2024–2025

Graduate Staff Handbook

Memorial Sloan Kettering Cancer Center

Welcome to Memorial Sloan Kettering Cancer Center

For more than a century, Memorial's fight against cancer has been a testament to the dedicated efforts of our staff and the courage of our patients. As you embark on your training here, we want you to know that you are an integral and valued member of our community. Our residents and fellows are essential to the delivery of high quality patient care and to our cancer care research efforts. Our atmosphere is one of innovation and excellence, and it is my hope that this learning environment will facilitate your education, nurture your professional growth and foster your journey as a life-long learner.

It is truly a great pleasure to welcome you to Memorial Sloan Kettering Cancer Center.

Monika Shah, MD
Designated Institutional Official for ACGME
Deputy Physician-in-Chief, Education and Faculty Affairs

Table of Contents

On the cover: Daniel Gorovets, MD, Associate Program Director - Radiation Oncology and Nikhil Mankuzhy, MD, Radiation Oncology Resident.

Welcome to MSK

About MSK

Memorial Sloan Kettering (MSK) is the largest privately operated non-profit cancer center in the world. For more than a century, MSK has been dedicated to caring for patients afflicted with cancer, advancing biomedical knowledge through research, and training health care professionals in the specialties and subspecialties of cancer care. The Center's present and future course continues to be built on this foundation.

The institution comprises three corporations: Memorial Hospital for Cancer and Allied Diseases, the treatment unit; Sloan Kettering Institute, the research unit; and Memorial Sloan Kettering, the unit which formulates policies, develops long-range plans and coordinates the activities of the Hospital and Institute.

MEMORIAL HOSPITAL incorporates a 514 bed inpatient unit with approximately 25,187 (2023) admissions and 176,790 patient days. The Hospital averages a 94.7% (2023) occupancy rate and an average length-of-stay of 7 days (2023). MSK provides clinical services that span the continuum of cancer care, including screening programs, perioperative services (including surgery), chemotherapy and biologic therapy infusion, radiation oncology, and urgent/intensive care. These services are provided to adult and pediatric patients in a range of care units.

OUTPATIENT SERVICES are delivered within Memorial Hospital in either the Enid Haupt Pavilion or the Bobst Building as well as in off-site program locations within Manhattan and surrounding communities. Memorial's New York City sites include

Brooklyn Infusion Center
557 Atlantic Avenue
Brooklyn, NY 11217

Clinical Genetics
222 East 70th Street

Evelyn H. Lauder Breast Center and MSK Imaging Center
300 East 66th Street

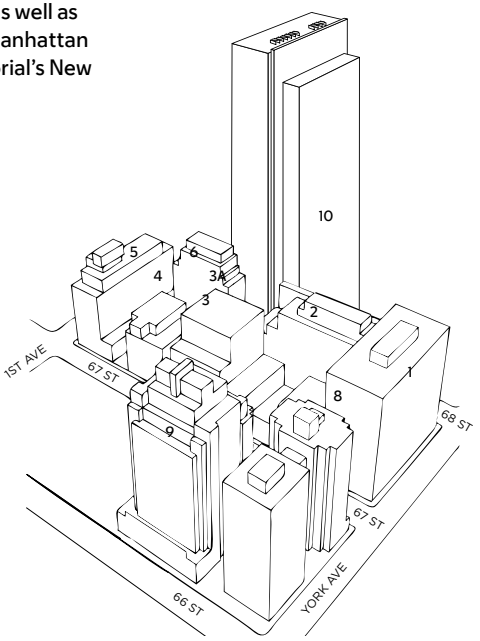
Josie Robertson Surgery Center
1133 York Avenue

MSK—64th Street
205 East 64th Street

Laurance S. Rockefeller Outpatient Pavilion
160 East 53rd Street

Ralph Lauren Center for Cancer Care
1919 Madison Avenue

Rockefeller Research Laboratories
430 East 67th Street



LEGEND

1. Memorial Hospital
2. Bobst Clinical Office Building
3. Enid A. Haupt Pavilion

3A. MRI Building

4. Radiation Oncology
5. Schwartz Building
6. Howard Building
7. Sloan House
8. Scholars Residence Building
9. Rockefeller Research Laboratories
10. Mortimer B. Zuckerman Research Center

Sidney Kimmel Center for Prostate and Urologic Cancers
353 East 68th Street

Mortimer B. Zuckerman Research Center
417 East 68th Street

David H. Koch Center for Cancer Care
503 East 74th Street

MSK also has community-based outpatient treatment centers where patients can receive outpatient radiotherapy, chemotherapy, surgical consultation, and dermatologic services in their home communities, but still delivered by Memorial Sloan Kettering's expert staff. These outpatient treatment centers are located in Northern New Jersey, and Westchester, Nassau and Suffolk counties.

MSK's Vision, Mission & Core Values

Our vision, mission, and core value statements are a common language to describe our institutional aspirations and the enduring character of MSK.

Our vision is to be the world's leading authority on cancer, our mission is to end cancer for life, and our core values are the fundamental beliefs that shape our culture.

MSK's core values include:

- **Respect for the individual:** we value each person's contribution and create an environment that embraces diverse perspectives.
- **Excellence through inclusion:** we recruit, retain and develop diverse talent, and seek to create a community that reflects all populations we serve.
- **Integrity:** we have the courage to say what we mean, matching our behaviors to our words, and taking responsibility for our actions.
- **Innovation with lasting impact:** we challenge ourselves to constantly learn and improve.
- **Stewardship:** we each take responsibility for strengthening MSK to better serve our global cancer community, today and in the future.
- **One MSK:** we work together to do what no one else can in cancer care.

As a member of the graduate staff, you are an integral part of MSK's vision, mission, and core values.

MSK's Commitment to Graduate Medical Education

The mission of Memorial Hospital for Cancer and Allied Diseases (Memorial) is the progressive control and cure of cancer through programs of prevention, diagnosis, treatment and cure of cancer and allied diseases. This is achieved through excellence, vision and cost effectiveness in patient care, research, education and outreach. Inherent in this mission is a commitment to Graduate Medical Education, which is endorsed and supported by the Board of Governing Trustees. Specific to education, Memorial is committed to fulfilling its mission by providing the necessary financial support for administrative, educational, and clinical resources, including personnel, to support a broad range of programs of graduate education and postgraduate training for scientists and health professionals in the areas of cancer and related diseases and disciplines. This commitment includes a focus on diversity as a key element of our strategy for recruiting and training the next leaders in cancer care as well as a thoughtful and directed focus on understanding and addressing disparities in health care and cancer treatment among underrepresented groups.

To maintain and continuously improve the quality, productivity and organization of Graduate Medical Education programs, Memorial's Medical Staff and Hospital Administration ensure the allocation of required leadership and resources to achieve compliance with internal policies and procedures and to meet the requirements of outside accreditation organizations. Memorial strives to instill its philosophy of multidisciplinary patient-centered care in all Graduate Staff by providing an educational environment that ensures the safe and appropriate delivery of care to patients, taking into consideration the patient's quality of life during and after treatment.

Our affiliation and proximity to The New York-Presbyterian Hospital/Weill Cornell Medical Center, Weill Cornell University Graduate School of Medical Sciences Hospital for Special Surgery, and Rockefeller University allow our students to participate in one of the world's most outstanding medical and scientific community. The commitment of the Medical Staff and Hospital Administration assures that Memorial's clinical trainees are provided the required guidance, supervision, educational curriculum and personal development needed to become outstanding members of the medical community.

SOURCE: Administrative Policy and Procedure #1001; Rules and Regulations of the Medical Staff #536.

Graduate Medical Education Oversight and Administration

Memorial Hospital conducts more than 100 separate clinical training programs. Approximately 80 of these are full-time training programs, with 340 FTE positions; the remainder are rotating programs. There are 1,200 rotating residents and clinical fellows per year, equating to another 130 FTE. Each training program is under the direct supervision of a Training Program Director/physician. With the assistance of other faculty, Training Program Directors are responsible for developing and implementing a comprehensive, well-organized and effective curriculum, both academic and clinical, which includes the presentation of core specialty knowledge supplemented by current scientific advancements. Each Training Program Director is also responsible for developing effective measures to assess and evaluate trainee performance and competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and system-based performance. Training Program Directors are responsible for providing regular and timely performance feedback to their trainees.

Training Program Directors serve as members of the Hospital's Graduate Medical Education (GME) Committee, whose membership also includes Hospital Administrators and elected residents and fellows. The GME Committee provides oversight and guidance for all graduate medical education activities. All training programs are reviewed on a regular basis for their excellence of education, satisfaction of trainees, and compliance with the requirements of various accrediting and oversight organizations, including the Accreditation Council for Graduate Medical Education (ACGME), the agency which accredits most clinical training programs in the US, and the New York State Department of Health.

The Office of Graduate Medical Education provides administrative support to the GME Committee and individual training programs. The Office is responsible for managing trainees' appointment to the medical staff and for providing information on their arrival. GME Office staff are available as an ongoing resource for administrative issues that may arise during a trainee's affiliation with MSK. The Office is also responsible for conducting an annual review of residents' work hours to ensure compliance with both ACGME and New York State regulations for clinical trainees.

The GME Office is located in room M2101A. The telephone number is 212-639- 6788. Additional information for residents can also be found on the GME OneMSK site, which can be accessed through the Table of Contents>Graduate Medical Education.

Before you start...

Complete online training — your coordinator will assist

- HIPAA
- MSK Required Regulatory Training
- Code of Conduct

MRI training (if assigned to the OR)

1. Log on to Workday
2. Select My Learning
3. Scroll to the bottom of the page to find MRI Safety: Level 1 Training in the table of available certifications
4. Under the MRI course title:
   - Select "Register"
   - Click "Complete Registration"
   - Select "Launch" to begin the course
   - Make sure to select "View Summary" and "Launch" for each of the activities listed. You must complete the first activity before the second can be launched.
5. At the end of the training video you will be instructed to submit a Health Screening Questionnaire to Employee Health Services to document implants, etc.
6. Notify your Program Coordinator that you have completed training and OR access can now be requested
7. Prior to entering the OR:
   - Empty your pockets and place cell phone/pager, other belongings in locker
   - Self-Screen at a wall mounted ferromagnetic detector (FMD)
   - Remember: The MRI magnet *is always on!*

Navigate the Healthcare Information System (HIS):

- There are several computer-based self-paced training modules available via OneMSK:
  - Use this link for GME Courses: https://tinyurl.com/4xvd35j2
  - Additionally, the LIP Resource Library under the "Education" tab includes links to several courses
- For live instructor-led training, submit a Digital Training Request Form at https://tinyurl.com/ktcxphae
- Use your MSK login to access the HIS/CIS System

Your Program Orientation should cover:

- Program supervision and escalation policy — guidelines as to when and under what circumstances to alert supervisors (chiefs, fellows or attendings, etc.). Examples may include changes in patient condition, end-of-life decisions, or disagreement in patient management among health care team members.
- Program handoff procedure — how to safely transition patients to the next care team
- Back-up coverage policy if you are too fatigued to complete your daily assignment

Your Unit Orientation should cover:

- Identity of the unit's nurse leader
- Patient evacuation procedures
- Location of the unit's fire alarm pull stations, fire extinguishers, and emergency exits

Life Safety/Fire Safety

- Emergency telephone numbers are listed on phones.
  To report a fire call Ext. 6000 and activate Fire Alarm pull box
- RACE procedures for evacuation
  - **RESCUE:** Rescue persons in immediate danger
    ALARM: Activate the closest interior pull station.
  - Dial Ext. 6000 to report fire location
  - **CONFINE:** Confine fire by closing doors and windows
  - **EVACUATE: Move horizontally to the next building;**
    move down at least 3 floors, or follow building evacuation plan

- PASS procedures for using a fire extinguisher
  - **PULL** the pin
  - **AIM** nozzle at the base of the fire
  - **SQUEEZE** the handle
  - **SWEEP** from side to side

Report/Receive Critical Values:

- Lab staff will contact the licensed practitioner (as privileged and credentialed) stating patient has critical value
- The licensed practitioner (as privileged and credentialed) reads critical value and two patient identifiers (name and DOB or MRN) back to lab staff or electronically acknowledges critical value through Voalte
- Lab staff confirms value is correct
- Record of notification (licensed practitioner name, number, time and date of notification and acceptance) is documented in the laboratory report
- Refer to Table of Contents>Laboratory Medicine> General Information> Critical Values

Communicate with Staff Wearing Vocera Badges:

- If you receive a page in the form of 4646*XXXXX you have been paged from a Vocera badge
- To return a call, dial Ext. 4646 (onsite) or 212 639-4646. When prompted, dial digits on pager after the 4646
- To initiate a call dial Ext. 4646 (onsite) or 212 639-4646. When prompted say the person or group's name, or enter an extension
- Remember — once you are connected you will be heard through a speaker. If you need to communicate sensitive information, ask the person to call you back via a house phone

File an Electronic Death Certificate in NYS:

- Must be filed electronically by a licensed practitioner (as privileged and credentialed)
- The reporting licensed practitioner must be preregistered in the online system and take online training
- Staff at the Admissions Center can assist physicians in the registration process
- More information can be found in the Policies and Procedures section of this handbook

Safely Use Restraints When Necessary

- Restraints should be used only to provide for the safety of the patient and others after less restrictive measures have been attempted and found ineffective
- Every effort should be made to prevent, reduce and eliminate restraint use
- Refer to the OneMSK for further information on the safe use of restraints. GME webpage>House Staff>Restraint Training for LIPs

SOURCE: Rules and Regulations of the Medical Staff #217

Central Venous Access

- The PICC team is available 9am to 5pm Monday-Friday at Ext. 122-6888 or pager 3596.
- After hours and on weekends, resources are available to establish urgent/ emergent central venous access, via Anesthesia (intraoperative setting), the Department of Surgery, ICU consult, and IR (who respond on weekends for emergent central line placement e.g. patient in blast crisis).

Medically Urgent Transfers Into Memorial Hospital

- All transfers into Memorial should be done only for medically urgent situations.
- The transfer must be medically necessary and the patient's condition must be assessed as stable.
- The availability of active medical intervention at Memorial should be confirmed prior to making a transfer.
- More information can be found in the Hospital Policies and Procedures section of this Handbook

SOURCE: Rules and Regulations of the Medical Staff #104 and 104-B

Reporting of Concerns

- Reporting to Improve Safety and Quality (RISQ) — report actual events and near misses that have the potential to cause harm and instances of incivility as outlined in Rule and Regulation #554. Click the Start Button > MSK Event Reporting > RISQ or click RISQ from Quick Links located in HIS
- Confidential reports of concerns about your training environment can be made by calling Ext. 6788 or submitted through the GME webpage on OneMSK. Click on Confidential Feedback and enter your comment.
- For confidential reporting about Compliance issues, trainees can report their concerns to either the Compliance Hotline: 844-MSK-Line (844-675-5463) or by going to MSKCC.alertline.com/gcs/welcome.

- For consultation and consideration of patient care issues, trainees can contact MSK's Ethics Committee by calling Ext. 8604 (and through CIS for urgent requests).
- Trainees in ACGME-accredited programs can also confidentially report concerns or complaints about their residency education or learning environment to the ACGME. Instructions can be found under the Residents and Fellows section on their website.
- Complaints can also be submitted to the New York State Department of Health. Information can be found on their website: https://www.health.ny.gov/ or by emailing hospinfo@health.state.ny.us.
- Work hours complaints or concerns may also be reported directly to IPRO, a New York State Department of Health contractor responsible for monitoring resident work hours and conditions by using the email account: residenthours@ipro.org.

Remember to wear your MSK ID badge at all times, and return it to your coordinator upon completion of your training.

Find it on OneMSK...

>TABLE OF CONTENTS for links to:

- **ePrescribe Guidelines**
- **Infection Control** — including hand hygiene and information on specific diseases and organisms
- **Look alike/Sound alike medications** — Medication names at a high risk for confusion
- **Language Assistance Program** — Cultural Resources including Translation and Interpreter services and Cultural Awareness tools for delivering culturally competent care
- **Medical Library** — for online references and journals
- **Code of Conduct**
- **Graduate Medical Education** for:
  - Graduate Staff Handbook
  - House Staff Clinical Privileges
  - Duty Hours Regulations and compliance monitoring
  - Recognizing excessive fatigue

>PATIENT CARE STANDARDS AND GUIDELINES

- Go to Clinical Council in TOC.
- Alternatively, go to DIVISION OF QUALITY AND SAFETY (DQS) site and select "Clinical Council" under "Helpful OneMSK Sites".
- Standards and Guidelines may also be accessed by logging into HIS and clicking "Standards and Guidelines" under "Clinical Tools". (e.g., Adult Anticoagulant Therapy Guideline)

>DIVISION OF QUALITY AND SAFETY

- RISQ reporting
- Quality of Care and Patient Safety Plan

>COMPLIANCE HOTLINE for information on how to report concerns confidentially

>ETHICS COMMITTEE for information on when and how to get an Ethics Consult

>REGULATORY AFFAIRS for information on Joint Commission preparation and policy updates

Additional Resource:

>START MENU>MSK CLINICAL REFERENCE MANUALS & TUTORIALS

- Clinical Reference Manuals & Tutorials including Hospital Formulary and Adult (and Pediatric) Chemotherapy and Biologic Therapy Guidelines

Focus on Patients

Quality and Safety Initiatives

The Division of Quality and Safety (DQS) oversees all institutional programs related to patient care quality and safety with the goal of providing the highest quality and safest patient care. To accomplish its mission, DQS is guided by the following:

- Incident Case Review
- Measure and Compare
- Continuous Improvement
- Memorial Hospital for Cancer and Allied Diseases Staff Involvement

With its commitment to promoting a culture of quality and patient safety, DQS provides a path for GME trainees to partner with staff in patient safety and quality improvement.

At MSK, there are numerous patient safety initiatives designed to promote a safe patient journey. Some are listed below, and further information can be found on the Division of Quality and Safety page on OneMSK.

Patient Identification

It is Memorial Hospital policy that all patients be identified prior to provision of care and when providing care or treatment for the patient. **The patient's room number or physical location is never used to identify the patient.** Proper identification of patients requires vigilance, including special attention when ordering medications and treatments, particularly via computerized order entry systems.

- **Patients with Patient Identification Wristband:** Compare the order, specimen label, requisition, etc. with last name and first name observed on wristband and medical record number observed on wristband.
- **Patients without Patient Identification Wristband:** Compare the order, specimen label, requisition, etc. with last name and first name spelled by patient and date of birth stated by patient.

If any discrepancy is determined during these processes, immediate clarification must be determined prior to care, treatment, service or data entry. Please refer to Administrative Policy and Procedure #4509 for additional information.

"Time Out" Procedures

A "time out" procedure to verify patient identity, procedure and laterality is required for all invasive procedures regardless of hospital location. Please refer to Rules and Regulations of the Medical Staff #214 for additional information.

Hand Hygiene

Patients with cancer are at particular risk for hospital-acquired infection. Hand hygiene is the simplest and most effective way to prevent these infections. The leadership of MSK has identified this as a major focus for improving care, and MSK has adopted the World Health Organization (WHO) guidelines to inform this process. Whether staff prefer hand sanitizer or conventional washing, hand hygiene MUST occur before and after patient contact, before an aseptic task, after the risk of exposure to bodily fluids, and after contact with patient surroundings, even if you did not physically touch

the patient. **These five moments of hand hygiene are required without exception, regardless of whether gloves are used or not.**

Please refer to the OneMSK Infection Control Manual, Policy IC.2.3, for additional information.

Infection Control

Memorial Hospital requires employees to observe "Standard Precautions" when caring for all patients. These precautions are designed to reduce the risk of transmission of blood borne pathogens and the risk of transmission of other pathogens from moist body substances. Any questions should be directed to Infection Control at Ext. 7814.

For further information see the Infection Control Manual on OneMSK.

Verbal Orders

Orders for patient care and treatment, including medications, should be placed directly into CIS or on the appropriate document by the licensed practitioner (as privileged and credentialed). Verbal orders for patient tests and treatment shall be used infrequently and shall be accepted and recorded consistent with the scope of practice authorized by applicable New York State license, certification, or registration. The individual accepting the order must promptly record it, including the name of the ordering practitioner. The order should then be read back to the ordering individual to ensure that the order has been recorded correctly. Verbal orders shall be authenticated by the ordering practitioner within 48 hours.

SOURCE: Rules and Regulations of the Medical Staff #204. Medication

Reconciliation

Medication reconciliation is an important National Patient Safety Goal. It refers to the process of documenting a complete list of a patient's current medications, comparing that list against the admission, transfer, and discharge medication orders for the patient, and then eliminating or adding orders to make the current list appropriate to the patient's current condition. The purpose is to avoid errors that are likely at points in the care trajectory when there is a transfer of responsibility for the patient, as well as errors that may occur when more than one care provider is prescribing drugs for a patient. At MSK, all clinicians are expected to obtain an accurate list of all medications that the patient is taking, and review and revise that list when the patient is admitted to, transferred within or discharged from the hospital or is seen during an outpatient visit in which medication may be prescribed.

SOURCE: Rules and Regulations of the Medical Staff #211A

Reducing Patient Falls

Preventing patients from getting injured by a fall is a priority both nationwide and here at MSK. There are a number of things staff can do to prevent falls from occurring:

- Certain medications increase a patient's fall risk, such as hypnotic, anticonvulsant, and analgesic drugs. Order the lowest effective dose to decrease the likelihood of a patient falling.
- Nearly half of patient falls at MSK are related to patients going to and from the bathroom. Encourage patients to call for assistance.
- Leave the bed and side rails in the position in which you found them before examining or treating the patient.

- Report unsafe situations or broken equipment to the nursing or secretarial staff.
- Ensure that patient activity orders are appropriate.

Patients at high risk for falls can be identified by a special yellow wrist bracelet and yellow socks, as well as on the patient information header in CIS.

Error-Prone Medical Abbreviations

Practitioners shall comply with the National Patient Safety Goals and refrain from using error-prone abbreviations in all medical record entries (orders, progress notes, etc.). The following list of error-prone medical abbreviations has been approved by the Medical Board:

NO! Error-Prone Practice	YES! Required Practice
U, u, l, IU	unit(s)
ug, Ug, μg	mcg
QD, Q.D., qd, q.d.	daily
QOD, Q.O.D., qod, q.o.d.	every other day
UD	use as directed
MS, MSO_4	morphine sulfate
$MgSO_4$	magnesium sulfate
B.I.W.	twice weekly or 2 times a week
T.I.W.	3 times weekly or three times a week
SC, SQ, sq, or sub q	subcut, SUBQ or subcutaneous(ly)
OS, OD, OU	left eye, right eye or both eyes
AS, AD, or AU	left ear, right ear or both ears
½ tablet	half tablet
Do not use terminal zeros for doses expressed in whole numbers i.e., **NOT "5.0 mg"**	5 mg
Always use zero before a decimal when the dose is less than a whole number i.e., **NOT ".5 mg"**	**0**.5 mg

Emergency Response

Any employee or staff member who encounters a problem requiring an emergency response at the York Avenue Super Block, David H. Koch Center for Cancer Care, and Josie Robertson Surgery Center, can call Ext. 6000 for assistance.

An emergency response page to the hospital code team or call to Ext. 6000 should be initiated for any person with a life threatening event, or in immediate risk for a life-threatening event (e.g., unconscious, pulseless, apneic, compromised airway, rapidly deteriorating hemodynamic status).

Any employee or staff member who encounters an emergency at any facility other than the York Avenue Super Block should follow the emergency response process specific to that facility.

SOURCE: Medical Staff Rule and Regulation #207

Rapid Response Team

The Rapid Response Team (RRT) is available at all times to assist and provide support in the care of patients, visitors and employees who develop signs of clinical deterioration. Any staff member, patient or visitor may activate the RRT. Activation of the RRT does not require any approval. The RRT may be notified by calling Ext . 6000 within the Hospital and following operator prompts. The operator will activate a page to the appropriate RRT team, who will immediately report to the patient care area.

The RRT will be responsible for responding to acute changes in the health status of patients, visitors or employees that occur on the main campus, which is defined as any MSK facility between the area bounded by York Avenue, 1st Avenue, East 67th and East 69th Street, including the garage. A special Pediatric team will respond to pediatric emergencies.

Criteria for calling the RRT include:

- acute change in heart rate;
- acute change in elevation or decline in blood pressure;
- acute change in respiratory rate or decline in O2 saturation;
- acute change in mental status;
- acute change in motor function;
- clinically significant bleeding;
- status epilepticus;
- patient's failure to respond to treatment for an acute problem or symptom;
- concern or worry about the patient's condition;
- Interventional Radiology Hemoptysis
- Sepsis Alert (CIS initiated) as per Sepsis Screening and Early Resuscitations Protocol Standard;
- Behavioral Rapid Response;
- Acute Coronary Syndrome (ACS) standard (activated by RRT);
- Emergency Intubation (activated by RRT);
- Stroke Alert standard (activated by RRT);
- Initiation of Surgical Airway standard (activated by RRT);
- Pericardial Tamponade workflow (activated by RRT);
- Symptomatic Cord Compression standard (activated by RRT);
- Acute Limb Ischemia standard (activated by RRT);
- Pulmonary Embolism Response team (activated by RRT).

SOURCE: Medical Staff Rule and Regulation #242

Pain Management

When any patient is admitted to the hospital, a pain regimen should be ordered on admission. Several online tools are available on OneMSK to help with this, and can be found via the Splash Page in HIS on the item labeled "Pain Management".

The decision as to which regimen to initiate depends upon:

- whether the patient can tolerate a PO regimen or is NPO, and
- if they are opioid-naïve (i.e. have not been on pain medication prior to admission) or opioid-tolerant.

	Opioid-Naïve No Pre-admit pain meds	Opioid-Tolerant Yes Pre-admit pain meds
Takes PO	**ORAL PRN MEDS**	**CONTINUE PAIN MEDS**
NPO	**IV PRN MEDS (or PCA)**	**CONVERT TO IV PCA**

Under the heading 'Pain Admission Wizard' in the HIS Pain Management Link, you can find more tools. You may also discover supplementary resources in CIS under 'File/Print Reports/Pain Tools'.

For opioid-naïve patients, an around-the-clock dosing regimen with "prn" rescues (oral or intravenous) is recommended as the initial approach for managing frequently recurring or continuous chronic cancer-related pain.

Patients receiving opioid prescriptions for cancer-related pain, especially those with no history of substance abuse, are unlikely to develop addiction. Patient-Controlled Analgesia (PCA) can be prescribed by any service up to a specific maximal dosage. However, a formal pain consultation is required if the dosage exceeds these limits. To ask for a formal pain consult, simply type 'Pain' in the CIS Orders section. For patients on a surgical service, consultation with the Anesthesia Pain Service at beeper 7553 is necessary for all pain indications. For all other patients, , the Supportive Care Service should be consulted at beeper 1694. The CIS order will automatically alert the respective teams upon release.

Opioid-tolerant patients may experience withdrawl symptoms if opioids are abruptly discontinued or naloxone is administered. The pain requirements for such patients are often higher compared to opioid-naïve individuals. If opioid-tolerant patients present with significant pain complaints upon admission, they should be managed in consultation with a Pain Service (type 'Pain' in CIS Orders).

Should pain persist, dosage adjustments can be made until satisfactory relief or manageableside effects are achieved. Before increasing the opioid dose, it is important to carefully assess the patient's sedation level and respiratory status h, especially for those who are relatively opioid-naïve, or require significant opioid escalation. If side effects hinderadequate pain relief with one opioid, switching to another can be considered using online tools. When transitioning from one opioid to another, a dose reduction of 25% of the equianalgesic dose may be necessary, although the online tools accommodate for this adjustment.

For help with converting to intravenous methadone or transitioning from a moderate dose to a high dose of hydromorphone or fentanyl, please consult theAnesthesia Pain Service (beeper 7553) or the Supportive Care Service (beeper 1694) for assistance. Consulting with these services is required in such situations. Additionally, if you encounter restrictions when entering a drug or dose into the Clinical Information System, consulting with a Pain Service is necessary.

Antibiotic Management Program (AMP)

Ensuring appropriate antimicrobial use is important for our patients who are at increased risk for infection while undergoing treatment for their cancer. MSK has a longstanding antimicrobial stewardship program that is committed to working with trainees to optimize the treatment of infections, curb the development of antibiotic resistance, and reduce adverse events associated with antibiotic use through various activities:

- Approval of restricted anti-infective agents
- Follow-up of antimicrobial therapy once it has been started
- Guidance on dose adjustments and duration of therapy
- Review of possible drug-drug interactions
- Review of drug allergies
- Development of institutional prophylaxis and treatment guidelines.

Restricted anti-infective agents require antibiotic approval by paging beeper 1100 between the hours of 9 AM and 5 PM. Between 5 PM and 10 PM, the on-call ID fellow is available for approvals. For night orders (10 PM to 9 AM), "pending approval" can be used in the order, but approval must be obtained via beeper 1100 the following morning after 9 AM if the antibiotic is continued. Beeper 1100 is covered between 9 AM and 5 PM, 7 days a week; the on-call Infectious Disease fellow covers between the hours of 5 PM and 9 AM the next day. For all NON antibiotic approval- related infectious disease questions, please page the ID fellow on call via page operator; they are available 24/7. The AMP can also be reached by email at zzPDL_PHA_AMP. The AMP website, which contains links to the hospital antimicrobial formulary, dosing guidelines, and other resources, can be reached on OneMSK.

Medical Records

Each practitioner who is authorized to make entries in the computerized medical record shall receive a unique identifier code that allows the practitioner to make such entries. The practitioner is expected to understand that his or her unique identifier is as personal as his or her own signature, and the code therefore may be given to and/ or used by no one other than the practitioner to whom the code has been assigned.

Further information on the requirements for proper maintenance of patients' medical records can be found in Rules and Regulations of the Medical Staff #506.

Healthcare Information Systems (HIS)

The Healthcare Information System brings together data about a single patient from many sources and makes the comprehensive information easily accessible to clinicians. HIS is the integrated clinical application which provides the following information for our patients:

- Laboratory, Pathology, and Radiology results
- Surgery events
- Chemotherapy and Pharmacy profiles
- Treatment pathways and guidelines
- Order Management System
- Electronic Order Entry and Electronic Signature
- Electronic Medical Record (EMR)
- Documentation
- Billing

You may schedule a live instructor-led training session by submitting a Digital

Training Request Form at https://tinyurl.com/ktcxphae.

Drug Information: Sources

There are numerous drug information resources at MSK:

Lexicomp Online is a hospital-wide solution which includes the MSK Hospital Formulary. It provides clinicians access to three drug information resources within a single interface:

- Lexicomp — provides clear, concise, point of care drug information, including dosing, administration, warnings and precautions, as well as clinical practice guidelines, and other tools such as Trissel's IV Compatibility Database and UpToDate®. Under Patient Education, clinicians can also print complete patient educational packets with information on medications, conditions, and/ or procedures. Adult- and pediatric-specific medication leaflets are available in up to 19 languages.
- AHFS — offers comprehensive research solution, recognized as a CMS compendium to assist in reimbursement.
- Clinical Pharmacology – ability to find drugs by indication, adverse reaction rates and National Drug Code (NDC).

Access to Lexicomp Online is available to all MSK staff as follows:

1. From the **Start** Menu, go to "MSK Clinical Reference Manuals & Tutorials" » "Hospital Formulary"
2. A link to Lexicomp Online is also available on the Healthcare Information System (HIS) homepage under "Clinical Tools"

The Department of Pharmacy home page contains additional drug information resources that include but are not limited to Micromedex 2 .0, Clinical Pharmacology, AHFS Drug Information, and Trissel's Handbook of Injectable Drugs. These can be found under Drug Policy » Clinical References. For more information, see the OneMSK Pharmacy page.

Mobile Resources

MSK staff also has access to:

- **Lexicomp for mobile devices**
  MSK has a site-wide subscription to Lexi-SELECT, which includes 19 databases.
- **Micromedex 2.0 for mobile devices**
  Includes Micromedex Drug Reference, Micromedex Drug Information, Micromedex Drug Interactions, and Micromedex IV Compatibility.
- **About Herbs app**
  MSK's very own — presented by MSK's Integrative Medicine Service.

The Department of Pharmacy also publishes its own **Adult Chemotherapy & Biologic Therapy Guidelines**, the **Pediatric Chemotherapy Guidelines**, the **Pediatric Medication Guidelines**, and **Parenteral Medication Guidelines** *(formerly* known as the IV Medication Guidelines). These can all be accessed via the "**Start**" button » "MSK Clinical Reference Manuals & Tutorials"

The Drug Policy Management group of the Division of Pharmacy Services consists of Pharmacy Managers and Clinical Coordinators who can answer questions on drug

policies, guidelines, Pharmacy & Therapeutic committee actions, or drug information specific to clinical use in MSK. Phone numbers are 646-888-1048, 646-449-1007 or 646-888-0985.

Language Assistance Program

MSK is committed to respecting the communication preferences of all patients, caregivers and visitors by providing free interpretation and translation services to limited-English proficient (LEP) individuals, and accommodation to patients with vision, hearing, and speech impairment.

Patients are asked by Patient Access Service and Patient Financial Service staff at the time of their initial contact to indicate their preferred language for discussing health care. This is documented in Cadence (the scheduling system) and in RMS (the registration and inpatient billing system), and it appears on the patient information tab in the Clinical Information System.

MSK has a robust Language Assistance Program staffed by full-time, freelance and agency professional medical interpreters for interpretation and translation services. In addition, there are a number of resources available to frontline staff to ensure we communicate with patients in their preferred language:

- To request an in-person interpreter, email interpreters@mskcc.org or place a CIS order. When emailing, please include patient name, MRN, language, provider name, date and time, location, and estimated length of the encounter in your request. On demand telephone and video interpretation services are available 24/7, established for internal use only.
  - Propio is MSK's primary partner for all on demand telephone and video interpretations services. To access, download the Propio One mobile application, call (646) 506-3897, or go to ONE.PROPIO-LS.COM on any web browser. If prompted, enter access code MSK123.
  - For more information on how to access additional phone and video service, please visit the Language Services OneMSK page or reference the details in Administrative Policy and Procedure #3002.
- Language Services supports requests for translation of vital documents such as medical records and reports, clinical forms, letters, instructions and more. To make a request, email interpreters@mskcc.org with an electronic copy of the document.
- For educational resources specifically, many are available in Spanish, Russian and Simplified Chinese through Patient & Caregiver Education on OneMSK. Requests can be made to translate documents for future use by emailing Patient & Caregiver Education.
- Consents and other documents, including the patients' Bill of Rights, are available in Spanish and Russian (the predominant languages among our patients whose primary language is not English).
- Clinicians, trainees/students, and other members of MSK with fluency in a patient's preferred language are encouraged to participate in the voluntary MSK Bilingual Competency Program (BCP). The BCP provides an opportunity for staff to assess their ability to communicate with patients in a language other than English. Verified individuals are able to communicate directly with patients under the specifications of their job description, but may not use their identified language for medical interpretation for other staff members in clinical areas.

Optimal patient/caregiver communication is enhanced by (and may depend critically upon) use of a patient's preferred language. Effective patient/caregiver communication has been linked to an increase in patient satisfaction, better adherence to treatment recommendations and improved outcomes. Research has shown that effective patient/caregiver communication is necessary for patient safety.

SOURCE: Administrative Policy and Procedure #3002.

Protected Health Information (PHI)

Disposal of protected health information:
Use locked bins marked Confidential Document. PHI includes:

- patient arm bands
- specimen labels — individual or sheet
- Lab specimen forms
- IV bag or medication container label
- post-it notes with patient name or MRN
- X-ray, CT Scan, MRI or other films
- CD with medical records or radiology images

Storage of protected health information:

- All PHI should be stored on a MSK network drive (not computer hard drive) to be securely maintained.
- Storage on portable devices such as laptops and USB drives is prohibited
- PHI must not be sent to personal email accounts

Resident Fatigue: Prevention, Identification and Management

Scientific evidence supports that long hours and sleep loss have a negative effect on resident performance, learning and well-being. Fatigue and its impact on patient care and safety is particularly pressing at Memorial, given its unique patient population with high patient acuity and service intensity.

Both NYS and the ACGME limit resident work hours and regularly monitor the Hospital's compliance with work hours restrictions. The ACGME also requires all training programs to educate faculty and residents to recognize the signs of fatigue and adopt and apply policies to prevent and counteract the potential negative effects.

Working more than 80 hours per week is correlated with a greater likelihood of personal accident or injury, serious conflict, mood disturbances, significant medical error, weight change, and the increased use of alcohol and other medications "to cope."

Sleep deprivation results in adverse physiologic changes and it impairs cognitive processes resulting in diminished attention, concentration, vigilance, decision making and memory. It increases tolerance for risk, decreases empathy and motivation for learning and contributes to medical errors.

Symptoms of sleepiness include yawning and nodding off during conferences; "microsleeps" — a few seconds of "sleep" that the "awake" resident may not even recognize; increased tolerance for risk; passivity or irritability; inattention to detail; decreased cognitive function and increased errors.

Too little sleep or disrupted sleep are common reasons for fatigue among medical trainees. Additionally, the anxiety of being on call and/or the anticipation of sleep interruption can impair sleep and lead to fatigue. However, people may also display symptoms of "fatigue" or attribute symptoms to fatigue when the etiology is in fact anxiety, depression, stress, burnout or career dissatisfaction.

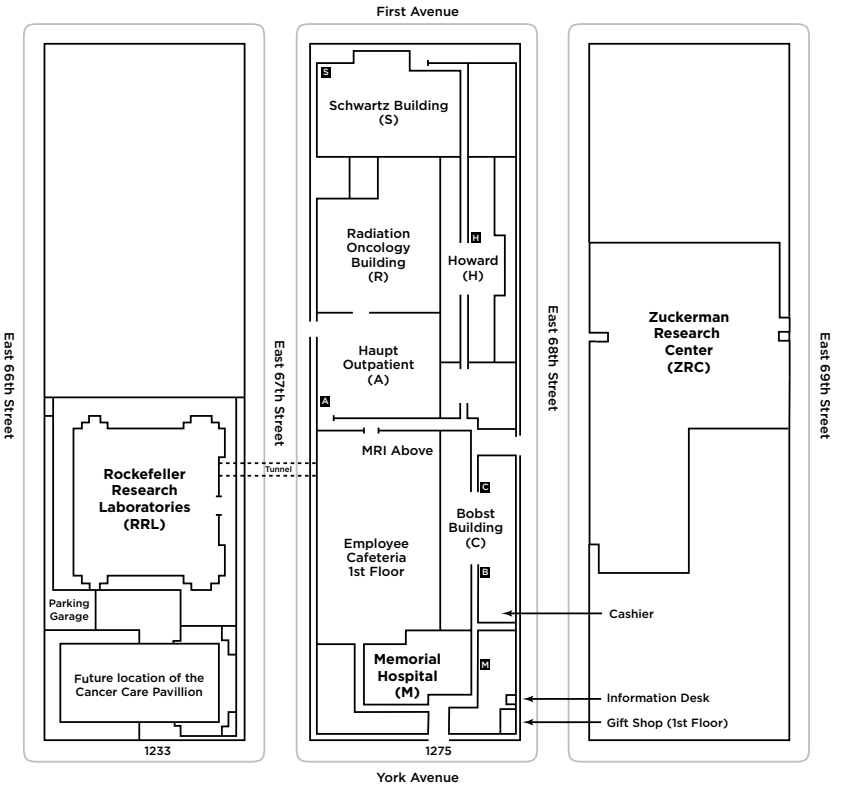
Learning to recognize and manage fatigue is essential for all professionals. Part of the management of fatigue is learning to work efficiently, to leave work as is already required, and to set priorities for "time off" pursuits such as professional reading, family and friends, hobbies, sport or exercise, and spiritual and community connections.

Concerns about excessive service demands or excessive fatigue, either in oneself or in one's colleagues, must be reported to the Training Program Director or Chief Resident or fellow. They are responsible for mitigating excessive service demands or fatigue by adjusting residents' schedules, and for ensuring that back up support systems are in place.

Confidential reports of concerns about your training environment can also be submitted through the GME webpage on OneMSK. Click on Confidential Feedback and enter your comment.

Specific information on work hours restrictions at MSK is presented in the Professional Conduct section of this handbook.

MSK Main Campus Maps



Elevator Banks

- S Schwartz
- H Howard
- A Outpatient
- C B Bobst
  The Security Office is located in the basement level of the Bobst Building. Take elevator B or C to the basement level or staircase A down and follow signs to the Security Office.
- M Memorial

Phone Numbers of Interest

Memorial Hospital phone numbers: 212-639-XXXX.
From inside the Hospital, you can dial 7, then the last 4 digits directly.
To dial out, press 9 then 1 (area code) + number.

Name	Numbers
GME Office	6788
Help Desk	646-227-3337
Housing Office	646-888-8403
Employee Health Services	646-888-4000
Ethics Consults	8604
HR Resource Center	646-677-7411
Legal Affairs	646-227-2100
Compliance	646-227-2622
Operator	212-639-2000
Page Operator Inside	7886
Page Operator Outside	212-639-7900
Telecommunications	2534
EMERGENCY	**6000**
Rapid Response Team	6000
Fire Emergency	7850
Security	7866
Admitting	7841
Bed Board	7881
Anesthesia	8118
Clinical Information	2887
Nursing Office	6895
Adult Day Infusion	6888
Private Duty Nursing	6892
O.R. Scheduling	5922
O.R. Control Room (A634)	5924
Pathology	5905
Patient Condition Information	7081
Patient Representatives	7202
Pharmacy	
Inpatient – M12	8476
Inpatient – M18	3764
Outpatient	646-888-0730
Radiation Oncology Consult	6809
Radiology	7298
CT Body	8318
MR Body	8063
Neuroradiology	2361
Nuclear Medicine	7377
Interventional Radiology	7946
Social Work	7020
Spiritual Care	5982
Urgent Care Center	7203

Laboratories

EKG	7096
Hematology	7058/59
Microbiology	7806
Pulmonary Function	8492
Urinalysis	646-608-1080

Patient Floors/Nursing Stations

2nd Fl. Dialysis Unit	6836
4th Fl.Nurses Stationl	6920
5th Fl.Nursing	6924
6th Fl. O.R. Rooms A 634	5924
6th Fl. Post-Anesthesia	7566
8th Fl. Nursing (Medicine BM)	6938
9th Fl. Pediatrics Outpatient	5948
9th Fl. Pediatrics Nurses Station	6911
Neurology Nurses	6975
10th Fl. Nursing (Breast & Gyn)	6934
12th Fl. Nursing (Medicine)	6942
14th Fl. Nursing (Surgery)	6946
16th Fl.Nursing (Gastro)	6954
17th Fl. Nursing (Surgery)	6930
18th Fl. Nursing Station	6987
19th Fl. Nursing (VIP)	6300

Education Offices

Anesthesia & Critical Care	6673
Medicine	5809
Medical Physics	8740
Neurology	6340
Neurosurgery	8557
Pathology & Laboratory Medicine	7456
Pediatrics	5966
Psychiatry	646-888-0200
Radiation Oncology	6800
Radiology	3383
Surgery/Urology	7537

Professional Conduct

Licensure Requirements

Consistent with New York State (NYS) requirements, Memorial Hospital's licensure policy for trainees differs based on the individual training program's accreditation agency and/or status. However, individual training programs are permitted to establish a program-specific licensure policy requiring a higher level of licensure than that required under the general policies below. Inquiries about an individual program's licensure policy should be directed to either the Training Program Director or the Program Coordinator.

Trainees in ACGME-Accredited Programs
Memorial Hospital does not require licensure for residents or fellows training in programs accredited by ACGME unless otherwise specified by the Training Program Director. This applies to both full-time and rotating house staff.

Trainees in Programs NOT accredited by the ACGME
All residents and fellows enrolled in training programs which are not accredited by ACGME must have either a NYS license or limited permit. The only exception applies to out-of-state rotating fellows who are 1) licensed in their home state and 2) scheduled to be at Memorial for less than 6 months. Fellows in non-ACGME-accredited programs meeting both criteria are exempt from the requirement for NYS license or limited permit. Rotating fellows will be defined based on the position they hold at their home institution in conjunction with their delineation of privileges while at Memorial Hospital.

For work outside the scope of the training program
All residents and fellows who work outside the scope of their training program must have a full NYS license. Limited permits are not acceptable.

Additional Requirements
A copy of the license/limited permit must be sent to the Graduate Medical Education Office for inclusion in your record.

Trainees must inform NYS Office of the Professions of all address changes. It is the responsibility of the trainee to renew his/her license or limited permit on a timely basis and send a copy of such renewal to the Graduate Medical Education Office.

National Provider Identifier (NPI)

All house staff (licensed and unlicensed) are required to obtain an NPI number. This number is required by HIPAA regulation to identify health care providers on patient medical records and prescriptions; prescriptions submitted to a retail pharmacy without an NPI number will be rejected.

To apply, please complete the online application at nppes.cms.hhs.gov.

Note: you must have a U.S. Social Security number to apply for an NPI number. If your SSN is pending, you will be able to apply for your NPI number after you start your training program.

DEA Number

If you do not have your own Federal DEA Number (registered with your full New York License) the GME Office will assign a suffix of MSK's Institutional DEA number for your use

MEMORIAL HOSPITAL DEA#: AM5712472 ____(suffix)

Full-time trainees licensed in the state of NY may be required to obtain their own Federal DEA Number. Please verify directly with your Program Coordinator or Training Program Director. For information contact the DEA at 1-800-882-9539 or complete the online application (Form 224) on their web site: https://www.deadiversion.usdoj.gov/drugreg/registration.html

Health Commerce System (HCS) Account for I-STOP Compliance

New York State requires physicians to have their own HCS account to consult an online Prescription Monitoring Program Registry (PMP) prior to prescribing schedule II, III and IV medications. Trainees should check with their Training Program Director or Program Coordinator to determine whether a personal HCS account will be required.

Mandatory Prescriber Training

Pursuant to Public Health Law §3309-a(3), individuals licensed to prescribe controlled substances, as well as medical trainees who prescribe controlled substances under a facility DEA registration number, must complete approved course work or training in pain management, palliative care and addiction. Course work or training must be completed every three years. The New York Chapter American College of Physicians offers a course for a small fee at www.scopeofpain.org/core-curriculum/online-training/. A free course is offered by the University at Buffalo at https://pharmacy.buffalo.edu/academics/continuing-education/events/opioid-prescriber-education-program.html A copy of your certificates of completion must be submitted to your MSK Program Coordinator.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

All Memorial Hospital graduate staff shall maintain the confidentiality, privacy, security and availability of all protected health information in records maintained by the Hospital in accordance with any and all health information privacy policies adopted by the Hospital to comply with current federal, state and local laws and regulations, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). All trainees are required to complete HIPAA training.

All materials containing patient information are considered confidential and must be discarded in an appropriate secure manner. Paper documents should be discarded in secured Confidential Document Bins. Consult with clinic staff for proper disposal of other materials or return to patient. Examples of items containing protected information include: stamped chart pages, patient room card, patient arm band, post-its with patient name or MRN, fax with clinical information, X-ray, CT scan, MRI or other films, specimen labels (individual or sheet), lab specimen forms with patient name, IV bag or medication container label, CD with medical records or radiology images.

Storage of confidential patient information on portable electronic devices such as laptops and USB drives is prohibited. All such information should be stored on a Memorial network drive (not the computer hard drive) in order to maintain adequate security.

Professional Liability Insurance

Memorial Hospital provides professional liability insurance for its employed house staff while acting within the scope of their employment for duties as assigned by their department. This professional liability insurance coverage applies to covered loss events that occurred during their employment at Memorial Hospital but were unknown and not submitted as claims until after their employment ended. Rotating house staff should check with their institution to determine insurance coverage.

If you have any questions concerning this coverage or are named as a defendant in a malpractice action, contact the Office of General Counsel at 646-227-2100.

Communications

Each member of the Graduate Staff is entitled to an E-mail address. Pagers are assigned depending on service needs prior to arrival and are available for pick-up in Telecommunications. Pager numbers are listed in the MSK online directory. Pagers must be returned in working order upon termination of employment. Graduate staff will be subject to penalty if pagers are broken or misplaced.

Training in the Identification and Reporting of Child Abuse

All trainees are required to complete course work or training in the identification and reporting of child abuse. Graduates of medicine and osteopathic programs in NYS after September 1, 1990 are credited with having completed this course work as part of their curricula and are not required to take an additional course. The course is offered on-line at www.elearnonline.net. Select "Course Offerings" from the top menu, "New York" under State Mandated Courses, then choose NYS Child Abuse: Identification & Reporting". The GME Office requires copies of certificates of completion for this course.

New York State Law requires that all professional hospital personnel report cases of suspected child abuse or neglect to the New York State Central Registry for Child Abuse and Maltreatment when there is reasonable cause to suspect that a child, seen before them in their professional capacity, is abused or neglected. It is important to note that the law does not require certainty before reporting. A person who participates in good faith in making a report is protected from any liability, civil, or criminal, that might result from the action. However, willful failure to report a case of suspected child abuse or neglect by a person who is required to report, is a Class A misdemeanor.

SOURCE: Administrative Policy and Procedure Manual #2101

Training in Infection Control

All trainees are required to complete training in Infection Control once every four years. The course is offered on-line at www.elearnonline.net. Select "Course Offerings" from the top menu, "New York" under State Mandated Courses, then choose "Mandated NYS Infection Control Training for Healthcare Professionals". The GME Office requires copies of certificates of completion of this course.

Work Hours Policies

New York State Hospital Code 405.4(b)(6) regulates the average number of hours a house officer, with inpatient care responsibilities, is allowed to engage in training activities. A copy of the relevant section of the Hospital Code is available through the GME Office. Separately, the ACGME has requirements on duty hours for trainees in all ACGME accredited training programs.

There is a limit of 80 hours for a trainee's scheduled workweek averaged over a four-week period and inclusive of all in-house call and moonlighting. Additionally, time spent on patient care activities while on at-home call must also count towards the 80 weekly limit.

Assigned work periods shall not exceed 24 consecutive hours. An additional 3 hours may be used as transition time, with no new patients assigned to the trainee during that period. Trainees must also be provided one 24-hour period of scheduled non-working time per week.

There must be non-working periods of no less than 8 hours scheduled between duty periods, with 10 hours recommended. For residents in ACGME-accredited programs, a non-working period of no less than 14 hours must be scheduled following 24 hours of in-house duty. Fatigue mitigation strategies, especially after 16 hours of continuous duty and between the hours of 10 PM and 8 AM, are recommended. Information is provided in the Handbook section "Resident Fatigue: Prevention, Identification and Management".

All moonlighting or dual employment by residents and fellows outside the scope of their training program must be pre-approved and continuously monitored by the program director, and any such hours worked must be counted towards the 80 hour limit.

MSK conducts regular internal audits of resident work hours to monitor compliance with New York State and ACGME regulations. The ACGME also monitors work hours during site visits.

See also "Moonlighting Policy".

Confidential Reporting of Educational and Work Environment Concerns

If residents or fellows have concerns about compliance or other potentially sensitive issues, there are many avenues within the Hospital where these concerns can be reported. Where confidentiality is not an issue, trainees are encouraged to discuss concerns with any of the following: their training program director; the Chief Resident or Fellow; the GME Office; or the Chair of the GME Committee, Dr. Kay Park. For confidential reporting, trainees can report their concerns to either the Compliance Office or Compliance Hotline: 844-MSKLine. The MSK Compliance Hotline is available 24 hours a day, every day of the year. It is managed by an outside company that specializes in hotline services. All calls are confidential and callers are not required to identify themselves. Additionally, trainees can submit a concern online at mskcc.alertline.com/gcs/welcome. MSK has policies that protect callers' confidentiality and that protect against retaliation by another staff member. Additional information can be found on the Compliance Hotline website or by calling the Compliance Office at 123-2622 (646-227-2622).

Trainees can confidentially report concerns or complaints about their education or learning environment to the GME office via the "Confidential Feedback" link on the GME page of OneMSK.

Trainees in ACGME-accredited programs can also confidentially report concerns or complaints about their residency education or learning environment to the ACGME. Instructions can be found under Residency Services on their website.

Complaints can also be submitted to the New York State Department of Health. Information can be found on their website: www.health.state.ny.us/nysdoh/hospital/key.htm or by emailing hospinfo@health.state.ny.us.

Work hours complaints or concerns may also be reported directly to IPRO, a New York State Department of Health contractor responsible for monitoring resident work hours and conditions, by using the email account: residenthours@ipro.org.

Conflict Resolution

When conflicts arise regarding the care of patients, the Patient Representative Department (Ext. 7202) should be contacted for assistance in resolution.

A Patient Representative will involve appropriate administrative, clinical and/or legal staff.

Ethics Committee

MSK's Ethics Committee will provide consultation and consideration of patient care issues that involve ethical dilemmas. Consultation may be requested by anyone involved in the care of patients. Requests can be made by submitting an Ethics Consultation order with CIS or by calling the ethics consultation service at 212-639- 8604. Patients or families who wish to consult the Ethics Committee may do so directly by submitting an Ethics Consultation within the MyMSK Patient Portal or by calling 212-639- 8604. Any ethics consultation order requested within CIS or on the telephone will become part of the patient's medical record.

During evening and weekend hours, requests should be made to the Nursing Supervisor who will contact the Administrator-On-Call when appropriate.

For more information go to OneMSK>Table of Contents>Ethics Committee.

SOURCE: Administrative Policy and Procedure #3003

Supervisory Responsibilities of Trainees

As part of a trainee's professional development, each resident is expected to assume an appropriate degree of responsibility for the teaching and supervising of other residents and students. The level of supervisory responsibility is determined by each program's Training Program Director. Trainees in MSK-sponsored fellowship programs who hold full licensure in New York State may be jointly appointed both as members of the Graduate Staff and as Instructors. Their primary privileges and responsibilities are those of Graduate Staff members as outlined in their Delineation of Clinical Privileges. Instructor status will be utilized at the direction of each Training Program Director as appropriate.

Gifts From Patients or Vendors

At all times, MSK staff provide patient care that meets the highest clinical, professional and ethical standards, in accordance with MSK's respect for patients' rights, as well as with all applicable Federal and New York State law. The following guidelines specifically govern the solicitation and acceptance of gifts from patients or vendors. Any staff member with questions about how to apply this policy should contact the Compliance Officer at 646-227-2622 or compliance@mskcc.org.

a. MSK staff members may not solicit donations or accept gifts of cash or cash equivalents (i.e. personal checks, gift cards) from patients. Patients who wish to make a contribution or donation should be directed to the Office of Development at 646-227-3549 or devgads@mskcc.org. Patients may identify the specific program to which they would like their contribution applied, as long as use of the funds is consistent with institutional goals and policies.
b. Gifts of cash and cash equivalents (such as gift certificates) should be politely declined. If the gift cannot be declined (i.e. patient left gift when employee was not available), the MSK staff member who received the gift should consult with their manager as soon as possible.
c. MSK staff members are discouraged from accepting gifts from patients, though there are limited circumstances under which non-cash gifts of modest value may be accepted.
d. Gifts of significant value should be politely declined. On occasion, situations may arise in which the greater good of the institution would be served by not offending the patient. Such instances should be reported to the Compliance Officer. No gift may be accepted if it is intended by the patient to gain access to specific medical services.
e. MSK staff members may not accept any gift or gratuities from industry, including cash or cash equivalents; gifts that serve a purely personal benefit (e.g., tickets, CD's); business novelties or promotional materials (items with company logo); drug samples or coupons; or financial or in-kind support for MSK sponsored meetings.
f. Meals or receptions hosted by industry at professional or educational meetings are acceptable as long as they are modest, infrequent and conducted in a way that is conducive to exchange of information and there is a bona fide scientific, educational or business collaboration purpose for the meeting.
g. Fellows and residents may accept industry support for travel as long as an appropriate MSK staff member selects the meeting and the individual(s) who will attend the meeting.

More information related to gifts from patients can be found on the compliance OneMSK site, which can be accessed through the Table of Contents>Compliance or mskcc.sharepoint.com/sites/pub-Compliance

SOURCE: COMP-C004: Gifts from Patients to MSK Staff, COMP-C002: Policy for Interaction with Industry

The Impaired Physician

Recognizing Physician Impairment

A presentation on recognizing physician impairment including substance abuse and fatigue is given by an MSK attending psychiatrist during the annual Graduate Staff Orientation program. Topics covered in this lecture include: the definitions of impairment; signs and symptoms of acute fatigue and intoxication and withdrawal; behaviors of the intoxicated and otherwise impaired physician; late stage personal, legal, professional, family and societal consequences of substance abuse and other untreated impairments; New York State reporting requirements for impaired physicians; and the process of and success of rehabilitation programs for impaired physicians. Information on fatigue prevention, identification and management can be found under the "Patient Safety" section.

Psychiatric Evaluation and Treatment of Resident Physicians

Residents have access to a comprehensive support network through the Employee Assistance Program (EAP) which includes onsite psychotherapy services provided by Dr. Penni Morganstein and a dedicated psychologist, Dr. Chanchal Sharma through the MSK Employee Health Services. Additionally, Employee Health providers are adept at assessing physician impairments related to medical and mental health challengs, as well as substance misuse.

For more information about the EAP program and available services, residents can visit magellanascend.com or call 800-327-8793. For information about Dr. Penni Morganstein and her services, residents may contact her directly at 917-968-6379

MSK is committed to adhering to all New York State Office of Professional Conduct regulations regarding the reporting of physician misconduct including impairment secondary to dementia, substance abuse and other mental illnesses.

Guidelines on the Management of Resident Physician Impairment

- Residents attest to having no physical or mental impairment (including substance abuse and dependence) that will interfere with their work performance when they apply for appointment to the graduate staff.
- Residents are provided information about physician impairment, including substance abuse, by an attending psychiatrist during the annual incoming Graduate Staff Orientation.
- During the Graduate Staff Orientation program, residents are told to self-report impairment, including substance abuse, to their Training Program Director. Residents are advised to report suspected impairment in their colleagues to their Training Program Director and/or Department Chairman.
- Training Program Directors have been advised by memorandum and at the Graduate Medical Education Committee meetings to report suspected impairment, including substance abuse, to the Chairman of the Graduate Medical Education Committee and/or to the Physician-in-Chief. The Physician-in-Chief assures that reporting of impaired physicians meets New York State Office of Professional Conduct requirements (including evaluation, monitoring, psychiatric treatment/ rehabilitation, and back-to-work clearance).
- Consistent with HR Policy 208 (Substance Abuse), anyone who observes a trainee on the premises acting in a manner that indicates the individual may be violating this policy should refer the matter to the program director, GMEC

Chair, GME Director, or if after hours, the Administrator-On- Call. If Employee Health is open, the trainee may be escorted for evaluation. If Employee Health is closed, the Administrator-On-Call will determine whether or not to refer the individual to the UCC.

Americans with Disabilities Act

Memorial Sloan Kettering Cancer Center is committed to complying with all applicable laws including the ADA regulations. If you have any questions or concerns regarding ADA, please call the HR Resource Center at 646-677-7411.

Policy Against Harassment and Discrimination

MSK is committed to a work environment in which all individuals are treated with respect and dignity. Everyone has the right to work in a professional atmosphere that prohibits harassment, discrimination and retaliation. MSK expects that all work relationships among employees or between employees and persons outside the institution will be business-like and free of discrimination, harassment and retaliation.

An employee who believes he or she is being harassed, discriminated and/or retaliated against should inform the individual who is the source of the perceived harassment, discrimination and/or retaliation that the employee is offended by the behavior and request that it be stopped If, for any reason, the employee does not feel comfortable discussing the perceived harassment, discrimination and/or retaliation directly with the individual who is the source of the perceived conduct, or if the employee has requested that the behavior stop and it has not stopped, the employee should immediately report the conduct to his or her manager, any other management-level employee of MSK, an Employee Relations Advisor, any representative of the HR Legal & Regulatory Affairs Department or the MSK Compliance Hotline (844-MSKLine or mskcc.alertline.com/gcs/welcome). Employees may also complain verbally or in writing by submitting a complaint using the Workplace Harassment complaint form available on OneMSK. There is no requirement to use the complaint form.

If the harassment, discrimination and/or retaliation complaint is reported to someone other than a representative of the Human Resources Department, the individual hearing the complaint must report it to an Employee Relations Advisor or the HR Legal & Regulatory Affairs Department. The HR Representative will promptly and thoroughly investigate the complaint, ensuring confidentiality to the extent possible throughout the investigation process. The investigation may include individual interviews with parties involved and, where necessary, with individuals who may have observed the alleged conduct or may have other relevant knowledge.

Based on the findings of the investigation, the HR Representative will recommend appropriate action, if any, to be taken. Such action may include training, referral to counseling and/or disciplinary action, such as a warning, reprimand, withholding of a promotion or pay increase, reassignment, temporary suspension with or without pay, or termination of employment, as MSK determines is appropriate under the circumstances.

An HR Representative, in connection with appropriate management, will inform both the employee complaining of harassment, discrimination and/or retaliation and the individual alleged to have engaged in said behavior of the results of the investigation, and will ensure that any agreed-upon action is carried out.

MSK prohibits retaliation against any individual who reports harassment or participates in the investigation of such reports.

SOURCE: HR Policy Manual #102

Equal Opportunity/Affirmative Action

Memorial Sloan Kettering Cancer Center's ongoing commitment to equality, diversity and inclusion entails creating an atmosphere where our people can perform at their very best and providing equal opportunity to all employees and applicants. Furthermore, MSK is committed to taking affirmative steps to promote the employment and advancement of minorities, women, persons with disabilities, and protected veterans. Every year, MSK develops affirmative action programs to support its commitment to equal employment opportunity, consistent with MSK's policies and obligations as a federal contractor.

It is MSK's policy to provide equal opportunity, in accordance with all applicable federal, state and local civil rights laws, to all of its employees and applicants for employment without regard to race, color, religion, creed, gender, age, sex, national or ethnic origin, marital, caregiver, familial or partnership status, sexual orientation, actual or perceived gender identity or expression or transgender status, pregnancy, sexual and reproductive health choices, citizenship status or alienage, disability, status in the uniformed services of the United States (including veteran status), credit history, unemployment status, genetic predisposition or carrier status, status as a victim of domestic violence, sexual violence or stalking, arrest and conviction record or any other category protected by applicable law of qualified persons consistent with MSK's Affirmative Action Program. Equal employment opportunity applies to all terms and conditions of employment, including but not limited to hiring, classification, promotion or transfer, discipline, discharge, layoff, compensation, job training, and benefits.

Any complaint of discrimination or harassment based upon race, color, religion, creed, gender, age, sex, national or ethnic origin, marital, caregiver, familial or partnership status, sexual orientation, actual or perceived gender identity or expression or transgender status, pregnancy, sexual and reproductive health choices, citizenship status or alienage, disability, status in the uniformed services of the United States (including veteran status), credit history, unemployment status, genetic pre-disposition or carrier status, status as a victim of domestic violence, sexual violence or stalking, arrest and conviction record or any other category protected by applicable law is to be referred immediately to an employee's manager or an Employee Relations Advisor. The employee's manager must immediately inform an Employee Relations Advisor of all discrimination complaints; however, employees also may bring their complaints directly to any Employee Relations Advisor or any other management-level employee for appropriate action. In accordance with the Policy against Harassment and Discrimination, such matters will be treated confidentially, and there will be no retaliation against any employee who brings or is involved in a complaint. For more information on the complaint procedure, employees may refer to MSK's Policy against Harassment and Discrimination, HR Policy 102.

All MSK employees have the right to use restroom and locker room facilities based on and consistent with their chosen gender presentation, and to use the name and pronouns of their choosing, provided that all legal employment records, including but not limited to payroll and insurance documents, must match an employee's legal name.

In accordance with applicable laws, MSK is also committed to affirmative action in the employment of qualified disabled individuals, qualified disabled veterans and veterans covered by the Veterans Employment Opportunities Act.

MSK's EEO policy, as well as its affirmative action obligations, includes the full and complete support of MSK, including its Chief Executive Officer.

SOURCE: HR Policy Manual #101

Social Media Rules for Employees

All online communication by MSK employees or their representatives and/or vendors are subject to all of our Policies and Procedures, such as the Code of Conduct, our Policy on Electronic Communications, the Information Systems Handbook, our media procedures, HIPAA regulations and all other relevant policies, including federal copyright laws. If you are communicating online and endorsing MSK or its activities in an advertisement, testimonial or similar context, you must disclose your affiliation with MSK (even if your communication is not part of your official work responsibilities). MSK activities include patient care, biomedical and related research, clinical trials, drug development, and education and training programs. When communicating in these situations, you should make it clear that you are speaking for yourself, and not on behalf of MSK. If you comment or post on MSK's Facebook page (beyond just "liking" an item), you should identify yourself as an employee if you haven't already done so in your public profile.

Other common sense advice:

- Never use a pseudonym or "anonymous" account when commenting on MSK's Facebook page or other MSK social media channels
- Always maintain confidentiality. Make sure that you do not disclose any confidential or proprietary information about MSK's activities, such as intellectual property, trademarked information, or protected health information (PHI) that is subject to HIPAA. The posting of harassing, discriminatory, and/or defamatory material in violation of our policies against harassment and discrimination can result in disciplinary action up to and including termination of employment.
- Do not use your MSK e-mail address when expressing your views and opinions online.
- Our logos and names belong to the organization. You should not use MSK's name, the official logos of MSK, the Sloan Kettering Institute, or the Gerstner Sloan Kettering Graduate School of Biomedical Sciences, or any related marks or images to promote or endorse any product, cause, political party, or candidate.
- MSK employees are discouraged from connecting with their patients online unless the relationship existed before their treatment at MSK.
- Physicians should exercise caution when posting comments online that may be considered medical advice, and should note that these comments can be subject to liability.
- Before sharing any MSK information, first make sure that it has already been made public by MSK. When doing so you must also disclose your affiliation with Memorial Sloan Kettering. If you have any questions about whether certain information has been released to the public, contact Marketing & Communications.
- Remember that social media is very public – and it's forever. If you would not want your manager, others at MSK, or another potential employer to see your comments, you should not post them on the Internet.

See more on OneMSKMarketing & Communications>Social Media Guidelines for Employees

Compliance Program

Memorial Sloan Kettering Cancer Center's Compliance Program ("Compliance Program" or "Program") underscores MSK's commitment to the principles and standards of how we conduct business, including compliance with all federal and state laws and MSK's own policies. The goal of the program is to reduce or eliminate the likelihood of errors or situations that are considered improper, or that give even an impression of impropriety.

Under the Compliance Program, all persons associated with MSK, including employees, Board members, volunteers as well as vendors and subcontractors who do business on our behalf are expected to act in good faith and with their best efforts to comply with those parts of the Program that apply to their job specific duties, including supervisory responsibilities. The Compliance Program is intended to provide staff with accurate guidance regarding applicable laws and regulations. MSK staff should rely on and comply with that guidance in their day-to-day job responsibilities. In doing so, MSK staff will be appropriately fulfilling their compliance duties.

The Compliance Program is overseen by the Joint Audit and Compliance Committee of the Board of Managers who has delegated responsibility for management of the program to the Senior Vice President, Chief Risk Officer. The institutional Code of Conduct describes the governing values and standards for conduct for everyone associated with the Center.

As part of its commitment to ethical and legal conduct, any MSK employee or individual performing work on behalf of MSK who has a concern about the propriety or ethics of the work is obligated to report it. Available resources for reporting concerns are management staff, the Compliance Department, Human Resources, Patient Safety or the MSK Hotline, which provides an anonymous reporting option.

MSK's policies on non-retaliation and confidentiality protect those who report their concerns in good faith. The identity of the person who makes a report will only be revealed if it is absolutely required to conduct the investigation and will be revealed only to those who have a clear need to know.

MSK does not employ or contract with individuals or entities who have been excluded from federal health care program reimbursement. A check on exclusion status is performed on all prospective and current employees, vendors, and referring clinicians. Individuals who are excluded or have reason to believe they are at risk of being excluded must report this information immediately to the Compliance Department.

The Compliance Program provides training to staff on compliance topics periodically and ad hoc, as needed. The Program also responds to staff questions and reports of non-compliance, conducts audits, and ensures prompt and effective resolution of any problems identified.

Procedure

- To report instances of known or suspected non-compliance: The employee must immediately bring such information to their supervisor or to the attention of the SVP, Chief Risk Officer (123-2955). Anonymous reports can be made by calling the MSK Hotline at 844-MSK- LINE (844-675-5463) or on-line at MSKCC.alertline.com/gcs/welcome.
- To ask questions about the Compliance Program: Employees can consult the Program's website on OneMSK or call the Compliance Office directly (123-2622).

- To report exclusion or risk of exclusion from federal health care programs: The employee must immediately inform their supervisor or the SVP, Chief Risk Officer (123-2955).

SOURCE: Administrative Policy and Procedure #2309

Training at MSK

Accreditation Council on Graduate Medical Education (ACGME)

The mission of the Accreditation Council on Graduate Medical Education (ACGME) is to improve the quality of health care in the United States by ensuring and improving the quality of graduate medical education experiences for physicians-in-training. The ACGME establishes national standards for accreditation and continual assessment of graduate medical education programs. You may access specific program requirements and other information at www.acgme.org.

Competency-Based Training

In recent years, the ACGME has shifted the focus of graduate medical education towards an emphasis on program outcomes and actual accomplishments. At the heart of this initiative is the specification of a set of six general competencies and the development of dependable methods for assessing attainment of these through evaluation systems. ACGME-accredited residency programs must now require residents to obtain competencies at the level of a new practitioner in the six areas listed below:

1. Patient Care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health
2. Medical Knowledge about established and evolving biomedical, clinical, and cognate sciences and the application of this knowledge to patient care
3. Practice-Based Learning and Improvement that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care
4. Interpersonal and Communication Skills that result in effective information exchange and teaming with patients, their families, and other health professionals
5. Professionalism, manifested through a commitment to professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population
6. Systems-Based Practice, or actions that demonstrate an awareness of and responsiveness to the larger context and system of health care; and the ability to effectively call on system resources to provide care that is of optimal value

SOURCE: ACGME website at www.acgme.org/what-we-do/accreditation/common-program-requirements/.

Feedback and Evaluation

Evaluation and feedback are fundamental components of resident and fellow education and training. Training programs must provide timely feedback regarding trainees' ongoing performance and competence to ensure each trainee's progressive development into a fully competent practitioner.

In turn, both training programs and their faculty need to receive feedback from their trainees to ensure continuous improvement in all aspects of the training program. Feedback clarifies goals and expectations, reinforces good performance,

reduces anxiety and insecurity about performance, provides basis for correcting mistakes, demonstrates your interest and investment in the learner, provides guidance, and provides a reference point for evaluation.

SEEKING AND GIVING FEEDBACK, TIPS FOR TRAINEES:

- At the beginning of each rotation, **review rotation objectives**.
- **Set personal goals** for each rotation and discuss these with the attending when you begin the rotation. Revisit this discussion at the midpoint of the rotation to assess progress.
- **Schedule feedback sessions** with your attendings in advance.
- After a rotation ends, create a learning plan and/or next steps to continue to improve.

FEEDBACK PEARLS/PRINCIPLES:

- Feedback should:
  - Be **expected and criteria based**
  - Be **objective, timely, and brief**
  - Allow for **recipient reflection**
- **Make plans for follow up** (as appropriate) — what is the next step/goal, and when will you meet again?

FEEDBACK MODEL "ASK-TELL-ASK":

- Ask learner to **assess own performance first:** phrase questioning to allow meaningful reflection.
- **Tell what you observed:** diagnose and explanation using specific observed behaviors, limit quantity.
- Ask learner for their **understanding and strategies for improvement:** "What could you do differently?", coaching comes into play here.

For tips on seeking and giving feedback, visit the GME page on OneMSK.

Evaluation of Trainee Performance by Program Faculty

Trainees' evaluations are performed based on either the frequency specified by the accrediting organization's program requirements or the policy set forth by the GMEC. Rotating residents are formally evaluated at the end of their assigned training period. Full-time trainees are evaluated at least twice a year — generally at the mid-point and at the end of the academic year. Additional evaluations may occur at the end of each rotation within the program, as required or as benefits the trainee's development. Programs may also use pre-tests to determine any knowledge deficits which can be addressed through curricular changes. In general, these evaluations assess the trainee's mastery of educational objectives to determine whether the trainee has achieved the knowledge, skills and professional competencies required for promotion to the next level of training or completion of training.

Upon satisfactory completion of a training program, the Program Director will provide a summative evaluation for each resident which will become part of the resident's permanent record. This evaluation documents the resident's performance during the final period of education, and confirms that the resident has demonstrated sufficient competence to enter practice without direct supervision. Trainees who transfer into another institution's training program prior to completion of the program at Memorial will also receive a summative evaluation to document their level of performance and skill attainment achieved prior to transfer.

Non-Promotion
In the event that a training program director determines that a trainee is not eligible for promotion to the next level of training, the trainee will receive a written notice of intent which may then be grieved. Except in circumstances where the primary reason for non-renewal occurs less than three months prior to the end of the agreement, such notice will be sent no later than three months prior to the end of the resident's current agreement.

New Innovations Resident Management System

MSK utilizes a web-based system called New Innovations (NI) to automate various GME-related processes including evaluations and work hours reporting. Trainees will be assigned a user name and password for access to the NI internet site: www.new-innov.com/Login/Login.aspx.

In general, a trainee's username and password will be initially set to the first initial of their first name plus full last name. For example, for John Smith the username and initial password would be jsmith. Trainees are advised to change their password the first time they log on. For problems logging into the system, trainees should contact their program coordinator for assistance.

Evaluations
At the end of each rotation or semi-annually, faculty will be notified via email to complete evaluations on the trainees they have supervised. Periodically, trainees will receive email notices to complete evaluations on their supervising faculty. In addition, trainees and faculty will have the opportunity each year to evaluate their program for its effectiveness, compliance with accrediting agency requirements, etc. These assessments make an important contribution to the continuous effort to improve the effectiveness and high quality of the Hospital's training programs. All evaluations by trainees remain confidential. Evaluations of trainee performance are accessible for review by the trainee, upon request.

Work Hours
MSK conducts regular internal audits of resident work hours to monitor compliance with New York State and ACGME requirements through the NI system. Program coordinators will distribute information on the timing and duration of the internal audit, and provide informational materials on how to enter information into the NI system.

Resident and Fellow Forum

All full-time and rotating residents and fellows are encouraged to attend recurrent meetings with other residents to discuss topics relevant to their educational and work environment and other resident issues. These meetings are overseen by the Chief Residents and Fellows and resident members of the Graduate Medical Education Committee. Members of the Hospital's Administration may attend by invitation only. Full-time house staff will be notified of upcoming meetings by email, and rotating residents will be informed by their Chief Resident. Trainees are encouraged to suggest relevant topics for discussion to their program's Chief.

Call Rooms

When assigned to take in-house call, all rotating residents, and any full-time residents who reside beyond the immediate vicinity of the Hospital will be provided access to secure and convenient call rooms for rest.

Code of Conduct

In order to provide the best possible care to Memorial Hospital's patients and to protect the rights, health, and safety of fellow employees and visitors, MSK staff members must conduct themselves in a professional and cooperative manner while in hospital facilities or when involved in hospital business. This includes treating individuals in a respectful and courteous manner; working collaboratively with others; giving and receiving information clearly and concisely; responding to issues with a systemic problem-solving approach; initiating and following through on tasks; maximizing time and resources; and making a continuous effort to improve job performance.

REFERENCE: See OneMSK > Table of Contents > Code of Conduct

Conferral of M.D. Degree

The NYS Board of Regents is empowered to confer the M. D. degree on physicians who hold a New York State license and meet specific eligibility requirements. Information on eligibility, application process and cost can be found at: https://www.op.nysed.gov/professions/physicians/conferral-md-degree

Dress Code

The Center expects residents and fellows to wear appropriate professional attire. White coats and scrubs are provided to Graduate Staff.

- In addition to a white coat, employees may wear blouses, shirts, polo or oxford shirts with collars, sweaters, casual skirts and dresses, long pants, business suits, pant suits, blazers or sport coats, casual slacks, shoes, dress sandals, loafers or other appropriate professional attire.
- House staff, including rotating house staff, may not wear white coats bearing an institutional logo of their home institution.

This is the minimum standard required for all Memorial Hospital employees. Training program directors may impose additional requirements. Refer to the HR Policy Manual for Employees (Policy 216) on OneMSK for more information.

Name of Record

Your legal name as it appears on your U.S. Social Security card will become part of your personnel records. Your MSK Identification Badge and all certificates of completion will reflect this legal name.

Moonlighting

A full-time trainee enrolled in a training program at MSK who wishes to engage in moonlighting as a physician or other health care provider, inside or outside Memorial Hospital must obtain prior written approval of their Training Program Director (TPD).

Note that a TPD has the option to prohibit any or all trainees in their program from any or all moonlighting, and may rescind approval at any time. A trainee cannot be required to moonlight.

Prior written approval must be obtained for all moonlighting, including any of the following:

- internal moonlighting (within Memorial Hospital)
- external moonlighting (outside of Memorial Hospital)
- compensated or volunteer moonlighting
- recurring or one-time moonlighting
- minor or substantial time commitments

The Memorial Hospital Moonlighting Request form must be submitted to the trainee's TPD. If approved, a copy of the Request form for an external moonlighting activity must also be sent to the Graduate Medical Education Office. If substantive changes are made to the initial agreement, or at the start of a new academic year, a new Request form must be submitted.

A trainee must possess a full license to practice medicine in a State before engaging in moonlighting or any clinical work in that State outside the scope of their training program. Permission to moonlight will be granted only to a trainee who is in, and maintains, high academic standing in their program. All decisions related to permission for moonlighting are the sole responsibility of the TPD, and are not subject to appeal or grievance.

House staff who are sponsored on visas for clinical training are not permitted to moonlight, as the work authorization associated with the visa approval does not extend to activities outside the scope of their training program.

All moonlighting activities count toward the number of hours worked when calculating Work Hours totals. The TPD will require regular reports from each trainee who moonlights, to ensure compliance with both New York State regulations regarding work hours limitations, as well as ACGME restrictions if applicable. The TPD will also monitor for signs of fatigue when trainee returns from moonlighting.

Note that malpractice coverage provided for each trainee by Memorial Hospital does not cover any external moonlighting performed by the trainee outside the scope of their Memorial Hospital training program. Any trainee who engages in external moonlighting must provide their own malpractice coverage and provide documentation of that coverage to the TPD.

While engaging in external moonlighting, a trainee must not display any form of MSK identification (such as ID badge, a white coat with a Memorial Hospital patch, etc.). A trainee's MSK DEA Registration Number must not be used for any purpose during external moonlighting.

Any remuneration for moonlighting must be paid directly to the trainee, not to Memorial Hospital.

Failure to comply with all Memorial Hospital moonlighting policies, or misrepresentation of the nature or scope of outside moonlighting, can impact upon a trainee's appointment, up to and including immediate termination of employment.

See also "Work Hours Policies".

Emergency Operations and Disasters

In the event that the Center must activate the Emergency Operations Plan, The Hospital Incident Command System (HICS) will be used as the organizational structure for disaster response at the Center as well as all MSK sites. All residents and fellows assigned to a specific training site are responsible to the respective Incident Commander and/or Medical Care Director at that site as specified in the HICS chart designation. Each program and/or department will conduct internal workforce management through designation of faculty, residents and fellows to response teams, consistent with the hospital and medical staff policy and procedure for disaster response, and/or by the internal department policy. The Incident Commander and/or Medical Care Director (or equivalent) of the HICS will determine as necessary faculty, resident and fellow reassignment or redistribution to areas of need, superseding departmental plans for workforce management. Information on the location, status and availability of residents and fellows during disaster response and recovery will be provided by the Designated Institutional Official (DIO) or designee in coordination with GME administration, program directors and/or chief residents

Disaster Plan for Training Continuity

Should an event or set of events cause significant alteration or interruption of Memorial's ACGME-accredited training programs, the Hospital will follow the disaster plan guidelines established by the ACGME. The Designated Institutional Official (DIO) will be in contact with all program directors to assess the impact on the educational experience of each program and to determine whether there has been disruption of each program's ability to maintain the educational experience, either temporarily or permanently. Training Program Directors will immediately assess their programs' function and if necessary, develop a recovery strategy, timetable and written plan to address response, recovery and resumption of education and services. In the event that the DIO and program directors determine that a program can no longer provide the appropriate educational experience for the residents, the DIO and program directors will expeditiously seek temporary transfers until such time as the educational program can once again be satisfactorily provided at the Hospital, and/or seek permanent transfers to other programs or institutions. Every effort will be made to ensure that each resident in the affected programs will be able to complete the training year.

Residency Closure/Reduction Procedures

If the institution intends to reduce the size of a residency program or close a residency program, the Hospital will inform all affected residents, the GME Committee and Designated Institutional Official (DIO) as soon as possible. In the event of such a reduction or closure, the Hospital will make every effort to allow residents already in the program to complete their education. If any residents are displaced by the closure of a program or a reduction in the number of residents in a program, the Hospital will assist the residents in identifying appropriate programs in which they can continue their education.

Curtailment of Rotations

On rare occasions, the performance or behavior of a rotating trainee does not meet Memorial standards or objectives of the training program. The Training Program

Director will evaluate challenged trainees and determine whether remediation of the resident's deficiencies is possible and warranted; or whether to curtail the rotation. In such an event, the Training Program Director will notify the home institute Training Program Director; and inform other institution-specific or oversight agencies as required or deemed appropriate.

Counseling and Remediation Process for House Staff

At times the conduct, behavior or performance of a trainee may not meet the standards or objectives of the training program. Such circumstances require careful and deliberate intervention. The remediation process is initiated and managed by the training program director in consultation with program faculty, department leadership, the GMEC Chair and GME Office. Information on the remediation process stages can be obtained from the GME office. Ideally, the remediation process will move sequentially through each stage; however, steps may be skipped if performance concerns are well-documented and serious, especially those with implications for safe patient care.

Grievance Procedure: Due Process for Graduate Staff

A Member of the Graduate Staff, (House Staff Officer) referred to in this section as a "Trainee," at Memorial Hospital for Cancer and Allied Diseases, may be an Intern, a Resident or Fellow. Memorial Hospital ("Hospital") may (a) place a Trainee on probation, or (b) suspend a Trainee's postgraduate medical education and training at the Hospital for a specified or indeterminate period, or (c) terminate a Trainee's postgraduate medical education and training before the Trainee's current term ends, or (d) decline to certify that a Trainee has completed satisfactorily his or her postgraduate medical education and training at the Hospital. These actions may be undertaken if the Trainee:

i. fails to acquire at least the same professional knowledge and skill that Trainees at the Hospital are expected to acquire at the same level of postgraduate medical education and training, or
ii. fails to carry out satisfactorily his or her professional responsibilities, or
iii. fails to comply with expected standards of personal or professional conduct, or
iv. by virtue of his or her actions or threatened actions, presents an unacceptable danger to patients, colleagues or to the institution, or
v. violates any Center-wide policies or procedures.

In the event of a disciplinary action defined above, the Program Director will give written Notice ("Notice") to the Trainee as soon as practicable.

If the Trainee disagrees with the Program Director, the Trainee may, within five (5) business days after receiving the Notice, deliver a grievance in writing to the Program Director stating in detail why the Trainee disagrees with the disciplinary action ("Grievance").

Promptly upon receipt of the Grievance, the Program Director will request that the Chair of the Graduate Medical Education Committee ("GMEC") appoint a Review Committee to consider and make recommendations concerning the Grievance.

The Chair of the GMEC (or if the Chair of the GMEC has a directly conflicting interest in the case, the Vice-Chair of the GMEC) will appoint the Review Committee to consist of the following:

- One member of the Department's attending staff;
- An appropriate Trainee in any MH GME program; and
- A Training Program Director from another clinical department. This person will serve as the Review Committee's presiding officer ("Review Committee Director").
- Staff support will be provided by the Office of Graduate Medical Education, who shall not be a voting member of the committee.

The Trainee will be informed in writing of the membership of the Review Committee, and that the Notice and the Grievance has been delivered to the Review Committee Director. The Review Committee Director will provide the other members of the Review Committee with the Notice and the Grievance.

The Review Committee Director will promptly convene a meeting of the Review Committee inviting the Trainee's Training Program Director, and the Trainee to attend. The Department Chair or designee of the Department Chair will also be invited to attend. The meeting will be closed to everyone except the previously mentioned individuals. The Trainee and/or the Trainee's Training Program Director or Department Chair may request that specific member(s) of the Hospital's attending staff and training staff or other Hospital employee(s) attend the meeting to deliver testimony to aid the Review Committee in resolving the Grievance. The Review Committee may exercise its discretion in determining whether to honor such request(s) and may determine to call other or additional persons to give evidence. In addition to the Grievance, the Trainee, the Training Program Director and the Department Chair may present an additional written statement to the Review Committee. One or more member(s) of the Hospital Administration may be present to assist with the proceedings. Legal counsel will not be permitted at the meeting. All in attendance at the meeting may take notes of the meeting, but no tape or video record or transcription may be made at the meeting.

The Review Committee will consider the views of the involved parties and any facts properly presented to the Review Committee. The Review Committee will present a written Finding regarding how to resolve the Grievance ("Finding") and deliver a copy of the Finding to the Trainee, the Chair of the GMEC, Program Director and the Department Chair. The separate views of any member of the Review Committee may also be stated in writing, and appended to the Finding.

If either the Trainee or the Program Director disagrees with the Finding, he or she may appeal to the Deputy Physician-in-Chief (DPIC) of Education and Faculty Affairs (or designee) by written notice delivered to the DPIC of Education and Faculty Affairs (or designee) within five (5) business days of receipt of the Finding.

The DPIC of Education and Faculty Affairs (or designee) will review the Notice, the Grievance and any other written material the Trainee submitted to the Review Committee, all other documents submitted to the Review Committee, the Finding, and any separate views of the Review Committee members.

The DPIC of Education and Faculty Affairs (or designee) will meet with the Trainee, the Department Chair (or designee) and the Review Committee Director, in separate meetings. A member of Hospital Administration will be present to take notes and gather additional information as needed. Thereafter, within five (5) business days, s/he will render a decision ("Decision") with respect to the Grievance and will notify the Trainee, the Program Director, Department Chair, and Chair of the GMEC in writing of the Decision. The Decision will be delivered by hand to the Trainee or sent via overnight delivery.

The Decision of the DPIC of Education and Faculty Affairs (or designee) shall be final and binding on all parties.

Immediately upon Notice of a disciplinary action of suspension or termination, the Trainee is required to return his or her Memorial Hospital Employee Identification Badge, office keys, pager and all other Memorial property to his or her Training Program Director. In the event the suspension is lifted, or the termination is reversed and the Trainee is cleared to return to the Training Program, the items noted above will be returned to the Trainee.

The Trainee may continue to occupy Hospital housing during the Grievance procedure with the understanding s/he will be responsible for rent up until the date the apartment is vacated, as per the terms of the Housing Lease. In the event the final Decision is termination from a training position at Memorial Hospital, the Trainee must vacate Memorial Housing within five (5) days of the final decision date.

Hospital Policies and Procedures

Hospital Policies and Procedures can be found on OneMSK > Table of Contents > Administrative Policy and Procedure Manual.

Rules and Regulations of the Medical Staff can be found on OneMSK > Table of Contents > Rules and Regulations of the Medical Staff.

Key policies are summarized below. At the end of this section, there is a list of pertinent Hospital Policies and Procedures with references to the appropriate Intranet source.

Advance Directives

Advance directives are written instructions about health care treatment made by adult patients before they lose decision-making capacity. Memorial Hospital complies with the Federal Patient Self-Determination Act, the New York State Health Care Proxy Law (PHL Article 29-C), and the Family Health Care Decisions Act (PHL, Article 29-CC). These laws allow patients to execute advance directives regarding their care and to designate a health care agent to make decisions on their behalf should they lose capacity to do so. If the patient does not designate a health care agent, the patient's surrogate will make decisions based on the patient's advance directives (See Rule and Regulation #545: Family Health Care Decisions Act — Identifying and Designating Surrogates for Patients without Decision-Making Capacity). Patients are informed of these rights at the time of registration and admission. It is the policy of Memorial Hospital not to discriminate against patients based on the presence or absence of advance directives.

Advance directives commonly take two forms: health care proxy designation and living will statements of treatment preference. The New York State Task Force on Life and the Law has chosen the Health Care Proxy as the preferred document in New York State. The Patient Representative Department is available to assist patients and answer their questions regarding advance directives.

Inquiry is made about the existence of a completed directive during outpatient nursing assessment, at admission, and at ambulatory surgery. If a patient submits a document, it is placed in the patient's medical record. In the absence of such a document, patients are offered assistance in completing one. If the patient has such a document but has not provided it to the hospital, the substance of the directive should be documented in the medical record. Advance Directives are filed under ADVANCE DIRECTIVES/DNR in the electronic medical record.

SOURCE: Rules and Regulations of the Medical Staff #533

Patients Who Have Not Chosen to Designate a Health Care Agent

The Family Health Care Decisions Act (FHCDA) applies to treatment decisions for patients in New York State who do not have decision-making capacity and have not signed a health care proxy.

For more information on the FHCDA, see the following policies:

- Rule and Regulation #542: FHCDA – Overview
- Rule and Regulation #543: FHCDA – Determining Patient Incapacity
- Rule and Regulation #544: FHCDA – Evaluating Patients' Prior

Health Care Decisions
- Rule and Regulation #545: FHCDA – Identifying and Designating Surrogates for Patients without Decision-Making Capacity
- Rule and Regulation #546: FHCDA – Obtaining Consent

Deaths and Autopsies

Determination of Death

A determination of death must be made in accordance with accepted medical standards. Under New York State law (Title 10 Section 400.16) an individual who has sustained either (i) irreversible cessation of circulatory and respiratory functions, or (ii) irreversible cessation of all functions of the entire brain, including the brain stem, has expired.

Criteria

1. Cardiopulmonary Criteria: An individual with irreversible cessation of circulatory and respiratory functions is dead.
    a. Cessation is recognized by appropriate clinical examinations. Clinical examination will disclose at least the absence of responsiveness, heartbeat, and respiratory effort. The use of confirmatory tests such as EKG may be warranted, but are not required.
    b. Irreversibility of cardiopulmonary functions will be recognized by persistent cessation of functions during an appropriate period of observation and/or trial of therapy.
2. Neurologic Criteria: An individual with irreversible cessation of all brain functions, including the brain stem, is dead. Where indicated, the clinical diagnosis may be confirmed by laboratory testing.
    a. The existence of brain death can be certified by a single physician skilled in the techniques of brain death assessment. However, in instances where the patient is a potential organ and/or tissue donor, a second physician must also certify the time of death.
    b. Only attending neurologists, neurosurgeons, and critical care physicians may make a determination of brain death after specific criteria have been fulfilled. While a house officer may assess the patient and perform required tests, the final determination of brain death must be made by an attending physician. Additionally, the patient's primary attending shall participate in the determination whenever possible. Special requirements apply to the determination of brain death for a patient under the age of 18 years.
    c. For a patient under the age of 18 years, a pediatric critical care physician, pediatric neurosurgeon and/or a pediatric neurologist must be involved in any instance in which a determination of brain death is required. In an emergent situation where a pediatric neurosurgeon or neurologist is not available, an adult specialist may make the determination. Two clinical assessments must be performed at a minimum time interval as set forth in the "Mandatory Observations Period" section in Appendix 2: "Criteria for Determination of Death by Irreversible Cessation of All Functions of the Entire Brain, Including the Brain Stem (Age Under Eighteen Years)".

Notification of Family

Brain death is a medical determination and does not require specific consent from the patient's next of kin or health care agent (Surrogate Decision-maker). Under New York State law, however, reasonable efforts must be made to notify the next of kin or health care agent that the determination of death process is being undertaken.

1. If a patient has been determined to be brain dead, and the ventilator is to be disconnected, the family should be treated with dignity and respect. If family members insist, they should be given the opportunity to be present when the ventilator is disconnected. They should be advised in advance of the possible occurrence of isolated spinal automatic movements.
    a. It is the responsibility of an attending physician to discontinue the respirator.
    b. It is the responsibility of the nursing members of the treatment team to prepare the body for the morgue and to offer family/friends the opportunity to view the body prior to morgue transfer.
    c. Emotional support should be provided to the family during and after the determination. Social workers, Chaplains and Patient Representatives can assist.
2. A patient determined to be brain dead is legally dead. Memorial Hospital recognizes and respects deeply held religious beliefs which may differ with brain death standards for determining death.
    a. If a family has no religious objection to brain death as a determination of death, but psychologically cannot accept that the patient is dead and objects to the discontinuation of the ventilator, efforts should be made to address these concerns sensitively through consultation with all members of the health care team. Members of the chaplaincy office, the Patient Representative Department or the Ethics Committee may be helpful in resolving these issues.
    b. If a family expresses objections based on religious beliefs, the Ethics Committee should be consulted for assistance. Reasonable accommodation to religious beliefs will be as follows:
        i. The determination of brain death protocol will be initiated and completed. (See, as applicable to the age of the patient, either Appendix 1: "Criteria for Determination of Death by Irreversible Cessation of All functions of the Entire Brain, Including the Brain Stem (Age Eighteen Years or Older)" or Appendix 2: "Criteria for Determination of Death by Irreversible Cessation of All Functions of the Entire Brain, Including the Brain Stem (Age Under Eighteen Years)".
        ii. The patient may be maintained on the ventilator, except in triage situations. If the continued use of mechanical ventilator support would cause harm to another patient requiring its use, the support will be terminated.
        iii. The family should be provided assistance in transferring the patient to an accepting facility, if they wish transfer to occur.
    c. For all patients for whom brain death criteria have been met and in which ventilatory support is not immediately withdrawn, clinical decisions will be based on information gained from the brain death protocol, and based on accepted standards of treatment and clinical justification. In the event that a patient is determined to be brain dead, the following steps will be implemented:

i. DNR order written, no CPR at time of cardiac arrest (#4 DNR form; no signature or consent of family is required).
ii. No blood draws; no blood product support.
iii. No increase in ventilatory support or oxygen.
iv. Discontinuance of renal replacement therapy.
v. ICU bed will not be utilized.
vi. No new care will be initiated; no escalation of current level of care will occur.

SOURCE: Rules and Regulations of the Medical Staff #525

Medical Examiner Cases Policy

In accordance with the laws and regulation of the New York City and New York State, a death falls under the jurisdiction of the Office of Chief Medical Examiner (OCME) if it is unnatural or possibly unnatural, or if it presents compelling legal or public health implications. Such deaths must be reported promptly by telephone to the Medical Examiner by the attending physician/their designee, or advance practice provider (APP) after discussion with Hospital Administration. The Medical Examiner is not to be notified by the pathologist without prior consultation with the responsible physician or APP. Judgment should be exercised in determining those cases that should be reported to the Medical Examiner.

The types of deaths under the jurisdiction of the Medical Examiner are as follows:

a. Deaths associated with diagnostic, therapeutic, and anesthetic procedures or from complications of such procedures.
b. Deaths resulting from violence or casualty – All deaths resulting from violence, the external cause or agent of which may be mechanical, thermal, chemical, electrical, radiational, or any other form of trauma. This applies whether death results immediately and directly, or is indirectly related after a lapse of weeks, months, or even years. Suspected battered children are included in this category. This applies to deaths in hospitals following transfers from other hospitals regardless of where the injuries were sustained.
c. Deaths due to suicide.
d. Persons dying suddenly when in apparent good health.
e. Deaths occurring in any other suspicious or unusual manner.
f. The following are examples of cases which should be reported to the Medical Examiner in New York City for a determination as to the acceptance of the jurisdiction:
    i. When a fetus is born dead in the absence of a physician or midwife:
    ii. Stillbirths in the hospital need not be reported to OCME unless there is a history of maternal trauma or drug abuse, or the case has some other unusual or suspicious circumstance.
    iii. Deaths caused or contributed to by drug and/or chemical overdose or poisoning.
    iv. Deaths due to disease, injury or toxic agent resulting from employment.
    v. Deaths of all persons in legal detention, jails or police custody (includes any prisoner who is a patient in a hospital, regardless of the duration of hospital confinement).
    vi. Accidental related deaths (motor vehicle, industrial, home, public place, etc.)
g. Deaths from causes which might constitute a threat to public health.

h. Unexpected deaths when the cause of death is not immediately known.

The specific length of time in the hospital (e.g. death less than 24 hours after admission) is not sufficient reason to report the death to the OCME unless another reporting criterion is met.

A death from natural causes occurring at home does not fall under the jurisdiction of the Medical Examiner if a physician or APP treated the patient for the disease causing the death and has examined the patient at appropriate intervals relative to the patient's disease and condition (generally within 31 days).

Procedure

When there is a possibility of a Medical Examiner case, a request of next-of-kin for postmortem examination should not be made until the Medical Examiner has rendered their decision. For all locations other than 1275 York Avenue, the physician or APP is to notify the site administrator. The administrator on-site will then contact Memorial Hospital Administration, which can be reached at 212-639-5988, Monday – Friday, 9:00 am – 5:00 pm. At all other times, the physician or APP shall call the operator and ask to have the Administrator-On-Call paged.

Upon exercising judgment of a reportable situation and determining that the death is reportable Medical Examiner's Office case, the physician or APP in charge of the case telephones the Medical Examiner immediately at (212) 477-2030.

Health care facilities reporting cases to OCME Communications must present a completed ME Clinical Summary Worksheet 3.0 and the following additional required case-specific documents, as available, prior to removal of any decedent by the OCME from a healthcare facility citywide: Admission face sheet; Discharge summary (if unavailable, then Admission History and Physical examination); Emergency Medical Services Patient Care Report /Ambulance Call Report (PCR/ACR); Signed authorization for City burial (if being requested by decedent's family/next of kin).

When reporting a death, the physician or APP must obtain the Medical Examiner's case number and the name of the clerk or the Medical Examiner. This information must be included in the patient's chart and provided to the Admitting Office. Clerks in the Medical Examiner's Office are instructed to accept all cases reported and to

transmit the information about the case reported to the Medical Examiner or Medical Investigator. The Medical Examiner or Investigator will then decide whether to accept the case or turn it back to the hospital. In some cases, the Medical Examiner will accept the case and request the autopsy be completed by Pathology at MSK. If this occurs, the physician or APP must communicate this to the Admitting office and ensure that the family understands who is performing the autopsy. Should the physician or APP wish to speak to the Medical Examiner or Investigator directly, they should make this clear to the clerk. The authority and responsibility for determining whether a case is accepted falls within the jurisdiction of the Medical Examiner or investigator, and a record is kept in the Medical Examiner's Office of every death reported to it, and whether it is accepted, or turned back.

Regardless of whether the autopsy will be done by the Medical Examiner's Office or at MSK, the Admitting Office staff will notify the Pathology Department by emailing the autopsy status of the ME case to the zzPDL_PTH_Clinical_Autopsy_Alert.

When a case is accepted by the Office of Chief Medical Examiner, a physician or APP with knowledge of the decedent must complete a "New York City Government Record Form" (available in Admitting Office or in CIS Form #99-00934). A death certificate should not be completed if the case is accepted by the OCME unless the

OCME requests that the autopsy be done by MSK Pathology. In this case,

the top portion of the Death Certificate (Medical Certificate of Death) should be completed with the remaining left blank and provided to Pathology along with a completed Autopsy Consent Form (AP&P 4404).

A physician or APP must explain to the family of the deceased that the death is under the jurisdiction of the Medical Examiner. (Under these circumstances the body is usually sent to the Medical Examiner's Office where the body may be claimed.) If the family objects to a post-mortem examination by the Medical Examiner's Office they may be given the phone number of the Medical Examiner's Office, and a Patient

Representative (or the Administrator-On-Call if this occurs after regular hours) should be notified. However, the body may not be released to the family without

the permission of the Medical Examiner.

If needed, autopsy reports may be obtained by contacting the OCME.

For any "claim only" case (i.e., the identity of the decedent is unknown) to be removed from a Memorial facility, the decedent must be held at that location for a period of no less than 7 days from the date of death. Memorial Hospital staff members are to make every effort to release the case directly to an authorized funeral director upon demand. The claim only or city burial case may be reported to the OCME for removal beginning on day 8; Memorial staff must provide funeral directors with an OCME case number when requested. Please consult Administrative Policy & Procedure #4402 for more details on unclaimed bodies. Note: This does not apply to Medical Examiner cases.

FOR CASES REJECTED BY THE MEDICAL EXAMINER, a notation of the

conversation with the Medical Examiner's office, including the name of the individual spoken to and the "No Case" number, should be documented in the medical record. The physician or APP should then attempt to secure permission for an autopsy from the next- of-kin. The death should be processed and certified in the same manner as other non medical examiner deaths.

If a patient's next of kin/family requests an autopsy but prefers that the Medical Examiner perform the postmortem examination instead of a physician, the physician or APP is to contact the OCME. If the ME accepts the case, the above steps must be followed. If the ME rejects the case, in addition to documenting the "no case" number in the medical record, the physician or APP must communicate the OCME's decision to the patient's next of kin/family. If the next of kin still prefers that the autopsy be performed outside MSK, the physician or APP is to contact the Pathology Department. Pathology will engage Hospital Administration and the Office of General Counsel and Patient Representative Departments as necessary to decide how to proceed. The Pathology Department is also able to recommend third party pathologists if needed.

Death certificates must be completed via the New York City eVital system. Staff at the Admissions Center will assist the physician or APP in registering in eVital if they have not done so previously, and in completing the death certificate online.

SOURCE: Rules and Regulations of the Medical Staff #505

Autopsy
Every member of the Medical Staff shall be actively interested in securing autopsies.

Consent for Autopsy (form #56-03469)
The physician usually obtains consent from the person or persons entitled by law to give such permission — the authorized decision maker — immediately after expiration. It is desirable to receive consent from all persons in the highest-ranking category, but it is recognized that this is not always possible or practical. On these occasions, a notation should be made in the medical record stating the (i) reason that consent from all parties was not obtained and (ii) the status of the individual(s) serving as the next highest authorized decision maker(s). The autopsy may be performed with the consent of only designated individuals from the appropriate category. The authorized decision maker must be selected in the following order:

1. the person designated in an appropriately executed "Appointment of Agent to Control Disposition of Remains" pursuant to New York Public Health Law § 4201;
2. the decedent's surviving spouse or surviving domestic partner;
3. any of the decedent's surviving children;
4. either of the decedent's surviving parents;
5. any of the decedent's surviving siblings;
6. a guardian appointed pursuant to Article 17 or 17A of the Surrogate's Court Procedure Act or Article 81 of the Mental Hygiene Law;
7. any person who would be entitled to share in the estate of the decedent as specified in § 4-1.1 of the Estates, Powers and Trusts Law, with the person in closest relationship having the highest priority;
8. a duly appointed fiduciary of the estate of the decedent;
9. A close friend or relative who is reasonably familiar with the decedent's wishes, including the decedent's religious or moral beliefs, when no person higher on this list is reasonably available, willing, or competent to act, provided that such person has executed a written statement pursuant to Subdivision 7 of New York Public Health Law § 4201; or
10. A chief fiscal officer of a county or a public administrator appointed pursuant to Article 12 or 13 of the Surrogate's Court Procedure Act, or any other person acting on behalf of the decedent, provided that such person has executed a written statement pursuant to Subdivision 7 of New York Public Health Law § 4201

If a member of the class of highest-ranking authorized decision makers objects or there is a conflict regarding the performance of an autopsy, an Ethics consult should be made and the Legal Department can be contacted if necessary and appropriate. In these circumstances, an autopsy will not be performed unless the objecting party later consents to the procedure. Similarly, if an objection is voiced by a member of a class that is lower in rank than the highest-ranking authorized decision maker(s) who has consented to an autopsy, an Ethics consult should be made, and the Legal Department can be contacted if necessary and appropriate.

Completion of Consent Form

1. The patient identification must be indicated on the forms.

2. Time of death must be the same time as recorded in the death certificate.
3. The restriction section must be completed by the licensed practitioner (as privileged and credentialed) obtaining consent in order for the autopsy to be performed. If it is to be a routine autopsy indicate "none" in the restriction section. If there are restrictions, these must be stated clearly, e.g. "no head examination."
4. The form is signed by the authorized decision maker(s) and by the licensed practitioner obtaining the consent. The attending physician must be notified when an autopsy consent is obtained from the authorized decision maker(s). If the authorized decision maker(s) is not available on-site to provide consent, follow the procedures for telephone consent described below.
5. The authorized hospital administrator shall verify the signed permission and ascertain the legal authority of the individual giving autopsy permission. After hours (weekends and holidays, and between 5pm and 9am on weekdays), the Administrator-On-Call shall verify the signed permission and ascertain the legal authority of the individual giving autopsy permission.
6. The authorized hospital administrator shall sign the autopsy form and notify the clinical autopsy team (zzPDL_PTH_Clinical_Autopsy_Alert) promptly. After hours the Admitting Office shall obtain authorization from the Administrator-On-Call and notify the Pathology Department (zzPDL_PTH_Clinical_Autopsy_Alert).

Telephone Consent

If the person giving consent is not available to sign the Consent for Autopsy, oral permission is acceptable. The licensed practitioner (as privileged and credentialed) is to call the authorized decision maker to obtain consent. In addition to the licensed practitioner obtaining consent, one member of the hospital staff must be present and on the call to witness the oral telephone consent. Both the licensed practitioner and a witness must sign the consent form. The consenting party should state his/her name and the relationship to the decedent, and provide verbal consent to the autopsy while the witnesses are on the call. The oral consent needs to be subsequently verified in writing via fax or email from the authorized decision maker(s). The consent form may be faxed or emailed to the authorized decision maker(s) who shall sign and return the consent form via email (autopsy@mskcc.org) or fax (Admitting Office fax: 212- 717-3103). The authorized decision maker(s) may also send an email to autopsy@mskcc.org instead of signing the faxed consent form if only oral consent was previously obtained. The email message must contain a) the name/DOB of the deceased patient and the authorized decision maker(s)'s relationship to the patient, b) the type of autopsy being requested (i.e., full clinical, or clinical and LWP (Last Wish Program)) and c) any restrictions or special requests. Autopsy may not proceed until written consent is received from the authorized decision maker, unless approved by an authorized hospital administrator.

Autopsies Related to Deaths Outside the Hospital

Patients affiliated with Memorial Hospital can be brought back for autopsy if prior permission has been granted by the appropriate service. The family should make all transportation arrangements with a funeral director. If the death occurs during the evening or weekend, notify the Administrator-On-Call for approval. In cases where the patient dies out of state or outside of the five boroughs, the death certificate (or a copy) must accompany the deceased patient.

The following steps should be taken by the physician or his designee:

1. Contact both Pathology and the Admitting Office to inform them that the patient has died and is being returned for autopsy. Include the patient's Memorial Hospital medical record number.
2. If there is an autopsy consent form on file in the chart, only the death note should be written by the physician in the progress notes. Otherwise a fax authorizing the autopsy must be sent by the authorized decision maker(s).
3. The physician will complete an autopsy consent form and (if required) death certificate.
4. The Admitting Office will contact the physician when the forms are ready to be signed, and will follow the standard procedures in place for patients who expire in the Hospital.

REFERENCE: Rules and Regulations of the Medical Staff #402 and Administrative Policy and Procedure #4404

Notification of Next-of-Kin

It is the responsibility of the inpatient attending physician to notify the family when a patient has expired.

When family/next of kin is not available:

1. The care team should be made aware, and the Department of Social Work is available to assist with locating the next-of-kin.
2. If repeated attempts at contact are unsuccessful and over 2 hours have passed, the inpatient attending is to contact the Charge Nurse/Nurse Leader, Patient Representative Department, and Director of Social Work (Monday – Friday 9:00 am – 5:00 pm) or the Clinical Nurse Supervisor, On-Call Social Worker (who can be contacted through the operator), or Administrator-On-Call (after 5:00 pm Monday – Friday and Saturday – Sunday).
3. If the attempts to notify the family or next of kin by telephone are unsuccessful, a letter should be sent via UPS next-day delivery, asking the family to contact MSK. The social worker of the service will assist in drafting the letter, which needs to be signed by the Attending Physician.
4. If the above efforts were unsuccessful and contact is not made with the next of kin within 3-days, the NYPD is to be notified. Security will be responsible for calling 911 to report the unsuccessful notification to next of kin.
5. If the the patient's body is sent to a city mortuary, the original Request for Police Investigation (RFPI) will be mailed to:

   Missing Persons Squad
   New York Police Department
   2770 Frederick Douglass Blvd.
   New York, NY 10039
   Attn: Morgue Liaison Officer

If the patient's body is sent to a city mortuary, the original RFPI and a copy are attached.

REFERENCE: Rules and Regulations of the Medical Staff #201

Death Certificate

Upon expiration of a patient, a Department of Health "Certificate of Death" form is completed and signed by the Hospital physician or advance practice practitioner (APP), unless it is a case for the Medical Examiner's Office. By law, deaths must be medically certified within 24 hours.

1. When a patient expires on MSK premises, the physician or APP who pronounces a patient dead must write the appropriate death note in the chart (in the progress notes) indicating the time and cause of death. The physician or APP must also complete an Expiration Sheet, including information regarding autopsy (see #4404: Autopsies) and eligibility for eye donation (see #2301: Organ/Tissue/Eye Donation).
2. The expired patient's medical record which includes if the patient's family requested an autopsy or eye bank donation will be delivered to the Admissions Center by Nursing Support Services or a member of the clinical team as soon as possible.
3. The Admissions Center will page the physician or APP who pronounced the patient dead.
4. The physician, nurse practitioner, or physician's assistant will go to the Admissions Center and, if there is no autopsy to be performed, complete the relevant sections of the electronic death certificate, which is submitted online via the New York City Electronic Vital Events Registration System (eVital). Staff at the Admissions Center will assist the clinician in registering in the eVital system if they have not done so previously, and in completing the death certificate online.
5. It is the responsibility of the physician or APP to be available to complete the electronic death certificate. If the physician or APP is scheduled for the operating room or a day off, it is their responsibility to either come to the Admissions Center prior to being unavailable or to designate another physician, nurse practitioner, or physician's assistant the responsibility of completing the electronic death certificate.
6. While preferred, the death certificate does not have to be signed by the physician or APP who pronounced the patient dead. The eVital system allows for another physician or APP on staff to complete the form, but it is necessary that this individual be familiar with the patient's history in order for the proper cause of death information to be recorded. The physician or APP must include their license number on the death certificate
7. When rotating residents and PGY1 residents who do not yet have a license or limited permit complete the certificate, the license number of the supervising physician must be submitted to eVital. It is the responsibility of each department to develop a process that provides for the designation of a supervising physician's license number to be used on the death certificate when rotating and PGY1 residents are completing the certificate.
8. In order to avoid any problems in completing the death certificates of patients who die in the Urgent Care Center or in the outpatient areas, Admissions Center staff will assume the responsibility for ensuring that an appropriate eVital submittal is completed. The process involves having an Admissions Center staff member assist the physician or APP with completion of the death certificate via eVital in the Admissions Center.
9. Once the death certificate is properly biometrically signed and completed by the physician or APP, a copy is brought to the Security Office by an Admissions

Center employee. Name of the deceased and other pertinent information are entered into a bound log maintained by the Security Department.

10. When the funeral director arrives to remove the body, Security verifies that the director's license is current and that they enter the correct information in the log.
11. Security then either notifies the morgue attendant to assist the funeral director with removal of the deceased or assists the director himself (when there is no morgue attendant on duty). Verification of the identity of the deceased prior to release is the responsibility of the morgue attendant (when on duty) or the Security employee. Removals are made via the Schwartz Building freight elevator and the designated loading dock. A body can be released any hour and any day of the week.
12. Completion of a death certificate on a patient who expires outside of the Hospital in the absence of medical attendance:
    a. In cases where a patient expires in the absence of MSK medical attendance and the decedent had been under the continuous treatment of a physician or APP and had been seen shortly before their death (within 31 days), the physician or APP may complete the death certificate via eVital when, in their medical judgment, they are capable of identifying the cause of death.
    b. In cases where a patient had been released from MSK and had not been observed by their physician in over 31 days, the physician is to report the case to the Medical Examiner's Office. The Medical Examiner may, after a discussion with the physician, give permission for the physician to file the death certificate (see Administrative Policy and Procedure #4403).
    c. In cases where an autopsy is desired for a patient who expired in absence of MSK medical attendance, the completed death certificate (or a copy) must accompany the deceased patient. The procedure for autopsies related to deaths outside the Main Hospital is outlined in Administrative Policy and Procedure #4404.

    The death certificate is a part of the medical record and is thereby subject to all rules regarding release of such information (see Administrative Policies and Procedures #7002 and #7003).

SOURCE: Administrative Policy and Procedure #4402

Deceased Jewish Patients

1. On occasion, deceased Jewish patients may transfer to a funeral home directly from a hospital room. On all days except the Jewish Sabbath or a Jewish holiday, a deceased Jewish patient can remain in a hospital room for a reasonable* amount of time until removal by a funeral home. Sabbath occurs from sundown Friday through sundown Saturday. During this time, staff may grant requests from the family to tend to the body, including placing it from the bed to the floor, prior to funeral home arrival. Staff should be reminded not to cross the patient's hands. Soiling and bodily waste removal may take place. The patient's eyes and mouth, if possible, should be closed. All tubes or IV lines attached to the patient should not be removed but tied, clamped, or capped and wrapped with the patient's body. Washing and shrouding of the body will be administered by the burial society before internment. The patient's face and body should be covered by a clean sheet until the body is collected or transferred to the morgue.

a. Be aware that the family will call the Chevra Kadisha (Burial Society) to provide all physical care to the body, including preparation for burial, which will be conducted according to Jewish law.
b. If possible, allow the body to remain in the same room until cared for by the Chevra Kadisha.
C. If possible, allow the Chevra Kadisha to provide all physical care to the deceased, which will include covering the body, removing any tubes or equipment attached to the body, transferring the body, and preparing the body for burial.

2. On the Sabbath and Jewish holidays when funeral homes cannot comply with timely pick up of the body, the body should be transported by a patient escort to the morgue, where it will be checked-in by the Dieners in the morgue log book after a reasonable* time elapses. One family member or another representative of the patient may accompany the body at all times, including during transfer of the deceased to the hospital morgue. After transfer to the morgue, the family member or representative may remain with the body in the morgue antechamber.
   a. Be aware that if death occurs on the Sabbath or a Jewish holiday, the Chevra Kadisha will not be able to arrive until the Sabbath or holiday has ended. Allow a family member or representative to stay with the body. In cases in which the body is brought to the morgue, allow the family member or representative to sit outside of the morgue until the Chevra Kadisha arrives to care for the body.
3. If a reasonable* amount of time has lapsed and there is a patient who is awaiting hospitalization, Jewish families who refuse removal of the deceased should be directed to Spiritual Care Services and the Patient Representative Department during regular business hours or to the Administrator-On-Call if after hours.
   Please note: Coordination with Pathology Laboratory Administration and Patient Representatives will be needed during business hours. After business hours and weekend and holidays please contact the Administrator-On-Call to coordinate.

* "Reasonable" means sensitive to the needs of the institution. When indicated, if staff feel or sense that reasonable limits have been reached, staff should call the Spiritual Care Services and Patient Representative Department during regular business hours or to the Administrator-On-Call if after hours.

SOURCE: Administrative Policy and Procedure #4407

Do Not Resuscitate (DNR) Policy

A DNR order — an order not to attempt cardiopulmonary resuscitation in the event a patient suffers cardiac or respiratory arrest — may be written for any patient. The patient need not be terminally ill or an inpatient. The existence of a DNR order does not imply any other limitations of care. If the DNR order is being contemplated for an incapacitated patient without an agent (with or without a surrogate), refer to Medical Staff Rules and Regulations #542: Family Health Care Decisions Act for additional information. If a DNR order is being contemplated for an incapacitated patient with neither an agent nor a surrogate, an Ethics consult is required. Guidance for Nonhospital DNR Orders for patients with and without capacity can be found in

Rule and Regulation #518- A: DNR Policy — Nonhospital DNR Orders.

Consent

1. Obtain Consent

Consent to a DNR is obtained by the patient's attending physician, or the patient's NP or PA (if the patient is seen at a New York location). In New Jersey, a DNR order may only be written by an attending physician; APNs or PAs in New Jersey may not obtain DNR consents. The attending physician, PA, or NP will explain to the patient, agent or surrogate that the DNR order shall remain in effect during future care at all MSK locations, and will be periodically reviewed with the patient, agent or surrogate. The attending physician, NP, or PA will explain to the patient, agent or surrogate that the DNR consent can be rescinded at any time based on the patient, agent or surrogate wishes. An Ethics consult is required when a patient lacks capacity and has no agent or no surrogate.

2. Verbal Consent

The patient, agent or surrogate may provide consent in writing or verbally. Whenever feasible, the patient, agent or surrogate should provide consent in writing by signing a printed DNR consent form that is witnessed by an MSK employee involved in the care of the patient. If verbal consent is obtained, the consent must be witnessed by two adults, at least one of whom must be an MSK attending physician, NP, or PA. Such verbal consent and witnessing shall be documented in the paper consent, even though it is not signed by the patient.

3. Revocation of Consent

As stated in NYS Public Health Law New York's Family Health Care Decisions Act (FHCDA), "A patient, health care agent or surrogate may at any time revoke their consent to withhold or withdraw life-sustaining treatment by informing an attending physician or a member of the medical or nursing staff of the revocation." Any member of the staff informed of a revocation/cancellation shall immediately notify an attending physician, NP, or PA of the revocation/cancellation. The attending physician, NP, or PA informed of a revocation/cancellation of consent shall immediately document the patient's wishes to rescind using the DNR Documentation Note which will automatically cancel the CIS DNR order and remove DNR status from the CIS header. The attending physician, NP, or PA should notify the hospital staff directly responsible for the patient's care. A line should be drawn through all pages of the DNR consent form including the Non-Hospital DNR form with a signed, dated and timed notation that the patient rescinded DNR consent. The rescinded consent should be left in the paper chart until discharge, at which time the chart is sent to Health Information Management for scanning into the medical record. For outpatient, the same process as above will be completed with voided DNR documents sent for scanning into the medical record. If an agent or surrogate wishes to rescind a DNR consent issued by a patient who has subsequently lost capacity, the Ethics Committee should be consulted.

If a fellow or resident is notified by the patient or another clinical staff member of the patient's revocation/cancellation of the consent, the fellow or resident will notify the attending physician and shall immediately document the patient's wishes as above. The attending physician, NP, or PA will complete the attestation in the DNR Documentation Note within 24 hours.

If a patient expresses a desire to permanently rescind/cancel the DNR order prior to a procedure involving anesthesia, then this request will be communicated immediately to the primary attending physician, NP, or PA prior to the procedure. The attending physician, NP, or PA will follow the process described above for "Revocation of Consent."

4.Capacity for Consent

For Patients with Capacity: A fellow for resident may obtain consent for a patient with capacity in rare cases involving either 1) a rapid and unexpected change in the patient's condition when an attending physician, NP, or PA is unable to obtain an in-person consent, or 2) a patient requests a DNR after having discussed the same with an attending physician, NP, or PA earlier in the day, but at the time the patient decided to consent, the attending physician, NP, or PA was not present and was unable to enter a DNR order reflecting the patient's decision. A fellow or resident documents the patient's request for a DNR, referencing any prior discussion (including telephonic) between the patient and the attending physician, NP, or PA. The fellow or resident must consult with the attending physician, NP, or PA about the patient's request for a DNR as soon as reasonably possible.

For Patients without Capacity with Agent or Surrogate: A fellow or resident must contact an attending physician or APP to complete a determination of capacity, DNR paper consent, and DNR note. In rare cases when the attending is not in-house and an agent or surrogate requests a DNR after having discussed with an attending physician, NP, or PA earlier in the day, then the attending physician can contact the agent or surrogate with the resident or fellow present via phone to participate in discussion and complete determination of capacity.

For Patients without Capacity with no Agent and no Surrogate: A fellow or resident must contact the attending physician and request an Ethics consult for discussion. The attending physician will complete the required documentation.

For more information on determining lack of capacity, see Rule and Regulation #543: Family Health Care Decisions Act — Determining Patient Incapacity.

DNR Order Procedure

1. Review of DNR Orders

DNR orders must be reviewed whenever there is a change in prognosis or within 24 hours of any admission. A DNR order or review entered within 24 hours prior to admission fulfills the DNR review requirement at admission. During an admission, DNR orders must be reviewed every 10 days by the attending physician, NP, or PA. This review does not require the attending physician, NP, or PA to re-obtain consent from the patient, agent or surrogate if there has been no change in the patient's clinical condition.

If an outpatient presents for a follow-up visit, and 90 days have elapsed since last review, the primary attending physician, NP, or PA must review the DNR status. This review does not require the attending physician, NP, or PA to re-obtain consent from the patient, agent or surrogate if there has been no change in the patient's clinical condition.

All DNR reviews must be documented using the DNR Documentation Note. Although the DNR review is expected to be completed within the timeframes noted

above, the DNR order remains valid and will be honored if the review has not occurred within the timeframe.

2. Patients Entering the Operating Room

When a patient with a DNR order is to undergo an intervention with intravenous sedation or any type of anesthesia (regional or general anesthesia), such that the patient would ordinarily be expected to temporarily lack capacity during the peri-procedure period, the attending physician, NP, or PA will discuss the DNR order with the patient, agent, or surrogate before sedation/anesthesia. The patient may opt to suspend or to maintain their DNR order. If patient has a subsequent elective procedure scheduled on the same day, then all DNR discussions and consent must occur prior to first procedure. After the initial procedure, the patient is held in the PACU with DNR suspended until return for the subsequent elective surgery/procedure. An informational guide detailing the specific staff responsible for documenting the suspend is on the Medical Ethics webpage and the link to this webpage is available in the DNR Documentation Note.

The involved attending physician, NP, or PA will suspend the DNR by documenting the discussion in the DNR Documentation Note; when this note is completed it will automatically update the CIS header to "DNR Suspended." The consenting clinician will communicate the request with all staff members participating in the case.

In the event of an emergency surgery/procedure, a clinical judgement is made based on what is in the best interest of the patient. If the patient/agent/surrogate is present, then an abbreviated conversation is held to ascertain their wish on suspending DNR for the perioperative/peri-procedure period.

If a patient/agent/surrogate elects to maintain their DNR order throughout theperioperative period, the involved attending, NP or PA will document such discussion in the DNR Documentation Note and communicate with all staff members participating in the case. Any physician, NP or PA who objects to the decision to maintain DNR must inform the patient/agent/surrogate of their objections, make all reasonable efforts to transfer the patient's care to another physician and immediately notify the hospital Ethics Committee of their objection.

In an emergency, the patient's wishes must take precedence.

REFERENCES: Rules and Regulations of the Medical Staff #518

Informed Consent/Refusal for Diagnosis and Therapy

Definition of Informed Consent

A practitioner, as referenced herein, is an attending physician, a fellow, a resident, a registered nurse, a nurse practitioner, radiologist assistant, or a physician assistant.

A practitioner who will be performing a procedure (or in some circumstances will otherwise be involved in the procedure for which consent is being sought) is required to provide the patient (or their legal representative) a clear and concise explanation of the patient's condition and the proposed non-emergency treatment or procedure. The explanation must be provided in the patient's preferred language. This allows the patient (or their representative) to make a reasoned and well-informed decision concerning the treatment or procedure in question. The practitioner must discuss (i) the reasonably foreseeable potential risks, benefits, and alternatives, if any, to the proposed treatment or procedure; (ii) any problems related to expected/anticipated length of recuperation; (iii) the likelihood of achieving care and treatment goals; and

(iv) the risks and consequences of foregoing treatment. For any non- emergency treatment or procedure that is expected to involve anesthesia or a secondary treatment or procedure during the same encounter, the practitioner is to disclose the possibility that an anesthesiologist within the anesthesia service may participate in their care, and that a secondary related procedure may/will occur. If the practitioner conducting the consent discussion is not the individual who will ultimately perform the procedure or provide treatment, they must be (i) appropriately qualified and privileged to perform the same procedure or provide the same treatment that is the subject of the consent discussion; and (ii) familiar with the patient's medical record. The practitioner who will ultimately perform the procedure or provide treatment must also be appropriately qualified and privileged and familiar with the patient's medical record

Circumstances Requiring Written Informed Consent

1. The written informed consent of the patient or their legal representative (i.e., parent/legal guardian, patient-designated health care agent, surrogate or court-appointed health care guardian) must be obtained in each of the following circumstances:
    a. In connection with any surgery performed in an operating room;
    b. When an invasive procedure is performed. "Invasive procedure" is defined as a procedure that involves puncture or incision of the skin, or insertion of an instrument or foreign materials into the body. It does not include certain routine minor procedures. Please see the 405 FAQs for additional guidance.
    c. When general or regional anesthesia and/or intravenous sedation is administered for purposes other than surgery or an invasive procedure;
    d. For all diagnostic and/or therapeutic treatments or procedures associated with substantial risk;
    e. When radiation therapy and/or radiopharmaceutical therapy is utilized (use Patient Consent Form for Radiation Therapy, Form #99-99108);
    f. When blood or blood components are to be administered. For consent related to the administration of blood or blood components, please reference Medical Staff Rule and Regulation #226: Transfusion of Blood and Blood Products; and
    g. For clinical trials, see IRBPB SOP IC-701: General Requirements for Informed Consent and HIPAA Research Authorization and IRBPB SOP IC-702: Waivers and Alterations of Informed Consent.
2. Written informed consent is not required in a medical emergency and/or situation in which a patient is in immediate need of medical attention and an attempt to secure consent would result in delay of treatment resulting and significant/substantial risk to the patient's life. In a medical emergency where written consent cannot be obtained, all reasonable efforts are to be made to obtain the verbal consent of the patient or their legal representative. This should be documented in the patient's medical record by the practitioner involved. Documentation in the medical record should include the nature of the emergency, the inability to obtain consent from the patient, and efforts taken to obtain consent from a legal representative. If guidance is needed after hours, the Administrator on Call is available when there is a medical emergency where written consent cannot be obtained.
3. In cases where treatment, a procedure, or surgery is related to a patient's participation in a research protocol, separate written informed consent is to be obtained, and other requirements related to the specific research protocol

are to be followed in accordance with IRB approval and any applicable law(s). Please reference Medical Staff Rule and Regulation #508: Clinical Investigation.

4. A pelvic examination may not be performed on a patient who is anesthetized or unconscious unless (i) the examination is within the scope of the surgical procedure or diagnostic examination for which informed consent has been obtained, (ii) prior informed consent specific to the examination has been obtained, or (iii) a medical emergency exists as set forth in Section II above.
5. Note that some circumstances that are not directly subject to this policy may also require written informed consent (i.e. clinical genetic testing).

Persons Capable of Giving Informed Consent

An individual may consent to medical, dental, or other clinical services if they (i) have decision-making capacity (i.e., the ability to understand the nature and consequences of the proposed treatment, including the benefits, risks, and alternatives, and to reach an informed decision); and (ii) meet one of the following criteria:

1. The patient is 18 years of age or older
2. Health Care Agents: The person providing consent is an appropriately identified, legally authorized health care agent consenting on behalf of a patient who (i) is 18 years of age or older, (ii) has been determined to lack decision-making capacity, and (iii) previously (before losing decision-making capacity) designated the person providing consent as their health care agent. The designated agent must be clearly authorized to make health care decisions on the patient's behalf. For more information about the process for determining whether a patient lacks decision-making capacity for the purpose of empowering a health care agent to make decisions, see Medical Staff Rule and Regulation #543: Family Health Care Decisions Act – Determining Patient Incapacity.
3. Surrogates: A surrogate appointed to make decisions for a patient who is 18 years of age or older who has been determined to lack decision-making capacity and did not previously designate a health care agent. A person who is 18 years of age or older may be permitted to act as a surrogate in accordance with Medical Staff Rule & Regulation #545: Family Health Care Decisions Act – Identifying and Designating Surrogates for Patients without Decision-Making Capacity. For more information about the process for determining whether a patient lacks decision-making capacity for the purpose of recognizing a surrogate's authority to make decisions, see Medical Staff Rule and Regulation #543: Family Health Care Decisions Act – Determining Patient Incapacity.

---

[1] In any circumstance in which the person who is conducting the consent discussion is not the practitioner who is performing the procedure, the practitioner who is performing the procedure always remains responsible for ensuring that all necessary elements of an informed consent discussion (including risks, benefits, and alternatives to the procedure or treatment) have been included in the discussion. The practitioner who is performing the procedure must, prior to performing the procedure or providing the treatment, verbally review the prior consent conversation with the patient and write a brief note in the progress notes documenting that a complete review of the risks, benefits, and alternatives has occurred, and that all questions of the patient or legal representative have been answered.

4. Parents/Guardians: The parent or guardian of a patient who is under 18 years of age (even if the parent or guardian is under the age of 18). The written informed consent of one or both parents (if feasible) or of the guardian is to be secured. Minor patients are to be involved in the consent discussion whenever appropriate. If a parent or guardian is refusing administration of blood or blood products, see Medical Staff Rule and Regulation 226-D: Refusal of Transfusion of Blood and Blood Products. If a parent who is under the age of 18 is consenting to withhold or withdraw life-sustaining treatment for their child, see Medical Staff Rule and Regulation #546: Family Health Care Decisions Act – Obtaining Consent.
5. Emancipated Minors: The patient is under the age of 18 and is an emancipated minor. In New York, an emancipated minor is a person who is under the age of 18 who (i) is the parent of a child; (ii) has been married; or (iii) is 16 years of age or older and living independently from their parents or guardian. In New Jersey, an emancipated minor is an individual who is under the age of 18 and who (i) is the parent of a child or is pregnant, (ii) has been married, (iii) has entered military service, or (iv) has been previously declared by a court or an administrative agency to be emancipated. If an emancipated minor is consenting to withhold or withdraw life-sustaining treatment, see Medical Staff Rule and Regulation #546: Family Health Care Decisions Act – Obtaining Consent.
6. Runaway/Homeless minors: (i) Homeless youth (persons under age 18 who are in need of services and are without a place of shelter where supervision and care are available); and (ii) youth receiving services from an approve runaway and homeless youth crisis program or transitional independent living support program may alone consent to medical and dental treatment.

Procedure for Obtaining Consent

While the consent process is generally conducted in-person and includes the execution of necessary consent form(s) by the patient or their legal representative, in limited circumstances consent may be obtained via telephone. Please see the RR 405 Informed Consent FAQs for additional guidance.

Who May Obtain Consent

1. The practitioner who will be performing the procedure or providing the treatment should conduct the consent discussion with the patient or their legal representative, except as otherwise permitted by this Rule and Regulation. For more information on the scope of practice for Advanced Practice Providers (APPs), see Medical Staff Rule and Regulation #523: Advanced Practice Provider Division. For more information on the scope of practice for residents and fellows, please reference their department-specific clinical privileges forms. The practitioner must write a brief progress note documenting that (i) the reason for the procedure or treatment has been explained; and (ii) the risks, benefits, and alternatives, if any, of the proposed procedure or treatment have been discussed.
2. Registered Professional Nurses ("RNs") may obtain informed consent for those procedures that they perform (e.g. PICC Line Insertion) and from patients participating in applicable state immunization registries. An RN can consent a patient for an IRB-approved clinical trial under the following circumstances:
   a. The RN is named as a consenting professional on the face sheet of the study.

b. The RN is certified in human subjects research, and
c. The RN is knowledgeable about the protocol and is able to discuss the protocol fully with patients/subjects.

3. In limited circumstances, the person who conducts the consent discussion with the patient or their legal representative may be a practitioner other than the individual who will be performing the procedure or providing the treatment. Such other practitioner must be (i) duly qualified and privileged to perform the same procedure or provide the same treatment that is the subject of the consent discussion, and (ii) familiar with the relevant portion of the patient's medical record. In such a case, the individual who conducted the consent discussion must write a brief note in the progress notes (i) documenting the reason for the procedure or treatment; (ii) specifying that the risks, benefits, and alternatives (if any) of the proposed procedure or treatment have been discussed; and (iii) confirming that the practitioner(s) who will be performing the procedure or providing the treatment has/have been identified. If the practitioner performing the procedure is not known at the time of the consent discussion, the names of all potential practitioners who may perform the procedure must be listed in the consent form.
4. Notwithstanding the information provided in Paragraph #3 of this section, if a patient is undergoing multiple consecutive procedures in the same setting that are performed by different practitioners, then informed consent must be obtained as follows:
   a. When one practitioner is privileged and qualified to perform all procedures:
      - Consent for each procedure may be obtained by that practitioner. The practitioner obtaining consent must discuss and document the risks, benefits, and alternatives specific to each individual procedure. The consent note and consent form should include the names of the practitioners performing each procedure.
      - The practitioner who did not obtain the consent who is performing the procedure must, before the procedure, verbally review the prior consent conversation and write a brief note documenting that a review of the risks, benefits, and alternatives occurred and that all questions have been answered.
   b. When each practitioner is only privileged and qualified to perform their own procedure:
      - In general, each practitioner will need to have a consent discussion with the patient, document the discussion, and obtain signed consent for their own procedure.
      - There is a very limited exception which allows a primary practitioner to obtain consent for a secondary procedure performed by a different practitioner when the secondary procedure is necessary to facilitate the first. For more information, please see the RR 405 Informed Consent FAQs.

Completing Informed Consent Forms

1. The practitioner who is conducting the consent discussion completes the first paragraph of the patient consent form. Informed consent forms may not include any acronyms or abbreviations except spinal levels (C-Cervical, T-Thoracic, L-Lumbar, S-Sacral when identifying spinal levels – e.g., L4-5).
2. If the practitioner who is conducting the consent discussion is not the

individual who will be performing the procedure or providing the treatment, the patient consent form is also to include the name(s) of the practitioner(s) who will be performing the procedure or providing the treatment. The practitioner who is conducting the consent discussion must sign and date the certification on the consent form, attesting to the fact that they have discussed the risks, benefits, and alternatives of the proposed procedure or treatment with the patient or legal representative. At the time of the signing of the certification, the practitioner must also obtain the signature of the patient or their legal representative attesting to the fact that the risks, benefits, and alternatives have been disclosed and that all of the patient's or legal representative's questions have been answered.

3. The patient's informed consent is to be obtained prior to the proposed procedure or treatment to ensure the patient or their legal representative understands the risks and benefits involved. The conversation is to take place before the procedure or treatment and before sedation or anesthetic agents are initiated. This conversation must be documented in a separate note in the medical record and should include the date and time of the conversation. The patient or their legal representative must sign, date, and time appropriate line(s) of the consent form. Signatures must be obtained in ink on the paper consent form or, in limited circumstances, through an approved e-consent platform for virtual signature. A patient or legal representative may defer their signature, but the signature must be obtained prior to the procedure or treatment. At the time of signature prior to the procedure or treatment, the patient/legal representative should be asked if they have any questions. If they have questions, they must be referred to the practitioner performing the procedure or another practitioner that is (i) duly qualified and privileged to perform the same procedure or provide the same treatment that is the subject of the consent discussion, and (ii) familiar with the relevant portion of the patient's medical record.
4. A witness to the patient's or their legal representative's signature must also sign, date, and time the appropriate line(s) of the consent form. A Memorial Hospital employee, or a family member, friend, or other associate of the patient or their legal representative may serve as a witness to the patient's or their legal representative's signature as long as they are at least 18 years of age. If interpreter services are used the interpreter may serve as a witness. A witness must first verify the identity of the patient or legal representative, and either observe the patient or legal representative actively signing the form or otherwise confirm with the patient or their legal representative that the signature on the consent form is in fact the patient's or legal representative's signature. After doing so, the witness is to sign and date the form on the signature verification witness line.
5. Any person who obtains consent for a subject to participate in human subjects research must be approved or permitted to do so by the IRB in accordance with IRB policies. For more information, please see IC-706 Documentation of Informed Consent and Research Authorization.

---

[2] Conditions specific to the patient (i.e., co-morbidities, obesity, immunosuppression, smoking, or alcohol use) that enhance the risks or create additional risks should also be disclosed.

6. For consent to be considered informed, the practitioner conducting the consent discussion must engage the patient or their legal representative in a conversation and disclose the following in a manner permitting the patient or legal representative to make a knowledgeable evaluation and in language that the patient or legal representative can reasonably be expected to understand:
    a. The nature and purpose of the proposed treatment or procedure;
    b. The reasonably foreseeable risks, potential benefits, and side effects of the proposed treatment or procedure, as well as potential problems related to recuperation and the likelihood of achieving care and treatment goals;
    c. The reasonably foreseeable risks, potential benefits, and side effects related to alternatives, including the risks and consequences of no treatment; and
    d. The identity of the physician who has primary responsibility for the patient's care, and, when applicable, the fact that another practitioner or practitioners may be performing important tasks related to the procedure or surgery.
7. Hospital interpreter services are required for obtaining informed consent from patients or legal representatives for whom English is not their preferred language, including individuals who are hearing impaired (except in emergent circumstances when seeking a professional interpreter will delay care). Interpreter services may be requested following Administrative Policy & Procedure #3002: Patient Communication Assistance. If an interpreter is used, then the relevant box must be checked on the consent form and use of interpreter services must be documented in the consent note that is included in the medical record. Interpreters who assist with the interpretation of written informed consent forms can serve as both the interpreter and the witness unless the interpreter is remote.
8. If the patient lacks the capacity to consent to treatment and no appropriate legal representative for the patient is available to give consent in person, the practitioner who will be performing the procedure or providing the treatment may obtain consent from the appropriate legal representative by telephone or virtually. A witness is to listen to the conversation and sign and date the witness verification line. The practitioner will immediately document in the patient's chart the time of the conversation and the manner in which consent was obtained.
9. Consent Form Timeframe:
    a. A signed consent will be considered valid for no longer than forty-five (45) calendar days, beginning from the time the practitioner signs and dates the consent form, unless there is a significant change in the patient's condition, or another circumstance requiring a new consent in accordance with Section V below applies.
    b. If radiation oncology treatment is to be provided, the consent is valid for 45 calendar days from the date of simulation if the patient has not received any radiation treatment prior to simulation. If the patient has been receiving a planned course of therapy to a specific site and needs to stop treatment, they may resume treatment with the same consent if it is less than 45 calendar days old, unless there is a significant change in the patient's condition, or another circumstance requiring a new consent in accordance with Section V below applies.
    c. When a patient has consented to a treatment plan that includes multiple

repetitive procedures, repeated at specific intervals over a defined period of time (i.e., photodynamic therapy, bone marrow testing, and/or lumbar puncture), it will generally not be necessary for the practitioner to obtain a separate written consent for each such procedure. Although obtaining a separate written consent is not required, the practitioner who will perform each procedure during the course of a treatment plan shall reassess prior to that procedure whether a new consent is necessary. The practitioner who will be performing the procedure or treatment must include in the documentation that the discussion with the patient or their legal representative has included (i) an explanation of the need for one or more additional procedures; (ii) the expected interval and period of time during which the procedures will occur; and (iii) the practitioner(s) who will perform the procedure or treatment as part of the treatment plan. In general, a written consent for a treatment plan including multiple repetitive procedures shall be for a treatment plan no longer than twelve (12) months in duration from the date of practitioner's signature. However, written consent for multiple transfusions of blood or blood components may not be for a longer duration than that allowed by Medical Staff Rule and Regulation #226: Transfusion of Blood and Blood Products.

10. Although patient educational materials may not serve as a substitute to a consent discussion, all services are encouraged to supplement a patient's consent and understanding by use of written or audiovisual aids produced by MSK for the proposed procedure as well as the patient and family education materials available.

Obtaining a New Consent:

A new consent form must be obtained in each of the following circumstances:

- When a significantly different operation or procedure is to be performed that is substantially different from the operation or procedure for which the initial consent was originally given.
- If in the practitioner's judgement, there is a significant change in the patient's condition or plan of care.
- If more than 45 calendar days have elapsed since the consent form was last signed and dated except as described in Section IV (9c).
- If the consent form is altered after the patient or their legal representative has signed it or is illegible. See Section VI Amendments to Consent Forms for more information on altered consents.
- If the consent form is missing the date or, a signature, or any other required field.
- For surgery consents, if the blood consent box is checked, but the blood consent form is not complete.

Amendments to Consent Forms

A new consent may not be required if a patient or legal representative wishes to modify the written consent form. Any modifications are to be dated and initialed by the patient and discussed with the practitioner who is conducting the consent discussion. The practitioner who is conducting the consent discussion must document such change(s) in the progress notes, affirming that the risks, benefits, and alternatives of the procedure or treatment have been explained to the patient or legal representative. The practitioner is not obligated to proceed with the procedure if they are not in agreement with the patient's modifications to the consent form. The

practitioner should only agree to the requested changes if they deem the procedure safe to proceed with the proposed amendments. The practitioner accepting the changes is responsible for taking the necessary steps to ensure the patient's wishes are followed. If an MSK staff member makes changes to the consent form after the patient has already signed it, then a new consent form is required. A new consent is required if significant strikethroughs and alterations are made such that the patient or legal representative would not be able to comprehend the details of the consent.

Exceptions to Informed Consent

The Family Health Care Decisions Act authorizes an attending physician to decide about routine medical treatment and major medical treatment for incapacitated adult patients without a health care agent or surrogate. For more information, see Medical Staff Rule and Regulation #546: Family Health Care Decisions Act - Obtaining Consent. The Office of General Counsel should be contacted in this situation.

Additionally, the following situations do not require written informed consent:

1. Any medical emergency as documented in the chart by the responsible practitioner (see Section II(2)).
2. When the patient assures the practitioner who will be performing the procedure or providing the treatment that the patient would undergo the treatment or procedure regardless of the risk involved. Every effort should be made to have the patient sign the informed consent form. However, if the patient continues to decline signing the form (despite confirming that they would undergo the treatment or procedure regardless of the risk involved), the practitioner should (i) consult a second practitioner to witness the refusal, and (ii) document this in the patient's medical record.
3. When the patient indicates that they do not wish to be informed of matters involving their treatment, procedure or diagnoses. In this situation, the Ethics Committee may be consulted. This should be documented in the patient's medical record by the practitioner involved. For each subsequent treatment, procedure or diagnosis that require informed consent, a new consent or confirmation of patient's wishes to not be informed of matters involving their treatment, procedure or diagnoses must be sought and obtained.
4. If the practitioner reasonably believes that the manner and extent of disclosure could adversely or substantially affect the patient's condition after considering all the attendant facts and circumstances. In this situation, the Psychiatry and Behavioral Sciences Department may be consulted. This should be documented in the patient's medical record by the practitioner involved.

Consent Issues in the Intensive Care Unit

Written informed consent for most invasive procedures performed in the ICU must follow the informed consent process detailed in this policy. In light of the frequently emergent care rendered in the Intensive Care Unit (ICU) where patients are managed by Critical Care Medicine (CCM), attending physicians or designees on the CCM Service will, upon consultation/Rapid Response Team (RRT), and/or admission to the ICU, conduct a consent discussion with the patient or their legal representative regarding the procedures or treatments potentially to be performed or administered by practitioners in the ICU. This consent discussion will be briefly addressed in the admission or consultation note.

Consent is not needed for arterial and central venous catheter placement, intubation, mechanical ventilation, and bronchoscopy in the ICU once the patient has elected to proceed with ICU treatment.

Refusal to Consent

1. Every competent adult patient has the right to refuse consent for a specific procedure or leave Memorial Hospital against medical advice. If this occurs, it should be thoroughly documented in the medical record including (i) the treatment that was recommended, (ii) the risks of receiving the treatment, and (iii) the risks of not receiving the treatment. If the patient lacks decision making capacity, the decision to refuse consent or leave against medical advice will be made by the patient's legal representative. If an adult patient wishes to leave Memorial Hospital against medical advice, see Administrative Policy and Procedure #2204: Patients Leaving Hospital Against Medical Advice. If the parent of a pediatric patient wishes to remove their child from Memorial Hospital against medical advice, see Medical Staff Rule and Regulation #106: Pediatric Discharge Against Medical Advice. Patients leaving Memorial Hospital against medical advice will be asked to sign the Refusal of Treatment form (Form #56-08492).
2. If the patient refuses the transfusion of blood or blood products, see Medical Staff Rule and Regulation #226-D: Refusal of Transfusion of Blood and Blood Products

SOURCE: Rules and Regulations of the Medical Staff #405 & 405 FAQ

Intravenous Therapy Team and House Staff Responsibilities Regarding Vascular Access

The Intravenous Therapy Team

A group of specialized nurses and technicians are available to assist physicians in meeting the intravenous therapy needs of MSK patients.

1. The IV team tries to coordinate care and minimize venipunctures performed on all patients. Therefore it is recommended that all routine specimens be ordered in advance preferably the day before.
2. Times Available: The IV Team is available 24 hours a day, 7 days a week, including holidays.
3. Blood Draw Rounds start at 6:00 AM

House Staff Responsibilities re: Blood Specimens and Venous Access

MSK house staff is responsible for meeting the following intravenous therapy needs of their patients:

1. Drawing specimens which the IV Service is unable to obtain on specific patients. Two members of the IV Team will attempt to obtain the specimen before notifying the primary nurse.
2. Starting IVs on patients when the IV Service is unable to do so.
3. Drawing all emergency specimens when the IV Service is unavailable.
4. Obtaining approval from the respective laboratory director and drawing all specimens ordered as emergency but not on the approved list.
5. Positive Patient Identification: The Medical Board at MSK requires that all patient specimens must be labeled at the bedside at the time the specimen

is obtained. If you draw the blood you must label the specimens with the corresponding OMS label. Please note that all type and cross specimens require that the time be written in with the initials of the person obtaining the specimen.

Laboratory Policies and Critical Value Results

Critical results (also known as critical values) of diagnostic laboratory tests are those that represent a pathophysiologic state so at variance with normal as to potentially require immediate clinical intervention by a licensed caregiver.

Hematology, Clinical Chemistry and Microbiology

All laboratory results must be reviewed by a licensed technologist and released by electronic interface to the Clinical Information System (CIS). In addition to the normal results reporting process, critical values must be reported directly to a licensed practitioner (as privileged and credentialed) as follows:

A. Notification: All critical values must be reported directly to an appropriate licensed practitioner (as privileged and credentialed) within 60 minutes of the value's release to the CIS. In the event that the ordering clinician is unavailable, a critical value must be reported to another licensed practitioner (as privileged and credentialed)

B. Acceptance: Licensed practitioner Acceptance and Acknowledgement is required for all critical values; this can be completed via the following routes:

1. Verbal notification between a licensed practitioner and the laboratory where the name, MRN, and results must be read back to complete the acceptance
2. Electronic notification via Voalte where the licensed practitioner (as privileged and credentialed) must electronically acknowledge acceptance in the application

Whether a critical value is reported via a verbal exchange between the licensed practitioner (as privileged and credentialed) and the Laboratory or via the licensed practitioner's review of the CIS record, notification is not complete until the licensed practitioner reads the value and two patient identifiers (name and DOB or MRN) back to the reporting technologist to ensure accuracy.

C. Documentation: The laboratory will document the time the result was released, the time the licensed practitioner read the result back to the technologist, or if electronically acknowledged, the time of acknowledgement, and the name of the licensed practitioner who accepted the result. Periodic audits of this documentation must be performed in order to monitor compliance with the notification policy.

D. Critical Values Defined: Critical values were defined by the MSK Laboratory Utilization Committee, reviewed by the Clinical Council and approved by the Medical Board. The list of these tests and their critical values can be found in the Department of Laboratory Medicine Critical Values Policy (L ABM-OPER-POLC-1082).

Radiology

In Radiology, unexpected, life-threatening situations discovered by a radiologist constitute critical results.

The radiologist interpreting an imaging exam will determine whether a certain radiologic finding represents a critical result. If a radiology resident, fellow, or attending does deem a finding to be a critical result, he/she will discuss the finding

with a Licensed Independent Practitioner or physician assistant (PA) caring for the patient immediately upon recognizing that finding. Immediately is defined as the time when the life-threatening finding is recognized and contact with the LIP or PA is established without a break in the process of notification.

The discussion between the resident, fellow or attending and the LIP or PA caring for the patient must be documented in the final radiology report, and must include the full name of the LIP or PA who was notified, as well as the date and time of notification. Audits of such documentation will be performed in order to monitor compliance with the notification policy and will be reported to Radiology QA.

Critical results in Radiology include, but are not limited to:

- tension pneumothorax
- saddle or other extensive pulmonary embolism
- new deep vein thrombosis/thrombus in visceral vessel (for example: femoral, SVC, IVE, jugular, mesenteric, etc.)
- new thrombus, cardiac tumor, or foreign body within cardiac chamber
- feeding or nasogastric tube in the airway or lung
- active extravasation from a blood vessel
- splenic rupture
- ischemic bowel
- acute aortic dissection
- large acute hemorrhage (anywhere in body)
- acute territorial brain infarction
- opening pressure at lumbar puncture > 35. Note that both the service that ordered the puncture AND Neurology (beeper 1444) must be notified
- severe cord compress (ESCC2 or greater)

Other radiologic findings, not listed above, may be deemed as life-threatening critical results based on the radiologist's professional judgment.

Cardiology and Pulmonology

EKG technologists and ECHO Sonographers are to notify the proper physician or a member of the clinical team of any critical results immediately after the completion of the study. EKGs are reported within 20-minutes of recognition of the critical result. ECHOs and Stress tests are reported within 60-minutes of recognition of the critical result. The name of the clinician notified by telephone, the date and time of the notification must be documented.

In turn, when such values are reported the ordering clinician writes down, when possible, and reads back the value reported to confirm. Monitoring outcomes for critical results are aggregated, analyzed, and reported at the end of each quarter via the QA Reports for the Department of Medicine (DOM) QA Committee.

Cardiology: Critical Values Regarding EKG:

- Tachycardia or Bradycardia – rate < 30 > 160
- Life Threatening Ischemia – ECG-ST Elevation Suggesting Transmural Ischemia > 1mm ST Evaluation in 2 Contiguous Leads
- Life Threatening Arrythmias
- QTc Prolongation > 500 msec
- 2nd Degree (Mobitz type II) or 3rd Degree Heart Block Without Pacemaker
- Complete Heart Block Without Pacemaker

- Atrial flutter/fibrillation not previously known
- Left Bundle Branch Block (LBBB) not previously known
- Supraventricular Tachycardia (SVT)
- Marked ST depression consistent with subendocardial injury

Cardiology: Critical Values Regarding ECHOS:

- Intercardiac masses or thrombus
- Severe aortic stenosis
- Large pericardial effusion and/or findings suggestive of tamponade physiology
- Major change in EF, defined by one grade level drop in LV systolic function
- Severe LV systolic dysfunction (EF <= 30%)
- Severe pulmonary hypertension (PASP >70 mm Hg)

Cardiology: Critical Values Regarding STRESS TESTING:

- Extensive Ischemia
- Significant Abnormality of Heart Rate, Blood Pressure and Symptoms

Pulmonology

Pulmonary technologists are to notify the proper physician or a member of the clinical team of any critical results as soon as possible after the completion of the study. All critical results are reported within 60-minutes of recognition of the critical result. The name of the clinician notified by telephone, the date and time of the notification must be documented. In turn, when such values are reported the ordering clinician writes down (when possible) and reads back the value reported to confirm accurate receipt. Monitoring outcomes for critical results are aggregated, analyzed, and reported at the end of each quarter via the QA Reports for the Department of Medicine (DOM) QA Committee.

Critical Values Regarding Pulmonary Function Tests:

- Pulse Oximetry
- Resting oxygen saturation (SpO2) <90%
- Exercise Room Air Oxygen Saturation (SpO2) <88%
- Ventilatory Studies
- Vital Capacity (FVC or SVC) <1000mL or 30% of predicted
- FEV1 <800mL or 40% of the measured vital capacity
- DLCO (diffusing capacity) <30 % predicted after Hgb adjustment

SOURCE: Rules and Regulations of the Medical Staff #406

Pathology

Pathology critical results include interoperative pathology (frozen sections). Notification of results of critical tests will be made by the individual interpreting the tests to the ordering provider or their on-call designee.

Results of critical tests are to be communicated as soon as possible to the ordering physician, but no longer than 60 minutes from the time the specimen is received in the laboratory to the time the results are available, even if the results are normal.

Reporting times for critical tests are documented by the reporting department.

SOURCE: Rules and Regulations of the Medical Staff #406

Medication Reconciliation

Medication reconciliation is a multidisciplinary process intended to reduce adverse drug events. The reconciliation process identifies and resolves discrepancies by comparing medications that the patient is taking with newly prescribed medications. The process addresses duplications, omissions, interactions and the need to continue current medications.

There are 2 major components to medication reconciliation:

1. Creation of an accurate Home Medication List (HML) as reported by the patient, including all medications the patient is taking and
2. Maintenance (review and update) of current medications when the patient is admitted to, transferred within, or discharged from the hospital or is seen during an outpatient visit in which a medication may be prescribed.

Documentation of the medication reconciliation process including the electronic version of the Home Medication List (eHML) is completed in the MSK Clinical Information System (CIS).

A list of the required HML maintenance procedures for each care setting (see below) can be found in Regulation 211A of the Rules and Regulations of the Medical Staff on the MSK intranet:

- Outpatient Encounters including Outpatient Visit, Pre-Surgical Testing Visit;Outpatient IR/Endo Procedures, Ambulatory Surgery Program and Urgent Care Center treatment;
- Inpatient Encounters including Inpatient Admission, Transfer and Discharge, and
- Outpatient Radiology

SOURCE: Rules and Regulations of the Medical Staff, #211A

Medication Regulations

Members of the Medical Staff or other practitioners approved by the Medical Board shall prescribe medications from the approved Memorial Hospital Formulary, whenever feasible. Only drugs listed in the Formulary will be dispensed to outpatients. Each patient's response to their medication is monitored according to the clinical needs of the patient and addresses the patient's response to the prescribed medication and actual or potential medication- related problems.

Medication Orders

1. All orders for medications must be entered through the electronic order management system or written on the Physician Order Form (#56-08286. or other approved order forms by a practitioner with authorized clinical privileges. A complete medication order includes:
   - The full name of the patient and MRN
   - Age and weight, when appropriate (For pediatric patients: patient body weight must be included in the order: body surface area must be included in the order when relevant)
   - Drug name
   - Dose, frequency, and route of administration
   - Dosage form, when appropriate
   - Concentration, when appropriate

- Duration, when appropriate
- Clinical indications, when appropriate (i.e., prn orders and non-formulary medications)
- Specific instructions for use
- Name of prescriber
- Signature and contact number of prescriber
- Date and time

2. As needed ("prn") orders must include a time interval and an indication for use.
3. "Standing" medication orders in the Clinical Information System (CIS) expire after 365 days, with exception to those identified in the Automatic Stop Order policy.
4. Range, Titrating and Tapering Medication orders:
   - When a range dose order is written, instructions on how the RN determines the indication, the dose and dosage interval in which to administer the medication must be included in the order.
   - Range dose orders must clearly define the reason for use. The RN should begin with the lowest possible dose initially. The dose used and patient response must be clearly documented. The dose may be increased at future intervals based upon the nursing assessment.
   - Orders for a range in frequency are not acceptable.
   - Titration orders must include parameters for dosage adjustment.
   - Taper dose orders must include the drug, dose amount, route and days of therapy or numbers of doses at each dose amount.
   - "Sliding Scale" orders must include the drug name, dose and route for each sliding scale and parameter. The order must also provide direction for management of the patient if the parameter falls above or below the scale.
5. "Resume" orders (i.e., blanket or summary orders) are not permissible. "Hold Orders" are only acceptable with a qualified, defined, standard nursing parameter.
6. Verbal orders should be used infrequently. A pharmacist or RN may accept a verbal order issued by attending and house staff physicians, nurse practitioners and physicians' assistants (for specific on scope of which verbal orders can be accepted by different clinical staff, see Medical Staff Rule and Regulation #204).

   A verbal order will not be accepted for intraoperative medications. Verbal orders for initiation or modification of chemotherapy or biologic therapy will not be accepted with the following exceptions.

   A verbal order from an attending physician may be accepted by a registered nurse or registered pharmacist for:
   - Administration of a chemotherapeutic, biologic or investigative agent for a patient whose lab values fall outside the original lab parameters set.
   - Modification of the administration rate once infusion has begun
   - Same-day resumption of infusion after resolution of a reaction at a rate delineated in the drug-specific MSK chemotherapy guideline or by a chemo/biologic therapy-privileged attending physician, nurse practitioner or physician assistant.

   The following elements are required for a verbal order:
   - Identification of a verbal order (V.O.), date and time of order, and name of prescriber

- Full name of patient and MRN
- Age and/or weight when appropriate (for pediatric patients: body weight must be included in the order; body surface area must be included in the order when relevant)
- Drug name
- Dosage form, when appropriate
- Dose, frequency and route of administration
- Concentration, when appropriate
- Duration, when appropriate
- Clinical indications, when appropriate
- Specific instructions for use
- Signature of the RN or pharmacist

The RN or pharmacist will document the verbal order on the physician order form or enter the information into the electronic order management system and write down and clearly read back to the elements of the order as described above.

The prescriber must authenticate verbal orders no later than 48 hours after the order was given.

The pharmacist will enter the order in CIS and the RN will document the order on the Medication Administration Record.

7. Automatic Stop Orders: All inpatient orders for controlled medications must be renewed every 7 days. Exceptions for individual medications will be determined by the Pharmacy and Therapeutic Committee.
8. Compound drug mixtures which are not commercially available are prepared by an onsite MSK-licensed pharmacist according to federal, state and institutional regulations.
9. When a medication related device is used with a medication, the prescriber will note this as part of the order (e.g., Fluorouracil 1000 mg/m2/day x 5 days IVCI via pump.)
10. Medication orders are reviewed by a pharmacist and potentially confusing elements of the order (i.e., Look/Sound Alike medication names) are clarified with the authorized prescriber, when necessary, to ensure the intended medications are dispensed and administered. A reference defining commonly prescribed Look/Sound Alike formulary medications is available in clinical areas; the pharmacy label utilizes TALL MAN lettering for these agents. For Chemotherapy, drugs are pre-defaulted on the electronic order forms or selected from a predefined drug library that incorporates the TALL MAN lettering into the agents' names.
11. Conversion of medications from intravenous to oral route will comply with pharmacy policies PHM0201-015.

Chemotherapy/Biologic Therapy Orders

The electronic "Adult Treatment Order" (eATO) or electronic "Pediatric Chemotherapy Order" (ePTO) forms are the only order forms to be used for prescribing parenteral or other chemotherapy/biologic/cellular therapy to be administered on-site except for the areas where the online functionality is not yet implemented or if the CIS ordering system is not functioning. A blank Adult Treatment Order form (ATO) is available in

Standard Register.

The orders may be entered/written by an attending physician, fellow, nurse practitioner, advanced practice nurse or physician assistant appropriately credentialed to do so by his/her department/service. Patients are to see an attending physician for a change in regimen/treatment plan that includes addition of one or more new antineoplastic agents. Orders entered/written by a fellow, nurse practitioner, advanced practice nurse or physician assistant who are not credentialed to independently prescribe these agents, must be approved online, or co-signed by an attending physician credentialed to do so by their department.

Chemotherapy/biologic/cellular therapy ordered in Clinical Information System (CIS) will be calculated based on prescribed base doses and the treatment dose will be rounded by the system, up to a maximum modification of 4.8%.

Standard antiemetic, hydration, and supportive medication guidelines (when applicable) are available to all clinicians on the MSK Intranet under "Chemotherapy and Biologic Therapy Guidelines". Each chemotherapeutic/biologic agent guideline referenced contains specific dose-related details regarding the severity of emetogenicity, specific hydration and supportive medications. Common disease-related combination chemotherapy regimens are posted with regimen-specific antiemetic guidelines. For combination therapy not specified on the web site use antiemetics recommended for the agent with the highest emetogenic potential.

Modifications to Standard Antiemetics, Hydration, and Supportive Medication on Adult Chemotherapy/Biologic Orders

If orders other than the MSK standard are to be used, the physician is required to check the applicable boxes and write/enter in new orders. The last order changed relating to antiemetics or supportive medications, by date, takes precedence over ALL PRIOR orders for the specific chemotherapy encounter and becomes the standard order for this patient, provided that those changes are within the guidelines approved by the Medical Board. An ordering physician may order antiemetics or other supportive medications outside of the standards, as clinically indicated. All modifications to hydration orders require a specific order for each chemotherapy treatment, based on specific patient need. Periodic Institutional Review of Guidelines is conducted through the Chemotherapy Practice Committee of the Hospital's Pharmacy and Therapeutics Committee.

Biosimilar Therapeutic Substitution Policy

- Biologic – A drug which is manufactured in a living system such as a microorganism or cell culture, and which replicates a natural substance such as an antibody, hormone, or enzyme.
- Reference Product – Also known as the originator; a reference product is the single biologic product, already approved by FDA, against which a proposed biosimilar product is compared.
- Biosimilar – A biosimilar is a biologic product that, as determined by the FDA, is highly similar to and has no clinically meaningful differences from an existing FDA approved reference product.
- Therapeutic Substitution – When a drug is switched for another in the same category without involving the prescriber.
- Dispensed as Written – A specific brand or generic is dispensed based on the prescriber's instructions.

In MSK Outpatient Clinic or Inpatient settings, pharmacists will be permitted to make therapeutic substitutions between reference products and their FDA approved biosimilar(s). Reference products and their FDA-approved biosimilars will be regarded as therapeutically equivalent with one another in prescribing, dispensing, and administration to patients in MSK hospital and clinic settings.

In MSK retail or specialty pharmacies, reference products and their biosimilars must be dispensed as written. The prescription must be filled and dispensed as written, whether by brand name or INN (International Nonproprietary Name), commonly known as a "generic" name. If a switch to another product is required (i.e., insurance company requirement) the pharmacist may contact the prescriber to ask them to discontinue the current order and enter new order.

Investigational Drugs

All drugs under investigation as defined by the Food and Drug Administration must first be approved by the Institutional Review Board before being used on patients in this institution. The protocol must include all requirements for the patient's appropriate informed consent.

It shall be the responsibility of the principal investigator or his designee to control distribution of the drug and maintain required records. All investigational drugs intended for human use should be received, logged, stored, and dispensed by the Division of Pharmacy Services. Investigational agents are to be administered by fellows, protocol attending physician or RN's if appropriate. Exceptions are subject to the discretion of the principal investigator, Division of Nursing and the Pharmacy and Therapeutics Committee as appropriate.

Upon discharge of a patient receiving an investigational drug, all remaining prepared stock of the drug will be returned to the pharmacy where the drug will be destroyed, returned to inventory or returned to the sponsor, as appropriate. If the patient is to remain on the investigational drug while at home, a separate outpatient prescription will need to be ordered.

Prescriptions for investigational drugs must be written/entered by an attending physician, fellow, or nurse practitioner. All orders must be printed out and signed by an attending credentialed to do so by his/her department. Alternatively, for fill at MSK prescriptions only, a printed signed copy is not required for dispensing if it is both entered and released electronically by an attending credentialed to do so by his/her department.

Verbal orders for investigational drugs may not be called in to a pharmacy, nor can they be accepted by an MSK pharmacy.

Restricted Drugs

With Medical Board approval, the use of certain drugs may be restricted from general hospital use. When there is an immediate need for a restricted drug, the appropriate service must always have a physician available for consultation.

Pharmaceutical Samples

Samples of pharmaceuticals may not be accepted or distributed for inpatient or outpatient use or for use by Employee Health Services.

Interactions with Industry
Adhere to institutional policy regarding interactions with industry (*COMP-C002: Policy for Interaction with Industry*). In general acceptance of gifts, meals, and financial contributions are not permitted. Sales representatives are not permitted on any MSK campus.

Unused Inpatient Unit-Dosed Medications
Medication remaining in the inpatient Unit Dose Bin cannot be given to the patient as a take home prescription.

Medication Use Evaluation Service
The goal of the Medication Use Evaluation (MUE) Service is to improve patient outcomes while decreasing healthcare costs. The MUE service is a method of performance improvement that utilizes an indicator-based, ongoing and systematic process to evaluate the use of medication. The indicators for evaluation focus on prescribing, dispensing, and administering medication as well as monitoring patient outcomes. This ensures medications are used appropriately, safely, and effectively. The identification of opportunities for improvement results in recommendations specifically designed to resolve these issues. The MUE effort is coordinated by the Clinical Staff of the Division of Pharmacy on a hospital-wide basis in conjunction with the Pharmacy and Therapeutics (P&T) Committee.

Prescription Orders for Outpatients and Patients Being Discharged
Medication dispensed to an outpatient by an MSK pharmacy or any other licensed pharmacy cannot be accepted back for patient reuse according to New York State Department of Health Board of Regents – part 29.

Non-Controlled Drugs
All prescriptions must be electronically submitted, whether it is being filled at MSK or at an outside pharmacy.

During downtime, if the prescription (Rx) is printed on NYS official prescription form, it must be signed by the licensed practitioner (as privileged and credentialed). If the prescription is written on hospital-issued NYS Official Prescription Forms, the licensed practitioner MUST stamp or print their name on the prescription.

Verbal orders for prescriptions for non-controlled drugs are accepted by Memorial Hospital retail pharmacies if the above stated downtime process is not an option. The pharmacist must comply with Federal and State regulations when taking in verbal/oral prescription as written in NYS, Pharmacy Guide, Article 137 section 6810(4). The pharmacist may utilize the telephone prescription form (located in Division of Pharmacy Policy 0202: Retail Pharmacy) for such orders. Verbal orders and verbal changes may not be accepted for chemotherapy and investigational medications.

Chemotherapy or Biologic Therapy
Prescriptions for chemotherapy and biologic therapy whether filled at MSK or at an outside pharmacy may be written/entered by an attending physician, nurse practitioner, or physician assistant credentialed to order chemotherapy independently. Orders entered by a nurse practitioner, physician assistant without independent privileges or a fellow must be signed by an attending physician credentialed to do so by their department. Verbal orders for chemotherapy and biologic therapy may not be called in to an MSK or outside pharmacy, nor can they be accepted by an MSK pharmacy.

Controlled Drugs (schedule II, III, IV, V medications)
All practitioners prescribing controlled drugs must have a DEA number to prescribe controlled substances. Non-licensed house staff will be assigned a three-digit suffix by the Memorial Hospital GME Office. This suffix is added on the hospital's DEA number to provide the legally required identification.

House Staff may not use suffixes or numbers issued at other institutions Refer to Medical Staff Rule and Regulation #246: Controlled Substances for details on controlled substances regulations in New York and #246-NJ: Controlled Dangerous Substance – New Jersey.

During downtime, if the prescription (Rx) can be printed on NYS official prescription form, the Rx must be signed by the licensed practitioner (as privileged and credentialed). If the prescription is written on hospital-issued NYS Official Prescription Forms, the licensed practitioner MUST stamp or print their name on the prescription. Verbal orders for prescriptions for controlled drugs should be reserved for emergency need only and only used if the above stated downtime processes are not an option. Only 5-days' supply can be verbally called into pharmacy. When the electronic prescribing system comes back up, an electronic cover Rx MUST be submitted to pharmacy for the verbal order. Please see Division of Pharmacy Policy 0202: Retail Pharmacy for more information regarding the downtime procedure.

Prescriptions for non-Formulary drugs will not be filled at MSK retail pharmacies. Patients will be referred to their local pharmacy.

All prescriptions will be filled on a generic basis unless a name-brand drug is written for and "DAW" has been entered in the appropriate box. If MSK does not carry the medication, the pharmacy will call the prescriber to ask for a switch to a formulary medication. If the prescriber does not wish to change the prescription, the pharmacist will refer the patient to an outside pharmacy.

Administration of Immunization Agents
Per Section 1 of the Pharmacy Policy and Procedure Manual, pharmacists properly certified by the New York State Education Department to administer immunization agents may administer influenza and pneumococcal disease vaccines as well as emergency anaphylaxis treatment to patients over the age of 18.

Administering Immediate-Use Compounded Sterile Products (CSPs)
Immediate-use CSPs require compliance with the conditions outlined in Rule and Regulation 212-D in order to ensure high quality sterile preparations and to reduce the potential for harm to patients.

Unexplained loss of prescription paper, pads, serialized stickers (institutional or practitioner specific) or controlled substances
The individual or department involved with the loss must notify Security and Pharmacy within two business days of suspected loss.

In the event of suspected theft, the local police must be notified, and a copy of the report must be obtained. Security will assist in initial notification to the police. The responsible party must file the report in person at the local precinct and obtain a copy. After obtaining the police report, report to the New York State Department of Health and the Federal Drug Administration. These reports should be coordinated through the Director of Pharmacy and Hospital Administration

Dietary Supplement/Herbal Medications
Herbal and homeopathic products and other similar remedies such as Ayurvedic and Traditional Chinese medicines, and food supplements, etc., cannot be positively identified as to their content (no federal standards exist and adulteration and misbranding are concerns) and because they are not classified as drugs by the FDA, these products may not be administered by anyone to inpatients in Memorial Hospital, including by a patient's family members and/or patient self-administration, except on IRB approved protocols per Medical Staff Rules and Regulations RR-212-C.

Patient's Own Medication
Non-Formulary Drugs brought into the hospital by patients (patient's own medication) during hospitalization shall not be administered unless the drugs have been identified by the pharmacist on staff. In order to administer a non-formulary medication, there must be a written or electronic order in the patient's chars. The process of verifying, dispensing and storing patient's own medication while patient is hospitalized is described in Pharmacy P&P 0201. Upon discharge, the remaining supply should be returned to the patient. Patient's own drugs which are listed in the MSK formulary are not to be used during the patient's hospitalization; they should be packaged and sealed and given to the patient's family or stored securely and returned to the patient at the time of discharge, provided such action is approved by the practitioner responsible for the patient.

SOURCE: Rules and Regulations of the Medical Staff #211 & 212

ePrescribe

Trainees (with or without NYS licensure) will be able prescribe in RxWriter using MSK's DEA along with the personal unique suffix issued by the GME office. You will be required to select a supervising attending for each prescription written. Your initial registration with Allscripts will be facilitated by the GME office and the CIS team, but an additional registration step will be required to electronically prescribe controlled substances (EPCS). You will be notified on your first day of training to complete this registration step if necessary.

For additional information and training videos, go to the ePrescribe page on OneMSK.

If you have issues with your ePrescribe access, please contact ePrescribe@mskcc.org during business hours, or the helpdesk after hours at 646-227-3337. The ePrescribe team is available Monday through Friday 9am to 5pm EST.

If you are unsure of your practitioner/prescribing status, please check with your program director.

State Medicaid — OPRA

Ordering, Prescribing, Referring, Attending for House Staff with Full NYS License and Federal DEA Numbers
The Affordable Care Act (ACA) requires physicians to be enrolled in state Medicaid programs if they continue to order or refer services reimbursed by the fee-for-service (FFS) Medicaid program. While house staff do not directly bill for services, they WILL order, prescribe or refer, and therefore must enroll as **non-billing providers**.

For House Staff Without Licensure or DEA:
Trainees without licensure or their own Federal DEA number are not required/ eligible to enroll at this time. For Medicaid billing purposes, pharmacy claims for services ordered by unlicensed house staff **must include the supervising physician's NPI number**.

Federal Medicare — Part D Enrollment

Unlicensed trainees are not required to enroll in Medicare for the purposes of writing Part D prescriptions. Prescriptions written by unlicensed trainees will include the enrolled MSK attending physician's name and National Provider Identifier (NPI) number (signature is not required). Licensed trainees are permitted to enroll in Medicare, however, if an enrolled MSK attending physician's name is included on the prescription, the licensed trainee does not need to enroll.

Prescription Monitoring Program (I-STOP Compliance)

The New York State Department of Health (DOH) requires that prescribers consult an online Prescription Monitoring Program Registry (PMP) at the state's Health Commerce System (HCS) website prior to prescribing schedule II, III and IV medications. This involves implementation of a state law intended to curb abuse of these drugs — the "Internet System to Track Over-Prescribing (I-STOP).

- Prescribers are required to query the system in all instances in which a schedule II, III or IV prescription is to be provided to a patient in an outpatient setting, or at the point of discharge from an inpatient setting.
- PMP query will also be required for ambulatory surgery patients being discharged from the PACU with schedule II, III or IV prescriptions.
- The query must take place within 24 hours prior to writing the prescription.
- As of now, unlicensed residents or physicians with limited permits are not able to establish accounts as prescribers but may function as Users/Designees.

The ability to access the system requires that clinicians or designees have an active HCS account.

Physicians with full NYS license (with or without Federal DEA)
Must apply for their own account:

- Go to the website to apply for a HCS Medical Professions account: commerce.health.state.ny.us/public/hcs_login.html
- Select "Sign up Here" found under "Login." A dialog box will pop up asking if you "hold a professional medical license issued by the New York State Department of Education"
- Select "Yes" It will take you to a new page where you can apply for an HCS Medical Professions account.
- On the new page, select "Apply for an HCS Medical Professions account" and follow the steps to create an account
- Your name in this section must match what is on your photo ID. A list of acceptable forms of identification can be found below
- Once you have clicked "confirm" print your Account Registration Competition information and email it along with a photo ID to Casey Mileo, HCS Coordinator in the GME Office

Unlicensed Physicians and Limited Permit Holders:

- Go to the website to apply for a HCS Medical Professions account: commerce.health.state.ny.us/public/hcs_login.html
- Select ""Sign up Here" found under "Login
- A dialog box will pop up asking if you "hold a professional medical license issued by the New York State Department of Education"
- Select "No" It will take you to a new page where you can apply for an HCS Non-Medical Professions account
- On the new page, select "Register for an account (for non-medical professionals)" and follow the steps to create an account
- Your name in this section must match what is on your photo ID. A list of acceptable forms of identification can be found below
- Once you have clicked "confirm" print your Account Registration Competition information and email it along with a photo ID to Casey Mileo, HCS Coordinator in the GME Office

List of acceptable forms of identification

- US Passport with photo and name
- US driver's license with photo and name
- US Federal, NY State ID card with photo
- Driver's license issue by the Canadian government
- Unexpired foreign passport with I-551/I-94
- Alien Registration card with photo
- Unexpired temporary resident card (INS-688)
- Unexpired employment card (INS-688A)
- Unexpired reentry permit (INS I-327)
- Unexpired refugee travel document (INS I-571)
- Unexpired employment document (INS I-688B)

Organ/Tissue/Eye Donation

Consideration of organ, tissue and/or eye donation is initiated when a patient has been pronounced dead, when death is imminent or when the process for determination of brain death has been initiated. Upon becoming preliminarily aware that changes in a patient's condition or status may trigger consideration of donation, Nursing staff will communicate with physicians involved and assist in facilitating communications with LiveOnNY (formerly the New York Organ Donor Network).

Upon pronouncement of death, the physician completes the Notice of Expiration and the Expiration Information Sheet (Form #56-04905). The physician who has pronounced the patient dead (or has determined that a patient's death is imminent) then calls the LiveOnNY at 800-443-8469. The call needs to be made within one hour of pronouncement, or within one hour of determination of imminent death, as defined by criteria outlined in the Medical Staff Rule and Regulation #227.

LiveOnNY will assess for suitability of organ, tissue or eye donation, based on clinical information provided by the reporting physician. In the case of brain death, the physician and the LiveOnNY staff will consult to ensure that the family understands brain death before the request for donation is made. The request is to be made after the initial death assessment is positive, but may be deferred until after the confirmatory testing is completed. If brain death will not be declared and the family

elects to withdraw support, determination of cardiac death or irreversible cessation of circulatory and respiratory functions is made. If the patient is eligible for donation, the LiveOnNY representative will make the request for organ, tissue or eye donation.

If it is determined that the patient is a suitable candidate for organ and/or tissue donation, the LiveOnNY will request consent from the individual authorized to make decisions as to the patient's remains. If it is determined that the patient is a suitable candidate for eye donation, the LiveOnNY will contact the Eye Bank for Sight Restoration and the Eye Bank will request consent. The request will usually be carried out by telephone with support from hospital staff.

A patient's prior consent for donation, if known, is to be honored. If consent is sought from others, this will proceed in accordance with New York State requirements as to persons with legal authority to make decisions on the disposition of a deceased person's remains. In order of priority, the individual authorized to make such decisions would be:

1. the person designated in an appropriately executed "Appointment of Agent to Control Disposition of Remains" (see appendix to MSR&R/AP&P);
2. the decedent's surviving spouse or domestic partner;
3. any of the decedent's children eighteen years of age or older;
4. either of the decedent's parents;
5. any of the decedents siblings eighteen years of age or older;
6. a guardian appointed pursuant to Article 17 or 17A of the Surrogate's Court Procedure Act or Article 81 of the Mental Hygiene Law;
7. a duly appointed fiduciary of the estate of the decedent.
8. a close friend or relative who is reasonably familiar with the decedent's wishes, including the decedent's religious or moral beliefs, when no person higher on this list is reasonably available, willing, or competent to act, provided that such person has executed a written statement pursuant to subdivision seven of § 4201 of the Public Health Law; or
9. a chief fiscal officer of a county or a public administrator appointed pursuant to article twelve or thirteen of the surrogate's court procedure act, or any other person acting on behalf of the decedent, provide that such person has executed a written statement pursuant to subdivision seven of § 4201 of the Public Health Law.

A previously-appointed health care agent s not authorized to give organ donation consent unless the agent appears in the list above or is otherwise authorized to dispose of the body.

SOURCE: Administrative Policy and Procedure #2301 and Rules and Regulations of the Medical Staff #227

Radiology Images and Reports

Radiology (Including Molecular Imaging)

When requesting a radiologic examination, the physician should include on the requisition all relevant clinical history and any specific questions to be answered in order to maximize the diagnostic yield.

To provide additional training opportunities in the ordering and/or interpreting of scans, a faculty radiologist — the "CT Doc of the Day" — is available for consultation each weekday by calling the CT Reading Room at Ext. 8318 or 6405. Trainees are encouraged to use this resource as a means of furthering their education and reducing the incidence of unnecessary or nonproductive testing. From 6pm -10pm, the Body Imaging Fellow is available for Body consultation (see contact information below).

Images and Reports

All radiology images are available for viewing shortly after an exam is acquired, either on PACS or on the PACS Web application on the clinical hospital workstations, even before they are reported.

The printed report is available in PACS and CIS first as a Preliminary Report (i.e., before being edited, possibly changed, and subsequently verified by the attending radiologist) and then as a final report. The Electronic Medical Record (EMR) only shows the final report. Contact the HELP desk at 123-3337 or 646-227-3337 for help if you have difficulty accessing the images or reports.

Obtaining Off-Hours Emergency Radiologic Studies and Consultations

The following information is provided to facilitate the obtaining of Emergency radiologic studies and consultations during off-hours from 10 PM – 8 AM any day of the week or weekend and on major Memorial Hospital Holidays.

CT/Ultrasound/Radiographs

To *obtain* Body CT

- Monday – Friday
  - **8 AM – 10 PM**: Contact CT front desk Ext. 122-7280. If no response, contact the RA at Ext. 122-8318
  - **10 PM – 8 AM**: Call the RA at Ext. 122-8318 . If no response, contact Evening Shift Body Attending (**10 PM – 12 AM**) or Night Shift Body Attending (**12 AM – 8 AM**) via the Page Operator (122-7900)
- Saturday, Sunday, or Major Holiday
  - **8 AM – 10 PM**: Contact CT front desk Ext. 122-7280. If no response, contact the RA at Ext. 122-8318 from **10 AM to 10 PM**
  - **10 PM – 8 AM:** Call the RA at Ext. 122-8318. If no response, contact Evening Shift Body Attending (**10 PM – 12 AM**) or Night Shift Body Attending (**12 AM – 8 AM**) via the Page Operator (122-7900)

For *results* on an Emergency Body CT

- Monday – Friday
  - **6 PM – 10 PM**: Call Ext. 122-8318
  - **10 PM – 8 AM:** Call the RA at Ext. 122-8318. If no response, contact Evening Shift Body Attending (**10 PM – 12 AM**) or Night Shift Body Attending (**12 AM – 8 AM**) via the Page Operator (122-7900)
- Saturday, Sunday, or Major Holiday
  - **8 AM – 10 PM**: Call Ext. 122-8318. If no response, contact Body Fellow via the Page Operator (122-7900) from 10 am to 10 PM
  - **10 PM – 8 AM**: Call the RA at Ext. 122-8318> If no response, contact Evening Shift Body Attending (**10 PM – 12 AM**) or Night Shift Body Attending (**12 AM – 8 AM**) via the Page Operator (122-7900)

To *obtain* an Emergency US study

- Monday – Friday
  - **6 PM – 10 PM**: Contact US department Ext. 122-2990. If no response, contact Body Fellow on call via Page Operator (122-7900)
  - **10 PM – 8 AM**: Call the RA at Ext. 122-8318. If no response, contact Evening Shift Body Attending (**10 PM – 12 AM**) or Night Shift Body Attending (**12 AM – 8 AM**) via the Page Operator (122-7900)

- Saturday, Sunday, or Major Holiday
  - **8 AM – 10PM**: Contact US department at Ext. 122-2990.
    If no response, contact CT Body Reading Room at 122-8318 or the Body Fellow on Call via Page Operator (122-790)
  - **10 PM – 8 AM**: Call the RA at Ext. 122-8318. If no response, contact Evening Shift Body Attending (**10PM – 12AM**) or Night Shift Body Attending (**12 AM – 8 AM**) via the Page Operator (122-7900)

For results of Emergency Radiographs

- Monday – Friday
  - **8AM – 6PM**: Call Ext. 122-2799
  - **6 PM – 10 PM**: Call Body Resident Ext. 122-8318.
  - **10 PM – 8 AM**: Call the RA at Ext. 122-8318. If no response, contact Evening Shift Body Attending (**10 PM – 12 AM**) or Night Shift Body Attending (**12AM – 8AM**) via the Page Operator (122-7900)
- Saturday, Sunday, or Major Holiday
  - **8 AM – 8 PM**: Call Ext. 122-2799. If no response call Ext. 122-8318
  - **8 PM – 8 AM**: Call the RA at Ext. 122-8318. If no response, contact Evening Shift Body Attending (**8 PM – 12 AM**) or Night Shift Body Attending (**12 AM – 8AM**) via the Page Operator (122-7900)

*Real Time Call info can also be found at: app.qgenda.com/landingpage/mskccrad
*Radiologist may be paged if Fellow or resident cannot be reached.

Interventional Radiology
Contact **Interventional Fellow** via Page Operator.

Molecular Imaging and Therapy (Nuclear Medicine)
Contact **Nuclear Medicine Resident** or **Nuclear Oncology Fellow** via Page Operator

Neuroradiology
M-F 6:00 PM-6 AM, Sat-Sun 24 hours, and holidays 24 hours, contact Neuroradiologist via pager 2752
All other times, contact Radiologist Assistant (RA) at ext. 2361

To *schedule* an Emergency CT study

- Sunday – Saturday, Holidays, **6 PM – 7 AM**
  Contact: CT Traffic 122-2461 Or CT Tech via Page Operator 122-7900

To *obtain* Results for an Emergency CT study

- Monday – Friday, **6 PM – 12 AM**
  Contact Neuroradiologist via pager 2752
- Monday – Friday, **12 AM – 5 AM**
  Call reading room x8313 and ask for Radiologist Assistant (RA) on duty.
  (if no one on duty, please page Neuroradiologist via pager 2752)
- Monday – Friday, **5 AM – 7AM**
  Contact Neuroradiologist via pager 2752
- Saturday, Sunday, Holidays **7 AM – 5 PM**
  Contact Neuroradiologist via pager 2752
- Saturday, Sunday, Holidays **5 PM – 7 AM**
  Contact Neuroradiologist via pager 2752

To *consult* on an Emergency Neuroradiology CT or MRI

- Daily, **6 PM - 8 AM**
  Contact **Neuroradiologist** via pager 2752

For Neuroradiologic MRI or other Neuroradiology studies:

- Monday-Friday, **6 PM – 8 AM**
  Saturday, Sunday, or Major Holidays, **8 AM – 8 AM** (next day)
  Contact Neuroradiologist via pager 2752

Reportable Incidents

New York State Reporting

The New York State Department of Health (NYSDOH) requires reporting of adverse events, or "emergencies and other incidents which threaten the safety of the patients or the staff in the hospital". Incidents in this category are evaluated by the Hospital and determined to be either "trackable events" or require the submission of a root cause analysis (RCA) form according to guidelines provided by the NYSDOH.

Under the law, the following types of incidents are considered reportable:

Level 1 Events (Root Cause Analysis Required)

- Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process within a healthcare setting
- Surgery or other invasive procedure performed on the wrong site
- Surgery or other invasive procedure performed on the wrong patient
- Wrong surgical or other invasive procedure performed on a patient
- Unintended retention of a foreign object in a patient after surgery or other invasive procedure
- Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biologic specimen
- Patient death or serious injury associated with a fall while being cared for in a healthcare setting
- Patient death or serious injury associated from failure to follow up or communicate lab, pathology, or radiology test results
- Death or serious injury of patient or staff associated with the introduction of a metallic object into the MRI area
- Patient death or serious injury in circumstances other than those related to the natural course of illness, disease or proper treatment in accordance with generally accepted medical standards
- Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting
- Patient death or serious injury associated with a medication error
- Intraoperative or immediately post-operative/post procedure death in an ASA Class 1 or Class 1E patient
- Death or serious injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a healthcare setting
- Patient suicide, attempted suicide or self harm that results in a serious injury while being cared for in a healthcare setting
- Patient death or serious injury associated with patient elopement
- Patient death or serious injury associated with the use or function of a device in patient care in which the device is used for functions other than intended
- Abduction of a patient of any age
- Discharge or release of a patient of any age who is unable to make decisions to

an unauthorized person
- Sexual abuse/sexual assault on a patient or staff member within or on the grounds of a healthcare setting

Incidents in Level 1 are evaluated by the Division of Quality and Safety and determined to be either "trackable events" (submission of a Short Form) or require the submission of a root cause analysis (RCA) form according to guidelines provided by the New York State Department of Health.

Level 2 Events (No Root Cause Analysis required)

- Misadministration of radiation or radioactive material
- Strike by hospital staff
- External disaster outside the control of the hospital which affects facility operations
- Termination of any services vital to the continued safe operation of the hospital or to the health and safety of its patients and personnel;
- Poisoning occurring within the hospital
- Hospital fire or other internal disaster in the hospital disrupting patient care or causing harm to patients or staff

Procedure

- An incident report should be completed online in the RISQ system when a patient has suffered an injury and/or for any event on the NYPORTS list (see below). In addition, any patient who has suffered an adverse event with the potential for injury should be reported.
- The Administrator-On-Call is to be called after hours or on weekends for New York State reportable incidents. Any incident report involving the 900 series on the NYPORTS list should be followed up by the Sentinel Events procedures outlined in Policy and Procedure #2008 (except codes 914 and 931-935, which only require the submission of a short form).
- The Division of Quality and Safety will determine whether the incident is "reportable through an RCA" or "short form" under current New York State Department of Health guidelines, and will handle accordingly.
- The written follow-up report will be submitted electronically to the New York State Department of Health by the Division of Quality and Safety.

Additionally, Blood administration errors must also be reported under Section 58-2.16 (a) in accordance with the policy outlined in the Blood Bank Procedure Manual. Serious equipment malfunctions must also be reported to the FDA in accordance with the Safe Medical Devices Act of 1990. Misadministration of radioactive material must also be reported to the New York City Department of Health Bureau of Radiation Control and the Bureau of Environmental Radiation Protection in accordance with applicable guidelines.

SOURCE: Administrative Policy and Procedure #2003

Sentinel Events

A sentinel event is defined as a patient safety event that reaches a patient and results in death, permanent harm (regardless of severity of harm), or severe harm (regardless of duration of harm) not primarily related to the natural course of the patient's illness or underlying condition. According to the Joint Commission, "severe harm" is defined as life-threatening bodily injury (including pain or disfigurement) that interferes with or

results in loss of functional ability or quality of life that requires continuous physiological monitoring or surgery, invasive procedure, or treatment to resolve the condition.

The Division of Quality and Safety must be informed of all sentinel events. After hours, notification should be given to the Administrator-on-Call. In addition, an event report must be entered into the MSK web-based reporting system, Reporting to Improve Safety and Quality (RISQ), within 24 hours of the occurrence of the event. The Deputy Physician-in-Chief for Quality and Safety will determine whether the incident is reportable under current State guidelines to the NYSDOH through the NYPORTS system, and will handle accordingly. The Deputy Physician-in-Chief for Quality and Safety will determine whether the incident is reportable under current State guidelines to the NYSDOH through the NYPORTS system, and will handle accordingly (See Administrative Policy and Procedure #2003 – Incident Reports – New York State Reporting).

Memorial Hospital for Cancer and Allied Diseases has mechanisms for the support of staff who have been involved in sentinel events. Such mechanisms include supervisory consultation, referral to Employee Assistance Programs, and education.

SOURCE: Administrative Policy and Procedure #2008

Adverse Events/Serious Reportable Events

Information on "never events" or adverse events can be found in Administrative Policy and Procedure #2311.

Family Abuse and Neglect

All professional hospital personnel are required by NY and NJ law to report cases of suspected child abuse or neglect to their respective State Central Registry. Mandated reporters are required to report suspected child abuse or maltreatment when, in their professional roles, they are presented with reasonable cause to suspect abuse or maltreatment. Reasonable cause to suspect child abuse or maltreatment means that, based on observations, professional training and experience, an assessment has been made and determines the parent or person legally responsible for a child has harmed that child or placed him/her in imminent danger or harm.

A person who participates in good faith in making a report is protected from any liability, civil, or criminal, that might result from the action. However, willful failure to report a case of suspected child abuse or neglect by a person who is required to report, is an offense.

An abused child refers to a child less than eighteen years of age whose parent or other person legally responsible for his care:

- Inflicts, or allows to be inflicted upon the child serious physical injury;
- Creates, or allows to be created, a substantial risk of physical injury;
- Commits, or allows to be committed against the child a sexual offense as defined in the penal law

A maltreated child is a child under eighteen years of age who is defined as a neglected child by the Family Court Act or who has had serious physical injury inflicted upon him by other than accidental means

A neglected child is a child under eighteen years of age whose physical, mental or emotional condition has been impaired or is in danger of becoming impaired as a result of the failure of his parent or other person legally responsible for his care to exercise a minimum degree of care.

Procedure

1. All nursing, medical, social work and other clinical personnel in service units complete training regarding child abuse and neglect as part of the Required Regulatory Training on Patient Safety.
2. Patients are screened for child abuse at the initial nursing assessment at each admission to the hospital or first outpatient visit. All members of the clinical team/s involved with the patient/family may also identify concerns on initial encounter or any other point in the treatment course.
3. Suspected cases of child abuse and/or neglect should be referred to Social Work as soon as possible. If you are unsure as to how to contact the social worker assigned to your area, please call the Social Work Department at: 212-639-7020.
    a. For evenings/nights/weekends/holidays – social worker on call can be reached through the Page Operator at 212-639-7900.
4. Should a report to the state agency be indicated, the care team including the attending physician and nurse leader need to be informed. In addition, the Social Work Director, and the Senior Vice President overseeing Pediatrics and Social Work, and the Administrator On Call (for evenings, nights and weekends) need to be consulted prior to initiating the report with the applicable state agency. For patients treated within Pediatrics, the Senior Director of Pediatrics also needs to be consulted.
5. The primary social worker will collaborate with the team and the Director of Social Work to ensure all subsequent internal administration necessitated by the report, which includes but is not limited to:
    a. New York: Submitting LDSS 2221-A form; or
    b. New Jersey: Communication with the Child Protection and Permanency (CP&P) Intake Unit in the county in which the child resides.

    The designated Abuse/Neglect Coordinator for all MSK facilities is the Director of Social Work. The A/N Coordinator can be reached at Pager 4567 or Long Range Pager: 917-457-2727.

For More information regarding Family Abuse and Neglect, please refer to Administrative Policy and Procedure #2101

Restraints and Restrictive Devices

Principles Guiding the Use of Restraints

This policy has been developed to ensure the safety of patients and the protection of their rights by defining standards that govern the use of restrictive and restraining devices and the health care team's responsibilities in their use. The use of restraints may be necessary to provide for the safety of the patient and others after less restrictive measures have been attempted and are found ineffective. Restraints are instituted in a time-limited manner and governed by clear ordering, assessment and documentation policies and procedures.

Every effort is made to prevent, reduce and eliminate restraint use by exploring less restrictive or non-restrictive alternatives when possible. These alternative measures are documented in the medical record.

All restraints require a comprehensive assessment evaluation and order by a licensed practitioner (as privileged and credentialed). Standards that govern restraint use fall into two categories:

1. Restraint for non-violent/non-self destructive behavior management
2. Restraint for violent or self-destructive behavior management

These requirements are not specific to any treatment setting, but to the situation for which the restraint is being used. The use of restrictive devices applied and monitored by law enforcement is not governed by these restraint standards.

Restraint Orders and Assessments

Use of Restraints for Acute Medical and Surgical Care

A restraint order issued by a licensed practitioner (as privileged and credentialed) is required before the application of restraints for both violent/self-destructive and non-violent/non- self-destructive behavior. In emergency situations, this order may be obtained during the emergency or within 1 hour after the restraint has been applied. In such emergencies, the patient shall be kept under continuous supervision as warranted by the patient's physical condition and emotional state until the licensed practitioner arrives onsite and conducts their assessment.

Orders by a Licensed Practitioner (as Privileged and Credentialed)

- An order is required before the application of restraints or within 1 hour of the emergency application of restraints.
- If the restraint order is not obtained from the patient's treating physician, consultation with the treating physician must occur as soon as possible.
- The attending physician is notified of all restraint orders for any patient under their care through CIS immediately after the order is initiated.
- Restraint orders for non-violent/non-self-destructive behavior are limited to 24 hours. A renewal restraint order is required every 24 hours.
- Restraint orders for violent/self-destructive behavior are time-limited and require renewal restraint orders within the following time frames:
  - 4 Hours for patients 18 years of age or older
  - 1 hour for patients ages 9 to 17
  - 30 minutes for patients under 9
- An in-person comprehensive assessment is required with every restraint order and must be completed again with each subsequent renewal order

Assessment

The patient is assessed a minimum of once every 30 minutes while in restraints. (Vest restraints require a reassessment a minimum of once every 2 hours.) While in restraints violent for self-destructive behavior, a patient must be monitored through continuous in-person observation going monitoring and assessment is documented on the Restraint Flow Sheet. The Restraint Flow Sheet includes the following documentation:

a. Type of restraint
b. Behaviors requiring restraint
c. Less restrictive alternative measures attempted
d. Vital signs
e. Assessment of the patient's condition, frequency of observation, and related follow-up care.
f. Patient/family education
g. Continued need for physical hold
h. Continued need for continuous in-person observation

The Nursing Supervisor must be notified of each patient in restraints. This is also communicated to Nursing and Hospital Administration through the daily "Nursing Unit Report".

Please see Rules and Regulations of the Medical Staff #217 for specific policy statements, categories of restraints (physical vs. chemical) and ordering, assessment, evaluation and documentation requirements.

Transfers

Inter-Hospital Transfers into Memorial Hospital

1. Transfers will be arranged only after the patient/surrogate has received complete information regarding the need for and alternatives to such a transfer.
2. All transfers into Memorial
   a. should be approved by an attending after discussion with an attending from the transferring hospital.
   b. ICU Transfers must additionally be cleared with the ICU Director and/or ICU consult attending
   c. For admissions to Medical Services, the MSK attending is also responsible for notifying the Chief Department of Medicine Admissions Coordinator.
   d. Transfers to the SDU must additionally be cleared by the SDU Director and/or ICU consult attending.
3. The transfer may not proceed until an MSK bed is available at the appropriate level of care for the patient (i.e. telemetry, isolation or intensive care services).
4. If transfer is delayed or deferred for more than 24 hours, the clinical status of the patient must be updated, and the availability of a bed must be reconfirmed.
5. The Urgent Care Center physician on duty must be notified of all transfers from an ICU or ER type facility, from out-of-state, or any transfer of potentially unstable patients. The name of the physician (may be the Urgent Care Center physician for Medicine services) who is to examine the transferred patient upon arrival should be provided to the Urgent Care Center staff.
6. All inter-hospital transfer patients will be screened by an Urgent Care Center RN for vital signs and mental status, before admission to a floor or unit. If the patient is unstable, the patient should be further evaluated and stabilized in the Urgent Care Center before admission.

Information on Intra-Hospital transfers, Hospital Transfers out of Memorial Hospital can be found on OneMSK: Rules and Regulations of the Medical Staff #104

Information on Transfer of Patients to New York-Presbyterian Hospital for Operative Procedures can be found in Rules and Regulations of the Medical Staff #529

Transfer of Critically Ill Patients to New York–Presbyterian Hospital Policy

Critically ill patients who are to be transferred to The New York–Presbyterian Hospital (NYPH) may be transferred by the NYPH ambulance service or 911. Instructions on using the NYPH ambulance service are below:

1. **Contact Physician at New York–Presbyterian Hospital (NYPH):**
   The attending physician, fellow, or APP responsible for the patient should call the NYP Stat 24/7 Physician Access Transfer Center 1-800-NYPSTAT (800-697-7828). Let them know you are calling from the Memorial Hospital to Initiate a Patient Transfer/MD-to MD Conference. NYPH will require the following:

a. Patient name and date of birth
b. Primary diagnosis/required service.
c. Requested NYP campus: Weill Cornell
d. Your name and phone number
e. Name of sending hospital (MSK) and phone number of our MSK nursing unit.
f. Patient's status:
    - Current condition
    - Desired time for transfer
    - Plan of care

When indicated, the NYP Stat RN will initiate a three-way conversation with the appropriate NYPH MD. This MD may be an Emergency Room physician, Cardiologist, Neurologist, etc.

2. **Transfer Process:**
When informed by NYPH that they will be accepting the patient; the unit assistant will fax the patient face sheet to NYP STAT at 212-746-8737 and follow up with a phone call to confirm receipt. Please be certain to include in the fax our medical record number and the name of the accepting MD at NYPH. NYPH, through NYP STAT will:
    a. arrange for the ambulance and advice of ambulance ETA. The patient may go to the ED or directly to the appropriate inpatient setting.
    b. provide accepting NYPH location (Unit and Room Number and Unit Telephone Number)
    c. advise sending RN to give report to receiving NYPH RN.
3. **Contact Nurse at New York–Presbyterian Hospital:** The Primary MSK Nurse responsible for the patient being transferred must call the respective receiving nurse to confirm knowledge of transfer and bed availability and report on status.
4. **Duplication of Medical Chart:** The Primary Nurse should arrange for a duplicate copy of the pertinent components of the patient's medical record to be sent with the patient to NYPH. This can be obtained from Health Information Management (HIM) by calling 646-227-2089.
5. **Notification of Family and Documentation:** The physician must notify the patient or family of the need for and alternatives to such a transfer and documentation of such notification should be made in the medical record.
6. If a patient is transferring to NYPH for a procedure and is expected to return to MSK, the MSK admitting office should be notified of the approximate date and time of return in order to assure a bed is available. If the patient is to return to a special care unit (ICU or SACU) that unit's medical director or designee must be notified. These notifications are the responsibility of the MSK attending or their designee.

SOURCE: Administrative Policy and Procedure #4501

Hospital Policies and Procedures: OneMSK Sources

Admission

Conditions of Admission
Physical Examination: Minimal requirements for work-up on all Memorial Hospital admissions
SOURCE: Rules and Regulations of the Medical Staff #101, #237

Restriction of Admissions
SOURCE: Rules and Regulations of the Medical Staff #102

Emergency Admissions
SOURCE: Rules and Regulations of the Medical Staff #103

Admission of Patients — Urgent Care Center
SOURCES: Administrative Policy and Procedure #4007; Urgent Care Center Policy and Procedure Manual

Discharge
SOURCE: Rules and Regulations of the Medical Staff #105

Management of Disruptive Behavior in Psychiatrically Disturbed Patients
SOURCE: Administrative Policy and Procedure #4503

Orders for Treatment
SOURCE: Rules and Regulations of the Medical Staff #204

Preoperative Orders/ICU Orders/Orders for Transfer
SOURCE: Rules and Regulations of the Medical Staff #204

Restraint Orders
SOURCE: Rules and Regulations of the Medical Staff #217.

Patients' Bill of Rights/Patients' Responsibilities
Memorial Hospital abides by the Patients' Bill of Rights, as specified in the State Hospital Code. The Bill of Rights is posted throughout the Hospital and on OneMSK: Administrative Policy and Procedure #3001 and #3001-NJ

Transfusion of Blood and Blood Products
SOURCE: Rules and Regulations of the Medical Staff #226

Consent Policy
SOURCE: Rules and Regulations of the Medical Staff #405

Autologous Transfusion Policy
REFERENCE: Rules and Regulations of the Medical Staff #226-B

Transfusion Reactions
SOURCE: Rules and Regulations of the Medical Staff #226-C

Refusal of Transfusion of Blood and Blood Products
SOURCE: Rules and Regulations of the Medical Staff #226-D

For Your Benefit — Full-Time House Staff Only

Benefits

All paid full-time graduate staff are eligible to participate in MSK's benefits program. You choose the benefits that best meet the needs of you and your family. The cost is shared between you and MSK. Most contributions toward your share of the benefits are paid with before-tax dollars, which means they will be deducted from your pay before payroll taxes are applied.

Visit MSKbenefits.mskcc.org, and type "Clinical Trainees" in the FIND IT *fast* search bar to learn about your benefits options including:

- Medical (includes prescription coverage)
- Dental
- Vision
- Family Building benefit
- Flexible Spending Accounts (FSA) for Health Care and Dependent Care
- Health Savings Account (if enrolled in UnitedHealthcare Consumer Driven Health Plan, UHC CDHP)
- Voluntary supplemental health insurance policies, including Accident Insurance, Specified Disease Insurance, and Hospital Indemnity Insurance
- Life Insurance
- Long-Term Disability (LTD)
- Accidental Death and Dismemberment (AD&D)
- Commuter Benefits
- Retirement Savings Plan (Note: You can contribute and invest. MSK does not make contributions to this plan.)
- Wellness

When do benefits take effect?

Once you make your benefit elections, your elected/waived medical coverage will take effect the first of the month coinciding with or following your first day of training, based on whether or not your training begins on the first of the month. (Example: If your first day of training is July 1, your benefits will be effective on July 1. If your first day of training is July 15, coverage will be effective August 1).

If your first day of training is after the first of the month, you will be assigned temporary medical coverage for the duration of that month until your benefit choices take effect at the start of the next month. If you are reporting for orientation prior to your first day of training and wish to arrange interim medical coverage, you may contact the HR Resource Center at 646-677-7411 or HRRC@mskcc.org.

When do you make your benefits elections?

You must enroll in or actively waive benefits within 31 days from your first day of training. You will learn how to enroll during orientation. Note: You can't make your elections before your training start date, but you can visit MSKbenefits.mskcc.org to explore your options (type "Clinical Trainees" in the FIND IT *fast* search bar at the top of the screen).

What if I don't enroll or actively waive?
If you do not enroll in or actively waive coverage within 31 days from your your first day of training, you will be assigned default coverage. Your dependents will not be covered if this occurs, and you will not be able to make any changes to your enrollment. (See below for details on when you can make changes.) To learn about default coverage, visit MSKbenefits.mskcc.org, and search for "Default Coverage."

Who is eligible for coverage?
In addition to covering yourself, you can choose to cover your eligible dependents under your medical, dental, vision and AD&D coverage. Eligible dependents include:

- Your spouse (opposite- or same-sex)
- Your domestic partner (opposite- or same-sex)
- Your children (including your spouse/domestic partner's children) until the end of the calendar year in which they reach age 26
- Children for whom you, your spouse, or domestic partner serve as legal guardian through the end of the calendar year in which they reach age 26
- For certain plans, unmarried children beyond age 26 who are incapable of self-support because of a physical or mental disability

Note about Domestic Partner coverage:
Coverage for your domestic partner requires documentation verifying their eligibility. If you are interested in obtaining this coverage, visit MSKbenefits.mskcc.org, and type "Dependent Verification Documentation" in the FIND IT fast search bar to see what types of documentation are required. Contact the HR Resource Center at 646-677-7411 or via e-mail at HRRC@mskcc.org for further details. [Note: The value of the coverage provided to your domestic partner (and their children) will be imputed income for you unless your domestic partner qualifies as your tax dependent.]

Can I change my benefit elections in the future?
The benefits you elect will cover you (and any covered eligible dependents) through the end of the current calendar year. For the next calendar year, you will be eligible to make changes during the annual Open Enrollment period, usually held in November.

For the current year, it is important to be certain about your benefit decisions because you cannot modify them unless you (or your dependents) have a *Change in Status Event*.

Examples of a *Change in Status Event* include:

- You get married, divorced, legally separated, or have your marriage annulled in civil court
- You form or terminate a domestic partnership
- You have a child, adopt a child, or a child is placed with you for adoption
- Your child loses eligibility for dependent coverage
- Your spouse, domestic partner, or child gains or loses coverage under another benefit plan, or that coverage is significantly changed

If you have a *Change in Status Event*, visit MSKbenefits.mskcc.org, and search for "Change in Status Event" to learn how to make changes to benefit elections through Workday. Important: You must submit a change through Workday within 31 days of the qualifying event. Otherwise, you'll have to wait for the next annual Open Enrollment period to change your benefit elections.

What other benefits are available?
Graduate staff may also take advantage of other benefits such as:

- **MSK Voluntary 403(b) Retirement Savings Plan** — you fund this account with before-tax dollars and/or Roth after-tax dollars. MSK does not make any contributions to this plan on your behalf.
- **Commuter Spending Account Program** — you set aside before-tax dollars to pay for eligible transit or parking expenses related to your commute to and from work.
- **Guided Wellbeing** — This online portal provides a gateway to custom resources and on-demand content. Gain access to evidence-based tools and tips aimed at supporting your overall wellbeing.
- **Counseling, Coaching & On-Demand Emotional Wellbeing Resources** — You have access to free, confidential short-term and supportive services 24/7/365 for you and members of your household. Licensed counselors are available in person, by phone, or via a wide array of virtual therapy options to support you. Visit the Emotional wellbeing page to learn more.
- **Employee Discount Program**

Questions?
For more details, visit MSKbenefits.mskcc.org. Plan-specific support resources can be found by clicking on "Contacts." For enrollment questions, contact the HR Resource Center at 646-677-7411 or via e-mail at HRRC@mskcc.org.

Payroll

You can authorize direct deposit of your pay on your first day of work through Workday by clicking on the Pay worklet and selecting Payment Elections from the Actions menu. Deposits may be made into as many as three separate accounts.

PGY Level Calculation For FTHS

Stipends for Full-Time House Staff (FTHS) are based on the resident's or fellow's post graduate years of U.S. or Canadian clinical training, as determined by the Office of Graduate Medical Education in consultation with the training program director.

Only U.S. specialty-specific training is used in this calculation, including required prerequisite training years (a preliminary internship year, for example).

For surgical subspecialties, up to 2 years of research embedded within the surgery residency period will be counted towards PGY calculation, such that someone can be given credit for up to 7 years of residency (or 5 years clinical plus 2 years research).

Professional experiences not included in PGY calculation include:

- Employment
- Military service
- Research (expect for the surgical exemption noted above)
- Time spent obtaining other professional degrees

Training experiences not included in PGY calculation include:

- Repeated training
- Training outside of the current specialty
- Partial years of training

Credit for training outside of the U.S. or Canada may be granted based on training program director approval, although similar guidelines should be followed.

Credit will not exceed the required prerequisite years of the equivalent U.S. or Canadian pathway.

Absences from Work

Details regarding absence procedures may be obtained by contacting the Graduate Medical Education Office or Training Program Director. MSK grants leaves to its employees for a variety of life events. However, such leaves by house staff may impact their ability to satisfactorily complete the requirements of their training program. House staff should also consider whether their Medical Specialty Board has established a minimum required training period in order to be eligible for certification. House staff will be provided with information relating to eligibility for certification during their program orientation.

Satisfactory Completion of Training Programs
Each Program Director has established a standard for time needed for program completion, either the institutional minimum of 42 weeks or greater per academic year. If it becomes apparent that a trainee will not be able to fulfill program requirements due to time away from work, the Graduate Medical Education Office must be notified immediately.

If leave time causes a trainee's time in a program to fall short of the program requirement, the Program Director in consultation with the GME Office may do any of the following:

1. Terminate the trainee's appointment, unless the leave is covered by the Family and Medical Leave Act (FMLA) or New York Paid Family Leave (NYPFL). (See Time-Off Policies and Procedures below.)
2. Continue the appointment with the understanding that the program requirements have not been met. The resident may return to work and remain through the conclusion of the appointment period although he or she may not have met the training requirements and this will be so noted on future requests for references or verification of training.
3. Continue the appointment and permit a one-year extension, if the position is available, to allow successful program completion.
4. Make-up time of shorter duration may be arranged depending on housing and budgetary constraints. Housing and Stipend during a make-up period cannot be guaranteed.

Once the Program Director and GME decides whether to continue an appointment, they will inform the resident of the decision.

Time-Off Policies and Procedures

Professional Leave of Absence
Permission for professional leave of absence for academic advancement is at the discretion of each program director who will determine if the request can be granted within the context of the program's educational requirements. Such leave may affect or preclude fulfillment of the necessary requirements for completion of the training program. Refer to Satisfactory Completion of Program Requirements, above.

Personal Leave of Absence
At the discretion of the Program Director, personal leave of absence may be granted for any personal reason not covered under the listed leaves of absence policies. Such personal leave may affect or preclude fulfillment of the necessary requirements for

completion of a training program. The Program Director may respond as outlined in Satisfactory Completion of Program Requirements, above.

Vacation
House staff are provided a minimum of one week (five business days) of vacation/paid time off annually. Additional paid time off is set by each Training Program Director, consistent with institutional policies. Trainees should contact their departmental GME Coordinator for specific details regarding program vacation/paid time off guidelines, including instructions on how to request and schedule vacation time.

Sick Leave (including Pregnancy and Childbirth)
Sick leave is provided when an employee becomes ill or is injured and, as a result, is unable to work. House staff are provided 56 hours of sick and/or safe time per calendar year under the New York City Earned Safe and Sick Time Act (ESSTA), as outlined in the forthcoming section titled NYC Paid Safe and Sick Leave Law. If this leave causes a trainee's time in a program to fall short of the program requirements, the Program Director may respond as outlined under Satisfactory Completion of Training Program Requirements, above. Pregnancy and bonding leaves are coordinated through Sick Leave and the Additional Leave and Pay Policies described below. (If you are not the birth mother, a child is being placed with you for adoption/foster care, or you are caring for a sick family member, see Additional Leave and Pay Policies below).

For additional information about Sick Leaves, please refer to Human Resources policies #403 and #502.

Notification Procedure
1. If you cannot report to work due to an illness or injury, you must notify your Program Director immediately.
2. If you feel you have sustained an injury/illness at work, refer to the Workers' Compensation section below.
3. If you have an illness or injury that lasts four or more consecutive calendar days and causes you to miss work, you must call MSK's disability insurance carrier (MetLife), at 833-622-0138 on the fourth day to report your absence.

MSK Short-Term Disability
When an extended illness or injury causes absence from work for more than seven consecutive days, MSK's Short-Term Disability plan provides for the continuation of regular salary for up to an additional twenty-five (25) weeks. To receive continued pay, leaves must be reviewed and approved by MetLife, MSK's disability administrator. The Short-Term Disability benefit is 100% of pay for 12 weeks (after a 7-day waiting period where sick time or vacation time, if out of sick time - will be used), followed by 85% of pay for an additional 13 weeks. As per the Notification Procedure, trainees must coordinate a leave through their Program Director and MetLife (this includes absences related to pregnancy).

Short-Term Disability lasts for up to 26 weeks during a 52-week rolling-back period, and may not be taken intermittently or in increments of less than one work week, except in cases where MetLife and your department have approved you for an eligible reduced work schedule.

Staff remaining in housing will be required to maintain rent payments. In situations of documented disability, Short-Term Disability will be maintained for a

maximum of twenty-six weeks or until the conclusion of the appointment, whichever is less. If you are still disabled at the conclusion of your appointment, you may be entitled to continued benefits under state disability, if applicable. MetLife can assist you with these benefits.

Short-Term Disability runs concurrently with other types of leave that you may be eligible for, including FMLA. Short-Term Disability does not cover leave time taken to bond with a newborn (following the disability period) or newly-placed adopted or foster child. See Additional Leave and Pay Policies below.

Following six months of disability, a trainee may be eligible to receive Long Term Disability benefits. The coverage level would depend in part on the elections made during benefits enrollment through Workday.

Workers' Compensation

If you feel you have sustained an injury/illness at work, you must immediately contact your Program Director and complete an online incident report through Workday within 24 hours. (After you log in, select "Incidents" to begin.) If you are unable to access or complete the online incident report within 24 hours of the incident, your Program Director can and must complete it on your behalf. Broadspire is our Workers' Compensation administrator. They will assign you a claims adjuster and claim number and will contact you approximately one to two days after your incident report is filed. If you have lost time from work, you must also call MetLife at 833-622-0138 to determine what disability and leave protection plans may apply and to apply for a leave under those plans.

Return to Work

When returning to work, you may need to be cleared by Employee Health by calling 646-888-4000 or via email to EHWS@mskcc.org if either of the following is true:

- You have direct patient contact in your role and have been out of work due to your own illness for more than three (3) days
- You have been absent from work due to your own illness for a period of two weeks or more.

You may need to ask your healthcare provider to complete a Work Capacity Form. Please contact Employee Health at least two business days prior to your return to work.

Bereavement Leave

MSK allows employees up to three working days of paid bereavement leave to make funeral arrangements or otherwise deal with the death of a relative. The employee is required to take bereavement leave within two weeks of the date of the relative's death.

HR Policy 404.

Additional Leave and Pay Policies

Depending on your specific circumstances, the following leave and pay policies may apply. Please contact MetLife (MSK's Leave of Absence Partner) at 833-622-0138 to determine your specific eligibility.

Family and Medical Leave Act (FMLA)
FMLA provides the right to return to the same or an equivalent position, with some exceptions. An absence under FMLA may affect or preclude fulfillment of the necessary requirements for completion of the training program. A trainee may return to the program through the conclusion of the appointment period although they may not have met the program requirements, and this will be so noted on future requests for references or verification of training. The Program Director may consider granting an extension as outlined in Satisfactory Completion of Training Program Requirements above to allow for completion of program requirements. FMLA leave runs concurrently with other types of leave that you may be eligible for, such as Sick Leave, Short-Term Disability and Workers' Compensation (see sections above). Any coverage under MSK's healthcare plans will be continued throughout your FMLA leave period.

Qualifications
House Staff who have worked for MSK for 12 months and for at least 1250 hours in the preceding 12 month period may be eligible for up to 12 work weeks of unpaid leave under the FMLA for certain family and medical reasons (including birth of a child, care of a newborn, the placement of a child for adoption or foster care and/ or the House Staff's and/or family member's serious health condition and/or qualifying exigency for family called to covered active military duty to a foreign country) during a 12 month period.

Paid Parental and Caregiver Leave for Full-Time House Staff

Benefits-eligible full-time House Staff receive up to six (6) weeks of fully-paid leave for the following covered events:

- Birth, care, and bonding with a newborn child.
- Care and bonding with an adopted or foster child.
- Care for an immediate family member (spouse, child or parent) with a serious health condition.

The six weeks of caregiver leave for a relative include the 56 hours of ESSTA time mentioned in the Sick Leave section. ESSTA time runs concurrently with time away for a caregiver leave of absence.

New York Paid Family Leave (NYPFL) for MSK-Employed Full-Time House Staff

MSK's benefits-eligible full-time house staff working in New York State are entitled to twelve (12) weeks of partially-paid leave for the following covered events:

- To provide care to a family member due to a serious health condition;
- To bond with a newborn within the first year of the child's life, or for the first year after the adoption or placement for foster care;
- For qualifying exigencies arising out of an employee's spouse, domestic partner, child or parent being on or called to active duty as a member of the Armed Forces, National Guard or Reserves.

Twelve weeks of leave will be paid at 67% of the employee's average weekly wage up to the cap set by the state. Employees may be required to use unused vacation time (all but 5 days) in lieu of NYPFL benefits depending on whether they have FMLA entitlement remaining at the time of their leave.

House staff are advised to consider the impact such a leave may have on their ability to satisfy all MSK, accreditation agency, and/or certifying board training requirements within the academic year. Any extension of training time due to leave time is not guaranteed and must be approved by both the program director and GME Office prior to the start of the leave. Please note that in the event that an extension of training is approved, trainees residing in MSK housing will be expected to vacate their unit as originally scheduled.

Qualifications

- Benefits-eligible house staff who work at least 20 hours per week are eligible to receive this partially-paid benefit once they have worked 26 consecutive weeks. Benefits-eligible house staff working fewer than 20 hours per week are eligible once they have worked 175 cumulative days.
- New York Paid Family Leave runs concurrently with other types of leave for which they may be eligible, including FMLA.

Other Important Information

- House staff must provide at least 30 days' advance notice of the leave to both their program director and to MetLife (833-622-0138), whenever practicable.
- MetLife will determine leave eligibility, track requested leave time and issue a leave approval.
- If the employee still has FMLA entitlement remaining by the time their leave begins, they must use unused vacation time (all but 5 days), in lieu of NYPFL benefits.
- If the employee does not have FMLA entitlement by the time their leave begins, they may choose whether or not to use unused vacation time for NYPFL, or receive only the partially-paid benefit. If they opt to receive only the NYPFL benefit, they will be paid by MetLife.
- Employees may not receive more than 26 weeks of state and/or federal leave-related benefits, including disability, workers' compensation and family leave, in a 52-week period.

NYC Paid Safe and Sick Leave Law

New York City requires employers to allow employees to use up to **56 hours of sick or vacation time per calendar year** (defined as January 1 to December 31) for the reasons listed below.

- Going to your own medical appointments or recovering from an illness (counted as sick time).
- Caring for a family member (child, parent, spouse, domestic partner, sibling, grandparent or grandchild) during an illness or taking them to medical appointments (counted as vacation time).
- Taking time off because a public health emergency has been declared in New York City (counted as vacation time).
- If you or a family member has been a victim of a family offense matter, sexual offense, stalking or human trafficking (counted as sick time).

To ensure that your time is properly protected, you must take these steps:

- To the extent possible, you must give your program director at least seven days' notice before taking sick or vacation time for scheduled absences, like medical appointments, for yourself or a family member.

- If you use vacation time to care for a family member, whether scheduled or unscheduled, or for a public health emergency, you must provide written confirmation to your program director that the time was used for legitimate purposes.

Health Services for House Staff at MSK

Employee Health Services (EHS)
Employee Health offers evaluation and treatment for work-related illness and injuries, return to work evaluations, as well as OSHA, New York State and City, and Center mandated medical surveillance programs that include testing and immunizations. Prior to July 1st of each academic year, newly appointed incoming interns, residents, and fellows will receive information regarding the need for an initial history and physical examination and blood tests, as well as information about services provided by Employee Health.

In the event of an on-the job injury (sharps injury, blood borne pathogen exposure, chemical exposure, etc.), all residents, interns, and fellows are required to report

the incident to their supervisor immediately and complete the online Employee Incident Report. The supervisor will call Employee Health and schedule a same- day appointment. Required follow-up of any on-the-job injury will be done at Employee Health or referred to an appropriate provider.

In the event of an on-the job injury after hours (after 6pm and before 8am or on weekends), all residents, interns, and fellows are required to report the incident to their supervisor immediately, complete the online Employee Incident Report and to go to the Urgent Care Center (UCC). Required follow-up of any on-the-job injury will be done at Employee Health or referred to an appropriate provider.

For returning residents, interns, and fellows, an annual assessment and completion of a health assessment for symptoms of active TB (HAFATB) (if applicable) are required. You will be notified when you are due for these evaluations. Employee Health is located at 222 East 70th Street, between 2nd and 3rd Avenues, with hours from 8 am to 6 pm, Monday through Friday. Services are also available on the main campus Monday through Friday from 9 am to 5 pm in room MG03. To schedule an appointment or for information call 646-888-4000 or email EHWS@mskcc.org. Compliance with Employee Health requirements is a condition of continued employment.

Work-Related Stress
Working at a cancer center can require a high degree of personal hardiness and resilience. Good self-care, including healthcare, not only maintains one's well-being but also maximizes one's ability to care for patients and their families. Trainees are encouraged to make use of all available support mechanisms including their training program director or the confidential voluntary mental health services, below. Training program directors will monitor residents' wellbeing through a variety of mechanisms including faculty, peer and other evaluations, administrative meetings and personal observation. The training program director can recommend appropriate interventions as needed such as schedule changes, additional training or clinical support, or referral for voluntary counseling. If you have concerns about burnout or compassion fatigue, resources are readily available.

Voluntary Mental Health and Supportive Services
Both residents (at the Graduate Staff orientation program) and Training Program Directors (at the Graduate Medical Education Committee and through communications with the Office of Graduate Medical Education) are advised about the availability of confidential mental health services for residents and their families. Residents may obtain voluntary confidential mental health evaluation, counseling and/or appropriate referral by contacting Magellan. Mental health services provided by Magellan are for voluntary (self) referrals, are time limited, and are provided at no cost to the resident.

Residents do not have to be enrolled in an MSK medical plan. Licensed counselors are available in person, by phone, or via messaging therapy to support with:

- Addressing mental health concerns such as stress, depression, anxiety, or grief
- Coping with harmful thoughts, mood swings or trauma
- Seeking treatment and support for alcohol or drug misuse
- Developing better parenting and caregiving skills for children and elders
- Handling everyday demands and major life transitions
- Improving relationships and resolving conflicts
- Managing stress at work and school

You can also take advantage of Magellan's wide array of on-demand resources. Offerings include webinars, podcasts, and other self-help resources for topics such as cultivating resiliency, practicing self-care, managing work/life stressors, and more. Learn more by visiting magellanascend.com or by calling 800-327-8793.

Administrative Evaluation

Administrative evaluation of residents may be initiated by the Training Program Director (after consultation with the Department Chairman) because of concern that the resident's work performance has significantly deteriorated due to a potential medical issue, mental health status (such as depression or anxiety), or substance misuse and where the resident's ability to continue in the training program is in question.

The Training Program Director informs the resident that an administrative referral to Employee Health is required. Based on the results of the administrative referral, Employee Health will work in conjunction with the department and Employee Relations advisor to recommend appropriate treatment and next steps. If the resident requires a medical leave, the resident will be required to come through Employee Health for a return-to-work evaluation prior to their return to the training program.

Housing

The Center prefers trainees to reside in Center-owned housing in order to staff around-the-clock programs in patient care and research, and to provide a realistic and practical training experience. In the event the Center does not have sufficient vacant housing stock to accommodate all trainees, the Department Chairperson will allocate housing units based on programmatic need and responsibilities.

While every effort will be made to offer Center-owned housing units on a year-to-year basis to other trainees, namely research-only trainees and those continuing at Memorial past the prescribed years of training for their program, such housing may not be available.

Meals and Laundry

Prepaid meal cards are provided to trainees when assigned to in-hospital call duties; when assigned to work on Thanksgiving, Christmas and New Year holidays; and at other times as specified by their program.

All trainees are issued clean lab coats and scrubs on the first day of their program. Soiled laundry may be exchanged for clean garments as often as needed through the Linen Department. All lab coats and scrubs must be returned at the end of the program.

Tobacco-Free Campus

MSK is a healthcare institution committed to the prevention and treatment of cancer. Smoking and tobacco use, major preventable causes of cancer in this country, are therefore prohibited. MSK is a tobacco-free facility. Employees, ambulatory patients, visitors, volunteers, vendors, students, trainees, and any other individuals conducting business with Center employees on Center premises are prohibited from using tobacco products within any Center building, on any sidewalk, within any courtyards and/or any property surrounding all sites that are owned and operated by MSK (including research facilities and the regional network) and within 15 feet of any entrance or exit (including loading docks, parking garages and parking lots) of all work sites that are leased by the Center. The aforementioned sites will be referred to collectively as "MSK Center Campuses". Cigarettes, cigars, pipes and all other smokeless tobacco products are prohibited from use within and on all MSK Center Campuses. Electronic cigarettes are prohibited from use within all MSK facilities. The FDA does not recognize this product as an approved smoking cessation device. Referrals for tobacco cessation programs to assist those employees who wish to stop using tobacco products are available through MSKQuits! and the Employee Wellness Program. To support patients and visitors who want to quit, there are regularly scheduled sessions by the Tobacco Cessation Program, with information available on OneMSK.

SOURCE: Administrative Policy and Procedure #8112

Recycling and Sustainability

The MSK Green Team develops and promotes sustainable programs and processes within MSK, with a focus on reducing the Center's impact on the environment. Initiatives include energy efficiency, waste and recycling, paper reduction, food services, and greening the OR. For more information, go to the Sustainability page on OneMSK.

Recycling Program:

- Bottles and cans
  - Plastic bottles (no caps), metal cans, glass bottles, juice cartons
- Non-confidential Paper
  - Copy paper, envelopes, newspapers, magazines, tissue boxes, equipment boxes, glove boxes, take out boxes from the cafeteria, etc.

Items should be placed in the appropriate green recycling bin.
Contact: recycling@mskcc.org

Onsite Services

- ATM (operated by Citibank)
- Cafeteria: Hours of operation: 6:30 AM – 10:30 AM, 11:00 AM – 11:00 PM (Lunch/Dinner), Monday to Friday. Reduced hours on weekends: 7 AM – 8 PM. Vending machines are available 24 hours a day.
- Human Resources Office: There is an adjunct office located in the main Hospital complex in room C174.
- Jitneys: During main business hours there are regularly scheduled jitneys transporting staff between the main campus and the 53rd Street site, and the 633 3rd Avenue site. 53rd Street jitneys leave from the 67th Street entrance of the main hospital. 633 3rd Avenue jitneys leave from the entrance of Rockefeller Research Labs at 430 East 67th Street.

Parking

To determine eligibility for MSK Parking, call the Housing office at 646-888-8403.

Other Resources

MSK Websites

The MSK web sites — both OneMSK and Internet — are valuable resources. OneMSK includes the MSK telephone and pager directory; listings of Memorial Hospital physicians with their clinical expertise and publications; a directory of Sloan Kettering Institute researchers; census information and facility updates. OneMSK offers information on relevant clinical topics such as pharmacoeconomic issues, formulary changes, infection control rates and sensitivities. It also contains a wide array of employee benefit material, including access to the Workday system, the Center Bulletin, the daily cafeteria menu, and employee discounts.

Online reference guides, including the Laboratory Reference Guide, Infection Control Manual and Hospital Formulary can also be accessed from any Windows Workstation Start Menu under Reference Manuals & Tutorial (Clinical Reference Manuals).

The MSK Internet site (www.mskcc.org) contains information on institutional resources available to the public including general cancer information and links to approved web-based sources, information on the Survivorship and Integrative Medicine programs, a reference guide to herbs, botanicals and other supplements, as well as numerous other resources.

Medical Library

The MSK Medical Library is operating virtually for the foreseeable future. To learn more about the online services available and to connect with library staff, please visit the Medical Library's home page (library.mskcc.org) or click the Library link located on the OneMSK homepage under Resources. The Library's extensive online data resources can be accessed at all times from any Hospital computer.

The Medical Library home page can be used to link users to an extensive collection of online resources including databases, electronic journals, e-books, and access to the library catalogues of the other institutions which together with MSK comprise the Tri-Institute: Rockefeller University and Weill Medical College of Cornell University. In addition, programs and departments have specialty-specific libraries and reference materials available for resident use.

Information on these is provided during the training program's orientation of new residents.

Design and Creative Services

Our Design and Creative Services group serves as MSK's in-house creative department and collaborates with stakeholders across MSK to bring our communications to life with clear, compelling, and effective visual design, illustration, photography, and animation. This in-house team of creative experts produce high-quality visual assets that are used across all mission areas and serve a wide variety of audiences. Some projects this group produces include, but are not limited to: MSK News; Annual Reports; educational brochures; newsletters; branding; infographics; medical illustrations; animations; photography (portraiture, editorial, events, and clinical); invitations and event collateral; direct mail; print and digital signage; and web and social graphics. We work closely with our Marketing & Communications colleagues, as well as various departments throughout the institution.

Our group works with the Branding team to ensure that all projects are communicated within brand guidelines, clearly and consistently across all channels. We also work hand in hand with the Editorial team to ensure that the content within our pieces is in the MSK voice and tone.

The digital asset management system is maintained by us, providing photography, video and illustrations for use internally and externally.

Please contact Design and Creative Services if:

- You need guidance on what creative needs your department could benefit from
- You would like to arrange a photo shoot
- You are in need of medical illustration or animation
- You are looking for a brochure, newsletter, invitation, direct mail piece to be created
- Need help designing digital or print signage

Please coordinate all orders with your departmental program coordinator in order to determine the appropriate cost center or fund to charge. You should not charge the cost center listed on your ID badge. The office is open Monday – Friday, 9:00 AM – 5:00 PM. For more information, email graphics@mskcc.org.

COVID-19 Information Hub

The COVID-19 Information Hub on OneMSK is intended to give you the latest updates from MSK regarding safety standards and resources, clinical guidance, and much more. Please check these pages for updates.

COVID Hub for Clinical Guidelines: https://mskcc.sharepoint.com/sites/pub-COVID19/SitePages/Clinicians-Updates-COVID19.aspx

Index

Memorial Sloan Kettering
Cancer Center