your tube with the Hollister Tube Label before leaving the patient’s room. Record the date and time of collection and sign the following: (If your signature is missing, the specimen will be rejected)
2. Insert the Hollister Recipient I.D. wristband label into the pink plastic Hollister Bracelet and attach to the patient’s arm or leg. Remove any previously issued Hollister Bracelet. **Note:** Due to the limited space on the Hollister Recipient I.D. wristband label it is acceptable for the phlebotomist to initial instead of sign this wristband label.

**Remember:** The SF 518 Form is incomplete without 2 signatures i.e. the phlebotomist and witness OR the phlebotomist and the patient (next to their name)

For more detailed information see procedures “Completing the SF 518 Request Form” and “Collection of Blood Bank Specimens” at nurses stations or in lab.

**Transfusion Service Guidelines For Authorized Units Of Blood For Elective Surgery V**

1. These guidelines are based on the “usual” requirements for the cases performed at VAMC. If a patient’s clinical condition should require more blood than noted below, the reason must be noted with the blood order, and on the or request.

When this reason is not indicated, the blood bank staff will make every attempt to obtain information. If information cannot be obtained, the blood order will be processed as per the request. The blood bank director will be notified by blood bank staff. The blood bank director will contact the attending surgeon ASAP.

2. When a type & screen (less than 72 hours old) has been ordered for a patient preoperatively, blood will be available in the blood bank within 15 minutes.

3. Surgical procedures listed on the following pages are those indicated in the hospital’s Maximum Surgical Blood Order Schedule (MSBOS) as requiring the number of red blood cells indicated. All other procedures should be submitted as a Type and Screen if there is any anticipation that blood may be needed.
<table>
<thead>
<tr>
<th>Procedure</th>
<th>Count</th>
<th>Description</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Surgery</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A/P Resection</td>
<td>1</td>
<td>Hepatectomy</td>
<td>6</td>
</tr>
<tr>
<td>Antrectomy &amp; Vagotomy (Gastrectomy)</td>
<td>1</td>
<td>Hepatectomy with cell saver</td>
<td>6</td>
</tr>
<tr>
<td>Esophageal Resection</td>
<td>2</td>
<td>Pancreatectomy</td>
<td>4</td>
</tr>
<tr>
<td>Gastrectomy</td>
<td>1</td>
<td>Splenectomy</td>
<td>2</td>
</tr>
<tr>
<td><strong>Cardiovascular &amp; Cardiopulmonary</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aorto-Femoral bypass graft</td>
<td>2</td>
<td>Renal Artery Repair</td>
<td>3</td>
</tr>
<tr>
<td>Femoral-popliteal bypass graft</td>
<td>2</td>
<td>Resection, abdominal aortic aneurysm</td>
<td>3</td>
</tr>
<tr>
<td>Pericardiectomy</td>
<td>2</td>
<td>Resection, abdominal aortic aneurysm with cell saver</td>
<td>2</td>
</tr>
<tr>
<td>Pneumonectomy, lobectomy</td>
<td>2</td>
<td>Saphenous vein bypass</td>
<td>1</td>
</tr>
<tr>
<td>Porta-caval shunt</td>
<td>6</td>
<td></td>
<td></td>
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<tr>
<td><strong>Otolaryngology</strong></td>
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<td></td>
</tr>
<tr>
<td>Glossectomy</td>
<td>1</td>
<td>Mandibulectomy</td>
<td>1</td>
</tr>
<tr>
<td>Jaw, neck &amp; tongue dissection</td>
<td>1</td>
<td>Maxillectomy</td>
<td>1</td>
</tr>
<tr>
<td>Laryngecctomy, with RND</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Neurosurgery</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACDF (Anterior Cervical Discectomy with bone Insertion Spacer Fusion &amp; plate)</td>
<td>2</td>
<td>Tumor</td>
<td>2</td>
</tr>
<tr>
<td>Craniotomy Aneurysm</td>
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<td></td>
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<tr>
<td><strong>Orthopedics</strong></td>
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</tr>
<tr>
<td>Total Hip</td>
<td>4</td>
<td>Total Hip with cell saver</td>
<td>2</td>
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</table>
### Laboratory Information

#### Maximum Surgical Blood Order Schedule (cont.)

<table>
<thead>
<tr>
<th><strong>Gynecology</strong></th>
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<th><strong>Urology</strong></th>
<th>2</th>
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<tr>
<td>Debulking for Ovarian Cancer</td>
<td>4</td>
<td>Total Abdominal Hysterectomy with Node Dissection</td>
<td>4</td>
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<tr>
<td>Laparoscopic Assisted Vaginal Hysterectomy</td>
<td>2</td>
<td>Total Abdominal Hysterectomy for Malignant Disease</td>
<td>2</td>
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<tr>
<td>Pelvic Exenteration</td>
<td>4</td>
<td>Vaginal Hysterectomy</td>
<td>2</td>
</tr>
<tr>
<td>Radical Hysterectomy without Lymph Node Dissection</td>
<td>4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Emergency Release of Blood**

When a situation is so urgent that one or more units of blood must be released without typing the recipient, Group 0 red blood cells will be issued. Male patients and females 50 years or older will receive 0 Rh Positive red blood cells. Females less than 50 years old will receive Group 0 Rh Negative red blood cells until a sample is submitted to the Blood Bank and the type of the patient is determined.

An emergent release of blood requires the requesting physician to sign the Emergency Blood Release Form stating the reason for the request. The signing of this form indicates that the physician has weighed the risk of transfusing the blood without the performance of the standard compatibility procedures and deemed a delay in the transfusion to jeopardize the patient’s life.
Heparin Dosing Guide

The following guidelines approved by the Chief of Medicine Chief of Hematology/Oncology, Philadelphia VA Medical Center. Effective 11/05/04.

NOTE: The VA computer system only accepts Heparin Orders in cc/hr (conversion: 50 units/ml)

Heparin Dosing Guidelines
1) Order Baseline APTT, PT, CBC
2) Give Bolus at 70 units/kg (Total Dose Range 3000 – 7000 units)
3) Start Infusion at 18 units/kg hours (Do Not exceed 1800 units/hour)
4) Order APTT in 6-8 hours
5) Re-order APTT 6-8 hours after each dose change

Therapeutic range: 67 – 104 seconds
(Serum levels of 0.3 – 0.7 units/ml by antifactor Xa levels)

Dosing Adjustments During Therapy
For APTT Below Therapeutic Range:

If APTT< 36 seconds: Re-bolus at 35 units/kg; Increase infusion by 3 units/kg/hour
If APTT is 36-66 seconds: Do Not Re-bolus; Increase infusion by 2 units/kg/hour

For APTT Above Therapeutic Range:

If APTT is 105 – 165 seconds: Decrease Infusion by 1 unit/kg/hour
If APTT is 166 – 218 seconds: Hold infusion for 30 minutes, then Decrease infusion by 2 units/kg/hour
If APTT is> 218 seconds: Hold infusion for 90 minutes, then Decrease infusion by 3 units/kg/hour

Cardiac Labs
Effective 1/10/2002 at 3pm, all cardiac LABS must be drawn in green top tubes. If you do not have green top tubes on your wards, please get the tubes from the laboratory (3b138). If you have any questions, you can contact William Dibattista PhD at ext 4421 or Rosemary Millili at ext 6307.
Homocysteine
1. Homocysteine levels are done Tuesdays and Thursdays.
2. All Homocysteines must be collected in a pre-chilled yellow SST tube. This can be accomplished by pre-chilling a Yellow SST tube in a bag of ice or ordering special collection coolers to pre-chill the tubes. The specimen must be kept on ice and immediately delivered to the laboratory for processing.
3. If there are any questions please contact Rosemary Millili, MT(ASCP) at x6302.

PRO BNP
Chemistry offers a proBNP level for the risk assessment of Congestive Heart Failure (CHF). Testing is done 7 days/24 hours and is collected in a yellow top tube. Reference ranges are different than BNP levels and are reported with the results.
Radiology Patients Requiring Sedation
IV conscious sedation must be done by a trained physician/provider, usually an anesthesiologist/anesthetist (they should be paged). Please note: no medications are to be brought from the medical floors to radiology.

General Radiographs
The Radiology Department is staffed 24hrs a day by a Radiology Technologist for General Radiographs. These will be officially read the following day during regular hours.

CT Scans
CT Scan hours are from 7:00 a.m. to 10:00 p.m., Monday through Friday. All films that must be read at HUP after hours will have to be sent by courier after notifying the receiving radiology house-staff. (see below)

Neuro CT
Contact the VA Operator who will connect you directly to the technologist on call. Once the study is completed, CD of the images will be transmitted by courier electronically to HUP for preliminary interpretation by the Neuroradiology fellow on call (before 10pm) or the Radiology Resident On-call. Any questions or additional information should be conveyed directly to the HUP Radiology Resident on call on beeper (215) 961-5231 or at 215-662-7707. Once the Resident or fellow has interpreted the examination, a faxed report will come back to both the Emergency Room and the Radiology Department. Preliminary interpretation can also be given verbally if the ordering physician’s name and beeper number is on the request.

Body CT
For after-hours body CT scans, contact the VA Operator who will connect you directly to the technologist on call. If the technologist has questions about the indication or type of procedure, he or she will ask the ordering physician to call the VA attending radiologist on call for clarification. A CD of the exam will be couriered to HUP after completion. You must contact the HUP Radiology resident on call on beeper 215-961-5231 or 215-662-7707.

Angio/Interventional Radiology
For any emergent Angiography or Interventional procedure, contact the VA operator to page the HUP Interventional Radiology fellow on call. The study will be performed at the VA Medical Center.

Emergency after hours studies at HUP:
1. Obtain approval of the appropriate HUP Radiology House Staff.
Section II: Practical Information

Radiology

2. Fill out a form 10-7078 and have it signed by the appropriate VAH personnel.
3. Patient transfer to HUP can be arranged through the MAA at extension 5802.
4. Transport the patient, accompanied by the appropriate medical staff (RN or physician who can stay with the patient during the entire time at HUP) and the 10-7078 form. The patient will not be accepted at HUP and will be returned to the VAH if either the accompanying medical personnel or 10-7078 is not with the patient.

MRI
The MRI Section currently has hours of operation from 7:00 a.m. – 11:30 p.m. M-F. If an emergent MRI needs to be performed after-hours, the study will need to be performed at HUP. This must be cleared by the HUP Neuroradiology Fellow or Body Imaging Fellow on call. This individual can be reached through the HUP Operator at 215-662-4000 where you would ask for the appropriate individual on-call. All patients sent out for emergency procedures MUST be accompanied by a physician or RN who can take care of and watch the patient. That person MUST stay for the entire procedure and accompany the patient back to the VAH.

If an emergency after-hours MRI is performed at the VA, a preliminary interpretation can be requested of the Neuroradiology fellow (cases of head or spine MRI) or the Body Imaging Fellow (cases of non-Neuro MRI). They are available via the HUP operator as above.

Ultrasound
Ultrasound Coverage at the VA is Monday through Friday, 8:00 a.m. – 5:30 p.m. Vascular Lab Ultrasound (extension 6666) is available at the same hours.

There is no weekend ultrasound coverage. Any patient needing an ultrasound during off hours needs to be transported to HUP. This must be approved by the HUP Body Imaging Fellow. Patients sent out for emergency procedures MUST be accompanied by a physician or RN who can take care of and watch the patient. That person MUST stay for the entire procedure and accompany the patient back to the VAH.

Emergency ultrasound will be very rare. If a Venous Doppler is required, HUP is only staffed to perform unilateral studies above the knee. This is true of any patients including the HUP ED and HUP inpatients.

Transporting Films/patients After Hours
Patient transfer to HUP can be arranged through the MAA at extension 5802. Films/CD’s that must be read at HUP after hours, are sent by courier. The technologist on-call can contact the courier to schedule a delivery.
Nuclear Medicine Service

NOTE: For scans not listed below, call x5865

General Information

- The more complete the comments in the request, the more targeted the exam.
  1. Please use signs & symptoms not terms like: r/o CAD, r/o osteo
  2. Use tests to confirm clinical suspicion, evaluate for possible ____________________.
- Do not underestimate the power of the plain film before going high tech.
- Patients must be able to lie still for 20-30 minutes at a time for most studies, often longer.
- Placing order in chart or computer does not guarantee test gets done.
  (i.e. call to confirm inpatient nuclear test is scheduled).
- Emergency scans during normal working hours (M-F 7-3:30) must have:
  1. Electronic order
  2. Phone call to DR to approve
  OPTIONS: Call nukes fellow on call (215) 314-0864
  (call operator for additional info. If this doesn’t work)
  E-mail Dr. Park if you are having systemic trouble obtaining on-call studies at park.chan@va.gov.
- EMERGENCY PATIENTS MUST BE ACCOMPANIED IN DEPARTMENT ON CALL.
- RESULTS ARE dictated on the Power Scribe. Hit the “Reports” tab, then select “Imag- ing” (local only).
- When in doubt about radiation issues, ask us or call Radiation Safety Office x6009.
- At present (4/2007), Nuclear Medicine services are not available in-house after hours; alternative studies or transfer to HUP must be arranged.
- Procedures not done at PVAMC and can be purchased from HUP (when approved):
  PET scan, Schilling, RBC mass.
  Contact Chief Technologist at X6585.

Nuclear Cardiac Stress Test

- To assess MAR, risk stratify, confirm CAD, treatment efficacy, etc.
- NPO after MN, no caffeine for 24hrs before test
- Hold Unnecessary medications if possible
- Outpatient appointment, call X5865
- Inpatient, in 1-2 days, place order, call day before to confirm.
- Wt limitation: 300lbs
Two flavors: Exercise or Persantine Stress
Nuclear medicine will not change patient’s cardioprotective meds before test unless requested specifically, i.e. Please perform off beta blocker. Ordering physician is responsible for informing patient. Patients will be given a trial of exercise unless a chemical stress test is requested.

Three-phase Bone Scan
- Evaluate bone/soft tissue infection, AVN, occult fracture, RSDS
- No patient preparation needed. Procedure takes 3-5 hours.
- Outpatient appointment, call X5865
- Inpatient, in 1-2 days, place order, call day before to confirm.
- Wt. Limitation: 350 lbs. for all camera tables, regardless of procedure being performed.

Total Body Bone Scan (For Mets)
- Evaluate all bones for osteoblastic metastasis, metabolic bone disease, arthritis, Paget’s, etc.
- No patient preparation needed. Procedure takes 3-5 hours.
- Outpatient appointment, call X5865
- Inpatient, in 1-2 days, place order, call day before to confirm.
- Wt. Limitation: 350 lbs.

Infection Imaging (Indium Leukocyte/3-phase Bone Scan)
- Evaluates sites of clinical suspicion for active infection. When a prosthesis is being evaluated, a Bone Marrow scan is automatically included to reduce false positive reading.
- No patient preparation needed. Procedure takes 2 days, with patient’s blood labeled/reinjected.
- Inform us whether pt is on Abx & how long, when, if applicable, prosthesis was placed.
- Outpatient appointment, call X5865
- Inpatient, in 1-2 days, place order, call day before to confirm.
- Wt. Limitation: 500 lbs.
- For suspected osteo of the spine, call us to consider gallium
- For FUO workup, call us before scheduling as gallium may be useful.

V/Q Scan For Pulmonary Embolism
- Provides a probability for PE based on segmental V/Q mismatch.
- No patient prep necessary.
- Pt must be able to breathe on room air for 4-6 minutes.
Intubated patients cannot have a ventilation scan (only lung perfusion).
A recent CXR MUST BE ORDERED within 2-4 hours of the test.
False positives occur in lung ca, vasculitis, tuberculosis.

**Bleeding Scan For GI Bleed**
- Localizes likely source of a patient who is actively bleeding.
- No patient prep necessary. Pt must be able to lie still for 1-2 hours and be well hydrated.
- Very unlikely that angiography will detect bleeding site if nuclear test negative.

**Hepatobiliary Scan**
- Tracks patency of intra- and extrahepatic biliary system. (cholecystitis, obstruction, bile leak, etc)
- GB must not have just contracted (postprandial) or not recently contracted, (i.e. prolonged fasting). Best timing if patient is NPO after MN and has scan done within 12 hours of eating.
- False positives for acute cholecystitis in EtOH abuse, pancreatitis.
- Morphine i.v. (0.04mg/Kg i.v.) increases specificity.

**Thyroid Uptake And Scan**
- The only modality that unequivocally identifies functioning thyroid tissue.
- Evaluates hyperthyroidism, hypothyroidism, thyroid cancer, goiter, autonomy
- The only modality where there is the most confusion over patient prep: Always perform BEFORE i.v. contrast tests, i.e. CT, angiography, etc. 2 day test, pt MUST be off iodine & thyroid meds for a month or more (Call us!)
- TFT’s should have been ordered before the scan, if possible.
- False positives occur in lung ca, vasculitis, tuberculosis.

**Total Body Thyroid Scan For Thyroid Mets**
- The only modality that identifies functioning metastatic thyroid tissue if TSH is above 30.
- A modality where there is the potential for confusion over patient prep: Always perform BEFORE i.v. contrast tests, i.e. CT, angiography, etc.
- 2 day test, pt MUST be off iodine & thyroid meds for a month or more.
- Patient must be S/P thyroidectomy (Call us!)
- TFT’s should have been ordered before the scan to assure sufficient TSH elevation.

**Renal Flow And Function Scan**
Section II: Practical Information

Nuclear Medicine

- Provides a physiological assessment of the renal blood flow, function, evaluation of possible obstructing sites.
- Good hydration before the test.

Captopril Renal Flow And Function Scan
- Provides a physiological assessment of hemodynamically significant renal artery stenosis.
- More accurate than angiography in detecting functional stenosis.
- Patient must be off ACE-inhibitor for one week, off diuretic for 24 hours.
- Good hydration before the test.
- Always Call and inform our service before ordering as this requires a 2 part test.

Gastric Emptying Study
- To determine whether motility is impaired as in gastroparesis or outlet obstruction.
- Patient preparation: NPO after MN. Patient must not be allergic to eggs.
- Patient must be able to lie flat for 1-2 hours.
- Inform staff if patient is on Reglan.

Other Scans Available
- Renal Flow And Function Scan With Diuretic Renogram
- Salivary Gland Function Study
- Liver Spleen Scan
- Tumor Imaging*
  - MDP Bone Scan, Gallium-67 Citrate, Indium-111-Pentetreotide, I-131-MIBG
- Hepatic Hemangioma Study*
- CSF Leak Study*
- Brain Spect*
- I-131 Treatment*
- SM-151 Treatment
- Parathyroid Scan
- Testicular Scan

* Please Contact A Nuclear Attending For More Information
Nuclear Medicine Pearls:

- “SPECT” scans provide anatomic/functional information in 3-dimensions, like CT.
- There is no such entity as an “IODINE ALLERGY” in nuclear medicine.
- Allergy to “sulfa” drugs is not a contraindication to “sulfur” colloid scans.
- Radiation doses to patients for most Nukes studies are comparable to a CT scan.
- Patients actually glow in the dark if the ambient light is dim enough and you are looking through sodium iodide crystal.
Using templates
When using templates, boilerplates, and/or canned text, care must be taken that these methods support clinical care and accurate documentation, not simply expedite the process.

Hard-copy documents
For hard-copy paper records, blue or black ink is preferred to ensure readability when records are copied and/or scanned. The ink should be permanent (no erasable or water-soluble ink should be used). Never use a pencil to document in the health record. Black ink is preferred for records that will be scanned.

Symbols and Abbreviations
Symbols and abbreviations will only be used in the medical record when approved by the Medical Staff. All unapproved abbreviations can be found under the tool bar location in CPRS. Never use abbreviations in the final diagnosis of a discharge summary or as a diagnosis or procedure on an operative report.

Copy and Paste
The Copy and Paste functionality must be used with caution. Clinical, financial and legal problems may result when text is copied in a manner that implies the author or someone else obtained historical information, performed an exam and/or documented a plan of care when the author did not personally do so.

Copy and paste tenets
1. Never copy the signature block of another provider into another note.
2. Never copy patient health care information documented by another health care provider.
3. Never copy entire laboratory findings, radiology reports and other information in the record verbatim. Data copied into the record must be specific and pertinent to the care provided.

Other Documentation Issues
Derogatory or critical comments are to be avoided
Individual employee names are not to be included in health record documentation unless the purpose is to identify practitioners for continuing care.
The Philadelphia VA Medical Center defines a complete medical record within the
time frame during which the record is completed after discharge, but not to exceed
30 days after discharge.

**Documentation Requirements By Note Type (JCAHO)**

**Emergency Room Assessment**
- Signed within 24 hours of assessment
- Required elements
  1. Time and means of arrival to ER
  2. Care received prior to arrival to ER
  3. Presenting Problem
  4. History of Present Illness
  5. Pertinent review of systems
  6. Pertinent examination
  7. Diagnosis/Assessment
  8. Treatment Plan
  9. Reason for ordering test/consult/change in medication
  10. Condition at discharge/transfer to ward
  11. Notation of Leaving AMA, if indicated

**Inpatient History & Physical**
- Available within 24 hours of admission to any unit and/or observation
- Available within 72 hours of admission to Nursing Home Care Unit
- H&P over 30 calendar days old is not acceptable and a new H&P must be documented
- Annual H&P is required for the Nursing Home Care Unit
- Required elements of an H&P
  1. Chief Complaint
  2. Reason for Admission
  3. History of Present Illness
  4. Significant past medical/social/family history
  5. Pertinent Review of Systems
  6. Diagnosis/Conclusion/Impression
  7. Plan
Inpatient Progress Note
- Signed immediately after bedside observation
- Document at a frequency appropriate to patient’s condition
- Sufficient detail to permit continuity of care and transferability

Transfer Note
- Signed prior to patient’s transfer from:
  - Psychiatry to Medicine, Surgery, Urology, Cardiology, SICU, MICU etc.
- Required Elements
  1. Reason for Transfer
  2. Summary of care/treatment provided to care
  3. Patient’s physical and psychosocial status at transfer

Procedure Note (Non-operating Room)
- Signed immediately after non-OR procedure
- Required elements:
  1. Name of Procedure
  2. Details of procedure
  3. Finding and conclusions
  4. Tissue Removed, if indicated
  5. Complications, if indicated

Pre-Operative Interval (H&P) Note
- Signed prior to surgical procedure
- Required elements:
  1. Statement that original H&P is still accurate
  2. Statement confirming that the surgery is still necessary
  3. Statement that condition not changed since original H&P (or document any changes)

Operative Report
- Dictated/typed immediately after procedure and signed as soon as available for signature
- Required elements:
  1. Indication for the procedure
  2. Operative Findings
  3. Procedure(s) performed and description of procedure(s)
4. Estimated blood loss, if indicated
5. Specimen(s) removed, if indicated
6. Post-Operative diagnosis
7. Name of primary surgeon and assistants

Post-Operative Note (Day Of Procedure Note)
- Signed immediately following surgery
- Required elements:
  1. Pre-Operative diagnosis
  2. Post-Operative diagnosis
  3. Procedure(s) performed
  4. Findings
  5. Specimen(s) removed, if indicated
  6. Name of primary surgeon and assistants

Observation (23-hour) Discharge Summary
- Available prior to patient’s discharge from Observation
- Required elements
  1. Reason for admission to Observation
  2. Procedures performed/treatment provided
  3. Diagnoses/conditions treated during Observation
  4. Disposition
  5. Discharge Instructions to patient and/or family (if not admitted)

Discharge Summary Note
- Available prior to patient’s discharge
- Required elements
  1. Reason for admission
  2. Procedures performed
  3. Hospital course/treatment provided
  4. Diagnoses/conditions treated during hospitalization
  5. Discharge Instructions to the patient and/or family, as appropriate

Discharge Instructions
- Signed prior to patient’s discharge
- Required elements
  1. Medications dispensed at discharge and instructions, if applicable
2. Diet recommendations
3. Physical activity recommendations

Consult
- Signed within 24 hour of visit
- Required elements
  1. Indication that the patient’s record was reviewed
  2. History of presenting problem
  3. Pertinent examination
  4. Findings for making diagnosis or for providing treatment

Outpatient History And Physical
- Available within 24 hours of visit
- Completed at patient’s first visit and annually thereafter
- Required elements
  1. Chief complaint/reason for visit
  2. History and data relevant to the presenting problem(s)
  3. Assessment of the problem
  4. Plan to treat the problem
  5. Reason (medical necessity) for ordering tests/consults/med change(s)
  6. Diagnosis(es) treated during the visit or that require further treatment
  7. Follow-up treatment/patient instructions
Computer Codes
You will receive several different codes when you are at the VA:

1. Access Code (given to you when you arrive – 6 characters, usually 3 numbers and 3 letters) and Verify Code (your password, which you create when you first log-on, should have at least 8-12 characters, both letters & numbers and punctuation) to enter VistA, the Computerized Patient Record System.

2. A six-digit Provider Number for dictations and prescriptions (EX: 102123).

3. A Windows username & password. Your username is: “VHAPHI” plus the first 5 letters of your last name plus your 1st initial (all one word). Your password when you first log on is “password1” At this point the system will prompt you to type in a new 6-character password. This gets you to the point where you can use Windows to click on an icon such as “SmartTerm” to run VistA. (The domain should always be VHA04).

4. For ICU people: you will also get an ID number to access CareVue, the ICU computers for vitals, I/O’s, etc

5. You will need to create a Signature Code once you get your access / verify codes for VistA (“^tbox”, then “el” -- the system will prompt you; hit return if your information is correct; type “medicine resident” where it says “title”; add your pager number where it says “digital pager”) To make your life easier, you can use either your access OR verify code for your signature. This will enable you to sign discharge summaries and orders on the computer.

Printing
Notes can be printed from the CPRS GUI. With the note open, select “File” from the toolbar and select “print.” Enter the name of the printer - Printer names on the floors mimic the floor name (ex: 6 west = “WD 6W”, MICU = “MICU”).

VA Computer Help Services
Computers, Printers & Microsoft Office
For computers, printers, miscellaneous peripheral support, security logon changes and MS Office applications - contact the Help Desk at x4357 (HELP). The preferred method of reporting a problem is to have your department submit a request. Please have the following information available whenever you contact the Help Desk:

1. Basic Description: a brief description of the problem
2. Device identification - IP Address, computer name, etc.
Section II : Practical Information

Computers

3. Room#-Bldg#
4. Contact person’s name & telephone
5. Equipment barcode or serial #
6. Comments: Additional information about the problem.

Telecommunications
For telephone or voice mail problems, contact the Help Desk at x4357 or have your department submit a request. For all telephone moves, adds or changes - the request should be submitted via a Telephone Service Request (TSR) and forwarded to the Help Desk.

For digital or voice pager problems, dial x2502 or “0” for the Telephone Operators.

Clinical Support
For assistance with CPRS GUI, RAI/MDS, Dental Record Manager contact the Clinical Applications Coordinators via the Help Desk at x4357. The Clinical Applications Coordinators are Joyce Askew, Eghosa Guobadia, Joan Diorio and Angela Scrimalli.

Computer Codes, Etc.
Contact the specific staff in your department assigned to this function.

After Hours Support For CPRS
Call the operator and ask for the CAC (Clinical Application Coordinator) on call.
How To Look For And Sign Your Unsigned Progress Notes

Access VistA by clicking on icon that looks like a computer screen and type “PHIVISTA” at USERNAME prompt. Your access and verify codes are the same as the GUI system.

Select Clinical User View Menu Option: \prog

Type ‘^’ to stop, or choose a number from 1 to 3: 2 Progress Notes User Menu

Select Progress Notes User Menu Option: 3 All MY UNSIGNED Progress Notes

A list like the following will come up (you may need to hit return for more if you have more than 12 outstanding):

<table>
<thead>
<tr>
<th>Patient</th>
<th>Document</th>
<th>Ref</th>
<th>Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>XXX</td>
<td>(CXXXXX)</td>
<td>09/13/07</td>
<td>unsigned</td>
</tr>
<tr>
<td>2</td>
<td>XXX</td>
<td>(GXXXXX)</td>
<td>09/09/07</td>
<td>unsigned</td>
</tr>
<tr>
<td>3</td>
<td>XXX</td>
<td>(BXXXXX)</td>
<td>09/07/07</td>
<td>unsigned</td>
</tr>
<tr>
<td>4</td>
<td>XXX J</td>
<td>(YXXXXX)</td>
<td>09/06/07</td>
<td>unsigned</td>
</tr>
</tbody>
</table>

You can sign, browse (just look at), delete with the commands at the bottom. Ex: You can select all at one time (ex: “1-4”) and it will take you through them one by one and edit as you go if desired).

Select Progress Note(s): (1-4): 1-4

**HINT:** If you go in to edit a note, to get out of the note and go to the next one, hit <Num Lock> (on top left of number pad on keyboard) and then the letter ‘e’. (yes, that is correct - <Num Lock><e>)

If you chose “sign” the system will keep going through the summaries, you can just put “Y” to sign.

Ready for Signature: Next Screen//Y

Enter your Current Signature Code: YourSignatureCode

**UP-TO-DATE**

Up-to-Date is available on-line through the GUI system – Just look under the tools menu when a patient chart is open.
To Get Records From Other VA’s
This application in CPRS will bring over data on the Reports tab only at this point in time. Providers can retrieve data from any VA location where the patient has been seen. Also, if the patient has been discharged from the military in the past 15 years that data is retrievable as well.

Here is the process:
1. Click on the REPORTS tab.
2. Click on the REMOTE button and place a check mark next to the site you want to get data from. If you want data from all the sites listed, put a check mark next to All sites.
3. Then go over to the reports listing on the left hand column. There are many different reports. Any marked LOCAL ONLY will only give you access to Philadelphia data.
4. If you choose reports under the Clinical Reports list, the listing will start with a column for the facility. Philadelphia data will load first then the other sites will be queried for data. If the provider leaves the Remote block open, he/she can see the status of the loading of the data. When that status says DONE, the reports will be in the listing.
5. If you choose a report from the Health Summary list, each facility will have a tab for the data. To get the information from the other site, you will need to click on the tab for the facility then scroll through the report to get the data.

Computer/Information Security
Please read carefully the security agreement you will sign to obtain your computer access codes. These rules of behavior are monitored closely and violations of the regulations could result in loss of your computer access.

Most specifically, please remember:
1. Never allow another person to use your access code; always use your own codes
2. Always log off the computer terminal you are using when you are finished
3. We are all legally, morally and ethically responsible to protect the privacy and confidentiality of our patients/employees personal records
4. If you suspect that your computer has been infected with a virus:
   - STOP using the computer
   - Contact ADPAC, supervisor, Information Security
5. Report all computer/telephone problems to your ADPAC or the IRM Help Desk x4357.

Any questions involving information security, contact the Information Security Officer, x5159 or 215-308-1086.

The VA offers an on-line “Cyber Security Awareness Course.” VHA regulations require that all individuals having access to VA systems must be provided with refresher awareness materials or briefings at least annually.

To access this course, go to the following address:
http://vaww.vaww.ees.aac.va.gov (intranet)
http://www.ees-learning.net/dod/loginhtml.asp?v=dod
Attending Practitioner Responsibilities
For all care in which interns, residents or fellows are involved.

Documentation of all patient encounters must identify the supervising practitioner and indicate the level of involvement.

Four types of documentation of resident supervision are allowed:
1. Attending progress note or other entry into the medical record.
2. Attending addendum to the resident’s note.
3. Co-signature by the attending implies that the supervising practitioner has reviewed the resident note, and absent an addendum to the contrary, concurs with the content of the resident note or entry. Use of CPRS function “Additional Signer” is not acceptable for documenting supervision.
4. Resident documentation of attending supervision. (Includes involvement of the attending (e.g., “I have seen and discussed the patient with my supervising practitioner, Dr. ‘X’, and Dr. ‘X’ agrees with my assessment and plan”), at a minimum, the responsible attending should be identified (e.g., “The attending of record for this patient encounter is Dr. ‘X’”)

Inpatient: New Admission
Attending must see and evaluate the patient within 24 hours.

Documentation: An attending admission note or addendum documenting findings and recommendations regarding the treatment plan within one calendar day of admission. (No exceptions for weekends or holidays).

Inpatient: Continuing Care
Attending must be personally involved in ongoing care.

Documentation: Any of the 4 types of documentation, at a frequency consistent with the patient’s condition and principles of graduated responsibility.

Inpatient: ICU Care (includes SICU, MICU, CCU, etc.)
Because of the unstable nature of patients in ICUs, attending involvement is expected on admission and on a daily or more frequent basis.

Documentation: Admission documentation requirements (see Inpatient: New Admission above) plus any of the 4 types of documentation daily.

Inpatient: Discharge or Transfer
Attending must be personally involved in decisions to discharge or transfer the patient to another service or level of care (including outpatient care).
**Documentation:** Co-signature of the discharge summary or discharge/transfer note. If patient is transferred from one service to another, the accepting attending should treat the patient as a New Admission – see above.

**Outpatient: New Patient Visit**
Attending must be physically present in the clinic. Every patient who is new to the facility must be seen by or discussed with an attending.
**Documentation:** An independent note, addendum to the resident’s note, or resident note description of attending involvement. Co-signature by attending alone is not sufficient documentation.

**Outpatient: Return Visit**
Attending must be physically present in the clinic. Patients should be seen by or discussed with an attending at a frequency to ensure effective and appropriate treatment.
**Documentation:** Any of the 4 types of documentation. The attending’s name must be documented.

**Outpatient: Discharge**
Attending will ensure that discharge from a clinic is appropriate.
**Documentation:** Any of the 4 types of documentation.

**Surgery / OR Procedures**
Except in emergencies, attending surgeon must evaluate each patient pre-operatively.
**Documentation:** Attending must write a pre-procedural note describing findings, diagnosis, plan for treatment, and/or choice of procedure to be performed (may be done up to 30 days pre-op).

**Informed Consent** must be obtained according to policy. Attending level of involvement is documented in the VistA Surgical Package. Post-op documentation per JCAHO requirements and local medical center bylaws.

**VistA Surgery Package Codes**
**Level A: Attending Doing the Operation.** Attending performs the case, but may be assisted by a resident.

**Level B: Attending in OR, Scrubbed.** Attending is physically present in OR or procedural room and directly involved in the procedure. The resident performs major portions of the procedure.

**Level C: Attending in OR, Not Scrubbed.** Attending is physically present in OR or procedural room observes and provides direction to resident.
Resident Supervision

Level D: **Attending in OR Suite, Immediately Available.** Attending is physically present in OR or procedural suite and immediately available for supervision or consultation as needed.

Level E: **Emergency Care.** Immediate care is necessary to preserve life or prevent serious impairment. Attending has been contacted.

Level F: **Non-OR Procedure.** Routine bedside or clinic procedure done in the OR. Attending is identified.

**Consultations (Inpatient, Outpatient, Emergency Department)**
Attending physician must supervise all consults performed by residents.
Documentation: Any of the 4 types of documentation; use of consult management package is highly encouraged.

**Radiology/Pathology:**
Documentation: Radiology or pathology reports must be verified by the radiology or pathology attending.

**Emergency Department (ED):**
The ED attending must be physically present in the ED, and is the attending of record for all ED patients. The ED attending must be involved in the disposition of all ED patients.
Documentation: An independent note, addendum to the resident’s note, or resident note description of attending involvement. Co-signature by the attending alone is not sufficient.

**Routine Bedside & Clinic (Non-OR) Procedure**
(e.g., LPs, central lines, centeses)
Setting-dependent supervision and documentation; principles of graduated responsibility apply.
Documentation: Resident writes procedure note that includes the attending’s name. Any of the 4 types of documentation.

**Non-routine, Non-bedside, Non-OR Procedure**
(e.g., cardiac cath, endoscopy, interventional radiology)
Attending must authorize the procedure & be physically present in the procedural area.
Documentation: Any of the 4 types of documentation: attending’s name and degree of involvement must be documented.

Section III: Policies and Systems Issues

Resident Supervision
The assignment of service connected percentage and disability code is based on the degree of disability as determined by the rating board decision following the submission of a claim that a veteran’s illness or injury was incurred in or aggravated by military service.

An adjunction condition, although not service connected, is medically determined to be associated with or is aggravating a disease or condition, which is service, connected. A veteran is entitled to receive treatment for an adjunct condition, however the adjunct is not a condition that is specifically rated, VA can bill the insurance carrier as well as those responsible for co-payments for treatment provided for the adjunct condition.

A secondary condition is defined as a condition that has been caused or is the result of a service connected and treatment provided is also billable.

It is important that the clinician be aware of the patient’s service connected conditions. This information is available by clicking the patient’s name in the blue square in the upper left corner in CPRS. It is also found on the encounter form for outpatient visits. If a patient is being treated for a service-connected condition during a visit, the provider should check the service-connected box on the encounter form “yes”. Service connected veterans are not charged an outpatient co-payment. They may be charged a medication co-payment if the medication is for non-service connected condition and the veteran is not rated greater than 50% service-connected. If the veteran has health insurance, a claim will be submitted to the insurance carrier for the treatment of non-service-connected conditions.
Please 1) work on these interventions, 2) encourage everyone to do the same… we can’t do it without you!

**Prevent Infections**

**Surgical peri-operative issues**
- Use both pre-op and post-op antibiotic template for every patient having surgery, even if no antibiotics indicated (that is a selection). IF antibiotics indicated for > 24 hours post-op for suspected or proven infection (the only indication according to national surgical guidelines), clearly document in template (use checkbox)!
- Maintain peri/post-op normothermia, glucose <200, hair removal only at time of surgery and only with depilatory cream or electric clippers (never razors)

**Central line insertions**
- Full gown, mask, gloves and large sterile drapes for central line insertions
  - Please use the cprs “central line template” (very easy!) to document procedure
- ICUs: use paper “Daily Rounding Sheet” during attending rounds
- Use paper line insertion sheet (in kit) during insertion (ICUs->ask nursing; on floor use for reference during procedure)

**Flu vaccination**
- Get your flu vaccination every year (you can get one here in a clinic or on the wards… just ask) to protect the patients you are caring for.
- Flu vaccination and pneumococcal vaccination for all patients on discharge when indicated (see “reminders”)

**Hand Hygiene**

1) **Easy version**: Clean your hands every time you enter or leave a patient room. (*possible exception: running in for code*)

2) **More detailed version**: If hands are not visibly soiled, use an alcohol-based hand rub (preferred) or wash hands with antibacterial soap and water (acceptable) to routinely decontaminate hands in the following situations:
   - Before and after having direct contact with patients or their environment
   - Before and after gloving (yes, even before you put on non-sterile gloves)
   - Before donning sterile gloves when inserting a central intravascular catheter
   - Before inserting indwelling catheters, or other invasive devices that do not
Infection Control

require a surgical procedure

- If moving from a contaminated-body site to a clean body site during patient care wash hands with antimicrobial soap and water for 10-15 seconds whenever hands are visibly soiled, before eating, and after going to the bathroom.

Isolation procedures

Note that contact and droplet isolation applies to the patient and equipment in their room/environment. Some conditions require more than one type of isolation. There are four types of isolation precautions (in addition to hand hygiene when entering/leaving room):

- **Contact**: e.g., for MRSA or VRE: gown and gloves (also an surgical mask if the patient in coughing and the infection is in the respiratory tract).
- **Droplet**: e.g., for suspected influenza, Neisseria meningitides (first 24 hours if bacterial meningitis etiology not known): surgical mask, gloves, and gown.
- **Airborne**: e.g., for Tuberculosis: N-95 respirator (mask). Never put an N-95 on a patient. Patients on airborne precautions should wear a surgical mask when being transported.
- **Note**: Always wear personal protective equipment (PPE) whenever contact with blood, body fluid, secretions and excretions (except sweat), non-intact skin, or mucous membranes is anticipated, regardless of whether the patient is on isolation or not.

- **Isolation/PPE is always available in wall cabinets on all wards** (no rolling carts)

**MRSA program**: all non-psych floor inpatients have nares swabs for MRSA (nursing does them) on admission, transfer and discharge. Be attentive (and encourage others) to using full contact precautions for these rooms (and any others on contact precautions). We are monitoring adherence to isolation on wards.

- We are not swabbing staff
- **Contact isolation patients**: encourage to stay in rooms, but OK if they don’t
- **Droplet/Airborne patients**: must not leave their rooms unattended...
Needlestick/blood or body fluid exposure
In the event of a needlestick or other exposure you should REPORT TO THE VA OCCUPATIONAL HEALTH OFFICE immediately (X5888). After hours (or if Occupational Health is not immediately available), you should report to the VA ER (X6003). Timing is important if prophylaxis with HIV meds is to be effectively used! You must be evaluated even if you do not plan on receiving prophylactic therapy (you’ll want to have the offered baseline hepatitis and hiv labs…think about it).

Residents and students are also welcome to be evaluated, tested and counseled at the HUP Occupational Health Office (662-2354), but must do this IN ADDITION TO being evaluated at the VA.

As a federal facility, the VA has special reporting requirements. Your supervisor (or designee) is required to complete an accident report to meet the requirements of the Safe Needle Act. The medical tests provided through Occupational Health are handled in accordance with Privacy Act regulations and are therefore protected. They may contact you for the details of your exposure so they may complete the accident report and correct any hazardous conditions.

If asked by Occupational Health (or the VA ER) to order blood work on a “source” patient, there are group studies set up in the VA computer systems to facilitate the process. If you are able to obtain written consent to run an HIV antibody screen on a source patient, order a Needlestick #1 group study. If you are unable to obtain consent for the HIV testing, request a Needlestick #2 group study.

Please Note: HIV tests cannot be run on veterans without their written consent, even in the event of a blood and body fluid exposure (This is a Federal Law and differs from the Pennsylvania State regulations).

Questions/Concerns
- Infection Control Practitioners
  - Clarence (Ed) Lyons: pager 215-894-0806, x2137
  - Caroline Sausman: pager 215-894-0812, x2916
- The HIV Coordinator, Molly McLaughlin: x4006
- Hospital Epidemiologist, Darren Linkin, linkin@mail.med.upenn.edu, pager: 215-374-4327
- Click “Infection Control” on the homepage for our website (intranet only).
Advance Directives

Advance directives must be addressed with all patients.

- An Advance Directive often called a Living Will is a legally recognized document that puts into writing a person's wishes regarding medical treatment that he/she would or would not want in the event that he/she loses the ability or capacity to make those decisions.

- Veterans have the right to accept or refuse medical treatment, including life-sustaining treatment.

- Federal Regulation enables a competent adult to designate another person to make health care decisions for that adult should he/she lose the ability to do so.

- Under Federal Regulations, adult patient can request a “Do Not Resuscitate” order (DNR). The DNR instructs the medical staff not to try to revive the patient if breathing or the heartbeat has stopped.

- Federal laws require that hospitals ask patients if they have an advance directive or want information about advance directives. This information is provided to our patients on admission.

- Patient Representatives, Social Workers, Case Managers or anyone engaged in patient care can be contacted to provide information, education and assistance in filling out the and advance directive.

- Complete forms must be appropriately witnessed, signed and dated. The patient has the right to change or revoke an advance directive at any time.

- Advance directives become a part of the medical record. The hospital must ensure that the patient’s wishes are carried out.

- Copies of the advance directive must be sent with the patient on discharge to another hospital, nursing home, sub-acute care facility, rehabilitation facility or hospice.

- Concerns regarding the implementation of advance directives may be referred to the Patient Representative, Social Worker, Case Manager or the Ethics Advisory Committee.

- The Ethics Committee also handles these issues.

Ethics Advisory Committee

The Ethics Advisory Committee responds to request for an ethics consultation from patients, families and the medical community. The need for an ethics consultation
arises when there are disagreements and/or conflicts between patients, family members and/or health providers concerning patient’s care and rights. Members of the ethics advisory committee will attempt to identify and clarify the conflicting issues and suggest options for their hopeful resolution. The Ethics Advisory Committee’s involvement includes cases that present ethical problems such as,

- Contested medical decisions about patient care;
- Implementation of advance directives;
- Implementation of a Do Not Resuscitate Order;
- Protection of patient’s human rights and human dignity;
- The provision of necessary and appropriate care.

In addition, the ethics advisory committee serves as a resource for medical ethics education of staff members.

**Access to the Ethics Advisory Committee....**

Members of the medical community at the VA Medical Center, including patients and their families, physicians, nurses and social workers may directly access the Philadelphia VA Ethics Advisory Committee by calling the Ethics Pager Number at 215 581-7131, or individual ethics committee member. An ethics consult can also be generated electronically via the computer. The ethics advisory committee of open access serves as a resource for hopeful resolution of medical ethics issues that may arise from the delivery of health care, and/or medical encounters.

**Palliative Service**

Palliative Care improves the quality of life of patients and their families facing life-threatening illness, through the prevention and relief of suffering by early identification and assessment of physical, psychosocial and spiritual health.

The Palliative Service at the PVAMC is a consultative service offering:

- Treatment recommendations options for symptoms including pain, nausea/vomiting, dyspnea, anxiety, agitation, depression, fear
- Assistance to patients and families with advanced planning
- Facilitation of discussions transitioning care from curative to palliative Assists with discussions regarding hospice care
- Facilitation of appropriate hospice placement
- Bereavement counseling
Multidisciplinary support to patients, families, and other health professionals with end-of-life issues

**Hospice Eligibility Criteria Partial Guidelines**

- Cancer that is inoperable or metastatic for which there is only palliative chemo therapy or radiation
- Heart Disease: HF at rest, EF < 20%, Frequent ER visits, new dysrhythmia, poor response to diuretics, vasodilators
- Pulmonary: Dyspnea at rest, right heart failure, O2 Sat <88% on O2, PC02 >50, unintentional weight loss
- Dementia: unable to walk, eat independently and safely, single word or no speech, incontinent, frequent ER visits, Albumin<2.5, aspiration pneumonia, pyelonephritis, UTI, septicemia in past year
- Liver: PT > 5, Albumin<2.5, Refractory ascites, unintentional weight loss, jaundice, encephalopathy, variceal bleeding
- Renal: Not a candidate or refuses dialysis, Creatinine clear. <10cc/min(15cc/min for diabetics), serum Creatinine >6.0mg/dl
- Failure to thrive: Mainly in bed, assistance with ADLs, BMI <22, delines or not responding to nutritional support, frequent ER, decubiti, wt.loss

Refer through CPRS: Palliative Consult.

*Call Palliative Service: Ext. 4142, pager 215-899-0455*

**Patient Rights and Responsibilities**

Patients have the rights to:

- Receive the highest possible quality care PVAMC is able to provide;
- Receive services that are courteous & respectful of their human rights and dignity;
- Receive services that are tailored to their particular needs and expectations in total respect for their privacy and confidentiality;
- Receive services in a safe clinical environment;
- Access information that pertains to them, including their medical records;
- Receive complete information about their care;
- Know the names and positions of all providers involved in their care;
- Refuse to participate as subjects in research, and
- Receive a copy of the Patient Bill of Rights.
Patients have the responsibility to:
- Provide accurate information about their past and current medical history.
- Respect the rights of other patients, staff and visitors.
- Ask for an explanation if they do not understand what is being told to them.
- Provide feedback to the hospital on services provided and any safety issues that they find relevant to good clinical practice.

At the PVAMC all patients receive a copy of Patient Rights and Responsibilities in the Patient Information Guide. A copy is also posted on patients units. Patients are assisted in exercising their rights through the Patient Representative Program (See MCM 00-11 “Patient Representative Program”) and the ethics committee.

Patient Satisfaction
Patient satisfaction is continuously measured by participation in the Survey process. This data provides insight into our patient’s perceptions of quality care and service received. The information is processed to improve Health Care delivery at PVAMC.

Confidentiality
All hospital personnel have the responsibility to protect patient’s confidentiality at all times. This includes the following:
- To avoid having conversations regarding patients in elevators, cafeteria or hallways.
- To Speak about patient care in designated areas
- To Secure patient records
- To avoid sharing computer access code
- To release Patient’s records only with the patient’s written authorization or as otherwise required by law. Release forms are available in Medical Records.

All information concerning patients is considered strictly confidential. This right is to be preserved at all times and in all locations inside or outside the facility. Information, whether available verbally, in written documents, or accessed through a computer or other media, should be carefully guarded and communicated only as needed for patient care purposes or official hospital business.

Hearing-Impaired and Language –Challenged Patients
Signing and foreign language interpreters can be made available through the Patient Representative, Nursing Supervisor or Admitting Office. Telecommunication Devices for the Deaf (TDD) are obtained by calling the “Patient Trouble Line”, Extension 4646.
DNR policy:
1. The attending physician has the responsibility to determine the patient’s decision-making capacity (documentation in a progress note implied), and to write or countersign the DNR order.

“The order must be written into the patient’s medical record by the attending physician or in his/her absence, the resident physician responsible for the immediate care of the patient. In these cases, the resident physician responsible for the immediate care of the patient will contact the attending physician or designee for consultation and appropriate action. If the attending physician agrees, the DNR order may be entered by the resident physician. **The resident order must be signed or rewritten by the attending physician during the next regular working day. Verbal or telephone orders for DNR are not acceptable.**”

2. The attending physician or surgeon must discuss with the patient (or surrogate) proposed suspension of the DNR order or advance directive during the operative and peri-operative period and the patient’s decision about whether or not to suspend the DNR order should be documented in the record.

3. A new DNR order must be validated with the patient and (re-)written on admission (even from the VA NH) and upon within-hospital transfer.
Privacy & Confidentiality Regulations
1. The following laws & regulations affect the use & disclosure of identifiable information:
   - Freedom of Information Act (FOIA)
   - The Privacy Act (PA) [Covers all federal agencies]
   - The VA Claims Confidentiality Statute
   - Confidentiality of Quality Assurance Review Records
   - Confidentiality of Drug Abuse, Alcohol Abuse, HIV & Sickle Cell Records
   - Health Insurance Portability & Accountability Act of 1996 (HIPAA); includes the Privacy Rule.

2. USE = sharing, application, analysis…of information within the entity that maintains the information.

3. DISCLOSURE = release or transfer of information outside the entity that maintains the information.

Patients’ Rights Under HIPAA
1. Patients have a right to:
   - Receive a notice of privacy practices (will be mailed to all enrolled veterans)
   - Request copies of health information (from medical records dept)
   - Request changes/corrections to own records (written request to provider or medical records)
   - Request a list of all disclosures made of own records (medical records)
   - Receive communications confidentially (e.g. To PO box vs. Home)
   - Request restrictions on use & disclosure (e.g. Limit what family is told)

Specific Information About Uses And Disclosures
The authority for use & disclosure of information for treatment, payment & health care operations depends upon the requesting party.
1. There are certain uses & disclosures that Do NOT require patients’ written authorization.

2. If a request comes from within the VHA (Veterans Health Administration), one can use information, EXCEPT psychotherapy notes, for treatment, payment & health care operations.

3. If a request comes from other VA Entities (Veterans Benefits, National Cemetery), one can disclose information, EXCEPT health information, to fulfill the agency mis-
sion. Health information for treatment, payment & healthcare operations may be disclosed if a Business Associate Agreement is in place.

4. One can disclose identifiable information to VA Contractors if the contractor is performing a service related to treatment, payment & healthcare operations and it is within the scope of the contract.

5. The local Research & Development Committee should be contacted for inquiries for information for research purposes.

6. Authorization from the patient is required for the following:
   - For any purpose other than treatment, payment & healthcare operations
   - Where no other legal authority exists
   - For marketing

7. The following are true regarding a patient’s psychotherapy notes:
   - The USE of psychotherapy notes is limited to those directly involved in treatment.
   - The DISCLOSURE of psychotherapy notes as well as records of treatment for alcohol/drug abuse, HIV & sickle cell require the patient’s written authorization.

**Release of Patient Information Outside the VA System**

1. One may disclose individually identifiable health information without authorization to a non-VA provider:
   - For treatment purposes
   - For payment purposes
   - For health care operations purposes
   - In an emergency

2. The following are true regarding disclosure of individually identifiable health information (without the patient’s authorization) to Family & Next of Kin:
   - General information (location, condition) may be disclosed without authorization
   - Authorization is not required when information is given in the presence of the individual
   - Authorization is not required when information is given outside the presence of the individual when determined to be in patient's interest
   - Authorization is not required when disclosing HIV status to spouse/partner ONLY IF this fact has been included in the pre-test counseling.
3. Statutes & Regulations control non-health and health information may be released to individuals & agencies, including the following:
   - Other Federal Agencies
   - Public Registries/Health Databases
   - Courts & Attorneys
   - State Veterans Homes
   - Members of Congress or Congressional Committees

**Operational Requirements**
The medical center must:
   - Maintain an accounting of disclosures, six years
   - Establish complaint procedures
   - Provide training for all staff

**Penalties**
The following are true regarding penalties for violations
   - Violators of the Privacy Act (PA) [Covers all federal agencies] may be charged with misdemeanor and fined up to $5000
   - Violators of the Confidentiality of Drug Abuse, Alcohol Abuse, HIV & Sickle Cell Records may be fined between $5000-$20,000
   - Violators of the Health Insurance Portability & Accountability Act of 1996 (HIPAA) Privacy Rule may be fined up to $50,000 & face a prison term of up to one year.

**Freedom Of Information Act (Foia)**
FOIA requires disclosure of VA records, or portions thereof, to any person upon written request. Administrative records are made available to the greatest extent possible. Previously mentioned laws & regulations control the release of individually identifiable information & individually identifiable health information. There are specific exceptions that permit withholding of certain information from disclosure. Always refer FOIA requests to the FOIA Officer.

Refer questions to:  
Privacy Officer – Timothy Graham, x6270  
FOIA Officer – Timothy Graham, x6270  
Research – Mary Costigan, x7847  
HIPAA – Brendan Minihan, x6320
Ethics Training for Residents and Fellows
Residents and fellows should remember that they are paid federal employees during their VA rotations. As such, they are required to follow federal rules and regulations and are required to receive information/have training regarding ethics, particularly as applies to receiving gifts from outside sources. The following section will serve as “Ethics Training” for residents. Please review this important section.

Gifts From Outside Sources
Most executive branch employees know there are rules about whether or when they may receive gifts from outside sources. This pamphlet provides a brief overview of those gift rules by answering some of the frequently asked questions concerning gifts from outside sources.

What Is A Gift?
Almost anything of monetary value, such as cash, meals, paperweights, trips, concert tickets, and services.

What Is Not A Gift?
A cup of coffee, modest refreshments which are not part of a meal, and items of little intrinsic value such as greeting cards, or plaques and certificates intended solely for presentation. These, among other things, may be accepted without worrying about who is giving them to you or why.

The Basic Rule
Q: What is the basic gift rule that applies to me as a Federal employee?
A: As an employee of the executive branch, you may not solicit or accept a gift that is given because of your official position or that is given to you by a prohibited source, unless the item is either not considered to be a gift or falls within one of the exceptions to the basic rule.

What Is A Prohibited Source?
A person or organization that seeks official action by your agency; does business or seeks to do business with your agency; has activities that are regulated by your agency; or has interests that may be affected by you when you are doing your job. This includes any organization the majority of whose members are described within one of these categories.
Some Exceptions to the Basic Rule
The $20/$50 Exception

Q: Can I accept any gift as long as it is not worth more than $20?
A: Almost. The exception allows you to accept gifts of $20 or less on a single occasion, but remember, not more than $50 per year per source. (The source is the entire organization, so you may not accept gifts exceeding the $50 per year per source limit just because different employees in the same organization pay for them each time.) If several gifts are given to you at the same time, you may keep those items whose total value when added together does not exceed $20. You may never accept gifts of cash, and you may not pay the difference for gifts exceeding the $20 limit. Finally, you may not accept gifts so frequently that you appear to be using your public office for personal gain.

Q: Why a $20 limit?
A: The $20 limit was designed to be reasonable and simple. Reasonable, because it allows employees to accept gifts that most people would agree are inconsequential. Simple, because it’s an easy standard to apply.

Q: Is there a more generous exception for holiday celebrations? Every year, some prohibited sources host holiday parties and invite employees from our office and throughout our agency to attend. Normally, the cost is $25 or $30 per person.
A: There is no special exception for holiday celebrations. If the cost of attendance exceeds $20, then obviously you may not accept an invitation to attend using the $20 exception. Your ethics official can advise you whether any of the other gift exceptions or exclusions apply.

Q: I work in a Federal facility alongside employees of a company that is an agency contractor. I recently got married and the contractor employees want to contribute money to purchase a microwave oven for me as a wedding gift. Could I accept that gift?
A: No. The $20 exception to the gift rule states that an employee may accept gifts having an aggregate market value of $20 or less “per occasion.” Accordingly, an employee may not use this exception to accept a gift worth more than $20 regardless of how many people contributed toward it.
Gifts from Family and Friends

Q: My brother-in-law works for a firm that does business with my agency. May I accept a gift from him?

A: Sure, as long as the gift is clearly motivated by a personal relationship and your brother-in-law, and not his firm, pays for the gift. We sometimes call this personal relationship exception the “family and friends” exception.

Q: Let’s say that one of my long-time close friends performs contract work for my agency and is therefore a prohibited source. May I use the “family and friends” exception to accept gifts from her, or should I apply the $20/$50 limit?

A: Again, as long as the circumstances make it clear that the gift is motivated by a personal friendship rather than your position with the Government, you may accept any gift from your friend using the “family and friends” exception. Relevant factors to consider include the history of the relationship and whether the friend personally pays for the gift. If you have any reason to suspect either the motivation or the source of payment for the gift, you can always decline the gift, pay the market value for it, or abide by the $20/$50 limit.

What Is Market Value?

Market value is the retail price that you, the recipient of the gift, would have to pay to purchase it. If you cannot readily determine the retail value of a gift, you may estimate its value by consulting the retail cost of items of similar quality. If a ticket entitles you to food, refreshments, entertainment, or any other benefit, the market value is the face value printed on the ticket.

Discounts

Q: I doubt that discounts available to the public or offered to all Government employees would be prohibited. But what about discounts that are offered only to certain groups of Government employees, like all of the computer specialists at my agency?

A: First, you are correct in noting that discounts offered to the public or to all Government employees are not considered to be gifts for purposes of the gift rule. You are also correct to question whether Government employees may accept discounts that discriminate among Government employees on the basis of type of official responsibility, or rank, or rate of pay. These types of discounts, because they are limited or targeted, would be gifts for purposes of the gift rule and could only be accepted if...
an exception applied. There are several rather specific exceptions that would allow Government employees to accept discounts (e.g., reduced membership fees or similar benefits) offered to limited groups or classes of Government employees (e.g., employee associations or agency credit unions) under certain circumstances. However, before applying any of these exceptions to your situation, you should probably seek an ethics official’s advice.

Gifts of Free Attendance

Q: I sometimes receive invitations of free attendance for events hosted by private sector companies and other sponsors that do business with my agency. These events are very useful for both me and the agency because I learn about industry trends and make professional contacts. If my supervisor approves of me attending these kinds of events, is it okay for me to accept the offer of free attendance?

A: You may be able to accept the offer of free attendance based on the exception for certain widely attended gatherings. An ethics official or other authorized individual must make a determination that your attendance is in the agency’s interest because it will benefit agency programs and operations. Other factors to be considered are: the source of the invitation and whether that person has interests that may be substantially affected by the performance (or nonperformance) of your official duties; the number and identity of other participants expected to attend; and the market value of the gift of free attendance. Note that this exception does not permit you to accept travel and lodging expenses, although these items may be accepted under other authorities.

Limitations on the Use of the Exceptions

Q: If there’s an exception that allows me to accept a gift, is it always appropriate to use the exception?

A: Not always. You may never accept a gift for being influenced in the performance of an official act; you may never solicit or coerce the offering of a gift; and you may not accept gifts from the same or different sources so frequently that it appears you are using your public office for private gain.

Disposing of a Gift

Q: What do I do with a gift that I cannot accept?

A: You may pay the donor market value for the gift if you want to keep it. If not, you
may return it. If the gift is perishable, such as food or flowers, it may be shared within
your office, donated to charity or destroyed, as long as an ethics official or your
supervisor grants approval.

Seeking Advice

Q: Anything else I need to be aware of?

A: If you have any questions regarding gifts, always seek your ethics official’s advice.
Even if a gift falls under one of the exceptions to the gift rule, it is never inappropri-
ate and frequently prudent for you to decline a gift offered by a prohibited source
or given because of your official position, especially when the gift is offered by a
person or organization whose interests could be affected by your official actions.

Note: The gifts from outside sources rule is found in 5 C.F.R. part 2635, subpart B.
In accordance with VHA Handbook 1004.1, Informed Consent, diagnostic and therapeutic treatments (including transfusions) or procedures must be undertaken only with prior, informed consent of the patient. There is a detailed Medical Center Memorandum, 11-59 Informed Consent that can be found on the PVAMC website at http://vaww.va.gov/philadelphia/mcm.html. Informed consent will include a full explanation, by the practitioner privileged to do the procedure, of the risks, benefits and alternatives of therapy with the patient.

In order to give informed consent, the patient, or the patient’s surrogate decision-maker, must understand the nature of the treatment or procedure to be undertaken, the benefits and risks of the treatment, the alternatives to the proposed course of action, and the expected outcome if the treatment is declined. The practitioner must explain this information in language that the patient can understand. The patient must be allowed to ask questions and to make a decision freely without coercion or duress. The consent process is completed by appropriate documentation in the medical record.

The patient’s signature should be obtained on a VA authorized iMed consent form, using computers equipped with a special signature pad. The patient’s signature on a VA authorized iMed consent form must be witnessed and the consent form is automatically entered into the patient’s electronic medical record. A properly executed consent form is valid for a period of 30 calendar days. The informed consent discussion between the practitioner and patient must be documented in the medical record. The iMed consent must be filled out by a practitioner who is capable of performing the procedure and who will be participating in the procedure.

The following are required elements of any informed consent document:

- The date and time the discussion took place and whether consent was or was not given.
- The patient’s mental status at the time the information was provided and consent given, e.g. alert, sedated, anxious, confused, lethargic, etc.
- The practitioner’s assessment of whether the patient has decision-making capacity.
- The name(s) of all the practitioner(s) immediately responsible for the perfor-
mance and, if applicable, the supervision of the treatment or procedure.

- A brief description of the proposed treatment or procedure, if appropriate.

- A statement that relevant aspects of the treatment or procedure including indications, risks, benefits, and alternative options have been discussed with the patient in language the patient understood.

- A statement that the patient had an opportunity to ask questions and that the patient indicated comprehension of the discussion.

- A statement that the patient freely consented to the treatment or procedure without fraud, duress, deceit, or coercion.

- If the patient refuses or revokes consent, the progress note must include a statement that the patient’s reasons and the expected outcome were discussed.

- The signature of the practitioner writing the note.
Below is an algorithm from the hospital policy:

**PATIENT HAS DECISIONAL CAPACITY**

- **VERBAL CONSENT TREATMENTS**
  - *Most treatment procedures*
  - *Document informed consent discussion in progress notes*

- **SIGNATURE CONSENT TREATMENTS**
  - *Document informed consent discussion in progress notes*
  - *Patient must sign approved form*

**PATIENT LACKS DECISIONAL CAPACITY** (see algorithm next page as well)
Acceptable ways for surrogate to consent:
1. Telegram
2. Mail or Fax
   - Must mail typewritten letter and consent form to surrogate and signed copy ultimately returned
3. Telephone
   a) recorded on tape, transcribed, signed by transcriptionist, tape kept locked OR, if pt declines recording -
   b) witnessed by second VA employee
      - both sign note
      - note includes:
        - date, time
        - ID and signature of both employees
        - ID of person contacted and their authority to act as surrogate brief procedure description
PATIENT LACKS DECISIONAL CAPACITY

Psychology or Psychiatry consult if due to mental illness

Consents must use a substituted judgement standard based on knowledge of "what the patient would have wanted". If the patient’s wishes are unknown, then the decision may be based on the patient’s best interests.

PATIENTS WITH SURROGATES

For all treatments including life-sustaining treatments:
1. Health care agent

2. Legal or special guardian

3. Next of kin
   - spouse --> adult child -->
   - parent --> adult sibling -->
   - grandparent --> adult grandchild

4. Close friend
   - *18 years or older
   - *signed statement re: regular contact and familiarity with pt values verified by SW

PATIENTS WITHOUT SURROGATES

GO TO NEXT PAGE
PATIENTS WITHOUT SURROGATES (cont)

**SIGNATURE CONSENT TREATMENTS**

Certify no surrogate available
* attending physician and
* social worker

Attenting physician statement
“concur with and participate in
treatment decision

Chief of Service or Designee
concur with treatment decision

**LIFE-SUSTAINING TREATMENTS**

Follow advance directive/DNR

Certify no surrogate available
* attending physician and
* social worker

Attenting physician statement
“concur with and participate in
treatment decision

Convene special committee
* Chief of Staff approve or disapprove
  committee recommendation

* Hospital Director approve or disapprove committee recommendation

**Emergency care** should be provided as attempts at obtaining consent are under-
way if the patient’s life is in danger or if serious impairment of the health of the pa-
tient may result if treatment is delayed. The attending physician must be contacted
and concur. The **Chief of Staff** (call the operator to contact him) MUST be notified
of these circumstances and concur.
Patient Safety, Accidents, and Incidents

Patient Safety Officer x5219
Risk Management Officer x6273

Risk Management/Incident Reports
The PVAMC Patient Incident Report is to be completed whenever an event occurs that deviates from what is expected to occur during the normal procedure.

1. **Incident Reports** – are used to report any untoward event involving a patient and any “close call” in patient care. Incident reports are completed by nurses or physicians and are to be forwarded immediately to your VA-based residency director or Risk Management (with verbal notification to your VA-based residency director). Documentation in Medical Record should include details of the event, patient assessment, and interventions; do NOT document in the medical record that an incident report was done. (see instructions for completing an incident report at the end of this section)

2. **Accident Reports** – for visitors are initiated by any employee or staff member. These are forwarded to the Safety Office. The report should be completed immediately after the occurrence by the person with knowledge the incident. All information reported should be as factual and non-judgmental as possible.

Any employee who witnesses or is involved in a patient injury (i.e. fall, medication error, incident of abuse, etc.) is required to report the injury to the patient’s caregiver and an incident report (Form 10-2633) is to be initiated.

For additional information see MCM 11-30 “Special Incident Involving a Patient.”
Completing a Patient Incident Report

Step 1 - Data Entry
1. Click on the DHCP (or “VISTA”) icon on your PC desktop.
2. Enter your CPRS access and verify code.
3. You may need to type “^” then “enter” to get to an active prompt at first log on.
4. At the active prompt, type “^brief” (for Brief Incident Enter/Edit)
5. **DIVISION: 1. PHILADELPHIA, PA VAMC** Enter: “1”
6. **INCIDENT:** type “??” (double question marks ‘??’ will give you the list of incidents)
7. Hit “enter” again and type in the number that corresponds best to the incident type.
8. **DATE OF INCIDENT:** enter DATE and TIME of incident. (e.g., 11/21/06@0900.)
9. **INCIDENT LOCATION:** (double question marks ‘??’ will give you the list) – select appropriate area.
10. **SELECT PATIENT:** enter patient name and social security number (confirm – YES – then hit enter/return.)
11. **SELECT PATIENT:** will display again. Hit “enter” at this prompt.
12. **INCIDENT DESCRIPTION:** No existing text Edit? No// type ‘yes’.
13. Enter description of incident. Be as detailed as possible including all assessment, evaluation and treatment the patient received. NOTE – Please do not record in the patient’s computerized medical record (CPRS) that an incident report was completed, but do record the history of the event in CPRS in a non-punitive, non-argumentative way.
14. After typing all information, hit ‘Num Lock’ (release key) plus ‘E’ or ‘F1’ (release key) to exit this window.
15. **WITNESSED:** ?? Type ‘Yes’ or ‘No’
16. **Is this information correct?** Type ‘Yes’ or ‘No’ (If no, system will make you edit each section again)

Step 2 - Print Patient Incident Report Worksheet
1. Press ‘RETURN’ to continue, ‘^’ to stop: hit ‘return’
2. At the prompt: **Select SYSTEM COMMAND OPTIONS Option:** type ‘pseudo’ (for Pseudo 10-2633 Incident Worksheet)
3. **Do you wish to generate a blank 10-2633?** Type ‘No’
4. **Select Patient:** Enter patient name and social security number OR hit space bar ONCE and enter/return (this will provide you with the name of the last patient you were working with.)
5. Confirm that this is your patient & type ‘Yes’

6. **Print on Device: HOME// enter your printer name**  Some examples of floor printer names to enter (enter the first few letters and some selections will come up):
   - MICU1$PRT
   - SICU1$PRT
   - WD 5S
   - WD5EAST$PRT
   - WD6WEST$PRT
   - WD7SOUTH$PRT

7. Sign and date the “SIGNATURE AND TITLE OF REPORTER” section

8. Write: N/A in PHYSICIAN’S EXAMINATION FINDINGS/ACTIONS section (medical students should have a physician – resident or attending – complete this section)

9. Repeat this process to print a second copy.

**Step 3 - Returning Paperwork**

Residents should return the signed hardcopy to the locked box outside of the Quality Management Office *(located on the first floor in the hallway that Police Offices are on)* or in locked boxes on inpatient units.

**Note:** that the Patient Safety Office will get a copy of the electronic support, but a hardcopy with original signature is needed as well.
JCAHO National Patient Safety Goals

Please note that goals are program-specific, so all 15 goals & requirements may not apply to our facility. For information on other goals (total of 15 goals) and for FAQ’s, visit http://joint-commission.org/patientsafety/nationalpatientsafetygoals.

Requirements for each goal are indicated by the following key for healthcare settings at PVAMC: H=Hospital, BH=Behavioral Health (for Opioid Treatment Program & MHICM), HC=Home Care, LTC=Long Term Care

Goal 1: Improve the accuracy of patient identification.

Requirements –
A. Use at least 2 patient identifiers (neither to be the patient’s room number) when providing care, treatment or service. (BH, HC, H, LTC)
B. Prior to the start of any surgical or invasive procedure, conduct a final verification process to confirm the correct patient, procedure and site using active – not passive – communication techniques. (HC, LTC) *please note that for the hospital, this requirement is surveyed under the Universal Protocol

Goal 2: Improve the effectiveness of communication among caregivers.

Requirements –
A. For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the information record and “read-back” the complete order or test result. (BH, HC, H, LTC)
B. Standardize a list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the organization. (BH, HC, H, LTC)
C. Measure, assess and, if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values. (BH, HC, H)
E. Implement a standardized approach to “hand off” communications, including an opportunity to ask and respond to questions. (BH, HC, H, LTC) *please refer to MCM 11-10, “Hand Off Communication”

Goal 3: Improve the safety of using medications.

Requirements –
B. Standardize and limit the number of drug concentrations used by the organization. (BH, HC, H, LTC)
C. Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs
used by the organization, and take action to prevent errors involving the inter-
change of these drugs. (BH, HC, H, LTC)

D. Label all medications, medication containers (e.g., syringes, medicine cups, basins),
or other solutions on and off the sterile field. (H)

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

Requirements –

A. Comply with current Centers for Disease Control and Prevention (CDC) hand-hy-
giene guidelines. (BH, HC, H, LTC)

B. Manage as sentinel events all identified cases of unanticipated death or major
permanent loss of function associated with a health care-associated infection. (BH,
HC, H, LTC)

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

Requirements –

A. There is a process for comparing the patient’s current medications with those
ordered for the patient while under the care of the organization. (BH, HC, H, LTC)

B. A complete list of the patient’s medications is communicated to the next provider of
service when a patient is referred or transferred to another setting, service, practitioner
or level of care within or outside the organization. The complete list of medications
is also provided to the patient on discharge from the facility. (BH, HC, H, LTC)

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

Requirements –

B. Implement a fall reduction program including an evaluation of the effectiveness of
the program. (HC, H, LTC)

**Goal 10: Reduce the risk of influenza and pneumococcal disease in institution-
alized older adults.**

Requirements –

A. Develop and implement a protocol for administration and documentation of the flu
vaccine. (LTC)

B. Develop and implement a protocol for administration and documentation of the
pneumococcus vaccine. (LTC)

C. Develop and implement a protocol to identify new cases of influenza and to man-
age an outbreak. (LTC)

**Goal 13: Encourage patients’ active involvement in their own care as a patient safety strategy.**
Requirements –
A. Define and communicate the means for patients and their families to report concerns about safety and encourage them to do so. (BH, HC, H, LTC)

**Goal 14: Prevent health care-associated pressure ulcers (decubitus ulcers).**
Requirements –
A. Assess and periodically reassess each patient’s risk for developing a pressure ulcer (decubitus ulcer) and take action to address any identified risks. (LTC)

**Goal 15: The organization identifies safety risks inherent in its patient population.**
Requirements –
A. The organization identifies patients at risk for suicide. [(BH) and (H - applicable to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals)]
B. The organization identifies risks associated with long-term oxygen therapy such as home fires. (HC)
# Prohibited Abbreviations

*Appendix “A” to MCM NO. 136-77*

<table>
<thead>
<tr>
<th>Unacceptable Abbreviation(s)</th>
<th>MS, MSO4, MgSO4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intended Meaning</td>
<td>Morphine Sulfate or Magnesium Sulfate</td>
</tr>
<tr>
<td>Misinterpretation</td>
<td>Confused for one another.</td>
</tr>
<tr>
<td>Correction</td>
<td>Write “morphine sulfate” or “magnesium sulfate.”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Unacceptable Abbreviation(s)</th>
<th>cc*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intended Meaning</td>
<td>Cubic Centimeters</td>
</tr>
<tr>
<td>Misinterpretation</td>
<td>Misread as U (units)</td>
</tr>
<tr>
<td>Correction</td>
<td>Use “mL” for milliliters</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Unacceptable Abbreviation(s)</th>
<th>U, u</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intended Meaning</td>
<td>Unit</td>
</tr>
<tr>
<td>Misinterpretation</td>
<td>Misread as zero (0), four (4), or cc. Can cause overdose - e.g. 4U read as “40” or 4u read as “44”</td>
</tr>
<tr>
<td>Correction</td>
<td>Unit has no acceptable abbreviation; write “unit.”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Unacceptable Abbreviation(s)</th>
<th>IU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intended Meaning</td>
<td>International Unit</td>
</tr>
<tr>
<td>Misinterpretation</td>
<td>Mistaken as IV (intravenous) or ten (10)</td>
</tr>
<tr>
<td>Correction</td>
<td>Write “international unit.”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Unacceptable Abbreviation(s)</th>
<th>Q.D., Q.I.D., Q.O.D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intended Meaning</td>
<td>Once daily, four times daily, and every other day</td>
</tr>
<tr>
<td>Misinterpretation</td>
<td>Mistaken for each other. The period after the Q and/or the “O” can be mistaken for an “I”</td>
</tr>
<tr>
<td>Correction</td>
<td>Write once daily, four times daily, or every other day</td>
</tr>
</tbody>
</table>
### Section III: Policies and Systems Issues

#### Patient Safety

<table>
<thead>
<tr>
<th>Unacceptable Abbreviation(s)</th>
<th>Zero after a decimal point (e.g. - 1.0mg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intended Meaning</td>
<td>1mg</td>
</tr>
<tr>
<td>Misinterpretation</td>
<td>Misread as 10mg (if decimal point is not seen)</td>
</tr>
<tr>
<td>Correction</td>
<td>Never use terminal zeroes for dose expressed in whole number.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Unacceptable Abbreviation(s)</th>
<th>T.I.W., TIW, tiw</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intended Meaning</td>
<td>Three times a week</td>
</tr>
<tr>
<td>Misinterpretation</td>
<td>Mistaken for three times a day or twice weekly resulting in an overdose</td>
</tr>
<tr>
<td>Correction</td>
<td>Write “3 times weekly” or “three times weekly.”</td>
</tr>
</tbody>
</table>
Sedation
Sedation is the administration and monitoring of drugs used for invasive or constraining procedures that have the potential of depressing protective reflexes.

The independent practitioners involved in conscious sedation procedures must be appropriately credentialed and privileged. Trainee must be appropriately supervised. See MCM 112-03, “IV/Conscious Sedation”.

Physical Restraints
Seclusion and restraints are used as a therapeutic intervention to prevent injury to self and/or others. Our goal is to become a restraint-free environment. Order restraints are used only after alternative measures have been considered. All orders are time limited and must be assessed and reviewed by a physician. PRN orders (as needed) are not acceptable. The Restraints Order Form must be used. See MCM 11-70, “Physical Restraint Policy”

Writing Restraint Orders
To write a restraint order (on-line):
1) Go to notes section of charts.
2) Select: “New note”
3) Enter: “restraint” when prompted for title
4) Select either (see below for indications)
   Physician/Provider Behavior Restraint Note OR
   Physician/Provider Medical Healing Restraint Note
5) Completing the template that comes up will generate BOTH a restraint order and a restraint note
6) Restraint orders AUTOMATICALLY expire at the time that defaults, so another note/order must be written to continue

Restrains may be ordered for EITHER medical or behavioral reasons

Medical reasons:
Definition: To promote medical healing (high potential for removing lines, or disrupting equipment in use, etc) .......

Timing: Order may be written for up to 24 hours;
Can only be renewed/rewritten after face-to-face interaction with patient

OR
Section III: Policies and Systems Issues

Behavioral reasons:
Definition: Emergency situation imminent observable risk of injury to self or others.
Timing: Order may be written for up to 4 hours only
Once the above order expires (after 4 hours), the RN may continue restraints, after reassessment, for an additional 4 hours.
Requires continuous re-assessment and documentation including: documentation of face-to-face assessments, alternatives tried and patient’s response, events leading to restraint, documentation of notification/extensive counseling of family, and debriefing after the Restraint Event.

- COMPLETELY filling out the restraint order form satisfies the majority of the required physician documentation for medical reasons.
- In addition to the order form, you MUST document use of justification of restraints/protective devices and further plan of care IN DAILY PROGRESS NOTES.
- Please see complete policy handbook available at nurses stations for more specific information.
- NOTE: There are no prn restraint orders.
Pain Policy and Pain Service

- It is the policy of the PVAMC to provide optimal pain management to all veterans.
- All patients must be screened for the presence of pain and have a pain assessment if pain is present.
- Pain assessment should include:
  1. Intensity, location, frequency, duration, quality.
  2. Alleviating and aggravating factors.
  3. Pain history including medication, other methods for pain control and their effectiveness.
  4. Effects of pain on function and quality of life.
  5. Usual coping response to stress or pain.
  6. The patient’s comfort (pain relief) goal.
  7. Physical exam.
  8. Clinical impression based on inspection and intervention.
- Note that there is a “Pain Assessment” note in GUI that contains a template with most of these elements.
- The inpatient team (physician, NP, PA, RN, pharmacist, SW, case mgr) must document pain management plan and discharge plan for pain.
- Pain Management Service is available as a resource to informally discuss and advise, x 6043 or provide Formal Pain Management consults.
- Reassessment for pain should occur and be documented.
  1. With each new report of pain.
  2. Following any pain control intervention.
  3. For pain greater than personal relief goal.
Opioid Management Reference

Principles of Pharmacologic Management:

1. The initial choice of analgesic is based on the mechanism of pain (e.g. nociceptive, visceral, myofascial or neuropathic) and the individual's medical, psychological, and social history.
   - Patients with nociceptive pain should be started on an NSAID which should be continued even when an opioid is added (unless contraindicated).
   - Patients with neuropathic pain should always have a trial on a TCA (e.g. nortriptyline in older patients or amitriptyline) or an anticonvulsant (e.g. gabapentin) to which an opioid may be added.
   - Patients may have a combination of mechanisms

2. Dose to ceiling of non-opioids if side effects permit. Consider opioids after other reasonable attempts at analgesia have failed.

3. There is no maximum dose or analgesic ceiling with opioids. Increase opioid dose until pain relief is achieved or side effects are unmanageable before changing medications.

4. Continue with or add nonpharmacologic modalities such as heat, ice, positioning, relaxation, distraction.

5. Administer drugs orally whenever possible. Avoid intramuscular injections.

6. Administer analgesics “around the clock” rather than prn for persistent pain.

7. Avoid meperidine and propoxyphene since accumulation of neurotoxic metabolites can lead to CNS excitability and seizures.

8. Addiction occurs very rarely in patients who receive opioids for pain control. Evidence of aberrant drug-related behaviors must be carefully assessed. Structured prescribing and monitoring with random urine drug testing can facilitate the differentiation between substance misuse, abuse and addiction vs. undertreated pain.

9. Assess pain, pain relief, and side effects frequently and adjust the dose accordingly. Change to another drug if side effects are unmanageable.
Opioid Equivalency Table

Equianalgesic doses are *approximate*. Individual patient response must be observed. Doses and intervals between doses are titrated according to the patient’s response.

<table>
<thead>
<tr>
<th>Opioid</th>
<th>Parental Dose (mg)</th>
<th>Oral Dose (mg)</th>
<th>Duration (hours)</th>
<th>Recommended Frequency (hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine (IR)</td>
<td>10</td>
<td>30</td>
<td>3-4</td>
<td>q 4-6</td>
</tr>
<tr>
<td>Morphine (SR)</td>
<td>N/A</td>
<td>30</td>
<td>8-12</td>
<td>q 12</td>
</tr>
<tr>
<td>Oxycodone (Percocet)</td>
<td>N/A</td>
<td>20</td>
<td>3-4</td>
<td>q 4-6</td>
</tr>
<tr>
<td>Oxycodone (SA) (Oxycontin)</td>
<td>N/A</td>
<td>20</td>
<td>8-12</td>
<td>q 12</td>
</tr>
<tr>
<td>Hydromorphone (Dilaudid)</td>
<td>1.5</td>
<td>7.5</td>
<td>3-4</td>
<td>q 4-6</td>
</tr>
<tr>
<td>Codeine</td>
<td>130</td>
<td>200</td>
<td>3-4</td>
<td>q 4-6</td>
</tr>
<tr>
<td>Hydrocodone (Vicodin, Lortab)</td>
<td>N/A</td>
<td>30</td>
<td>3-4</td>
<td>q 4-6</td>
</tr>
<tr>
<td>Methadone (Dolophine)</td>
<td>See Below Table</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Fentanyl Conversion  Recommended Frequency: q72 hours

<table>
<thead>
<tr>
<th>Fentanyl Patch</th>
<th>Morphine mg/24 hrs po</th>
<th>Morphine mg/24 hrs IM/IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td>30-90</td>
<td>10-30</td>
</tr>
<tr>
<td>50</td>
<td>91-150</td>
<td>31-50</td>
</tr>
<tr>
<td>75</td>
<td>151-210</td>
<td>51-70</td>
</tr>
<tr>
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<tr>
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<td>111-130</td>
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<td>451-510</td>
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<td>250</td>
<td>571-630</td>
<td>191-210</td>
</tr>
<tr>
<td>300</td>
<td>691-750</td>
<td>231-250</td>
</tr>
</tbody>
</table>

Since onset of action is 12-24 hours and time to peak analgesia is 24-72 hours, patients should receive short-acting opioids during titration as needed until analgesia is achieved. Another option is to give the last dose of current long-acting opioid with patch application.

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Equianalgesic Dose Conversion Guides

\[
\text{New Dose} = \frac{24\text{hr dose of current period} \times \text{Equianalgesic table dose of new opioid}}{\text{Equianalgesic table dose of current opioid}}
\]

This guide illustrates one method of changing from one opioid or route of administration to another. Clinicians must be able to identify appropriate opioid doses when a patient requires a change of opioid and/or route of administration. Mastering this skill enables the clinician to determine the dose of a new opioid that is approximately equal in analgesic effect to the dose of the former opioid.

Switching opioids:
Because of incomplete cross-tolerance, begin the new opioid at 10-25% lower than calculated dose. For elderly patient you might think about decreasing by 25-50%.

Opioids on Formulary at Phila VAMC
Codeine: 30mg
Codeine 15mg/APAP 300mg (Tylenol # 2)
Codeine 30mg/APAP 300mg (Tylenol # 3)
Codeine 60mg/APAP 300mg (Tylenol # 4)
Hydrocodone (Vicodin) 5 mg/Acetaminophen 500mg
Hydromorphone (Dilaudid): 2mg, 3mg, 4mg
Dilaudid suppository: 3 mg
Morphine IR: 15mg, 30 mg
Morphine SA (MS Contin): 15mg, 30mg, 60mg, 100mg
Morphine oral solution: 10mg/5ml
Morphine concentrated solution: 20mg/1ml
Morphine Injection: 2 mg/1ml; 150mg/30ml
Morphine suppositories: 10mg, 20mg
Methadone: 5 mg, 10 mg
Oxycodone (short-acting) 5 mg
Oxycodone (Endocet, Percocet) 5mg/Acetaminophen 325mg
Propoxyphene (Darvocet N) 100mg/Acetaminophen 650mg
Restricted: Fentanyl (Duragesic) patch: 25 mcg, 50 mcg, 75 mcg, 100 mcg
Nonformulary: Oxycodone SA (Oxycontin): 10mg, 20mg, 40mg, 80mg
Miscellaneous: Acetaminophen 325 mg, Butalbital 50 mg, Caffeine 40mg (Fioricet)

Opioid Dosing/Titration Guidelines
Initiating Oral Opioids:
1. Short-acting opioids should be prescribed for pain that is episodic on a “prn” schedule.
2. Long-acting or sustained release opioids should be used only for continuous pain.
   - Morphine and methadone are first line long-acting opioids
   - Fentanyl is restricted with the following exceptions: inability to swallow intact pills, documented intolerable adverse effects to other long-acting opioids.
   - Long-acting oxycodone (e.g. oxcontin) is nonformulary and can be considered after trial and failure of other formulary opioids.
3. Titrate the opioid by increments of 25-50% until either analgesia is achieved or intolerable side effects. Peak drug effect occurs within 1.5 to 2 hours after oral administration of short-acting opioids. Therefore, it is safe for patients to take a second opioid dose 2 hours after the first dose if side effects are mild at that time.
4. Rescue doses for cancer pain. When a long-acting opioid is administered, a PRN (short-acting) rescue dose should be available every 2-3 hours starting at 10% of the total 24 hour long-acting dose. The PRN rescue dose should be titrated as needed up to 25% of the 24 hour dose. Increase the long-acting dose when rescue doses are consistently needed more than 3-5 times per day.
5. Rescue medications for chronic nonmalignant pain. Some patients may require additional opioid analgesic to manage unexpected exacerbations of pain. Episodic increases in pain can be treated with short-acting opioid or an extra 1-2 doses of their usual opioid medication on bad days. Consistent use of extra doses may indicate that the baseline long-acting opioid needs to be increased or the patient is expressing an unmet need for something other than pain. Reassessment of pain, medication schedule, associated symptoms, & psychosocial issues is recommended.
6. It is strongly recommended that you utilize the Opioid Treatment Plan note in CPRS and do random urine drug testing to monitor adherence to the treatment plan.
7. Anticipate and vigorously treat side effects.
   ****Start bowel regimen when opioids are started.****

Documentation
Clear documentation in the patient’s medical record should include the diagnosis for which the opioids are being prescribed. Ongoing assessment should specifically address:
   - Degree of analgesia (on 0-10 scale or other scale acceptable to patient)
   - Opioid-related side effects
   - Functional status (e.g. physical activities, social functioning)
   - Existence of aberrant drug-taking behaviors
Medical Center Security

- Always wear HUP or VA ID badge
- VA police X6226
- Log completely off computer
- Keep valuables locked

Police Notification
In the event that a Police Officer is needed for an emergency dial extension 6225 or 911. For non-emergencies call extension 6226.

Security High Risks/Sensitive Areas

Emergency Room – The emergency room in any hospital has the potential to be a very volatile area. The unexpected nature and/or circumstances that bring patients, their families and friends to an emergency room can create problems during this highly emotional time. Staff frequently are the recipient of hostile words or attitudes and threats of violence from the patients, their family and friends. Reports of weapons being found on patients are real, and police confiscate all weapons and notify Philadelphia Police, as appropriate. Situations such as these add to an already emotionally charged atmosphere and staff believe they are vulnerable to violence from those who use the emergency room. All emergency room staff are sensitive in their dealings with distraught family members and friends. This coupled with understanding the dynamics of the community we serve has a positive impact on our success with patient care and patient satisfaction.

Pharmacy – The pharmacy stores and dispenses a large number of drugs needed for the care and recovery of patients. Many of the drugs are high cost and/or considered controlled substances. Because of this, there is a real potential for theft and/or fraud to obtain these drugs. The pharmacy has internal security systems in place (i.e. controlled access, closed circuit TV monitoring systems, panic alarms and inventory control) to assist in maintaining a safe environment.

Inpatient Psychiatry Units – To enhance safe patient management, these units are locked and a buzzer/key system is in place to provide a safe environment for patients, visitors and staff. Police officers respond to requests from medical staff to assist them, when appropriate, in a team approach in the handling of out of control patients.
Crime Prevention
The hospital maintains a Police and Security Service Department that is staffed to provide service 24 hours a day, 365 days a year. The primary goal of the police force is to maintain a safe and secure environment. A very important component of a safe and secure environment is crime prevention. Crime prevention is everyone’s responsibility and all employees are expected to participate. Protecting personal belongings and safeguarding hospital property should be a high priority for every employee. All offices should be locked when unoccupied and personal belongings should be locked up/safe-guarded at all times when not in use. Also, every employee should be familiar with His/Her surroundings in order to be able to recognize activity that is “out of the ordinary” or suspicious in nature. Reporting unusual activity is the cornerstone to an effective crime prevention program. If in doubt, call extension 6225. To report a theft, vandalism, or any other police and security problem call extension 6225 as soon as possible upon discovery of a problem.

Responding to Bomb Threats
All employees should know what to do if a bomb threat is received. It is always desirable that more than one person listen in on the call if possible. A calm response to the bomb threat caller could result in obtaining additional information. This is especially true if the caller wishes to avoid injuries or death. If told the building is occupied or cannot be evacuated in time, the caller may be willing to give more information on the bomb’s location, components, or method of initiation. Remember, the bomb threat caller is the best source of information about the bomb.

When a bomb threat is called in, follow this procedure:
1. Keep the caller on the line as long as possible. Ask him/her to repeat the message. Write down every word spoken by the person. Use the bomb threat checklist to take notes.
2. Ask the location of the bomb and the time it is set to go off.
3. Inform the caller that the building is occupied and that detonation of the bomb could result in death and/or serious injury to innocent people.
4. Pay attention to background noises, such as motors running, music playing or any other noise which may give a clue to the location of the of the caller.
5. Listen Closely to the voice (male or female), voice quality (calm, excited, etc.), accents and speech impediments.
6. Immediately after the caller hangs up, report the call to your supervisor and police at Ext. 6225.
7. Remain available to talk to police personnel.

When a handwritten threat is received, save all materials, including any envelope or container. Once the message is recognized as a bomb threat, further unnecessary handling should be avoided. Every possible effort must be made to retain such evidence as fingerprints, handwriting, typewriting, paper and postal marks. These will be essential in tracing the threat and identifying the writer. Written messages are usually associated with generalized threats and extortion attempts, however, a written warning of a specific device may occasionally be received.

Any type of bomb threat (either written or verbal) should not be ignored.

**Bomb Threat Checklist**

Exact time of call: __________________________________________________________

Exact work of caller: ______________________________________________________

**Questions to Ask:**
1. When is the bomb going to explode? ______________________________________
2. Where is the bomb? _____________________________________________________
3. What does it look like? __________________________________________________
4. What kind of bomb is it? _______________________________________________
5. What will cause it to explode? ___________________________________________
6. Did you place the bomb? ______________________________________________
6. Why? __________________________________________________________________
7. Where are you calling from? _____________________________________________
8. What is your address? __________________________________________________
9. What is your name? ____________________________________________________
**Caller’s Voice (circle):**
Calm  Disguised  Nasal  Angry  Broken
Stuttering  Slow  Sincere  Lisp  Rapid
Giggling  Deep  Crying  Squeaky  Excited
Stressed  Accent  Loud  Slurred  Normal

If voice is familiar, whom did it sound like? _________________________________

**Threat Language**
Well-spoken  Irrational  Foul  Incoherent

**Were there any background noises? (Circle appropriate noise)**
Street noise  Voices  Animal Noise
PA System  Music  Machine Clear
House noises  Motor  Noise Static
Factory Machinery  Office  Long Distance

Remarks: _____________________________________________________________

Person receiving call; _________________________________________________

Telephone number call received at: ______________________________________

Date: _______________________________________________________________

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**Report Call Immediately to Your Supervisor and Police at x6225.**
Before a fire occurs:
- Report all potential and actual fire and safety hazards.
- Read the Hospital’s Fire Safety Plan. (Red Book)
- Read the evacuation plan and know the location of the fire alarm boxes.
- Know which type of extinguisher to use and how to use it.
- In event of fire, explosion or smoke (from unknown source) quick action is imperative. The code word for the procedure is RACE.

What to do in a fire
If you discover a fire: RACE
- Rescue person(s)/patients/staff in immediate danger
- Alarms - pull fire alarm and dial 2000
- Contain/confine the fire. Close all doors and windows
- Extinguish the fire, if possible. If not, evacuate the area.

If you use the fire extinguisher: PASS
- Pull the pin
- Aim at the base of the fire
- Squeeze the handle
- Sweep onto the fire from side to side

Use the correct class of fire extinguisher
- A – Class: Ordinary (paper, cloth, mattress, etc.)
- B – Class: Flammable liquids (alcohol, grease, etc.)
- C – Class: Electrical (motors, bio-medical equipment)
  
Use CO2 (BC) or Dry Chemical (ABC)

Fight the fire with your back to the exit.

Evacuation Procedures
Horizontal
- Evacuation from the immediate fire area.
- Evacuation from one area to another beyond the fire doors.

Vertical
- Evacuation down to another floor via stairs
- Evacuation out of building (Do not use elevators during fire)
Smoking
The Philadelphia Veterans Affairs Medical Center is a smoke-free institution.

Sprinklers
*Remember:* Do not store anything within 18 inches of the height of a sprinkler.

Disaster Plan And Emergency Preparedness

Emergency Preparedness
- Disaster code is “code 99.”
  - May be internal (bomb threat, water contamination, etc.).
  - Or external (unanticipated inflow of large number of casualties).
  - Report to your assigned floor when a code 99 is called and wait for instruction from your Chief Resident, attending or nurse manager of the area.
- Red phones indicate emergency telephone service.
- Red outlets are connected to the emergency power source.

There are four functions of the disaster plan:
- Mitigation
- Preparedness
- Response
- Recovery

To initiate the Disaster Plan, the operator will announce: “Code 99”
- In case of Disaster Plan implementation, all employees must report immediately to their assigned areas

List your assigned area here: ________________________________________________________________

- Employees at the end of their shift are not to leave until the alert is over, and/or is approved by their supervisor
- A copy of the Disaster Plan is available in each department/unit in the Handbook of Emergency Procedures and in the Safety office.

When the disaster is terminated the operator will announce: “Code 99 All Clear”
Utilities and Medical Equipment

Utility System

Remember:

- Emergency power availability varies depending on location.
- A red electrical receptacle indicates that emergency power is available at that outlet. Life support devices should be plugged into emergency power outlets at all times.
- Details on emergency power for your work location can be obtained from your supervisor.

Emergency power is available throughout the Medical Center in the event of a power failure. If you experience a loss of utilities (water, electric, medical gas, etc.), contact Engineering Service immediately. Dial 5811. After hours contact the Duty Engineer via the telephone operator.

Medical Equipment Failures

Safe Medical Devices Act (SMDA)

The SMDA of 1990 requires the hospital to report incidents where a medical device has, or may have caused or contributed to a serious illness, serious injury or death. All employees are responsible for prompt reporting and documentation of medical device-related incidents. Employees should report the incident via an electronic work order to Biomedical Engineering and to call Biomed at x5829 (this is in addition to attending to the patient as needed, removing the equipment from service, labeling the equipment “Do Not Use”, saving any disposables and their packaging if applicable, and recording any equipment settings in use at the time of the incident if applicable). Please refer to MCM 11-58 “Safe Medical Devices Act/Incident Reporting.”

For an emergency, dial x5829. After hours contact the Duty Engineer via the telephone operator.
Hazardous Materials
The OSHA and the Right to Know Laws require that information about the use of hazardous substances be provided in the workplace. Information is available to all PVAMC personnel regarding hazardous substances.

The Medical Center provides its personnel with training and protective equipment to use when working with hazardous substances. It is your responsibility to be aware of potential hazards and to use personal-protective equipment when necessary.

Information on hazardous substances is available through three sources:
1. Labels on containers: name of substance, potential hazards, and precautions to take when handling the substance
2. The Material Safety Data Sheets (MSDS) a document that gives details of each substance. These are available in every department/unit. Please note the location of this manual in your department/unit.
3. The contact person is the Industrial Hygienist. Dial x4104.

Radiation Safety
For radiologic emergencies (radioactive spill or unusual events), contact the Radiation Safety Officer. Dial x6009. Pager 877-591-7592.

For further information consult the yellow Radiation Safety Manual.
Mission Statement
Our mission is to provide high quality health care and social services to veterans while maintaining the highest level of professional and ethical standards. We strive for excellence in teaching and research to conquer disease and improve the quality of life of the veterans.

Vision
We will serve as a preferred provider of primary, tertiary, and long-term care in a safe, customer-focused environment. A continuum of compassionate and state of the art care will be provided in a timely manner in accordance with the most current clinical practice acquired through education and research. The Medical Center will foster a relationship with our medical and educational affiliates for the betterment of patients and staff. Our health care team will meet the needs of the veterans and their families.

Values
We will provide service to veterans by incorporating:

- Trust
- Respect
- Excellence
- Compassion
- Commitment