YALE-NEW HAVEN HOSPITAL
MEDICAL STAFF POLICY
HAND HYGIENE AND CONTACT PRECAUTIONS

Purpose:
To establish a policy to address Medical and Affiliated Medical Staff members who display willful disregard of hospital standards regarding hand hygiene and contact precautions.

Scope:
All Members of the Medical and "Affiliated" Medical Staff

Policy:
In order to minimize the incidence of nosocomial infection rates at Yale-New Haven Hospital and promote patient safety, members of the Medical and Affiliated Medical Staff must comply with hand hygiene and contact precaution procedures.

Understanding that non compliance with procedure is often the result of distraction or simple forgetfulness rather than a blatant disregard for patient safety, individuals who readily respond in a positive manner to reminder, comment or challenge, and adjust their actions accordingly when reminded of Hospital policy, will not be subject to sanctions.

Individuals who fail to immediately respond and/or display continued resistance will be subject to the requirements as outlined in the Procedure described below.

Procedure:

When a practitioner refuses to respond to correction regarding hand hygiene and contact precautions, he/she is reported by the witnessing individual (nurse, resident, other staff member) to the Chief of Staff's Office (688-2604).

1. Upon occurrence of the first incident, the practitioner will be notified by the Chief of Staff that he/she is required to obtain a copy of the YNHH video presentation on Preventing Nosocomial Infections from the Chief of Staff's office and to meet with his/her Department Chief within one month. The practitioner will sign an attestation stating that he/she has watched the video and the Department Chief will countersign to confirm that the meeting took place. The attestation is kept in the individual's medical staff file in the Department of Physician Services. These requirements must be completed within one month of the incident or sanctions described in #2 below will be initiated. Compliance will be monitored by the Department of Physician Services.

2. After two incidents of non-compliance and/or the requirements described in #1 above have not been met after one month of the initial incident, a letter of warning will be sent by the Chief of Staff to the practitioner and his/her Department Chief. The letter will notify both individuals that an additional incident will result in suspension of privileges. At this time, the practitioner will also be required to meet with the Chief of Staff to explain why he/she fails to comply with hospital requirements or, as applicable, to fulfill the requirements as outlined in #1 above.

3. Following the meeting with the Chief of Staff, if a third incident of non-compliance occurs in one re-credentialing cycle (2 years) or the practitioner still fails to fulfill the requirements as outlined in #1 above, the individual shall be suspended from the Medical Staff for a period of two weeks. During the two week time period, the practitioner will be expected to complete the requirements outlined in #1 above in order for the suspension to be lifted.

Note: The timeframe for sanctions is coincident with the two-year period of medical staff appointment.

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