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The Chilton Physician
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CHILTON MEMORIAL HOSPITAL
discover a higher level of care

Arthur Suffin, MD
Medical/
Dental Staff
President

> Message from the president

Recently, *The Bergen Record* and *Star-Ledger* published the names of doctors and their malpractice payout data. This was done in the guise of the public's "right to know." As you may know, *The Bergen Record* won the right to publish this data despite the protests of the New Jersey Medical Society (NJMS). An appeal to the New Jersey Supreme Court by the NJMS to prevent this was unsuccessful. It is my opinion that the publishing of this sensitive material will serve no one well. I believe it will create increased patient anxiety and lead to a further degradation of physician-patient relationships.

The June quarterly staff meeting was well attended. Dr. Ronald Burns presented strategies and tactics about how to deal with intrusions from pharmaceutical providers, as well as denial of services from HMO-PPO, and the like. Handouts are available from Dr. Charles Ross for your review and office use and can be requested by calling **973-831-5080**.

Finally, please sign the yellow "Interdisciplinary Plan of Care Problem Need" lists. They are in all patients' charts, and must be signed for JCAHO compliance.

Arthur Suffin, MD

News Briefs

▼COLONOSCOPY WITHOUT SEDATION

John C. McConnell, MD, delivered a presentation titled "Colonoscopy Without Sedation" at the national meeting of the Society of American Gastrointestinal Endoscopic Surgeons in April. The presentation was based upon a study he conducted with Raffi Agopian, MD, Joel Nizin, MD, and Michael Slade, MD at the endoscopy units of Chilton Memorial and Valley Hospital.

Five factors where evaluated for their significance to predict which patients could have their colonoscopies without sedation. The study found that male patients were easier to colonoscope than female patients. Younger patients were easier to colonoscope than older patients. Endomorphic females were easier to colonoscope than other body types. Patients who had a previous hysterectomy were the most difficult to colonoscope.

Age, gender and body type were statistically significant factors. Willingness to try colonoscopy without sedation was the most statistically significant factor with a 95 percent confidence interval. Of those who underwent colonoscopy without sedation, 94 percent said they would prefer no sedation for their next examination. Cost savings would be considered substantial. The paper is to be published in *Surgical Endoscopy* later this year.

▼LOCAL REPORTER TO ADDRESS HOSPITAL PHYSICIANS

One in every 200 wanted pregnancies in the U.S. ends in stillbirth, and nine times as many babies are stillborn than die as a result of Sudden Infant Death Syndrome. Surprisingly, American society seems to know little about this family tragedy that devastates parents and family members.

Lorraine Ash, an award-winning health care and women's issues reporter with the *Daily Record*, has authored the recently released book, *Life Touches Life: A Mother's Story of Stillbirth and Healing*. Her book provides a compelling account of the death of her daughter and only child, and discusses the permanent impressions left by care givers involved in the treatment of stillborn mothers and the types of follow-up services needed.

Ash will address Chilton Memorial physicians, nurses, and social workers from **11:30 a.m. – 12:30 p.m. on Monday, July 19th in the education classroom** regarding stillbirth. She will discuss ways to make every person entering the room of the mother of a stillborn child aware of the situation, will outline services needed, and will share relevant resources for families.

The meeting is free and open to all interested. Continuing Education Units are available. To register, call **973-831-5169.**

Medical Executive Committee Report

The following actions of the Executive Committee resulted from the June 9, 2004 Executive Committee meeting and are presented for publication in *The Physician Newsletter*:

▼APPOINTMENTS

as reflected on the Delineation of Privilege form.

Anna Vinokur, MD, 97 West Parkway, Pompton Plains, NJ 07444 (973) 831-5121, recommended for appointment to the Provisional Staff in the Department of Pediatrics with "B2" (supervised) privileges in Pediatrics and Emergency Medicine. Dr. Vinokur joins J&J Pediatrics, and Drs. Amor, Devadan, Ginart, Jedlinski, Lopez and Lugo as a pediatric hospitalist.

▼TRANSFERS:

Jose Dosado, MD, recommended for transfer from the Provisional Staff to the Courtesy Staff in the Department of Pediatrics with existing privileges.

Alvin Edelstein, MD, recommended for transfer from the Emeritus Staff to the Emeritus Retired Staff in the Department of Pediatrics.

Caecilia Hostetler, MD, recommended for transfer from the Associate Staff to the Courtesy Staff in the Department of Family Practice with existing privileges.

Donna Konlian, MD, recommended for transfer from the Associate Staff to the Courtesy Staff in the Department of Medicine, Section of Cardiology, with existing privileges.

Harrold Leader, MD, recommended for transfer from the Active Staff to the Emeritus Staff in the Department of Medicine with existing privileges in Neurology.

▼INCREASED PRIVILEGES:

Phillip Devadan, MD, recommended for an increase in privileges to "A2" (unsupervised) privileges in Emergency Medicine.

▼RESIGNATIONS/LEAVE OF ABSENCE:

Bimla Paul, MD, voluntarily resigning from the Active Staff in the Department of Pathology.

Suzanne Pavlou, requesting a one-year Leave of Absence from the Department of Pediatrics.

Shams Qureshi, MD, voluntarily resigning from the Courtesy Staff in the Department of Psychiatry.

▼BUSINESS:

- The Executive Committee was informed that length of stay is still down.
- The Executive Committee was informed that the "Problem Needs List" will be placed in the chart in front of the progress notes. The physicians must sign this sheet on admission.
- The Executive Committee was informed that we are participating in ICU Comparative Measurement in collaboration with VHA. The core measures were identified.
- Education is ongoing in regard to DVT Prophylaxis.

▼REPORT OF THE PRESIDENT & CEO:

Deferred until the Quarterly Staff Meeting

TIME OUT:

New Surgical/Invasive Procedure Verification Process

On July 1, all hospitals accredited by the Joint Commission on Accreditation of Healthcare Organizations were required to adopt consistent policies and procedures to prevent wrong site, wrong procedure, and wrong patient medical errors.

Although Chilton Memorial and many other hospitals had similar, customized protocols in place years ago in their operating rooms, the new regulations are uniform nation-wide, and affect the operating room, emergency department, cath lab/ angio suite, radiology, breast center, endoscopy, and all patient care units.

The new policies, aimed at creating a uniform means to identify the intended site of procedure, verification process, and final time-out process for verification, affects every physician performing any invasive

(Continued)

procedure that requires patient consent, including surgery, implants, equipment, and X-rays.

Any site, procedure or person discrepancies noted during the verification and time out process are to result in an immediate halt to the procedure until all members of the team resolve the discrepancy.

In the case of a surgical/procedural emergency, a site mark and verification process may be omitted, but a "time out" should be performed unless the risk outweighs the benefit.

The Surgical/Invasive Procedure Verification Process

1) The surgical/invasive verification process and time-out process form is initiated by the scheduler at the time of booking a procedure or by the RN caregiver if the procedure is not booked through scheduling.
2) If the patient enters through the Access Center, the verification process to identify the correct patient, procedure and site will be verified.
3) Any time the responsibility of care for the patient is transferred to another caregiver, the stated information should be verified.
4) Before the patient enters the procedure/surgical room and prior to a bedside procedure, the information is once again verified.
5) Missing information or discrepancies must be addressed before starting the procedure.

Marking the Procedure Site

The site must be marked for procedures involving right/left distinction, multiple structures (such as fingers and toes), or multiple levels (as in spinal procedures).

Site marking is **NOT** required during procedures in which the practitioner performing the procedure remains with the patient continuously from the time the decision is made to do the procedure and consent is obtained from the patient up to the time of the procedure itself.

However, if the person performing the procedure leaves the presence of the patient for any amount of time during that interval, then the site should be marked (before leaving the patient) if the procedure involves right/left distinction or multiple structures.

1) The surgeon/physician is responsible to identify and mark the surgical/procedure site.
2) Whenever possible, the patient and/or family member/significant other shall be involved in the marking of the surgical/procedure site.
3) The mark must be unambiguous and consistent throughout the organization. It is required the surgeon/physician mark the site using his/her initials.
4) Site marking shall be done with an "indelible" marker (will not wash off with the usual skin prep) and be located so as to be visible after the patient is prepped and draped. Stick-on labels are not an acceptable substitute for marking directly on the skin.
5) Only the **correct** procedure site will be marked (e.g., not both sites, and not the incorrect site).
6) If there are multiple sites, a number indicating the number of sites will be placed before the marking. For example, if there are two sites, both sites will be marked "2 with initials" so that the operative staff will recognize that there are multiple (i.e., in this example, two) procedure sites.
7) When describing the laterality of a procedure site on the history and physical, operating room schedule, consent form, booking slips and any other documents where the procedure site is written out, abbreviations will not be used (e.g., left and right must be written out).

A final verification of the site marked must take place during the "time out."

If a patient refuses site marking, his/her signature must be obtained as stated on a pre-operative pre-procedure verification process form.

Procedures Which Do NOT Require Marking

- Certain routine "minor" procedures such as venipuncture, peripheral IV line placement, insertion of NG Tube or Foley Catheter
- C-sections
- Premature infants, for whom the mark may cause a permanent tattoo.
- Laparotomy: unless procedure involves operating on organs that have laterality and site is predetermined.

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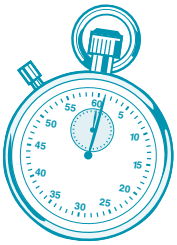
TIME OUT *(continued from page 3)*

- Laparoscopy: unless procedure involves operating on organs that have laterality and site is predetermined
- Single organ cases
- Interventional procedures for which the site of insertion is not pre-determined, for example, cardiac catheterization
- Dental procedures (Operative tooth name must be documented or marking of the operative tooth on the dental radiographs or dental diagram)
- Procedures done through or immediately adjacent to a natural body orifice (e.g., gastro-enteral endoscopy, tonsillectomy, hemorrhoidectomy), procedures on the vagina or other situations in which marking the site would be impossible or technically impractical.

The Time-Out Process Immediately Before Starting the Procedure

"Time Out" must be conducted in the location where the procedure will be done, just before starting the procedure. It must involve the entire team, use active communication, and be documented on the "Surgical/Invasive Procedure Verification & Time Out Process" form. Lists the names of the physician and all team members present.



TIME-OUT CHECKLIST

- Patient identification (G# & name from ID Band)
- Procedure verified
- Consent read aloud and agreed upon
- Correct site/side marked and visible to team after prepping and draping (unless exempt or verified above)
- Implants, special equipment and X-rays available (if applicable)
- Was prophylactic antibiotic given (if applicable)

Any site, procedure or person discrepancy noted will result in an immediate halt to the procedure until the discrepancy can be resolved by the entire team and will be briefly documented.

medical/dental staff calendar

Thursday, July 1
8:30 a.m. Credentials Committee
Board Room

Friday, July 2
8:30 a.m. Medicine
Cafeteria Conference Room

Tuesday, July 6
8 a.m. OB/GYN (CME)
OB Conference Room
Topic: "Thyroid Disease and Thyroid Nodules"
Speaker: Lucy Covello, MD - CMH

Friday, July 9
8:30 a.m. Medicine Business
Cafeteria Conference Room

9 a.m. Psychiatry
3-West Conference Room

Monday, July 12
7:30 a.m. Orthopedic Surgery
Cafeteria Conference Room

Wednesday, July 14
7:30 a.m. Cancer Case Review (CME)
Board Room

6 p.m. Anesthesia Meeting
Library

Thursday, July 15
8 a.m. Emergency Dept. Meeting
Cafeteria Conference Room

Thursday, July 15
11 a.m. Infection Control Meeting
Board Room

Friday, July 16
8:30 a.m. Medicine
Cafeteria Conference Room

Monday, July 19
11 a.m. – (CME) open to all departments
Topic "Stillbirth and SIDS"
Speaker: Lorraine Ash, Daily Record Reporter
Education Room

Tuesday, July 20
8 a.m. OB Business Meeting
OB Conference Room

Wednesday, July 21
7:30 a.m. Cancer Case Review (CME)
Board Room

8 a.m. Performance Improvement Steering Committee
Cafeteria Conference Room

Thursday, July 22
8 a.m. General Surgery
Cafeteria Conference Room

Friday, July 23
7:30 a.m. Thoracic Meeting
Library

Wednesday, July 28
7:30 a.m. Cancer Case Review (CME)
Cafeteria Conference Room

8 a.m. Performance Improvement Committee
Board Room

Thursday, July 29
8 a.m. Cardiac Cath
Cafeteria Conference Room

>our medical/dental staff

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