SGMC

2024

Provider Education Self-Study Notebook

2024

Provider Education Self-Study

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SGMC Health is a leading employer and provider of comprehensive healthcare services in South Georgia and North Florida. SGMC Health was founded in 1955 as a 100-bed community hospital. Today, the South Georgia Health System operates four campuses, SGMC Health Main *(285 beds)* and the SGMC Health Smith Northview in Valdosta, GA, the SGMC Health Lanier Campus *(25 beds)* & SGMC Health Villa *(62 beds)* located in Lakeland, GA, and the SGMC Health Berrien Campus *(63 beds)* located in Nashville, GA. These facilities serve a diverse population with a wide variety of inpatient and outpatient needs.

SGMC Health is committed to continuous growth and the improvement of services necessary to meet the healthcare needs of our region. In 2010, the Hospital Authority approved the construction of the region's finest Outpatient Imaging Center on the first floor of the SGMC Health Professional Building. A 5-story parking deck opened in July, 2012 and a new 130,000 square foot, 5-story tower housing the Dasher Memorial Heart Center and 96 private patient rooms opened in fall, 2013. SGMC Health is also recognized for award winning Stroke care and Cardiothoracic and Endovascular expertise.

As a not-for-profit hospital system, SGMC Health is owned by the citizens of this community. Our goal is to provide outstanding health care to all. With careful business management and planning, we are pleased to serve you with no local property tax support.

Some quick facts about SGMC (FY22)
Annual Inpatient Visits: 373,027
Annual Outpatient Visits: 291,874
FTE's in the System: Approximately 2,900
Medical Staff: 600+ (includes honorary, consulting & mid-levels)
Annual ER visits: 90,544

While SGMC provides comprehensive preventive, diagnostic, treatment and recuperative healthcare services, our primary service lines include:

- **Cancer** – The Pearlman Cancer Center – ranked One of America's Best by the Women's
    - Choice Awards for three consecutive years
- **Cardiothoracic and Vascular/Endovascular Surgery –** The Dasher Memorial Heart Center provides the full continuum of cardiac care from diagnostics to cardiothoracic, vascular and endovascular interventions and surgeries**.**
- **Emergency Services** – Services include a 40-bed ER with twin Helipads at the Main
    - Campus. Ambulatory care clinics are located at SGMC Health Urgent Care and Health Care South
- **Neurology** (including an award-winning Stroke Program with accredited Inpatient Rehab)
- **Radiology** & other imaging services
- **Surgical Services** (inpatient and outpatient)
- **Women & Children's Services** – Specialty mother/baby units at The Birthplace at
    - SGMC Health Main Campus

Affiliates of SGMC Health: Langdale Place, Hospice of South Georgia and the Langdale Hospice House, the SGMC Health Villa Convalescent Center, SGMC Health Dogwood Senior Health Center

For the latest in hospital news and developments, we invite you to explore our website, www.sgmc.org. For more information, contact Community Relations at 229-259-4022.

Our Mission, Vision, and Values

At SGMC Health we value...

Integrity	Excellence	Accountability	Respect
Be a role model.	Be remarkable.	Be there for others, always.	Be mindful, accepting and willing.

Hospital Board

As a public hospital, an eight-member Hospital Board governs SGMC Health. Each group appoints four representatives who each serve a 5-year term. Board members are community leaders who serve the hospital voluntarily. It's a labor- intensive job for which no Board member receives any monetary compensation. In terms of governance, the Board has the ultimate decision-making ability when it comes to the hospital.

Administration

Senior Executive Team:

Ronald E. Dean, MBA, FACHE
President and
Chief Executive Officer

Randy Smith, MS, BSN, RN
Senior Vice President, Chief Operating Officer

Pankaj Agrawal, MD
Senior Vice President and
Chief Medical Officer

John Moore, CPA
Senior Vice President and Chief Financial Officer

Johnny Ball, MBA, MHA, FACHE
Senior Vice President of Regional Hospital
Operations

Brenda Alexander, MS, SHRM-SCP
Vice President of South Georgia Physician Network
and Chief Human Resources Officer

Jim Zacharias, MBA, FACHE, FACMPE
Vice President of Network Development

Hilary Gibbs, MEd
Vice President and Chief Development Officer

Chuck Marshburn, MBA
Vice President and Chief Information Officer
and HIPAA Security Officer

Cherise Giddens, BSN, RN
Vice President and Chief Nursing Officer

INDICATES ENTRANCE

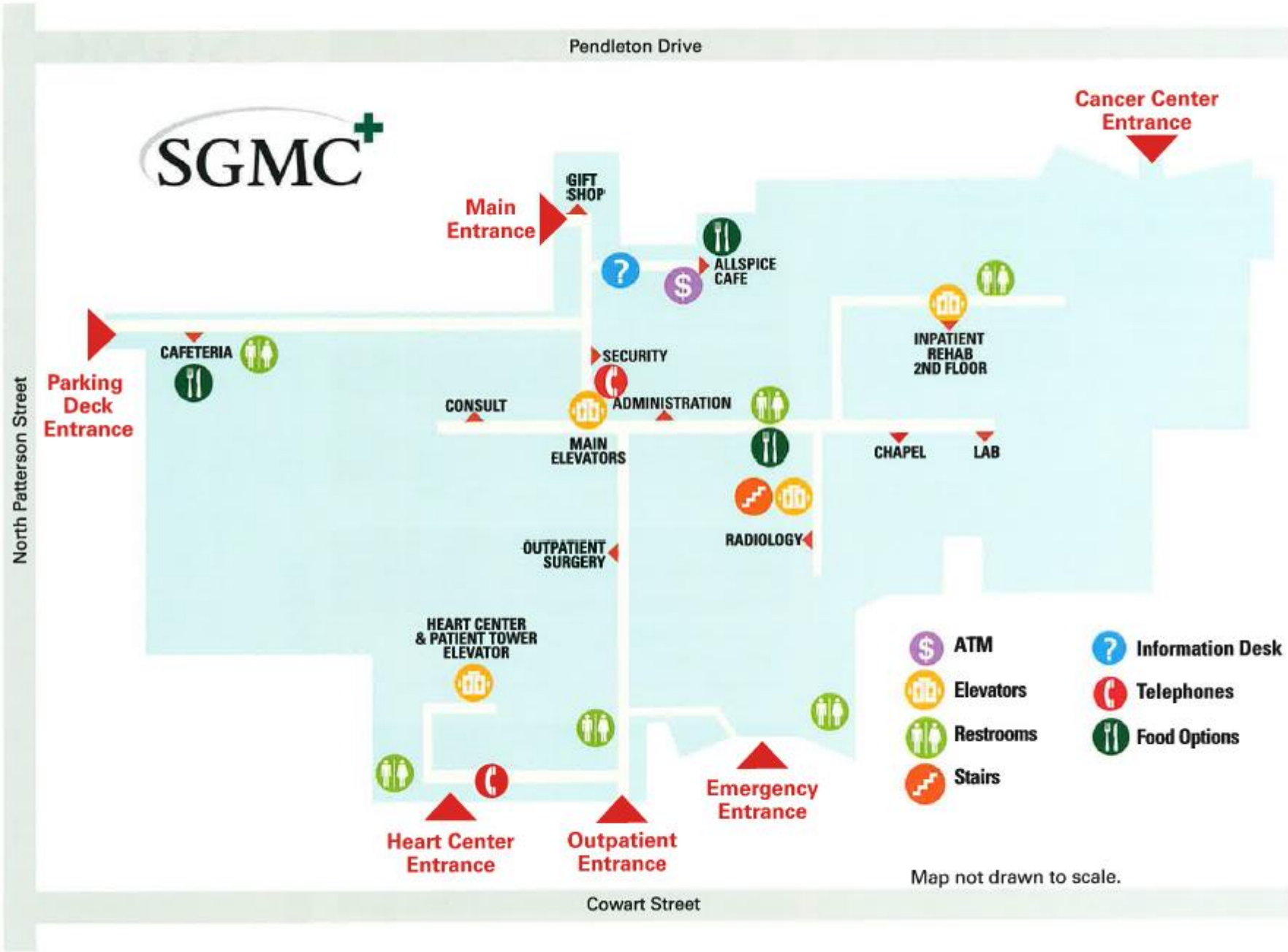
INDICATES PARKING

INDICATES PHYSICIAN ONLY PARKING

INDICATES PATIENT DISCHARGE

Medical Center Pharmacy

Map not drawn to scale
August 2013


Pendleton Drive
SGMC
Cancer Center Entrance
Main Entrance
GIFT SHOP
ALLSPICE CAFE
INPATIENT REHAB 2ND FLOOR
Parking Deck Entrance
CAFETERIA
SECURITY
CONSULT
ADMINISTRATION
MAIN ELEVATORS
CHAPEL
LAB
RADIOLOGY
OUTPATIENT SURGERY
HEART CENTER & PATIENT TOWER ELEVATOR
North Patterson Street
ATM
Elevators
Restrooms
Stairs
Information Desk
Telephones
Food Options
Emergency Entrance
Heart Center Entrance
Outpatient Entrance
Map not drawn to scale.
Cowart Street

Main Campus — PENDLETON DRIVE

First Floor

Administration	Gift Shop
AllSpice Cafe	Laboratory
Cafeteria	Outpatient Surgery
Chapel	Pearlman Cancer Center
Consult Rooms	Radiology
Emergency Department	Security

Second Floor

Labor and Delivery	Rooms 275-288
Inpatient Rehab	Rooms 201-216
Nursery	Rooms 231-259
Observation	
Pediatrics	Rooms 218-230
Post Partum	
Two East	

Third Floor

Apogee Physicians	
Family Pavilion	
GI/Endoscopy Suite	
Patient Rooms	Rooms 301-354

Fourth Floor

Neurodiagnostics	
Neurology	Rooms 401-417
Patient Advocates	
Patient Rooms	Rooms 443-467
Pulmonary Services	
Sleep Disorders Center	
Volunteer Services	

Fifth Floor

Intermediate Care Unit	
Patient Rooms	Rooms 501-517
5 East	Rooms 540-551

Dasher Heart Center and Patient Tower — COWART STREET

First Floor

Admissions	Outpatient Care

Second Floor

Cardiac Progressive Unit	Rooms 2201-2225

Third Floor

Cardiac Intensive Care	Rooms 2301-2325

Fourth Floor

Medical/Surgical Intensive	Rooms 2401-2425

Fifth Floor

Orthopedic/Neurosurgical	Rooms 2501-2525

Administrative Services Building — PENDLETON DRIVE

Cardiac Rehabilitation	Employee Health
Community Health	Foundation
Community Relations	Human Resources

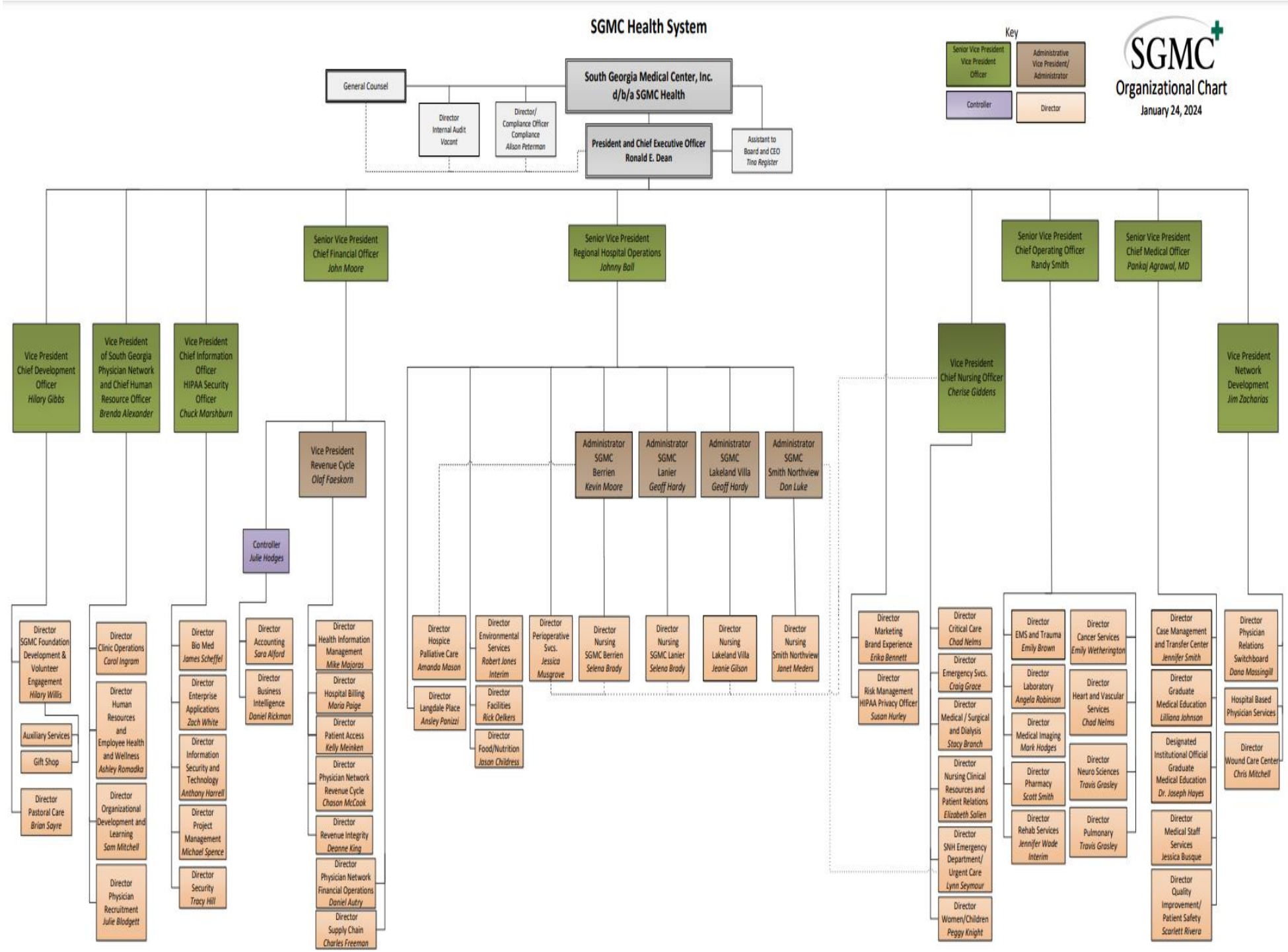
Professional Building — WOODROW WILSON

CardioVascular Institute	Dr. Sanders
Imaging Center	Walk In Lab

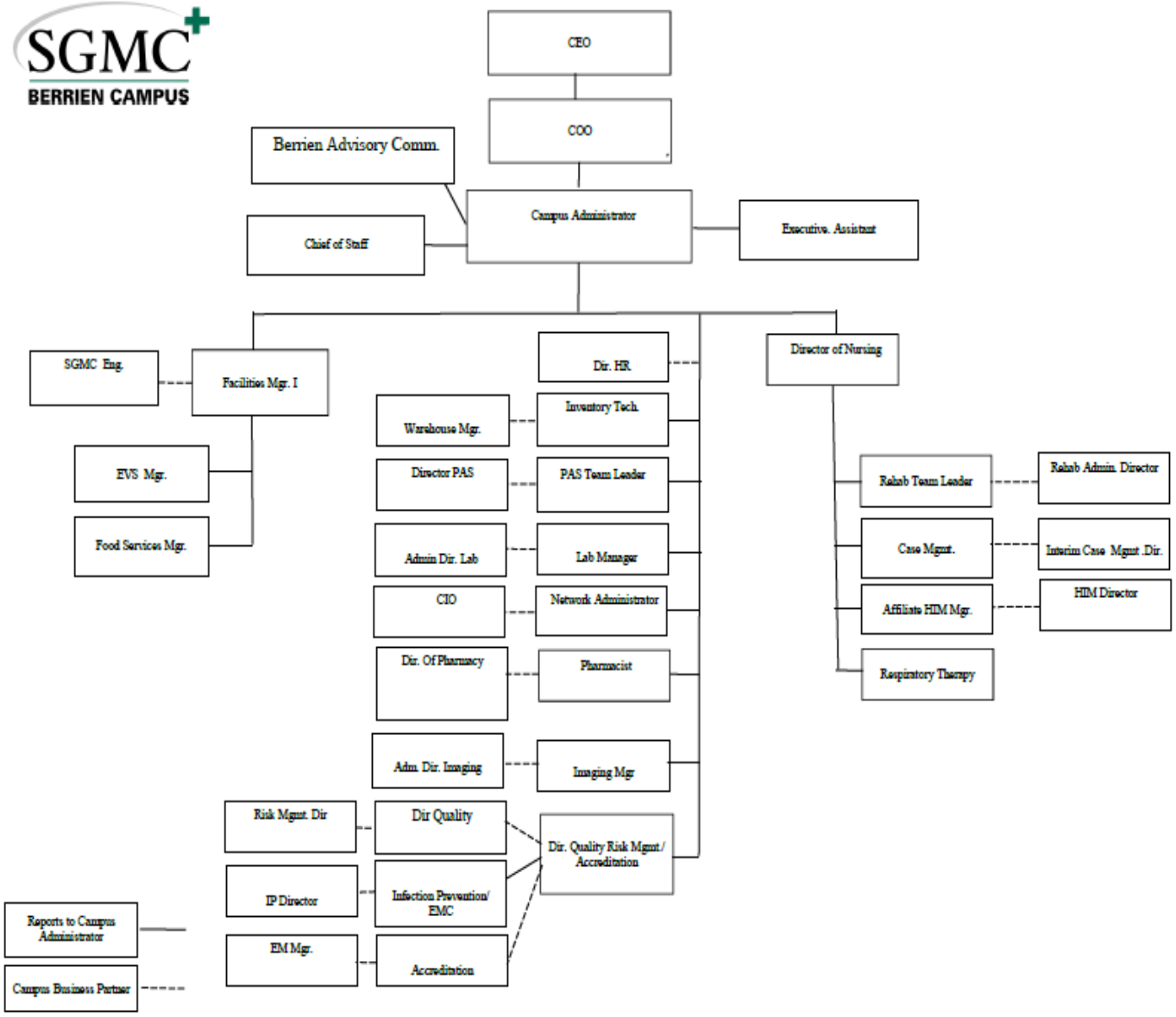
Surgery Center — NORTH PATTERSON

Spine Care Center	Outpatient Surgery

ADDITIONAL ON-CAMPUS LOCATIONS, **NOT** REPRESENTED ON MAP

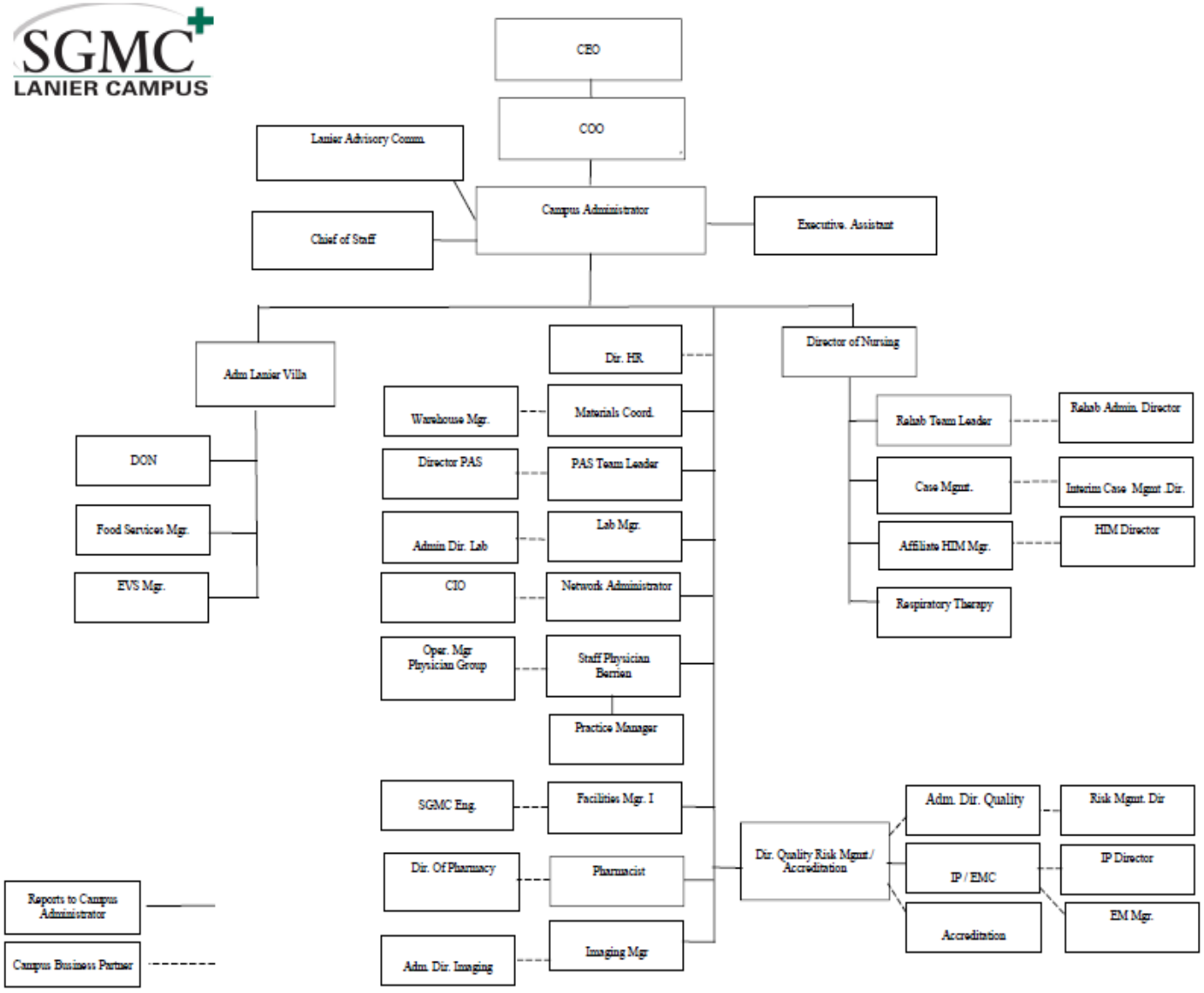

SGMC Health System
Key
Senior Vice President Vice President Officer
Administrative Vice President/ Administrator
Controller
Director
SGMC
Organizational Chart
January 24, 2024
General Counsel
South Georgia Medical Center, Inc. d/b/a SGMC Health
Director Internal Audit Vacant
Director/ Compliance Officer Compliance Alison Peterman
President and Chief Executive Officer Ronald E. Dean
Assistant to Board and CEO Tina Register
Vice President Chief Development Officer Hilary Gibbs
Vice President of South Georgia Physician Network and Chief Human Resource Officer Brenda Alexander
Vice President Chief Information Officer HIPAA Security Officer Chuck Marshburn
Senior Vice President Chief Financial Officer John Moore
Senior Vice President Regional Hospital Operations Johnny Ball
Vice President Chief Nursing Officer Cherise Giddens
Senior Vice President Chief Operating Officer Randy Smith
Senior Vice President Chief Medical Officer Pankaj Agrawal, MD
Vice President Network Development Jim Zacharias
Director SGMC Foundation Development & Volunteer Engagement Hilary Willis
Auxiliary Services
Gift Shop
Director Pastoral Care Brian Sayre
Director Clinic Operations Carol Ingram
Director Human Resources and Employee Health and Wellness Ashley Romadka
Director Organizational Development and Learning Sam Mitchell
Director Physician Recruitment Julie Blodgett
Director Bio Med James Scheffel
Director Enterprise Applications Zach White
Director Information Security and Technology Anthony Harrell
Director Project Management Michael Spence
Director Security Tracy Hill
Controller Julie Hodges
Director Accounting Sara Alford
Director Business Intelligence Daniel Rickman
Vice President Revenue Cycle Olaf Faeskorn
Director Health Information Management Mike Majoras
Director Hospital Billing Maria Paige
Director Patient Access Kelly Meinken
Director Physician Network Revenue Cycle Chason McCook
Director Revenue Integrity Deanne King
Director Physician Network Financial Operations Daniel Autry
Director Supply Chain Charles Freeman
Administrator SGMC Berrien Kevin Moore
Administrator SGMC Lanier Geoff Hardy
Administrator SGMC Lakeland Villa Geoff Hardy
Administrator SGMC Smith Northview Don Luke
Director Hospice Palliative Care Amanda Mason
Director Langdale Place Ansley Panizzi
Director Environmental Services Robert Jones Interim
Director Facilities Rick Oelkers
Director Food/Nutrition Jason Childress
Director Perioperative Svcs. Jessica Musgrove
Director Nursing SGMC Berrien Selena Brady
Director Nursing SGMC Lanier Selena Brady
Director Nursing Lakeland Villa Jeanie Gilson
Director Nursing Smith Northview Janet Meders
Director Marketing Brand Experience Erika Bennett
Director Risk Management HIPAA Privacy Officer Susan Hurley
Director Critical Care Chad Nelms
Director Emergency Svcs. Craig Grace
Director Medical / Surgical and Dialysis Stacy Branch
Director Nursing Clinical Resources and Patient Relations Elizabeth Salien
Director SNH Emergency Department/ Urgent Care Lynn Seymour
Director Women/Children Peggy Knight
Director EMS and Trauma Emily Brown
Director Laboratory Angela Robinson
Director Medical Imaging Mark Hodges
Director Pharmacy Scott Smith
Director Rehab Services Jennifer Wade Interim
Director Cancer Services Emily Wetherington
Director Heart and Vascular Services Chad Nelms
Director Neuro Sciences Travis Grasley
Director Pulmonary Travis Grasley
Director Case Management and Transfer Center Jennifer Smith
Director Graduate Medical Education Lilliana Johnson
Designated Institutional Official Graduate Medical Education Dr. Joseph Hayes
Director Medical Staff Services Jessica Busque
Director Quality Improvement/ Patient Safety Scarlett Rivera
Director Physician Relations Switchboard Dana Massingill
Hospital Based Physician Services
Director Wound Care Center Chris Mitchell

SGMC
BERRIEN CAMPUS



02/15/2018

SGMC
LANIER CAMPUS



02/15/2018

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Drive decision-making with a clinical search engine that gives you quick access to better evidence.

Fast
Thinks and works like a physician, recognizing concepts and offering shortcuts.

Complete
Draws relevant answers from a wide range of current, comprehensive content across 30+ medical specialties.

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Accessible at the patient's bedside or on the go, making it easy to discover, share and apply content anywhere.

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ClinicalKey®

The ClinicalKey interface offers a faster, more convenient way to access answers.

TOPIC PAGES

View Quick, Point-of-Care Content

- Access over 1,400 disease topic pages covering risk factors, treatments, clinical manifestations, and more.

1 SEARCH RESULTS AND FILTERS

Source Type
- Filter search results by a broad spectrum of content types, from journal articles, MEDLINE, books and images to clinical trials and Procedures Consult videos.

Specialties
- Sort by all major medical and surgical specialties.

Study Type
- Organize results by systematic reviews, meta analysis, randomized control trials and narrative reviews.

Time
- View results from the last 6 months, 12 months, 18 months, 2 years or 5 years. Results are automatically sorted by relevance.

2 SCOPED SEARCH

Access from Any Screen
- Use Scoped Search from anywhere in ClinicalKey, even inside book or journal content.

Restrict by Any Content Type
- Narrow search results by one of all content types available – not just books and journals.

Search within Content
- When already inside book or journal content, limit search results to that publication only or a particular portion of it.

3 PERSONAL ACCOUNT

Customize Your Access
- Create a personal account to gain CME credit and to access customizable features like the Presentation Maker and Saved Content.

4 PRESENTATION MAKER

Select with a Single Click
- Add images to a presentation by clicking the Presentation Maker icon – multiple images can be added at one time using the icon in the upper right of the screen.

Name and Manage
- Access the Presentations item in the User Menu to edit multiple presentations at once, using the Create, Change and Delete functions.

Export with Ease
- Use the Export button to convert your presentation to PowerPoint from either desktop or mobile.

5 SAVED CONTENT

Click and Save
- Hover over a search result and click the Save icon to add content to Saved Content – use the icon in the upper right of the screen to add multiple items.

Tag for Convenience
- Organize saved items by tagging them with one or more tags on the Saved Content page, allowing for access later.

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Leverage insights for better patient outcomes anytime, anywhere with the ClinicalKey mobile app – available for both Apple® and Android™ devices.

- Open the App Store on your mobile device
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Download the ClinicalKey mobile app today.

For more information, please contact

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An Internet connection is required to use the ClinicalKey MobileApp. If you have questions regarding your remote access, notify your institutional administrator.

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KEY11Spod

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Introducing the New ClinicalKey Experience

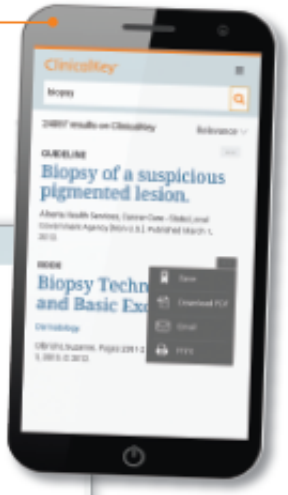
With ClinicalKey's new enhancements, users have access to the most current and complete clinical content. Its redesign was built for easier navigation on any device. The result: ClinicalKey finds relevant answers and related information as quickly as it's needed.

New Features

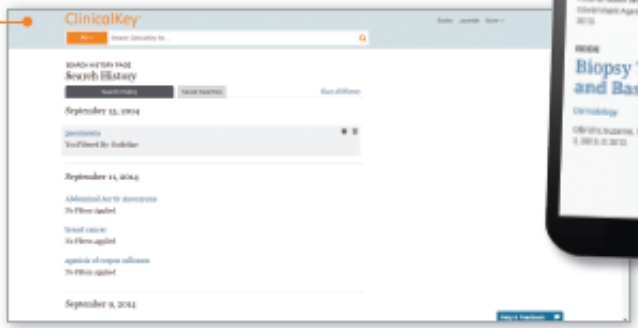
Patient Education Customization provides users the ability to add special instructions and care provider contact information. It also allows users to choose text size for printing.

Topic Pages on more than 1,400 disease conditions provide a comprehensive overview covering risk factors, clinical manifestations, treatments and more for quick point-of-care decisions with resource links for a deeper dive into the materials that specialty physicians need.

Mobile Optimization means that ClinicalKey adapts to users' phone, tablet or mobile device so they can continue to discover fast answers and deep evidence – anytime, anywhere.



Retained Search History lets users view past sessions. Search results can also be emailed.



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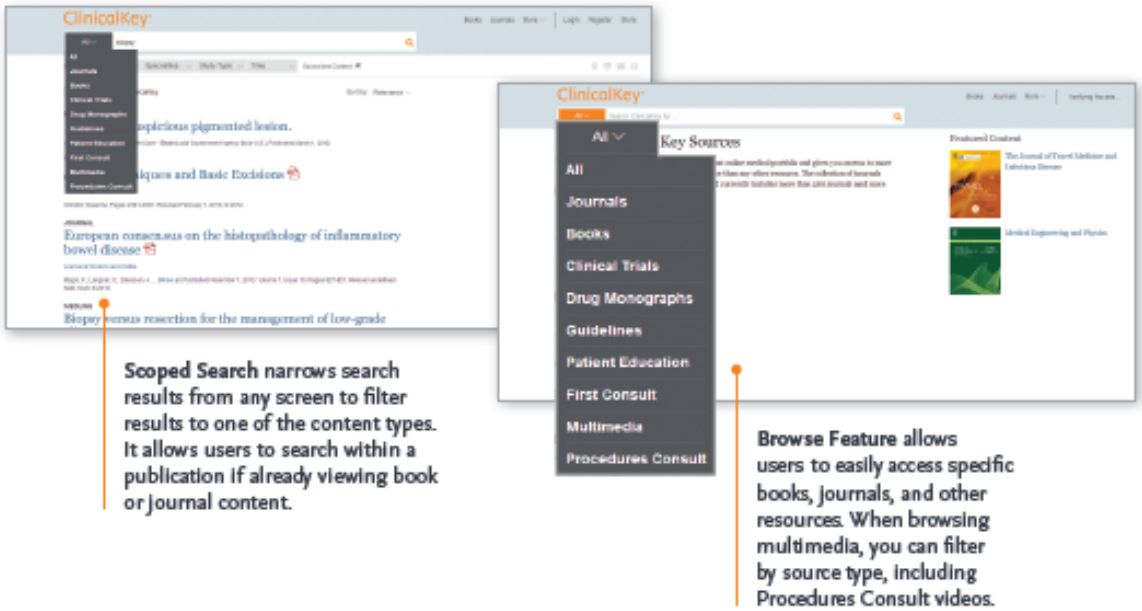
Enhanced Features

Presentation Maker eases the process of sharing, manipulating and storing content for later use. Users have the ability to create, name and manage multiple presentations.

Saved Content gives users the ability to save and add custom tags to content, which allows easy access for future reading and reference.



Scoped Search narrows search results from any screen to filter results to one of the content types. It allows users to search within a publication if already viewing book or journal content.

Browse Feature allows users to easily access specific books, journals, and other resources. When browsing multimedia, you can filter by source type, including Procedures Consult videos.

Use ClinicalKey today! Contact your institutional administrator with any questions.

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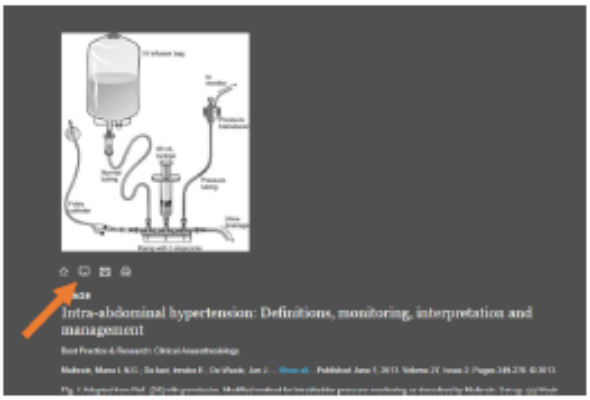
ClinicalKey Quick Tip: Presentation Maker

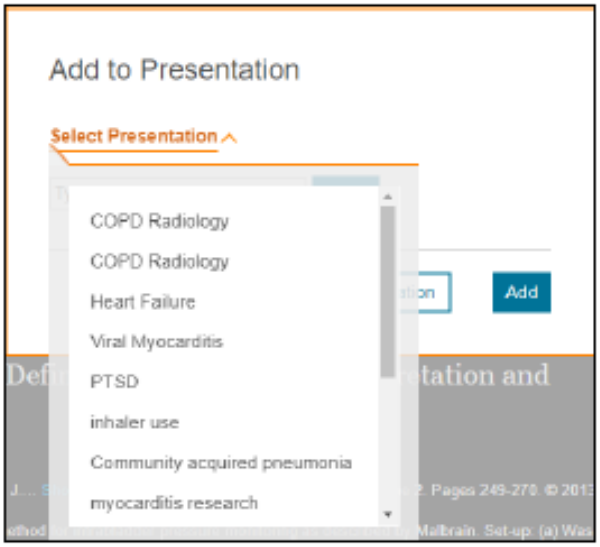
Want to easily create a presentation? Use the Presentation Maker.

- If you have not already, create a personal account by clicking **Register** in the upper right corner of ClinicalKey. This will allow you to save images to the Presentation Maker for fast access later.

- Create presentations by selecting images from search and browse results. After finding an image you want to include, click the **Add to Presentation** button to save the image to your presentation. This can be done directly from the search results page, or from within the content page.



- After clicking the **Add to Presentation** button, a window will display asking you to create a new presentation, or choose an existing one. Select the presentation you want, then click **Add**. ClinicalKey now adds the image to your presentation.



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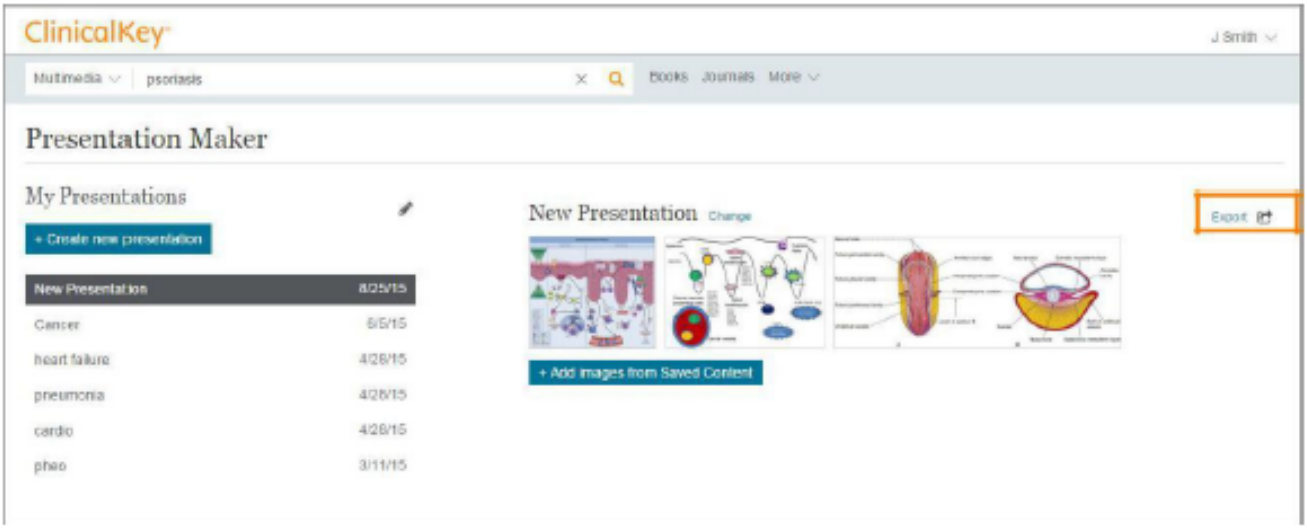
- To view and edit your presentations, simply click the **Presentations** option under your account menu. From here you can edit the presentation name, add or remove images, or create a new presentation.

- When you're ready, click **Export** to transfer your presentation to PowerPoint or Keynote. The images, along with their citations, will be put into slides for you to easily edit and present.



Start using the Presentation Maker today to see how ClinicalKey saves you time and makes it easy to share content!

Get started now at ClinicalKey.com!

Emergency Codes

To Initiate a Code:

***All overhead codes begin with the words: "Now Hear This" ***

- SGMC Main Campus: Call 0 and Operator will announce code 3 times
- SGMC Berrien Campus: Dial 8799 and announce code 3 times
- SGMC Lanier Campus: Dial 8858 and announce code 3 times

Codes may be called for any of the following:

Rapid Response Team

A clinical response team can be summoned at any time by any hospital employee, patient or family member to assist in the care of a patient who appears to be deteriorating BEFORE the patient has a cardiac arrest or other adverse event. This team is made up of the Administrative Coordinator, Critical Respiratory Care Practitioners and Critical Care Nurses. The primary care physician is notified when a rapid response code is called on one of his/her patients.

Code Blue

This code is called when an adult patient needs CPR. The response team is made up of the Administrative Coordinator, a physician, a Critical Respiratory Care Practitioner, and a Critical Care Nurse, and the primary care nurse.

Code Pink

This code is called when a pediatric patient needs CPR. The response team is made up of the Administrative Coordinator, a physician, a Critical Respiratory Care Practitioner, a Nursery Nurse, and the primary care nurse.

Code Red

This code is called for a fire. If you discover a fire, do the following:

- **R**escue anyone in immediate danger
- **A**larm – pull the fire alarm AND call 5555
- **C**onfine the fire – close all doors and shut off all immediate electricity & gas in the room. (Note: do not shut off the main O2 valve in the hallway)
- **E**vacuate/**E**xtinguish the fire only if you have been trained to use a fire extinguisher or
    - Evacuate the area if you are in immediate danger or if you are directed to do so.
    - If you are in an area above or below the area that the code is called for, respond as if you were in the fire area. Otherwise, continue your routine activities but listen for further announcements. LIP's at the fire's point of origin will respond as above/or as directed by supervisory staff. LIP's not at the fire's point of origin will remain in their work area unless otherwise directed by supervisory personnel.

Code Grey

Whenever a situation arises where a patient, visitor, or other person is becoming aggressive or threatening, Security needs to be notified. This is done by calling 0 and one of the following Codes will be called:

- Code Grey – Level 1 – used to request that Security respond STAT
- Code Grey – Level 2 – used when Security is needed STAT because someone has a weapon
- Code Grey – Level 3 – used when Security is needed STAT because of a hostage situation

In both Level 2 and Level 3, Security will also notify the Valdosta Police Department to respond.

Code Yellow

This code is called when there is a bomb threat. If you are the person who receives a bomb threat:

- Alert a staff member and follow their directions.
- DO NOT HANG UP THE PHONE – even if the caller hangs up. We may be able to trace the call as long as the connection is not broken.

If you are working in an area where a bomb search is started:

- Do not turn ON or OFF any lights, cell phones, or electrical equipment of any type
- Do not open or touch any boxes or bags.
- You should not assist in the search – let a staff person know that you are leaving the area and then do so with only what you have on your person
- Do not pick up anything to take with you.

Code Triage

This code means that a mass casualty event has occurred in the community and the hospital will be receiving a large influx of patients.

- Code Triage – Level 1 – influx can be managed with current resources assigned to the ER
- Code Triage – Level 2 – influx is too large to be managed by current ER resources and the Labor Pool is being opened in Classroom A for additional hospital staff who are currently working in other areas to report to. These resources will then be reallocated to where they are needed.
- Code Triage – Level 3 – this is a full-blown mass casualty event and staff will be recalled from home and will report to the Labor Pool.
    - **Physicians may also be called in to assist with this event. They should report to the Medical Affairs Office on the 1st floor.**

Code D (Decontamination Team Activated)

This code is called when a biological, chemical, or radiological event has occurred in the community and patients will need to be decontaminated prior to being allowed into the hospital. A team of trained individuals will respond to the ER to set up a decontamination tent and decontaminate patients and the worried well as they arrive.

Code Orange

This is called when there is a hazardous chemical spill INSIDE the hospital. The spill team will respond to help assess whether or not the spill can safely be cleaned up by department staff. If it can, they will insure that the proper spill kit and PPEs are used. If it is too large to be safely cleaned up by the staff or there are fumes involved, the area will be evacuated and the County Fire Department Haz-Mat Team will be called in.

Code Adam

An infant or child is missing. It may be a patient or a visitor. In either case, all exits will be manned by staff and no one will be allowed to leave or enter the building. All bags, containers, or other places that a child could be hidden will be searched.

Code MIA

An adult is missing. Again, it may be a patient or a visitor. When this code is called, a description of the person will also be given if possible. Staff in areas located at or around exits and access points to the hospital will monitor these areas.

Weather Watch

Announced when conditions in the area are right for severe weather to develop. Staff will do the following—

Implement Level 1 Check-list Precautions:

- Secure extra blankets and pillows
- Close blinds on all windows
- Stay calm and assure patients and visitors that these are routine precautions that are always taken to prepare for any potential weather problems.
- Gather flashlights and insure that they are working
- Remove objects, such as plants and vases from windowsills; these might become projectiles if blown about in a high wind. Place objects in a safe place.
- Keep staff and visitors from standing in front of windows
- Identify which patients can be moved into the hallway or restroom if Level 2 checklist is implemented
- Listen for further announcements

Weather Warning (Level 1)

Announced when severe weather has been sighted. Visitors will be advised to remain indoors. **Staff will implement Level 1 check-list precautions listed above.**

- **Physicians & LLPs should remain in the hospital until the all clear is called.**

Weather Warning (Level 2)

Level 2 Check-list Precautions:

- Move all visitors and ambulatory patients to an interior hallway or in the restroom and have them sit and cover their heads with pillows, blankets, and arms
- **West Tower patients will be moved to restrooms**
- **South Tower patients will be moved to hallways**
- If patients cannot be moved from their rooms, make sure blinds are closed, turn them
- away from windows and lower the bed.
- Cover them with extra blankets and additional pillows.
- Close all nonessential doors. Unoccupied patient room doors should be closed.
- Move staff to an interior hallway and get them down on floor with visitors; provide them with pillows and blankets to cover their heads
- In non-patient care areas, move to an interior area away from all windows, get down, and cover your head; move to a lower level of the building if possible but do not use the elevator
- Distribute flashlights to staff in the event there is a power failure due to the storm
- Care should be taken not to block exits or fire equipment.
- Each department will implement plans to ensure the safety and security of its respective personnel and functions/materials.
- All personnel will be advised to stay indoors.
- Listen for announcements
- **If you are in the building when a Level 2 code is called, please help to move patients to safety and get yourself into a safe position in an interior hallway away from windows & glass.**

Accreditation: Det Norski Veritas (DNV)

The NIAHO® accreditation program is more than just another way to validate Medicare compliance. It is a complete foundation for quality management. One that reverses the "gotcha" mentality of old-style surveys, and engages everyone—from top management to front-line staff—to contribute new ideas. Our accreditation programs directly address CMS requirements and our certification programs leverage the guidance and best practices of clinical specialty organizations across healthcare.

Why is accreditation important?

- Enhances community confidence and provides a report card for the public
- Offers an objective evaluation of the organization's performance
- Stimulates the organization's quality improvement efforts
- Provides a staff education tool
- May be used to meet certain Medicare certification requirements
- Expedites third-party payment
- Often fulfills state licensure requirements
- May favorably influence liability insurance premiums and managed care contract decisions

Who are the surveyors?

The survey team consists of specially trained physicians, nurses, administrators, and facility engineers.

What do the surveyors do?

Surveyors evaluate each health care organization's compliance with DNV standards and identify the organization's strengths and weaknesses. The surveyors' goal is not merely to find problems, but also to provide education and consultation so health care organizations can improve.

What does a surveyor do during an individual tracer?

During an individual tracer activity, the surveyor(s) will:

- Follow the course of a patient's care, treatment, and service throughout the hospital to assess the relationships among disciplines and departments and important function in the care, treatment, and services provided
- Evaluate the performance of processes relevant to the care, treatment, and coordination of distinct but related processes
- Identify vulnerabilities in care processes

What is an individual-based system tracer activity?

Individual-based system tracers explore one specific system or process across the organization, focusing on the experiences of specific patients or activities relevant to specific topics such as medication management; procurement, use, storage, and waste.

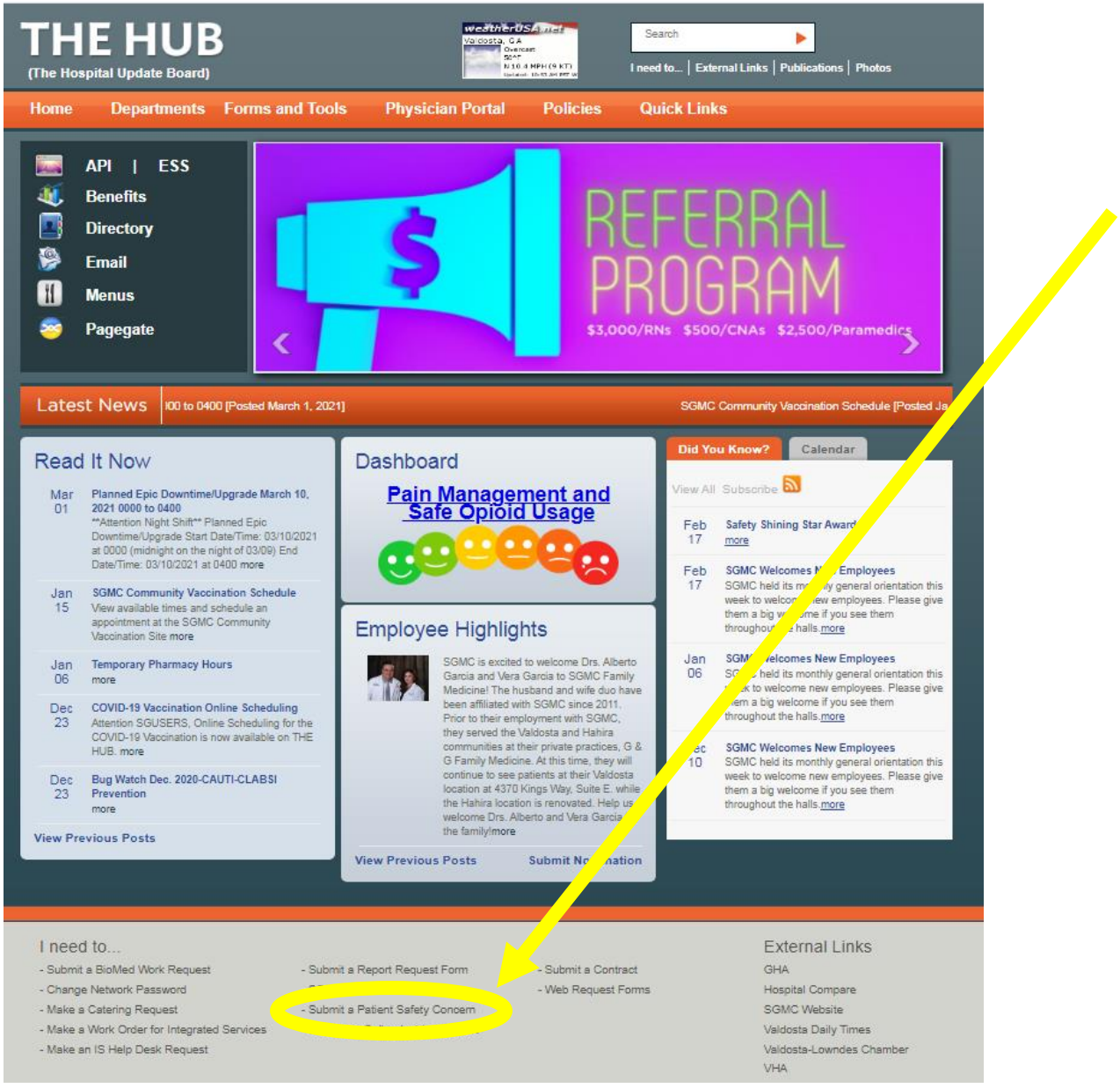
Coordination and communication among disciplines and departments will be evaluated. The point of contact at SGMC for DNV is the Accreditation and Regulatory Compliance System Director @ 229-259-4113. Any employee who feels they have unresolved issues about the safety or quality of care provided at SGMC has the right to contact the DNV. This is strictly confidential; no punitive or disciplinary action will be taken

Patient Safety

Patient safety is a top concern for employees and medical staff at SGMC.

Patient Safety includes health care issues from any department. Every department eventually has some impact on Patient Safety. Be proactive, now is the time to speak up about a safety issue that has been concerning you. Hopefully, we can really take a look at even the simplest tasks we do every day, and make our patient care even more safe and efficient.

Please contact the **SGMC Patient Safety Alert Line** with your observations and suggestions to improve patient safety. Any safety issue identified will be directed confidentially to the appropriate person or department. **Call (229) 333-1707 or submit a Patient Safety Concern on the HUB (below)**.

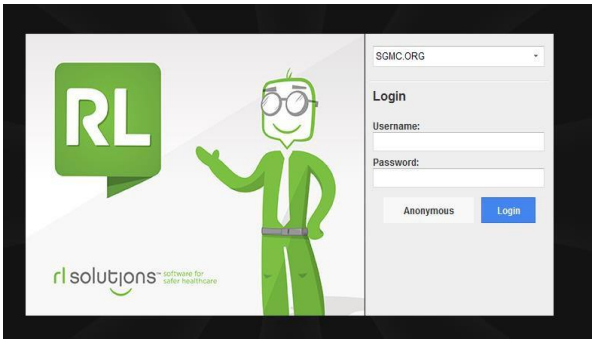


Incident Reporting

How to enter an incident online through **RL Solutions**:

1. Click on the RL Solutions Icon located on any SGMC desktop as seen below:

2. Login using your network username and password



3. Choose the most appropriate category and complete all areas with a green asterisk

HIPAA Information

Confidentiality

- HIPAA
- Patients rely on healthcare professionals to protect and respect their personal information.
- Federal regulations require healthcare professionals to do the same through the **H**ealth **I**nsurance **P**ortability & **A**ccountability **A**ct of 1996, also known as HIPAA.
- HIPAA includes regulations that govern how we use and release our patients' **P**rotected **H**ealth **I**nformation (PHI).
- PHI
- Only those staff members who are directly involved in the patient's care should be given Protected Health Information (PHI). Remember that patient care involves clinical staff as well as non-clinical such as registration clerks, pastoral care, and social workers.
- PHI is any information about the patient's past, present or future medical conditions and treatment.
- PHI is billing and payment records for the provision of health care services.

Confidentiality

- Breach
  - A Breach is defined as the access, use, release, or receiving of "unsecured" PHI. If a breach occurs, the patient must be notified. The HITECH Act requires us to notify the patient and the Department of Health & Human Services (HHS) when there is a breach.
  - If the breach includes >10 patients, we must report to the patients and HHS within 60 days.
  - If the breach includes >500 patients, we must report to the patients, HHS, and the media
  - There are tiers and penalty amounts for different types of violations.
  - HHS will determine which tier was violated.
  - You personally could be fined:
  - *$50,000 per violation*
  - *Up to $1.5M per calendar year*

Confidentiality

- Privacy rules apply to everyone:
  - Employees
  - Physicians
  - Volunteers
  - Students/Interns
  - Contracted Service Staff
  - Vendors
  - Only those staff members who are directly involved in the patient's care should be given patient information. Remember that the patient care involves clinical staff as well as non-clinical staff such as Registration/Information Desk Clerks, Pastoral Care, and Social Workers.

Report a Complaint or a Grievance

Complaint

- A complaint is a written or verbal **concern** from a patient or their legal representative regarding any aspect of care that can be effectively addressed and resolved **promptly**.
- Complaints afford our organization the chance to embrace opportunities and determine what we can do to address potential practice, process, or procedural shortcomings.
- Through **Immediate Service Recovery**, a simple apologetic gesture and swift correction of the issue can turn the patient's experience into a positive one and provide us with a learning opportunity.
- If the patient is not satisfied with the Service Recovery Process, the patient or their legal representative should be informed of their right to file a grievance.

Grievance

- A grievance is a written or verbal **request** by a patient or legal representative to have the facility review their concern about any aspect of their care. This is with any complaint which cannot be resolved promptly.

Filing a Grievance

- A grievance should be captured by entering into RL Solutions/Feedback located on the HUB/shortcut icon on desktop. Those informed of the grievance should document the details and complete the form in all areas where information is required.
- Once the grievance is completed and submitted it will automatically generate a communication to the Director of Patient Relations and the associated departments leadership team.
- When grievances concern patient injury or the threat of legal action Risk Management will be notified by Patient Relations.

Department managers receiving a grievance notification through RL Solutions should take action **immediately as per CMS there is a 7 day window to respond and/or resolve the grievance.

In Closing

- Treat ALL patients and family members with courtesy, respect, compassion, kindness and confidence.
- Know and practice your patient's rights.
- Your patients' experience becomes your experience.
- Service Recovery is key to nurturing for a positive patient experience and possibly avoid a grievance.
- Informative care lends to better outcomes
- Practice with confidentiality.
- Embrace opportunities for performance improvement.

Security Officer: Chuck Marshburn (229-333-1153)
Oversees safeguards designed to protect the confidentiality, integrity and availability of electronic health information.

Privacy Officer: Susan Hurley (229-333-1191)
Oversees what information should be protected, who is authorized to access, use or disclose information. Investigates complaints and assists with breach notification.

Audits:
The Hospital Authority routinely performs audits of electronic applications in order to monitor unauthorized access. The Department of Health and Human Services is also scheduling covered entities for on-site visits, evaluating privacy and security practices.

Fair Warning - Currently Monitored HIPAA Violations at SGMC:

- Coworker Snooping: Accessing Coworker's medical records
- Household Snooping: Accessing any family member's records, including children, or anyone that lives at your address
- Neighbor Snooping: Accessing medical records of patients that live close to your address
- VIP/Patient of Interest: Patients that are listed as a "No Info" patient or are deemed as VIP
- Self-Exam: Accessing your personal medical records with the use of your SGMC issued password. This is a policy violation regarding the use of facility assigned passwords

HIPAA Sanctions:

For Intentional Breaches:

- 1st Offense: 5-day Suspension
- 2nd Offense: Termination

For Unintentional Breaches:

- 1st Offense: Verbal coaching/Written warning
- 2nd Offense: 3-day Suspension
- 3rd Offense: Termination

Infection Prevention and Control

INFECTION PREVENTION & CONTROL

Proper Hand Hygiene

The **most important** thing that you can do for infection prevention is very simple. **WASH YOUR HANDS!**

INFECTION PREVENTION & CONTROL

When to Perform Proper Hand Hygiene

Use soap and water when:

- When hands are visibly soiled
- At the beginning of your shift
- After you use the restroom
- Before and after eating
- When caring for patients with C diff or diarrhea
- Before donning gloves
- After removing gloves
- After any contact with medical equipment or any inanimate object (chairs, tables, bed) in the immediate vicinity of the patient.

Alcohol hand gel counts as hand washing:

EXCEPT WHEN:

- Your hands are visibly soiled*
- Patient that you are working with has C-Diff*

*You must use soap and water in these situations!!!

Equipment Cleaning

All equipment must be cleaned with an approved cleaning product such as an alcohol wipe prior to using the equipment for patient care.
For example: Stethoscopes & Otoscopes

Dressing Supplies

Single use dressing supplies must be disposed of if not used completely.
For Example Iodoform

Lab Clean Sink

The clean sink in the Lab is for hand hygiene.
Urine specimens should not be poured down this sink drain.

Clean sink for hand hygiene

Expiration Dates

Prior to using a supply – check the expiration date.
Out dated supplies should not be used.

Standard Precautions

Standard Precautions requires all health care workers (HCW) to routinely use appropriate barrier precautions to prevent skin and mucous membrane exposure when blood or other body fluids of any patient is anticipated. See SPP 2.045 on the HUB

What are Standard Precautions designed to do?

- To reduce the risk of body fluids exposure to the healthcare worker
- To reduce the risk of transmission of micro-organisms from sources of infections in hospitals.

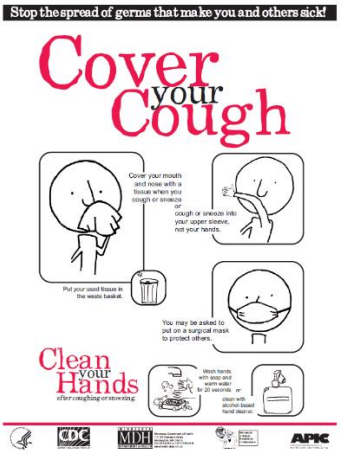
PPE (Personal Protective Equipment)

- Wear gloves. Gloves are encouraged with all patient contact and contact with the patient's environment.
- Never reuse disposable gloves
- Perform hand hygiene before / after wearing gloves
- Wear a mask and eye protection and/or face shield if fluids could splash into face
- Wear a gown if fluids could splash onto clothes
- Remove contaminated PPE slowly, and prior to leaving the patient care area
- Wash hands after removing PPE
- Use a resuscitation device when providing rescue breathing

Respiratory Hygiene

Healthcare personnel are advised to observe Droplet Precautions (i.e., wear a mask) and hand hygiene when examining and caring for patients with signs and symptoms of a respiratory infection. Healthcare personnel who have a respiratory infection are advised to avoid direct patient contact, especially with high risk patients. If this is not possible, then a mask should be worn while providing patient care.

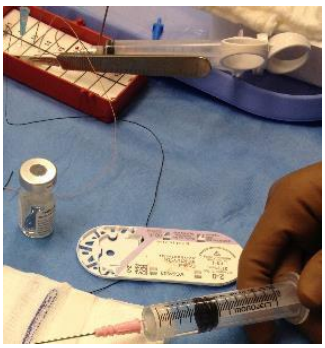
The elements of Respiratory Hygiene/Cough Etiquette include:



- Education of healthcare facility staff, patients, and visitors
- Posted signs, in language(s) appropriate to the population served, with instructions to patients and accompanying family members or friends;
- Source control measures (e.g., covering the mouth/nose with a tissue when coughing and prompt disposal of used tissues, using surgical masks on the coughing person when tolerated and appropriate);
- Hand hygiene after contact with respiratory secretions; and
- Spatial separation, ideally >6 feet, of persons with respiratory infections in common waiting areas when possible. Covering sneezes and coughs and placing masks on coughing patients are proven means of source containment that prevent infected persons from dispersing respiratory secretions in the air.

Safe Injection Practices

Outbreaks of viral hepatitis can be prevented by adherence to basic principles of aseptic technique for the preparation and administration of parenteral medications. These include:



- The use of a sterile, single-use, disposable needle and syringe for each injection given
- Prevention of contamination of injection equipment and medication.
- Whenever possible, use of single-dose vials is preferred over multiple- dose vials, especially when medications will be administered to multiple patients.

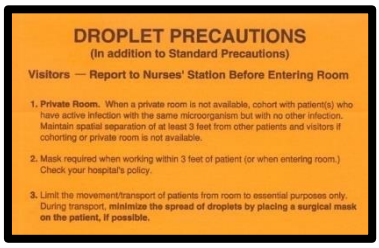
Infection Prevention Practices for Special Lumbar Puncture Procedures:

Face masks are effective in limiting the dispersal of oropharyngeal droplets. The Healthcare Infection Control Practices Advisory Committee (HICPAC) concludes that there is sufficient experience to warrant the additional protection of a face mask for the individual placing a catheter or injecting material into the spinal or epidural space.

- Face masks are recommended for the placement of central venous catheters.
- Face masks should be worn to prevent droplet spread of oral flora during spinal procedures (e.g., myelogram, lumbar puncture, spinal anesthesia).

Transmission Based Precautions

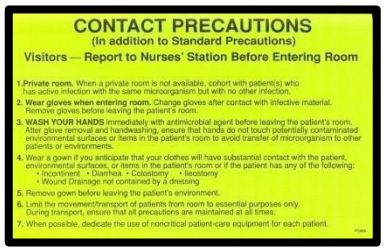
Transmission Based precautions include Standard Precautions with the addition of, or a combination of, Droplet, Contact, and Airborne Precautions.



Droplet Precautions Require the Following:

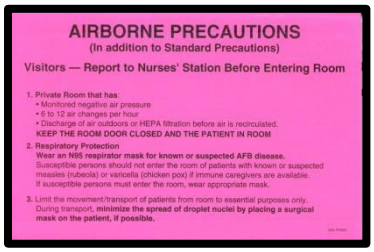
1. **Private Room.** When a private room is not available, cohort with patient(s) who has active infection with the same microorganism but with no other infection. Maintain spatial separation of at least 3 feet from other patients and visitors if cohorting or private room is not available.
2. Place droplet precaution instructions on the patients' door. (Obtain permission to post sign from the patient or family member and document in focus notes "permission received")
3. Mask is required when entering the room.
4. Limit the movement/transport of patients from room to essential purposes only. During transport, minimize the spread of droplets by placing a surgical mask on the patient, if possible.

Contact Precautions Require the Following:



1. **Private room**. When a private room is not available, cohort with patient(s) who has active infections with the same microorganism but with no other infection.
2. Notify Infection Prevention.

3. Place contact precaution instructions on the patients' door. (Obtain permission to post sign from the patient or family member and document in focus notes "permission received")
4. **Wear gloves when entering the room.** Change gloves after contact with infective material. Remove gloves before leaving the patient's room.
5. **WASH YOUR HANDS** immediately with antimicrobial agent before leaving the patient's room. After glove removal and handwashing, ensure that hands do not touch potentially contaminated environmental surfaces or items in the patient's room to avoid transfer of microorganisms to other patients or environments.
6. Wear a gown if you anticipate that your clothes will have contact with the surfaces, or items in the patient's room or if the patient has any of the following: incontinence, diarrhea, colostomy, ileostomy, wound drainage not contained by a dressing.
7. Remove gown before leaving the patient's environment.
8. Limit the movement/transport of patients from room to essential purposes. During transport, ensure that all precautions are maintained at all times.
9. When possible, dedicate the use of non-critical patient-care equipment for each patient.



Airborne Precautions Require the Following:

When a patient is suspected of, or known to have a disease transmitted by the airborne route, Nursing shall:

1. Notify Infection Prevention.
2. Place airborne precaution instructions on the patients' door. (Obtain permission to post sign from the patient or family member and document in focus notes "permission received")
3. Keep doors closed at all times.
4. Wear N95 or HEPA mask. Visitors should wear regular mask. (Tape regular mask on the door)
5. Limit the transport of the patient from the room for essential purposes only. If transport is necessary, have the patient wear a regular mask.

How to Protect Yourself

General Principles of PPE

- Hand Hygiene should always be performed despite PPE use.
- Remove and replace if necessary any damaged or broken pieces of re-usable PPE as soon as you become aware that they are not in full working order.
- Remove all PPE as soon as possible after completing the care and avoid contaminating the environment outside the isolation room; any other patient or worker; and yourself.
- Properly discard all items of PPE and perform hand hygiene immediately afterwards.

Due to COVID-19 Emphasis is on PPE Donning & Doffing

How to Put On (Don) PPE

How to Take Off (Doff) PPE

OSHA Bloodborne Pathogens

Pathogens including Hepatitis B, Hepatitis C, and HIV are spread by:

- Hands
- Needlestick Injuries
- Cuts, scrapes, or other breaks in the skin
- Splashes into the mouth, nose, or eyes
- Using infected drug needles
- Sexual transmissions
- Pregnant women can pass pathogens to their babies

Protect Yourself!

- Use required equipment and labels for your job!
- Practice Sharps Safety
  - *Never bend, break, or recap needles!*
- Safety Sharps
  - *Needles designed to prevent injuries*
- Sharps Disposal
  - *Puncture proof containers for used sharps*
- Biohazard Waste
  - Regulated waste containers displaying the biohazard symbol
- Keep food and beverages where they belong
  - Do not store in areas reserved for infectious materials
- Don't eat or drink in patient care areas
- Don't handle contact lenses or lip balm in potentially contaminated areas
- Wipe up spilled blood or other body substances
  - Use paper towels and a solution of chlorine bleach and water
  - Call Housekeeping for large spills
  - Fingernails must be kept short (no more than 3mm from the nail bed) clean, and healthy. Artificial nails, acrylic overlays, and J nails are not to be worn. Polish can be worn if not chipped and not worn more than four days. Except in surgical services areas. See SPP 2.054 Fingernail Policy.

Exposure Protocol Includes:

- Sharps Injuries
  - Needles
  - Blades
  - Glass with blood and/or body fluids
- Exposure to any blood or potentially infectious body fluid via mucous membranes or non-intact skin.

Needlestick Protocol

- Wash Area.
- Notify Infection Prevention or Administrative Coordinator by calling the switchboard and a nurse will assist you with the Exposure Protocol.
- Fill Out Hospital Employee Incident Report through RL Solution.
- Initial and Follow-up Lab Testing.
- Infection Prevention and Control will assist you with follow up.

Employee Infection Prevention

- Prevention of Occupational Illness
  - Influenza Vaccines
- **Important:** In accordance with CMS mandated reporting requirements: All physicians must report vaccination status to the facility. MDs must report if they have taken a flu shot or sign a declination form for documentation.

Remember- free benefit! Receive your annual flu shot through Employee Health.

Patient Infection Prevention

- Prevention of Health Care-Associated Infections Including:
  - Urinary Tract Infection
  - Bacteremia
  - Pneumonia
  - Surgical Site Infection
  - Clostridium Difficile

- Consequences of Health Care-Associated Infections
  - Increased Length of Stay and cost
  - Decreased Patient Satisfaction

Catheter-Associated UTIs

We have taken steps toward decreasing catheter-associated urinary tract infections (CAUTIs), including general education to all staff who handle urinary catheters. Measures can be taken to reduce CAUTIs. Infection Prevention and Control staff and clinical nurse specialists are working with nursing to ensure these guidelines are followed.

Measures to be taken:

- Assess the need for the foley catheter frequently
- When placing order for a foley, choose the Nurse Driven protocol for removal
- Order removal of the indwelling catheter when no longer indicated
- Do not write “Foley PRN.” Indicate why an indwelling catheter should be placed and write parameters for use of an indwelling catheter.

Central Line Infections

Studies show that hospital-acquired central line infections can be prevented by utilizing a set of guidelines developed by the Centers for Disease Control. An insertion checklist is provided in the standardized kit to be completed during insertion of the line.

The central line insertion bundle has five components:

- Hand hygiene, before catheter insertion or manipulation. Use of gloves does not obviate hand hygiene.
- Use maximum barrier precautions with standardized approved kit for insertion
- Use Chlorhexidine skin antisepsis in patients older than 2 months of age
- Optimal catheter site selection (the subclavian vein is the preferred site for non- tunneled catheters in adults)
- Daily review of line necessity with prompt removal of unnecessary lines.

Reasons for catheterization in the femoral vein site should be documented in the provider's procedure note.

Surgical Site Infections

Prevention of Surgical Site Infection recommendations include:

- Antimicrobial prophylaxis
- When hair removal is necessary, use clippers. Use of razors is inappropriate. Use the term clipped, never shaved for method of hair removal when documenting.
- Control serum blood glucose levels and avoid hyperglycemia preoperatively.
- Effective skin prep.
- Surgical scrub and hand hygiene, surgical dress attire/draped.
- Follow appropriate antibiotic administration protocols for selection, timing and discontinuation.
- Make sure your patient understands your post-discharge instructions including prevention of SSI.

Clostridium difficile Infection (CDI) Prevention Initiative

Prevention of hospital acquired *Clostridium difficile* infections is a prevention strategy, which includes:

- Use and select antibiotics judiciously.
- Use Contact Precautions: for patients with known or suspected *Clostridium difficile*-associated disease.
- Perform Hand Hygiene with soap and water, alcohol foam is not effective.
- Use gloves and a gown when providing patient care.

Hospital Quality Measures

How can SGMC help you provide evidence-based quality care to patients?

- Use appropriate computer entry orders sets
- Call a Quality Improvement Specialist for any questions 259-4015

Quality Measure Compliance

The Centers for Medicare and Medicaid (CMS) release benchmarks for hospitals to use as guidance in determining compliance with Quality Measures (formerly known as Core Measures). These benchmarks are updated regularly based on performance of hospitals nationally. South Georgia Medical Center accepts these benchmarks as targets for Quality Measure compliance. All patient charts which are found to be non-compliant with any measure are reviewed individually for opportunities to improve performance. Non-compliance that can be attributed to Physician performance is reviewed through the Peer Review process.

Comfort Measures Only

In certain situations, at the physician's discretion, it is appropriate to not aggressively treat a patient. In most of the Quality Measures, using one of the following phrases/words will exclude the case from the population. In these situations, documentation must clearly state the patient will receive:

- Comfort Measures, Comfort Care, or Comfort Only
- DNR-CC
- End of Life Care, Terminal Care or Terminal Extubation
- Hospice or Hospice Care
- Documentation of Brain Death, Brain Dead, or Organ Harvest will also satisfy the documentation requirements
    - An order for No Code, DNR, DNI, Limited Code or Palliative Care does not satisfy the documentation requirements.

Inpatient Measures

IP Stroke

- Thrombolytic therapy administered greater than 30 minutes after arrival, must have a documented reason for delay
- If thrombolytic therapy is not given to patients who arrive within 4.5 hours of last know well, a reason must be documented
- Assessment of LDL must be drawn within 48 hours of arrival
- NIHSS within 12 hours of arrival
- DAST completed and documented prior to anything oral
- VTE prophylaxis mechanical or pharmacological or document reason why not
- Discharge on statin medications: A reason must be documented for non-treatment if the statin daily dose does not meet the guideline recommended dose. Patients 75 y/o or younger should receive a high intensity dose unless contraindicated. Patients greater than 75 y/o should receive a moderate or high dose.
- Discharge on antithrombotic therapy or document why not
- Stroke education, includes accurate medication reconciliation at discharge
- Assessed for rehabilitation
- Stroke/TIA order sets are available to assist in meeting stroke core measures.

memo

TO All Admitting Physicians/APPs

FROM: Steven Brian Dawson MD, Medical Director, Stroke Program

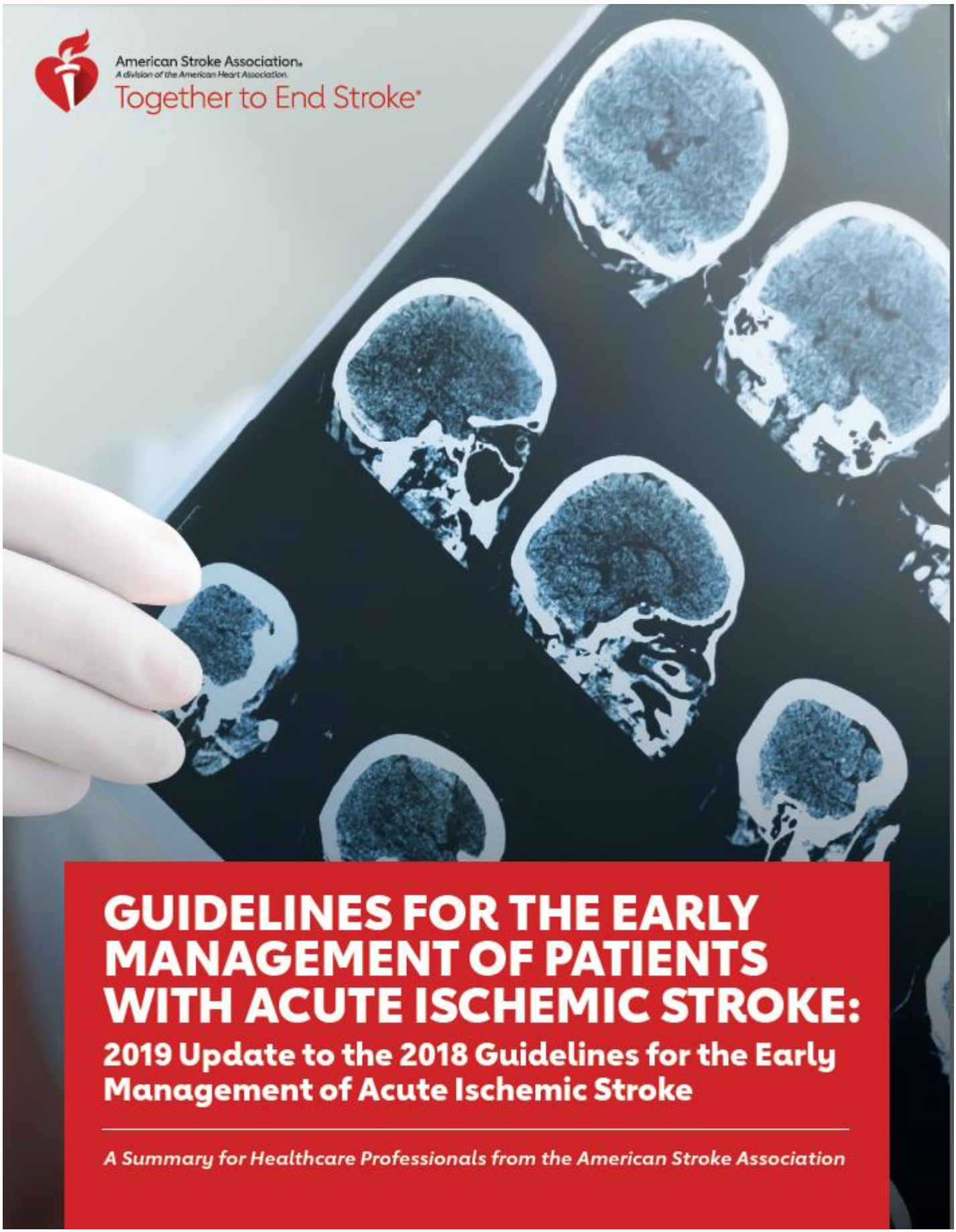
RE: Stroke Admissions Protocol

Dear all,

Please use the appropriate stroke order set when admitting any stroke or potential stroke patient. These order sets are developed to meet all core measures and quality metrics.

For patients admitted with acute ischemic stroke/TIA, stroke-like symptoms, stroke rule-outs, or hemorrhagic strokes (non-traumatic), please use the appropriate admission order set below:

- Ischemic Stroke/TIA without Thrombolytic Therapy
- Ischemic Stroke with Thrombolytic Admission
- Hemorrhagic Stroke Admission



GUIDELINES FOR THE EARLY MANAGEMENT OF PATIENTS WITH ACUTE ISCHEMIC STROKE:

2019 Update to the 2018 Guidelines for the Early Management of Acute Ischemic Stroke

A Summary for Healthcare Professionals from the American Stroke Association

KEY TAKEAWAYS

The 2019 guideline updates the 2018 acute ischemic stroke (AIS) guideline with content based on recent clinical trials and clarifies previous recommendations. The guideline is a comprehensive one, addressing AIS management from acute symptoms onset in the prehospital phase through two weeks post-acute stroke. It provides guidance on which patients are eligible to receive IV alteplase, mechanical thrombectomy and other care to reduce long-term morbidity. This summary focuses on recommendations related to the diagnosis of acute ischemic stroke and its treatment with IV alteplase and/or mechanical thrombectomy.

- IV alteplase within 4.5 hours of stroke onset remains the standard of care for most ischemic stroke patients, providing the opportunity for more favorable outcomes. Patients eligible for IV alteplase should receive it, even if mechanical thrombectomy is being considered.
- Mechanical thrombectomy evaluation and treatment should occur as rapidly as possible to ensure the treatment of as many eligible patients as possible.
- Mechanical thrombectomy is recommended within 16 hours and reasonable up to 24 hours in selected patients with AIS with large vessel occlusion in the anterior circulation greater than 6 hours from symptom onset who meet certain advanced imaging criteria.
- The benefits of both IV alteplase and mechanical thrombectomy are time dependent. The earlier the treatment within the time window, the greater the benefit to patients.

Regional systems of early stroke care should be developed that coordinate first-contact services with local and regional hospitals to achieve minimum delay time from symptom onset to definitive treatment.

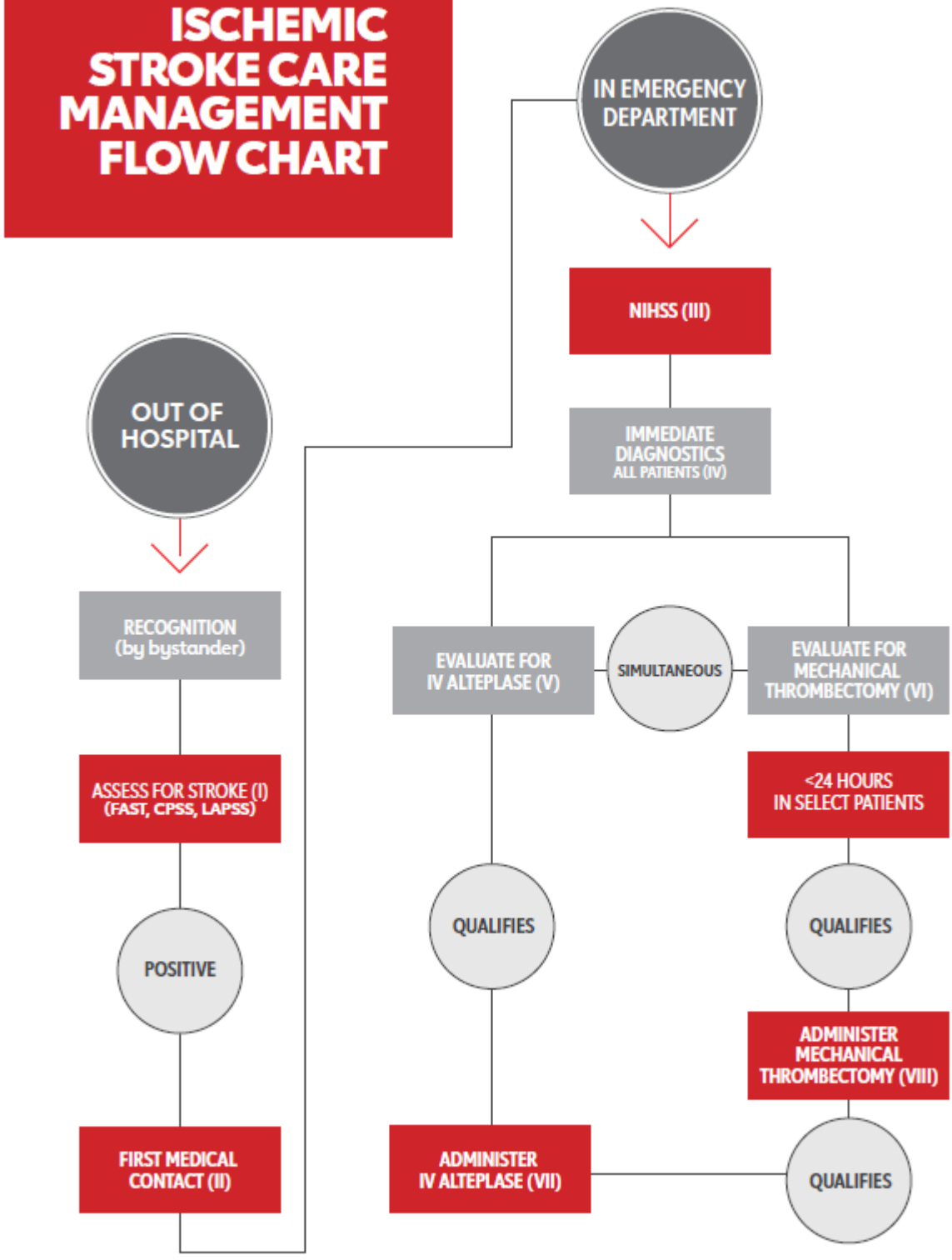
- Recommend brain imaging studies, in most cases non-contrast computed tomography (CT), be performed as quickly as possible for patients who may be candidates for IV alteplase and/or mechanical thrombectomy.
- Time from symptom onset to IV alteplase should be as short as possible and never more than 4.5 hours.
- Time from first stroke symptom to mechanical thrombectomy should be as quickly as possible within up to 24 hours in select patients.
- To achieve expedited care, public awareness of the signs of stroke and importance of calling 9-1-1 immediately by the community is needed.[1]

The path to achieve these goals is represented in the flow chart on the next page

PLEASE REFER TO THE FULL GUIDELINES, AVAILABLE AT STROKE.ORG/AISTOOLKIT, FOR MORE DETAIL ON SPECIFIC RECOMMENDATIONS.

REFERENCES: 1. Guidelines for the Early Management of Patients with Acute Ischemic Stroke: 2019 Update to the 2018 Guidelines for the Early Management of Acute Ischemic Stroke: A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association. 2. Modi_ed from Kothari RU, Pancioli A, Liu T, Brott T, Broderick J. Cincinnati Prehospital Stroke Scale: reproducibility and validity. Ann Emerg Med. 1999;33:373-378. With permission from Elsevier. http://www.strokeassociation.org/idc/groups/stroke-public/@private/@wcm/@hcm/@gwtg/documents/downloadable/ucm_428607.pdf 3. Summer D, Leonard A, Wentworth D, et al. Comprehensive Overview of Nursing and Interdisciplinary Care of the Acute Ischemic Stroke Patient. Stroke 2009;40;2911-2944.

EARLY ACUTE ISCHEMIC STROKE CARE MANAGEMENT FLOW CHART



PLEASE REFER TO THE FULL GUIDELINES, AVAILABLE AT STROKE.ORG/AISTOOLKIT, FOR MORE DETAIL ON SPECIFIC RECOMMENDATIONS.

TEXT COPY FOR NUMBERED SECTIONS OF THE FLOW CHART

EMS Team to identify if there is evidence of an Acute Ischemic Stroke

I Assess for stroke using a validated screening tool, such as F.A.S.T., Cincinnati Prehospital Stroke Scale, or Los Angeles Prehospital Stroke Screen[3]

F	A	S	T
Face Drooping	Arm Weakness	Speech Difficulty	Time to Call 911

**also note time of day - hour and minute*

II First Medical Contact (EMS Provider)[1] – Assess and manage ABCs (airway, breathing, circulation)

- Check and monitor blood pressure, but do not treat
- Initiate cardiac monitoring
- Provide supplemental oxygen to maintain O2 saturation > 94%
- Establish IV access
- Determine blood glucose and treat accordingly
- Determine time of symptom onset or last known normal, and obtain family contact information, preferably a cell phone
- Triage and rapidly transport patient to the closest healthcare facility able to administer IV alteplase
- Notify hospital of pending stroke patient arrival
- For patients who are not eligible for IV thrombolysis and have a strong probability of large vessel occlusion (LVO) stroke, follow procedures that should be established to transport patient to the closest healthcare facility able to perform mechanical thrombectomy

III NIHSS in Emergency Department

IV Immediate Diagnostics[1]

- Brain imaging study as quickly as possible. In most cases, noncontrast computed tomography (NCTT) will provide the necessary information
- Blood glucose level (only the assessment of blood glucose must precede the initiation of IV alteplase in all patients)
- Oxygen saturation
- Platelet count
- Markers of cardiac ischemia
- Prothrombin time (PT)/INR
- Activated partial thromboplastin time (aPTT)
- ECG

Immediate Diagnostics – Select Patients[1]

- For patients who otherwise meet criteria for mechanical thrombectomy, a noninvasive intracranial vascular study is recommended during the initial imaging evaluation of the acute stroke patient but should not delay administration of IV alteplase if indicated

TEXT COPY FOR NUMBERED SECTIONS OF THE FLOW CHART: *Continued*

V IV alteplase eligibility[1]

Indications (Class I Recommendations -- Recommended Care)

- **If within 3 hours of onset and:**
  - ≥ 18 years of age
  - Severe stroke
  - Mild but disabling stroke
- **If 3–4.5 hours from onset,18–80 years of age, and:**
  - Without a history of both diabetes mellitus and prior stroke
  - NIHSS score ≤25
  - Not taking any OACs
  - Without imaging evidence of ischemic injury involving more than one third of the MCA territory
- **If BP can be lowered safely and maintained < 185/110 mm Hg**
- **With blood glucose > 50 mg/dL**
- **With mild to moderate early ischemic changes on NCCT**
- **With antiplatelet drug monotherapy or combination therapy**
- **With end stage renal disease with normal aPTT**

Additional Recommendations (Class IIa and IIb).

Situations requiring individual patient risk benefit assessment for which administration of IV alteplase may be considered

- **If 3–4.5 hours from onset**
  - >80 years of age (COR IIa)
  - Both prior stroke and diabetes mellitus (COR IIb)
  - Mild but disabling stroke (COR IIb)
  - NIHSS > 25 (COR IIb)
- **Pre-existing disability (mRS ≥ 2 COR IIb)**
- **Pre-existing dementia (COR IIb)**
- **Moderate to severe ischemic stroke with early improvement but remain moderately impaired and potentially disabled (COR IIa)**
- **Seizure at the time of onset, if evidence suggests that residual impairments are secondary to stroke (COR IIa)**
- **Initial blood glucose levels <50 or >400 mg/dL that are subsequently normalized (COR IIb)**
- **Clinical history of potential bleeding diathesis or coagulopathy (COR IIb)**
- **History of warfarin use and an INR ≤1.7 or a PT <15 s (COR IIb)**
- **Lumbar dural puncture in the preceding 7 days (COR IIb)**
- **Arterial puncture of a noncompressible blood vessel in the preceding 7 days (COR IIb)**
- **Recent major trauma (within 14 days) not involving the head (COR IIb)**
- **Major surgery in the preceding 14 days (COR IIb)**
- **History of gastrointestinal or genitourinary bleeding (>21 days) (COR IIb)**
- **Women who are menstruating and do not have a history of menorrhagia (COR IIa)**
- **Women with recent or active history of menorrhagia without clinically significant anemia or hypotension (COR IIb)**
- **Recent or active vaginal bleeding causing clinically significant anemia (after emergency consultation with a gynecologist) (COR IIa)**
- **Extracranial cervical arterial dissection (COR IIa)**
- **Intracranial arterial dissection (COR IIb)**
- **Small or moderately-sized unruptured and unsecured intracranial aneurysm (COR IIa)**
- **Giant unruptured and unsecured intracranial aneurysm (COR IIb)**
- **Unruptured and untreated intracranial vascular malformation, if high likelihood of morbidity and mortality outweigh the anticipated risk of ICH (COR IIb)**
- **Small number of cerebral microbleeds (CMBs) demonstrated on MRI (COR IIa)**

TEXT COPY FOR NUMBERED SECTIONS OF THE FLOW CHART: *Continued*

- Previously high burden of CMBs (>10) demonstrated on MRI if there is potential for substantial benefit (COR IIb)
- Extra-axial intracranial neoplasm (COR IIb)
- Concurrent acute MI, followed by percutaneous coronary angioplasty and stenting if indicated (COR IIa)
- MI in the past 3 months: Non-STEMI or STEMI involving the right or inferior myocardium. (COR IIa)
- MI in the past 3 months: STEMI involving the left anterior myocardium (COR IIb)
- Major AIS likely to produce severe disability and acute pericarditis (COR IIb), after urgent consultation with cardiologist
- Moderate AIS likely to produce mild disability and acute pericarditis (COR IIb)
- Major or moderate AIS likely to produce severe or mild disability and known left atrial or ventricular thrombus (COR IIb)
- Major AIS likely to produce severe disability and cardiac myxoma or papillary fibroelastoma (COR IIb)
- AIS due to complications of cardiac or cerebral angiographic procedures (COR IIa)
- Systemic malignancy and >6 month life expectancy in the absence of other contraindications (COR IIb)
- Pregnancy, when anticipated benefits of treating severe or moderate stroke outweigh increased risk of uterine bleeding (COR IIb)
- Early postpartum period (<14 days after delivery) (COR IIb)
- History of diabetic hemorrhagic retinopathy or other hemorrhagic ophthalmic conditions but potential increased risk of visual loss should be weighed against anticipated benefits (COR IIa)
- Sickle cell disease in adults (COR IIa)
- Hyperdense middle cerebral artery sign (COR IIa)
- Illicit drug use (COR IIa)
- Stroke mimics (COR IIa)

Contraindications (Class III -- Harm)

- CT reveals an acute intracranial hemorrhage
- CT brain imaging exhibits extensive regions of clear hypoattenuation
- Prior ischemic stroke within 3 months
- Recent severe head trauma within 3 months
- Acute head trauma (Posttraumatic infarction that occurs during the acute in-hospital phase)
- Intracranial/spinal surgery within the prior 3 months
- History of intracranial hemorrhage
- Symptoms and signs most consistent with an subarachnoid hemorrhage
- Structural GI malignancy
- Gastrointestinal bleeding event within 21 days
- Platelets <100 000/mm3
- INR >1.7
- aPTT >40 s
- PT >15 s
- Treatment dose of LMWH within the previous 24 hours
- Taking direct thrombin inhibitors or direct factor Xa inhibitors unless laboratory tests are normal or the patient has not received a dose of these agents for >48 hours (assuming normal renal metabolizing function)
- Symptoms consistent with infective endocarditis
- Known or suspected to be associated with aortic arch dissection
- Intra-axial intracranial neoplasm

Contraindications (Class III -- No Benefit)

- Otherwise eligible patients with mild but nondisabling stroke

TEXT COPY FOR NUMBERED SECTIONS OF THE FLOW CHART: *Continued*

VI Evaluate for Mechanical Thrombectomy (< 24 hours)[1]

- Evaluation for IV alteplase and evaluation for mechanical thrombectomy happens simultaneously
- Within 6 hours:
  - Prestroke mRS score 0–1
  - Causative occlusion of the ICA or proximal MCA (M1)
  - Age ≥18 years
  - NIHSS score of ≥6
  - ASPECTS of ≥6
  - Within 6-24 hours
  - Causative occlusion of the ICA or M1
  - Meets eligibility criteria for DAWN or DEFUSE3 trials

VII Administer IV alteplase[1]

- Infuse 0.9 mg/kg (maximum dose 90 mg) over 60 minutes, with 10% of the dose given as a bolus over 1 minute
- IV alteplase remains the recommended therapy, but it may be reasonable to choose tenecteplase (single IV bolus of 0.25-mg/kg, maximum 25 mg) over IV alteplase in patients without contraindications for IV fibrinolysis who are also eligible to undergo mechanical thrombectomy
- Admit the patient to an intensive care or stroke unit for monitoring for at least 24 hours
- If the patient develops severe headache, acute hypertension, nausea, or vomiting or has a worsening neurological examination, discontinue the infusion (if IV alteplase is being administered) and obtain emergent CT scan
- Measure BP and perform neurological assessments every 15 minutes during and after IV alteplase infusion for 2 hours, then every 30 minutes for 6 hours, then every hour until 24 hours after IV alteplase treatment
- Increase the frequency of BP measurements if systolic BP is >180 mm Hg or if diastolic BP is >105 mm Hg. Administer antihypertensive medications to maintain blood pressure at or below these levels
- Abciximab should not be administered concurrently with IV alteplase
- IV aspirin should not be given within 90 minutes after the start of IV alteplase
- The efficacy of IV glycoprotein IIb/IIIa inhibitors tirofiban and eptifibatide coadministered with IV alteplase is not well established (COR IIb)
- Delay placement of nasogastric tubes, indwelling bladder catheters, or intra-arterial pressure catheters if the patient can be safely managed without them
- Obtain a follow-up CT or MRI scan at 24 hours after IV alteplase before starting anticoagulants or antiplatelet agents

VIII Administer Mechanical Thrombectomy[1]

- Stent retrievers remain the recommended choice of device for mechanical thrombectomy. The use of other devices as first line may be reasonable in some circumstances. The use of a proximal balloon guide catheter or a large-bore distal-access catheter, rather than a cervical guide catheter alone, in conjunction with stent retrievers may be beneficial
- In patients who undergo mechanical thrombectomy, it is reasonable to maintain blood pressure ≤180/105 during and for 24 hours after the procedure

American Stroke Association.
A division of the American Heart Association.
Together to End Stroke®

For more information visit:
stroke.org/AISToolkit

IP Sepsis

Early Management Bundle, Severe Sepsis/Septic Shock - This measure includes the following components:

- Contraindications to care
- Initial lactate level, repeat lactate
- Blood cultures drawn and appropriate antibiotics administered within the specified timeframe
- Documentation of septic shock
- Hypotension-fluid resuscitation, vasopressors and documentation of vital signs
- Cardiopulmonary evaluation
- Capillary refill examination
- Peripheral pulse evaluation
- Skin examination
- Central venous pressure measurement
- Cardiovascular ultrasound performed
- Passive leg raise exam
- Fluid challenge

These measures have specific timeframes attached. Please refer to the Sepsis Pocket Card Reference.

IP Perinatal Care

- Early Elective Delivery Prior to 39 weeks, either Vaginal or Operative, without a Medical Indication
- Cesarean Section-Nulliparous Term Singleton Vertex only-rate based
- Exclusive Breast Milk Feeding during Newborn's Entire Hospitalization-rate based
- Percentage of infants with unexpected newborn complications among full-term newborns with no pre-existing conditions.

IP Emergency Department

- Time from ED Arrival to ED Departure for Admitted Patients
- Decision to Admit Time to ED Departure for Admitted Patients

IP Immunization

- Influenza Vaccination overall rate (March-October)

Outpatient Measures

OP Chest Pain/OP AMI

- ASA on Arrival or document reason why not
- Median Time to ECG

OP ED Throughput

- Median Time from ED Arrival to ED Departure for Discharged ED Patients
- Door to Diagnostic Evaluation by Qualified Medical Personnel

OP Stroke

- Head CT or MRI Scan Interpretation within 45 Minutes of ED Arrival for Acute Ischemic Stroke/Hemorrhagic Stroke Patients
- NIHSS within 12 hours of arrival

Cardiology Measures

AMI Metrics:

- Door to balloon timer for STEMI <90 minutes
- Aspirin within 24 hours of arrival
- LVF documentation or plan for assessment after discharge
- If EF <40%, prescribed ACEI/ARB or Entresto if appropriate, document any contraindications
- Aspirin & Beta blocker prescribed at discharge
- High intensity statin* prescribed at discharge if <= 75 years, and no contraindications
- Moderate-intensity statin* if >75 with contraindication/intolerance to high-intensity statin documented
- P2Y12 inhibitor prescribed at discharge, including medical treatment only NSTEMIs
- Aldosterone antagonist for patients with EF < 40% with history of HF or Diabetes
- Cardiac Rehab

Cath PCI Metrics:

- Door to balloon timer for STEMI < 90 minutes
- Aspirin at discharge
- High-intensity statin* prescribed at discharge if <=75 years and no contraindications
- Moderate-intensity statin* if >75 with contraindication/intolerance to high-intensity statin documented
- P2Y12 inhibitor prescribed at discharge
- Pre and post procedure creatinine
- Cardiac rehab

***High-Intensity statins include:**

- **Atorvastatin 40-80mg**
- **Rosuvastatin 20-40mg**

***Moderate-Intensity statins include:**

- **Atorvastatin 10-20mg**
- **Rosuvastatin 5-10mg**
- **Simvastatin 20-40mg**
- **Pravastatin 40-8-mg**
- **Pitavastatin 2-4mg**

Extra Information

Ejection Fraction *– Discharge diagnosis of STEMI or NSTEMI:*

Documentation of LVEF performed during **this stay** is required. If echo is planned for after discharge, please document as such.

Heart Failure

If you document any kind of acute heart failure, please document the **NYHA classification**.

Cardiac Rehabilitation Referral is Indicated for:

- STEMI/NSTEMI patients (with PCI and those with medical treatment only)
- PCI only patients

Must be referred to an outpatient Cardiac Rehabilitation program. Documentation of medical reason or patient-oriented reason for **not providing** a cardiac rehabilitation referral is required.

Lab Values

- Creatinine level reported is immediately prior to PCI, and the **highest** level within 5 days after intervention.
- Hemoglobin level reported is immediately prior to PCI, and the **lowest** level within 3 days after intervention.

For Procedure Providers

- Document **EF** or best description of LV function – normal, fair, mildly reduced, moderately reduced, or severely reduced
- Document **TIMI** flow pre and post intervention
- Document **lesion length**
- Document **residual stenosis** after treatment

***Questions about the Cardiology Registries?**
Contact: Quality Department
Laura Taylor x4155
LaShaun Vetzel x4020

eCQMs

eCQMs (electronic Clinical Quality Measures) are Quality Measures in an electronic format. Quality Measures were previously exclusively manually abstracted-that is, abstractors read through the entire chart and gathered information to "meet the measures." As healthcare requirements change and technology improves, we will be transitioning into electronically extracting the needed information. This transition will take years to fully implement; however, we completed our first successful electronic submission in early 2017. We have continued to submit the required eCQMs on a yearly basis since then. We will be submitting two quarters of data for the first time in 2021.

SGMC

Discharge Medications and Referrals

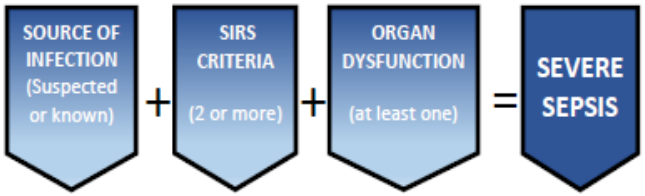
No exclusions unless contraindicated

RX at DC	AMI (STEMI/ NSTEMI)	PCI Includes balloon and/or Stent	ICD
Aspirin	✓	✓	
P2Y12 (i.e., Plavix, Effient, Brilinta	✓	✓	
Statin	✓	✓	
Beta Blocker	✓		✓ If EF<40% or has hx of prior MI
ACE/ARB or Entresto for LVSD (EF< 40%)	✓	✓	✓
Aldosterone Antagonist for LVSD (EF< 40%)	✓ With Hx of CHF or DM		
Cardiac Rehab Referral	✓	✓	

Documentation of NSTEMIs vs. Type 2 MI

Category	Etiology of myocardial injury	Management	Suggested documentation	ICD-10 codes
Type 1 NSTEMI	Acute coronary plaque rupture / erosion	IV heparin, early cath/PCI	Type 1 NSTEMI or simply "NSTEMI"	I 21.4
Type 2 MI	Ischemic imbalance due to supply / demand mismatch	Treat underlying cause. IV Heparin, antiplatelet agents, cath/PCI often not indicated and may even be harmful.	"Type 2 MI due to [underlying cause]" (See below)	Code underlying cause as primary diagnosis; code I21.A1 (Type 2 MI) as **secondary** diagnosis
Non-MI troponin elevation	Non-ischemic mechanism		"Non-MI troponin elevation due to [underlying cause]"	Code underlying cause as primary diagnosis; code R78.89 (abnormal chemistry) as **secondary** diagnosis

Underlying causes of Type 2 MI	Underlying causes of Non-MI troponin elevation
Cardiac causes such as: • Tachyarrhythmias (Afib w/RVR, SVT, VT) • Bradyarrhythmias • Severe aortic valve disease • Hypertrophic cardiomyopathy • Aortic dissection • Coronary vasospasm • Coronary embolism • Coronary vasculitis • Coronary endothelial dysfunction	Cardiac causes such as: • Tachyarrhythmias • Acute heart failure • Stress cardiomyopathy • Myocarditis • Pericarditis • Endocarditis
Systemic causes such as: • Hypertensive crisis • Shock • Acute hypoxia (as in COPD exacerbation) • Severe anemia • Non-cardiac surgery	Systemic causes such as: • Hypertensive crisis • Pulmonary embolism • Sepsis • Renal failure/ESRD • Rhabdomyolysis • DKA



SEVERE SEPSIS

Note: All 3 above must be met and documented by the MD/NP/PA within 6 hours of each other

SIRS Criteria	
Temp > 100.9 F	WBC > 12,000
Temp < 96.8 F	WBC < 4,000
HR > 90	Bands > 10%
Resp > 20	

Organ Dysfunction	
SBP < 90	UOP < 0.5 ml/kg/hr for 2hrs
MAP < 65	Bilirubin > 2.0
SBP decrease > 40	Platelets < 100,000
Lactate > 2	INR > 1.5 or PTT > 60 secs
Creatinine > 2.0	New intub/bipap for resp failure

Note: If organ dysfunction is due to preexisting condition, it **must be documented** by the provider.

Example: Patient's creatinine is 4.0 due to history of ESRD.

Severe Sepsis Presentation Time:

- The time at which the last criteria (listed above) is met OR
- Triage time if patient presents to ED and meets all criteria on arrival OR
- The time the MD/NP/PA documents Severe Sepsis or Septic Shock…even if all other criteria is not met.
- **Begins 3 and 6 hour windows of care.**

Within 3 hours

- **Obtain lactate level**
- **Blood Cultures before antibiotics**
- **Antibiotic administration per CMS guidelines**

Within 6 hours

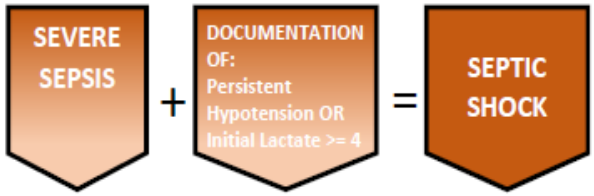
- **Obtain repeat lactate level if the initial lactate was > 2.0**

Crystalloid Fluid Administration

Crystalloid fluids must be given prior to, at the time of, or after presentation of 1 of the following: Initial hypotension (SBP < 90, MAP <65, or decrease in SBP > 40 documented by a provider), initial lactate >= 4, or documentation of septic shock. **Quantity must at least be 30ml/kg.**

Palliative Care/Comfort Measures Acceptable Terms		
Comfort Care	End of life care	Palliative Care
Comfort measures	Hospice	Terminal Care
Comfort only	Hospice Care	Withdraw Care

Must be documented within 3 hours of severe sepsis presentation time.



SEPTIC SHOCK

Persistent Hypotension within the hour following the conclusion of the crystalloid fluid administration of 30 ml/kg is evidenced by 2 consecutive documented recordings of:

- SBP < 90 or
- MAP < 65 or
- Decrease in SPB by > 40 documented by the MD/NP/PA as being related to infection, severe sepsis, or septic shock

Septic Shock Presentation Time:

- The time at which the last criteria (listed above) is met OR
- Triage time if patient presents to ED and meets all criteria OR
- The time the MD/NP/PA documents Severe Sepsis or Septic Shock…even if all other criteria is not met.
- **Begins 3 and 6 hour windows of care.**

Within 3 hours

- **Obtain lactate level**
- **Blood Cultures before antibiotics**
- **Antibiotic administration per CMS guidelines**

Within 6 hours

- **Administer Vasopressors per CMS guidelines for persistent hypotension within 1 hour following IV crystalloid fluids of 30 ml/kg**
- **Document repeat assessment of fluid status and tissue perfusion to include all of the following:**
  - Vital Signs (must include T, P, R, and BP)
  - Cardiopulmonary exam with reference to both heart and lungs
  - Capillary refill exam
  - Peripheral pulse evaluation with reference to location
  - Skin exam with reference to color
- **In lieu of above 5 step assessment, ANY TWO of the following are required:**
  - CVP measurement
  - Central Venous Oxygen measurement
  - Bedside CV ultrasound (Echo, TEE, Doppler Echo)
  - Passive leg raise exam performed by the MD/NP/PA
  - Fluid Challenge performed after crystalloid administration completed

Sepsis Antibiotic MONOTHERAPY Any on this list may be used alone
Avelox (Moxifloxacin)
Avycaz (Ceftazidime/avibactam)
Claforan (Cefotaxime)
Doribax
Doripenem
Ertapenem
Fortaz (Ceftazidime)
Primaxin (Imipenem/Cilastatin)
Invanz (Ertapenem)
Levaquin (Levofloxacin)
Maxipime (Cefepime)
Merrem (Meropenem)
Rocephin (Ceftriaxone)
Teflaro (Ceftaroline fosamil)
Timentin (Ticarcillin/clavulanate)
Unasyn (Ampicillin/sulbactam)
Zerbaxa (Ceftolozane/tazobactam)
Zosyn (Piperacillin/tazobactam)

Sepsis Antibiotic COMBINATION THERAPY
ONE FROM COLUMN A + ONE FROM COLUMN B

COLUMN A	COLUMN B	
Aminoglycoside (Gentamicin)	Cephalosporins 1st-2nd gen (Ancef)	
or	Clindamycin (Cleocin) IV	or
Aztreonam (Azactam)	Daptomycin (Cubicin)	or
or	Glycopeptides (Vancomycin)	or
Ciprofloxacin (Cipro)	Linezolid (Zyvox)	or
	Macrolides (Zithromax)	or
	Penicillins (Ampicillin)	

Sepsis VASOPRESSORS	
Norepinephrine	Levophed
Epinephrine	Adrenalin
Phenylephrine	Neosynephrine
Dopamine	Inotropin
Vasopressin	Pitressin

Please contact Quality Improvement/Patient Safety at x4015 for questions or assistance with Quality Measures.

Joint Commission Stroke Quality Measures

Venous Thromboembolism (VTE) Prophylaxis

Must be given by the end of inpatient hospital day 2 or have a reason documented why not indicated by the end of inpatient hospital day 2.

Examples of VTE Prophylaxis:
Heparin SQ, Xarelto, Eliquis, Lovenox, Coumadin, Sequential Compression Devices (SCDs)

Examples of exclusionary documentation:
"No VTE prophylaxis due to patient low risk for VTE, ambulating"
"No VTE prophylaxis due to bleeding, no pharmacologic prophylaxis, no mechanical prophylaxis"

Discharged on Antithrombotic Therapy

Must be discharged on an antithrombotic or have reason documented why not indicated.

Examples of Antithrombotics:
Aspirin, Aggrenox, Plavix, Eliquis, Pradaxa, Arixtra, Full dose Heparin , Xarelto, Coumadin

Examples of exclusionary documentation:
"No antithrombotic due to thrombocytopenia."
"No anticoagulation due to risk of bleeding."

Stroke Education

Patient and/or caregiver must have received written instructions/educational materials that address the following 5:

1. Risk Factors for Stroke
2. Stroke Warning Signs and Symptoms
3. How to activate EMS for stroke
4. Their prescribed medications

**Please note that what is ordered/prescribed at discharge by the Physician must match what the nurse lists on the patients discharge instruction form as well as the discharge summary's list of discharge medications. Also, make sure that ALL medications (i.e. over the counter, prescriptions, home medications) that the patient is to take after discharge are listed on the discharge medication reconciliation.

5. Follow up with Physician

Stroke/TIA patients are given stroke education by the stroke team and/or staff nurse. It is also listed on the printed instructions that is given to the patient and/or family at discharge.

IV Thrombolytic Therapy

1. If IV t-PA is not given, must have documented reason why not by end of hospital day 2.
2. If IV t-PA is administered > 60 minutes after arrival, must have documented reason for the delay by end of hospital day 2.

"No IV t-PA due to:

- Delay in arrival
- Unknown Last Known Well
- Seizures
- Symptoms too mild
- Rapid improvement
- Severe Stroke, NIHSS>25
- History of previous ICH
- Elevated BP despite treatment

Examples of exclusionary documentation:
"Delay in administering IV t-PA due to patient and/or family providing consent."
"IV t-PA administered > 60 minutes due to care team unable to determine eligibility."

Assess for Rehabilitation

Documentation that the patient was assessed for and/or received rehabilitation services during this hospitalization or have a reason documented why not indicated.

Example (can be dictated in a note or listed in orders):
"Patient assessed for rehabilitation."

Examples of exclusionary documentation:
"Not assessed for rehab services due to patient returning to prior level of function, rehabilitation not indicated at this time."
"Patient not assessed for rehab services due to being unable to tolerate rehabilitation therapeutic regimen."
"Not assessed for rehab services due to patient/family refusal."

Anticoagulation Therapy for Atrial Fibrillation - Atrial Flutter

For current or past history of Atrial Fib/Flutter, must be discharged on an anticoagulant or have a reason documented why not indicated.

Examples of exclusionary documentation:
"No anticoagulation due to risk of bleeding."
"No anticoagulation due to high risk for falls."

Discharged on Statin Medication

Must be discharged on a statin medication if LDL>70 or have a documented reason why not indicated.
Please note that "Intensive statins" are recommended by AHA/ASA and because we are a Primary Stroke Center.

Approved Intensive Statins:

- Atorvastatin (Lipitor) 40 mg or 80 mg total daily dose
- Rosuvastatin (Crestor) 20 mg or 40 mg total daily dose
- Simvastatin (Zocor or generic) 80 mg total daily dose*
- Simvastatin/Ezetimibe (Vytorin) 10/80 mg dose*

Examples of exclusionary documentation:
"No statin at discharge due to past intolerance."
"No statin at discharge due to elevated liver enzymes."

Acceptable reasons for not prescribing an intensive statin at discharge:
"No intensive statin therapy at discharge is indicated because the patient is presently achieving target LDL or LDL<100 spontaneously or by medical therapy."
"No intensive statin therapy at discharge is indicated because the patient has no evidence of atherosclerosis."
"No intensive statin therapy at discharge is indicated because the patient has presence of hypertriglyceridemia that warrants treatment with an alternative lipid lowering agent such as a fibrate."

Antithrombotic Therapy by End of Hospital Day 2

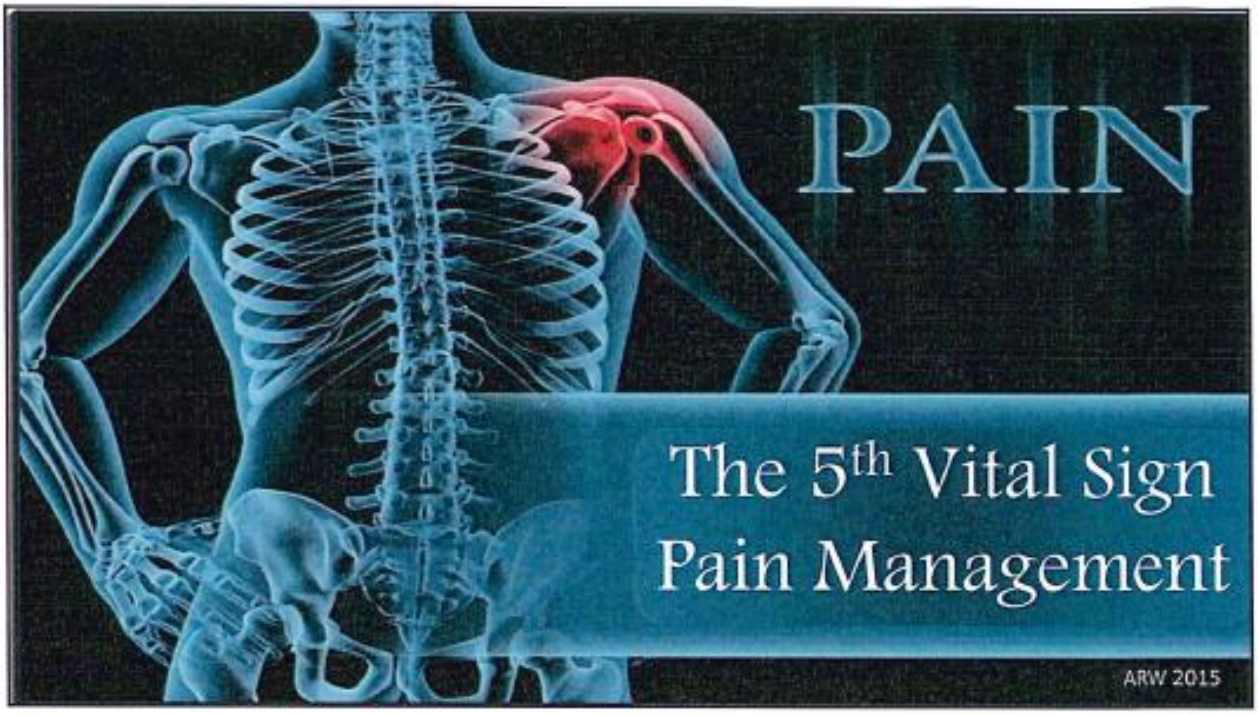
Must be given by end of hospital day 2 or have a reason documented why not indicated by the end of hospital day 2.

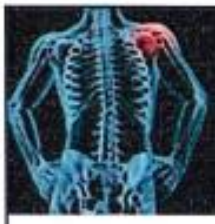
Examples:
Aspirin, Plavix, Heparin IV, Coumadin, Arixtra, Eliquis, Pradaxa, Lovenox

Examples of exclusionary documentation:
"No antithrombotic due to risk of bleeding."
"No antithrombotic due to thrombocytopenia."

Please use the appropriate Stroke iform when admitting a possible or actual Stroke/TIA patient to ensure that all needed orders are placed to help ensure compliance with Stroke Quality/Core Measures.

Contact Peggy Hart, RN, Quality Improvement Specialist at 259-4090 for questions or concerns.





OBJECTIVES:

Recognize

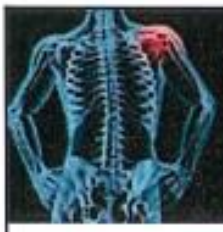
- Patients have the right to pain management.

Screen

- Patients should be screened for pain during initial assessment and when clinically required, during ongoing, periodic reassessment.

Educate

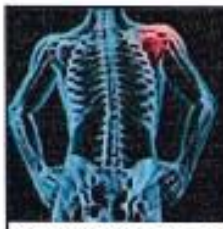
- Educate the patient suffering from pain, and their families about pain management.



UNRELIEVED PAIN

When the patient's pain is not relieved, the patient has an increased risk of the following.

Consequences of Unrelieved Pain	
✓ Poor Sleep	✓ Anxiety
✓ Reduced Mobility	✓ Poor Concentration
✓ Immune impairment/susceptibility to disease	✓ Impaired Relationships
✓ Chronic Pain	✓ Unplanned readmission
✓ Depression	✓ Unnecessary readmission
✓ Longer stays	✓ Increased outpatient visits

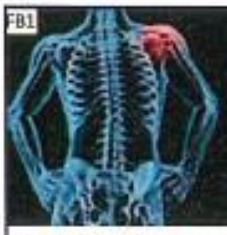


PAIN SCREENING

SGMC Policy is to do the following.

1. Conduct an appropriate assessment and/or reassessment of a patient's pain consistent with the scope of care, treatment, and service provided in the specific care setting in which the patient is being managed.

Care Setting	Initial Pain Assessment Screen	Routine Pain Reassessment Screen
Inpatient Care Settings	• Within 12 hours of admission.	• No less frequently than the minimum requirement for taking vital signs.
Emergency Department	• During the triage or initial assessment.	• At the time of discharge or transfer if pain was present.
Operative & Invasive Procedure Areas	• During pre-procedure assessment.	• Post procedure assessment no less frequently than the minimum requirement for taking vital signs.
Recurrent Outpatient Care Settings	• On establishment of care (first visit).	• At the conclusion of visit if pain issues were identified.



PAIN SCREENING

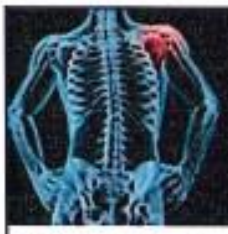
SGMC Policy is to do the following:

2. Require that methods used to assess a patient's pain are consistent with the patient's age, condition, and ability to understand.

The various pain scales available for use are.

- ❑ Wong-Baker Face Pain Rating Scale (English & Spanish)
- ❑ Nonverbal Pain Scale
- ❑ FLACC Scale for use with children
- ❑ NIPS Scale for use with neonates/infants
- ❑ Comparative Pain Scale
- ❑ Pain Assessment in Advanced Dementia (PAINAD) Scale

The nurse is responsible for choosing the correct scale based upon the age and condition of the patient as well as the patient's ability to understand. Please refer to the Pain Policy for specific tool examples.



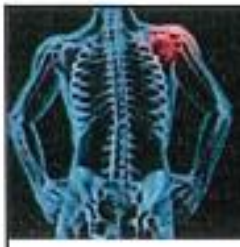
PAIN SCREENING

SGMC Policy is to do the following:

3. Treat the patient's pain or refer the patient for treatment.

Locate, read and be knowledgeable about the treatment of pain for the specific area you work in.

Inpatient Care Settings	Emergency Department
✓ Inpatients should receive treatment for any active pain issue (acute or chronic), when intensity exceeds their acceptable level.	✓ ED patients shall receive treatment for acute pain related to their chief complaint or presenting condition when intensity exceeds their acceptable level.
✓ Treatment shall be consistent with the patient's clinical presentation and objective findings.	✓ It is not within the scope of service in the ED to treat chronic pain conditions. Patients may be treated for acute exacerbation of chronic pain, but otherwise should be referred to an appropriate setting for treatment.
✓ The treatment modality selected shall be appropriate for the patient's needs. Treatment is to be provided in a timely manner.	

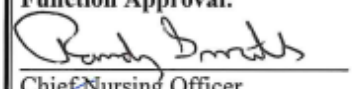
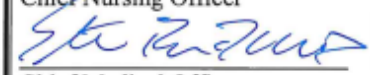


PAIN SCREENING

Operative & Invasive Procedure Settings	Recurrent Outpatient Care Settings (Primary Care Center, Infusion Centers Wellness Center etc.)

- ✓ These patients shall receive treatment for acute pain related to their chief complaint or presenting condition exceeds their acceptable level.
- ✓ It is not within the scope of service in these settings to treat chronic pain (unless specifically noted in the settings defined scope of service-e.g. pain clinic).
- ✓ Patients may be treated for acute exacerbation of chronic pain, but otherwise should be referred to an appropriate setting for treatment.
- ✓ When provided treatment shall be consistent with the patient's clinical presentation and objective findings. The treatment modality selected shall be appropriate for the patient's needs. Treatment is to be provided in a timely manner.

SOUTH GEORGIA HEALTH SYSTEM
SYSTEM POLICIES AND PROCEDURES

TITLE: Restraint and Seclusion **APPROVALS:** **Function Approval:**  Chief Nursing Officer  Chief Medical Officer  Chief Executive Officer	**FACILITIES:** ☒ SGMC ☒ SGMC Berrien Campus ☒ SGMC Lanier Campus ☐ SGMC Lakeland Villa	**SYSTEM POLICY NUMBER**: 2.006 (SPP 96) **FUNCTION:** ☐ 1.000 Administrative/ Operations ☒ 2.000 Clinical Services ☐ 3.000 Compliance ☐ 4.000 Environment of Care ☐ 5.000 HIPAA ☐ 6.000 Finance ☐ 7.000 Human Resources

PURPOSE

To guide the appropriate and safe management of patients who are restrained and/or in seclusion. To guide on appropriate utilization of alternatives to restrain and/or seclusion, as well as nonphysical interventions.

APPLICATION

This Policy is applicable to the following South Georgia Health System (SGHS) facilities: South Georgia Medical Center (SGMC), SGMC Berrien Campus, and SGMC Lanier Campus.

DEFINITIONS

Licensed Independent Practitioner (LIP) – a Medical Doctor (MD), Doctor of Osteopathy (DO), Psychologist, Psychiatrist, or any other Licensed Independent Practitioner as defined in the Medical Staff Bylaws and applicable state law.

Licensed Nurse – Registered Nurse (RN)

LPN – Licensed Practical Nurse

PCT – Patient Care Tech

Patient Population – Patient population will include any patient who enters the hospital for treatment or services including inpatient and outpatient.

Restraint is –

(A) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or

(B) A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

(C) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

Prolonged Restraint – Patients requiring prolonged use of restraints, as defined below, will undergo an evaluation by members of the treatment team to ensure appropriate alternatives have been considered and that there is a continued need for restraint use.

(A) Restraint used for greater than 72 hours for a non-violent patient. Exception to this is soft wrist restraint used to protect intubated patients.

(B) Restraint used for greater than 24 hours for a violent patient.

SGHS Facilities do not utilize seclusion practices.

Restraint Category

(A) Non-Violent or Non-Self-Destructive – Used to promote healing and improve the patient's well-being.

(B) Violent or Self-Destructive Behavior

i. Emergency measure

ii. Violent and/or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others.

Restraint Method

(A) Physical Restraint – Any manual method physical or mechanical device material or equipment that immobilizes or reduces the ability of a patient to move his/her arms, legs, body or head freely, or prevent the patient from voluntarily exiting the bed.

(B) Chemical Restraint – A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

Exceptions to Restraint Usage

(A) Restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests or to protect the patient from sliding out of bed, or to permit the patient to participate in activities without the risk of physical harm.

(B) Side Rails are not a restraint:
  i. When used to prevent the patient from sliding out of bed for beds with certain therapeutic surfaces, and other beds that have slippery surfaces;
  ii. When used for patients on turning beds for respiratory failure or other treatment modes (sport beds and other rentals for intubated, critically ill patients in the Critical Care Unit);
  iii. When used with gurneys to prevent patients from falling off the gurney;
  iv. When used with patients who are experiencing involuntary movements; or
  v. When used with patients who are not physically capable of getting out of bed regardless of whether side rails are raised or not.

(C) "Freedom" splints, when used as a reminder not to bend the arm on a cognitively intact patient, are not restraints.

(D) Therapeutic holding is not a restraint.

(E) Cribs, high chairs, strollers with straps, and the like are not restraint but commonly accepted baby/infant/child safety devices.

(F) Patients who are recovering from Anesthesia in the Post-Acute Care Unit (PACU) unless the use of restraint extends beyond normal recovery time.

(G) Patients may not be restrained to perform a test or procedure that the patient has refused and has the mental capacity to make medical decisions.

(H) Forensic and correction restrictions used for security purposes, i.e., handcuffs are not restraint.

POLICY

Restraint may only be used to ensure the immediate physical safety of the patient, staff, or others and must be discontinued at the earliest possible time. Alternative and nonphysical interventions are attempted prior to use of restraints.

I. Patients' Rights

All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time. When restraints are deemed necessary, such activity will be undertaken in a manner that protects the patient's health and safety and preserves his/her dignity, rights, and well-being. Restraints will be used for medical necessity only and not as a means of coercion, discipline, or convenience.

  a. Each patient will be respected as an individual.
  b. Staff will monitor and meet the patients' needs while in restraints.
  c. Staff will reassess and encourage release from restraints.
  d. The patient and family will be encouraged to participate in care and receive education as appropriate.
  e. Restraint will be applied and removed by qualified staff authorized to do so, and whose competencies have been validated.

II. Organizational Oversight

SGHS leadership staff, including LIP's, determine and direct the hospital's approach to the use of restraints in the care of patients by:

a. Approving the restraint policy/procedure outlining risks, preventive strategies, effective alternative, criteria for use, education of the patient and family, and the care of the patient in restraints.
b. Providing appropriate staffing for safe and effective use of restraint alternative(s) and restraint(s).
c. Assuring that staff is trained and competent to minimize the use of restraints and to use restraints safely with consideration of the patient's dignity and well-being.
d. Including the restraint reduction plan as part of the organization's performance improvement plan.
e. Refining patient assessment processes to identify earlier the potential risk of dangerous patient behavior and the prevention, when appropriate, of those behaviors.
f. Assuring restraints are used in conformity with all prevailing laws, regulations, and accreditation standards.

PROCEDURE

I. Alternatives to Restraint Use

The use of restraint is limited to those situations for which there is adequate and appropriate clinical justification. Restraints may only be used when less restrictive interventions have been determined to be ineffective to protect the patent and/or others from harm prior to the application of restraints.

II. Assessment and the Decision to Use Restraints

- A patient assessment is completed by the LIP prior to restraint application to determine the justification for the restraint and to select the appropriate restraint.
- Restraint is applied when alternative strategies or less restrictive interventions have been determined to be ineffective to protect the patient or others from harm.
- Restraint use associated with non-violent or non-self-destructive behavior may be indicated only when it directly supports medical healing.
- Assessment of the patient is required prior to administering a restraint. The assessment should include a physical assessment to identify medical problems that may be causing the behavior changes in the patient. The assessment must be documented in the medical record and contain:
    - Rationale for use; and
    - What alternative, less restrictive intervention was considered and/or attempted.

III. Selecting the Least Restrictive Type

The type or technique of restraint used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm.

a. "Freedom" splints are considered a restraint when applied to a patient who cannot readily remove them. They are a restraint when applied on both limbs. They are a restraint when applied to the functioning arm of someone who does not have use of the other arm (for instance, someone with hemiplegia from a stroke).
b. Siderails

Siderails are considered a restraint

i. When used to prevent a patient from getting out of bed; or
ii. When used to create a barrier with other furniture to prevent a patient from voluntarily exiting the bed.

c. Soft limb wrist and/or ankle (1-4 points)
d. Chemical
e. Locking restraints (Intensive Care Units and ED only)

IV. Safe Application of Restraints

- Restraints will be applied correctly and appropriately according to the manufacture's recommendation by competent, trained staff.
- Soft restraint straps will be secured to the bed frame (not side rails, in a slip knot for quick release in an emergency).
- Sharp objects will be kept away from the patient.
- Locking restraint keys will be readily available so that restraints may be released immediately in emergency situations.

V. Restraint Orders

a. Restraint is used in accordance with the order of the physician or other LIP who is responsible for the care of the patient and is authorized to order restraint in accordance with state law.
   i. If the attending physician did not order the restraint, the attending physician (or treating physician) must be consulted as soon as possible.
b. Restraint is only used after the order of the physician or other LIP is entered, unless an emergency situation exists, in which case the order must be entered immediately (i.e. within a few minutes) of the utilization of restraint.
c. Orders for restraints are documented in the electronic health record (EHR) in the patient's chart.
d. All orders are time limited as follows, and restraints must be discontinued at the earliest possible time, regardless of the length of time identified in the order.
e. Orders will not be accepted as a standing order or on an as-needed (PRN) basis. Staff cannot discontinue a restraint intervention, and then re-start it under the same order. A "trial release" constitutes a PRN use of restraint, therefore is not permitted.
   - A temporary, directly-supervised release, however, that occurs for the purpose of caring for a patient's needs (e.g. toileting, feeding, or range of motion exercises) is not considered a discontinuation of the restraint intervention. As long as the patient remains under direct staff supervision, restraint is not considered to be discontinued because the staff member is present and is serving the same purpose as the restraint.
f. Chemical intervention orders include the following:
   i. Medication name, dose, route and that it is a STAT or NOW order.

VI. Non-Violent/Non-Self Destructive

- Orders:
  INITIATION
  i. The registered nurse (RN) caring for the patient may initiate non-violent/non-self-destructive restraints based on appropriate assessment of the patient when the LIP is not available.
  ii. The RN will notify the patient's LIP of restraint initiation and obtain a written/telephone order as soon as possible.
    - The telephone order will be authenticated within 24 hours.
  iii. If the initiation of the restraint is based on a **significant change in the patient's condition**, the RN will **immediately** notify the LIP. An order, based on examination of the patient by the LIP, is entered in the EHR immediately (i.e. within a few minutes) of initiation of the restraint.

  CONTINUATION
  i. A new restraint order must be completed at least once each calendar day AND is based upon an examination of the patient by the LIP.

- Reassessment and Monitoring
  - Monitoring is accomplished by observation, interaction with the patient, or related direct examination of the patient by qualified staff.
  - The RN is responsible for reassessing and monitoring the patient in restraints and monitoring documented in the record.
    - The RN may delegate components of monitoring to other competent staff members within the scope of their practice or licensure.
    - The RN is responsible for supervising all delegated monitoring components.
    - When the licensed practical nurse (LPN), paramedic, and/or PCT notices a change from the previous data collected, the RN will be notified immediately.

- Monitoring Frequency and Parameters:
  - A physical and behavioral assessment should be obtained within one (1) hour of initiation of restraints. The patient's vitals should be monitored per routine or physician order and as needed as the patient's condition warrants.
  - The following must be documented on initiation and at least every shift and as needed:
    - Nursing assessment
    - Restraint type
    - Less restrictive and other actions to prevent restraint
    - D/C criteria for restraint release
    - Patient/Family education

- Monitor and document the following on initiation and at least every 2 hours as appropriate or more often as required by LIP order or state law provisions.
    - The LPN or paramedic may assist with the data collection of these components:
        a. Restraint Status/ clinical justification
        b. Restraint site assessment
        c. Orientation/LOC
    - The LPN, paramedic, or PCT may assist with the data collection of these components:
        a. Nutrition/hydration
        b. Activity/position
        c. Toileting
        d. ROM (to restrained limbs)

VII. Violent and/or Self Destructive Behavior that jeopardizes the immediate physical safety of the patient, staff, or others (Behavioral Restraints)

- Order Initiation and Continuation
    - Violent Restraint Initiation

      IN AN EMERGENCY where the patient can reasonably be expected to immediately bring harm upon him/herself or others:
        - A qualified RN may apply the restraints then call the LIP to request the order and the face to face patient evaluation.
        - The face to face evaluation must occur immediately (i.e. within a few minutes) of restraint application.
        - The LIP must enter an order for the restraint immediately (i.e. within a few minutes).
        - A physical and behavioral assessment should be obtained within one (1) hour of initiation of restraints, then per routine or physician order and as needed as the patient's condition warrants.

      The initial LIP evaluation includes:
        - The patient's immediate situation;
        - The patient's reaction to the intervention;
        - The patient's medical and behavioral condition and the need to continue or terminate the restraint;
        - Documentation that the RN or the LIP worked with the patient and staff to identify ways to help the patient regain control; and
        - Revises the patients plan of care for treatment and services as needed.
    - Each order for restraint instituted for a violent or self-destructive patient may only be renewed in accordance with the following limits up to a maximum of twenty-four (24) hours.
        - Four (4) hours for 18 years of age or older

- Two (2) hours for 9 years of age - 17 years of age
- One (1) hour for 8 years of age and younger

- A face to face behavioral and physical evaluation must occur with one (1) hour of restraint application.
- The initial order for restraint of a violent or self-destructive patient may be renewed only up to a maximum of twenty-four (24) hours. After this period, the LIP responsible for the care of the patient must assess the patient prior to issuing a new order for restraints.

- Any patient in restraints who must be transported off the unit for testing is accompanied by an RN/LPN and Security as needed.
- Chemical Restraint Initiation- Initial assessment and ordering parameters are the same as for physical restraints. It is not the intent of this standard to interfere with the clinical treatment of patients who need therapeutic doses to improve their ability to function in the world around them.
  - A chemical restraint is a medication or a dose of a medication that is NOT a standard treatment or dose for the patient's condition.
  - If the medications used are a standard part of treatment for the patient's medical or psychiatric condition they are not considered a chemical restraint.
- Reassessment and Monitoring
  - Monitoring is accomplished by observation, interaction with the patient, or related direct examination of the patient by qualified staff.
  - The RN is responsible for reassessing and monitoring the patient in restraints.
    - The RN may delegate components of monitoring to other competent staff members within the scope of their practice or licensure.
    - The RN is responsible for supervising all delegated monitoring components.
    - When the LPN, paramedic, and/or PCT notices a change from the previous data collected, the RN will be notified immediately.
- Monitoring Frequency and Parameters:
  - All episodes of violent restraints should have the following documented by the RN on initiation
    - Date and time of initiation
    - Restraint Position
    - Restraint location
    - Restraint type
    - Alternative interventions
    - Reason for restraint
    - Vital signs (within 1 hour of initiation)
    - Actions taken
    - PRN med given
    - Discontinued (D/C) criteria for restraint release
    - Patient or family education as appropriate

- Monitoring and document the following at least every 15 minutes unless otherwise indicated by patient condition (e.g. the patient is too agitated to release restraint, or perform Range of Motion (ROM))
    - Level of Consciousness/Orientation (RN, LPN, or Paramedic
    - Clinical Justification (RN, LPN, or Paramedic)
    - Restraint site and circulation assessment of any restrained limbs (RN, LPN, or Paramedic
- Monitoring and document the following no less than every two (2) hours
    - ROM to restrained limbs (RN, LPN, paramedic, or PCT)
    - Fluid/Nourishment (RN, LPN, paramedic, or PCT)
    - Toileting (RN, LPN, paramedic, or PCT)
- Monitoring Chemical Restraints
    - Describe the specific behaviors necessitating chemical restraint.
    - Monitoring of vital signs including capnography, sedation and behavior each time a chemical restraint is administered.
        a. Monitoring should be based off the medication prescribed. If patient is sedated, monitoring of vital signs and mentation should be at least every 15 minutes until the patient: Retains the ability to maintain and protect the airway
        b. Absence of respiratory distress; no signs of snoring, obstructive airway, stridor, retractions or croupy cough.
        c. All vital signs are stable relative to the pre-restraint measurements.
        d. A minimum of thirty (30) minutes from last dose of sedation.

VIII. Patient/Family Education

- To the extent feasible, depending on the emergent nature of the use of a restraint, the reasons for such use will be explained to the patient and/or to an appropriate family member acting on behalf of the patient.
    - If unable to notify family prior to initiation of restraints, the family will be notified as soon as possible of the initiation of restraints, as appropriate.
    - Education will be documented in the medical record.

IX. Discontinuation

- Patients will be removed from medical restraints when the reason for the use of restraint is no longer present or when alternative strategies have become successful.
- If the reassessment by the qualified registered nurse indicates that the reason for the use of restraint(s) no longer applies, the patient may be removed from restraint.
- If the restraints are removed and the alternatives tried are ineffective, and reinitiating of restraint is indicated, a new order must be obtained and a face to face assessment completed by the ordering LIP in the appropriate time frame.

X. Documentation

- Documentation will be completed for every patient restraint episode upon initiation, and as defined in policy/procedure, and will be maintained in the EHR.

- Documentation should provide clinical justification for use and document clinical oversight, including documentation of alternatives/nonphysical interventions that were attempted.
- The following elements will be included:
  (i) The one (1)-hour face-to-face medical and behavioral evaluation if restraint is used to manage violent or self-destructive behavior;
  (ii) A description of the patient's behavior and the intervention used;
  (iii) Alternatives or other less restrictive interventions attempted (as applicable);
  (iv) The patient's condition or symptom(s) that warranted the use of the restraint; and
  (v) The patient's response to the intervention(s) used, including the rationale for continued use of the intervention.

XI. Reporting Deaths to CMS

- The following types of patient deaths are reported by SGMC Quality Department to the regional office of the Centers for Medicare & Medicaid Services (CMS) by telephone, fax, or other electronic means no later than the close of the next business day:
  - Each death that occurs while a patient is in restraint, except for deaths occurring when the patient was in soft, two (2) point wrist restraints and is not secluded;
  - Each death that occurs within twenty-four (24) hours after the patient has been removed from restraint except deaths occurring when the patient was in soft, two (2) point wrist restraints and was not secluded; and
  - Each death known to a SGHS facility that occurs within one (1) week after restraint was used when it is reasonable to assume that the use of the intervention contributed directly or indirectly to the patient's death.
- The date and time that the death was reported to CMS is recorded in the deceased patient's medical record.
- SGHS will maintain a log of all deaths that occur:
  - While a patient is in soft, two (2) point wrist restraints and no seclusion is used; or
  - Within twenty-four (24) hours of the removal of soft two (2) point wrist restraints and no seclusion is used.
  - Each entry in the log is made no later than seven (7) days after the death has occurred.
- Each entry includes:
  - Name of the responsible practitioner
  - Patient's name
  - Date of birth
  - Date of death
  - Medical record number
  - Primary diagnosis
- SGHS facilities make the log available for CMS upon request, in either written or electronic form.

XII. Education

a. Training Documentation
   i. The hospital will document in the staff record that the training and demonstration of competency were successfully completed.
b. SGHS provides education for staff that have direct patient care responsibility prior to the application of any restraint, as part of orientation and at least annually.
c. Staff are trained and demonstrate competency in the application of restraints, monitoring, assessment, and providing care for a patient in restraint.
d. Staff providing direct patient care are required to have education, training and demonstrated knowledge based on the specific needs of the patient population in at least the following:
   i. Techniques to identify staff and patient behaviors events and environmental factors that may trigger circumstances that require restraint.
   ii. The use of nonphysical intervention skills.
   iii. Choosing the least restrictive intervention based on an individualized assessment of the patients medical or behavioral status or condition.
   iv. The safe application and use of all types of restraint used in the hospital including training in how to recognize and respond to signs of physical and psychological distress (for example positional asphyxia).
   v. Clinical identification of specific behavioral changes that indicate that restraint is no longer necessary.
   vi. Monitoring the physical and psychological well-being of the patient who is restrained, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the one (1)-hour face-to-face evaluation.
   vii. The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.
   viii. Emergency response system (Code Blue and Rapid Response).
   ix. The inherent risk of physical safety and psychological well-being of the patient and staff.
   x. Potential to produce serious consequences, such as physical and psychological harm, loss of dignity, violation of a patients' rights and even death.
e. The assessments of competencies listed above are provided through a computer based learning module. Additionally, skills validation may be utilized as a method of competency validation as needed and as determined for new products, introduction of evidence based practice or changes in regulation.
f. Medical staff and allied health professionals are trained appropriate to their patient population, regarding the safe and effective use of restraints including:
   i. Restraint Policy;
   ii. Assessment and Reassessment of the patient in restraints; and
   iii. Ordering of restraints

RESPONSIBILITY

The individual serving in the following capacity is responsible for the content of this Policy:
Chief Nursing Officer

POLICY HISTORY

Original Adoption Date: November, 1990

Review/Revision History:

Reviewed: 9/1994, 4/1997, 1/2010
Revised: 9/1998, 1/2000, 11/2000, 5/2001, 1/2002, 12/2003, 2/2007, 11/2007, 2/2015
Revised and Renumbered: 5/2015
Revised: 2/9/2017, 5/21/2019, 9/9/2022, 2/3/2023

SOUTH GEORGIA HEALTH SYSTEM
SYSTEM POLICIES AND PROCEDURES

TITLE: Clinical Alarms	**FACILITIES:**	**SYSTEM POLICY NUMBER**: 2.038
APPROVALS:	☒ SGMC	**FUNCTION:**
Function Approval:	☒ SGMC Berrien Campus	☐ 1.000 Administrative/ Operations
Chief Nursing Officer	☒ SGMC Lanier Campus	☒ 2.000 Clinical Services
Chief Medical Officer	☐ SGMC Lakeland Villa	☐ 3.000 Compliance
3/31/2021		☐ 4.000 Environment of Care
Chief Executive Officer		☐ 5.000 HIPAA
		☐ 6.000 Finance
		☐ 7.000 Human Resources

PURPOSE

The purpose of this Policy is to provide guidance for monitoring patients through the use of and response to clinical alarms. Clinical alarms are a tool contributing to patient safety by providing an alert to a potential or existing hazardous patient condition.

APPLICATION

This Policy is applicable to the following SGHS Facilities: South Georgia Medical Center ("SGMC"), SGMC Berrien Campus, and SGMC Lanier Campus.

DEFINITIONS

Medical Device means a piece of equipment designated by the Food and Drug Administration as a medical device.

Qualified Personnel means personnel employed by SGHS that have received and passed training to perform a task or duty.

SGHS means South Georgia Health System, a trade name used by the Hospital Authority of Valdosta and Lowndes County, Georgia for the hospitals, nursing home, clinics and health care facilities and services owned and operated by the Hospital Authority of Valdosta and Lowndes County, Georgia.

SGHS Facility means, for purposes of this Policy, SGMC, SGMC Berrien Campus, and SGMC Lanier Campus. Such facilities are referred to as a "SGHS Facility" in the singular, and collectively as "SGHS Facilities."

POLICY

Use of Clinical Alarms

SGHS Facilities use clinical alarms when available on patient monitoring and care equipment or per plan of care (i.e., bed alarms) pursuant to the Procedure set forth below.

PROCEDURE

A. Medical Equipment/Device Alarms

1. Clinical alarms are used when available on patient monitoring equipment or per plan of care (i.e., bed alarms).
    a) At no time are clinical alarms disabled, inactivated or set at such extremes that the alarm would not alert caregivers when outside of the normal or expected range for the patient, except when the patient is on comfort care or palliative care.
    b) Alarms are actionable – a response is needed.

2. Alarm parameters are set in such a manner that they are consistent with the patient's clinical presentation and care needs. Alarm parameters will be set either at the default settings by the manufacturer or as ordered by the patient's provider and may only be adjusted or changed by qualified personnel.

3. All SGHS Facility staff members who use medical equipment should check alarm settings to ensure that they are appropriate and that audible alarms will be clearly discernible relative to ambient and competing noise.
    a) Noise reduction efforts for the comfort of patients and families are followed.
    b) Patients and families may request alarms be lowered in volume, in conjunction with staff, to determine what is safe for the patient, yet maintaining the quieter environment and allowing alarms to remain a patient safety tool.
    c) Clinical alarms are only temporarily silenced and not disabled unless the patient is on comfort care, palliative care and/or a clinician is in constant attendance.

4. Staff members are oriented to the use and rationale for alarm use:
    a) As part of orientation upon hire.
    b) When new medical devices are introduced.
    c) Based on departmental learning needs assessment, additional education and evaluation of competency will be provided as necessary.

5. Clinical staff respond to clinical alarms when heard and to visual alarms when activated. Clinical alarms may be responded to by those listed below, but not limited to, as any other clinical staff may respond to clinical alarms:
    a) Ventilator alarms are responded to by respiratory care practitioner, registered nurses, and physicians.
    b) Cardiac monitors, including fetal monitors, and other hemodynamic monitors are responded to by registered nurses, physicians, nurse practitioners,

physician's assistants, respiratory care practitioners, and paramedics.

c) Pulse oximeters are responded to by registered nurses, licensed practical nurses, physicians, nurse practitioners, physician's assistants, respiratory care practitioners, and paramedics.
d) Bed alarms/chair alarms are responded to by all staff.
e) IV pump alarms are responded to by registered nurses and licensed practical nurses.
f) Tube feeding pumps are responded to by registered nurses and licensed practical nurses.
g) Alarms for other clinical equipment (i.e. CPAP/BiPAP) are responded to by licensed personnel on the unit.

B. Alarm Settings, Preventative Maintenance & Testing

1. Each SGHS Facility Clinical Engineering Department is responsible for performing preventative maintenance and testing on all alarms on patient physiological monitoring and patient care equipment at the time the equipment is placed into service and annually based on risk category.

2. The above general provisions apply regardless of whether the SGHS Facility owns, borrows, rents or leases the equipment for long term or short term use (i.e., demonstration).

C. Alarm Failure and Alarm Related Incidents

1. Any patient monitoring or clinical equipment alarm failure that caused or may have caused a death, serious injury, serious illness or a material change in the plan of care is reported in accordance with applicable SGHS Facility policies. The equipment is immediately removed from service, labeled with an out of service tag and secured. Risk Management and Clinical Engineering should be notified of incident and location of secured equipment.

2. Staff members should not bypass alarm functions. Any bypass of an alarm function must be reported on an Unusual Occurrence Report.

3. Clinical Managers/Directors are responsible for assuring that all individuals adhere to the requirements of this policy, that these procedures are implemented and followed and that instances of noncompliance with this policy are reported via an Unusual Occurrence Report.

D. Patient Safety and High Risk Areas

1. As applicable to the SGHS Facility, the following SGHS Facility clinical areas have a formal alarm evaluation and management program including the general requirements outlined below:
    a) MSICU, CICU, CPU, ED, OR, PACU, GI Lab, L&D, Nursery, Dialysis, and Special Procedures.

2. The SGMC Clinical Equipment Action Team, the SGMC Berrien Campus Environment of Care Committee ("EOC") or the SGMC Lanier Campus EOC as applicable, in cooperation with the Clinical Engineering Department, will outline and maintain the program. Minimum required components of this program include:
    a) Annual inventory of all alarms.
    b) Risk Assessment.
    c) New and periodic alarm training for patient care staff.

RESPONSIBILITY

The individuals and departments primarily responsible for the content of this Policy: SGMC Clinical Equipment Action Team, SGMC Berrien Campus EOC, SGMC Lanier Campus EOC

POLICY HISTORY

Original Adoption Date: December 18, 2015

Review/Revision History:
Revised: 10/2017, 01/26/2018, 3/11/2021

Antimicrobial Stewardship

Program designed to provide guidelines to develop institutional strategies for appropriate use, selection, dosing, and duration or antibiotic regimen.

Primary Goal

Optimize clinical outcome while minimizing unintended consequences of antibiotics use.

Secondary Goal

Improvement quality of care while possibly reducing cost.

Effectiveness of Stewardship Programs

Financially self-supported Improve patient care Reduce antibiotic use by 22-36 %. Annual saving on large community hospitals: $200,000 - 900,000

CORE STRATEGIES

- Prospective Audits/intervention feedback
- Formulary Restriction/Preauthorization
- Antibiotic Cycling (no supported by clinical trials) Antibiotic Order Forms
- Combination Therapy
- Streaming/ De-escalation Therapy (based on culture report and elimination of redundant therapy).
- Dose optimization: based on individual patient characteristics, micro-organism, site of infection, pharmacology-dynamics.
- Parenteral/Oral conversion. (guidelines reduce LOS/Cost/ Improve patient safety

Prospective Audits/Intervention Feedback.

- Daily Culture and Sensitivity Review (SGMC Pharmacy Reviews Daily) Use of surveillance software (TheraDoc is used by the Pharmacy)
- On antibiotics with no positive cultures Pathogen resistant to current antibiotics De-escalation opportunities
- Duplicate beta-lactam coverage

Formulary Restriction/Preauthorization

- Restrict certain antibiotics to the Infectious Disease Physician
- Consider preauthorization requirements for Clindamycin which may decrease the onset of Healthcare-associated C. Diff

Antibiotic Cycling

- Scheduled removal and substitution of a specific antibiotic or class to prevent or reverse resistance (this is not supported by clinical trials)

Antibiotic Orders/ Forms

- Studies indicate decrease antibiotic consumption
- Automatic stop orders for duration of therapy
- Discontinue antibiotics at 1-2 days for perioperative prophylaxis

Combination Antibiotic Therapy

- Insufficient data to recommend routine use of combination therapy
- Does have a role in critically ill patients at risk for multidrug-resistant pathogens

Parenteral/Oral Conversion

- Clinical criteria for conversion established by SGMC Pharmacy and Therapeutics Committee
- Pharmacy may convert if established criteria met
- Programs decrease costs and improve patient safety

Pharmaceutical Services

South Georgia Medical Center offers a wide range of pharmaceutical services that benefit both providers and patients. There is at least one pharmacist available on-site 24 hours a day, 7 days a week at the main campus. Our professional staff welcomes any questions that you may have concerning medications or services we provide. We invite you to stop by the pharmacy at any time to meet your pharmacy team and look forward to working with you.

–Pharmacy Administration

Department of Pharmacy

Pharmacy Administration Team

Administrative Director of Pharmacy Services: Scott Smith—x4870
Manager of Operational Services: Mark Mulllis— x2873
Manager of Clinical Services: Todd Woodard— x4408
Pharmacy Secretary: Renee Broome— x4869
Pharmacy Office Fax— 229-259-4872
Administrative Hours of Operation: 8am-5pm; Monday-Friday

Central Pharmacy

Main Extension—4865
IV Services (including Pharmacokinetic dosing, TPN/PPN, IV drug information)—2870
Order Entry Services (including drug information, dosing adjustment)—2868/3277
Narcotic or Dispensing Cabinet Issues—2869/4892
Pharmacy Purchasing, Issuing and Receiving—4868/2866
Central Pharmacy Fax—259-4867

Locations

The Department of Pharmacy has dispensing service locations in Central, Main Surgery, Medical Oncology, and in the Ambulatory Surgery Center off site. We also provide pharmacy services at our off-site locations SGMC Berrien and Lanier campuses and SGMC Outpatient Plaza. Retail Pharmacy services are located on the first floor of the Main hospital. Clinical pharmacy services are available throughout all areas of the pharmacy department.

Hours of Operation

Central Pharmacy	24 Hours	Ext 2865/2868/3277
OR Pharmacy	6am—5pm (M-F)	Ext 4786/4787
Medical Oncology Pharmacy	7am—3:30pm (M-F)	Ext 4632/5469
Ambulatory Surgery Pharmacy	6am—2pm (M-F)	Ext 1756
Clinical Pharmacy Office	7am—3:30pm (M-F)	Ext 4408/4409/4418
Unit Based Pharmacist Services	7am—4pm	2T/3T—2342 4T/5T—2442 3W/5W—4563 4W/4S—3404
SGMC Berrien Campus	7am—3:30pm	Ext 8620
SGMC Lanier Campus	7am—3:30pm	Ext 8876
SGMC Smith Northview	7am—3:30pm	Ext 8390
Medical Center Retail Pharmacy	9am-5pm (M-F)	Phone 433-7150 Fax 433-7169

Pharmacokinetic Dosing/Monitoring
Anticoagulation Dosing/Monitoring
Nutritional Support Services
Unit Based Pharmacist Support
Code Blue/Pink Response
Drug and Dosing Information
Drug Interaction/Duplication Monitoring

Formulary

SGMC operates under a managed formulary system. Our current formulary can be viewed on "The HUB." Specific formulary addition or deletion requests can be made to the P&T Committee. Non-formulary drugs, drugs pending formulary approval and restricted drugs are not routinely stocked in the pharmacy; therefore, these medications may take up to 72 hours to obtain. If a non-formulary or restricted drug is ordered, you will be contacted by a pharmacist with an alternative suggestion or a request for an alternate order.

Therapeutic Substitutions

Authorization is given to the Department of Pharmacy through P&T Committee to therapeutically substitute certain classes of medications to follow formulary compliance. A complete listing of formulary substitutions can be found on SGMC intranet "The HUB" under the Pharmacy Department page.

Stop Order Policy

Narcotic and Antibiotic orders will stop after 10 days of therapy unless reordered. Respiratory Medications (excluding long term therapy) will stop after 5 days of therapy unless reordered.

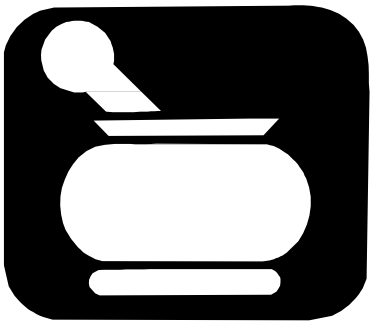
Adverse Drug Reporting

SGMC pharmacy monitors adverse drug reactions by use of the ADR hotline that can be reached at ext. 4873. More information can be obtained in hospital policy SPP 2.077 (PP19-00) Adverse Drug Reaction Reporting.

South Georgia Medical Center

Pharmacy & Therapeutics Update

A Publication of the SGMC Pharmacy & Therapeutics Committee



Increased Risk of Nephrotoxicity with Zosyn/Vancomycin Combination

Current research indicates an increased risk of nephrotoxicity in patients treated with vancomycin & Zosyn (piperacillin/tazobactam). This combo is commonly used in hospitalized patients for broad spectrum therapy where there is a need for gram positive coverage and anti-pseudomonal activity. The proposed mechanism of kidney injury is via penicillin related acute interstitial nephritis, exacerbated by vancomycin-induced renal cellular necrosis.

The studies reviewed showed the following:

- Nephrotoxicity risk increased with steady state vancomycin concentrations >/= 15 µg/ml.
- Concomitant use of pip/tazo + vancomycin increased rates of nephrotoxicity compared with vancomycin alone (16.3% vs 8.1%)
- Diabetics with osteomyelitis treated with pip/tazo + vancomycin were also found to be at increased risk compared to the same population treated with cefepime + vancomycin

Although more research is needed on this topic, increased monitoring in patients treated concomitantly with piperacillin/tazobactam + vancomycin seems prudent. Consideration of risk factors such as older age, existing renal failure, and the addition of any nephrotoxic agents should also be taken when determining antibiotic selection.

References:

1. Burgess, L. D. and Drew, R. H. (2014), Comparison of the Incidence of Vancomycin-Induced Nephrotoxicity in Hospitalized Patients with and without Concomitant Piperacillin-Tazobactam. *Pharmacotherapy*, 34:
   670–676. doi:10.1002/phar.1442
2. Rutter, W. C., Cox, J. N., Martin, C. A., Burgess, D. R., & Burgess, D. S. (2017). Nephrotoxicity during Vancomycin Therapy in Combination with Piperacillin-Tazobactam or Cefepime. *Antimicrobial Agents and*
   Chemotherapy, *61*(2), e02089–16. http://doi.org.proxy-remote.galib.uga.edu/10.1128/AAC.02089-16
3. Linda L. Cheng. AKI From Combined Vancomycin and Piperacillin/Tazobactam: How Real Is the Risk? - Medscape - Dec 30, 2014.

SOUTH GEORGIA HEALTH SYSTEM
SYSTEM POLICIES AND PROCEDURES

TITLE: Adverse Drug Reaction Reporting **APPROVALS:** **Function Approval:** Director of Pharmacy Chief Nursing/Operating Officer 1/10/2023 Chief Executive Officer	**FACILITIES:** ☒ SGMC ☒ SGMC Berrien Campus ☒ SGMC Lanier Campus ☐ SGMC Lakeland Villa	**SYSTEM POLICY NUMBER:** 2.077 **FUNCTION:** ☐ 1.000 Administrative/ Operations ☒ 2.000 Clinical Services ☐ 3.000 Compliance ☐ 4.000 Environment of Care ☐ 5.000 HIPAA ☐ 6.000 Finance ☐ 7.000 Human Resources

PURPOSE

The purpose of this Policy is to provide a method for monitoring the safety of drug use in the SGHS Facility and for reporting adverse drug reactions that occur.

APPLICATION

This Policy is applicable to the following SGHS Facilities: South Georgia Medical Center ("SGMC"), SGMC Berrien Campus and SGMC Lanier Campus.

DEFINITIONS

Adverse Drug Reaction or *ADR* means any unexpected, unintended, undesired or excessive response to a drug that:

a. Requires discontinuing the drug (therapeutic or diagnostic);
b. Requires changing the drug therapy;
c. Requires modifying the dose (except for minor dosage adjustments);
d. Necessitates admission to a hospital;
e. Prolongs stay in a health care facility;
f. Necessitates supportive treatment;
g. Significantly complicates diagnosis;
h. Negatively affects prognosis; or
i. Results in temporary or permanent harm, disability or death, this includes an allergic reaction and an idiosyncratic reaction.

Serious ADR means an adverse drug reaction that is life threatening, permanently disabling, requires hospitalization (initial or prolonged), or has an outcome of death, congenital anomaly, or requires medical or surgical intervention to prevent permanent impairment or damage.

SGHS means South Georgia Health System, a trade name used by the Hospital Authority of Valdosta and Lowndes County, Georgia for the hospitals, nursing home, clinics and health care facilities and services owned and operated by the Hospital Authority of Valdosta and Lowndes County, Georgia.

SGHS Facilities means, as used in this Policy, SGMC, SGMC Berrien Campus, and SGMC Lanier Campus. Individually, such SGHS Facilities are referred to in this Policy as a "SGHS Facility".

Significant ADR means a drug related incident that may result in serious harm, injury, or death to the patient.

POLICY

SGHS Facility staff immediately reports, Adverse Drug Reactions, that have harmed or have the potential to harm the patient or if the outcome of the error is unknown.

PROCEDURE

1. SGHS Facility nursing staff monitor patients receiving medication to identify the presence of an ADR.

2. Upon determining the possibility of an ADR, the nurse should first notify the attending physician to determine a cause/effect profile and determine the mode of treatment and then notify the Pharmacy.

3. ADR's are reported to the Pharmacy and Therapeutics Committee.

4. An Adverse Drug Reaction is reported in the following manner:
   a. SGHS Facility staff are encouraged to report Reactions without fear of retribution or SGHS Facility disciplinary action.
   b. SGMC: Any member of the healthcare team can quickly and efficiently report an ADR by dialing the **ADR HOTLINE** at **(229) 259-4873 or filing a report in the electronic unusual occurrence reporting software (link available on the HUB).** The following information will be requested when using this number:
      i. Patient Name
      ii. Patient Account Number
      iii. Patient Healthcare Record Number
      iv. Location & Room Number
      v. Suspected Drug(s) causing ADR
      vi. Nature of the Reaction
      vii. Action Taken
      viii. Did the reaction resolve?
      ix. Name of Person Reporting ADR
   c. SGMC Berrien Campus and SGMC Lanier Campus – Filing a report in the electronic unusual occurrence reporting software (link available on the HUB)

5. A description of each suspected ADR and outcome should be documented in the patient's healthcare record by the nurse and/or the physician.

6. External Reporting:
   a. FDA
      i. Serious ADRs should be reported to the FDA ***after consultation with the attending physician*** and upon direction of the appropriate Pharmacy & Therapeutics Committee.
      ii. This shall be the responsibility of the Pharmacy Department.
   b. Georgia State Board of Pharmacy
      If reported is required, the occurrence of a Significant Adverse Drug Reaction is reported to the Georgia State Board of Pharmacy.

7. Record Keeping:
   a. SGMC– Documentation of reported ADRs is recorded and maintained in the Department of Pharmacy pursuant to the then-current SPP, *Document Retention.*
   b. SGMC Berrien Campus/SGMC Lanier Campus – Documentation of reported ADRs are maintained in the pharmacy pursuant to the then-current SPP, *Document Retention.*

8. Review:
   ADR reports are reviewed and evaluated by the applicable SGHS Facility Medical Staff Pharmacy and Therapeutics Committee on a quarterly basis.

RESPONSIBILITY

The individual(s) and department(s) primarily responsible for the content of this Policy:
The Administrative Director of Pharmaceutical Services, the Manager of Operations Services, the Manager of Clinical Services and the Department of Pharmacy.

POLICY HISTORY

Original Adoption Date: December 1976
Review/Revision History:
Revised: 08/08
Reviewed: 01/03, 05/06, 01/12
Revised and Renumbered from PP 19-00 to SPP 2.077: 09/23/16
Reviewed: 10/2/19
Revised: 11/18/2022

Medical Records Department

Completion of Records Contacts

Cynthia Webb – cynthia.webb@sgmc.org - (229) 259-4984 or mobile 229-539-5809
Karen Davis – karen.davis@sgmc.org - (229) 259-4981

SGMC Health

Incomplete/Delinquent Health Record Notification Guide

- **14 DAYS**
  Providers and their practice managers will be notified by email and text message if they have incomplete records 14 days or older. These records should be completed in the next 7 days.

- **18 DAYS**
  Providers will be notified with a telephone call if they have incomplete records 18 days or older to complete by the following week.

- **21 DAYS**
  Providers will be notified by the Chief Medical Officer of any records 21 days or older will must be completed within 4 days to avoid becoming delinquent.

- **28 DAYS**
  Providers will be notified by the Chief of Staff followed with a Certified Letter they will relinquish all clinical privileges if their delinquent records are not completed by the first working day of the following week.

- **30 DAYS and OVER**
  Providers will be locked out of Epic and relinquish all clinical privileges. They will need to request access to complete delinquent records.

- **32 DAYS and OVER**
  All staff membership and clinical privileges are permanently relinquished. **Provider will have to reapply for staff membership and pay $100.00 for each delinquent record.**

Dictation – Dragon Medical One voice recognition is used for dictation. Voice qualification and set up of templates is completed through the Epic training sessions. Limited work types can be completed by traditional dictation – Ambulatory Notes, Operative Procedures and Significant Events (codes, etc.). Directions for traditional dictation are attached.

Clinical Documentation Improvement – Clinical Documentation Improvement Nurses review admissions focusing on assuring the medical record documentation clearly and accurately reflects the acuity of the patients' condition(s). The CDI staff will work with you and occasionally query you for clarification of conditions not clearly documented. This team is there to assist you in presenting the most accurate clinical picture in terms that a coder can use to accurately report all pertinent data.

Coding – Teresa Farr, RHIT, CCS (229) 433-8060 (mornings), (229) 259-1788 (afternoons) In order to code records completely and accurately, please **document the reason** for evaluating, treating or monitoring the patient clearly and specifically.

Document if conditions being treated are **acute or chronic.** This is an important consideration in determining the severity of illness of your patients, along with other documented complications and comorbid conditions (cc's) which increase resource utilization and length of stay. These conditions also impact the DRG assigned.

If records are not complete, or if there is unclear or conflicting information, the coders may send you a coding query. Please respond as quickly as possible by completing/adding the documentation in the Discharge Summary. You will receive the query through your inbox messaging in Epic.

Dictation Instructions

DOCUMENT REVIEW INSTRUCTIONS – Listen to Completed Reports

1. Dial 333-1122.
2. Enter Provider ID and press # key.
3. Interrupt prompted message and press *1, choose 3 to review.
4. Enter work type and press # key.
5. Enter account number and press # key.

1 = play
2 = stop
3 = rewind
5 = get next dictation
6 = go to end of dictation
7 = continuous forward
8 = go to beginning of dictation
9 = disconnect

DICTATION INSTRUCTIONS:

1. Lift handset and press speed dial button (if outside line, dial 333-1122). To interrupt message, begin next step.
2. Enter provider ID and press # key.
3. Enter valid work type and press # key.
4. Enter 7-digit account number and press # key.
5. Press 2 or use handset functions to begin dictation.
6. Press 5 to end current report and start new dictation – OR – press 9 to disconnect from the system. Job ID will be given at the end of each dictation session.

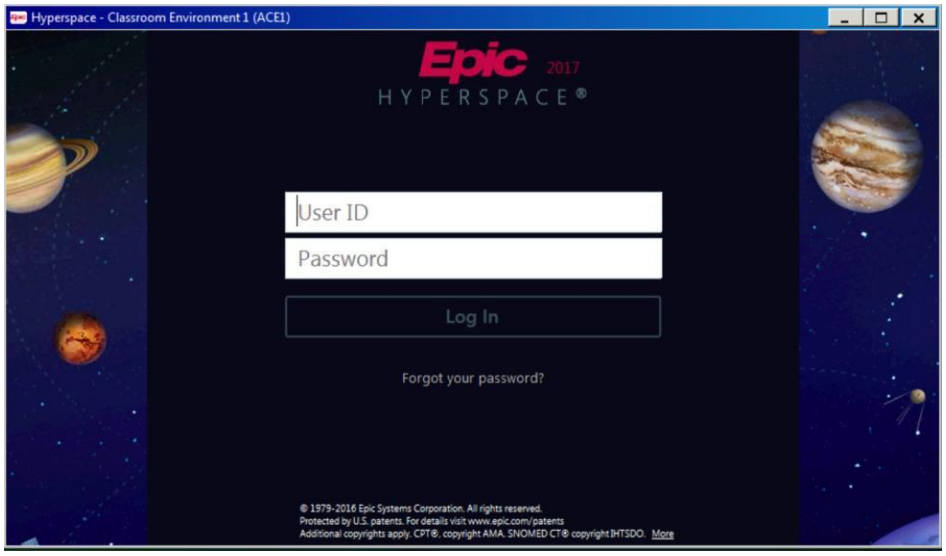
1 = play back
2 = dictate
3 = rewind & playback
4 = pause
5 = new dictation
6 = fast forward
8 = go to beginning of report
9 = disconnect
***6 = prioritize (use for legitimate STAT dictation ONLY before disconnecting)**

HOSPITAL WORK TYPES:

10 – History and Physical
20 – Discharge Summary
25 – Significant Event
30 – Operative Note
33 – Ambulatory Note
40 – Consults
50 – Progress Note
62 – Clinic Note
71 – Letter

EPIC Provider EHR Training

South Georgia Medical Center went live on Epic November 1, 2017. This change to the integrated electronic health system allows providers to have access to patient data in the hospital as well as their offices. Numerous modules are now available to streamline workflows. For example, the Emergency Department utilizes Epic's ASAP module when seeing patients in the ED. With this EHR specialization, providers need to receive thorough training to ensure that they understand Epic and the proper workflow documentation.



Initial Training. Epic training for new providers is scheduled by the Medical Affairs office working with the Principal Trainers in the Epic Department. Initial training requires 3-4 hours. At the conclusion of this training, an assessment is given to ensure that an appropriate level of understanding has been achieved. Thus, a score of 80% is required.

Personalization and Efficiency Training. Providers should also receive personalization training which allows providers to develop custom order sets as well as other customizations to improve efficiency within the system. Providers are encouraged to attend Thrive sessions which provides continuing training, tips and tricks. These sessions are offered the first Thursday of the month from 7am-7pm.

Deficiencies can be signed off in Epic via the provider's Inbox, a topic covered during provider training.

Dragon Medical One is available for providers who request it. Limited licenses are available; however, providers can be added to a wait list for additional license availability. Training is provided by Epic Principal Trainers.

- Providers should work with Medical Affairs for initial training. Documentation of successful Epic assessment is held in Medical Affairs.
- Personalization training can be scheduled by reaching out to the Epic Orders Team at 229.333.1340 or scheduled during initial training.

Additional Epic Applications

- EpicCare Link – Access to healthcare data for healthcare professionals: link.sgmc.org
- Epic My Chart – A fully functional patient portal: mychart.sgmc.org
- Epic Community Connect – An affordable healthcare electronic health record and practice management system for clinics desiring to partner with SGMC. Connect allows clinics to replace their current EHR with Epic's ambulatory EHR.

SOUTH GEORGIA HEALTH SYSTEM
SYSTEM POLICIES AND PROCEDURES

TITLE: Epic Downtime Procedures **APPROVALS:** **Function Approval:** HIPAA Security Officer/Chief Information Officer 3/17/2021 Chief Executive Officer	**FACILITIES:** ☒ SGMC ☒ SGMC Berrien Campus ☒ SGMC Lanier Campus ☒ SGMC Lakeland Villa	**SYSTEM POLICY NUMBER**: 5.084 **FUNCTION:** ☐ 1.000 Administrative/ Operations ☐ 2.000 Clinical Services ☐ 3.000 Compliance ☐ 4.000 Environment of Care ☒ 5.000 HIPAA ☐ 6.000 Finance ☐ 7.000 Human Resources

PURPOSE

The purpose of this Policy is to establish procedures for continuing patient care and financial processes during Epic application and/or system downtimes.

APPLICATION

This Policy is applicable to the following SGHS Facilities: SGMC, SGMC Berrien Campus, SGMC Lanier Campus and SGMC Lakeland Villa.

DEFINITIONS/ACRONYMS

BCA means Business Continuity Access.
BCA Hyperspace means Read-only version of Hyperspace as of moment Epic goes down.
BCA PC means Business Continuity Access personal computer (downtime computer).
BCA Web means Business Continuity Access link to Epic.
CSN means Contact Serial Number.
DEF means Downtime Event Form
H&P means History and Physical.
HIM means Health Information Management.
IS means Information Services.
MAR means Medication Administration Record.
MRN means Medical Record Number.
OP means Outpatient.
PC means Personal Computer.
ROI means Release of Information.

SGHS means South Georgia Health System, a trade name used by the Hospital Authority of Valdosta and Lowndes County, Georgia for the hospitals, nursing home, clinics and health care facilities and services owned and operated by the Hospital Authority of Valdosta and Lowndes County, Georgia.

SGHS Facilities means, for purposes of this Policy, SGMC, SGMC Berrien Campus, and SGMC Lanier Campus. Individually, such SGHS facilities are referred to in this Policy as a SGHS Facility.

POLICY

The following downtime procedures should be followed in the event of an Epic or system downtime to provide continuity of business and patient care.

PROCEDURE

It is recommended that each unit maintain a downtime Binder that includes this Policy.

A. UNPLANNED Downtime/Issue- Initial Communication

1. Person/entity discovering the downtime/issue will immediately report to the SGHS Helpdesk (229-333-1147).
2. The SGHS Helpdesk will:
   - Immediately notify Epic Support Network Operations Center (NOC) of the issue
   - Immediately notify SGHS Main Campus Administrative Coordinator on duty
   - Notify IS Division Leadership within 30 minutes of issue being reported

B. UNPLANNED Downtime-Announcement of Downtime

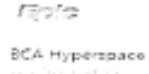
1. The SGHS Helpdesk will:
   - Notify IS Division Leadership and confirm the announcement:
     *LEVEL UNKNOWN: "Attention all personnel: We are experiencing difficulties with Epic. Please refer to your Epic Downtime Procedures."
     * LEVEL KNOWN: "Attention all personnel: We are experiencing a Level ___ Epic downtime. Please refer to your Epic Downtime Procedures."
   - Notify Switchboard Operator to make the overhead announcement and to repeat it every 60 minutes during the downtime.
   - Send announcement email to sgusers
2. The Switchboard Operator will:
   - Announce the downtime via overhead speaker, and repeat every 60 minutes during the downtime
3. IS Division Leadership will:
   - Determine the Downtime Level.
   - Instruct IS Helpdesk to update announcements to Switchboard and sgusers
   - Determine the need for and initiate the Command Center
   - Implement the communication process on Addendum #13

C. PLANNED Downtime - Announcement of and Preparation for

Epic Project Team Leadership or Environment Release Manager or Designee to notify the following:

- Notification begins two (2) weeks in advance to Epic users/Connect Partners/Department Managers/Hospital Administration/Epic Hosting Representatives/Epic Technical Coordinator
- Notification will be posted on the HUB seven (7) days in advance.
- During maintenance Epic sends a warning message to users that have a Citrix session open
- Notify Switchboard Operator to make the overhead announcement 10 minutes prior to the downtime. "Attention all personnel, Epic will go down at (time), please use the BCA Hyperspace icon during this time."
- Send announcement email to sgusers
- Utilize the communication processes as needed on addendum #13
- In the event there is an emergent need for a planned downtime message, notifications may not be displayed in advance. The Information Systems Operator will reach out to administrative coordinators to relay the need for said downtime, and the event should then be relayed to all area/department managers

4. **Downtime Levels and Information: TABLE 1**

Epic Downtime Type	Level	Downtime Event	Use this workstation	Use this Icon for Epic access and printing:
Unplanned	1 (One)	SGHS Network is up. Epic Production Server is down.	Any workstation	For READ ONLY: 
	2 (Two)	SGHS Network is up. Access to Epic Network is down (BCA Hyperspace and Production is unavailable)	Any workstation	For READ ONLY: BCA Web 
	3 (Three)	SGHS Network is down	BCA icon only on designated downtime PC (red)	FOR READ ONLY 
Planned Print extra Patient Labels		SGHS Network is up	Any workstation	For READ ONLY:  *If BCA or Hyperspace is unavailable, use BCA Web)

5. **Nursing Staff on each floor/unit are responsible for:**
   - Logging all Admissions (including ED admissions), Discharges and Transfers during downtime on the Downtime Event Form (DEF) located on the desktop of every BCA Computer (Addendum 12).
   - Forwarding DEFs to the Bed Planner as soon as possible to ensure bed planner has all forms prior to the end of downtime.

6. **Downtime Reports**
   - Downtime reports may be printed as needed.
   - Downtime reports may be accessed from Epic BCA Printing (Level 3 icon)
     - Only accessible on BCA computer
   - Log in and view reports important for each respective area.

7. **Printing Blank Order Sets - Printing Blank Order Sets**
   During downtime, all orders should be written on paper Physician's Orders – Blank (Form 84200069), found on Forms on Demand (SGMC Intranet.) Paper requisitions should be placed on all orders. Blank copies of top order sets by floor are accessible for printing during downtime. To print, open the PRD BCA Printing icon on your floor's BCA Workstation (should have sticker labeling it as BCA), select (one click) the report for the appropriate order set, and click the print button on the bottom right of the window

8. **When/How to Verify Medications**
   - The nurse should verify medications using reports from BCA Web, BCA Hyperspace, or designated BCA downtime PC, and new physician's orders.
   - The MAR report should be validated against the physician's paper orders for the past eight (8) hours and the Active Order Summary Report to verify medication accuracy.
   - Nurses should use the MAR report as the paper MAR for medication administration.
   - All orders should be written on paper Physician's Orders Forms.
   - Paper requisitions should be placed on all orders.
   - All medication orders should be faxed to the pharmacy, 259-4867 (may need to enter the full 7-digit fax number if auto fax is set to 4-digit number). In the event of a power outage, they should be delivered to pharmacy by courier.

9. **How to Forward Dietary Reports**
   - Dietary reports will be printed on the medical units and faxed or tubed to nutrition services.
   - Dietary consults will be faxed to the dietician's office, completed on paper downtime forms available in dietary, and entered or scanned into the healthcare record once system operations resume.

10. **To bring the System back up after Downtime**
    - Restart interfaces – (Interfaces Team is responsible)

- Individual Application Analysts are responsible for running basic validation scripts if indicated. These validation scripts are stored on SharePoint in the On Call Section.
- Turn on ADT Downtime Recovery Mode – (Interfaces, ADT or Grand Central Analyst is responsible).
- Notify the ADT Registration Staff that they may begin backfilling data – (Interfaces, ADT or Grand Central Analyst is responsible). See Addendum #7 PAS
- Once the data is backfilled, turn off Recovery Mode - (Interfaces, ADT or Grand Central Analyst is responsible).

11. **Notification of Downtime Resolution**
    Command Center should ask the Switchboard to make the following announcement: "Attention all personnel. Epic Systems are now up." (Repeat x 2)

12. **Documentation Reconciliation for Inpatient and Outpatient Units**
    The reconciliation of information back into the system must occur as follows:

***Orders	<2 hours	2-8 HOURS ****** See Note ******	>8 hours
Admission History	NO	NO	NO
V/S (last 4 hours, most recent Or any significant)	YES	YES	YES
I&O (Shift Totals only)	YES	YES	YES
Assessment/Interventions	YES	NO	NO
PT/OT/ST	YES	NO	NO
Medication History	YES	YES	YES
Medication Administration	YES	YES	YES
Discharge Medications	YES	YES	YES

Must address all overdues in the system when it comes back up and indicate to see paper documentation

13. **Documentation of Orders** - Once the system comes back up, scheduled orders that did not get completed during the downtime will be entered in the system (examples: exams, treatments, ALL dietary orders, any consults, and nursing orders such as vital signs, dressing changes, etc.). Do NOT enter medication orders in the system that have been faxed to pharmacy as they will be entered in the system by Pharmacy.

14. **EndoTool Documentation Downtime Procedures**
    Refer to SGHS SPP, *EndoTool-Glucose Management System.*

D. DEPARTMENT SPECIFIC ADDENDA

Health Information Management (HIM)	Addendum #1
Laboratory (Beaker)	Addendum #2
Outpatient and Specialty Clinics (Cadence)	Addendum #3
Ambulatory/Outpatient Clinics (Ambulatory)	Addendum #4
Cardiology (Cupid)	Addendum #5
Radiology (Radiant)	Addendum #6
Patient Access/Scheduling (Prelude Grand Central)	Addendum #7
Interfaces (Bridges)	Addendum #8
Emergency Department (ASAP)	Addendum #9
OR and Anesthesia (OP Time)	Addendum #10
Endoscopy/GI Surgical Department (Ambulatory)	Addendum #11
Downtime Event Form DEF	Addendum #12
Communication Contact Information	Addendum #13

RESPONSIBILITY

The individual(s) and Department(s) primarily responsible for the content of this Policy:
Health Information Management Director and/or their designee and Epic Project Leadership

POLICY HISTORY

Original Adoption Date: November 1, 2017

Review/Revision History:
Revised: 01/05/2018, 11/1/2019, 2/19/2021

Addendum #1

Health Information Management Downtime Procedure – HIM

Procedure for continuity in Health Information Management (HIM) processes during computer downtime events.

PROCEDURE

1. Epic
    a. When caregivers cannot access the Epic system for historical patient data, the One Content imaging system will be utilized to access historical patient data. Patient data may be accessed by patient name or MRN.
    b. Complete records prior to Epic will be available through One Content. Post Epic information, limited to scanned documents, will be available through One Content.
    c. HIM staff will assist caregivers in obtaining any patient data from other providers for critical needs during downtime events.
2. 3M Encoder
    a. Loss of the 3M Encoder functionality for a limited time of one (1) work day or less will result in a delay of coding for that limited period. Beyond one (1) day, the coding staff will utilize coding books to assign codes and manually enter the codes into Epic for abstracting and final billing.
3. Release of Information (ROI)
    a. One Content will be utilized to retrieve historical patient information in response to information requests.
    b. The HIM Clerical Supervisor will be contacted to scan any current information not yet scanned into One Content.
    c. ROI does not process emergent requests for information. Current information not available due to the Epic system downtime will be delayed until that information can be accessed.
4. 3M/360 Clinical Documentation
    a. Clinical Documentation Improvement staff will utilize what current clinical data is available in the event of Epic downtime.
    b. During periods of 3M/360 downtime, staff will resort to completing paper based queries when needed. Census lists will be utilized to refer to patient review lists.

Addendum #2

Laboratory Department Downtime Procedure - BEAKER

Procedure for continuity in laboratory Workflows: (Clinical Laboratory, Atomic Pathology Laboratory & Blood Bank Laboratory)

Procedure:

Laboratory will accept downtime request for STAT orders from the units. The downtime request must include: Patient Name, Location, CSN or HAR #, MRN#, DOB, Collection date/time and ordering physician. Mark test to be ordered clearly. (A patient label can be placed on the form) Note: Downtime forms are located on the HUB under Forms on Demand.

1. Laboratory Staff will use the downtime order forms to collect STAT patient draws. Staff will document the collection date, time and employee ID on the downtime order form. Use Patient labels on the floor to label specimens at the bedside. Document the collection date, time and employee ID on each specimen.

2. Specimens that accompany downtime orders forms must include two (2) patient identifiers (room number is not an identifier), collection date/time and employee number/name. Use Patient labels on specimens if available.

3. Laboratory Staff will call all critical/toxic results to units. Print outs from the instrument will be sent to the units via the pneumatic tube system (where available) or hand carried by a qualified staff member throughout the down time.

4. After downtime the Laboratory Staff will review patient records for orders and if need place orders in EPIC using the downtime orders form when the system is back up for use. Blood Bank Staff will place orders for Blood Bank Testing once the system is back up for use and contact units to place orders for product after downtime.

5. Lab will enter downtime results either manually or by specimen linking.

Addendum #3

All Outpatient Scheduling Downtime Procedure - CADENCE

Procedure for continuity in scheduling workflows.

PROCEDURE

1. When the electronic system is unavailable, scheduling departments will be unable to schedule new appointments within the system.
2. Schedulers have access to the following Cadence Downtime reports for use during downtime which are located in the BCA system:
    a. Downtime Department Appointments Report
    b. Staff Daily Report
3. Upon identification of the Epic system being down, the Department Supervisor or Manager will notify the scheduling & pre-registration staff, and all other necessary staff, as deemed necessary of the downtime.
4. Scheduling and Pre-registration will continue to answer calls.
    a. If a caller is requesting a same day appointment, the schedulers will utilize the Staff Daily Report in order to manually schedule the appointment on paper. After the downtime, staff will then backlog the appointments into the system.
    b. If a non-urgent appointment is needed, staff will inform the caller that the scheduling system is currently unavailable. Staff will collect all contact information for the patient (Name, DOB, and Phone Number), so that the patient may be contacted for scheduling once the system is available.
    c. For the SGA Central Scheduling department, when the system is available, staff will resume scheduling from the orders/referrals placed into the system.
    d. Staff will collect all contact info for all cancelled, re-scheduled, or schedule requests.
    e. Place callback information in an appointed area.
5. Scheduling & Registration staff will utilize the Downtime Department Appointments Report to identify expected patient arrivals for the day.
    a. As patients arrive for their appointments, staff will mark them arrived on the report. They will also record all relevant registration information on the Downtime Appointments Report.
    b. Place all registration information in an appointed area.
6. Upon system recovery, the Supervisor & Manager will inform staff of system availability and assign individuals to:
    a. Complete all cancelations
    b. Call patients regarding reschedule requests
    c. Complete all remaining call backs in order of receipt
    d. Record contacts made and continue to attempt to reach all patients/calls
    e. Input all registration information
7. For SGA Cancer Center and SGA Apheresis, all scheduling is done in Mosaiq. The Supervisor or Manager will appoint a staff member to verify that any appointments scheduled in the 3rd Party System (Mosaiq), during the Epic downtime have flowed into Epic as expected by checking the Epic schedules.

Addendum #4

Ambulatory/Outpatient Clinics Downtime Procedure - AMBULATORY

Procedure for continuity in Outpatient areas.

PROCEDURE

1. Ambulatory clinics should follow the listed downtime procedures in event of an Epic or system downtime, planned or unplanned, to provide continuity of business and patient care.
2. Each Ambulatory clinic/department should have a designated workstation (computer) and printer for downtime. If possible, this workstation and printer should be connected to generator power so documents can be printed in event of a power outage. There are, however, clinics which do not have any alternate power source in event of a power outage. For these clinics, after a period of one hundred twenty (120) minutes with no power, the clinic will close for the day.
3. There will be an Epic folder on the desktop of the designated workstation. Each night at 10:00 pm, Epic will push out necessary patient information to allow the clinics to function the following day even through an Epic downtime. This information will include:
    a. Patient schedule for the following day
    b. Clinical information on each patient to assist with direct patient care (current medications, allergies, medical and surgical history, and last vital signs)
4. Each clinic should have a list of forms needed to document care on the patients for that day, as well as where these forms are located in order to be printed out for use.
5. Each clinic should have a physical folder in the department containing each of the documents they will need for patient care. Documentation of patient care will occur on these forms during the downtime.
6. For any downtime lasting less than two (2) hours, the information will be transcribed back into the Epic system from the downtime forms.
7. For downtime lasting between two (2) and four (4) hours, vital signs, chief complaints, history and assessments will be transcribed back into the Epic system. Progress notes and orders will be scanned into the OneContent system.
8. For downtime lasting over four (4) hours, all documentation will be scanned into the OneContent system.

Addendum #5

Cardiology Department Downtime Procedure-Cupid

Procedure for continuity in cardiology workflows.

INVASIVE CARDIOLOGY- downtime procedures:

1. Manually enter the study in McKesson Cardiology with the following information (select the **NEW** icon -- *Do **NOT** use Emergency)*:
    a. Name (last and first)
    b. MR# with three leading 0's
    c. Gender
    d. DOB
    e. Physician
    f. Procedure Type-select cath procedure
    g. Proc. Sub type – select diagnostic (do not exit—see next step)
2. Click on Advanced at the top; a second window will open. This is where you will enter the accession number. This may be any number that has not been used previously. The accession number must match in Toshiba.
3. Manually enter the patient in Toshiba using the same accession number. If the accession numbers do not match, the images will not link to McKesson.
4. Complete study in McKesson Cardiology.
5. Create a temporary case in the supply dispensing station.
6. Create a temporary patient in the medication dispensing station.
7. For lab and radiology requests, use downtime request slips.
8. For exams using ACTs: obtain an i-STAT analyzer from the lab that does not require patient barcode scanning.

NON-INVASIVE CARDIOLOGY-downtime procedures:

1. Manually enter the study in McKesson Cardiology with the following information:
    a. Name (last and first)
    b. MR# with three leading 0's
    c. Gender
    d. DOB
2. Complete study in McKesson Cardiology.
3. For Non-Invasive appointments using medications or supplies: create a temporary patient in the supply dispensing cabinet as well as the medication dispensing station.

INVASIVE AND NON-INVASIVE CARDIOLOGY -- Procedure for entering information in Epic when downtime is complete:

1. The order for the Invasive procedure / Non-Invasive appointments will need to be placed in Epic and scheduled.
2. The manually entered patient in McKesson Cardiology will need to be merged to the correct accession number that is created when the order is placed in Epic.
3. Do not forget to begin and end Non-invasive appointments so the charges will get dropped.

4. For outpatients, pertinent information will need to be entered by the nurse, on the Patient's Pre-procedure navigators so that when/if the patient comes back for other encounters the information will be in the system.
    - Allergies
    - History
    - Medication list
    - Height & weight
5. Information such as consents, H&P, vital signs and nursing notes that were documented on paper can be scanned into Epic.
6. For Invasive procedures: the Epic procedure log needs to be completed by staff for the following items:
    - Staff present for procedure;
    - Procedure start and finish times;
    - Sedation start and stop times;
    - Medications administered during procedure;
    - Procedures performed;
    - Implants;
    - Radiation Tracking: Dose (mGy), Fl Time (min);
    - If intervention was performed, document Intervention time;
    - Charge Entry (don't forget to charge for procedure).
7. For Invasive procedures supplies: staff will transfer case in the supply dispensing station to reconcile the temporary case to the permanent case.
8. For Non-Invasive appointments using supplies: staff will reconcile the temporary patient in the supply dispensing station with the patient in Epic.
9. For Non-Invasive appointments where medications were administered: nurse will document the medications in the MAR with correct times. This is necessary for correct documentation as well as charging for the medication.

Addendum #6

Radiology Department Downtime Procedure - RADIANT

Procedure for continuity in radiology workflows.

PROCEDURE

1. Recommended procedure when Epic is down (PACS is still available):
    a. Hospital Staff should use manual Downtime slips.
    b. Notify Radiology Department by phone and fax the manual Downtime slip to Radiology. Radiology will place all orders in Epic once the system is functional.
    c. Enter patient and exam information, including MR Number directly into the modality. (MR number can be found by searching for patient in Carestream, if patient has had an imaging exam previously). Accession number should also be assigned. This number will be assigned as follows: DT, which stands for Downtime, patient's date of birth and the time of the exam in military time.
        i. Ex: DT1214741645. Use proper punctuation and spelling.
    d. Perform exams, send images to PACS, and document times on downtime slips
    e. Radiology Staff needs to retain a copy of the manual Downtime slips to assist with placing orders after Epic is functional.
    f. All results can be viewed in Carestream Vue Motion on all floors and in the Emergency Department. This applies to STAT or "wet" reads also.
2. Recommended procedure when Epic is available again.
    a. Orders will need to be placed in Epic by Radiology staff after verifying patient has been registered in the system.
    b. After orders have been placed in Epic, use the downtime slips to perform normal begin and end exam workflow.
    c. Manually reconcile exams in PACS with orders from Epic.
    d. Manual cleanup work may need to be performed to match the accession number in Epic with the accession number in PACS.

Addendum #7
ADT Downtime Procedure —PRELUDE/GRAND CENTRAL

Procedure for continuity in ADT workflows.

PROCEDURE

During downtime, Bed Planners and Nursing staff will use the SGA, BER, and LAN Downtime Census reports to access the facilities' most up-to-date information on patients currently admitted. This report includes patient specific information (patient name, sex, and DOB), as well as encounter specific information (CSN, attending provider, service, patient class, diagnosis, admit date, unit, room, and bed status). This report will update every hour, previous to the downtime, and will be available from the BCA PCs through the BCA printing application for users to print.

COLLECTING REGISTRATION INFORMATION

Patient Access users will use the BCA Hyperspace Environment on their computer (only in the event that production is down, but, access to Epic is still available) to view only patient information to determine if a patient is new or existing. If access to Epic is completely down, the BCA workstation in each area must be used. The patient information will be collected during downtime using paper downtime registration forms located in each registration area.

The Prelude or Grand Central Analyst will provide each Patient Access Manager an updated printed list of reserved CSNs and the HIM analyst will provide a list of downtime MRNs to distribute to employees for planned and unplanned downtimes. These lists will be kept as hard copies in each area and will only be updated when the amount of accounts available is 200 or less. After the system goes down, this list will be distributed by Patient Access Managers to all PAS staff. The Grand Central analyst will run a report after each downtime to determine how many downtime CSNs were used and update/ replace list if needed.

During planned downtime users will complete the following steps:

- Assign a reserved CSN to all patients
- Assign a reserved MRN to new patients only
- Patient Access users will still have access to view the patient station to obtain existing patient's MRNs if access to epic is still available.
- Downtime armbands will be hand written on a blank label and should include at a minimum, the following items:
    1. Patient name
    2. Date of Birth
    3. Reserved CSN #
    4. Reserved MRN# (If new patient to SGMC. All existing, will not have reserved MRN)

During unplanned downtime users will complete the following steps:

- Assign a reserved CSN to all patients
- Assign a reserved MRN to all patients

- Downtime armbands will be hand written on a blank label and should include at a minimum, the following items:
  1. Patient name
  2. Date of Birth
  3. Reserved CSN #
  4. Reserved MRN#

LOGGING PATIENT EVENTS

Bed Planners will be responsible for entering new direct admissions (origin being outside SGMC) and nursing staff will enter discharges and transfers (including ED admits) on Downtime Event Forms (DEFs) located on the BCA PC as a local document. These forms include the date and time of the event, event type, patient name, MRN, and CSN. Each DEF should be placed in a designated folder in each area for recovery.

BACK LOADING EVENTS

After a downtime, a designated person from nursing staff on each unit is responsible for obtaining all DEFs to begin back loading events, ensuring that they are delivered to the Bed Planner.

The downtime recovery mode will be enabled by the Prelude or Grand Central Analyst. Doing so, will push a downtime patient station option to all ADT/PAS users. This option will prompt users to enter the patient's downtime CSN when creating one of the following types of encounters:

- New Admission
- New Hospital Outpatient Visit (HOV) * communication will be made from Radiology so orders can be linked to the HOV encounter
- New L&D Assessment
- New ED Arrival

Upon recovery mode being enabled, Bed Planners at SGMC Main Campus and nursing staff at affiliate campuses (Berrien/ Lanier) will need to backload ADT events (Discharges/Transfers) into the system by using the DEFs collected from each area.

Priority of Back loading of events:

1. Discharge only events; entering these first will help avoid bed locks.
2. Transfer only events and admissions that occurred during downtime in chronological order for patients that are still in-house after a downtime.
3. Events where patients arrived and left during downtime.

Once Prelude and Grand Central users have finished back loading, the system will be opened to all end users.

After an unplanned downtime:

- There will be duplicate patient records due to Epic being unavailable.
- These patients will have to be marked for merge by Patient Access Services staff after back loading events when Epic is opened to all end users.
  The chart correction staff will complete the patient merges after they have been discharged.

Addendum #8

Interfaces Department Downtime Procedure - BRIDGES

Procedure for continuity in Patient Access workflows to show all census beds. Explain the downtime policy and procedures for any integrated systems that work closely with Epic. Third party systems that depend on Epic to interface messages to it, how will that workflow be handled during downtime.

PROCEDURE

During downtime, Patient Access and Nursing staff will use the SGA, BER, and LAN Downtime Census reports to access the facilities' most up-to-date information on patients currently admitted. This report includes patient specific information (patient name, sex, and DOB), as well as encounter specific information (CSN, attending provider, service, patient class, diagnosis, admit date, unit, room, and bed status). This report will update every hour and will be available from the BCA PCs for users to print.

DURING A PLANNED DOWNTIME:

- Start all interfaces after planned downtime is over (if the auto start functionality does not start them)
- Priority 1:
    - Grand Central (ADTs)
    - Orders – alert Orders Team that interfaces are back up so that they may communicate accordingly to end users.
    - Results
- Priority 2:
    - Transcription
    - Pharmacy Orders/Dispense
    - Device Integration
    - Imaging
- Priority 3:
    - Charge/Billing/Coding – alert Prelude, PB and Cadence so that they may start and reset their interfaces.
    - Scheduling
    - Others

DURING AN UNPLANNED DOWNTIME

- Start all interfaces once EPIC has been brought back on line.
- Priority 1:
    - Grand Central (ADTs)
    - Orders
    - Results

- Priority 2:
  - Transcription
  - Pharmacy Orders/Dispense
  - Device Integration
  - Imaging
- Priority 3:
  - Charge/Billing/Coding
  - Scheduling
  - Others – alert Grand Central and Prelude Teams that interfaces are up to begin backfilling data.

Addendum #9

Emergency Department, Urgent Care (UC), UC Procedures, & Youth Care Downtime Procedure – ASAP

Procedure for continuity in outpatient areas.

PROCEDURE

1. Departments should follow the listed downtime procedures in event of an Epic or system downtime, planned or unplanned, to provide continuity of business and patient care. Staff will utilize established down time forms with progress notes for narrative documentation for physicians and nursing staff. Staff will utilize radiology and lab down time forms. We will also use preprinted discharge instructions.
2. Department should utilize white boards for tracking patients name and location.
3. Departments should have a designated workstation (BCA computer) and printer for downtime. Workstation and printer should be connected to generator power so documents can be printed in event of a power outage. There is one BCA Computer in each department. For SGA ED there is one in Zone 1,2 and 3.
4. BCA Workstations contains 2 Icons.

BCA Hyperspace (View only) BCA Web - for Printing Reports

Reports available to print will include: Clinical information on each patient to assist with direct patient care such as current home medications, Orders, Allergies, Medical/Surgical History, and last vital signs.

5. Each department should have a physical folder/binder referencing forms to be used in the event of downtime. Binder should include the following: Copy of the downtime policy, a list of all forms, where these forms are located, and an original copy of each form.

6. Packets of downtime forms should be pre-made and ready for immediate use in the event of down-time. They are shelved in the nursing stations.

7. Back Charting Requirements as follows:

Downtime Lasting LESS THAN 1 hour Back Charting Requirements – Any Patient	
Content to be Back Charted	**Who to Perform Task**
All Documentation	Nursing and Physicians
All Nursing Orders (EKG, IV, Dressing, Foley, Splint, etc.)	Nursing
All Lab Orders	Laboratory Department
All Radiology Orders	Radiology Department
All Medications Orders (Fax all orders to Pharmacy, even if removed from ED med dispensing cabinet)	Pharmacy will Enter Orders

Administration of all Meds once meds have been entered into EPIC	Nursing will complete the med administration
Once all orders have been entered into EPIC and, meds administered in EPIC, if applicable, patient may be removed from track board, back stamping discharge time.	Nursing

Downtime Lasting GREATER THAN 1 hour Back Charting Requirements – DISCHARGED PATIENTS	
Content to be Back Charted	**Who to Perform Task**
Triage Information (Arrival Date/Time, Acuity, C/O.)	Registration/Nursing.
Attending Provider (Add To treatment Team)	Nursing
Discharge Information (Disposition, Disposition Time)	Nursing
All Lab Orders	Laboratory Department
All Radiology Orders	Radiology Department
Medications Removed from Unit dispensing cabinet	Nursing
Medications Provided from Pharmacy	Pharmacy
Once all orders have been entered into EPIC and, meds administered in EPIC, if applicable, patient may be removed from track board, back stamping discharge time.	Nursing
All Other documentation will be scanned into One Content (Nursing Notes, MD Progress Notes)	Health Information Management

Downtime Lasting GREATER THAN 1 hour Back Charting Requirements – ADMITTED PATIENTS	
Content to be Back Charted	**Who to Perform Task**
Triage Information (Arrival Date/Time, Acuity, C/O, Allergies, Home Meds, History)	Registration/Nursing.
Vital Signs Last 4 hours	Nursing
All Nursing Orders (EKG, IV, Dressing, Foley, Splint)	Nursing
All Lab Orders	Laboratory Department
All Radiology Orders	Radiology Department
All Medications Orders (Fax all orders to Pharmacy, even if removed from ED medication dispensing cabinet)	Pharmacy will Enter Orders
Administration of all Meds once meds have been entered into EPIC	Nursing will complete the med administration
All Other documentation will be scanned into One Content Nursing Notes, MD Progress Notes)	

Addendum #10

OR/Anesthesia Department Downtime Procedure – Facilities OpTime Department

Procedure for continuity in perioperative workflows.

PROCEDURE

1. Recommended OR procedure when Epic is down:
    a. Cases will need to be scheduled by calling OR schedulers or OR front desk to add on cases.
    b. OR staff should document on a paper format, capturing critical information for patient care and charges.
        - Patient care: medications, allergies, height, weight, LDAs, specimens, and lab tests/results
        - Charges: Case tracking event times, supplies, implant information.
2. Recommended OR procedure once epic is available:
    a. Cases that were added during downtime should be scheduled in Epic, with case times added to advance patient to correct perioperative area.
    b. Paper documents such as H&Ps, consents and nursing notes with vital signs will be scanned into Epic upon termination of downtime.
    c. Complete documentation may be back charted into Epic per managers' discretion.
3. Supplies: The OR staff will need to add a temporary Case in supply dispensing cabinet in order to retrieve and return items: when Epic is back online; the staff will then reconcile to the correct Case in dispensing cabinet so that the supplies will be filed into the correct log.

Addendum #11

Endoscopy/GI Surgical Department Downtime Procedure – AMBULATORY

Procedure for continuity in SGMC Endoscopy department workflows.

PROCEDURE

1. Recommend endoscopy procedure when Epic is down:
    a. Procedures will need to be placed and scheduled by OR schedulers in designated endoscopy locations: Main OR schedulers/Outpatient Plaza Schedulers on their board.
    b. When Epic is up and running the Endoscopy Procedure will be documented in Epic. The endoscopy staff will add pertinent information in on the Epic system such as:
        - Allergies
        - History
        - Medication list
        - Height & weight
2. Information like consents, H&P, and nursing notes that were documented on paper along with vital signs will be scanned into Epic.
3. Endoscopy procedure log documentation: At the manager's discretion, the Epic procedure log will be completed by the staff for the following items:
    a. Staff
    b. Procedure start and finish times
    c. Sedation start and stop times
    d. Medications given during procedure
    e. Procedures performed
    f. Implants & supplies not part of the supply dispensing system
4. Supplies: The endoscopy staff will need to add a temporary Case in the supply dispensing system in order to retrieve and return items: when Epic is back online; the staff will then reconcile to the correct Case in the supply dispensing system so that the supplies will be filed into the correct log.

PROCEDURE

1. Recommended procedure when Provation MD & Manoscan are down:
    a. Hospital Staff will continue to document in Epic.
    b. Providers may complete their Procedural note directly in Epic.
2. Recommended procedure when Provation is available again.
    a. If scheduling message appears in Provation after the case was completed, the Provider or endoscopy staff may delete the scheduled case in Provation MD to eliminate duplication of the procedural note.

Addendum #12

Downtime Event Form (DEF)

DOWNTIME EVENT FORM

Time of THIS Event	Date of THIS Event	Contact Serial Number (CSN)

Patient Name	EMPI/MRN ID Number	Affix patient LABEL here

Origin Room/Bed (Enter the bed the patient is currently in)

Destination Room/Bed (Enter the bed the patient is moving to)

Event Type (Circle the ADT event that is taking place. Each event needs a new Downtime Event Form)

Admission	Transfer	Discharge (w/Disposition) _____
ED Arrival	ED Roomed	ED Dismiss
L&D Assessment	L&D Laboring	Newborn Admission
Hospital Outpatient Visit (HOV)	L&D Delivery (Enter newborn info here AND do Event From for Newborn also)	
Update Admission	Birth Time/Date:	Band ID:
	Birth Weight/Length:	Admitting Prov:

Patient Class (Circle appropriate patient class that will be associated with THIS Event Form)

Inpatient	Emergency	Ambulatory Surgery
Outpatient	Urgent Care	Recurring Outpatient
Observation	Surgery Admit	Perpetual Outpatient
Contract	Outside Patient No Charge	

Accommodation Code (Circle the accommodation code that will be associated with THIS Event Form)

Med/Surg/OB	Nursery	Observation
Outpatient	Nursery Level II (unit specific criteria)	
Emergency	Custodial Care Level I (used by direction of case manager)	
Intensive Care	Custodial Care Level II (used by direction of case manager)	

Service (Enter the service that is associated with THIS Event From)

Attending Provider (Enter the attending provider for the patient. This is who is caring for the patient NOW)

Additional Information (Enter any other important information that will be necessary for recovery)

Staff Member responsible for this Action (The staff completing this form must sign it here)

Addendum #13

Communication Contact Information

- SGMC Main Campus Pharmacy (229-259-4865)
- SGMC Main Campus Administrative Coordinator (229-259-4491).
- SGMC SNH – Main - 229-433-8000
- Diabetes Management Center (229-433-7200)
- Wound Care (229-249-5080)
- Cardiac Rehabilitation (229-245-6211)
- Occupational Medicine (229-433-7300)
- Healthcare South (229-433-7300)
- SGMC Berrien - Nurse's Desk (house supervisor) – 229-433-8690
- SGMC Lanier - Nurse's Desk (house supervisor) – 229-433-8408
- SGMC Lakeland Villa Campuses
  - Main (229-433-8425)
  - Nurses Station (229-433-8844)
- SGMC Cardiology Clinic (229-433-8160)
- SGMC Cardiovascular Institute (229-433-6608)
- SGMC Surgery Suite (229-433-1711)
- SGMC General Surgery 2704 N OAK F (229-242-4996)
- SGMC General Surgery (229-244-0034) Retterbush
- SGMC Urology (229-316-2990)
- SGMC Neurology and Neurosciences (229-242-1234)
- SGMC Valdosta Medical Clinic (229-242-8480) ON ATHENA as EHR
- SGMC Family Medicine Lakeland (229-433-8909)
- SGMC Family Medicine Nashville (229-433-8730)
- SGMC Family Medicine Hahira (229-247-7767)
- SGMC Family Medicine North Valdosta (229-433-8181)
- SGMC Sleep Services (229-259-4462)
- Connect: Kidney Care & Hypertension Clinic (229-247-1414)
- Connect: Valdosta Women's Health Center (229-333-0277)
- Connect: Partnership Health Clinic (229-245-0020)

Environment of Care/Life Safety Information

Safety Management

- Practice safe work habits and report any safety concerns to a department Director and/or the SGMC Safety Officer at x4043
- Report all on-the-job injuries or job-related illnesses to a department Director and Employee Health. If Employee Health is not available report to the Emergency Department and/or House Supervisor
- Each department has an Emergency/Safety Sub-Plan that contains information specific to the department. The information can be reviewed by contacting the department Director
- All Hospital Personnel should actively participate in all surveys and drills that are conducted in the facility to be prepared for any real-world incidents that may occur
- Detailed information regarding the Emergency Operations Plan and Emergency Codes for each campus can be found by accessing the "Policies" section of the hospital intranet page "The HUB"
- Detailed information regarding the elements of the Environment of Care for each campus can be found by accessing the "Policies" section of the hospital intranet page "The HUB"

Facts About Fire

A fire requires three elements in order to burn: oxygen, heat, and fuel. If one element is missing or removed, there can be no fire.

Fires are classified by the type of fuel that causes the fire:

- Class A fires involve normal combustibles (such as wood and paper).
- Class B fires are related to flammable liquids and gases that easily catch on fire (Such as gasoline, grease, and oil).
- Class C fires are caused by electrical energy overload or breakdown (as in electrical wiring or malfunctioning medical equipment).
- Class D fires involve combustible metals usually found in laboratories or chemical plants.
- Class K fires involve combustible cooking fluids, such as oils and fats.

Fire Prevention

Fire prevention is every employee's responsibility. Actions in almost every job in a health care facility can be done in such a way as to improve fire prevention. If an employee sees any practices or situations that reduce fire protection for patients or employees, that employee must immediately correct and report those problems.

In the Event of Fire: **RACE**

RACE stands for the four steps to follow in the event of a fire:

- **R**emove/**R**escue persons from immediate danger.
- **A**ctivate the alarm closest to the fire area. Alert persons in the immediate area by announcing the code phrase "Code Red" several times.
- **C**ontain fire by closing doors and windows where the fire is located.
- **E**xtinguish the fire by using the proper type of fire extinguisher, when appropriate.

If evacuation is needed, it will be ordered by the House Supervisor, Administrator, or the Fire Department. Personnel at offsite facilities outside of the Hospital or at business occupancies should use the nearest exit at the facility if fire or smoke is discovered.

In the Event of Fire: **Choosing a Fire Extinguisher**

Remember to follow the specific policy given to you at your facility about whether you should use an extinguisher for small fires or leave all extinguishment to firefighters.

There are six different types of fire extinguishers. Class A, B, C, and K fire extinguisher are the types normally found in health care facilities. Most organizations have a Class ABC extinguisher to address Class A, B, or C fires. Some areas such as a laboratory may also have a Class D fire extinguisher that is to be used on chemical fires. Special instructions on how to use a Class D fire extinguisher are required when attempting to put out a chemical fire. When using a Type K fire extinguisher on a cooking fire, always allow the hood suppression system to operate first.

In the Event of Fire: **PASS**

If you use a fire extinguisher on a small fire, remember to PASS in order to use the fire extinguisher properly:

- **P**ull the pin.
- **A**im at the base of the flame.
- **S**queeze the handle.
- **S**weep from side to side.

Fire Safety in the OR

Fire safety must be addressed at timeout by all staff.

Always have sterile saline or sterile water available in the event of an emergency.

Routine Protocol:

Fuel

- When an alcohol based solution is used, use minimal amount of solution and allow sufficient time for fumes to dissipate before draping. Observe drying time, minimum of 3 minutes. Do not drape patient until flammable prep is fully dry.
- Do not allow pooling of any prep solution, including under the patient.
- Remove bowls of volatile solution from sterile field as soon as possible after use.

Ignition Source

- Protect all heat sources when not in use.
- Activate heat source only when active tip is in line of sight.
- De-activate heat sources before tip leaves surgical site.

- Check all electrical equipment before use.

High Risk Protocol:

- Use appropriate draping techniques to minimize oxygen saturation.
- Electrical Surgical Unit setting should be minimized.
- Encourage use of wet sponges.
- Basin of sterile saline and bulb syringe available for suppression purposes only.

Anesthesia Care Provider Consideration:

- A syringe full of saline will be available, in reach of the anesthesia care provider, for procedure within the oral cavity.
- Documentation of oxygen concentration/flows. Use of “MAC Circuit” for oxygen administration.

Response to Fire

- Remove material on fire from patient and extinguish.
- If extinguishing of floor, ensure staff surgical attire is protected.
- Treat patient/protect surgical site.
- May need to stop surgical procedure.
- May need to remove patient from room/area.
- May need to shut off low of oxygen and nitrous oxide.
- May need to disconnect electrical power sources.
- Many need to activate fire alarm system.
- Shut off medical gas valve to operating room or zone valve to area.

Summary

As an employee of a health care facility, you must understand how to recognize fire hazards, how to prevent fire hazards, and how to respond to fire in the event that it occurs. Fire prevention actions, such as proper storage of cleaning materials or chemicals and keeping halls free of blockages, can be taken every day by all employees to prevent fire and/or allow rapid evacuation if a fire occurs. Since a fire or explosion can endanger the lives of both patients and employees, one of your most important job responsibilities is to maintain actions to prevent fire.

CHEMICAL SAFETY

Hazard Communication

Hazardous Materials & Waste Management Plan (SPP 4.016)

Hazardous Materials – Any substance which has been determined to be either a *health hazard* or a *physical hazard.*

The first step in using chemicals safely is to recognize those materials that may be hazardous to your health or physical safety.

CHEMICAL SAFETY

Hazard Communication

Hazard Communication

Information concerning the hazardous material you work with can be found on container **labels** and **Safety Data Sheets**.

Safety Data Sheets (SDS) give information on how to use, store, and dispose of chemicals as well as what PPEs to use when using one of these products and first aid for exposure to a product.

SDS sheets are located on the HUB under the “Forms and Tools” Tab. Select the “SDS Information” link.

Each department maintains a **red Hazard Communication Notebook** which contains safety and other information concerning hazardous materials.

CHEMICAL SAFETY

Hazard Communication

Hazard Communication

Pictograms on labels alert users of the chemical hazards to which they may be exposed.

Each pictogram consists of a symbol on a white background framed within a red border and represents a distinct hazard(s).

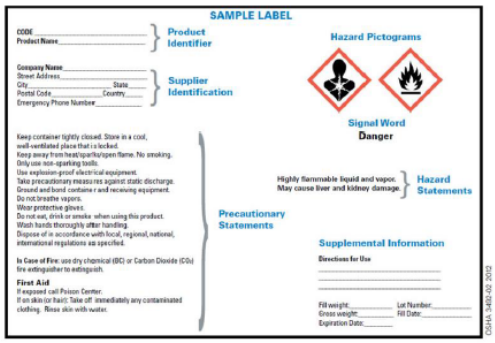
The pictogram on the label is determined by the chemical hazard classification.

CHEMICAL SAFETY

Hazard Communication

Labeling

All types of hazardous materials are identified with adequate and legible labels which include: the name given on the SDS, chemical name, hazard class, designation of the degree of hazard (e.g. danger, warning, poison) precautions that should be taken with the substance, organs the hazardous materials could adversely affect, and instructions in case of contact or exposure.



Signal Words

These words are used to alert the reader of health, physical, and environmental hazards, and the hazard's level of severity.

"Danger" and "Warning" are the only two signal words used.

Knowing how to read warning labels and SDS's could save your life – or that of someone else!

CHEMICAL SAFETY

Hazardous Materials & Waste Management

Storage

Hazardous materials are stored in clearly marked containers in strictly controlled safety storage area.

Those chemicals specified by the U.S. Environmental Protection Agency (EPA) and/or OSHA as special hazards are stored in a secure area, accessible only by authorized personnel.

Disposal

SGHS Facility personnel should correctly identify and classify any waste before placing it into the waste stream.

To assure the safety of patients, visitors, and employees, waste identified as hazardous should be disposed of in an environmentally safe manner as directed by the applicable SDS.

At SGMC, the Director of Engineering should be consulted before disposal of any hazardous materials or waste. At other SGHS Facilities, the appropriate Engineering Manager should be consulted before disposal of any hazardous material.

CHEMICAL SAFETY

Emergency Exposure

Hazardous Materials – Chemical Exposures

Routes to Exposure

1. Breathing / Inhalation
2. Skin Absorption
3. Swallowing / Ingestion
4. Eye
5. Mucous Membranes

In an emergency exposure, do not take the time to look up an SDS. Notify your supervisor and go to the Emergency Department for help. An exposure report should be completed and sent with the employee when he or she is transferred for medical attention.

CHEMICAL SAFETY

PPE

Personal Protective Equipment (PPE)

- Personal protective equipment, commonly referred to as "PPE," is equipment worn to minimize exposure to serious workplace injuries and illnesses. These injuries and illnesses may result from contact with chemical, radiological, physical, electrical, mechanical, or other workplace hazards.
- Personal protective equipment may include items such as gloves, safety glasses and shoes, earplugs or muffs, hard hats, respirators, or coveralls, vests and full body suits.

Eye Wash Protection

Eye Wash Protection

Whenever the eyes or body of a person could be exposed to Corrosive or Caustic material, each SGHS Facility provides equipment for the flushing and quick drenching in the work area for immediate emergency use. The eyewash station should be accessible to the worker within ten (10) seconds.

Hazardous Materials Spill Response

Hazardous Materials Spill Response Plan (SPP 4.009)

The majority of spills that occur at SGHS Facilities are formaldehyde/formalin and chemotherapy medications/waste.

The majority of spills that occur in SGHS Facilities will be of small, discrete quantities of materials. Some spills may require assistance in assessing. When a spill occurs, it is necessary to determine the threat posed by the material.

The SGHS Facility personnel member who has spilled the material or discovered the leak must determine the following:

1. What has been spilled?
2. Is the quantity and nature of the spilled material such that the individual causing the spill can clean it up?

Hazardous Materials Spill Response

If the answer is **YES**: Contact the departmental supervisor and initiate clean-up procedures.

If the answer is **NO**: Activate the Spill Support Team and contact departmental supervisor.

Activation of the Spill Support Team (Code Orange)

1. To activate the Spill Support Team ("Code Orange"), a SGHS Facility staff member should dial the emergency number for the operator and advise him/her of the spill.

CHEMICAL SAFETY

Hazardous Materials Spill Response

2. The SGHS Facility staff member contacting the operator should be prepared to provide the operator with the following information:

   a) Location of the spill;
   b) Hazardous material that was spilled;
   c) Number of injuries (if any);
   d) Approximate quantity of spill;
   e) Reporting person's location; and
   f) Reporting person's name.

3. The SGHS Facility operator will over-head page the Spill Support Team to the appropriate location of the spill by announcing, "Now hear this…Now hear this, "(Code Orange) (location of spill), I repeat (Code Orange) (location of spill). To be repeated two (2) times.

ELECTRICAL & EQUIPMENT SAFETY

Submitting Work Requests

Submitting Work Requests (SPP 4.005)

The Engineering Department provides prompt response to work requests in order to keep SGHS Facility equipment safe and in good repair.

Routine Repairs

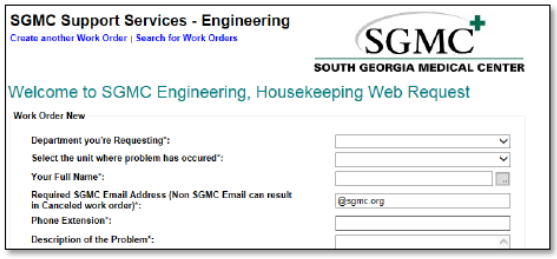
Major Repairs or Installations

Emergency Repairs

After normal business hours (0730 – 1630 Mon. – Fri.) the Engineering Dept. personnel may be reached through the PBX Operator or campus operator.

ELECTRICAL & EQUIPMENT SAFETY

Work Orders Procedures



Routine Repairs

Complete and submit a Maintenance Work Request Form by following the **link on the HUB**.

Major Repairs or Installations

Complete and submit a Maintenance Work Request Form and have the request approved by both the Department and Division Managers (see SPP 4.005).

Emergency Repairs/Requests

Call the Service Center at ext. 4048.

Preventing Electrical Fires

Electrical Cord Safety

Electricity is something we all take for granted. It does its job, day after day, without us actually seeing it or even giving it a second thought. But this complacency can lead us to ignore potentially unsafe conditions that, if left unchanged, can lead to a fire starting, or even an electrocution.

ELECTRICAL & EQUIPMENT SAFETY

Preventing Electrical Fires

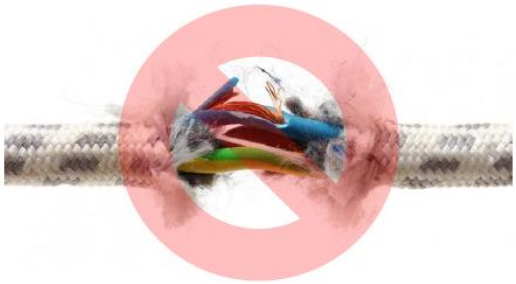
Electrical Cord Safety

Using staples, nails or similar devices to attach electrical cords to the wall – Nails, staples, wire, and similar objects can break through the insulating jacket of electrical cords; either immediately when they are applied, or later after months or even years of wear and tear. This could eventually lead to sparks or excessive heat building up and igniting a fire.

Preventing Electrical Fires

Electrical Cord Safety

Running electrical cords through doorways or windows – If the door or window gets closed, the cord can become pinched, which can damage the outer jacket of the cord. This too could eventually lead to sparks or excessive heat build-up, igniting a fire.



ELECTRICAL & EQUIPMENT SAFETY

Preventing Electrical Fires

Preventing Electrical Fires

Leaving unsafe electrical cords in service

If you find a cord that is being used improperly, or is damaged, please notify your supervisor immediately, or submit a work order on the HUB.

DO NOT try to repair a cord unless specifically authorized. Your quick action could prevent an unfortunate accident from occurring.

ELECTRICAL & EQUIPMENT SAFETY

Emergency power is supplied to the red wall receptacles only. Use them for important medical devices before a potential outage could occur.

ELECTRICAL & EQUIPMENT SAFETY

Preventing Electrical Fires

Do not use extension cords in patient care areas.

Electrical cords should never be placed under rugs or other items.

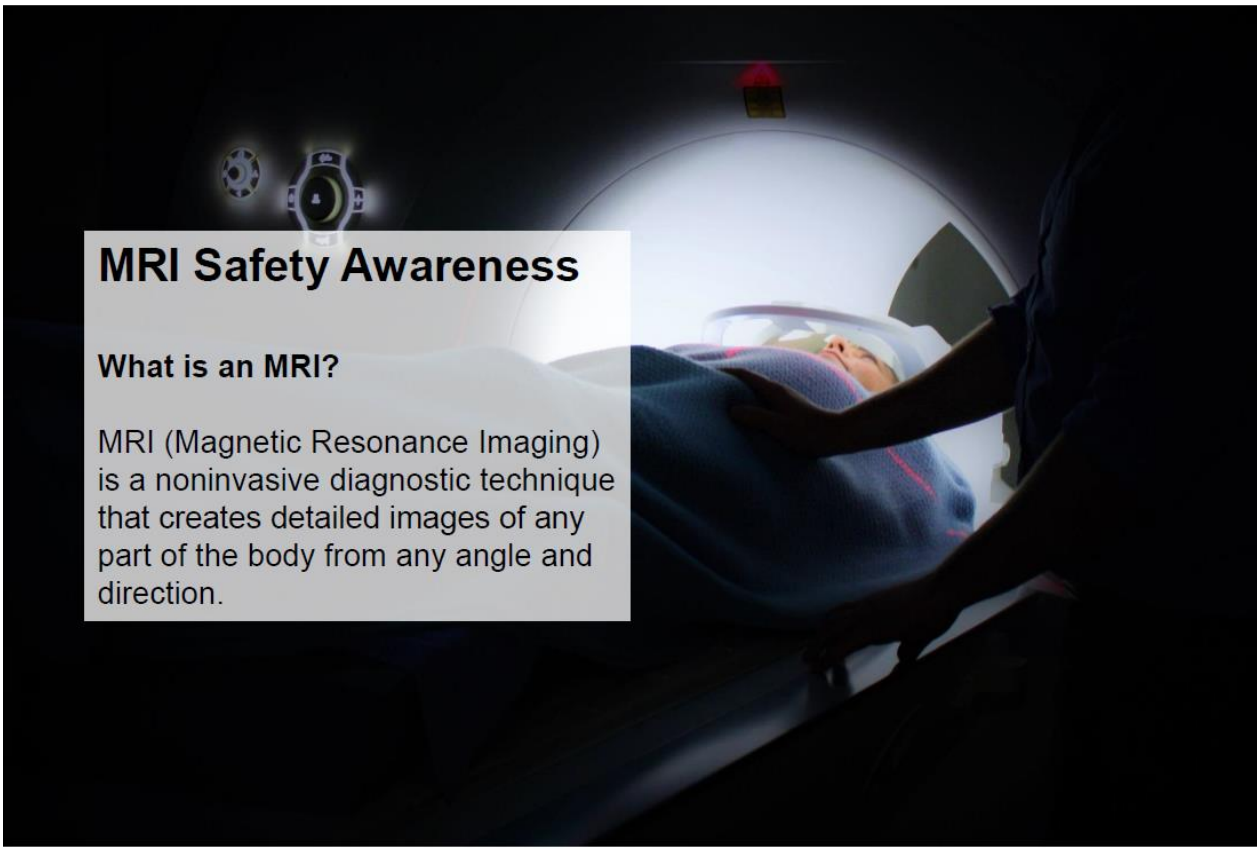
Do not use any item with a damaged cord or plug.

ELECTRICAL & EQUIPMENT SAFETY

Lockout/Tagout

Lockout/Tagout cont'd.

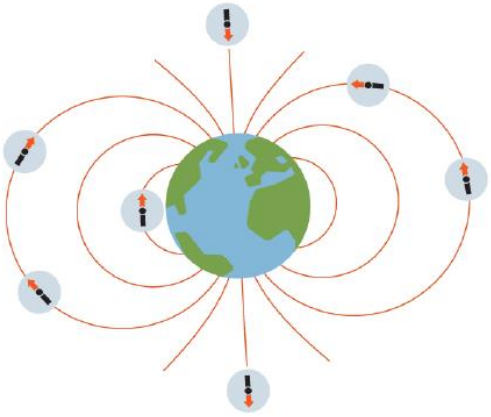
Compliance with the lockout/tagout standard prevents an estimated 120 fatalities and 50,000 injuries each year. Workers injured on the job from exposure to hazardous energy lose an average of 24 workdays for recuperation (OSHA).

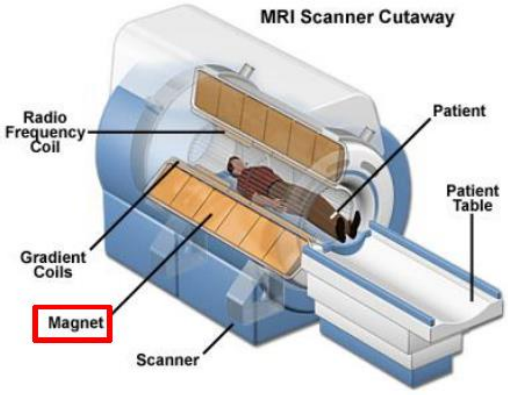


ELECTRICAL & EQUIPMENT SAFETY

MRI Safety Awareness

The biggest and most important component in an MRI system is the MAGNET.





A typical MRI scanner has a magnetic field that is ***30,000 times stronger than the earth's magnetic field!***

MRI Safety Awareness

ELECTRICAL & EQUIPMENT SAFETY

MRI Safety Awareness

Precautions

The MRI suite can be a very dangerous place if strict precautions are not observed.

ELECTRICAL & EQUIPMENT SAFETY

MRI Safety Awareness

Metal objects can become dangerous projectiles. Items such as paperclips, pens, keys, scissors, hemostats, & stethoscopes should be removed before entering the area.

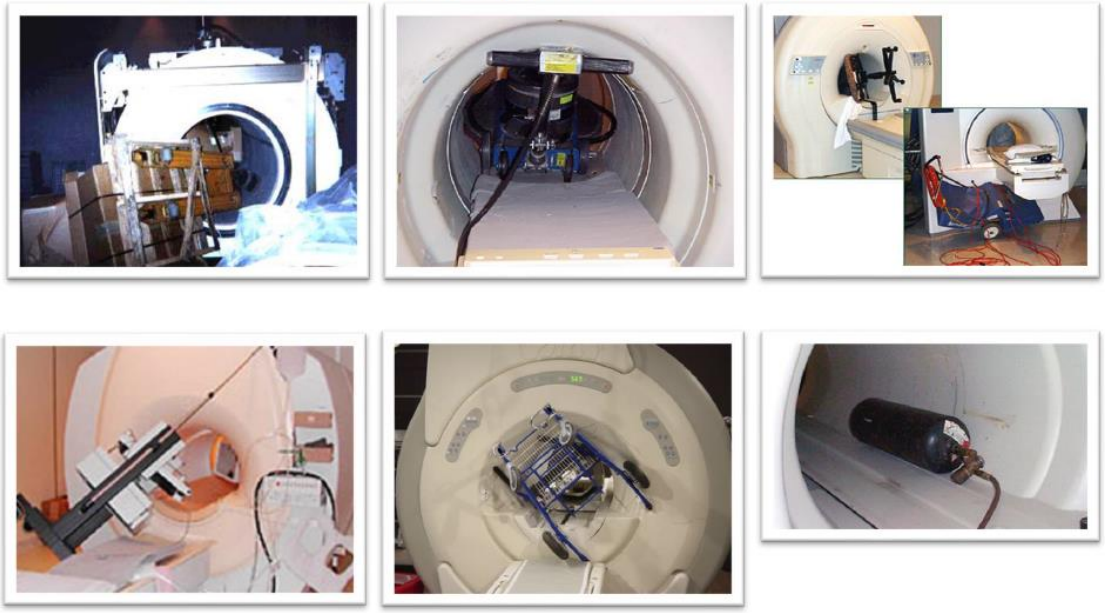
ELECTRICAL & EQUIPMENT SAFETY

MRI Safety Awareness

Even jewelry, belt buckles, metal bra hooks, and hearing aids can be pulled into the scanner.

MRI Safety Awareness

Examples of items pulled into MRI machines.

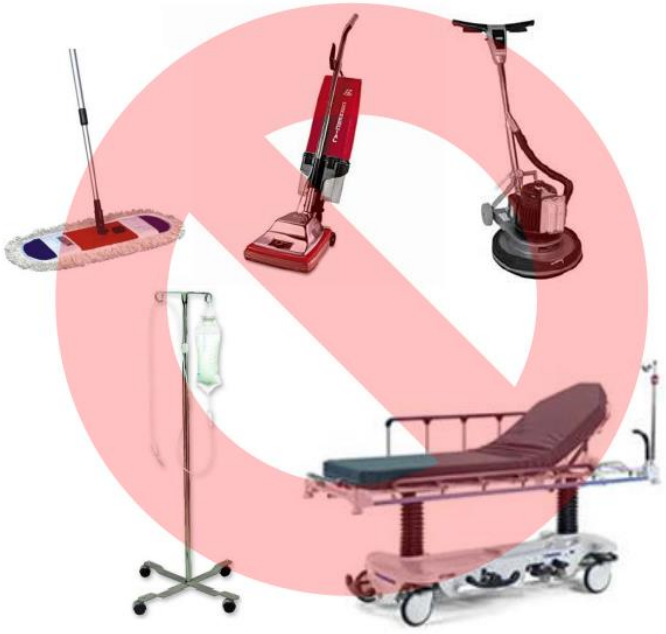


ELECTRICAL & EQUIPMENT SAFETY

MRI Safety Awareness

Other items that could become projectiles due to the pull of the magnet.

- mops
- mop buckets
- floor waxers
- vacuum cleaners
- IV poles
- oxygen tanks
- patient stretchers
- wheelchairs
- equipment carts
- heart monitors



MRI Safety Awareness

What about Internal Objects?

The following items have the potential to cause injury to a person. A MRI staff member will investigate thoroughly to make sure it is safe for the individual to enter the MRI area.

- Metallic fragments in the eye
- Pacemakers
- Aneurysm clips
- Dental implants
- Orthopedic implants
- Metal staples
- Certain tattoos
  - Certain chemicals in tattoo ink can cause a reaction in the patient's skin when exposed to the MRI magnet.

ELECTRICAL & EQUIPMENT SAFETY

MRI Safety Awareness

What Should I Do?

- Receive permission from MRI staff before entering the area.
- Direct patients and visitors to the Radiology Desk - not the MRI department.
- Remember that no metal objects are allowed in the MRI area.

Excerpt from the Emergency Operations Plan
Policy # 4.017 effective 2/15/2023

Regarding Medical Staff

I. General Provisions

A. This Emergency Operations Plan (EOP) is designed to establish guidance for controlling and coordinating the six (6) critical areas of emergency management in order to assess SGMC's needs and prepare personnel to respond to an Incident/Emergency/Disaster. The six (6) critical areas are:

1. Communication
2. Resources and assets
3. Safety and security
4. Staff responsibilities
5. Utilities management
6. Patient clinical and support activities

B. This EOP is coordinated with various county emergency management agencies and ensures that Incident Command is integrated into and consistent with each community.

C. This EOP incorporates the Hospital Incident Command System (HICS) and an all hazards response.

D. This EOP shall be in compliance with all state, federal, or other applicable laws and regulations.

II. Covered Locations/ Occupancies Types

A. This EOP covers healthcare occupancies and business occupancies, including:

1. SGMC Main Campus Building (Healthcare occupancy)
2. Administrative Services building (Business occupancy)
3. Outpatient MRI (Business occupancy)
4. Patient Financial Services (Business occupancy)
5. SGMC Mobile Healthcare Services (Business occupancy)
6. Family Practice – Greystone 1 & 2 (Business occupancy)
7. South Georgia Medical Center Occupational & Industrial Medicine and Health Care South (Business occupancy)
8. Surgery Center - Ambulatory Surgery Center (Ambulatory surgery occupancy)
9. Wound Healing / Youth Care (Business occupancy)
10. Professional Building (Business occupancy)
11. Diabetes Management Center (Business occupancy)
12. SGMC Outpatient Plaza (Healthcare occupancy)
13. SGMC Family Medicine Hahira (Business occupancy)
14. SGMC Family Medicine Lakeland (Business occupancy)
15. SGMC General Surgery (Business occupancy)
16. SGMC Valdosta Medical Clinic (Business occupancy)
17. SGMC Family Medicine, Nashville (Business occupancy)

B. Business Occupancies

1. The normal hours of operation for most business occupancies is Monday through Friday from 0800 to 1700.
2. Not all business occupancies are designated as disaster receiving stations.
3. Business occupancies have a specific department Incident/ Emergency/Disaster sub-plan. Business occupancies are considered during SGMC's HVA and department specific sub-plans are drafted to identify their response to care for patients, staff and visitors in their area in an emergency.
4. Business occupancies participate in one (1) EOP drill per year.

C. Healthcare Occupancies

1. This EOP is activated at the Surgery Center and the SGMC Outpatient Plaza during exercises or real-world events when this EOP is activated by SGMC.

2. The SGMC Outpatient Plaza Campus develops separate plans for utilities due to their differing provider. For all other EOP areas, the SGMC Outpatient Plaza Campus falls within the scope of this EOP and follows the designated codes listed in the plan.

XIII. Granting Disaster Volunteer Privileges

A. Volunteer Licensed Independent Practitioners (EM.02.02.13 2015 EP: 1-9)

1. During disasters, SGMC may grant disaster privileges to volunteer licensed independent practitioners. SGMC grants disaster privileges to volunteer licensed independent practitioners only when the Emergency Operations Plan has been activated in response to a disaster and SGMC is unable to meet immediate patient needs.
2. The Administrator or his designee, the Chief of Staff or his designee or the Medical Director are authorized to grant disaster privileges to volunteer licensed independent practitioners.
3. SGMC distinguishes volunteer licensed independent practitioners from other practitioners by providing volunteers with identification badges that says “volunteer” and are red at the bottom of the badge.
4. The Medical Staff oversees the performance of volunteer licensed independent practitioners.
   a) The Service Chief and Department Chairman or their designee provide supervision for practitioners working in their department.
   b) The supervision may be by direct or indirect observation, monitoring and/or medical record review to the extent possible during and following the disaster.
   c) Before a volunteer is considered eligible to function as a volunteer licensed independent practitioner, SGMC obtains his or her valid government-issued photo identification (for example, a driver’s license or passport) and at least one (1) of the following:
      i. Current picture identification card from a health care organization that clearly identifies professional designation;
      ii. A current license to practice;
      iii. Primary source verification of licensure;
      iv. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), Georgia's State Emergency Registry of Volunteers (SERVGA) or other recognized state or federal response organization or group;
      v. Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances; or
      vi. Confirmation by a licensed independent practitioner currently privileged by the hospital or by a staff member with personal knowledge of the volunteer practitioner’s ability to act as a licensed independent practitioner during a disaster.

5. SGMC determines within seventy-two (72) hours of the practitioner's arrival if granted disaster privileges should continue.

a) Primary source verification of licensure occurs as soon as the immediate emergency situation is under control or within seventy-two (72) hours from the time the volunteer licensed independent practitioner presents him- or herself to SGMC, whichever comes first.
b) If primary source verification of a volunteer licensed independent practitioner's licensure cannot be completed within seventy-two (72) hours of the practitioner's arrival due to extraordinary circumstances, SGMC will document all of the following:
    i. Reason(s) it could not be performed within 72 hours of the practitioner's arrival;
    ii. Evidence of the licensed independent practitioner's demonstrated ability to continue to provide adequate care, treatment, and services; and
    iii. Evidence of SGMC's attempt to perform primary source verification as soon as possible. If, due to extraordinary circumstances, primary source verification of licensure of the volunteer licensed independent practitioner cannot be completed within seventy-two (72) hours of the practitioner's arrival, it is performed as soon as possible. Primary source verification of licensure is not required if the volunteer licensed independent practitioner has not provided care, treatment, or services under the disaster privileges.

B. Volunteer Licensed, Certified or Registered Practitioners Who are Not Licensed

Independent Practitioners (EM.02.02.15 2015 EP: 1-9)

1. During Incident/Emergencies/Disasters, SGMC assigns disaster responsibilities to volunteer practitioners who are not licensed independent practitioners only when the Emergency Operations Plan has been activated in response to a disaster and SGMC is unable to meet immediate patient needs. Also see, SGMC policy, Assignment of Disaster Responsibilities to Volunteer Practitioners
2. The Chief or Chief Elect of the Medical Staff or the Chief Medical Officer, the Assistant Administrator for Patient Care Services, the Assistant Administrator for Clinical Services, and the Assistant Administrator for Ancillary Services or the Administrator on Call are responsible for assigning disaster responsibilities and overseeing the professional performance of non-physician volunteer practitioners who are assigned disaster responsibilities. SGMC staff should directly observe volunteers' performance.
3. SGMC distinguishes volunteer practitioners who are not licensed independent practitioners from other practitioners by an identification badge along with the word "volunteer".
4. Before a volunteer practitioner who is not a licensed independent practitioner is considered eligible to function as a practitioner, the hospital obtains his or her valid government-issued photo identification (for example, a driver's license or passport) and one (1) of the following:
    a) A current picture identification card from a health care organization that clearly identifies professional designation;
    b) A current license, certification, or registration;
    c) Primary source verification of licensure, certification, or registration (if required by law and regulation in order to practice);
    d) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), Georgia's State Emergency Registry of Volunteers (SERVGA), or other recognized state or federal response organization or group;
    e) Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances; or
    f) Confirmation by hospital staff with personal knowledge of the volunteer practitioner's ability to act as a qualified practitioner during a disaster.

5. Based on its oversight of each volunteer practitioner who is not a licensed independent practitioner, SGMC determines within seventy-two (72) hours after the practitioner's arrival whether assigned disaster responsibilities should continue. Primary source verification occurs as soon as the immediate Incident/Emergency/Disaster situation is under control or within seventy-two (72) hours from the time the volunteer practitioner presents him- or herself to the hospital, whichever comes first. If primary source verification cannot be completed within 72 hours due to extraordinary circumstances, SGMC will document all of the following:

a. Reason(s) it could not be performed within seventy-two (72) hours of the practitioner's arrival;
b. Evidence of the volunteer practitioner's demonstrated ability to continue to provide adequate care, treatment, or services; and
c. Evidence of the hospital's attempt to perform primary source verification as soon as possible.

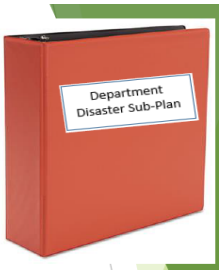
6. If, due to extraordinary circumstances, primary source verification of licensure of the volunteer practitioner cannot be completed within seventy-two (72) hours of the practitioner's arrival, it is performed as soon as possible.

7. Primary source verification of licensure, certification, or registration is not required if the volunteer practitioner has not provided care, treatment, or services under his
or her assigned disaster responsibilities.

Departmental Sub-plans

- Departmental Sub-plans are located in two places. It is the responsibility of the employee to know where these are located and how to obtain them.
  1. *A hard copy of the Sub-plans should be located in a central location in your department and should be accessible to all staff.*
  2. *Electronic versions of the Sub-plans are located on The HUB "Emergency" Page.*
- Departmental Sub-plans should be reviewed and updated regularly
- Departmental Sub-plans contain important "department specific" information for **all Emergency Codes**.

You must know the answers to these questions:
>Where is my department's disaster plan located?
>What does it contain?
>Where do I report during a disaster?
>What are my specific responsibilities during a disaster?



NOTE: Physicians and other ancillary staff who do not work in a particular department, but visit various departments, should follow the lead of staff in those areas if a code is called.
They should take note of where fire extinguishers and fire-pull stations are located, and possible exits and evacuation routes.

Excerpt from the Emergency Operations Plan Policy # 4.017 effective 2/15/2023 ***Page 61-62***

*Emergency Operations Plan Policy # 4.017 **l**ocated on HUB: Policies/Environment of Care, Emergency Management, Life Safety/Emergency Operations Plan*

Abuse and Neglect Education

ABUSE & NEGLECT

"Mandated Reporters"

"Mandatory reporters" are persons in certain professions who are required by law to report suspected child/adult abuse or neglect. This list includes:

- Physicians (including interns and residents)
- Hospital or other medical personnel
- Registered Professional Nurses
- Licensed Practical Nurses
- Social Workers

Georgia Law:

Physicians and hospital staff must report suspected abuse and non-accidental injuries. Knowing and willful failure to report child/adult abuse is a MISDEMEANOR.

Georgia law provides immunity to any person who, in good faith, makes a report as described in System Policy & Procedure 2.005.

SGMC Growing Healthy Together

ABUSE & NEGLECT

Who is at Risk for Abuse and/or Neglect?

Spouses and Significant Others

The Elderly

Children

SGMC Growing Healthy Together

ABUSE & NEGLECT

Signs of Abuse & Neglect

What is Abuse & Neglect?

Abuse

Being treated in a harmful, injurious, or offensive way

- Physical
- Emotional
- Sexual
- Financial (Elderly)

Neglect

Having essential things withheld

- Physical
- Medical
- Emotional
- Educational (Children)

SGMC Growing Healthy Together

ABUSE & NEGLECT

Signs of Neglect – *What to Look For*

Children

- No preventive medical care
- Poor hygiene or dirty
- Fatigue
- Poor school attendance
- Complaints of hunger
- Left unattended
- Appear undernourished
- Lack appropriate clothing

Elderly

- Unattended physical problems or medical needs
- Poor hygiene
- Constant fatigue or listlessness
- Consistent hunger
- Abandonment
- Inappropriate dress
- Missing assistive devices or devices are in poor repair
  - Glasses, dentures, hearing aides, walking devices

SGMC Growing Healthy Together

ABUSE & NEGLECT

Signs of Abuse in Children

- Trauma marks (bruises, welts, lacerations on back &/or abdomen or bruises in various stages of healing)
- Unexplained skin lesions
- Lesions in different body areas reportedly from same injury
- Lesions/burns that have distinctive patterns (such as shape of an iron or cigarette
- Burns that are reportedly secondary to accidental immersion in hot water
- Unexplained lacerations to face, mouth, eyes, or external genitalia
- Evidence, upon examination, of old fractures
- Spiral fractures
- Bite marks
- Unusual wariness of adults
- Obvious untreated medical/physical problems
- Ingestion of noxious substances

Signs of Sexual Abuse in Children

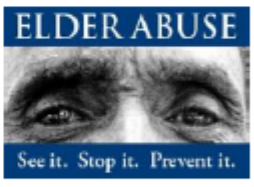
- Pain or itching in genital area
- Bruising or bleeding in the perineal area
- Venereal disease (pre-adolescent group)
- Difficulty sitting or walking
- Pregnancy
- Sexual behavior or knowledge inappropriate for age
- Anal injuries
- Reports of sexual assault by caretaker

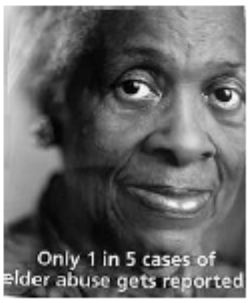
SGMC Growing Healthy Together

ABUSE & NEGLECT

Signs of Abuse in the Elderly

- Unexplained bruises, black eyes, welts, wounds usually in various healing stages
- Unexplained burns usually to the soles of feet, palms or buttocks
- Unexplained healed and unhealed fractures
- Patchy hair loss
- Bed sores





Signs of Sexual Abuse in the Elderly

- Pain or itching in genital area
- Bruising or bleeding in genital and or anal area
- Torn, stained or blood on underclothing
- Difficulty sitting or walking

SGMC Growing Healthy Together

ABUSE & NEGLECT

Abuse/Non-Accidental Injury/Suspicious Death Reporting
(SPP 2.005)

Steps to Take Per SPP 2.005

1. Notify the Administrator On Call at your facility *(also inform your immediate supervisor)*
2. Be prepared to report and document the following:
   a. Assessment information, including subjective and objective information
   b. Direct patient quotes, when available
   c. Date, time and name of entities and/or person notified
   d. Name of person making any report.

The disclosure is also entered in the Disclosure Log.

SGMC Growing Healthy Together

ABUSE & NEGLECT

Conclusion

Administrator On Call will contact the appropriate organizations/authorities.

It is important for all staff to remember:

1) Provide a safe and private setting for conversations to occur.

2) Record statements using as many exact quotes as possible. **Do not analyze** or interpret the recollections of the victim.

3) If the victim is medically unstable, unconscious, or under the influence of drugs or alcohol, any formal interview should be postponed. Notify the Administrator On Call as to the condition of the individual.

SGMC Growing Healthy Together

ABUSE & NEGLECT

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SGMC Growing Healthy Together

ABUSE & NEGLECT

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SGMC Growing Healthy Together

SOUTH GEORGIA HEALTH SYSTEM
SYSTEM POLICIES AND PROCEDURES

TITLE: Care of the Dying Patient **APPROVALS:** **Function Approval:** Chief Nursing Officer Chief Medical Officer 5/24/2024 Chief Executive Officer	**FACILITIES:** ☒ SGMC ☒ SGMC Berrien Campus ☒ SGMC Lanier Campus ☐ SGMC Lakeland Villa	**SYSTEM POLICY NUMBER**: 2.017 **FUNCTION:** ☐ 1.000 Administrative/ Operations ☒ 2.000 Clinical Services ☐ 3.000 Compliance ☐ 4.000 Environment of Care ☐ 5.000 HIPAA ☐ 6.000 Finance ☐ 7.000 Human Resources

PURPOSE:

The purpose of this Policy is to provide guidance for caring for a dying patient, including accommodation of the patient's physical, psychological, emotional, and spiritual needs.

APPLICATION:

This Policy applies to the SGHS Facilities which are selected above and listed as follows: South Georgia Medical Center ("SGMC"), SGMC Berrien Campus and SGMC Lanier Campus. Such facilities are referred to as a "SGHS Facility" in the singular, and collectively as "SGHS Facilities".

DEFINITIONS:

SGHS means South Georgia Health System, a trade name used by the Hospital Authority of Valdosta and Lowndes County, Georgia for the hospitals, nursing home, clinics and health care facilities and services owned and operated by the Hospital Authority of Valdosta and Lowndes County, Georgia.

SGHS Facility means, for purposes of this Policy, SGMC, SGMC Berrien Campus, and SGMC Lanier Campus.

POLICY:

A. SGHS Facilities provide appropriate physical, psychological, emotional and spiritual support to the dying patient and his / her family support persons.

B. SGHS Facility staff are educated on the needs of dying patients and their families and measures to accommodate such needs.

PROCEDURE:

SGHS Facilities believe that concern and respect for the patient's comfort and dignity should guide all aspects of care during the final stages of the patient's life.

A. Initial Assessment

1. During the initial assessment of patients who are near or at the end of their lives, SGHS Facility nursing personnel determine any social, spiritual or cultural variables that may influence the patient's and the patient's family members' perception of grief.

2. Information gathered from such assessment should be documented in the patient's healthcare record.

B. Patient Care

Based on the assessment of the patient's needs, care should be provided to meet the patient's needs, as appropriate, including, but not limited to:

1. Accommodating a patient's physical needs, which may include:
   a. Repositioning the patient frequently;
   b. Changing or straightening linens and gown as needed;
   c. Providing skin care;
   d. Adjusting room temperature and lighting to patient comfort;
   e. Observing for incontinence or anuria, and, as appropriate, obtaining a provider's order to catheterize patient; changing the patient's linens as needed; and providing perineal care;
   f. Cleaning patient's mouth frequently, removing oral secretions with gentle suction as needed;
   g. Offering fluids frequently, as appropriate;
   h. Providing eye care as needed; and
   i. Providing pharmacological and non-pharmacological pain relief measures.

2. Accommodating a patient's psychological / social / emotional needs, which may include:
   a. Explaining care and treatments;
   b. Answering questions;
   c. Allowing the patient / family member to talk, express feelings, and share worries and concerns. This may be accomplished by:
      i. Allowing the person to express feelings and emotions in his/her own way;
      ii. Providing presence and listening;
   d. Taking time to talk to patient even if he / she appears not to hear;
   e. Respecting patient's need for privacy - Some patients will want to have time alone; and
   f. Providing the patient private room if available.

3. Accommodating a patient's spiritual / cultural needs, which may include:
   a. Offering to contact a member of the Clergy, Hospital Chaplain, or other person;

b. Respecting the patient / family's religious beliefs;
c. Allowing social, spiritual and / or cultural expressions of grief, as appropriate;
d. Respecting the patient's privacy during spiritual moments; and
e. Handling religious objects such as medals, pictures, statues, Bibles as valuables.

4. Providing treatment of the patient's primary and secondary symptoms that respond to treatment or as appropriate.

5. Allowing family support and involvement to the extent the patient desires and as appropriate to care.

6. Respecting the patient's end of life decisions, as appropriate.

7. Educating the patient and family as early as possible and as often as needed about symptoms, what to expect, and options.

8. Respecting the needs of the patient and the patient's family by:
   a. Showing concern by being available, courteous, and considerate;
   b. Using appropriate touch to convey concern;
   c. Respecting the patient's and family's right to privacy and allowing the patient's family members to spend as much time with the patient as possible (visiting hours do not apply if the patient is dying);
   d. Allowing family members to help care for the patient if they wish and if it is acceptable to the patient. If they do not wish to participate in care, suggesting they take a break when SGHS Facility staff is providing care for the patient;
   e. Recognizing that family members in their grief go through stages similar to the dying person. If the family is angry, not taking this anger personally and continuing to treat the patient and family with courtesy and respect; and
   f. If the patient or his / her family request clergy, communicating this request immediately.

RESPONSIBILITY

The individual serving in the following capacities is responsible for the content of this Policy: Chief Nursing Officer

POLICY HISTORY

Original Adoption Date: October 1997 (Originally PCS I-J-10)

Review/Revision History:
Reviewed: 3/09, 3/12
Revised: 3/00, 3/06
Revised and renumbered: 8/07/15
Revise: 4/30/18, 5/13/2021

LifeLink: Understanding Organ and Tissue Donation

LifeLink® of Georgia

Understanding Organ and Tissue Donation

Who is LifeLink® *of Georgia*?

LifeLink *of Georgia* is the federally designated organ and tissue recovery organization for the state of Georgia, also referred to as an OPO (organ procurement organization.)

Who is a potential organ donor?

Any patient on a ventilator with a neurological injury or anyone evaluated for brain death, terminal wean or change in resuscitation status may be a candidate for organ donation.

Who is a potential tissue donor?

Every patient who dies may be a potential tissue donor.

Recoverable tissues include skin, bone, corneas, tendons, heart valves and saphenous veins.

Did you know?

- The donor family is never charged for donation.
- The removal of donated organs and tissues is similar to any other surgical procedure, taking place in a sterile operating room environment.
- The family may proceed with any funeral arrangements they wish, including a viewing.
- You play a vital role in the organ and tissue donation process!
- One organ, eye, and tissue donor can help save or enhance the lives of sixty people!

Who calls LifeLink®?

Anyone from the healthcare team with access to the medical record can call the Donation Referral Line at 800-882-7177.

Why is it important to call?

It's required by CMS, Joint Commission and regulatory agencies policies regardless of age or medical/social history.

Calling preserves the option of donation by allowing for determination of medical suitability and donor designation status. A collaborative plan of care can also be identified.

Thousands of patients awaiting transplant depend on the donation referral so donation can be an option and lives can be saved.

When is the appropriate time to call LifeLink?

Call the Donation Referral Line as soon as a vent dependent patient meets the clinical triggers as defined by **LifeLink** (see reverse). Patients who die from cardiac death should be referred within one hour of the cardiac time of death.

Who talks to the patient's family about donation?

LifeLink Family Care Coordinators, in collaboration with the healthcare team compassionately speak with families to convey donation options.

Can I talk to the family about donation?

Any individual who initiates a discussion or provides information about donation or requests donation must be an OPO representative or have been trained by the OPO to have this discussion.

If a family members brings up donation, contact **LifeLink**

Please do not mention donation to the family.

Tiffney Waits had a bubbly personality and was deeply loved by her family, especially her husband, Josh, and two children. Tragically, a car accident claimed her life in 2013. Tiffney's young son who survived the accident that took his mom's life says, "My mom is a superhero. She saved the lives of others with donation, just like she saved ours."

De'Jael was diagnosed with dilated cardiomyopathy, a condition in which the heart's ability to pump blood is decreased, only a few short weeks following her second birthday. She had hardly begun to live before her life was threatened. Thanks to her donor family, De'Jael got a second chance to grow up. "De'Jael would not be alive without their loved one. It is because of them she can live out her dreams as a normal, healthy, child," says her mom, Karema. Now, almost seven years old, De'Jael is full of life and ready to tackle the world.

When should I call LifeLink for Initial Assessment of Organ and Tissue Donation?

- **CMS regulations require you to call within one hour after a cardiac death.**
- **CMS regulations require you to call within one hour of the following triggers being met.**

If your patient is intubated and shows evidence of the following:

- Coma
- Stroke
- Hypoxia
- Brain Tumor
- Cerebral Injury
- Near-Drowning
- Cerebral Edema
- Cerebral Hemorrhage

AND
Any of the following criteria are met:

- GCS≤5, not sedated
- Unresponsive or posturing
- No pupillary or corneal reflex
- No cough or gag
- No spontaneous respiration
- Discussion of DNR or withdrawal of support

OR THE FAMILY ASKS ABOUT DONATION, PLEASE CALL LIFELINK IMMEDIATELY.

Donor Referral Line: 1-800-882-7177

It really is all about the 1's....

1 donor at a time
1 donor family at a time
1 transplant candidate at a time
1 day at a time
....and each 1 of YOU!

Patient Rights: Guiding Actions

We should always:

- Provide considerate, respectful care.
- Treat with common courtesy.
- Greet with a knock and wait before entering.
- Introduce self with name and title.
- Respect patient and family wishes.
- Protect patient privacy.

Patient Rights: Guiding Actions

Patients are entitled to know:

- Care team names
- Always wear your name badge properly.
- Write your name and complete the in-room patient communication board.
- How to reach care team
- Explain the use of the nurse call button.
- Explain how to dial the nurses' station.

Patient Has The Right To…

- Receive information from physicians and clinical staff to discuss the benefits, risks, and costs of appropriate treatment alternatives.
- Make informed decisions regarding his or her care.
- Considerate, respectful care with recognition of personal dignity.
- Confidentiality.
- Have adequate health care.
- Freely voice complaints and receive a timely resolution of complaints concerning his/her care.

Interpretation

Limited English Proficiency

- It is our patients right to protect those with Limited English Proficiency by offering interpretation services to bridge the communication gap. They have the right to understand what is going on just the same as you and me.
- Failing to provide proper language translation to limited or non-English speaking and/or hearing impaired patients is a violation of patient civil rights and is an Office of Civil Rights Title VI violation (OCR Title VI).
- An OCR Title VI violation is easy to avoid by simply using one of our interpretation services!

Interpretation Cont'd.

Interpretation Services

- World Wide Interpreters (WWI)
  - Provides our staff with professional, medical-certified translation support of over 200 languages 24/7.
  - Available through dedicated cordless phones located throughout our facilities.
  - Available on any phone by dialing 1-800-945-7889.

- DT Interpreting (DeafTalk)
  - Monitor on wheels that allows a patient to visually see a deaf interpreter provide sign language and also allows the interpreter to verbally speak to our employees simultaneously.
  - Interpretive services for the hearing impaired are available 24/7.
  - Assistance in use is required by all departments as it must follow the patient throughout their admission process.
  - During normal business hours, contact Patient Relations for assistance. During evening, nights, weekends, and holidays, call the House Supervisor for assistance.

Interpretation Cont'd1

Conditions of Using Interpretation:

- You must ALWAYS use an interpreter service provided by SGMC to translate foreign languages for ALL patients that either speak little or no English.
- Use of other employees to translate care is NOT permitted.
- Use of family members, or other services for language interpretation is strongly discouraged.
- Not using SGMC interpretation services which provide interpreters who are trained to communicate in a non-biased professional, and medical way could be considered discrimination.
- Through the selected SGMC interpreting service, you may ask the patient if they would prefer to use their own interpreter.
- If the patient refuses our interpretation services do the following:
  - Document it by having the patient complete a waiver which is located on "Forms on Demand."
  - You must use the SGMC WWI service to interpret the waiver to the patient.
  - Once explained and completed, the patient must sign the waiver and staff will place it in the patient's chart.
  - Always document that you used an WWI Interpreter.

Make Informed Decisions

Making Informed Decisions

- Patients are entitled to know about their medical status and treatment.
- Patients may refuse or accept treatment. They may be asked to sign documents stating their decisions and retain the right to stop treatment at any point.
- Most surgical and invasive procedures require written, informed consent which includes:
  - Patient's name
  - Witness(es)'s name(s)
  - Person's name performing the procedure
  - Risks
  - Complications
- Unless an applicable exception applies, a person who undergoes any surgical or invasive procedure or transfusion of blood or blood products must consent to such procedure and be informed in general terms of the consent.

An Advance Directive

Advance Directives

- An Advance Directive is any legal document that states a patient's treatment preferences in extreme circumstances.
- Living Will
- Durable Power of Attorney for Health Care
- Federal law requires patients over 18 years of age to be asked if they have an Advance Directive.
- At SGMC, the patient is queried at the time of registration as to whether they have an Advance Directive. Please refer to Advance Directive Policy SPP 1.008.
- After admission, if the patient requires additional information or guidance on how to complete and Advance Directive, a consult must be submitted through EPIC for Patient Relations to respond.

Living Will vs. Durable POA for Healthcare

- Living Will
  - A document which states an individual's wishes regarding medical treatments and life-sustaining measures.
  - A living will is equal to an Advance Directive.

- Durable Power of Attorney for Healthcare
  - Allows a patient to appoint someone to make treatment decisions for them if they are unable to do so.
  - This differs from the Living Will which allows patients to make their own decisions prior to treatment.
  - A Durable Power of Attorney for Health Care is equal to an Advance Directive.

Advance Directives

Special Considerations

- If patients are admitted without an Advance Directive and are not able to make their own treatment decisions, the next of kin (Spouse, legal guardian of adult (in the absence of spouse/child - or if either have given up rights to make decisions or are unfit), adult child/children, adult sibling(s), grandparents, adult grandchild, adult niece/nephew, aunt or uncle related in the first degree, or adult friend) in that order, are the decision makers.
- An ethics committee may be able to make suggestions to resolve conflicts when the patient's family and physician cannot agree.
- When no family is available, two or more physicians must certify in writing the need for specific treatment.
- If the patient is near death, has no Advance Directive and no family members, SGMC has specific policies regarding end-of-life care.

What is Healthcare Compliance?

The Compliance Program promotes the prevention, detection and resolution of actions that do not conform to legal, policy or business standards.

In summary, the Compliance Program helps the hospital be more ethical and helps prevent Fraud, Waste and Abuse.

What is Fraud, Waste and Abuse (FWA)?

Healthcare Fraud, Waste and Abuse refers to the misrepresentation or intentional misuse of resources, funds and services in a healthcare setting.

- Fraud is the misrepresentation of information to gain undeserved payment for a claim.
- Waste involves spending federal healthcare dollars on services that are unnecessary.
- Abuse includes any practice that is not consistent with the goals of providing patients with services that are medically necessary, meet professionally recognized standards and are fairly priced.

Healthcare Laws

There are laws designed to prevent Fraud, Waste and Abuse that apply to SGMC because of our participation in federally funded programs such as Medicare and Medicaid. These include specific billing requirements for government programs and other third-party payors.

- False Claims Act
- Anti-Kickback Statute
- Civil Monetary Penalties Law
- Exclusion Statute
- Stark Law

We all have a responsibility to watch for and report Fraud, Waste and Abuse.

SGMC is committed to identifying, preventing, investigating and reporting potential Fraud, Waste and Abuse. This commitment requires each of us to take the topic very seriously.

Part of our commitment includes implementing policies and procedures, conducting training and education and performing monitoring and auditing activities.

What can you do?

- Only bill for services provided that are medically necessary
- Use appropriate medical record documentation
- Use only licensed staff for patient care
- Dispense drugs only when there is a legitimate medical purpose
- Provide only necessary services to patients
- Never knowingly present a false or fraudulent claim for payment or approval
- Never offer or accept anything of value in exchange for a referral
- Never accept kickbacks from any third party for SGMC business
- Report suspected or actual Fraud, Waste and Abuse as soon as possible directly to the Compliance Officer or through the Compliance Hotline

The stakes are high…

Failure to comply with Fraud, Waste and Abuse laws can result in:

- Fines
- Prison time
- Program Exclusion

Compliance with SGMC Policies

To help us comply with Fraud, Waste and Abuse laws, SGMC has implemented various internal policies for the organization.

- Corporate Compliance Program (SPP 3.001)
- Code of Conduct (SPP 3.002)
- Compliance Reporting and Non-Retaliation (SPP 3.003)
- Conflict of Interest (SPP 3.004)
- Code of Ethics (SPP 3.005)

What is Ethics?

Because SGMC exists to serve people, we believe that our decisions and actions should be guided by ethical considerations.

- Ethics is knowing the difference between right and wrong, good and bad, fair and unfair.
- It is your means of deciding a course of action, making a choice between right and wrong, based upon your personal values.

Ethics in the Workplace

Captain Compliance says....

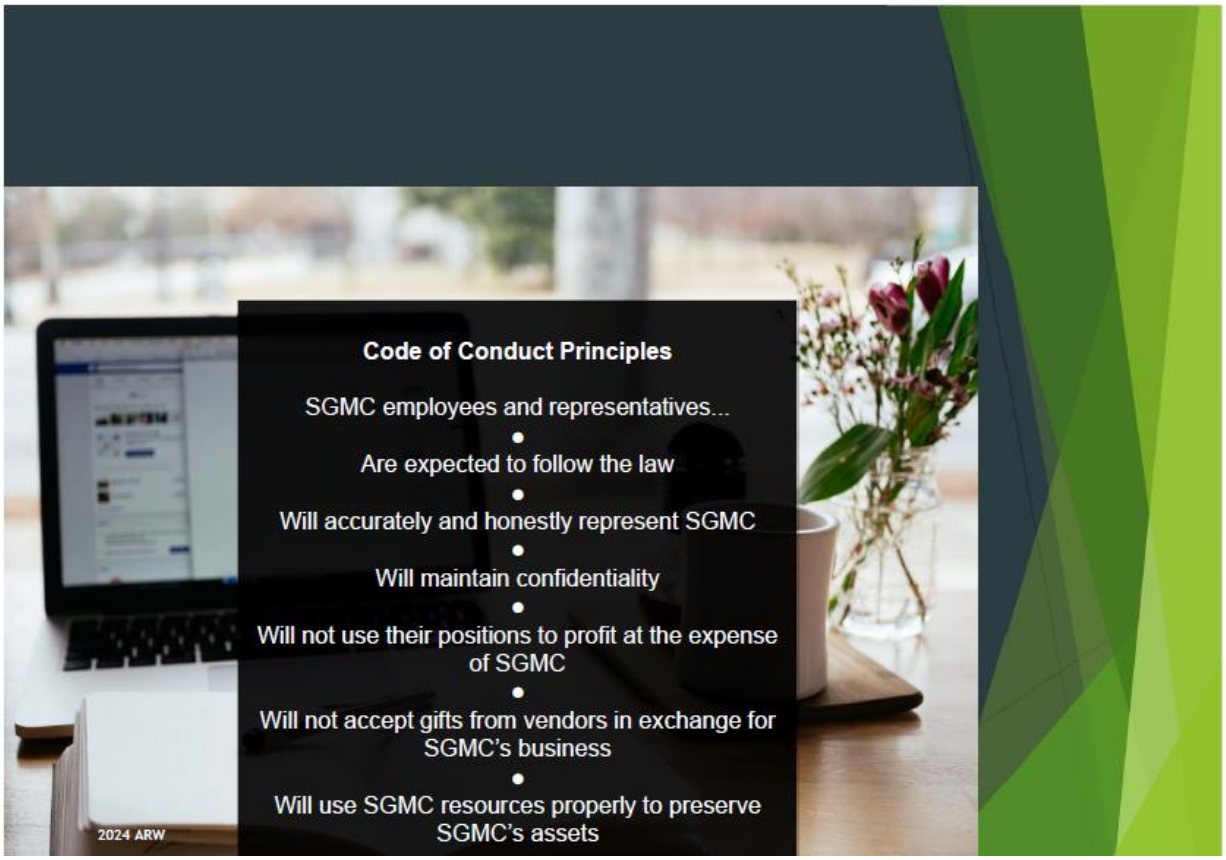
Here are some examples of unethical work behaviors:

- Spending time on tasks unrelated to work while clocked in
- Gossiping about co workers
- Intentionally working slow
- Not complying with a supervisor's direction
- Behaving in an unfriendly manner
- Speaking poorly about the organization to others
- Shifting blame to others
- Withholding help and support from coworkers

Ethical behavior promotes Teamwork and Unity in the workplace.

Code of Conduct

- The SGMC Code of Conduct has been adopted by The Hospital Authority Board to provide standards by which employees and others acting on behalf of SGMC will conduct themselves.
- Every employee is responsible for following the principles outlined in the Code of Conduct.
- The Code of Conduct is located on the HUB under: Departments/Compliance>Code of Conduct



Use of Resources

We all benefit when we use SGMC resources efficiently. Our assets are anything that belongs to SGMC; including our equipment, supplies, funds and property that we own or lease.
Carelessness, theft and waste have a direct effect on our operations.
We must all use SGMC's assets responsibly.

What can you do?

- Use SGMC's resources for business purposes only
- Protect all devices that contain information about SGMC and/or our patients
- Show good judgment when incurring expenses on behalf of SGMC

Gifts and Entertainment

Building strong and positive relationships with our business partners and patients is part of what makes SGMC a trusted healthcare provider.

While building these relationships, we must remember that we may never accept gifts, services, entertainment or other things of value that would influence our ability to make fair and objective business decisions on behalf of SGMC.

What can you do?

- Accept only non-monetary gifts valued less than $50 from patients and their families.
- For patients and their families who wish to give you a monetary gift to show appreciation for the excellent care that you've provided, direct them to the SGMC Foundation to make a gift in your honor.
- Inform existing vendors that meals they wish to provide should only be provided in combination with product education during a "lunch and learn" type environment.

Responsibility to Voice Concerns

Reporting concerns about potential violations or misconduct is a responsibility for us all. It's not always easy to speak up but SGMC can only address and resolve issues that we are made aware of.

The sooner we speak up about our concerns, the sooner we can work to make things better. This is a critical step in honoring our commitment to providing extraordinary care for our patients and a positive work experience for everyone here at SGMC.

What happens when you raise a concern?

All reported concerns are taken seriously. Compliance reviews all reports received through the Compliance Hotline, performs necessary timely investigations and takes appropriate actions while keeping matters as confidential as possible.

[Any HR related concerns are communicated to HR and they perform those types of investigations.]

You may report confidentially at any time. However, the more information Compliance has will help us perform a more thorough investigation. If you feel comfortable providing contact information, please do.

SGMC's Non-Retaliation Policy

No SGMC employee or person acting on behalf of SGMC who reports, in good faith, suspected misconduct shall be retaliated against or otherwise disciplined. [SPP 3.003]

Retaliation is not only a violation of policy but, in many cases, is also a violation of the law. If you feel that you are being treated differently because of a concern you raised, report it immediately.

EMTALA

EMTALA: It's the law for those working on the frontline.

What is EMTALA?

The Emergency Medical Treatment and Labor Act (EMTALA) is a federal law that requires anyone coming to an emergency department to be stabilized and treated, regardless of their insurance status or ability to pay. The Act specifically addresses the following:

- Medical Screening Exam
- Stabilization Treatment
- Transfers

Who is protected by EMTALA?

- Individuals who present to the ED and request care for a medical condition
- Individuals presenting on hospital property (main campus and hospital-owned and-operated ambulances)
- Individuals presenting for medical treatment in the ED who are in non-hospital ambulances on hospital property

So what does all of that mean to you?

Simply put, it means that EMTALA is triggered when any patient presents to the Emergency Department or hospital property (including driveways, parking lots, sidewalks within 250 yards of the hospital; Labor & Delivery and Youth Care, etc.) requesting an exam or treatment for a possible emergency medical condition. At a minimum, they must receive an appropriate medical screen by "Qualified Medical Personnel" and, if needed, receive medical stabilization and an appropriate transfer if necessary. In other words…

- If a person presents on hospital property other than the ED (i.e., they come in the wrong door) and requests treatment, or if no verbal request is made, a reasonably prudent person would conclude they need emergency treatment, care must be provided (go and assist the patient to the ED). For example, if a patient pulls up to outpatient center with chest pain, we cannot tell them to drive to the ED entrance. We should put them in a wheelchair and escort them to the ED for evaluation and a medical screen.

Who are Qualified Medical Personnel?

- EMTALA allows for individual hospitals to identify, in their Board Approved Medical Bylaws, "qualified medical personnel" who may perform the medical screening exam.
- South Georgia Medical Center SPP 2.002 also states that medical screenings may be done by:
  - Labor/Delivery: Obstetricians, nurse midwives, and RN's, in conjunction with an Obstetrician or nurse midwife.
  - All other SGMC Dedicated Emergency Departments: Physicians, physician's assistants, nurse practitioners and nurse midwifes.

Caution: Triage & a Medical Screening Exam are not the same thing.

What is an Emergency Medical Condition?

A medical condition manifesting itself by acute symptoms severity (including pain, psychiatric condition, substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:

- Serious jeopardy to health of individual or unborn child
- Serious impairment
- Serious dysfunction

According to CMS (*Center for Medicare Services)* Interpretive Guidelines: Some intoxicated individuals may meet the definition of "emergency medical condition" because the absence of medical treatment may place their health in serious jeopardy or result in serious dysfunction of a bodily organ. Further, it is not unusual for intoxicated individuals to have unrecognized trauma. Likewise, an individual expressing suicidal or homicidal thoughts or gestures, if determined dangerous to self or others, would be considered an "emergency medical condition."

What is an Acceptable Medical Screening?

CMS Interpretive Guidelines state:

- Individuals coming to the ED must be provided a medical screening beyond initial triage.
- The medical screening must be the same medical screening that the hospital would perform on any other individual with those same signs & symptoms, regardless of diagnosis, financial status, race, color, national origin, or disability.
- A "medical screening examination" is the process required to reach, with reasonable clinical confidence, the point at which it can be determined whether a medical emergency does or does not exist.
- Depending upon the patient, this process will vary from only a brief H&P to a complex process involving ancillary studies and specialty consultations.

EMTALA Stabilization

To stabilize means:

- No material deterioration is likely to result from or occur during transfer
- Delivery of child and placenta
- Psychiatric patients are protected and prevented from injuring or harming self or others
- Care provided within the capabilities and capacity of the staff and facilities available

Transferring Hospital's Responsibilities:

Appropriate Transfer:

- There has been physician communication, receiving physician has accepted patient and receiving facility has agreed to accept.
- Effected through qualified personnel, transportation and equipment.
- All available medical records related to emergency medical condition are copied and sent with patient.
- Services performed before transfer are documented.
- Risks/Benefits of transfer have been explained and patient consented.
- All transfer paperwork is thoroughly completed and accompanies patient.

- Hospital with specialized capabilities and capacity to treat may not refuse a transfer who requires such capabilities.

EMTALA Violations May Result in...

- Patient harm
- Medical termination by CMS (Center for Medicare/Medicaid Services)
- Fines (up to $50,000 per violation) – hospital and physician
- Civil suits
  - Failure to provide appropriate medical screen
  - Failure to stabilize – emergency medical condition must be resolved
  - Failure of on-call system – failure to timely provide on-call doctor
  - Failure to accept transfer

The Simple Rules

1. Never turn a patient who is requesting treatment away from the facility once they are on hospital property.
2. Always perform a medical screening if the patient is requesting services.
3. Log in every individual who "present" and document their complaint and disposition. (This includes those who do not complete the registration process (John Doe) and those who leave before the MSE is completed.)
4. Triage patients per protocol.
5. Provide medical screening exam in non-discriminatory manner by physician or authorized provider and document vital signs during stay and at time of discharge and transfers.
6. Do not delay medical screening to discuss payment.
7. Document the name of the facility, name of the physician and the hospital representative accepting the patient's written consent or refusal.
8. Provide medically appropriate transport, personnel, and equipment.
9. Certify benefits outweigh risks of transfer.
10. When transferring, provide medical records and complete transfer forms.
11. Document all pertinent information; Document stability status at discharge (pain assessment, vital signs, tubes/drains, IVF, etc.)

Items of Interest

- New regulations do not pertain to inpatients; however, be cautious about refusing an inpatient transfer from another hospital that has recently developed an emergency condition that is beyond the resources of the referring hospital.

Practical Case Studies

Case 1

The on-call cardiologist receives a call from a small rural hospital wanting to transport a 50 y/o male with chest pain to your facility. The rural hospital has done an EKG and performed blood work. Your on-call physician denies the transport suggesting that the patient be admitted to the rural hospital for observation. The rural hospital does not have a cardiologist on staff.

Is case #1 an EMTALA Violation?

- **YES!!**
- Why?
  - Under EMTALA, if a hospital does not have the staff or the resources to treat and stabilize a patient with an emergency medical condition, a tertiary care center (or any hospital) who does have the resources, has to accept the patient if requested.

Case #2

A local law enforcement agency presents to the ED with a subject whom they have arrested. They request a psychiatric evaluation on the subject. The hospital has no psychiatric beds available. The triage nurse advises the law officers of this and they voluntarily take the subject to another hospital.

Is case #2 an EMTALA violation?

YES!!

- Why?
- The patient was presented on hospital grounds and a request for services was made. At a minimum, the patient should have had a medical screening completed and documented. If the law officers voluntarily decide to leave without a medical screening, it should be documented with the appropriate details that the officers were encouraged to stay with the patient, that the risks of leaving without a medical screen were explained, and that the officers left without the patients being seen.

Use caution when dealing with psych patients. ED physicians and staff should appropriately document any symptoms on which the determination that an emergency medical condition exists is based. Items to screen for:

- Does the patient have a history of violence to himself or others?
- Has the patient made a suicide attempt or voiced suicidal ideations?
- Is the patient a potential danger to others through violent actions or threats?
- Is substance abuse present that could impair their judgement or are they showing signs of confusion for which a reason cannot be determined

Case #3

A 23 y/o female presents to the ED requesting a suture removal. The wound appears to be healing appropriately and appears to be free from infection. The patient receives a medical screen and appears not to be suffering from any emergency medical condition. Due to the high volume of patients in the ED, the patient is referred to her primary care physician for suture removal.

Is case #3 an EMTALA Violation?

- **NO!**
- Why?
  - Once the patient received a medical screening from qualified medical personnel and it was found that an emergency medical condition did not exist, EMTALA is no longer applicable. The medical screening, however be documented.

Case #4

You work with SGMC's ambulance service and respond to a minor MVA. The patient is from out of town and requests to be taken to the closest hospital for evaluation. Your partner examines the patient and tells the patient that he doesn't need to be transported by ambulance. You and your partner return to service.

Is case #4 an EMTALA Violation?

- **YES!!**
- Why?
    - If this patient is later found to have an emergency medical condition, EMTALA has been violated. A hospital-based ambulance is an extension of the hospital. In addition, EMTs and Paramedics are not recognized in the hospital bylaws as "Qualified Medical Personnel" for purposes of the medical screening exam.

Case #5

A 21 y/o female is brought by an outside ambulance to the ED. The patient is complaining of intermittent back pain. The patient is 38 weeks gestation with her first child. No radio reports have been given and the patient arrives unexpectedly. The EMTs say the patient is to be admitted to OB. You direct the ambulance crew to another nearby hospital.

Is case #5 an EMTALA Violation?

- **Yes!!**
- Why?
    - The patient may be in active labor. Without knowing any prior history, there is a potential danger of redirecting this patient without performing a medical screen.
    - Rule of thumb for active labor: It is active labor until observation for an acceptance period of time can prove otherwise (required to "certify false labor").

For addition information on EMTALA refer to HPP 105 or if suspected violation contact Administration at ext. 4126 or the Risk Management Office at ext. 1191.

Section 1557 of the Affordable Care Act

Training Objectives:

During this training, participants will learn how the following will apply to SGMC employees:

- Background on Section 1557
- Section 1557's nondiscrimination requirements
- Federal enforcement of Section 1557

What is Section 1557?

- The nondiscrimination section of the Affordable Care Act (ACA).
- Important to achieving the ACA's goals of expanding access to health care and coverage, eliminating barriers, and reducing health disparities.
- ***Prohibits discrimination on the basis of race, color, national origin, sex, age, or disability*** in certain health programs and activities.
- Builds upon longstanding nondiscrimination laws and provides new civil rights protections.

Who must comply with Section 1557 regulation?

- All health programs and activities that receive Federal financial assistance from HHS (Health and Human Services).
- Where an entity is principally engaged in health services or health coverage, ***ALL*** of the entity's operations are considered part of the health program or activity, and must be in compliance with Section 1557 (e.g., a hospital's medical departments, as well as its cafeteria and gift shop).

Discrimination based on an individual's race, color or national origin is prohibited
Under Section 1557, SGMC may *not*:

- Segregate, delay or deny services or benefits based on an individual's race, color or national origin. For example:
  - A covered entity may not assign patients to patient rooms based on race.
  - A covered entity may not require a mother to disclose her citizenship or immigration status when she applies for health services for her eligible child.
- Delay or deny effective language assistance services to individuals with limited English proficiency (LEP).
- The term "national origin" includes, but is not limited to, an individual's, or his or her ancestor's, place of origin (such as a country), or physical, cultural, or linguistic characteristics of a national origin group.
- Section 1557 protects all individuals in the United States who experience discrimination based on any of Section 1557's prohibited bases.

Requirements for communication with LEP individuals

SGMC must take reasonable steps to provide meaningful access to each individual with limited English proficiency (LEP). Reasonable steps may include the provision of language assistance services, such as oral language assistance or written translations. (See SPP 1.004 (HPP 004) Patient Communication Services)

Discrimination based on an individual's sex is prohibited.

SGMC must: Provide equal access to health care, and other health programs without discrimination based on sex.

Discrimination based on an individual's age is prohibited.

SGMC may not exclude, deny or limit benefits and services based on an individual's age.

Discrimination based on an individual's disability is prohibited.
An individual may not be excluded or denied benefits or services because of a disability. SGMC must provide auxiliary aids and services to individuals with disabilities free of charge and in a timely manner when necessary. Auxiliary aids and services include, but are not limited to:

- Qualified sign language interpreters
- Captioning
- Large print materials
- Screen reader software
- Text telephones (TTYs)
- Video remote interpreting services

Federal Enforcement

- The U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR) enforces Section 1557 for programs that receive funding from HHS.
- When OCR finds violations, a covered entity will be required to take corrective actions.
- If a covered entity refuses to take corrective actions, OCR may suspend or terminate Federal financial assistance from HHS. OCR may also refer the matter to the U.S. Department of Justice for possible enforcement proceedings.
- Section 1557 also provides individuals the right to sue covered entities in court for discrimination if the program or activity receives Federal financial assistance from HHS or is a State-based Marketplace℠.

Policies and procedures related to Section 1557
For additional information on SGMC facility-specific policies related to Section 1557, go to The HUB (Hospital Update Board); click on "Policies"; from the "SGMC Policies and Procedures" section, click on "Policies and Procedures (SPP formally known as HPP)", and then locate the policies listed below for review:

- SPP 1.006 (HPP 02) Patient Rights and Responsibilities
- SPP 1.004 (HPP 004) Patient Communication Services
- SPP 1.009 (HPP 19) Complaints and Grievances

SOUTH GEORGIA HEALTH SYSTEM
MEDICAL STAFF POLICIES

TITLE: Medical Staff, LLP & AHP Support	FACILITIES:	MEDICAL STAFF POLICY NUMBER: 4
APPROVALS: **Approved by Medical Staff** 02/2023 **Approved by Hospital Authority:** 03/2023 **Effective Date:** 04/17/2002	☒ SGMC ☐ SGMC Berrien Campus ☐ SGMC Lanier Campus ☐ SGMC Lakeland Villa ☐ SGMC Smith Northview	

PURPOSE

The purpose of this Policy is developed and implemented by the Medical Staff Support Committee. The Medical Staff recognizes that impaired Staff Members are individuals who have dedicated their lives to helping others and are now in need of help, and recognizes that providing this help must remain a primary goal of the Medical Staff Support Policy. Therefore, this policy follows a non-punitive approach, in which the Medical Staff works as an advocate for rather than an adversary of the provider, while seeking to protect patients from harm. The Medical Staff further recognizes that when the Staff Member denies a problem, necessary action must be taken for the protection of both the Staff Member and the patient.

APPLICATION

This Policy is applicable to South Georgia Medical Center ("SGMC").

DEFINITIONS

Capitalized terms not otherwise defined in this Policy shall have the meaning ascribed to them in the SGMC Medical Staff Bylaws.

"*Approved treatment program*" is a program for alcoholism or substance abuse treatment that is approved by the Georgia Professional Health Program, Inc. as further described at https://gaphp.org/.

"*Chief Executive Officer*" or CEO means the Chief Executive Officer of South Georgia Medical Center.

"*Designated Chairmen*" are the Chief of Staff or his/her designee, the Chief Medical Officer, and the chairman of the Department in which the individual has Clinical Privileges or Clinical Functions, or his/her designee.

"Impaired Staff Member" or *"Impaired Provider"* for the purpose of this Policy refers to a Physician, Dentist, Limited License Professional ("LLP"), or Allied Health Professional ("AHP"), who because of age, physical, psychiatric or other medical conditions or because of the use of alcohol, illegal drugs or prescribed or over-the-counter drugs that impair clinical judgment or ability may be unable to provide appropriate patient care or may otherwise constitute a direct and immediate threat to the health, welfare, and safety of patients, other staff members, and SGMC personnel.

"Positive result" of an alcohol or other drug test means the detection of alcohol or another drug in concentrations deemed significant by the U.S. Department of Health and Human Services on both an initial screening test and a confirmatory test of the same specimen.

"Provider" means a Physician, Dentist, LLP or AHP.

"Reasonable suspicion" is one based on documentation of specific, contemporaneous physical, behavioral, or performance indicators consistent with probable substance abuse or psychiatric or other medical conditions.

"SAMSHA" means the Substance Abuse and Mental Health Services Administration, a branch of the U.S. Department of Health and Human Services.

POLICY

1. General. In conjunction with the Medical Staff Bylaws, this Policy provides a mechanism for management of Medical Staff through corrective or rehabilitative action pursuant to MS 14, SR 1 of the National Integrated Accreditation for Healthcare Organizations ("NIAHO") Accreditation Requirements. Such action may result from behavior that is likely to be detrimental to patient safety or the delivery of quality care and/or other conduct disruptive to SGMC operations. Any officer of the Medical Staff, the CEO or the CMO may initiate this corrective or rehabilitative action.

2. Promotion. This Medical Staff Support Policy will be promoted to Medical Staff members and Hospital employees by the Medical Staff Support Committee to promote visibility and use. The promotion should emphasize the advocacy program and non-punitive nature of this Policy. In addition, confidentiality of reports should be stressed to encourage reporting of potentially impaired providers. The Medical Staff goals are to support the impaired provider to obtain rehabilitation services and to protect patient safety within the organization.

3. Education. The Medical Staff Support Committee, working in harmony with other members of the Medical Staff, Medical Staff Officers, Hospital Administration and various committees, strives to promote educational opportunities to assist individuals to be aware of efforts to maintain good health and to recognize signs of impairment of their own health as well as that of others.

3. Reports.

   a. Third Party Reports. Reports to the Medical Staff Support Committee about a Provider who may be an impaired Provider should be encouraged and accepted from nurses, colleagues,

other SGMC personnel, patients and family members. Anonymous reports will be accepted, with appropriate consideration given to the inherent benefits and detriments of such reports.

1) Immediate Reports. Immediate reports shall be made if a SGMC employee or Provider:

i. has a reasonable suspicion that a Provider is impaired and is currently providing or attempting to provide services to a patient at SGMC; or

ii. reasonably believes that a Provider's impairment has contributed to an accident or incident.

If an immediate report is required by this provision: (i) a Hospital employee shall immediately notify his or her supervisor or director, who shall immediately notify a Designated Chairman; and (ii) a Provider who suspects impairment shall report directly to the Designated Chairman. The Designated Chairman receiving the report shall notify the Chairman of the Medical Staff Support Committee.

2) Self-Reporting. Providers that are impaired or such report is substantiated shall be encouraged to voluntarily report and enroll in the Georgia PHP program. Failure of a Provider to self-report and enroll in the Georgia PHP program may result in the Medical Staff engaging in reporting to the Georgia PHP Program or to engage in mandatory reporting to the State Board, as required by state laws.

3) Notifications following Receipt of Reports. The Designated Chairman will notify the person making a report that the report has been received, The Designated Chairman will request for the Medical Staff Support Committee to provide any updates and progress reports to the Medical Executive Committee. Any compliance letters from a treating provider or the Georgia PHP shall be protected as privileged peer preview and medical review and shall only be submitted by Georgia PHP to the Chairman of the Medical Support Committee or his or her designee.

b. Self-reporting. All Providers must submit a written report to the CMO or his or her designee of any change in the Provider's psychiatric or other medical status that might possibly affect the quality of patient care rendered by the Provider within the limits of their Clinical Privileges or Clinical Functions. Such reports should be made immediately upon the Provider becoming aware of the change. If the Provider desires to continue providing patient care in SGMC, the Provider shall be referred to the Medical Support Committee Chairman for consultation. Depending upon the circumstances, the Medical Support Committee may require Provider to report to the Georgia PHP program and engage in regular follow up with the Medical Support Committee.

4. Request for Testing and Evaluation.

a. Reasonable Suspicion testing. If any Designated Chairman, based on a personal review and evaluation of the report, finds a basis for a reasonable suspicion of impairment, the

Designated Chairman may request that the individual provide specimens for the purpose of determining the alcohol or other drug content of the individual's system or submit to other appropriate psychiatric or other medical evaluation.

b. Post-incident testing. A Provider whose performance either is reasonably believed to have contributed to an accident or incident at a SGMC-owned or operated facility, or cannot be discounted as a contributing factor to an accident or incident, may be tested for the presence of alcohol or other drugs in his or her system upon request of any Designated Chairman, the Chief Executive Officer, the Chief Operating Officer or the Medical Director. Such testing shall be performed immediately upon request and as soon as possible following the accident or incident, with a goal of collecting the specimen within twenty-four hours of the accident or incident in order to obtain more accurate information regarding the Provider's status at the time of the accident or incident.

c. Procedures for Testing or Evaluation.

Substance Abuse. Specimen collected shall comply with applicable procedures from time to time established by SGMC, which shall be in accordance, to the extent reasonably possible, with guidelines published by SAMHSA. All persons involved in the collection, testing and reporting under this procedure shall respect the privacy and confidentiality of the information obtained and report information relating to the collection and testing in a manner to observe such confidentiality.

Specimens for alcohol or other drug testing may include a person's blood, urine or hair. The Designated Chairman requesting the test shall specify the type of sample to be collected for testing. The Designated Chairman requesting the test or his or her designee shall monitor the collection of the specimens and shall document in the Provider's Medical Staff file the collection procedures followed, assignment of confidentiality code, and the Provider's written acknowledgement of the specimen and assigned code. The specimen shall be labeled using the confidentiality code to avoid identification of the individual involved. The specimens will be transported to the SGMC Laboratory for confidential (coded) testing at a laboratory that is certified by and in compliance with guidelines from time to time established by SAMHSA.

A Specimen Custody and Control Form shall be completed and used to provide a chain of custody for any specimen collected. Efforts shall be made to minimize the number of persons handling specimens.

If the Provider to be tested refuses to cooperate with the collection process, such refusal shall be communicated to the Designated Chairman who requested the testing. Such refusal shall be documented in the medical staff file and may be grounds for suspension or revocation of any or all parts of a Provider's Clinical Privileges, Clinical Functions or Medical Staff membership.

All specimens will be tested by a laboratory that is certified by and in compliance with guidelines from time to time established by SAMHSA. Test results shall be reported in writing to the Designated Chairman identifying all results. The method of reporting

results shall be sensitive to confidentiality and privacy. Results may not be provided orally or by telephone.

All positive test results shall be reviewed by a CMO or his or her designee who must review medical history, diet, herbal, over the counter and prescription drug use.

Any specimens for which positive results are found shall be preserved and retained for at least two (2) years, or until resolution of all legal or administrative challenges involving such specimen, whichever is longer.

Reports of positive test results shall be maintained and securely filed by Medical Staff Affairs confidential file for the Provider for a period of at least five (5) years or until all legal and administrative challenges to the test results are resolved. Reports of negative results shall be retained for at least one year or for such longer time period as may be requested by the Provider. All such records shall be treated confidentially.

Test results and related reports may be made available to the Designated Chairmen and the Chairman of the Medical Support Committee. Test results and related reports with respect to an Allied Health Professional will be made available to the sponsoring physician(s). Test results may be considered by any official Medical Staff Committee or other deliberative body with responsibility of making recommendations or decisions concerning Medical Staff membership or Clinical Privileges or Clinical Functions. Any further distribution of such information will be made on a need to know basis.

Psychiatric Disorders. Psychiatric evaluation must be performed by a psychiatrist approved by the Chief of Staff and/or CMO, who may be an independent psychiatrist unassociated with SGMC. The evaluating psychiatrist will report to the Chairman of the Medical Support Committee. The Provider's failure to cooperate with the evaluation or refusal to consent to release of reports may be grounds for suspension or revocation of any or all parts of a Provider's Clinical Privileges, Clinical Functions or Medical Staff membership.

Based on the evaluation, the psychiatrist must determine the extent of the impairment and assist the Designated Chairmen in determining the appropriate level of restrictions on the Provider's Clinical Privileges or Clinical Functions, if applicable.

Physical Disorders. Evaluation of possible physical disorders must be performed by an appropriate physician or physicians approved by the Chief of Staff. The evaluating physician will report to the Chairman of the Medical Support Committee or the Chief of Staff or his designee requesting the evaluation the Provider's refusal to consent to evaluation or to release of reports. Such refusal may be grounds for suspension or revocation of any or all parts of a Provider's Clinical Privileges, Clinical Functions or Medical Staff membership.

The evaluating or treating physician(s) shall assist the Designated Chairmen in determining the appropriate level of restrictions on the Provider's Clinical Privileges or Clinical Functions, if applicable.

5. Intervention.

a. Substance Abuse. Upon receipt of a positive test result, the Designated Chairman may temporarily suspend Provider's Clinical Privileges or Clinical Functions and he or she will be relieved of any SGMC responsibilities or duties while receiving assessment and treatment and the provider shall be referred to the Georgia PHP program.

b. Psychiatric Disorders. Following evaluation and diagnosis of a psychiatric disorder resulting in impairment, a psychiatrist approved by the Chairman of the Medical Support Committee shall determine the frequency and nature of psychiatric care. The approved psychiatrist shall report to the Chairman of the Medical Support Committee or his or her designee when the Provider is sufficiently stable for removal of restrictions on Clinical Privileges or Clinical Functions. Such report shall be made available to the Designated Chairmen and the Chief Executive Officer.

c. Physical Disorders. Following evaluation and diagnosis of a physical disorder resulting in impairment, a physician approved by the Chairman of the Medical Support Committee shall provide ongoing evaluation and management of the disorder. The approved physician shall report to the Designated Chairman or his designee to include the Medical Affairs Office when the Provider is sufficiently stable for removal of restrictions on Clinical Privileges or Clinical Functions. Such report shall be made available to the Designated Chairmen and the Chief Executive Officer.

6. Reinstatement.

Upon receipt of the treating physician's report and other documentation required above, the Provider's Clinical Privileges or Clinical Functions may be reinstated by the Medical Executive Committee.

Proctoring of patient care may be required following reinstatement. The Department Chairman shall initially determine the number and type of cases which must be proctored.

a. Substance abuse. Following reinstatement of Clinical Privileges or Clinical Functions, the Provider must receive follow-up assessment at an approved treatment program. Such assessment must include random monitored urine drug screens. During the treatment and monitoring, the Georgia PHP shall provide compliance reports to the Chairman of the Medical Support Committee or his or her designee. The Chief of Staff may approve in writing deviations from the above requirements. Deviation or failure to comply without such written approval shall result in automatic removal from the Medical Staff.

b. Psychiatric or other medical disorders. The treating psychiatrist or other physician shall determine the frequency of follow-up care or assessments following reinstatement of Clinical Privileges or Clinical Functions. The psychiatrist or other physician shall send a written, non-restricted report regarding the individual's status to the Chairman of the Medical Support Committee at least quarterly during the treatment and monitoring. If the

Provider's condition remains stable for two years, the report's frequency may be changed to yearly or at the discretion of the psychiatrist or other physician.

c. Relapse. Upon receipt of evidence of relapse of a substance abuse problem or recurrence of a psychiatric or other medical condition resulting in impairment, or a physician's statement of pending relapse or recurrence, the Provider must re-enter an approved treatment program or resume psychiatrist or other medical treatment. Refusal to re-enter a treatment program or to resume psychiatric or other medical treatment shall result in automatic removal from the Medical Staff and/or LLP or AHP appointment.

7. Refusal.

A Provider's refusal to cooperate with substance abuse testing or psychiatric or other medical evaluations, refusal to consent to release of non-restricted reports of treatment or follow-up, or refusal to cooperate with treatment shall constitute grounds for suspension or revocation of all or any part of the Provider's Clinical Privileges, Clinical Functions, Medical Staff membership, or LLP or AHP status.

8. Hearing rights.

Action taken with respect to a Practitioner's Medical Staff membership or Clinical Privileges or application for membership or Clinical Privileges as a result of refusal to cooperate with testing, treatment or follow-up shall give the affected Practitioner the right to a hearing and appellate review as provided in Article XII of the SGMC Medical Staff Bylaws. LLPs who do not maintain Clinical Privileges and AHPs shall be entitled to the hearing rights, if any, provided by the LLP/AHP Manual then in effect.

9. Medical Review.

The Medical Executive Committee, each Medical Staff Department, the Professional Qualifications Committee, the Quality Management Committee and the Medical Staff Support Committee are each responsible in part for evaluating and improving the quality of care rendered at the Hospital and for determining that health services rendered were performed in compliance with applicable standards of care. All actions, reports and proceedings of such committees in connection with this procedure shall be made and conducted in furtherance of those responsibilities. All information furnished to any of these committees, their chairmen or other representatives are given in that context and shall be entitled to the maximum confidentiality and protection afforded by law.

POLICY HISTORY

Original Adoption Date: 04/17/02

Review/Revise History:

Reviewed: 10/08
Reviewed and format updated: 04/17
Revised: 06/20, 03/23

SGMC-Workplace

Drug use prohibitions:

- Alcohol
- Illicit drugs
- Prescription drugs
  - The proper use of medication prescribed by physicians is not prohibited; however SGMC does prohibit the misuse of prescribed medications.
  - Any employee who is taking any mind or mood altering substance which might impair safety, performance, or motor functions must immediately report to their supervisors the use of medication that may impair their ability to perform.
  - Failure to report may result in disciplinary action.

Types of Testing

- SGMC is required to conduct the following types of drug tests:
  - Follow-up testing
  - Post accident
  - Pre-employment
  - Reasonable suspicion
  - Random testing

WORKPLACE VIOLENCE

- By the end of this training module, the participant will be able to:
  - Identify workplace violence according to the OSHA definition and SGMC Policy language
  - Distinguish between the 4 types of workplace violence
  - Demonstrate your roles and responsibilities related to workplace violence
  - Know how and why we need to report workplace violence through the appropriate channels.
  - Recognize behavioral warning signs of violence.

OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION

- OSHA defines workplace violence is "Any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site".

SGMC DEFINES WORKPLACE VIOLENCE AS:

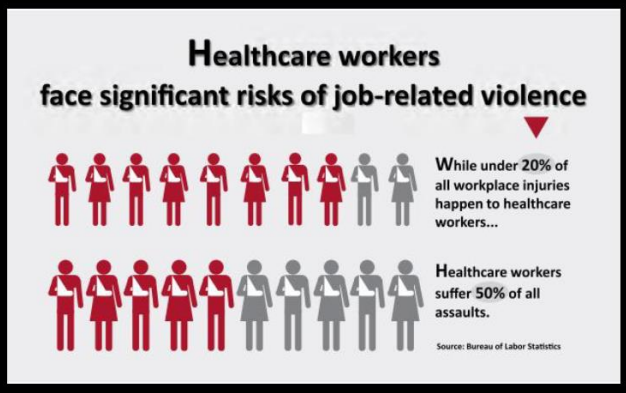
- Verbal, nonverbal, written, or physical aggression
- Threatening, intimidating, harassing, or humiliating words or actions
- Bullying
- Sabotage
- Sexual Harassment
- Physical assaults
- Other behaviors of concern involving staff, licensed practitioners, patients or visitors
- These events can occur on, or be directed at any SGMC property. This would also include an emergency scene with SGMC EMS present.

4 TYPES OF WORKPLACE VIOLENCE

- **Type 1**: **Criminal Intent**: These acts of workplace violence include robbery, trespassing, shoplifting, terrorism. People committing these crimes have no relationship with business or its employees.
- **Type 2**: **Customer/Client**: The customer or client becomes violent while interacting with the business. Healthcare workers are at the highest risk for this type of violence
- **Type 3**: **Employee-on-Employee**: These acts are perpetrated by an employee or past employee who attacks or threatens another employee
- **Type 4**: **Personal Relationship**: The perpetrator has a personal relationship with the victim.

PREVALENCE OF WORKPLACE VIOLENCE IN HEALTHCARE

- All around, we see that workplace violence in healthcare seems to be trending upward.
  - A survey from Premier has found that 40% of healthcare workers have experienced workplace violence within the last two years.
  - Rates of workplace violence in healthcare almost doubles from 2010 to 2021
  - Healthcare experiences the highest risk of injury caused by workplace violence at a rate that is 5x the average.



BEHAVIORS NOT TOLERATED INCLUDE BY NOT LIMITED TO:

- Threats or violent acts occurring on the premises, regardless of the relationship between the two parties and behavior that can affect the safety of SGMC Patients/Residents and staff
- Threats of violent acts resulting in the conviction of an employee, staff members, or third-party contractor performing services for SGMC
- Threatening or aggressive contact toward another individual
- Threats of harm to a patient/resident, staff member, family, or friends
- Unauthorized surveillance or stalking
- Harassing or threatening emails, phone calls, texts, memos, or any form of communication
- Intentional threat of destruction of property or other associated property at SGMC
- Indirect threats of physical or emotional harm
- Unauthorized possession of weapons
- Harassment of any nature
- This includes bullying which can often presents as:
  - Verbal attacks or verbal assault
  - Threatening, intimidating, or humiliating behaviors
  - Sabotage

ROLES AND RESPONSIBILITIES: EMPLOYEES

- Staff should:
  - Support a zero-tolerance culture for violence
  - Interact responsibly with others
  - Be familiar with facility policies and procedures related to workplace violence
  - Know your response plan in various violent acts
  - Report actual or perceived acts of violence
  - Cooperate in any investigations
  - Complete training and education
  - Participate in post-incident activities and counseling

ROLES AND RESPONSIBILITIES: EMPLOYEES (CONTINUED)

- Immediately report any violent, threatening, or harassing behavior regardless of injury or severity. Complete a report in the electronic incident reporting system (RL Solutions)
- Inform their Department Manager/Director and Security of any situation where potential for violence as a result of domestic abuse, custodial disputes, orders for protections, restraining orders, or other threats are present.
- Utilize Security Escorts (call ext 4030) or a buddy system when personal safety may be jeopardized. Avoid threatening situations and use extra care in elevators, stairwell, and parking areas.
- Understand the concept that violence should be expected, but may be avoided or mitigated through preparation.

ROLES AND RESPONSIBILITIES: DEPARTMENT LEADERS

- Provide and promote a safe and secure environment for assigned staff
- Conduct department-specific education on risks, safeguards and preventing assaults
- Encourages staff to report conditions that compromise safety and security
- Ensures staff know the locations and are familiar with the operation of their department emergency devises
- Offers conflict and crisis intervention to include de-escalation technique training to staff working in areas prone to violence.
- Ensures employees who work in cashier, retail, and similar type operations are tainined on proper responses during robberies, thefts, or other criminal acts
- Works to limit the number of persons who are working alone in remote areas and provides engineering controls/safety devices when lone work is necessary
- Coordinates risk assessments with Safety Officer and Safety Committee members as appropriate.

BEHAVIORAL WARNING SIGNS

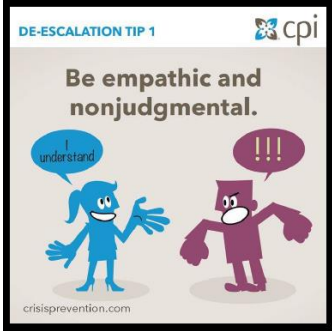
- Excessive tardiness or absences
- Increased need for supervision
- Lack of performance
- Change in work habits
- Inability to concentrate
- Signs of Stress
- Change in attitude
- Weapons fascination
- Drugs and alcohol abuse
- Not taking responsibility for their own actions.

AVENUES FOR MORE GROWTH

- Violence or threats of violence in all forms are unacceptable workplace behavior.
- Crisis Prevention Institute (CPI) De-escalation training is mandatory for all Emergency Department and Security Personnel.
- Other staff may signup through the education department for the full CPI course that includes de-escalation classroom education along with physical disengagement practice.
- SGMC has a Workplace Violence Committee in place to monitor reporting and review incidents
  - If incidents are not reported, it is hard to take appropriate actions to address them

CRISIS PREVENTION INSTITUTES' DE-ESCALATION TIPS

BE EMPATHIC AND NONJUDGMENTAL



- *The agitated person's perception of the issue is real enough to them.*
- *Take time to listen to the issue and avoid criticizing or judging*

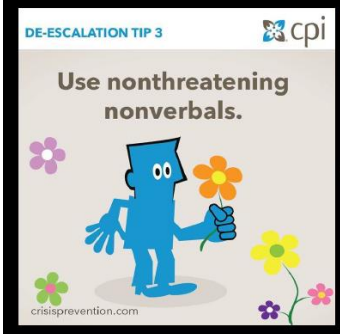
RESPECT PERSONAL SPACE

- *Allow personal space between you and the person who is escalating (roughly 1.5-3 feet away)*
- *When entering personal space to provide care, always explain your actions to set expectations*

SGMC

CRISIS PREVENTION INSTITUTES' DE-ESCALATION TIPS

USE NONTHREATENING NONVERBALS



- *Be mindful of your nonverbal cues (e.g. gestures, facial expressions, movements)*
- *Keep your tone and body language neutral to prevent escalation of behavior*

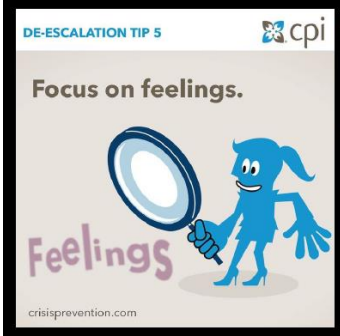
AVOID OVERREACTING

- *Control your behavior and responses by not overreacting*
- *Keep calm, rational, and professional*
- *Positive self-reinforcement can help you to calm your emotions during escalation*

SGMC

CRISIS PREVENTION INSTITUTES' DE-ESCALATION TIPS

FOCUS ON FEELINGS



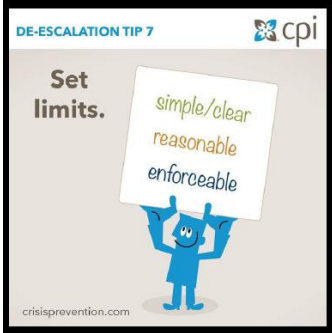
- *The person's feelings will drive their actions*
- *Try using supportive statements like "That must have been scary" to lead them to de-escalating*

IGNOR CHALLENGING QUESTIONS

- *When the person poses challenging questions, power struggles can arise.*
- *Redirect attention back to the issue at hand*

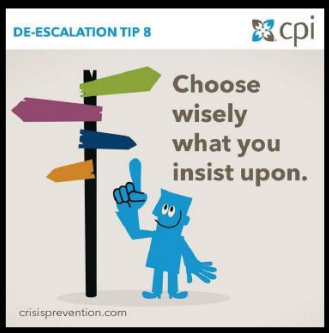
CRISIS PREVENTION INSTITUTES' DE-ESCALATION TIPS

SET LIMITS



- *If the person is belligerent, defensive, or disruptive make sure to give clear, simple, and enforceable limits.*
- *Offer choices and consequences*

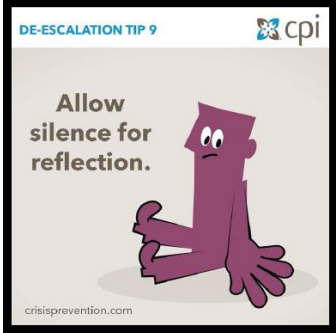
CHOOSE WISELEY WHAT YOU INSIST UPON



- *Be thoughtful about which rules are negotiable and which are not*
- *If you can allow the person to make some choices, this may help alleviate escalating behaviors*

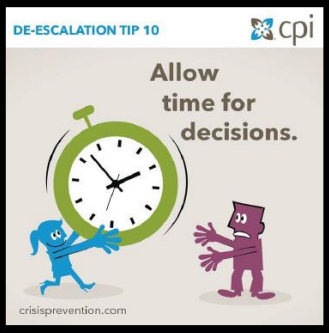
CRISIS PREVENTION INSTITUTES' DE-ESCALATION TIPS

ALLOW SILENCE FOR REFLECTION



- *Silence allows for reflection on what has happened*
- *This time may allow them to recollect themselves*
- *Silence is a powerful communication tool!*

ALLOW TIME FOR DECISIONS



- *Upset people struggle to think clearly*
- *Give them time to think what you have communicated*
- *Rushing decisions will further agitate someone already struggling*

What can every employee do to improve communication and teamwork in our organization?

Develop a culture of "Mutual Support"

- **Offer to help one another!**
- **Provide effective feedback!**
  - Timely
  - Respectful
  - Specific
  - Directed toward improvement

SGMC Cascading Communications System

Hospital Authority

I. Committee Meetings
- Finance Committee – monthly
- Quality Committee – every other month
- Personnel Committee - as needed
- Buildings & Grounds – as needed
- Joint Conference – as needed
- Compliance Committee - quarterly

II. Board Meeting – monthly
III. Board individuals and CEO - as needed

Senior Executives

I. Executive Daily Huddle – Daily – 1 hour
II. CEO & Individual Executives – Weekly – Feedback & Assistance
III. Medical Staff and Committee Meetings

Communicators Should Ask:
- Who is responsible for communicating news to staff?
- What should the communication include?
- When should this information be communicated?
- Why should this information be communicated?
- How will the information be communicated?

Leadership

I. Executives with All Directors – weekly – Thursdays – 1 hr.
- Hospital Updates

II. Executive with Respective Directors (collectively) – weekly
- Share Data from Executive Report
- Review Metrics / Scorecard pillars
- Coach

III. Executive with Individual Directors – as needed
- Feedback & Assistance

IV. Executive with entire Division (leaders and staff) – quarterly
V. Leader Walk (Rounding)
- Executives Rounding with Leaders
- Solicit Feedback
- Assessing Effectiveness and Accountability of Communication

Frontline

I. Directors with Frontline Managers (collectively) – weekly
- Share Information
- Review Metrics / Scorecard pillars
- Coach
- Leader Walk (Rounding)

II. Directors with Frontline Managers (individually) – as needed
- Feedback & Assistance

III. Frontline Managers with Staff
- Daily Huddle
- Leader Walk (Rounding)
- Monthly Staff Meeting

Feedback Loop:
- Employee Assistance/Needs
- Clarification
- Obstacles and Barriers
- Achievements
- Effectiveness of Communication Patterns

Diversity & Inclusion: We're All in This Together

- Traditional diversity awareness programs have focused on the treatment of women and minorities.
- However, differences arise from a host of other traits as well, including:
  - Age
  - Sexual orientation
  - Religious beliefs
  - Physical abilities
  - Educational background
  - Whether someone has children
  - Even being an engineer versus being a salesperson

- These traits or "profiles" cause people to:
  - Make inaccurate assumptions
  - Create separation
  - Treat people unfairly

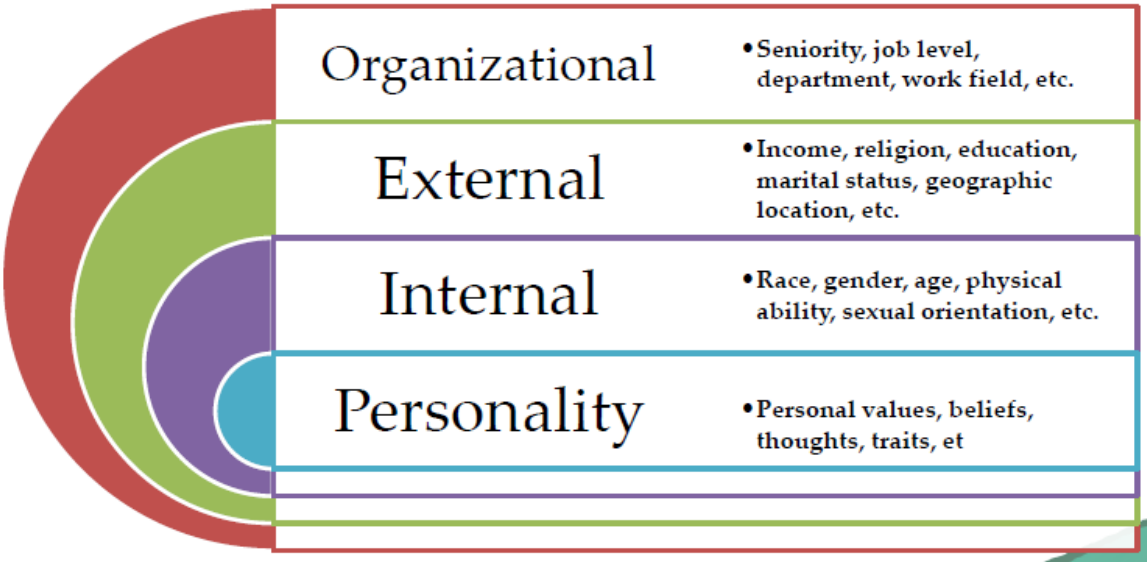
What is Diversity?

- Diversity awareness has evolved from focusing solely on eliminating discrimination to proactively seeking inclusion.
- In the end, diversity is about cultivating meaningful relationships.
- The table highlights what diversity is and isn't within organizations working toward an inclusive workplace.

Diversity is……	Diversity is Not…..
Based on Inclusion	Based only on representation
A mindset, continuous process and a way of doing business	A one-day program or two-hour training
Always imperative and proactive	Only important when there is a discrimination complaint

Dimensions of Diversity

Diversity is more than differences in race, gender or age. It includes every characteristic that makes individuals unique, including diversity of thought! Let's take a look at 4 key dimensions of diversity:



Why Focus on Diversity?

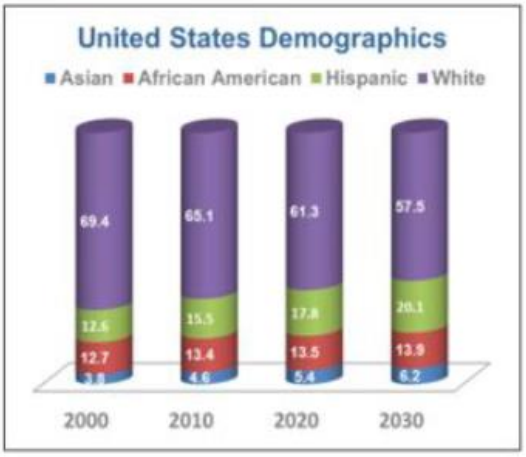
Why Focus on Diversity? Changing Demographics

- Society's demographics are changing!
- The search for talent demands understanding and responding to those demographic shifts.
- The U.S. Census Bureau estimates the number of Americans belonging to minority groups will increase 1 in every 4 Americans currently to 1 in every 2 by 2050.

Demographic Trends: Race

Demographics Trends: Race

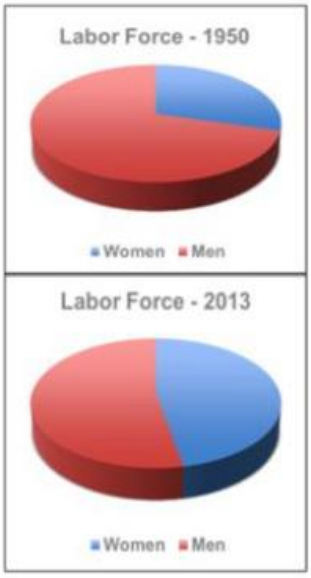
- As the nation's demographics change, so do workforce demographics.
- Organizations embracing these changes and tapping into all sectors of our diverse population have a competitive advantage over organizations that do not.



Demographic Trends: Women

Demographic Trends: Women

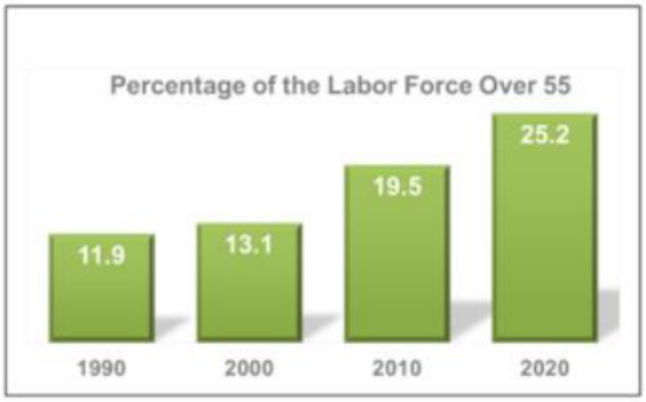
- **Demographic changes are not limited to race or ethnicity.**
- **In 1950, women represented less than 20% of the workforce.**
- **By 2013, women accounted for almost 47% of the workforce.**
  - **Per U.S. Bureau of Labor Statistics, 2013**



Demographic Trends: Age

Demographic Trends: Age

- The age of employees is also an important demographic factor that has and will continue to change
- The table shows the changes in how many people over the age of 55 are in the workforce.
- By 2020, the Bureau of Labor Statistics estimates half the workforce will be comprised of Millennials with Gen Xers moving into more management and leadership roles and some Baby Boomers exiting the workforce.
- Remember, people are exiting the workforce later so we have the most generations in the workforce currently than any other time in history.



Diverse Workforce: Advantages

Diverse Workforce: Advantages

- Attract Talent
  - Reaching our to a wider labor pool allows us to attract the best talent available (regardless of demographic background).
- Improve Problem Solving & Innovation
  - Having diverse workgroups increases the number of perspectives available, which increases the likelihood of finding the best possible solutions to prevent or resolve organizational problems.
- Better Serve Our Patients
  - Diverse groups of individuals have knowledge about more segments of the nation, which allows us to tailor services to best meet the needs of the greatest number of people.

What is Inclusion?

What is Inclusion?

- Removing of obstacles stopping people from fully participating and contributing to the team/organization.
- Providing appropriate/adequate access to information and resources to all organizational members.
- Involving team members in critical work group processes.
- Allowing team members to be part of and influence decision-making processes.

- Question: How can you demonstrate commitment to attaining and maintain a diverse and inclusive workforce?
- Answer: You play an integral role in the process by:
  - Treating all co-workers, colleagues and patients with dignity, respect and professionalism.
  - Learning about and valuing differences in cultural and background

Foster a Culture of Inclusion

Foster a Culture of Inclusion

- Set an example by modeling the values
- Hold yourself and others accountable
- Look for growth opportunities

Promoting Inclusion through Civility

Promoting Inclusion through Civility

- Be open-minded
- Say what you mean
- Be respectful
- Remember pleasantries:
  - Address conflict in private
  - Be aware of your tone and volume, don't try to sound defensive or combative
  - Don't interrupt when others are talking
  - You could be wrong, don't become so attached to your ideas and opinions that you're unable to admit when someone else is right.

Promoting Inclusion through Civility

Promoting Inclusion through Civility

- Depersonalize comments, it's often an action or behavior that's bothering you, not the person themselves
- Allow others to respond, give your attention:
  - Try to find a win/win
  - Use active listening

Active Listening

Active Listening

- When engaging in these drivers of diversity and inclusion, it is also important to exhibit and model active listening.
- The goal of active listening is to go beyond just listening to respond to truly understanding what another person is saying.
- There are 5 key elements of listening to understand:

5 Elements of Active Listening	
Pay attention	• Give the speaker your undivided attention and acknowledge their message.
Show that you are listening	• Use your body language and gestures to convey your attention, for example nodding your head or smiling.
Provide feedback	• Reflect on what is being said and ask questions. • Periodically restate what the other person said in your own words to make sure you understand correctly.
Defer judgment	• Don't chime in with your feelings or interrupt the speaker.
Respond appropriately	• Listening to understand is respectful; you add nothing by arguing or attacking the speaker

Outcomes of Inclusion

Outcomes of Inclusion

- Awareness and implementation of inclusion can help everyone feel more:
  - Respected, Supported, Valued and included
  - Comfortable sharing ideas and resources with team members

Key Takeaways

Diversity has many advantages:

- Improve problem solving
- Increase innovation
- Attract the best talent
- Allows us to better serve our patients

SGMC is committed to promoting diversity and inclusion in the workplace

- Diversity must be considered in all areas of our day-to day interactions and business practices

To be inclusive we need to:

- Understand obstacles and subtle biases impacting inclusion
- Be self-aware of unintentional and intentional bias, prejudice, stereotyping
- Foster an inclusive work environment by engaging in civil behaviors.

SGMC Health

Acknowledgement of Receipt of Physician Education Self-Study

By signing below, I signify that I have received the Physician Education Self-Study in its entirety and understand that I am responsible for knowing the content of these topics:

Quick Facts
Mission, Vision & Values
Administration Team
SGMC Main Campus Map
SGMC Organizational Chart
SGMC Berrien Organizational Chart
SGMC Lanier Organizational Chart
Clinical Key
Emergency Codes
Accreditation: Det Norske Veritas (DNV)
Reporting Patient Safety Concern
Reporting Incident Reports HIPAA
National Patient Safety Goals
Infection Prevention and Control
Hospital Quality Measures (CMS)
Stroke Admissions Protocol
Guidelines for the Early Management of patients with Acute Ischemic Stroke; 2019 Update to the 2018 Guidelines for the Early Management of Acute Ischemic Stroke
Quality Measures Quick Study Pain
Restraint and Seclusion Policy
Clinical Alarm Policy
Antimicrobial Stewardship
Adverse Drug Reaction Reporting
Pharmacy Department Orientation
Medical Records Department Orientation
Dictation Instructions
EPIC Provider EHR Training
EPIC Downtime Procedures Environment of Care/Life Safety Emergency Operations Plan Excerpt
Abuse and Neglect Education
Care of the Dying Patient Policy
Violence in Workplace
Safety & Security
Biohazardous Waste
Unusual occurrence reporting
Abuse & Neglect
Patient rights & responsibilities
Fire/OR Fire Training
Cultural Sensitivity & Diversity
Life Link: Understanding Organ and Tissue Donation
EMTALA
Nondiscrimination Provision of the ACA Section 1557
Impaired Staff Member

I understand that I may direct any questions regarding the content of this self-study to the Office of Medical Staff Services. The self-study contents are available at anytime on the SGMC Health website under Medical Staff Services.

Printed Name:_____

Physician Signature:_____

Date: _____