CREDENTIALED

STAFF

ORIENTATION

BAPTIST MEDICAL CENTER SOUTH

BAPTIST MEDICAL CENTER EAST

PRATTVILLE BAPTIST HOSPITAL

MONTGOMERY SURGICAL CENTER
An introduction for new physicians to the personnel and services within the Baptist Health system, as well as an orientation to the Medical Staff Bylaws, Rules & Regulations and the policies and procedures of the various departments they will utilize.

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About Baptist Health

At Baptist Health we're thinking about the future of central Alabama as well as all the people who live here. We're deeply committed to providing Montgomery, its residents and our neighbors in the surrounding areas with healthcare that compares with the finest available anywhere. And as we look ahead, all the signs point to a renewed emphasis on helping people to reduce their risks of illness and disease while teaching them to live healthier lives. For hospitals, it's the wave of the future. For Baptist Health it means continuing a focus on preventive care that we began many years ago--well ahead of its time.

So while other healthcare providers around the country hurry to get up-to-date by developing wellness programs and services like Baptist's, we're addressing the concerns of tomorrow. Like keeping costs down as we expand our services to meet the needs of central Alabama. And embracing new advancements that can shorten treatment and recuperation times. So while we continue to teach members of the community and their families how to stay healthy today, as we have in the past, we're using all our knowledge, skills and the most advanced technology available to improve healthcare for central Alabama.

Baptist Health also serves the community and local businesses with a wide range of wellness programs and services designed to help people live healthier and happier lives.

From open-heart surgery and rehabilitative services to community outreach and support groups encompassing almost any medical need or problem, Baptist is committed to serving the complete healthcare needs of the community. By successfully meeting those needs in so many ways, it's easy to see why Baptist Health has truly become central Alabama's healthcare leader.

Mission Statement

As a witness to the love of God through Jesus Christ, Baptist Health exists as a voluntary, not-for-profit organization to promote and improve the physical, emotional, and spiritual well-being of the people and communities it serves through the delivery of quality health care services provided within a framework of fiscal responsibility.

Vision

Help people in communities we serve maintain and improve their health and quality of life. Collaborate with other community organizations to provide needed services. Be the healthcare provider of choice for all who need care in the communities we serve. Be the employer of choice for healthcare professionals with a positive attitude. Be the healthcare system of choice for physicians and other healthcare providers. Provide high quality services at appropriate costs.
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American Home Patient

American HomePatient is one of the nation's leading providers for home healthcare products. Baptist Health and American HomePatient have a joint-venture partnership to provide a comprehensive system of care for at-home patients in the Montgomery area, 24-hours-a-day.

American HomePatient offers a complete line of home medical equipment and supplies. Furthermore, our reimbursement staff has experience with third-party billing and provides reimbursement management. They also work closely with patients, answering any questions they may have concerning eligibility, gathering medical documentation and help submit patient claims.

Toll Free 1(800) 895-6312
Phone (334) 613-0303
Fax (334) 613-0202

Baptist Health/American HomePatient
350 Taylor Rd.
Medical Plaza 2
Suite 2000
Montgomery, AL 36117
The Cardiovascular Care Center at Baptist Medical Center South, which provides patients a continuum of care not offered anywhere else in central Alabama. We offer a full array of state-of-the-art invasive and noninvasive procedures, both diagnostic and therapeutic. A list of which includes: cardiac catheterization and angiography; percutaneous coronary intervention (angioplasty, drug eluting stents, thrombectomy and atherectomy); intravascular ultrasound; intravascular pressure analysis; peripheral angiography and intervention, to include the newest laser technology (carotid, renal and extremities); echo-cardiography; nuclear medicine stress testing; cardiac CT angiography; cardiac rhythm management (permanent pacemakers, intracardiac defibrillators; bi-ventricular pacing); electro physiology testing; and radiofrequency ablation.

The center also has four state-of-the art digital Catheterization Labs, a dedicated 16 bed pre/post Cardiovascular Recovery Unit, an eight-bed CCU, a 25-bed Cardiology unit, an eight-bed CVICU, a 22-bed CVSU step down unit and Cardiac Rehabilitation. All areas have specially trained staff to care for our cardiac population.
The Cardiac Catheterization Lab in the Cardiovascular Care Center at Baptist South is staffed with registered nurses and registered cardiovascular technologists, all with advanced training in cardiac and vascular disease and procedural processes. Cardiologists and Electrophysiologists perform a vast array of invasive and non-invasive procedures.

Non-Invasive
- EKG
- Echocardiography (Transthoracic & TEE)
- Fluoroscopy
- Cardioversion
- Tilt Table Studies
- Cardiac Stress Testing
- Nuclear Cardiac Stress Testing

Invasive
- Left Heart Catheterization
- Left and Right Heart Catheterization
- Peripheral Vascular Angiography
- Percutaneous Coronary Intervention
- Peripheral Vascular Intervention
- Chronic Total Occlusion
- Electrophysiology (Diagnostic & Therapeutic)
- Device Implantation
  - Pacemaker
  - Implantable Cardiac Defibrillator
- Laser Lead Extraction
- Carotid Stenting
- Intravascular Balloon Placement
Cardiac Rehabilitation

Cardiac rehabilitation is a medically supervised program designed to optimize a cardiac patient’s physical, psychological and social functioning.

Baptist Health Cardiac Rehabilitation has been in operation since 1979. We take a team approach which includes the referring physician, dietitian, pharmacy staff, diabetic educator, the Cardiac Rehabilitation nurses, exercise physiologists and you. The involvement of these professionals is evidence of our commitment to provide the highest quality care for each patient and his or her family.

You will engage in a supervised exercise program while on a heart monitor. Licensed staff members are available at all times in the event you need emergency medical treatment.

Some of the benefits include strengthening and conditioning of your heart and lungs, controlling your weight, lowering your total cholesterol levels, understanding your medications, recognizing signs and symptoms of heart disease and when to seek medical attention and providing emotional support for you and your family.

The duration of your visits will depend on your risk factors and assessment done by the cardiac rehabilitation staff. Most patients usually qualify for 12-36 visits. The time allowed to complete these sessions is usually dictated by your insurance company.

Since 1998, the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR) has certified programs in order to recognize programs that were meeting the standards put forth in the published Guidelines for Pulmonary and Cardiac Rehabilitation.

The Cardiac Rehabilitation Program of Baptist Medical Center South has met the strict standards and been awarded certification through the American Association of Cardiovascular and Pulmonary Rehabilitation.

Entrance to the program will require a physician referral. If you feel you could benefit from our services, discuss the program with your physician and request a referral.

For more information call, (334) 286-3410. We can contact your physician for you.

Cardiac Rehabilitation
2119 East South Blvd.
Montgomery, AL 36116
The Center for Advanced Therapy is truly unique in that it is the only therapy center in the tri-county area offering services in four disciplines: speech therapy, physical therapy, occupational therapy and audiology.

Individualized, interdisciplinary care is provided by our professionally licensed and experienced staff of speech, physical and occupational therapists and Doctor of Audiology. Our interdisciplinary team meetings ensure that all patient goals are being addressed while not being duplicated. This team approach enables our patients to achieve their full potential.

The Center for Advanced Therapy offers evaluations and treatment for patients of all ages and abilities, with a particular focus on children with special needs such as those with Down Syndrome, Autism, sensory integration disorder, torticollis or other developmental delay.

All patients must have a physician referral and are seen by appointment only.

For more information, please call (334) 358-6501.
Recognized for excellence by the American Diabetes Associates since 1995, the Center for Diabetes is an excellent resource for those with diabetes in central Alabama. Certified diabetes educators who are both registered nurses and registered dietitians teach patients one-on-one and in small groups about all aspects of diabetes management including blood glucose testing (monitor usually provided), medication, diet and exercise. Certified insulin pump instructors provide insulin pump therapy. Special programs for those patients with gestational diabetes are offered. Services are available to outpatients by self or physician referral. Insurance can be filed for outpatients with a physician's referral. Center hours are Monday through Thursday, 8 a.m. to 4 p.m. and Friday 8 a.m. to 3 p.m.

Diabetes is a disease that requires daily self-management. It is a disease that you get a vote in how it will affect your health. Educating yourself in how to care for your diabetes is one of the first steps in managing the disease.

In addition, our registered dietitians are available to counsel individuals on a variety of nutritional meal plans aimed at improving cholesterol, blood pressure or any other disease that diet impacts. They can assist people with their weight management goals by providing sound nutritional counseling along with practical behavioral change recommendations.
Centering Parenting

Well-woman and well-baby care through the first year

CenteringParenting is a model of group care that integrates the three major components of care: health assessment, education and support, into unified care within a group setting. This group model of dyad care refers to two-part care between mother and child.

Six or seven mother/baby groups come together and parents learn care skills, participate in facilitated discussion and develop a support network with other group members. Parenting groups meet for eight to nine sessions through the baby’s first year. Group sessions will not only focus on your baby, but you will learn more about healthy eating, weight loss, exercise, finding time for yourself, delegating and much more.

CenteringParenting offers moms ease of mind when it comes to your new baby. You will always know when your baby is scheduled for an appointment for the entire year. Your baby will receive all of his or her well-baby check-ups (immunizations) and sick visits during the first year of life at CenteringParenting. This means no waiting to be seen and appointments last 90 minutes to two hours, so you have the opportunity to ask questions without feeling rushed. Moms will also learn to care for themselves while caring for their new baby. There is also a nurse practitioner on-call 24/7 for sick baby calls.

We will also cover:

• Well-woman care
• Postpartum care
• Family planning
• Mental health
• Breastfeeding
• Oral health
• Relationships, safe sex
• Infant attachment
• Life balance
• Achieve weight goals
Centering Parenting (con’t.)

Well-baby care:

- Infant growth and development
- Immunization
- Nutrition
- Illness
- Oral health
- Safety: car seats, childproofing
- Motor skills, milestones
- Cognition
- Behavior

Refreshments will be provided at each group session and infants will receive diapers at the end of each visit. After completion of the first year, a birthday party will be held for each group.

Come join us and learn interesting facts about parenting and of course have fun in the process.

Patients do not have to be a part of CenteringPregnancy to be a part of CenteringParenting. Sick babies will not be seen during well-baby check-ups. All immunizations will be provided at the visits and state of Alabama Blue Cards will be provided. Moms who receive Medicaid benefits will receive gas vouchers to help with transportation.

To learn more contact:
Khai Salaam, MSN, CRNP, program coordinator
Summer Bass, MSN, CRNP
Andrea Powell, clinical associate
Baptist Medical Center South
Parker Pavilion Suite 404
(334) 613-7034
centeringparenting@gmail.com
It's a boy! It's a girl! Engineers, doctors, lawyers, nurses and more are born each year at Baptist Medical Center South, where state-of-the-art technology, with half a century of medical expertise and a warm, nurturing atmosphere combine to ensure a safe, comfortable experience for mother and baby.

Centering Pregnancy Overview

As a commitment to improving healthcare, Baptist Medical Center South is proud to offer Centering Pregnancy as a unique method of providing prenatal care. Centering Pregnancy is a multifaceted model of group care that integrates the three major components of care: health assessment, education and support into a unified program within a group setting. Eight to 12 women with similar due dates meet together, learning care skills, participating in a discussion, and developing a support network with other group members. Each pregnancy group meets for a total of nine sessions throughout pregnancy and early postpartum.

Prenatal care will be provided by Program Coordinator, Khai Salaam, MSN, CRNP. Khai received her bachelor of science in nursing from Syracuse University, Syracuse, New York. She received her master’s in nursing, with a postgraduate specialization as a family nurse practitioner from Troy University. She is certified by the American Nurses Credentialing Center. She is also a member of Sigma Theta Tau Honor Society. Khai has more than 18 years of combined obstetrical and pediatric experience. Khai loves traveling and reading in her spare time.

Summer G. Bass has been with Centering Pregnancy as a certified registered family nurse practitioner since April 2012. She graduated magna cum laude with her bachelor's in nursing at Auburn University of Montgomery in 2004. In December 2011, she graduated with her master's in nursing from the University of South Alabama. She is certified through the American Academy of Nurse Practioners as a family nurse practitioner and is a member of Sigma Theta Tau Nursing Honor Socieity and Phi Kappa Phi Honor Society. Summer considers it a privilege to provide prenatal care using the model of centering healthcare. She uses her creative talents to bring an extra flare to Centering. In her spare time, she enjoys reading, Pure Barre, Pilates, and spending time with her daughter, husband and dogs.
Centering Pregnancy at Baptist South (con’t.)

It’s all about groups

You will be in a group with other women whose due dates are close to yours. In each of the nine sessions you will have a private time with your health care provider. You will also meet as a group to discuss questions about your pregnancy, childbirth, breastfeeding and other concerns. Refreshments will be provided at each visit and a baby shower with gifts for all is held for each group.

It’s all about self-care

You’ll learn to take your own blood pressure and weight and enter the information into your chart. You’ll receive information and tools to help you make healthier choices for you, your baby and your whole family. It’s all about women You’ll meet other expectant moms and have an opportunity to share stories and learn from one another. You’ll be able to talk about health issues that are important to you and all the things you’re going through physically and emotionally.

It’s all about time

At your first visit, you’ll receive a schedule of all the group times. This will make it easier to arrange childcare or meet work obligations. You won’t need to enroll in separate childbirth classes because everything will be covered in the group. Every minute of your time will be occupied, not spent sitting alone in a waiting or exam room.

Centering Program Baptist Medical Center South
Parker Pavilion, Suite 404
2065 East South Blvd.
Montgomery, AL 36116
(334) 613-7034
The Comprehensive Therapy Center at Baptist Medical Center East is the only facility offering families and the communities of central Alabama comprehensive rehabilitation services. Individualized treatment is provided by experienced and licensed occupational, physical and speech therapists.

In an outpatient setting, we use proven therapeutic methods and state-of-the-art equipment, while emphasizing patient education to prevent recurring physical or developmental problems. Our goal is to help individuals, both adult and pediatric, reach their maximum potential and return to the workforce or society as contributing members. Each of our three divisions - occupational, speech and physical therapies - offers a number of services for outpatients and inpatients at Baptist Medical Center East.

**Occupational Therapy**
Our occupational therapists use a comprehensive evaluation and treatment program to help patients achieve independence in daily living. Occupational therapy is helpful in treating neurological disorders, orthopaedic disorders and developmental disabilities through several programs and services, such as:
• Assessment for adaptive equipment needs
• Early intervention
• Feeding/swallowing evaluation and treatment
• Sensory integration therapy
• Splinting and orthosis fabrication
• Work injury
• Hand therapy by a certified hand therapist

**Speech Therapy**
Staffed by certified and licensed speech-language pathologists, our speech therapy program evaluates and treats communication and swallowing disorders from birth through geriatrics. Our services help with development and medically related disorders.
Communication disorders we treat include:
• Articulation
• Cleft palate
• Comprehensive and expressive disorders
• Deficiency in understanding language or expressing thoughts
• Dysarthria
• Hearing problems
• Language (adult and child)
• Oral motor/feeding dysfunction
• Stuttering
• Swallowing problems/disorders
Comprehensive Therapy Center (con’t.)

The Comprehensive Therapy Center offers inpatient and outpatient vital stimulation (NMES) to target swallowing disorders as well as modified barium swallow (MBS) studies. MBS is a video fluoroscopic test performed jointly by a speech language pathologist and a radiologist to diagnose swallowing disorders and aid in creating an appropriate treatment plan.

Physical Therapy/Aquatic Therapy
Our physical therapists are dedicated to helping relieve pain, restoring function, preventing disability, aiding with healing and helping patients adapt to a permanent disability when necessary. Physical therapy and aquatic therapy are beneficial for:
• Amputation
• Balance disorders
• Joint pain or limitation resulting from disease, injury or lack of use
• Neurological disorders
• Pre- and post-surgical management of orthopaedic cases
• Weakness or paralysis of skeletal muscles

Neonatal and Pediatric Therapy
Our pediatric physical, occupational, and speech therapists provide specialized treatment for neonates, infants, children and adolescents. They are dedicated to restoring function, preventing disability and helping patients achieve independence in daily living. They are beneficial for:
• Autism
• Assessment for special equipment needs
• Congenital disorders
• Developmental disorders
• Neuromuscular disorders
• Orthopaedic injuries
• Trauma-related disabilities

AmTrykes Demo Site
The Baptist Medical Center East Comprehensive Therapy Center is an Ambucs AmTrykes demo site. Therapists are able to fit disabled children and adults on these special tricycles. For more information about AmTrykes, visit www.montgomeryambucs.org.
Comprehensive Therapy Center (con’t.)

Appointments
Patients must have a physician's referral for treatment. Services are by appointment only and the Comprehensive Therapy Center staff will make every effort to service all patients.

The Comprehensive Therapy Center does not fall under the Medicare Part B therapy cap. This therapy cap limits the amount of services one can receive per year. Rehabilitation services not associated with a hospital are capped at $1740 per person, per year. This therapy cap does not apply to the Comprehensive Therapy Center.

To make an appointment, call (334) 244-8345.

Location
The Comprehensive Therapy Center is located on the first floor of the Medical Office Building, inside Baptist Medical Center East, 400 Taylor Rd., Montgomery, AL 36117.
4385 Narrow Lane Rd.
Montgomery, AL 36116
(334) 286-3116

Crossbridge Behavioral Health, an affiliate of Baptist Medical Center South, is committed to providing mental health services to individuals who are in crisis. Crossbridge has a skilled and dedicated team of psychiatrists, nurses, counselors, social workers and support staff to meet the needs of our patients, throughout central Alabama.

Our Mission
To provide comprehensive treatment for individuals seeking stabilization and improved quality of life.

Our Environment
Our modern, premier facility provides psychiatric services for Montgomery and surrounding counties. The forty-two bed facility provides a safe, comfortable environment that encourages positive change and growth.

Who We Serve
The most recent statistics indicate that one in five individuals will struggle with some form of significant mental or emotional issue and that one in 10 will require hospitalization. A number of environmental and genetic factors contribute to the onset of such conditions. Mental and emotional illness affects people indiscriminately regardless of gender, race or financial status. Like other health issues, untreated mental health problems worsen over time. Crossbridge provides encouragement, and state-of-the-art treatment in a therapeutic environment for people ages 19 and older.
WHAT IS CROSSBRIDGE BEHAVIORAL HEALTH?

Crossbridge Behavioral Health is Baptist Health's behavioral and emotional health facility. The new state-of-the-art facility opened in June 2010 and is licensed for 60 beds. Crossbridge is an affiliate of Baptist Medical Center South and is located near the hospital on Narrow Lane Road. Crossbridge utilizes a skilled and dedicated team of psychiatrists, nurses, professional therapists and paraprofessional staff to meet the needs of its patients through both inpatient and outpatient care.

The Crossbridge staff understands that just as the body often needs care from a physician, the mind does at times require a similar level of care. Every year we help countless individuals who struggle with depression or other forms of emotional disturbances get back on their feet and back into their lives.

It is our goal to provide a safe, healthy atmosphere for our patients as we work with them on the path to healing. Each individual is treated respectfully and compassionately in an intensive, crisis-oriented care program that efficiently utilizes multiple resources within an encouraging, therapeutic environment.

The Crossbridge staff has been recognized by multiple organizations and individuals for its outstanding service and dedication to providing quality mental health care. Our staff offers that same commitment to every individual it treats.

WHO NEEDS THE SERVICES WE OFFER?

The most recent statistics indicate that one of every five individuals will struggle with some form of significant depression or other mental or emotional issue and that one of every 10 will need hospitalization to overcome it. At Crossbridge, we provide adults ages 19 and up who are coping with such difficulties the level of care they need on the way to recovery. Patients 55 and older will generally be admitted to the geriatric unit.

A number of environmental and genetic factors can contribute to the onset of such conditions. Mental and emotional illness affects people indiscriminately regardless of gender, race or financial status. Like other health issues, if left unattended these disorders can worsen over time.

JUST A FEW ILLNESSES CROSSBRIDGE TREATS

- Depression
- Post-traumatic stress disorder
- Schizophrenia
- Bipolar disorder
- Mood disorders
- Anxiety disorders
- Psychosis
- Cognitive impairment, including dementia, with related behavioral and psychological symptoms or disturbances

ADULT PROGRAMS

Crossbridge has two distinct programs which focus on the needs of people with mood disorders (major depression, bipolar disorder) or psychosis (schizophrenia or others). Many times these patients have a secondary diagnosis of substance abuse.
GERIATRIC PROGRAM

The geriatric program at Crossbridge is devoted to helping older adults and their families. Growing older can be difficult. Many experience the loss of a loved one, a devastating injury or illness, increased use of medication and loss of independence. These are just some of the factors that can influence the physical, mental and emotional well-being of an older adult. The effect can result in depression, anxiety, confusion, agitation or additional indications that hinder with an older person’s quality of life.

The geriatric psychiatry program at Crossbridge Behavioral Health is devoted to helping our patients focus on these issues. In this program, a complete medical assessment is also conducted as needed to acquire a clear understanding of any separate medical problems, such as congestive heart failure, arthritis or diabetes.

In both programs, an individualized treatment plan is recommended to meet the specific needs of the patient. The programs provide a complete range of traditional and innovative treatments, including medication, music therapy, and intensive inpatient group therapy and outpatient support groups. Family education is provided as identified by the interdisciplinary team and upon a family member’s request.

CLINICAL TEAM

Each patient is cared for by an interdisciplinary team of physicians—psychiatrists, medical specialists, and other specialists—as well as nurses, social workers, therapists, psychiatric recreational therapists and chaplains.

INTAKE AND ADMISSIONS

Patients needing care typically arrive at an Emergency Department for assessment. Individual physicians may refer the patient to the Emergency Department for evaluation. The intake specialist at Crossbridge is available to assess patients as consulted by the Emergency Department physician. Intake assessment is available each day from 6 a.m. – 11 p.m. at (334) 451-0181. During the hours of 11 p.m. – 6 a.m. the charge nurse at Crossbridge can be contacted at (334) 286-3116. The charge nurse will usually advise coming to the Emergency Department for assessment. The physician in the Emergency Department and the intake specialist will collect information to determine if the client being referred meets inpatient admission criteria. Patients must be medically stable prior to admission.

Direct admissions may be considered through discussions between the private physician and the psychiatrist on call. This would be handled on a case by case basis depending on medical clearance.

DISCHARGE CRITERIA

Disposition is addressed for the patient during the admission process. It is expected that following the required assessment and treatment, the individual will return to the least restrictive discharge setting as identified by the treatment team during hospitalization. Follow-up is planned on an individual basis to involve the family physician and mental health resources.
WHAT ARE THE DIFFERENCES IN INPATIENT AND OUTPATIENT CARE?

Our inpatient program is designed for short-term, crisis stabilization to get patients back into their daily lives in a timely manner. During this type of care, patients receive assistance from one of the most qualified psychiatric treatment teams available. Our staff will see to it that you are treated with dignity and respect as it helps you return to your desired state of health. You will receive hands-on care in both group and individual settings as well as participate in a variety of therapeutic activities. The program also allows for individualized treatment with family involvement when possible.

The length of treatment varies depending on each individual’s needs. Upon the end of your inpatient care, you may be referred to a day program if need be. Otherwise, we will arrange for you to receive care within the community through one of the local counseling agencies or community organizations.

The day program features intensive group therapy with the same type of treatment team used in inpatient care. The patient’s care will be supervised by a psychiatrist. The program is typically designed for 10 sessions and transportation is available.

Once a patient has completed the day program, we will arrange for them to continue receiving regular care in the community.

WHAT ABOUT ALCOHOLISM AND OTHER ADDICTIVE DISEASES?

While our inpatient unit is not equipped to handle addictive diseases as a primary diagnosis, we do experience that many of our patients have these issues as a secondary diagnosis. If ordered or recommended by the Psychiatrist, a referral is made to a program specializing in addictive disease treatment.

HOW DO I KNOW IF I MIGHT NEED THIS TYPE OF CARE?

There are a number of symptoms of mental illness that often go unnoticed or unattended. If you are experiencing one or more of these symptoms, please seek assistance.

SYMPTOMS OF MENTAL ILLNESS

- Thoughts of suicide
- Strong feelings of anger
- Social withdrawal
- Confused thinking
- Long-lasting sadness or irritability
- Extreme highs and lows in mood
- Excessive fear, worrying or anxiety
- Dramatic changes in eating or sleeping habits
- Delusions or hallucinations (seeing or hearing things that are not really there)
- Increasing inability to cope with daily problems and activities
- Denial of obvious problems
- Many unexplained physical problems
- Abuse of drugs and/or alcohol

RESOURCES

Private Physicians
Local Emergency Departments
National Suicide Prevention Hotline (800) 273-TALK or 8255
Alabama Commission on Aging (800) 243-5463
Choice and Dying (800)-989-9455
Poison Control (800) 222-1222
Montgomery Area Mental Health Authority, Inc. (334) 279-7830 or (334) 271-2855 (deaf interpreter TTY and voice)
Recurring seizures or epilepsy impacts about 2.5 million Americans. According to the Centers for Disease Control and Prevention, epilepsy is a chronic neurological condition characterized by recurrent seizures and can be caused by many different conditions that affect a person’s brain.

The Epilepsy Center at Baptist Medical Center South offers individuals in the River Region who suffer from seizures a place they can be monitored and examined close to home. In the monitoring unit, our staff uses both EEG (electroencephalography) equipment to monitor brain activity and video cameras to record body movements during a seizure. This approach gives us a much greater understanding of seizures. The monitoring not only allows us to diagnose a seizure problem accurately, but also to design the best possible treatment plan. Patients are monitored in the unit continuously.

To learn more, please call (334) 286-3105.
Baptist Home Health consists of a team of healthcare professionals offering home-oriented alternatives to hospitalization, assistance following hospitalization and assistance with daily activities.

The service area covers eight counties: Montgomery, Autauga, Elmore, Macon, Bullock, Pike, Lowndes and Crenshaw. Registered nurses and licensed practical nurses provide excellent skill and care, while physical, occupational and speech therapists are experienced at restoring your ability to do for yourself. They round out their services with pediatric nursing and medical social services.

To qualify for home health, patients must meet three criteria:

- must have an attending physician who orders home health services
- must be homebound
- must need a skilled service (nursing, physical therapy or speech therapy).

Following the physician referral, home health will contact the patient and develop an individualized plan of care based on his or her needs and physician recommendations.

Baptist Home Health services are TJC accredited and covered by Medicare, Medicaid and most private insurance plans. Self-payment arrangements are also accepted.

For further information, please call Baptist Home Health at 334-395-5100.
Hospice

Baptist Hospice is a special way of caring for people with a life limiting illness. It is designed to help people spend their days living as comfortably as possible at home surrounded by their loved ones. Baptist Hospice strives to create a secure and caring environment that emphasizes the quality of life by focusing on the physical, emotional, social and spiritual needs of the patient and family. Baptist Hospice involves a caring team of compassionate, highly-trained professionals and dedicated volunteers who are committed to providing care to patients with life limiting illnesses.

If you have any questions, please feel free to contact Baptist Hospice at (334) 395-5000 or e-mail hospiceinfo@baptistfirst.org.

Baptist Hospice is recognized as a We Honor Veterans “Level One” Partner.
As one of the largest outpatient imaging providers in central Alabama, Baptist Health offers a complete range of imaging services in four conveniently located outpatient imaging facilities. These services include MRI/MRA, CT/CTA, PET/CT, Digital Mammography, Computerized Radiography (X-ray), Fluoroscopy, Nuclear Medicine, Ultrasound and DEXA for bone density measurements.

Montgomery Radiology Associates (MRA) provides sub-specialty radiologists at all Baptist Health hospital and imaging center locations. The highly skilled radiologists at MRA are board-certified by the American Board of Radiology and the majority have additional fellowship training in specialized areas of radiology, including breast imaging, neuroradiology, interventional radiology, musculoskeletal and nuclear medicine. The radiologists of MRA have the expertise and experience needed to make the diagnoses on which physicians and patients have come to expect and rely.

The outpatient imaging centers owned by Baptist Health are operated through a partnership with radiologists of MRA. It is through this relationship that MRA manages and provides the technical and clerical staffing for the four multi-modality imaging centers in Montgomery and Prattville, Ala.

The combined commitment of Baptist Health and the radiologists of MRA is to provide an accurate imaging diagnosis to our referring physicians in a timely manner at a location and time convenient to our patients.

Baptist Health and the radiologists of MRA - working together to bring state of the art and convenient imaging services in four outpatient locations to the physicians and patients of central Alabama.
Institute for Advanced Wound Care

Chronic or slow-to-heal wounds are not an uncommon occurrence. It is estimated that between 6 and 7 million Americans experience problems from chronic wounds.

A chronic wound is a wound that has resisted healing for three weeks or more.

The Institute for Advanced Wound Care at Baptist Medical Center South provides individuals with chronic wounds the most up-to-date medical treatments from renowned wound care specialists.

Severe wounds left untreated can lead to amputation or possibly death. The staff at the institute is prepared to help individuals with wounds resulting from:
- Diabetic ulcers
- Pressure ulcers
- Venous stasis ulcers
- Sickle cell ulcers
- Surgical incisions
- Skin cancers
- Spider bites
- Radiation wounds
- Keloids
- Burns
- Skin tears
- Traumatic wounds
- Pyoderma gangrenosum
- Ulcers caused by lupus
- Rheumatoid arthritis

Assuring that patients of the institute receive the best care available, the physicians at the Institute for Advanced Wound Care are involved in a number of research or clinical trials. These research projects enable them to provide patients with the most cutting-edge products and treatments available for chronic wounds. Institute patients are given the opportunity in some cases to participate in these trials, often at a reduced cost or at no expense.

Individuals may self-refer or have a physician referral to be treated at the institute. If you are experiencing complications from a chronic wound or have additional questions, please call the institute at (334) 286-3444.

Location information:
2167 Normandie Dr.
Montgomery, AL 36116
The Institute for Patient Safety and Medical Simulation is a partnership between Baptist Health and Auburn University. The Institute’s mission is to improve the quality of healthcare while reducing the likelihood of medical errors.

The 22,500 square-foot facility was conceived as a training center for new and experienced healthcare professionals. The training teaches physicians, experienced nurses, nursing students, residents, fellows, medical students, respiratory therapists, pharmacists, paramedics and other healthcare professionals through a unique combination of simulations training and an emphasis on SMART Training.

SMART Training promotes patient safety through the advancement of teamwork. It empowers team members to apply high-level communication skills and purpose-based decision making to yield the best outcomes for the patient.

This type of training truly impacts the care patients receive from Baptist Health employees. Patients and the community benefit greatly from having an institute of this nature in Montgomery. The technology being used and innovative processes being taught provide healthcare professionals with skills and knowledge that is unsurpassed.

For more information, please visit www.patientsafetysimulation.com.
Lymphedema Treatment Center

An effective way to manage lymphedema

The Baptist Health Lymphedema Treatment Center provides treatment to individuals with lymphedema, a condition that causes fluid build-up in soft body tissues and causes swelling. Lymphedema commonly affects arms, legs or joints, but can affect other parts of the body.

Lymph nodes, also called lymph glands are part of the body's immune system. They are connected like a chain and can be found alone or in clusters all throughout the body. They drain continuously to help prevent infectious fluid build-up. When lymph nodes are not working correctly, it disrupts the fluid flow resulting in swelling or lymphedema.

Lymphedema is an ongoing condition and cannot be cured, but with appropriate treatment and continued care it can be managed.

What causes lymphedema?

- Present at birth
- Cancer
- Trauma
- Infection from surgery
- Lymph node removal
- Radiation treatment

The Baptist Health Lymphedema Treatment Center uses complete decongestive therapy (CDT) to treat lymphedema. It is a non-invasive, highly effective treatment and has no side effects. CDT is provided by a certified lymphedema therapist five times a week for four weeks. Treatments can last one to two hours each. Follow-up visits will occur periodically to see how you are feeling.

To make an appointment with a certified lymphedema therapist, you will need a referral from your doctor. To learn more or to make your appointment, please call 286-2852.

Lymphedema Treatment Center
Suite 908 B
Morrow Tower
Baptist Medical Center South campus
2055 E. South Blvd.
Montgomery, AL 36116
(334) 286-2852
Since 1990, Montgomery Cancer Center has been a source of support, hope and healing for patients and their families. Its team of 14 physicians and dozens of health professionals provides understanding, compassionate, one-on-one attention with state-of-the-art technology and treatment.

Montgomery Cancer Center’s reputation for quality care extends outside Alabama. The Center was among the first outpatient facilities of its kind, performing cancer care in a physician office setting, offering the convenience of modern detection, diagnosis and treatment of cancer and blood diseases. On-site nurse practitioners and nursing staff continuously update their training, as do doctors - who regularly consult with a nationwide network of other physicians.

One of the largest freestanding centers in the United States, Montgomery Cancer Center also shares its main campus with its two subsidiaries, Montgomery Breast Center and Carmichael Imaging.
Montgomery Breast Center is devoted to women's health, providing advanced screening, diagnostic and treatment services all under one roof.

Experienced, caring physicians and professionals provide exceptional service - in most cases, delivering same-day test results.

Convenient and centrally located in a comfortable, state-of-the-art facility, Montgomery Breast Center is among the region's most respected resources for the diagnosis of breast cancer.

Contact Tina Hodge at THodge@montgomerycancercenter.com for more information.

One of the region's leading imaging centers, Carmichael Imaging offers advanced digital imaging services, including MRIs, CAT scans, PET/CT scans, nuclear medicine, digital X-rays and diagnostic ultrasounds.

The experienced physicians and staff work with patients of all types and their referring physicians to provide quality service. All technologies are operated by specifically trained and credentialed professionals, with two board-certified radiologists on-site to discuss findings and make recommendations, and registered nurses ready to assist patients.

A subsidiary of Montgomery Cancer Center and a fully accredited and certified Independent Diagnostic Imaging Facility (IDTF), Carmichael Imaging is located at the Center's main campus in Montgomery, along with Montgomery Breast Center.
The Neuroscience Institute is a center of excellence at Baptist Medical Center South, which embraces several specialties. Each dedicated to a unique continuum of care, groups represented include the Neuroscience Imaging Center, Neurosurgery Associates of Central Alabama, P.C., PT Solutions and the Center for Pain of Montgomery. These entities seamlessly work together to coordinate your care and challenge each other to ensure you receive the best diagnosis and treatment possible.

The cornerstone of the institute is the Neuroscience Imaging Center at Baptist Medical Center South. The center is dedicated to providing patients with comfortable imaging procedures and physicians with the highest quality images currently available.

Patients visiting the center have convenient access to our offices. Drive-up and valet parking are available for all patients.

MRI experience

In the past, a patient was required to spend a long period of time in a long, dark, claustrophobic "tunnel" and was subjected to extremely loud noises. These negatives no longer exist in our facility. We now use the MAGNETOM Espree, a comfortable, quiet, fast and top-of-the-line MRI scanner.

Designed with patient's comfort in mind

The new open design of the unit reduces anxiety and claustrophobia. Feet go in first and your head remains outside. Patients will constantly see the examination room and can communicate whenever they wish throughout the short scan time.

Form meets function

The extra large-Open Bore design is flared, giving children and elderly patients a wide open view that allows them to feel safe and relaxed. They can also have constant eye contact with those present. This new design can accommodate patients up to 440 pounds. The accessibility, flexibility and comfort makes this unit a completely new MRI experience.

Innovative CT

Our Siemens SOMATOM® Sensation CT (computed tomography) scanner allows the routine use of high performance Multi-slice CT. It provides
Neuroscience Institute (continued)

extended of anatomical areas while producing images with higher details, which is key in clinical applications such as early tumor detection. In addition, it also features clinical applications targeted at the diagnosis of specific regions of interest. The following provides a brief overview of those clinical applications:

- Highly detailed imaging with very short breath hold requirement using Multi-slice CT. Misregistration due to motion is virtually eliminated. This is especially important in trauma and pediatric examinations. Vasculature evaluation of the head, neck, thorax, abdomen, pelvis and extremities using CT Angiography. This provides an accurate picture of blood flow through the vessels in a fast, minimally invasive way.

- Evaluation of osteopathic and traumatic alterations of bone surface using 3-dimensional imaging. The clear view of the bone structure in 3D allows a fast and accurate assessment of the alterations that have taken place.

Scheduling

What makes our imaging center different is our determination to offer our patients the latest technologies that are not only dependable, but comfortable, and provide physicians with more accurate, higher quality images.

Schedule phone: 334-286-3160
Schedule fax: 334-286-3165

Hours of operation
Monday - Friday
7 a.m. - 5 p.m.

Neuroscience Institute
2065 E. South Blvd.
(Parker Pavilion)
Montgomery, AL 36116
Palliative Care

Palliative care is the medical specialty, offered to inpatients at Baptist Medical Center South, that focuses on relief of the pain and other symptoms of serious, life-threatening illness. The goal is to improve quality of life for patients and their families. Palliative care is appropriate at any point in an illness. It can be provided at the same time as curative treatment.

Palliative care at Baptist Medical Center South offers patients:

- Relief from symptoms including pain, shortness of breath, fatigue, constipation, nausea and loss of appetite
- Strength to carry on with daily life
- Improved ability to tolerate medical treatments
- Better understanding of your condition and your choices for medical care

At Baptist Medical Center South, our board-certified palliative care team includes physicians, nurses, pastoral care and social workers. Together with your own doctor, we make sure that you receive:

- Expert treatment of your pain and symptoms
- Close communication about your illness and treatment choices
- Coordination of your care among all of your healthcare providers
- Emotional and spiritual support for you and your family
- Referral and coordination of home care services

You may already have been referred to the palliative care team, but if not, just ask your doctor for a referral. We work together with your primary care physician, so you will not have to give up your own doctor. For more information, please call the Baptist Health palliative care team at (334) 451-1693.
Primary Stroke Center
Mission of the Primary Stroke Center

The Primary Stroke Center (PSC) is dedicated to providing the community and our patients with the best in stroke prevention and care. The PSC has a specially trained team of physicians, nurses, therapists and technicians available around the clock to provide appropriate treatment quickly so as to maximize the outcome and ultimately the quality of life for our patients.
Pulmonary Rehab

Lung disease - emphysema, asthma, lung cancer and other illnesses - can be very disabling. Because the disease causes shortness of breath and fatigue, it often interferes with an individual's ability to carry out even the simplest daily task. Lung disease cannot be reversed, but patients can achieve a more active, rewarding and productive lifestyle through pulmonary (lung) rehabilitation.

The pulmonary rehabilitation program at Baptist Health helps patients reach their highest level of exercise and activity, while developing self-management skills. Our comprehensive approach combines patient education, exercise, emotional and social support.

Baptist's pulmonary rehabilitation program uses a two-prong approach of education and exercise tailored to meet patients' individual needs.

- Individual and group settings provide patients and the family members with an overview of lung disease and how to manage it. The patient is re-trained in proper breathing techniques, as well as good nutrition and positive health habits to promote a new outlook on life.
- Physical conditioning is important for patients to increase their strength and endurance while controlling shortness of breath. The rehab team prescribes an individual exercise plan for each participant based on his/her screening and evaluations, goals and physician recommendations. Throughout the program, team members monitor each individual's progress by checking heart rates and oxygen saturation levels.

A medical director, who is a board-certified pulmonologist, leads the program. A team of professionals, including the referring (primary) physician, rehab coordinator, respiratory therapist, pharmacist, chaplain and others, all contribute to the patients' total well-being and teach them to care for themselves at an optimal level both at home and work.

A physician's referral is necessary to enter the pulmonary rehabilitation program.

For more information, please call (334) 286-2859.
Baptist Health is home to three Sleep Disorders Centers, Baptist Medical Center South, Baptist Medical Center East and at Prattville Baptist Hospital. Each center has the ability to diagnose up to 84 different sleep disorders. The Baptist Medical Center South Sleep Disorders Center opened as a two-bed sleep lab in July 1989. It can now accommodate eight patients per night, six nights a week and is accredited by the American Academy of Sleep Medicine. Since opening in January 2004, the Prattville Baptist Sleep Disorders Center now accommodates four patients per night. The Sleep Disorders Center at Baptist Medical Center East opened in 2006 and accommodates four patients per night, six nights a week. There are five board-certified physicians and a clinical psychologist on staff between the three centers.

The staff specializes in the diagnosis and treatment of all sleep disorders, including sleep apnea (non-breathing episodes during sleep), narcolepsy (a disorder of excessive sleepiness), sleep walking, night terrors, nocturnal myoclonus (periodic limb movements) and insomnia (lack of sleep). Patients do not need a physician referral for a sleep study. However, check with the center regarding insurance coverage prior to scheduling your study.

Recent studies have convinced doctors and medical experts that a lack of sleep can have serious consequences on a person's health. One study conducted by the California Department of Health found that people who get less than the recommended amount of sleep have a 70 percent higher mortality rate. Only one in three Americans get the proper amount of sleep. A lack of sleep can affect a person's immune system, slow reflexes and impair judgment. Approximately 40 million Americans suffer from serious sleep problems and 95 percent remain undiagnosed but the Baptist Health Sleep Disorders Centers can help!

For more information, contact one of our three centers at the numbers listed below.

- Baptist Medical Center South Sleep Disorders Center (334) 286-3252
- Baptist Medical Center East Sleep Disorders Center (334) 213-5051
- Prattville Baptist Sleep Disorders Center (334) 361-4335

Ask a Sleep Technologist
Do you have a question about your sleeping or maybe the lack of rest you are getting each night? E-mail our sleep technologist and have your question answered. You may also self-refer to the Baptist Sleep Disorders Centers, just be sure to send your name and a phone number.

Get the answers you need today by e-mailing Sleepcenter@baptistfirst.org.
The goal of the Uterine Fibroid Center at Baptist South is to provide a non-surgical, minimally invasive alternative to a hysterectomy for women with symptomatic fibroids.

Uterine fibroids are common benign tumors that grow from the muscular wall of the uterus. Fibroids may cause heavy bleeding, pelvic discomfort, bloated abdomen, anemia, leg pain, and create pressure on other organs such as the bladder and bowels.

As many as 80 percent of all women have uterine fibroids and approximately 5.5 million American women have symptoms severe enough to require treatment. Of the 600,000 hysterectomies performed each year in the U. S., one-third are for symptomatic uterine fibroids. Hysterectomy is an invasive surgical procedure in which the entire uterus is removed. Hysterectomy usually requires a four-to-six week recovery period. Myomectomy is the actual removal of the fibroids and is another surgery commonly performed to treat fibroids. Although it is uterine sparing, myomectomy is highly invasive and also requires a long recovery period.

The alternative to hysterectomy that is less invasive and spares the uterus is Uterine Fibroid Embolization (UFE). UFE is a minimally invasive procedure performed by an interventional radiologist. During the procedure, a small incision is made in the groin and a catheter is guided into the uterine arteries. Small particles are then injected via the catheter into the blood vessels that feed the fibroids and block the blood flow to the tumors. Most patients see rapid symptom relief and over time, the fibroids shrink.

Clinical studies have shown that UFE provides substantial improvement in major symptoms, including pain, pelvic discomfort and urinary problems. At the six-month follow-up, 94 percent of the women treated with UFE reported being satisfied with the procedure. Women returned to their daily activities more than three times faster than those who had a hysterectomy.

Women interested in more information about UFE can call the Uterine Fibroid Center at Baptist South at 286-2UFE (2833).
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<tr>
<th>Tab 2</th>
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<tbody>
<tr>
<td>Baptist Medical Center South</td>
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<tr>
<td>• Summary</td>
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<tr>
<td>• Leadership</td>
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<td>• Medical Staff Officers/Departmental Chairs</td>
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<tr>
<td>• Meeting Dates</td>
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</table>
Since its founding in 1963, **Baptist Medical Center South** has grown to become Montgomery's largest healthcare facility and Baptist Health's tertiary care center, offering unsurpassed specialty services and treatment. Through advanced technology, professional expertise and an exceptional level of personalized care, Baptist Medical Center South is the comprehensive resource for family healthcare in central Alabama. Known for its outstanding cardiovascular, orthopaedic, neurology and surgical services, Baptist Medical Center South is home to skilled and dedicated physicians, nurses and staff. The hospital offers residents of central Alabama an accredited sleep disorders center, a regional neonatal intensive care unit, a chest pain diagnosis and treatment center within the emergency department, a behavioral health treatment facility and family centered maternity care. Fully accredited by the Joint Commission on Accreditation of Healthcare Organizations (TJC), this licensed **454 bed**, faith-based, not-for-profit medical center is committed to meeting the healthcare needs of central Alabama with care and compassion.
Peter Selman

Chief Executive Officer
Baptist Medical Center South

Peter Selman became the CEO of Baptist Medical Center South in July 2013. Peter joined Baptist Health in 2009 as the CEO for Baptist Medical Center East. Prior to coming to Baptist Health, Peter served as CEO of DeKalb Regional Medical Center in Fort Payne, Ala. His senior leadership experience also includes terms as CEO of Cherokee Medical Center in Centre, Ala., CEO of Appling Hospital in Baxley, Ga. and vice president of Operations for Coosa Valley Medical Center in Sylacauga, Ala.

After receiving a bachelor’s degree in telecommunications from the University of Alabama, Peter earned a master’s in marketing and public relations from the University of Alabama and a master’s in health services administration from the University of Alabama at Birmingham. He is a fellow in the American College of Healthcare Executives.
### 2015

#### Medical Staff Officers-Chairs-Vice Chairs

<table>
<thead>
<tr>
<th>CHIEF OF STAFF</th>
<th>Julio E. Rios, M.D. - (334) 272-1050</th>
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<tbody>
<tr>
<td>CHIEF OF STAFF – ELECT</td>
<td>Mark H. LeQuire, M.D. - (334) 288-4624</td>
</tr>
<tr>
<td>SECRETARY-TREASURER</td>
<td>Tamjeed Arshad, M.D. - (334) 613-0807</td>
</tr>
<tr>
<td>IMMEDIATE PAST CHIEF OF STAFF</td>
<td>F. Donovan Kendrick, M.D. - (334) 281-6990</td>
</tr>
<tr>
<td>CREDENTIALS CHAIRMAN</td>
<td>Theodore R. Smith, Jr., M.D. - (334) 293-6670</td>
</tr>
<tr>
<td>MONTGOMERY FAMILY MEDICINE RESIDENCY PROGRAM DIRECTOR</td>
<td>Thomas G. Kincer, M.D. - (334) 613-3692</td>
</tr>
<tr>
<td>UAB HEALTH CENTER INTERNAL MEDICINE RESIDENCY PROGRAM DIRECTOR</td>
<td>Jewell Halanych, M.D. - (334) 284-5211</td>
</tr>
<tr>
<td>DEAN, UAB REGIONAL CAMPUS</td>
<td>W. J. Many, Jr., M.D. - (334) 284-5211</td>
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<tr>
<th>CHAIR</th>
<th>VICE CHAIR</th>
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<tbody>
<tr>
<td>ANESTHESIOLOGY DEPARTMENT</td>
<td>Jonathan Varner, M.D. - (334) 286-3579</td>
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<tr>
<td>James V. Harper, M.D. - (334) 286-3579</td>
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<tr>
<td>CARDIOLOGY DEPARTMENT</td>
<td>Thomas Wool, M.D. (Jan 2014 – Dec 2015) - (334) 613-0807</td>
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<tr>
<td>Wynne Crawford, M.D. (Jan 2014-Dec 2015) - (334) 280-1521</td>
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<tr>
<td>EMERGENCY MEDICINE DEPARTMENT</td>
<td>Julio E. Rios, M.D. - (334) 272-1050</td>
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<tr>
<td>John D. Moorehouse, M.D. - (334) 272-1050</td>
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<tr>
<td>FAMILY MEDICINE DEPARTMENT</td>
<td>Ashley McIntyre, M.D. (Jan 2015-Dec 2016) - (334) 279-8180</td>
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<tr>
<td>Maryluz Fuentes, M.D. (Jan 2015 – Dec 2016) - (334) 286-2390</td>
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<tr>
<td>MEDICINE DEPARTMENT</td>
<td>Vice Chair</td>
</tr>
<tr>
<td>Asad Khan, M.D. (Jan 2015 – Dec 2016) - (334) 213-6287</td>
<td>Juliane Isola, M.D (Jan 2015-Dec 2016) - (334) 286-3568</td>
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<tr>
<td>OB/GYN DEPARTMENT</td>
<td>Roosevelt McCorvey, M.D. (Jan 2015-Dec 2016) - (334) 356-4873</td>
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<tr>
<td>Patricia Elliott, M.D. (Jan 2015 – Dec 2016) - (334) 356-7749</td>
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<tr>
<td>PATHOLOGY DEPARTMENT</td>
<td>Vice Chair</td>
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<tr>
<td>Walter C. Bell, MD – (334) 286-2890</td>
<td>Samuel G. Borak, MD- (334) 286-2890</td>
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<tr>
<td>PEDIATRICS DEPARTMENT</td>
<td>William Sumners, M.D. (Jan 2015-Dec 2016) - (334) 288-8222</td>
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<tr>
<td>Mahmood Zaied, M.D. (Jan 2015 – Dec 2016) - (334) 293-6670</td>
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<tr>
<td>RADIOLOGY DEPARTMENT</td>
<td>No Vice Chair</td>
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<tr>
<td>David C. Montiel, M.D. (334) 288-4624 or (334) 386-2887</td>
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<tr>
<td>SURGERY DEPARTMENT</td>
<td>Vice Chair</td>
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<td>SURGERY REPRESENTATIVE</td>
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<td>MEDICINE REPRESENTATIVE</td>
<td>HOSPITALIST REPRESENTATIVE</td>
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The Annual Medical Staff Meeting is scheduled for October 19, 2015

<table>
<thead>
<tr>
<th>Department</th>
<th>Meeting Time</th>
<th>Location</th>
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<tr>
<td><strong>2015 Medical Staff Department/Committee Meeting Schedule</strong></td>
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<tr>
<td>Anesthesiology Department</td>
<td>Meetings held at 6:45am in the ACR</td>
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<tr>
<td>BMCS Advisory Board meeting</td>
<td>Meetings held at 5pm in the Bell Board Room</td>
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<tr>
<td>Cardiology Department</td>
<td>Meetings held at 7:00am in the ACR</td>
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Revised: 01/31/2014
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Revised: 01/31/2014
Baptist Medical Center East

- Summary
- Leadership
- Medical Staff Officers/Departmental Chairs
- Meeting Dates
- Key Personnel Contact List
Baptist Medical Center East is a 150-bed acute care hospital providing a broad range of health care services. The hospital was recently named one the nation’s 100 Top Hospitals by Thomson Reuters. Baptist East also received the 2010 HealthGrades Patient Safety Excellence Award™ classifying them in the top 5 percent in the nation for patient safety. In addition to general medical and surgical services, Baptist Medical Center East offers 24-hour emergency services, a state-of-the-art Labor and Delivery center, level II NICU, Medical/Surgical Intensive Care Unit, as well as general and specialized surgical services including orthopaedics, peripheral vascular, urological and eye laser. The Radiology Department at Baptist Medical Center East offers an array of inpatient and outpatient services including diagnostic, ultrasound, nuclear medicine, CT and MRI. The Therapy Center at Baptist Medical Center East offers occupational, speech and physical therapies to outpatients and inpatients. Also housed on the Baptist Medical Center East campus are the Baptist Breast Health Center, the Sleep Disorders Center and the Endoscopy Center.
Jeff Rains is the CEO of Baptist Medical Center East. Prior to joining Baptist East in July 2013, Rains was the CEO of Dekalb Regional Hospital. He has more than 13 years of healthcare leadership experience, including serving as CEO at Hartselle Medical Center in Hartselle, Ala. and COO at Riverview Regional Medical Center in Gadsden, Ala.

He received his bachelor’s degree in finance from the University of Alabama and his master’s in business administration from Middle Tennessee State University.
OFFICERS:

Chief of Staff: Dr. Benjamin Griggs – (o) 279-9333
Past Chief of Staff: Dr. Wallace Falero – (o) (o) 1-800-424-3672
Chief of Staff-Elect: Dr. Nina Nelson-Garett (o) 495-2600
Secretary: Dr. Vivan Hamlett- (o) 213-6287

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<tr>
<th>Department</th>
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<th>Vice-Chair</th>
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<tr>
<td>Surgery, Anesthesia, Pathology</td>
<td>Dr. Alan Berlin</td>
<td>Dr. John Tinglin</td>
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<tr>
<td></td>
<td>(o) 244-7874</td>
<td>(o) 271-0280</td>
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<tr>
<td>Family Medicine</td>
<td>Dr. Mark Lindsey</td>
<td>Dr. Kathy Lindsey</td>
</tr>
<tr>
<td></td>
<td>(o) 213-3606</td>
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<tr>
<td>Medicine</td>
<td>Dr. Radha Krothapalli</td>
<td>Dr. Dennis Woodling</td>
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<tr>
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<td>(o) 396-5570</td>
<td>(o) 279-9211</td>
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<tr>
<td>OB/GYN</td>
<td>Dr. Jennifer Logan</td>
<td>Dr. Allen Dupre</td>
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<tr>
<td></td>
<td>(o) 290-4200</td>
<td>(o) 279-9333</td>
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<tr>
<td>Pediatrics</td>
<td>Dr. Daria Anagos</td>
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<tr>
<td></td>
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<tr>
<td>Emergency Medicine</td>
<td>Dr. Kristi Witcher</td>
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<tr>
<td>Radiology</td>
<td>Dr. Jason Dorey</td>
<td>Dr. T Moore</td>
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<tr>
<td>Ethics</td>
<td>Dr. Lois Schulman</td>
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<td>(o) 213-6287</td>
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Other Specialty Representatives:

Anesthesia                           Dr. Jonathan Varner - (o) 286-3579
Pathology                             Dr. Kelley Taylor - (o) 312-9097
Hospitalist                           Dr. Vivan Hamlett- (o) 213-6287
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# Baptist Health
## Key Personnel Contact List
### 2015

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<th>Legal Counsel</th>
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<td>Jeff Rains, CEO</td>
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<tr>
<td>Kathy Gaston, CNO</td>
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<tr>
<td>David Grizzard, CFO</td>
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<td>Russ Tyner, CEO/President</td>
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</tr>
<tr>
<td>Robin Barca, SVP/COO</td>
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<tr>
<td>Julia Ventress, VP/Strategic Pl.</td>
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<td>Dr. Ben Griggs, Chief of Staff</td>
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</tr>
<tr>
<td>Dr. Nina Nelson-Garrett, Chief of Staff-Elect</td>
<td>495-2600</td>
</tr>
<tr>
<td>Dr. Wallace Falero, Past Chief of Staff</td>
<td>215-4485</td>
</tr>
<tr>
<td>Dr. Vivian Hamlett, Secretary</td>
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<td>Brandy Cox, Case Management</td>
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<td>Tasha Kelly, Registration</td>
<td>213-5165</td>
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<tr>
<td>Alicia Cargill, Chaplain</td>
<td>213-6265</td>
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<tr>
<td>Jill Oliver, PACU, OR, Day Surgery</td>
<td>244-8475</td>
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<tr>
<td>Tammy Farmer, ED</td>
<td>244-8340</td>
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<tr>
<td>Sharon Scanlan, Endoscopy</td>
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<td>Donna Todd, HIM</td>
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<td>Hospitalists</td>
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<td>Shirley Chapman, ICU, Telemetry</td>
<td>213-6396</td>
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<tr>
<td>Amy McAfee, L&amp;D</td>
<td>215-5998</td>
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<tr>
<td>James Foley, Laboratory</td>
<td>244-8545</td>
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<tr>
<td>Yvonne Willis, NICU</td>
<td>244-8244</td>
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<tr>
<td>Betty Matthews, WBN</td>
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<tr>
<td>Mallary Nelson, Kids Korner</td>
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<tr>
<td>Katrina Jones, 1 East</td>
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<tr>
<td>Karen Wyatt, 1 North</td>
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<tr>
<td>Lisa Haigler, 1 South, Dialysis</td>
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<tr>
<td>Rusty Page, Pharmacy</td>
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<tr>
<td>Tanya Leininger, Post Partum</td>
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<td>Jack Burks, Radiology</td>
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<tr>
<td>Dana Fitzpatrick, Therapy Center</td>
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<tr>
<td>Paula Brennan, Women’s Services</td>
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</table>
Prattville Baptist Hospital

- Summary
- Leadership
- Medical Staff Officers/Departmental Chairs
- Meeting Dates
Prattville Baptist Hospital is an acute care, 85-bed community hospital. Originally built in 1952 by two local physicians, Prattville Baptist Hospital has grown to offer a full range of health services to residents of Autauga and Elmore counties. As a progressive, community-oriented hospital, Prattville Baptist Hospital is committed to serving the community with the latest advancements in medical technology while continuing to provide compassionate care. In addition to general medical and surgical services, Prattville Baptist Hospital offers 24-hour emergency services, a dialysis center, as well as cardiopulmonary services. The Center for Advanced Therapy offers occupational, speech and physical therapies to outpatients, and also offers audiology services. The Radiology Department at Prattville Baptist offers an array of inpatient and outpatient services. The hospital is also home to the Sleep Disorders Center. Prattville Baptist is accredited by the Joint Commission on Accreditation of Healthcare Organizations (TJC), Prattville Baptist Hospital aims to exceed everyone's expectation everyday by providing unsurpassed patient care.
Ginger Henry joined Prattville Baptist Hospital in 1998. She served as manager of the Emergency Department until 2003 when she was promoted to chief nursing officer. A year later she was appointed CEO.

Ginger earned an associates degree in nursing from Troy University, a bachelor of science degree in nursing and a master’s degree in business administration from Auburn University Montgomery.

She serves on the Boards of Directors of the Prattville Area Chamber of Commerce, YMCA, and United Way. Ginger is also involved in multiple civic organizations in support of the Prattville community.
Prattville Baptist Hospital  
MEC MEMBERS 2015

MEC shall consist of the following members:
1 Chief-of-Staff
1 Chief-of-Staff Elect
1 Hospital Based Physician
1 Emergency Department
1 Surgery
1 Anesthesia
1 Radiology
2 Internal Medicine

1. R. Kenneth Nichols, M.D. – Chief-of-Staff – Internal Medicine  
   120 E. Main Street  
   Prattville, Alabama  36067  
   Phone:  361-0986

2. John Williams, M.D. – Past Chief-of-Staff  
   Cardiology Associates  
   1758 Park Place, Suite 101  
   Montgomery, Alabama  36106  
   Phone:  264-9191

3. Parham Mora, M.D. – Department of Surgery Chair  
   Mora Surgical Clinic  
   645 McQueen Smith Road, N., Suite 205  
   Prattville, Alabama  36067  
   Phone: 361-6126

4. Rachel Chance, M.D.  – HBP Chair – Chief-of-Staff Elect  
   Hospital Physician Services of Central Alabama  
   440 Taylor Road, Suite 3380  
   Montgomery, Alabama  36117  
   Phone:  213-6287

5. Julian Maha, M.D. – Emergency Department Chair  
   Team Health  
   4770-B Woodmere Blvd  
   Montgomery, Alabama  36106  
   Phone:  272-1050

6. Vacant – Family Medicine Chair

7. William (Bill) Saliski, D.O. – Internal Medicine Chair  
   Montgomery Pulmonary Consultants
1440 Narrow Lane Parkway  
Montgomery, Alabama  36111  
Phone: 281-4140

7. **Terry Williams, M.D. – Radiology Department Chair**  
Montgomery Radiology Associates  
2055 Normandie Drive, Suite 108  
Montgomery, Alabama  36111  
Phone: 288-4624

8. **Shannon Michael Peattie, M.D. – Anesthesia Department Chair**  
Premier Anesthesia  
2105 E. South Blvd.  
BMCS Department of Anesthesia  
Montgomery, Alabama  36116  
Phone: 286-3579
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Tab 5

Montgomery Surgical Center
Tenants of the three-story 85,000 square foot Taylor Medical Complex on the Baptist Medical Center East campus includes the **Montgomery Surgical Center** and professional offices.

The Montgomery Surgical Center is located on the first floor of the Taylor Medical Complex and has eight state-of-the-art, integrated operating rooms and two expanded endoscopy suites. Taylor Medical Complex provides much needed space for growing clinical services and is an attractive addition to the East campus.

The Montgomery Surgical Center became the first freestanding surgery center licensed in the state of Alabama. Founded in 1984 by a group of local physicians, the surgical center began operations with an average of 250 patients per month.

Since that time, the facility has expanded in physical appearance, as well as caseload size (currently averaging 1,000 patients per month). The center now houses 16 pre-operative bays, eight operating rooms, two Endoscopy rooms, 19 recovery bays, a business office and waiting areas.

Advanced procedures, improved medical technologies and new methods of post op pain management allow all patients to go home the same day. Montgomery Surgical Center is a multi-specialty facility offering general surgery, gastroenterology, gynecology, ophthalmology, orthopaedics, otolaryngology (ENT), plastics and pain management procedures.

The Montgomery Surgical Center is fully accredited by the Accreditation Association for Ambulatory Health Care (AAAHC).
Tab 6

Patient Rights

- Abuse, Neglect, Exploitation
- Diversity
- Confidentiality
- Restraints
- Pain Management
Abuse, Neglect, Exploitation

Staff education pertinent to the identification and procedures for handling identification and assessment for possible abuse, neglect and/or exploitation is required to be reviewed annually.

Definitions

**Abuse**: intentional maltreatment of a patient that may cause injury, either physical or psychological. This includes mental, physical, domestic, and sexual abuse.

**Mental abuse**: includes humiliation, harassment, and threats of punishment or deprivation

**Physical abuse**: includes hitting, slapping, pinching, kicking, burns, binding of limbs, controlling behavior through corporal punishment

**Sexual abuse**: includes sexual harassment, sexual coercion, sexual assault with or without penetration (fondling, forced participation in sexual fondling etc…)

**Neglect**: the absence of minimal services or resources to meet basic needs. Neglect includes withholding or inadequately providing food and hydration (in the absence of a legal document whereby this has been stipulated by the patient or healthcare proxy), clothing, medical care, hygiene. It may also include inadequate supervision of daily activities or placing the individual in an unsafe environment or situation.

**Exploitation**: taking advantage of another for one’s own benefit.
Recognition of Abuse

- Victims of abuse, neglect, and/or exploitation may come into the hospital through many channels.
- Hospital staff needs to be able to identify victims, give appropriate care, collect and safeguard evidentiary materials as required and make appropriate referrals to community resources.
- Recognizing that victims of abuse, neglect, and/or exploitation may have emotional needs, all possible efforts will be made to provide the patient with the emotional support needed as appropriate for the age, developmental level, and cultural, religious and spiritual beliefs of the patient.

Reporting and Recognizing Abuse, Neglect, and/or Exploitation- Children

- In accordance with Alabama Law, when any person under 18 years of age is treated for any condition that raises a suspicion of the person having been abused or neglected, it is mandatory that this suspicion be reported to proper law enforcement authorities.
- Upon discovery of any suspected abuse or neglect, an immediate report should be made to the Police Department Youth Aid (241-2790) 24-hours a day.
- During office hours, the Case Manager/Social Worker (CM/SS) should be notified. The on-call CM/SS personnel can handle child abuse cases after hours, if needed.
- The report should state the child’s name, his whereabouts, the names and addresses of his parents or guardians, if known, and the character and extent of his injuries.
- The report should give all other pertinent information regarding the child’s condition, its cause and the identity of any person(s) responsible for that condition.
- The Police Department Youth Aid will notify the Department of Human Resources, as necessary.
Reporting: Adults & Geriatrics

There is not mandated reporting of domestic abuse of competent adults.

It is mandatory under the Alabama Adult Protective Services Act, 1976, for the Department of Human Resources to investigate any adult, including the elderly or handicapped, who has been reported as being a victim of abuse, neglect or exploitation. Report to the Montgomery Police Department.

Failure to Report

- Failure to report a required report by a health care worker is a misdemeanor punishable by law.
- A person making a report in accordance with the law cannot be held liable for doing so.

*Section 26-14-1, et. seq. of the Code of Alabama, 1975*
Children: Birth to 17 Years of Age

Consent

- If a child presents for treatment of suspected abuse and/or neglect and is not accompanied by a parent or guardian, the child will be evaluated and treated as an emergency.
- The physician will document the need to proceed with treatment in the medical record. A special consent form is required for examination of alleged sexual abuse/rape victim.

Assessment: Children

The assessment of the abused, neglected, exploited child is multifaceted and focuses on the victim, the primary caregiver and the family with whom the victim resides. The assessment process should include biophysical and psychosocial behavior. Recognition factors may include, but are not limited to, the following:

- Bite marks
- Burns (do not correlate with history; imprint of objects, unusual location of burns)
- Long bone fractures (new or old) without correlation to history
- Internal organ injuries with unknown etiologies
- Bruising to back, genitals, mouth or in multiple locations
- Bruising in children less than 12 months old
- Fractures in children less than 12 months old
- Spinal Fractures
Assessment: Children (cont.)

- Head injuries that do not correlate with history
- Any injuries that do not correlate with history
- History of or x-rays, EEGs showing repeated or old injuries
- Child reports that abuse/neglect is occurring
- Harassment, name calling
- Pregnancies, STDs.
- Malnourished with failure to thrive
- Aggressive, antisocial behavior
- Withdrawn, apathetic and depressed

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Assessment: Children (cont.)

- External genitalia lacerations, abrasions, and/or bruising.
- Vaginal bleeding (other than menses), discharge, or infection
- Penile discharge, or infection
- Difficulty walking/sitting
- Pain/itching in genital area
- Venereal disease
- Over-protective parent no allowing child to be alone with staff members
- Parent minimizes the frequency or seriousness of injuries
- Delay in seeking treatment for injury
Interviewing Techniques: Children

DO’s
- Be supportive and sensitive through tone of voice, body language and the maintenance of eye contact.
- Sit at eye level with the child.
- Allow the child to relate the story with few interruptions.
- The child should be believed (until proven otherwise).
- Convey an attitude of support.
- Record statements accurately.

DO NOT’s
- Do not express or convey shock or surprise.
- Do not reflect judgments.
- Do not “lead” the child’s responses.
- Do not ask “open-ended” questions.
- Do not interview for extended periods of time.

Adults (18 – 64) and Geriatric (65 +)

Consent
The physician will document the need to proceed with treatment in the medical record.
A patient’s consent for treatment is obtained upon registration.
A special consent form is required for examination of alleged sexual abuse/rape victim.
Assessment: Adult & Geriatric

The assessment of the abused, neglected, exploited adult or geriatric patient is multifaceted and focuses on the victim, the primary caregiver and the family with whom the victim resides. The assessment process should include biophysical and psychosocial behaviors. Recognition factors may include, but are not limited to, the following:

- Multiple injuries or history of multiple injuries.
- Delay in seeking treatment, history of numerous doctors, not keeping appointments.
- Stress symptoms – migraine headaches, eating problems.
- Social problems such as overdoses, suicide attempt(s), alcohol or drug problems.
- Over solicitous partner.
- Conflict in history between victim and caretaker/spouse of the cause of injury.
- Injuries are inconsistent with history.

Assessment: Adult & Geriatric (cont.)

- Multiple injuries in various stages of healing.
- Injuries in area(s) covered by clothing.
- Lacerations, burns.
- Evidence of untreated decubiti.
- Homebound patients with evidence of decubitus or contractures.
- Poor hygiene; malnutrition, dehydration.
- Any injury during pregnancy.
- Self-induced abortions or multiple therapeutic abortions or miscarriages.
- Single car accidents; victim may also be the passenger.
- Emotional abuse or marital discord observed by the staff.
Assessment: Adult & Geriatric (cont.)

- Complaints of partner rape or sexual assault.
- Fearful, withdrawn behavior; fearful of caregiver.
- External genitalia lacerations, abrasions, and/or bruising.
- Vaginal bleeding (other than menses), discharge, or infection.
- Penile discharge, or infection.
- Difficulty walking/sitting
- Pain/itching in genital area
- Venereal disease

Interviewing Techniques

Dos

- Ask direct questions about the possibility of abuse.
- Assess safety of victim.
- Conduct the interview in private
- Maintain eye contact
- Approach the patient in a non-confrontational manner
- Explain how the information will be utilized
- Be direct, honest and professional
- Be understanding without compromising
- Get background information that may help in a thorough assessment
- Conduct the interview in simple and understandable terms

Don'ts

- Do not display disapproval of the situation
- Do not conduct the interview with persons present that may make the patient uncomfortable.
- Do not exploit the situation by asking unrelated questions
- Do not reveal the source of report
Intervention – Domestic Abuse

- Give emotional support and reassurance that domestic violence is a crime.
- Report to police if victim allows.
- Use very specific documentation on nature of injuries, victim behavior and quotes. Even if victim decides not to press charges now, he/she may later.
- Call a women’s shelter if victim requests.
- Offer 24-hour crisis numbers even if patient denies abuse or decides to return to spouse. Patient may need numbers at a later date.

Examination and Treatment

- The nurse and physician should attempt to establish rapport with the patient. Allow the patient to retain any personal property that provides comfort. Interviewing language and behaviors should be adjusted to the age of the patient to allow increased understanding by the patient.
- Treatment is based upon the extent of the injuries, both biophysical and psychosocial.
- Consultation may include
  - OB/GYN
  - Psychiatric
  - Internal medicine
  - Case Management
  - Chaplain Services
- Laboratory, radiological and other diagnostic tests may be ordered by the physician or at the request of an agency (police, DHR).
- Medication will be administered upon the order of the physician.
- Documentation
  - Must reflect the patient's examination and treatments
  - Appropriate reporting of the incident to the proper authorities and appropriate patient referrals must be noted.
Collection of Evidence

- The physician/registered nurse is responsible for the collection of the evidence needed as indicated by the agency requesting the evidence.
- To further maintain intactness of evidence, material collected is transferred in the appropriate SEALED container and/or medium from the attending physician/registered nurse to the agency representative requesting the evidence.

Referrals

- Case Managers are available to assist in the appropriate follow-up care and or to identify and recommend appropriate community resources for access to protective and/or advocacy services.
- Community Resource Manuals are located in the Emergency Department. Each case manager has his/her own resource manual for use during normal and on-call operating hours for the hospital.
- In the case of adults, hospital personnel will make a report to the Montgomery Police Department.
- If patient is a minor, the Police Department (BMC), Youth Aid or Department of Human Resources—Child Protective Services must be contacted.

Release of Information

- BMC Case Manager and Nursing personnel coordinate notification of the proper authorities. Release of information to the proper authorities is conducted by the Medical Record Department in accordance with the Medical Record Department Policy & Procedure Manual.
- The obtaining of photographs is coordinated with the appropriate authorities and the Director of Public Relations and/or his designee. Permission to photograph an individual is obtained on the appropriate form.
Diversity

Patient Rights

Ethics

Diversity is defined as “the fact or quality of being diverse; different”.

Ways we are different

- Race
- Culture/Ethnicity
- Gender
- Socioeconomic Status
- Family structure
- Age group/Generation
Language Resources

- Foreign Languages
  - Language Line available in all areas.
  - Only qualified medical interpreters should be utilized when informing the patient about their medical care (refer to policy)
  - Use of family, friends and children to perform as interpreters is not acceptable.

- Hearing Impaired
  - Qualified Interpreters* - made available at no cost to the patient.
  - Closed Caption TV
  - TTY/Voice- Alabama Relay Service for telephone communication.

- Speech Impaired
  - Written notes or picture charts
  - Family assistance, if appropriate

*Note: The Pastoral Care Office has a list of qualified interpreters.

Patient Rights

- Cultural and religious practices can influence the patient’s decisions related to their medical care.

- As a competent adult patient, they have the right “to exercise personal religious or cultural beliefs, as long as they do not interfere with consenting diagnostic procedures or treatment or infringe upon the rights of other people in the hospital”.

- “We will provide care in a manner that is sensitive to cultural, racial, religious and other differences”.

- Patients receive & copy of their rights & responsibilities at the time of admission.

(*Patient Rights and Responsibilities/Healthcare Safety Policy)
Ethics

- Contact the Nursing Supervisor if you need to access the Ethics Committee.
- In the event of a conflict related to medical decisions, Nursing Service personnel, the Chaplains, the hospital attorney and the hospital Ethics Committee can assist with the decision making process.

Spiritual Care

Chaplains are available to assist patients and families with their spiritual needs.

The Pastoral Care Office can contact the patient’s priest, minister or Rabbi, when requested.
Effective Communication

- **Communication is the key** when working with patients and families.
- Effective communication should occur between:
  - Doctor & patient/family
  - Doctor & hospital staff
  - Hospital staff & patient & family/decision makers
  - Patient & hospital staff
  - Patient & family

Working Together

- Bridging the gaps between cultures makes it easier for us to work together
- Learn more about the people you work with
- Respect the fact that we are not all alike
Confidentiality

- Patients have the right to expect that all communications and records pertaining to their care will be treated as confidential by the employees of Baptist Health.
- Baptist Health views confidentiality as a guarding and limiting of any discussion regarding medical condition, diagnosis or treatment by staff, physician, or other members of the health care team.
- In other words…you may not share information with anyone who is not directly involved with the patient’s care.

Patient Right to Privacy & Confidentiality

- Every patient connected to Baptist Health has the right to privacy and confidentiality.
- All discussions, consultations, examinations and/or treatments will be conducted so as to protect each patient’s privacy and confidentiality of information.
- Under no circumstances is a medical record or copy of a medical record ever to leave the building without proper authorization.
Patient Rights to Confidentiality

- The patient has a right to expect that all communications and records pertaining to his care will be treated as confidential by the hospital, except in cases when reporting is permitted or required by law.
- The patient has the right to expect that the hospital will emphasize the confidentiality of this information when it releases it to any other parties entitled to review information in these records.

Access to Patient Records

- The following personnel have access to patient records:
  - Utilization Review
  - Social Services/Case Managers
  - Pharmacy Staff
  - Physicians
  - Medical Records employees
  - Administration
  - Infection Control
  - Dieticians
  - Quality Management
  - Risk Management
  - Patient Education
  - Radiology
  - Respiratory
  - Laboratory
  - Employees/departments involved in the direct care of the patient
Visual and Auditory Barriers

To protect the dignity of individual patients, visual and/or auditory barriers will be utilized to the greatest extent possible without jeopardizing observation and safe care of patients.

- **Visual Barriers** – obstruct the patient from the view of uninvolved parties and include, but are not limited to, blinds in the side windows of the critical care units, curtains and doors in the ED, Outpatient and Radiology Departments, and curtains in semi-private rooms in the hospital.

- **Auditory Barriers** – obstruct sound from traveling to uninvolved parties as much as possible and include, but are not limited to, acoustical design to the remodeled areas, curtains between stretchers and beds, distance between patient interview areas, patient waiting areas, and patient care areas, and window/partitions between areas in patient accounts department.

Security of Information

- The confidentiality, security and integrity of all patient health information is assured through controlled collection, use and display of data.

- Baptist Health recognized the need for and right to patient confidentiality regarding all data and information and all information shall be regarded as confidential and; therefore, made available only to authorized users.
Electronic Records

- Workstations are to be logged out at night, at the end of a shift, or when not in use. Sensitive information is not to be displayed where unauthorized persons can see it.

- Access to information and data is on a need-to-know basis in order to perform job duties. Patient account numbers, medical record numbers and physician ID numbers are used to protect confidentiality in reporting process.

Filming/Photos

- Consent is obtained for recording or filming made for purposes other than the identification, diagnosis, or treatment of the patient.

- Under no circumstances should filming, recording or photography be used without a signed consent on the medical record.

- See policy: Filming, Recording, Photographing (For purposes other than patient identification, diagnosis, or treatment)
Restraint/Seclusion

- Staff members who have direct patient care contact will have education and training regarding the use of restraints and seclusion annually.
- All staff are responsible for the proper procedure, observation, monitoring and documentation requirements for restraint and seclusion.

Purpose/Philosophy

- Baptist Health is committed to preventing and reducing restraint and seclusion use, striving to eliminate use, and prevention of restraint injuries.
- Restraint or seclusion is only to be used when less restrictive interventions are ineffective or not viable or when there is an imminent risk of a patient harming himself or herself, staff or others.

Types of Restraint

- There are two types of restraint recognized at Baptist Health:
  - Use of restraint for
    - Nonviolent/Non Self-Destructive behavior
    - Violent/Self-Destructive behavior
- The type of restraint is not specific to the setting the patient is in, but to the situation the restraint is being used to address the behavior.
Use of Restraint

- Restraint and seclusion will only be used with an order from a physician and will be limited to situations which there is an assessed need for its use.
- During the use of restraint and seclusion, the patient’s rights, dignity and well being will be protected and respected.
- The use of restraint will be addressed in the patient’s plan of care and/or treatment plan.

Definition: Physical Restraint

- A restraint is any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely; or a drug or medication when it is not a standard treatment or dosage for the patient’s condition.
- Physical force may be human, mechanical or a combination thereof attached to the patient’s body that he/she cannot easily remove.
- Holding a patient in a manner that restricts his/her movement constitutes restraint for that patient.
Exceptions -
Not Governed by Policy

- The use of handcuffs and other restrictive devices applied by law enforcement officials are considered forensic restrictions.
- Limiting mobility or temporarily immobilize in relation to a medical, post surgical or dental procedure.
- Certain situations do not apply to the standards for restraint and seclusion, example: use of side rails to protect the patient from falling out of bed.
- See Baptist policy for more information.

Alternatives to Restraint

- Assess comfort and physical needs:
  - Toileting Needs- Do they need to use the bathroom? Are they clean and dry?
  - Temperature- too warm or cold
  - Pain/Discomfort
  - Nutritional needs
  - Do they want to sit up in a chair?
  - Are they ready to go back to bed?
- Assess environment to decrease stimuli.
  - Turn volume down on TV or turn TV off if it is irritating the patient.
  - Encourage visitors to speak quietly and limit number of visitors in the room at one time.
- Speak in a calm, reassuring voice.
- Explain procedures carefully and assess understanding.
- Use verbal redirection techniques.
- Use side rails to prevent the patient from falling out of bed.
  - Must document side rails used to protect patient safety, ex. after administering narcotic—otherwise side rails are restraint.
- Ask the family to stay with patient.
  - The family can help to reorient the patient.
  - The number of family members present at one time may need to be limited.
Restraint Orders

(Nonviolent/Non Self-Destructive behavior)

- Licensed Independent Practitioner (LIP) - any practitioner permitted by both law and the hospital as having the authority under his/her license to independently order restraints, seclusion or medication for patients.
- Orders for restraint and seclusion must be either written or verbally given by a LIP.
- A doctor of medicine or osteopathy may delegate the task of ordering restraints to an advanced practitioner or a physician assistant to the extent recognized by law.
- Orders can never be written as a PRN or standing order.
- A qualified nurse can initiate a restraint order after an appropriate assessment, but the physician must be notified to obtain a written or verbal order within 24 hours for nonviolent/non self-destructive behavior use.

Orders must contain the following elements:

- Date and time
- Reason for restraint/seclusion
- Type of restraint/seclusion to be used
- Duration (time limit) for restraint
- If verbal order, date/time and signature of RN writing the order
- Physician’s signature, date and time
Physician Notification:

For nonviolent/non self-destructive behavior ...

- The physician must be notified within 12 hours of initiation and a verbal or written order must be obtained.
- If the restraint was initiated due to significant changes in the patient’s condition, the physician must be notified immediately.

Reassessment by LIP

- The patient must be re-evaluated by a LIP once each calendar day for nonviolent/non self-destructive behavior.

- LIP=Licensed Independent Practitioner

Order Renewal

- When the original order is about to expire, an RN can report to the physician the results of the most recent assessment and request a renewal of the original order for another period of time.

- The time period cannot exceed the time limits specified in the policy.
  - For nonviolent/non self-destructive behavior - up to 24 hours

- The order can only be renewed up to a total of 24 hours.

- The MD must evaluate the patient face-to-face once each calendar day.
Monitoring
At a minimum, the following parameters are monitored and documented

- Vital signs
- Circulation & ROM
- Hydration needs
- Hygiene/Elimination
- Level of distress and/or agitation
- Mental status
- Skin integrity
- Physical Status and Comfort

- The actual monitoring may be delegated to assistive personnel with oversight by the registered nurse. (see policy)

- Every 2 hours for nonviolent/non self-destructive behavior
- Refer to policy for more information

Restraint Devices

- Restraint will be implemented in the least restrictive manner.
- Types (listed from least restrictive to most restrictive)
  - mitts
  - vest
  - elbow immobilizer
  - soft limb - 1 or 2 extremities
  - soft limb - 3 or 4 extremities
  - seclusion
  - hard limb ("leathers")
Restraints: Who Can Apply?

- Only Licensed nursing staff may apply initial restraints after proper education and training.
- The following personnel may release and reapply restraints during performance of care after appropriate education and return demonstration:
  - Licensed nurses
  - Clinical Associates and Patient Care Technicians
  - Physical Therapists, LPTAs, PT/OT Techs III
  - Respiratory Therapists, RT Techs
  - Lab Techs, Phlebotomists
  - Radiology Techs

Note: Staff not trained in the application or release of restraints must consult the Licensed Nurse, PCT or Clinical Associate to release and/or reapply the restraint.

Discontinuation of Restraints

- The patient will be continually assessed for the opportunity to remove restraints.
- Restraint should be discontinued when the clinical treatment is discontinued (lines remove, extubated, etc.) or the patient's actions no longer warrant the need for restraint.
Violent/Self-Destructive behavior
Restraint and Seclusion

- Any use of restraint and seclusion for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member or others.

Definition: Seclusion

- The involuntary confinement of a patient in a room or area where he/she is physically prevented from leaving; usually in a locked room; may only be used for the management of violent or self-destructive behavior that jeopardized the immediate physical safety of the patient, a staff member, or others.

- Seclusion will only be used in circumstances described above.
Definitions: Timeout

- A **timeout** is the restriction of a patient for any period of time to a designated area from which the patient is not physically prevented from leaving and for the purpose of providing the patient an opportunity to gain self control.

Alternatives to Restraint

- Speak in a calm, reassuring voice.
- Explain procedures carefully and assess understanding.
- Attempt to redirect agitated patients to another topic.
- Use de-escalation techniques such as non violent crisis prevention.
Restraint Orders (Violent/Self-Destructive behavior)

- Licensed Independent Practitioner (LIP) - any practitioner permitted by both law and the hospital as having the authority under his/her license to independently order restraints, seclusion or medication for patients.
- Orders for restraint and seclusion must be either written or verbally given by a LIP.

- A doctor of medicine or osteopathy may delegate the task of ordering restraints to an advanced practitioner or a physician assistant to the extent recognized by law.
- Orders can never be written as a PRN or standing order.
- A qualified nurse can initiate a restraint order after an appropriate assessment, but the physician must be notified to obtain a written or verbal order within one hour for behavioral management.

Orders must contain the following elements:

- Date and time
- Reason for restraint/seclusion
- Type of restraint/seclusion to be used
- Duration (time limit) for restraint
- If verbal order, date/time and signature of RN writing the order
- Physician’s signature, date and time
Emergency Application of Restraint/ Seclusion for Violent/Self-Destructive behavior

- Restraint and/or seclusion use is limited to emergencies for behavioral health care reasons to protect the patient against injury to self or others because of violent/self-destructive behavior, AND non-physical interventions would not be effective.
- In the event of an emergency, restraint and seclusion can be initiated by an RN following a thorough assessment.
- Following the application, a verbal order for restraint must be obtained from the physician and assessment by the physician within one hour.
- This one hour assessment may be done by a behaviorial health RN or PA who has been trained to conduct such an assessment.

Physician Evaluation for Violent/Self-Destructive Behavior Restraint

- The purpose of this evaluation is to evaluate
  - the immediate situation,
  - the patient's reaction to the intervention,
  - the patient's medical and behavioral condition
  - the need to continue the restraint and seclusion and to work with the patient and staff to identify ways for the patient to regain control and to revise the treatment plan as appropriate.
- If the patient recovers quickly and is released from restraint/seclusion within the first hour of use, the physician must still complete the one-hour face to face evaluation.
Physician Notification for Restraint/Seclusion

- The physician must be notified within one (1) hour.
- The physician or other qualified staff must perform a face-to-face evaluation within one (1) hour.

Order Renewal

- When the original order is about to expire, an RN can report to the physician the results of the most recent assessment and request a renewal of the original order for another period of time.
- The time period cannot exceed the time limits specified in the policy.
- The order can only be renewed up to a total of 24 hours.
- The MD must do a face-to-face evaluation once each calendar day.
- If any restraint or seclusion is discontinued prior to the expiration of the original order, a new order must be obtained prior to re-initiating seclusion or applying restraint if the behavior reoccurs.
- Restraints and seclusion should be ended at the earliest possible time.
Time Limits

- For Violent/Self-Destructive behavior restraint -
  - Up to 4 hours for adults 18 years and older
  - Up to 2 hours for ages 9-17 years
  - Up to one hour for children under 9 years

Reassessment by LIP

- For Violent/Self-Destructive behavior restraint, the patient must be re-evaluated at least every 24 hours if they are 18 years and older or every 4 hours for patients ages 17 years and younger.

- LIP=Licensed Independent Practitioner
Monitoring

At a minimum, the following parameters are monitored and documented:

- Vital signs
- Circulation & ROM
- Hydration needs
- Hygiene/Elimination
- Level of distress and/or agitation
- Mental status
- Skin integrity
- Physical Status and Comfort

- Every 15 minutes for Violent/Self-Destructive behavior restraint/seclusion

If restraint and seclusion are used simultaneously, the patient must be continually monitored either face to face by an assigned staff member OR by a staff member using both video and audio equipment. The staff member must be in close proximity to the patient and all areas of the room must be visible.
Types of Restraints & Proper Application

- Vest:
  - A vest is one type of restraint device.
  - Knowledge of how to properly tie the vest is essential to maintain patient safety.

- Apply vest to patient with the part of the vest labeled “FRONT” across the patient’s abdomen.

- The vest should close in the back.
- The straps should come straight over the shoulder and straight off to each side of the bed - Do Not cross the straps!

Vest

- Make sure that the top of the vest does not move up toward the patient’s neck.
- The proper placement of the vest should be checked frequently.
Types of Vests

- Vest types may vary between facilities and are subject to change.
- It is important to correctly apply the vest.
- Follow manufacturers guidelines for proper application.

Types of Restraints & Proper Application

- Mitten restraints may be ordered for some patients.
- They allow the patient hand movement within the mitten but prevent the patient from being able to disconnect tubing, etc.
- Care should be taken to apply the mitten to allow adequate circulation and hand movement within the mitten.
The elbow immobilizer is a splint that can be used as a restraint alternative for all ages to help prevent tube pulling.

- These multi-purpose arm Splints (left) offer a gentle reminder to restrict arm movement, without resorting to rigid arm splints.
- The Splint is easy to apply with hook and loop straps and the nylon end loops may be pinned or clipped to the patient's sleeve to prevent it from sliding off.
- Translucent fabric allows the Splint to remain in place during X-rays.
  Optional Translucent Attachment Clips (#8162) can be left in place for X-rays. Filled with tiny, flame retardant polystyrene beads, the Freedom Splint acts as an immobilizer for limbs to protect tubes or IV lines.
- Machine washable. One per package. Infant through adult sizes available.

Types of Restraints & Proper Application

- Wrist Restraint
  - All staff who apply wrist restraints must follow proper procedure when applying the restraints
  - The patient must be properly assessed while the restraints are in use.
Application of Wrist Restraints

- **Step 1:**
  - Explain the procedure to the patient & family.
  - Follow policy.
  - Obtain wrist restraints.
  - Place restraint in open position under patient’s wrist.

- **Step 2:**
  - Wrap the soft padding of the wrist restraint around the patient’s wrist.
  - The restraint should be secure but not too snug.

- **Step 3:**
  - Check the restraint by placing one finger under each side of the restraint.
  - The two fingers should be able to touch in the middle.

- **Step 4:**
  - Secure the buckle in the top of the restraint.
  - This should not make the restraint tighter. It is used to keep the restraint from coming loose.

- **Step 5:**
  - After the buckle is secured, check the restraint again.
  - Check for adequate circulation.
  - Check hand movement.

- **Step 6:**
  - The next step is to apply the “quick release” buckle to the nylon strap.
  - This is an important step to maintain the patient’s safety in the event the patient needs to be quickly removed from the bed.
Application of Wrist Restraints

- **Step 7:**
  - After the “quick release” buckle is attached, secure the buckle in place to the second (lower portion) strap that secures to the bed frame.

- **Step 8:**
  - Check the buckle to make sure it is in proper alignment.
  - The lower half of the buckle should *never* be secured to a moving part of the bed.
  - Special handles are available on the bed frame for securing the strap.

Securing Restraints

- Never tie restraints to side rails or areas where the bed moves.
- Always secure to stationary parts of bed frame.
Leather Restraints

- In certain circumstances, it may be necessary to apply leather restraints.
- Please refer to the policy and procedure for specific information.
- Not all clinical areas stock leather restraints. If you need assistance to obtain leather restraints, please notify your supervisor.

Special Considerations for the Geriatric Patient

- There are several reasons why special care should be taken to prevent problems with Geriatric Patients. These include:
  - Skin is more susceptible to bruising and breakdown
  - Bone demineralization and muscle changes
  - Increase in mental confusion and disorganization
  - Increase in lower extremity edema
  - Urinary incontinence and/or retention
- Restraints should be avoided whenever possible.
Special Considerations for the Pediatric Patient

- Pediatric patients are very unpredictable and more frequent observations are required when they are restrained.
- Attention is to be given to assess for and avoid bed entrapment.
- Restraints should be avoided whenever possible.

Special Considerations for the Cognitive and physically limited patient

- Cognitive and physically limited patients are at higher risk for restraint injury. More frequent observations are required.
- Restraints should be avoided whenever possible.
Documentation (all restraints)
per episode must include:
- the patient’s behavior prior to restraint/seclusion
- interventions used and alternatives tried and/or considered
- the rationale for the use (patient’s condition or symptom(s) that warranted the use of restraint or seclusion)
- the patient’s response to use
- how the least to most restrictive techniques and devices were considered or tried
- any injuries sustained during the process
- the patient’s understanding of the reason for the restraint/seclusion
- the patient’s understanding of the criteria that must be met for the removal of restraint/seclusion
- rationale for continued use of restraint/seclusion

Restraint Validation
- Each employee who applies restraints must be observed (by a validator) tying and untying the restraints and this should be documented on their competency skills validation form annually.
- The restraint policy including safety measures and alternatives should be reviewed.
- Please contact Education if you have questions.
Staff Education

- All staff authorized to apply and/or re-apply physical restraint or seclusion:
  - Receive training in the safe use of restraint including the application and removal of restraints, physical holding techniques, take down procedures and implementation of seclusion.
  - Be CPR Certified
  - Complete CPI training as required for application of behavioral restraint

- Direct Care Staff must be able to:
  - Identify factors that require the use of restraint or seclusion
  - Select the least restrictive intervention
  - Identify when restraint or seclusion is no longer necessary
  - Monitor the physical and psychological well being of the patient
  - Use de-escalation, mediation and self protection techniques and time-out
  - Recognize signs and symptoms of physical distress
  - Monitor vital signs and meet the basic care needs of the patient

Staff Education (cont.)

- In addition to all of the aforementioned educational requirements, Behavioral Health Nurses validated with competencies authorized to conduct the one hour assessment following restraint use for behavioral management must have training on medical and physical symptoms that may cause behavioral symptoms
Staff Education Verbal De-escalation

- **Verbal de-escalation is a technique, utilizing strategic words or phrases to reduce the heightening of a potentially violent situation.**
- Encourage thought. Ask questions beginning “how?” and “when?” Try to get details of the reasons for his/her anger. This will help to refocus the situation on his/her intent to act out the anger. *Don’t:* Use questions beginning “why?” this has been found to be provoking.
- Give clear instructions. Be brief. Be assertive. Negotiate options with the person, i.e. “shall we go over here?” “Would it be better if I phoned...” *Don’t:* Invite assault, i.e. “go on then, try it!”

Staff Education Verbal De-escalation

- **Eye contact and body posture.** Allow the person greater body space. Stand at a “friendly” angle to the person (45 degrees). Keep an “open” posture with hands by sides but palms turned outward. *Don’t:* Stare. Keep your hands behind your back or in your pockets. Fold your arms across your chest.
- **Personalize your self.** Remind the person who you are and that you are trying to help him/her. Use words such as “we” or “us” to emphasize cooperation.
- **Show concern.** Nod your head and show that you’re listening. Encourage the person to talk by saying “go on...” “I see...” etc. *Don’t:* Use phrases like “calm sown” or “don’t get upset”. Instead try “I understand that you are feeling upset right now and we are here to help you as much as we can.”
- **Mood match.** Try to match the person’s arousal but not his/her emotion. Display empathy but not anger.
Staff Education Physical Holding Techniques (Behavioral Health Only)

- Use at least two people, one must be trained on restraint application
- One person is to observe the patient for any signs of physical distress or respiratory difficulty
- Avoid excessive force around chest
- Do not cover mouth or nose
- Avoid any contact on or near the patient’s throat

Reporting of Patient Deaths While in Restraint and/or Seclusion

- Any patient death that occurs while a patient is restrained or in seclusion, deaths within 24 hours after the patient has been removed from restraints, or where it is reasonable to assume that a patient’s death within one week of use of restraints is a direct or indirect result of use of restraint or seclusion, will be reported by hospital staff to the Nursing Supervisor, Administrator on call and the Quality Manager for the facility.
- All deaths of patients restrained for behavioral management reasons of violent, aggressive, or combative behavior toward self or others will be reported by the Quality Manager to the CMS Regional Office by telephone no later than the close of business the next business day following the knowledge of the patient’s death. The date and time of notification will be documented in the medical record.
  - See policy for more information
Baptist Health Pain Management

Goal
1. To individualize and implement a pain management plan for each patient in need of this service.
2. To promote, support and participate in the development and execution of educational activities related to pain management.
3. To educate patients and their families, when appropriate, about their roles in managing pain and the potential limitations and side effects of pain treatments.

Purpose of Pain Management: to control & provide physical, emotional and spiritual support for patients experiencing acute or chronic pain.

Acute Pain
Pain that is associated with a clear cause:
- Injury
- Inflammation
- Trauma
Recent onset, short duration.
To avoid Undertreatment & Overtreatment, frequent reassessment of the patient's pain is required
- Treatment of acute pain can be difficult since intensity of pain can change dramatically over a short period of time.
- Under treatment risks excessive suffering & poses medical risks.
- Overtreatment poses medical risks.

Chronic Pain
Pain over a period of time of longer duration. Chronic pain is associated with long term chronic illnesses such as:
- Cancer
- Back injury
- Joint disease
- Nerve damage
Chronic pain may lack an identifiable physical cause. It's the most common cause of long-term disability.
Mixed Pain (Unspecified Pain)

Common in serious or end-stage diseases. Can be caused by:
- Trauma that damages tissue and nerves.
- Burns that burn skin as well as nerve endings.
- External nerve compression.
- Tumor nerve compression.
- Sciatica from herniated disc pressing on nerves.

Treatment:
Combination of pharmacological agents:
- NSAIDs
- Opioids
- Adjuvant medications
- Non-pharmacological interventions

What is Pain Management?

Pain management includes pharmacological & non-pharmacological approaches to prevent, reduce or stop pain.

It requires an interdisciplinary approach because of the different causes and types of pain & pain syndromes.

The elements of the interdisciplinary approach to Pain Management include the following:
- Treating the underlying cause of pain
- Pharmacological therapies
- Non-pharmacological therapies
Barriers to Pain Management in the Healthcare Setting

- Belief that patient’s are not the authority about their pain.
- Lack of thorough assessment & thorough, frequent reassessment.
- Ineffective communication.
- Misinterpretation of patient’s presentation.
- Belief that patient’s are “clock watchers” or “drug-seekers”.
- Patient concerns about side effects
- Cultural/Spiritual beliefs

Assessment & Reassessment of Pain

- Assess pain on admission.
- Reassess pain:
  - With shift assessment
  - Change in caregiver
  - Complaints of pain
  - Within the appropriate time frame after implementation of pharmacological &/or nonpharmacological interventions.

Communication

- Give a thorough shift report/patient handoff to staff.
- The complete pain assessment/reassessment is to be documented in the Clinical Information System (Cerner).
- The patient’s pain level at the time of the intervention is to be documented on the Medication Administration Record (MAR). The patient’s pain comfort level with reassessment is to be documented on the MAR.

If we do not assess/reassess pain, we will never be able to relieve pain!
Pain Management is a Team Approach!

The cause of the patient's pain & how the patient deals with it determines what team members play a role in the pain management plan. The following may be members of the team:

- Patient &/or family
- Physician
- Nurse
- CA/PCT
- Pharmacist
- Respiratory Therapist/Technician
- Physical Therapist/Technician
- Radiology Technician
- Phlebotomist
- Dietician
- Case Manager
- Pastoral Care
- Psychologist
- Dietician
- Case Manager
- Pastoral Care
- Psychologist

Patient Education

The Pain Management plan needs to be reviewed with the patient &/or family.

- Patient’s role as a member of the pain management team.
- Pain medication ordered.
- Side effects/complications of the pain medication.
- ALL pain management interventions.
- PCA - Patient-Controlled Analgesia, when appropriate.

www.bedsidepainmanager.com
Neonate/Infant

“What is painful to an adult is painful to an infant until proven otherwise.” -Franck, 1989

Uncontrolled pain in the neonate/infant affects all organ systems & can be life threatening.

Reduced tidal volume & vital capacity in the lungs
- Change in respiration
- Decreased oxygen saturation

Increased demands on the cardiovascular system
- Increased heart rate
- Increased blood pressure

Hypermetabolism resulting in neuroendocrine imbalances
- Electrolyte disturbances
- Hyperglycemia
- Metabolic acidosis

Neonate/Infant: Assess pain using “pain cues”

- Crying
- “Cry face”
- Grimacing
- Irritability/agitation
- Abdominal guarding
- Elevated heart rate/blood pressure
- Change in respiration
- Rigid posturing
- Limp/flaccid/decreased activity
- Clenched hands
- Hand splaying
- Sleeplessness

Parents know when their child is hurting so ask for their input.

Document change in “pain cues” to show improvement.
Neonatal Infant Pain Scale - NIPS

Composed of the following 6 indicators with descriptors:

- Facial expression – relaxed, grimacing
- Cry – no cry, whimper, vigorous
- Breathing patterns – relaxed, changed
- Position/movement of extremities – relaxed, flexed/extended
- State of arousal – sleeping/awake, fussy

Each indicator is scored with 0 or 1 except “cry”, which has 3 possible indicators & is scored with a 0, 1 or 2.

Infants should be observed for 1 minute in order to fully assess each indicator.

Neonate/Infant

Difficult to distinguish between pain & agitation.

**Pain**
- Decreased respiratory effort (guarding)
- BP/HR increase; can decrease
- Diaphoresis
- Palmar sweating
- Metabolic changes

**Agitation**
- Increased respiratory effort
- Increased HR & RR with activity only
- No diaphoresis
- No palmar sweating
- No metabolic changes

*With agitation, evaluate the environment and provide comfort measures (non-pharmacological).*
Pediatric Patients

Pain assessment & management is difficult in this age group due to their inability to effectively communicate their needs.

❖ Obtain a thorough pain history including the words the child uses to indicate pain ("hurt", "owie", "boo-boo", etc.).
❖ Communicate at the child’s level of understanding when assessing & reassessing pain - Remember, some children regress when they are hospitalized.
❖ Children may not verbalize their pain because they are afraid of getting a "shot"; assessment/reassessment must be thorough.
❖ Often undertreated due to the parent's misguided fear of addiction & the nurse/physician’s inability to communicate with the patient.

Pediatric Pain Assessment

Includes pain scales as well as pain cues.

Wong Baker Faces Scale

Riley Pain Scale

Behavioral scale that can be utilized with pediatric patients that are nonverbal or cannot understand Wong/Baker Faces scale.

Composed of the following indicators:
❖ Facial Expression
❖ Body Movement
❖ Sleep
❖ Verbal/Vocal
❖ Consolability
❖ Response to Movement/Touch
Geriatric Patients

“Kids are not little adults and older patients are not simply older adults.”

Geriatric patients are as different as pediatric patients due to unique changes that occur as they age.

Hepatic function progressively decreases - decreased hepatic blood flow/mass leads to altered drug metabolism

Renal function progressively decreases - decreased glomerular filtrate/creatinine clearance leads to altered drug clearance.

Increase in body fat & a change in fat distribution

Decrease in muscle mass

Protein binding in serum diminishes

Because of these changes geriatric patients have an increased chance of toxicity from virtually all drugs.

Geriatric Patients

Assessment is complicated by the following:

- Under-reporting of symptoms
- Existence of multiple medical comorbidities exacerbating the patient
- Increased prevalence of cognitive impairment

In addition to using the specific term “pain” when interviewing older adults, also use terms such as “discomfort”, “aching”, “soreness”, etc."

Geriatric patients, whether cognitively impaired or not, are often underdosed with acute pain; especially true for patients dealing with chronic pain.
Cognitive, Language Impairments or Unconscious/Unresponsive Patient

- Interview caregivers
- Assess for non-verbal behaviors &/or vocalizations
- Assess for alterations in function that may be signs of pain
- Assess & reassess pain without exception.
- If verbally unresponsive but can use finger/hand to signal, Wong/Baker Face scale could be used.
- Use “pain cues”
- Use Riley Pain scale

### Riley Pain Scale Assessment Tool

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Facial</strong></td>
<td></td>
</tr>
<tr>
<td>Neutral/smiling</td>
<td>0</td>
</tr>
<tr>
<td>Frowning/grimacing</td>
<td>1</td>
</tr>
<tr>
<td>Clenched teeth</td>
<td>2</td>
</tr>
<tr>
<td>Full cry expression</td>
<td>3</td>
</tr>
<tr>
<td><strong>Body Movement</strong></td>
<td></td>
</tr>
<tr>
<td>Calm, relaxed</td>
<td>0</td>
</tr>
<tr>
<td>Restless/fidgeting</td>
<td>1</td>
</tr>
<tr>
<td>Moderate agitation or</td>
<td>2</td>
</tr>
<tr>
<td>moderate mobility</td>
<td></td>
</tr>
<tr>
<td>Throbbing, falling,</td>
<td>3</td>
</tr>
<tr>
<td>insistent agitation</td>
<td></td>
</tr>
<tr>
<td>strong voluntary</td>
<td></td>
</tr>
<tr>
<td>immobility</td>
<td></td>
</tr>
<tr>
<td><strong>Sleep</strong></td>
<td></td>
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<td>Sleeping quietly with</td>
<td></td>
</tr>
<tr>
<td>easy respirations</td>
<td>0</td>
</tr>
<tr>
<td>Restless while asleep</td>
<td>1</td>
</tr>
<tr>
<td>Sleeps intermittently</td>
<td>2</td>
</tr>
<tr>
<td>(sleep/awake)</td>
<td></td>
</tr>
<tr>
<td>Sleeping for prolonged</td>
<td>3</td>
</tr>
<tr>
<td>periods of time</td>
<td></td>
</tr>
<tr>
<td>interrupted by jerky</td>
<td></td>
</tr>
<tr>
<td>movements or unable</td>
<td></td>
</tr>
<tr>
<td>to sleep</td>
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</tr>
<tr>
<td><strong>Verbal/vocal</strong></td>
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<tr>
<td>No cry</td>
<td>0</td>
</tr>
<tr>
<td>Whimpering, complaining</td>
<td>1</td>
</tr>
<tr>
<td>Pain crying</td>
<td>2</td>
</tr>
<tr>
<td>Screaming, high-pitched cry</td>
<td>3</td>
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<tr>
<td><strong>Consolability</strong></td>
<td></td>
</tr>
<tr>
<td>Neutral</td>
<td>0</td>
</tr>
<tr>
<td>Easy to console</td>
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</tr>
<tr>
<td>Not easy to console</td>
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<tr>
<td>Inconsolable</td>
<td>3</td>
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<tr>
<td><strong>Response to Movement/Touch</strong></td>
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</tr>
<tr>
<td>Moves easily</td>
<td>0</td>
</tr>
<tr>
<td>Wines when touched/moved</td>
<td>1</td>
</tr>
<tr>
<td>Cries out when moved/touched</td>
<td>2</td>
</tr>
<tr>
<td>High-pitched cry or</td>
<td></td>
</tr>
<tr>
<td>scream when touched</td>
<td></td>
</tr>
<tr>
<td>or moved</td>
<td></td>
</tr>
</tbody>
</table>

Difficult to Manage Patient

Make sure epidural catheter is patent (dressing not damp/wet &/or catheter not lying in the bed).

Notify the physician if the Pain Management plan is not working, the patient is not reaching their “comfort zone”.

Make sure IV is patent, not infiltrated.
Pain Reassessment

When is pain reassessed?
- With each shift assessment
- Change in caregiver
- With each new report of pain
- After non-pharmacological interventions
- Within one (1) hour of pharmacological intervention or sooner depending on scope of practice:
  - 20 minutes following IV pain medication
  - 30 minutes following IM pain medication
  - 60 minutes following PO pain medication
  - 20 minutes following rectal pain medication

Patient-Controlled Analgesia – PCA
Use of pain pump to deliver IV pain medications (PCIA).

May be delivered by a continuous &/or bolus method.
Allows patient participation by balancing sedation & pain.
Safe method of delivering pain medication as long as the patient is the only person activating the bolus button.

Education of safety features of pump important to eliminate fear of overdose.

ONLY the physician that is ordering the pain pump settings & following the effectiveness of the pain management plan can write orders relating to pharmacological pain management (pain pump, breakthrough medications, pm pain medications, etc) until pain pump discontinued.
Patient Controlled Epidural Analgesia
Use of pain pump to deliver epidural pain meds (PCEA).

Anesthesiologists, CRNAs & PACU RNs can set up the GemStar PCEA pump.
Anesthesiologists & CRNAs are the only ones that can connect to the patient after program has been entered.
With a physician’s order, RNs can make changes to the program.
RNs & LPNs can review the program & review history for documentation on the PCEA flowsheet.

Care of the PCEA Patient
For complications, stop pump, notify anesthesiologist immediately!

If sensation &/or movement of the lower extremities is decreased/absent, notify anesthesiologist!
Continuous pulse oximeter must be maintained until epidural catheter is discontinued, then continue checking oxygen saturation every 4 hours X24 hours.
Patient may assume any position desired; use caution in moving & turning to avoid dislodging or displacing catheter.
Do not change dressing, may dislodge or displace catheter.
Do not administer narcotics for 12 hours post-administration unless ordered by the anesthesiologist who is in charge of the patient’s pain management plan.
PCA Assessment/Reassessment

Assess every hour times 1, every 2 hours times 1 then every 4 hours until therapy is discontinued.

Always assess 1 hour after a change has been made in the PCA settings.

Document on PCIA/PCEA flowsheet:
- Program review
- History review
- Complete patient assessment

Range Order Guidelines

- Start with lowest dose ordered.
- Reassess effectiveness at time frame recommended for route of administration (20 min IV, 30 min IM/SC, 60 min PO, 20 min rectal).
- Titrate upward after each reassessment to maximal ordered dose for the prescribed dosing interval until “comfort zone” is reached.
- If the maximal dose is given during the prescribed dosing interval without the patient reaching their “comfort zone”, Notify the physician.

NOTE:
Total amount of additional doses can not exceed the maximum amount of dose range ordered.
See policy to address opioid tolerant patient pain management considerations.
**IV Dosing Time Interval**

IV peak onset of action is 20 minutes.  
The patient may be given subsequent doses every 20 minutes *until one of the following occurs*:

- Patient reaches their “comfort zone”.
- Maximal dose in the dose range is achieved.
- Total dosing time interval is achieved.

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**IM Dosing Time Interval**

IM peak onset of action is 30 minutes.  
The patient may be given subsequent doses every 30 minutes *until one of the following occurs*:

- Patient reaches their “comfort zone”.
- Maximal dose in the dose range is achieved.
- Total dosing time interval is achieved.
PO Dosing Time Interval

PO peak onset of action is 60 minutes.
The patient may be given subsequent doses every 60 minutes until one of the following occurs:
- Patient reaches their “comfort zone”.
- Maximal dose in the dose range is achieved.
- Total dosing time interval is achieved.

Range Order Guidelines

For subsequent doses, if the physiological assessment reveals no signs of sedation or respiratory depression, start with the highest effective dose where the patient’s “comfort zone” was achieved.
Therapeutic Duplication

Physician has ordered one or more routes of administration for a single medication OR has ordered more than one medication.

Use the following criteria to determine the appropriate route/medication to administer to the patient.

- Patient’s reported pain level.
- Results of physiological assessment for acute pain.
- REMEMBER – chronic pain patient’s physiological responses may not be indicative of pain.
- Effectiveness of prior interventions.
- Stage of recovery of post-op patients:
  - Immediate post-op may require IV/IM
  - Day prior to discharge, oral would be more appropriate.

Recognition & Management of Complications of Pain Management

- Sedation
- Respiratory Depression
- Spinal Headache
- Inadvertent Subdural Penetration with the Catheter
Sedation Level Scale

Allows an objective assessment of sedation on a standard scale.

1. Wide awake – may administer opioid dose if needed
2. Drowsy, easily aroused – may administer opioid dose if needed
3. Sleep, easily aroused – may administer opioid dose if needed
4. Mostly sleeping, difficult to arouse, drifts off to sleep during conversation – Do Not Administer Opioid; Notify Physician*
5. Unable to arouse, somnolent, minimal or no response to physical stimulation – Do Not Administer Opioid; Notify physician*

NOTE:
*Oral/IV/IM pain medications – Notify patient’s physician.
*PCIA – Notify the physician that is ordering the pain medication/pain pump settings (patient’s physician or Anesthesiologist)
*PCEA – Notify the Anesthesiologist.

Respiratory Depression

Caused by a reduce sensitivity of the respiratory system to CO2.

Recognition:
- Respiratory rate equal to or less than 8; may have episodes of apnea.
- Slow process; can occur 6-24 hours after drug was started.
- Downward trend in respiratory rate – report RR in shift report & to CAs/PCTs.

NOTE:
- PCIA – Notify the physician that is ordering the pain medication/pain pump settings (patient’s physician or Anesthesiologist)
- PCEA – Notify the Anesthesiologist.
Administration of Narcan for Respiratory Depression

NOTE: *May induce acute withdrawal symptoms in patients who are opioid dependent.*

Mix one ampule (0.4mg/ml) of Narcan & 10ml of normal saline. Give 0.1mg (2.5ml) slow IV push every one (1) minute prn to maximum of 0.4mg. Patient should open his/her eyes & talk to you within 1-2 minutes.

Spinal Headache

**Recognition:**
- C/O “terrible headache”
- Indicative of chronic leak of CSF
- Brain descends slightly into cranial vault

**Treatment:**
- Strict bedrest until resolved (usually 1-3 days)
- Blood patch – draw blood from antecubital space & inject into epidural space at same level of initial puncture; works as glue which prevents CSF leakage
Inadvertent Subdural Penetration with the Catheter

Causes:
- Catheter threaded into epidural space & forced through membrane
- Catheter migration

S/S will be rapid with bolus administration; gradual with continuous infusion:
- Vasodilation
- Numbness
- Leg weakness

Treatment:
- Notify physician
- Remove catheter

Side Effects of Pain Management

Common Side Effects:
- Constipation
- Nausea & Vomiting
- Pruritis
- Urinary Retention

Treatment:
- Administer ordered medications
- Call physician if there are no orders or if side effects are not relieved
CA/PCT Documentation

Document patient’s response to the question “Are You Hurting?” in the OTHER box under the Safety Check column whether it be yes or no.

If the answer is yes, document to whom you reported the pain.

Remember to change the time to reflect when screening & reporting took place.

Summary

- Assess/reassess without exception!
- Believe the patient!
- Use a scale to document pain intensity & response.
- Identify needs!
- Collaborate with team members!
- Educate patient &/or family, when appropriate, about the pain management plan.
- Implement pain management plan.
- Notify physician if pain management plan ineffective!
HIPAA

- Compliance
- Conflict of Interest
- Important Healthcare Laws and Regulations
- Ethics
Baptist Health
Corporate Compliance
and HIPAA
Education

Content – Corporate Compliance

The learning objectives for this training module will be:

- Define Compliance
- Increase knowledge of Compliance Laws, Rules, and Regulations
- Explain importance of Documentation, Coding, and Billing
- Heighten awareness of HIPAA Privacy and Security requirements
- Define process on how to report compliance and HIPAA concerns
What is Compliance?

Compliance is...
A process of following the rules, laws, and policies that apply to our organization to prevent, identify and correct questionable conduct and promote honest and ethical behavior in the day-to-day operations. Basically, it is doing the right thing in our responsibilities toward each other and others.

Examples include:
• Appropriately documenting and billing for medically necessary services provided to our patients
• Maintaining honesty and integrity in our communication with others and in our business practices
• Keeping confidential information private

Healthcare facilities have corporate compliance programs to help prevent misconduct. A good compliance program reduces the risk of error or fraud by giving guidelines for how to do your job in an ethical and legal way.

Integrity in Action

Our Code of Ethical Behavior and education regarding the Deficit Reduction Act of 2005:
• Gives all Baptist Health workforce members a clear understanding of what is expected of them in the workplace
• Pledges our commitment to honest, ethical business practices
• Requires professionals within our facilities to follow the ethical standards of their profession
Everyone is Responsible for Compliance

Many laws and regulations govern what we can and cannot do in our workplace and address activities such as:

- Conflicts of interest and commitment
- Accurately documenting services provided
- Following coding rules for services provided
- Adhering to billing regulations
- Responding to audits and investigations

Conflict of Interest

A conflict of interest occurs when an individual or organization is involved in multiple interests, one of which could possibly corrupt the motivation for an act in the other.

A conflict of interest means situations in which financial or other personal considerations may adversely affect, or have the appearance of adversely affecting, an employee’s professional judgment in exercising any duty or responsibility.
Conflicts of Interest and Commitment
Hospital employees may not:

- Participate in financial, business, or other activities that are illegal or interfere with their primary hospital responsibilities.
- Use their position to influence hospital business decisions in a manner that could lead to personal benefit for themselves or their families.
- Misuse or abuse hospital resources including hospital employees' time, equipment and supplies or the hospital's name and reputation.

Documentation, Coding and Billing
- Patient care services must be documented accurately and completely in the medical record. A complete medical record facilitates the ability of the physician and other health care professionals to evaluate and plan patients' immediate treatment and to monitor their health care over time. The same complete medical record allows for the justification of medical necessity, accurate and timely claims review and payment, appropriate utilization review, and quality-of-care evaluations and data collection for a variety of other needs.
- Patient care services rendered must be accurately and completely coded to ensure both proper billing and the integrity of the medical data base. The resources published annually necessary to code health services are the Current Procedural Terminology (CPT) book, the Healthcare Common Procedural Coding System (HCPCS) book, the International Classification of Diseases (ICD-9) book, the CPT Assistant and Coding Clinic or their electronic equivalents. It is important to use the current version of these coding resources as coding changes from year to year.
- Baptist Health bills only for patient care services rendered and documented; the company adheres to the billing requirements of Medicare, Medicaid, other government-sponsored programs and other commercial payors. "If a patient care service provided is not documented, it did not happen and we will not bill for it."
Responding to Audits and Investigations

Local, state and federal agencies have broad legal authority to investigate Baptist Health, review its records, and talk to employees.

Investigations can be related to areas such as:
- Documentation, coding, and/or billing
- Patient abuse and complaints
- Regulatory violations
- Emergency care practices (EMTALA)
- Communicable diseases

Responding to Audits and Investigations

- Do not release or copy any documents without authorization. If the investigator has a search warrant, do not obstruct the process, but take careful notes of everything the investigator does.
- Do not create or alter any reports or documents.
- Do not volunteer or provide information not requested.
- Maintain a list of the information or documents requested and any information which you provided.
- Do not destroy hospital documents at any time, especially while there is an investigation, audit, or litigation pending.
- Do not discuss the investigation with other employees or anyone outside of Baptist Health.
- Please contact the Compliance Officer or General Counsel if you receive a search warrant or are approached by a representative of the government or governmental agency.
Important laws and regulations for healthcare are:

- False Claims Act
- Mail and Wire Fraud Statutes
- Deficit Reduction Act
- Anti-Kickback Statute
- Patient Anti-Dumping Statute (EMTALA)
- Red Flag Rules
- Recovery Audit Contractor (RAC) Audits
- HIPAA Privacy and Security Regulations
- American Recovery and Reinvestment Act

In recent years, government agencies have started to look more closely for healthcare fraud and misconduct.

A lot of federal money has been used to investigate and prosecute suspected fraud.

This has increased the number of providers convicted of fraud.

The government might investigate your facility as a result of:

- Random selection
- Suspicious billing patterns
- Patient complaints
- Whistle-blower complaints

Looking for the root causes of a compliance problem can help identify ways to prevent similar problems in the future.
The False Claims Act:
The False Claims Act makes it illegal to submit a falsified bill to a government agency for reimbursement.

The Federal False Claims Act:
• Applies to healthcare
• Contains a whistleblower provision
• Carries strong penalties for violation
• Increased the number of providers convicted of fraud

Several states have laws focusing on False Claims in addition to the Federal False Claims Act.

Mail and wire fraud statutes make it illegal to use the U.S. Mail or electronic communication as part of a plan to defraud.

For example, these statutes make it illegal to mail a fraudulent bill to Medicare.

Penalties are:
• Fines of up to $250,000
• Up to 30 years in jail
The Deficit Reduction Act of 2005:

- Promotes the use of the Federal False Claims Act and its whistleblower provisions.
- Focuses on eliminating fraud, waste, and abuse in the Medicaid Program.
- Created the Medicaid Integrity Program that calls for increased audits of providers submitting claims for reimbursement to Medicaid.

Anti-Kickback Statute

The Medicare and Medicaid Patient Protection Act of 1987 is commonly known as the **Anti-Kickback Statute (AKBS)**.

This law makes it illegal to ask for or receive kickbacks, bribes, or rebates for:

- Referring a patient for an item or service that will be paid for by a government program (such as Medicare)
- Purchasing an item or service that will be paid for by a government program
- The AKBS also makes it illegal to offer or pay a kickback, bribe, or rebate related to a Medicare item or service.
Possible penalties for violating the Anti-Kickback Statutes are:

- $25,000 fine
- Up to five years in jail
- Exclusion form Medicare and Medicaid

EMTALA

The Emergency Medical Treatment and Active Labor Act (EMTALA) is commonly known as the Patient Anti-Dumping Statute. This statute that requires Medicare hospitals to provide emergency services to all patients. These services are:

- Medical screening for patients who may have an emergency condition.
- Stabilizing care for patients who do have emergency condition.
- Hospitals must provide these services, whether or not the patient can pay.
Patient Anti-Dumping Statute: Penalties

If a hospital violates EMTALA, possible penalties are:

- Up to $50,000 per violation for hospitals with 100 beds or more
- Up to $25,000 per violation for hospitals with fewer than 100 beds
- Exclusion from Medicare

Red Flag Rules

The Federal Trade Commission (FTC) has issued a set of regulations known as the “Red Flag Rules”. The Red Flag Rules protects patients from identity theft. “Red Flags” are warning signs that signal the risk for identity theft. Hospitals must:

- Identify relevant “Red Flags”
- Detect “Red Flags”
- Prevent and mitigate identity theft
- Update programs periodically
Medical Identity Theft

Medical identity theft is one of the fastest growing types of identity theft. Medical identity theft occurs when personal information, such as health insurance numbers and social security numbers, are retrieved from workforce members and non-workforce members at medical facilities.

Always safeguard protected health information (PHI). Use the designated shred boxes to properly discard PHI. Do not place documents containing PHI in regular trash cans/bins.

If you work in an area that collects credit card information for billing and/or purchases, immediately discard credit card numbers in the designated shred boxes in your work area when the work task is completed.

Recovery Audit Contractor (RAC) Audits

The Recovery Audit Contractors (RACs) identify potential payment errors in such areas as medical necessity, coding, and lack of documentation to support the submitted claim and recapture the payments.

The Recovery Audit Contractor (RAC) program, which began in late 2009, is a cost containment effort aimed to identify improper payments within Medicare programs as well as process improvements to reduce or eliminate future improper payments.

The Federal Government has projected that use of these audits could yield at least $2 billion over the next three years.
HIPAA Privacy & Security Regulations

The HIPAA Privacy and Security Rule protects the patient’s right to privacy and security of their health information.

From the HIPAA Compliance Plan Policy & Procedure Manual:
"Baptist is firmly committed to complying with HIPAA, both because it is legally required to do so, and because it is the right thing to do. Assuring the integrity and privacy of confidential health information is fundamental to our mission. Baptist and our workforce and professionals have always been committed to these underlying ideals. HIPAA merely means Baptist will need to work harder and follow new processes in achieving these goals, and it adds additional penalties for noncompliance."

Protected Health Information (PHI)

The Health Insurance Portability and Accountability Act (HIPAA) of 1996, a federal law, has as its goal to make health insurance more portable, health care more cost-effective, and the sharing of health information more confidential and secure. The portions of the law that are important for the purposes of this review are those that deal with protecting the privacy and security of health data, which HIPAA calls protected health information (PHI).

Information, including demographic data, about patients that is created or received by a HIPAA covered entity (such as Baptist Health) in the course of:
- providing treatment
- obtaining payment for treatment or other health care services
- teaching/learning
- conducting research
**Protected Health Information (PHI)**

Individually identifiable health information that is PHI are:

- Name
- Address
- Dates (birth, admit, discharge, death)
- Phone numbers
- Fax numbers
- Electronic mail addresses
- Social Security numbers
- Medical record numbers
- Health plan beneficiary numbers
- Account numbers
- Certificate / license numbers
- Automobile license plate numbers, vehicle identifiers and serial numbers
- Device identifiers and serial numbers
- Web universal Resource Locator (URL)
- Internet protocol (IP) address number
- Biometric identifiers, including finger or voice prints
- Full face photographic images and any comparable images
- Any other unique identifying number, characteristic or code

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**Protected Health Information (PHI)**

Data Types Protected by HIPAA:

- Photographic image
- Spoken and verbal information including voice mail messages
- Written documentation and all paper records
- Electronic databases and any electronic information, including research information and electronic medical records, containing PHI stored on a computer, PDA, memory card, USB drive, or other electronic media
HIPAA – Uses & Disclosures

HIPAA regulations allow the use and disclosure of protected health information to facilitate treatment, payment, and health care operations activities (TPO):

- When HIPAA permits use or disclosure of PHI, Baptist Health must use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.
- PHI is accessed for business and/or work-related purposes only—those purposes outlined for treatment, payment, or health care operations (TPO).
- The use and disclosure of PHI are restricted to those individuals who have a WORK-RELATED need to know the confidential information.

HIPAA – Permitted Uses and Disclosures

The Privacy Rule states that PHI may be used and disclosed for Treatment, Payment, and Healthcare Operations (TPO), which means:

- PHI may be disclosed to other providers for treatment, e.g., communicable diseases to the Health Department, and poisonous substances to Poison Control Centers.
- PHI may be disclosed to other covered entities for payment.
- PHI may be disclosed to other covered entities that have a relationship with the patient for certain healthcare operations such as quality improvement initiatives, case management and compliance reviews.
- PHI may be disclosed to the individual who is the subject of the information.
HIPAA – Top Do’s and Don'ts

- Do not discuss or share PHI with coworkers, family, or friends unless they have a business/work-related need to know (TPO purposes).
- Limit PHI used or disclosed to the minimum necessary PHI to accomplish the purpose.
- Do not share your user ID, password, or other means of system access with anyone.
- Log off a computer if it is to be left unattended for any time, or if a coworker needs to use it.
- Do not use your access to the clinical systems to look up your own medical information or information on your family, friends, or co-workers.
- Never take photographs of patients or their families with personal devices. Refrain from taking pictures in patient care areas.

CAUTION

HIPAA Tips: Safeguarding Faxes

- Refrain from sending highly confidential information in a fax when possible.
- Double-check the contents of all information being faxed or mailed outside of Baptist Health, and the intended recipient’s contact information for completeness and accuracy.
- Double check fax numbers before dialing and check confirmation sheets to verify that the transmission was successful and accurate.
- Use fax cover sheets and fax confirmation sheets at all times.
- Limit the PHI to the minimum necessary.
- Ensure that confidential information is not left on the fax machine.
- If faxed information containing PHI had been sent in error, notify the Privacy Coordinator promptly.
Extra HIPAA Tips

- Do not send emails containing PHI outside of the Baptist Health network. If you need to do so, you must contain the Help Desk to have the email encrypted.
- Verify information such as name, date of birth, and the last digits of the social security numbers prior to discussing account information with patients.
- Do not disclose patient information outside the scope of regular work duties without obtaining prior authorization.
- When leaving a message for a patient at their residence or place of employment, never disclose the nature of the phone call and never disclose PHI.
- When leaving a message, leave only your name, employer and phone number as the message. In the event the person taking the message for the patient insists on knowing why you are calling, you may state that the call is regarding an important business matter and no more.
- Workforce members should not bring family members or friends into the work area for extended periods of time without the permission of a supervisor.

Social Networking

- There is no expectation of privacy on social media websites because social media websites are a public forum. Some sites allow you to put in place privacy settings but they do not insulate you from discovery. Individuals would have freedom of speech only when speaking on matters of public concern.
- Workforce members may not engage in personal social media networks during work time and/or with Baptist Health resources. This would also include the use of personal devices. i.e. BlackBerry, iPhone, etc. for social networking.
- Workforce members should not make any derogatory comments about co-workers, managers, etc. on social media sites, and should not talk about patients even if the patient is not identified by name or unit.
- Workforce members should report any known activity that violates Baptist Health policy to their manager immediately. All reported activity will be fully investigated by Compliance and Human Resources.
- Workforce members who are in violation of Baptist Health policy will be subject to corrective action up to and including termination.
- Baptist Health is an at-will employer and may choose to not employ you if your behavior is not in line with our core values and expected standards. A policy that explicitly addresses social media use is forthcoming.
Social Networking: Scenario

A nurse on the floor, logs onto her personal Facebook page after work to share the events of her day with friends and other hospital employees who are Facebook friends. While on the website, the nurse goes to the Facebook “Wall” and writes “I had the most bothersome and annoying patients in the ICU today”. Several of the nurse’s Facebook friends that are also hospital employees make comments based on the post. Is this a violation?

Yes. This is a violation. The nurse has violated Baptist Health policy and possibly HIPAA regulations. The nurse’s other hospital employee friends on Facebook are also in violation if they participated in the conversation. Employees should not talk about patients on social media sites even if the patient is not identified by name or unit.

Social Networking: Scenario

A conversation on Twitter reads:

Employee A: WUP? On my way to work.
Employee B: Listening 2 news. Waiting on EMS to arrive with vics.
Employee C: Like a zoo in trauma bay.
Employee B: Pager just went off. Got 2 scrub n. Most r gun shot vics Long nite ahead n already tired.
Employee A: Be there n a sec. Oops spoke to soon. News blocking entrance. Check your text msg. Sending photo of scene outside ER.

Has any violation occurred here?

Yes. Workforce members identifying themselves as working at Baptist Health should understand their postings are an extension and a reflection of Baptist Health. There is no expectation of privacy on social media websites. All information is public.
Friend in the Hospital: Scenario
A staff member recognizes an acquaintance, realizes the acquaintance is a patient in the hospital, and shares this information with someone else. Has the staff member violated HIPAA?

Yes, if the staff member shared the information not related to his or her job. Recognizing the patient would be considered an incidental disclosure. Disclosing this information to another person, however, would be considered an inappropriate release of PHI.

Checking on a Family Member: Scenario
Jennifer is a nurse on Unit 5. Her mother has been admitted to another unit and she knows her mother has had some tests and that the results should be in the system by now. Jennifer looks up her mother’s record and reads the test results. Did Jennifer violate HIPAA or the organization’s related policies?

Yes. This is a HIPAA and a policy violation and subject to disciplinary action, even if Jennifer’s mother doesn’t complain.

While she had good intentions, Jennifer used her ID and password for personal reasons not related to her job.
Camera Phones: Scenario

Wanda, an emergency room nurse, was on duty when a family was brought into the emergency room after an automobile accident. The family included a set of infant twin boys, and Wanda was assigned to care for them. Wanda used her cell phone to take a picture of her with the boys. To let her friends know of her involvement, Wanda sent friends a text message about the accident, along with pictures of her and the twin boys. Was Wanda wrong?
Yes. Wanda violated several privacy and security regulations, as well as hospital policy. Photographs should never be taken in patient care areas and should never be taken with personal portable devices, for example, cell phone cameras.

Log Off While Leaving: Scenario

Dora walks away from a shared workstation without logging off. She’s not concerned, since she remembers that the system times out after 10 minutes. Bill walks by, notices that the workstation is still logged on with no one around, and quickly looks up the medical details on Roxanne, a woman he’s dating. Later, Roxanne becomes suspicious when Bill reveals that he knows private medical information about her. Roxanne calls the facility and complains to the privacy officer. Has Dora violated any rules?
Yes. Dora is ultimately responsible for any system activity which occurs under her logon ID and password. Dora can be sanctioned for failure to log off and leaving the data vulnerable to unauthorized disclosure and tampering.
Baptist Health HIPAA Standards

Baptist Health has developed both privacy and security core standards to govern how the institution and its Workforce shall operate to comply with HIPAA.

Noncompliance with these standards can result in disciplinary action up to and including termination of employment or clinical privileges.

Policies for Baptist Health Information Systems

The following policies are intended to effectively communicate HIPAA information security guidelines to all users of Baptist Health System information systems.

HIPAA Privacy Rule: Penalties

CRIMINAL penalties are:

- Fine of up to $50,000 and jail time up to one year for knowingly obtaining or revealing protected health information (PHI)
- Fine of up to $100,000 and jail time up to five years for obtaining or revealing PHI under false pretenses
- Fine of up to $250,000 and jail time up to ten years for obtaining or revealing PHI and intending to use the information for gain or harm

CIVIL penalties for violation of HIPAA are:

- Up to $100 per violation
- Up to $25,000 per calendar year for multiple violations

These penalties may be applied to organizations/entities as well as to individuals.
**HIPAA Developments**

**American Recovery and Reinvestment Act ("ARRA") - Stimulus Act**

- Expands privacy and security provisions of the Health Insurance Portability & Accountability Act ("HIPAA")
- Describes breach notification and reporting obligations
- Outlines business associate obligations
- Imposes increased enforcement and penalties

**Breach Notifications**

We must notify individuals, the government and in some instances, local media, of "breaches" of "unsecured protected health information".

- A "breach" is the unauthorized acquisition, access, use or disclosure of "unsecured" protected health information which compromises the security or privacy of the information, except where an unauthorized person to whom the information is disclosed would not reasonably have been able to retain the information.

- Unsecured protected health information is PHI that is not secured through the use of a technology or methodology that renders it unusable, unreadable or indecipherable and that is developed or endorsed by the American National Standards Institute (ANSI).

**Exceptions:**

- Any unintentional acquisition, access or use of PHI by an employee if made in good faith in course of employment and no further disclosure
- Any inadvertent disclosure from an individual who is authorized to access PHI to another similarly situated individual at the same facility and no further disclosure.
- Unauthorized disclosure in which an unauthorized person to whom PHI is disclosed would not reasonably have been able to retain information.
Breach Notifications

For all breaches of unsecured protected health information, we must:

- Notify affected individuals within 60 calendar days of discovery
- Maintain log of breaches and submit annually to Department of Health & Human Services to be published on public website
- If more than 500 individuals are affected, we must:
  - Notify affected individuals within 60 calendar days of discovery
  - Post on a public website
  - Notify the Department of Health & Human Services "immediately"
  - Notify major media outlets in the Montgomery area

Business Associate Obligations

HIPAA privacy and security obligations will apply directly to vendors and service providers for hospitals, physicians and health plans.

- Government can impose penalties directly on third party vendors and service providers if they violate HIPAA standards.
- Vendors and service providers must notify the hospitals, physicians and health plans of any breaches by the vendors and service providers.
Increased Enforcement and Penalties

State Attorneys General are authorized to bring civil actions in U.S. District Court for HIPAA violations. Injunction or damages of $100 per violation, not to exceed $25,000 aggregate identical violations during a calendar year.

Increased Civil Money Penalties - 4 tiers

- "Unknowing Violations" - $100 per violation, not to exceed $25,000 for identical violations during a calendar year
- "Reasonable cause but not willful neglect" - $1,000 per violation not to exceed $100,000 for identical violations during the calendar year.
- "Willful neglect" - $10,000 per violation, not to exceed $250,000 for identical violations during a calendar year.
- "Willful neglect" violation not corrected within 30 days - $50,000 per violation, not to exceed $1,500,000.

By February 2012, affected individuals may be entitled to a percentage of civil monetary penalties collected.

HIPAA Basic Workforce Responsibilities

Patient and employee information from any source and in any form (such as paper, talking, computers) is confidential.

I shall protect the privacy and confidentiality of patient and employee information. Access to this information is allowed ONLY if I need to know it to do my job.
I Agree That:

- **I WILL ONLY** access information I need to do my job.
- **I WILL NOT** show, tell, email, copy, give, sell, review, change or improperly dispose of any confidential information unless it is part of my job. If it part of my job to do any of these tasks, I will follow the correct department procedure (such as shredding confidential papers before throwing them away).
- **I KNOW** that confidential information I learn on the job does not belong to me.
- **I AM RESPONSIBLE** for my use or misuse of confidential information.
- **I WILL KEEP** my computer password secret and I will not share it with anyone.
- **I WILL** ensure that any media device (laptop, PDA, flash drive) I am responsible for that contains patient information is appropriately encrypted.
- **I WILL** protect the privacy of our patients and employees.
- **I WILL NOT** use camera phones to take pictures in patient areas.

Open Lines of Communication

Lines of communication must be **open** and **effective** to support our compliance program.

Open communication increases the ability to:

- Identify problems early
- Correct problems promptly
Consequences of Misconduct

When a provider is convicted of fraud, penalties can include:

- Criminal fines
- Civil damages
- Jail time
- Exclusion from Medicare or other government programs

In addition, a conviction can lead to serious public relations harm.

Workforce members will be subject to discipline, up to and including termination, and are not excluded from criminal fines, civil damages, jail time, and exclusion for Medicare or other government programs.

Response to Compliance Problems

The Corporate Compliance Program provides for a prompt response to any compliance problems. All reported or suspected problems are reviewed. If the review shows that there is a problem, the problem should be corrected right away. Looking for the root causes of a compliance problem can help identify ways to prevent similar problems in the future.

The plan for correction may include:

- Self-reporting to government agencies
- Reimbursement of any overpayments
- Looking into the root cause of the problem
- Discipline for workforce members involved
Reporting Misconduct

If you suspect or become aware of an inappropriate use or disclosure of PHI or access to a system, you have a responsibility to report this activity to your supervisor, the Privacy Coordinator, the Corporate Compliance Officer, or the Information Security Director.

You may report by phone toll-free to the Baptist Health Ethics Hot Line at 1-800-621-5966

If you prefer to remain anonymous, leave sufficient details to allow the Privacy Team to investigate your concerns.

"High ethical standards are vital to workplace morale and productivity, and maintaining them is a core value for Baptist Health."

Ethics Hot Line

Reports to the Baptist Health Ethics Hot Line:

- Allow the caller to remain anonymous.
- Are handled in strict confidence.
- Are handled in a way that protects the privacy of any patient involved.
- Will be thoroughly evaluated in a timely manner.
Reporting Compliance Concerns

You may also report compliance concerns by:

- Addressing concerns with your supervisor or manager through your normal chain of command
- If you are uncomfortable speaking with your supervisors, or have continuing concerns after having done so, you may seek the assistance of Corporate Compliance Officer by calling 334-273-4417.

If a caller chooses to identify themselves, their confidentiality will be protected to the extent permitted by law.

Reporting Concerns: Non-Retaliation

Baptist Health will not tolerate retaliation against any workforce member who in good faith reports a possible legal or compliance concern.

Your manager cannot fire you or take actions against you because you reported what you honestly believed to be illegal or improper conduct.

If it is determined that you have been subject to retaliation by your supervisors, those responsible will be investigated, and violators will be subject to disciplinary action, up to and including termination.

You cannot make-up or exaggerate reports of wrongdoing to protect yourself or hurt someone else.
Remember

The Corporate Compliance Officer is available to provide prompt response to any compliance concerns. You may seek the assistance of the Corporate Compliance Officer by calling 334-273-4417.

If you would like to report your concerns anonymously, you can call the Baptist Health Ethics Hot Line which is toll-free, 1-800-621-5966.

Remember who to contact for compliance concerns!

Compliance Contact Information

Department Phone Number
334-273-4442

Email
corporatecompliance@baptistfirst.org

Corporate Compliance Website
www.baptistfirst.org/corporatecompliance

Ethics Hotline
1-800-621-5966
Tab 8

Environment of Care

- Safety and Security
- Hazardous Materials
- Fire Safety
- Medical Equipment
- Utilities
- MRI Safety
The Joint Commission
Environment of Care Chapters

A. Safety and Security
B. Hazardous Materials and Waste
C. Fire Safety
D. Medical Equipment
E. Utilities

SAFETY OFFICER
System Safety Officer - Chip Hicks / 286-3286

The Safety Officer of Baptist Health has the authority to intervene or halt operation if conditions warrant. The Facilities Management/Engineering Managers at each facility have the authority to intervene or halt operation in the absence of the System Safety Officer.

Contact the Safety, or Facilities Management/Engineering Departments to reach these individuals.
Safe Environment Management Practices

- Maintain a safe physical environment by practicing “On Going Hazard Surveillance”. On going hazard surveillance means to constantly be on the look out for safety issues and reporting those issues immediately when identified.
- Report any unsafe condition or practice to your manager or the Safety Office
- Injury prevention & investigation:
  - Root Cause Analysis, Risk Assessments, following prescribed hospital, and departmental safety policies & procedures.
- What is the most common injury in healthcare today? (Hint: see next slide)

Prevention of Back Injuries

- Size up the load.
- Get help, if needed.
- Hold load close.
- Bend your knees.
- Lift with your legs.
- Keep back straight.
- Don’t twist.
- Assist devices.

*refer to Baptist Health Safe Patient Lifting and Mobilization policy.
ELECTRICAL SAFETY

1. Inspect all equipment prior to use.
2. Immediately report frayed cords, broken plugs, loose or broken electrical outlets to Facilities Management for repair.
3. Remove defective equipment from service.
4. DO NOT USE MULTIPLE ADAPTERS
5. Report all shocks during use of equipment to Facilities Management or the Bio Medical Department.
6. If an employee injury occurs while using any equipment:
   - Notify your supervisor, Employee Health and BioMed.
   - Remove equipment from service.
   - Place an “out of service” tag on the equipment
7. Be able to identify when the hospital is running on emergency generator power. Two appropriate responses are:
   - All of the lights in your area may not be working
   - Call Engineering if you are in doubt

Smoking/Tobacco Policy

- Smoking is allowed outside the building in designated areas only.
- The smoking policy includes all patients, visitors, staff, and physicians.
- All Baptist Health locations are scheduled to be totally smoke/tobacco free beginning January 1, 2011.
HOSPITAL CODES

CODE YELLOW - CHEMICAL SPILL
CODE RED - FIRE
CODE ORANGE - BOMB THREAT
CODE BLUE - CARDIOPULMONARY ARREST
CODE PINK - INFANT/PEDIATRIC/GERIATRIC ABDUCTION
CODE D - DISASTER PLAN IMPLEMENTATION
CODE SECURE - LOCK DOWN OF FACILITY
CODE 8 - ACTIVE SHOOTER/HOSTAGE
CODE STRONG (BMCE & PBH Only) - COMBATIVE PERSON

IMPLEMENT TORNADO WARNING - Facility may be in the path/directly impacted

BAPTIST MEDICAL CENTER SOUTH DIAL 6666
BAPTIST MEDICAL CENTER EAST DIAL 8888
PRATTVILLE BAPTIST HOSPITAL DIAL 3500
STATE YOUR LOCATION AND TYPE OF EMERGENCY

Baptist Health

CODE YELLOW

SPILL ACTIONS

1. Contain the spill
2. Notify supervisor and Environmental Services if not a hazardous chemical spill
3. Department in control of the chemical is responsible for cleanup.
4. Obtain appropriate MSDS by using MSDS Binderview program in CITRIX
5. If you are unable to locate the appropriate MSDS sheet, contact the Safety Officer for Baptist Health or, during an emergency only, you may use the Fast Fax Service by calling 1-888-362-7416.
6. The Emergency Room at each facility has a master list of MSDS sheets.
CODE RED
ACTION / THINGS TO DO
Fire in Your Area:
R-Rescue anyone in danger
A-Pull fire alarm and call emergency number to notify operator -state location
C-Confine the fire, close doors, Also “C”lear “C”orridors
E-Evacuate and-or extinguish the fire

The Fire Management Plan empowers nursing staff assigned to a unit to shut off the oxygen during a fire emergency without authorization from a supervisor.
- Make sure you are familiar with the locations of the oxygen shut off valves in your area
- Anytime the fire alarm sounds you should take immediate action regardless of the fire or alarm location. Implement “RACE”...Close doors, Calm patients and visitors, Prepare to respond if fire/smoke threatens your area.

FIRE EXTINGUISHER USE
P.A.S.S.
P-pull the pin in the handle trigger.
A-aim at the base of the fire
S-squeeze the handle
S-sweep from side to side.

FIRE PREVENTION
Your responsibilities as an employee of Baptist Health
- Know location of the Fire Plan Safety, Infection Control, Employee Health Manual, or SICEHM as it sometimes referred to. The manual may be viewed in Citrix under Policies and Procedures for your specific hospital, or in hard copy in the Emergency Department and Administrative offices at each hospital.
- What number do you call for a fire emergency?
- Know where to evacuate to, and why. (See “Red Dot Door” on next slide)

Daily Housekeeping:
Ensure there are no obstructions in front of fire extinguisher, fire pull station or medical gas shut-off locations. A distance of 36 inches must be kept clear at all times adjacent to and in front of these locations.
- Ensure fire emergency exits are not obstructed
- Ensure there is no stored equipment in the corridors, or in the stairwells.
- Only crash carts and isolation carts are permitted in the corridors as “In use items.”

Baptist Health
Evacuation

- Horizontal - if possible, evacuate to an adjacent smoke compartment on the same floor.
  - RED DOT DOORS
  - Designate smoke compartment separations.
  - When evacuating, go through a RED DOT DOOR and into another smoke compartment. Red dots identify compartment separations.

ALWAYS USE THE STAIRS DURING A FIRE SITUATION
Never the elevators!

USE THE STAIRS DURING A FIRE ALARM
NOT THE ELEVATORS!

Evacuation:
- **Horizontal** - if possible, evacuate to an adjacent smoke compartment on the same floor, or follow exit signs to the nearest safe exit
- **Vertical** - evacuate to another smoke compartment above or below your location.
- **Total Facility Evacuation** - evacuating the entire facility is to be used only as a last resort, when horizontal and vertical evacuation cannot be accomplished.

*Smoke compartment separations are identified by smoke doors (double doors in the corridors). When the fire alarm sounds smoke doors will close automatically.*
CODE ORANGE
BOMB THREAT
Action / Things To Do
- Keep caller on the line as long as possible
- Try to determine:
  - Age and sex
  - Nationality
  - Background Noises
- Notify the hospital operator immediately by calling your facility's emergency number.
  BMC South – 6666, BMC East – 8888, PBH - 3500
- Operator will announce “Code Orange”
- Department manager and selected staff will look for suspicious packages or items that might contain a bomb.

CODE PINK
- Missing infant, child, or elderly person
- Overhead announcement made by PBX operators
- The announcement will contain Race, Sex, and Age of the missing patient/visitor, etc.
- All departments monitor assigned exits
- Detain suspicious individuals.
Code D
Mass Casualty Incident

- Facility Disaster Plan
- Responses to:
  - Plane crash
  - Bomb explosion
  - Nuclear, Biological, Chemical weapons.

CODE STRONG
(BMCE and PBH Only)

- Staff determines need for assistance to manage combative behavior.
- Staff calls emergency security number.
- Security personnel respond and evaluate situation.
- Security notifies operator to announce, “Code Strong”.
- All available male personnel respond to announced location.
CODE 8 – Active Shooter/Hostage

HOW TO RESPOND
WHEN AN ACTIVE SHOOTER IS IN YOUR
IMMEDIATE AREA OR VICINITY

• Determine the most reasonable way to protect your own life.

RUN, HIDE or FIGHT

• Be aware that patients and visitors are likely to follow the lead of employees and managers during an Active Shooter situation.

• Contact Security immediately “5555” or Law Enforcement “911”.

RUN

Can I escape safely?

• Make sure it’s safe to do so
• Evacuees should leave behind their belongings
• Visualize entire escape route before beginning to move
• Avoid using elevators or escalators.
• DISTANCE is a tactical advantage, GET IT however you can!!
HIDE

- Move to a secure area
- Lock the door
- Silence any electronic devices
- Blockade the door with heavy furniture
- Cover all windows
- Turn off all lights
- Lie on the floor
- Remain silent

As a LAST RESORT if you have no other OPTION

FIGHT !!!!
If your life is in immediate danger
- Attempt to disrupt and/or incapacitate the shooter
- Act as aggressively as possible against the shooter
- Throw items at the shooter
- Use improvised weapons
- Yell, scream, make noise (Distraction)
- Most of all “Commit To Your Actions”

TORNADO WARNING
“IMPLEMENT TORNADO WARNING ACTIONS”
Baptist Medical Center monitors a 24 hour weather surveillance system. When a tornado warning is announced do the following:
- Move ambulatory patients to center hallways, away from glass & windows.
- Have patients sit on floor or in a sturdy chair against a wall, with a pillow to shield their heads from flying debris. Keep patients on one side of the hallway to allow for emergency access to the hallway.
- Non-ambulatory patients are to remain in bed with the bed moved away from windows. Close all blinds, drapes, and doors. You may allow one visitor to remain in the room with non-ambulatory patients.
- Visitors are directed to a waiting area as outlined in the Tornado Plan.
EMERGENCY PREPAREDNESS

- Effective response to disasters, which are natural or man-made:
  - Tornado
  - Bomb Threat
  - Mass Casualty Incidents
- All response plans are located in the Safety/Infection Control/Employee Health Manual (SICEHM).
- The SICEHM can be accessed in CITRIX under “Baptist Health Policies and Procedures”, then select appropriate hospital and then select SICEHM.
- A hard copy of the SICEHM is also maintained in Administration at each facility.

* Drills are conducted regularly.

SECURITY

System Security Director, Ed Alford - 286-2241

- The Safety Officer of Baptist Health has the authority to intervene or halt operation
- Always wear your identification badge while at work.
- Park in designated areas for employees.
- Lock up your valuables when you arrive at work.
- Request escorts if you are arriving or leaving work at unusual times.
- Report suspicious individuals immediately to Security

• TO REACH SECURITY IN AN EMERGENCY - Dial 5555
  BMC SOUTH: 5555    BMC EAST: 5555
  PRATTVILLE BAPTIST HOSPITAL: 5555
MEDICAL EQUIPMENT

ACTION / THINGS TO DO

Know how to use equipment properly
- Document staff training on all equipment
- Inspect equipment for defects prior to use.
- PM (Preventative Maintenance) stickers on equipment must be within one year, except for defibrillators which must be within 6 months.
- Report all defective or out of date equipment to your supervisor and BioMed.

- DO NOT USE MALFUNCTIONING EQUIPMENT - TAG AS DEFECTIVE AND REMOVE FROM WORK AREA
  - All equipment must be inspected by BioMed prior to use.
  - All essential equipment must be plugged into a red receptacle.

SAFE MEDICAL DEVICE ACT OF 1990

Reporting incidents in which a medical device is connected to the death, serious injury or serious illness of any individual, is required by law, and is accomplished through the Risk Management Department and the Bio-Medical Engineering Department.
UTILITIES MANAGEMENT

COMMON UTILITY SYSTEMS
- Electrical
- Telephones
- Water
- Medical Gas
- Heating, Ventilation, and Air Conditioning
- Nurse Call System
- P.A. System
- Sewer Lines
- Elevators

UTILITY FAILURES

ACTION / THINGS TO DO (refer to Safety Manual)

• Report utility failures to the Facilities Management or Engineering Department.

• After hours/weekends call the engineer on duty by notifying hospital operator.

• In the event of loss of electricity be sure essential patient equipment is plugged into electrical outlets powered by the Emergency Generators. They will be red or have the word “emergency” on the outlet.

• During electrical disruption, limit use of non-essential equipment and lighting.
Electronic Information Systems: Downtime

- In the event of scheduled or unplanned downtime, maintain downtime forms and requisitions in your department.
- In the event of major disruption of computer services, Baptist Health will implement the Information Services Disaster Recovery Plan. This contingency plan includes a set of readily workable back-up plans that accommodate the expected range of emergency events.
- See Baptist Health Information Management Plan and BH Policy and Procedures/Clinical Informatics “Cerner Downtown” policy for more information.

HAZARDOUS MATERIALS

- Hazardous chemicals used in the department are listed on Department Safety Checklist
- Obtain appropriate MSDS by using MSDS Binderview program in CITRIX
- Obtain hard copy Material Safety Data Sheets in the Emergency Department, or call MSDS Fast Fax @ 1-888-362-7416.
- Report any new chemical to the Safety Office.
- Do not bring cleaning chemicals from home. Request needed cleaning supplies from EVS.
NFPA Hazard Diamond

Blue (Health Hazard) - May cause health problems if acute exposure occurs by ingestion, inhalation, or physical contact.

Red (Flammability) - Evaluates the risk of materials to fireburst based on factors relative to the substance and surrounding environment.

Yellow (Reactivity) - Advises that a substance may react violently under certain conditions or exposures.

White (Specific Hazard) - Refers to the substances with specific hazards or properties such as oxidizers.

CITRIX Home Page. Scroll down to locate SDS Binderview Icon

Baptist Health
Click On SDS Binderview Icon to open program.

MRI Safety

- MRI Safety Applies to:
  - Patients
  - Accompanying family members
  - MRI staff
  - Attending healthcare professionals
  - Security, Housekeeping and others who may find themselves in or near the MRI suite
MRI Safety
(Magnetic Resonance Imaging)

- The goal of MRI Safety is to prevent harm to patients
- Multiple Safety strategies must be used to reach this goal
- Some safety strategies include:
  - Personnel/patient restrictions
  - Warning signs
  - Specialized training for MR personnel
  - Patient/Non MR Personnel screening
  - MR suite design and layout

MRI Safety: Never Assume

- Never assume that an implanted device is compatible or safe unless it is clearly documented in writing
- Never assume that people (including clinical staff) know that the Magnet is always on.
MRI: Screening

- All patients must be thoroughly screened.
- All patients must be interviewed using the MRI safety questionnaire. Provide for privacy for the interview.
- All patients must be screened by two individuals who have undergone MRI Safety training.
- If you have any questions about the MRI screening form contact the MRI department.
- ALL Non MR personnel wishing to enter MRI suite must first pass the MR screening process
- Even physicians (anesthesia) must be screened before entering the scan room.

MRI Safety: Overview

- Family members and ancillary personnel accompanying the patient into the scan room should be screened as if they are going through the procedure themselves.
- In preparation for the MRI exam, patient should be changed into a hospital gown.
- If a patient can not answer the screening questions, ask a family member or guardian.
- Screening questionnaires should include: prior injuries, prior surgeries and implants, pregnancy.
MRI Safety: Overview (cont.)

- All patients should be monitored verbally and/or visually.
- **Contraindications** for MRI include but are not limited to ferrous intracranial vascular clips, cardiac pacemaker.
- Patients arriving in wheelchairs or stretcher with O2 tanks should be provided with MR safe equipment and their equipment stored away from the magnetic field.

MRI Safety: Outpatient Centers

- Any hospital inpatient going to an outpatient imaging center for an exam must have their chart with them and a nurse must accompany the patient to the facility for the test.
Incident / Injury

- Notify your supervisor immediately.
- Complete QA report & give to supervisor.
- Supervisor or employee notify the Employee Health Office (after hours leave message on Employee Health Office phone)
- Employee Health Office or Supervisor assess injury and arranges medical care as appropriate.
- Employee follows up with Employee Health after treatment.

Incident / Injury: Medical Evaluation

- South and East employees: non emergent care is provided by Atlanta Highway PriMed. Prattville employees, report to Silver Hills PriMed. When PriMeds are not open, non emergent care will be provided by facility Emergency Department.
- All emergent cases and needle sticks and mucous membrane exposures are treated in facility ED.
- All work-related accidents /injuries must contact facility Employee Health nurse immediately and regardless of whether or not medical treatment is needed. After hours, contact facility Nursing Service Supervisor and leave Employee Health a voice mail message about occurrence.
Infection Control

- Respiratory Hygiene
- Standard Precautions
- Contact Precautions
- Airborne Precautions
- Droplet Precautions
- Immunosuppressed Precautions
- Exposure Control Plan
INFECTION CONTROL

WASH YOUR HANDS: This practice has shown to be the most effective means of minimizing the spread of germs from one person to another.

Note: Patient Care providers are not allowed to wear artificial nails.

Respiratory Hygiene/
Cough Etiquette

Purpose:
- To control the spread of any organism that transmits via droplet or airborne routes.
- In the context of Standard Precautions, the use of cough etiquette is an economical and relatively simple measure to take and can be invaluable in preventing transmission of many types of respiratory illnesses, including influenza, SARS, tuberculosis, and the common cold.
Elements of Cough Etiquette

- Cover mouth and nose when coughing or sneezing
- Use tissues to contain all respiratory secretions
- Dispose of all tissues in an appropriate waste receptacle (do not leave lying on tables)
- If no tissues are available, use sleeve

Elements of Cough Etiquette (cont.)

Perform hand hygiene after all contact with respiratory secretions
- Avoid touching any surfaces in the vicinity of a patient with respiratory symptoms
- If there is contact with surfaces, perform hand hygiene before caring for patient
Standard Precautions

- To reduce transmission from recognized and unrecognized sources of infection in hospitals

Specifications:
- Gloves
- Mask
- Gowns
- Hand-hygiene
- Needle safety

Isolation Guidelines

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<tbody>
<tr>
<td>Contact Isolation</td>
<td>Contact Precautions</td>
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<tr>
<td>AFB (Tuberculosis) Isolation</td>
<td>Airborne Precautions</td>
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<td>Strict Isolation</td>
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<tr>
<td>Immunosuppressed Precautions</td>
<td>Immunosuppressed Precautions</td>
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What about AFB Isolation?
Use Airborne Precautions (N95 Mask required)
Contact Precautions

**Contact Precautions:**
To prevent transmission of infections by direct contact
- MRSA, VRE, scabies
- Clostridium difficile, diarrhea, incontinence
- Uncontained draining wounds

**Specifications:**
- Private Room
- Gloves
- Gowns

Airborne Precautions

**Airborne Precautions:**
To decrease risk of airborne transmission of infectious diseases
- Disseminated Zoster, Chickenpox
- Measles
- Hemorrhagic Fevers
- *Tuberculosis
- *Smallpox
- *SARS
  *requires N95 Mask

**Specifications:**
- Private Negative Pressure Room,
- Door must remain closed,
- Mask (N95 Respirator),
- Patient must wear a mask when transported.
- Gloves and Gowns not indicated.
- Hands must be washed after touching patient or potentially contaminated articles.
Droplet Precautions

To decrease the risk of droplet transmission through close respiratory or mucous membrane contact with respiratory secretions.

- Influenza, Mycoplasma pneumonia
- Strep pharyngitis or pneumonia

Specifications:
- Private Room (negative pressure not required)
- Mask if within 3 feet of patient
- Patient must wear a mask for transport

Immunosuppressed Precautions+

To minimize the chance of acquiring an infection from caregivers, visitors, or another patient.

- Leukemia
- Pts taking cancer therapy
- Some HIV patients
- Patients with low platelet counts + physician driven

Specifications:
- Private Room (required)
- No uncooked food or fresh fruit
- No fresh of potted flowers
- Door must remain closed
- Strict handwashing before and after patient contact
- No visitors who have a cold, fever, or infection.
STANDARD PRECAUTIONS

Standard precautions means treating all blood, body fluids, secretions, excretions, *except sweat*, nonintact skin, and mucous membranes as potentially infectious.

BLOODBORNE PATHOGENS

These are viruses that are carried in a person’s blood or certain other body fluids that cause disease. The other body fluids that may spread the bloodborne pathogens are:

1. Blood products (such as plasma)
2. Amniotic fluid (fluid in the uterus of a pregnant women)
3. Fluids surrounding the brain, spine, heart, and joints
4. Fluids in the chest and abdomen

Bloodborne Pathogens (Cont.)

**HEPATITIS B & HEPATITIS C**: attack the liver and can cause:

- Active hepatitis—a flu like illness that can last for months.
- Chronic Carrier State—person may have no symptoms, but can pass HBV to others.
- Cirrhosis, Liver Cancer, and Death

**HUMAN IMMUNODEFICIENCY VIRUS (HIV)**: causes AIDS (Acquired Immune Deficiency Syndrome)

- HIV attacks the immune system, making the body less able to fight off infections. In most cases these infections eventually cause death.
- Other diseases caused by bloodborne pathogens: syphilis, malaria.

**ALABAMA INFECTED HEALTHCARE WORKER ACT**

Any HIV or Hepatitis B infected healthcare worker, who performs invasive procedures, must notify the Director of Infection Control of the Alabama Department of Public Health of his/her infections.
Bloodborne Pathogens (Cont.)

Bloodborne pathogens can be spread when infected fluids enter the body through:

- Needlestick injuries
- Cuts, scrapes, and other breaks in the skin
- Oral, vaginal, or anal sex
- Sharing infected drug needles
- Pregnant women infected with HBV or HIV can pass the infection to their babies.

Exposure Control Plan


Baptist Health Exposure Control Plan is located in all departments.

Engineering Controls: Physical equipment that isolates or removes the bloodborne pathogen hazard from the work place.

New Safety Products are continually evaluated.

Examples: Retractable IV Catheters
Self-sheathing needles
Ventilation systems
Sharps containers
Exposure Control/Safety Devices Used at Baptist Health

- IV Safety catheters
- Needleless IV ports
- Safety Needles
- Blood Transfer Device

Exposure Control Plan Components

**Work Practice Controls:** Actions by employees/students which minimize their exposure to the bloodborne pathogens.

Examples:
- Handwashing
- Placing contaminated sharps in appropriate containers
- No eating or drinking where there is a potential for exposure
Exposure Control Plan Components

Use of Personal Protective Equipment: Equipment provided to protect employees/students from possible exposure.

Examples: Gloves, Gowns, Mask / Face Shields, Goggles

Glove Usage

- Gloves should be properly fitting
- Gloves should be replaced immediately when torn or contaminated
- Do not wash or disinfect gloves for reuse
- Use hypoallergenic gloves when indicated by patient or healthcare provider history
- Decontaminate hands after glove removal
Exposure Control Plan Components

**Housekeeping Measures:** Ways of maintaining a clean and sanitary condition in our facility and thus minimize possible exposure to the bloodborne pathogens.

**Examples:**
- Proper disposal of regulated waste
- Cleaning schedule
- Proper clean up of spills

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Exposure Control Plan Components

**Post-exposure:** What to do if you are exposed to blood or body fluids / needlestick:

**Procedure:** Treat all blood/body fluids as infectious!

- ANY exposure to blood/body fluids must be reported IMMEDIATELY
- Report to Emergency Department for exposure treatment.
- Follow-up with Employee Health
Tab 10

Patient Safety

- National Patient Safety Goals
- Identifying Stroke
- Healthcare Error Reporting
- Impaired Healthcare Worker
- Quality – FPPE/OPPE
NATIONAL PATIENT SAFETY GOALS

FOCUS: Reduction of Medical/Health Care Errors

Note: Gaps in the goal numbering indicates that the goal has either been retired, is now scored in another area of The Joint Commission survey or it does not apply to hospitals.

The Basic Patient Safety Program Includes:

Proactive action aimed at effective avoidance of adverse patient outcomes:
- \( \textit{find the problem BEFORE it is a problem; take action to eliminate it.} \)

- Effective response to actual occurrences:
  - \( \textit{fast effective response to problems to minimize bad outcomes, and prevent similar occurrences.} \)

- Reduction of medical/health care errors:
  - \( \textit{proactive risk assessment and prevention: everyone’s job!} \)
We Have a Patient Safety Program in order to:

- Reduce risks to patients;
- Focus on processes & systems;
- Provide a non-punitive environment for reporting safety issues by staff;
- Involve staff in analysis of errors and/or near misses;
- Improve staff involvement in identifying opportunities to improve safety and reduce errors.

Staff and Safety: Responsibilities

- Report any identified issues to your manager.
  - actual events
  - possible events
  - any unsafe condition
- Complete a Quality Assurance Report on all actual events.
PROACTIVE RISK ASSESSMENT
Definitions

Sentinel Event:
A sentinel event is defined as an unexpected occurrence involving death or serious physical or psychological injury, OR THE RISK THEREOF, not related to the natural course of the patient’s illness or underlying condition.

MINIMIZING ERRORS

What can you do to improve patient safety?

- Listen to your patients
- Barriers
- History
- SMART Training
- Assessment
- Listen to your peers
- Health Care Team

Time
Occurrences
Minimizing Errors:
What can you do?

- Teach your patient about their plan of care: medications, tests, treatments.
- Work with the whole healthcare team as a team.
- Be proactive with patient education!
- Be HUMBLE - listen to your patients; we all make mistakes.
- If your patient questions you DO NOT take it personally.
- Take a step back and double check yourself.
- Be proactive with yourself, too!
- Ask Questions. Stop the healthcare team if you feel an error has been made or will occur.

SAFETY GOAL

Improve the accuracy of patient identification

Use at least two patient identifiers whenever:

- taking blood samples or other specimens
- administering medications
- administering blood products
- providing treatments or procedures

Label containers for blood & other specimens in the presence of the patient.

The 2 patient identifiers used by Baptist Health facilities are: Name and Date of Birth
Universal Protocol

- Prior to the start of any surgical or invasive procedure, conduct a “time out” and verify:
  - The Correct Patient (name and date of birth)
  - Correct Procedure
  - Correct side/site is verified and position is verified.
  - Other elements may be verified based on the patient procedure.

- Use ACTIVE communication techniques.

Universal Protocol (cont.)

- Every member of the team who is involved in the procedure should be involved in the “time out” verification process.

- The operative site should be marked prior to the procedure. The patient should be included in the site marking (if possible).

- This verification process also applies to non-OR settings and bedside procedures.
SAFETY GOAL
Improve the effectiveness of communication among caregivers

Require “read-back” of the complete order or test result by the person receiving the order or result to the person giving the order or result

- Write down what is said...
- Read back what you wrote
- Be exact!

SAFETY GOAL
Improve the effectiveness of communication among caregivers

**Reporting Critical test results**

- Critical test results must be acted upon within 30 minutes of receipt of the results.
- Critical test results are those results such as positive blood cultures, panic lab values, or abnormal radiological results which are imperative to call to the physician. This excludes:
  - Individual or serial results, which are already covered by physician’s orders. Examples include blood glucose, potassium, cardiac enzymes, hemoglobin and hematocrit.
  - Previously reported abnormal results.

*Review policy for more details*
Reporting Critical test results

- Critical test results are to be treated as a priority patient care need.
- The reporting department will record the name of the registered nurse/licensed practical nurse to which the information is given.
- The nurse receiving critical test results must read back the results to ensure accuracy of the information.
- Reporting critical test results accurately and in a timely manner (within 30 minutes) to the physician helps to ensure that appropriate therapy is initiated at the earliest possible time.
- This reporting time should be measured and action should be taken to improve the timeliness of reporting and receipt of critical test results, if appropriate.

Reference: Baptist Health, General Patient Care Policy: Reporting Critical Test Results/Laboratory/Positive Blood Cultures/Panic Lab Values/Radiology/ABG’s

SAFETY GOAL
IMPROVE THE SAFETY OF USING MEDICATIONS

- Label all medications, medication containers, and other solutions on & off the sterile field in perioperative & other procedural settings.
- Reduce the likelihood of patient harm associated with the use of anticoagulation therapy
  - Use approved written protocols
  - Use accepted guidelines to manage food/drug interactions
  - Provide education to patient and families

Reference: Baptist Health, General Patient Care Policy: Reporting Critical Test Results/Laboratory/Positive Blood Cultures/Panic Lab Values/Radiology/ABG’s
SAFETY GOAL
Accurately and completely reconcile medications across the continuum of care

Obtain and document a full list of patient's current medications upon admission
- Involve the patient in collecting the medication history
- Medications are reconciled when patients transfer within the hospital.
- When the patient is transferred or discharged, a complete list of medications should be given to the new provider or patient.

SAFETY GOAL
Use Alarms Safely

- Make improvements to ensure that alarms on medical equipment are heard and responded to on time.
  - Pay attention to alarms and check to see what is causing the alarm.
  - Utilize alarms effectively to keep the patient safe from harm (example: fall bed alarm)
  - Avoid silencing alarms.
  - Identify defective equipment and have Biomed repair alarms that are not working properly.
SAFETY GOAL
Reduce the risk of health care-acquired infections

- Follow CDC or WHO guidelines for hand hygiene.
  - Wash hands before and after each patient contact, when changing gloves, and after touching patient equipment, bedrails, or other high touch areas such as doors.
  - Use soap and water for 20 seconds if hands are soiled.
- Implement evidenced based practices to prevent health associated infections related to:
  - Multiple drug resistant organisms
  - Surgical site infections
  - Central line associated infections

SAFETY GOAL
The Organization Identifies Safety Risks Inherent in Its Patient Population.

- Identify patients at risk for suicide.
  - Place patient on suicide precautions and communicate this during hand-off.
  - Follow all safety precautions while providing patient care, treatment and services.
  - Patient will have an attendant/sitter as deemed necessary in the policy.
  - Follow policy regarding care of patient and limiting restricted items.
  - Educate the family about the safety precautions including the need to leave all bags and personal items outside the room/facility when visiting.
Suicide Precautions

- Patients who are admitted with suicide precautions should have their chart appropriately labeled as such. Place a white sticker on the chart-back spine, write the letters ‘S.P.’ on the sticker.
- Suicide Precautions should be a part of the Hand-Off Communication procedure to ensure all appropriate patient care providers are aware of necessary safety precautions to follow while providing patient care, treatment and

---

Suicide Precautions

- **Patient Care Items**
  - No medications are allowed to remain in the patient's room.
  - If indicated, remove all potentially dangerous items from the room, such as plastic trash liners, gloves, extra linen, extra pillows/ pillowcases, etc. 
- **Personal Items**- On admission, the staff will search the patient’s belongings and review safety precautions with the family / significant other.
  - These items are not to be allowed in the patient’s room. Razors, fingernail files, nail clippers, knives, scissors, eye brow sharpeners, hair picks with sharp handles / teeth, mirrors, make-up in glass bottles, anything made of glass (perfume, etc...) clothes hangers, items with cords, aerosol containers, plastic bags, pens, pencils, etc. (see policy for more information)
Other Patient Safety Initiatives

- **Dangerous, Unapproved Abbreviations**
- Examples include:
  - U or u (must spell out “unit” or “units”)
  - IU (mistaken for IV)
  - Failure to place a zero before a decimal dose (.1 mg or .5)
    - **Always use a “leading zero”**
  - Placing a zero after a decimal point (1.0 mg)
    - **Never use a “trailing zero”**
  - MgSO₄; MSO₄; or MS (must be written out)
  - QD, QOD (easily confused)

“Hand off” Communication

- Staff who are involved in transferring a patient to another care provider should communicate the patient’s condition, treatments, procedures and other pertinent information to the staff receiving the patient.
- The staff involved must provide an opportunity to ask and respond to questions.
  - Examples: shift change, temporary coverage of assignments, physician to physician, OR to unit, floor to ICU, etc.
"Hand off" Communication

- The primary objective of the "hand-off" is to provide accurate information about a patient's care, treatment and services, current condition and any recent or anticipated changes. The information communicated must be accurate and complete.
- The staff involved must provide an opportunity to ask and respond to questions.
  - Examples: shift change, temporary coverage of assignments, physician to physician, OR to unit, floor to ICU, etc.
- Interruptions during "hand-offs" are limited to minimize the possibility that information would fail to be conveyed or would be forgotten.

Refer to "Hand-Off Communication" Policy for more information

SBAR Communication

- S=Situation
  - This is (your name)
  - I am calling about (pt. name and room number)
  - I am calling because (brief statement of the problem, when it started, severity)
- B=Background
  - Reason for admission:________
  - Vital Signs: BP___ T___ P___R___ SaO2
  - Level of Consciousness, any other pertinent data (lab results, current meds, code status)
- A=Assessment
  - "I believe the problem is: (Say what you believe the problem is or
    - "I'm not sure what the problem is but the patient's condition is worsening."
    - "The patient is unstable and I am worried."
    - The problem may be cardiac/neuro/respiratory, etc.)
- R=Recommendation
  - "I suggest or Could we: (say what you would like to see done)
    - Can you come see the patient?
    - Would you like a consult?
    - Can we transfer the patient to ICU?
    - Would you like any tests done?
  - Once orders are received, ask:
    - How often do you want vital signs taken?
    - If there is no improvement, how long do you want us to wait before calling you back?

Refer to "SBAR Communication" Policy for more information
Other Patient Safety Initiatives
Reduce the Risk of Patient Harm Resulting From Falls

- Patient falls constitute a major proportion of hospital occurrences and can result in injury, extended stays, and decreased independence.
- Assess and periodically reassess* each patient’s risk for falling, including the potential risk associated with the patient’s medication regimen.
  *on admission and each shift for adult patients.
- All patients should be placed on Safety Precautions.

Refer to Baptist Health’s policy for Fall Prevention/Fall Risk Assessment.

Inpatient Fall Reduction Strategy

- **Fall Risk Assessment** – *(age 18 and older)* Patients are assessed for fall risk on admission and with each shift assessment utilizing the following criteria:
  - 70 or More Years
  - Confusion/Disorientation (including medication or anesthesia)
  - Incontinence
  - Lurching, Swaying, Shuffling Gait
  - Decreased Muscular Coordination
  - Hearing or Visual Impairment
  - Consistently low BP
  - History of Recent Falls
  - Cardiovascular Agents
  - Diuretics
  - Sedatives/Psychotropics/Tranquilizers
  - Narcotics

*See policy for information for other age groups
Other Patient Safety Initiatives
Reduce the Risk of Patient Harm Resulting From Falls

- Safety rounds are made every two- (2) hours on inpatients regardless of their status.
- Take action to address any identified risks.
- If risk factors identified, place patient on Fall Precautions.
- Educate the patient regarding calling for help.
- Encourage the family to stay with the patient if they are at risk for falls.

Identifying & Monitoring Patients at Risk for Falls

- Patients who at risk for falls are identified with a special armband. (refer to policy)
- These patients need to monitored frequently and assisted when needed for all aspects of care.
- They should not be walking alone nor should they be allowed to get out of bed, chair, off stretchers without assistance.
- If they are found walking alone they need to be escorted back to the patient care unit and/or someone assigned to watch them closely while they await test or procedure.
Other Patient Safety Initiatives
Encourage Patients’ Active Involvement in Their Own Care As a Patient Safety Strategy.

- Define and communicate the means for patients and their families to report concerns about safety and encourage them to do so.
  - Teach patients and family how to call for assistance.
  - Have call buttons easily within reach.
  - Encourage them to communicate their concerns to the patient care team.
- Educate the patient about their plan of care.
- Encourage them to ask questions and be involved in their care.
- If the patient has a question about their medication or other procedures, listen to the patient and answer their questions.
- Patients should be a well-informed.

Other Patient Safety Initiatives
Improve recognition and response to changes in patient condition

- “The organization selects a suitable method that enables health care staff members to directly request additional assistance from a specially trained individual(s) when the patient’s condition appears to be worsening.”
- Baptist Health has implemented a procedure for calling the Rapid Response team at all facilities.
  - Baptist South - ICE Team
  - Baptist East and Prattville - Rapid Response Team

Refer to Annual Review Part IV for more information about Rapid Response/ICE Teams
Stroke

- A stroke occurs when blood flow to the brain is interrupted.
- There are two types of strokes
  - Ischemic- due to lack of blood flow from a blockage
  - Hemorrhagic- due to rupture of a blood vessel/artery within the brain

Stroke Facts

- Over 700,000 strokes occur annually
- Strokes occur more in males than females
- Females tend to die more after having a stroke than males
- African Americans have more stroke than any other race
- Every Adult is at risk for having a stroke but strokes can be prevented
F.A.S.T.

- F.A.S.T is used to help identify someone having a potential stroke.
  - F- Facial drooping/ mouth drooping or “twisted”
  - A- Arm weakness/ inability to lift or grip on
  - S- Speech disturbances
    - Inability to understand what someone is saying
    - Inability to understand what the person is saying (slurred speech)
  - T- Time to call
    - 6666- Baptist South- Stroke Team
    - 8888- Baptist East-RRT
    - 793500- PBH- RRT
    - 911 if outside of the hospital

Stroke Community Education

- Strokes can be prevented and the best way to prevent a stroke is to know your risk factors and the signs/symptoms of a stroke
- If you would like more information about Stroke Prevention and Recognition and/or to have our Stroke Coordinator speak for your event please contact:

  Sharon Silverman RN, BSN, CNRN, NVRN-BC
  Stroke Coordinator
  Baptist Medical Center South
  334-286-3052
HEALTHCARE ERROR REPORTING

Healthcare Error

- DEFINITION: Anything that is outside the expected or anticipated outcome in the delivery of healthcare.

- EXAMPLES of Unanticipated Occurrences:
  - Medication Errors
  - Missed Treatments
  - Equipment Malfunction
  - Procedures on wrong patient due to improper identification of patient
  - Surgery on wrong side/site

Reporting Healthcare Errors

HOW can errors be reported?

- Verbally: tell the manager about the incident.
- Quality Assurance Report or QA (preferred method): fill out a QA and turn it in.
- Baptist East- Call “Oops” line
- Baptist South- Call Safety line
QUALITY ASSURANCE REPORT - What is it?

- The Quality Assurance (QA) Report is the standard tool used by Baptist Health when actual or potential adverse events occur or are identified:
  - for claims management (legal)
  - for performance improvement purposes.
- The QA report is one of the key performance improvement tools of our organization.

WHY COMPLETE A QA REPORT? Benefits of Reporting

- Allows for timely risk identification and reporting throughout ALL areas of the organization.
- Prompt reporting can minimize the potential loss associated with the adverse event AND can minimize or eliminate a similar event in the future.
Reporting Occurrences

- A Quality Assurance/Risk Management Report (QA/RM Report) is completed on all occurrences (errors in medication or treatment, accidents, thefts, damages, unusual occurrences, etc.) involving patients, visitors and employees WITHOUT EXCEPTION.
- These QA/RM Reports must be completed within 24 hours after the occurrence.

Where do I submit the QA report?

- You should give a QA report to your immediate supervisor.
- Ultimately, the QA report is forwarded to the Quality Management Department for aggregation, analysis and trending.
DISCLOSURE
Informing the Patient and/or Family

Who tells the patient and family?

- Disclosures will be discussed with the physician
- The physician determines who will inform the patient of the adverse event.
Impaired Healthcare Worker/Physician Impairment

Overview:
- Joint Commission standards require that processes be established to identify and manage matters of individual health for physicians as well as other hospital staff.

Causes of Impairment
- Policy provides a process whereby a Healthcare Professional who may be experiencing, or may suffer from a condition that could cause or is causing impairment can be identified and assisted to avoid patient harm.
- Such conditions that can and do cause impairment include but are not limited to the following: substance abuse or dependence, mental illness, disruptive behavior, physical disabilities, and senility.
Recognition Red Flags

- Red flags of impairment include:
  - Physical appearance: poor hygiene; long sleeves in warm weather, unkempt appearance
  - Family/home: marital problems; unexplained absences from home; financial problems; medicinal use of alcohol.
  - Office: unexplained absences; excessive working; complaints by patients and/or family members; inappropriate orders; excessive ordering of drugs
  - Hospital: inappropriate response to calls/pages; decrease of quality; rounds at odd hours; refusing to work relief (unexplained)
  - Other: repeatedly 'ill' on Mondays; alcohol on breath; tremors; high drug waste

Reporting Signs of Impairment

- Issues can be reported to Medical Staff leadership or Administration for follow-up.
- Your supervisor can also assist you in reporting any concerns.
Alabama
Physician Health Program

Eric B. Hedberg, M.D
Medical Director
800 239-6272 (MASA)
334 954-2596 (Private Line)
Email: staff@alabamaphp.org

Alabama
Voluntary Disciplinary Alternative Program

Mary Ed Davis, MSN, FNP
Alabama Board of Nursing
PO Box 303900
Montgomery AL 36130-3900
TEL: (334) 293-5200
www.abn.state.al.us
FPPE and OPPE

Where Did It Come From?

• In 2008, The Joint Commission (TJC) implemented a new standard mandating detailed evaluation of practitioners’ professional performance as part of the process of granting and maintaining practice privileges in a healthcare organization.
What is FPPE?

Focused Professional Practice Evaluation (FPPE) involves more specific and time-limited monitoring of a provider’s practice performance in three situations:
1. when a provider is initially granted practice privileges;
2. when new privileges are requested for an already privileged provider; and
3. when performance non-conformance involving a privileged provider is identified (through the OPPE process or by any other means such as complaints or significant departure from accepted practice.)

When do we do FPPE?

TJC doesn't mandate a specific time period of FPPE. Therefore, each hospital can choose the period of time for each FPPE episode.
However, the FPPE process should:
1. be clearly defined and documented with specific criteria and a monitoring plan;
2. be of fixed duration; and
3. have predetermined measures or conditions for acceptable performance.
What is OPPE?

Ongoing Professional Practice Evaluation (OPPE) is intended as a means of evaluating professional performance on an ongoing basis for three reasons:

1. as part of the effort to monitor professional competency;
2. to identify areas for possible performance improvement by individual practitioners; and
3. to use objective data in decisions regarding continuance of practice privileges.

When do we do OPPE?

• Once a provider has achieved practice privileges in a health care organization, TJC requires that performance data be collected with evaluation of the provider conducted more frequently than annually.
• Evaluation done annually or less frequently is considered by TJC as “periodic” not “ongoing.”
BAPTIST FPPE & OPPE PROCESS

Physicians:
FPPE – First 6 months after coming on staff/granting of privileges; first 6 months after additional privileges are granted; and anytime there are extenuating circumstances for further investigation. (File review is most common way of obtaining FPPE on physicians).
OPPE – In an ongoing rotation files are periodically reviewed; matrix are reviewed and core measures are examined.

AHP/SLS:
FPPE/OPPE – Every 6 months (in or around March and September of each year) the System Medical Staff Office (SMSO) will send out evaluations to the AHP/SLS practitioner to have completed and sent back to the SMSO. This information is forwarded to the quality departments of the facilities where that practitioner practices. Any evaluations not returned will be deemed an automatic termination of privileges.
Tab 11

Emergencies/End of Life

- RRT/ICE Teams
- Care of Dying Patient
- Organ Donation
- Donation after Cardiac Death
RRT/ICE Team

What is it?

A team of health care providers who serve as a resource for the general nursing units where there is an actual, perceived or suspected deterioration or changes in patient condition.

Who are they?

- **South**- The team is made up of an ICU Nurse, Nurse Manager or Nursing Supervisor and a Respiratory Therapist.
- **East**- The Emergency Department answers RRT calls. ER Staff respond and notify other team members/disciplines as needed.
- **Prattville**- Nursing Supervisor responds and notifies appropriate members of the team based on patient need (i.e. Respiratory Therapy, Lab, Radiology, etc.)
Who can call the RRT/ICE Team?

- Any physician, staff member, patient or family member may call the team.
- Patients receive information about the teams on admission.

RRT/ICE Team Notification

- Baptist South- 6666
- Baptist East- 8888
- Prattville Baptist- 451-0584

What to say when you call the team:
- Staff members are to state that the RRT/ICE Team is needed in room#_____ or clearly state the exact location if the patient is not in their room.
- Patients or family members are to state that they are a patient/family member and state their name and the room number or location.
Criteria for Calling the Team

- Certain loss or unexplained ability to speak
- Certain loss or unexplained ability to move
- Certain onset of confusion or bizarre behavior
- Reports of inability to breathe
- Reports of severe chest pain
- Reports of worst headache they have ever had
- Shortness of breath
- New onset of altered mental status
- Seizures

MEWS

- Modified Early Warning Scoring Alert
  - Uses vital signs to detect early signs of decompensation in an adult patient.
  - The MEWS system will calculate a score by looking back 16 hours (located in vital signs section of IView) and will trigger an alert for the staff to assess the patient and determine what actions are needed.

Refer to Medical Early Warning Scoring Alert (MEWS) or Rapid Response Policy for more information.
A/N/D=Allow Natural Death

- A decision to change the goal and the modalities of treatment. The new goal is to enhance the quality of life remaining for the patient and family while supporting the patient’s autonomy and dignity. It is a decision to allow the patient to die naturally and as gently as possible. Procedures not medically necessary to meet these goals should be omitted or withdrawn.

- The A/N/D order is documented by the attending physician on the Resuscitative Status Order at the patient's/agents (DPAHC/Proxy)/surrogate decision-maker’s direction and placed in the front of the Physician’s Order section in the medical chart.

(see Patient Rights: Allow Natural Death (A/N/D) Policy, Resuscitative Status Order)
Care of the Dying Patient/ End of Life Care

Grief Process

- Denial and Shock
  - “No, not me.”

- Anger
  - “Why me?”
  - At God, at the doctor, at the nurse, at family, etc.

- Bargaining
  - “Yes, me…but…”

- Guilt
  - Things you did or didn’t do.
  - Forgive yourself!
Grief Process

- Depression
  - “Yes, me.”

- Loneliness
  - As changes happen, you may feel lonely and afraid.

- Acceptance/Accommodation
  - “Yes, me.. and I will make the best of each moment/day.”

- Hope
  - Cure vs. healing
  - Expressions of hope

Spiritual Needs

- Explore and Address Patient/Family Need for religion
  - How can my faith help me?
  - What does my faith say about illness and suffering?
  - How can my faith help me cope with the illness?

- A healthy religious faith, used appropriately can:
  - Influence one’s fundamental view of how death fits into life.
  - Provide motivation for grief work.
  - Is a great antidote for loneliness.
  - Sustain strength through supportive ministry & belonging.
Symptom Management is the First Priority.

Focus efforts on providing physical & emotional comfort to both patient & family.

A focused assessment of the patient’s symptoms begins with a history and physical exam.

Symptom Management

“Fear of the unknown” is always greater than “fear of the known” so most families will want to know the signs of approaching death & the comfort measures that can be provided.

The following symptoms help us understand how the body prepares itself for the final stage of life.

Not all of these symptoms will appear at the same time, and some may never appear.
Symptom Management

- Decreased appetite
- Increased periods of sleeping
- Incontinence
- Mottling (appearance of uneven spots)
- Decreased hearing & vision
- Changes in breathing
- Confusion
- “Death Rattle”
- “Nearing Death Awareness”

Creating an Environment Conducive to Communication

Must consider the needs of the patient & family.

- Good nurse-patient communication is essential:
  - Draw chair to the bedside.
  - Give the patient your full attention indicating that you value what the patient has to say.
Creating an Environment Conducive to Communication

- Determine the resources necessary to respond to the patient's questions:
  - Clergy
  - Case Managers
  - Translators
  - Physicians
  - Etc.
  - Patient & family members may need different information at different times, ex. Patient may not want to know the prognosis yet but the family member does.
    - Need to arrange a time for a private meeting with the physician.

It's important to remember that what occurs at the dying patient’s bedside determines the family’s memory of his death.

If the nurse treats the patient & family with empathy, effective communication takes place & symptoms are managed, this exceedingly difficult time can be deeply meaningful to all involved.
End of Life Care

- Patients who are approaching the end of life have the same rights and responsibilities as other patients.
- Advanced directives must be respected and communicated to the physician and all staff members.
- All members of the health care team must recognize the special needs of these patients:
  - Support will be provided to meet the psychological, spiritual, cultural and personal needs of the patient and his/her family.
  - Respect will be maintained for the individual’s values, beliefs and preferences.

End of Life Care

- Patients will be offered involvement in their own care as they are able, considering their perception of limitation and demands of that care.
- Render treatment of primary and secondary symptoms as ordered by the physician.
- Assess the patient’s pain status at appropriate intervals, providing ordered pain medication as needed.
End of Life Care

- Assess the cultural, psychosocial and spiritual concerns of the patient regarding dying and expression of grief.
- Offer psychosocial and spiritual support to the patient utilizing a multi-disciplinary approach.
- Explain all care and treatments to patient.
- Allow the patient to express feelings.
- Notify family members when the patient wishes to see them.
- Contact a member of pastoral care if appropriate.

End of Life Care

- Provide nursing care that is established in collaboration with the patient.
  - Take vital signs as ordered; observe for pallor, diaphoresis and decreased levels of consciousness.
  - Reposition the patient at least every 2 hours making sure the bed sheets cover him loosely.
  - Change the bed linens and patient’s gown as needed, providing skin care and adjusting the room temperature for patient comfort.
End of Life Care

- Observe for incontinence or anuria. Obtain an order to catheterize the patient if needed.
- Suction the patient’s mouth and upper airway to remove secretions; elevate head of bed to decrease respiratory resistance.
- Offer fluids frequently; lubricate patient’s lips and mouth with glycerin swabs.
- If the comatose patient’s eyes are open, provide appropriate eye care:
  - Instill eye drops or lubricant as ordered by physician.
  - Tape eyes shut with paper tape.
- Provide assistance, as requested by the physician, in dealing with sensitive issues of withholding resuscitative services, foregoing or withdrawing life-sustaining treatment, autopsy, or tissue/organ donation.

End of Life Care: Documentation

- Document:
  - Changes in patient’s vital signs, intake and output, and level of consciousness.
  - Time of respiratory arrest.
  - Time of cardiac arrest.
  - Time of notification of the physician.
Organ Donation

“Nationally, nearly 105,000 people are waiting for an organ transplant. A new person is added to the waiting list every 18 minutes. For an average of nineteen people per day, the wait is too long and they die before a suitable organ is available. In Alabama, approximately 3,400 people are waiting for a transplant.”

Organ Donation

- Organ Donation is a choice that patients and families make in the event of death.
- All patients must be evaluated as potential organ or tissue donors.
- All hospitals must have an agreement with an appropriate organ procurement organization (OPO) and follow its rules and regulations.
- This CBL is based on policy that has been revised to meet the new requirements set forth from Joint Commission on organ procurement.
Organ Donation Policy

- Any ventilator dependent patient whose death is imminent and/or is being considered for Withdrawal of Life Support MUST be assessed using the ‘Clinical Triggers for Potential Organ Donation’ form BHX 0014.
- If a ventilator-dependent patient meets three or more of the criteria, the Alabama Organ Center (AOC) should be notified IMMEDIATELY to complete an assessment of potential organ/tissue donations.
- Do not approach the family about donation.
- Any patient who experiences death MUST be evaluated as a potential organ or tissue donor.
- This includes any patient who presents to Baptist Health Emergency Department who is DOA or expires in the ED.

Organ Donation

- The Alabama Organ Center is the organ procurement organization for Baptist Health.
- In the event of death, the nursing supervisor, charge nurse, nurse assigned to the care of the patient or nurse designee will obtain and complete the appropriate form* and contact the Alabama Organ Center and the Alabama Eye Bank (AEB) within 60 minutes (1 hour) of death on the number listed on the referral form.

*BH Alabama Organ Center Referral Donor Form, Form #CO 15013
Alabama Organ Center

- **AFTER** the AOC representative has been notified of the potential for donation, the Nursing Supervisor/Chaplain/trained Designated Requester and/or the AOC representative can approach the family to discuss the potential organ and/or tissue donation. If the family/proxy/surrogate agrees, then the BH/AOC/AEB representative will obtain the appropriate consents and follow the procedures set forth below as appropriate for the situation.

- If the Alabama Organ Center (AOC) Referral Center determines that the patient is a suitable candidate for organs/tissue or AEB for eyes, **and** the family consents, the physician will be notified.

---

**Donations of Tissue/Organs/Eyes, Upon Consent of Family**

- The nurse in the Critical Care Unit/ED/Nursing Unit will phone the AOC in Birmingham to confirm the possibility of donation and provide patient information from the nurse and chart.

- The AOC representative may complete this process, if already present at the hospital. **HAVE CHART AND ROUTINE REFERRAL DONOR FORM READY.**
Organ Donation - Refusal

- If the family/proxy/surrogate is not willing to consider organ/tissue donation, this decision should be documented on the BH Alabama Organ Center Referral Donor Form and it will be placed in the Medical Record.

Care of Organ Donor/Family

- Notify the AOC of clinical triggers in ventilator dependent patients.
- Ensure that brain death criteria have been met and documented.
- Ensure that consent form for organ donation has been completed in conjunction with the AOC.
- Obtain blood samples for laboratory analysis as prescribed by the OPO coordinator.
- Administer intravenous fluids and medication (including vasoactive agents) as prescribed by the OPO coordinator.
- Support liberal family visiting should family desire to be present with their loved one for DCD organ donors.
- Transfer the patient to the operating room as directed by the OPO coordinator for organ donation.
- Provide family support (chaplain service).
- Provide a method for the family to obtain information about the recovery process.
Documentation

- Family education.
- Determination of brain death.
- Completed consent form for organ donation and recovery.
- Complete donor record, including vital signs, assessment, treatment, and the clinical status of the donor. Document outcome of donation request. Document transfer of management to the AOC.
- Communication with the family with summary of information provided and response of the family.

ORGAN DONATION AFTER CARDIAC DEATH (DCD) CBL

Definition of Terms

DCD= organ recovery from a patient who is pronounced dead on the basis of irreversible cessation of circulatory and respiratory functions.

Healthcare Team= any Baptist Health staff member and physician involved in the care of the patient.

O-TDC= Organ-Tissue Donation Committee.

Surrogate= family or legally appointed persons making decisions on behalf of the patient.
Purpose

- Demonstrate respect for patients/surrogate regarding organ donation.
- Recovery of organs for transplantation.
- Maintain integrity & quality of organ and tissues for recovery.
- Support family/legal surrogate throughout DCD process
- Support Baptist Health staff participating in organ and tissue recovery through DCD.

Policy

- The process will be consistent with “Organ/Tissue/Eye Donation Guidelines” policy.
- Candidates for DCD must meet certain criteria.
Criteria for DCD

- The patient must have a non-recoverable illness or injury that has caused neurologic/body system failure resulting in ventilator dependence.
- The surrogate and medical staff have decided to withdraw life-sustaining treatment.
- The opinion of the healthcare team and Alabama Organ Center staff is that cardiopulmonary death is likely to occur within one hour following the withdrawal.
- There are no medical contraindications to organ donation as determined by the AOC.

Notification for Determining Suitability for Donation

- Notify the Alabama organ Center (AOC) to determine suitability
- Notify the attending/covering physician of AOC notification for purpose of donor evaluation
- Notify the following once it has been determined that donation is an option:
  - Nurse Manager/ Charge Nurse/ Nursing Supervisor
  - Chaplain
Determining Suitability

- The process for determining suitability is a multidisciplinary process involving members of the healthcare team in collaboration with the AOC.

Remember:

- The Chaplain is key to providing support to the family/surrogate and the healthcare team and serves as the advocate for the family/surrogate in the process of informed consent.
Informed Consent

- Once the patient has been determined to be suitable for DCD the Chaplain will address any ethical concerns with the healthcare team before approaching the family/surrogate for consent.
- The Ethics Committee is available to address any concerns.
- If the surrogate consents to DCD, the routine forms and process will be followed by the AOC Coordinator.
- If the surrogate does not consent to DCD, the process for withdrawal of life-sustaining treatment and care will follow normal protocols.

Consent Process

- Decision for withdrawal of treatment and decision for DCD will be made independently of one another.
- Once criteria for DCD has been met the surrogate will be approached by the AOC coordinator and/or Chaplain to request consent.
Presentation of Organ Donation Request

- This presentation (made to the surrogate) shall include:
  - Explanation of DCD and opportunity for donation.
  - Explanation of medical and ethical rationale for DCD.
  - Clear statement that the surrogate is free to agree or refuse.
  - Period of time for questions about the process.
  - Period of time to consider their decision.
  - Any additional procedures needed for DCD.
  - Documentation of the surrogate’s decision.

Plan for Withdrawal

- The plan for withdrawal will be discussed with the surrogate during the consent process.
- The AOC Coordinator will explain the options for withdrawal and answer any questions.
Goals for Plan to Withdrawal

- The ability to successfully recover organs for transplantation.
- Meeting the needs of the family regarding grief and appropriate time with the patient.

Withdrawal Process

- AOC will assemble the transplant team and alert the Surgery staff once suitability has been determined and the informed consent has been obtained.
- The surrogate may choose to have life sustaining treatment removed in the operating room or another area.
- If withdrawal occurs on the nursing unit femoral lines will be placed for administration of organ preserving fluids once the pronouncement of death has taken place. This requires informed consent to be obtained from the surrogate.
Withdrawal Process

- Once in the operating room, if the patient does not expire within one hour after withdrawal from life-sustaining treatment the patient will be transferred back to a bed on the nursing unit.
- The Chaplain will notify the family in person, if they have chosen to remain at Baptist Health. If not, he will contact them using the phone number they provided before leaving the hospital.
- Palliative care will be provided to the patient and the family will be supported.

Care of the Patient

- The comfort and needs of the patient will be continually evaluated and addressed by the healthcare team members.
- The patient will not undergo CPR if they should suffer cardiac arrest. The AND*/DNR+ Order will be followed throughout the course of care.
- Any procedures necessary for patient management will require informed consent from the surrogate.

*Allow Natural Death
+Do Not Resuscitate
Care of the Family

- The family shall be supported by the healthcare team, the hospital Chaplain, as well as the family’s clergy, if so desired.
- Once the patient is taken to surgery, the Chaplain will provide updates to the surrogate.
- If DCD is not successful the patient will be moved back to a nursing unit bed and the Chaplain will continue to provide support throughout the dying process.

Pronouncement of Death

- The Institute of Medicine has recommended that death be pronounced after 5 minutes of absent cardiopulmonary function.
- Death will be pronounced by the attending physician or his/her designee.
- The certifying physician will not be part of the transplant or recovery team.
- The patient will be apneic, pulseless, and unresponsive.
Pronouncement of Death Process (continued)

- The pronouncement of death will include an ECG tracing and may include an arterial pressure monitor tracing.
- **FIVE** minutes of ventricular fibrillation, asystole, or pulseless electrical activity will be sufficient for determination of death.

Organ and Tissue Recovery

- Surgical recovery of organs will take place following pronouncement of death. This recovery process takes place in the operating room.
- Once recovery of organs has taken place the body will be cleaned and transported to the morgue or designated holding area.
- If the family wishes to view the body this shall take place prior to transfer to the morgue.
- The chaplain will coordinate this process.
Costs for Organ and Tissue Recovery

- The AOC will be responsible for cost once the surrogate consents to organ recovery unless:
  - Surrogate withdraws consent during the process.
    - Costs revert to responsible party at time consent is withdrawn.
  - The pronouncement of death does not occur within the appropriate timeframe for recovery of organs.
    - Costs revert to responsible party upon admission to the unit the patient is sent to from the operating room.

Quality Review

- A committee will review all cases of DCD. They also review cases in which consent is not given.
- Interviews will be conducted and will include all healthcare team members, the AOC Coordinator, OR staff, and Chaplain.
- A follow-up phone call will be made to the donor family within 8 weeks.
- The committee will monitor the rate of successful transplantation. AOC will provide this information.
- An annual report will be made to the O-TDC and QI committee of each Baptist facility.
Care of Baptist Health Staff

- The following staff (ICU, ED, OR staff, Chaplains, Residents & physicians, as appropriate) will be trained in the protocol and unique medical aspects of DCD.
- DCD may present some staff members with a conflict of conscience and they should be allowed to forego participation.
- Staff members will be offered an opportunity for debriefing and discussion. The chaplain will be responsible for providing this opportunity within 72 hours of completion of attempted DCD.

Documentation

- Documentation includes any consent forms used for organ recovery and procedures performed. This will include the “Withdrawal of Life Support” forms.
- “Clinical Triggers for Potential Organ Donation” form.
- “Pre-op checklist”.
- Complete “donor record” with vital signs, assessment, treatment, and clinical status of the donor.
- Other documentation will include family education, palliative care provided, the determination of cardiac death by the physician, any communication with the family with a summary of information provided and response of the family, any unexpected outcomes, and any additional interventions.
DCD- Summary

- Baptist Health believes it is ethically appropriate to consider DCD.
- It is intended to provide surrogates with an additional option for donation that complies with the patient's previously expressed wishes or authorized surrogate’s directives.
- This option is offered after the surrogate has chosen to forego life-sustaining treatment.
Tab 12

Technical

- Dictation Instructions
- eMAR Handbook
- Downtime/Recovery Policy
- Policy Manager
**DICTATION INSTRUCTIONS**

Lift the handset
1. Listen for message prompts
2. Enter your four (4) digit physician ID#. The number must be valid in order to allow entry. **If your # is less than 4 digits, precede with zero’s.**
3. You will be prompted to enter a facility code:
   - 1 – South
   - 4 - East
   - 5 - Prattville
4. Enter the two digit work type.
   - 00 – Stat/Preoperative H&P’s
   - 01 – History and physical
   - 02 – Consult
   - 03 - Operative note
   - 04 - Discharge summary
   - 05 - Cath – South
   - 06 - ED note
   - 08 - EEG
   - 09 – EVR (evoked response)
   - 22 - Letter
   - 30 – Crossbridge H&P
   - 31 – Crossbridge DS
   - 32 – Crossbridge consult
   - 40 - Surgical critical care note
   - 44- Critical care note
   - 50 - Palliative care note
   - 55 - Sleep lab consult
   - 66 - East Pre-operative H&P
   - 60 - Palliative care note
   - 66 - East Pre-operative H&P
   - 70 - Sleep lab study
   - 77 - PFT
   - 88 - EKG
   - 99 – Off service note

You will then be prompted to enter a ten digit account number (example 0123456789 – if you don’t know the account number you can enter all 0’s, 2’s, etc. If you do please be sure to specify your name, the name of the patient and spell the patient’s name). **You will then be prompted to begin dictation.**

**DICTATION PHONE LINES**

- 286-2750 (South)
- 286-2751 (South)
- 286-2752 (South)
- 244-8520 (East)
- 361-3150 (Prattville)

The telephones are voice activated so press: 1 – listen, 2 – dictate, 3 – rewind, 4 – pause, 5 – end report, 7 – fast forward, 8 – go to beginning, 9 – DISCONNECT

If you have questions contact Dana Baker, Transcription Coordinator at 286-2953 or beep the coordinator on call at 516-4710
# Order of Recording

**HISTORY & PHYSICAL**

1. Identification  
   a. Type of Report  
   b. Patient’s Name  
   c. Medical Record #  
   d. Room #  
   e. Date of Admission  
   f. Attending Physician  
2. Chief Complaint  
3. Present Illness  
4. Past Illness  
5. Family History  
6. Social History  
7. Review of Systems  
   a. General  
   b. Skin  
   c. HEENT  
   d. Neck  
   e. Respiratory  
   f. Cardiovascular  
   g. Gastrointestinal  
   h. Genitourinary  
   i. Gynecological  
   j. Musculoskeletal  
   k. Neuro-psychiatric  
8. Physical Examination  
9. Impression  
10. Plan of Treatment

**CONSULTATION**

1. Identification  
   a. Type of Report  
   b. Room #  
   c. Patient’s Name  
   d. Medical Record #  
   e. Attending Physician  
   f. Date of Consultation  
   g. Consulting Physician  
2. Findings  
   a. Review of History  
   b. Physical Examination  
3. Impression  
4. Recommendations

**DISCHARGE SUMMARY**

1. Identification  
   a. Type of Report  
   b. Patient’s Name  
   c. Medical Record #  
   d. Date of Admission  
   e. Date of Discharge  
   f. Attending Physician  
2. Principle Diagnosis  
3. Secondary Diagnosis  
4. Principle Procedure  
5. Other Procedures Performed  
6. Reason for Admission to Hospital & Physical Findings  
7. Pertinent Labs, X-Rays, etc.  
8. Hospital Course  
9. Condition of Patient at Discharge  
10. Instructions to Patient at Discharge  
   a. Diet  
   b. Limitations of Physical Activity  
   c. Medications  
   d. Follow-Up Care

**OPERATIVE REPORT**

1. Identification  
   a. Type of Report  
   b. Patient’s Name  
   c. Medical Record #  
   d. Room #  
   e. Surgeon  
   f. Assistant Surgeon  
   g. Date of Operation  
   h. Attending Physician  
2. Pre-Operative Diagnosis  
3. Post-Operative Diagnosis  
4. Name of Operation  
5. Description of Findings  
6. Procedures  
7. Specimens Removed  
8. Condition of Patient
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7) View existing Pharmacy Note

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ORDERS REVIEW

1) **Orders for Nurse Review** button

2) **MAR VIEW**

Click here to review new orders, if activated

Eyeglasses beside the order indicates this is a new order that has not been reviewed

2) Change Default Views

1) Right click on blue bar

2) Select “Change Search Criteria”

3) Select “Sort by next task due” and “Save as default sort”

**current program code does not allow this change to save if you close the patient’s chart**
3) Utilize Navigation Bars

1) Right Click on your entry to view option list

2) Select “Modify” to modify your entry, or

3) Select “Unchart” meds to unchart your entry

**You can only modify or unchart your own documentation entries**

4) Modify existing medication administration documentation
5) View/edit existing Admin Note

Click on the Admin Note icon inside the medication box.

This new window opens with information from a previous nurse about administering this medication.
- To edit, just add to or delete from the note.
- To remove note, click Clear button.

6) Create a new Admin Note

1) Right click anywhere inside the medication box to bring up the options list.
2) Select "Create Admin Note".

**3) This window opens which is a free text field for writing nurses notes about the medication on the MAR.**
7) View existing Pharmacy Note

1) Click on the Push Pin icon
2) An Order Information window opens to show notes from the pharmacy about the selected medication

MAR SUMMARY VIEW

8) Change Default Views
9) Current work timeframe

1) Right click on blue bar
2) Select “Change Defaults”

Current work timeframe is highlighted in Yellow

3) A new window opens to change default settings

Mar Summary Defaults

- Default Settings
  - Changes how far back you see overdue meds
  - Changes how far forward you see future meds
  - Changes your work timeframe interval
  - Changes the direction in which medications flow on the screen
  - Changes how medication due times are sorted on the screen

**Current program code does not allow this change to save if you close the patient’s chart**
MEDICATION ADMINISTRATION WIZARD

10) **Medication Administration** button; toolbar customization

- Click here to scan your patient and the medications

If your Wizard button is not visible on your toolbar, find it by clicking here to customize the toolbar by adding/removing buttons

You can also slide your entire toolbar over or below to the next line by clicking and dragging on the stacked dots. These steps will allow you to customize your toolbar for future use.

- Toolbar Settings are one-time settings that will persist for all future log-ins and patients

11) Scan armband appropriately

Scan the Aztec symbol, not the linear barcode

**DO NOT use Caps Lock**

12) Process for missing or defective armband

**After clicking the Wizard button, this window opens for you to scan your patient**

If your patient’s wristband will not scan or is missing, click here to override

**Before overriding, check the following:**

1) Ensure the “Caps Lock” key is not on.
2) Make sure you are scanning the Aztec symbol.
3) Try adjusting the angle of the scanner and scan again.
4) If these steps don’t work, click the “Next” button

**Don’t forget to replace your patient’s wristband for future scanning needs.**
13) Administer scheduled medication – Routine medication

**After scanning your patient, this window opens for you to scan medications.**

If the medication will not scan, click here to override; you must comment why you did not scan your medicine. See also #24, Process for "Bad Barcode" problem.

**NOTE:** If the medication cannot be successfully scanned, follow the procedures specified by the Pharmacy for notifying them of medications that will not scan. See also #25, Med Request documentation.

**After scanning, you will receive a blue checkmark beside the correct medication, if it is:**

1) On time
2) The dose scanned matches the prescribed dose
3) The medication’s form matches the prescribed route, and
4) The medication requires no further documentation.
14) Administer scheduled medication – Needs additional information entered

15) Trended data in the Medication Charting Window

**After scanning your patient, this window opens for you to scan medications - Click on blue circle/white X icon or on Results to open medication documentation**

**After opening the medication documentation box, document in the required field(s) to activate the OK button**

**Trend data can be viewed by clicking on the hyperlink; this will take give you the previous results of the requested data**
16) Administer scheduled medication – Insulin
17) View Pharmacy note - Insulin sliding scale in the **Medication Charting Window**

**After scanning the medication this window popped up to warn you the medication scanned requires dosing information - Click OK**

**After opening the medication documentation box, document in the required field(s) to activate the OK button**
18) Document medication “Not given”

- From the MAR, you can document a dose of medication as “Not Given” if you do not intend to give that dose later.

  - For example, if it is 1417, and a patient did not get the 1000 dose of Aristocort A because he was in surgery and his next dose is at 1400; you can mark the 1000 dose as not given and give only the 1400 dose.

- To chart “Not Given” click on the 1000 dose button.

**HINT:** Chart Sliding Scale Insulin doses “Not Given” for therapeutic blood sugar ranges in the same way.

- Select the following reason:

**NOTE:** For therapeutic blood sugar ranges, select the following reason:
19) Administer PRN medication (including pain documentation)

**After scanning your PRN medication, a medication documentation window will open to chart the reason for giving the PRN medication.**

- If the medication is for pain, you will be prompted to chart your patient’s pain score; this info will transfer over to iView.

- Once all required information is charted, you will be able to sign your documentation.
Some medications come in dosage forms that do not always match the exact ordered dose. In these cases, when you scan the medication, you will get a warning message. The next two examples demonstrate the process to correctly administer your medication in these cases.

NOTE: With any warning message, nurses should take a timeout to carefully evaluate the situation.

20) Process for “Overdose” warning

After scanning the medication this window popped up to warn you the medication scanned is more than what is prescribed - Click OK

After clearing the pop-up, the selected medication will be in bold red, prescribed dose is under the details column
- Open the medication documentation window by either clicking on the red circle warning icon, or on results
- Modify the medication dose to match the prescribed amount
- Physically reduce the dose amount to the appropriate level by breaking the pill or partially wasting the liquid volume
21) Process for “Underdose” warning

After scanning the medication, if the amount scanned is less than the prescribed dose, the Wizard will return a red triangle exclamation icon.

- If you have the additional medication to complete the desired dose, simply scan the additional medication.
- If you do not have the additional medication, you can still sign off on the underdose, but once you give the remainder of the medication, you will need to modify your administration documentation on the MAR.
Sometimes when you try to give your medication, you will get early or late administration warnings. The next two examples demonstrate the process to correctly administer your medication in these cases. In these cases, you must use your nursing judgment to decide if the medication can safely be given at the time you scan it. The computer cannot do that for you. The decision also depends on the type of medication being given. **CAREFULLY evaluate the medication administration warning before proceeding with your choice to give now, later, or not at all.**

22) Process for “Early Administration” warning

After scanning the medication, a window popped up warning you that you are giving this medication late:
- Note scheduled date/time vs. the date/time you are trying to give it
- Select a reason for giving the medication late

23) Process for “Late Administration” warning

After scanning the medication, this window popped up warning you that you are giving this medication early:
- Note when the last dose was given
- Select a reason for giving the medication early
- Select Not Given to document this medication will not be given for this time slot

If you choose to give the medication early select a reason from the drop down list.
24) Process for “Bad Barcode” problem

After attempting 2-3 times to scan a medication and ensuring you are scanning the proper barcode, you may declare that you have a “bad barcode”

- You may *override* scanning by clicking on the small box at the left margin
- You will get this warning pop-up reminding you that you are not scanning; click **YES** to continue the administration
- **Save the packaging for the pharmacy**

After overriding the scanning process, you will need to open the medication documentation window and comment on your reason for bypassing the scan process

- Click on the **Comment** button
- A free-text window will open for you to give your reason for bypassing the scan process

See also #25, **Med Request documentation**.
25) **Med Request documentation**

Once you are finished administering you medications, return to the MAR:
- Right click on the medication with the bad barcode
- Select **Med Request** from the options list
- You will get another pop-up window with a drop-down list of reasons to send to pharmacy
- Select **Bad Barcode** from the list

From the Medication Wizard, scan your IV fluid:
- The Bag # starts at 1 and will increase by one when you scan each subsequent IV bag
- Select your site from the drop-down list if this is a new IV, otherwise it will auto-populate
- Volume and Rate will auto-populate based on the profiled order
- Click OK to finish documentation

26) **Administer scheduled medication – IV Fluids**
27) Charting changes to existing IV Fluid

IV fluids are the only entry on the MAR that you can modify regardless of who charted it. 

1) Right click on the most recent entry 
2) Select Modify from the list 
3) The IV charting window opens 

From this window, you can select and modify any of the options in the left column. 
Each option opens a different charting area in the bottom of the window.

In this example, you are documenting a site change: 
- Select Site Change to open the charting window below 
- Select the new site from the drop down list 
- Click Apply

Continued on next page…
After you apply your changes, a new entry will populate on the top section of the window, showing the documentation change(s) you made.

When you are done sign by clicking the Checkmark in the top left corner.
28) Create/document an AdHoc order

If you get an order for a STAT medication and it is not yet profiled on your patient’s medication list, you will not be able to scan it.

To add the medication as an Ad Hoc dose, click the \textbf{Create order and document} button.

After clicking the \textbf{Create order and document} button, you will be allowed to scan your new medication (you should not have to search since you will have pulled your medication from the pyxis already).

It will open up a “One-Time Order” documentation sheet to enter the new med order. After all required info is entered; you will be able to sign.

This medication will be listed on your MAR in the \textbf{Discontinued} section as a one-time dose.
HAND-HELD DEVICES

1) Align screen function

1) Click Align Screen icon

2) Click Align Screen button

3) Tap and follow the “plus sign” target to all 5 spots on the screen

1
2
3
4
5

4) When alignment is complete you will return to this screen; click OK to exit

5) You should return to the home screen
2) Log into Cerner

3) Scan armband appropriately

4) Due Task band
5) Administer a scheduled medication
6) **To be Signed** band

![Diagram of eMAR Handbook](image)

2) Your desired medication window will appear.
   - Document any required information
   - Tap Save when complete

4) Without searching for the medication you wish to give; simply scan the medication window.

3) Your desired medication window will appear.
   - Document any required information
   - Tap Save when complete

7) After you sign, the HHD will refresh and your entry will disappear from the screen.
   - **Your work will not transmit to the eMAR server until you sign**.
8) Administer a profiled PRN medication

1) Without searching for the medication you wish to give; simply scan the medication.

2) Your desired medication window will appear.
   - Document any required information
   3) Tap Save when complete

4) Tap the dropdown list to find and tap To Be Signed

5) Review or Remove your entry, as desired

6) Tap SIGN when complete
9) **Overdue Task** band

1) Tap the dropdown list to find and tap **Overdue Tasks**

2) Overdue tasks will be listed chronologically

10) Create/document an AdHoc order

1) Without searching for the medication you wish to give; simply **scan the medication**

2) A warning message will appear asking if you want to add a new medication order. Tap **YES** to continue.
12) View trend data (labs, vitals)

1) From your patient home screen, tap the GRAPH icon

2) This will open the results section
3) Tap the dropdown menu and select the results you wish to view

6) Tap the dropdown list to find and tap To Be Signed

7) Review or Remove your entry, as desired
8) Tap SIGN when complete

3) A medication order window will open
4) Document required fields
5) Tap SAVE

1) From your patient home screen, tap the GRAPH icon

2) This will open the results section
3) Tap the dropdown menu and select the results you wish to view
13) Exit Cerner

When you are done working with your HHD, it is critical that you exit your workflow.
- To exit workflow, tap the **Workflow** menu in the bottom right corner and select **Exit**.
- Doing this verifies that you have signed and transmitted your data before logging off.
- Failure to Exit could result in lost data due to untransmitted information.
Downtime and Recovery Policy
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Section 1: Clinical Departmental and Staff Preparation

Planned downtime of the Baptist Health IT systems will be implemented in a controlled fashion. In the event an unplanned downtime occurs, the Baptist Health IT department’s ability to move quickly, safely, and efficiently from the automated system to a manual system will depend on how well the staff is prepared.

In addition to the Baptist Health Downtime and Recovery Policy please refer to your department downtime processes.

**Downtime Definitions**

**Downtime** is when a group of users are unable to access their applications.

**Planned Downtime** will occur when the system is unavailable due to maintenance. Planned downtime will be announced well before the downtime period, and will be approved by Key Informatics, IT, and operational team members.

**Unplanned Downtime** occurs when the system is unavailable due to an emergency situation. Unplanned downtime may occur at any time during the day or night. The status of the system availability will be communicated during this time period.

Downtime (whether planned or unplanned), is categorized into three levels. These levels correspond to the severity of the downtime, and define the type of recovery process required when the system is returned to normal operation. The three levels are:

- **Level 1**: Less than two hours of downtime.
- **Level 2**: More than two hours of downtime.
- **Level 3**: More than eight hours of downtime.

Each Clinical Department should take the following steps to ensure they are prepared for planned or unplanned downtime:

1. Each staff member should be aware of his or her responsibilities, and the actions he or she should take. Proficiency in the use of the Baptist Health IT systems, and familiarity with downtime procedures will be part of the annual performance evaluation of each staff member who uses the system to perform his or her job.

2. Each department should prepare a set of manual documentation packages, manual requisitions and applicable logs to be stored on the unit for use when a manual chart must be assembled. There should be enough documentation packets for each bed on a given unit, and should be sufficient to accommodate normal patient volumes.

3. Each manual documentation packet should contain the following documents for each patient **currently admitted** when downtime occurs:
a. Vital Sign/I&O Flowchart [form #GR13201]
b. Progress notes [form #PN 30001]
c. Blank MAR [form #MA 12009] Physician order sheets [form #PH 35001]
d. Unit-specific flow sheet
e. Critical Results Form
f. Shift Assessment
g. Any other departmental specific documents

4. Each manual documentation packet should contain the following documents for each newly admitted patient during downtime:

a. Admission history
b. Advance directive
a. Vital Sign/I&O Flowchart
b. Progress notes
c. Blank MAR
d. Physician order sheets
e. Unit-specific flow sheet(s)
f. Labels and wristband
g. Critical Results Form
h. Shift Assessment Form
i. Any other departmental specific documents

5. At the conclusion of the downtime, new manual documentation packages should be created and stored in the departments.

6. Each staff member should be familiar with data recovery procedures.

7. Department Managers will be responsible for directing proper data recovery on their units. House Supervisors and/or Charge Nurses will facilitate data recovery in the absence of a Department Manager.

8. Data recovery must be completed within 24 hours of the system being returned to normal operation.

9. An open bridge line for manager and leadership to obtain status updates and direct questions during downtime and recovery will be made available.

10. A designated Baptist Health operational team member will provide regular communication updates to Baptist Health staff.

11. Employees should reference the downtime and recovery policy located in the Baptist Health Policy Manager and on the unit designated PC desktop.
Section 2: Initial Evaluation of System Errors

Initial Troubleshooting

1. Any issue with a Baptist Health IT system should initially be reviewed with a Super User or other staff member on the unit. If the issue is not resolved, then the IT Help Desk should be contacted.

2. If there is no Super User on the unit, or if the Super User cannot assist with the problem, the user will contact the IT Help Desk for additional assistance.

3. The IT Help Desk will contact an onsite IT analyst to review the issue and escalate as appropriate.

4. The IT Escalation Manager contacts the Baptist Leadership Team to notify them of the downtime, and activates the Communication Bridge phone lines. As a combined team, IT and Baptist leadership determine the severity/call level, and make a decision on the appropriate plan of action.

5. Once leadership determines there is a downtime, if available, IT will start a Citrix banner message with information about the downtime.

6. Between the hours of 0700 and 2100, overhead paging is the mode of downtime notification. The Baptist Health operational designated team member will coordinate the paging. When downtime occurs between the hours of 2100 and 0700, the hospital supervisor activates the facility phone chain for user notification.

7. When the system is unavailable, manual documentation should be initiated immediately until further information about the system status is available.

Section 3: Initializing Downtime Procedures

System Status Announcements provided by overhead paging & Citrix Banner

Status check: The [SYSTEM NAME] system is down for initial problem investigation- The clinical departments should be prepared for possible downtime. During this time some documentation may be kept manually as needed, but full downtime procedures are not activated.

Level 1: The [SYSTEM NAME] system may be down for up to two hours- The initial evaluation has been completed, and the system may be down for up to two hours. Downtime procedures should be activated as appropriate for the particular department.

Level 2: The [SYSTEM NAME] system may be down greater than two hours- The initial evaluation has been completed and the system may be down for more than two hours. Full downtime procedures should be implemented as appropriate for the particular department.
Section 4: Clinical Documentation during Downtime

1. For planned downtime, a preprinted MAR will be printed by each unit, utilizing the “Downtime MAR Report” icon on the designated unit PC.

2. Once the documents have been printed, the Unit Clerk/designee will ensure the downtime documents are appropriately collated and available to nurses.

3. The completed downtime documentation packets will be available at the nursing station. Nurses will pick up documentation packets and put the documents into each patient’s nursing record.

4. Providers will use printed downtime power plans for orders. Downtime powerplans can be printed from the downtime PCs on each unit. The transcription system will be used for provider documentation when available. Paper will be used for everything else.

5. New orders written during downtime will be handled in the following manner:
   a. Verbal or written orders taken by licensed professionals will be written on a downtime power plan or order sheet in the patient’s chart.
   b. A copy of the medication orders will be scanned or faxed to the pharmacy. Any nursing actions taken with regard to such an order (e.g. noting the start time of a medication) will be documented on the order sheet prior to being scanned / faxed.
   c. Orders for laboratory and radiology that are needed during the downtime time frame will be sent using the appropriate downtime requisition form. Radiology orders will also be called to the department. All orders are to be placed on the downtime log by Radiology and Laboratory.

      Downtime requisitions for laboratory and radiology orders will be completed by the UC/designee and must accompany the patient or the specimen to the appropriate department.

   d. Point of Care Testing orders for patients who do not have a barcoded armband should be sent to the Lab as a Lab test rather than Point of Care test.
   e. Orders for Diets and Therapies will be called to the appropriate department.
   f. The UC/designee will notify the patient’s assigned nurse of any new orders written by a provider.
   g. The nurse will update the downtime chart or paper MAR with the appropriate information.

6. The clinical staff will document patient care activities on the appropriate documents as follows:
a. Medication administration will be documented on the paper MAR.
b. Intake and output information will be documented on the Vital Sign/I&O Flowchart.
c. Vital signs will be documented on the Vital Sign/I&O Flowchart.
d. Nursing assessments will be documented on the shift assessment form.
e. Physician orders and progress notes will be documented on the paper chart.
f. Additional forms may be used as appropriate to document special care activities.

Note – The 724 System is for viewing. Print outs of this data should not be used for documentation.

7. Any information collected before the downtime chart report was distributed (such as vital signs, I & O measurements, or other information) will be added to the downtime documentation.

8. Patient results and prior documentation will be viewed through 724. 724 is a system that is locally available on designated computers in each clinical area to access a limited, near real time data set for each patient in the Cerner system up to the start of downtime. Refer to the 724 Downtime Viewer User Guide.

Data that can be viewed from 724 are:

<table>
<thead>
<tr>
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9. Patient results for Laboratory and Radiology will be returned to the units as follows:

a. All results will be printed or faxed to the patient’s location.
b. Stat critical or abnormal results will be called to an RN at the patient’s location.

10. Stat or critical results for Laboratory and Radiology that are called to the nursing unit will be written on the downtime critical results form. The person receiving the results will be responsible for notifying the patient’s nurse of the results.

11. The UC/designee will notify the appropriate nurse of any results that have been delivered to the nursing station.

12. If downtime extends over a shift change or there is caregiver exchange, the nurse to nurse hand-off communication will include review of paper MAR (medications ordered, given and to be given).
13. Once the system is returned to normal operation, electronic documentation and processes will resume.

**Section 5: New Admissions during Downtime**

Patients who are admitted during planned or unplanned downtime will not have a downtime chart report available to use for documentation during the downtime.

1. The admitting department will complete a manual face sheet for each patient admitted during downtime.

2. The patient will be sent to the unit with the following documentation:
   a. The manual face sheet
   b. Patient admission orders
   c. Patient labels and armbands

3. If the patient does not have a copy of his or her admitting orders, the Nurse or appropriate designee will call the admitting physician for Admission orders.

4. If the Admission is generated by the nursing unit (in the case of a newborn, for example) the unit will call Bed Control / Patient Access or Nursing Supervisor to notify them of the new Admission.

5. The UC/designee will establish chart for the patient using a downtime packet. Each page will be labeled with the patient’s name, medical record number, room and bed, and admitting physician’s name.

7. The manual chart will be used for the downtime recovery process. Specific information for new Admissions during downtime must be entered into the electronic medical record systems during the recovery process. Refer to Section 8.

**Section 6: Medication Administration Procedures during Downtime**

The following procedures will be used to support the process of medication administration and documentation during system downtime:

1. In the event of Downtime (planned or unplanned downtime of greater than two hours) each nursing unit will initiate printing of a paper MAR from designated desktop computers (refer to section 4 above).

2. The nurses will compare the contents of 724 order data and eMAR documentation to ensure
all of physician medication orders are accurately reflected on the paper MAR.

3. The nurses will handwrite new orders on the paper MAR that are written during downtime. The nurses will include the following information for each order:
   a. Medication name as written on the order sheet
   b. Dose
   c. Frequency
   d. Route
   e. Special instructions
   f. Administration hours

4. If there is not enough space on the paper MAR to document all of a patient’s medications, then additional blank copies of the paper MAR will be labeled with the patient’s identification and utilized with the printed-paper MAR. Each page should include a page reference in the following format “1 of 3”.

5. A downtime MAR extends from 07:00 – 06:59. A new paper MAR should be obtained every 24 hour time period starting 07:00. Each time a new paper MAR is introduced, nursing staff will reconcile it to the present paper MAR.

6. If a licensed provider writes new medication orders, or if a licensed provider verbally communicates new medication orders to a nurse or respiratory therapist, the nurse or UC/designee will scan / fax the new medication order to the pharmacy upon receipt of the order. Medication administration times should follow the Baptist Health Medication Admiration Guidelines policy and Medication Administration, Transcribing/Documentation-EMAR policy (refer to Nursing Service Policy and Procedure manual) and documented appropriately on the paper MAR.

7. Medication administration will be documented on the paper MAR during downtime.

   Medication documentation includes the following applicable items:
   a. Routine administration of medications
   b. Documentation of held doses
   c. Documentation of late doses
   d. Documentation of pain scores
   e. Documentation of follow-up responses to medications
   f. Blood pressure, heart rate, temperature or any other information that is required.
   g. Lot number, manufacturer and expiration date for immunizations

8. During downtime, the night nurse will perform an audit of the paper chart and the paper MAR. Any discrepancies noted on the paper MAR would be written on a physician order
9. Once the IT department announces that the downtime is over, the nursing department will begin the recovery process (See Section 8: Recovery from Downtime).

10. Refer to the Nursing Service Policy-Medication Guidelines – Transcribing and Documentation eMAR

Section 7: Discharging and Transferring Patients during Downtime

Due to the increased potential for errors during downtime, it is necessary to limit room and bed changes unless due to a change in the patient’s acuity requiring a higher level of care (i.e.: Med/Surg to Critical Care). Once normal system operation has been restored, and the recovery process is complete, then room and bed changes may resume.

**Transferring a patient to a new unit**

1. The transferring unit will call Bed Control / Patient Access or Nursing Supervisor as appropriate and request a room and bed assignment.

2. Bed Control / Patient Access or Nursing Supervisor will notify the transferring unit of the new room and bed assignment.

3. The transferring unit will contact the receiving unit and give a report on the patient’s condition.

4. The transferring unit will move the patient to the receiving unit with all of the transferring unit’s downtime documentation.

5. The receiving unit will be responsible for the appropriate recovery process.

**Transferring a patient to the OR**

1. The transferring unit will contact the OR and issue a report on the patient’s condition.

2. The transferring unit will send the patient’s downtime documentation to the OR with the patient.

**Transferring a patient from the PACU**

1. The PACU will call Bed Control / Patient Access or Nursing Supervisor and request a room and bed assignment.

2. Bed Control / Patient Access or Nursing Supervisor will notify the transferring unit of the
new room and bed assignment.

3. The PACU will contact the receiving unit and give a report.

4. The PACU will transfer the patient and the downtime documentation to the receiving unit.

5. The receiving unit will create a downtime document packet for the patient based on the unit’s downtime procedures and the patient’s documentation requirements.

**Transferring a patient from the Emergency Department**

1. The ED will call Bed Control or Nursing Supervisor and request a room and bed assignment.

2. Bed control or Nursing Supervisor will notify the ED of the new room and bed assignment.

3. The ED will contact the receiving unit and give a report.

4. The ED will transfer the patient and the downtime documentation to the receiving unit.

5. The receiving unit will create a downtime document packet for the patient based on the unit’s downtime procedures.

**Discharging a patient during downtime**

1. The discharging unit will call Bed Control / Patient Access or the Nursing Supervisor and notify them of the discharge.

2. The downtime documents will be added to the patient’s chart and maintained on the patient’s nursing unit until the recovery process is complete.

**Section 8: Recovery from Downtime**

After a period of downtime (planned or unplanned) the clinical departments will begin the recovery process. This process is used to update the electronic medical record with the information collected on various downtime forms while the system was unavailable.

The recovery process follows a sequence involving multiple departments. Your department will be notified when to start entering new data (real time documentation) into the electronic medical record and when to start your recovery process of back loading data.

**Downtime Recovery Sequence**

Upon system restoration, IT will validate the system is fully restored and functioning. Interface activity held during downtime will be started and monitored. Once interface have completed back loading and resumed real time processing IT
will start the following notification sequence:

1. Before real time documentation can begin patient access / registration must be given time to complete back loading of admissions, transfers and discharges.
2. Once registration has completed their recovery steps, pharmacy, lab and radiology will be notified to complete their back loading of orders and results.
3. Once these departments have completed their recovery steps, an overhead page will occur to alert all other clinical areas to begin back loading steps and start using the system for real time charting.

**In order to ensure a high level of patient care, all documentation recovery must be completed within 8 hours of the system’s return to normal operations.**

**Recovery Reconciliation and Back Loading Processes**

Once the system is available to the clinical departments the recovery process will begin. The amount of information that will be entered into electronic medical record systems will depend on the length of the downtime.

Once the system resumes normal operation the Cirix banner bar will display the type of recovery that will be conducted.

Census reconciliation will be done by nursing on each floor.

A narrative entry will be entered under “Nurses Notes” when the system is available. This note will state “Narrative notes exist on paper for the time and date range of [ENTER DATE RANGE].”

Example: Narrative notes exist on paper for the time and date range of 10/30/12 06:00 to 10/30/12 14:00.

All paper documentation created during downtime will remain in the patient’s paper chart on the unit and will be incorporated into the final patient record at the point of discharge.

Regardless of the downtime level, all information on new Admissions during downtime is entered into the electronic medical record.

For patients transferred during the downtime, the receiving unit/facility will be responsible for the recovery process.

For patients discharged during the downtime, the discharging unit is responsible for the recovery process.

**Clinical Orders and Diagnostic Results**

1. Pharmacy, Radiology, Lab, Respiratory and Rehab Services orders and results performed during the downtime are back entered by those departments with actual order and result date
and times.

2. All future orders are held on the nursing units and entered by unit staff when the system is available. When the system comes back online, the nurse caring for the patient back enters all other orders and future diagnostic orders with **actual order date and time**. All orders written signed by providers during downtime are entered as *Written* orders. Verbal orders taken during downtime are entered as *Verbal* orders.

3. A Nurse collect list will be run by Lab to confirm all nurse collects have been obtained.

**Clinical Documentation Recovery**

1. Regardless of the amount of downtime experienced the following information will be updated by the responsible clinician in the EMR system for any Admission that occurred during the downtime:
   a. Nursing Admission history
   b. Height, weight
   c. Allergies
   d. Code status order
   e. Pregnancy status
   f. Lactation status
   g. Advance directives
   h. Isolation status
   i. Admitting diagnosis order

2. ED patients that arrive and depart during the downtime will not have data manually back entered.

   ED patients still in the ED at time of recovery will have the following data back entered: Home Medications, Allergies and Height and Weight. Remaining documentation for the ED stay will be entered in the EMR once the system is back up.

   ED patients admitted during the downtime will have all documentation charted as identified under New Patient Admits. Medications orders will be faxed to pharmacy by the inpatient nurse for back entry by pharmacy.

3. If the downtime was less than two hours (Level 1), the following information will be entered for all non-ED patients into the EMR system:
   a. All clinical assessments
   b. All vital signs
   c. All medication administration (eMAR)
   d. All intake and output
   e. Home Medications
   f. Immunizations

4. If downtime was greater than two hours (Level 2), the following information will be entered
for all non-ED patients into the EMR system:

a. Most recent vital signs
b. All intake and output
c. All medication administration (eMAR)
d. Home Medications
e. Immunizations

5. Narrative notes will be kept on paper for all levels of downtime and will not be recovered to the electronic record.

6. Nursing will perform a full order reconciliation after all orders have been back entered by their respective departments.

7. Tasks on the Task List that are overdue will be charted as “Not Done” with the reason “System Down, See Downtime Form” selected.

**Charges**

1. Charts will be evaluated for charges and back entered per department policy using appropriate charting forms or batch charge entry (i.e. ED, OR, Supplies, etc.)

**Scheduling**

1. All scheduling changes for current or future appointments should be entered or updated in the electronic system.

### Section 9: Star Registration Downtime

The Star system experiences downtimes both planned and unplanned. During Star downtimes patients are registered into Cerner, when available, via the Star Downtime Patient Registration conversation accessible through PM Launch.

When Star is brought back up, those patients that were registered into the system using the downtime registration must also be registered in Star.

When both STAR and Cerner are down, manual logs will be utilized and the previously outlined recovery processes will be followed.

### Section 10: Pyxis and MedProx Downtime

The Pyxis and MedProx system experiences downtimes both planned and unplanned. During Pyxis and MedProx downtime, the medication cabinets will be placed on override and keys will be utilized to unlock drawers for access to medications. Pharmacy should be contacted for medications not stored in department. Medication orders should still be entered electronically. If the EMR is down as well, medication orders should still be faxed/scanned to Pharmacy.

### Section 11: Network Downtime
Paper processes as outlined above should be followed until network access is recovered

Section 12: Departmental Specific Downtime Policies and Processes

All units are responsible for monthly testing of downtime systems including accessing 724 System, printing a current downtime MAR, a downtime Powerplan and any applicable downtime forms.

All departments should have supplemental downtime policies, procedures and processes to address department specific documentation and needs.

Departments should include but are not limited to the following information:

- Designated staff responsibilities for down time
- Designated staff responsibilities for recovery back loading
- Staffing resource needs
- Downtime forms to be utilized
- Designated area of downtime packages
- 724 Device location/ designation
- Local downtime printer location/ designation
- Staff education on Downtime processes
Welcome to Baptist Health Policy Manager
End User

What is Policy Manager?

Baptist Policy Manager is a website where all Baptist Health policies are stored and maintained. All policies are searchable with automated tracking of:
(a) user competencies on new and revised policies and
(b) sign off of approval process for new and revised policies.
Objectives:

- Identify location of policy manager icon
- Understand policy manager log in process and the function of policy manager
- Locate search field and navigate to policies
- Locate Favorites section
- Understand the competency function of policy manager and the completion of competencies

Welcome to Baptist Health Policy Manager – End User

The icon for Policy Manager is conveniently located on the Citrix home page... (you do not need to log into Citrix first)
Guest Log In
https://baptisthealthpolicies.ellucid.com

You can Browse or Search Manuals from the Guest Log In; however, you must Log In to complete Competencies...

The user name and password for Policy Manager is **your individual Citrix login**; which is your first initial, middle initial, last name.... ex: ctmurphy and the password is your citrix password.
The user name and password for Policy Manager is your individual Citrix login; which is your first initial, middle initial, last name…. ex: ctmurphy and the password is your citrix password.

The first time you log in you will notice a bar along the top….go to My Preferences.
The **Notifications** section is how you will receive notification of new policies and competency assignments – select the bottom 4 items – do not select the top item.

You will now receive emails in your groupwise account when new policies/competency assignments have been sent.

**Groupwise:** You will receive notification by email of new policies or if a competency is required – either by signature or quiz.
Go to…
Browse Manuals Tab

Select…
Your Hospital or Manual
Select... The **Department** you are looking for

Select... The **Policy** you are looking for
You can add selected (check mark) policy to “My Favorites” section – just by the click of a button!

Go to… Search Tab; Type in name or words of policy and click hourglass.
Select... Your Hospital or the manual ...find policy

Go to... Advanced Search
Competencies...

- Competencies in Policy Manager involves
  - Reviewing Newly developed or Revised Policies

- Two ways to document Competencies
  - Electronic Signature
  - Completing a quiz

- Notification of competencies will be checking your competency tab or by email