



# **Medical Staff** Orientation

## Clinical Practice Expectations

The goal of the Medical Staff of Brandon Regional Hospital is to meet the healthcare needs of the community by providing the highest quality of care to our patients.

In an effort to accomplish this goal, the Medical Staff has articulated the generally accepted criteria that govern the practice of medicine within this Hospital and all members of the Medical Staff are expected to adhere to these principles.

1. Abide by the Bylaws, Rules and Regulations and other policies and procedures of the Medical Staff of Brandon Regional Hospital.
2. **Ensure good standing as a member of the Medical Staff by:**
  - a. Maintaining current licensure and ongoing continuing medical education and training as well as following the State of Florida CME requirements.
  - b. Completing and submitting in a timely fashion all documentation needed for credentialing at the time of appointment and reappointment.
  - c. Practicing within your approved delineation of privileges.
  - d. Participating in the Peer Review process by analyzing and responding fully and promptly to the Peer Review inquiries regarding quality of care issues.
  - e. Informing the Medical Executive Committee promptly of the initiation and eventual outcome of any proceeding that may affect membership on the Medical Staff.
3. Contribute to the medical community by participating, as possible, in Medical Staff Committee assignments. Involvement in other activities such as preceptors or volunteer community programs both in and outside of the Hospital are encouraged.
4. **Exercise good judgment in the delivery of quality medical care to include:**
  - a. Examining patients promptly on their admission to the Hospital and developing a plan of care
  - b. Providing open and ongoing communication with patients and their families regarding the patient's condition and plan of care provided that the patient (when possible) has given permission to give out this information
  - c. Following generally accepted medical practice in the ordering of medications and blood products
  - d. Maintaining acceptable standards of quality of care and utilizing, when appropriate, approved physician order sets and clinical pathways, and abide by CMS core measure standards
  - e. Avoiding inflammatory dictation on the medical record
  - f. Adhering to current JCAHO National Patient Safety Goals (to include):
    - Improve the effectiveness of communication among caregivers by "reading back" verbal or telephone orders and critical values;

- Adhering to a standardized list of abbreviations, acronyms and symbols that are not to be used throughout the organization;
  - Complying with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines;
  - Complying with the "time-out" requirement for procedures and surgeries.
5. Participate in the Emergency Department Call and the care of house patients when requested and as directed by Departmental Rules and Regulations.
  6. **Maintain medical records consistent with Medical Staff Bylaws, Rules and Regulations, and policies/procedures including:**
    - a. Dictating or writing a complete history and physical within 24 hours of patient admission and prior to transfer to the operating room
    - b. Completing a brief written operative note immediately after surgery with a full dictated or written operative note on the day of surgery
    - c. Ensuring all medical record entries are legible, and include the date, time, signature of the provider or other responsible provider
    - d. Providing a progress note at least daily in the critical care areas and for other patient care areas that updates the patient's condition and plan of care and addresses their need for continued stay in the acute care facility
    - e. Completing the medical record within thirty (30) days of discharge.
  7. Maintain a cooperative, collegial relationship with fellow physicians, nurses, case managers, social workers, other Hospital staff and patients and their families thus avoiding disruptive, disrespectful and threatening behavior or communication.
  8. **Communicate effectively with the other members of the healthcare team including nurses, therapists, other physicians and anyone involved in the welfare of patients. This includes:**
    - a. Responding timely to pages when on call
      - Immediately to ED and Critical Care Stat pages
      - Within thirty (30) minutes for all other pages
    - b. Keeping other members of the team informed of the plan of care.
    - c. Arranging with another member of the Medical Staff of Brandon Regional Hospital for coverage when not available to ensure continuous physician coverage (24 hours/day, 7 days/week).
    - d. Communicating directly with consulting physicians regarding the specific reason and urgency for requested consultation and diagnostic testing.

**I have received and read the above expectations.**

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**Applicant's Signature**

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**Date**



## **Mission**

**To provide our patients with quality care through innovation, education and compassionate care.**

## **Vision**

**As a compassionate community hospital, we will be the destination of exceptional care by exceptional people.**

## **Values**

**Brandon Regional Hospital is dedicated to providing quality, relationship-based care that promotes healing through:**

- **Accountability**
- **Safety**
- **Integrity**
- **Collaboration**
- **Compassion**







### Acute Care Services

- 422 – Bed full service acute care hospital – 26,000 admissions a year
- 25 – Bed Behavioral Health Unit
- 2,029 Employees, 226 Volunteers and 637 Physicians

### Cardiac Program

- 6 Labs (3 Cardiac Cath, 2 Special Procedures, 1 EP) – 8,000 cases a year
- Open Heart Surgery

### Surgical Services

- 14 Operating Suites – 9,300 Surgeries a year
- DaVinci Robotic & Minimally Invasive Surgery
- Open Heart, Orthopedics, Neurosurgery
- GYN Onc, Bariatric Center

### Women's & Children's Services

- OB/GYN – 3,500 Babies a year
- Nursery, Neonatal Intensive Care Unit (NICU) Level II & III
- Pediatrics
  - Pediatric Medical Unit
  - Pediatric Emergency Department
  - Pediatric Intensive Care Unit (PICU)
  - Pediatric Anesthesiologist

### Hospital Statistics

- Age & Gender Distribution (2013)
  - Female median age – 52.8
  - Male median age – 53
- Population
  - 2013 Area population – 452,784
  - 2018 Projected growth – 486,997
  - 2013 Average household income - \$66,212



## Quality Achievements

- LeapFrog “A” Hospital
- The Joint Commission – Triennial Accreditation
- TJC Top Performer Award – 3<sup>rd</sup> year in a row
- TJC Disease Specific Certification:
  - Primary Stroke Center
  - AMI
  - HF
  - CABG
  - Total Joint – Hips and Knees
- Chest Pain Center with PCI by the Society of Chest Pain Centers
- “3 Star” Designation (highest ranking) by the Society of Thoracic Surgeons
- Bariatric Center of Excellence by the American Society of Metabolic and Bariatric Surgeons
- Accredited Breast Center by the National Accreditation Program for Breast Centers
- Blue Cross/Blue Shield Center of Distinction-Cardiac & Orthopedic Care
- US News and World Reports National Ranking in 4 specialties
- American Heart Association Get With the Guidelines Gold Plus

**Brandon Regional Hospital  
Medical Executive Committee  
(Including Vice Chairman)  
2015 - 2016**

<b>Chief of Staff</b>	Daniel Lorch, MD
<b>Chief of Staff-Elect</b>	Farrukh Saeed, MD
<b>Secretary-Treasurer</b>	Anjan Shah, MD
<b>Representative at Large</b>	Gopal Grandhige, MD
<b>Representative at Large</b>	Vijay Narasimha, MD

<b>Imm Past Chief of Staff</b>	Michael Siegman, MD
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<b>Anesthesiology</b>	Chairman	Daniel Kramer, DO
	Vice Chairman	Jorge Acosta, MD
<b>CV Med/Cardiac Surgery</b>	Chairman	Stephen Mester, MD
	Vice Chairman	Tehreen Khan, MD

**General/Family Practice**

<b>Pediatrics Department</b>	Chairman	Hamid Latif, MD
	Vice Chairman	Sudarsan Kamisetty, MD

<b>Medicine Department</b>	Chairman	Margaret Colleran, MD
	Vice Chairman	Farooque Dastgir, MD

<b>OB/GYN Department</b>	Chairman	James Baron, MD
	Vice Chairman	Antoinina Watkins, MD

<b>Surgery Department</b>	Chairman	Thomas Davison, MD
	Vice Chairman	Francisco Itriago, MD

<b>Emergency Department</b>	Chairman	Jennifer Waxler, DO
	Vice Chairman	Marc Portner, MD Ellis

<b>Diagnostic Imaging</b>	Chairman	Norsoph, MD
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	Vice Chairman	Frank Taylor, MD
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<b>Pathology Department</b>	Chairman	Richard Fernandez, MD
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**Brandon Regional Hospital**



# **HCA Code of Conduct** A Tradition of Caring



# Purpose of Our Code of Conduct

Our Code of Conduct provides guidance to all HCA colleagues and assists us in carrying out our daily activities within appropriate ethical and legal standards. These obligations apply to our relationships with patients, affiliated physicians, third-party payers, subcontractors, independent contractors, vendors, consultants, and one another.

The Code is a critical component of our overall Ethics and Compliance Program. We have developed the Code to ensure we meet our ethical standards and comply with applicable laws and regulations.

The Code is intended to be comprehensive and easily understood. In some instances, the Code deals fully with the subject covered. In many cases, however, the subject requires additional guidance for those directly involved with the particular area to have sufficient direction. To provide additional guidance, we have developed a comprehensive set of compliance policies and procedures which may be accessed on the Ethics and Compliance site of our Intranet, as well as our external web site at [www.hcahealthcare.com](http://www.hcahealthcare.com). Those policies expand upon or supplement many of the principles articulated in this Code of Conduct.

The standards set forth in the Code apply to all HCA facilities and employees operating in the United States. The standards are mandatory and must be followed. A separate Code of Conduct has been developed for our facilities outside the United States.

## Code of Ethics for Senior Financial Officers & Chief Executive Officer

Under the Sarbanes-Oxley Act of 2002 and related Securities and Exchange Commission (SEC) rules, the Company is required to disclose whether it has adopted a written Code of Ethics for its Senior Financial Officers and the Chief Executive Officer (CEO). Any amendments to, or implicit or explicit waiver of, the Code of Ethics for Senior Financial Officers and the CEO must be publicly disclosed as required by SEC rules. "Senior Financial Officers" include, but are not limited to, facility, Division and Group Chief Financial Officers (CFOs)

and controllers, and Corporate officers with financial accounting and reporting responsibilities, including the Executive Vice President and Chief Financial Officer. The Code must be reasonably designed to deter wrongdoing and to promote: honest and ethical conduct, including the ethical handling of actual or apparent conflicts of interest between personal and professional relationships; full, fair, accurate, timely and understandable SEC filings and submissions and other public communications by the Company; compliance





with applicable governmental laws, rules and regulations; prompt internal reporting of violations of the Code; and accountability for adherence to the Code.

The CEO and all Senior Financial Officers are bound by all provisions of this Code of Conduct and particularly those provisions relating to ethical conduct, conflicts of interest, compliance with law, and internal reporting of violations of the Code. The CEO and all Senior Financial Officers also have responsibility for full, fair, accurate, timely and understandable disclosure in the periodic reports and submissions filed by the Company with the SEC as well as in other public communications made by the Company ("Public Communications"). Accordingly, it is the responsibility of the CEO and each Senior Financial

Officer promptly to bring to the attention of the internal working group responsible for the review of the Company's periodic SEC reports ("Disclosure Committee") any information of which he or she may become aware that materially affects the disclosures made by the Company in its Public Communications. The CEO and each Senior Financial Officer also shall bring promptly to the attention of the Disclosure Committee any information he or she may have concerning significant deficiencies in the design or operation of internal controls which could adversely affect the company's ability to record, process, summarize and report financial data; or any fraud, whether or not material, that involves management or other employees who have a significant role in the Company's financial reporting, disclosures or internal controls.

The Corporate Ethics and Compliance Steering Committee shall determine appropriate actions to be taken in the event of violations of the Code by the CEO and the Company's Senior Financial Officers. Such actions shall be reasonably designed to deter wrongdoing and to promote accountability for adherence to the Code. In determining what action is appropriate in a particular case, the Corporate Ethics and Compliance Steering Committee shall take into account all relevant information, including the nature and severity of the violation, whether the violation was a single occurrence or repeated occurrences, whether the violation appears to have been intentional or inadvertent, whether the individual in question had been advised prior to the violation as to the proper course of action and whether or not the individual in question had committed other violations in the past. The Corporate Ethics and Compliance Steering Committee must report periodically any actions taken pursuant to this paragraph to the Audit and Compliance Committee of the Board of Directors.

Any waiver of or amendments to the Code of Ethics for Senior Financial Officers and the CEO must be approved by the Audit and Compliance Committee of the Board of Directors.



# Leadership Responsibilities

While all HCA colleagues are obligated to follow our Code, we expect our leaders to set the example, to be in every respect a model. We expect everyone in the organization with supervisory responsibility to exercise that responsibility in a manner that is kind, sensitive, thoughtful, and respectful. We expect each supervisor to create an environment where all team members are encouraged to raise concerns and propose ideas.

We also expect that they will ensure those on their team have sufficient information to comply with laws, regulations, and policies, as well as the resources to resolve ethical dilemmas. They must help to create a culture within HCA which promotes the highest standards of ethics and compliance. This culture must encourage everyone in the organization to share concerns when they arise. We must never sacrifice ethical and compliant behavior in the pursuit of business objectives.

Specific guidance for leaders throughout the organization regarding their responsibilities under our Ethics and Compliance Program is included in a supplement for leaders to this Code. Leaders at all levels of the organization should use that guidance to most effectively incorporate ethics and compliance into all aspects of our organization.

In addition, all leaders should be mindful that HCA supports and utilizes various training mechanisms to

ensure that our supervisors have excellent managerial skills. These training tools are coordinated by the Corporate Human Resources Department. The foundational principles in such tools reflect the basic concepts of our Ethics and Compliance Program. The Ethics and Compliance Program, together with our leadership training efforts, encourages what we refer to as “principled leadership.” Such leadership assumes that those in our organization will lead by example, will confront problems directly and candidly, will be inclusive in making decisions as to who should participate in the decision-making process, will try to give the maximum responsibility to those who work with them, and will emphasize effective team-building. In addition to these fundamental approaches to principled leadership, we expect those in our organization to understand and care about their colleagues at work. Though HCA is a large organization, its work is accomplished each day, for the most part, in small team settings. This encourages all leaders to try to ensure that the talents of each member of the organization are utilized to the maximum extent possible and that we give careful attention to the professional development of all of those within HCA.

# Our Fundamental **Commitment to** STAKEHOLDERS

## **WE AFFIRM THE FOLLOWING COMMITMENTS TO HCA STAKEHOLDERS**

### **To Our Patients:**

We are committed to providing quality care that is sensitive, compassionate, promptly delivered, and cost-effective.

### **To Our HCA Colleagues:**

We are committed to a work setting which treats all colleagues with fairness, dignity, and respect, and affords them an opportunity to grow, to develop professionally, and to work in a team environment in which all ideas are considered.

### **To Our Affiliated Physicians:**

We are committed to providing a work environment which has excellent facilities, modern equipment, and outstanding professional support.

### **To Our Third-Party Payers:**

We are committed to dealing with our third-party payers in a way that demonstrates our commitment to contractual obligations and reflects our shared concern for quality healthcare and bringing efficiency and cost effectiveness to healthcare. We encourage our private third-party payers to adopt their own set of comparable ethical principles to

explicitly recognize their obligations to patients as well as the need for fairness in dealing with providers.

### **To Our Regulators:**

We are committed to an environment in which compliance with rules, regulations, and sound business practices is woven into the corporate culture. We accept the responsibility to aggressively self-govern and monitor adherence to the requirements of law and to our Code of Conduct.

### **To Our Joint Venture partners:**

We are committed to fully performing our responsibilities to manage our jointly owned facilities in a manner that reflects the mission and values of each of our organizations.

### **To the Communities We Serve:**

We are committed to understanding the particular needs of the communities we serve and providing these communities quality, cost-effective healthcare. We realize as an organization that we have a responsibility to help those in need. We proudly support

charitable contributions and events in the communities we serve in an effort to promote good will and further good causes.

### **To Our Suppliers:**

We are committed to fair competition among prospective suppliers and the sense of responsibility required of a good customer. We encourage our suppliers to adopt their own set of comparable ethical principles.

### **To Our Volunteers:**

The concept of voluntary assistance to the needs of patients and their families is an integral part of the fabric of healthcare. We are committed to ensuring that our volunteers feel a sense of meaningfulness from their volunteer work and receive recognition for their volunteer efforts.

### **To Our Shareholders:**

We are committed to the highest standards of professional management, which we are certain can create unique efficiencies and innovative healthcare approaches and thus ensure favorable returns on our shareholders' investments over the long term.



# Patients

## Quality of Care & Patient Safety

Our mission is to provide high quality, cost-effective healthcare to all of our patients. To that end, we are committed to the delivery of safe, effective, efficient, compassionate and satisfying patient care. We treat all patients with warmth, respect, and dignity and provide care that is both necessary and appropriate. HCA has a comprehensive program to promote the quality objectives of the organization. In promoting a high quality of care, HCA facilities are focused on the attentiveness and dedication of service to patients; the utilization of evolving technology to ensure quality and patient safety and to create an overall culture that makes patient safety paramount; a comprehensive and effective approach to handling the issues of credentialing and privileging of members of the medical staff; and the creation of effective peer review mechanisms within the medical staff. As a general principle, HCA aspires to a standard

of excellence for all caregivers within its facilities, including the entire facility team, which is committed to the delivery of safe, effective, efficient, compassionate and satisfying care and services.

There are increasingly numerous measures that relate in some way to the quality of patient care. These include, for example, the Conditions of Participation of the Centers for Medicare and Medicaid Services (CMS), the standards and surveys of The Joint Commission, the consensus measures of the National Quality Forum, and the principles of the Leapfrog Group for Patient Safety. HCA is attentive to all of these standards and seeks to establish systems that reflect the best practices required or implied by these various standard-setting efforts.

This commitment to quality of care and patient safety is an obligation of every HCA colleague. Accordingly, it is a fundamental principle of being part of HCA that each person dedicates himself or herself to

achieving the goals described here. In addition, in any circumstance where an HCA colleague has a question about whether the quality or patient safety commitments set forth herein are being fully met, that individual is obligated to raise this concern through appropriate channels until it is satisfactorily addressed and resolved. Such channels include those established at the facility, and if necessary, beyond the facility, including the HCA Ethics Line. In addition to the facility and HCA channels, HCA colleagues are provided resources and guidance as to how to solicit intervention or review by external quality partners including The Joint Commission, state survey agencies or state quality improvement organizations.





We make no distinction in the availability of services; the admission, transfer or discharge of patients; or in the care we provide based on age, gender, disability, race, color, religion, or national origin. We recognize and respect the diverse backgrounds and cultures of our patients and make every effort to equip our caregivers with the knowledge and resources to respect each patient's cultural heritage and needs. We are mindful that the populations in those communities we serve are becoming even more diverse. Accordingly, we are structuring more formal programs to ensure that HCA colleagues are equipped to meet these articulated commitments for multi-cultural competency in patient care. The hospital respects the patient's right to and need for effective communication.

Each patient is provided with a written statement of patient rights and a notice of privacy practices. These statements include the rights of a patient to make decisions regarding medical care, the right to refuse or accept treatment, the right to informed decision-making, and a patient's rights related to his or her health information maintained by the facility. Such statements conform to all applicable state and Federal laws, including but not limited to the Health Insurance Portability and Accountability Act of 1996 (hereinafter referred to as HIPAA).

We seek to involve patients in all aspects of their care, including giving consent for treatment and making healthcare decisions, which may include managing

pain effectively, foregoing or withdrawing treatment, and, as appropriate, care at the end of life. The hospital addresses the wishes of the patient relating to end of life decisions. As applicable, each patient or patient representative is provided with a clear explanation of care including, but not limited to, diagnosis, treatment plan, right to refuse or accept care, care decision dilemmas, advance directive options, estimates of treatment costs, organ donation and procurement, and an explanation of the risks, benefits, and alternatives associated with available treatment options. Patients have the right to request transfers to other facilities. In such cases, the patient is given an explanation of the benefits, risks, and alternatives of the transfer.

Patients are provided information regarding their right to make advance directives regarding treatment decisions, financial considerations and the designation of surrogate healthcare decision-makers. Patient advance directives or resuscitative measures are honored within the limits of the law and our organization's mission, philosophy, values, and capabilities.

In the promotion and protection of each patient's rights, each patient and his or her representatives are accorded appropriate confidentiality, privacy, security, advocacy and protective services, opportunity for resolution of complaints, and pastoral care or spiritual care. Patients have the right to an environment that preserves dignity and contributes to positive self-image. Patients are treated in a manner that preserves their dignity,



autonomy, self-esteem, civil rights, and involvement in their own care. HCA facilities maintain processes to support patient rights in a collaborative manner which involves the facility leaders and others. These structures are based on policies and procedures, which make up the framework addressing both patient care and organizational ethics issues. These structures include informing each patient or, when appropriate, the patient's representative of the patient's

rights in advance of furnishing or discontinuing care. Patients receive information about the person(s) responsible for their care, treatment and services. Patients and, when appropriate, their families are informed about the outcomes of care, treatment and services that have been provided, including unanticipated outcomes. Patients are also involved as clinically appropriate in resolving dilemmas about care decisions. Facilities maintain processes for prompt resolution of patient grievances which include informing patients of whom to contact regarding grievances and informing patients regarding the grievance resolution. The hospital addresses the resolution

of complaints from patients and their families. Patients have the right to refuse care, treatment, and services in accordance with the law and regulations. HCA facilities maintain an ongoing, proactive patient safety effort for the identification of risk to patient safety and the prevention, reporting and reduction of healthcare errors. HCA colleagues receive training about patient rights in order to clearly understand their role in supporting them.

We strive to provide health education, health promotion, and illness-prevention programs as part of our efforts to improve the quality of life of our patients and our communities.

## Patient Information

We collect information about the patient's medical condition, history, medication, and family illnesses in order to provide quality care. We realize the sensitive nature of this information and are committed to maintaining its confidentiality. Consistent with HIPAA, we do not use, disclose or discuss patient-specific information, including patient financial information, with others unless it is necessary to serve the patient or required by law.

HCA colleagues must never use or disclose confidential information that violates the privacy rights of our patients. In accordance with our privacy and security policies and procedures, which reflect HIPAA requirements, no HCA colleague, affiliated physician, or other healthcare partner has a right to any patient information other than that necessary to perform his or her job.

Subject only to emergency exceptions, patients can expect their privacy will be protected and patient specific information will be released only to persons authorized by law or by the patient's written authorization.

# Emergency Treatment

We follow the Emergency Medical Treatment and Active Labor Act ("EMTALA") in providing an emergency medical screening examination and necessary stabilization to all patients, regardless of ability to pay. Provided we have the capacity and capability, anyone with an emergency medical condition is treated. In an emergency situation or if the patient is in labor, we will not delay the medical screening and necessary stabilizing treatment in order to seek financial and demographic information. We do not admit, discharge, or transfer patients with emergency medical conditions simply based on their ability or inability to pay or any other discriminatory factor.

Patients with emergency medical conditions are only transferred to another facility at the patient's request or if the patient's medical needs cannot be met at the HCA facility (e.g., we do not have the capacity or capability) and appropriate care is knowingly available at another facility. Patients are only transferred in strict compliance with state and Federal EMTALA regulatory and statutory requirements.

# Physicians

Health care facilities like those owned and operated by HCA reflect a collaboration between those who are part of HCA and those who have been credentialed and privileged to practice in HCA facilities. As in any collaboration, each party has important roles and responsibilities. HCA is committed to providing a work environment for physicians and other privileged practitioners who practice in our facilities that is excellent in all respects. We know that historically members of our medical staffs have interacted with those who work in our hospitals in a respectful and supportive way. We appreciate this and know that we can expect it to continue. We encourage members of our Medical Staffs to be familiar with this Code of Conduct. There are many portions of this Code of Conduct that pertain to ethical or legal obligations of physicians in hospitals, and this document is likely to be a helpful summary of those obligations for our medical staff members.

## Interactions with Physicians

Federal and state laws and regulations govern the relationship between hospitals and physicians who may refer patients to the facilities. The applicable Federal laws include the Anti-Kickback Law and the Stark Law. It is important that those colleagues who interact with physicians, particularly regarding making payments to physicians for services rendered, providing space or services to physicians, recruiting physicians to the community, and arranging for physicians to serve in leadership positions in facilities, are aware of the requirements of the laws, regulations, and policies that address relationships between facilities and physicians.

If relationships with physicians are properly structured, but not diligently administered, failure to administer the arrangements as agreed may result in violations of the law. Any arrangement with a physician must be structured to ensure compliance with legal requirements, our policies and procedures, and with any operational guidance that has been issued. Most arrangements must be in writing and approved by the Legal Department. Failure to meet all requirements of these laws and regulations can result in serious consequences for a facility.

Extending Business Courtesies and Tokens of Appreciation to Potential Referral Sources Any entertainment, gift or token of appreciation involving physicians or other persons who are in a position to refer patients to our healthcare facilities must be undertaken in accordance with corporate policies, which have been developed consistent with Federal laws, regulations, and rules regarding these practices. HCA colleagues must consult Company policies prior to extending any business courtesy or token of appreciation to a potential referral source.

Keeping in mind that it is essential to be familiar with the laws, regulations, and policies that govern our interactions with physicians, two overarching principles govern our interactions with physicians:

**We do not pay for referrals.** We accept patient referrals and admissions based solely on the patient's medical needs and our ability to render the needed services. We do not pay or offer to pay anyone — colleagues, physicians, or other persons or entities — for referral of patients.

**We do not accept payments for referrals we make.** No HCA colleague or any other person acting on behalf of the organization is permitted to solicit or receive anything of value, directly or indirectly, in exchange for the referral of patients. Similarly, when making patient referrals to another healthcare provider, we do not take into account the volume or value of referrals that the provider has made (or may make) to us.

## Legal and Regulatory Compliance

HCA provides varied healthcare services in many states. These services are provided pursuant to appropriate Federal, state, and local laws and regulations, and the conditions of participation for Federal healthcare programs. Such laws, regulations, and conditions of participation may include, but are not limited to, subjects such as certificates of need, licenses, permits, accreditation, access to treatment, consent to treatment, medical record-keeping, access to medical records and confidentiality, patients' rights, clinical research, end-of-life care decision-making, medical staff membership and clinical privileges, corporate practice of medicine restrictions, and Medicare and Medicaid program requirements. The organization is subject to numerous other laws in

addition to these healthcare laws, regulations, and the conditions of participation.

We have developed policies and procedures to address many legal, accreditation, certification and regulatory requirements. However, it is impractical to develop policies and procedures that encompass the full body of applicable law, standards, conditions and regulation. Obviously, those laws, standards, conditions and regulations not covered in organization policies and procedures must be followed. There is a range of expertise within the organization, including operations counsel and numerous functional experts (i.e., Responsible Executives), who should be consulted for advice concerning human resources, legal, regulatory, standards and the conditions of participation requirements.



Anyone aware of violations or suspected violations of laws, regulations, standards and the conditions of participation, or Company policies and procedures must report them immediately to a supervisor or member of management, the Facility Human Resources Manager, the Facility Ethics and Compliance Officer (ECO), the Division ECO, the Ethics Line, or the Corporate Ethics and Compliance Officer.

## Accreditation & Surveys

In preparation for, during and after surveys, HCA colleagues must deal with all accrediting and external agency survey bodies in a direct, open and honest manner. No action should ever be taken in relationships with accrediting or external agency survey bodies that would mislead the accrediting or external agency survey teams, either directly or indirectly.

The scope of matters related to accreditation or external agency survey is extremely significant and broader than the scope of this Code of Conduct. The purpose of our Code of Conduct is to provide general guidance on subjects of wide interest within the organization. Accrediting bodies and external agency survey entities may address issues of both wide and somewhat more focused interest.

From time-to-time, government agencies and other entities conduct surveys in our facilities. We respond with openness and accurate information. In preparation for or during a survey or inspection, HCA colleagues must never conceal, destroy, or alter any documents; lie; or make misleading statements to the agency representative. Colleagues also must never attempt to cause another colleague to fail to provide accurate information or obstruct, mislead, or delay the communication of information or records relating to a possible violation of law.





# Business & Financial Information

## Accuracy, Retention, & Disposal of Documents and Records

Each HCA colleague is responsible for the integrity and accuracy of our organization's documents and records, not only to comply with regulatory and legal requirements but also to ensure records are available to support our business practices and actions. No one may alter or falsify information on any record or document. Records must never be destroyed in an effort to deny governmental authorities that which may be relevant to a government investigation.

Medical and business documents and records are retained in accordance with the law and our record retention policy, which includes comprehensive retention schedules. Medical and business documents include paper documents such as letters and memos, computer based information such as e-mail or computer files on disk or tape, and any other medium that contains information about the organization or its business activities. It is important to retain and destroy records only according to our policy. HCA colleagues must not tamper with records. No one may remove or destroy records prior to the specified date without first obtaining permission as outlined in the Company records management policy. Finally, under no circumstances may an HCA colleague use patient, colleague or any other individual's or entity's information to personally benefit (e.g., perpetrate identity theft).

## Coding & Billing for Services

We have implemented policies, procedures and systems to facilitate accurate billing to government payers, commercial insurance payers, and patients. These policies, procedures, and systems conform to pertinent Federal and state laws and regulations. We prohibit any colleague or agent of HCA from knowingly presenting or causing to be presented claims for payment or approval which are false, fictitious, or fraudulent.

In support of accurate billing, medical records must provide reliable documentation of the services we render. It is important that all individuals who contribute

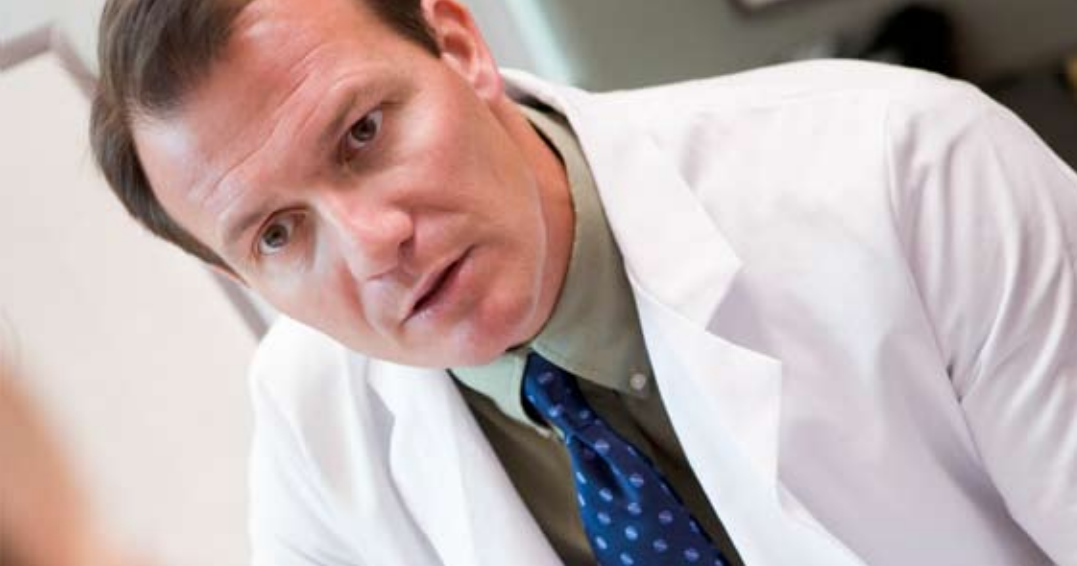
to medical records provide accurate information and do not destroy any information considered part of the official medical record.

Accurate and timely documentation also depends on the diligence and attention of physicians who treat patients in our facilities. We expect those physicians to provide us with complete and accurate information in a timely manner.

Any subcontractors engaged to perform billing or coding services are expected to have the necessary skills, quality control processes, systems, and appropriate procedures to ensure all billings for government and commercial insurance programs are accurate

and complete. HCA expects such entities to have their own ethics and compliance programs and code of conduct. In addition, third-party billing entities, contractors, and preferred vendors under contract consideration must be approved consistent with the corporate policy on this subject.

For technical coding questions in a hospital or ambulatory surgery center contact the 3M Coding Helpline at 1-800-537-1666. For billing and other coding questions in a hospital, freestanding imaging/radiation oncology center, or physician's practice, contact the Regs Helpline by e-mail at Regs Helpline.



## Confidential Information

The term “confidential information” refers to proprietary information about our organization’s strategies and operations as well as patient information and third party information. Improper use or disclosure of confidential information could violate legal and ethical obligations. HCA colleagues may use confidential information only to perform their job responsibilities and shall not share such information with others unless the individuals and/or

entities have a legitimate need to know the information in order to perform their specific job duties or carry out a contractual business relationship, provided disclosure is not prohibited by law or regulation. Confidential information, also referred to as “sensitive information,” covers virtually anything related to HCA’s operations that is not publicly known, such as personnel data maintained by the organization; patient lists and clinical information, including individually identifiable patient information; patient financial information, including credit card data and social security numbers; passwords; pricing and cost data; information pertaining to acquisitions, divestitures, affiliations and mergers; financial data; details regarding federal, state, and local tax examinations of the organization or its joint venture partners; proprietary information from a research sponsor or the data generated from the research;

strategic plans; marketing strategies and techniques; supplier and subcontractor information; and proprietary computer software. In order to maintain the confidentiality and integrity of patient and confidential information, colleagues must protect such information



in accordance with information security policies and standards when it is e-mailed outside the Company or otherwise sent through the Internet; stored on portable devices such as laptops and portable digital assistants (PDAs);

or transferred to removable media such as CD or USB drive. These policies and standards require, among other things, that the individual and/or entity be validated and the information be encrypted.

Use of due care and due diligence is required to maintain the confidentiality, availability and integrity of information assets the Company owns or of which it is the custodian. Because so much of our clinical and business information is generated and contained within our computer systems, it is essential that each HCA colleague protect our computer systems and the information contained in them by not sharing passwords and by reviewing and adhering to our information security policies and standards.

Any HCA colleague who knows or suspects confidential information to have been compromised must report the potential security breach to the Facility ECO, Facility Privacy Officer (FPO), or Facility Information Security Official (FISO).

If an individual’s employment or contractual relationship with HCA ends for any reason, the individual is still bound to maintain the confidentiality of information viewed, received or used during the employment or contractual business relationship with HCA. This provision does not restrict the right of a colleague to disclose, if he or she wishes, information about his or her own compensation, benefits, or terms and conditions of employment. Copies of confidential information in an employee’s or contractor’s possession shall be left with HCA at the end of the employment or contractual relationship.

## Cost Reports

We are required by Federal and state laws and regulations to submit certain reports of our operating costs and statistics. We comply with Federal and state laws, regulations, and guidelines relating to all cost reports. These laws, regulations, and guidelines define what costs are allowable and outline the appropriate methodologies to claim reimbursement for the cost of services provided to program beneficiaries.

Several HCA policies address cost report compliance and articulate our commitment to: maintain and distribute a Reimbursement Manual to Reimbursement Department personnel that includes corporate and departmental policies and procedures; provide effective and timely education and training programs for Reimbursement Department personnel regarding Federal and state laws, regulations and guidelines, and corporate policies; maintain a standardized work paper package to provide consistency in the preparation, organization, presentation, and review of cost reports; apply a uniform cost report review process; identify and exclude non-allowable costs; adhere to documentation standards; and use transmittal letters to report protested items and make other appropriate disclosures. Also, we submit our cost report process to internal audits and maintain a peer review process.

All issues related to the preparation, submission and settlement of cost reports must be performed by or coordinated with our Reimbursement Department.



## Electronic Media & Security Requirements

All communications systems, including but not limited to computers, electronic mail, Intranet, Internet access, telephones, and voice mail, are the property of the organization and are to be used primarily for business purposes in accordance with electronic communications policies and standards. Limited reasonable personal use of HCA communications systems is permitted; however, users should assume these communications are not private. Users of computer and telephonic systems should presume no expectation of privacy in anything they create, store, send, or receive on the computer and telephonic systems, and the Company reserves the right to monitor and/or access communications usage and content consistent with Company policies and procedures.

Colleagues may not use internal communication channels or access to the Internet at work to view, post, store, transmit, download, or distribute any threatening materials; knowingly, recklessly, or maliciously false materials; obscene materials; or anything constituting or encouraging a criminal offense, giving rise to civil liability, or otherwise violating any laws. Also, these channels of communication may not be used to send chain letters, personal broadcast messages, or copyrighted documents that are not authorized for reproduction.



Colleagues who abuse our communications systems or use them excessively for non-business purposes may lose these privileges and be subject to disciplinary action.

Colleagues shall comply with HCA's information security policies and standards governing the use of information systems. Only assigned user IDs and "SecureID" cards shall be used. Individuals may only use officially assigned User IDs and passwords and are not permitted to share or disclose any password

that is used to access HCA systems or information. Portable devices and removable media, such as laptop computers, PDAs, USB drives, CDs and external hard drives, must be physically secured at all times. Colleagues shall never use tools or techniques to break or exploit HCA information security measures or those used by other companies or individuals.



## Financial Reporting & Records

We have established and maintain a high standard of accuracy and completeness in documenting, maintaining, and reporting financial information. This information serves as a basis for managing our business and is important in meeting our obligations to patients, colleagues, shareholders, suppliers, and others. It is also necessary for compliance with tax and financial reporting requirements.

All financial information must reflect actual transactions and conform to generally-accepted accounting principles. All funds or assets must be properly recorded in the books and records of the Company. HCA

maintains a system of internal controls to provide reasonable assurances that all transactions are executed in accordance with management's authorization and are recorded in a proper manner so as to maintain accountability of the organization's assets.

We diligently seek to comply with all applicable auditing, accounting and financial disclosure laws, including but not limited to the Securities Exchange Act of 1934 and the Sarbanes-Oxley Act of 2002. Senior financial officers receive training and guidance regarding auditing, accounting and financial disclosure relevant

to their job responsibilities. They are also provided the opportunity to discuss issues of concern with the Board of Directors' Audit and Compliance Committee. Anyone having concerns regarding questionable accounting or auditing matters should report such matters to the Board of Directors' Audit and Compliance Committee by calling the HCA Ethics Line (1-800-455-1996).



## Intellectual Property Rights and Obligations

Any work of authorship, invention, or other creation (“Development”) created by a colleague during the scope of the colleague’s employment with HCA shall be considered the property of HCA, including any patent, trademark, copyright, trade secret or other intellectual property right in the Development.

Whether something is developed during the scope of a colleague’s employment depends on a number of factors, including: the nature of the colleague’s work, whether the Development is related to HCA’s business, whether the colleague was directed to produce the Development as part of the colleague’s work, whether the colleague utilized HCA intellectual property or resources at least in part to make the Development, and whether the colleague created the Development while being paid by HCA. If any Development created is copyrightable or patentable, then it will be considered a “Work for Hire” under the United States Copyright Act, with HCA being considered to be the author and owner of such work.

When creating Developments for HCA, colleagues shall respect the intellectual property rights of others. Any works or inventions created by colleagues prior to employment by HCA shall be disclosed to HCA upon commencement of employment, and management and Legal Department approval shall be obtained prior to any use of these works or inventions in a Development for HCA.

By signing the acknowledgment card at the end of this Code of Conduct, a colleague specifically agrees to be bound by these provisions of the Code of Conduct. As such, the acknowledgment card serves as an assignment by the named colleague to HCA of all right, title, and interest in all Developments created by the colleague within the scope of his or her employment, as well as an appointment of the Secretary for HCA as the colleague’s attorney-in-fact to execute documents on his or her behalf for the foregoing purposes. Colleagues shall assist HCA in obtaining and enforcing intellectual property rights in their Developments, while employed by HCA and after termination of employment.

# Workplace Conduct & Employment Practices

## Conflict of Interest

A conflict of interest may occur if an HCA colleague’s outside activities, personal financial interests, or other personal interests influence or appear to influence his or her ability to make objective decisions in the course of the colleague’s job responsibilities. A conflict of interest may also exist if the demands of any outside activities hinder or distract a colleague from the performance of his or her job or cause the individual to use HCA resources for other than HCA purposes. HCA colleagues are obligated to ensure they remain free of conflicts of interest in the performance of their responsibilities at HCA. If colleagues have any question about whether an outside activity or personal interest might constitute a conflict of interest, they must obtain the written approval of their supervisor and ECO before pursuing the activity or obtaining or retaining the interest. Clinical decisions will be made without regard to compensation or financial risk to HCA leaders, managers, clinical staff, or licensed, independent practitioners.

No waiver of this conflict of interest provision may be granted to an Executive Officer (i.e., an officer subject to Section 16 of the Securities Exchange Act of 1934) unless approved in advance by the Audit and Compliance Committee of the Board of Directors.

## Controlled Substances

Some of our colleagues routinely have access to prescription drugs, controlled substances, and other medical supplies. Many of these substances are governed and monitored by specific regulatory organizations and must be administered by physician order only. Prescription and controlled medications and supplies must be handled properly and only by authorized individuals to minimize risks to us and to patients. If one becomes aware of inadequate security of drugs or controlled substances or the diversion of drugs from the organization, the incident must be reported immediately.

## Copyrights

HCA colleagues may only copy and/or use copyrighted materials pursuant to the organization's policy on such matters.

## Substance Abuse and Mental Acuity

To protect the interests of our colleagues and patients, we are committed to an alcohol and drug-free work environment. All colleagues must report for work free of the influence of alcohol and illegal drugs. Reporting to work under the influence of any illegal drug or alcohol; having an illegal drug in a colleague's system; or using, possessing, or selling illegal drugs while on HCA work time or property may result in immediate termination. We may use drug testing as a means of enforcing this policy.

It is also recognized individuals may be taking prescription or over-the-counter drugs, which could impair judgment or other skills required in job performance. Colleagues with questions about the effect of such medication on their performance or who observe an individual who appears to be impaired in the performance of his or her job must immediately consult with their supervisor.

HCA is an equal opportunity workforce and no one shall discriminate against any individual with regard to race, color, religion, sex, national origin, age, disability, sexual orientation, or veteran status with respect to any offer, or term or condition, of employment. We make reasonable accommodations to the known physical and mental limitations of qualified individuals with disabilities.

## Diversity and Equal Employment Opportunity

HCA actively promotes diversity in its workforce at all levels of the organization. We are committed to providing an inclusive work environment where everyone is treated with fairness, dignity, and respect. We will make ourselves accountable to one another for the manner in which we treat one another and for the manner in which people around us are treated. We are committed to recruit and retain a diverse staff reflective of the patients and communities we serve. We regard laws, regulations and policies relating to diversity as a minimum standard. We strive to create and maintain a setting in which we celebrate cultural and other differences and consider them strengths of the organization.

## Harassment and Workplace Violence

Each HCA colleague has the right to work in an environment free of harassment and disruptive behavior. We do not tolerate harassment by anyone based on the diverse characteristics or cultural backgrounds of those who work with us. Degrading or humiliating jokes, slurs, intimidation, or other harassing conduct is not acceptable in our workplace.

Sexual harassment is prohibited. This prohibition includes unwelcome sexual advances or requests for sexual favors in conjunction with employment decisions. Moreover, verbal or physical conduct of a sexual nature that interferes with an individual's work

performance or creates an intimidating, hostile, or offensive work environment has no place at HCA.

Harassment also includes incidents of workplace violence. Workplace violence includes robbery and other commercial crimes, stalking, violence directed at the employer, terrorism, and hate crimes committed by current or former colleagues. Colleagues who observe or experience any form of harassment or violence should report the incident to their supervisor, the Human Resources Department, a member of management, the Facility ECO, or the Ethics Line.

## Health and Safety

All HCA facilities comply with all government regulations and rules, HCA policies, and required facility practices that promote the protection of workplace health and safety. Our policies have been developed to protect our colleagues from potential workplace hazards. Colleagues must become familiar with and understand how these policies apply to their specific job responsibilities and seek advice from their supervisor or the Safety Officer whenever they have a question or concern. It is important that each colleague immediately advise his or her supervisor or the Safety Officer of any serious workplace injury or any situation presenting a danger of injury so timely corrective action may be taken to resolve the issue.

## Hiring of Former/Current Government & Fiscal Intermediary/Medicare Administrative Contractor Employees

The recruitment and employment of former or current U.S. government employees may be impacted by regulations concerning conflicts of interest. Hiring employees directly from a fiscal intermediary or Medicare Administrative Contractor requires certain regulatory notifications. Colleagues should consult with the Corporate Human Resources Department or the Legal Department regarding such recruitment and hiring.

## Ineligible Persons

We do not contract with, employ, or bill for services rendered by an individual or entity that is excluded or ineligible to participate in Federal healthcare programs; suspended or debarred from Federal government contracts and has not been reinstated in a Federal healthcare program after a period of exclusion, suspension,

debarment, or ineligibility. We routinely search the Department of Health and Human Services' Office of Inspector General and General Services Administration's lists of such excluded and ineligible persons. A number of Company policies address the procedures for timely and thorough review of such lists and appropriate enforcement

actions. Colleagues, vendors, and privileged practitioners at one or more HCA facilities are required to report to us if they become excluded, debarred, or ineligible to participate in Federal healthcare programs.

## Insider Information and Securities Trading

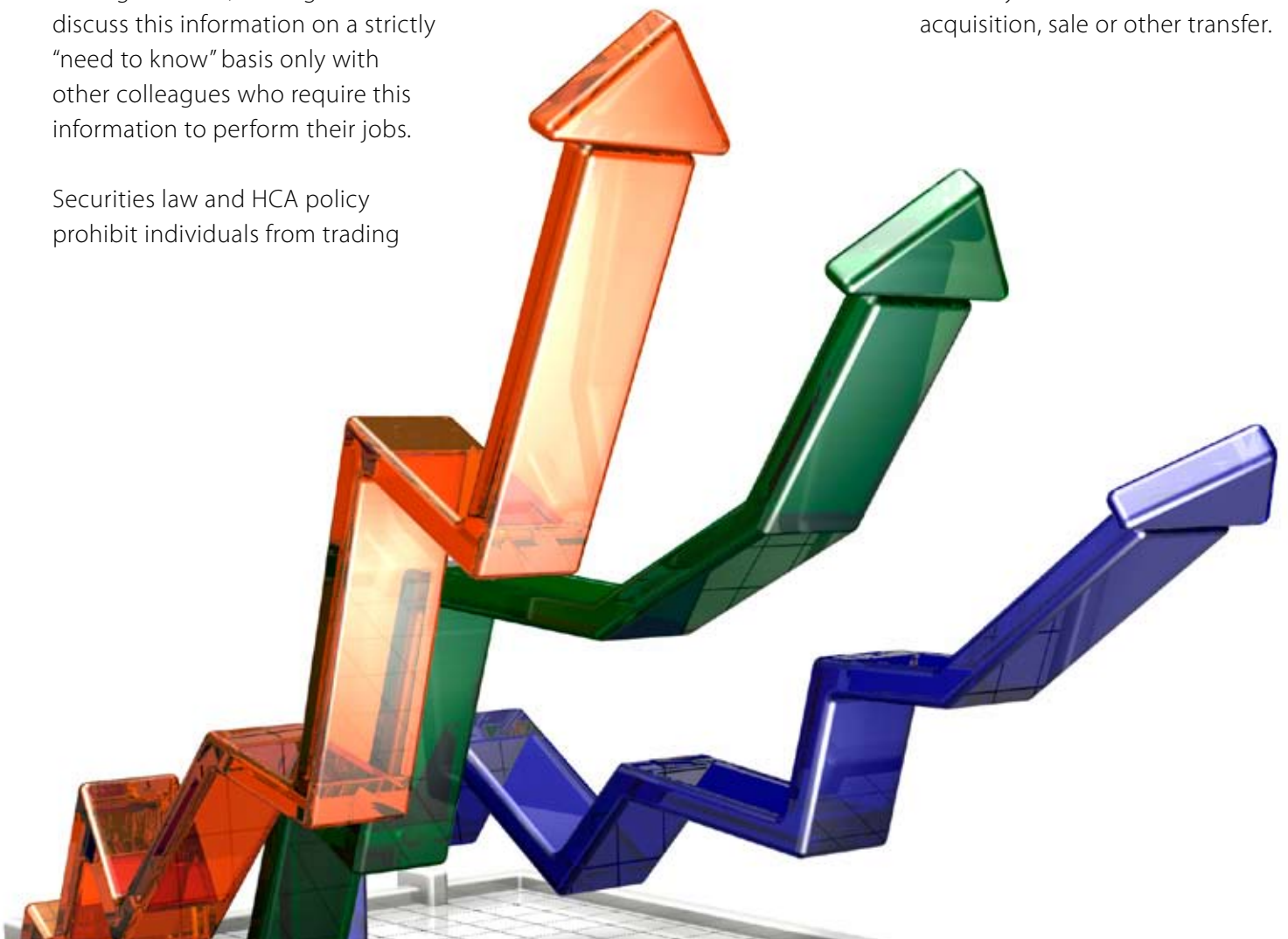
While HCA is no longer a publicly listed company, one or more of its debt or equity securities may from time to time be publicly registered under the various securities laws or otherwise have an active trading market. In the course of colleagues' employment with HCA, they may become aware of non-public information about HCA material to an investor's decision to buy or sell the organization's securities. Non-public, material information may include, among other things, plans for mergers, marketing strategy, financial results, or other business dealings. Regardless of whether our securities are publicly registered or traded, colleagues may not discuss this type of information with anyone outside of the organization. Within the organization, colleagues should discuss this information on a strictly "need to know" basis only with other colleagues who require this information to perform their jobs.

Securities law and HCA policy prohibit individuals from trading

in the marketable securities of an organization or influencing others to trade in such securities on the basis of non-public, material information. These restrictions are meant to ensure the general public has complete and timely information on which to base investment decisions.

If an HCA colleague obtains access to non-public, material information about the organization, or any other company while performing his or her job, the colleague may not use that information to buy, sell, transfer, gift or effect other transactions of securities of HCA or that other company. Even if he or she does not buy, sell, transfer, gift or effect other transactions of such securities based

on what he or she knows, discussing the information with others, such as family members, friends, vendors, suppliers, and other outside acquaintances, is prohibited until the information is considered to be public. Information is considered to be public twenty four hours after a general release of the information to the media. Any HCA colleague desiring to purchase, sell, gift or otherwise effect a transfer of HCA equity securities, and any HCA officer or member of HCA's Board of Directors (including immediate family members or entities they may control) desiring to purchase, sell, gift or otherwise effect a transfer of securities of HCA (debt or equity), is required to pre-clear such transfer with HCA's corporate secretary's office in advance of such acquisition, sale or other transfer.





## Relationships Among HCA Colleagues

In the normal day-to-day functions of an organization like HCA, there are issues that arise which relate to how people in the organization deal with one another. It is impossible to foresee all of these, and many do not require explicit treatment in a document like this. A few routinely arise, however. One involves gift giving among colleagues for certain occasions. While we wish to avoid any strict rules, no one should ever feel compelled to give a gift to anyone, and any gifts offered or received should be appropriate to the circumstances. A lavish gift to anyone in a supervisory role would clearly violate organization policy. Another situation, which routinely arises, is a fund-raising or similar effort undertaken by individual colleagues, in which no one should ever be compelled to participate. Similarly, when the Company or a facility determines to support charitable organizations such as the United Way, no colleague should be compelled to contribute to the charitable organization, nor should there be any workplace consequences of such non-participation.

## License and Certification Renewals

Colleagues, individuals retained as independent contractors, and privileged practitioners in positions which require professional licenses, certifications, or other credentials are responsible for maintaining the current status of their credentials and shall comply at all times with Federal and state requirements applicable to their respective disciplines. To assure compliance, HCA may require evidence of the individual having a current license or credential status.

HCA does not allow any colleague, independent contractor or privileged practitioner to work without valid, current licenses or credentials. Each colleague must have evidence of current and valid licensure, certification, registration, accreditation or credential as required by their position description. Each facility must have appropriate processes and procedures to assure documentation of compliance with each position description requirement.

## Personal Use of HCA Resources

It is the responsibility of each HCA colleague to preserve our organization's assets including time, materials, supplies, equipment, and information. Organization assets are to be maintained for business-related purposes. As a general rule, the personal use of any HCA asset without prior supervisory approval is prohibited. The occasional use of items, such as copying facilities or telephones, where the cost to HCA is insignificant, is permissible. Any community or charitable use of organization resources must be approved in advance by one's supervisor. Any use of organization resources for personal financial gain unrelated to the organization's business is prohibited.

## Relationships with Subcontractors and Suppliers

HCA is the majority owner and managing general partner of HealthTrust Purchasing Group (HPG). On behalf of its member entities, including HCA, HPG negotiates contracts with supply and service vendors. HPG has a Code of Conduct and Business Relationship Statement that outline its commitment to ethical and compliant behavior and its expectations of the same by its contractors. Copies of the Code and Statement are available on HPG's website at: [www.healthtrustpg.com](http://www.healthtrustpg.com). HPG

participates in the Healthcare Group Purchasing Industry Initiative as a founding member. This is an umbrella group of the largest healthcare group purchasing organizations in the country intended to promote the highest standards of business conduct in these activities.

Those seeking to be suppliers of HCA should understand that virtually all of the system-wide procurement effort is executed, in effect, by the HealthTrust Purchasing Group. As in any

large organization, once central procurement decisions have been made, it is anticipated that local facilities will utilize the negotiated contracts. Organizations that compete unsuccessfully through HPG for national agreements with HCA, or, for whatever reason, elect not to compete in such processes, should not be disappointed by efforts of those in the HCA supply chain to maintain compliance with negotiated national agreements. We encourage those with new technologies or product innovations to be certain that HPG fully understands their capabilities.

We must manage our consulting, subcontractor, and supplier relationships in a fair and

reasonable manner, free from conflicts of interest and consistent with all applicable laws and good business practices. We promote competitive procurement to the maximum extent practicable.

Our selection of consultants, subcontractors, suppliers, and vendors will be made on the basis of objective criteria including quality, technical excellence, price, delivery, adherence to schedules, service, and maintenance of adequate sources of supply. Our purchasing decisions will be made on the supplier's ability to meet our needs, and not on personal relationships and friendships.

We employ the highest ethical standards in business practices in source selection, negotiation,

determination of contract awards, and the administration of all purchasing activities. We comply with contractual obligations not to disclose vendor confidential information unless permitted under the contract or otherwise authorized by the vendor.

## Research, Investigations, & Clinical Trials

We follow the highest ethical standards in full compliance with Federal and state laws and regulations in any research, investigations, and/or clinical trials conducted by our physicians and professional staff. We do not tolerate research misconduct, which includes activities such as making up or changing results, copying results from other studies without performing the clinical investigation or research, failing to identify and deal appropriately with investigator or institutional conflicts of interest, and proceeding without Institutional Review Board (IRB) approval. Our hospitals' first priority is always to protect the patients and human subjects and respect their rights during research, investigations, and clinical trials.

Physicians conducting clinical trials of investigational products and services are expected to fully inform all subjects of their rights and responsibilities of participating in the clinical trial. All potential subjects asked to participate in a clinical trial are given a full explanation of alternative services that might prove beneficial to them. They are also fully informed of potential discomforts and are given a full explanation of the risks, expected benefits, and alternatives. The

subjects are fully informed of the procedures to be followed, especially those that are experimental in nature. Refusal of a potential subject to participate in a research study or the voluntary withdrawal of his or her participation in an existing study will not compromise his or her access to services or other benefits to which he or she is otherwise entitled. A subject's voluntary informed consent to participate in a clinical trial is documented and retained pursuant to Company and hospital policies.

Any HCA facility or colleague applying for or performing research of any type must follow all applicable research guidelines and privacy policies and maintain the highest standards of ethics and accuracy in any written or oral communications regarding the research project. As in all accounting and financial record-keeping, our policy is to submit only true, accurate, and complete costs related to research grants. Any HCA facility or colleague engaging in human subject research must do so in conjunction with IRB approval and consistent with Company policies regarding human subject research and IRBs.

# Competitive Activities & Marketing Practices

We operate in a highly competitive environment. Our competitive activities must conform to the high standards of integrity and fairness reflected in this Code of Conduct. The Company requires compliance with antitrust and other laws governing competitive activities, and with the Company’s written policies governing interactions with competitors, customers and suppliers.

## Antitrust and Unfair Competition

The Company has strict restrictions on communications with competitors, which are set forth in Company policy. Generally, colleagues are not to discuss with competitors non-public “competitively sensitive topics” as defined in the policy. Because the antitrust laws are so complex and their application can depend upon the conditions in local markets, it is not practical to adopt written policies to govern all situations. Colleagues should consult with their supervisors or the Legal Department for guidance concerning competitive activities, laws and policies relating to their areas of responsibility.

## Marketing and Advertising

Consistent with laws and regulations that may govern such activities, we may use marketing and advertising activities to educate the public, provide information to the community, increase awareness of our services, and to recruit colleagues. We strive to present only truthful, fully informative, and non-deceptive information in these materials and announcements.

While it is permissible to compare and contrast our services and prices, it is against Company policy to intentionally disparage other persons or businesses based on information that is untrue, or not known to be true, or to intentionally interfere with another business’s contractual and business relationships through wrongful means. This does not prevent fair, non-deceptive competition for business from those who may also have business relationships with a competitor.

## Foreign Corrupt Practices Act

The United States Foreign Corrupt Practices Act (FCPA) requires us to exercise care in our dealings with foreign government officials, employees, or representatives; and members of their families. The FCPA prohibits providing anything of value to any of these individuals for the purpose of obtaining or retaining business. Under the FCPA, HCA is responsible for the actions of its agents and representatives. Before offering anything of value to foreign government officials, employees or representatives or a member of their family, an HCA colleague must obtain advice from the Corporate Ethics and Compliance Department or the Legal Department.

# Environmental Compliance

It is our policy to comply with all environmental laws and regulations as they relate to our organization's operations. We act to preserve our natural resources to the full extent reasonably possible. We comply with all environmental laws and operate each of our facilities with the necessary permits, approvals, and controls. We diligently employ the proper procedures to provide a good environment of care and to prevent pollution.

In helping HCA comply with these laws and regulations, all HCA colleagues must understand how job duties may impact the environment, adhere to all requirements for the proper handling of hazardous materials, and immediately alert supervisors to any situation regarding the discharge of a hazardous substance, improper disposal of hazardous and medical waste, or any situation which may be potentially damaging to the environment.

## Business Courtesies

### General

This part of the Code of Conduct should not be considered in any way as an encouragement to make, solicit, or receive any type of entertainment or gift. For clarity purposes, please note that these limitations govern activities with those outside of HCA. This section does not pertain to actions between HCA and its colleagues or actions among HCA colleagues themselves.

### Receiving Business Courtesies

We recognize there will be times when a current or potential business associate, including a potential referral source, may extend an invitation to attend a social event in order to further develop a business relationship. An HCA colleague may accept such invitations, provided: (1) the cost associated with such an event is reasonable and appropriate, which, as a general rule, means the cost will not exceed \$150 per person; (2) no expense is incurred for any travel costs (other than in a vehicle owned privately or by the host entity) or overnight lodging; and (3) such events are infrequent. The limitations of this section do not apply to business meetings at which food (including meals) may be provided. Prior to accepting invitations to training and educational opportunities

that include travel and overnight accommodations at reduced or no cost to a colleague or HCA, consult our policies and seek appropriate approvals.



HCA colleagues may accept gifts with a total value of \$75 or less in any one year from any individual or organization who has

a business relationship with HCA. For purposes of this paragraph, physicians practicing in HCA facilities are considered to have such a relationship. Perishable or consumable gifts given to a department or group are not subject to any specific limitation. HCA colleagues may accept gift certificates, but may never accept cash or financial instruments (e.g., checks, stocks). Finally, under no circumstances may an HCA colleague solicit a gift.

This section does not limit HCA facilities from accepting gifts, provided they are used and accounted for appropriately.



## Extending Business Courtesies to Non-referral Sources

No portion of this section, “Extending Business Courtesies to Non-referral Sources,” applies to any individual who makes, or is in a position to make, referrals to an HCA facility. Such business courtesies are addressed in the Extending Business Courtesies to Potential Referral Sources section of this Code and Company policies.

## Meals and Entertainment

There may be times when a colleague wishes to extend to a current or potential business associate (other than someone who may be in a position to make a patient referral) an invitation to attend a social event (e.g., reception, meal, sporting event, or theatrical event) to further or develop a business relationship. The purpose of the entertainment must never be to induce any favorable business action. During these events, topics of a business nature must be discussed and the host must be present. These events must not include expenses paid for any travel costs (other than in a vehicle owned privately or by the host entity) or overnight lodging. The cost associated with such an event must be reasonable and appropriate. As a general rule, this means the cost will not exceed \$150 per person. Moreover, such business entertainment with respect to any particular individual must be infrequent, which, as a general rule, means not more than three times per year. Consult Company policy for events that are expected to exceed \$150 or were not expected to but inadvertently do exceed \$150. That policy requires establishing the business necessity and appropriateness of the proposed entertainment. The organization will under no circumstances sanction any business entertainment that might be considered lavish or in questionable taste. Departures from the \$150 guideline are highly discouraged.

## Sponsoring Business Events

Also, HCA facilities may routinely sponsor events with a legitimate business purpose (e.g., hospital board meetings or retreats). Provided that such events are for business purposes, reasonable and appropriate meals and entertainment may be offered. In addition, transportation and lodging can be paid for. However, all elements of such events, including these courtesy elements, must be consistent with the corporate policy on such events.

## Gifts

It is critical to avoid the appearance of impropriety when giving gifts to individuals who do business or are seeking to do business with HCA. We will never use gifts or other incentives to improperly influence relationships or business outcomes. In order to avoid embarrassment, an effort should be made to ensure that any gift we extend meets the business conduct standards of the recipient’s organization. Gifts to business associates who are not government employees must not exceed \$75.00 per year per recipient. Any gifts to Medicare or Medicaid beneficiaries must not exceed \$10.00 per item nor total more than \$50.00 per year per recipient. An HCA colleague or facility may give gift certificates, but may never give cash or financial instruments (e.g., checks, stocks). The corporate policy on business courtesies permits occasional exceptions to the \$75 limit to recognize the efforts of those who have spent meaningful amounts of volunteer time on behalf of HCA.

U.S. Federal and state governments have strict rules and laws regarding gifts, meals, and other business courtesies for their employees. HCA does not provide any gifts, entertainment, meals, or anything else of value to any employee of the Executive Branch of the Federal government or its fiscal intermediaries, except for minor refreshments in connection with business discussions or promotional items with the HCA or facility logo valued at no more than \$10.00. With regard to gifts, meals, and other business courtesies involving any other category of government official or employee, colleagues must determine the particular rules applying to any such person and carefully follow them.



# Government Relations & Political Activities

The organization and its representatives comply with all federal, state, and local laws governing participation in government relations and political activities. As a general policy, HCA funds or resources are not contributed directly to individual political campaigns, political parties, or other organizations which intend to use the funds primarily for political campaign objectives. Those who seek exceptions to this general rule may only do so after obtaining the appropriate approvals required in relevant policies. Organization resources include financial and non-financial donations such as using work time and telephones to solicit for a political cause or candidate or the loaning of HCA property for use in the political campaign. The conduct of any political action committee is to be consistent with relevant laws and regulations. In addition, political action committees associated with the organization select candidates to support based on the overall ability of the candidate to render meaningful public service. The organization does not select candidates to support as a reflection of expected support of the candidate on any specific issue.

The organization engages in public policy debate only in a limited number of instances where it has special expertise that can inform the public policy formulation process. When the organization is directly impacted by public policy decisions, it may provide relevant, factual information about the impact of such decisions on the private sector. In articulating positions, the organization only takes positions that it believes can be shown to be in the larger public interest. The organization encourages trade associations with which it is associated to do the same.

It is important to separate personal and corporate political activities in order to comply with the appropriate rules and regulations relating to lobbying or attempting to influence government officials. No use of corporate resources, including e-mail, is appropriate for personally engaging in political activity.

A colleague may, of course, participate in the political process on his or her own time and at his or her own expense. While doing so, it is important HCA colleagues not give the impression they are speaking on behalf of or

To obtain further guidance on an ethics and compliance issue or to report a suspected violation of our Code of Conduct:

- DISCUSS the situation with your supervisor;
- DISCUSS the situation with a member of local management or your local Ethics and Compliance Officer; or
- CALL the Corporate Ethics Line at 1-800-455-1996.

representing HCA in these activities. Colleagues cannot seek to be reimbursed by HCA for any personal contributions for such purposes.

At times, HCA may ask colleagues to make personal contact with government officials or to write letters to present our position on specific issues. In addition, it is a part of the role of some HCA management to interface on a regular basis with government officials. If a colleague is making these communications on behalf of the organization, he or she must be certain to be familiar with any regulatory constraints and observe them. Guidance is always available from the Corporate Government Relations and Legal Departments as necessary.

# The Company's Ethics & Compliance Program

## Program Structure

The Ethics and Compliance Program is intended to demonstrate in the clearest possible terms the absolute commitment of the organization to the highest standards of ethics and compliance. The elements of the program include setting standards (the Code and Policies and Procedures), communicating the standards, providing a mechanism for reporting potential exceptions, monitoring and auditing, and maintaining an organizational structure that supports the furtherance of the program. Each of these elements is detailed below.

These elements are supported at all levels of the organization. Providing direction, guidance and oversight are the Audit and Compliance Committee of the Board of Directors; the Corporate Ethics and Compliance Steering Committee consisting of senior management; and the Corporate Ethics and Compliance Policy Committee consisting of senior management and representative facility CEOs.

The Chief Ethics and Compliance Officer for the organization and the Ethics and Compliance Department are responsible for the day-to-day direction and implementation of the Ethics and Compliance Program. This includes developing resources (including policies and procedures, training programs, and communication tools) for and providing support (including operating the Ethics Line, conducting program assessment, and providing advice) to Facility ECOs and others.

Responsible Executives are individuals in the Corporate Office who have expertise in various areas of compliance risk and who

are called upon in their areas of expertise to lead policy and training development efforts, conduct monitoring and auditing as appropriate, and provide advice.

Playing a key role in ensuring the successful implementation of our Ethics and Compliance Program, Facility ECOs are responsible for distributing standards, ensuring training is conducted, conducting monitoring and responding to audits, investigating and resolving Ethics Line cases, and otherwise administering the Ethics and Compliance Program in their facilities. Hospital ECOs are also expected to establish and maintain a Facility Ethics and Compliance Committee (FECC) to assist them in these efforts. All Divisions and Markets have appointed Division or Market ECOs, who assist in directing and assessing the Ethics and Compliance Program for their Divisions or Markets.

Another important resource who may be able to address issues arising out of this Code of Conduct is the Human Resources Manager. Human Resources Managers are highly

knowledgeable about many of the compliance risk areas described in this Code of Conduct that pertain to employment and the workplace and are responsible for ensuring compliance with various employment laws. If a concern relates to specific details of an individual's work situation, rather than larger issues of organizational ethics and compliance, the Human Resources Manager is the most appropriate person to contact. In that we promote the concept of management autonomy at local facilities, every effort should be made to resolve workplace conduct and employment practice issues through the individual's supervisor and the Human Resources Manager at the local facility. Experience has shown that this is an effective and productive way to deal promptly with these matters. Division Human Resources Managers also assist in investigating and resolving Ethics Line cases and workplace conduct and employment practices issues. HCA routinely reviews the operation of this problem solving procedure and may periodically modify the details of the approach in order to maximize its effectiveness. In circumstances where you seek to utilize the problem solving procedure, we encourage you to inquire about the specifics of how the procedure operates. Your local human resources department or representative can provide this information.

All of these individuals or groups are prepared to support HCA colleagues in meeting the standards set forth in this Code. Membership lists for each of the Corporate entities and the Facility ECOs can be found at the Ethics and Compliance site on the organization's Intranet.

## Setting Standards

With respect to our Ethics and Compliance Program, we set standards through this Code of Conduct, ethics and compliance policies and procedures and, occasionally, through other guidance mechanisms, such as Compliance Alerts and advisory memoranda. It is the responsibility of each individual to be aware of those policies and procedures that pertain to his or her work and to follow those policies and procedures.

## Training and Communication

Comprehensive training and education has been developed to ensure that colleagues throughout the organization are aware of the standards that apply to them. Code of Conduct training is conducted at the time an individual joins the organization and annually for all colleagues. Compliance training in areas of compliance risk (e.g., billing, coding, cost reports) is required of certain individuals. Company policies outline the training requirements.

All ethics and compliance training is required to be recorded in the Company's learning management

system, the HealthStream Learning Center (HLC). Through the HLC, system administrators and ECOs track colleagues' compliance with their training requirements and report such information as necessary.

Many resources regarding our program are available to all HCA colleagues on our Intranet and to the general public on the Internet. We encourage all colleagues to frequently visit both sites.

## Resources for Guidance and Reporting Concerns

To obtain guidance on an ethics or compliance issue or to report a concern, individuals may choose from several options. We encourage the resolution of issues, including human resources-related issues (e.g., payroll, fair treatment and disciplinary issues), at a local level. Colleagues should use the human resources-related problem solving procedure at their facility to resolve such issues. It is an expected good practice, when one is comfortable with it and think it appropriate under the circumstances, to raise concerns first with one's supervisor. If this is uncomfortable or inappropriate, the individual may discuss the situation with the Facility Human Resources Manager, the Facility ECO, or another member of management at the facility or in the organization. Individuals are always free to contact the Ethics Line at 1-800-455-1996.

HCA makes every effort to maintain, within the limits of the law, the confidentiality of the identity of any individual who reports concerns or possible misconduct. There is no retribution or discipline for anyone who reports a concern in good faith. Any colleague who deliberately makes a false accusation with the purpose of harming or retaliating against another colleague is subject to discipline.

## Personal Obligation to Report

We are committed to ethical and legal conduct that is compliant with all relevant laws and regulations and to correcting wrongdoing wherever it may occur in the organization. Each colleague has an individual responsibility for reporting any activity by any colleague, physician, subcontractor, or vendor that appears to violate applicable laws, rules, regulations, accreditation standards, standards of medical practice, Federal healthcare conditions of participation, or this Code. If a matter that poses serious compliance risk to the organization or that involves a serious issue of medical necessity, clinical outcomes or patient safety is reported locally, and if the reporting individual doubts that the issue has been given sufficient or appropriate attention, the individual should report the matter to higher levels of management or the Ethics Line until satisfied that the full importance of the matter has been recognized. If a matter that poses concern regarding the safety or quality of care provided to a patient in the hospital is identified and was reported locally but thought to be unresolved, an additional avenue for reporting is available through notification to The Joint Commission. There will be no retaliatory disciplinary action taken against an employee who reports concerns to The Joint Commission.





# **Brandon Regional Hospital** Parking & Facility Information

## Purpose

To provide designated parking for patients, visitors, volunteers, physicians, students and employees. This is required to assure that visitors and patients have available parking near the entrances and so that employee cards can be monitored for safety and security reasons

## Policy

- The hospital will provide parking to all patients and visitors near the main entrance of the hospital, near the Emergency Department, and in the Parking Garages.
- Volunteers are considered visitors and may park in areas designated for visitors.
- Physicians have designated parking that is posted. It is necessary for physicians to display a hospital permit that can be hung from the vehicle rear view mirror to park in their designated areas. These hanging permits can be obtained through the Physician Services office. Physicians may also choose to park in any public space.
- Employees have been given the following designated areas and times:
  1. The South Parking Garage - Employee parking 24 hours a day, Monday through Sunday. Vehicle must display parking permit issued at Human Resources. Security will issue temporary permits to Agency Employees for a week at a time (ID Badge required). Employees should use levels above three during daylight hours in order to give access to our patients and visitors. Night shift employees must remove cars from lower levels by 8:00 a.m.
  2. Parson's Parking Lot Monday through Sunday, 24 hours a day except as designated by cones and signage. Parking spaces striped in yellow are for designated patron parking only.
  3. Employees may park in the North parking garage (near the corner of Oakfield and Parsons). Employees should use levels above 3 during daylight hours in order to give access to our patients and visitors.
  4. Ground parking on campus is reserved for patients, visitors and physicians 24 hours a day, Monday through Sunday. Employees may not park in any ground level parking spaces at any time.
  5. Those employees who work in offices at Oakfield Medical Plaza may park in either of the parking garages, or in non-reserved parking spaces in Oakfield. Employees may not park at the Oakfield parking lot if they are only attending events in the classrooms.
  6. Employee parking is available at the Oakfield Medical Plaza from 7:00 p.m. Until 8:00 a.m. Monday through Friday with no time restraints on Saturday and Sunday. Exceptions are designated by cones and signage. Reserved parking spaces are reserved 24 hours a day, 7 days a week.
  7. Employee Vehicle Permits/decals must be affixed to the driver's side lower front windshield.
  8. All employees will be issued an Employee Vehicle Permit/decal through Human Resources during the orientation process and anytime during regular business hours (Monday - Friday, 7:30 a.m. - 4:00 p.m.).
  9. There are posted parking places for specific employees such as "Employee of the Quarter", "Employee of the year", etc. that may be found in areas that are not employee parking areas. Only the designated employee may park in such an area.
  10. A security officer escort may be requested by employees during the hours of darkness by contacting the PBX operator or the **Woman's Center** desk.

- If your vehicle is parked in non designated areas, or does not display a hospital permit/decal you are subject to the following action:
  1. First Offense - Ticketed with warning.
  2. Second Offense - Ticketed with warning.
  3. Third Offense - Vehicle immobilized. Requires written counseling by a supervisor in order to have the immobilizer boot removed.
  4. Fourth Offense - Ticketed and vehicle towed at owners expense.
- All handicapped employees must display handicapped tags/placard and must have severe physical disability, mobility problems, and substantial impairment to ambulation.
- All vehicles should be locked with valuables hidden from view.

**Exceptions to this policy are given to employees who have a physician statement requesting special parking requirements.**

## Definitions

Procedure: \_\_\_\_\_  
\_\_\_\_\_

Equipment (If Applicable): \_\_\_\_\_  
\_\_\_\_\_

References: \_\_\_\_\_  
\_\_\_\_\_

Related Policies: \_\_\_\_\_  
\_\_\_\_\_



<b>Code Red</b>	Fire / Fire Drill/ Smoke
<b>Code Blue</b>	Cardiac or Respiratory Arrest
<b>Code Blue Pediatrics</b>	Cardiac or Respiratory Arrest / Infant or Pedi
<b>Code Pink</b>	Infant or Pediatric Abduction
<b>Code Grey</b>	Security Response Needed
<b>Code Grey/Caution</b>	Security Response Needed / Weapon Involved
<b>Code Green</b>	Mass casualty
<b>Code Orange</b>	Haz-Mat Exposure / Biological Weapons
<b>Code Black</b>	Bomb Threat
<b>Code Yellow</b>	Security Lockdown
<b>Code White</b>	Hostage Situation
<b>Code Brown</b>	Severe Weather Imminent
<b>Code D</b>	Command Center Activation
<b>Code Active Shooter</b>	Location Announced Overhead
<b>Evac Evac Evac</b>	Evacuation of Announced Location Required

# Floor Plans & Telephone Directory

## Welcome to Brandon Regional Hospital

We hope that you find this guide helpful and if you have any questions, please stop by the Information Desk, one of our Security desks or contact the hospital operator by dialing "0" on a hospital phone or (813)681-5551 using an outside phone line or cell phone.

Brandon Regional Hospital is a 422-bed acute care facility offering a wide range of services and specialty programs including the Brandon Heart & Vascular Institute, the Baby Suites, and Spine Care Center.

In addition to our main campus, Brandon Regional Hospital has several departments located across the

street, on the north side of Oakfield Drive, in Oakfield Medical Plaza. These include our Community Education Classrooms A, B, C and E; Education Department, Medical Records, Human Resources, H2U (Health, Happiness & You), Marketing/Public Relations, Employee Health & Risk Management.

We are conveniently located at the corner of Oakfield Drive and Parsons Avenue in Brandon, and offer free parking throughout our campus, which includes our North Parking Garage serving Tower C patient rooms and the Women's Center, Baby Suites and NICU, and the South Parking Garage serving Tower A and B patient rooms, Admitting, Outpatient Registration, surgery services and the Brandon Heart & Vascular Center.



## SAFETY MANAGEMENT

Our Safety Management program encompasses Emergency Preparedness, Equipment and Utilities Management, Hazardous Materials Management, Life Safety (“Fire Safety”) and Facility Security. Every department has Safety Management policies and procedures available on the Intranet. They include information regarding Emergency Preparedness and Codes. Physicians are responsible to know our Emergency Codes and Response.

The switchboard operator announces all emergency codes and location overhead, three times in succession. Once the emergency condition is resolved, the switchboard operator will announce that the situation is all clear. **The Charge Nurse or Supervisor will direct responsibilities or actions in the event of an emergency situation.** All emergencies are reported by dialing “1999”, from any phone in the hospital.

DIAL 1999 TO HAVE CODE and/or LOCATION PAGED	
CODE RED: Fire / Fire Drill/ Smoke (Know evacuation routes, location of extinguishers; follow directions of charge nurse)	CODE GREEN: Mass Casualty (Meet in Emergency Room area)
CODE BLUE: Cardiac Or Respiratory Arrest (ED physician response)	CODE ORANGE: Hazardous Material Exposure/Biological Weapons (Avoid location of exposure and follow direction of unit leadership and Incident Commander); if involved in spill - secure area; protect respiratory track; notify leadership and/or call Code Orange by dialing 1999.
CODE BLUE PEDIATRIC: Cardiac Or Respiratory Arrest / Infant Or Pediatric (ED physician response)	CODE BLACK: Bomb Threat (Follow directions of security personnel as indicated)
CODE PINK: Infant Or Pediatric Abduction (Assist with search as directed by nurse leader on unit; stop all individuals who are acting suspiciously or carrying a large package; contact security immediately)	CODE YELLOW: Security Lockdown (Follow directions of security personnel as indicated)
CODE GRAY: Security Response Needed (Follow directions of security personnel as indicated)	CODE WHITE: Hostage Situation (Avoid location of situation and follow directions of security personnel as indicated)
CODE GRAY/CAUTION: Security Response Needed / Weapon Involved (Follow directions of security personnel as indicated)  ACTIVE SHOOTER: Announced overhead 3x “Active Shooter” & Location (Follow directions of security personnel as indicated)	CODE BROWN: Severe weather imminent (Medical staff members on call will be contacted to coordinate their participation in providing coverage. Includes those physicians who are designated on call during the period. Any need for sheltering of these physicians’ families at the hospital will be determined at the time the physicians are contacted.)
CODE D: Command Center Activation (Physicians will be called by Medical Staff Dir, Emergency Dept. Dir., or designee to come to hospital if this occurs; if in hospital, please report to ED)	EVAC EVAC EVAC: Evacuation Of Announced Location Required (Follow direction of Medical Staff Liaison – Dr. Craig Smestad-Chief Medical Officer-Administration)

Remember the acronym “**RACE**” in the event of a fire:

R → Remove everyone from the immediate fire area.

A → Activate fire alarm—Pull the nearest fire alarm pull box & dial “1999”

C → Contain the fire

E → Extinguish the fire

The *Fire Alarm System* consists of an **audio component** (overhead bells and chimes ring for a

few seconds) and **visual component** (*fire alarm indicator lights in the ceiling/wall will continuously flash until the Code Red is cleared*). **Do not use the elevators when the Code Red is in progress** unless the fire department has assured that they are safe to use and you need to transport a patient or necessary equipment. Every hospital unit has an evacuation route posted. Be familiar with the location of these maps and extinguisher location as well. If you have a question about the location of these, please discuss this with the department director or manager at the earliest opportunity. Elevators may not function, **and** they act like a chimney drawing in the heat and smoke!

To use the fire extinguisher, remember “**PASS**”:

**P** → Pull the pin

**A** → Aim the nozzle at the base of the fire

**S** → Squeeze the handles together

**S** → Sweep the nozzle from side to side

**Utilities Safety** Essential equipment and utilities include the fire alarm system, nurse call system, telephone communications, medical gas, vacuum system, elevator, major plumbing, electrical distribution, emergency generator and other equipment necessary to maintain the hospital's environment of care in a safe and functional manner. Whenever any utility system is not operating, the staff will institute the appropriate response. The Nursing Supervisors, Respiratory Therapy or Facilities has the ability to shut off medical gases in an emergency.

The Safe Medical Devices Act (**SMDA**) of 1990 requires facilities to report medical device incidents that involve serious injury, serious illness, or death. Please contact the Unit Director or Manager if you find that equipment is in need of repair.

**The OSHA regulation called *Hazard Communication*** requires facilities to provide information and training regarding hazardous materials to all employees. The **Safety Data Sheets** can be found in the *Hazardous Materials and Waste Management (HazMat) Plan* and through the HazSoft (SDS) icon on every computer desktop. All individuals are responsible to know the location of the HazMat Manual in the area in which they are working! The SDS uses the trade name of materials and include information regarding: who to contact for emergency information, Toxicity Hazards, Health Hazards, Fire & Explosion Hazards, and Precautions for Safe Handling. Please note that eyewash stations are located in strategic areas of the facility. Be familiar of where these are located especially in those areas in which you provide patient care or administer medications. All physicians should be informed about location of eyewash stations and their use. Rinsing should take place at least 15 minutes or longer when a contaminant reaches the eye. Hold the eye lids open and roll eyeballs so flushing fluid will flow on all surfaces of the eye and under the eyelid.

**Hospital Security** is the responsibility of all staff, students, visitors, volunteers, and Security Officers. Keep alert and notify Security of any problems. Our facilities are smoke-free. Smoking is not allowed anywhere on the hospital campus.



# **Brandon Regional Hospital** Policies & Procedures

# Hospital Acquired Conditions - Groupings

Never Events	Infection Prevention	Patient Safety
<ul style="list-style-type: none"><li>▪ Delivery of ABO-incompatible blood products</li><li>▪ Object left in during surgery</li><li>▪ Air embolism<ul style="list-style-type: none"><li>▶ Iatrogenic Pneumothorax</li><li>▶ Legionnaires' Disease</li></ul></li></ul>	<ul style="list-style-type: none"><li>▪ Mediastinitis after coronary artery bypass graft (CABG) surgery</li><li>▪ Vascular catheter-associated infections</li><li>▪ Catheter-associated UTI<ul style="list-style-type: none"><li>▶ Surgical site infections</li><li>▶ Ventilator-associated pneumonia</li><li>▶ Staph Aureus Septicemia</li><li>▶ Clostridium Difficile-Associated Disease (CDAD)</li></ul></li></ul>	<ul style="list-style-type: none"><li>▪ Falls and fractures, dislocations, intracranial and crushing injury and burns</li><li>▪ Pressure ulcers<ul style="list-style-type: none"><li>▶ Delirium</li><li>▶ Glycemic Control</li><li>▶ DVT/Pulmonary embolism</li></ul></li></ul>

**August 2008 the final rule will list which of the proposed conditions will be effective October 1, 2008**

\*Proposed condition in the FY 2009 IPPS proposed rule

## Purpose

To provide a standardized list of Do Not Use Abbreviations, acronyms, symbols and dose designations that are not to be used throughout the organization.

One of the major causes of medication errors is the use of potentially dangerous abbreviations, acronyms, symbols, and dose designations. Underlying contributing factors include illegible handwriting and/or failure of health care providers to communicate clearly with one another. These factors have been identified as the root cause of several medical errors.



## Policy

- Brandon Regional Hospital has a standardized list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the organization.
- Do not use abbreviations.
- A “trailing zero” may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. “Trailing Zero” [may not](#) be used in medication orders or other medication related documentation.
- Brandon Regional Hospital’s Do Not Use list applies to all orders and all medication-related documentation where handwritten or entered as free text into a computer.
- Preprinted forms should not include any abbreviations identified as “not to be used”.

## Do Not Use List

Do Not Use	Problem	Use
U (unit)	Mistaken for (zero), the number “4” (four) or “cc”	Write “unit”
IU (International Unit)	Mistaken for IV (Intravenous) or the number 10 (ten)	Write “International Unit”
QD., QD, q.d., (daily) Q.O.D., QOD, q.o.d, qod. (every other day)	Mistaken for each Period after the Q mistaken “l” and the “O” mistaken for “l”	Write “daily” and Write “every other day”
Trailing zero, Lack of leading zero (.X mg)	Decimal point is missed	Write X mg or 0.X mg
MS, MSO <sub>4</sub> and MgSO <sub>4</sub>	Can mean morphine sulfate or magnesium sulfate. Confused for one another	Write “morphine sulfate” Write “magnesium sulfate”

### Clarification of Orders with “Do Not Use” Abbreviations

- Anytime an order is unclear, it must be clarified with the ordering practitioner. The same requirement applies for orders containing “do not use” abbreviations. The nurses and pharmacists exercise discretion to determine when an order is not clear and in those cases the ordering practitioner must be contacted for clarification.
- The goal of Brandon Regional Hospital is to eliminate the use of “do not use” abbreviations and every effort is made to provide ongoing education to nurses and physicians
- When an order clarification is necessary, the order clarification is documentation by the licensed health care provider (i.e. RN, Respiratory Therapist, Pharmacist) who contacted the prescriber.

A verbal order is written in the Physician’s Orders to clarify the order.

#### Example: Order written by Dr. X as Lasix 20 MG Po QD

- RN Called Dr. X and clarified that the order was for “daily”
- RN documents on the Physician Orders: **Clarification of above order (or write out order) - Lasix 20 MG Po DAILY**
- T.O. Dr. X/Nurse RN (Read back and Confirmed)

# Sentinel Event

## Purpose

- Have a positive impact in improving patient care, treatment, and services
- Establish a mechanism for the prevention, reporting, and investigation of sentinel events
- Provide guidance after an event is suspected to have occurred
- To outline the process for conducting a root cause analysis, when there is an adverse outcome that meets criteria
- Focus the attention on understanding the causes that underlie an event and assessing systems and processes to reduce the probability of such an event in the future
- Increase the general knowledge about sentinel events, their causes, and strategies for prevention

**Scope - Organization wide, including all medical staff.**

## Policy

- All staff have an affirmative duty to report suspected sentinel events (adverse outcomes) to their supervisor, the Director of Quality Management, and the Risk Management Department via Occurrence Reporting.
- The following events, should they occur, are to be considered a sentinel event:
  - a. An event which results in the unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition. (This includes events, but is not limited to, hospital acquired infections, diagnostic errors which include misdiagnosis leading to an incorrect choice of therapy, misinterpretation of test results, failure to properly act on an abnormal test result, equipment failures, intravascular air embolism occurring while the patient is hospitalized, use or function of a device in patient care in which the device is used or functions other than as intended, use of contaminated drugs, devices, or biologics provided by the Hospital, spinal manipulation, hypoglycemia occurring after admission, burn).
  - b. Any patient death, paralysis, coma, or other major permanent loss of function associated with a medication error.
  - c. Suicide of any patient receiving care, treatment and services in a staffed around-the-clock care

setting or within 72 hours of discharge.

- d. Any elopement that is unauthorized departure resulting in a temporally related death (suicide, accidental death, or homicide) or major permanent loss of function.
- e. Any intrapartum (related to the birth process) maternal death.
- f. Unanticipated death of a full-term infant.
- g. Any perinatal death unrelated to a congenital condition in an infant having a birth weight greater than 2,500 grams.
- h. Abduction of any patient receiving care, treatment and services.
- i. Discharge of an infant to the wrong family.
- j. Assault, homicide, or other crime resulting in patient or staff member's death or major permanent loss of function within or on the hospital's grounds.
- k. Rape.
- l. Patient fall that results in death or major permanent loss of function as a direct result of the injuries sustained in the fall.
- m. Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities.
- n. Surgery on the wrong patient or wrong body part.
- o. Unintended retention of a foreign object in a patient after surgery or other procedure.
- p. Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter)

- q. Prolonged fluoroscopy with cumulative dose >1500 rads to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose.
  - r. Any near miss (see definition in this policy).
  - s. Death or loss of function following a patient leaving against medical advice (AMA).
  - t. Unsuccessful suicide attempts.
  - u. Death or serious injury while in seclusion or restraints to include the use of bedrails (whether or not the restraints contributed to the death).
  - v. Intraoperative or immediately post-operative death in a normal healthy patient (American Society of Anesthesiologists Class 1 patient).
  - w. Stage III or IV pressure ulcers acquired after hospitalization.
  - x. Any incident involving a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances.
  - y. Death or serious injury associated with an electric shock.
  - z. Care ordered by or provided by someone impersonating a licensed health care provider.
- Sentinel events shall be identified, investigated and assessed as a matter of policy for review by counsel in anticipation of litigation.
  - Staff will be educated to all aspects of this policy through general orientation and as part of the annual required education.
  - Medical Staff, Allied Health Professionals, Contracted Staff, and Vendors will be educated to all aspects of this policy in their general orientation.
  - The primary focus will be to provide quality patient care and each event will be viewed as an opportunity for improvement.
  - Hospital leadership will maintain overall responsibility for the implementation of mechanisms to identify and manage sentinel events.
    - a. The primary goal of leadership and staff will be the protection of the patient from injury once it is suspected that a sentinel event has occurred.
    - b. The patient will be protected from further injury to the extent that the Hospital and Medical Staff can provide intervention and services.
    - c. Disclosure of the event to the patient and/or legal representative will occur according to the Hospital's policy, Patient/Family Notification of a Significant Medical Error.
  - In an effort to maintain a blame free environment, the Hospital will focus on the processes involved in the event, rather than on the individuals.
  - Events will be reviewed for determination of meeting the criteria for adverse events as defined by Florida Statute §395.0197(507d) and will also be reviewed to determine if a sentinel event has occurred.
  - When a sentinel event occurs, an appropriate response by immediate staff includes:
    - a. Securing a copy of the patient's medical record and any other pertinent documentation at the time of the event;
    - b. Immediately noting any environmental features (e.g., lighting, noise)
    - c. Securing any physician evidence (e.g., equipment, vials, syringes, electronic data such as rhythm strips, etc.)
    - d. Obtaining statements from those involved as soon as possible.
  - When a sentinel event occurs, an appropriate response by leadership includes:
    - a. Conducting a timely, thorough, and credible root cause analysis;
    - b. Developing an action plan designed to implement improvements to reduce risk;
    - c. Implementing the improvements; and
    - d. Monitoring the effectiveness of those improvements.

## Definitions

Action plan is the product of the root cause analysis that identifies the strategies that the Hospital intends to implement in order to reduce the risk of like events occurring in the future. The plan should address responsibility for implementation, oversight, pilot testing as appropriate, time lines, and strategies for measuring the effectiveness of the actions.

Adverse event is defined as follows: an event over which health care personnel could exercise control and which is associated in whole or part with medical intervention, rather than the condition for which such intervention occurred; and which results in one of the following:

- Unexpected death
- Brain or spinal damage
- Surgical procedures performed on wrong patient or wrong site
- Wrong surgical procedure performed
- Surgical procedure to remove foreign object from other surgical procedure
- Surgical repair of injuries or damaged from planned surgical procedure where the damage was not a recognized, specific risk as disclosed to the patient and documented through the informed consent process
- Permanent disfigurement
- Fracture / dislocation of bones and joints
- Unexpected transfer to higher level of care
- The performance of a surgical procedure that is medically unnecessary or other wise unrelated to the patient's diagnosis or medical condition



Adverse outcome for this policy is defined as a death or major permanent loss of function that is associated with the treatment (including 'recognized complications') or lack of treatment of that condition, or otherwise not clearly and primarily related to the natural course of the patient's illness or underlying condition. It does not include an outcome that is related to the natural course of the patient's illness or underlying condition.

Common cause is a factor that results from variation inherent in the process or system. The risk of a common cause can be reduced by redesigning the process or system.

Major permanent loss of function means sensory, motor, physiologic, or intellectual impairment not present on admission requiring continued treatment or lifestyle change. When major permanent loss of function cannot be immediately determined, applicability of this policy will not be established until either the patient is discharged with continued major loss of function, or two weeks have elapsed with persistent major loss of function, whichever occurs first.





Near miss is used to describe any process variation that did not affect an outcome but for which a recurrence carries a significant chance of a serious adverse outcome. A near miss meeting this definition is considered a sentinel event.

Rape as a sentinel event is defined as unconsented sexual contact involving a patient and another patient, staff member, or other perpetrator while being treated or on the premises of the Hospital, including oral, vaginal, or anal penetration or fondling of the patient's sex organ(s) by another individual's hand, sex organ, or object.

Risk thereof includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

Root cause analysis is a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis focuses primarily on systems and processes, not on individual performance. It progresses from special

causes in clinical processes to common causes in Hospital processes and systems and identifies potential improvements in the process or systems that would tend to decrease the likelihood of such events in the future or determines, after analysis, that no such improvement opportunities exist.

Sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. These events are called sentinel because they signal the need for immediate investigation and response. The terms sentinel event and medical error are not synonymous; not all sentinel events occur because of an error and not all errors result in sentinel events. However, all sentinel events are considered adverse events.

Serious injury specifically includes loss of limb or function.

Special cause is a factor that intermittently and unpredictably induces variation over and above what is inherent in the system. It often appears as an extreme point (such as a point beyond the control limits on a control chart) or some specific, identifiable pattern in data.



## Procedure

- Events that are externally reportable to a state or federal agency must be subject to this policy, i.e. rape, abduction, code 15 reports, injuries under the Medical Device Act.
  - If any person determines that a potential sentinel event has occurred, immediate action within the scope of his/her practice should be taken to reduce the risk of injury to the patient. Examples include, but are not limited to.
    - a. If a treatment is in process that may be the cause of such an event, the treatment should be ceased immediately.
    - b. If a medication is suspected of causing an adverse event, the medication should be discontinued immediately.
  - Immediate action should be taken to safeguard the patient's medical condition (i.e., Code Blue initiated, oxygen obtained, etc.).
  - The patient's attending physician and prescribing physician, where applicable, will be notified of the adverse event in order to guide staff in providing reversal or counter balancing treatment and to protect the patient from further consequences.
  - The event shall be reported to the Director of Quality Management immediately and to the reporting employee's supervisor.
    - a. Initial notification to the Director of Quality Management is to be made by telephone and/or beeper. If the Director of Quality Management cannot be reached, the Director of Quality Management is to be notified. If neither of these individuals can be reached, the Administrator on Call shall be notified.
    - b. An occurrence report must be completed per Hospital policy.
  - The Director of Quality Management shall inform the Director of Risk Management of all potential sentinel events.
    - a. The Director of Quality Management, in conjunction with the Risk Manager, will determine whether or not the event meets the definition of a sentinel event.
    - b. When appropriate, a committee comprised of key management staff and/or medical staff may be convened to review the event and proposed corrective action(s).
- A root cause analysis will be done by a focus team when a sentinel event has been determined to have occurred.
    - a. The Director of Quality Management will initiate and conduct the root cause analysis. If the Director of Quality Management is not available, the Hospital's Risk Manager will conduct the root cause analysis. Initiation of the root cause analysis should occur as soon as possible, and not later than 30 days after knowledge of the event.
    - b. The members of the focus team will be determined by the circumstances of the event. Minimally, the investigation shall include the hospital and medical staff involved in the event, the Director of Quality Management, and the Risk Manager.
    - c. The focus team will meet as often as necessary, and will obtain whatever resources are necessary, to conduct a credible root cause analysis. An action plan will be developed, as applicable within 45 days after knowledge of the event.

- d. A root cause analysis and any resulting action plan is considered to be peer review and part of the performance improvement process and is privileged and confidential.
- e. The Director of Quality Management will share the results and any recommendation and/or action affecting a medical staff member with the Chief Executive Officer and the Chief of Staff.
- f. The Director of Quality Management will provide pertinent information from the results of the root cause analysis and ongoing monitoring and tracking of corrective actions related to the event to the Medical Executive Committee and the Board of Trustees.
- g. The Quality Management Department will be responsible for maintaining all records of the root cause analysis.



## AN ACCEPTABLE ROOT CAUSE ANALYSIS SHOULD BE THOROUGH AND CREDIBLE AND CONTAIN THE FOLLOWING CHARACTERISTICS:

### To be credible, the root cause analysis must do the following:

- a. Include participation by the leadership of the organization and by individuals most closely involved in the processes and systems under review.
  - b. Be internally consistent (that is, not contradict itself or leave obvious questions unanswered).
  - c. Provide an explanation for all findings of “not applicable” or “no problem”.
  - d. Include consideration of any relevant literature.
- **An action plan will include:**
- a. Identification of changes that can be implemented to reduce risk or formulates a rationale for not undertaking such changes; and
  - b. Identifies, in situations where improvement actions are planned, who is responsible for implementation, when the action will be implemented (including any pilot testing), and how the effectiveness of the actions will be evaluated.
  - c. Reporting and monitoring to the appropriate leaders and committees for analysis and continued follow up.

### To be thorough, the root cause analysis must include the following:

- a. A determination of the human and other factors most directly associated with the sentinel event and the process (es) and systems related to its occurrence.
- b. An analysis of the underlying systems and processes through a series of “Why?” questions to determine where redesign might reduce risk.
- c. An inquiry into all areas appropriate to the specific type of event as described in the attached TJC Root Cause Analysis Table.
- d. An identification of risk points and their potential contributions to this type of event.
- e. A determination of potential improvement in processes or systems that would tend to decrease the likelihood of such events in the future, or a determination, after analysis, that no such improvement opportunities exist.

- Brandon Regional Hospital recognizes that conscientious staff who are involved in a sentinel event are themselves victims of the event and may require support post event. The Hospital is committed to providing individuals with additional support through human resources, pastoral services, EAP and other services as deemed appropriate.
- The Risk Manager will review the occurrence for determination of whether the event meets a) mandatory reporting requirements to regulatory agencies, as required by laws and regulations, that include CMS, FDA, SMDA, AHCA, and local law enforcement, and b) insurance carrier guidelines. The Risk Manager will report meeting reporting deadlines when applicable.
- The Ethics and Compliance Officer will submit as a "Probable Reportable Event" (PRE) as required by the CIA and submit a Probable Claim Report (PCR) to HCII, if indicated.
- Sentinel Event data and Sentinel Event Alerts published by TJC will be used in proactive performance improvement activities including selection of FMECA project.
- Data regarding medical errors will be used in proactive performance improvement activities including selection of FMECA projects (e.g. data from IOM, ISMP, CMS, etc.).
- Reports will be provided, at least annually to the Board of Trustees on system or process failures and actions taken to improve safety, to include both actual occurrences and proactive risk assessments (e.g. FMECA's).
- The Sentinel Event and any external agency surveys resulting from the event will be reported to Corporate Quality Standards Department.
- The Sentinel Event will be voluntarily reported to The Joint Commission.

### Equipment (if Applicable)

None

### Related Policies

- Policy 1.947.014: Patient/Family Notification of Significant Medical Error/Adverse Event
- TJC 2009 Table 2. Minimum Scope of Root Cause Analysis for Specific Types of Sentinel Events

### Reference - Include but not limited to:

- Florida Statute 395
- TJC Comprehensive Accreditation Manual for Hospitals, January 2009
- QRS Guidelines, January 2009





# Evidence Based Performance Measures

## Right Care for Ever Patient Every Time

### Acute Myocardial Infarction (AMI)

- Aspirin at arrival (within 24 hr. pre/post arrival or document contraindication (i.e. allergy or GI bleed)
- Aspirin prescribed at discharge or document contraindication
- ACE or ARB for LVSD (EF <40%) or document contraindication (i.e. stop ACE/ARB due to renal insufficiency)
- Beta Blocker on discharge or document contraindication
- Primary PCI under 90 minutes from arrival for ST elevation or LBBB
- Smoking cessation counseling

### Outpatient Surgical Procedures

- Prophylactic antibiotics within 1 hr. of incision
- Appropriate recommended antibiotic for the procedure

### Pneumonia

- Blood culture in the ED before antibiotic administration
- Blood cultures within 24 hrs. of admission for patients transferred or admitted to the ICU
- Initial antibiotic within 6 hrs. of arrival
- Appropriate antibiotic for community acquired pneumonia (CAP) for immunocompetent patients in the ICU
- Appropriate antibiotic for community acquired pneumonia (CAP) for immunocompetent patients in the Non-ICU
- Smoking cessation counseling
- Pneumococcal vaccine administered
- Influenza vaccine administered during season (October to March)

### Heart Failure

- Evaluation of the LVS Function (typically echocardiogram) or documentation of previous evaluations performed prior to hospitalization
- ACE or ARB for LVSD (EF <40%) or document contraindication (i.e. stop ACE/ARB due to renal insufficiency)
- Smoking cessation counseling
- Discharge instructions to include a copy of the medication reconciliation dated and timed on day of discharge.
- Documentation on discharge summary stating patient is to take medications per medication reconciliation.

### Surgical Care Improvement Program (SCIP)

- Prophylactic antibiotics within 1 hr. of incision
- Appropriate selection of antibiotic for the procedure
- Discontinue the prophylactic antibiotic within 24 hrs. or for CABG 48 hrs. (unless otherwise indicated and documented suspected post op infection)
- Appropriate hair removal (no shaving)
- Ordered venous thromboembolism (VTE) prophylaxis, mechanical and/or pharmacological, ordered and administered 24 hours prior to surgery incision time, up to 24 hours after surgery end time. If VTE prophylaxis is not administered, physician/PA/ARNP documentation in progress note is needed indicated specific (i.e. bleeding risk).
- Beta blocker administered preoperatively (24 hours prior to incision through discharge from PACU) if patient was on Beta Blocker prior to hospitalization

**Acute Pain**  
**in a patient**  
**with**  
**Chronic Pain**



# Acute Pain in a patient with Chronic Pain

- More than 75 million patients in the USA suffer from Pain
- Annual National Economic cost is greater than \$500 Billion
- When Acute Pain is not treated in time, it can convert into Chronic Pain
- Chronic Pain is no longer a symptom but a multisystem disease
- Treatment algorithms for Chronic Pain are complex and necessitate the use of multidisciplinary teams

# Consequences of Unrelieved Pain

- Poor sleep
- Anxiety & lack of concentration
- Reduced mobility
- Immune impairment / Susceptibility to disease
- Unplanned & unnecessary readmissions
- Longer stays in the hospital
- Increased Out Patient Visits
- Chronic pain & depression
- Impaired relationships

# Joint Commission on Pain



## Requires Organizations to:

- Recognize the Right of patients to appropriate assessment and management of pain
- Screen patients for pain during initial & periodic re-assessments during their stay
- Educate patients suffering from pain about pain management

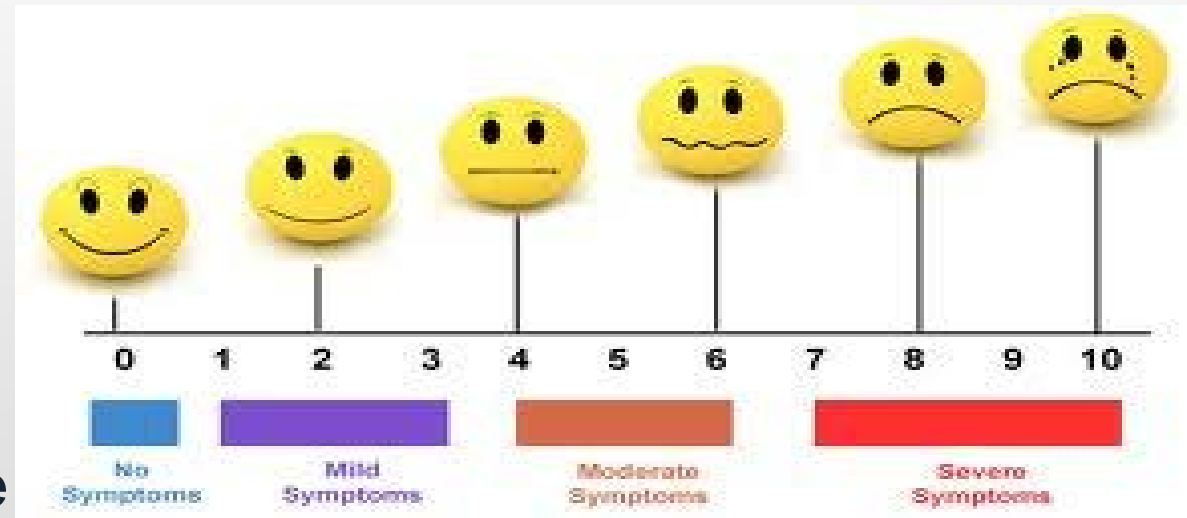


# Plan

- **Treat Acute Pain aggressively & prevent it from converting to Chronic Pain**
  - **Identify & address the cause of Acute Pain (Nociceptive, Idiopathic, Psychogenic & Neurogenic): Recent onset, transient and usually from an identifiable cause**
  - **Treat Chronic Pain (ongoing pain, lasting greater than 3 - 6 months and adversely affecting the patient's lifestyle) concurrently**
  - **Treat noninvasively as much as possible initially**
  - **Goal: Improving function and sustaining quality of life**
- \* A thorough History & Physical is a requirement before treating any patient**

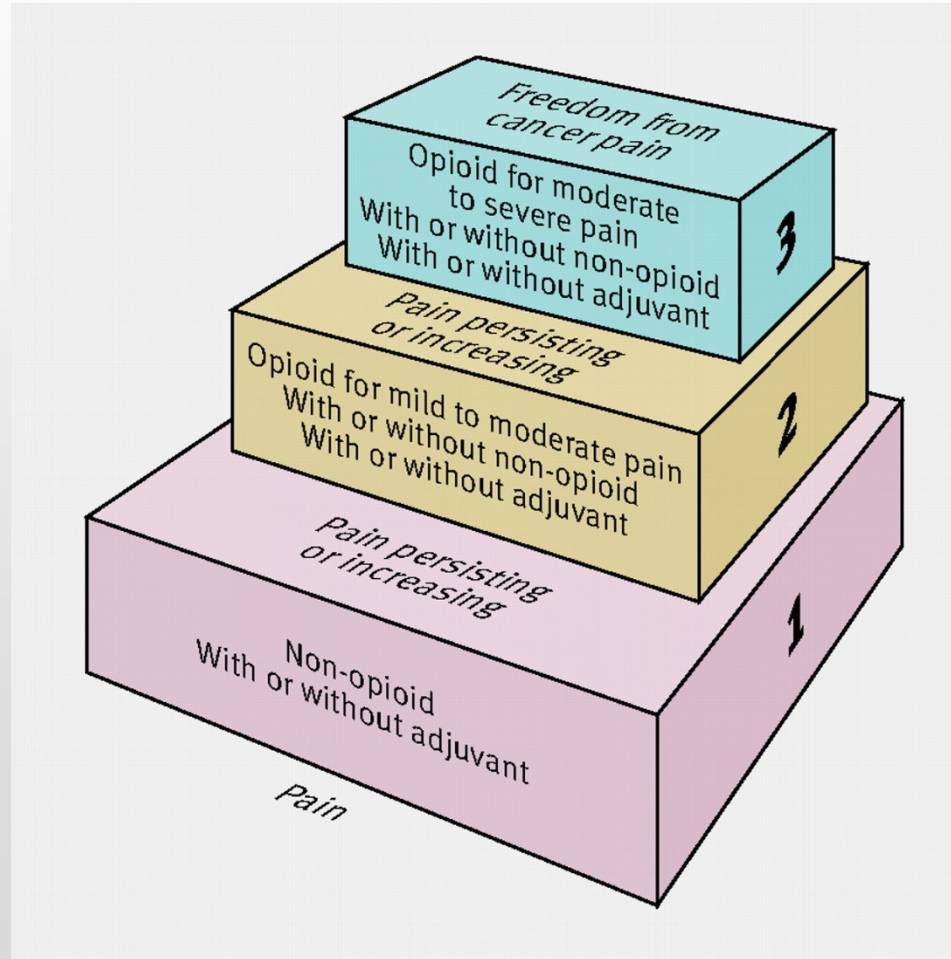
# Pain Assessment

- Visual Analog Scale
- Numerical Scale
- Pain Faces Scale
- Verbal Pain Intensity Scale
- Non Verbal Pain Assessment Tool



\* Wong – Baker Pain Scale

# WHO Pain Treatment Ladder for Acute Pain



# Monitoring Pain Management

## 1. Analgesia & Activities of Daily Living

- i. Teach patient to use the pain rating scale & report pain beyond a comfort level
- ii. Ask patient about level of pain at frequent intervals
- iii. Accept & act upon a patient's report of pain
- iv. Discuss goals & limitations of the pain treatment plan

## 2. Adverse Effects & Aberrant drug related behavior

- i. Anticipate side effects & benefits /complications & adjust dose accordingly
- ii. Avoid using multiple Opioids concurrently
- iii. Consider decreasing Opioid dose to avoid side effects. Add a non-opioid instead to maintain adequate pain relief

# Mild Pain

- **Non – Opioids: NSAIDS, Acetaminophen, Toradol**
- **Adjuvants: Antidepressants, Anticonvulsants, Medications for insomnia, anxiety, muscle spasms**
- **Short Acting Pain meds: Peak analgesic action within 1 – 2 hours & Sustained pain relief only 4 hours**
- **Long Acting Opioids: Sustained pain relief 8 – 12 hours**



# Moderate to Severe Pain: Opioids

- Codeine
- Oxycodone / Oxycontin
- Oxycodone with Acetaminophen / Percocet
- Oxycodone with Aspirin / Percodan
- Hydrocodone with Acetaminophen / Vicodin, Lortab
- Tramadol with Acetaminophen / Ultracet
- Morphine
- Hydromorphone / Dilaudid
- Fentanyl / Duragesic
- Methadone

# Plan

- Continue existing medications for Chronic Pain
- Give Baseline Medications round the clock
- Give 10% of Total Daily Dose PRN
- Try short acting medications first
- Give half the usual dose for special populations like elderly or patients with renal or hepatic impairment
- Use Opioid Conversion tools when changing medications
- Use Longer Acting medications for Continuous Pain & Shorter Acting medications for Breakthrough Pain

# Opioid Conversions

**“Morphine” is the GOLD standard for Conversion Tables!**

- Morphine 1 mg IV = 3 mg PO
- Dilaudid 10 times more powerful than Morphine
- Fentanyl 100 times more powerful than Morphine
- Oxycodone PO 1.5 times stronger than Morphine PO
- Calculate 24 hour total dose given. Convert to equivalent dosage by strength & route of administration for a different medication

# Watch Out for.....

- Nausea, vomiting, stomach upsets & irritations, constipation
- Respiratory Depression, especially with Obesity, Obstructive Sleep Apnea & Elderly
- Bradycardia, Hypotension
- Dizziness, Delirium, Amnesia, Altered Behavior
- Itching & hives
- Addiction, Dependence, Ceiling Effect & Withdrawal symptoms if using Opioids longer than 10 days
- Hyperalgesia
- Pregnancy & Breastfeeding

# How to manage risks...

- Respiratory Depression: Go up incrementally in dosage “Start Low, Go Slow” .....Narcan by bedside
- Pruritis: Antihistamines
- Constipation: Laxatives, Stool Softeners, Increase fluid intake
- Nausea/Vomiting: 5HT3 Blocker like Zofran
- GI Protection: H2 Antagonists like Pepcid & PPIs like Nexium
- Addiction: “Red Flag” if patient insists on a particular medication only. Refer to Pain Specialist if suspicious



# Non Pharmacological Pain Management

- **Smoking Cessation**
- **Behavioral & Psychotherapy**
- **Physical Therapy & Rehab**
- **Complementary Medicine: Massage, Yoga**
- **Relaxation Techniques, Exercise & Lifestyle Changes**

# Anesthesiology Department at Brandon Hospital

- Pre - Operative: Preemptive Analgesia
- Intra - Operative Pain Relief
- **Post - Operative Pain Management**
  - PCA (Patient Controlled Analgesia) for Ob/Gyn & Ortho
  - Intrathecal & Epidural Narcotics
    - ❖ Obstetrics
    - ❖ Lung, Abdominal & Orthopedic Surgery
    - ❖ Caudal Blocks for Pediatrics
    - ❖ Neurology related Post Dural Puncture Headaches
  - Nerve Blocks for Shoulder & Knee Surgeries
    - ❖ Single Shot & Continuous

# Anesthesiology Department at Brandon Hospital

Continued.....

- Anesthesia & Pain Relief for Patients at Satellite Locations like the Cath Lab, EP Lab, MRI, CT & other Radiology procedures
- Chronic Pain Specialists: Trigger Points, Facet Blocks, Epidural Steroids, TENS, Pain Pumps, Sympathetic Blocks .....

# Resources

- <http://www.asahq.org/>
- <http://theacpa.org/>
- <http://neurocritic.blogspot.com.au/2013/09/update-on-ketamine-in-palliative-care.html>
- <http://www.hospiceofmarion.com/assessing-pain.html>
- [http://www.jointcommission.org/assets/1/18/Pain\\_Management.pdf](http://www.jointcommission.org/assets/1/18/Pain_Management.pdf)



## Infection Prevention and Control Physician Orientation

### Hand Hygiene

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***Hand hygiene is the single most important measure to reduce the risk of transmitting infectious organism from one person to another.***

- Hands should be washed frequently with soap and water, alcohol based hand rubs OR antiseptic hand wash and thoroughly dried preferably using a disposable paper towel.
- Wash hands after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn.
- Wash hands immediately after gloves are removed, between patient contacts, and when indicated to avoid transfer of microorganisms to other patients or environments.
- It may be necessary to wash hands between tasks and procedures on the same patient to prevent cross contamination of different body sites.
- Wash hands with any activity that involves hand to face contact such as eating and normal grooming etc.

*The use of gloves does not replace the need to perform hand hygiene*

### Gel in, Gel out

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#### When to use Gel

Foam or gel is acceptable in most cases EXCEPT when hands are visibly dirty or following contact with body fluids. If the patient is in isolation for C. diff you may prefer to hand wash, BRH is following the CDC tier 1 recommendations for C. diff and alcohol or hand washing are allowed.

#### When to use soap

Hands should be washed with soap and water if visibly soiled.

## Precaution/Isolation Protocols

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### Standard Precautions

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Standard Precautions are designed to reduce the risk of transmission of pathogens from moist body substances and applies to all patients receiving care in hospitals, regardless of their secretions, and excretions except sweat, regardless of whether or not they contain visible blood, non-intact skin, and mucous membranes. These include:

- Hand Hygiene
- Safe Injection Practices
- Use of gloves, gown, mask, eye protection, or face shield, depending on the anticipated exposure





## Transmission-based Precautions

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### Contact Precautions - Used for Infections Transmitted by Contact i.e. MRSA, ESBL+ and KPC/CRE organisms, MDRO P. aeruginosa, MDRO A. baumannii, VRE, RSV

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- Perform hand hygiene before entering and before leaving room.
- Wear gloves when entering room or cubicle, and when touching patient's intact skin, surfaces, or articles in close proximity
- Wear gown when entering room or cubicle and whenever anticipating that clothing will touch patient items or potentially contaminated environmental surfaces.
- Use patient-dedicated or single-use disposable equipment or clean and disinfect shared equipment (i.e. Stethoscope) between patients.

### Droplet Precautions - Used for infections transmitted through droplets – i.e. Seasonal influenza, Mycoplasma pneumonia, Bacterial meningitis, RSV

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- Perform hand hygiene before entering and before leaving room
- Wear mask when entering room

### Airborne Infection Isolation Precautions - Used for infections transmitted when particles are aerosolized – i.e. TB, Measles

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- Perform hand hygiene before entering and before leaving room
- Wear N95 respirator when entering room
- Discard N95 after exiting room
- Keep door closed

If your patient meets airborne precaution criteria (TB screening) she/he will be put in isolation. A MD order is not required to place a patient on Isolation. If later test results show the patient does NOT have TB, the patient precaution will be discontinued. N95 Particulate Filter Respirators (masks), of the proper type and size, are readily available for all physicians and LIPs caring for patients requiring airborne isolation. The patient will be instructed to cover his/her mouth when coughing or sneezing. Fit testing for N-95 particulate respirator masks available at BRH is available for all physicians and LIPs to ensure they are properly protected when providing patient care. Fit testing is available through the Employee Health Office located in Oakfield Plaza.

***BRH requires that EVERYONE with potential exposure to airborne infections is fit tested for an N-95 particulate respirator mask prior to providing patient care.***

## Personal Protective Equipment

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PPE is provided to physicians while attending patients at BRH. The standard types of PPE available are:

- Non-powdered gloves, latex free gloves, hypoallergenic gloves
- Isolation gowns, impervious gowns
- Face shields, masks, safety glasses, respirator masks

PPE is located in each patient area/room in the PPE cabinets, in the clean utility rooms and other areas as designated by the department directors in the different departments throughout the facility. If the PPE is not available on the units, or if there



# Brandon Regional Hospital

is a specific type of PPE desired in the department, contact the charge nurse, unit manager, or department director for assistance.

**All physicians using PPE must observe the following precautions:**

- Wash hands immediately or as soon as feasible after removal of gloves or other PPE.
- Used PPE may be disposed of in regular trash containers if not soiled with blood/body fluids or in biohazard labeled containers if soiled with blood/body fluids.
- Wear gloves when it can reasonably anticipated that there may be hand contact with blood/body fluids or contaminated items/surfaces.
- Wear appropriate face and eye protection when splashes pose a hazard to the eye, nose, or mouth.
- Remove PPE after it becomes contaminated.
- **PPE must be removed when leaving the patient and/or clinical area.**

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## Infection Control Initiatives

BRH utilizes the CDC/NHSN surveillance definition of health care-associated infection and criteria for specific types of infections. For the purposes of NHSN surveillance in the acute care setting, the CDC defines a Hospital Acquired Infection as a localized or systemic condition resulting from an adverse reaction to the presence of an infectious agent(s) or its toxin(s). There must be no evidence that the infection was present or incubating at the time of admission to the acute care setting. Accurate documentation is essential to ensure appropriate diagnosis coding. ***Please contact the Infection Prevention department for a more detailed overview of our infection control initiatives and surveillance criteria.***

***One of the National Patient Safety Goals is to reduce the risk of health care-associated infections by implementing evidence-based practices. Please review and follow the guidelines below in your daily practice.***

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## Catheter-Associated Bloodstream Infections (BSI Prevention Bundle)

Laboratory-confirmed bloodstream infections (LCBI) are determined with the following criteria:  
LCBI criteria 1 and 2 may be used for patients of any age, including patients >1 year of age.

**LCBI must meet at least 1 of the following criteria:**

1. Patient has a recognized pathogen cultured from 1 or more blood cultures  
**and** organism cultured from blood is not related to an infection at another site.
2. Patient has at least 1 of the following signs or symptoms: fever (>38°C), chills, or hypotension;  
**and** signs and symptoms and positive laboratory results are not related to an infection at another site;  
**and** common skin contaminant (ie, diphtheroids [*Corynebacterium* spp], *Bacillus* [not *B anthracis*] spp, *Propionibacterium* spp, coagulase-negative staphylococci [including *S epidermidis*], viridans group streptococci, *Aerococcus* spp, *Micrococcus* spp) is cultured from 2 or more blood cultures drawn on separate occasions.
3. Patient <1 year of age has at least 1 of the following signs or symptoms: fever (>38°C, rectal), hypothermia (<36°C, rectal), apnea, or bradycardia;  
**and** signs and symptoms and positive laboratory results are not related to an infection at another site;  
**and** common skin contaminant (ie, diphtheroids [*Corynebacterium* spp], *Bacillus* [not *B anthracis*] spp, *Propionibacterium* spp, coagulase-negative staphylococci [including *S epidermidis*], viridans group streptococci, *Aerococcus* spp, *Micrococcus* spp) is cultured from 2 or more blood cultures drawn on separate occasions.



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## BRH CL-BSI Prevention Bundle includes:

- Perform hand hygiene before catheter insertion or manipulation. Use of gloves does not obviate hand hygiene.
- Avoid using the femoral vein for central venous access in adult patients. Several nonrandomized studies show that the subclavian vein site is associated with a lower risk of CLABSI than is the internal jugular vein.
- Use maximal sterile barrier precautions during CVC insertion.
- A mask, cap, sterile gown, and sterile gloves are to be worn by all healthcare personnel involved in the catheter insertion procedure.
- The patient is to be covered with a large sterile drape during catheter insertion.
- Use a chlorhexidine based antiseptic for skin preparation in patients older than 2 months of age. The antiseptic solution must be allowed to air dry before puncturing the skin.
- Use a catheter checklist for CVP insertion and use an all inclusive cart or kit.
- Use of Universal Protocol Time Out for all CVC insertions.
- Assess the need for continued intravascular access on a daily basis during multidisciplinary rounds. Remove catheters not required for patient care.

## Surgical Site Infection (SSI) Prevention

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### Surgical site infection

SSI's include:

Infections occurring within 30 days after the operative procedure if no implant is left in place;  
or 90 days for CDC designated operative procedures with an implant.

### BRH SSI Prevention strategies include:

- Pre-operative shower/bathing with CHG the night before and morning of surgery. (CHG is available for patients through Pre-admission Testing).
- When hair removal is necessary, use clippers or depilatory method. Use of razors is inappropriate. Use the term clipped, never shaved for method of hair removal.
- Cardiac surgery patients blood glucose level control post-operatively.
- Follow appropriate antibiotic administration protocols for selection, timing and discontinuation.
- Make sure your patient understands your post-discharge instructions including prevention of SSI.

## Multi-Drug Resistant Organisms and C. difficile

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### MRSA Surveillance Screening

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HCA has launched an initiative in response to the increasing problem of Hospital Acquired Infections (HAI) and specifically, Methicillin-Resistant Staphylococcus aureus (MRSA) infections. Brandon Regional Hospital is committed to the efforts of reducing and ultimately eliminating the unnecessary spread of MRSA. All admissions to the hospital get screened during initial assessment to determine if they meet criteria for nares screening.

Healthcare providers can prevent the spread of MRSA with hand hygiene but the MRSA Initiative at Brandon Regional Hospital goes beyond that. Brandon Regional Hospital is committed to ensuring that every patient room is thoroughly disinfected, that gloves and gowns are worn to help create a protective barrier, and that patients carrying MRSA are identified and managed appropriately.

Highlights of the MRSA Initiative at Brandon Regional Hospital include the following:

- Performing nasal screening on all patients coming in for high risk surgical procedures (heart, spinal, and orthopedic procedures), patients coming in from communal living facilities including; long term care facilities, nursing homes, and correctional facilities, all out-born neonates or transfer babies admitted to NICU, all hemodialysis patients and all patients that have had previous positive cultures.
- Prompt initiation of contact precautions for those patients with positive cultures so that the MRSA does not spread
- The use of gowns, gloves, and masks for use by patients, staff, and visitors to prevent transmission
- Adult ICU patient's have CHG bathing and nares decolonization protocol implementation on admission or transfer into the ICU.
- Compulsive hand hygiene since hand hygiene remains the easiest and most effective method of stopping the spread of MRSA and other healthcare-associated infections thorough cleaning and appropriate use of products that are necessary to reduce the transmission of MRSA

The recommended surgical prophylaxis on patients with positive screens includes:

- Chlorhexidine Gluconate bathing daily
- Bactroban nasal ointment twice a day for 5 days perioperatively
- Vancomycin as prophylaxis

BRH strongly believes that these precautions will help reduce the rates of not just MRSA, but of other highly resistant infections, such as Vancomycin Resistant Enterococcus and Clostridium difficile colitis.

#### **Clostridium difficile (CDI) Prevention Initiative**

Brandon Regional Hospital is committed to the prevention of hospital acquired C. difficile infections and has in place a Clostridium difficile prevention strategy, which includes:

- Use and select antibiotics judiciously.
- Use Contact Precautions: for patients with known or suspected C. difficile-associated disease.
- Perform Hand Hygiene
- Use gloves and a gown when entering patients' rooms and during patient care.

#### *CDI Clinical Diagnosis*

Only diarrhea stools should be tested. Clostridium difficile fecal assays are not indicated in patients who are passing solid stools unless there is evidence of ileus. Repeat testing is not recommended if symptoms have resolved.

**Indications for work-up for *Clostridium difficile* include:**

- Patients in whom nosocomial diarrhea due to non-infectious causes has been excluded (osmotic diarrhea due to oral nutrition, non specific diarrhea)
- Patients with febrile diarrhea, with or without leukocytosis
- Patients with diarrhea that persists after discontinuing the offending drug
- Patients with diarrhea and previous hospitalization and / or antibiotic use

#### ***Clostridium Difficile Infection (CDI) Surveillance Definitions***

CASE TYPE	DEFINITION
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<b>Healthcare facility-onset, healthcare facility-associated CDI</b>	CDI symptom onset > 48 hours after admission to a healthcare facility.
<b>Community-onset, healthcare facility-associated CDI</b>	CDI symptom onset in the community or $\leq$ 48 hours from admission, provided symptom onset was less than 4 weeks after the last discharge from a healthcare facility.
<b>Community-associated CDI</b>	CDI symptom onset in the community or 48 hours or less after admission to an HCF, provided that symptom onset was more than 12 weeks after the last discharge from an HCF.
<b>Indeterminate onset CDI</b>	CDI case patient who does not fit any of the above criteria for an exposure setting (e.g. onset in the community greater than 4 weeks but less than 12 weeks after the last discharge from an HCF).
<b>Unknown case</b>	Exposure setting cannot be determined because of lack of available data.
<b>Recurrent CDI</b>	An episode of CDI that occurs 8 weeks or less after the onset of a previous episode provided that CDI symptoms from the earlier episode resolved.

#### Frequently questions asked by physicians include:

**1. Repeat testing for test of cure**

It is **NOT** recommended to perform a test of cure in patients who have responded to therapy.

1. Toxin may persist despite clinical response to treatment.
2. A positive test at the end of therapy does not predict who will develop a recurrent or relapse.
3. There is insufficient data to recommend extending contact precautions on the basis of a positive test.

**2. Only submit loose or watery stools for *C. difficile* testing**

Only watery or loose stools should be tested for *C difficile* because the rate of colonization is high in hospitalized patients. A positive result in a normal formed stool sample proves that the patient is colonized with *C difficile* but not necessarily infected (exception is when you suspect CDI in a patient with intestinal ileus which occurs in less than 1% of cases).

**3. How many stools should be submitted for suspected *C. difficile* infection?**

Newer kits presently available yield more reliable results making repeat testing of limited benefit.

#### Ventilator Associated Pneumonia Event (VAE) Prevention Bundle

By definition, ventilator-associated pneumonia event (VAE) is an airway infection that develops after the patient was intubated.

**The VAE Prevention bundle includes:**

- Hand hygiene before and after handling patient or patient's equipment or supplies
- Elevate the Head of the Bed 30-45° by flexing bed or reverse Trendelenberg (as appropriate, unless contraindicated)
- Oral Care
  - Assess oral cavity at least every shift
  - Brush teeth each shift
  - Oral care every 2 hours





# Brandon Regional Hospital

- Hypopharyngeal/subglottic suctioning at least q6h and as necessary
- Daily “Sedation Vacation” and daily assessment of readiness to extubate (as appropriate)
- Peptic ulcer disease prophylaxis (as appropriate)
- Deep vein thrombosis (DVT) prophylaxis (as appropriate)

## Catheter-Associated Urinary Tract Infection (CAUTI) Intervention Bundle

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It is the goal of BRH to prevent catheter-associated urinary tract infections (CAUTI), which will in turn improve patient outcomes, decrease length of stay and improve Patient Safety and Outcomes.

### Recommended components of care:

- Avoid unnecessary urinary catheters.
- Insert urinary catheters using aseptic technique.
- Maintain urinary catheters based on recommended guidelines.
- Review urinary catheter necessity daily and remove promptly.

### Approaches considered unnecessary for routine CAUTI prevention:

- Screening for asymptomatic bacteriuria in catheterized patients
- Treating asymptomatic bacteriuria in catheterized patients except prior to invasive urological procedure
- Changing catheters routinely
- Adding antiseptic or antimicrobial solutions to urinary drainage bags
- Performing routine meatal cleaning with an antiseptic/antimicrobial agent

### Foley catheters are indicated for:

- Obstruction/gross hematuria
- Urologic Studies/Surgery
- Neurogenic Bladder
- Stage 3 or 4 sacral decubiti (*incontinence*)
- Hospice or Palliative Care (*patient request*)

### Foley catheters are not indicated for:

- Incontinence
- Immobility
- Obtaining urine specimens
- Close monitoring of outputs
- (outside ICU's)

Thank you for your assistance in providing safe care.

J. Vasquez, MD  
Infection Control Committee Chair

Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee. Guideline for isolation precautions: preventing transmission of infectious agents in healthcare settings, 2007. Available at <http://www.cdc.gov/ncidod/dhqp/pdf/isolation2007.pdf> Accessed February 24, 2010.

Jane D. Siegel, MD; Emily Rhinehart, RN MPH CIC; Marguerite Jackson, PhD; Linda Chiarello, RN MS; the Healthcare Infection Control Practices Advisory Committee. Management of multidrug-resistant organisms in healthcare settings, 2006. Available at <http://www.cdc.gov/ncidod/dhqp/pdf/ar/MDROGuideline2006.pdf> Accessed February 22, 2010.

Centers for Disease Control and Prevention. Guideline for hand hygiene in health-care settings: recommendations of the healthcare infection control practices advisory committee and the HICPAC/SHEA/APIC/IDSA hand hygiene task force, 2002. Available at <http://www.cdc.gov/mmwr/PDF/rr/rr5116.pdf> Accessed February 24, 2010.

HCA Clinical Services Group. HCA Clinical Policies, Healthcare Associated Infections, 2010. Available at <http://atlas2.medcity.net/portal/site/hai> Accessed March 8, 2010

## *Clostridium difficile* testing

Only unforned stool specimens are accepted for testing. Rapid enzyme immunoassay test for *C. diff* antigen (glutamate dehydrogenase) for presence of *C. difficile* in stool specimen and toxins A and B for presence of toxigenic strain of *C. difficile*

Stool submitted for testing

EIA ANTIGEN AND TOXIN  
TEST PERFORMED

RESULT INTERPRETATION:

ANTIGEN = POSITIVE  
TOXINS A/B =  
NEGATIVE

RESULT = INDETERMINATE ; WILL  
AUTOMATICALLY REFLEX TO C. DIFF PCR  
TESTING; POSITIVE PCR = POSITIVE FOR  
TOXIGENIC *C. difficile* and NEGATIVE PCR =  
NEGATIVE FOR TOXIGENIC *C. fifficile*

ANTIGEN = NEGATIVE

NO *C. difficile* detected , no further  
testing

ANTIGEN POSITIVE  
TOXIN A/B = POSITIVE

RESULT = POSITIVE FOR  
TOXIGENIC *C. difficile*



# **HCA Code of Conduct** Case Management



# Case Management Department Overview

The utilization review process encompasses all clinical areas of the hospital, including inpatient, outpatient observation, emergency department and pre-admission reviews. **All** admissions to the facility are screened for appropriateness of admission **status**, level of care, appropriate utilization of resources and discharge planning based **on** pre-determined screening criteria. The utilization review process and discharge screens are discussed with the attending physician and if resolution has not occurred, are referred to a Physician Advisor for review. The Utilization Review Committee also reviews cases **concurrently** and **retrospectively** as needed. Appropriate referrals are made to Risk Management, Quality Management, Infection Control, Rehabilitation, Dietary, Pharmacy, Skin Care Program, and other ancillary departments as needs and/or questions are identified through case review.

## Performance Objectives

- Maintain Medicare ALOS at or below budget target
- Maintain Overall LOS at or below budget target
- Maintain Medicaid ALOS at or below budget target
- Maintain Self Pay ALOS at or below budget target
- Reduce **denial rate by payers**
- Reduce Focus DRG LOS to GMLOS
- Maintain Observation Visits and LOS below budget targets
- Maintain 30 readmission rates consistent with benchmarks
- Assessment within 24 hours of Discharge Planning Consult request



# Organizational Structure and Staff Resources

**Case Management Department Director** - Provides organization and management of the function, policies, procedures, budget and staff of the Case Management Department in accordance with the philosophy, goals and mission of Brandon Regional Hospital, standards of care, regulatory requirements and accreditation guidelines.

**Case Management Department Manager** - Provides oversight of day-to-day staff assignments, productivity, and procedural compliance including initial and concurrent review certifications, patient status assignment, and discharge planning. Coordinate concurrent and retrospective denial management for government and non-government payors.

**Case Management Supervisor** - Provides oversight for Utilization Management and Discharge Planning for the ED, Observation Patients, the Chest Pain Center, and Initial Medical Necessity Reviews for ED Admits, Same Day Surgery Admits, Direct Admits, and Transfers.

**Case Manager** - Performs utilization management, discharge planning and resource management in accordance with state, federal guidelines and hospital/department Policy and Procedures. Conducts medical necessity reviews to determine appropriate status assignment, level of care and continuing care needs. Performs psychosocial assessment, and reassessment, develops and implements the patient's discharge plan in accordance with the standards of care and makes appropriate community referrals.

**Insurance Coordinator** - Coordinates data entry into collections, Medicaid Web site, and Meditech, and provides liaison with PAS regarding certifications and recertifications as well as denials.

**Department Secretary** - Provides clerical, data entry, secretarial and receptionist support to the Case Management Department, coordinates communication between third party payors and Case Managers regarding requests for medical necessity information and discharge planning needs.

**Physician Advisor** - The Physician Advisor functions to balance clinical and medical expertise with the appropriate allocation of clinical resources. The Physician Advisor is the medical expert with issues related to Utilization Management and serves as a liaison between members of the Medical Staff, Case Management Staff, Hospital Administration, and third party payors. The Physician Advisor will evaluate medical necessity, level of care, treatment plans, and end of life issues, and other pertinent information to ensure hospital resources are optimized in accordance current medical practice and hospital policy and procedure.

# When & How To Initiate Discharge Planning

In order to facilitate a safe and timely discharge for your patients, it is important to assure that post-hospital services are in place prior to the actual discharge.

Remember to request a consultation for Discharge Planning whenever your patient needs any of the following services:

- Durable Medical Equipment and/or Supplies
- Respiratory Equipment and Supplies
- Home Health Services
- Home Infusion Services
- Skilled Nursing/Extended Care Facility Services
- Hospice Services
- Dialysis
- Medications for Financially Needy Patients

**Physicians shall write an order for Discharge Planning specifying the needed services.**

Nursing Staff shall enter a consultation request for Discharge Planning in the Order Entry Module of Meditech when a discharge planning need is identified by nursing assessment, ancillary staff, patient/family request, or physician order. The Case Manager on duty shall review and prioritize all consultation requests within 2 hours.

The Case Manager shall initiate the discharge plan within 24 hours of a consultation for patients with a discharge order.

**The Case Manager shall document Discharge Planning interventions as follows:**

- Discharge Planning Assessment in PCM.
- Discharge Planning Notes in PCM including patient/family contacts, barriers, service/placement referrals, provider contact information, and referral outcomes.
- Place a Discharge Planning Information Sheet on the front of the chart with directions for final arrangements and required notifications.

The patient should not be discharged until appropriate post hospital care services are in place. Please refer to the Case Management PCM Notes.

## How to Contact the Case Manager

You may contact the Case Manager assigned to your unit for questions about medical necessity or discharge planning services.

### Weekend & Holiday Coverage

Weekend and holiday coverage is limited to medical necessity reviews, observation stays, and finalizing services for targeted patients who are on the anticipated discharge roster. Follow-up with patients and families on continuing discharge planning needs may be best coordinated by the Unit-based Case Manager, Monday through Friday. Requests for new SNF, ALF, Dialysis, HHA, or DME referrals may not be readily coordinated after-hours and weekends since payor authorization and service provider admissions personnel are not available to finalize decisions. Please help to facilitate timely discharge planning by obtaining orders during normal business hours, whenever possible.





# **HIPAA Privacy** Keys to Success

## How does HIPAA affect you?

- Coversheets with confidential statement need to be used on all external faxes.
- Screens will need to be placed out of public view when possible
- Patient charts will need to be placed in secure area
- All PHI (e.g., dietary slips) will need to be placed in shred containers (e.g., Shred-It bins)
- Patient information must only be accessed if there is a **need to know** and only the **minimum necessary** may be used.
- Patient family members will give a passcode for other than directory releases
- Patient consent must be obtained before speaking in front of family members or visitors
- Registration will be giving out a Notice of Privacy Practices to every patient. Physicians in the OHCA are covered by the facility's Notice
- Patients will be given the option to "opt out" of directory
- Patients have a right to a copy of their medical record
- Written patient authorization is required for most disclosures that are not related to treatment, payment, or health care operations

## What is protected by HIPAA (PHI)?

Name  
Address including street, city, county, zip code and equivalent geocodes  
Names of relatives  
Name of employers  
All elements of dates except year (i.e. DOB, Admission, Discharge, Expiration, etc.)  
Telephone numbers  
Fax Numbers  
Electronic e-mail addresses  
Social Security Number  
Medical record number  
Health plan beneficiary number  
Account number  
Certificate/license number  
Any vehicle or other device serial number  
Web Universal Resource Locator (URL)  
Internet Protocol (IP) address number  
Finger or voice prints  
Photographic images  
Any other unique identifying number, characteristic, code

## Disclosing PHI to Family Members and Friends Who Call the Unit

- Patient will be assigned a four-digit passcode that will be needed to obtain non-directory information
- Distribution of passcode will be the responsibility of the patient
- Passcode may be changed during treatment
  - Revocation and password change form must be routed to FPO

## Verification of Requestors

- **Requestors via phone will need:**
  - Patient SS#, DOB and one of the following:
    - Account number, street address, medical record number, birth certificate, insurance card or policy number
  - Scenarios
    - Unknown physician calling from cell phone
    - Family member or friend calling without passcode



**External Faxing Guidelines**

- Limit when possible
- Verify fax number
- Utilize preset numbers when applicable
- Fax machine located in secure location
- **ALWAYS** use cover sheet with confidentiality statement for transmittals
- Highly sensitive information should NEVER be faxed (HIV status, abuse records, etc.)

**Patient's Right to Access**

- Forward to HIM for processing
- Must be able to provide access and/or electronic or paper copy of record
- If patient is in-house, HIM will manage access process

**Patient's Right to Amend**

- Forward request to HIM for processing
- Right of patient to request amendment to records. Request must be in writing
- Cannot change or omit documentation already in the medical record
- If patient in in-house HIM will manage amendment process

**Patient's Right to Opt out of Directory**

- Patient can opt out of directory at anytime but will probably happen during admission process
- You may not acknowledge the patient is in the facility or give information about the patient to friends, family or others who may inquire
- Can still release information to family and friends with 4-digit passcode as defined in the Directory policy.

**Right to Privacy Restrictions**

- Patients have the right to request a privacy restriction of their PHI
- **NEVER** agree to a restriction that a patient may request
- All requests must be made in writing and given to the FPO to make a decision on
- NO request is so small that it should not be routed to the FPO

**Patient Privacy Complaints**

- FPO must maintain complaint log in accordance with the complaint process
- **ALL** privacy complaints must be routed to the FPO
- Responses cannot be accompanied by retaliatory actions by the hospital
- Disposition of complaint must be consistent with the facility's Sanctions for Privacy and Information Security Violations

**Accounting of Disclosures (AOD)**

- Authorized by the patient
- Used for treatment, payment or health care operations
- Released to individuals themselves
- Used for national security or intelligence purposes
  - Used for law enforcement agencies that have custody of an inmate
- Disclosed as part of a limited data set
- Releases that occurred before April 14, 2003

**Notice of Privacy Practices**

- Patient will receive Notice upon each registration
- Outlines patient rights
  - Breach Notification
  - Right to Access
  - Right to Amend
  - Fundraising and the Right to Opt Out
  - Confidential Communication
  - Right to Privacy Restriction
  - Right to Opt out of Directory
- Physicians in the OHCA are covered by the facility's Notice for hospital patients

### **Sharing Information with Other Treatment Providers**

- Information may be shared for TPO with physicians and office staff, hospitals, or other treatment facilities on mutual patients
- Need to verify the identity of the requestor according to policy
- PHI can be released for reasons of treatment, payment or health care operations

### **Breach Notification**

- HITECH provisions require the following notifications when breaches (as defined in the regulations) occur:
  - To the *patient*
  - To the *Department of Health and Human Services*
  - To the *media* when the breach involves more than 500 individuals in the same state or jurisdiction

### **Ensuring Security Compliance**

- Ensure users log off terminals when not in use.
- Computers should have screen savers whenever possible.
- Computer screens should be positioned so information (PHI) is not readable by the public or other unauthorized viewers.
- Printers should be positioned in protected locations so that printed information is not accessible or viewable by an unauthorized person.
- PHI must be properly disposed of in shred bins.

### **Common Exposures**

- Discussions of patient information in public places such as elevators, hallways and cafeterias
- Printed or electronic information left in public view (*e.g.*, charts left on counters)
- Discussing patient information on social networking sites (*e.g.*, Facebook, Twitter)
- PHI in regular trash
- Records that are accessed without need to know in order to perform job duties
- Unauthorized individuals (*e.g.*, patient visitors) hearing patient sensitive information such as diagnosis or treatment

### **Sanctions**

- Two categories of privacy and security violations
  - Negligent
    - *Accidental/inadvertent and/or due to lack of proper education or an unacceptable number of previous violations*
  - Intentional
    - *Purposeful or deliberate violation of privacy or information security policies or an unacceptable number of previous violations*

# CDI Specialists

## **What is CDI?**

Clinical Documentation Improvement is a team approach to improving concurrent documentation practices through ongoing provider education and by seeking clarification when clinical documentation can't be matched with an ICD-9\_CM code or a more specific code is available. CDI Specialists at Brandon Regional Hospital are Registered Nurses with both clinical and Case Management experience.

## **Goals of CDI:**

The goal of the CDI Specialist is to help facilitate clear, concise, clinically accurate information in the medical record through identification of incomplete, vague and/or missing diagnoses.

## **What can CDI do for you?**

The CDI Specialist can help to facilitate and obtain the appropriate documentation that is required within the health record to accurately represent the severity of illness, expected risk of mortality and complexity of care for the patient. The CDI Specialist can also provide education and documentation tips to help translate the clinical condition into coding language.

## **The Query Process**

The CDI Specialist reviews records concurrently. When a condition or diagnosis is identified as requiring clarification or greater specificity, a query is issued to the Attending or Consulting Physician. If the query remains unanswered for 48 hours, the CDI Specialist will send a "gentle reminder" fax to the Physician office/service. A follow up phone call will be placed to the office/physician if query is still unanswered after another 48 hours. If the query still remains unanswered after another 48 hours, the CDI Specialist will notify the department Physician Advisor who will then reach out to the Physician.

Dear Dr: \_\_\_\_\_

Date: \_\_\_\_\_

Please review the question below as clarification is needed to accurately reflect the severity of illness for your patient PATIENT NAME who was admitted on ADMIT DATE.

**Based on your clinical judgment, can you provide the known or suspected condition(s) that represent(s) the clinical indicators listed below?**

Question

The medical record reflects the following diagnosis(es)/procedure(s) in the \_\_\_\_\_ (list source document(s) and date(s) and associated disease process, trauma or surgery (e.g. GI Hemorrhage, neoplasm, chronic disease, ulcer, Open Reduction with Internal Fixation of femoral fracture, etc.):

Diagnosis or Procedure from the medical record with source citation that supports asking the question.

Check here if indicator is present	Clinical Indicators	Value(s), Location, and/or date(s) in the medical record which reflects the clinical findings
X	Significant drop in H&H (Hemoglobin and/or Hematocrit)	H/H 10.3/32.4 to 7.8/26.2 Labs 11/19-11/21/2013
X	Hypotension	BP 88/62, 77/48, 95/64-Vitals 11/21/13
X	Transfusion(s)	2 units PRBCs Blood Bank Record 11/21/13
	Palpitations/Rapid Heart Rate	
X	Syncope/Dizzy/Light Headed	Dizziness-Attending PN 11/21/13
	Fatigue/Lethargy/Weakness	
	Iron Supplements	
X	Other Clinical Indicator: History of GI Bleed with AVM (Requires two of the above clinical indicators to be present in order to add an "other clinical indicator")	GI Consult 11/20/13

Clinical Indicators with location from the medical record

If known, please document the diagnosis and acuity for which you are evaluating, treating, or monitoring this patient (e.g. acute blood loss anemia, chronic blood loss anemia, anemia of chronic disease, neoplastic anemia, other unspecified anemia or other more appropriate diagnosis) in the box below and/or within the body of the medical record.

Reasonable Clinical Options & examples of detail needed

Physician Response goes here

☐

If no additional information is available please initial in or check the box, sign, date and time.

☐

If unable to determine, please initial in or check the box, sign, date and time.

\_\_\_\_\_  
PHYSICIAN SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
TIME

Thank you for your consideration of the query. In responding to this query, please exercise your independent professional judgment. The fact that a question is asked does not imply that any particular answer is desired or expected. If you have any questions, please utilize the contact name below.

Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**PHYSICIAN QUERY FORM N1** (effective date: 9/1/13)  
**THIS FORM IS A PERMANENT PART OF THE MEDICAL RECORD**



\*QUERY2\*

Patient Name: \_\_\_\_\_

Admit Date: \_\_\_\_\_ D/C Date: \_\_\_\_\_

MR#: \_\_\_\_\_

Acct #: \_\_\_\_\_



Check here if the query generated was verbal

# HPF Webstation: CDI Concurrent Queries

## **HPF WebStation: CDI Concurrent Queries**

The Horizon Patient Folder (HPF) WebStation is an intranet-based application that enables staff to view Electronic Medical Records (EMR) from a queued list of assignments. Concurrent queries are now sent to a physician using HPF. Guidelines for querying a physician do not change, but submission is done via HPF. This module will go over the concurrent query submission and review process for Clinical Documentation Improvement (CDI) staff.

## **HPF WebStation: CDI Concurrent Queries**

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## **Course Objectives**

By the end of this module you will be able to:

- Search/View Records
- Initiate Concurrent Queries
- Access Queues
- Process Assignments
- Complete Assignments
- Re-route Incomplete Concurrent Queries

The screenshot shows the HPF WebStation interface. At the top right, it says 'User: Coder Student 100' and 'Last Refresh: 07/17/2012 03:19 PM'. There are buttons for 'Change Password' and 'Sign Out'. Below this is a navigation bar with 'Assignment Worklist' and 'Patient Search' tabs. The 'Patient Search' tab is selected and marked with a red circle '1'. Below the tabs are 'Options' and 'Help' links. The main search area contains several input fields: 'Facility' (a dropdown menu), 'Encounter' (text box with 'D00000000707'), 'Last Name' (text box), 'MRN' (text box), 'First Name' (text box), 'EPN' (text box), 'Admitted' (text box with a calendar icon and '(mm/dd/yyyy) +/-'), 'DOB' (text box with a calendar icon and '(mm/dd/yyyy)'), 'Age' (text box with 'years +/-'), 'Sex' (dropdown menu), 'SSN' (text box), 'Discharged' (text box with a calendar icon and '(mm/dd/yyyy) +/-'), and 'GPI' (text box). There are 'Search' and 'Reset' buttons. A red circle '3' is over the 'Search' button. Below the search area is a 'Search Results' section. It contains a table with the following data:

Encounter	MRN	Patient	EPN	Facility	Pt Type	Service	Admitted ▼	Discharged	Age	GPI
<a href="#">D00000000707</a>	<a href="#">D000000033</a>	<a href="#">SARTAIN, TERESA</a>	KYAD33	COCBA1A - Community Medical Center	IN - Inpatient	ICU - INTENSIVE CARE	11/19/2009 08:57 PM		29	

A red circle '5' is over the first encounter number in the table. A red circle '4' is over the 'Facility' column header. A red circle '2' is over the 'Last Name' and 'First Name' fields.

## Patient Search

Upon login to HPF WebStation, there are 2 tabs at the top left: Assignment Worklist and Patient Search. Use the Patient Search tab to perform a search.

### Step-by-Step

1. Click the **Patient Search** tab.
2. Type the information associated with your desired patient (i.e. facility, encounter/account information, MRN, demographic information).
3. Click **Search**.
4. Your results display under **Search Results**.
5. To view an account, click the hyperlink to the corresponding encounter number.  
*The viewer opens in a separate window.*

### Notes:

- When entering search information, the best results come from the most specific information possible.
- Search results can be sorted by any column by clicking the column header. Only one column can be sorted at a time.



**1**

**2**

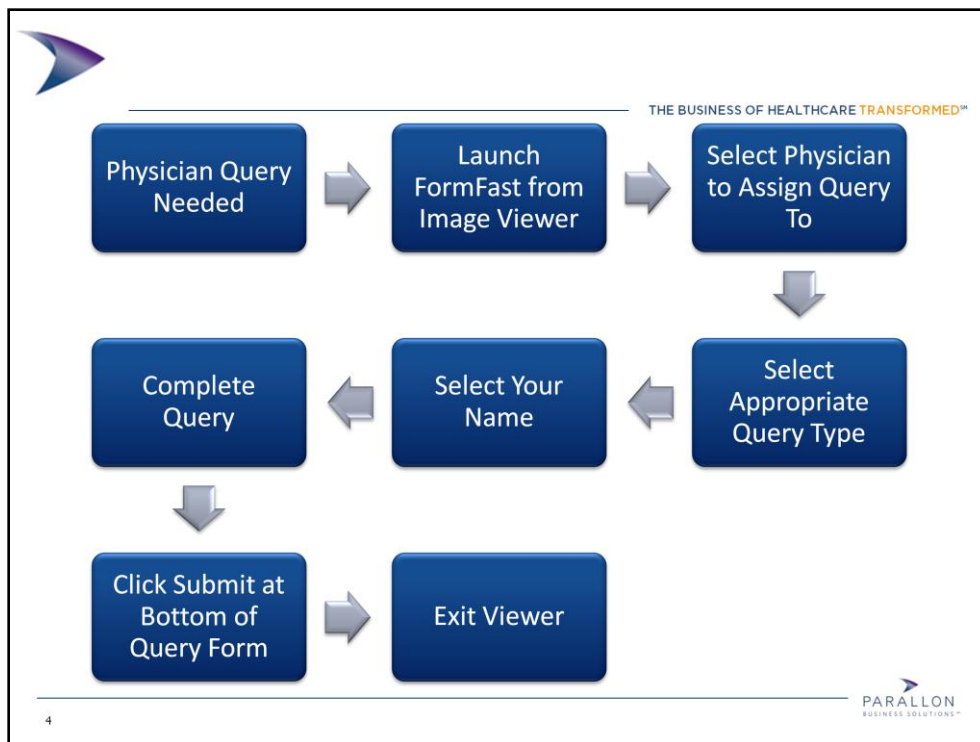
**3**

## View Patient Information

The viewer provides access to available documents in HPF for that account. If the patient is still in the facility, it only has documents that have been electronically fed into the system.

## Step-by-Step

1. Maximize the viewer window by clicking the middle square in the top right corner of the viewer window.
2. Click on the **All Documents** or **Coding** tab. The **All Documents** tab allows you to view all available documents. The **Coding** tab isolates only "coding critical" documents.
3. Scroll through the available documents by using the arrows at the bottom right corner or PAGE UP and PAGE DOWN on your keyboard.



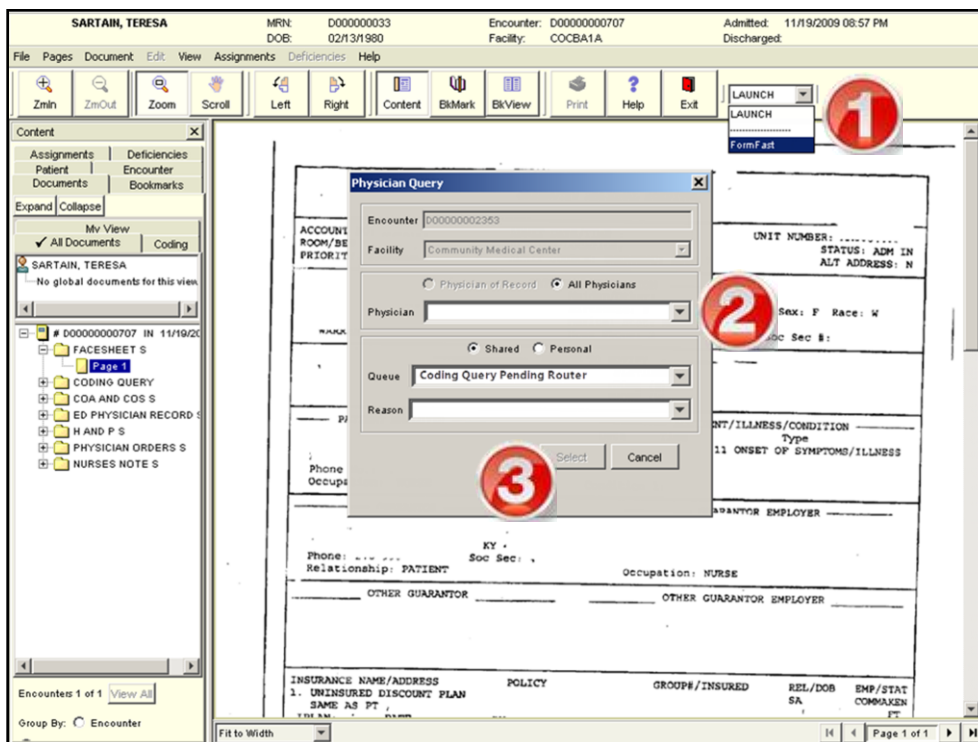
### Concurrent Query Process

Follow the normal HCA concurrent query process, using both HPF WebStation and the FormFast application. This is a high-level overview of the concurrent query process. Concurrent queries look slightly different in the HPF environment as changes had to be made to allow for the electronic completion process. REGS department has reviewed and approved FormFast query forms.

1. With an account open in the WebStation viewer, select **FormFast** from the **Launch** drop-down list on the image viewer toolbar.
2. Select the physician from the drop-down menu.
3. Select the appropriate query form in FormFast.
4. Select your name.
5. Complete the concurrent query form according to HCA policies.
6. Submit the concurrent query form to the physician.
7. Exit the viewer from the image toolbar.
8. Review the completed concurrent query when it appears in the Completed Concurrent Query Q.

#### Notes:

- Following the creation of your query, you must log back into HPF in order for the query to appear.
- To avoid incomplete submission for General Specificity Forms and General Forms, fully review and complete all fields before submitting.



## Initiate Concurrent Queries

If you determine there is a need to query the physician concurrently, the first step is to launch FormFast from the viewer.

### Step-by-Step

1. From the image toolbar, click **FormFast** from the Launch drop-down box.
2. Select the appropriate **Physician** from the drop-down menu.  
*The Queue name and Reason auto-populate after the physician is selected.*
3. Click **Select**.  
*FormFast opens in a separate window.*

### Notes:

- The **Physicians of Record** radio button will show only physicians that have a relationship in HPF to the current account. The **All Physicians** radio button will show all available physicians.
- Never edit or alter the auto-populated Queue name or reason field.

**FormFast**  
Enterprise Workflow

Documents  
Workflow Inbox  
User Settings  
Logout

v4.5.7

**QIO Forms**

Jamie Dore

Search Clear --Change Category-- --Set Default--

	Document ID	Description	Type	FileName
<a href="#">START</a>	H01_ABLA	H01_Acute_Blood_Loss_Anemia Workflow: H01_ABLA	PDF	QIO_Query_Form_Acute_Blood_Loss_Anemia_20090519.pdf
<a href="#">START</a>	H02_Acute_Renal_Fail	H02_Acute_Renal_Failure Workflow: H02_Acute_Renal_Failure	PDF	H2_QIO_Query_Form_Acute_Renal_Failure_Query_Form_20110308.pdf
<a href="#">START</a>	H03_Angina	H03_Angina Workflow: H03_Angina	PDF	QIO_Query_Form_Angina_Pectoris_20090519.pdf
<a href="#">START</a>	H04_AspirationPN	H04_Aspiration_Pneumonia Workflow: H04_AspirationPN	PDF	QIO_Query_Form_Aspiration_Pneumonia_05192009.pdf
<a href="#">START</a>	H05_CKD	H05_Chronic_Kidney_Disease Workflow: H05_CKD	PDF	QIO_Query_Form_Chronic_Kidney_Disease1.pdf
<a href="#">START</a>	H06_COPD	H06_COPD Workflow: H06_COPD	PDF	QIO_Query_Form_COPD_05192009.pdf
<a href="#">START</a>	H08_Debride_IP	H08_Debridement_Inpatient Workflow: H08_Debride_IP	PDF	QIO_Query_Form_Inpatient_Debridement.pdf
<a href="#">START</a>	H09_Decubitus	H09_Decubitus_Ulcer Workflow: H09_Decubitus	PDF	QueryDecubitusUlcer_20090519.pdf
<a href="#">START</a>	H10_Occasion_Admit	H10_Dx_Occasioning_Admission Workflow: H10_Occasion_Admit	PDF	QIO_Query_Form_Dx_Occasioning_Admission_20090519.pdf
<a href="#">START</a>	H11_General	H11_General Workflow: H11_General	PDF	QIO_Query_Form_General_20090519.pdf
<a href="#">START</a>	H12_Gen_Specificity	H12_Gen_Specificity Workflow: H12_Gen_Specificity	PDF	H12_QIO_Query_Form_General_Specificity_20110308.pdf
<a href="#">START</a>	H13_General_Sepsis	H13_General_Sepsis Workflow: H13_General_Sepsis	PDF	QIO_Query_Form_Generalized_Sepsis1.pdf
<a href="#">START</a>	H14_Heart_Failure	H14_Heart_Failure Workflow: H14_Heart_Failure	PDF	QIO_Query_Form_Heart_Failure_20090519.pdf
<a href="#">START</a>	H15_Infectious_Org	H15_Infectious_Organism Workflow: H15_Infectious_Org	PDF	H15_QIO_Query_Form_Infection_Organism_20110308.pdf
<a href="#">START</a>	H16_Malnutrition	H16_Malnutrition Workflow: H16_Malnutrition	PDF	QIO_Query_Form_Malnutrition_20090519.pdf
<a href="#">START</a>	H17_Pathology	H17_Pathology_Finding Workflow: H17_Pathology	PDF	H17_QIO_Query_Form_Pathology_Finding__20110308.pdf

## FormFast – Query Form Selection

Once FormFast is open, you need to select the appropriate HCA standard query form. All REGS approved queries are built in FormFast.

### Step-by-Step

4. Select the appropriate query form from the list presented in FormFast by clicking on the **Start** button to the left of the query.

*By clicking the start button rather than the name of the query, the query form is automatically populated with physician and patient information.*

### Note:

If you start a query or select the wrong query form, and back out, the query still populates the **Coding Pend for Query Q** even if you do not complete the query and do not hit submit.

The screenshot displays the FormFast application interface. On the left is a vertical navigation menu with links: Documents, Workflow Inbox, User Settings, and Logout. A red circle with the number '5' is overlaid on the 'User Settings' link. The main content area is titled 'Search For Form Fill Data' and shows a table of results. The table has columns for Code, Name, and Phone. There are three rows of data, each with a 'Select' button to its left. The user's name 'Jamie Dorety ()' is displayed in the top right corner. The version number 'v4.5.7' is visible in the bottom left corner of the main area.

	Code	Name	Phone
Select	CDI	Specialist A	111-1111
Select	CDI	Specialist B	222-2222
Select	CDI	Specialist C	333-3333

## FormFast - Contact

Contact information is also automatically populated on the query.

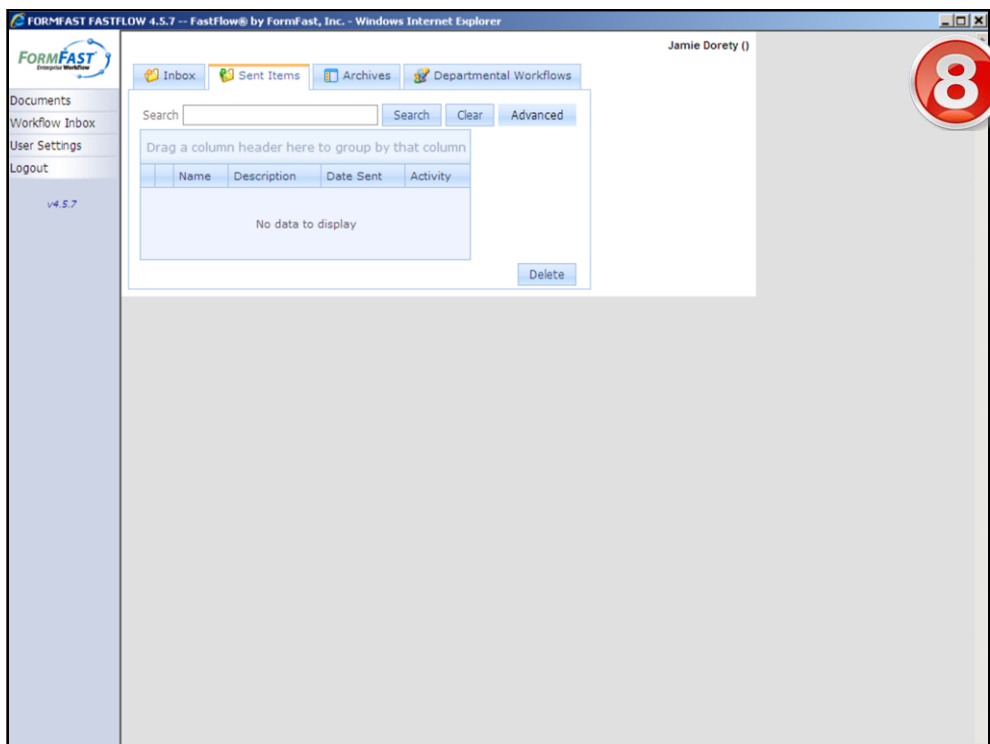
## Step-by-Step

5. On the next screen, select your name to automatically populate your contact information on the concurrent query.



To avoid incomplete submission for General Specificity Forms and General Forms, fully review and complete all fields before submitting.





## FormFast – Complete

Once the query form is submitted, a screen appears displaying the queries that have been submitted.

## Step-by-Step

8. Click the **X** in the upper right corner to close FormFast and return to HPF.

**SARTAIN, TERESA**      MRN: D000000033      Encounter: D0000000707      Admitted: 11/19/2009 08:57 PM  
 DOB: 02/13/1980      Facility: COCBA1A      Discharged:

File Pages Document Edit View Assignments Deficiencies Help

Zoom In Zoom Out Zoom Scroll Left Right Content Bookmark Bookmark View Print Help Exit LAUNCH

Content

Assignments Deficiencies  
 Patient Encounter  
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My View  
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SARTAIN, TERESA  
 No global documents for this view

# D0000000707 IN 11/19/2009  
 Page 1  
 CODING QUERY  
 COA AND COS  
 ED PHYSICIAN RECORD  
 H AND P S  
 PHYSICIAN ORDERS  
 NURSES NOTE S

Encounters 1 of 1 View All  
 Group By: Encounter

Fit to Width Page 1 of 1

GR AL

ACCOUNT NO: ROOM/BED PRIORITY: ADM SER ADM

UNIT NUMBER: STATUS: ADM IN ALT ADDRESS: N

Maiden/Other: Birthdate: 0 Age: 31 Sex: F Race: W  
 Marital Stat: M Religion: Home Phone: 2 Soc Sec #: 11

PERSON TO NOTIFY  
 RELATIONSHIP: PHONE (H) PHONE (W)

PATIENT EMPLOYER ACCIDENT/ILLNESS/CONDITION  
 Date Time Type 11 ONSET OF SYMPTOMS/ILLNESS

Phone No.: Occupation: NURSE Condition 1:

GUARANTOR GUARANTOR EMPLOYER  
 KY Soc Sec: Relationship: PATIENT Occupation: NURSE

OTHER GUARANTOR OTHER GUARANTOR EMPLOYER

INSURANCE NAME/ADDRESS POLICY GROUP/INSURED REL/DOB EMP/STAT  
 1. UNINSURED DISCOUNT PLAN SAME AS PT 5A COMMEXEN IT

## Closing Viewer

Once the FormFast process is complete, you may exit the viewer using the Exit (red door) icon.

## Step-by-Step

9. Click **Exit**.

# Working Completed Concurrent Queries

HPF WebStation

User: Coder Student 100  
Last Refresh: 07/17/2012 03:55 PM

Change Password Sign Out

Assignment Worklist Patient Search

Options Help

My List 0

Completed Concurrent Query Q 4

Coding Pend for Query Q 48

TRN: Completed Concurrent Query Q

Process Process All Complete Reassign Print

Status	Patient	Pt Type	MRN	Encounter	Facility	Discharged	Reason
<input checked="" type="checkbox"/> Ready	NATOLI, DAPHNIA	SDC - Same Day Surgery	D0000000271	D00000002739	COCHCA1 - Frist Medical Center	07/07/2009 07:49 AM	Baumgarten, Elizabeth :...
<input type="checkbox"/> Ready	ALONZO, WILMER	RCR - Recurring	D0000000279	D00000002819	COCHCA1 - Frist Medical Center	07/07/2009 08:11 AM	Baumgarten, Elizabeth :...
<input type="checkbox"/> Ready	GREENE, DEWEY	IN - Inpatient	E000000105	E00000001034	COCHCA2 - HIM Regional Hospital	07/06/2009 02:54 PM	Coder Student123 :...
<input type="checkbox"/> Ready	STOKERY, SEAN	SDC - Same Day Surgery	E0000000375	E000000003730	COCHCA2 - HIM Regional Hospital	07/09/2009 12:01 PM	Walker, Alene :...

1-4 of 4 assignments

## Queues/Assignments

In order to review a completed query, you need to access queues. Upon login to HPF WebStation, there are 2 tabs at the top left: **Assignment Worklist** and **Patient Search**. Use the **Assignment Worklist** tab to access queues.

When the **Assignment Worklist** tab is selected, a list of workflow queues are visible on the left side of the screen. Think of these queues as an electronic worklist containing a list of assignments (accounts) that are waiting to be processed.

You can only see the queues to which you have been given access based on your job function. The number to the right of the queue name indicates the total number of assignments within that queue. If there are no assignments in a queue, it does not display in the worklist. For example, if there are no completed concurrent queries, the **Completed Concurrent Query Q** does not display.

HPF WebStation

User: Coder Student 100  
Last Refresh: 07/17/2012 03:55 PM  
Change Password Sign Out

Assignment Worklist Patient Search

Options Help

My List 0

Completed Concurrent Query Q 4  
Coding Pend for Query Q 48

TRN: Completed Concurrent Query Q

Process Process All Complete Reassign Print

Status	Patient	Pt Type	MRN	Encounter	Facility	Discharged	Reason
<input checked="" type="checkbox"/> Ready	NATOLI, DAPHNIA	SDC - Same Day Surgery	D0000000271	D00000002739	COCHCA1 - Frist Medical Center	07/07/2009 07:49 AM	Baumgarten, Elizabeth :...
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1-4 of 4 assignments

## Assignment Worklist

Within each queue, a list of assignments in discharge date order is visible, with the oldest date at the top. At the bottom right of the screen, the number of assignments on the current page appears along with the total number of assignments. You can click on a column heading to sort the assignments by facility, patient name, etc. To view assignments on the next page, click the **Next** button (lower right-hand corner of screen). The **Completed Concurrent Query Q** contains assignments that are ready to be reviewed. The **Coding Pend for Query Q** contains assignments that are waiting on physician completion.

## Notes:

- Assignments can be sorted by any column by clicking the column header. Only one column can be sorted at a time.
- While a query is waiting for a physician response, an assignment is found in the **Coding Pend for Query Q**. Upon physician completion or decline, those assignments are automatically routed to the **Completed Concurrent Query Q** to be reviewed.
- If the concurrent query is declined by a physician, *DECLINED* will show in the **Reason** field.

HPF WebStation

User: Coder Student 100  
Last Refresh: 07/17/2012 03:55 PM

Change Password Sign Out

Assignment Worklist Patient Search

Options Help

My List 0

Completed Concurrent Query Q 4

Coding Pend for Query Q 48

TRN: Completed Concurrent Query Q

Process Process All Complete Reassign Print

Process	Patient	Pt Type	MRN	Encounter	Facility	Discharged	Reason
<input checked="" type="checkbox"/>	ATOLI, DAPHNIA	SDC - Same Day Surgery	D0000000271	D00000002739	COCHCA1 - Frist Medical Center	07/07/2009 07:49 AM	Baumgarten, Elizabeth :...
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<input type="checkbox"/>	STOKERY, SEAN	SDC - Same Day Surgery	E0000000375	E000000003730	COCHCA2 - HIM Regional Hospital	07/09/2009 12:01 PM	Walker, Alene :...

1-4 of 4 assignments

## Process Assignments

In order to review the completed concurrent queries, process assignments from the Completed Concurrent Query Queue.

### Step-by-Step

1. Click on **Assignment Worklist** (if not already selected).
2. Click the **Completed Concurrent Query Q** to display assignments within that queue.
3. Click the **Reason** column heading in order to sort the assignments by CDI staff name.
4. Select your assignments by clicking the check box on the left of the assignments worklist.
5. Click **Process**.

### Notes:

- If more than one assignment is selected, the viewer opens one at a time starting with the first on the list. When the current assignment is completed, the next one on the list automatically opens without having to return to the assignment worklist.
- If the concurrent query is declined by a physician, *DECLINED* will show in the **Reason** field.



**RICHARDS, LEE** MRN: D000000207 Encounter: D0000002353 Admitted: 12/01/2010 07:49 AM  
 DOB: 04/29/1973 Facility: COCBA1A Discharged: 12/01/2010 07:50 AM

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Print

**6**

Content

Bookmarks Assignment Encounter Documents

Expand Collapse

My View ☒ All Documents Coding

RICHARDS, LEE

No global documents for this view

☐ # D0000002353 CLI 12/01/2010  
☐ FACESHEET S  
☒ Page 1  
☐ Page 2  
☐ PHYSICIAN ORDERS S  
☐ CONSENT TO TREATMENT  
☐ RADIOLOGY S  
☐ CONCURRENT QUERY

Encounters 1 of 1 View All

Group By: ☐ Encounter

**Cmplt**

SKYLINE MEDICAL CENTER

ADMIT DATE/TIME: SERVICE/LOCATION: COMPUTERIZED TOMOGRA STATUS: REG CLI  
 ADMIT SOURCE: PHYSICIAN REFERRAL 1 ALT ADDRESS: N

PATIENT INFORMATION

RD Maiden/Other: Birthdate: 03/ Age: Sex: Race: 1  
 Marital Stat: M Religion: Soc Sec #:

PERSON TO NOTIFY

RD RELATIONSHIP: SPOUSE  
 PHONE (H): 61  
 PHONE (W): 1

PATIENT EMPLOYER

PT. Date Time 11 ONSET OF SYMPTOMS/ILLNESS

Phone No.: 1 Occupation: DISPATCHER Condition 1:

GUARANTOR

JERRY RD TN 37148  
 Phone: Soc Sec: 03, 4  
 Relationship: PATIENT Occupation: DISPATCHER

OTHER GUARANTOR

ID OTHER GUARANTOR EMPLOYER  
 SERV

SPOUSE 13 OFFICE MANAGER

Fit to Width Page 1 of 2

## Complete Assignment

Review the assignment from the Completed Concurrent Query Q. If no additional query is required, you get to complete the assignment.

## Step-by-Step

- Click **Complete** on the viewer toolbar.

## CDI "GOLDEN RULES"

Please write legibly (**unusable by anyone for anything if illegible!!**)

Please use the **"problem specific"** approach for all charting

Please dictate all H&Ps, consultations, procedure notes, operative reports, and discharge summaries **ON THE DAY OF SERVICE** to the patient

Please list **ALL Diagnoses** in D/C summary - **Particularly CDI Queried Diagnoses!**

Please pay attention to CDS nurse queries - **They are here to help you!**

Remember **"Present On Admission"** if an unrealized problem is discovered or realized later on in hospitalization and was present at admission

Please write out all arrhythmia names and all **"hypo-"** or **"hyper-"** electrolyte **"-emias"**

Consider **alternative** descriptors to labeling disease processes as **"post-op"**

**Do not use** symbols and/or arrows to describe disease processes

**"Possible, probable, suspect, likely, etc."** OK w/ CMS but **must be in D/C summary**

**Acidosis** - pH < 7.35, pCO<sub>2</sub>>45, HCO<sub>3</sub><18, anion gap >12

**Alkalosis** - pH > 7.45, pCO<sub>2</sub><28, HCO<sub>3</sub>>28

### Acute Encephalopathy

Definition: Global cerebral dysfunction in absence of structural brain disease.

Please consider this as opposed to "altered mental status", "confusion", "delirium", "mental status changes", "acute psychosis", "unresponsiveness"

"Please document suspected cause such as "hypertensive", "post-ictal", "anoxic", "toxic/metabolic", "uremia", "alcohol/drug induced", "hepatic",

"infectious (UTI, meningitis, prions, malaria, AIDS, rabies, neurosyphilis, etc.)"

### Acute Exacerbation of COPD

Is there acute or chronic respiratory failure? Home Oxygen?

### Acute Myocardial Infarction - First episode of care?

troponin > 99th percentile +sx

### Anemia

GI bleed, GSW, epistaxis, etc. is "anemia due to acute blood loss"

Please document that "anemia" as a **separate problem** from its cause

**\*2 pt drop in Hgb** after surgery is **"Drop in HCT** - expected due to specific procedure"

**BMI and "Morbid Obesity"** document in chart if BMI ≥ 35

### Chest Pain is a symptom (cause?)

-pleuritic, GERD, musculoskeletal, anxiety, angina, etc.?

**Cirrhosis:** Caused by which virus, ETOH, etc.?

Is there **"Hepatic Encephalopathy?"**

Is there **"Spontaneous Bacterial Peritonitis?"**

Is there **"Portal Vein Thrombosis?"**

Are there **"Esophageal Varices w/ Bleeding?"**

Is there **"Ascites" and/or "Jaundice?"**

### Decubitus Ulcer Documentation must include **Exact Location & Stage:**

**Stage 1:** nonblanchable erythema of intact skin

**Stage 2:** partial thickness skin loss involving epidermis, dermis, or both

**Stage 3:** full-thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia

**Stage 4:** full-thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (i.e., tendon, joint capsules)

### Diabetes Mellitus - Need *type and control status:*

"Type 1", "Type 2", or "secondary?" **AND** "Controlled" or "Uncontrolled?"

uncontrolled = several in-house blood sugars > 200 **OR** HbA<sub>1c</sub> ≥ 7.0

Please list all known diabetic complications (short or long-term)

### Excisional Debridements - Must be titled as **"Excisional Debridements"**

1) Specifics of wound site, location, & size    2) Depth debrided to in tissue layers

3) Removal of devitalized/necrotic tissue    4) Exact instrumentation used

### Hypertension - **"Accelerated" or "Malignant" (BP ≥ 180/110 with intervention)**

as opposed to hypertensive "urgency" or "emergency" or "crisis"

### Pathological Fracture due to Osteoporosis - "Did the fracture occur due to a ground level fall?"

### Stroke v. TIA

TIA - brief cerebral, spinal, or retinal ischemia without acute infarction (nothing on MRI)

Stroke - neurological symptoms with evidence of stroke on neuroimaging

Aborted Stroke - transient symptoms due to ischemia with normal MRI (look for t-PA)

**"Syncope with collapse"** as opposed to "L.O.C."



# BRUNDAGE MEDICAL GROUP

## CLINICAL DOCUMENTATION - 5 HEAVY HITTERS!

### Sepsis Definitions:

**"Sepsis"** = "SIRS" *plus* suspected infection (pneumonia, cellulitis, device, etc.):

**"SIRS"** = any 2 of these 4: - Temp > 100.4F(38.6C) or < 96.8F(36C) - Pulse > 90 - RR > 20  
- WBC's > 12,000 or < 4,000 or WBC differential w/ > 10% bands

Consider **"Sepsis due to UTI"** vs. "urosepsis"

Use "SIRS" from a non-infectious source" If SIRS without infection eg. Pancreatitis

**"Severe Sepsis"** = Sepsis with evidence of end-organ damage"

**"Septicemia"** = Sepsis w/ bacteremia "Bacteremia" is a lab finding

**Shock:** Failure of circulatory system to maintain adequate blood flow

**Septic** - Sepsis refractory to fluid resuscitation requiring pressors

**Cardiogenic** - Decreased C.O. Is there an IABP? Is there a Dobutamine drip?

**Anaphylactic, Hypovolemic, or Hemorrhagic**

**Pneumonia** - Simple, CAP, HAP, VAP

"Due to suspected/causative organism(s)" and/or "Aspiration?"

If the antibiotics are zosyn (or cefepime) and vanco - do you suspect GNR and MRSA?

If the antibiotics include clinda/flagyl - do you suspect aspiration?

### Respiratory Failure: Acute, Chronic, Acute on Chronic

**"Acute Respiratory Failure"** if resp distress but ICU and vent NOT necessary and  
pH 7.35 & pCO<sub>2</sub> > 50 or pO<sub>2</sub> < 60 \*(Sat <88%)\*

**"Chronic Resp Failure"** = Normal pH w/ high pCO<sub>2</sub> on ABG and/or on home O<sub>2</sub>"

### Congestive Heart Failure

Acute v. chronic, systolic v. diastolic v. both, right v. left ventricular dysfunction

**CHF** - Need **cause** and **temporality**:

Cause = **"Systolic"** (EF ≤ 40 %) or **"Diastolic"** (normal EF) or both

Temporality = **"Chronic"** or **"Acute"** or **"Acute on Chronic"**

**\*Note:** Still need to list EF at least once in chart for core measures

### Acute Renal Failure/Acute Kidney Injury

Serum creatinine increased by 0.3 mg/dl over baseline OR...rise in serum Cr ≥ 1.5 x baseline

**Chronic Kidney Disease** (as opposed to *CR* or *CRF*):

GFR = >90	Stage I
GFR = 60 to 89	Stage II
GFR = 30 to 59	Stage III
GFR = 15 to 29	Stage IV
GFR = <15 (no HD/PD)	Stage V
ESRD = on dialysis	

**REMEMBER TO DOCUMENT DIAGNOSES AND NOT SIGNS/SYMPTOMS**

**MUST THINK IN INK!!!**

**IF YOU TREAT IT . . . CALL IT!**



# **Brandon Patient Placement Center**



# One Call Does It All

- Provide a "One Call Does It All" to admit patients
- Provide support to you through a dedicated Patient Flow Coordinator
- Track measurements of Success
- Twice a day bed status meeting with Directors and Nursing Supervisors to determine bed availability.
  - Pending Discharges
  - Direct Admits
  - OR & Cath Lab schedule and bed placement needs
  - Isolation Patients

## Direct Your Patients

Only when bed has been assigned.

### Tower A

Monday - Friday

6:00 a.m. - 5:00 p.m.

(Regular Business Hours)

### After Hours & Weekends:

Admitting in the Emergency Department

Taken by: \_\_\_\_\_ Date/Time: \_\_\_\_\_

Admitting Doctor: \_\_\_\_\_ Admit Date/Time: \_\_\_\_\_

Caller: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Has Patient been here before? ☐ Yes ☐ No

Patient Name: \_\_\_\_\_ Sex: ☐ Male ☐ Female

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Phone #: \_\_\_\_\_

Primary Insurance Name: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Admission Priority (Check One) ☐ Elective ☐ Emergent ☐ Urgent

Admission Status (Check One) ☐ Inpatient ☐ OBS

Bed Type (Check One) ☐ ICU ☐ PUC/TELE ☐ OBS/TELE

☐ MED/TELE ☐ Medical/Surgical

If patient has any relevant history or condition such as: MRSA (or other isolation needs), Tubes, Wounds, or from a Long Term Care Facility, please list here: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Location: (You must choose one of the options below)

☐ Patient is at Doctor's office

☐ Patient is at home Contact Name/ Telephone Number: \_\_\_\_\_

☐ Patient is on his/her way to the hospital. ☐ Auto ☐ Ambulance

☐ Transfer From: ☐ TGH ☐ SBH ☐ Hawthorne

Contact Name/Telephone Number: \_\_\_\_\_

Utilization Notified Time: \_\_\_\_\_ Name: \_\_\_\_\_

# Direct Admissions

## Patient Reservations

- Call Patient Placement Center (PPC) at 571-6073.
- After calling the PPC: Fax the Patient Reservation form along with physician order to the PPC at 571-3374.
- Call 571-2468 for forms
- Bed Status will be given at that time.

### Continuity of Care

Provide Clinical data when calling in Direct Admissions:

- Reduce phone calls to office
- Facility insurance certification
- Prevent long wait times for patients upon arrival

### Clinical Data Needed

- Reason for the hospital stay and admitting diagnosis
- Admission status: observation or inpatient
- Level of care: ICU, PCU, Telemetry or Med/Surg
- Provide doctors orders, office notes, diagnostic test results and/or imaging studies
- Indicate any special needs (isolation and equipment)
- Name of Admitting Physician

# National Patient Safety Goals

- It's our goal to practice patient safety every day at Brandon Regional Hospital.
- Everyone plays a vital role in providing a safe environment for our patients.
- From the office clerk to the pharmacist to the nurse and physician to the patient, it's everyone's responsibility!
- National Patient Safety Goals focus on problematic areas in health care and solutions to improve safety.

### Accurate Patient Identification

- Correctly identify a patient when giving medication, transporting to another department, performing a procedure (x-ray, surgery, cardiac cath)
- 2 patient identifiers: Name & Date of Birth
- Use open-ended questions "For your safety, please tell me your name and birthday."
- Unresponsive patients - Compare armband to available document (requisition)
- Pre-procedure time out
- Label specimens in the presence of the patient
- Never use room number

### Do Not Use List

#### Effective Communication Among Caregivers

- Avoid Verbal orders when possible
- **Read back** verbal order and telephone order
- **Read back** critical test results
- Do not use abbreviations
- Use SBAR for "Hand-off" Communications
  - a. SBAR report (Situation, Background, Assessment & Recommendation)
- "Got Chart"

Do Not Use	Problem	Use
U (unit)	Mistaken for (zero), the number "4" (four) or "cc"	Write "unit"
IU (International Unit)	Mistaken for IV (Intravenous) or the number 10 (ten)	Write "International Unit"
QD., QD, q.d., (daily) Q.O.D., QOD, q.o.d, qod. (every other day)	Mistaken for each Period after the Q mistaken "I" and the "O" mistaken for "l"	Write "daily" and Write "every other day"
Trailing zero, Lack of leading zero (.X mg)	Decimal point is missed	Write X mg or 0.X mg
MS, MSO <sub>4</sub> and MgSO <sub>4</sub>	Can mean morphine sulfate or magnesium sulfate. Confused for one another	Write "morphine sulfate" Write "magnesium sulfate"



# High Alert Medications

- IV antiarrhythmics
- Chemotherapy agents
- Concentrated electrolytes (K, Ca, Mg, NaCl, Phos)
- Heparin
- Insulin
- Narcotics / analgesia / sedation
- Neuromuscular blocking agents / sedation critical care
- IV thrombolytics
- TPN
- IV vasoactive agents



## Reduce the Risk of Health-Care Associated infections

- Hand hygiene
- Alcohol-based scrubs
  - a. Hand gel in elevators, at exits, in cafeteria, etc.
- Artificial fingernails cannot be worn in clinical settings
- MRSA screening & isolation protocols
- Determine if an infection is PRESENT ON ADMISSION (POA) and document that in the medical record
  - a. Infections that originate in the hospital are considered nosocomial (hospital-acquired) and costs associated with them are not reimbursed by CMS

**NOTE:** unanticipated death or loss of function due to a health-care associated infection is considered a sentinel event

## Medication Safety

- Look-alike/sound-alike drugs:
  - a. Kept in different drawers
  - b. Flagged with a look alike/ sound alike Notification
  - c. Tall Man Lettering used in Meditech
- Label all medications, medication containers, etc. in all areas
  - a. Sterile labels markers are available to be dropped on sterile field for scrub nurse to label medications
- Anticoagulation therapy safety
- Remove concentrated electrolytes from patient care units
- High alert meds must be co-signed by 2 nurses for accuracy

## Eliminate Wrong Site, Wrong Patient , Wrong Procedure Surgeries

Universal Protocol

- Time Out must be completed immediately prior to beginning a procedure
- Use the Boarding pass to document
- Physician marks the procedural/ operative site

## Safety of Infusion Pumps

- All infusion pumps now have a free flow protection mechanism

## Effectiveness of Clinical Alarm Systems

- Respond immediately to all clinical alarms

## Reconcile Medications Across the Continuum of Care

- On admission, nurse obtains a list of meds patient currently takes at home and enters into the computerized medical record
  - a. A form is generated for the physician to review and sign (not a physician order)
- On transfer the patient's medication list is reviewed for accuracy
- At discharge all current hospital meds and the list of home meds prints out for physician signature
- A copy of this printout is given to patient
- Designed to minimize Adverse Drug Events

## Reduce the Risk of Patient Harm Resulting from Falls

- Identify patients at risk to fall through assessment and reassessment each shift and PRN
- Alert all hospital employees of patient's risk of falling
  - a. Orange armbands, red socks, falling leaves, bed alarms
- Evaluate medications as possible contributing factors

## Encourage Patients to be Involved in Their Own Care

- Encourage patients and families to speak up about
  - a. Care
  - b. Treatment
  - c. Services
- Provide patients and families with ability to report concerns
  - a. Risk Management ext #1234
- The Speak Up™ Campaign is used to educate patients and families

## Identify Safety Risks Inherent in Brandon Regional Hospital Population

- 1500 Suicides occur in hospitals annually!
- Identify patients at risk for suicide and/or elopement using elopement risk and suicide screening and assessment tools

## Recognize and Respond to Changes in a Patient Condition

- Rapid Response Team
- Anyone activates
- Immediate response

# Speak Up™

- Speak up if you have questions or concerns, and if you don't understand, ask again. It's your body and you have a right to know.
- Pay attention to the care you are receiving. Make sure you're getting the right treatments and medications by the right health care professionals. Don't assume anything.
- Educate yourself about your diagnosis, the medical tests you are undergoing, and your treatment plan.
- Ask a trusted family member or friend to be your advocate.
- Know what medications you take and why you take them. Medication errors are the most common health mistakes.
- Use hospital, clinic, surgery center, or other type of health care organization that has undergone a rigorous on-site evaluation against established state-of-the-art quality and safety standards, such as that provided by The Joint Commission.
- Participate in all decisions about your treatment. You are the center of the health care team.

# HCAHPS Survey

## SURVEY INSTRUCTIONS

- ◆ You should only fill out this survey if you were the patient during the hospital stay named in the cover letter. Do not fill out this survey if you were not the patient.
- ◆ Answer all the questions by checking the box to the left of your answer.
- ◆ You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

- ☐ Yes  
☒ No → **If No, Go to Question 1**

***You may notice a number on the survey. This number is used to let us know if you returned your survey so we don't have to send you reminders.***

***Please note: Questions 1-25 in this survey are part of a national initiative to measure the quality of care in hospitals. OMB #0938-0981***

Please answer the questions in this survey about your stay at the hospital named on the cover letter. Do not include any other hospital stays in your answers.

### YOUR CARE FROM NURSES

1. During this hospital stay, how often did nurses treat you with courtesy and respect?  
  
☐ 1 Never  
☐ 2 Sometimes  
☐ 3 Usually  
☐ 4 Always
2. During this hospital stay, how often did nurses listen carefully to you?  
  
☐ 1 Never  
☐ 2 Sometimes  
☐ 3 Usually  
☐ 4 Always

3. During this hospital stay, how often did nurses explain things in a way you could understand?

- ☐ 1 Never  
☐ 2 Sometimes  
☐ 3 Usually  
☐ 4 Always

4. During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?

- ☐ 1 Never  
☐ 2 Sometimes  
☐ 3 Usually  
☐ 4 Always  
☐ 9 I never pressed the call button

## **YOUR CARE FROM DOCTORS**

5. During this hospital stay, how often did doctors treat you with courtesy and respect?
- <sup>1</sup> ☐ Never  
<sup>2</sup> ☐ Sometimes  
<sup>3</sup> ☐ Usually  
<sup>4</sup> ☐ Always
6. During this hospital stay, how often did doctors listen carefully to you?
- <sup>1</sup> ☐ Never  
<sup>2</sup> ☐ Sometimes  
<sup>3</sup> ☐ Usually  
<sup>4</sup> ☐ Always
7. During this hospital stay, how often did doctors explain things in a way you could understand?
- <sup>1</sup> ☐ Never  
<sup>2</sup> ☐ Sometimes  
<sup>3</sup> ☐ Usually  
<sup>4</sup> ☐ Always

## **THE HOSPITAL ENVIRONMENT**

8. During this hospital stay, how often were your room and bathroom kept clean?
- <sup>1</sup> ☐ Never  
<sup>2</sup> ☐ Sometimes  
<sup>3</sup> ☐ Usually  
<sup>4</sup> ☐ Always
9. During this hospital stay, how often was the area around your room quiet at night?
- <sup>1</sup> ☐ Never  
<sup>2</sup> ☐ Sometimes  
<sup>3</sup> ☐ Usually  
<sup>4</sup> ☐ Always

## **YOUR EXPERIENCES IN THIS HOSPITAL**

10. During this hospital stay, did you need help from nurses or other hospital staff in getting to the bathroom or in using a bedpan?
- <sup>1</sup> ☐ Yes  
<sup>2</sup> ☐ No → If No, Go to Question 12
11. How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?
- <sup>1</sup> ☐ Never  
<sup>2</sup> ☐ Sometimes  
<sup>3</sup> ☐ Usually  
<sup>4</sup> ☐ Always
12. During this hospital stay, did you need medicine for pain?
- <sup>1</sup> ☐ Yes  
<sup>2</sup> ☐ No → If No, Go to Question 15
13. During this hospital stay, how often was your pain well controlled?
- <sup>1</sup> ☐ Never  
<sup>2</sup> ☐ Sometimes  
<sup>3</sup> ☐ Usually  
<sup>4</sup> ☐ Always
14. During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?
- <sup>1</sup> ☐ Never  
<sup>2</sup> ☐ Sometimes  
<sup>3</sup> ☐ Usually  
<sup>4</sup> ☐ Always

**15. During this hospital stay, were you given any medicine that you had not taken before?**

<sup>1</sup> ☐ Yes

<sup>2</sup> ☐ No → If No, Go to Question 18

**16. Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?**

<sup>1</sup> ☐ Never

<sup>2</sup> ☐ Sometimes

<sup>3</sup> ☐ Usually

<sup>4</sup> ☐ Always

**17. Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?**

<sup>1</sup> ☐ Never

<sup>2</sup> ☐ Sometimes

<sup>3</sup> ☐ Usually

<sup>4</sup> ☐ Always

#### **WHEN YOU LEFT THE HOSPITAL**

**18. After you left the hospital, did you go directly to your own home, to someone else's home, or to another health facility?**

<sup>1</sup> ☐ Own home

<sup>2</sup> ☐ Someone else's home

<sup>3</sup> ☐ Another health facility → **If Another, Go to Question 21**

**19. During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?**

<sup>1</sup> ☐ Yes

<sup>2</sup> ☐ No

**20. During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?**

<sup>1</sup> ☐ Yes

<sup>2</sup> ☐ No

#### **OVERALL RATING OF HOSPITAL**

**Please answer the following questions about your stay at the hospital named on the cover letter. Do not include any other hospital stays in your answers.**

**21. Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?**

<sup>0</sup> ☐ 0 Worst hospital possible

<sup>1</sup> ☐ 1

<sup>2</sup> ☐ 2

<sup>3</sup> ☐ 3

<sup>4</sup> ☐ 4

<sup>5</sup> ☐ 5

<sup>6</sup> ☐ 6

<sup>7</sup> ☐ 7

<sup>8</sup> ☐ 8

<sup>9</sup> ☐ 9

<sup>10</sup> ☐ 10 Best hospital possible

22. Would you recommend this hospital to your friends and family?

<sup>1</sup> ☐ Definitely no  
<sup>2</sup> ☐ Probably no  
<sup>3</sup> ☐ Probably yes  
<sup>4</sup> ☐ Definitely yes

### **UNDERSTANDING YOUR CARE WHEN YOU LEFT THE HOSPITAL**

---

23. During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.

<sup>1</sup> ☐ Strongly disagree  
<sup>2</sup> ☐ Disagree  
<sup>3</sup> ☐ Agree  
<sup>4</sup> ☐ Strongly agree

24. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.

<sup>1</sup> ☐ Strongly disagree  
<sup>2</sup> ☐ Disagree  
<sup>3</sup> ☐ Agree  
<sup>4</sup> ☐ Strongly agree

25. When I left the hospital, I clearly understood the purpose for taking each of my medications.

<sup>1</sup> ☐ Strongly disagree  
<sup>2</sup> ☐ Disagree  
<sup>3</sup> ☐ Agree  
<sup>4</sup> ☐ Strongly agree  
<sup>5</sup> ☐ I was not given any medication when I left the hospital

### **ABOUT YOU**

---

There are only a few remaining items left.

26. During this hospital stay, were you admitted to this hospital through the Emergency Room?

<sup>1</sup> ☐ Yes  
<sup>2</sup> ☐ No

27. In general, how would you rate your overall health?

<sup>1</sup> ☐ Excellent  
<sup>2</sup> ☐ Very good  
<sup>3</sup> ☐ Good  
<sup>4</sup> ☐ Fair  
<sup>5</sup> ☐ Poor

28. In general, how would you rate your overall mental or emotional health?

<sup>1</sup> ☐ Excellent  
<sup>2</sup> ☐ Very good  
<sup>3</sup> ☐ Good  
<sup>4</sup> ☐ Fair  
<sup>5</sup> ☐ Poor

29. What is the highest grade or level of school that you have completed?

<sup>1</sup> ☐ 8th grade or less  
<sup>2</sup> ☐ Some high school, but did not graduate  
<sup>3</sup> ☐ High school graduate or GED  
<sup>4</sup> ☐ Some college or 2-year degree  
<sup>5</sup> ☐ 4-year college graduate  
<sup>6</sup> ☐ More than 4-year college degree



**30. Are you of Spanish, Hispanic or Latino origin or descent?**

- <sup>1</sup> ☐ No, not Spanish/Hispanic/Latino  
<sup>2</sup> ☐ Yes, Puerto Rican  
<sup>3</sup> ☐ Yes, Mexican, Mexican American, Chicano  
<sup>4</sup> ☐ Yes, Cuban  
<sup>5</sup> ☐ Yes, other Spanish/Hispanic/Latino

**31. What is your race? Please choose one or more.**

- <sup>1</sup> ☐ White  
<sup>2</sup> ☐ Black or African American  
<sup>3</sup> ☐ Asian  
<sup>4</sup> ☐ Native Hawaiian or other Pacific Islander  
<sup>5</sup> ☐ American Indian or Alaska Native

**32. What language do you mainly speak at home?**

- <sup>1</sup> ☐ English  
<sup>2</sup> ☐ Spanish  
<sup>3</sup> ☐ Chinese  
<sup>4</sup> ☐ Russian  
<sup>5</sup> ☐ Vietnamese  
<sup>6</sup> ☐ Portuguese  
<sup>9</sup> ☐ Some other language (please print): \_\_\_\_\_

---

**THANK YOU**

**Please return the completed survey in the postage-paid envelope.**

**[NAME OF SURVEY VENDOR OR SELF-ADMINISTERING HOSPITAL]**

**[RETURN ADDRESS OF SURVEY VENDOR OR SELF-ADMINISTERING HOSPITAL]**

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# HCAHPS Survey

## SURVEY INSTRUCTIONS

- ◆ You should only fill out this survey if you were the patient during the hospital stay named in the cover letter. Do not fill out this survey if you were not the patient.
- ◆ Answer all the questions by completely filling in the circle to the left of your answer.
- ◆ You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

☐ Yes

☐ No → If No, Go to Question 1

***You may notice a number on the survey. This number is used to let us know if you returned your survey so we don't have to send you reminders.***

***Please note: Questions 1-25 in this survey are part of a national initiative to measure the quality of care in hospitals. OMB #0938-0981***

Please answer the questions in this survey about your stay at the hospital named on the cover letter. Do not include any other hospital stays in your answers.

### YOUR CARE FROM NURSES

1. During this hospital stay, how often did nurses treat you with courtesy and respect?

☐ Never

☐ Sometimes

☐ Usually

☐ Always

2. During this hospital stay, how often did nurses listen carefully to you?

☐ Never

☐ Sometimes

☐ Usually

☐ Always

3. During this hospital stay, how often did nurses explain things in a way you could understand?

☐ Never

☐ Sometimes

☐ Usually

☐ Always

4. During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?

☐ Never

☐ Sometimes

☐ Usually

☐ Always

☐ I never pressed the call button

## **YOUR CARE FROM DOCTORS**

---

5. During this hospital stay, how often did doctors treat you with courtesy and respect?

<sup>1</sup>0 Never  
<sup>2</sup>0 Sometimes  
<sup>3</sup>0 Usually  
<sup>4</sup>0 Always

6. During this hospital stay, how often did doctors listen carefully to you?

<sup>1</sup>0 Never  
<sup>2</sup>0 Sometimes  
<sup>3</sup>0 Usually  
<sup>4</sup>0 Always

7. During this hospital stay, how often did doctors explain things in a way you could understand?

<sup>1</sup>0 Never  
<sup>2</sup>0 Sometimes  
<sup>3</sup>0 Usually  
<sup>4</sup>0 Always

## **THE HOSPITAL ENVIRONMENT**

---

8. During this hospital stay, how often were your room and bathroom kept clean?

<sup>1</sup>0 Never  
<sup>2</sup>0 Sometimes  
<sup>3</sup>0 Usually  
<sup>4</sup>0 Always

9. During this hospital stay, how often was the area around your room quiet at night?

<sup>1</sup>0 Never  
<sup>2</sup>0 Sometimes  
<sup>3</sup>0 Usually  
<sup>4</sup>0 Always

## **YOUR EXPERIENCES IN THIS HOSPITAL**

---

10. During this hospital stay, did you need help from nurses or other hospital staff in getting to the bathroom or in using a bedpan?

<sup>1</sup>0 Yes  
<sup>2</sup>0 No → If No, Go to Question 12

11. How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?

<sup>1</sup>0 Never  
<sup>2</sup>0 Sometimes  
<sup>3</sup>0 Usually  
<sup>4</sup>0 Always

12. During this hospital stay, did you need medicine for pain?

<sup>1</sup>0 Yes  
<sup>2</sup>0 No → If No, Go to Question 15

13. During this hospital stay, how often was your pain well controlled?

<sup>1</sup>0 Never  
<sup>2</sup>0 Sometimes  
<sup>3</sup>0 Usually  
<sup>4</sup>0 Always

14. During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?

- <sup>1</sup>0 Never
- <sup>2</sup>0 Sometimes
- <sup>3</sup>0 Usually
- <sup>4</sup>0 Always

15. During this hospital stay, were you given any medicine that you had not taken before?

- <sup>1</sup>0 Yes
- <sup>2</sup>0 No → If No, Go to Question 18

16. Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?

- <sup>1</sup>0 Never
- <sup>2</sup>0 Sometimes
- <sup>3</sup>0 Usually
- <sup>4</sup>0 Always

17. Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?

- <sup>1</sup>0 Never
- <sup>2</sup>0 Sometimes
- <sup>3</sup>0 Usually
- <sup>4</sup>0 Always

#### **WHEN YOU LEFT THE HOSPITAL**

---

18. After you left the hospital, did you go directly to your own home, to someone else's home, or to another health facility?

- <sup>1</sup>0 Own home
- <sup>2</sup>0 Someone else's home
- <sup>3</sup>0 Another health facility → If Another, Go to Question 21

19. During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?

- <sup>1</sup>0 Yes
- <sup>2</sup>0 No

20. During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?

- <sup>1</sup>0 Yes
- <sup>2</sup>0 No

#### **OVERALL RATING OF HOSPITAL**

---

Please answer the following questions about your stay at the hospital named on the cover letter. Do not include any other hospital stays in your answers.

21. Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?

- <sup>0</sup>0 0 Worst hospital possible
- <sup>1</sup>0 1
- <sup>2</sup>0 2
- <sup>3</sup>0 3
- <sup>4</sup>0 4
- <sup>5</sup>0 5
- <sup>6</sup>0 6
- <sup>7</sup>0 7
- <sup>8</sup>0 8
- <sup>9</sup>0 9
- <sup>10</sup>0 10 Best hospital possible

**22. Would you recommend this hospital to your friends and family?**

- <sup>1</sup>0 Definitely no
- <sup>2</sup>0 Probably no
- <sup>3</sup>0 Probably yes
- <sup>4</sup>0 Definitely yes

### **UNDERSTANDING YOUR CARE WHEN YOU LEFT THE HOSPITAL**

---

**23. During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.**

- <sup>1</sup>0 Strongly disagree
- <sup>2</sup>0 Disagree
- <sup>3</sup>0 Agree
- <sup>4</sup>0 Strongly agree

**24. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.**

- <sup>1</sup>0 Strongly disagree
- <sup>2</sup>0 Disagree
- <sup>3</sup>0 Agree
- <sup>4</sup>0 Strongly agree

**25. When I left the hospital, I clearly understood the purpose for taking each of my medications.**

- <sup>1</sup>0 Strongly disagree
- <sup>2</sup>0 Disagree
- <sup>3</sup>0 Agree
- <sup>4</sup>0 Strongly agree
- <sup>5</sup>0 I was not given any medication when I left the hospital

### **ABOUT YOU**

---

**There are only a few remaining items left.**

**26. During this hospital stay, were you admitted to this hospital through the Emergency Room?**

- <sup>1</sup>0 Yes
- <sup>2</sup>0 No

**27. In general, how would you rate your overall health?**

- <sup>1</sup>0 Excellent
- <sup>2</sup>0 Very good
- <sup>3</sup>0 Good
- <sup>4</sup>0 Fair
- <sup>5</sup>0 Poor

**28. In general, how would you rate your overall mental or emotional health?**

- <sup>1</sup>0 Excellent
- <sup>2</sup>0 Very good
- <sup>3</sup>0 Good
- <sup>4</sup>0 Fair
- <sup>5</sup>0 Poor

**29. What is the highest grade or level of school that you have completed?**

- <sup>1</sup>0 8th grade or less
- <sup>2</sup>0 Some high school, but did not graduate
- <sup>3</sup>0 High school graduate or GED
- <sup>4</sup>0 Some college or 2-year degree
- <sup>5</sup>0 4-year college graduate
- <sup>6</sup>0 More than 4-year college degree

**30. Are you of Spanish, Hispanic or Latino origin or descent?**

- <sup>1</sup>0 No, not Spanish/Hispanic/Latino
- <sup>2</sup>0 Yes, Puerto Rican
- <sup>3</sup>0 Yes, Mexican, Mexican American, Chicano
- <sup>4</sup>0 Yes, Cuban
- <sup>5</sup>0 Yes, other Spanish/Hispanic/Latino

**31. What is your race? Please choose one or more.**

- <sup>1</sup>0 White
- <sup>2</sup>0 Black or African American
- <sup>3</sup>0 Asian
- <sup>4</sup>0 Native Hawaiian or other Pacific Islander
- <sup>5</sup>0 American Indian or Alaska Native

**32. What language do you mainly speak at home?**

- <sup>1</sup>0 English
- <sup>2</sup>0 Spanish
- <sup>3</sup>0 Chinese
- <sup>4</sup>0 Russian
- <sup>5</sup>0 Vietnamese
- <sup>6</sup>0 Portuguese
- <sup>9</sup>0 Some other language (please print):  
\_\_\_\_\_

**THANK YOU**

**Please return the completed survey in the postage-paid envelope.**

**[NAME OF SURVEY VENDOR OR SELF-ADMINISTERING HOSPITAL]**

**[RETURN ADDRESS OF SURVEY VENDOR OR SELF-ADMINISTERING HOSPITAL]**

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## Sample Initial Cover Letter for the HCAHPS Survey

[HOSPITAL LETTERHEAD]

[SAMPLED PATIENT NAME]  
[ADDRESS]  
[CITY, STATE ZIP]

Dear [SAMPLED PATIENT NAME]:

Our records show that you were recently a patient at [NAME OF HOSPITAL] and discharged on [DATE OF DISCHARGE]. Because you had a recent hospital stay, we are asking for your help. This survey is part of an ongoing national effort to understand how patients view their hospital experience. Hospital results will be publicly reported and made available on the Internet at [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare). These results will help consumers make important choices about their hospital care, and will help hospitals improve the care they provide.

Questions 1-25 in the enclosed survey are part of a national initiative sponsored by the United States Department of Health and Human Services to measure the quality of care in hospitals. Your participation is voluntary and will not affect your health benefits.

We hope that you will take the time to complete the survey. Your participation is greatly appreciated. After you have completed the survey, please return it in the pre-paid envelope. Your answers may be shared with the hospital for purposes of quality improvement. [OPTIONAL: You may notice a number on the survey. This number is used to let us know if you returned your survey so we don't have to send you reminders.]

If you have any questions about the enclosed survey, please call the toll-free number 1-800-xxx-xxxx. Thank you for helping to improve health care for all consumers.

Sincerely,

[HOSPITAL ADMINISTRATOR]  
[HOSPITAL NAME]

*Note: The OMB Paperwork Reduction Act language must be included in the mailing. This language can be either on the front or back of the cover letter or questionnaire, but cannot be a separate mailing. The exact OMB Paperwork Reduction Act language is included in this appendix. Please refer to the Mail Only, and Mixed Mode sections, for specific letter guidelines.*

## ***Sample Follow-up Cover Letter for the HCAHPS Survey***

[HOSPITAL LETTERHEAD]

[SAMPLED PATIENT NAME]  
[ADDRESS]  
[CITY, STATE ZIP]

Dear [SAMPLED PATIENT NAME]:

Our records show that you were recently a patient at [NAME OF HOSPITAL] and discharged on [DATE OF DISCHARGE]. Approximately three weeks ago we sent you a survey regarding your hospitalization. If you have already returned the survey to us, please accept our thanks and disregard this letter. However, if you have not yet completed the survey, please take a few minutes and complete it now.

Because you had a recent hospital stay, we are asking for your help. This survey is part of an ongoing national effort to understand how patients view their hospital experience. Hospital results will be publicly reported and made available on the Internet at [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare). These results will help consumers make important choices about their hospital care, and will help hospitals improve the care they provide.

Questions 1-25 in the enclosed survey are part of a national initiative sponsored by the United States Department of Health and Human Services to measure the quality of care in hospitals. Your participation is voluntary and will not affect your health benefits. Please take a few minutes and complete the enclosed survey. After you have completed the survey, please return it in the pre-paid envelope. Your answers may be shared with the hospital for purposes of quality improvement. [OPTIONAL: You may notice a number on the survey. This number is used to let us know if you returned your survey so we don't have to send you reminders.]

If you have any questions about the enclosed survey, please call the toll-free number 1-800-xxx-xxxx. Thank you again for helping to improve health care for all consumers.

Sincerely,

[HOSPITAL ADMINISTRATOR]  
[HOSPITAL NAME]

*Note: The OMB Paperwork Reduction Act language must be included in the mailing. This language can be either on the front or back of the cover letter or questionnaire, but cannot be a separate mailing. The exact OMB Paperwork Reduction Act language is included in this appendix. Please refer to the Mail Only, and Mixed Mode sections, for specific letter guidelines.*

## OMB Paperwork Reduction Act Language

*The OMB Paperwork Reduction Act language must be included in the survey mailing. This language can be either on the front or back of the cover letter or questionnaire, but cannot be a separate mailing. The following is the language that must be used:*

### English Version

“According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0981. The time required to complete this information collected is estimated to average 8 minutes for questions 1-25 on the survey, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Centers for Medicare & Medicaid Services, 7500 Security Boulevard, C1-25-05, Baltimore, MD 21244-1850.”



# Heart Failure

Guidelines defining systolic and diastolic heart dysfunction were developed in 1994 by the Agency for Healthcare Research and Quality in association with the American Heart Association and the American College of Cardiology.

On October 1, 2002, the ICD-9-CM codes were modified to provide greater specificity as to the type of heart failure (congestive, diastolic, systolic, combined diastolic and systolic), as well as identifying the failure by their more specific identifications.

Heart failure may be reported as the principal diagnosis if it is the condition occasioning (reason for)

the admission or as a secondary diagnosis if it is monitored and/or treated with maintenance drugs or becomes decompensated during the inpatient stay.

When documentation is incomplete, ambiguous or conflicting, or there are positive findings on cardiac catheterization, echocardiogram, or chest x-ray that are indicative of heart failure, the coding staff must initiate a physician query to obtain clarification of the patient's condition.

The following “[Physician Documentation Tips](#)” will facilitate reporting heart failure to the highest level of specificity in code assignment:

- Does the patient have diastolic, systolic, or combined diastolic/systolic dysfunction?
  - If heart failure is present is it

acute and/or chronic?

- Does the patient have congestive heart failure?
  - Is the congestive heart failure decompensated, stable on medication, history only without current treatment?
  - Is the congestive heart failure rheumatic in origin?
- Is the cause or precipitating factor of heart failure
  - Aortic and/or mitral valve disorder?
  - Cardiomyopathy
  - Hypertensive heart disease (benign, malignant/accelerated, or unspecified?)
  - Myocardial infarction (acute on this admission, treated within 8 weeks of hospitalization, or history only without current management)?

Physician documentation that includes data elements from each of the columns in the table below will assist the coder in identifying the most appropriate code assignment for heart failure.

Type of Failure	Acuity	Presence of Congestive Heart Failure	Examples of Cause
<ul style="list-style-type: none"> <li>• Diastolic</li> <li>• Systolic</li> <li>• Combined diastolic systolic</li> <li>• Congestive</li> <li>• Left ventricular</li> <li>• Right ventricular</li> </ul>	<ul style="list-style-type: none"> <li>• Acute</li> <li>• Chronic</li> <li>• Acute on Chronic</li> <li>• Unspecified</li> </ul>	<ul style="list-style-type: none"> <li>• Decompensated /Acute</li> <li>• Chronic on medication</li> <li>• Rheumatic</li> <li>• History only not on medication</li> </ul>	<ul style="list-style-type: none"> <li>• Cardiomyopathy</li> <li>• Hypertensive Heart Disease</li> <li>• Myocardial infarct</li> <li>• Valve disorder</li> </ul>

The coder relies on physician documentation in identifying the most appropriate code, to reflect the severity of the patient's illness and avoid the query process.

# S.I.R.S/Sepsis

S.I.R.S. (Systemic Inflammatory Response Syndrome) is a systemic inflammatory response manifested by two or more of the following:

- Temperature >38 or <36 degrees C
- Heart Rate >90 beats /Min
- Respiratory Rate >20 breathes/Min or PaCO<sub>2</sub><32 mm Hg
- WBC >12,000/ul or <4,000/ul, or 10% immature (band) forms

Sepsis is a systemic inflammatory response to an infection. The diagnosis requires at least 2 SIRS criteria plus a proven or suspected infection, Bacteremia is not a requirement for the diagnosis of sepsis. S.I.R.S. + Infection = Sepsis

(Chest 101: 1644-55, 1992; Cohen & Powderly : Infectious Diseases, 2nd ed., 2004. Chapter Clinics in Geriatric Medicine, 23:3. 2007; AJM, 120, 1012-1022, 2007

# Definitions for Sepsis-related Clinical Conditions

SIRS Systemic inflammatory response to an insult or injury, independent of cause, with more than one of the following manifestations:

- Temperature > 100.4 F or < 96.8 F
- Heart Rate >90 beats /Min
- Tachypnea, as manifested by a respiratory rate > 20 breathes/min or hyperventilation, as indicated by PaCO<sub>2</sub><32 mm Hg
- Alteration of white blood cell count > 12,000 cells/mm, < 4,000 cells/mm, or the presence of > 10% immature neutrophils

**Sepsis** - SIRS resulting from infection (bacterial, viral, fungal, or parasitic)

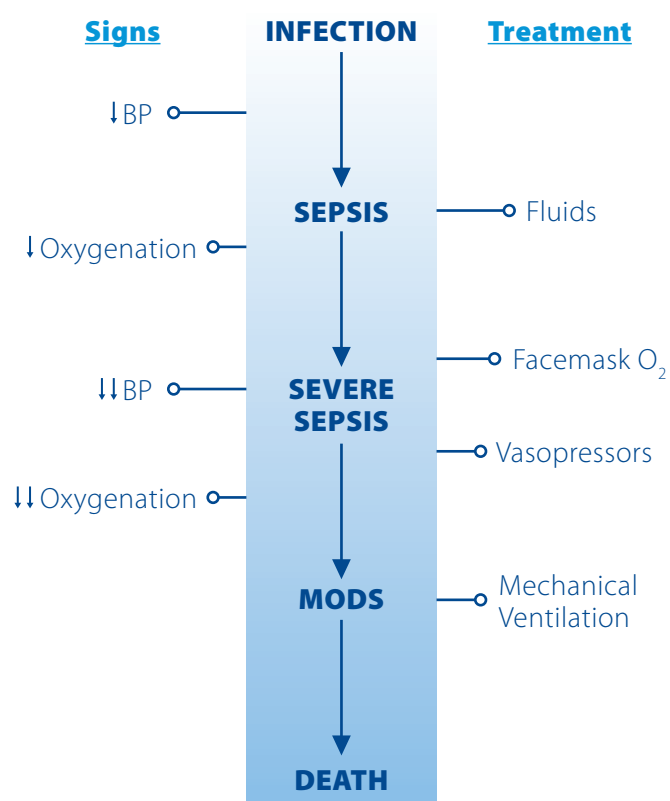
**Severe Sepsis** - Sepsis associated with signs of at least one acute organ dysfunction, hypoperfusion, or hypertension

**Septic Shock** - Sepsis-induced hypotension persisting despite adequate fluid resuscitation

**MODS** - Multiple Organ Dysfunction Syndrome. Presence of altered function of two or more organs in an acutely ill patient such that homeostasis cannot be maintained without intervention.

This document lists some (but not all) common clinical criteria that may be used to screen patients for severe sepsis. It is intended for healthcare professional educational purposes only. By providing this document. Lilly is not making recommendations on diagnosis or treatment of any particular patient. The judgment of the physician/clinician, based on knowledge of the specific patient, should always be the deciding factor.

Reference: Bone RC, Balk RA, Cerra FB, et al. Crit Care Med. 1992;20:864-874.



# Brandon Regional Hospital

## Emergency Room Coverage

### Purpose

To provide a mechanism to assure the Emergency Department is prospectively aware of which specialist and/or sub-specialist is covering for each service provided by Brandon Regional Hospital and shall be available to provide screening and treatment necessary to stabilize individuals with emergency medical conditions.

### Policy

- The following specialties will have an Emergency Room On-Call Schedule: Cardiology, Family Practice, General Surgery, Ophthalmology, Internal Medicine, E.N.T., Pediatrics, OB/GYN, Plastic Surgery, Orthopedics, Neurology, Neurosurgery, Gastroenterology, Vascular Surgery, Pain Management, Pulmonary and Urology.

- Active staff members shall serve on the Emergency Room On-Call Service and may act as consultants if granted appropriate privileges

Provisional-Active staff members shall provide on the Emergency Room On-Call Service for their respective specialty. Exact exchanges of days will be allowed.

- A solo practitioner, joining the medical staff, will be required to take emergency room call. Arrangements may be made with other groups to assist with coverage, however, must be noted in writing by both parties.

- The On-Call Schedule will be published prior to the beginning of the applicable month.

- The method for rotation of the physicians on the schedule shall be established and approved by each medical staff department. The Medical Staff coordinator shall produce the monthly schedule for each department according to the established rotation. The Department Chairman or his/her designee may complete the department on call schedule so long as it is forwarded to the Medical Staff Coordinator for timely publication.

- Once the schedule is published, it is the responsibility of the physician to obtain an alternate when he/she is unable to take the call. These changes will be forwarded the Medical Staff Office Provisional/Active staff members may only arrange for exact exchanges of days, and cannot "give away" call.

- Should an on call physician refuse or fail to respond to the ED in a reasonable amount of time as determined by the ED physician, the Department Chairman, Vice-Chairman or Chief of Staff in that order will be contacted to arrange coverage.

- The Department Chairman will investigate the non-response and report to the Executive Committee for further action

as outlined in the Medical Staff Bylaws. Should a patient transfer be necessary as a result of the physician's unavailability, the physician's name will be provided on the transfer form as required by federal statute.

- The on-call schedules will be retained in the Medical Staff office for a period of 5 years.
- Resignations from the Medical Staff will not be accepted in good standing until any published on call responsibility has been met or coverage by another staff member has been arranged by the resigning physician. Such acceptance of coverage responsibility must be communicated to the Medical Staff Office following the usual procedure to initiate published call schedule changes. Should a physician leave staff without proper notification of the Medical Staff Office, and as a result his/her call rotation is left uncovered, the group with which this physician had a professional association will be expected to cover the on call rotation.





## Procedure

### Preparation of the Monthly Schedule

#### The Medical Staff Coordinator will:

- Prepare the rotating call approximately one to three months in advance.
- Review the schedule with the department chairpersons as necessary before publication.
- Hand carry a copy of the new schedule to the Emergency Department and assure that it is placed in the ED On Call Roster binder.
- Post call schedule on the bulletin board located in the Physician Lounge.
- Mail call to affected staff members. Forward copy to Emergency Room and Emergency Room Call Roster Binder.
- Upon receipt of any changes in the call, copy the change and forward them to Emergency Room. Retain a copy for binder.

### Changing the Schedule After Publication

#### The on call physician will:

- Complete and sign the Emergency On-Call Responsibility Transfer. Have the physician accepting the call to sign the form.
- Forward/deliver the completed form to the Medical Staff Office in time to assure the medical staff Coordinator's receipt of the form within usual business hours (7:30 pm - 4:00 pm)

- Monday through Friday). Should the change be last minute and delivery to Medical Staff Coordinator cannot be assured prior to the change going into effect. The physician on-call will contact the Nursing Supervisor at 571-5109 or 571-2468 and inform the supervisor of the request to change. The physician will provide the supervisor of all information required on the Emergency On-Call Transfer Form". The Nursing Supervisor will notify the ED of the change. Both the transferring and the accepting physician will be required to stop by the Medical Staff Office within 7 working days to sign the transfer form. Failure to do so may result in disciplinary action. All changes made by the Nursing Supervisor, must be relayed the next business day (Monday-Friday) to the Medical Staff Coordinator. Verbal changes in the schedule will only be accepted in unavoidable emergency situations.

### The Medical Staff Coordinator:

- Revise the On-Call Schedule showing changes in italic bold print and will note the revision# of the schedule.
- Will take a copy of the revised schedule to the ED for placement in the ED On-Call binder Joint Commission Sentinel Event Alert: Evaluate Disruptive Behavior

The Joint Commission issued a Sentinel Event Alert asking hospitals to be proactive in their management of abusive, intimidating and disruptive behavior. Joint Commission reminded us that if we don't address these behaviors through effective systems, then in effect we are indirectly promoting it. There is plenty of literature that points out that disruptive behavior in the hospital setting can lead to:

- Medical Errors
- Decreased patient satisfaction
- Increased cost of care
- Preventable adverse outcomes
- Decreased team work
- High staff turnover
- Increased malpractice risk

If you witness or at the target of disruptive behavior please report it via an occurrence report, call extension 1234, or give a call to the Chief Medical Officer at 571-5135. Your report will be kept confidential and you will be protected from retaliation.

# Impaired and/or Disruptive Practitioner

## Purpose

This policy is intended to provide guidelines for the identification, review, intervention, action and rehabilitation of physically or psychologically distressed or impaired, including substance abuse and/or alcohol abuse, and/or disruptive practitioners.

The Medical Staff and Hospital leaders have a process to provide education about health issues related to Practitioners and others with clinical privileges. The process addresses physical, psychiatric, or emotional illness and facilitates confidential diagnosis, treatment, and rehabilitation of individuals who suffer from a potentially impairing condition. It is the policy of this hospital to properly investigate and act upon concerns that an individual who is a member of the Medical Staff or who has clinical privileges is suffering from impairment. The Hospital will conduct its investigation and act in accordance with pertinent state and federal law, including, but not limited to, the Americans with Disabilities Act (ADA). An "Impaired Individual" is one who is unable to perform clinical privileges that have been granted with reasonable skill and safety to patients or to perform other Medical Staff duties because of physical, mental, emotional or personality disorders, including deterioration through the aging process or loss of motor skill, or excessive use or abuse of drugs, including alcohol.

## Policy

The Hospital is committed to provide a work environment where all employees can work together comfortably and productively. It is the policy of the Hospital for all individuals working in the Hospital to treat others with respect, courtesy, and dignity and to conduct themselves in a professional and cooperative manner. In dealing with incidents of impaired and/or disruptive conduct, the protection of patients, employees, physicians, and others in the Hospital and the orderly operation of the Hospital are paramount concerns. This policy is intended to provide guidelines for the identification review, intervention action and rehabilitation of practitioners who are considered to be impaired or disruptive.

- Practitioner includes physicians (MO and DO), dentists, podiatrists and Allied Health Professionals, as identified in the Medical Staff Bylaws/Rules and Regulations
- Impaired Practitioner: One who is unable to practice medicine with reasonable skill and safety to patients because of a physical or mental illness, including deterioration through the aging process or loss of motor skill, or excessive use or abuse of drugs, including alcohol.
- Disruptive Behavior: Disruptive conduct or behavior is defined as that which adversely affects or impacts Hospital operations or the ability of others to perform their jobs completely, or interferes or tends to interfere with the provision of safe, quality patient care at the Hospital.

## Physical or Psychological Impairments:

Physical and/or psychological impairment includes, but is not limited to:

- Medical and psychological problems
- Substance abuse and/or alcohol use or abuse
- Conditions which may be rehabilitated if appropriate treatment is received and physical conditions which may, as determined by the Hospital and its Medical Staff, present a risk to patients, employees, co-workers and others who come into contact with the affected practitioners

## Disruptive Conduct or Behavior

Disruptive conduct or behavior is defined as that which adversely affects or impacts Hospital operations or the ability of others to perform their jobs competently, or interferes or tends to interfere with the provision of safe, quality patient care at the Hospital. For the purpose of this policy, examples of "disruptive conduct" include but are not limited to:

- Rude or abusive behavior or comments to Hospital personnel. Allied Health Professionals, patients, or Practitioners.
- Negative comments to patients about other Practitioners, nurses or other Hospital personnel or Medical Staff members or about their care and treatment in the Hospital.
- Verbal attacks, which are of a personal, irrelevant or go beyond fair, professional conduct, and that are directed to Hospital personnel. Medical Staff, Allied Health Professionals, contracted staff, or patients.
- Irrelevant or inappropriate comments, drawings, or illustrations made in a patient's medical records or other Hospital business records, impugning the quality of care in the Hospital or attacking particular Practitioners, Allied Health Professionals, nurses, other Hospital personnel, or Hospital policies.
- Criticism that is addressed to a recipient in such a manner that it intimidates, undermines confidence, belittles or implies stupidity or incompetence or some other type of public humiliation.
- Disruption of Hospital operations, Hospital or Medical Staff committee(s) or department affairs.
- Lying, cheating, knowingly making false accusations, altering, or falsifying any patient's medical or Hospital documents.
- Verbal or physical maltreatment of another individual, including physical or sexual assault.
- Harassment, including words, gestures and actions, verbal or physical, that interferes with a person's ability to competently perform his or her job.
- Conduct or behavior that causes a hostile or offensive work environment. Such behaviors may include, but are not limited to: offensive comments, jokes, innuendos, sexually-oriented statements, printed materials, material distributed through electronic media or items posted on walls or bulletin

boards. Hostile Work Environment may also be created by conduct or behavior that is directed at a specific person or persons that causes substantial emotional distress.

- Sexual harassment including conduct or behavior that includes unwelcome sexual advances, requests for sexual favors, and all other verbal or physical conduct of a sexual or otherwise offensive nature, particularly if ;
- Submission to or rejection of such conduct is used as the basis, by suggestion that it may affect an individual's employment.
- Such conduct has the purpose or effect of creating an intimidating, hostile, or offensive work environment. Behaviors that engender a hostile or offensive work environment may include, without limitation, offensive comments, jokes, innuendos and other sexually oriented statements, printed material, material distributed through electronic media, or items posted on walls or bulletin boards.
- Sex harassment can also include making or threatening reprisal following a negative response to the verbal or physical sexual conduct or behavior, and any other such behavior or conduct as defined by state and federal law and regulations
- Conduct of a criminal nature, including but not limited to assault and battery, rape, or theft shall be handled through local law enforcement officials in accordance with Hospitality policy, local and state laws.

## Hospital Policies:

Nothing in this policy is intended to replace, supersede or conflict with other Hospital policies. This policy is intended to outline processes for review and action concerning complaints/reports of possible physical or psychological impairments and/or disruptive conduct by Medical Staff appointee.

# Definitions

## Self Reporting

During the application process, all applicants must report information about their ability to perform the clinical privileges that they are requesting. Each Medical Staff member or other individual with clinical privileges is responsible for reporting any change in his/her abilities that might possibly affect the quality of patient care rendered by him/her as related to the performance of his/her clinical privileges and/or Medical Staff duties. Such reports should be made immediately upon the individual becoming aware of the change. Each practitioner is also responsible for self referral. If a practitioner is aware that he/she has a medical, psychological, substance and/or alcohol problem, it is that practitioner's responsibility to seek help.

## Report and Identification of Physical and/or Psychological Impairments and/or Disruptive Conduct:

Concerns or suspicions regarding a possible physical and/or psychological impairment, disruptive conduct and/or suspected unsafe treatment of a patient by any practitioner holding appointment and/or clinical privileges at the Hospital should be reported immediately in writing on an Occurrence Report to the Hospital's Risk Manager, who shall investigate the matter. If the situation is urgent, telephone contact must be made immediately to the Administrator-on-call. If a Hospital employee reports a concern or makes a complaint or allegation to his supervisor, but refuses or otherwise fails to make a report, under this policy it is expected that the supervisor make the report in writing to the Hospital's Risk Manager. All individuals other than patients making a report under this policy shall use the occurrence Reporting system. Patient complaints may also be processed under this policy. Patient complaints must be in writing. The employee or manager receiving the written report will enter an Occurrence Report and forward the complaint to the Risk Manager.

## Complaint Review:

The Chief of Staff, Department Chief, Chairperson of the Credentials Committee or CEO or his designee, with assistance from the Hospital's Risk Manager, shall make sufficient inquiry to satisfy themselves

that the complaint, allegation, or concern is credible, after which it shall be submitted in writing to the Executive Committee. If any of the inquiring individuals believe it to be in the best interest of the Hospital and the appointee concerned, they may, but are not required to, discuss the matter with the affected appointee. When a concern or question involving behavior/conduct has been referred to the Executive Committee, that committee shall determine either to discuss the matter with the appointee or to begin an investigation. An investigation shall begin only after a formal resolution of the Executive Committee to that effect. The Executive Committee may also, by formal resolution, initiate an investigation on its own motion. If the Board wishes to begin such an investigation, it shall also formally resolve to do so, but may delegate the actual investigations, and shall keep the CEO fully informed of all action taken in connection therewith.

## Chief of Staff and/or Department Chief Review:

The complaint will be reviewed and documented by the Chief of Staff and/or Department Chief, who may choose to discuss with the practitioner one-on-one. The Chief of Staff and/or Department Chief will report a satisfactory resolution reached with the practitioner, the complaint will be referred to the Executive Committee.

## Executive Committee Procedure:

Upon resolving to initiate an investigation, the Executive Committee shall meet as soon as possible:

- If the concern states sufficient information to warrant a recommendation, the Executive Committee, at its discretion, may make such a recommendation, with or without a personal interview with the individual being investigated.
- If the concern does not state sufficient information to warrant a recommendation, the Executive Committee shall immediately investigate the matter, appoint a subcommittee to do so, or appoint an ad hoc investigating committee consisting of up to three (3) persons who may or may not hold appointments to the Medical Staff. This ad hoc investigating committee shall not include partners,



associates or relatives of the individual being investigated.

- The executive Committee, its subcommittee or the ad hoc investigating committee shall have available to the full resources of the Medical Staff and the Hospital, as well as the authority to use outside consultants, if needed. The Executive Committee may also require a physical and/or mental examination of the individual being investigated by a physician or physicians satisfactory to the committee, and shall require that the results of such examination be made available for the committee's consideration.
- The individual being investigated shall have an opportunity to meet with the investigating committee before it makes its report. At this meeting (but not as a matter of right, in advance of it) the individual shall be informed of the general nature of the evidence supporting the question being investigated and shall be invited to discuss, explain or refute it. This interview shall not constitute a hearing, and none of the procedural rules provided in this policy with respect to hearings shall apply. A summary of each interview shall be made by the investigating committee and included with its report to the Executive Committee.
- If a subcommittee or ad hoc investigating committee is used. The Executive Committee may accept, modify or reject the recommendation it receives from that committee.

The MEC may, by resolution and upon approval of the board, establish an ad-hoc committee to perform one(1) or more Staff functions. In the same manner, the MEC may, by resolution and upon approval of the Board, dissolve or rearrange committee structure, duties or composition as needed to better accomplish Medical Staff functions. Any function required to be performed which is not assigned to a standing or special committee shall be performed by the MEC.

#### **Appoint of a Committee:**

If the Executive Committee determines further review is necessary and in the case of a report of practitioner impairment or disruptive behavior, may request appointment of a subcommittee or an Ad Hoc Committee, which shall be instructed to initiate a review of the matter.

**Any referral of a matter to the MEC, subcommittee or an Ad Hoc Committee under this policy shall include, if known the following information:**

- The date and time of the questionable actions or conduct;
- The nature of the actions or conduct and the names of any witnesses to the actions or conduct;
- Whether the actions or conduct affected or involved a patient in any way and, if so, the name and hospital number of the patient;
- The basis for questioning the actions or conduct;
- Whether any action was taken at the time the questioned action or conduct became known; and

- A copy of the completed occurrence Report or patient complain, as applicable.

#### **Corrective Action:**

Any person authorized to take immediate corrective action may also impose immediate corrective action, as outlined below, pending completion of the review or investigation and action, as applicable.

#### **Medical Staff Bylaws –**

Appointment, Reappointment and clinical privileges

[Section VII Disciplinary Action](#)

[Section VII Part C Summary Suspension](#)

- The Chief of Staff, the chief of a clinical department, the Chairperson of the Credentials Committee, the Chief Executive Officer, or the Chairperson of the Board shall each have the authority to suspend all or any portion of the clinical privileges of a Medical Staff appointee or other individual whenever failure to take such action may result in an imminent danger to the health and/or safety of any individual or to the orderly operations of the Hospital. Such a summary suspension shall be deemed an interim precautionary step in the professional review activity.
- Such summary suspension shall become effective immediately upon imposition, shall immediately be reported in writing to the Chief Executive Officer, the Chief of Staff and the Chairperson the Credentials committee, and shall remain in effect unless or until modified by the Chief Executive Officer or the Board

**Report:**

The MEC shall make whatever report it deems appropriate to the CEO and Board for review and action. The report may suggest:

- That no action is justified
- Issue a written warning
- Issue a letter of reprimand
- Impose terms of probation
- Impose a requirement for consultation (PRN intervention)
- Recommend reduction of clinical privileges
- Recommend suspension of clinical privileges for a term
- Recommend revocation of staff appointment or
- Make such other recommendations as it deems necessary or appropriate

If the action of the Executive Committee does not entitle the individual to a hearing, the action shall take effect immediately without action of the Board and without the right of appeal to the Board. A report of the action taken and reasons therefore shall be made to the Board through the CEO, and the action shall stand unless modified by the Board.

Any recommendation by the Executive Committee that would entitle the affected individual to a hearing shall be forwarded to the CEO, who shall promptly notify the affected individual by certified mail, return receipt requested. The CEO shall then hold the recommendation until after the individual has exercised or has waived the right to a hearing, after which the CEO shall forward the recommendation of the Executive Committee, together with all supporting information to the Board (or its committee) to answer any questions that may be raised with respect to the recommendation.

In the event a board determines to consider modification of the action of the Executive Committee and such modification would entitle the individual to a hearing, the CEO shall notify the affected individual and no final action shall be taken until the individual has exercised or waived the right to a hearing.

**If Intervention is Recommended**

If the MEC, CEO and/or Board determines that intervention, in the form of examination, evaluation, diagnosis, treatment and/or monitoring is necessary, it will be recommended that the practitioner obtain treatment, monitoring and support. The affected practitioner may be referred to appropriate professional internal or external resources. All costs for treatment, monitoring and support shall be the responsibility of the affected practitioner.

Monitoring will be required of the affected Practitioner until the rehabilitation or any disciplinary process is complete, with monitoring periodically thereafter, if required. The hospital's primary concerns are not only that the physician receives help, but that we assure patient safety.





### **Practitioners Refusal or Failure to Comply or Cooperate**

If the practitioner fails or refuses to agree to comply or cooperate with the proposed action, the CEO shall refer the matter to the MEC with a request for initiation of an investigation for potential corrective action. The affected practitioner shall not be entitled to procedural rights outlined in the Medical Staff Bylaws/Rules & Regulations. Refusal or failure by the affected practitioner to submit required reports or test results or to complete the agreed upon program shall be deemed to be a resignation of appointment and/or clinical privileges and a waiver of the procedural rights outlined in the Medical Staff Bylaws/Rules & Regulations and other rights to which the affected practitioner may otherwise have been entitled.

### **Completion of Requirements**

Once the affected practitioner believes he has completed the requirements of the MEC, CEO and/or Board action, the affected practitioner may submit a request for termination of monitoring and the requirements the affected practitioner agreed to comply with to the MEC. The MEC shall review the matter to determine whether the requirements of the MEC, CEO and/or Board action and/or restrictions in, limitations of, or leave of absence from appointment and/or limited privileges should be terminated. If the MEC denies the affected practitioner's request in whole or in part, the affected practitioner shall be notified in writing. The affected practitioner shall be given ten(10) days to notify the MEC, through the Medical Staff Office, whether he will continue to comply with the requirements of the MEC, CEO and/or Board's action or whether he wishes the MEC to take further action. If the MEC's recommendation or action is adverse, the affected practitioner is entitled to exercise or waive the procedural rights outlined in the Medical Staff Bylaws/ Rules and Regulations.

### **Professional Review**

It is intended that the review, processes and actions outlined and authorized in this policy are taken in the course of professional review and constitute professional review action. It is also intended that the professional review bodies, reviewers, participants and witnesses in the professional review processes outlined in this policy and all professional review records and forms created, generated or reviewed pursuant to the policy, be covered by the confidentiality, immunity and other protections available under applicable state and federal law. This confidentiality will be extended to all parties.

### **Notification(s) TPO Practitioner**

All notification(s) to practitioner will be sent certified mail, return receipt requested.

### **National Practitioner Data Bank Reporting Requirements**

Professional review action, based on reasons related to professional competence or conduct, adversely affecting clinical privileges for a period longer than 30 (30) days; or voluntary surrender or restriction of clinical privileges while under, or to avoid, investigation must be reported to the National Practitioner Data Bank.

### **Adoption, Amendment & Repeal**

This policy may be adopted, amended or repealed upon approval of the MEC and the Board of Trustees of the Hospital.



# Handling the Suspected Impaired and/or Disruptive Practitioner

## Purpose

This policy is intended to provide some guidance and direction on how to proceed when confronted with a potentially impaired or disruptive practitioner.

## Policy

The impaired and/or disruptive practitioner may be identified by any member of the Medical Staff, hospital staff, patient, visitor or by the general public.

## Definitions

- **Practitioner:** Includes physicians (MD and DO) dentists, podiatrists and Allied Health Professional, as defined in the Medical Staff Bylaws/Rules and Regulations.
- **Impaired Practitioner:** One who is unable to practice medicine with reasonable skill and safety to patients because of a physical or mental illness, including deterioration through the aging process or loss of motor skill, or excessive use or abuse of drugs, including alcohol.
  - a. **Drugs/Substances that may be involved:**
    - Alcohol
    - DEA classified drugs/controlled substances chemical substances or drugs listed as controlled substances under federal state and or local laws that have not been prescribed for the practitioner for the treatment of a medical condition.
  - b. **Signs or symptoms of impairment may include the following:**
    - Stupor
    - Slurred speech
    - Strong odor of alcohol on breath
    - Inappropriate or dangerous orders or treatments
  - c. **Suspected impairment may include:**
    - Large weight gain or loss
    - Social withdrawal
    - Unexplained absences
    - Conducting rounds at unusual hours
    - Complaints of practitioner forgetfulness from nurses/patients
    - Arrest for DUI
    - Intoxication at social events
    - Personality changes
    - Repeated "illness"
    - Neglecting medical staff duties
    - Missing appointments with patients
- **Disruptive Behavior:** Disruptive conduct or behavior is defined as that which adversely affects or impacts hospital operations or the ability of others to perform their jobs competently, or interferes or tends to interfere with the provision of safe, quality patient care at the Hospital.

For the purpose of this policy, examples of "disruptive conduct" include, but are not limited to:

  - a. Rude or abusive behavior or comments to Hospital personnel, Allied Health Professionals, patients, or Practitioners.
  - b. Negative comments to patients about other Practitioners, nurses or other Hospital personnel or Medical Staff members or about their care and treatment in the Hospital.
  - c. Verbal attacks, which are directed to Hospital personnel, Medical Staff, Allied Health Professionals, contracted staff, or patients.
  - d. Irrelevant or inappropriate comments, drawings, or illustrations made in a patient's medical records or other Hospital business records, impugning the quality of care in the Hospital, or attacking particular Practitioners, Allied Health Professionals, nurses, other Hospital personnel, or Hospital policies.
  - e. Criticism that is addressed to a recipient in such a manner that it intimidates, undermines confidence, belittles or implies stupidity or incompetence or some other type of public humiliation.
  - f. Disruption of Hospital operations, Hospital or Medical Staff committee(s) or departmental affairs.
  - g. Lying, cheating, knowingly making false accusations, altering, or falsifying any patient's medical records or Hospital documents.

- h. Verbal or physical maltreatment of another individual, including physical or sexual assault.
- i. Harassment, including words, gestures and actions, verbal or physical, that interferes with a person's ability to competently perform his or her job.
- j. Conduct or behavior that causes a hostile or offensive work environment. Such behaviors may include, but are not limited to: offensive comments, jokes, innuendos, sexually-oriented statements, printed material, material distributed through electronic media or items posted on walls or bulletin boards. Hostile Work Environment may also be created by conduct or behavior that is directed at a specific person or persons that causes substantial emotional distress.

- k. Sexual harassment including conduct or behavior that includes unwelcome sexual advances, requests for sexual favors, and all other verbal or physical conduct of a sexual or otherwise offensive nature, particularly if:
  - Submission to or rejection of such conduct is used as the basis, by suggestion, that it may affect an Individual's employment.
  - Such conduct has the purpose or effect of creating an intimidating, hostile or offensive work environment. Behaviors that engender a hostile or offensive work environment may include, without limitation, offensive comments, jokes, innuendos and other sexually oriented statements, printed material, material distributed through

electronic media, or items posted on walls or bulletin boards.

- Sexual harassment can also include making or threatening reprisal following a negative response to the verbal or physical sexual conduct or behavior, and any other such behavior or conduct as defined by state and federal law and regulations.
- l. Conduct of a criminal nature, including but not limited to assault and battery, rape, or theft shall be handled through local law enforcement officials in accordance with Hospital policy, local and State laws.



## Procedure

Report and Identification of Physical and/or Psychological Impairments and/or Disruptive Conduct:

Concerns and suspicions regarding possible physical and/or psychological impairment, disruptive conduct and/or suspected unsafe treatment of a patient by any practitioner holding appointment and/or clinical privileges at the Hospital should be reported immediately in writing on an Occurrence Report to the Hospital's Risk Manager, who shall investigate the matter. If the situation is urgent, telephone contact must be made immediately to the Administrator-on-call. If a Hospital employee reports a concern or makes a complaint to his supervisor, but refuses or otherwise fails to make a report, under this policy it is expected that the supervisor make the report in writing to the Hospital's Risk Manager. All individuals making a report under this policy, other than patients, visitors or the general public, shall use the Occurrence Reporting system. Patient complaints may also be processed under this policy. Patient complaints must be in writing. The employee or manager receiving the written report will enter an Occurrence Report and forward the complaint to the Risk Manager.

## Complaint Review

The Chief of Staff, Department chief, Chairperson of the Credentials Committee or CEO or his designee, with assistance from the Hospitals Risk Manager, shall make sufficient inquiry to satisfy themselves that the complaint, allegation, or concern raised is credible, after which it shall be submitted in writing to the Executive Committee. If any of the inquiring individuals believe it to be in the best interest of the Hospital and the practitioner concerned, they may, but are not required to, discuss the matter with the affected practitioner. When a concern or question involving behavior/conduct has been referred to the Executive Committee, that committee shall determine either to discuss the matter with the practitioner or to begin an investigation. An investigation shall begin only after a formal resolution of the Executive Committee to that effect. The Executive Committee may also, by formal resolution, initiate an investigation on its own motion. If the Board wishes to begin such an investigation, it shall also formally resolve to do so, but may delegate the actual investigation.

## Chief of Staff and/or Department Chief Review

The complaint will be reviewed by the Chief of Staff and/or Department Chief, who may choose to discuss with practitioner one-on-one. The Chief of Staff and/or Department Chief will report a satisfactory resolution reached with the practitioner to the CEO or his designee. If a resolution cannot be reached with the practitioner, the complaint will be referred to the Executive Committee.

## Committee Process

As outlined in the Impaired and/or Disruptive Practitioner Policy.

If the investigation produces sufficient evidence that the practitioner is impaired or has been disruptive, the CEO shall meet personally with that practitioner or designate another appropriate individual to do so. The practitioner shall be told that the results of an investigation indicate that the practitioner suffers from an impairment or disruptive behavior that affects his/her practice. The practitioner will not be told who filed the report, and does not need to be told the specific incidents contained in the report. Confidentiality will be extended to all parties.

## Actions to Be Taken

Depending upon the severity of the problem and the nature of the impairment, the Hospital has the following options:

- Re quire the practitioner to undertake a rehabilitation program as a condition of continued appointment and clinical privileges
- Impose appropriate restrictions on the practitioner's hospital practice; or
- Immediately suspend the practitioner's privileges in the Hospital until rehabilitation has been accomplished, if the practitioner does not agree to discontinue practice voluntarily.



In all of the above instances, the Physician's Recovery Network of Florida (PRN) will be contacted by the CEO or his designee for intervention purposes. In addition, the practitioner should be strongly encouraged to voluntarily contact the PRN for assistance.

The Hospital shall seek the advice of Hospital counsel to determine whether any conduct must be reported to law enforcement authorities or other government agencies, and what further steps must be taken.

The original report and a description of actions taken shall be filed in a confidential file in the Medical Staff Services Department. If the investigation reveals that there is no merit to the report, the investigation report shall be destroyed. If the investigation reveals that there may be some merit to the report, but not enough to warrant immediate action, the report shall be maintained in the practitioner's confidential file, and



the practitioner's activities and hospital practice shall be monitored until it can be established whether there is an impairment or disruptive behavior problem.

The CEO or Chief of Staff shall inform the individual who filed the report that follow-up action was taken.

Throughout this process, all parties shall avoid speculation, conclusions, gossip, and any discussions of the matter with anyone outside those described in this policy.

In the event there is an apparent or actual conflict between this policy and the Medical Staff Bylaws/Rules and Regulations, or other policies of the Hospital or its Medical Staff including the due process sections of the Bylaws, Rules and Regulations, or policies.

## **Rehabilitation**

Hospital and Medical Staff leadership, along with the PRN Program, shall assist the practitioner in locating a suitable rehabilitation program. The Hospital shall not reinstate a practitioner until it is established, to the Hospital's satisfaction, that the practitioner has successfully completed a rehabilitation program in which the Hospital has confidence.

## **Reinstatement**

Upon sufficient proof that a practitioner who has been found to be suffering an impairment or disruptive behavior has successfully completed a rehabilitation program, the Hospital may consider reinstating that practitioner to the Medical Staff.

When considering an impaired or disruptive behavior practitioner for reinstatement, the Hospital and its Medical Staff leadership must consider patient care interests to be paramount.

The Hospital must first obtain a letter from the Medical Director of the rehabilitation program where the practitioner was treated. The practitioner must authorize the release of this information. The letter from the Director of the rehabilitation program shall state:

- Whether the practitioner is participating in the program
- Whether the practitioner is in compliance with all the terms of the program
- Whether the practitioner attends program meetings

regularly (if appropriate)

- To what extent the practitioner's behavior and conduct are monitored
- Whether, in the opinion of the rehabilitation program Director, the practitioner is rehabilitated
- Whether an after-care program has been recommended to the practitioner and, if so, a description of the after-care program
- Whether, in the Program Director's opinion, the practitioner is capable of resuming medical practice and providing continuous, competent care to patients OR:
  - The Hospital must obtain a letter from the Medical Director of the Physician's Recovery Network of Florida (PRN) that the practitioner has satisfactorily completed a rehabilitation program and has signed an after-care monitoring agreement with PRN. The letter from the PRN Medical Director shall also state:
    - Whether the practitioner is capable of resuming medical practice and providing continuous, competent care to patients
    - To provide monitoring information concerning the practitioner's compliance with his/her after-care monitoring agreement to the Hospital, if requested.

The practitioner must inform the Hospital of the name and address of his or her primary care practitioner, and must authorize the primary care practitioner to provide the Hospital with information regarding his or her condition and treatment. The Hospital has the right to require an opinion from other practitioner consultants of its choice.

The Hospital shall request the primary care practitioner to provide information regarding the precise nature of the practitioner's condition, the course of treatment, if the practitioner is considered rehabilitated and is the practitioner capable of resuming medical practice and providing continuous, competent care to patients.

## Completion of Requirements

Once the affected practitioner believes he has completed the requirements of the MEC, CEO and/or Board action, the affected practitioner may submit a request for termination of monitoring and the requirements the affected practitioner agreed to comply with to the MEC. The MEC shall review the matter to determine whether the requirements of the MEC, CEO and/or Board action and/or restrictions in, limitations of, or leave of absence from appointment and/or limited privileges should be terminated. If the MEC denies the affected practitioner's request in whole or in part, the affected practitioner shall be notified in writing. The affected practitioner shall be given ten (10) days to notify the MEC, through the Medical Staff Office, whether he will continue to comply with the requirement of the MEC, CEO and/or Board action or whether he wishes the MEC to take further action. If the MEC's recommendation is adverse, the affected practitioner is entitled to exercise or waive the procedural rights as outlined in the Medical Staff Bylaws/Rules and Regulations.

Assuming all information the Hospital received indicates that the practitioner is rehabilitated and capable of resuming patient care, the Hospital must take the following additional precautions when restoring clinical privileges:

- The practitioner must identify a practitioner who is willing to assume responsibility for the care of his or her patients in the event that he or she is unable or unavailable to care for them.
- The Hospital shall require that the practitioner to provide the Hospital with periodic reports from his or her primary care practitioner, for a period of time specified by the Executive Committee, stating that the practitioner is continuing treatment or therapy, as appropriate, and that his or her ability to treat and care for patient in the Hospital is not impaired.
- The practitioner must agree to cooperate with PRN when requested for monitoring updates from the Hospital.



## Monitoring

The Department Chairman, or his designee, shall monitor the practitioner's exercise of clinical privileges in the Hospital. The Medical Executive Committee shall determine the nature of that monitoring after reviewing all the circumstances.

The practitioner must agree to submit to an alcohol or drug screening test (if appropriate to the impairment) at the request of the Executive Committee, the CEO or his designee.

The Medical Executive Committee may institute flexible requirements pertaining to the monitoring of an individual. At minimum, monthly contacts with PRN shall be conducted for a one-year period. This time period may be extended, at the discretion of the Executive Committee and/or CEO.

Monitoring will be required of the affected Practitioner until the rehabilitation or any disciplinary process is complete, with monitoring periodically thereafter, if required. The hospital's primary concerns are not only that the physician received help, but that we assure patient safety.



### **Practitioner's Refusal or Failure to Comply or Cooperate**

If the practitioner fails or refuses to comply or cooperate with the proposed action, the CEO shall refer the matter to the MEC with a request for initiation of an investigation for potential corrective action. The affected practitioner shall not be entitled to procedural rights outlined in the Medical Staff bylaws/Rules and Regulations. Refusal or failure by the affected practitioner to submit required reports or test results or to complete the agreed upon program shall be deemed to be a resignation of appointment and/or clinical privileges and a waiver of the procedural rights outlined in the Medical Staff Bylaws/Rules & Regulations and other rights to which the affected practitioner may otherwise have been entitled.

### **Notification(s) to Practitioner**

All notification(s) to practitioner will be sent certified mail, return receipt requested.

### **Initial Appointment**

When an applicant for initial appointment has current or past history of impairment or disruptive behavior, the application will be reviewed by the Department Chief, who will make recommendations on the requested clinical privileges. Final disposition is at the discretion of the Board of Trustees, based on the Department Chief's Medical Executive Committee recommendations.

### **National Practitioner Data Bank Reporting Requirements**

Professional review action, based on reasons related to professional

competence or conduct, adversely affecting clinical privileges for a good period longer than thirty (30) days; or voluntary surrender or restriction of clinical privileges while under, or to avoid, investigation must be reported to the National Practitioner Data Bank.

### **Requests for Information**

All requests for information concerning the impaired practitioner shall be forwarded to the Department Chief, Chief of Staff or CEO for response.

### **Adoption, Amendment and Appeal**

This policy may be adopted, amended or repealed upon approval of the MEC and the Board of the Hospital.

## **Impaired and/or Disruptive Practitioner Policy**

### **Purpose**

To promote effective and efficient use of hospital resources via review for the appropriateness of inpatient and or/or outpatient care.

### **Policy**

As approved by the Utilization Management Committee, all elective and all direct admissions will be reviewed on a pre-admission basis for the medical necessity for admission and the appropriateness of ancillary services.

### **Procedure**

- Doctor's office will call Admitting to book either a direct admission, elective admission or observation status. Admitting clerk will forward a copy of the reservation form to Case Manager as soon as possible. Clerk will contact Case Manager to notify of all direct admissions by beeper. All direct admits are to be reviewed as soon as possible.
- The Case Manager will then contact the admitting physician for orders or to clarify any questions regarding plan of treatment of status.
- If the criteria is met, the admission is approved after reviewing SI/IS criteria as approved by the Utilization Review Committee

- If the criteria is not met, the Case Manager will attempt to obtain additional information from the physician to support the admission or attempt to negotiate to have the patient treated on an outpatient basis or assigned to outpatient observation status.
- If there is still a lack of IS/SI criteria, the case will be referred to the Physician Advisor and the Case Manager will document this referral in Meditech.
- The Physician Advisor will then determine if the case is medically necessary:
  - If the Physician Advisor approves the admission, the Case Manager will notify the admitting physician and the admission will proceed.
  - If the Physician Advisor does not approve the admission based upon available information, he/she will contact the attending physician.
- The Physician Advisor will discuss the case with the attending and then decide if admission can be approved.
  - If the admission is approved, it will proceed.
  - If the admission is not approved by the Physician Advisor and the attending physician still wants the admission to proceed, a second Physician Advisor will be contacted. If the attending still wants the admission to proceed a notice of noncoverage for admission will be issued to the Medicare, Medicaid or Champus patient in accordance with HCFA and PRO regulations.
- If the admission is cancelled, the Case Manager will notify the Admitting Department Supervisor by telephone.
- If the notice of noncoverage for admission is needed, the Case Manager will notify the Director of Utilization Management and attending physician and then proceed to give the notice to the patient when he arrives at the hospital. For elective admits, notice will be sent certified overnight mail, return receipt requested.
- The Case Manager will enter all admissions, including elective, direct and observation patients into the Admission Log kept in the Utilization Management office.
- All Emergency Room admissions will be screened and entered in the log book. If there is a question as to the medical necessity or bed assignment the ER physician or attending physician will be called and the case discussed.
- The Case Manager will notify the Admitting office and the UM Director if there is any problem with admission.
- Pre-Admission discharge planning for orthopedic patients
  - When the Case Manger receives the notice of impending admission, she or another Utilization Management staff member will send the patient an invitation to the pre-operative orthopedic class.
  - Discussion will take place as to the usual post surgical needs of patients with similar surgeries, i.e. care giver in home for first 4-6 days, home health for physical therapy or short term rehab in ECF
  - If there is a potential need for extended care she will request that the patient and/one family member visit area ECF's prior to admission.

# History and Physicals for Operative and Invasive Procedures

## Purpose

To communicate relevant and current patient health care information from one health care professional to all health care professionals involved in the care of the patient.

## Policy

It is the policy that all patients must have a current legibly written or transcribed history and physical to enhance the continuity of safety and quality in patient care.

## Procedure

The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient.

This record shall be current and include identification date; complaint; personal history; family history; history of present illness; physical examination; special reports such as consultations, clinical laboratory and radiology services, and other diagnostic and/or therapeutic studies, provisional diagnosis; final diagnosis; condition on discharge; summary or discharge note; clinical resume; and autopsy report when performed.

- A complete admission history and physical examination shall, in all cases be written or dictated within 24 hours after admission of a patient.
- If an H&P has been performed and documented within thirty (30) days of the patient's admission to the hospital or admission for a scheduled operative or invasive procedure, a legible copy of that H&P examination may be used in the patient's medical record, provided an update is performed by a licensed independent practitioner or designee with privileges to perform H&Ps, and it is documented prior to the procedure or at the time of or within 24 hours of admission. This update may be written or otherwise recorded on, or attached to, the previous H&P, or written in a progress or consult note.
- An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within 30 days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a Qualified Physician, a Qualified Oral maxillofacial Surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

## This updated History and Physical must:

- Address the patient's current status and/or any changes in the patient's status: if there are no changes in the patient's status, this should be specifically noted
- Include an appropriate physical examination of the patient to update any components of the exam that may have changed since the prior history and physical, or to address any areas where more current data is needed
- Confirm that the necessity for the admission, procedure, or care is still present
- Be written or otherwise recorded on, or attached to, the previous History and Physical, or written in a progress or consult note; and be placed in the patient's medical record prior to the operative procedure or at the time of, or within 24 hours of admission.
- Inpatient Surgeon: No update is required for any surgery performed in the same admission covered by a previously updated H&P Note: (Any changes in the patient's condition prior to surgery would be documented in progress notes.)
- Outpatient Surgery: If valid H&P is written more than 24 hours prior to a procedure or surgery, an update must be performed and placed on the chart before the procedure.
- The H&P can originate from previous hospital admission, from a previous hospital, from a surgeon or PCP's office, or from a previous procedure.