Medical Staff Orientation

Education Packet

Community Medical Center | RWJBarnabas HEALTH

Dear Provider:

Welcome to RWJ Barnabas Health Community Medical Center. We are excited to have you as part our team and look forward to your participation.

In order to ease your transition to your hospital community, we are providing access to pertinent information online at www.rwjbh.org/cmcdocs. This site will provide you with information about our hospital structure, history, mission, and values, as well as policies, procedures, bylaws, rules & regulations, code of conduct, and HIM.

Things to do and know:

- You will receive emails regarding system access login: (1) Epic Team, (1) Network Team, (3) Health Information Management
- Sign-up for Epic Training
- Security: Badge pick-up
- Physician Wellness Criteria: Tuberculosis screening must done annually
- Influenza and COVID-19 documentation is required
- Medical Staff Quality: Medical records must be kept current as per Bylaws, CPOE should be >85%, HCAHPS Physician Communication Goal is >85%
- Hospital Wi-Fi is: BHGUEST Passoword: bhwifi!!

We are pleased to have you on the Medical Staff and look forward to working with you.

Medical Staff Services

Medical Staff President: William Strazella, DO

Chief Executive Officer: Patrick Ahearn

Chief Medical Officer: Meika Neblett, MD

Chief Nursing Officer and Vice President of Patient Care Service: Donna Bonacorso, RN, MSN, NEA-BC

Administrative Leadership

- **Chief Executive Officer President: Patrick Ahearn –** Patrick.Ahearn@rwjbh.org

  Executive Assistant: Sarah McCrudden– Sarah.McCrudden@rwjbh.org
- **Chief Medical Officer: Meika Neblett, MD–** Meika.Neblett@rwjbh.org

  Executive Assistant: Alexis Murtagh – Alexis.Murtagh@rwjbh.org
- **Chief Operating Officer: Aaron F. Hajart–** Aaron.Hajart@rwjbh.org

  Executive Assistant: Sarah McCrudden– Sarah.McCrudden@rwjbh.org
- **Chief Nurse Officer: Donna Bonacorso –** Donna.Bonacorso@rwjbh.org

  Executive Assistant: Donna Hardin – Donna.Hardin@rwjbh.org
- **Chief Human Resources Officer: Debbi Patti –** Debbie.Patti@rwjbh.org

  Corporate Care: Caryl Russo – Caryl.Russo@rwjbh.org
- **VP Ancillary & Support Services: Neil Bryant –** Neil.Bryant@rwjbh.org

  Assistant Vice President: Kelley Weidner – Kelley.Weidner@rwjbh.org

  Executive Assistant: Alexis Murtagh – Alexis.Murtagh@rwjbh.org
- **VP Finance: Christopher Reidy –** Christopher.Reidy@rwjbh.org

Medical Staff Office and Clinical Medical Education Hours and Contact Information

OFFICE HOURS: 8:00am to 4:30pm – Monday through Friday (excluding observed holidays)

- **Director: Millie Odera, MSPH**
  Millie.Odera@rwjbh.org
- **Credentialing Coordinator: Janine Zebrowski**
  Janine.Zebrwoski@rwjbh.org
- **Administrative Coordinator / IRB Coordinator: Becca Petillon, BSPH**
  Becca. Petillon@rwjbh.org
- **Administrative Coordinator / Medical Ed Physician Coordinator: Jennifer A. Kuzma, BS, CPhT**
  Jennifer.Kuzma@rwjbh.org

Medical Staff Officers 2025

- **President:** William Strazzella, DO
  Phone: 732-557-6030

- **Vice President:** Karambir Dalal, MD
  Phone:732-849-1075

- **Secretary:** Michael Spedick, M.D.
  Phone:732-244-4400

- **Treasurer:** Marie Bonvicino, M.D.
  Phone:732-691-3525

Department Chairs and Section Chiefs 2025

Anesthesia	Bernard Lane, MD
Emergency Medicine	Gerardo Chiricolo, MD
Medicine	Prabhat Sinha, MD (Chair)
Gastroenterology	Carl Raso, MD
Nephrology	Jose Iglesias, DO
Pulmonary	Dhiren Shah, MD
Hematology/Oncology	Gurpreet Lamba, MD
Cardiology	Najib Alturk, MD
OB/GYN	Gerardo Lopez, MD
Family Medicine	Dennis Novak, MD
Orthopedics	Sundeep Saini, DO
Neurology	Sumul Raval, MD
Pathology	Randah Al-Kana, MD
Pediatrics	Alexander Feldman, DO
Podiatry	Michael Plishchuk, DPM
Radiology	Douglas Gibbens, MD
Ophthalmology	Elyse Trastman-Caruso, M.D.
Otolaryngology	Steven Kupferberg,MD
Urology	Peter Howard, MD
Surgery	Steven Priolo, MD (Chair)
General Surgery	Steven Priolo, MD
Neurosurgery	Steven Priolo, MD
Oral Surgery	Elisa Velzaquez, MD
Plastic Surgery	Russell Ashinoff, MD
Robotics	Steven Lowry, MD
Thoracic Surgery	Peter Scalia, MD
Breast	Sumy Chang, MD
Bariatrics	Ragui Sadek, MD
Vascular Surgery	Vijay Kamath, MD
Colorectal Surgery	Steven Lowry, MD

Committee Meetings

Committees	Chair and/or Contact	Frequency	Day	Time
Medical Executive Committee	William Strazzella, DO	Monthly	1st Tuesday	**6:00pm**
Blood Utilization Committee	Paolo Miguel Ata	Quarterly	2nd Tuesday	**2:30pm**
Credentials Committee	Karambir Dalal, MD	Monthly	3rd Monday	**5:30pm**
Critical Care Committee	Dhiren Shah, MD	Quarterly	2nd Tuesday	**7:30am**
Infection Prevention Committee	Guarav Nagar	Every other month	2nd Tuesday	**12:00pm**
Bio-ethics Committee	Bruce Ackerman	Quarterly	Bi-Monthly	**12:00pm**
Quality Committee	Melissa Grando	Monthly	4th Tuesday	**7:30am**
Medical Education Committee	David D'Ambrosio, MD	Quarterly	2nd Wednesday	**8:00am**
OR Advisory Committee	Steven Priolo, MD Kathy Saitta-Martinez	Bi-Monthly	3rd Wednesday	**7:00am**
Robotics Committee	Steven Lowry, MD Kathy Saitta-Martinez	Quarterly	3rd Tuesday	**7:00am**
Pharmacy & Therapeutics Committee	Anne Chekenian Dr. Jose Iglesias	Monthly	4th Tuesday	**8:00am**
Bylaws Committee	Marie Bonvicino, MD	Call of the Chair	Call of the Chair	**8:00am**
Performance Improvement Council Committee	Laila Reed	Monthly	3rd Friday	**7:30am**
STEMI Review Committee	Robin Nolan	Monthly	4th Tuesday	**6:00pm**
Cancer Committee	TBD	Quarterly	2nd Friday	**8:00am**
Radiation Safety Committee	Jaime Reuter	Quarterly	3rd Wednesday	**12:00pm**
Cardiac Cath QA	**Robin Nolan**	**Quarterly**	**2nd Thursday**	**5:30pm**

Peer Review/Committee Meetings

Meetings	Chair and/or Contact	Frequency	Day	Time
Anesthesiology Peer Review	Angela Romano	Monthly	1st Thursday	**6:30am**
Cardiology Peer Review	Kelly Lovering	Monthly	4th Wednesday	**5:30pm**
Antimicrobial Stewardship Program	Gargi Patel	Bi-Monthly	2nd Tuesday	**12:00pm**
CMC Board of Trustees	Sarah McCrudden	Varies	1st Thursday	**8:00am**
CMC Board of Trustees (Annual)	Sarah McCrudden	Once a year	3rd Thursday	**8:00am**
CME Program	Jennifer Kuzma	3x a month	1st, 3rd, 4th Thursday	**12:00pm**
ICU Peer Review	Kelly Lovering	Monthly	4th Wednesday	**12:00pm**
IM/FP Peer Review	Kelly Lovering	Monthly	4th Wednesday	**9:00am**
Neurology Peer Review	Kelly Lovering	Monthly	3rd Tuesday	**9:00am**
OB/GYN Peer Review	Melissa Grando	Monthly	2nd Thursday	**7:15am**
Orthopedic Peer Review	Angela Romano	Quarterly	3rd Tuesday	**5:30pm**
Pediatric Peer Review	Melissa Grando	Quarterly	2nd Tuesday	**12:00pm**
Podiatry Peer Review	Angela Romano	Quarterly	4th Monday	**5:00pm**
Radiation Oncology QA	Tara Boyars	Monthly	4th Thursday	**12:30pm**
Radiology Peer Review	Jaime Reuter	Quarterly	3rd Wednesday	**12:00pm**
Surgery Peer Review	Angela Romano	Monthly	2nd Monday	**7:00am**
Utilization Review	Jessica Campanella	Monthly	4th Wednesday	**7:30am**
Vascular Peer Review	Angela Romano	Quarterly	2nd Monday	**5:30pm**

Department Meetings

Departments	Chair and/or Contact	Frequency	Day	Time
Anesthesiology	Taylor Kelly	Quarterly	3rd Thursday	7:00am
Cardiology	Najib Alturk, MD Becca Petillon	Quarterly	2nd Thursday	6:00pm
Emergency	Gerardo Chiricolo, MD Kayla Marchlewski	Monthly	2nd Tuesday	8:00am
Family Medicine	Dennis Novak, MD Becca Petillon	Quarterly	3rd Tuesday	8:00am
Medicine	William Strazzella, DO Becca Petillon	Quarterly	3rd Thursday	6:00pm
Neurology	Tejas Deliwala, MD Becca Petillon	Quarterly	3rd Tuesday	5:30pm
Obstetrics and Gynecology	Gerardo Lopez, MD Becca Petillon	Quarterly	3rd Thursday	7:00am
Ophthalmology	Elyse Trastman-Caruso, M.D. Jennifer Kuzma	Quarterly	4th Monday	5:30pm
Orthopedics	Michael Pensak, MD Jennifer Kuzma	Quarterly	3rd Tuesday	5:30pm
Pediatrics	Christina Piela, MD Becca Petillon	Quarterly	2nd Tuesday	12:00pm
Otolaryngology	Stephen Kupferberg, MD Becca Petillon	Quarterly	4th Friday	8:00am
Pathology	Randah Al-Kana, DO	Quarterly	4th Friday	4:30pm
Podiatry	Megan Lubin, DPM Becca Petillon	Quarterly	4th Monday	5:30pm
Radiology	Douglas Gibbens, MD Jamie Reuter	Quarterly	3rd Wednesday	5:30pm
Surgery	Steven Priolo, MD Jennifer Kuzma	Quarterly	2nd Monday	6:00pm
Urology	Peter Howard, MD Jennifer Kuzma	Quarterly	1st Wednesday	7:00am

Community Medical Center
Periop Important Phone Numbers

Hospital Emergency #		*****111**
Outside Line		Dial 9 before number; for long distance dial 9 +1 before number. If unable to connect, go thru Operator.
Perioperative Administrative Director	Kathleen Saitta-Martinez, MSN, MBA, RN, CNOR	732-557-8992 or x 18992 in house
OR Director	Antonette Chiappano, RN	732-557-8045 or x 18045 in house
Director PACU, SDS, ENDO & PAT	Antonette Chiappano, MSN, RN, CNOR	732-557-4020 or x 14020 in house
OR #		732-557-8040 or x 18040 in house
OR Scheduling	Samantha Sickler	732-557-8068
Holding Area		732-557-8000 X 11412 or X 11412 in house
Periop Educator	Debra Laurie MSN, RN, CNOR	732-557-4018 or x 14018 in house
CMC Safety Officer	Robert Day	732-557-8000 x 14079
IT		732-557-8965 or x 18965 in house
SIS	Ashley Siegle, MSN, RN	732-557-8071 or x 18071 in house
PACU		732-557-8019 or X 18019 in house
SDS		732-557-8018 or X 18018 in house
PAT		732-557-8004 or X 18004 in house
ENDO		732-557-8000 x 11580 or X 11580 in house

Community Medical Center
Patient Care Services Phone Numbers

DONNA C. BONACORSO, MSN, RN, NEA-BC CHIEF NURSING OFFICER & VICE PRESIDENT OF PATIENT CARE SERVICES			
DEPARTMENT	NAME	OFFICE	UNIT
ASSISTANT VICE PRESIDENT	Stephanie Cron, MSN, RN	11018/18715	
3A - PCU/Centralized Telemetry	Susan Buckley, BSN, RN	18947	18113
3B - Surg Unit II / Tele / Float Pool	Cheryl Vaccaro, BSN, RN	11383	18124
3D - Transitional Care Unit - TCU	Jennifer Horath, MA, LNHA	12442	12270
3E - Orthopedics/3C Swing Unit	Julie Rood, BSN, RN	12469	18253, 18125
4A - Med/Surg III	Cecile Gayanilo, MSN, RN, RNC	14081	18114
4B - Oncology/Vascular Access Team	Ariana Wilson, BSN, RN	11542	18107, 11068
4P - PCU	Janice Pierce, BSN, RN BC Wound Care, Lynda Wechkus, BSN, RN, WCC	18188	18254/ 18274
Bed Management	Robert Day	12471	18002
Nursing Supervisors **Sitters (inhouse)**	Nicole Jackson, BSN, RN Kim Clements, DNP, RN, NEA-BC, CCRN	11331	
ASSISTANT VICE PRESIDENT	KIM CLEMENT, DNP, RN, NEA-BC, CCRN	12162	
2A – PCU	Lindsey Hacker, BSN, RN	12433	18112
2C – PCU	Karen Tinio, BSN, RN	11466	18106
2D – PCU	Jennifer Nugent, BSN, RN, CMSRN, Director	18103	18102
5A - Nursery	Donna Fitzpatrick, MSN, RNC, Director	18746	18105
5B – L & D		12093	18033
5C – Pediatrics			18108
5E / 5F – Mother/Baby			18104

DEPARTMENT	NAME	OFFICE	UNIT
2B – Swing **2E1 – CCU** **2E2 – SICU** **2F – MICU**	Francis Bergonio, BSN, RN . **RRT x11066; or Vocera 12780 and speak "Rapid Response"**	11018/18715	
Respiratory Therapy/Neuro/Sleep Center	Frank Rizzuto, RRT-NPS	11238	
ADMINISTRATIVE DIRECTOR	NICOLE JACKSON, BSN, RN	18286	
Emergency Department	Louisa Guida, BSN, RN	13728	12909
Emergency Screening	Kelly Ryan, BSN, RN, ADPC, ED/CRISIS	12921	12909
Observation	Pamela Bogan, BSN, RN	18197	18273
ADMINISTRATIVE DIRECTOR	KATHLEEN SAITTA-MARTINEZ, MSN, MBA, RN, CNOR	18992	
Operating Room	Antonette Chiappano, MSN, RN, CNOR	18045	18040
PACU/SDS/PAT/SPEU	Antonette Chiappano, MSN, RAN, CNOR	14020	18019 18018 11580
Central Sterile Processing	Michael Wilke, BBA, CRCST	18978	
Center for Bariatrics	Joseph Cavanaugh	13959/12033	18966
Hemodialysis	Jayme Welch	720-703-5391	18091
ASSISTANT VICE PRESIDENT, Service Line Development	KIMBERLY GARNER, MBA, BSN, RN, CMSRN	11560	
Neuroscience Services, Primary Stroke Center, Sleep Center	Lindsey Smith, MSN, RN, SCRN, Director Morgan Sypniewski, BSN, RN, EMT, Stroke Coordinator Gerald J. Ferencz, M.D., Medical Director	18149 18198	
ASSISTANT VICE PRESIDENT, Patient Care Services	STEPHANIE CRON, MSN, RN	12286	
Cardiology Services	Tara Iorio, BSN, RN, CVRN-BC	12837	18031
DIRECTOR – NURSING FINANCE	JEFFREY ANDERSON, MBS, BSN, RN-BC	18029	
Staffing Office		18014	
DIRECTOR – CENTER FOR PROFEESIONAL DEVELOPMENT, INNOVATION & RESEARCH (CPDIR)	SUSAN URBANEK, MSN, RNC-OB	11534	18015
Clinical Nursing Educators			
OTHER INFORMATION:	VOCERA 12780		
Joint Program Coordinator	Lisa Marchlewski, BSN, RN	18194	
Inpatient Hospice		12500	12495
Infection Control	Gaurav Nagar	18265	
Human Resources – Nurse Recruiter	Tish Chirumbolo	18747	
Outpatient Infusion	Jaytinder Singh Sarah Manning	18239 12404	
Directors of Patient Care Revised 05.14.24			

DONNA C. BONACORSO, MSN, RN, NEA-BC CHIEF NURSING OFFICER & VICE PRESIDENT OF PATIENT CARE SERVICES			
DEPARTMENT	***NAME***	***OFFICE***	***UNIT***
Licensed Nursing Home Admin. - 3D	***JENNIFER HORATH, MA, LNHA***	**12442**	**12270**
TCU	Lauren Mulrooney, MSN, RN, CNML, Director of Nursing	18097	
Assistant Vice President	***STEPHANIE CRON, MSN, RN***	**12286**	
3A - PCU/Centralized Telemetry	Susan Buckley, BSN, RN	18947	18113
3B - Surg Unit II / Tele / Float Pool	Cheryl Vaccaro, BSN, RN	11383	18124
3F Med-Surg	Jill Miller, BSN, RN	15542	18289
3E - Orthopedics	Julie Rood, BSN, RN .Lisa Marchlewski, MHA, BSN, RN, Joint Program Coordinator	12469 18194	18253
4A - Med/Surg III	Cecile Gayanilo, MSN, RN, RNC	14081	18114
4B - Oncology	Ariana Wilson, MSN, RN OCN	18228	18107
4E - PCU	Janice Pierce BSN, RN, BC . Wound Care, Lynda Wechkus, BSN, RN, CWOCN	18188 .11014	18254
4F -PCU	Brianna Smith, BSN, RN	18255	18274
Assistant Vice President	***KIM CLEMENTS, DNP, RN, NEA-BC, CCRN***	**12162**	
2A – PCU	Jenna Hisey, BSN, RN, Interim DPC (Lindsey Hacker, BSN, RN)	12433	18112
2C – PCU	Karen Tinio, BSN, RN	11466	18106
2D – PCU	Jennifer Nugent, BSN, RN, CMSRN	18103	18102
5A Nursery; 5B L&D; 5E/5F Mother-Baby	Donna Fitzpatrick, MSN, RNC	18746, 12093	18105, 18033, 18108
2E1 - CCU; 2E2 - SICU; 2F - MICU	Francis Bergonio BSN, RN **. RRT x11066; or Vocera 12780 and speak "Rapid Response"**	12126 .	18101, 18109, 18110
Vascular Access Team		11068	
Respiratory Therapy	Frank Rizzuto, RRT-NPS	11238	
Administrative Director	***NICOLE JACKSON, BSN, RN***	**12096**	
Emergency Department	Louisa Guida, BSN, RN	13728	12909
Emergency Screening	Kelly Ryan, BSN, RN, ADPC, ED/CRISIS	12921	12909
Observation/RDU	Pamela Bogan, BSN, RN	18197	18273
Administrative Director	***KATHLEEN SAITTA-MARTINEZ, MSN, MBA, RN, CNOR***	**18992**	
Perioperative Services	Antonette Chiappano, MSN, RN, CNOR	18045	18040, 18019, 18018, 11580
Central Sterile Processing	Michael Wilke, BBA, CRCST	18978	11107
Hemodialysis	Jayme Welch (DaVita)	720-271-3366	18091
Director - Nursing Finance	***JEFFREY ANDERSON, MBA, BSN, RN-BC***	**18029**	
Staffing Office		18014	
Director-Center for Professional Development, Innovation & Research (CPDIR)	***SUSAN URBANEK, MSN, RNC-OB***	**11534**	**18015**
ADDITIONAL RELATED SERVICES:			
Assistant Vice President, Service Line Development	***KIMBERLY J. GARNER, MBA, BSN, RN, CMSRN***	**11560**	
Neuroscience Services, Primary Stroke Center, Sleep Center, Neuro Diagnostic	Lindsey Smith, MSN, RN, SCRN, Director . Morgan Sypniewski, BSN, RN, EMT, Stroke Coordinator	18149 (Lindsey) .12292 (Morgan)	
Assistant Vice President for Business Development	***JESSICA RUZOW, MBA***	**12108**	
Cardiology Services	Tara Iorio, BSN, RN, CVRN-BC	12837	18031
Bed Management	Robert Day	12471 / 12189	
Infection Control	Gaurav Nagar	18265	
Outpatient Infusion	Jatinder Singh X18239 Sarah Manning x12404		
Medical Staff Office	18082	18082	
VNA Hospice	12500/12495	12500 / 12495	
Bariatrics	Joseph Cavanaugh / Amber Cutone	12033 / 13959	
Nursing Supervisors	Cell #: 848-224-3508	11331	
Human Resources		18030	
Directors of Patient Care Revised May 7, 2025			

Physician Lounge

The Physician Lounge is located on the first floor next to the Medical Staff Office and includes:

- Restrooms
- Coat closet
- Computer workstations
- Television
- Communication bulletin boards
- Coffee, tea, soup (lunch only), and snacks are available all day

Bylaws, CMC Medical Staff Rules & Regulations, and Policies and Procedures

See “Bylaws, Policies and Procedures” section on: www.rwjbh.org/community-medical-center/for-healthcare-professionals/for-providers/)

Photo ID Badge

Physician Photo Badge for Community Medical Center
(1st Floor)

Contact: Valerie Hewatt x11248
HOURS: 8:30am to 12:30pm - Monday through Friday
1:30pm to 4:30pm – Monday through Friday

Your ID Badge will be available for pickup in the Medical Staff Office after the Board of Trustees has approved your application and you have completed/returned the Orientation Attestation Form.

***Please contact Security for badge access/issues**

Health Information Management

- For HIM Help please call: 732-557-8155

HIM Leadership Information

- Lesley-Ann Adams Vice President, HIM Operations
Phone: 862-236-0659 Email: Lesley.adams@rwjbh.org
- Carolyn Maguire Vice President, HIM Coding
Phone: 201-209-2492 Email: Carolyn.Maguire@rwjbh.org
- Margaret Keating Assistant Vice President, HIM Coding Quality
Phone: 732-557-8133 Email: Maggie.Keating@rwjbh.org
- Kimberly Good Systems Director, HIM Operations- Regulatory / Release of Information
Phone: 732-557-8133 Email: Kim.Good@rwjbh.org
- Katty Holley Systems Director, HIM Operations Document Management
Phone: 732-923-9230 E-Mail: Katty.Holley@rwjbh.org
- Melinda Sager Systems Director, HIM operations & Deficiency Management
Phone: 201-687-1421 Email: Melinda.sager@rwjbh.org

Hybrid Medical Record

EPIC is the EMR for electronic documents.

Onbase- Software utilized to digitize medical record documentation and upload it into Epic .

Galen – Archived medical records from previous EMRs available in Epic for reference (dating back to 2020)

Suspension

The following are the conditions that will result in suspension. Once completed Epic automatically releases the suspension of admitting privileges

- **History and Physical Examination-** must be on the medical record at the time of discharge (Bylaws and Joint Commission on Accreditation require its presence no later than at the end of the first twenty-four (24) hours of hospital stay or within thirty (30) days of an elective admission.

- **Report of Operation-** must be on the medical record at the time of discharge (Joint Commission on Accreditation requires its presence immediately after surgery.) Undictated operative or invasive procedure report(s) more than 24 hours after the date of the procedure. All inpatient and outpatient surgical / procedures are included in this time frame (Cardiac Caths / Interventional Radiology / Minor Room / Endoscopies, etc.)

- **Medical Record is completed** within 15 days of discharge

- **Physician Post Discharge Queries**: No documented response within 7 days of being written

Health Information Management
Documentation Platforms

Situation and Background

Epic utilizes **Dragon Medical One** dictation to facilitate timely documentation of reports and notes. If needed, Community also offers the dictation service **Acquity** where dictated reports are interface into to Epic.

Assessment

Dragon Medical One is the recommended platform to document physician reports in place of traditional dictation. Dragon PowerMic Mobile can be downloaded and installed from Google Play or Apple Apps to utilize Dragon from your cell phone. In addition, there are power mics located throughout the hospital. Epic Haiku / Canto can also be downloaded and downloaded and installed from Google Play or Apple Apps to document reports in the Epic EMR. Dragon is embedded in both software applications.

Recommendation

All Physicians (and providers who are credentialed to document reports in the chart) **are highly encouraged** to utilize Dragon technology when dictating reports / notes for immediate availability of the information for patient care and provider communication.

Dragon

Nuance® Dragon® Medical One Quick Reference Guide

Correcting and deleting
- Scratch that
- Delete that
- Undo/Redo that
- Select <XYZ>
- Select that (selects last utterance)
- Select first/last/next word/all
- Select <word> through <word>
- Unselect that
- Correct <XYZ>
- Correct that
- Resume with <XYZ> (deletes text up to that word)

Inserting lines and spaces
- New paragraph
- New line
- Insert before/after <XYZ>

Capitalizing
- Cap that
- Cap <XYZ>
- All caps on/off
- All caps that

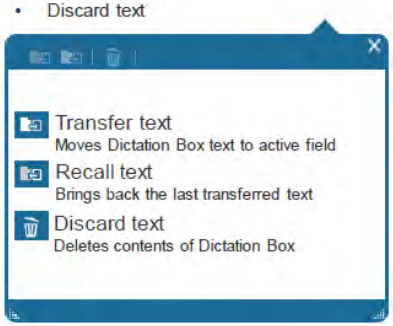
Navigating
- Go to beginning/top
- End of sentence/paragraph
- Go back
- Go to bottom/end
- Insert before/after <word or phrase>

Getting help
- Give me help
- What can I say

Dictate Punctuation:

Say	To type
Comma	,
Period or full stop	.
Exclamation point, exclamation mark	!
Question mark	?
Colon	:
Semi colon	;
Open quote ... Close quote	" ... "
Open paren ... Close paren	(...)

Useful Dictation Box Commands:
- Open/close dictation box
- Transfer text
- Discard text



Microphone Control

Standby Mode:
Enter: Say Go to sleep/Stop Listening/Stop Recording
Exit: Say Wake up

Microphone Best Practices
Headset:
- Position the microphone just below your mouth and approx. 3-5 fingers or 2" away from chin
- Click the Microphone button on the DragonBar to talk
- Click the mic to stop recording or say **Stop Listening**
- Pause briefly before and after saying commands to ensure they are recognized
- Speak in full sentences, including punctuation

PowerMic:
- Hold PowerMic in non-dominant hand
- Press and hold red talk button to dictate
- Release button to turn microphone off

Managing Your Vocabulary
Add words:
1. Say Add Word or say Add that to Vocabulary
2. Type correct spelling

Note: you can enter a new single word, acronym or a short phrase

3. Click Default Pronunciation or click the mic icon to TRAIN

Note: It is not necessary to press the talk button to train a word

Manage your custom words:
1. Say Manage Vocabulary > search for the word/phrase to change/delete/train > correct as needed

Note: if the word/phrase has already been trained, delete and re-add to correct spelling

2. Click + to add a new word/phrase

Health Information Management
Dictation Platform

DICTATION INSTRUCTIONS

Inside the Facility:

Barnabas Health Behavioral Center:	Ext. 24613
Community Medical Center:	Ext. 13823 or ***600
Monmouth Medical Center:	***600
Monmouth Southern Campus:	Ext 24613 or ***600

Outside the Facility, dial: (844) 446-1509

Step 1: Enter your Dictation ID, followed by the # key.

Step 2: Press 1 to Dictate or 3 to Review.

Step 3: Enter Facility Location Code, followed by the # key.

BHBH: 9	MMC: 6
CMC: 8	MSC: 7

STANDARD WORK TYPES

24	History and Physical
55	Consultation
122	Operative Report
17	Discharge Summary
44	Procedure Note
45	Progress Note
62	Electroencephalogram
100	Video Electroencephalogram
141	Behavioral Health Psychosocial Assessment

BASIC DICTATE KEYS

1	Play
2	Record/Pause
3	Rewind
4	Pause/Stop
5	New Dictation – Done
6	Go to End
7	Fast Forward
8	Rewind to Beginning – to Start
9	Suspend/Pend
0	Help
*	STAT (Prioritize dictation)

CARDIOLOGY WORK TYPES

182	Cardiac Catheterization
88	Echocardiography
128	Holter Monitor
104	Stress Test Report
136	Cardioversion
132	Coronary Angioplasty
103	Tilt Table Test
102	Transesophageal Echo Report
105	Nuclear Stress Test
106	Stress - IV Nuclear
120	Peripheral Angioplasty

Please note – **Faxed / E-Mailed copies of Dictated Reports will no longer be sent once the cutover occurs. These Reports will now be in your Epic Inbox. Copies of your reports can be found there.**

Community Medical Center's Restraint Use Philosophy

Recognizing that all patients have the right to freedom from restraint of any form, and restraints can only be utilized to ensure the immediate physical safety of the patient, staff or others, restraints will:

- Only be utilized when clinically appropriate
- Be the least restrictive and most effective method
- Be discontinued as soon as risk is no longer present/threat of harm is no longer present
- Never be used as a means of coercion, discipline or retaliation
- Only be used as a last resort

Always consider underlying causes for behavior requiring restraints

What is a Restraint?

Any physical or mechanical device, or manual method, which immobilizes or reduces the patient's ability to freely move his or her arms, legs, body or head.
The following items are <u>not</u> considered restraints:

- Safety and positioning products used temporarily when a patient is undergoing a test or procedure
- Orthopedic devices, surgical dressings, adaptive supports such as braces, age appropriate devices such as crib, high chair belts
- Handcuffs or shackles used by law enforcement officials

Indications for Restraint

Non Violent/Non Destructive (NVND) ‘Medical’ Restraint

Directly supports medical treatment & healing and is necessary to protect the patient from harm

Violent Self-Destructive (VSD) ‘Behavioral’ Restraint

Used to protect the patient from immediate risk of harm/injury to self or others

Physical Hold

Holding a patient in a manner that restricts the patient’s movement against the patient’s will is considered a restraint

A physical hold falls under the Violent Self Destructive ‘Behavioral’ category and requires a face to face evaluation

Physicians Orders

- A physician order is required before a restraint is applied
- If an emergent circumstance exists, an RN may initiate the restraint, followed by an MD face to face evaluation and order within one hour
- No standing orders, protocols or verbal/telephone orders for restraints
- Renewal of order: prior to renewing order, face to face must be completed. If the order is not renewed by end of present order, the restraint is discontinued at end of ordered time

Timeframes for Orders

NVND 'Medical' Restraint

Up to 24 hours

VSD 'Behavioral' Restraint

- Adults up to 4 hours
- Adolescents(9-17 of age) up to 2 hours
- Under age 9 up to 1 hour

Face to face assessment required within one hour

Contraindications to Restraints

Fractured limbs
CPAP/BiPAP
Open Wounds
IV, Ostomy or incision sites that can be compromised
Pregnancy
Elevated intracranial pressure

Discontinuation of Restraints

When the risk of harm and associated behavior are no longer present, and the restraint is not needed to protect the patient, staff or others from harm, **the restraint will be discontinued**

RN may remove restraints from patient based on assessment

If patient requires restraints again, even within original order timeframe, a new order and face to face assessment is required

The Joint Commission Requirement: Standard of Care Stroke Measures

Primary Stroke Center Performing Mechanical Thrombectomy

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The Joint Commission Requirement: Standard of Care Stroke Measures

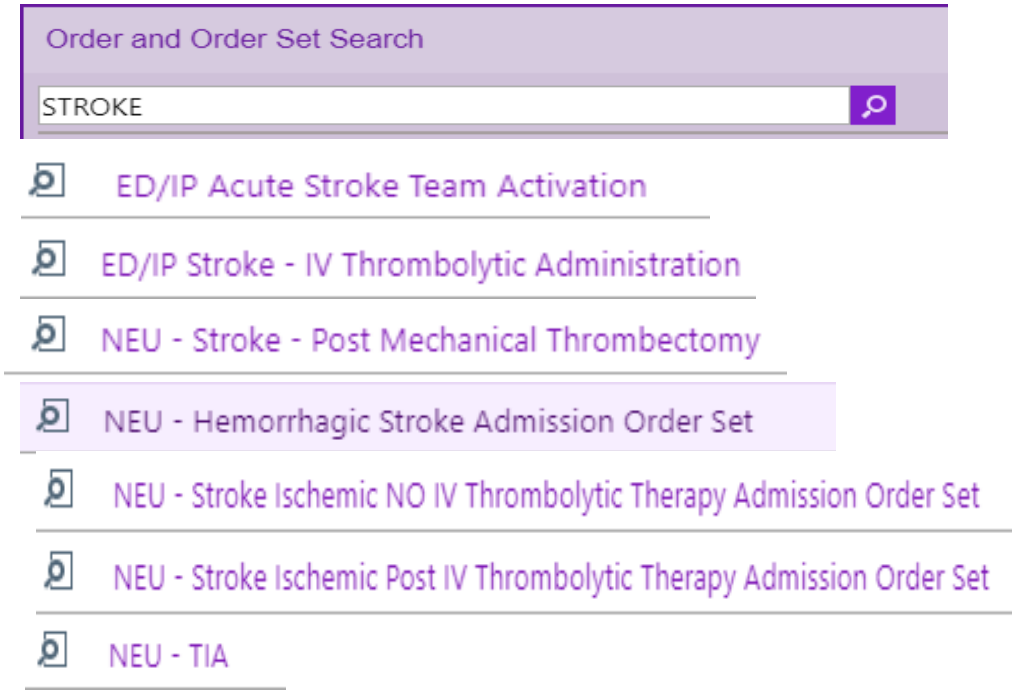
Core Measure	Indication	Resources
STK-1: DVT Prophylaxis	Order within 24 hours of admission	SCD / Heparin / Lovenox If refusing one modality **must** order another or **document not a candidate** for either pharmalogical or mechanical DVT prophylaxis
STK-2: Discharge on Antithrombotic	If patient is not a candidate- You **must** document a reason why in progress note	Aspirin/ Plavix / Brilinta
STK-3: Anticoagulation Therapy for Atrial Fibrillation/Atrial Flutter	If patient is not a candidate- You **must** document a reason why in progress note	Coumadin/ Xarelto / Eliquis / Pradaxa / IV Heparin
STK-4: Stroke IV Thrombolytic Therapy	Door to Needle Goal- 60 minutes or less. If patient is not a candidate- You **must** document a reason why in progress note	Tenecteplase (TNK) and Alteplase (TPA)
STK-5: Antithrombotic Therapy by End of Hospital Day 2	Must be give STAT ASA in ED if not an IV thrombolytic candidate. Then ordered daily by the primary attending or neurologist. If patient is not a candidate- You **must** document a reason why in progress note.	Aspirin / Plavix / Brilinta If patient is NPO, order RECTAL ASA
STK-6: Discharge on Statin Medication	LDL greater than or equal to 70 must be prescribed a statin medication inpatient AND on discharge. If patient	Any Statin Medication: Atorvastatin / Simvastatin / Pravastatin

Core Measure	Indication	Resources
STK-8: Stroke Education	System Wide Stroke Education Booklet / Education Packet	Provided and documented by nursing. Please ensure there is a neurology follow up documented in the AVS at discharge
STK-10: Assessed for Rehab	All stroke patients must be assessed by rehab services unless a documented reason why not ordered	Physical Therapy / Occupational Therapy / Speech Evaluations for all stroke diagnosis
CSTK-01: NIHSS	NIHSS **must** be documented on all stroke patients within the first **12 hours of admission** on patients. If the patient is to receive IV thrombolytic therapy an NIHSS must be documented before administration	NIHSS- Must be certified in order to perform Achieved by AHA online
STK-OP-1: Door In Door Out	This measure reports the median time (in minutes) from hospital arrival in the emergency department to transfer of a hemorrhagic stroke or an ischemic stroke patient to another hospital	The door in door out goal is LESS than 120 minutes
Additional Mechanical Thrombectomy Quality Measures		
CSTK 02: Modified Rankin Score (mRS) at 90 days	Ischemic stroke patients treated with thrombolytics or mechanical thrombectomy for whom a 90 day mRS is obtained via telephone or in-person	Stroke APN to perform a 90 day call back to any acute neuro intervention patients and document mRS
CSTK-05: Hemorrhagic Transformation	Captures proportion of ischemic stroke patients who develop a symptomatic intracranial hemorrhage within 36 hours of thrombolytic therapy or mechanical thrombectomy	Clinical Deterioration: 4 point increase in NIHSS, brain imaging resulting in intracranial hemorrhage

Core Measure	Indication	Resources
CSTK-08: Thrombolysis in Cerebral Infarction (TICI) Post Treatment Reperfusion Grade	Captures the proportion of *ischemic stroke* patients with a **post-treatment reperfusion grade of TICI 2B or higher** in the vascular territory beyond the target arterial occlusion at the end of mechanical thrombectomy	TICI Score at end of procedure: 2B, 2C, 3
CSTK-09: Arrival time to Skin Puncture	Median time from hospital **arrival to the time of skin puncture** to assess the artery for endovascular treatment	Puncture time during thrombectomy. Door to puncture goal: Less than 90 minutes

Stroke Order Sets

- **Clinical Practice Guidelines:** Embedded with order sets
- **MUST** be used on **ALL** patients admitted with a diagnosis of stroke or with suspicion of stroke



Stroke Contact Hours

- As a Primary Stroke Center accredited by The Joint Commission, the following providers are required to obtain **8 Stroke/Cerebrovascular contact hours *YEARLY* as identified as part of the acute stroke team**.
- Acute Stroke Team:
  - ED Providers
  - ICU Providers
  - Hospitalist Providers
  - Neurology Providers

ADVANCED PRIMARY STROKE CENTER

Joint Commission Disease Specific Certification STROKE:

Guidelines derived from:

- Brain Attack Coalition (BAC): Recommendations for Primary Stroke Centers
- American Stroke & Heart Associations (ASA/AHA): Statements for Stroke

Stroke Program Leadership

Medical Director – Gerald Ferencz, MD

Admin. Director, Neuroscience Development – Kim Garner, MBA, BSN, RN, CMSRN

Director, Neuroscience – Lindsey Smith, MSN, RN, SCRN

Stroke Coordinator – Amanda Leibowitz, BSN, RN, SCRN

The program receives full support from the Senior Leadership Team and the Board of Trustees.

CMC Guidelines Inclusion/Exclusion Screening for Intravenous Administration of IV Thrombolytics*

A. Inclusion Criteria: (Requires all Yes)	**Yes**	**No**
☐ Diagnosis of Ischemic stroke causing measureable neurological deficit	☐	☐
☐ Onset of symptoms < 3 hours before beginning treatment (if greater than >3 hours or < 4.5 hours refer to section (C)	☐	☐
☐ Age greater than or equal to 18 years	☐	☐
☐ Patient/family able to understand benefits/risks of IV thrombolytic	☐	☐

C. Additional Warnings for IV thrombolytic therapy use from 3-4.5 hour:

☐ None
☐ Age > 80 years
☐ Severe Stroke (NIHSS > 25)
☐ Taking an oral anticoagulant regardless of INR
☐ History of both diabetes AND prior ischemic stroke

CMC Guidelines Inclusion/Exclusion Screening for Intravenous Administration of IV Thrombolytics*

B. Exclusion Criteria (Do not administer IV thrombolytic to treat acute ischemic stroke in the following situations in which risk of bleeding is greater than the potential benefit):

- Current intracranial hemorrhage
- Subarachnoid hemorrhage
- Active internal bleeding
- Recent bleeding within 21 days
- Recent (within 3 months) intracranial or intraspinal surgery or serious head trauma, or ischemic stroke
- Presence of intracranial conditions that may increase the risk of bleeding
- Hypodensity of mass effect suggesting infarction of 1/3 of hemisphere or greater
- History of intracranial hemorrhage, vascular malformations, aneurysm, larger number > 10 cerebral micro bleeds, intracranial neoplasm
- Bleeding diathesis*
- Platelet count < 100,000
- Anticoagulant (warfarin) with INR > 1.7 or PT > 15 seconds
- Concurrent use of direct thrombin inhibitors and Xa inhibitors; Pradaxa (dabigatran), Eliquis (apixaban), Xarelto (rivaroxaban) The use of IV thrombolytic therapy in patients taking direct thrombin inhibitors or direct factor Xa inhibitors has not been firmly established but may be harmful.† (COR III: Harm; LOE C-EO)§| IV thrombolytic therapy should not be administered to patients taking direct thrombin inhibitors or direct factor Xa inhibitors unless laboratory tests such as aPTT, INR, platelet count, ecarin clotting time, thrombin time, or appropriate direct factor Xa activity assays are normal or the patient has not received a dose of these agents for >48 h (assuming normal renal metabolizing function).
- LMWH within prior 24 hours
- PTT > 40 seconds related to unfractionated heparin, advanced liver or renal disease
- Current uncontrolled hypertension (Systolic > 185 mm Hg or diastolic > 110 mm Hg)
- Blood glucose < 50mg/dl (unless symptoms remain after treatment)
- Unable to determine edibility

Case Management

Danielle Leone, LCSW, ACM-SW
Director, Case Management
Danielle.Leone@rwjbh.org
(973) 803-7518 cell
(732) 557-8000 x 10094 office
Jessica Pansulla, RN, BSN
Assistant Director, Case Management
Jessica.Pansulla@rwjbh.org
(609) 389-2891 cell
(732) 557-8000 x 11307 office

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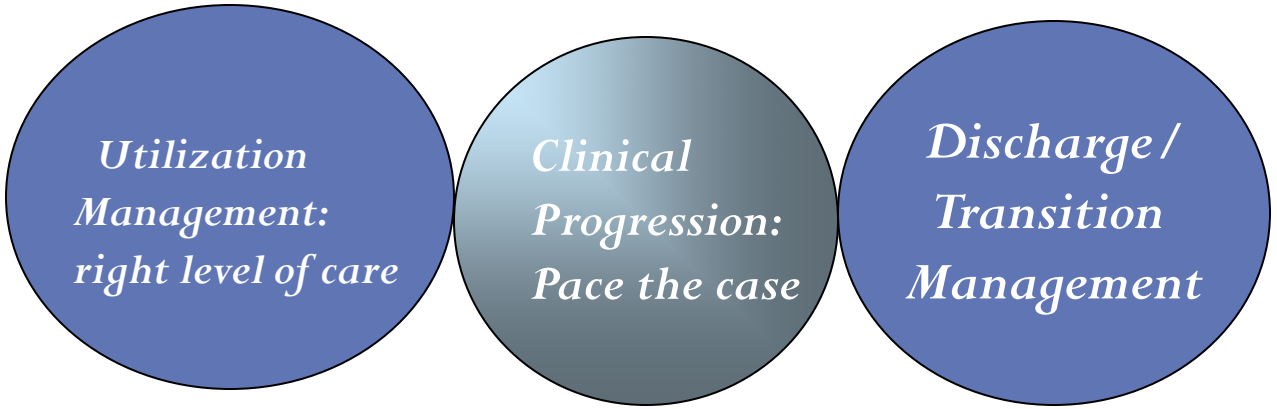
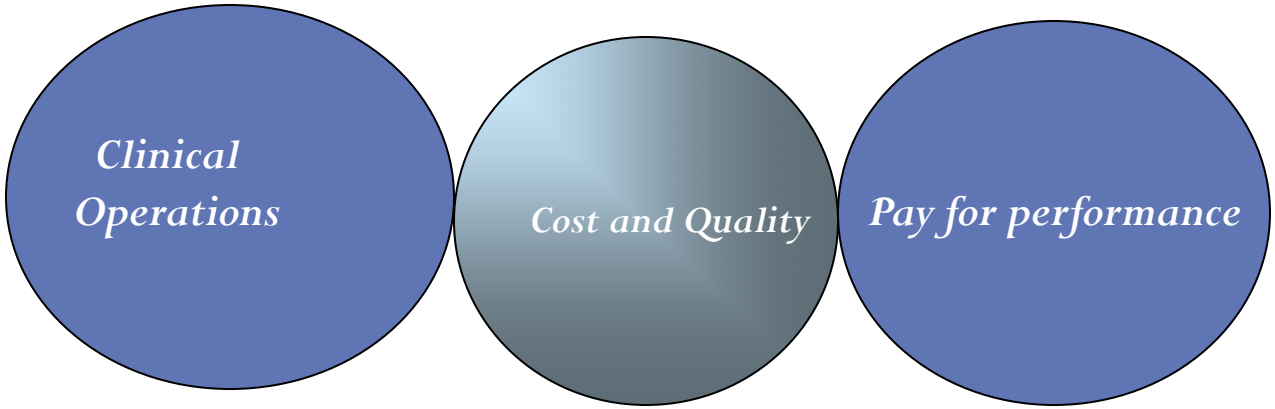
Care Coordination: The Linkages!



- **Care Coordination:**
  - **Managing the elements and sequencing of care to achieve targeted outcome(s).**
    - *Historically, "discharge "was the outcome. In current best practice, outcomes are the reasonable state of stability to transition patients for further recovery and sustainability in the community.*
    - *Provider offers treatments, education, and information and referrals to achieve the outcomes.*
- **Best achieved:**
  - **When there is a focus on coordination of care as a highly- standardized process, and always using a multi-disciplinary model.**
- **Begins prior to entry to the "building":**
  - *Scheduling, booking, Direct Admits, ED/ RDU, and even Peri-op and from Home care and rehab*

Care Coordination:
Case Management and Social Work
Transect all domains



- **Clinical Operations:**
  - Case Management, Bed Management, Capacity Management, Operational Delay prevention, Productivity, Logistics, effective use of portals (ED, RDU, Hospice, Cath lab,)
- **Cost and Quality**:
  - Care Coordination using multidisciplinary model, CDIP and DRG Maximization, Clinical effectiveness, Utilization management, Discharge Planning, Post acute preferred network
- **Pay for Performance:**
  - Transitions in Care, Population Health, Readmission prevention, Bundled payments, Patient Satisfaction, Employee engagement and community narrow networks .

Case Managers and Physician: Collaboration IS KEY!

- **<u>Chronic communication</u> regarding assessment of where is the patient along the clinical care trajectory is essential.**
  - **Case Mangers and MDs will discuss:**
    - Is the patient in the right place/unit/bed/level of care at the right time?
    - Has the MD determined the accurate Status orders for LOC?
      - If Observation LOC, MDs are mindful to use limited number of consultants
      - Is the MD applying interventions or tests to *an inpatient* that are most appropriate for *outpatient level of care*.
    - What is post dc Plan for patient/family self-management/ transition to alternative setting in the community?
    - Rx, treatment, DME, clinical needs and barriers
  - **Social Work and MDs will discuss:**
    - Target date for discharge
    - Advance directive/POLST/ capacity issues
    - Functional recommendations for post acute care
    - Clinical and social barriers to safe transition

UTILIZATION CRITERIA AND DENIAL PREVENTION

- Utilization Criteria:
  - Managed care, commercial and self pay uses Milliman and Interqual criteria
    - HURC (Hospital Utilization Review Corporation) is 3rd party UM contract company
    - Denials management adheres to managing our clinical course with respect to criteria
  - Medicare: Follows CMS 2 qualifying midnight rule,
    - Versalus: 3rd party UM company

METRICS BENEFICIAL TO PHYSICIANS

- Performance and Operational metrics that engage and benefit MDs:
    - LOS: Greater than 4 days, greater than 65 years old and 4 day LOS, RDU Observation Hours, etc.
    - Denials: By Payer, by LOS, By DRG
    - Case Mix Index
    - Avoidable days report– supports MDs when resources or services not available
    - Utilization Review of Denials (by $, MD, LOS, and by cause and payer)
    - MD Discharge orders before 11am;
    - Actual discharges within 2 hours of MD order
    - RWJBH Homecare and Hospice performance

Clinical Documentation Management Program

Mary Jane Christian, RN, BSN, MS, CCRN
Assistant Vice President of Clinical Documentation Improvement

Contact: 862-236-0445

Clinical Documentation Management Program: Goals

- Bridge the Gap between Medical Provider and Coding Professional
- Reflects the clinical picture of each the patient
- Ensures Accurate, Complete and Compliant Documentation
- Assists with Improving Physicians overall Performance.
- Measures and Impacts Quality Scores (i.e. PSI's and HAC's)
- Captures the Severity of Illness (SOI), Risk of Mortality (ROM) and Mortality Index for each Patient.
- Assist in capturing correct LOS assignment.
- Reduce backend coding Professional Queries.
- Documentation Compliance

*****The Clinical Documentation Team (CDS') at CMC is comprised of all RN's that have been in the field for over 10 years or more**

Documentation Continuous through Medical Record

- Important for the Attending Physician to document all information from the Consultants into the Progress Notes and Discharge Summary to avoid conflicting documentation.
- Clinical Documentation Improvement (CDI) Clarifications are asked while the patient is hospitalized.
- Agreed Responses to Clinical Documentation Improvement (CDI) Clarifications need to be entered into the Progress Notes and carried through to the Discharge Summary.
- Responses to the Clinical Documentation Improvement Clarifications are permanent parts of the Medical Record.
- Will improve the Provider's communication and validate the Length of Stay (LOS)
- Will assist in capturing the correct Severity of Illness, Risk of Mortality and Mortality Ratio. (PSI)
- Identifies reliable and useful data for Quality Reporting (PSI's and HAC's)
- Will assist in avoiding Retro/Back-end Queries by Coding Professionals
- Provider documentation must be entered into the Progress Notes and carried through to the Discharge Summary for Coding Professionals to Code the Medical Record.
- Will make Provider documentation compliant for CMS, RAC, and Regulatory Organizations

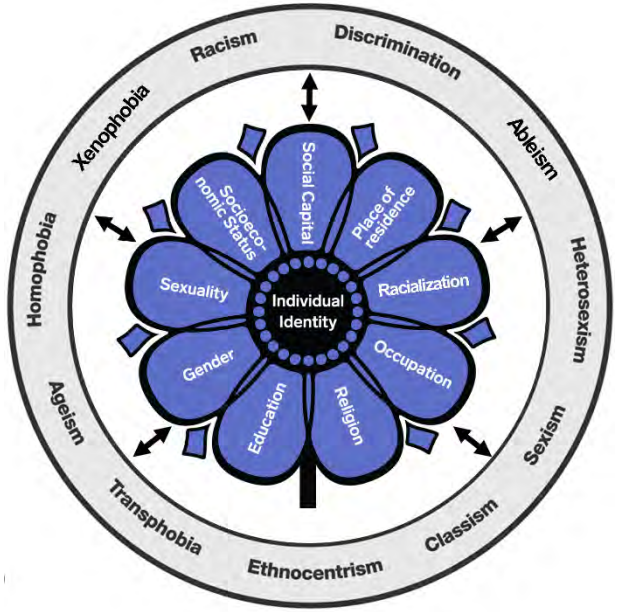
Your Clinical Documentation Team at CMC

- Mary Jane Christian: Assistant Vice President of Clinical Documentation: 862.236.0445
- Dawn Meehan CDI Clinical Educator: Dawn.Meehan@rwjbh.org
- Lisa Askey: Extension - 13134
- Megan Azambuja: Extension - 13133
- Susan Barry: Extension 10324
- Arlene Dato: Extension 10543
- Lito Lingat: Extension 10553
- Brenda Matin: Extension 13136
- Liesel Seiser: Extension 10314
- Mary Ann Wheeler: Extension 13135

Physician Advisor and MD/DO Partnership

- Role of Physician Advisor: internal and external
    - Clinical review process
    - Regulatory Compliance
- Examples of daily communication goals:
    - BPCI bundled payments and right level of care
    - Level of Care (LOC)
    - Length of Stay (LOS)
    - Outpatient testing versus inpatient
    - Status orders
    - Denial risk and actual denials

Office Diversity & Inclusion



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Office Diversity & Inclusion

Cultivating an environment of…

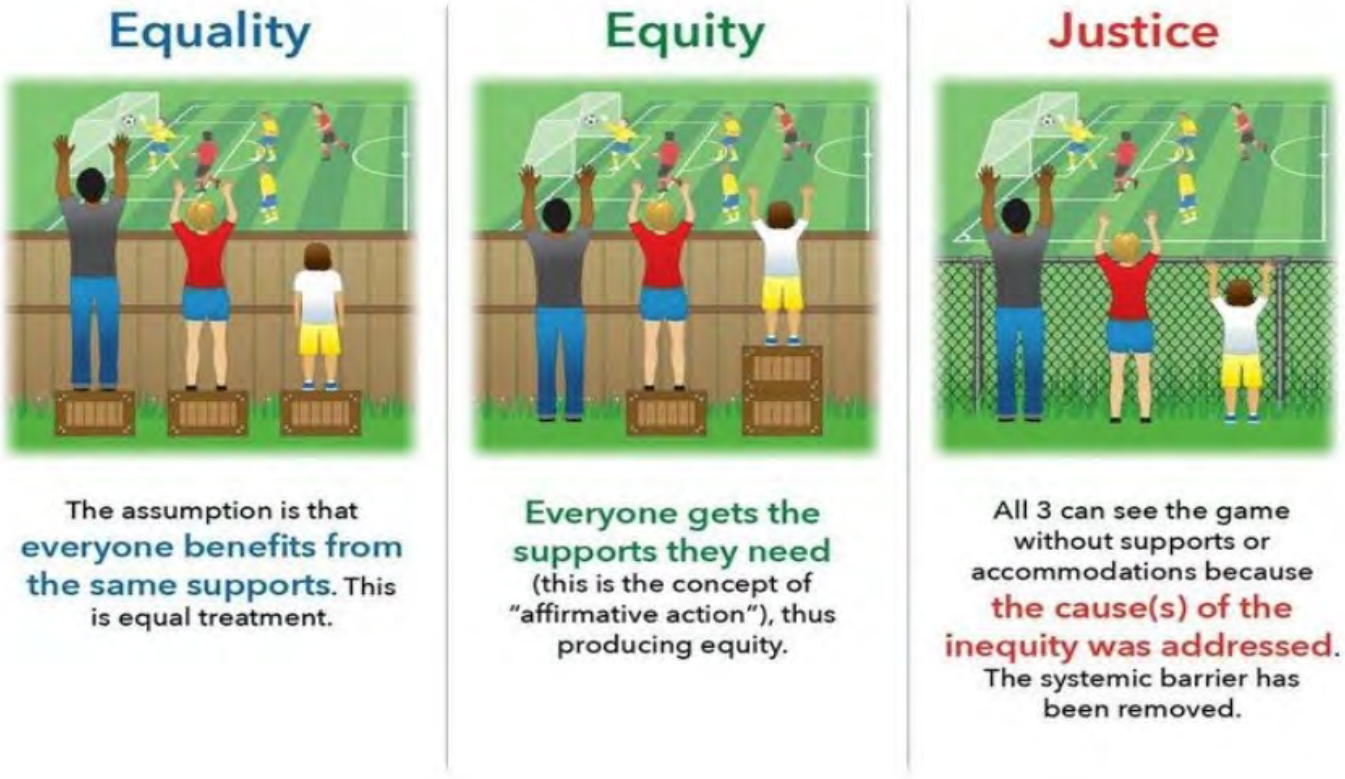
- *Mutual Respect* for *ALL*.
  - Colleagues
  - Patients
  - Family Members
  - Community
- *Healthcare Equity* where everyone can be their healthiest selves
- *Employment Experience*
  - Hiring, Promoting and Performance management

Regardless of…

- Race
- Ethnicity
- Age
- Linguistics
- Gender+
- Sexual Orientation
- Abilities
- Religion
- and more…

Our Goal

Health Equity is defined as the ***"attainment of the highest level of health for all people."***



Equity for our Staff is ***"providing opportunities for advancement & growth to reach their highest level of potential."***

RWJBH Policies: Employees

Fair Employment Practices: Equal Employment Opportunity and Freedom from Discrimination, Harassment and Retaliation

https://thebridge.rwjbh.org/Resource.ashx?sn=FairEmploymentPracticesPolicy_FINAL_6102022

-RWJBH is committed to a work environment in which all individuals are treated with respect and dignity and believes each individual has the right to work in a professional atmosphere that respects Protected Characteristics, promotes equal employment opportunities, and prohibits discriminatory practices, including harassment. With that goal, RWJBH requires our work environment be free from inappropriate dialogue and conduct. RWJBH will not tolerate any form of unlawful discrimination or harassment and requires our employees to assist in maintaining our workplace goals by using our reporting processes. RWJBH will not tolerate any retaliation for good faith reporting of concerns or complaints.

RWJBH Policies: Patient

Requests for or Refusal by a Patient and RWJBH Workforce Members with Personal Characteristics

https://thebridge.rwjbh.org/Resource.ashx?sn=RequestsfororRefusalbyaPatientandRWJBHWorkforceMem

-Patients, as well as their family members, representatives and visitors are expected to recognize and respect the rights of our other patients, visitors, and RWJBH Workforce Members. Discrimination, verbal threats, threats of violence, disrespectful communication and/or harassment of other patients or of any RWJBH Workforce Member, for reasons related to race, color, age, culture, disability (physical or intellectual), ethnicity, gender, gender identity or expression, language, military/veteran status, sex, national origin, religion or sexual orientation (collectively or individually, "Personal Characteristics"), will not be tolerated. This prohibition applies to a patient's family members, representatives, and visitors, as well as the patient.

2-RWJBH will not accommodate requests for or refusal by a patient for the services of RWJBH Workforce Members based on a Personal Characteristic of a RWJBH Workforce Member, except in the limited situation where the patient (or other individual on the patient's behalf) requests that an accommodation based on gender only is necessary to protect a patient's religious or cultural beliefs ("Accommodation Exception"). When an Accommodation Exception is requested, RWJBH will evaluate the request on an individual basis and may accommodate or refuse to accommodate such request.

Sepsis

Inpatient Process

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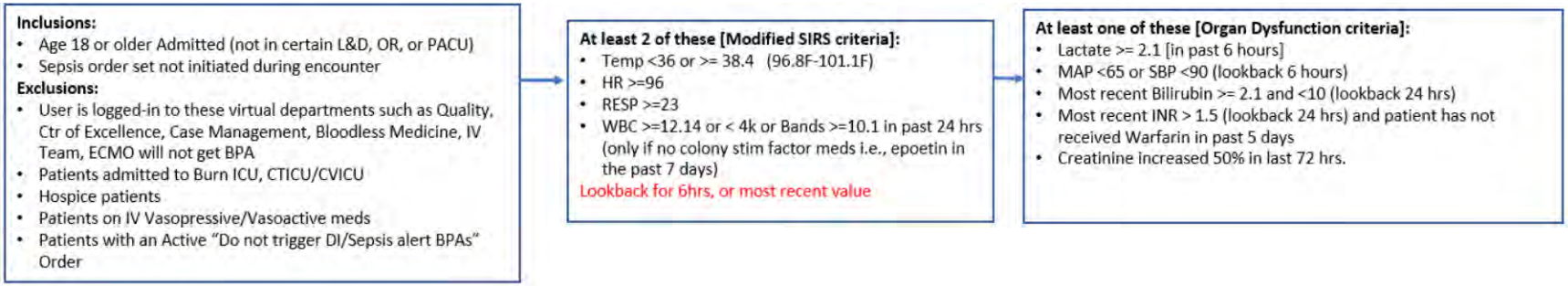
What is sepsis?

- Sepsis is a life threatening condition caused by the body's response to infection, which can lead to tissue damage, organ failure, amputations and death.
- Situation: Missing early identification and interventions for patients identified as a Sepsis Alert with the risk for progression to severe sepsis/septic shock.
- Background: Inpatient nurses rely on Providers for orders to begin the bundle for Sepsis Alerts. Waiting on callbacks from admitting Physicians cause a delay in initiating Sepsis Bundles.
- Assessment: A new process with an interdisciplinary team will focus on improving the current barriers in treating sepsis patients. Education needs to be provided on new inpatient process for all medical surgical areas
- Recommendation: Standardized protocol on what to do when a Sepsis Alert is triggered. CBL to review sepsis bundles and standards of care.

WHAT TRIGGERS A SEPSIS ALERT?



EPIC SEPSIS BEST PRACTICE ADVISORY BASED ON ST JOHNS SEPSIS ALGORITHM

INPATIENT PROCESS FOR SEPSIS ALERTS

- RN OR PROVIDER RECEIVES THE SEPSIS BPA
- RN OR PROVIDER MUST DIAL ***111 TO NOTIFY THE OPERATOR TO ANNOUNCE "MEDICAL ALERT, SEPSIS RESPONSE TEAM, UNIT"
- OPERATOR WILL ANNOUNCE VIA VOCERA; VOCERA GOES TO RRT, RN, RESPIRATORY, HOSPITALIST, VASCULAR ACCESS TEAM, RN SUPERVISOR
- OPERATOR WILL CALL INPATIENT NURSING UNIT WITH SEPSIS ALERT AND ROOM NUMBER

<u>The Sepsis Response Team</u>
Rapid Response Nurse
Hospitalist, APN, PA
Respiratory Therapist
Vascular Access Team (VAT)

Hospitalist to call Attending Physician and inform of Sepsis Alert

Primary Nurse Responsibilities

- While waiting for Sepsis Response Team:
  - Get an initial set of vitals
  - Check blood sugar
  - Make sure patient has working IV site
  - Have "WOW" at beside with patient chart open
  - Document Sepsis Alert in Critical Events

Sepsis Response Team Responsibilities

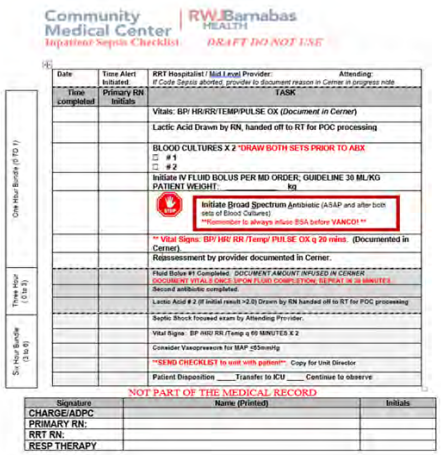
- Initiate Sepsis bundle in Epic

  or

- Abort Sepsis Alert in Epic, PROVIDER MSUT DOCUMENT REASON FOR ABORTING INCLUDING ALTERNATIVE RATIONALE FOR PATIENT MEETING CRITERIA

SEPSIS : 1 HOUR BUNDLE

To be completed within 1 hour of presentation upon receiving orders



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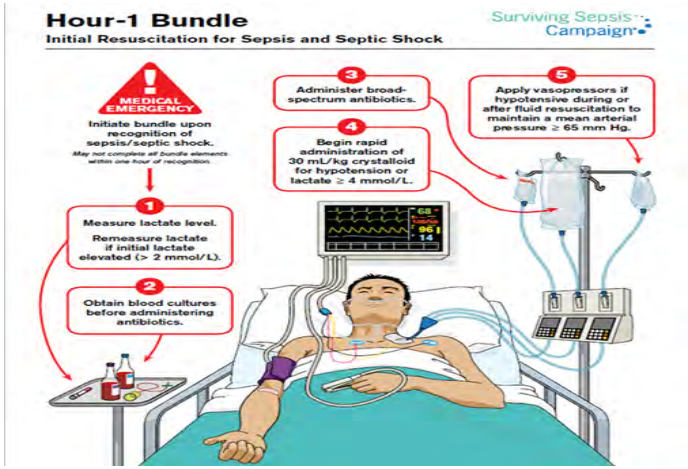
Inpatient Sepsis Checklist — DRAFT DO NOT USE

Date:	Time Alert Initiated:	RRT Hospitalist / Mid Level Provider: Attending: *If Code Sepsis aborted, provider to document reason in Cerner in progress note*	
Time completed	Primary RN Initials	TASK	
		Vitals: BP/ HR/RR/TEMP/PULSE OX (*Document in Cerner*)	
		Lactic Acid Drawn by RN, handed off to RT for POC processing	
		BLOOD CULTURES X 2 *DRAW BOTH SETS PRIOR TO ABX ☐ #1 ☐ #2	
		Initiate IV FLUID BOLUS PER MD ORDER; GUIDELINE 30 ML/KG PATIENT WEIGHT: _____ kg	
		Initiate Broad Spectrum Antibiotic (ASAP and after both sets of Blood Cultures) **Remember to always infuse BSA before VANCO!! **	
		** Vital Signs: BP/ HR/ RR /Temp/ PULSE OX q 20 mins. (Documented in Cerner)	
		Reassessment by provider documented in Cerner.	
		Fluid Bolus #1 Completed. *DOCUMENT AMOUNT INFUSED IN CERNER* *DOCUMENT VITALS ONCE UPON FLUID COMPLETION, REPEAT IN 20 MINUTES*	
		Second antibiotic completed.	
		Lactic Acid # 2 (if initial result >2.0) Drawn by RN handed off to RT for POC processing	
		Septic Shock focused exam by Attending Provider.	
		Vital Signs: BP /HR/ RR /Temp q 60 MINUTES X 2	
		Consider Vasopressors for MAP ≤65mmHg	
		SEND CHECKLIST to unit with patient Copy for Unit Director	
		Patient Disposition ____Transfer to ICU ____ Continue to observe	

One Hour Bundle (1 TO 1) | Three Hour (3 to 5) | Six Hour Bundle (3 to 6)

NOT PART OF THE MEDICAL RECORD

Signature	Name: (Printed)	Initials
CHARGE/ADPC:		
PRIMARY RN:		
RRT RN:		
RESP THERAPY		



- Vitals – BP/HR/RR/TEMP/PULSE OX – document in Epic
  - Vital Signs Q20 minutes – document in Epic
- Lactic Acid drawn by RN, no tourniquet, send on ice
  - hand off to RT for Point of Care processing
- Obtain blood cultures X2
  - Both sets to be drawn prior to administration of antibiotics
- Initiate IV fluid bolus per Provider order
  - Guideline 30mL/kg
- Initiate Broad Spectrum Antibiotics per Provider order
- INITIATE INPATIENT SEPSIS CHECKLIST!!!!!

Sepsis 3 Hour bundle

- To be completed within 3 hours of presentation upon receiving orders
  - Fluid bolus completed – document amount infused in Epic
  - Vitals once upon fluid completion & Repeat in 30 minutes
    - BP/HR/RR/TEMP/PULSE OX – document in Epic
  - Second antibiotic completed
  - Draw 2nd Lactic Acid if initial result >2.0
    - If necessary to be drawn by RN and handed off to Respiratory for POC processing

When crystalloid fluids were required for septic shock there must be a note by an LIP within six hours of septic shock that indicates a reassessment was performed

The Transitional Care Unit at Community Medical Center

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What Is a Transitional Care Unit?

- A skilled nursing/sub-acute facility is an in-patient rehabilitation and medical treatment center staffed with trained medical professionals that give patients round-the-clock assistance with healthcare and activities of daily living (ADLS). A skilled nursing facility **is a temporary residence for patients undergoing medically-necessary rehabilitation treatment**. Typically the skilled nursing facility is located within a nursing home that provides **custodial care** to residents who live onsite 24/7.
- The Transitional Care Unit "TCU" is defined as a distinct unit within an acute care general hospital that utilizes long-term care beds to provide subacute and very much operates like a skilled nursing facility.
- The TCU patient's admission must be medically necessary with an acceptable admitting diagnosis.
- What makes the TCU different from a traditional skilled nursing/sub-acute facility?
  - The average length of stay is 8 days or less
  - Patients admitted to the TCU need to be able to meet their discharge goals in about 8 days and have a prescribed discharge plan to return to their original community setting
  - TCU does not accept patients that are already residents at a long term care facility unless that facility cannot accommodate the patient's current medical needs
  - Although patients who are accepted to the TCU should no longer require intensive diagnostic or invasive procedures, should this become medically necessary during the patients stay, the TCU has direct access to these services through the main hospital
- When considering a patient for TCU, the main focus is the patient's discharge plan and their ability to transition to their original community setting with the appropriate available resources.
  - Common diagnosis/services provided are patients in need of post surgical care, IV antibiotic therapy, wound care to include wound vac management, cardiac management, pain management and respiratory therapy.
  - Patients receive 1-2 hours of rehabilitation services 7 days a week with their individualized plan of care based on their needs and ability
  - Currently TCU does not accept patients who need weaning off high-floor oxygen or in need of vent support.

Benefits of using The Transitional Care Unit at Community Medical Center:

- Optimal continuity of care
  - Typically a TCU patient can continue to see their primary care physician and their specialty care physicians.
  - TCU also uses Epic and therefore has access to the patient's complete medical record
  - The TCU patient continues to have access to the services they received while in the hospital provided that these services are relevant to the reason the patient was originally admitted to TCU
- Better management of the patient's Length of Stay
  - The TCU shares the common goal of getting the patient to their original community setting as soon as the patient is medically ready
  - The TCU works closely with the population health department in managing our "bundle" patients
- The TCU follows many of the same clinical pathways and policies and procedures that are utilized in the hospital setting
- The TCU has access to the RRT which enhances our ability to treat in place or when needed, have the patient directly admitted to an inpatient unit.
  - This alleviates the need for the TCU patient to be sent the emergency room for assessment

Please contact us if you have a potential patient referral or if you have any questions or concerns:

- Alberto Samante, RN - Director of Case Management
- Jennifer Horath, MA, LNHA – Nursing Home Administrator for TCU
- The Transitional Care Unit at Community Medical Center (732) 557-2270 or ext. 12270

Introduction to Healthcare Risk Management

Bruce Ackerman, Director of Risk Management, Local Privacy Officer

Phone: (732) 557-8032 or Internal Ext. x18032

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What is Risk Management?

- A process used to reduce and, when possible, eliminate the risk of injury to patients, visitors, employees, volunteers and medical staff, as well as to protect the hospital's financial resources.

- A department that oversees the risk management program at the hospital. Works closely with the Legal Affairs Department and serves as a resource that is available for consultation.
- Oversee potential and actual malpractice claims at Community Medical Center.

Goals of Risk Management

- To strive for the highest quality of care achievable utilizing *available resources.*
- To identify *actual* and *potential* problems in an effort to *proactively* reduce or eliminate risks and harm to all individuals at the facility.
- Investigate issues when they occur and share results with the appropriate departments and committees that can make changes.
- Reduce liability for the hospital, medical staff, and employees.
- Protect the financial assets of the organization.

What is Negligence?

- Professional Negligence – Failure to perform duties according to the standard of care.
- Most medical malpractice lawsuits make a claim of negligence. To prove this claim, plaintiff must prove:
  - Duty/Standard of Care
  - Breach (Deviation from the duty/SOC)
  - Damages (Harm)
  - Causation (breach in SOC cause damages)

The Standard of Care

- The ordinary and reasonable skill as commonly used by another healthcare professional in similar circumstances. (reasonable person)
- Defined by:
  - Policies and Procedures
  - National Standards
  - Training/Education
  - Textbooks, etc.
- The SOC is dynamic and changes as there are advances in medicine, etc.
- In medical malpractice cases, experts generally will be used to testify about the SOC.

Documentation must demonstrate that the proper standard of care was provided

How can you reduce your risk?

- Adhere to the appropriate standard of care.
- Effectively communicate and document care.
- Provide patients with sufficient and appropriate information about treatment and include any potential risks associated with treatment.
- Develop A Good Bedside Manner - A patient/family's decision to consult an attorney is often triggered more by anger over the manner in which a healthcare provider interacted with them rather than by actual treatment issues.

Handoff Communication

- Handoff Communication (Introduced by TJC as a National Patient Safety Goal in 2008.)
- Even the best executed handoff has an inherent risk.
- Ideally, the number of handoffs should be reduced or, when possible, eliminated including verbal orders.
- Must be an interactive process.
- When necessary to handoff care of a patient, there should be a systematic approach to the handoff process (i.e. SBAR, read back and verify, repeat back)

Guideline for Patient and/or Family Disclosure

- Promptly: within 24 hours.
- Done with physician and administration present
- Express regret
- Explain on the fact as to what happened, not how or why
- Explain prognosis and how the event will effect the patient and what we are doing to mitigate the harm.
- Admit if an error and take responsibility and apologize
- Inform of full investigation will follow and follow-up communication with patient or family.

Documentation

- Documentation is a practitioner's responsibility during patient care.
- Documentation records the clinician's evaluation of the patient and response to care and treatment
- Accurate documentation can be one of your best defenses in a lawsuit.
- Medical malpractice cases can be rendered indefensible due to problems with the medical record
- Charting and documentation will be used in a medical malpractice case. It provides valuable evidence regarding the patient's condition, treatments, and response to treatments.
- You can't always control the patient's response to care, but you can control the way you document care.
- Attorneys will try to argue "if it wasn't written, it wasn't done"

DOCUMENTATION

Hints/Tips

- DO
  - Write legibly
  - Date, **time** and sign all entries in the medical record.
  - Correct entry errors properly (even minor errors).
    - Manual entries- Draw a single line through the error, but let it remain readable. Date, time and initial this correction. Write the correct information if applicable.
    - Electronic entries- delete entry and amend if applicable. Deleted note will remain and flagged as redacted.
  - Document a patient's refusal or inability to provide information or complete information
  - Use only approved abbreviations

- DO NOT
  - Do not lose or destroy medical records
  - Do not add to someone else's notes
  - Use the medical record to criticize others
  - Document self serving statements after an adverse event has occurred
  - Document derogatory remarks about a patient
  - Proxy Chart – charting others actions as if they were your own.

Informed Consent

- Licensed independent practitioners (LIP's) must obtain a patient's consent after a discussion of the material risks, benefits, alternatives and potential outcomes (preferably by the person performing and/or recommending the procedure).
- Provide information that a reasonable or prudent patient in similar circumstances would want to know before undergoing a procedure or treatment.
- Informed consent is a process, not a form. The informed consent process must be documented.
- Care providers must respect the patient's decision.

Patient Refusal

- Based on informed choice (think of it as "informed refusal")
- Must include discussion of the consequences of refusal
- Legally competent patients may refuse any care
- Care providers must respect the patient's decision
- Refusal must be carefully documented in the medical record.

Confidentiality and Privacy

- In a Healthcare facility, we must take measures to prevent unauthorized disclosure of protected health information (PHI).
- PHI includes any information relating to a person's health condition, medical treatment or payment for health services that is created or received by the Hospital and that may identify the individual (including images, even if patient not identified).
- Always take measures to protect unauthorized access to or disclosure of PHI. These measure include:
  - Maintaining patient confidentiality and privacy at all times.
  - Never sharing or displaying a password to any computer system. Avoid creating simple passwords such as "password 123".
  - Do not walk away from log-in.
  - Properly disposing of anything that contains PHI.
  - Refraining from discussion of patient care in public areas or with others who are not part of the care team without the patient's permission.
  - Never disclosing PHI without patient authorization.

Confidentiality and Privacy

- Exceptions:
  - Healthcare facilities may use and disclose PHI for the purpose of Treatment, Payment and Health Care Operations without obtaining a written authorization from the patient. Information may also be disclosed to certain oversight agencies (i.e. NJDOH)

- Questions about privacy and confidentiality should be directed to the Privacy Officer.

Safety Event (Incident) Reporting

- A Patient Safety Event (incident) is any unusual occurrence, accident, or mishap, which is not consistent with the routine operation of the hospital, or routine care of the patient.
- The event may be an error, poor outcome, or an accident, which could have or has resulted in a patient injury.
- A safety event could be an unsafe condition, that does not specifically effect anyone, but could result in harm, e.g. unsecured narcotics, unsecured O2 cylinder, etc.
- All events involving patients, physicians, visitors, volunteers, vendors, students, and employees will be reported immediately using the online incident reporting system..
- The Event Report is a confidential management tool used to accurately and objectively and document the facts surrounding an event.
- All reports are reviewed and investigated.
- Reports are never copied or distributed without approval from the Risk Management Department.
- Some incidents may identify events that require further investigation and may be reportable to certain regulatory agencies (i.e. NJDOH).

Safety Event (Incident) Reporting

- Events must be reported to the within 24 hours of the occurrence.

- Any event resulting in harm requires immediate investigation and should also be called in to the Patient Safety Hotline (22082)
- The first person to discover the event should be the person to write the report. The manager/supervisor should also be notified

- The narrative description should be a chronological summary of the facts and circumstances
- Name, date, age and status of the patient involved should be included
- Report should be factual and concise

How to enter a Safety Event Report

- A “Verge Safety Reporting” shortcut can be found on the desktop of all computers that have Internet access.

- After the event type is selected, a data entry screen will appear
- If you are reporting a patient event, you will need to use the patient’s medical record number and admission date and/or account number in order to look up the patient
- All requested data must be filled out and saved to submit the event

Other Ways Safety Event Reports are used

- **Information from incident reporting and safety hotline calls can help identify:**
  - Investigation/Follow up – incident reports alerts risk management of issues that are then reviewed to ensure proper follow up.
  - Potential Compensable Events (PCE) – incident reports may help identify events that could possibly result in a claim for monetary compensation due to harms incurred while on hospital property. May trigger reporting to insurance carriers.
  - Serious Preventable Adverse Events / Reportable Events – incident reports may identify issues that require intense analysis of a processor a Root Cause Analysis (RCA). Some of these events must also be reported to an official agency such a the NJDHSS.

EMTALA

Emergency Medical Treatment and Labor Act

It is the policy of Community Medical Center to comply with the standards of EMTALA regulations in providing a medical screening examination and such further treatment as may be necessary to stabilize an emergency medical condition for any individual coming to the Emergency Department seeking treatment, regardless of the individual's medical or psychiatric condition, race, religion, age, gender, color, national origin, immigration status, sexual preference, handicap, or ability to pay. CMC shall not delay providing an appropriate medical screening examination or further medical examination and stabilizing treatment to inquire about an individual's method of payment or insurance status or to request preauthorization from a managed care plan.

Refer to Policy at https://thebridge.rwjbh.org/

Fire Safety

Robert Day

Director, Fire & Safety

Fire Safety

- Fire Alarm Procedures & CMC Fire Plan
  - R.A.C.E.
  - Pull Fire Alarm or Call Emergency Phone Number ***111
  - Oxygen shut off responsibilities

- Fire Alarm Activation
  - What will happen when the alarm is pulled?
    - The alarm will sound
    - Fire & Smoke doors will close
    - Fire Department will be automatically notified
    - HVAC system will shut down

- Compartmentation
  - Specialty style of building construction – fire walls, fire doors, smoke doors, automatic closing doors, self-closing doors & patient room doors

Fire Safety

- At the Scene of a Fire, remember “R.A.C.E.”….

R	Rescue	Move patients to a safe area
A	Alarm	Pull the fire alarm or notify the Hospital Operator at ***111
C	Confine / Contain	Close all doors
E	Extinguish / Evacuate	Extinguish small fires when able or Evacuate through fire doors

Fire Safety

- Away from the scene of the fire…
  - Close all doors
  - Clear the corridors
  - Listen for the PA announcements
  - Follow all instructions by responding police and fire officials

- Evacuation
  - Horizontal
    - Going from one fire compartment to another compartment
    - This is the first means of evacuation on a nursing unit
  - Vertical
    - Going from one floor to a floor below
    - This would only be done if you could not do a horizontal evacuation
    - Know where your vertical evacuation route leaves the building

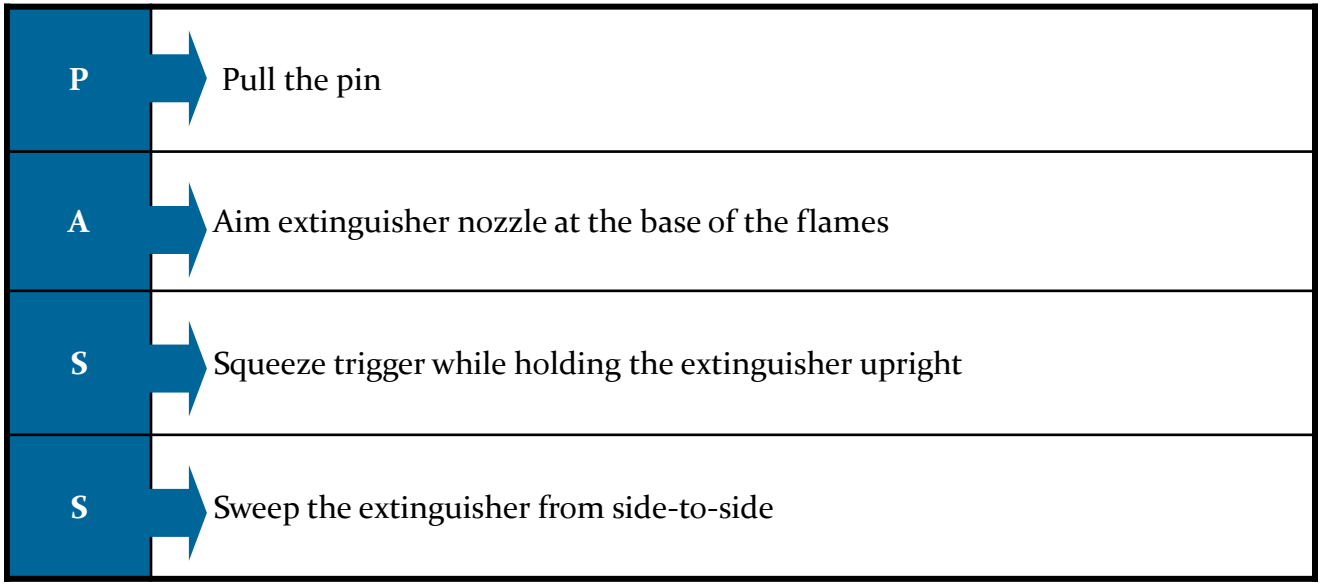
Fire Safety

- Fire Extinguishers
  - Always located within 75’

Water	Class “A”	Ordinary Combustibles
Co2	Class “B-C” fires	Liquids
Dry powder	Class “B-C” fires	Electrical
Dry powder	Class “A-B-C” fires	All
K type for kitche		Grease Fires

Fire Safety

- Fire Extinguisher Operations, remember “P.A.S.S.”…



Fire Safety

- Know the location of….
  - Fire alarm pull stations
  - Fire extinguishers
  - Fire doors and smoke doors
  - Oxygen shut off stations
  - Evacuation Routes
  - Emergency Operations Plan

- The fire safety equipment listed above can never be blocked by equipment, carts, stretchers, wheelchairs, etc.

Plain Language Emergency Alerts

Making it easier to respond to emergencies

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Three Types of Alerts

1. Facility Alert
2. Security Alert
3. Medical Alert

Facility Alert

Just as it sounds, a Facility Alert is any type of emergency that affects all or part of the building and occupants. Examples include:

- Hazardous Materials spill
- Evacuation of all or part of the facility
- Fire
- Command Center Activation
- Weather Emergency

Security Alert

Any security threat to the facility or a specific location within. Examples include:

- Active Shooter
- Bomb Threat
- Disruptive / Disorderly Persons
- Elopement
- Missing Person (Child / Infant / Adult)

**Some Security Alerts may not be announced overhead

Medical Alert

Any medical emergency that requires a clinical response from throughout the facility. Examples include:

- Mass Casualty Incident
- Cardiac Arrest
- Sepsis Alert
- Rapid Response Team

How Do I initiate an Emergency Alert?

When an emergency occurs:

1. Call the emergency phone number ***111
   *If calling from an inpatient bedside phone, dial x555
2. Give your name and extension
3. State the emergency using this script
   A. Type of Alert (Facility, Security, Medical)
   B. Type of Emergency (e.g. Fire, Missing Person, Stroke)
   C. Detailed Location of the emergency
   D. If needed, specific directions

CMC Approved Alerts

Medical Alert

- Any Medical Emergency Requiring a Specialized Response May Be Used
- Mass Casualty Incident

Terminating an Alert

- Once the emergency situation has been resolved some alerts may need to be cancelled, the announcement terminating an emergency will be:
- “All Clear” – Repeated 3 times via overhead page

Emergency Alerts

Community Medical Center's Emergency Alerts
Facility Alert + Fire Alarm + Location
Facility Alert + Hazardous Materials Incident + Location
Security Alert + Infant/Child Abduction + Location + Description
Security Alert + Security Assistance + Location
Security Alert + Patient Elopement + Location
Security Alert + Suspicious Item / Bomb Threat + Location + Directions (as needed)
Security Alert + Hostage Situation + Location

Emergency Alerts

Community Medical Center's Emergency Alerts
Security Alert + Active Shooter + Location + Directions (as needed)
Medical Alert + Mass Casualty Incident + Location OR Facility Alert + Command Center Activation + Location
Medical Alert + Pediatric Cardiac Arrest + Location
Medical Alert + Adult Cardiac Arrest + Location
Medical Alert + Hypothermia Response Team + Location
Medical Alert + Stroke Response Team + Location
Medical Alert + Sepsis + Location
Medical Alert + Malignant Hyperthermia Response Team + Location
Medical Alert + Rapid Response Team + Location
All Clear

Interpreters

- There are 30 Martti's throughout Community Medical Center's Campus
- Martti's are our designated device for our limited English proficient patients (including those who require ASL services)
- Martti's can be found at any nurses station or in the staffing office located on the 2nd floor
- Patient Experience oversees the Martti interpretation devices, they must stay plugged in at all times and be connected to BHMOBILE Wi-Fi
- If requested, a tutorial on how to use the Martti can be arranged with Eva Bautista in Patient Experience at extension 18078 or email Eva.Bautista@rwjbh.org
- In addition, there are instructions attached to each Martti device

Interpreters

- For Language Assistance: (information in the policy “Language Interpretation Services”) RWJBH is committed to ensuring that the diverse needs of our patients are met and recognizes that all patients have a fundamental right to effective communication related to healthcare needs. It pertains to our Limited English proficiency, Deaf/Hard of Hearing and Low Vision/Blind population.
- If an in person interpreter is required for any patient please contact patient experience OR the staffing office (outside of business hours 8a-4p M-F)
- In person interpreters can only be scheduled and approved by the above listed departments

September 2023

VISIT THE SAFETY TOGETHER INTRANET PAGE FOR MORE RESOURCES

SAFETY LESSONS

Our Patient Story

A 28 year old Turkish speaking female arrived to our L&D department for a scheduled cesarean section. The patient spoke no English, but her husband was perceived to be fluent in English, and was at her bedside throughout her stay. Over the course of 2 days, the patient was consented for procedures and medications without the use of translator services. On the third day of her stay, after welcoming her newborn son, the care team entered the room and attempted to use the MARTTI IPad to consent for a circumcision. The calls dropped multiple times, and they decided to rely on a family member to translate. The procedure was carried out, and when the newborn was returned to the room, the mother was distraught, as it was against her cultural wishes to have the procedure performed at this time.

WHAT WENT WRONG?

- We did not follow appropriate protocols when caring for the mother or newborn. Patient Rights state that we must communicate with patients in their preferred languages.

HOW DID THIS HAPPEN?

- Staff / Providers did not perceive the lack of translation services to be an immediate threat to patient safety.
- Staff / Providers were unaware of redundant services.

HOW DO WE PREVENT THIS FROM HAPPENING AGAIN? Our Action Plan:

- **Cross Check:** A multi-disciplinary team conducted a Root Cause Analysis.
- **You & Me Together:** Share this patient safety story as a learning opportunity. Align our October Health Literacy Awareness Month with tasks to raise awareness!
- **Focus on the Task:** Cognitive aids will be placed on all MARTTI devices. Badge buddies will be created.
- **Accurately Communicate:** CBLs were sent out house-wide, inventories of all equipment were conducted, SBARs were distributed. Memos and flyers were shared with providers / residents.

What Success Looks Like

1. Don't harm me.
2. Help me.
3. Be nice to me.

Above the surface you see the **Symptoms** of the problem

Dig deeper to find the **Root Cause** of the problem

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Safety together.

RWJBarnabas HEALTH

Continuing Medical Education

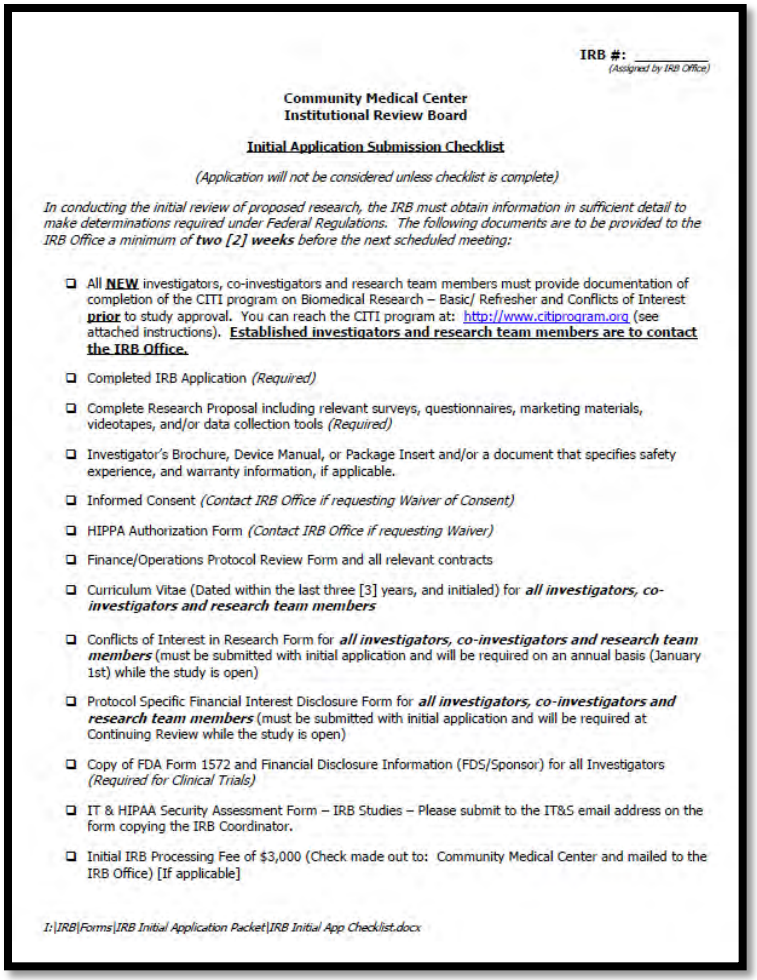
- Community Medical Center offers weekly engaging and diverse activities in healthcare continuing medical education (CME). Through CMC's activities in healthcare CME, the information is presented on clinical practice, quality improvements, healthcare delivery, and more to help you, our physicians and advanced practice providers, best serve the patient!

- If you wish to become a speaker, please reach out to the Jennifer Kuzma, Administrative Coordinator at 732-557-8527

Institutional Review Board (IRB)

- All research must be approved by the IRB before it can be conducted.
- Request an initial application by contacting the IRB office at 732-557-8059 or email Becca.Petillon@rwjbh.org
- Theresa.Nielsen@rwjbh.org

- Meetings are held on the first Wednesday of every other month at 8:00 am
- Application along with the required documents must be submitted a minimum of two (2) weeks before the meeting



IRB #: _____
(Assigned by IRB Office)

Community Medical Center
Institutional Review Board

Initial Application Submission Checklist

(Application will not be considered unless checklist is complete)

*In conducting the initial review of proposed research, the IRB must obtain information in sufficient detail to make determinations required under Federal Regulations. The following documents are to be provided to the IRB Office a minimum of **two [2] weeks** before the next scheduled meeting:*

- ❑ All **NEW** investigators, co-investigators and research team members must provide documentation of completion of the CITI program on Biomedical Research – Basic/ Refresher and Conflicts of Interest **prior** to study approval. You can reach the CITI program at: http://www.citiprogram.org (see attached instructions). **Established investigators and research team members are to contact the IRB Office.**
- ❑ Completed IRB Application *(Required)*
- ❑ Complete Research Proposal including relevant surveys, questionnaires, marketing materials, videotapes, and/or data collection tools *(Required)*
- ❑ Investigator's Brochure, Device Manual, or Package Insert and/or a document that specifies safety experience, and warranty information, if applicable.
- ❑ Informed Consent *(Contact IRB Office if requesting Waiver of Consent)*
- ❑ HIPPA Authorization Form *(Contact IRB Office if requesting Waiver)*
- ❑ Finance/Operations Protocol Review Form and all relevant contracts
- ❑ Curriculum Vitae (Dated within the last three [3] years, and initialed) for ***all investigators, co-investigators and research team members***
- ❑ Conflicts of Interest in Research Form for ***all investigators, co-investigators and research team members*** (must be submitted with initial application and will be required on an annual basis (January 1st) while the study is open)
- ❑ Protocol Specific Financial Interest Disclosure Form for ***all investigators, co-investigators and research team members*** (must be submitted with initial application and will be required at Continuing Review while the study is open)
- ❑ Copy of FDA Form 1572 and Financial Disclosure Information (FDS/Sponsor) for all Investigators *(Required for Clinical Trials)*
- ❑ IT & HIPAA Security Assessment Form – IRB Studies – Please submit to the IT&S email address on the form copying the IRB Coordinator.
- ❑ Initial IRB Processing Fee of $3,000 (Check made out to: Community Medical Center and mailed to the IRB Office) [If applicable]

I:\IRB\Forms\IRB Initial Application Packet\IRB Initial App Checklist.docx

Implicit Bias Education

- To prevent healthcare disparities, RWJBH system Ending Racism has determined that all healthcare providers complete this course. Please click the link below to the NJHA site:
- https://education.njha.com/courses/43377
- Please bring a copy of your Certificate of Completion to the Credentials Committee Interview or to the Medical Staff Office

Thank you.

Orientation Attestation

ORIENTATION Attestation – Please print this ONE Slide and fax to the Medical Staff Office 732-557-8935

I acknowledge that I have received, reviewed and understand the orientation documents that were sent to me via email. I understand that changes may be made to these documents at any time in order to maintain compliance with federal and state requirements, accreditation standards and the mission, vision, and values of RWJBH Community Medical Center. I understand that Medical Staff policies are also available on the physician extranet (portal) **www. thebridge.rwjbh.org** or through the Medical Staff Office and that it is my responsibility to review these policies and comply with them.

I understand it is my responsibility to open and read e-mails/correspondence that is sent by the Medical Staff Services department on behalf of the Medical Staff and Administration Leadership(s).

Print Name: _____

Signature _____ Date _____