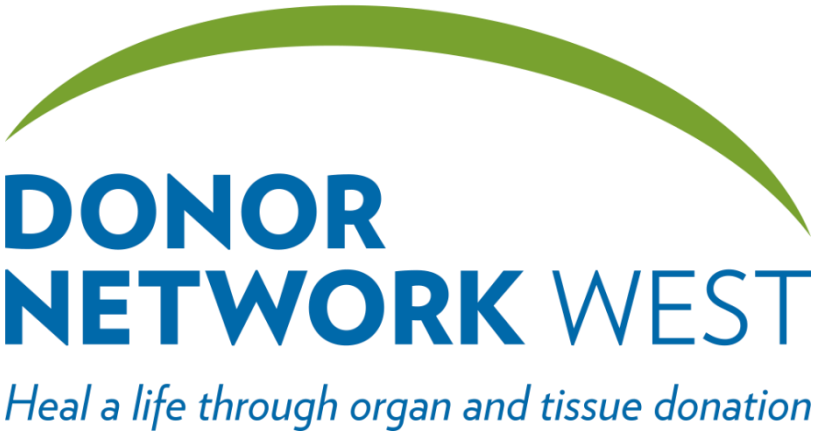


# Lead Recovery Personnel Credentialing Manual

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Effective Date:

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## Table of Contents

Credentialing Requirements for Lead Organ Recovery Personnel ..... 4
Orientation Checklist for Recovery Personnel ..... 5
Surgeon And Physician Code Of Conduct And Assurance Of Safe Working Environment ..... 6
Lead Recovery Personnel Experience Form ..... 17
Program Director Authorization ..... 18
Lead Recovery Personnel Qualifications ..... 19
Verifying Lead Recovery Personnel Qualifications ..... 22
Lead Recovery Personnel Qualification and Verification Process Maps ..... 23
Visiting Organ Recovery Team Temporary Privileges Request Form ..... 25

## Credentialing Requirements for Lead Organ Recovery Personnel

Prospective surgeons/non-physician recovery personnel will collect and submit the following documents to initiate the Donor Network West credentialing process:

- ☐ Copy of Valid **Medical License** (if applicable)
- ☐ Copy of updated **Curriculum Vitae**, including information regarding residency training/completion, Board certification and/or eligibility (American or foreign equivalent)
  - Statement of Experiences and Qualifications to perform unsupervised organ recoveries (if not evident in the curriculum vitae).
- ☐ Copy of current **Certificate of Insurance**
- ☐ Complete **Recovery Personnel Experience Form**
- ☐ Signed **Program Director Authorization**

**Please submit records to:**

Fax: (925)480-3809

Email: SurgQualify@dnwest.org

## Orientation Checklist for Recovery Personnel

Prospective surgeons/non-physician recovery personnel must participate in an orientation to Donor Network West, conducted by Donor Network West staff.

- ☐ Organizational Overview & Mission Statement
- ☐ Organ Donation Org Chart, Key Contacts and Contact Information
- ☐ Donor Evaluation and Clinical Management Guidelines
- ☐ Donation After Cardiac Death
- ☐ Transportation and Logistics Protocols (Local vs. Import)
- ☐ Recovery Personnel Credentialing Requirements & Documentation
- ☐ Code of Conduct Agreement for Organ and Tissue Recovery Personnel (Signed)
- ☐ Application for Research Data and Biomaterial

| **I have discussed and understand the procedures and protocols outlined in this checklist.** | |
|---|---|
| **Print Name** | **Signature** |
| **Transplant Center** | **Date** |

| **OPO Personnel Conducting Orientation** | **Date** |
|---|---|

**Please complete this page and fax to (925) 480-3809 or email to: SurgQualify@dnwest.org**

## Surgeon And Physician Code Of Conduct And Assurance Of Safe Working Environment (OR-F-027)

### 1.0 PURPOSE

**1.1** The purpose of this document is to provide guidance to surgeons and surgical organ recovery specialists (SORS) of behavioral expectations and conduct when working in donor-related scenarios.

### 2.0 SCOPE

**2.1** This SURGEON AND PHYSICIAN CODE OF CONDUCT AND ASSURANCE OF SAFE WORKING ENVIRONMENT (Code of Conduct) serves as an expectation for and assurances to Donor Network West (DNWest) staff that physicians, including transplant surgeons and all members of the recovery team, as well as donor hospital physicians and providers adhere to behavioral conduct expectations in all interactions with DNWest and donor hospital non-physician staff.

### 3.0 RESPONSIBILITIES

**3.1** All surgeons, physicians, and DNWest staff are expected to understand and are responsible for monitoring and moderating their own behavior and completing their review of this Code of Conduct.

**3.2** It is the responsibility of all employees to maintain a work environment free of threats or acts of violence. Each employee is expected to report threats or circumstances that have the potential for threatening workplace safety, especially when the act, behavior, or communication is abusive and could cause another person physical or psychological harm, or the act, behavior, or communication interferes with an employee's work performance.

**3.3** Managers and supervisors have the responsibility to make their subordinates aware of these expectations in general, and reporting mechanism, in particular.

### 4.0 REFERENCES:

**4.1** DNW Policy

**4.1.1** HR-M-001 Employee Handbook

**4.1.2** OR-P-001 Lead Organ Recovery Surgeon/Non-Physician Recovery Personnel Qualification

### 5.0 ACRONYMS & DEFINITIONS

**5.1** JCR – Joint Commission Resources

**5.2** ASTS – American Society of Transplant Surgeons

**5.3** Violence - An unwanted or hostile physical contact

**5.4** Harassment - Includes a statement, gesture, or action that is offensive, not welcomed, and that interferes with job performance or causes unnecessary discomfort, humiliation, or harm to another person. Displays of anger, intimidation, ridicule.

**5.5** Physical Attack - Includes any unwanted or hostile physical contact such as hitting, fighting, pushing, shoving, or the throwing of objects

**5.6** Property Damage - Behavior or acts that contribute to the destruction or damage of private property

**5.7** Threat - The expression of a present or future intent to cause physical or mental harm; an expression constitutes a threat without regard to whether the party communicating has the present ability to do harm and without regard to whether the expression is contingent, conditional, or future.

## 6.0 DOCUMENTATION / FORMS:

**6.1** CODE OF CONDUCT AGREEMENT FOR ORGAN AND TISSUE RECOVERY PERSONNEL (Attachment 7.4)

## 7.0 ATTACHMENTS

**7.1** Joint Commission Resources. Sentinel Event Alert. Issue 40, July 9, 2008. Behaviors that undermine a culture of safety.

**7.2** American Society of Transplant Surgeons: Surgeon Code of Conduct

**7.3** Lead Organ Recovery Personnel Expectations and Responsibilities

**7.4** CODE OF CONDUCT AGREEMENT FOR ORGAN AND TISSUE RECOVERY PERSONNEL

## 8.0 MATERIALS / SUPPLIES

**8.1** N/A

## 9.0 PROCEDURE

### 9.1 Reporting of Threats:

When a DNWest hospital or recovery team member observes unprofessional conduct that violates, or potentially violates, this Code, the team member shall (1) address the surgeon or recovery staff team member directly to try and resolve the problem; or if the issue merits, (2) shall report the perceived unprofessional conduct as described below. In most cases, personal communication with the alleged Code violator can resolve the situation. If direct communication with the violator does not resolve the problem or if direct communication is deemed not to be the best or most effective option under the circumstances, then the Vice President of Organ Operations or the OPO designee should bring the perceived violations to the surgeon's Department Chief or the staff member's supervisor.

**9.1.1** Threat Involving Immediate Danger: Any employee, who becomes aware of a threat or act of violence that is urgent and poses an immediate danger, should contact hospital Security immediately if the threat is outside DNWest. In addition, they must notify their immediate supervisor and the Chief Medical Officer as soon as possible.

**9.1.2** Threat Not Considered to Be Urgent: Any employee who becomes aware of behavior or communication that is not deemed to be of an immediate nature, should first address the recovery staff or team member directly to try and resolve the problem and, as needed, shall contact his/her direct supervisor or the Human Resources Department. This includes volatile situations occurring outside of the workplace that have the potential for spilling over into the workplace (for example, domestic violence).

**9.1.3** Threats Involving Patient Safety due to Loss of Organ. Surgeons are responsible for patient safety for both the intended recipient and other waiting recipients, all of whom ultimately may suffer damages up to and including loss of life if an organ is not recovered.

**9.1.4** Threats Involving Surgical Responsibilities During Operative Recovery. Surgeons are responsible for patient safety immediately prior to, during, and after the recovery of organs. This may include honoring the donor gift by assuming recovery responsibilities for other patients beyond his/her own patient if requested by DNWest, and by treating the donor, OPO, and hospital staff with professionalism and respect.

**9.1.5** If the threat involves a physician, patient, guest, or volunteer, the employee should report the threat to the appropriate department director and the Human Resources Department at the hospital where the threat occurs. In addition, the employee should report this threat to their own supervisor at DNWest.

**9.1.6** The appropriate management level, in conjunction with the Human Resources Department will promptly investigate all reports. The DNWest Management Team will convene to assist with the investigation and to recommend preventive measures against workplace violence, as appropriate.

**9.1.6.1** Confidentiality will be maintained during the investigation to the extent that it is reasonably possible.

**9.1.6.2** Disruptive behavior/harassment complaints will be addressed in accordance with the DNWest EMPLOYEE HANDBOOK (HR-M-001) and the DISCRIMINATION/ SEXUAL HARASSMENT/RETALIATION policy (HR-P-103) and may involve transplant center administrative staff.

**9.1.6.2.1** Examples of disruptive behavior include but are not limited to:

- Profane or disrespectful language
- Demeaning behavior, such as name-calling
- Sexual comments or innuendo
- Inappropriate touching, sexual or otherwise
- Racial or ethnic jokes
- Inappropriate outbursts of anger
- Throwing instruments, charts, or other objects
- Criticizing other caregivers in front of families, teams, or other staff
- Inappropriate comments that undermine DNWest and/or donor hospital staff or the process of organ and tissue donation
- Failure to adequately address safety concerns or donor care needs expressed by another caregiver
- Intimidating, demeaning, or ridiculing behavior
- Deliberate failure to adhere to organizational policies without adequate evidence to support the chosen alternative
- Retaliation against any member of the healthcare team who has reported an instance of violation of the Code of Conduct or who has participated in the investigation of such an incident, regardless of the perceived veracity of the report
- Repeated tardiness that disrupts the donation process by delaying the family's end of life process or impacts donor hospitals and other recovery teams

**9.1.6.3** Retaliation for reporting threats or acts of violence is prohibited.

**9.2 Corrective Action:**

**9.2.1** Donor Network West Employee: Corrective action in the case of DNWest employees, up to and including discharge, may be taken to address employee actions that are in violation of this Code and in concert with DNWest's EMPLOYEE HANDBOOK (HR-M-001) and the DISCRIMINATION/SEXUAL HARASSMENT/RETALIATION policy (HR-P-103).

**9.2.2** Physician/Surgeon: Non-Donor Network West Employee:

The privilege of recovery responsibility on behalf of the OPO is at the discretion of the OPO. Unprofessional conduct, or violation of this Code of Conduct, can lead to recovery privileges being revoked or limited, made subject to conditions, or other disciplinary action or penalty by the OPO. This may mean that an offending surgeon/recovery personnel or staff member may be temporarily or permanently precluded from participating in organ and tissue recoveries within the OPO service area as described below.

**9.2.2.1** First Occurrence: DNWest medical leadership and/or management (CMO, or Manager) will notify the physician of the complaints and discuss his/her actions that are in violation of this policy. If the offense is deemed egregious, then the physician's credentialing program and supervisor will be notified at the first offense.

**9.2.2.2** Second Occurrence: DNWest will notify the physician's immediate supervisor of the behavior on second occurrence. Notification shall be done by letter and verbally.

**9.2.2.3** Suspension of Recovery Privileges:

**9.2.2.3.1** Corrective action, with due process up to and including prohibiting a surgeon from having recovery privileges with DNWest, may be taken to address surgeon actions that are in violation of this Code of Conduct.

**9.2.2.3.2** Immediate suspension until due process is completed shall occur with the following behavior:

- physical abuse;
- criminal behavior;
- substance abuse.

**9.2.3** The employee may complain or make statements to DNWest's Human Resources Department and/or the Human Resources Department of the physician's affiliated hospital at his or her own discretion.

**9.2.4** DNWest (either the Chief Medical Officer and/or the employee's manager or both) will follow-up with the employee making the complaint as to the action taken.

## 7.0 ATTACHMENTS

### ATTACHMENT 7.1

### JOINT COMMISSION RESOURCES, SENTINEL EVENT ALERT, ISSUE 40, JULY 9, 2008.

### BEHAVIORS THAT UNDERMINE A CULTURE OF SAFETY.

Intimidating and disruptive behaviors can foster medical errors, (1,2,3) contribute to poor patient satisfaction and to preventable adverse outcomes, (1,4,5) increase the cost of care, (4,5) and cause qualified clinicians, administrators and managers to seek new positions in more professional environments. (1,6) Safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment. To ensure quality and to promote a culture of safety, health care organizations must address the problem of behaviors that threaten the performance of the health care team.

Intimidating and disruptive behaviors include overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities. Intimidating and disruptive behaviors are often manifested by health care professionals in positions of power. Such behaviors include reluctance or refusal to answer questions, return phone calls or pages; condescending language or voice intonation; and impatience with questions. (2) Overt and passive behaviors undermine team effectiveness and can compromise the safety of patients. (7, 8, 11) All intimidating and disruptive behaviors are unprofessional and should not be tolerated.

Intimidating and disruptive behaviors in health care organizations are not rare. (1,2,7,8,9) A survey on intimidation conducted by the Institute for Safe Medication Practices found that 40 percent of clinicians have kept quiet or remained passive during patient care events rather than question a known intimidator. (2,10) While most formal research centers on intimidating and disruptive behaviors among physicians and nurses, there is evidence that these behaviors occur among other health care professionals, such as pharmacists, therapists, and support staff, as well as among administrators. (1,2) Several surveys have found that most care providers have experienced or witnessed intimidating or disruptive behaviors. (1,2,8,12,13) These behaviors are not limited to one gender and occur during interactions within and across disciplines. (1,2,7) Nor are such behaviors confined to the small number of individuals who habitually exhibit them. (2) It is likely that these individuals are not involved in the large majority of episodes of intimidating or disruptive behaviors. It is important that organizations recognize, that it is the behaviors that threaten patient safety, irrespective of who engages in them.

The majority of health care professionals enter their chosen discipline for altruistic reasons and have a strong interest in caring for and helping other human beings. The preponderance of these individuals carry out their duties in a manner consistent with this idealism and maintain high levels of professionalism. The presence of intimidating and disruptive behaviors in an organization, however, erodes professional behavior and creates an unhealthy or even hostile work environment – one that is readily recognized by patients and their families. Health care organizations that ignore these behaviors also expose themselves to litigation from both employees and patients. Studies link patient complaints about unprofessional, disruptive behaviors and malpractice risk. (13,14,15) “Any behavior which impairs the health care team’s ability to function well creates risk,” says Gerald Hickson, M.D., Associate Dean for Clinical Affairs and Director of the Center for Patient and Professional Advocacy at Vanderbilt University Medical Center. “If health care organizations encourage patients and families to speak up, their observations and complaints, if recorded and fed back to organizational leadership, can serve as part of a surveillance system to identify behaviors by members of the health care team that create unnecessary risk.”

<u>Root causes and contributing factors</u>

There is a history of tolerance and indifference to intimidating and disruptive behaviors in health care. (10) Organizations that fail to address unprofessional behavior through formal systems are indirectly promoting it. (9,11) Intimidating and disruptive behavior stems from both individual and systemic factors. (4) The inherent stresses of dealing with high stakes, high emotion situations can contribute to occasional intimidating or disruptive behavior, particularly in the presence of factors such as fatigue. Individual care providers who exhibit characteristics such as self-centeredness, immaturity, or defensiveness can be more prone to unprofessional behavior. (8,11) They can lack interpersonal, coping or conflict management skills.

Systemic factors stem from the unique health care cultural environment, which is marked by pressures that include increased productivity demands, cost containment requirements, embedded hierarchies, and fear of or stress from litigation. These pressures can be further exacerbated by changes to or differences in the authority, autonomy, empowerment, and roles or values of professionals on the health care team, (5,7,16) as well as by the continual flux of daily changes in shifts, rotations, and interdepartmental support staff. This dynamic creates challenges for inter-professional communication and for the development of trust among team members.

Disruptive behaviors often go unreported, and therefore unaddressed, for a number of reasons. Fear of retaliation and the stigma associated with “blowing the whistle” on a colleague, as well as a general reluctance to confront an intimidator, all contribute to underreporting of intimidating and/or disruptive behavior. (2,9,12,16) Additionally, staff within institutions often perceive that powerful, revenue-generating physicians are “let off the hook” for inappropriate behavior due to the perceived consequences of confronting them. (8,10,12,17) The American College of Physician Executives (ACPE) conducted a physician behavior survey and found that 38.9 percent of the respondents agreed that "physicians in my organization who generate high amounts of revenue are treated more leniently when it comes to behavior problems than those who bring in less revenue."(17)

Existing Joint Commission requirements

Effective January 1, 2009 for all accreditation programs, The Joint Commission has a new Leadership Standard (LD.03.01.01)* that addresses disruptive and inappropriate behaviors in two of its elements of performance:

EP 4: The hospital/organization has a code of conduct that defines acceptable and disruptive and inappropriate behaviors.

EP 5: Leaders create and implement a process for managing disruptive and inappropriate behaviors.

In addition, standards in the Medical Staff chapter have been organized to follow six core competencies (see the introduction to MS.4) to be addressed in the credentialing process, including interpersonal skills and professionalism.

Other Joint Commission suggested actions

1. Educate all team members – both physicians and non-physician staff – on appropriate professional behavior defined by the organization’s Code of Conduct. The Code and education should emphasize respect. Include training in basic business etiquette (particularly phone skills) and people skills. (10, 18,19)
2. Hold all team members accountable for modeling desirable behaviors and enforce the Code consistently and equitably among all staff regardless of seniority or clinical discipline in a positive fashion through reinforcement as well as punishment. (2,4,9,10,11)
3. Develop and implement policies and procedures/processes appropriate for the organization that address:
    - “Zero tolerance” for intimidating and/or disruptive behaviors, especially the most egregious instances of disruptive behavior such as assault and other criminal acts. Incorporate the zero tolerance policy into medical staff bylaws and employment agreements as well as administrative policies.
    - Medical staff policies regarding intimidating and/or disruptive behaviors of physicians within a health care organization should be complementary and supportive of the policies that are present in the organization for non-physician staff.
    - Reducing fear of intimidation or retribution and protecting those who report or cooperate in the investigation of intimidating, disruptive, and other unprofessional behavior. (10,18) Non-retaliation clauses should be included in all policy statements that address disruptive behaviors.

- Responding to patients and/or their families who are involved in or witness intimidating and/or disruptive behaviors. The response should include hearing and empathizing with their concerns, thanking them for sharing those concerns, and apologizing. (11)
- How and when to begin disciplinary actions (such as suspension, termination, loss of clinical privileges, reports to professional licensure bodies).

4. Develop an organizational process for addressing intimidating and disruptive behaviors (LD.3.10 EP 5) that solicits and integrates substantial input from an inter-professional team including representation of medical and nursing staff, administrators, and other employees. (4,10,18)

5. Provide skills-based training and coaching for all leaders and managers in relationship-building and collaborative practice, including skills for giving feedback on unprofessional behavior, and conflict resolution. (4,7,10,11,17,20) Cultural assessment tools can also be used to measure whether or not attitudes change over time.

6. Develop and implement a system for assessing staff perceptions of the seriousness and extent of instances of unprofessional behaviors and the risk of harm to patients. (10,17,18)

7. Develop and implement a reporting/surveillance system (possibly anonymous) for detecting unprofessional behavior. Include ombuds services (20) and patient advocates, (2,11) both of which provide important feedback from patients and families who may experience intimidating or disruptive behavior from health professionals. Monitor system effectiveness through regular surveys, focus groups, peer and team member evaluations, or other methods. (10) Have multiple and specific strategies to learn whether intimidating or disruptive behaviors exist or recur, such as through direct inquiries at routine intervals with staff, supervisors, and peers.

8. Support surveillance with tiered, non-confrontational interventional strategies, starting with informal "cup of coffee" conversations directly addressing the problem and moving toward detailed action plans and progressive discipline, if patterns persist. (4,5,10,11) These interventions should initially be non-adversarial in nature, with the focus on building trust, placing accountability on and rehabilitating the offending individual, and protecting patient safety. (4,5) Make use of mediators and conflict coaches when professional dispute resolution skills are needed. (4,7,14)

9. Conduct all interventions within the context of an organizational commitment to the health and well-being of all staff, (11) with adequate resources to support individuals whose behavior is caused or influenced by physical or mental health pathologies.

10. Encourage inter-professional dialogues across a variety of forums as a proactive way of addressing ongoing conflicts, overcoming them, and moving forward through improved collaboration and communication. (1,2,4,10)

11. Document all attempts to address intimidating and disruptive behaviors. (18)

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* The 2009 standards have been renumbered as part of the Standards Improvement Initiative. During development, this standard was number LD.3.10.

**Update (September 2016): The Joint Commission**

Behaviors that undermine a culture of safety continue to be a problem in health care. While the term "unprofessional behavior" is preferred instead of "disruptive behavior," the suggested actions in this Alert remain relevant.

A workplace environment that is safe and free of hostility or harassment is necessary to optimize the efficient recovery of organs and tissue. Thus, each OPO should have a formal policy for addressing the conduct of staff and physicians in the donor hospital setting. The following guidelines are recommended to each OPO as a standard for the conduct of the recovery surgeon, but these guidelines are pertinent for of all members of the recovery team.

Code of Conduct of the Organ and Tissue Recovery Personnel

Members of the recovery team participating in organ and tissue recovery activities within an OPO service area will treat all personnel in the donation process with professional courtesy and respect.

Organ and tissue recovery personnel should conduct themselves in a manner that promotes an effective and productive setting particularly in the operating room, but also during the entire recovery process. Proper conduct avoids displays of anger, intimidation, ridicule and other abusive behavior. Each organ and tissue recovery surgeon, as head of their recovery team, must assume primary responsibility for preventing improper conduct such as harassment of personnel during the recovery process.

Addressing a Breach of the Code:

Organ and tissue recovery personnel have an obligation to object to unprofessional conduct by surgeons and staff participating in the recovery process. In the case of observed unprofessional conduct, if directly addressing the surgeon or recovery team staff member does not resolve the problem, there is an obligation to report the misconduct to the Chief Medical Officer of the OPO or other appropriate authority as designated by the OPO. The Chief Medical Officer or OPO designee has the responsibility of assessing reported violations of the Code of Conduct engaging in personal communication with the surgeon or staff member in an appropriate and timely manner. If a personal communication does not resolve the offensive conduct, the OPO should bring the misconduct to the attention of the surgeon's Chief of Service or the staff member's supervisor.

Repeated Breach of the Code:

The privilege of recovery responsibility on behalf of the OPO can be approved or revoked by the OPO depending on conduct. Accordingly, conduct deemed unprofessional may be subject to disciplinary action by the OPO. This disciplinary action could result in a request to the surgeon's Chief of Service that the offending surgeon's privileges to participate in organ and tissue recovery activities be revoked within the OPO service area. In the case of misconduct on the part of a recovery team staff member other than a surgeon, the request could be made to the staff member's supervisor. If the misconduct is not resolved by this procedural step, the OPO may refuse to permit the offending surgeon or staff member from participating in organ and tissue recovery activities within the OPO service area.

**ATTACHMENT 7.3**

**LEAD ORGAN RECOVERY PERSONNEL EXPECTATIONS AND RESPONSIBILITIES**

**Expectations of Lead Organ Recovery Personnel:**

- If you accept an organ, or are going on the recovery, make every attempt to be punctual. If you are running behind, communicate this to the DNWest Coordinator.
- When onsite, surgeons must review the chart with the DNWest Coordinator for key elements including ABO, infectious disease testing, etc. You may be asked to assist with transporting to the OR.
- If requested by the DNWest Coordinator, please be prepared for a brief conversation with the donor family – the coordinator will assist you with this. When necessary, donor families appreciate seeing a surgeon "face to face" and a brief thank you for their gift.
- If an organ is believed to be non-transplantable in OR, inform the DNWest Coordinator ASAP so appropriate steps can be taken.
- If an organ is deemed inappropriate for the initial candidate, surgeons who are present at the recovery may be needed to recover the organ for a candidate at another center. In the interest of time and process, it is not possible to have another surgeon come and evaluate the organ. We ask that surgeons communicate with DNWest and other centers and recover organs for the benefit of the entire process.
- Surgeons must notify the DNWest Coordinator of any surgical damage during the recovery, regardless of its perceived effect on outcome.
- Surgeons may bring an assistant and/or observer, but must notify DNWest, and are at all times as lead surgeons responsible for the behavior of the teams they are bringing to the donor OR.
- Surgeons are needed to collect associated lymphatic tissue and vessels and to provide anatomical measurements of the organs.
- Ensure all paperwork is completed prior to departing, all op notes are signed, Coroner paperwork is completed, kidney paperwork and QA survey is completed.
- Donation is a high impact, low frequency event at many hospitals and the events of one case will linger either positively or negatively for an extensive time period. Please remember that we are guests in the donor hospital – be respectful of the staff and the donor at all times. We aim to make this process as smooth as possible, and need you to assist us with this. Our goal is to have each donor experience at a hospital set the tone for the next case.

**Responsibilities of Lead Organ Recovery Personnel:**

The responsibilities of a lead recovery individual include but are not limited to:

- Providing signatures on all DNWest intra-operative paperwork;
- Ensuring accurate and complete organ anatomical descriptions;
- Ensuring organs are packaged in accordance with current procedure;
- Oversight of the overall donor recovery process, including the actions of any/all personnel from his/her program, as related to the organ(s) they are recovering;
- Ensure Compliance with the SURGEON AND PHYSICIAN CODE OF CONDUCT AND ASSURANCE OF SAFE WORKING ENVIRONMENT (OR-F-027).

**ATTACHMENT 7.4**:

**CODE OF CONDUCT AGREEMENT FOR ORGAN AND TISSUE RECOVERY PERSONNEL**

Members of the recovery team participating in deceased donor organ and tissue recovery activities must treat the donor and all personnel in the donation process with professional courtesy and respect and in conjunction with our organizational values and mission.

Organ and tissue recovery personnel should conduct themselves in a manner that promotes an effective and productive setting, particularly in the operating room, but also during the entire recovery process. Proper conduct avoids displays of anger, hostility, intimidation, ridicule, harassment, belittling, name-calling, insults, bullying, and other abusive behavior.

All organ and tissue recovery personnel have an obligation to address unprofessional conduct by surgeons and staff participating in the recovery process. Each organ and tissue recovery lead surgeon/recovery personnel, as head of their recovery team, must assume primary responsibility for preventing and correcting improper conduct and Code of Conduct violations during the recovery process.

**Procedure for Addressing a Breach of the Code of Conduct:**

When a team member observes unprofessional conduct that violates, or potentially violates, this Code of Conduct, the team member shall (1) address the surgeon or recovery staff team member directly to try and resolve the problem without further escalation; or (2) shall report the perceived unprofessional conduct to the Vice President of Organ Operations, or the OPO designee. Donor Network West Leadership, or the OPO designee, shall be responsible for timely assessment of reported violations of this Code of Conduct. In most cases, personal communication with the alleged Code violator can resolve the situation.

If direct communication with the violator does not resolve the problem, or if direct communication is deemed not to be the best or most effective option under the circumstances, then the Vice President of Organ Operations, or the OPO designee, should bring the perceived violations to the surgeon's Department Chief or the staff member's supervisor.

This Code is in addition to any other applicable complaint reporting procedures for unlawful harassment, retaliation or discrimination, including third party harassment.

**Breach of the Code:**

The privilege of recovery responsibility on behalf of the OPO is at the discretion of the OPO. Unprofessional conduct, or violation of this Code of Conduct, can lead to recovery privileges being revoked or limited, made subject to conditions, or other disciplinary action or penalty by the OPO. This may mean that an offending surgeon/recovery personnel or staff member may be temporarily or permanently precluded from participating in organ and tissue recoveries within the OPO service area.

I have read and understand this Code of Conduct and agree to adhere to it at all times. I understand that my violation of this Code of Conduct can and will lead to adverse consequences, up to and including revoking of privileges to participate in organ and tissue recovery on behalf of Donor Network West. I further acknowledge that I have been provided with a duplicate copy of this signed document for my future reference.

| | |
|---|---|
| Print Name | Signature |
| Institution | Date |
| DNW CEO Janice Whaley (Signature) | Date |
| DNW CMO Waldo Concepcion (Signature) | Date |

## Lead Recovery Personnel Experience Form

All prospective lead recovery personnel must meet the experience requirements established by the Donor Network West Medical Advisory Board and Board of Directors, as outlined on this form, and submit them to Donor Network West.

| Organ | Heart | Lung | Pancreas | Liver | Kidney |
|---|---|---|---|---|---|
| **Required Case Experience #** | **5** | **5** | **10**<br>**5 *(islets only)*** | **20** | **20** |

**Applicant Name:** _____ **Transplant Center:** _____

| UNOS ID & Hospital | Organs Procured | Proctoring Surgeon | UNOS ID & Hospital | Organs Procured | Proctoring Surgeon |
|---|---|---|---|---|---|
| **1** | | | **11** | | |
| **2** | | | **12** | | |
| **3** | | | **13** | | |
| **4** | | | **14** | | |
| **5** | | | **15** | | |
| **6** | | | **16** | | |
| **7** | | | **17** | | |
| **8** | | | **18** | | |
| **9** | | | **19** | | |
| **10** | | | **20** | | |

**Please complete this page and fax to (925) 480-3809 or email to: SurgQualify@dnwest.org**

## Program Director Authorization

Applicants must provide a signature of the Transplant Center's Program Director confirming their ability to act as the primary surgeon/non-physician recovery personnel for organ recovery procedures.

I certify that all submitted information verifying my qualifications is true and correct and recognize that falsification of information is grounds for suspension of my privileges to perform organ recoveries for Donor Network West.

Applicant Name: _____ Transplant Center: _____

Email Address: _____ Phone Number: _____

_____ _____

Signature of New Organ Recovery Personnel Date

As Transplant Center Program Director, I affirm that the individual indicated on this qualification document is proficient to act as the primary surgeon/non-physician recovery personnel for organ recovery procedures.

_____ _____

Print Name of Program Director Date

_____

Signature of Program Director

**Please complete this page and fax to (925) 480-3809 or email to: SurgQualify@dnwest.org**

## Lead Recovery Personnel Qualifications

**1.0 PURPOSE:**

**1.1** The purpose of this document is to describe the process for qualifying and maintaining qualification documentation for lead organ recovery surgeons, foreign medical graduates, and non-physician recovery personnel.

**2.0 SCOPE:**

**2.1** This process applies to the qualification of all lead recovery personnel (surgeons, foreign medical graduates, and non-physician recovery personnel) from the Donor Network West (DNWest) donor service area (DSA).

**3.0 RESPONSIBILITIES:**

**3.1** The DNWest Operations Senior Management and Chief Medical Officer are responsible for oversight of DNWest's lead recovery personnel qualification process. Transplant centers, lead recovery personnel/ applicants, and DNWest staff are responsible for adhering to the process as outlined.

**4.0 REFERENCES:**

**4.1** AOPO Standards:

- § CL.6.0 Operating Room Procedures

**4.2** CMS 42 CFR Part 486 Conditions of Participation

- § 486.326(a) – Standard: Qualifications
- § 486.348 – Quality Assessment and Performance Improvement (QAPI)

**4.3** UNOS Bylaws

- Appendix B, D.6: Transplant Program Key Personnel

**5.0 DEFINITIONS:**

**5.1** *Lead Organ Recovery Personnel*—The person responsible for all aspects of the donor procurement for the organ(s) he/she is recovering and for completing all DNWest donor recovery documentation signatures; by definition this person cannot serve in a lead capacity prior to meeting DNWest's qualifications. Also referred to as "lead recovery personnel" in this document.

**5.2** *Supervised Recovery* – An organ recovery in which the trainee performs the critical part of the operation under the supervision of the already approved individual.

**6.0 MATERIALS / SUPPLIES:**

**6.1** None.

**7.0 PROCESS:**

**7.1 Qualification Requirements**

**7.1.1** Qualifications

**7.1.1.1** Individuals performing organ recovery procedures must submit their qualifications to DNWest to include the following documentation:

- Medical license (if applicable);
- Current curriculum vitae;
- Statement about experience and qualifications to perform unsupervised organ recoveries (if not evident in the curriculum vitae);
- Evidence of current malpractice coverage either through an affiliated university or an individual practice policy if self-insured.
- Signed Code of Conduct Agreement for Organ and Tissue Recovery Personnel
- Recovery Personnel Experience Form
- Signed Program Director Authorization Form

**7.1.2** Experience

**7.1.2.1** Before assuming the role of lead recovery personnel for any organ recovery, all individuals must demonstrate adequate experience. All potential lead recovery personnel must be supervised in the minimum number of organ recoveries by an AOPO Credential Network (ACIN) or a DNWest credentialed primary surgeon. Minimum experience by organ type is as follows:

- 20 Kidney Recoveries
- 20 Liver Recoveries
- 5 Pancreas Recoveries for Islet Transplant
- 10 Pancreas Recoveries for Solid Organ Transplant
- 5 Heart Recoveries
- 5 Lung Recoveries
- 1 DCD Recovery (only required to serve as lead surgeon on a DCD recovery).

**7.1.2.2** Documentation of recovery experience will minimally include UNOS identification number, organ(s) recovered, and identification of the supervising surgeon.

**7.1.2.3** The completed qualification forms are submitted either by fax (925) 480-3809 or email SurgQualify@dnwest.org.

## 7.2 Qualification Process

**7.2.1** Each transplant program within the DNWest donor service area (DSA) will notify DNWest of any new staff surgeons, foreign medical graduates, and non-physician recovery personnel.

**7.2.2** The lead recovery personnel applicant will send all required documentation to DNWest as soon as possible once all requirements have been met.

**7.2.3** DNWest Operations Senior Management verifies that all submitted documentation is accurate, complete, and authorizes new lead recovery personnel.

**7.2.4** The DNWest Chief Medical Officer will review any new lead recovery personnel requests annually to confirm qualifications.

## 7.3 Orientation:

**7.3.1** DNWest Senior Management provides an orientation to DNWest to all new lead recovery personnel. Participation in these orientations ensures that all individuals are oriented competently, consistently, and thoroughly in all procedures relating to recoveries on behalf of DNWest.

**7.3.2** The new lead recovery personnel orientation is provided to all new individuals at the time DNWest is notified of their arrival to the transplant program, or no later than one (1) months following their lead organ recovery qualification.

**7.3.3** New lead recovery personnel are required to provide documentation of participation in the DNWest orientation by signing the ORIENTATION CHECKLIST.

## 7.4 Maintaining Qualifications and Training Documentation

**7.4.1** DNWest Quality Systems (QS) will ensure the following:

**7.4.1.1** Verify all credentialing documents are complete and current for all credentialed lead recovery personnel.

**7.4.1.2** Monitor license expirations, obtain copies of renewed licenses from the respective website (i.e. https://search.dca.ca.gov/ ), upload to the Surgeon Qualification List on the Portal, and update expiration dates.

**7.4.1.3** When malpractice insurance expires, work with recovery personnel or transplant center to obtain current insurance certificates.

**7.4.1.4** Notify DNWest Senior Management in the case of lapsed lead recovery personnel qualifications.

**7.4.1.5** Maintain records for lead recovery personnel on the DNWest SharePoint Portal to verify current status at each program.

**7.4.1.6** Archive all credentialing information for historical purposes.

**7.4.1.7** Reconcile DNWest's SharePoint Portal list of qualified lead recovery personnel with the ACIN list on a regular basis.

**7.4.2** DNWest QS will also:

**7.4.2.1** Perform periodic review of the lead recovery personnel qualification list and the ACIN list for accuracy.

**7.4.2.2** Perform periodic review of year-to-date audit findings with the DNWest Chief Medical Officer.

**7.4.2.3** Send the following ACIN Verification Notification statement via email to AOPO (with a cc to the VP and the Director of QS) as per audit schedule, and attach a PDF of the email to the audit item on the SharePoint list. Text of statement:

"**The list of lead recovery personnel acting on behalf of DNWest has been reviewed and is verified as accurate. Licenses and certificates are confirmed current."**

## 7.5 Audit Process

**7.5.1** Qualified Surgeons - Non Local Lists and Documentation

**7.5.1.1** Quality Systems Specialist will verify lead recovery personnel status by accessing the ACIN list.

**7.5.1.2** Once status and credentials have been verified in the ACIN site, add lead recovery personnel to iTransplant.

**7.5.1.3** Utilize the weekly Missing Surgeons Report to identify which non-Local surgeons need to be added to iTransplant.

**7.5.2** Qualified Surgeons – Local List and Documentation

**7.5.2.1** Validate the Surgeon Qualification List by reconciling with the ACIN List to ensure all Active Local Surgeons are present.

**7.5.2.2** Verify all Active Local Surgeons are qualified to recover the appropriate organ types by ensuring the applicable boxes are checked.

**7.5.2.3** Validate that Medical licenses are current and present.

**7.5.2.4** Validate that Medical Malpractice are current and present.

**7.5.2.5** Ensure all credentialing information is archived.

**7.5.2.6** Review audit findings with the Chief Medical Officer biannually.

**7.5.2.7** Send annual ACIN Verification Notification to AOPO.

## 7.6 Oversight by the Donor Network West Medical Advisory Board

**7.6.1** The Medical Advisory Board will review the surgical quality of donor recoveries on an as needed basis and make recommendations for further orientation and/or continuation of organ recovery privileges.

**7.6.2** The Medical Advisory Board, in its discretion, reserves the right at any time to assess the surgical competency and/or professional conduct of any individual performing organ recoveries. Lead recovery personnel cooperation is expected in any such assessment. This assessment may include, but is not limited to:

- Completed DNWest variance reports;
- Individual assessments submitted by transplant surgeons, clinical procurement coordinators, donor hospital personnel, or other individuals involved in the donation process;
- Assessment of compliance with all DNWest Medical Advisory Board guidelines regarding surgical competency and professional conduct.

**7.6.3** The DNWest Chief Medical Officer, in conjunction with DNWest Senior Management and the Medical Advisory Board, will provide immediate feedback to specific program directors when surgical errors occur. The Medical Advisory Board, in its discretion, reserves the right at any time to recommend denial of organ recovery privileges to the lead recovery personnel performing recoveries on behalf of DNWest or to impose conditions on the individual's participation during donor recoveries.

**7.6.4** Recommendations of the Medical Advisory Board will be enacted by majority vote.

## Verifying Lead Recovery Personnel Qualifications

**8.0 PROCESS**:

**8.1** The Organ Preservation Coordinator (OPC) must complete all lead recovery personnel verifications prior to recovery and document in iTransplant progress note with the subject, “Surgeon Qualification.” The Organ Allocation Coordinator (OAC) can serve as a backup for this verification if needed.

**8.1.1** Local lead recovery personnel qualifications are verified by reviewing the DNWest SharePoint Portal list of qualified lead recovery personnel.

**8.1.2** Non-local lead recovery personnel qualifications are verified by accessing the ACIN list, either on the DNWest SharePoint Portal or the ACIN website.

**8.2** In the event of a DCD recovery, at least one of the lead recovery personnel (regardless of the number of recovery teams) is required to meet the qualifications of having participated in a prior DCD recovery.

**8.2.1** Local lead recovery personnel DCD qualifications are documented on the DNWest SharePoint Portal list of qualified lead recovery personnel.

**8.3** In the event that the non-local lead recovery personnel’s qualification cannot be verified via the ACIN, the non-local recovery personnel will be required to complete and sign a VISITING ORGAN RECOVERY TEAM TEMPORARY PRIVILEGES REQUEST prior to recovery.

**8.3.1** Contact the non-local transplant program to attain completion of the form prior to the team arriving to the donor hospital.

**8.3.2** If a completed form cannot be obtained prospectively, it will be completed on site and affirmed by the RC.

**8.4** The OPC must verify that the lead recovery personnel present for the recovery is the same individual who was documented as qualified to recover in the iTransplant progress notes. The Clinical Procurement Coordinator (CPC) can serve as backup for this verification if needed.

**8.4.1** If the lead recovery personnel is not the identified individual, they must be qualified or complete a VISITING ORGAN RECOVERY TEAM TEMPORARY PRIVILEGES REQUEST prior to incision.

**8.5** The CPC must verify that the lead recovery personnel documented as qualified to recover, is documented as the lead recovery person on the iTransplant organ data pages and signs the OR paperwork.

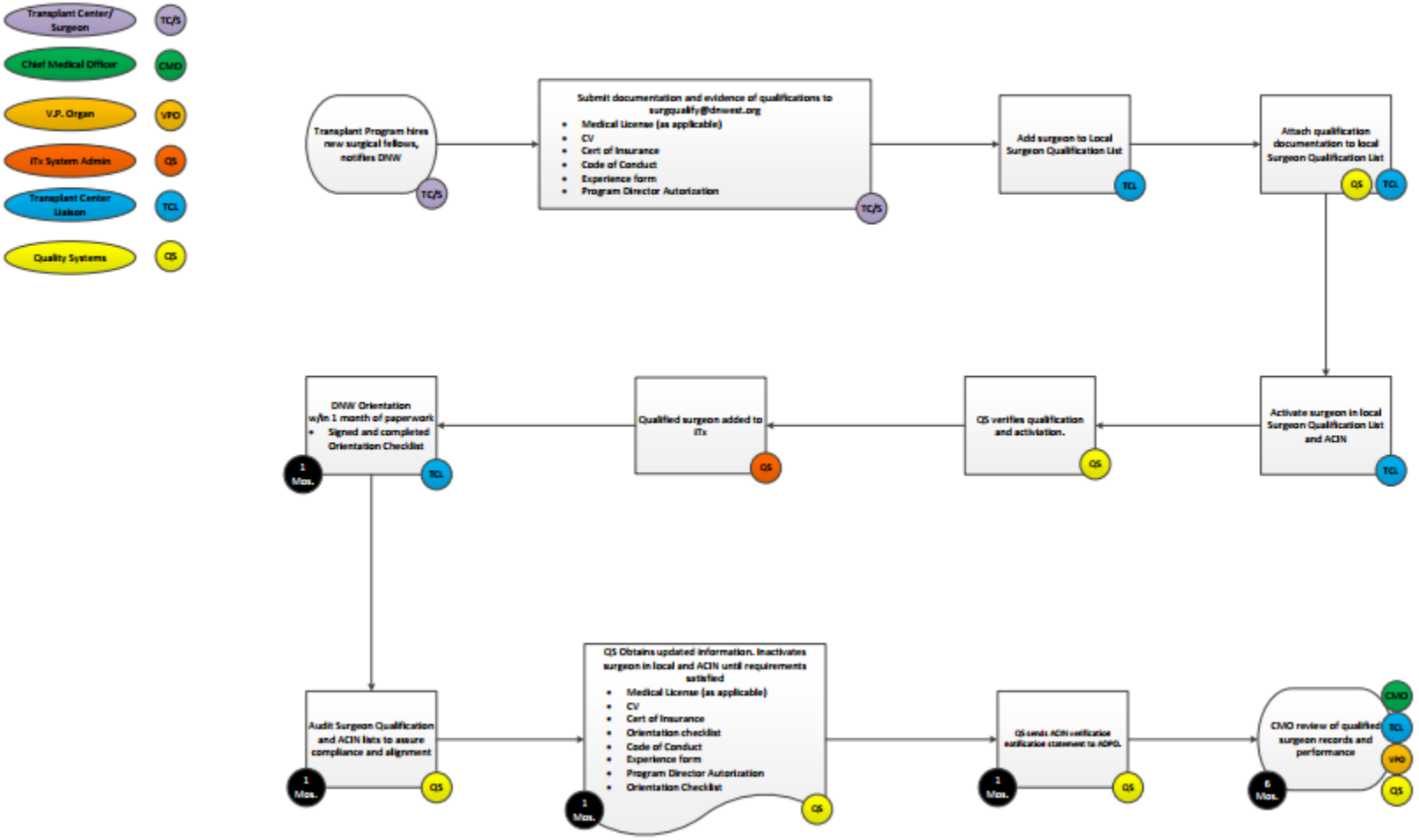
**8.6** The COM will be notified of all discrepancies to evaluate for potential emergency qualification approval (for local recovery surgeons only) and will document in the occurrence handling system.

**8.6.1** Emergency approval will require immediate submission of required paperwork and written or verbal confirmation from the program director or designee, verifying completion of qualification requirements and submission of required documents by end of next business day.

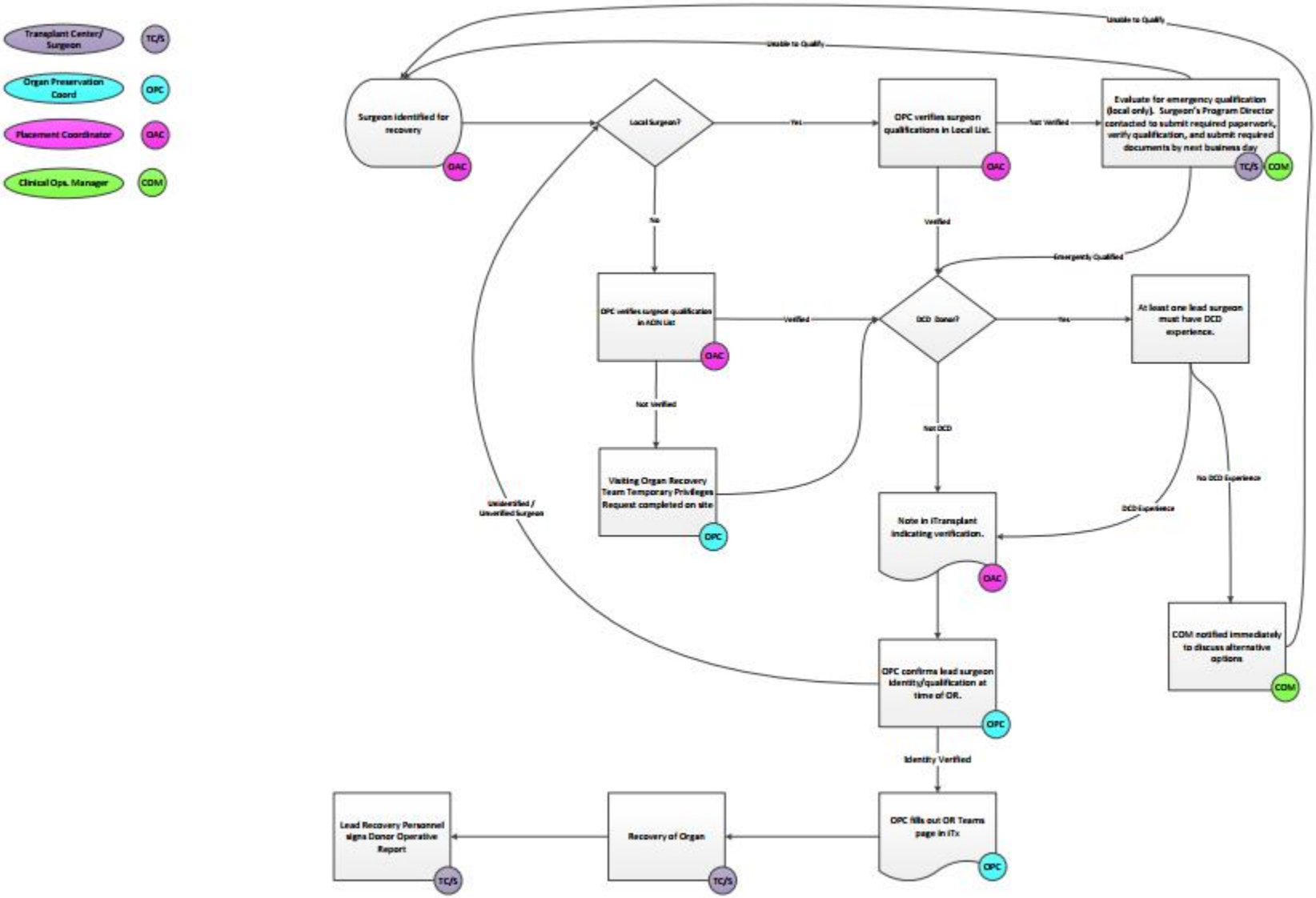
**8.6.2** The CPC/OPC/OAC will be notified in the event of emergency qualification approval.

A transplant program’s inability to provide an approved lead recovery personnel will result in the withdrawal of the organ offer to that program unless arrangements are made with other recovery teams.

# Surgeon Qualification Process Map



## Lead Recovery Personnel Verification Process Map



## Visiting Organ Recovery Team Temporary Privileges Request Form

**UNOS ID:** _____ **Donor Hospital:** _____

**Lead Procurement Surgeon Information**

Name: _____ Medical License #/State: _____

Transplant Center: _____

Address: _____

Phone #: _____

Position: _____

**Check organs to be recovered:** ☐ Heart ☐ Lung ☐ Liver
☐ Pancreas ☐ Kidney ☐ Intestine

**Is this a DCD Recovery:** ☐ Yes ☐ No

**Additional Surgeons**

| | |
|---|---|
| Name | License #/State |
| Name | License #/State |
| Name | License #/State |

**Additional Team Members**

| | |
|---|---|
| Name | Position |
| Name | Position |
| Name | Position |

As lead surgeon of this recovery team, I certify that I am a member of the staff of the institution named above that I have privileges there to perform this surgery and that I am covered by medical malpractice insurance Upon request, I will provide written verification of this coverage either by copy of my insurance face sheet o by letter from my institution's medical staff office. I further certify that I agree to be bound by the medical staf bylaws and medical staff policies in all matters relating to my temporary clinical privileges. I hereby assume responsibility for the actions of myself and all members of this team as listed on this form. We will act in a manner that is professional, respectful to others, and reverent towards the organ donor.

_____ _____
Chief Procurement Surgeon Signature Date & Time

_____ _____
Donor Network West Coordinator Signature Date & Time

**Please complete this page and fax to (925) 480-3809 or by email to: SurgQualify@dnwest.org**