

MAYERS MEMORIAL HOSPITAL DISTRICT

POLICY AND PROCEDURE

AMA: LEAVING AGAINST MEDICAL ADVICE

Page 1 of 4, plus attachment

Leaving Hospital Against Medical Advice MMH598

DEFINITION:

For all intents and purposes, the word “patient(s)” refers to all customers receiving health care services in our facilities, including inpatients, outpatients, residents and clients.

POLICY:

On occasion, a patient may demand to leave the hospital although the patient’s physician has not ordered his or her discharge and has specifically indicated that the discharge is against medical advice. An adult with the capacity to make health care decisions has the right to decide whether or not to submit to medical treatment. It is specifically provided that the patient has the right to “leave the hospital even against the advice of the physician” [Title 22, Section 70707 (b) (10)]. If the patient lacks the legal authority to make health care decisions, the patient has the right to have a legal representative make the decision to stay or leave for him or her. As a general rule, if a competent patient persists in the decision to leave the hospital, the patient’s decision must be respected.

However, before a patient is discharged prior to the completion of treatment or contrary to medical advice, the patient’s physician must first attempt to provide the patient (or legal representative) with information regarding why continued hospitalization is recommended, the potential consequences of the action (the risks involved in leaving, the benefits of continued hospitalization and any alternatives, such as transfer to another facility or outpatient treatment), so that the patient may make an informed decision on whether or not to leave the hospital.

Carefully document the facts surrounding a patient’s departure and specifically the actions that were taken to assure the patient’s safety. Several precautions may be taken in addition to warning a patient if it would be dangerous for the patient to drive because of a medical condition or medication the patient has taken. If it appears that the patient is helpless or otherwise in a condition that indicates he/she should not be allowed to leave the hospital alone, hospital administration should be notified immediately. Arrangements such as an ambulance are advisable whenever it appears that a patient would be likely to harm himself or others in the process of leaving the hospital unless such precautionary measures are taken. Hospital personnel will not, under any circumstances, accompany the patient once they have left the hospital premises.

PROCEDURE:

1. Whenever a patient states that he/she intends to leave the hospital before the physician has ordered the patient's discharge, the patient's physician should be contacted immediately. The physician is asked to discuss the request with the patient, either by telephone or in person, as appropriate.
2. If the patient attempts to leave the hospital before discussing the matter with the physician, the patient should be informed that their physician has been contacted and will explain the risks and consequences of leaving the facility to them prior to departure.
3. In addition, when appropriate, hospital personnel may request the assistance of the on-call physician
4. Whenever a demand is made by a patient (or the patient's legal representative) to leave the hospital before treatment is completed or contrary to the advice of the attending physician, the "Leaving Against Medical Advice" form is completed (see attached). This form documents that the patient was given information regarding possible risks that may result from a decision to leave against medical advice the benefits of continued hospitalization any alternatives and that the patient nevertheless decided to leave.
5. Whenever possible, the signature on the "Leaving the Hospital Against Medical Advice" form should be the same as the "Conditions of Admission" agreement. If the patient refuses to sign, the notation "patient refuses to sign" should be made in the space provided for the patient's signature. The witness should sign the form, note the exact time and date and enter a brief note concerning the circumstances of refusal.
Thorough documentation is very important.
6. Distribution of Form Copies:
 - a. The original should be placed in the patient's medical record
 - b. Copy sent to the directors of nurses (SNF or Acute as applicable)
 - c. A "QRR Report" form should also be completed and forwarded to the Director of Quality.
7. The hospital should take appropriate precautions to ensure that the patient leaves the hospital in a safe manner. The attending physician should be involved in the transportation arrangements, as physicians are required to take reasonable steps to protect their patients and third parties who may be victims of a patient's dangerous conduct.

SPECIAL CONSIDERATIONS:

Hospitals and physicians generally do not have an affirmative duty to stop a patient who insists on driving home after being warned that they are not in a condition to drive safely. Any AMA patient that is thought by medical staff or hospital employee to pose a traffic hazard by driving, will trigger telephone notification to the appropriate Law Enforcement Agency.

All attempts will be made by hospital staff to assist in arranging safe patient transportation.

If it is a patient's wish to leave the hospital against medical advice and that patient has an emergency medical condition which has not been stabilized, the federal "anti-dumping" laws may apply.

REFERENCES:

CHA Consent Manual 2017 Chapter 6 page 6.5 & 6.6
EMTALA Policy, section IX

COMMITTEE APPROVALS:

P&P:

MAYERS MEMORIAL HOSPITAL DISTRICT

POLICY AND PROCEDURE

ANNUAL EMPLOYEE INFLUENZA VACCINATION

Page 1 of 3, plus the following Attachment(s)

Annual Employee Influenza Vaccination Consent MMH316

Influenza Received Elsewhere Form MMH445

Mayers Memorial Hospital District (MMHD) Religious Accommodation Form MMH446

Seasonal Influenza (Flu) Vaccine Declination Statement MMH447

Reasonable Accommodation Form MMH448

The Shasta County Public Health Officer has issued a mandate that all healthcare workers who work in licensed healthcare facilities and ambulance services must either receive the influenza vaccine or wear a mask from November 1st through March 31st. If influenza surveillance data demonstrates an unusually late peak and continued widespread influenza activity in the spring, the Shasta County Health Officer may extend the period during which the masking shall apply.

DEFINITIONS:

Healthcare workers (HCW): CDC defines HCW as all persons, paid and unpaid, who work in health care settings who have potential for exposure to patients or infectious materials or contaminated surfaces. HCW refers to not only physicians, nurses, CNAs, EMTs and paramedics but also lab and imaging personnel, social workers, pharmacists, students, volunteers, maintenance, billing, patient access, purchasing, environmental services, dietary and clerical personnel. HCW also includes employees in both full-time and part-time positions as well as medical staff, contractors and Mayers Memorial Hospital District (MMHD) Board members.

Masks: Masks are protective coverings for the face that cover the mouth and nose to prevent inhalation of dangerous substances or to prevent the dispersal of infective materials. Simple surgical/procedure masks are sufficient protection (N95 masks are not required) for those HCW declining the influenza vaccine. The face masks should be changed or appropriately discarded when leaving patient care areas, going off duty or if they become soiled or wet.

Flu season: November 1st through March 31st is defined as flu season based on California hospital, sentinel provider and lab detection surveillance of peak flu weeks for the last 12 years. This information provides the basis for the mandate determining that unvaccinated HCW are required to wear masks for the duration of this period while in any patient care area.

Health facility: Any health care direct service organization that provides care to patients, including but not limited to, general acute care hospitals, skilled nursing facilities, clinics, medical offices and ambulance services.

For all intents and purposes, the word “patient(s)” refers to all customers receiving health care services in our facilities, including inpatients, outpatients, residents and clients.

POLICY:

Mayers Memorial Hospital District (MMHD) wants to ensure a safe and healthy work environment, free of preventable communicable disease by providing annual influenza vaccinations free of charge to employees, physicians, volunteers, students, contract staff and board members. By providing this service, MMHD works to protect patients from becoming infected through exposure to infected HCW. In order to comply with local, state and federal laws, all personnel will be required to either accept or decline the influenza vaccine annually by a written statement.

PROCEDURE:

- 1) All healthcare workers will be offered the influenza vaccine annually at no cost to the employee.
- 2) Information about the influenza vaccine and transmission of influenza will be made available to all employees.
- 3) Healthcare workers who choose to decline the vaccine will sign a declination form and be required to wear a surgical/procedure mask at all times while in the hospital during the influenza season (November 1st through March 31st) of each year. The health officer for Shasta County may alter these dates at his/her discretion.
- 4) Healthcare workers who receive their vaccination at a location other than MMHD **MUST** provide proof of vaccination to Employee Health by October 31st of each year or he/she will be required to wear a mask as described above.
- 5) Any MMHD employee who chooses NOT to be vaccinated and NOT wear a mask during the influenza season as defined by the Shasta County Public Health Officer will be given a verbal and written warning first. If the employee continues to disregard the masking mandate, he/she will be removed from the schedule without pay until April 1st.
- 6) Mask free zones are non-patient care areas such as the following:
 - a) Cafeteria/dining areas/patios
 - b) Break rooms
 - c) Board room

- d) Maintenance building
 - e) Storage shed
 - f) HIM room
 - g) Purchasing area
- 7) Once an individual who has not been vaccinated leaves a mask free zone, they must apply the mask appropriately before entering any patient area or hallway.
- 8) Any individual who experiences an adverse reaction to the vaccine will report it to the Employee Health nurse immediately.
- 9) It is the responsibility of the Employee Health nurse or designee to obtain informed consent, administer the vaccine and provide the appropriate follow-up if an individual experiences an adverse reaction.

SPECIAL CONSIDERATIONS:

Written medical waiver from a physician is required if the employee states that he/she has a true medical contraindication to the flu vaccine. If the employee claims personal belief against the flu vaccine, written documentation of this must accompany the declination form.

REFERENCES:

Shasta County Health Officer: Mandatory Influenza Vaccination or Masking of Health Care Workers during the 2013-14 Influenza Season
Health & Safety Code, 1288.7, subdivision (a); California Code of Regulations, Title 8, 5199, subdivision (c)(6)(D) and (h)(10)

APPROVALS:

IC: 12/6/2017

MAYERS MEMORIAL HOSPITAL DISTRICT

BOARD POLICY AND PROCEDURE

BOARD MEMBER APPOINTMENT PROCESS

ORIGINATING DATE: 03/98

EFFECTIVE DATE:

REVISION DATE: 12/18/07, 3/8/10-BQC

MANUAL(S): Board, Administration, Medical Staff

Page 1 of 2 plus the following Attachment(s)
CERTIFICATE OF APPOINTMENT

POLICY:

Appointment of board members shall take place in open meetings per the Brown Act and Health Care District Law. The remaining members of the district board shall make the appointment within 60 days after either the date on which the district board is notified of the vacancy or the effective date of the vacancy, whichever is later.

PROCEDURE:

The district shall notify the Shasta County Elections office and the Board of Supervisor's Clerk's office of the vacancy no later than 15 days after either the date on which the District board is notified of the vacancy or the effective date of the vacancy, whichever is later.

A "Notice of Vacancy" is prepared and posted in at least three conspicuous places for at least 15 days including information required by Election Code 10515.

A regular or special board meeting is scheduled to conduct interview of all applicants. All interviews will be conducted according to a pre-set list of questions established by Board.

The selection process is as follows:

1. Printed ballots will be distributed to board members. The ballots should be retained (in an envelope, one for each separate vote) in the event of questions or validation is necessary at a later time.
2. Board secretary (or Clerk to the Board) is to collect written ballots. (Note: The purpose of written ballots vs. oral is so that board members do not influence each other.)
3. Board secretary (or Clerk to the Board) reads the votes aloud, stating the board member's name and candidate name.

4. A majority vote of the board (not quorum) confirms one candidate. If vote does not result in a majority, only the top two vote-getters are advanced to a second vote. Board must keep balloting until one candidate receives a majority vote.
5. The newly-appointed board member is announced.
6. The district's Clerk to the Board will prepare the Affidavit/Oath of Office form.
7. The newly-appointed board member must sign the form in the presence of a Notary Public who will provide the oath of office.
8. The new board member is considered a voting member of the Mayers Memorial Hospital District Board of Directors.

REFERENCES:

Election Code (California Law)
MMHD Bylaws (District)
Ralph M. Brown Act
Shasta County Elections Department

COMMITTEE APPROVALS:

BQC: 3/8/10
BOD: 3/29/10

Author: Marlene McArthur
File/Path Name: <P:\Policies and Procedures\Administration>

CERTIFICATE OF APPOINTMENT

This certifies that, at a **[special or regular]** district meeting held on **[date of meeting]**

[name of newly-appointed Director]

was appointed to the office of Director, Mayers Memorial Hospital District, for the term ending **[date]**

IN WITNESS WHEREOF, I hereunto set my hand
this _____ day of _____, _____.

[name]¹
[title], Mayers Memorial Hospital District
County of Shasta, State of California

STATE OF CALIFORNIA)
) ss
County of Shasta)

I, **[name]**, do solemnly swear (or affirm) that I will support and defend the Constitution of the United States and the Constitution of the State of California against all enemies, foreign and domestic; that I will bear true faith and allegiance to the Constitution of the United States and the Constitution of the State of California; that I take this obligation freely, without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties upon which I am about to enter.

[signature of newly-appointed Director]

Subscribed and sworn to before me, this _____ day of _____, 2010.

[name and title]²

¹ The appointment should be signed by the Chairman of the Board, the Secretary of the Board, or the Clerk to the Board.

² A notary public may witness the oath.

MAYERS MEMORIAL HOSPITAL DISTRICT

POLICY AND PROCEDURE

BOARD OF DIRECTORS' JOB DESCRIPTION

ORIGINATING DATE: 6/8/10
REVISION DATE:
MANUAL(S): Administration, Board of Directors

Page 1 of 4

Job Description: MMHD Board of Directors

Core Responsibilities

A hospital governing board must fulfill certain fundamental or core responsibilities in overseeing the efforts of the organization. These responsibilities cluster around six major areas:

- 1. Financial Oversight**
- 2. Quality Oversight**
- 3. Setting Strategic Direction/Mission Oversight**
- 4. Self-Assessment & Development**
- 5. Management Oversight**
- 6. Advocacy**

The Board fulfills these responsibilities by adopting specific outcome targets against which to measure the organization's performance. To accomplish this, the board must:

- Establish policy guidelines and criteria for implementing the mission statement.
- The board also reviews the mission statements of any subsidiary units to ensure that they are consistent with the overall mission.
- Evaluate proposals brought to the board to ensure that they are consistent with the mission statement.
- Monitor programs and activities of the hospital and any subsidiary units to ensure mission consistency.
- Periodically review, discuss, and amend the mission statement if necessary to clarify board responsibilities.

Financial Oversight

The board has responsibility for the financial soundness of the organization. To accomplish this, the board must:

- Review and approve overall financial policies, guidelines and plans for the District.
- Receive and review regularly financial reports, including hospital performance compared to the budget, and operating ratios to assess actual performance compared to projections.

- Review major capital plans proposed for the organization and any subsidiaries.
- Establish criteria for determining how much support should be given to services that lose money.
- Adopt annual budget that reflects the board's goals for the hospital.
- Ensure that the financial, capital, and strategic plans are aligned – and that the community's asset is properly managed.

Quality Oversight

This board has the responsibility to assess the quality of all services provided by all individuals who perform their duties in this facility or under this board's sponsorship. To do this, the board must:

- Make quality of care and patient safety top priorities for the organization.
- Approve and oversee quality improvement initiatives recommended by senior management and the medical staff.
- Assume responsibility for the action of all physicians, nurses, and other individuals who perform their duties in the organization's facilities.
- Review and carefully discuss quality reports that provide comparative statistical data, and set measurable policy targets to ensure continual improvement in quality performance.
- Carefully review recommendations of the medical staff regarding new physicians who wish to practice in the organization and approve these recommendations if appropriate.
- Reappoint individuals to medical staff using comparative outcome data to evaluate how they have performed since their last appointment.
- Appoint physicians to governing body committees and seek physician participation in the governance process to assist the board in its patient quality-assessment responsibilities.
- Regularly receive and discuss malpractice data reflecting the organization's experience and the experience of individual physicians who have been appointed to the medical staff.
- Regularly receive and discuss data about medical staff to assure that future staffing will be adequate in terms of ages, numbers, specialties, and other demographic characteristics.
- Monitor programs and services to ensure that they comply with policies and standards relating to quality.
- Take corrective action to improve quality performance when appropriate and/or necessary.

Setting Strategic Direction/Mission Oversight

The board has the responsibility to recommend the future direction that the organization will take to meet the community's health needs. To fulfill this responsibility, the board must:

- Establish and review MMHD mission/vision/values.
- Consider the needs of the community and collect data to determine those needs when creating or revising a mission and vision for the hospital.
- Reevaluate the mission annually and reflect on it monthly to direct board meetings.
- Review and approve a comprehensive strategic plan that is clear, concise and specific including supportive policy statements.
- Ensure that the organization's strategic plan is consistent with the mission and that the hospital's actions are aligned with the plan. Regularly review progress toward meeting goals in the strategic plan to assure that the board is fulfilling its mission.

- Periodically review, discuss, and amend the strategic plan to ensure its relevance to the mission.
- Communicates and articulates clear strategic direction for the hospital to community, physicians, management, and staff.

Self-Assessment & Development

A board must assume responsibility for itself – its own effective and efficient performance. To discharge its stewardship responsibilities to its “owners,” the board must:

- Annually participate in a formal board evaluation process.
- Evaluate board performance of individual board members to determine the appropriateness of continued service on the board.
- Maintain and update policy statements regarding roles, responsibilities, duties, and job descriptions for the board itself and its members, officers, and committees.
- Participate both as a board and as individuals in orientation programs and continuing education programs.
- Recognize and nurture existing board members, and provide existing board members with opportunities to grow and develop as leaders.

Management Oversight

The board is the final authority regarding oversight of management performance by the CEO and support staff. To exercise this authority, the board must:

- CEO oversight, which includes hiring, terminating, disciplining, rewarding and ongoing performance evaluations using goals and objectives agreed upon at the beginning of the evaluation cycle of the CEO.
- Support and assist the CEO to help achieve the organization’s mission.
- Communicate regularly with the CEO regarding goals, expectations, and concerns in regard to overall hospital’s performance.
- Seek clarification about management actions or hospital performance that it does not understand.
- Clearly and consistently define the limits of the CEO authority.
- Periodically survey CEO employment arrangements at comparable organizations to ensure the reasonableness and competitiveness of his or her compensation package.
- Periodically review management succession plans to ensure leadership continuity.
- Ensure that the CEO has complete and up-to-date policies in place for management of staff, and has a clear understanding of board’s expectations.
- Establish specific performance policies that provide the CEO with a clear understanding of board expectations, and update these policies based on changing conditions.
- The board does not interfere in the routine business of management.

Advocacy

The board needs to focus on advocacy and lobbying around public policy issues. In order to take an activist role, the board must:

- Use the ability to advocate to legislators, the community, or prospective donors on behalf of the organization as a criterion in the selections process of new board members.

- Identify legislative goals/public policy advocacy priorities for board members at least every two years.
- Review a survey of community perceptions of the organization at least every three years.
- Assist the organization in communicating with key external stakeholders (e.g., community leaders, potential donors).
- Actively support the organization’s fund development program (e.g., board members give according to their abilities, identify potential donors, participate in solicitations, serves on fund development committees).
- Expect individual board members to engage in advocacy efforts with legislators.
- Adopt a policy regarding information transparency, explaining to the public in understandable terms the organization’s performance on measures of quality, safety, pricing, and customer service.

Finally, the board is responsible for managing its own governance affairs in an efficient and effective way. To fulfill the responsibility, the board must:

- Maintain written conflict-of-interest policies that include guidelines for the resolution of existing or apparent conflicts of interest.
- Periodically review the board’s own structure to assess appropriateness of size, diversity, committees, tenure, and turnover of officers and chairpersons.
- Ensure that each board member understands and agrees to maintain confidentiality with regard to information discussed by the board and its committees.
- Maintain efficient and timely communication with any subsidiary boards.
- Adopt, amend and, if necessary, repeal the articles and bylaws of the organization.
- Maintain an up-to-date board policy manual, which includes specific policies covering its specific duties of care, loyalty, and obedience, and its oversight responsibilities in the areas of finance, quality, strategic planning, self-assessment and development, management oversight and advocacy.

SPECIAL CONSIDERATIONS (Optional):

This job description replaced the originating 1999 MMHD Job Description and Code of Ethics P&P.

REFERENCES (Required):

Governance Institute; MMHD 1999 BOD Job Description, Responsibilities and Duties and MMHD BOD Code of Ethics.

COMMITTEE APPROVAL: Board Quality Committee (Kerns/Brubaker): 6/8/2010

BOARD APPROVAL: Regular Board Meeting 7/28/10

Author: mm
 File/Path name: (P&P Coordinator will complete this field when the policy is released).

MAYERS MEMORIAL HOSPITAL DISTRICT

POLICY AND PROCEDURE

Drug Supply Chain Security Act Compliance Plan

Page 1 of 3

POLICY:

The Drug Supply Chain Security Act (DSCSA) was enacted to prevent adulterated or fraudulent Rx products from entering the supply chain. This act creates national traceability requirements for all Rx products beginning with the manufacturer and extending through the entire supply chain. Mayers seeks to only dispense and administer Rx products that have a traceable pedigree. Record retention begins at the pharmacy level July 1, 2015.

PROCEDURE:

1. Primary Wholesaler
 - a. Medication received from the primary wholesaler (McKesson) is tracked electronically.
 - b. The information can be viewed at McKesson's website in the following way:
 - i. >Pharmacy Management / Programs
 - ii. >>Reports
 - iii. >>>Traceability Reporting
 - iv. Select NDC, Invoice and date range to view the supply chain history for a specific Rx product.
 - c. McKesson electronically stores 6 years of data.
2. Drop Ship Items and items from Sterile Compounding Pharmacies.
 - a. The invoice for drop ship items is scanned and saved electronically, filed by NDC.
 - b. The hard copy of the invoice is copied and the copy is filed by NDC and retained for 6 years.
3. Outside Pharmacy (Borrow/Trade)
 - a. When a Rx product is borrowed from a local outside pharmacy, a copy of the invoice for that item will be requested.
 - b. When the invoice is received, document that it was for a borrowed product.
 - c. The invoice is scanned and saved electronically, filed by NDC.
 - d. The hard copy of the invoice is filed by NDC and retained for 6 years.

- e. When a local outside pharmacy borrows a Rx product or has a product returned to them to replace a borrowed product, provide the “Traceability Report” to the outside agency as in #1.
4. Secondary Suppliers / Wholesalers
 - a. Mayers does not routinely purchase from secondary suppliers. These are considered high risk suppliers and every effort should be made to investigate the legitimacy of wholesaler and provided drugs.
 - b. The DSCSA provides for federal licensing of wholesalers to prevent
 - c. If a Rx product is purchased from a secondary supplier:
 - i. Verify the company has a valid California pharmacy license.
 - ii. Request a traceability report prior to purchasing.
 - iii. If an item is purchased, retain records per the Drop Ship Item procedure.
 5. Returned Products—Primary Wholesaler
 - a. Rx products returned to McKesson require:
 - i. The Rx product was originally purchased from McKesson
 - ii. The Rx product is saleable
 - iii. A manual or electronic signature on the return authorization
 6. Monitor/report any suspicious/illegitimate products in the supply chain.
 - a. Refer to “FDA issues draft guidance on identifying suspect drug products in the supply chain” <http://www.fda.gov/drugs/drugsafety/ucm400520.htm>
 7. To scan
 - a. On the NS3 copy machine
 - >Send
 - >Address Book
 - >DSCSA (check the box)
 - Hit OK
 - Scan
 - b. The scan will appear in the DSCSA folder in pharmacy My Document
 - c. Move the scan from here to the specific folder (i.e. McKesson Drop Ship) and the specific NDC within that folder
 - d. Stamp the original to indicate scanned once scan complete.

REFERENCES:

1. PUBLIC LAW 113–54—NOV. 27, 2013; TITLE II—DRUG SUPPLY CHAIN SECURITY. Accessed June 14, 2015 <http://www.gpo.gov/fdsys/pkg/PLAW-113publ54/pdf/PLAW-113publ54.pdf#page=13>

2. McKesson Corporation. Drug Supply Chain Security Act: What to expect and how to prepare. Accessed June 14, 2015
<https://connect.mckesson.com/wcmStaticFiles/WCM/Programs/DSCSA/Articles/PHARMA%20DSCSA%20Customer%20Presentation%20Jan%202015%20Revised.pdf>

APPROVALS:

Quality:

MAYERS MEMORIAL HOSPITAL DISTRICT

Patient's Name: _____

I am voluntarily leaving the hospital against the advice of Dr. _____ and a representative of the hospital administration.

I have been told by the doctor about the risks and consequences involved in leaving the hospital at this time, the benefits of continued treatment and hospitalization, and the alternatives, if any, to continued treatment and hospitalization.

I hereby release the doctor, any other doctors involved in my care, the hospital and its employees and agents from all responsibility for any injury or ill effects, which may result from this action.

I understand that the doctor named above and other doctors who provide services to me are not employees or agents of the hospital. They are independent medical practitioners.

Date: _____ Time: _____ AM / PM

Signature: _____
(patient/legal representative)

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(legal representative)

Signature: _____
(witness)

Print name: _____
(witness)

I declare that I have personally explained to the patient the risks and consequences involved in leaving the hospital at this time, the benefits of continued treatment and hospitalization, and the alternatives, if any, to continued treatment and hospitalization.

Remarks: _____

Date: _____ Time: _____ AM / PM

Signature: _____
(physician)

Print name: _____
(physician)

Approvals:

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LEAVING HOSPITAL AGAINST MEDICAL ADVICE MMH598

(3/03) California Hospital Association Page 1 of 1 Form 5-3

MAYERS MEMORIAL HOSPITAL DISTRICT

Nombre del Paciente: _____

Voluntariamente salgo del hospital en contra del consejo del (*nombre de médico*) _____
_____ y un representante de la administración del hospital.

El doctor me ha informado de los riesgos y consecuencias relacionados con salir del hospital en este momento, de los beneficios del tratamiento y hospitalización continuados, y las alternativas, en su caso, al tratamiento y la hospitalización continuados.

Por medio de la presente exonero al médico, a cualesquiera otros médicos involucrados en mi atención médica, al hospital y a sus empleados y representantes de toda responsabilidad por cualquier lesión o efecto adverso que pueda resultar de esta acción.

Entiendo que el médico cuyo nombre se indica anteriormente y otros médicos que me brindan servicios no son empleados ni agentes del hospital. Son médicos facultativos independientes.

Fecha: _____ Hora: _____ AM / PM

Firma: _____
(paciente o representante legal)

Si no lo firma el paciente, indique la relación con éste: _____

Nombre en letra de imprenta: _____
(*representante legal*)

Firma: _____
(testigo)

Nombre en letra de imprenta: _____
(*testigo*)

I declare that I have personally explained to the patient the risks and consequences involved in leaving the hospital at this time, the benefits of continued treatment and hospitalization, and the alternatives, if any, to continued treatment and hospitalization.

Remarks: _____

Date: _____ Time: _____ AM / PM

Signature: _____
(*physician*)

Print name: _____
(*physician*)

Approvals:

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LEAVING HOSPITAL AGAINST MEDICAL ADVICE MMH598

(3/03) California Hospital Association Page 1 of 1 Form 5-3

MAYERS MEMORIAL HOSPITAL DISTRICT

NOTICE OF PRIVACY PRACTICES:

Acknowledgement of Receipt

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of *Mayers Memorial Hospital District*. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice by: accessing our web site at www.mayersmemorial.com or by contacting our organization at 1-530-336-5511 OR toll free at 1-877-545-7241.

I acknowledge receipt of the *Notice of Privacy Practices* of Mayers Memorial Hospital District.

Signature: _____ Date: _____
(patient/parent/conservator/guardian)

Print Name: _____

INABILITY TO OBTAIN ACKNOWLEDGEMENT

Complete only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

Patient's Name: _____

Reasons why the acknowledgment was not obtained:

- Patient refused to sign this acknowledgement even though the patient was asked to do so and the patient was given the Notice of Privacy Practices
- Other: _____

Signature of provider representative: _____ Date: _____

Print provider representative name: _____



Mayers Memorial Hospital District

Mayers Memorial Hospital District

43653 Highway 299E

PO Box 459

Fall River Mills, Ca. 96028

(530)336-5511

info@mayersmemorial.com

NOTICE OF PRIVACY PRACTICES

EFFECTIVE 9/16/2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact Sherry Wilson at (530) 336-5511.

WHO WILL FOLLOW THIS NOTICE

This notice describes our hospital's practices and that of:

- Any health care professional authorized to enter information into your hospital chart.
- All departments and units at Mayers Memorial Hospital District and the Burney campus.
- All employees, volunteers, staff and other hospital personnel.

All these entities, sites and locations follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or health care operations purposes described in this notice.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the hospital. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the hospital, whether made by hospital personnel or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private (with certain exceptions);
- Give you this notice of our legal duties and privacy practices with respect to medical information about you;
- Notify you if there is a breach of your protected health information; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

DISCLOSURE AT YOUR REQUEST

We may disclose information when requested by you. This disclosure at your request may require a written authorization by you.

FOR TREATMENT

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, health care students, or other hospital personnel who are involved in taking care of you at the hospital. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different departments of the hospital also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and X-rays. We also may disclose medical information about you to people outside the hospital who may be involved in your medical care after you leave the hospital, such as skilled nursing facilities, home health agencies, and physicians or other practitioners. For example, we may give your physician access to your health information to assist your physician in treating you.

FOR PAYMENT

We may use and disclose medical information about you so that the treatment and services you receive at the hospital may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about surgery you received at the hospital so your health plan will pay us or reimburse you for the surgery. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. We may also provide basic information about you and your health plan, insurance company or other source of payment

to practitioners outside the hospital who are involved in your care, to assist them in obtaining payment for services they provide to you.

FOR HEALTH CARE OPERATIONS

We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the hospital and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many hospital patients to decide what additional services the hospital should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other hospital personnel for review and learning purposes. We may also combine the medical information we have with medical information from other hospitals to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

Appointment Reminders

We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the hospital.

Treatment Alternatives

We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Products and Services

We may use and disclose medical information to tell you about our health-related products or services that may be of interest to you.

Fundraising Activities

We may use medical information about you, or disclose such information to a foundation related to the hospital, to contact you in an effort to raise money for the hospital and its operations. We would only release contact information, such as your name, address and phone number and the dates you received treatment or services at the hospital. If you do not want the hospital to contact you for fundraising efforts, you must notify our Marketing Manager at (530) 336-5511.

Hospital Directory

We may include certain limited information about you in the hospital directory while you are a patient at the hospital. This information may include your name, location in the hospital, your general condition (e.g., good, fair, etc.) and your religious affiliation. Unless there is a specific written request from you to the contrary, this directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they don't ask for you by name. This information is released so your family, friends and clergy can visit you in the hospital and generally know how you are doing.

To Individuals Involved in Your Care or Payment for Your Care

We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. Unless there is a specific written request from you to the contrary, we may also tell your family or friends your condition and that you are in the hospital.

In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. If you arrive at the emergency department either unconscious or otherwise unable to communicate, we are required to attempt to contact someone we believe can make health care decisions for you (e.g., a family member or agent under a health care power of attorney).

For Research

Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, as long as the medical information they review does not leave the hospital.

As Required by Law

We will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety

We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

Organ and Tissue Donation

We may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans

If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation

We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Activities

We may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report regarding the abuse or neglect of children, elders and dependent adults;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law;
- To notify emergency response employees regarding possible exposure to HIV/AIDS, to the extent necessary to comply with state and federal laws.

Health Oversight Activities

We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.

Law Enforcement

We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the hospital; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors

We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities

We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others

We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates

If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose medical information about you to the correctional institution or law enforcement official. This disclosure would be necessary 1) for the institution to provide you with health care; 2) to protect your health and safety or the health and safety of others; or 3) for the safety and security of the correctional institution.

Multidisciplinary Personnel Teams

We may disclose health information to a multidisciplinary personnel team relevant to the prevention, identification, management or treatment of an abused child and the child's parents, or elder abuse and neglect.

Special Categories of Information

In some circumstances, your health information may be subject to restrictions that may limit or preclude some uses or disclosures described in this notice. For example, there are special restrictions on the use or disclosure of certain categories of information — e.g., tests for HIV or treatment for mental health conditions or alcohol and drug abuse. Government health benefit programs, such as Medi-Cal, may also limit the disclosure of beneficiary information for purposes unrelated to the program.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you.

Right to Inspect and Copy

You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but may not include some mental health information.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to Mayers Memorial- Medical Records Department. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the hospital will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend

If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the hospital.

To request an amendment, your request must be made in writing and submitted to Mayers Memorial Hospital- Medical Records Department. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for the hospital;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Even if we deny your request for amendment, you have the right to submit a written addendum, not to exceed 250 words, with respect to any item or statement in your record you believe is incomplete or incorrect. If you clearly indicate in writing that you want the addendum to be made part of your medical record we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

Right to an Accounting of Disclosures

You have the right to request an “accounting of disclosures.” This is a list of the disclosures we made of medical information about you other than our own uses for treatment, payment and health care operations (as those functions are described above), and with other exceptions pursuant to the law.

To request this list or accounting of disclosures, you must submit your request in writing to Mayers Memorial Hospital- Health Information Management (HIM). Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free.

For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

In addition, we will notify you as required by law if your health information is unlawfully accessed or disclosed.

Right to Request Restrictions

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are required to agree to your request to restrict disclosure of your protected health information to a health plan if:

- The disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and
- The protected health information pertains solely to a health care item or service for which the individual, or person other than the health plan on behalf of the individual, has paid the covered entity in full.

Otherwise, we are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to Mayers Memorial Hospital-Medical Records Department. In your request, you must tell us 1) what information you want to limit; 2) whether you want to limit our use, disclosure or both; and 3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Mayers Memorial Hospital District Chief Nursing Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of this Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

You may obtain a copy of this notice at our website: <http://www.mayersmemorial.com/>

To obtain a paper copy of this notice visit: Mayers Memorial Hospital at 43563 Highway 299E Fall River Mills, Ca.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the hospital. The notice will contain the effective date on the first page, in the top right-hand corner. In addition, each time you register at or are admitted to the hospital for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the hospital or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the hospital, contact Sherry Wilson, CNO at Mayers Memorial Hospital at 43563 Highway 299E Fall River Mills, CA 96028. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

We are required to receive written authorization to use or disclose PHI in certain situations. Some examples of which include: disclosures to a life insurer for coverage purposes; a pre-employment physical or lab test; disclosures to a pharmaceutical firm for their own marketing purposes; most uses or disclosures of psychotherapy notes; marketing communications; and sales of PHI.

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, this will stop any further use or disclosure of your medical information for the purposes covered by your written authorization, except if we have already acted in reliance on your permission. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.



Mayers Memorial Hospital District

Patient Responsibility

To provide you with the best possible care we need your cooperation. We request that you:

1. Provide to the best of your knowledge, accurate and complete information about your present illness and other matters relating to your health.
2. Tell us if you do not understand instructions given to you by our staff or if you think you will not be able to carry out these instructions.
3. Follow the treatment plan recommended by the physician responsible for your care. This may include following the instructions of the nursing and allied health personnel as they carry out the coordinated plan of care, implement the physicians' orders and other hospital policies and procedures.
4. You are responsible for your actions if you refuse treatment or do not follow physician's instructions.
5. You are responsible for assuring that financial obligations of health care are fulfilled as promptly as possible and provide the hospital with necessary information regarding coverage's of your hospital charges.
6. You are responsible for following hospital rules affecting patient care and conduct
7. You are responsible for being considerate of rights of other patients to receive medical care without disruption or interference and for assisting in control of noise and the number of visitors.
8. That you are respectful of the property of other persons and of the property of the hospital.
9. You, your family and friends observe the NO SMOKING rules within the hospital building and restrict smoking to the designated areas only.
10. If you or a family member would like to speak with available clergy, please contact the Nurse's Station and the nurse in charge or the Ward Clerk will assist you.

Should you have any problems regarding ethical issues while in the hospital please contact the Director of Quality or Social Services.

Approvals: QI: 12/14/16

Permanent Part of Medical Record

MMH452 Page 1 of 1

PATIENT RESPONSIBILITY

Attached to policy: Admission Policy, Acute

MAYERS MEMORIAL HOSPITAL DISTRICT

POLICY AND PROCEDURE

PHYSICIAN ORDERS -- VERBAL AND/OR TELEPHONE

Page 1 of 3

DEFINITION:

For all intents and purposes, the word “*patient(s)*” refers to all customers receiving health care services in our facilities, including inpatients, outpatients, residents and clients.

Verbal orders are orders for medication, treatments, laboratory studies, intervention or other patient care that are communicated as oral, spoken communications between senders and receivers face to face or by telephone.

POLICY:

To establish standards for accepting, transcribing and confirming verbal or telephone physician’s orders. [42 CFR §485.635(d)3]

PROCEDURE:

1. Physician verbal and telephone orders shall be used only in situations where the ordering physician is not available to electronically enter the order and delay will result in a compromise in patient care and written or electronic communication is not feasible.
2. The use of verbal orders when the physician is at the nurse’s station is discouraged.
3. Verbal orders may be given by the following within their scope of practice, education, hospital privilege and licensure:
 - A. Physicians
 - B. Nurse practitioners/CRNA (Certified Registered Nurse Anesthetist)
 - C. Physician assistants
 - D. Registered pharmacists
 - E. Physical therapists
 - F. Licensed dietitians
4. Only the following healthcare practitioners can accept verbal and telephone orders. Orders are to be within the professional’s scope of practice.
 - A. Registered Nurses
 - B. Registered Pharmacists
 - C. Licensed Respiratory Therapists
 - D. Physical and Occupational Therapists
 - E. Licensed Dietitians
 - F. Licensed Vocational Nurses
5. Verbal orders for the following are not accepted:
 - A. Antineoplastic agents (parenteral and oral, including non-chemotherapeutic indications)
 - B. Colony stimulating factors (e.g. G-CSF *Neupogen*®)
 - C. Initiation of unfractionated heparin infusion

- D. Increases in patient controlled analgesia pump dosages above 50% (see P&P PCA Pumps)
 - E. Category of care (DNR/Code Status)
 - F. Withdrawal of life support
 - G. Continuation of physical restraints (See also the *Restraints and Seclusion, Use of [Physical Restraints]* policy and procedure located in the Med/Surg and Emergency Room manuals.)
6. Verbal or telephone orders shall be electronically entered by the professional who accepts the order and is to include:
 - A. Name of the patient
 - B. Age and weight of patient, when appropriate
 - C. Date and time
 - D. Instructions/drug order, including dose, dosage form, frequency and route.
 - E. Notation that the order is a verbal or telephone order
 - F. Quantity and/or duration as appropriate
 - G. Purpose or indication
 - H. Name of the practitioner issuing the order
 - I. Signature of the healthcare professional receiving the order
 7. The individual accepting the verbal order must immediately reduce the order to writing on the physician order sheet and then read back the order in its entirety (including the patient's name) to the prescribing practitioner at the time the order is given. Once confirmed the transcriber is to document "R&C" (for "read back and confirmed").
 8. After "R&C" is completed the individual accepting the verbal order will enter the order into the EMR and destroy the written note if not secure.
 9. The individual accepting the verbal order is responsible for "flagging" the order in the EMR to alert the practitioner to cosign the order.
 10. Nursing staff and other healthcare professionals are permitted to act upon verbal orders provided the orders contain the appropriate information and are within the scope of practice for said healthcare professional.
 11. AUTHENTICATION: Verbal and telephone orders shall be countersigned by the prescribing practitioner as soon as possible (i.e., the next time the prescribing practitioner provides care to the patient, assesses the patient, or documents information in the patient's medical record), but not later than:
 - 24 hours for Med/Surg (Acute Care), or
 - 30 days for SNF (Skilled Nursing Care).

SPECIAL CONSIDERATIONS:

If the prescribing practitioner is unable to authenticate his or her verbal order in a timely manner (e.g., the ordering practitioner gives a verbal order which is written and transcribed, and then is "off duty" for the weekend or an extended period of time), then it is acceptable for a covering practitioner to co-sign the verbal order of the prescribing practitioner. The signature indicates

that the covering practitioner assumes responsibility for his/her colleague's order as being complete, accurate and final.

NOTE — A physician assistant or nurse practitioner may not “co-sign” to authenticate a physician's verbal order.

REFERENCES:

1. C-0297, 42 CFR 485.635(d)(3) and Interpretive Guidelines
2. Institute for Safe Medication Practices. *ISMP's List of High-Alert Medications*. www.ismp.org accessed 8/10/05.
3. Louisiana State University Health Sciences Center-Shreveport. *Policy and Procedure—Verbal and/or Telephone Physician's Orders*. January 2003.
4. Medical College of Ohio Hospitals. *Policy and Procedure—Verbal Orders*. February 2002.
5. Medical Staff Briefing. *CMS may relax regulations governing the authentication of verbal orders*. HCPro, Inc. June 2005.
6. Medical University of South Carolina (MUSC) *Policy Manual—F08 Verbal Orders*. October 2003.
7. University of North Carolina Hospitals. *Nursing Policy—Physician Orders: Policy for Transcription*. August 2003.
8. Title 22, *Licensing & Certification of Health Facilities and Referral Agencies*; § 76896 and 702639.

MAYERS MEMORIAL HOSPITAL DISTRICT
POLICY AND PROCEDURE
POST FALL ASSESSMENT AND DOCUMENTATION

Page 1 of 2

DEFINITION:

For all intent and purposes, the word patient refers to all customers receiving health care services in our facilities, including inpatients, outpatients, residents and clients.

Fall: An unintentional change in position coming to rest on the ground, floor or onto the next lower surface (eg., onto a bed, chair, or bedside mat.)

Fall With Significant Injury: A fall resulting in serious injury or hospitalization (eg. Broken hip).

POLICY:

To provide information necessary in the assessment of residents after a fall episode and to facilitate fall prevention. Nursing staff takes appropriate actions to reduce the risk of patient harm due to falls.

PROCEDURE:

1. At the time of the initial assessment, the Nurse on duty will:
 - a. Complete a full body assessment including vitals, pain scale, neurological assessment, oxygen saturation, and any signs or symptoms of injury including a complete skin assessment and severity.
 - Documentation in the nurses notes is to be completed each shift for 72 hours and includes vital signs, neuro checks, pain assessment (using the pain scale) and any new evidence of signs or symptoms of injury. NOTE: Neuro checks are required on patients that have had an unwitnessed fall or a head injury (per P&P Neurologic Checks).
 - b. If an injury occurs initiate care plan Fall With Injury.
 - c. Notify the resident's doctor, responsible party and the CNO.
 - d. Notify Ombudsman, and DHS immediately or as soon as possible, but within 24 hours for falls with a significant injury.
 - e. Update the Morris Fall scale under the assessment tab in the EMR.
 - f. All risk management forms are reviewed the DON and trends are discussed at the SNF Quality Care Team meeting. And then reported to Board Quality.
 - g. Complete the Risk Management form in the EMR.
 - h. Nursing team will meet to determine the following:
 - what happened
 - how the fall occurred
 - why the fall happened e.g.; medical condition, medications, other factors
 - where appropriate interventions in place prior to the fall
 - how can similar outcomes be avoided

Deleted: , plus the following attachment(s)¶
Post Fall Huddle Packet MMH559¶
Fall Risk Assessment Form MMH186¶
Care Plan – Fall with Injury MMH130P¶
Neuro Check Sheet MMH154¶
Skin Evaluation and Assessment Sheet MMH128¶
Post-Fall Assessment MMH147¶
Post Fall Huddle, MMH559¶

Deleted: An unintentional change in position coming to rest on the ground, floor or onto the next lower surface that results in an injury or evidence of a fracture that requires the patient to be transferred to a hospital.

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Deleted: Quality Review Report (QRR)

Deleted: and Post Fall Huddle, MMH559 and submit copies to the Charge Nurse with a copy of the Post Fall Assessment MMH147

Deleted: .

Deleted: <#>Send completed documents to the CNO. (QRR's are trended monthly and reported to the Quality Care Team committee by the CNO).¶
<#>Direct a Post Fall Huddle including all available multi-disciplinary team members available, such as nursing staff and CNA's as soon as possible, but within 24 hours of the fall to determine¶

- what care plan interventions will be implemented or discontinued
- what specific considerations as to why the fall might have occurred
- was the call light on, and for how long
- environmental factors, if any
- other resident or visitor involvement

2. Notify the Resident Assessment Coordinator (RAC) by leaving a message by phone.
3. [Charge Nurse](#) for Skilled Nursing reviews all fall documentation, nursing notes, skin assessment, and care plans for effectiveness of the interventions and attend the IDT meeting
4. All falls will be discussed in the next Inter-Disciplinary Team Meeting (IDT)

SPECIAL CONSIDERATIONS:

Staff education: The Director of Staff Development, or designee, will conduct incidental in-service when Fall With [Significant](#) Injury Occurs and as needed for staff review of policy and procedure and Fall Prevention strategies.

REFERENCES:

F-Tag 324 Sec483.25(h)(2) Accidents: Supervision and assistance provided for prevention.

APPROVALS:

Quality: 10/11/2016

Deleted: <#>and placing a copy of the Post Fall Huddle Packet MMH559 in the RAC's box.¶
<#>Fax a copy of the Post Fall Huddle Packet MMH559 to the Physical Therapy department.¶

Deleted: <#>The Post Fall Huddle Packet MMH559 will be placed in the Physicians Progress Note section and remain there for 30 days and then moved to the Fall Assessment section of the medical record.¶

MAYERS MEMORIAL HOSPITAL DISTRICT

POLICY AND PROCEDURE

PUBLIC INTERFACE

ORIGINATING DATE: 03/99
REVISION DATE: 12/05/07
MANUAL(S): Board, Administration, Med Staff

Page 1 of 1

POLICY:

BOARD CORRESPONDENCE:

Correspondence from the board will be approved by the board or its chairperson. Except for reports that are legally required to be sent out over the secretary or treasurer's name, all correspondence from the board will be over the chairperson's name. All correspondence from the board will be written on Mayers Memorial Hospital District (MMHD) stationery. Use of MMHD letterhead will be limited to official agency business only.

No material or information disclosed in closed sessions of the board will be released to a person not entitled to receive it, unless the legislative body authorizes disclosure of that confidential information (Ralph M. Brown Act, Section 54963).

BOARD MEMBERS SPEAKING FOR THE BOARD TO THE PUBLIC OR MEDIA:

Individual board members may not speak to the public or the media on behalf of the board unless authorized by the board to do so.

When speaking about MMHD or about board action, board members should be careful to define when their remarks represent personal opinion and when their remarks represent official board position. Board members must be aware that they are always seen as board members even when they designate comments as person.

REFERENCES:

The Ralph M. Brown Act

APPROVALS:

BQC: 1/11/10
Board of Directors: 1/27/10

Author: Unknown
File/Path Name: [..\BOARD OF DIRECTORS](#)

MAYERS MEMORIAL HOSPITAL DISTRICT

POLICY AND PROCEDURE

RESTRAINTS OR SECLUSION (PHYSICAL RESTRAINTS), USE OF

Page 1 of 11, plus the following attachment:

Restraint Record, Med/Surg (Acute Care) -- MMH250

POLICY:

The purpose of this policy is to provide a consistent, standardized organizational-wide policy for the assessment, application, and evaluation of physical restraint and seclusion of patients.

SECTIONS:

- I. PHILOSOPHY** (page 1)
- II. DEFINITIONS** (page 2)
- III. EXCLUSIONS** (page 2)
- IV. MEDICAL RESTRAINT (Physical Restraint for Medical Purposes)** (page 4)
- V. BEHAVIORAL RESTRAINT AND SECLUSION (Physical Restraints for Behavioral Purposes)** (page 7)

I. PHILOSOPHY:

Mayers Memorial Hospital District (MMHD) acknowledges its primary and essential role in patient advocacy, and strives to ensure that every patient receives respectful care in a therapeutic environment that maintains his or her rights, dignity, and safety. Because restraint has the potential to produce serious consequences (including physical and psychological harm, loss of dignity, and even death), staff at MMHD will work actively to prevent, reduce, and attempt to eliminate the use of restraint/seclusion through preventive strategies and the use of effective alternatives. Restraint will be used only to prevent harm to the patient or others and will not be used as a form of punishment, retaliation, or discipline, or for the convenience of the staff.

Both the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Centers for Medicare and Medicaid Services (CMS) have developed standards regarding restraint/seclusion use. The agencies' expectations regarding the use of restraint and seclusion are not uniform; therefore, the more stringent of the standards were used in developing this policy, including situations where only one entity was silent on an aspect of restraint/seclusion use.

II. DEFINITIONS:

RESTRAINT: Any method (chemical or physical) of restricting an individual's freedom of movement, physical activity, or normal access to his/her body.

SECLUSION: Involuntary confinement of a person *alone* in a room where the person is physically prevented by *another individual* or a *locked door* from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.

PHYSICAL RESTRAINT: Any manual method, physical device, material, or equipment attached or adjacent to the patient's body that he/she cannot easily remove, and which restricts freedom of movement or access to one's body (e.g., leg/arm restraints, hand mitts, soft wrist restraints, vests, lap cushions or trays, or side rails).

Medical Restraint: A physical restraint used for the purpose of limiting mobility or temporarily immobilizing a patient whose actions interfere with medical management (e.g., pulling at a catheter, attempting to get out of bed).

Behavioral Restraint: A physical restraint is appropriate during an emergency for a patient with aggressive or violent behavior that may lead to harm to themselves or harm to others, in any location of the hospital.

CHEMICAL RESTRAINT: A chemical restraint is a medication used for the purpose of controlling behavior or to restrict the patient's freedom of movement and is not a standard treatment for the patient's medical condition. This does not include medications used for anxiety, agitation, or pain.

PATIENT: For all intents and purposes, the word "patient(s)" refers to all customers receiving health care services in our facilities, including inpatients, outpatients, residents and clients.

III. EXCLUSIONS:

For the purposes of this policy, the following **are not** considered restraint:

1. Standard practices that include limitations of mobility or temporary immobilization during medical, dental, diagnostic, or surgical procedures, and the immediate post-procedure care processes when these practices are considered an inherent part of the procedure (e.g., surgical positions, IV arm boards, papoose, protection of surgical and treatment sites in pediatric patients).
2. Adaptive support in response to assessed patient needs (e.g., orthopedic appliances).
3. Protective equipment such as helmets.
4. Forensic or correctional restrictions imposed by correctional authorities and used **solely for security purposes** (e.g., handcuffs, shackles). However, patients in both clinical **and** forensic restraint are subject to this policy for the *clinical* application of restraint or seclusion.

5. Therapeutic holding or comforting of children and adolescents.
6. The use of a “time-out” (a procedure used to assist a patient to regain behavioral control by removing the patient from his or her immediate environment and restricting the patient to a quiet area (or unlocked private room) for 30 minutes or less, when its use is consistent with the patient’s treatment plan.
7. Medications administered as a part of the psychiatric care plan, **without intent to restrict movement**, are not considered to be chemical restraint.
8. Medications administered as adjuncts to procedures, such as anesthetic agents or neuromuscular blockers, are not considered chemical restraint.
9. Voluntary mechanical support used to achieve proper body alignment, balance, or position so as to allow greater freedom of mobility than would be possible without the use of such mechanical support. **NOTE:** *Some devices such as Geri-chair or side rails serve multiple purposes. When these devices have the effect of restricting a patient’s movement, and cannot be easily removed by the patient, the device then constitutes a restraint. The following questions must be considered when determining whether a device serves as a restraint:*
 - a. Does the patient have the ability/skill to easily remove the intervention/device? If not, consider the device a restraint.
 - b. Is the patient’s freedom to move when the intervention is in place greater than their freedom to move without the device? If not, consider the device a restraint.
 - c. Is the patient’s access to his/her body with the device in place at least equal to the access without the device? If not, consider the device a restraint.
 - d. What is the intent of the device or intervention? If the intent is to restrict mobility, consider the device a restraint.
10. **Factors that may contribute to an increased risk of death:** The following have been identified as increasing the risk of death in the restrained person:
 - a. Restraining of patients who smoke. Patients shall not be allowed to smoke if restrained.
 - b. Restraining of patients with deformities that preclude proper application of restraining device. Alternatives to restraint will be used in patients whose deformities preclude the proper application of restraining devices such as the use of a sitter or family member in attendance.
 - c. Restraining of a patient in the prone position may predispose the patient to suffocation. Respiratory status will be included in every 2-hour assessment of the patient in restraint. Staff will ensure that the patients’ airway is unobstructed and prevent excessive pressure on the patients’ back to prevent restriction of lung expansion. Every attempt will be made to avoid restraining a patient in the prone position.
 - d. Restraining of a patient in the supine position may predispose the patient to aspiration. Respiratory status will be included in the every 2-hour assessment of the patient in restraint. The head of the bed will be elevated when possible

to minimize risk of aspiration and staff will ensure that the patients' head is free to rotate side-to-side.

- e. Restraining a patient in a room that is not under continuous observation by staff.

IV. **MEDICAL RESTRAINT** (Physical Restraint for Medical Purposes)

POLICY:

The primary reason for a **medical restraint** is to maintain a safe and therapeutic environment after alternatives to restraining have failed.

PROCEDURE:

1. **Competence:** All direct patient care staff in keeping with their scope of practice, will be assessed for competence before participating in the use of medical restraint, and will undergo ongoing education and training in the proper and safe use of restraint, including:
 - a. Underlying causes of patient behavior
 - b. How staff behavior affects the patient
 - c. Use of alternative techniques
 - d. Recognizing patients' physical distress
 - e. How to apply and remove medical restraint safely
 - f. Assisting patient in meeting criteria or discontinuing medical restraint
 - g. Recognizing readiness for discontinuing
 - h. Recognizing when to contact physician to evaluate or treat physical status
 - i. Recognizing how age, developmental considerations, gender, ethnicity, history of sexual or physical abuse affects the way individuals respond to restraint
 - j. How to respond to emergency clinical events (cardiopulmonary arrest)
 - k. Taking vital signs and interpreting their relevance to the physical safety of the patient in restraint
 - l. Recognizing nutritional and hydration needs
 - m. Checking circulation and ROM in extremities
 - n. Addressing hygiene and elimination
 - o. Addressing physical and psychological status and comfort

Registry or other temporary staff that work in direct patient care roles will be given a self-learning module to complete before participating in the application or monitoring process of the patient in restraint. In addition, they will be supervised by the qualified staff member assigned as a resource, when the initiation of restraint is necessary on an assigned patient to ensure that the proper safety procedures, orders, flow sheets, and monitoring are implemented.

2. **Orders:** Orders for medical restraint must be obtained from a physician, except during life-threatening situations (e.g., self-extubation).

Alternatives (e.g., increased observation and monitoring, re-orientation, distraction, medication for pain, or limiting number of caregivers) appropriate to the patient's situation, must be considered and when possible, attempted before initiating medical restraint.

If alternatives are not effective, the least restrictive restraint will be used in order, from least to most restrictive:

- a. 1-point soft limb restraint
 - b. 2-point soft limb restraint
 - c. Vest restraint
 - d. Vest restraint and 2-point soft limb restraint
 - e. 4-point soft limb restraint
 - f. 4-point soft limb restraint with vest restraint
 - g. 2-point leather limb restraints
 - h. 4-point leather limb restraints
3. **Initiation:** If a physician is not available to issue the order, an RN may initiate medical restraint after an appropriate assessment of the patient. The physician must be notified as soon as possible, but no later than **1 hour** after initiation, and telephone order obtained and entered into the medical record. **If the initiation of restraint is based on a significant change in the patient's condition, the RN will notify the physician immediately and obtain an order.**
 4. Each written order for a physical restraint or seclusion is limited to 4 hours for adults; 2 hours for children and adolescents ages 9 – 17; or 1 hour for patients under 9.
 5. **Assessment:** -After the original order expires, a physician must see and assess the patient before issuing a new order.
 6. **Reassessment:** Patients who are in medical restraint will be reassessed by an RN for:
 - a. Assessment of mental status and behavior
 - b. Physical and emotional well-being
 - c. Protection/maintenance of rights, dignity, and safety
 - d. Appropriate application of restraint
 - e. Feasibility of use of less restrictive method
 - f. Feasibility of removal of restraint

If the patient is sleeping, the nurse will observe the patient and ensure a safe environment but will not wake the patient unnecessarily.

7. **Care of the patient during medical restraint use:** The RN, or designee under the direction of the RN, will visually observe the patient every 15 minutes while restrained. At least every two hours, the following patient care needs will be addressed by the RN or designee:
 - a. Removal of restraints for 10 minutes with circulation check and ROM performed. If the patient is asleep, removal of restraint and circulation check will occur, ROM will not be performed.
 - b. Toileting needs while awake
 - c. Fluids/oral care provided while awake
 - d. Nutritional needs addressed while awake
8. **Discontinuation of medical restraint:** Patients and whenever possible, their families, should be made aware of the rationale for medical restraint use and the criteria for discontinuation (e.g., no longer attempting to get out of bed, no longer pulling at central line or dressings). Medical restraint will be discontinued when criteria are met.
9. **Notification of clinical leadership:** Notification of clinical leadership is required if an adverse event occurs related to medical restraint or the patient requires restraint for 72 hours or more.
10. Each episode of medical restraint requires the following information be documented in the patients' medical record on the [*Restraint Record, Med/Surg \(Acute Care\)*](#) (MMH250, attached):
 - a. Written, time-limited order for medical restraint
 - b. Patient behavior that demonstrated clinical justification for the use of restraint
 - c. Alternative interventions employed to avoid restraint and the result of the alternative methods
 - d. Type of restraint used
 - e. Time restraint was applied
 - f. Name of staff member applying restraints
 - g. Location of restraint
 - h. Education of the patient/family
 - i. Documentation of every 15 minute nursing observation and care provided while the patient is restrained are made by, or under the direction of and RN every **2 hours**, and will include the following:
 - Removal of restraints with circulation check and ROM performed. If the patient is asleep, removal of the restraint and circulation check will occur, but ROM will not be performed.
 - Toileting needs while awake.
 - Fluids/oral care provided while awake.
 - Nutritional needs addressed while awake.
 - Personal hygiene addressed at least once per shift.

11. **Reporting requirements:** The following must be reported to the physician:
 - a. Ineffectiveness of restraint in controlling patient actions.
 - b. Extremity, respiratory, or other physical complication resulting from restraint.
 - c. Any significant change in the patients' condition.
 - d. **The death of a patient that occurs while a patient is in *medical* restraint must be reported to CMS, DHS, and other appropriate agencies. Notify the Director of Risk Management or designee immediately.**

VI. BEHAVIORAL RESTRAINT AND SECLUSION (Physical Restraints for Behavioral Purposes)

PROCEDURE:

1. In order to use this policy in the clinical environment, the question of what setting the patient is in (medical-surgical or ER), and the reason the restraint or seclusion is being used must first be identified. The use of behavioral restraint in the acute inpatient areas may at times be necessary. When this emergency occurs, after handling the immediate situation, the staff will consult with the ER physician and the nursing supervisor to ensure that all safety procedures, monitoring tools, and notifications occur per policy.
2. The use of behavioral restraint and seclusion poses an inherent risk to the physical safety and psychological well being of the patient and staff. Therefore, the use of behavioral restraint and seclusion is limited to use only in an emergency, when there is an imminent risk of a patient physically harming him/herself or others, including staff.
3. **Performance Improvement:** Data on *all* episodes of behavioral restraint/seclusion will be collected, aggregated, analyzed, and shared with leadership, medical staff, and unit/department staff in order to identify circumstances under which restraint/seclusion are used, the incidence of use, and to seek opportunities to decrease or eliminate use when possible.
4. **Competence:** Direct patient care staff, in keeping with their scope of practice, will be assessed for competence before participating in the use of restraint and seclusion and will undergo ongoing education and training in the proper and safe use of restraint, including:
 - a. Underlying causes of patient behavior
 - b. How staff behavior affects the patient
 - c. Recognizing the patients' physical distress
 - d. How to hold
 - e. How to do a "take down"
 - f. How to remove restraint/seclusion
 - g. Assisting patient in meeting behavioral criteria for discontinuing restraint/seclusion
 - h. Taking vital signs and interpreting their relevance to the physical safety of the patient in restraints or seclusion

- i. Recognizing nutritional/hydration needs
- j. Checking circulation and ROM in the extremities
- k. Addressing hygiene and elimination
- l. Addressing physical and psychological status and comfort
- m. Recognizing readiness for discontinuing
- n. Recognizing when to contact physician to evaluate or treat physical status
- o. Recognizing how age, developmental consideration, gender, ethnicity, history of sexual or physical abuse affects the way individuals respond to restraint/seclusion
- p. How to respond to emergency clinical events (cardiopulmonary arrest)

Agency or other temporary staff that work with mental health patients will be given this policy to review prior to their caring for the patient.

5. Orders:

- a. Orders for behavioral restraint/seclusion must be obtained from a physician. Alternatives must be considered and tried when possible before applying restraint or seclusion. Examples of alternatives include de-escalation, limit setting, distraction, alteration in environment, increased observation and monitoring, and re-orientation. The alternative must be appropriate to the patient's behavior that places him/her at risk. If the alternatives are not effective, the least restrictive restraint will be used in order, from least to most restrictive:
 - 1-point soft limb restraint
 - 2-point soft limb restraint
 - Vest restraint (**split side-rails must be padded when a vest restraint is used**)
 - Vest restraint and 2-point soft limb restraint
 - 4-point soft limb restraint
 - 4-point soft limb restraint with vest restraint
 - 2-point leather limb restraints
 - 4-point leather limb restraints
- b. In emergency situations where the physician is not present or immediately available, and restraint or seclusion is necessary to manage the behavior of a violent and aggressive patient, the RN may initiate restraint/seclusion. Immediately after initiation, the RN must consult with the physician, give an update on the patient's physical and psychological condition, and obtain a verbal or written order. **The physician must perform a face-to-face assessment of the patient within 1 hour of the initiation of restrain/seclusion.** The order for restraints/seclusion must include:

- The reason for restraint/seclusion
 - The type of seclusion or restraint and number of restraints (eg, 2-point, 4-point)
 - Behavioral criteria for early removal
 - Date and time of order and defined length of time the restraint is to be used
 - **Each written order for restraint or seclusion is limited to 4 hours for adults 18 and older; 2 hours for children and adolescents ages 9-17; and 1 hour for patients under age 9.**
6. **Initiation:** The patients' family must be notified promptly of the initiation of restraint/seclusion unless the patient has placed a restriction on information provided to his/her family. When a patient is placed in restraint/seclusion, the following education will be provided to the patient and/or family:
- a. Explanation for clinical reason for restraint
 - b. Explanation for purpose and use of restraint
 - c. Explanation of monitoring and care that will be provided to the patient
 - d. Explanation of criteria necessary for termination of restraint
 - e. Any other information necessary to assure the safety and comfort, dignity, preservation of rights, and well being of the patient.
7. **Plan of Care:** The use of restrain/seclusion requires a written modification to the plan of care.
8. **Assessment:** If a telephone order is received, the physician must perform a face-to-face assessment of the patient within 1 hour of the initiation of restraint/seclusion.
9. **Reassessment:** Patients who are in restraint/seclusion will be reassessed following the parameters below or more frequently if the patients' condition warrants it:
- a. By the time the order for restraint or seclusion expires, the patient will receive an in-person reassessment by a physician to determine the efficacy of the patients' treatment plan and to identify methods to help the patient regain control. Therefore, **reevaluation takes place at least every 4 hours for adults 18 and older; 2 hours for children and adolescents ages 9-17; and 1 hour for patients under age 9, and a renewal order obtained if needed.**
 - b. The patient in both seclusion and restraint will be monitored continuously by an assigned staff member.
 - c. If the patient is sleeping, the nurse will observe the patient and ensure a safe environment but will not wake the patient unnecessarily.

10. **Care of the patient during restraint use:** The RN, or designee under the direction of the RN, will visually observe the patient every 15 minutes while restrained. At least every 2 hours, the following patient care needs will be addressed by the RN or designee:
 - a. Removal of restraints for 10 minutes with circulation check and ROM performed. If the patient is asleep, removal of restraint and circulation check will occur but ROM will not be performed.
 - b. Toileting needs while awake.
 - c. Fluids/oral care provided while awake.
 - d. Nutritional needs addressed while awake.

11. **Discontinuation of restraints/seclusion:** Patients and their families should be made aware of the rationale for restraint/seclusion use and the behavioral criteria for discontinuation (eg, ability to contract for safety, cessation of verbal threats, or physical violence). Restraint/seclusion will be discontinued when behavioral criteria are met.

12. **Notification of clinical leadership:** The Director of Performance Improvement will be notified and an occurrence report (QRR) completed when patients experience multiple (2 or more separate episodes of restraint/seclusion of any duration within 12 hours) or extended periods (more than 12 hours) of restraint/seclusion.

13. **Post-restraint and seclusion debriefing:** As soon as possible after discontinuing restraining/seclusion, a staff member should meet with the patient (and family if possible) to discuss the episode to identify the reason for the restraint/seclusion, to provide counseling for any psychological trauma that may have resulted, and to modify the treatment plan.

14. **Documentation:** Each episode of restraint/seclusion requires documentation in the medical record on the [*Restraint Record, Med/Surg \(Acute Care\)*](#) (MMH250, attached). This form contains all pertinent aspects of restraint/seclusion documentation.

15. **Reporting requirements:** The following must be reported to the physician:
 - a. Ineffectiveness of restraints in controlling behavior.
 - b. Extremity, respiratory, or other physical complications resulting from restraints.
 - c. Any significant change in patients' condition.
 - d. The death of a patient that occurs while a patient is in behavioral restraints/seclusion must be reported to CMS, DHS and other appropriate agencies. Notify the Director of Performance Improvement or any other member of Administration immediately.

REFERENCES:

DHHS [64 Fed. Reg. 36070-36089 (July 2, 1999); 42 C.F.R. Section 482. 13] Interim rule.
(States that the patient has the right to be free from restraints, of any form, for acute medical and surgical care that are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation by staff.)

[Health and Safety Code Section 1180 *et seq.*]

(“Covered entities” make certain efforts to reduce or eliminate the use of seclusion and behavioral restraints in these facilities-psychiatric units of general acute care facilities, acute psychiatric hospitals, psychiatric health facilities, crisis stabilization units, community treatment facilities, mental health rehab centers.)

Centers for Medicare and Medicaid Services (CMS), *Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation*, Federal Register, Vol. 77, No. 95, Wednesday, May 16, 2012, Rules and Regulations, <http://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/Downloads/CMS-3244-F.pdf>

CMS Conditions of Participation:

§482.13(e) Standard: Restraint or Seclusion

§482.13(f) Standard: Restraint or Seclusion: Staff Training Requirements

§482.13(g) Standard: Death Reporting Requirements

COMMITTEE APPROVALS:

ER: 3/9/2017

M/P&T: 8/1/2017

Mayers Memorial Hospital District

Succession Plan

It is the plan of Mayers Memorial Hospital District to secure leadership stability and responsibility of the hospital. The Board of Directors shall be responsible for implementing this plan and its related actions.

In the event the CEO of MMHD is unable to serve in the executive position and is gone from the physical presence for greater than four (4) weeks at a time, an interim CEO shall be appointed by the board.

Should the CEO announce plans for departure from Mayers Memorial Hospital District, an Interim CEO will be appointed by the Board of Directors for the time extending between the CEO's departure and the arrival of a new CEO. A search will be done by the Board of Directors for a CEO with the identified credentials being requisites for fulfillment of the position. It may be that the CEO's announced departure date and the arrival of a new CEO coincide so that an interim is not necessary.

Approved 12.22.09: Board of Directors

MAYERS MEMORIAL HOSPITAL DISTRICT

POLICY AND PROCEDURE

UNIT CLEANING

Page 1 of 3

DEFINITION:

For all intents and purposes, the word “patient(s)” refers to all customers receiving health care services in our facilities, including inpatients, outpatients, residents and clients.

The word “unit” indicates the patient care area (bed, bedside table, over bed table, chairs, etc.)

POLICY:

Units are cleaned to make the room a safe, sanitary and comfortable environment. The units are cleaned at the time of discharge, on a scheduled monthly basis for Skilled Nursing Facility (SNF) or more often, as needed. Housekeeping staff cleans units; nursing staff perform this task when housekeeping staff is not available. The housekeeping (Environmental Services department) works closely with the Infection Control Committee to further promote proper cleaning procedures.

Nursing staff will discard all disposable equipment (e.g. bedpans, urinals, graduated cylinders, emesis basins, washbasins, etc.) Flatware, glasses, dishes, water pitchers, etc. are to be returned to the kitchen for cleaning. The removal of linen and items soiled with body fluids should be completed prior the housekeeping staff cleaning a unit.

Equipment Needed (on Housekeeping Cart):

- Paper towels and wipes
- Toilet paper
- Trash can liners
- Cleanser, toilet bowl cleaner and glass cleaner
- Disinfectant solution in properly labeled containers
- Counter brush and dustpan
- Putty knife
- Dust mop
- Mop bucket with microfiber mops
- Floor – Caution ←” signs strategically placed
- Gloves and other personal protective equipment
- Room deodorizer

- All units are dust-mopped, wet-mopped, trash removed, toilet cleaned and flat surfaces wiped down with disinfectant daily.
- After dust mopping the floor, room cleaning will be done in a “Top-to-Bottom” order. Items closest to the ceiling will be cleaned first, the floor will be cleaned last with the walls and all attached flat surfaces cleaned also (i.e., suction, oxygen ports, blood pressure cuffs and windowsills).

PROCEDURE:

1. UNIT CLEANING (ROUTINE):

- a. Raise the bed to a comfortable working height. As bed is raised, check ceiling for cobwebs or water damage. Remove cobwebs once bed is raised. Dust off top of over-bed light and check light for working order.
- b. Clean all outside and inside surfaces of the over-bed table and nightstand with disinfectant solution on a wipe. Leave the drawers open for airing while working in the unit.
- c. Cleaning the bed: See: “*Bed Cleaning Policy*”.
- d. Wipe off TV and all cords. Check for proper functioning.
- e. Clean the sink with cleanser and wipe down cupboards and counters with disinfectant solution.
- f. Last area cleaned is the toilet room. Clean commode (toilet) with toilet bowl cleaner. Check walls for any gross stool or urine residue and disinfect. Clean the toilet seat risers in the bathroom with disinfectant solution. Let the riser air-dry.

2. Making up and restocking Unit:

- a. Make the bed according to policy. (review: *Bed Making* policy and procedure.)
- b. Refill toilet paper dispenser.
- c. Refill soap dispenser, hand sanitizer, paper towels from housekeeping cart and gloves from supplies in the utility room, if necessary.
- d. Check sharps disposal. Change if necessary, taking full containers to maintenance for storage and disposal.

4. The last step is to clean the floor, including the toilet room, starting with the area furthest from the door, working toward the doorway and out of the room, using the following procedures:

- a. Dust mop the floor.
- b. Damp mop the floor with disinfectant solution.
- c. Place “Wet Floor – Caution ←” sign outside of the door, leaving the sign in place until the floor is dry.

5. Notify Nursing staff once the unit has been cleaned, restocked and meets the housekeeping professional evaluation for patient/resident use.

ISOLATION ROOM:

1. Housekeeping or nursing staff assigned to the isolation room cleaning will wear gowns, mask, head-cover and gloves while in the room. Shoe covers are optional.
2. The following additions are made to cleaning:
 - a. All walls, vents, blinds and windows will be disinfected.
 - b. Privacy curtains will be changed.
 - c. The chain will be disinfected on light over the bed.
3. Following completion of the disinfecting process, the Nursing Supervisor will be notified. Infection Control may opt to culture the room in three to five different sites to evaluate the effectiveness of the cleaning technique.
4. When unit has been allowed to dry completely (approximately 1-hour), reassemble the unit.

SPECIAL CONSIDERATIONS:

Note working order of all equipment. Notify maintenance staff if any repairs are needed for ceiling, windows, screens, light fixtures, door hinges and handles, baseboards, flooring, etc. If immediate repairs are needed, contact Maintenance at once.

Disinfectant solution, stored in large volume receptacles, may be placed in smaller containers for safer handling and surface application. Smaller containers must be labeled for safety.

If contamination of ceiling is possible, the ceiling must also be disinfected.

REFERENCES:

Guidelines for Environmental Infection Control in Health-Care Facilities - Recommendations of CDC and the Healthcare Infection Control Practices Advisory Committee (HICPAC), June 6, 2003 / 52(RR10);1-42 (<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5210a1.html>)

APPROVALS:

Quality:

MAYERS MEMORIAL HOSPITAL DISTRICT

POLICY & PROCEDURE

UNUSUAL EVENTS

ORIGINATION DATE: 10/3/00
REVISION DATE: 02/22/05, 2/25/11, 6/7/12, 3/5/13
MANUAL(S): Acute, ER, Surgery, SNF, Employee

Page 1 of 8, plus the following attachments:

Unusual Event Flow Sheet MMH302

Unusual Event Root Cause Analysis Tool MMH303

Adverse Event Report MMH304

Medical Records Breach Report MMH305

POLICY:

Mayers Memorial Hospital supports the philosophy that untoward events should prompt a complete investigation (which is protected by law) in an effort to minimize the risk of additional liability and exposure and the purpose of which is to improve organizational performance and quality.

In an effort to maintain compliance with California healthcare codes, regulations and laws, Mayers Memorial Hospital District will comply with all mandated reporting requirements identified during the investigative process in a timely manner.

DEFINITIONS:

Adverse Events – “An adverse event or series of adverse events that cause death or serious disability of a patient, personnel, or visitor.” [HSC§1279.1 (b) (7)]

Serious Disability – “A physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment or loss lasts more than 7 days or is still present at the time of discharge from an inpatient health care facility, or the loss of a body part.” [HSC§1279.1 (d)]

Unusual Events – “Any occurrence such as epidemic outbreak, poisoning, fire, major accident, disaster, other catastrophe or unusual occurrence which threatens the welfare, safety or health of patients, personnel, or visitors *not meeting the definition of an Adverse Event.*” [Cal. Code Regs., tit.22, § 70737]

Medical Records Breach – “Unlawful or unauthorized access to, use or disclosure of, patients’ medical information.” [Senate Bill 541 (Chapter 605, Statutes of 2008)]

Medical Information – “Any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health care service plan,

pharmaceutical company, or contractor regarding a patient's medical history, mental or physical condition, or treatment. "Individually identifiable" means that the medical information includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the individual's identity." [California Civil Code, Section 56.05 (g)]

Unauthorized – "The inappropriate access, review, or viewing of patient medical information without a direct need for medical diagnosis, treatment, or other lawful use as permitted by the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code) or any other statute or regulation governing the lawful access, use or disclosure of medical information." [HSC §1280.15 (i)(2)]

Root Cause Analysis – A root cause analysis is defined as a process for identifying the basic and causal factor(s) that underly variation in performance, including the occurrence or possible occurrence of a untoward event. A root cause is the most fundamental reason a problem or situation occurs where performance and/or quality does not meet expectation. Mayers Memorial Hospital District will use the PDSA Model for Improvement, including the Unusual Event Flow Sheet and/or the Unusual Event Root Cause Analysis Tool (Attached).

EVENT CATAGORIES:

1. Adverse Events

a. Surgical Events

- i. Surgery performed on a wrong body part that is inconsistent with the documented informed consent for that patient. A reportable event under this subparagraph does not include a situation requiring prompt action that occurs in the course of surgery or a situation that is so urgent as to preclude obtaining informed consent.
- ii. Surgery performed on the wrong patient.
- iii. The wrong surgical procedure performed on a patient, which is a surgical procedure performed on a patient that is inconsistent with the documented informed consent for that patient. A reportable event under this subparagraph does not include a situation requiring prompt action that occurs in the course of surgery, or a situation that is so urgent as to preclude the obtaining of informed consent.
- iv. Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained.
- v. Death during or up to 24 hours after induction of anesthesia after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or

psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.

b. Product or Device Events

- i. Patient death or serious disability associated with the use of a contaminated drug, device, or biologic provided by the health facility when the contamination is the result of generally detectable contaminants in the drug, device, or biologic, regardless of the source of the contamination or the product. Also see P&P Medical Device Reporting (MDR).
- ii. Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. For purposes of this subparagraph, “device” includes, but is not limited to, a catheter, drain, or other specialized tube, infusion pump, or ventilator.
- iii. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.

c. Patient Protection Events

- i. An infant discharged to the wrong person.
- ii. Patient death or serious disability associated with patient disappearance for more than four hours, excluding events involving adults who have competency or decision making capacity.
- iii. A patient suicide or attempted suicide resulting in serious disability while being cared for in a health facility due to patient actions after admission to the health facility, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the health facility.

d. Care Management Events

- i. A patient death or serious disability associated with a medication error, including, but not limited to, an error involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment of drug selection and dose.
- ii. A patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.
- iii. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a facility, including events that occur within 42 hours postdelivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy.
- iv. Death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in a health facility.

- v. Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life. For purposes of this subparagraph, “hyperbilirubinemia” means bilirubin levels greater than 30 milligrams per deciliter.
 - vi. A Stage 3 or 4 ulcer, acquired after admission to a health facility, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission.
 - vii. A patient death or serious disability due to spinal manipulative therapy performed at the health facility.
- e. Environmental Events
- i. A patient death or serious disability associated with an electric shock while being cared for in a health facility, excluding events involving planned treatments, such as electric countershock.
 - ii. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by a toxic substance.
 - iii. A patient death or serious disability associated with a burn incurred from any source while being cared for in a health facility.
 - iv. A patient death or serious disability associated with a fall while being cared for in a health facility.
 - v. A patient death or serious disability associated with the use of restraints or bedrails while being cared for in a health facility.
- f. Criminal Events
- i. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.
 - ii. The abduction of a patient of any age.
 - iii. The sexual assault on a patient within or on the grounds of a health facility.
 - iv. The death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility.
- g. An Adverse Event or Series of Adverse Events
- i. That cause the death or serious disability of a patient, personnel, or visitor.
 - ii. That is an ongoing urgent or emergent threat(e.g. fire, building failure, evacuation, disaster, other catastrophe) to the welfare, health, or safety of patients, personnel, or visitors,.
2. Unusual Events
- a. Reportable Events (including, but not limited to)
- i. Epidemic outbreak in patient and/or visitor care areas that has been identified and is being medically managed.

- ii. Poisoning of patient, personnel or visitors not resulting in death or serious disability.
- iii. Temporary closing of any area or department of facility due to unsafe conditions.
- b. Non-reportable Events (including, but not limited to)
 - i. A death or injury of a person following a discharge “Against Medical Advice”.
 - ii. Minor degrees of hemolysis with no clinical sequelae.
 - iii. Malfunction or misuse of equipment that causes injury to a patient or personnel. The injury must not qualify as an Adverse Event.
 - iv. Injury to a patient, personnel, or visitor caused by abnormal facility conditions.

3. Medical Records Breach

- a. Reportable Events (including, but not limited to)
 - i. Viewing of patient information by personnel or volunteer for personal interest even if information gained is not disclosed to any other person.
 - ii. Faxes or e-mails are misdirected and received by someone other than a member of the hospital’s workforce, medical staff or affiliated business.
 - iii. Patient medical or billing information mistakenly sent to another person by hospital staff or by hospital subcontractor.
 - iv. Verbal or written disclosure of patient information by hospital staff member whether or not the staff member is currently employed by the hospital.
- b. Non-reportable Events (including, but not limited to)
 - i. Faxes or e-mails are misdirected and received by a member of the hospital’s workforce or by a member of the hospital’s medical staff.
 - ii. Disclosure of information for the purposes of obtaining payment.
 - iii. Viewing charts of patients the staff member is not caring for with the purpose of finding misplaced patient information.

CATEGORY REPORTING REQUIREMENTS:

1. Adverse Events

- a. All events recognized as an Adverse Event must be reported to the California Department of Public Health (CDPH) **no later than five (5) days after the adverse event has been detected UNLESS the event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors.**

- b. **An ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors must be reported no later than twenty-four (24) hours after the adverse event has been detected.**
 - c. The time frame is considered to be calendar days.
 - d. Failure to report these events within 24 hours or 5 days results in a civil money penalty of \$100 per day.
2. Reportable Unusual Events
 - a. Any occurrence such as epidemic outbreak, poisoning, fire, major accident, disaster, other catastrophe or unusual occurrence which threatens the welfare, safety or health of patients, personnel, or visitors *not meeting the definition of an Adverse Event*, must be reported as soon as reasonably possible [Cal. Code Regs., tit. 22, §70737]
 - b. Any unusual occurrence identified in this category must be reported to California Department of Public Health (CDPH).
 - c. All cases of reportable diseases shall be reported to Shasta County Public Health.
3. Medical Records Breach
 - a. All cases of Medical Records Breach must be reported to CDPH **no later than five (5) calendar days** after the unlawful or unauthorized access, use or disclosure **has been detected**.
 - b. Failure to report these events within 5 days results in a civil money penalty of \$100 per day

PROCEDURE:

1. When a potentially reportable event occurs, the staff member will notify the department manager and/or nursing supervisor detailing the account of the event.
2. The staff member will complete a Quality Review Report (QRR) according to our current report policy.
3. The department manager or nursing supervisor will notify either the Director of Quality (DOQ) and/or the Administrator on Call (AOC) within 4 hours of the event(s) occurrence, even after hours.
4. The DOQ and/or AOC will determine the category and reporting requirements (See Category Reporting Requirements) for the unusual event and will organize a meeting of the Unusual Event team. The DOQ and/or AOC will report event to the required authoritative bodies before confirmation by Unusual Event team when meeting delays impede reporting deadlines. All Adverse Events and Medical Records Breaches will be made via the Adverse Event Report or the Medical Record Breach Report (See attached).
5. The patient, or the party responsible for the patient, will be notified by the attending physician or peer designee of the nature of the adverse event by the time the report to CDPH is made. Such disclosure shall be reflected in the patient's record (See Disclosure of Unanticipated Outcomes Policy). The patient or the party responsible for the patient shall

not be provided with a copy of the report. The report to CDPH should **not** be placed in the patient's medical record, but should be retained by the Director of Quality Improvement/Risk Manager.

6. A meeting of the Unusual Event team will be convened within 96 hours of notification of the DOQ or AOC based on the urgency of the event, continued risk of safety, and reporting requirements. Members of the Unusual Event team will be incident dependent, but could include:
 - a. Chief Executive Officer
 - b. Chief Nursing Officer
 - c. Chief Clinical Officer
 - d. Chief of Staff or designee
 - e. Director/managing coordinator of involved department (s)
 - f. Director of Quality Improvement
7. This team will confirm the unusual event category and coordinate the initial and subsequent investigation to the event, if necessary, using the Unusual Event Flow Sheet.
 - a. The team will organize a task force if it is determined that a reportable Event has occurred. The task force will conduct an analysis using the Unusual Event Root Cause Analysis Tool and will implement identified changes. The task force will be responsible for subsequent analysis and modifications of changes as necessary.
 - b. If the event is determined to be a non-reportable event, the DOQ will organize a Quality Improvement Team (QIT) if it is determined that at least one of the following criteria has been met:
 - i. The Event involves an immediate and potentially repeatable threat to patient care and/or patient safety.
 - ii. The Event has significant potential for representing a serious underlying system or process problem in the organization.
 - iii. The Event has (or could have) potentially undermined public confidence in the organization.
 - iv. The Event requires immediate action to prevent possible reoccurrence.

The QIT will conduct an analysis using the Unusual Event Root Cause Analysis Tool and will implement identified changes. This team will be responsible for subsequent analysis and modifications of changes as necessary.
8. All action plans from the Unusual Event Root Cause Analysis Tool are to be submitted to the DOQ. The DOQ will be responsible for reporting the event, associated action plans and follow-up to the Quality Committees, and the Medical Staff and/or complete Board of Directors as necessary.

REFERENCES:

Medicare Standard 42 CFR 482.13 - Condition of Participation: Patient Rights

Title 22, California Code of Regulations, section 70737

Health and Safety Code Section 1279.1 (b) (7)

Health and Safety Code Section 1279.1 (d)

Health and Safety Code Section 1280.15 (i) (2)

Senate Bill 541 (Alquist, Chapter 605, Statutes of 2008)

Senate Bill 1301 (Alquist, Chapter 647, Statutes of 2006)

California Civil Code, Section 56.05 (g)

COMMITTEE APPROVALS:

P&P: 8/3/2017