

## GUIDING PRINCIPLES OF SOUTHEAST HEALTH

**MISSION** – Together we will evolve healthcare through innovation, compassion and partnerships.

**VISION** – With our collective expertise, we strive to be the best in patient experience and outcomes, instilling confidence within our community and empowerment among our employees.

**VALUES** -To accomplish our mission and vision, we uphold these values:

- **Vision for Change** – Our challenge in preparing for tomorrow's health need is to keep contemporary care available for those we serve. By evaluating the present, setting appropriate goals, being flexible and innovative, we prepare daily to meet and shape the future of health care in our region.
- **Access to Care** – We believe that all patients in our care are entitled to quality health services, information and confidentiality about their care, and treatment with dignity and compassion in all of life's stages.
- **Leadership with Responsibility** – Dedicated to maintaining public trust and a high level of integrity, our Hospital leaders strive to balance progress with costs, regulations and competition while always preserving the human touch. As a not-for-profit Hospital, we are pledged to enhancing quality of life through wise use of human and material resources in medical and civic endeavors.
- **Unity of Purpose** – A spirit of cooperation, mutual respect and concern is promoted by our Hospital family to deliver efficient and coordinated services. We also work together to provide patients and families with reassurances, support and care that is sensitive to all their needs.
- **Excellence in Performance** – At Southeast Hospital, we have made a commitment to excellence in individual performance, technology and facilities. This tradition of excellence is expressed by helping patients attain the highest quality of life they are capable of achieving and by providing regional leadership for health care issues and developments.
- **Service Above Self** – To demonstrate professionalism, ethics and devotion to duty is our charge; to serve with enthusiasm and compassion is our spirit. Recognizing that technology is in our hands and people are in our hearts, we take pride in giving our personal best for the benefit of others.

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### Medical Staff Functions/Responsibilities

The Medical Staff at Southeast is responsible to the Hospital's Board of Directors, through assignment to departments, Medical Staff committees or interdisciplinary Hospital committees, for/to:

- Departmental ongoing performance improvement and peer review activities and review of utilization of healthcare services (coordinate, monitor, evaluate, draw conclusions, formulate recommendations and initiate actions)

- Conduct reviews of surgical and other invasive procedures based on determined quality indicators.
- Medication usage evaluation to assure appropriate, effective use of drugs
- Development and approval of the drug formulary and of policies and procedures to accomplish pharmacy and therapeutics functions
- Review of blood usage for appropriate of effective use
- Require that patient records are complete, accurate, timely, legible, and clinically pertinent in alignment with the organization's Rules, Regulations, and Bylaws.
- Coordinate and review credentials investigations and recommendations regarding staff appointments and grants of clinical privileges and specified services
- Develop clinical policy for all clinical areas in the Hospital
- Provide continuing education
- Participate in review functions including plans for internal and external disasters, Hospital safety, utilization review, and infection prevention and control
- Develop and utilize criteria for deaths in which an autopsy is performed
- Through the performance improvement program, evaluate effectiveness of all functions through High Reliable Standardization of care, continuous process improvement, advanced information technology and a culture of safety and fairness.
- Provide leadership in organization performance activities related to processes primarily dependent upon activities of Medical Staff appointees
- Measure, assess, and improve appropriateness of clinical practice patterns based on clinical practice guidelines.
- Establish mechanisms to identify significant departures from established patterns of clinical practice and approved privileges and initiate corrective action when deemed appropriate
- Oversee the analysis of patient satisfaction data/trends and develop strategies for identified improvement.
- Provide oversight and assist with the creation of uniform standards to ensure patient safety and for the quality of care, treatment and services provided by practitioners with privileges
- Utilize evidence-based practice in the medical care of patients demonstrated by order sets, standing orders, standardized procedures and protocols

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### Physician Expectations

#### Technical Quality of Care:

- Achieve patient outcomes that consistently meet or exceed generally accepted medical staff standards as defined by comparative data, medical literature, and results of peer review activities
- Provide appropriate patient care, including the use of evidence-based guidelines, when available, as recommended by the appropriate specialty, in selecting the most effective and appropriate approaches to diagnosis and treatment

## Physician Expectations (Continued)

- Provide the patient comfort, including prompt and effective management of acute and chronic pain, according to accepted standards in the medical literature
- Actively participate in the provision of patient and family education to the plan of care and multidisciplinary rounds.

### Quality of Service:

- Ensure timely and continuous care of patients, 24 hours per day, seven days per week, by clear identification of covering physicians and by appropriate and timely answering service and electronic communications availability. Alternate coverage arrangements must be made for any period of time the practitioner is unavailable.
- Evaluate each patient as often as necessary-but at least daily-and document findings in the medical record at that time
- Participate in emergency room call coverage as determined by the departments
- Request inpatient consultations by providing adequate communication with the consultant, including a clear reason for consultation, and, for urgent or emergent requests, make direct physician-to-physician contact
- Respond to requests for inpatient consultations in a timely manner by performing the consult or otherwise notifying the referring physician.
- Delegate the responsibility for diagnosis or care of hospitalized patients only to practitioners who are qualified to undertake these responsibilities and are adequately supervised.
- Respond promptly to nursing requests for patient care needs
- Support the medical staff's efforts to maintain patient satisfaction rates for physicians
- Communicate effectively with other physicians and caregivers, patients, and their families
- When transferring care of a patient (i.e. physician to physician, emergency department to inpatient, and hospital to hospital, nursing home, or home health care), provide accurate information about care, treatment, services, current condition, and any recent or anticipated changes—allowing the opportunity for questions

### Patient Safety/Patient Rights:

- Participate in the hospital's efforts and policies to promote and maintain a patient safety culture, foster teamwork, and reduce medical errors
- Follow nationally recognized recommendations regarding infection control procedures and precautions when participating in patient care
- Maintain medical records that are consistent with the medical staff bylaws, rules, and regulations, including, but not limited to, chart entry legibility and appropriate abbreviations and timely completion of reports and notes
- Respect patient rights, including discussion of unanticipated adverse outcomes with patients/appropriate family members
- Respect patient privacy by not discussing patient care information and issues in public settings

- When seeing or attending patients, wear appropriate identification
- Discuss end-of-life issues when appropriate to a patient's condition, including advance directives and patient and family support, and honor patients' desires
- Report any questionable care to the Quality Management department
- Safety Event Reporting Link is on the Intranet/Compass
- Include of Palliative Care for chronic disease management of Hospice for end-of-life support in accordance with evidence-based guidelines.
- Complete patient medical history, including medication reconciliation within 24 hours of admission
- Complete Computer provider order entry to ensure accuracy of orders and reduce errors.

### Informed Consent:

- The patient or their representative has the right to make informed decisions regarding their care. Patient's rights include being informed of health status, being involved in care planning and treatment. This includes the right to request or refuse treatment.
- Giving informed consent to a treatment or a surgical procedure is one type of informed decision that patient/representative may need to make regarding the patient's plan of care.
- The informed consent discussion includes potential benefits, risks and side effects of the proposed care and likelihood of achieving goals and any potential problems that may occur. The discussion should also include reasonable alternatives which encompasses risks, benefits, side effects and risk related to not receiving proposed care, treatment or services.
- Informed consent is the responsibility of the physician or provider. Nursing staff may witness patient signatures for informed consent but cannot have discussions regarding procedure risks, benefits, or alternatives.
- The informed consent discussion is documented in the medical record prior to the procedure
- For care treatment or services (including infusion of blood products) requiring an informed consent form to be signed by the patient, the discussion is documented via the physician declaration on the consent form.
- A signed and dated informed consent document for an outpatient procedure is valid for ninety (90) days. If more than 90 days have elapsed since the consent document was signed, the consent and proposed procedure/treatment must be confirmed with the patient. The patient must initial and date the informed consent document, as well as the staff member confirming the proposed procedure/treatment. The patient's nurse must document that the proposed procedure/treatment was reconfirmed. Medical Staff Rules and Regulations, Article 6.02 State Operations Manual Appendix A Regulations and Interpretive Guidelines for Hospitals 11/9/2020, 42CFR 482.13 (b) (2), 42 CFR 482.51 (b) (2), 42 CFR 482.24 (c) (4) (v).

## Physician Expectations (Continued)

### Resource Utilization:

- Strive to provide quality patient care that is cost effective by cooperating with efforts to appropriately manage the use of valuable patient care resources according to comparative data and current professional standards
- Cooperate with guidelines and complete documentation for appropriate hospital admission, level-of-care transfer, and timely discharge to outpatient management when medically appropriate
- Ensure admission orders are authenticated, dated and timed prior to discharge and provide accurate and timely discharge orders and instructions in collaboration with other caregivers

### Peer and Coworker Relationships:

- Act in a professional, respectful manner at all times to enhance a spirit of cooperation, mutual respect, and trust among members of the patient care team
- Refrain from inappropriate behavior including, but not limited to, impulsive, disruptive, sexually harassing or disrespectful behavior, and derogatory or inflammatory medical record entries that are not directly related to the patient's clinical status or plan of care
- Address disagreements in a constructive, respectful manner away from patients or other noninvolved caregivers

### Citizenship:

- Review your individual and specialty data for all dimensions of performance and utilize these data for self-improvement to continuously improve patient care
- Respond in the spirit of continuous improvement when contacted regarding concerns about patient care
- Respond in a timely manner when provided information about issues requesting medical staff member input
- Make positive contributions to the medical staff by participating actively in medical staff functions and serving as requested
- In the spirit of early assistance, help to identify issues that affect the physical and mental health of fellow medical staff members and cooperate with programs that are designed to provide assistance
- Abide by the Medical Staff Bylaws and by all other lawful standards, policies, and rules and regulations of the hospital
- Abide by the ethical principles of the medical profession

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## Practitioner Illness and Impairment

The Impaired Practitioner/Practitioner Health Policy and Procedure details the mechanism for identification and appropriate management of impaired or potentially impaired practitioners. The main focus is successful rehabilitation and return to work.

Signs of potential impairment include but are not limited to self-medication, drunken driving charges, unexplained absences, inappropriate behavior, change in dress, change in attitude, long absences from office with disruption of appointments, cancelling of appointments without obvious conflicts, broken beeper syndrome and alcohol on breath at work.

The three major types of impairment are recognized to be substance abuse, mental illness, or physical illness.

If you suspect impairment, you are to contact the Chief of Staff or the Vice President/Chief Medical Officer. If neither is available, please call the Vice President of the Medical Staff or any member of the Medical Executive Committee. If you need assistance with an impaired practitioner immediately and cannot reach any of the above stated parties; contact the on duty ER physician at 5555.

Referrals, including self-referral, may also be made to the Missouri Physicians Health Program (1-800-274-0933 or 314-995-4990).

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## Lessons Learned from Root Cause Analyses, System or Process Failures and Results of Proactive Risk Assessment

- Safety Event Reporting link is on the Intranet/Compass

The Disclosures of Events and Patient Safety Events policy outlines Southeast's philosophy to foster open, honest, and ongoing communication with patients and to provide guidance in the process of disclosing to a patient a significant unanticipated Patient Safety Event. The treating/attending physician is a part of the disclosure which normally occurs within 24 hours of discovery of the event. Disclosure will be documented in the patient's medical record and will include communication that affords the patient or family an opportunity to confirm understanding and to receive answers to questions.

The Culture of Safety Policy promotes an atmosphere where all members of the healthcare team can focus on patient safety and the prevention of harm by routinely recognizing and reporting near misses, errors, and unsafe conditions without fear of reprisal. A successful culture of safety is dependent on all team members speaking up and holding each other accountable when an unsafe practice or unsafe condition as well as the behavior of other staff members, physicians, volunteers, etc. that has the potential for undermining a culture of safety is witnessed (such as disruptive behavior). It is based on the premise that we can count on each other and failure to speak up is essentially endorsing an unsafe practice.

When a serious adverse/sentinel event occurs, a root cause analysis is conducted to thoroughly review relevant processes for any necessary changes or improvements as defined by the organizational Serious or Sentinel Event Process policy. All hospital and medical staff personnel involved with or having direct knowledge of the event or condition are invited to participate in the root cause analysis/investigation activity. Any "lessons learned" from review of the event that can assist in preventing future events are shared with departments in the organization as appropriate. Events resulting in moderate or

## Lessons Learned from Root Cause Analyses, ..... (Continued)

significant patient harm are shared with the Patient Safety Committee, Quality Committee, the Medical Executive Committee, and the Hospital Board of Directors.

**Report Concerns to Outside Regulatory Agencies** - Concerns about provision of care may be reported to outside regulatory agencies, including The Joint Commission (TJC) and the Missouri Department of Health and Senior Services without fear of reprisal. Southeast Hospital will take no disciplinary or punitive action because an employee, physician, or other individual who provides care, treatment, or services, reports safety or quality-of-care concerns.

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### Medical Staff Emergency Response Roles

**The Hospital has a written Emergency Operations Plan.** Southeast Hospital utilizes an All-Hazards approach to Emergency Operations Planning and Response. The organization utilizes the Hospital Incident Command System (HICS) to guide the response and management of events that may exceed or overwhelm the resources and/or capacity of normal operations. The principles of such responses are guided by the National Incident Management System that was put into place by the Federal Government after 9/11.

The All Hazards Emergency Operations Plan is maintained on the Hospital Intranet Site (the Compass) in the Safety Section Folder and in a hard copy format within the red All Hazards Emergency Operations Plan binders, located in all departments and nursing stations. Red Quick Reference Emergency Guides are located in all departments and nursing stations as well and are wall mounted. Individual Response Plans located inside the Intranet Folder, the All Hazards Emergency Operations Plan and/or the Quick Reference Emergency Guides, provide direction for action in specific events such as but not limited to: Disaster/Mass Casualty, Severe Weather, Child Abduction (Code Adam), Utility and System Failure, Earthquake and Highly Contagious Communicable Disease Outbreak.

Overwhelming events could be External (Mass Casualty event, Hazardous Materials Release, Severe Weather) or Internal (Fire, Utility Failure, Bomb-Threat). The Administrator-on-call will assess the situation and with his/her team determine the level of response necessary. An Incident Command Center will be established to guide the work of the response. The response may result in a "Limited activation", "Partial activation", or Full activation".

#### **Medical Staff Responsibility - In the event of an officially declared emergency:**

If Southeast Hospital experiences an event that would result in the Partial or Full Activation of an Internal or External Emergency Response Plan, the Medical Staff Physicians and Limited Health Practitioners - Advanced (LHP-A's, including APRN's, CRNA's, and PA's) are expected to participate in the Hospital's Emergency Response and should report to their assigned hospital. Practitioners will be notified by the hospital utilizing standard communication technology (telephone, cell phone, pager, text) unless these systems are inoperable. In the event that standard communication technology is not available, the

hospital will utilize mass media communications (Radio, Television, Social Media) and may initiate "runners/messengers."

If the Hospital initiates a "Limited Activation", certain physicians or physician groups may be requested to participate in the response based on the level of physician/provider support needed. In these instances, individuals would be contacted as above, but generally mass media communication would not be necessary.

Practitioners employed by or privileged only at Southeast Hospital will report to Southeast and those employed by or privileged only at St. Francis Medical Center will report to St. Francis (including those on locum tenens assignments at these facilities).

If on-site at either Cape Girardeau hospital at the time an emergency is declared, physicians and LHP-A's are expected to remain at the facility and follow that hospital's protocol unless it is determined by Incident Command that a greater need exists at the other facility. Independent practitioners who are credentialed at both hospitals are asked to report to the hospital of their choice and should anticipate reassignment according to the specific needs of the situation.

Practitioners privileged at Southeast or St. Francis who normally practice outside the Cape Girardeau area will be asked to report to one of the Cape Girardeau facilities if they are not needed at their normal practice location.

At Southeast, Emergency Medicine Physicians and LHP-A's will report to the Emergency Department, and other physicians/LHP-A's will report to the Physicians' Lounge (the designated Physician Labor Pool Location) at Southeast. Only on-call providers who have been contacted directly by the Emergency Department should report directly to the Emergency Department or Surgery. The Chief of Staff or designee will be the Physician-In-Charge and will work with the "Operations – Medical Branch Section Chief" to dispatch physicians and LHP-A's from the Lounge to the treatment areas in which their specific expertise is required. Members of the Southeast Medical Staff will be responsible for supervision of non-staff practitioners who have been specifically credentialed to meet emergent patient needs.

The Southeast Hospital photo ID badge or other legal identification will be required for entry into the Hospital through the ED or Parking Garage Link (west side of the hospital). All other entries will be locked.

All practitioners will return to the Physicians' Lounge when released from a treatment area for reassignment, or for release upon resolution of the emergent situation. Continued need for practitioner services will be dictated by the nature, extent and duration of the emergency. The Hospital's Incident Command Center will work closely with the Physician-In-Charge and provide notice when the emergent event has officially ended.

Questions specific to Medical Staff responsibilities should be directed to Lori Merritt, RN, MSN, CFRN, the Department Director of Emergency Services (573-651-5531), or Laura Saupe, BSN, RN, CPHQ, Medical Staff Services Manager (573-651-5535).

## Fire Safety - Overhead Page "Facility Alert + Code Red + Location"

Written Fire Plans and Quick Reference posters are in all departments.

To report a fire, pull the nearest fire alarm and call the switchboard by dialing 5200 from any hospital phone or 573-334-4822 from a cell phone. If the switchboard does not answer, dial 7711# and announce "Facility Alert - Code Red" followed by location of fire.

When 'Facility Alert – Code Red + Location' (Fire page) is called, all security officers and facilities management personnel should report to the location of the fire page. All other employees should ensure all smoke doors and patient room doors are closed, remove all items from corridors, and remain in their work area for further instructions.

### Fire Safety - Overhead Page "Facility Alert + Code Red + Location" (Continued)

**Credentialed Medical Staff and Limited Health Practitioners – Advanced (LHP-As)** should assist with these activities as needed to ensure the safety of all.

Remember **RACE**: Rescue – Alarm – Confine – Extinguish/Evacuate

For Fire Extinguisher Use **PASS**: Pull – Aim – Squeeze – Sweep

**Do Not Use Elevators** during a fire alarm situation.

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## Environment of Care Risks and Awareness of Hazards

Each department has a written Department Specific Safety Plan as well as policies and procedures in place for assessing, reporting, and minimizing risks.

These **risks might include** but are not limited to hot surfaces, uneven walking surfaces, temperature extremes, violent or combative individuals, exposure to hazardous chemicals or blood and body fluids, slips and falls, excessive noise, electrical shock, sharps causing punctures or lacerations, terrorist events, blocked corridors or exits, missing fire extinguishers, burned out exit lights, etc.

**Report unsafe situations** (related to building deficiencies, construction hazards, and temporary measures implemented to maintain fire safety based on ILSM policy) to the manager of department in which it is found, to the Facilities Management Department, to the Safety Officer, to Hospital Administration, or to Quality Management as soon as discovered. The hospital operator will help with locating these individuals.

**Notices are posted** to advise of construction area hazards, detours, and work in progress to correct unsafe or potentially unsafe conditions.

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## Procedures to Follow When Electronic Information Systems Are Unavailable

In the event of planned or emergent, unplanned computer down time, hospital staff will be notified of the impacted information system components and will make computer generated forms available for charting and ordering.

Documentation – Progress notes, order forms, medication administration records, prescription pads and discharge instruction forms will be available. Unit staff will have access the master book of computer generated forms maintained in the House Supervisors Office, in Emergency Services and in Health Information Management (HIM). Prior Lab and Imaging diagnostic test results may be secured through those departments.

Registration – Procedures are in place to assure patient registration will continue in Emergency Services and in Patient Registration.

Telecommunication – In the event of telecommunications downtime, contact the House Supervisor or Hospital Operator for continuance of telephone communication.

Staff will be notified as information system access is restored and will act to bring the electronic medical record system entries current utilizing the paper documentation prepared during the down time.

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## All Medical Record Entries Are Signed, Dated, and Timed

All **entries** in the medical record, including all **orders, standing orders, and protocols** to be enacted must be signed, dated, and timed. This includes entries from all clinical staff that are documenting in the patient record of care. ***Please remember to sign, date, and time all medical record entries.***

**Pre-printed Order Sets, Protocols, and Standing Orders:** The written order to initiate a protocol or pre-printed order must be signed, dated, and timed by the ordering physician, prior to implementation of the protocol or order set. The standing order, pre-printed order, or protocol to be carried out must also be signed, dated, and timed for the record to be considered complete.

ORDER SETS (PPO): Orders which are written for specific disease state, medical staff department, or the organization which require input from the physician to complete the orders prior to use. These order sets consist solely of menus of treatment or care options designed to facilitate the creation of a patient-specific set of orders by a physician or other qualified practitioner authorized to write orders, and none of the treatment choices and actions can be initiated by non-practitioner clinical staff before the physician or other qualified practitioner actually creates the patient-specific order(s).

PROTOCOL: Utilized by the organization which are written with complete instructions for the appropriate licensed hospital personnel to follow once the physician, advanced practice nurse or physician assistant instructs them to use the protocols. \*Protocols are considered to be a predetermined set of orders that define appropriate interventions for a specific medical condition or intervention

## All Medical Record Entries Are Signed, Dated, and Timed (Continued)

**STANDING ORDERS:** Orders that permit treatment to be initiated in emergent situations without a prior specific order from the treating physician/practitioner where such treatment is initiated when a patient's condition meets certain pre-defined clinical criteria.

Documentation is to be legible (whether handwritten or printed). Use of secure text orders is not permitted.

Order Sets/Preprinted Orders	Protocols	Standing Orders/Standardized Procedures
Written menu of orders on a list for specific disease state, medical staff department, or the organization	Predetermined set of orders that define the specific appropriate interventions for a specific medical condition Written complete instructions/orders to be followed after order is given to implement the protocol	Standing orders permit treatment to be initiated in an emergency situation without a provider's specific order. The standardized procedure orders permit treatment to be initiated when it is part of an evidenced based treatment regimen. Standing orders and standardized procedures follow the same regulatory guidelines. They are in the medical record and the provider authenticates, dates, and times the standing order or standardized procedure order after the event
Requires provider to select the orders desired on the menu/list, complete any blanks within the order, date, time and authenticate the orders prior to initiation of the orders	One order to initiate the protocol activates all orders on the protocol	The patient's condition must meet specific predefined clinical criteria
Order Sets/Preprinted Orders	Protocols	Standing Orders/Standardized Procedures
Order set must be approved by involved physician or licensed provider, involved medical staff department, and Medical Executive Committee (MEC)	Must be approved by Nursing, Pharmacy & Therapeutics committee, and MEC.	Must be approved by Nursing, Pharmacy & Therapeutics committee, and MEC.
Each order set will have an assigned owner and provider champion	Each protocol will have an assigned owner and provider champion.	Each standing order/standardized procedure will have an assigned owner and provider champion
Reviewed every 3 years by the owner and provider champion or as evidence-based guidelines for orders change, any revisions approved by physician champion, involved department, and PAG.	Must be reviewed annually and/or when evidence changes Any revisions require medical staff, nursing and pharmacy approval.	Must be reviewed annually and/or when evidence changes Any revisions require medical staff, nursing and pharmacy approval.



	NON-VIOLENT BEHAVIOR	VIOLENT OR SELF-DESTRUCTIVE BEHAVIOR
Examples of Behavior	<ul style="list-style-type: none"> <li>• Patient is confused, unable to follow commands, actively pulling at lines/tubes/monitors</li> <li>• Patient is confused and unable/not allowed to ambulate but actively attempting to crawl out of bed or chair</li> </ul>	<ul style="list-style-type: none"> <li>• Violent or destructive behavior toward self or others (i.e., uncontrolled striking at others or self)</li> <li>• Violent destruction of physical environment</li> <li>• Adamant verbalization of harm to self or others</li> </ul>
Assessment	<ul style="list-style-type: none"> <li>• May be done by an RN to determine need after appropriate least restrictive interventions have been determined unsuccessful</li> </ul>	<ul style="list-style-type: none"> <li>• Face-to-face evaluation within one hour of application of restraint or seclusion by the Physician, APRN, PA or trained RN</li> </ul>
Order	<ul style="list-style-type: none"> <li>• Required from physician</li> <li>• Must be obtained within one hour when applied in emergency circumstances</li> </ul>	<ul style="list-style-type: none"> <li>• Required from physician</li> <li>• Must be obtained within one hour when applied in emergency circumstances</li> </ul>
Order Renewal	<ul style="list-style-type: none"> <li>• Must be renewed at a minimum of every three (3) calendar days (M-W-F).</li> <li>• This renewal order is based upon examination of the patient by the physician</li> </ul>	<ul style="list-style-type: none"> <li>• Time limited and renewable at the following time intervals for up to a total of 24 hours: <ul style="list-style-type: none"> <li>○ 4 hours for adults</li> <li>○ 2 hours for ages 9-17</li> <li>○ 1 hour for less than age 9</li> </ul> </li> </ul>
Physician Face-to-Face Evaluation	Must see and examine the patient each calendar day before writing a new or renewed restraint order	Must see and examine the patient every 24 hours before writing a new or renewed restraint order
Monitoring	At approximate two (2) hour intervals with documentation in EMR.	<ul style="list-style-type: none"> <li>• At approximate 15 minute intervals with documentation in EMR.</li> </ul>

## Restraints and Seclusion

Patient assessment and reassessment are crucial care-delivery steps, and guide subsequent physician orders for care. Specific to orders for restraint use, assessment and reassessment findings (and documentation of these findings) should support and provide the clinical justification for this intervention.

Southeast HEALTH's organizational policy, Restraint and Seclusion Guidelines, gives authority to the physician or other licensed practitioner to initiate restraint use when clinically justified to protect the patient or others from injury and when all other, less restrictive, measures have failed. Restraints are tied with a quick release knot in order to facilitate rapid release of restraint in an emergency situation.

The physician order for restraint use must include the medical justification or reason for the restraint or seclusion. Additionally, the physician order for restraint use identifies the type of restraint, is time-limited and must be renewed as described in the summary at right.

## Process to communicate medication shortages, outages, and substitution due to same

When a potential drug shortage is identified and it is determined that a local shortage will occur, pharmacists and the Chair of the Pharmacy and therapeutics Committee (P&T) will determine a suitable alternative. Should no therapeutically equivalent alternative be available, strategy will be developed with input from practitioners most frequently ordering the drug. Therapeutic substitutions and restrictions of shortage drugs will be approved jointly by the Director of Pharmacy and the P&T Committee Chair and will be communicated to the medical staff through multiple mechanisms (i.e. posting of notices in areas of visibility throughout the Hospital, email notification, MedNews Plus, etc.)

## Emergency Overhead Pages

Facility Alert – Code Red + Location  
Facility Alert – Tornado WATCH  
Facility Alert – Tornado WARNING  
Facility Alert – Bio/Chem Alert  
Security Alert – Code ADAM  
Security Alert – Code Green:Vulnerable Person  
Security Alert – Code Secure + Level of Response  
Security Alert – Armed Active Violent Intruder + Location  
Security Alert – Code STARR + Location  
Security Alert – Code Black  
Medical Alert – Code Blue + Location  
Medical Alert – Pediatric Code Blue + Location  
Medical Alert – Rapid Response + Location  
Medical Alert – Mass Casualty Incident  
Safety Alert – Code Sunflower  
Code Show-Me  
Code OUTLOOK

## Fire

Weather conditions indicate the possibility of a tornado  
Tornado has been identified in the area  
Biological/Chemical contamination alert  
Infant/Child reported abducted/missing  
Missing vulnerable adult/adolescent patient-elopement risk  
External threat to facility or staff  
Armed – Active violent intruder  
STARR team members respond to verbally/physically disruptive person  
Bomb threat  
Adult cardiac/pulmonary arrest  
Pediatric cardiac/pulmonary arrest  
Medical assistance needed: conscious person  
Mass casualty event with level of response (limited, partial, full)  
Patient fall  
TJC/CMS/DHSS Surveyors in the Hospital  
Immediate attention – ALL STAFF

## Preventing and Controlling Infection

Infection Prevention measures are required both by law and professional standards. Participation in the infection prevention program is a part of every job description and the responsibility of every practitioner treating or providing care for patients. **Good infection prevention principles and practices must be established and adhered to by all personnel to assure a safe environment by decreasing the spread of pathogens from one person to another, directly or indirectly.**

**One of the most important ways to address hospital acquired infections is by improving hand hygiene of health care staff.**

Infection Prevention standards and policies for specific departments and procedures may be accessed through the Hospital Intranet.

Each patient care unit will also have access to the OSHA Exposure Control Plan that includes "Bloodborne Pathogens and Tuberculosis Control."

Questions may be answered by contacting Infection Prevention at 651-5548. Infection prevention failures should be reported to Infection Prevention staff.

## Multidisciplinary Rounding

Multidisciplinary rounds are key to developing a culture of collaboration and improvement in all our Patient Care Units, allowing patient-centered care planning, prevention of harm, and improved patient outcomes. The rounds will facilitate implementation of evidence-based practices, established daily patient goals, identified safety risks, and prevented gaps and delays in care, all leading to decreased length of stay, decreased mortality rate, decreased ventilator days and decreased rates of ventilator-associated pneumonia and catheter-related blood stream infection rates in the Units. The central line should be reviewed/documented daily for need; central lines no longer deemed necessary should be removed. Indwelling urinary catheters should be assessed for need daily and said need documented. Expectation is that indwelling urinary catheters will be removed after one (1) midnight.

## Method to Communicate Emerging Infections That Could Cause Influx

**Infection Prevention receives notifications, advisories, and alerts from the Centers for Disease Control and Prevention, Missouri Department of Health and Senior Services, as well as local public health agencies. When these notifications are received, they are communicated to the Emergency Room Director, Vice President of Medical Affairs, Director of Physician Office Practices, and Hospitalists via email. The alert is posted to the Intranet, under the Physician tab. The alerts are placed in a folder "HEALTH**

NOTIFICATIONS.ADVISORIES.ALERTS". A summary of the alert with a link to the document is also included in the newest edition of MedNews Plus for Physicians.

## CAUTI

**Our goal is to minimize the utilization of urinary catheters (use under pads, frequent toileting or external urinary devices where possible). An order and reason for insertion must be initiated using the Urinary Catheter Protocol. Acceptable indicators for a urinary catheter are:**

- Hospice/End of Life
- Incontinence with pressure sores present (Stage III or IV)
- Surgery involving genitourinary tract
- Monitoring strict urinary output required for care of patient (Must have order for strict input/output and document hourly outputs. Remove after one (1) midnight and follow the bladder management pathway).
- Surgical patients (Discontinue by postoperative day 1 with order)
- Urinary tract obstruction not manageable by other means
- Acute urinary retention (remove after one (1) midnight with order and follow the Bladder Management Pathway)

See the Urinary Catheter Protocol and Clinical Pathway. **Indwelling urinary catheters should be assessed for need daily, and said need documented. Expectation is that indwelling urinary catheters will be removed after one (1) midnight. You can't get a CAUTI if the patient does not have a urinary catheter.**

## Surgical Site Infection Prevention

Any time a patient undergoes a surgical procedure there is potential for infection. It is important that we do everything we can to prevent this from occurring. At SEH, we expect you will:

- **Perform an appropriate scrub preoperatively** and have excellent hand hygiene practices while caring for all of your patients-not just the surgical patients
- If **removal of hair is necessary for the procedure, follow current policy** literature or endorsed by professional organizations. If necessary, hair should be clipped, not shaved.
- Don appropriate sterile surgical attire and maintain the sterile field
- **Administer appropriate prophylactic antibiotics; within 60 minutes of the start of the procedure and discontinue the antibiotic within 24 hours if appropriate based on the type of surgery and pharmacy re-dosing**
- **Use appropriate skin prep at the surgery site**
-



## Surgical Site Infection Prevention (continued)

- Educate your patient/caregiver on the signs and symptoms of infection and things they can do to decrease the risk of developing a surgical site infection.

### Surgical Site Infections and PATOS

- Identified surgical site infections related to specific surgeries are reported to regulatory agencies through the National Healthcare Safety Network (NHSN).
- Surgical site infections must meet specific NHSN surveillance criteria and definitions.
- **PATOS=Present at Time of Surgery and refers to the identification of infection present at the time of surgery.**
- If the patient has surgery and subsequently develops an infection, the index case is reviewed to see if an infection was present at the time of surgery. If PATOS=Yes, the infection is reported but does not count against our CMS reportable measures.
- **To meet PATOS, documentation must reflect that an infection was seen and at what tissue level. This documentation must be noted in the narrative portion of the operative report.**
- **Examples of words used to meet PATOS include: abscess, infection, purulence, pus, phlegmon, feculent peritonitis.**
- **Words ending in "itis", positive culture, perforation, contamination, necrosis, gangrene, fecal spillage, nicked bowel, inflammation, trauma do not meet PATOS unless there is also documentation of infection.**
- When observed, please provide detailed documentation of the presence of infection in the operative report.
- **Consistent with the American College of Surgeons criteria, the combination of a spontaneous fascial dehiscence or deliberate opening into the deep tissue level, at least one sign or symptom (fever or localized pain/tenderness), and a positive culture (or the surgeon chooses not to perform a culture) will meet the surveillance definition for Deep Incisional SSI.**

## Moderate or Deep Sedation

Before operative or other high-risk procedures, which include procedures completed in endoscopy, cath lab, radiology, and/or emergency department, etc. is administered: The practitioner must conduct a pre-sedation patient assessment. This assessment should be completed immediately before the sedation, documented and authenticated. The history and physical is NOT the pre-sedation assessment. The hospital assesses and reassesses its patients/relative to sedation/ASA Risk Classification. During patient assessments and reassessments, the hospital gathers the data and information it requires.

### Moderate or Deep Sedation (Continued)

#### Documentation of ASA Risk Classification Scores:

Assessment and Reassessment Data must accurately reflect the condition of the patient. Prior to administration of sedation the practitioner must assess the degree of the patient's

physical state by the use of the ASA Class description. The ASA Risk Classifications are as follows:

#### ASA Risk classification 1-5. Status Definition:

ASA-1 A normal healthy patient

ASA-2 -A normal patient with mild systemic disease

ASA-3 -A patient with a severe systemic disease that limits activity, but is not incapacitating

ASA-4 -A patient with an incapacitating systemic disease that is a constant threat to life

ASA-5 -A moribund patient not expected to survive 24 hours with or without the operation

## Universal Protocol Time Out

To prevent wrong site, wrong procedure, or wrong person surgery, the following guidelines based on the World Health Organization Universal Protocol, will be followed for all surgical and non-surgical invasive procedures. The Universal Protocol involves three separate processes: Pre-procedure verification, site marking, and the completion of a time-out prior to the start of the procedure.

A time-out is performed immediately prior to the procedure. Completion of the time-out is documented in the patient's electronic medical record. An intraoperative time-out is performed prior to the skin incision and after gowning and gloving. This is a "hard stop" in which all activities are to be suspended (unless there is a threat to patient safety). The time-out is preferably initiated by the surgeon, conducted by the circulator, and must involve all members of the surgical team. The time-out should include the patient if they are able.

1. A designated member (depending on the procedure to be done) of the team will conduct the time-out.
2. All staff involved in the procedure from the beginning will suspend activities (unless that suspension would compromise care of the patient) and verbally agree at minimum on the following elements:
  - a. Correct patient
  - b. Correct site
  - c. Correct procedure
3. In the event not all of the elements are agreed upon, the case will not continue until the discrepancy is resolved.
4. Any member of the patient's care team that comes in after the initial Time-Out was completed, will verify that it is the correct patient by stating the patient name, DOB, and treatment/service to be provided before providing care to the patient.

## Universal Protocol Time Out (continued)

The circulator or surgeon will perform the time-out in the following sequence:

1. Circulator/Physician initiates time out (after prepping/draping and just before incision) by stating their name, role, time
2. State patient name or have the patient state their name & procedure as listed on consent
3. Show consent to surgeon & verify as fully executed
4. State site is marked & visible or no site marking required (or marked on diagram)
5. State images and equipment available/ any equipment concerns
6. State fire risk assessed (State: Low, Medium, or High); prepped area dry with no pooling prior to draping
7. State patient allergies or NKDA

### CRNA/MDA/LOCAL NURSE

1. State name
2. State Antibiotic
3. State Antibiotic time
4. Any patient specific concerns

### PERFUSION

1. State name
2. State safety check complete

### SCRUB TECH

1. State name
2. State sterility met

### SURGEON (RN to prompt)

1. State critical or Non-routine events
2. State case duration
3. State anticipated blood loss

### ALL TEAM MEMBERS (At the completion of the time out, all team members must state):

1. I agree
2. No concerns

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## Multi-Drug Resistant Organism Infections

The CDC defines Health Care-Associated Infection (HAI) as an adverse condition that results from the presence of an infectious agent or its toxins. The HAI can be caused by infectious agents from many different sources such as skin contaminants, the nose or

mouth, or the GI tract. HAIs can also be caused by contaminated visitors, medical devices, the health care environment, or patient care providers. Multidrug-resistant organisms (MDRO) are microorganisms that are resistant to one or more classes of antimicrobial agents. These microbes increase lengths of stay, cost, and mortality. Prevention of health related infections is essential in the control of MDROs in the healthcare setting. More than 70% of the bacteria that cause HAI are resistant to at least one of the drugs most commonly used to treat them. Persons infected with an MDRO have longer hospital stays and higher hospital bills. Certain types of HAI are no longer covered under CMS. Based on consultation with the Infection Prevention and Control Committee, Centers for Disease Prevention and Control, Infectious Disease Physicians, and SEHealth Infection Control Risk Assessment the following pathogens have been identified as MDRO: Methicillin Resistant Staph Aureus (MRSA), Vancomycin Resistant Enterococcus (VRE), Clostridium Difficile (C.diff), organisms with Extended Spectrum Beta Lactam properties (ESBL), and several pathogens that fall into the category of Multi-Drug Resistant Gram Negative Bacteria. These are as follows but are subject to change:

- Stenotrophomonas maltophilia resistant to Bactrim (sulfamethoxazole & trimethoprim) and Levaquin (levofloxacin),
- Carbapenem-resistant organisms (CRO) including Carbapenem-resistant Enterobacteriaceae (CRE), Acinetobacter baumannii CRO, Pseudomonas aeruginosa CRO, and carbapenemase-producing organisms.

Patients are screened based upon risk factors and will be isolated as appropriate.

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## Prevention of Central Line Bloodstream Infections

When inserting a central venous line, the inserter will perform hand hygiene, wear mask, gloves, and a surgical hat. A large sterile drape that covers the patient from head to toe and a pre-approved skin preparation alcohol chlorhexidine will be used for each insertion unless contraindicated. A standardized kit will be used for central line insertion purposes.

\* The femoral vein will not be used for central line insertion unless other sites are unavailable

\* The central line should be reviewed/documented daily for need

\* Central lines no longer deemed necessary should be removed

\* An order is needed to insert a central line

\* An order is needed to access a port

Central line insertion infection rates are reviewed by the Infection Prevention and Control Committee.

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## Anticoagulant Therapy Assistance

The medical staff has approved order sets and policies for anticoagulant dosing and pharmacy monitoring utilizing evidence based, TJC driven guidelines. Physicians may consult a pharmacist to assist with questions in regards to anticoagulants in the

perioperative setting, reversal management, dosing for the initiation and maintenance of anticoagulants. Pharmacists are available to provide patients and families education on anticoagulants prescribed prior to the patient's discharge unless being discharged to another patient care facility.

## Sepsis

The American College of Chest Physicians (ACCP) and Society for Critical Care Medicine (SCCM) released a consensus statement in 1992 that provided the first published definitions for systemic inflammatory response syndrome (SIRS), sepsis, severe sepsis, septic shock, sepsis-induced hypotension and multiple organ dysfunction syndrome (MODS). The consensus statement provided robust verbal definitions and assigned objective clinical criteria for SIRS criteria, but did not supply specific clinical criteria to define end-organ dysfunction.<sup>2</sup> these definitions are provided in Table 1.

Southeast Health utilizes the St John's Sepsis alert in the Cerner EMR to help capture patients who may be at risk of sepsis. The nursing staff is advised to notify the provider for orders as needed. The sepsis order set, along with Rapid Response, is available to assist with the necessary actions for achieving the measures set forth by CMS. Compliance with the CMS sepsis measures has shown better outcomes and decreased mortalities in sepsis related cases, along with decreased length of stay.

Any further questions around the sepsis measure are welcomed in the Quality office, 573-651-5557. Please ask for Regina Moore or Dewayne Whitener. NEW ALGORITHM (see next page):

Table 1. Adapted from ACCP/SCCM consensus statement.

SIRS	
Criteria	Two or more of the following
	Temperature > 38°C or < 36°C
	Heart rate > 90 beats per minute
	Respiratory rate > 20 breaths per minute or PaCO <sub>2</sub> < 32 mm Hg
	White blood cell count > 12,000/cu mm, < 4,000/cu mm or > 10% immature (band) forms
Sepsis	The systemic response to infection manifested by 2 or more SIRS criteria
Severe sepsis	Sepsis associated with organ dysfunction, hypo perfusion or hypotension that may include but are not limited to, lactic acidosis, oliguria or an acute alteration in mental status
Septic shock	Sepsis-induced with hypotension despite adequate fluid resuscitation along with the presence of perfusion abnormalities that may include, but are not limited to, lactic acidosis, oliguria, or an acute alteration in mental status. Patients who are receiving inotropic or vasopressor agents may not be hypotensive at the time that perfusion abnormalities are measured.
Sepsis-induced hypotension	A systolic blood pressure < 90 mm Hg or a reduction of >/- 40 mm Hg from baseline in the absence of other causes for hypotension
MODS	Presence of altered organ function in acutely ill patients such that homeostasis cannot be maintained without intervention

## Good Hand Hygiene – Most Hospital Associated Infections Can Be Prevented by Good Hand Hygiene!

Appropriate hand hygiene is to be performed before/after patient or equipment contact, entering/exiting the patient environment (crossing the threshold into the patient's room), or moving from a dirty to clean task. Alcohol based hand sanitizers are conveniently located throughout the facility. Alcohol based hand sanitizers are not appropriate: when caring for a patient with C. diff or other spore forming organism, when hands are visibly soiled, before eating, after toileting.

Adherence to transmission based precautions is essential to prevent HAI. A patient that has been diagnosed with a potentially transmittable condition such as an MDRO or other infectious agent will be placed on one of three types of transmission based precaution depending on the pathogen; **Contact, Droplet, or Airborne**. A patient that has been placed on precautions will have an isolation cart located outside of his/her room. This cart will contain appropriate personal protective equipment and dedicated patient care equipment. **Contact** precautions entail a private room or may entail cohort with an appropriate roommate (see Management of Multi-Drug Resistant Organisms policies), appropriate personal protective equipment (gloves and gown must be worn, mask and eye protection if you anticipate splashing of bodily fluids), and appropriate hand hygiene with either an alcohol based hand sanitizer or soap and water. Appropriate hand hygiene for a patient with C.diff is soap and water. **Droplet** precautions are very similar but require the health care provider to don a mask and eye protection, in addition to gloves and gown, when entering the room. **Airborne** precautions require a specific mask, called an N-95 Respirator, and also require that the patient is placed in a special negative air flow room.

Any patient care equipment that is not disposable or is not feasible to dedicate to the patient on contact precautions must be thoroughly cleaned/disinfected after use. It is extremely important that contamination of the environment is kept to a minimum. For this reason, the Environmental Services Department has specific cleaning instructions for patients on precautions, especially after discharge. All personal protective equipment is to be removed prior to leaving the patient room and appropriate hand hygiene is required.

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### Influenza Vaccination

Influenza viruses are spread from person to person primarily through large-particle respiratory droplet transmission (e.g., when an infected person coughs or sneezes near a susceptible person). Transmission via large-particle droplets requires close contact between source and recipient persons, because droplets do not remain suspended in the air and generally travel only a short distance (less than or equal to 1 meter) through the air. Contact with respiratory-droplet contaminated surfaces is another possible source of transmission. Airborne transmission (via small-particle residue [less than or equal to 5µm] of evaporated droplets that might remain suspended in the air for long periods of time) is also thought to be possible, although data supporting airborne transmission are limited. The typical incubation period for influenza is 1—4 days (average: 2 days). Adults shed

influenza virus from the day before symptoms begin through 5—10 days after illness onset. However, the amount of virus shed, and presumed infectivity, decreases rapidly by 3—5 days after onset in an experimental human infection model. Young children also might shed virus several days before illness onset, and children can be infectious for 10 or more days after onset of symptoms. Severely immunocompromised persons can shed virus for weeks or months.

Using a medical staff approved evaluation process; SEH offers influenza vaccine screening and influenza vaccinations for its patients during the influenza season. The vaccine screen is available during the influenza season. **All employed hospital staff are required to receive the annual influenza vaccination unless an exemption is granted by Occupational Medicine or Administration. If an employee is granted an exemption, they are required to wear a surgical mask while working.** As always, appropriate hand hygiene, respiratory etiquette, and isolation practices are considered paramount for non-vaccine prevention measures. Per mandatory reporting, **credentialed providers not employed by SoutheastHEALTH must complete the influenza form annually to document vaccination status and may be asked to produce proof of vaccination.**

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### COVID-19

SoutheastHEALTH ("Southeast") is committed to providing a safe and healthy workplace for all our employees. Southeast has developed the following COVID-19 plan ("Plan"), which includes references to state and federal guidelines, including aspects of Occupational Safety and Health Administration's ("OSHA") COVID-19 Emergency Temporary Standard (ETS), processes and procedures, and other resources to minimize the risk of transmission of COVID-19.

Southeast is committed to putting patient, family, volunteer, staff and community safety at the forefront of all we do. Southeast takes the COVID-19 pandemic very seriously and has adopted a comprehensive approach to managing the situation as it develops. Southeast follows protocols as set forth by the Centers for Disease Control and Prevention ("CDC"), Centers for Medicare and Medicaid ("CMS"), and the Missouri Department of Health and Senior Services ("MODHSS"). These precautionary measures are meant to help keep everyone as safe as possible.

All employees are responsible for supporting, complying with, and providing recommendations to further improve this Plan. This Plan is a living document and updates will be considered as regulatory bodies, including the CDC, CMS, MODHSS, and others issue and/or update applicable guidance related to COVID-19. Employees are encouraged to follow their chain of command to provide feedback and/or suggestions. Suggestions will be evaluated and implemented based on feasibility, evidence, regulatory guidance, work flow, patient and employee safety. This Plan will be available to employees on the Southeast Intranet home page, under COVID Resources.

## COVID-19 (continued)

Southeast will provide protective clothing and equipment (e.g., respirators, gloves, gowns, goggles, face shields) to each employee in accordance with Standard and Transmission-Based Precautions in healthcare settings in accordance with CDC's "[Guidelines for Isolation Precautions](#)," and ensure that the protective clothing and equipment is used in accordance with OSHA's PPE standards (29 CFR 1910 subpart I).

- CDC COVID-19 Website: <https://www.sehealth.org/patients-visitors/covid-19-resource-center/>
- CDC COVID-19 Website: [Guidelines for Isolation Precautions](#)
- CDC COVID-19 Website: <https://www.cdc.gov/coronavirus/2019-ncov/index.html>
- CDC COVID-19 Frequently Asked Questions (FAQ's): <https://www.cdc.gov/coronavirus/2019-ncov/faq.html>
- OSHA COVID-19 Webpage: [https://www.osha.gov/SLTC/novel\\_coronavirus/](https://www.osha.gov/SLTC/novel_coronavirus/)
- OSHA Guidance Document [OSHA Guidance document 3990](#)

**All employed hospital staff are required to be vaccinated against COVID unless an exemption is granted by Occupational Medicine or Administration. If an employee is granted an exemption, they are required to wear a surgical mask while working. As always, appropriate hand hygiene, respiratory etiquette, and isolation practices are considered paramount for non-vaccine prevention measures. Per mandatory reporting, credentialed providers not employed by SoutheastHEALTH must complete a COVID form to document vaccination status and may be asked to produce proof of vaccination.**

## Assessment and Management of Pain

CMS requires hospitals to submit the Opioid eCQM (Electronic Clinical Quality Measure) to the IQR (Inpatient Quality Reporting) program. The data submitted will be publicly reported. This eCQM does more than tell the public about the hospital's prescribing practices. It may be used to improve patient care and do our part to reduce opioid addiction and overdoses. The measure looks at patients that are discharged with two prescriptions for opioids or an opioid/benzodiazepine at discharge.

The State of Missouri has joined the PDMP (Prescription Drug Monitoring Program) to review and limit the possibility of patients obtaining prescriptions from multiple providers.

Since 2018, we continue to review standards, and the hospital has established a multi-disciplinary team. The team is responsible for the oversight of pain management, safe opioid prescribing guidelines and data collection to monitor its performance.

The standard requires organizations to:

- Involve patients in developing their treatment plans and setting realistic expectations
- Provide ongoing education to staff and providers regarding safe and effective pain management.
- Screen patients for pain during their initial nursing assessment and when clinically required during ongoing periodic re-assessments. Assessments will be consistent with the patient's age, condition, and ability to understand. The following tools are available to assess pain:
  - For verbal patients able to self-assess pain, use the 0-10 numeric pain rating scale with 0 being no pain and 10 being severe pain (1-3 mild pain; 4-6 moderate pain; 7-10 severe pain).
  - For children/adolescents 3 years and older as well as non-verbal adults able to self-assess pain, use the FACES Pain Rating Scale (1-3 mild pain; 4-6 moderate pain; 7-10 severe pain).
  - For patients unable to communicate their level of pain, use the appropriate behavioral pain scale:
    - For non-critical care patients >18 years old, use the FLACC scale (1-3 mild pain; 4-6 moderate pain; 7-10 severe pain)
    - For critical care patients, use the CPOT scale (0-2 no pain; 3-4 moderate pain; 5-8 severe pain).

Our practice:

- As healthcare providers we shall be committed to pain management and respond quickly to reports of pain with evidence based pain management practices that incorporate both pharmacologic as well as non-pharmacologic modalities.
- Tools to assist with safe and effective pain management include the Prescription Drug Monitoring Program (link on the intranet) as well as assistance with referrals to outpatient opioid treatment programs (Social Services).
- All pain medications should be ordered with a clear indication for when to administer such as mild, moderate, or severe pain.
  - Duplication of therapy should be avoided. The following are procedures that will be followed unless otherwise indicated.
  - Multiple medications ordered with different routes for the same pain rating will be given in preferential order of oral -> IV -> IM.
  - Pain medication of different classes ordered for the same pain rating will follow the order of preference of acetaminophen 1<sup>st</sup>, NSAIDS 2<sup>nd</sup>, Opioids 3<sup>rd</sup> unless otherwise specified in the order.
  - New orders for the same medication class, same route, and same pain level will replace previous ones. (A new order for IV dilaudid for severe pain will replace an existing order for IV morphine for severe pain).
  - When orders are placed at the same time for the same medication class, same route, and same pain level, the order must be clarified with the prescriber (Morphine IV is ordered for severe pain as well as

## Assessment and Management of Pain (continued)

- Dilaudid IV for severe pain with no clear indication as to which one should be used first).
- Patients who are non-ventilated and receiving both supplemental oxygen and parenteral opioids (excluding procedural areas, emergency department, comfort measures only) will be considered at high risk for opioid induced respiratory depression. For these patients, capnography and the Pasero Opioid Induced Sedation Scale will be used as additional monitoring tools.
- Non-pharmacologic management or a combination of approaches as needed. Non-pharmacologic options may include physical therapy, Transcutaneous.
- Electrical Nerve Stimulation (TENS); massage, music therapy and heat or cold compresses.

### Education:

- Patient/family will be educated at discharge on:
  - Pain management plan of care,
  - Management of side effects, e.g. constipation, sedation, confusion etc.
  - Safe use, storage, and disposal of opioids if prescribed
  - Activities of daily living, including the home environment that might affect the pain management plan of care and strategies to address these issues
- Physicians will be involved in review of performance improvement data to assist with ongoing process changes and education

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## HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) was passed into law on August 21, 1996, and established standards for privacy of Individually Identifiable Health Information which is referred to as Protected Health Information (PHI). PHI is considered all individually identifiable information that is transmitted or maintained in electronic, paper, oral or any other form. It is created or received by the provider, health plan, employer, or health care clearinghouse; and it relates to the past, present or future physical or mental health care of the individual and can identify the individual.

Release of PHI is prohibited except for specific disclosures as outlined by the regulations such as to the individual; for treatment, payment or operations (TPO) with consent from the patient; and certain circumstances as specified such as to Business Associates. The Hospital has specific policies and procedures in place in accordance with HIPAA regulations; these can be accessed on the SoutheastHEALTH Compass. HIPAA violations should be reported to the Hospital's HIPAA Compliance Officer.

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## EMTALA

The Emergency Medical Treatment and Active Labor Act was passed to ensure access to emergency services regardless of the patient's ability to pay. The requirements of EMTALA are imposed on hospitals who participate in the Medicare program as a condition of participation. EMTALA requires that any hospital that provides emergency services perform a medical screening exam when a patient, or someone on a patient's behalf, requests examination or treatment for a medical condition. That screening exam determines whether the patient has an emergency medical condition. If an emergency medical condition exists, the hospital is required to stabilize the patient before discharge or transfer.

- If an individual comes to the Emergency Department for examination or treatment of a medical condition, then Southeast must provide an appropriate medical screening examination to determine if an emergency medical condition exists, and if one does, it must stabilize the emergency medical condition within its capabilities and capacity.
- An on-call physician who has been requested to come to the hospital to see a patient cannot refuse to come and the hospital cannot send the patient to the physician's office for examination. Both the hospital and the physician could be subjected to penalties for violating EMTALA including fines and exclusion from Medicare and Medicaid programs.
- EMTALA obligations end when a determination has been made that no emergency medical condition exists; when an individual is admitted to in-patient status; or when the patient is stabilized and appropriately transferred to another facility. EMTALA obligations do not end if a patient is placed on observation status.
- The organization is additionally EMTALA vulnerable for outside transfer requests regardless of ability to pay.
  - All transfer requests into the organization from outside facilities must be vetted through the Access Center to ensure EMTALA is not violated, and to ensure capacity and capability within the organization.

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## Mortalities

The public reporting of 30-day risk-standardized mortality measures is consistent with the priorities of Southeast Health, which aims to improve patient outcomes and reduce preventable mortality in patient care.

The publicly reported 30-day risk-standardized mortality measures include:

- Acute Myocardial Infarction (AMI)
- Chronic Obstructive Pulmonary Disease (COPD)
- Heart Failure (HF)



## Mortalities (continued)

- Pneumonia
- Stroke
- Coronary Artery Bypass Graft (CABG)

The Centers for Medicare & Medicaid Services (CMS) 30-day risk-standardized mortality measures assess a broad set of healthcare activities that affect patients' well-being. Patients who receive high-quality care during their hospitalizations and their transition to the outpatient setting will likely have better outcomes, such as survival, functional ability, and quality of life.

The rate of patient deaths in a hospital is shown as a mortality ratio that compares patients' actual mortality to their expected mortality.

The "observed-to-expected mortality" is a risk-adjusted measure of a hospital's mortality.

This ratio is created from two sets of numbers:

- **Observed mortality.** The rate of patient deaths in the hospital.
- **Expected mortality.** The expected average of hospitalized patient deaths with a particular illness or condition that are beyond the control of the medical center, such as age, gender and other medical problems.

The meaning of an O/E ratio depends on the score. A lower score is better.

- **Equal to 1.5.** The hospital's mortality is higher than expected.
- **Equal to 1.0.** The hospital's mortality is equal to what is expected.
- **Equal to 0.75.** The hospital's mortality is 25 percent lower than expected.

It is the expectation that practitioners document all patient problems and history so that appropriate Risk of Mortality (ROM) and Severity of Illness (SOI) scores are captured to demonstrate accurate Mortality Observed to Expected Ratio.

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## Antimicrobial Stewardship

Antimicrobial stewardship is rapidly becoming recognized as a necessary component of community health to achieve optimal patient outcomes. The overall purpose of stewardship is to optimize antimicrobial therapy while minimizing unintended consequences including toxicity, adverse drug events, and bacterial resistance. Appropriate selection of antibiotics for diagnosed indications will contribute to improved cure rates, reduced adverse events (i.e. drug induced renal insufficiency, *Clostridioides difficile* infections), and preserve the utility of our existing and limited antibiotic armamentarium.

Antimicrobial stewardship activities currently ongoing in Southeast Hospital include, but are not limited to, antibiotic restrictions; review and monitoring of patients on multiple antibiotics, duration of therapy longer than one week, and broad spectrum agents; and pharmacist-driven monitoring of renal dosing and IV to PO switches. Projects are also underway at select outpatient clinics to promote antimicrobial stewardship initiatives tailored to their specific needs.

There are several ways prescribers can embrace antimicrobial stewardship and preserve existing antibiotics. When prescribing antibiotics, prescribers should ensure the correct dose and duration of therapy is used for the infection being treated. Cultures should be ordered and reviewed to ensure optimal treatment. Finally, prescribers can look for opportunities to de-escalate empiric therapy and use the narrowest spectrum agent possible to treat the infection.

Please contact the Antimicrobial Stewardship Pharmacist at (573) 651-5536, with any questions.

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## Early Warning Signs of Change/Deterioration in Patient Condition/Rapid Response Team

Working in conjunction with Medical Staff, Southeast Hospital (SEH) has a protocol driven **rapid response team** which is available at all times to urgently identify and address warning signs of serious changes in patient's condition and when the physician should be contacted. Among the crises/concerns addressed by the Rapid Response Team are:

- Acute change in patient's condition
- Acute change in heart rate >130 or <45
- Acute change in systolic blood pressure <90
- Acute change in respiratory rate or shortness of breath
- Acute change in O<sub>2</sub> saturation
- Acute change in level of consciousness or mental status changes
- Chest Pain
- Suspected Stroke
- Seizure
- Staff member is worried about patient – Nursing concern "gut feeling"

In order to obtain a Rapid Response, call the operator at 5200.

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## Radiation Safety

Southeast Health has a Radiation Safety Program to ensure that uses of all sources of radiation are safe for hospital personnel, patients, and members of the public, and are in

## Radiation Safety (continued)

compliance with relevant regulations and standards, including from Nuclear Regulatory Commission, Department of Transportation, OSHA, Missouri Division of Radiological Health, and The Joint Commission.

Responsibility for the Radiation Safety Program is delegated to the Radiation Safety Officer (RSO), with oversight by Administration and The Radiation Safety Committee, which meets at least quarterly.

The Radiation Safety Officer for Southeast Hospital is Sam Hancock, PhD. Any questions or concerns about radiation safety can be addressed to him by phone or email.

### Personnel Monitoring of occupational exposure

The occupational exposure of hospital personnel, including employees, contract workers, and medical staff providers, who are deemed likely to receive >10% of the OSHA maximum permissible dose (MPD) is monitored using individually assigned radiation dosimeters. Dosimeters are collected monthly for processing and replaced by new dosimeters.

When not being worn, dosimeters must be stored in a radiation-free area that is accessible to staff assigned to monthly collection of dosimeters. Timely collection of all dosimeters is important for an effective radiation safety program. Please do not remove the dosimeters from the designated storage area or area of use.

During medical staff credentialing or re-credentialing, providers are asked to disclose their performance of procedures involving fluoroscopy. These possible radiation risks to these providers are then evaluated by the RSO, who may then assign appropriate dosimeters.

Those deemed appropriate for monitoring are assigned at least one dosimeter ("collar badge") that is worn in the neck area and outside any protective garments, such as a lead apron.

Those who are deemed at risk of receiving high doses to the collar dosimeter are also assigned a waist dosimeter. This dosimeter is worn under the lead apron at the front center of the waist. The use of dosimeters at both collar and waist locations allows the calculation of Effective Dose Equivalent (EDE) that takes into account the benefit of the protective garments. It is important to wear the two dosimeters correctly so that an accurate assessment of radiation risk can be obtained. While a collar dosimeter reading alone might exceed the MPD, the calculated EDE using an accurate waist dosimeter reading would be much lower. Improper wearing of the dual dosimeters can result in an apparent violation of the MPD, requiring an extensive investigation and report to OSHA.

Monthly reports of occupational exposure are posted on the Compass intranet site under Departments/ Radiation Safety/ Personnel Dosimetry Reports.

## ALARA

Southeast Health has a policy of maintaining occupational radiation exposures As Low As Reasonable Achievable (ALARA). As part of ALARA program, there are two thresholds that trigger investigation of an individual's occupational exposure. ALARA Level 1 = 10% and

### **Radiation Safety (Continued)**

ALARA Level 2 = 30% of the OSHA MPD. The RSO presents a quarterly report to the Radiation Safety Committee of the investigation of each individual who exceeds an ALARA threshold, and a determination is made whether to investigate further and/or take corrective action to address an identified problem.

### Use of Fluoroscopy

It has been well known since at least 1990 that lengthy fluoroscopic procedures can deliver a high radiation dose to the patient resulting in a deep non-healing ulcer from radiation damage. A more common, but still undesired, result of fluoroscopy is skin erythema at the site of beam entrance. These effects may not manifest until a period of weeks after the radiation exposure. In order to alleviate the risk of these sequelae, the radiation safety program includes the following provisions:

Providers identified as fluoroscopy users are provided instruction in basic radiation safety and personnel dosimetry during Medical Staff orientation. In addition, some practical guidelines for radiation safety of patients and staff are available in the online Medical Staff Guidelines in the Compass intranet site. Providers may at any time request additional information, training, or education on specific ionizing radiation producing equipment used or techniques to reduce radiation dose from the Radiation Safety Officer, member of the Radiation Safety Leadership team, Radiation Safety Committee, or equipment vendor. For each fluoroscopic procedure, hospital staff will monitor and record an indicator of patient radiation dose appropriate for the specific equipment. For each case in which a predetermined skin dose threshold is exceeded, a further review and/or patient evaluation will be done to assess for adverse radiation effects, as specified in the policy "Fluoroscopy Dose Management." These cases are then reviewed by the RSO and the Radiation Safety Committee. Performing providers may receive a request for additional information or be provided follow up by the RSO, contracted medical physicist, and/or Radiation Safety Committee on methods to reduce radiation dose and minimize potential for radiation induced injuries for reviewed case(s).

### Nuclear Medicine

Users of radionuclides are physicians who are authorized by the Nuclear Regulatory Commission for specific radionuclides, chemical and physical forms, and types of use. To be deemed an Authorized User by the NRC, the Southeast Hospital RSO must submit a license amendment application to the NRC. If approved, the Authorized User is then listed on the Southeast Hospital NRC license.

The Southeast Health NRC License and license conditions are available for viewing on the Compass intranet site under Departments/ Radiation Safety/ NRC License. The NRC regulations can be accessed at NRC.gov under Basic References/ Statutes and Regulations.

## Radiation Safety (continued)

### Pregnant Radiation Workers

The maximum permissible dose for occupational exposure of a fetus/embryo is much lower than for exposure of an adult, because of a much higher radiosensitivity of the rapidly growing tissues of a fetus. For a pregnant radiation worker, some work restrictions may be indicated for protection of the fetus. Most employees, however, would not need any changes to their work activities. In order for the Hospital to consider possible restrictions, and to initiate monitoring of the occupational exposure of the fetus, the employee must declare her pregnancy in writing, as specified in the policy "Pregnant Radiation Workers" which contains forms for declaration of pregnancy. For legal reasons, Hospital management cannot take any action based on an assumption of pregnancy.

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## Magnetic Resonance Imaging (MRI)

MRI represents a high-risk environment and requires specific safety practices and annual education to ensure optimal patient and personnel protection.

MRI uses a strong magnetic field and radio waves to create an image. The magnetic field surrounding the scanner can be dangerous if certain precautions are not taken. Inside the scan room, the magnetic field can attract ferromagnetic objects so strongly that they become a potentially lethal projectile. Such a projectile into the bore of the magnet can cause serious injury to the patient. Many common tools and objects present a projectile hazard in zone 4, for example stethoscopes, scissors, floor buffers, and wheel chairs. All items brought into zone 4 must be designated MRI safe.

It's important to know that the magnet is always on, even when not in use. An object such as a floor buffer can fly into the bore of the magnet and require extensive down time to quench the magnet so that the object can be removed.

Consumer products such as pagers, cell phones, cameras and analog watches may be damaged by the magnetic field. Pacemakers may be reprogrammed or turned off by the magnetic field. The magnet field erases credit cards with magnetic strips. Patients with ferrous intra-cranial vascular clips may be at risk due to the possible movement of the clip.

For safety purposes, the MRI suite is divided into zones.

- Zone 3 is the patient holding area and control room. No one is permitted access to zone 3 except under supervision of MRI staff.
- Zone 4 is the scan room, where hazards are greatest. NO ONE, EVEN IN A MEDICAL EMERGENCY) IS ALLOWED ENTRY TO ZONE 4 UNTIL BEING SCREENED BY MRI STAFF FOR METALLIC OBJECTS.

In the case of a medical emergency, first responders must not enter zone 4 without permission from the MRI staff and without first removing all metallic objects from their person.

The radio-frequency field may induce currents in wires that are adjacent or on the patient, causing skin burns. It may induce currents in intra-cardiac leads, resulting in inadvertent cardiac pacing.

### Cardiac Implanted Electronic Devices (CIED) devices

Patients with a CIED require special precautions as per policy, *MRI Policy for Patients with Cardiac Implanted Electronic Device (CIED) Devices*.

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## Practitioner Health and Culture of Safety

The Joint Commission (TJC) requires the Medical Staff to implement a process for identification and management of matters concerning individual practitioner health and behavior, separate from a disciplinary function. Every staff member, regardless of their position, has the responsibility to report any condition or behavior that has the potential to undermine our culture of safety within the hospital and/or adversely affect patient safety.

The Medical Staff Culture of Safety Policy may be found at the following website, under the Policy tab:

<https://www.sehealth.org/healthcare-professionals/for-physicians/medical-staff-guidelines>

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## Additional Information for Physicians

The Missouri State Medical Association has provided a confidential assistance and advocacy program for physicians, through the Missouri Physician's Health Program (MPHP). The MPHP provides necessary treatment resources to physicians in need of **Additional Information for Physicians (continued)**

support and facilitates the physician's return to health and safe professional functioning. The program is also available to spouses and families of Missouri physicians.

The MPHP hotline, (800) 274-0933, is a valuable and strictly confidential resource to address issues including substance abuse, mental health, physical illness and more. For more information, please visit [www.thempHP.org](http://www.thempHP.org), or contact the Chief Medical Officer.

## Maternal Safety

### Hemorrhage Procedure

- A hemorrhage cart will be available with a checklist and supplies
- Hemorrhage kits with emergency medication will be available for vaginal and C-section deliveries
- Active management of 3<sup>rd</sup> stage labor will include Pitocin administration for each delivery
- Part or all of the massive transfusion protocol will be implemented per physician discretion
- Hemorrhage risk will be assessed on admission and after delivery on each delivery
- Debriefs will occur to review process and workflows

### Preeclampsia Procedure

- All OB patients will have BP's monitored
- Toxemia work-ups will include lab work, serial BP's, and Fetal Heart Monitoring
- Magnesium sulfate will be available for prophylaxis against or for treatment of eclampsia
- Maternal-Fetal Medicine will be available on-site once a week, telemedicine once a week, or over the phone for consultation
- Patients with a hypertension complication will be scheduled for a blood pressure check follow-up appointment 1-2 weeks after discharge
- Debriefs will occur to review process and workflows

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## Transitional Care Department

The Transitional Care Department is responsible for assessment, transitional planning, and coordinating of patient care across the continuum. The Transitional Care Department works collaboratively with the multidisciplinary healthcare team, patients, and families to coordinate a smooth transition from one level of care to another, assisting in coordinating community resources to successfully manage the care of the patient in a post-acute environment.

### Team:

- Transitional Care Guide
- Transitional care Specialist (RN)
- Diabetes Educator
- Pulmonary Disease Navigator

### Types of Services:

- Interdisciplinary communication and care coordination in collaboration with Case Management.
- Assessment to address patient needs and coordinating resources.

- Verifying referrals to community and services including home care, palliative care and post-acute care.
- Motivational interviewing to determine patient perspective and goals for post discharge.
- Provide intensive disease specific education for diabetes and COPD
- Reinforcing care and discharge/transition instructions with patient, family, and care givers.
- Provide follow-up and telephone support of discharge plan for 30-60 days post-discharge based on patient needs.

The Transitional Care team may be reached at 573-331-6899.

### Background:

The Hospital Readmissions Reduction Program (HRRP) is a Medicare value-based purchasing program that encourages hospitals to improve communication and care coordination to better engage patients and caregivers in discharge plans and, in turn, reduce avoidable readmissions. The program supports the national goal of improving health care for Americans by linking payment to the quality of hospital care.

CMS includes the following six condition or procedure-specific 30-day risk-standardized unplanned readmission measures in the program:

- Acute myocardial infarction (AMI)
- Chronic obstructive pulmonary disease (COPD)
- Heart failure (HF)
- Pneumonia
- Coronary artery bypass graft (CABG) surgery
- Elective primary total hip arthroplasty and/or total knee arthroplasty (THA/TKA)

CMS calculates the payment reduction and component results for each hospital based on its performance during a rolling performance period. The payment adjustment factor is the form of the payment reduction CMS uses to reduce hospital payments. Payment reductions are applied to all Medicare fee-for-service base operating diagnosis-related group payments during the FY (October 1 to September 30). The payment reduction is capped at 3 percent (that is, a payment adjustment factor of 0.97).

### Readmission Reduction Efforts:

Southeast Health began readmission reduction efforts in 2015. The continued work of the committee resulted in the implementation of following evidence based initiatives:

- Modified LACE for readmission risk assessment (completed by Case Management)
- Scheduling of discharge follow up appointments according to risk score prior to patient's discharge
  - Low risk – Appointment within 14 business days

## Transitional Care Department (continued)

- Moderate risk - Appointment within 5-7 business days
  - High risk – Appointment within 48 hours of discharge (during business hours)
  - Complex – Appointment within 48 hours of discharge (during business hours)
- Automatic Nutrition and Pharmacy referrals for high/complex risk patients
- Development and Implementation of Transitional Care Department – providing support to patients pre and post discharge
  - High and Complex risk patients trigger a Transitional Care Consult – this consult may also be entered manually by providers
- Development and Implementation of the Community Based Palliative Care program – Consults are initiated by provider and Transitional Care referrals
- Development and Implementation of the Inpatient Palliative Care program- Consults are initiated by a provider order
- Development and implementation of the Pulmonary Disease Navigator
- Routine oral hygiene
- Development and implementation of the “Patient Care Coordination across the Continuum” policy. (this policy includes a Care Coordination Agreement and requires the signature of medical staff)
- Disease specific efforts for COPD/PN
  - Improved oral hygiene practices
  - Pulmonary Disease Navigator
  - Early diagnosis
  - Patient/family engagement
    - Increasing referrals for pulmonary rehab
  - Standardized education across inpatient and outpatient settings

## Primary Stroke Center

Southeast Hospital has been designated by The Joint Commission as a Primary Stroke Center since October 2007. We have also been recognized by the State of Missouri Time Critical Diagnosis system as a Level II Stroke Center since 2015.

- Patients suspected of having a stroke or TIA should be placed on the designated stroke unit (4East/Neurology or ICU) unless the patient has a more pressing medical issue requiring care on a different specialty unit.
- The appropriate evidence-based stroke order set should be utilized for patients suspected of having an ischemic or hemorrhagic infarct or a TIA.
- Stroke clinical practice guidelines can be accessed and viewed on the Southeast Health intranet
- All stroke and TIA patients are monitored for the following Joint Commission performance measures by Quality Management and reported monthly:
  - CSTK-01: NIHSS upon arrival

- STK-1: DVT prophylaxis by end of Day 2
- STK-2: Discharged on antithrombotic therapy
- STK-3: Patients with active or a history of atrial fibrillation/flutter received anticoagulation therapy at discharge
- STK-4: t-PA considered and administered if eligible
- STK-5: Antithrombotic medication by end of Day 2
- STK-6: Discharged on statin medication
- STK-8: Stroke education, which must include:
  - Activation of EMS
  - Follow-up after discharge
  - Medications prescribed at discharge
  - Risk factors for stroke
  - Warning signs and symptoms of stroke
- STK-10: Assessed for rehabilitation
- Smoking Cessation Counseling at or by DC
- Dysphagia screen before any food, fluid or medication
- STK-OP1: Door to transfer to another hospital from the ED

## Palliative Care

SoutheastHEALTH offers both Inpatient and Community-based palliative care services.

**Palliative care** focuses on expert assessment and management of pain and other symptoms, assessment and support of caregiver needs, and coordination of care. Palliative care attends to the physical, functional, psychological, practical, and spiritual consequences of a serious illness. It is a person- and family-centered approach to care, providing people living with serious illness relief from the symptoms and stress of an illness. Through early integration into the care plan for the seriously ill, palliative care improves quality of life for the patient and the family.

### Palliative care is:

- Appropriate at any stage in a serious illness, and it is beneficial when provided along with treatment of curative or life-prolonging intent.
- Provided over time to patients based on their needs and not their prognosis.
- Focused on what is most important to the patient, family, and caregiver(s), assessing their goals and preferences and determining how best to achieve them.
- Interdisciplinary to attend to the holistic care needs of the patient and their identified family and caregivers.

## Palliative Care (continued)

### SoutheastHEALTH General Guidelines and Referral Criteria for Palliative Care

Must be 18 years of age or older and have the **presence of a serious illness** and one or more of the following:

- a. New diagnosis of life-limiting illness for symptom control, patient/family support
- b. Decline in function, feeding intolerance, or unintended decline in weight (failure to thrive)
- c. Progressive metastatic cancer in patients not being followed by a SoutheastHEALTH Oncologist
- d. Two or more hospitalizations for the same illness within 90 days
- e. Difficult to control physical or emotional symptoms
- f. Patient or family psychosocial or spiritual distress
- g. Patient, family or physician request for information regarding hospice appropriateness
- h. Uncertainty or conflicts regarding the use of non-oral feeding/hydration in cognitively impaired, seriously ill or dying patients
- i. Chronic home oxygen use, high liter flow O2 (10L or greater) or Bipap/home ventilator
- j. Two episodes aspiration pneumonia within the last 6 months
- k. Team/patient/family needs help with complex decision making and determination of goals of care (examples might include: decisions regarding chemo therapy, dialysis, surgery, etc.).
- l. Prolonged or failed attempt to wean ventilator
- m. Multi-organ failure
- n. Consideration of ventilator withdrawal and other life sustaining treatment with expected death
- o. Anoxic encephalopathy
- p. Coma lasting more than 2 weeks.

A serious illness might include the following:

- |                       |                         |
|-----------------------|-------------------------|
| - ALS                 | - Kidney disease        |
| - Alzheimer's Disease | - Leukemia and Lymphoma |
| - Cancer              | - Liver disease         |
| - COPD                | - Multiple Myeloma      |
| - CHF                 | - Parkinson's disease   |
| - Dementia            | - Stroke                |

Inpatient Palliative Care Team consists of 2 full-time APRNs. APRNs in collaboration with physician(s) provide a spectrum of services for adult patients.

Examples of services provided:

- Goals of Care discussions
- Advanced Care Planning
- Education on Advanced Directives and Durable Power of Attorney for Healthcare

- Disease education for patient and family members
- Coordination of complex medical care
- Ethics Committee participation
- Guardianship discussions
- Frailty determination
- Morbidity and Mortality risk scoring
- Tracheostomy/PEG tube discussions
- Hospice discussions
- End-of-Life discussions
- Discontinuation of Life Support discussions
- Emotional support for patient, family members, and interdisciplinary team members

**The Inpatient Palliative Care team can be reached at 573-519-4979.**

Community-based Palliative Care Team consists of 3.3 APRNs, 1 Full-time LPN, Social Worker, and Spiritual Counselor, as needed.

The Community-based palliative care team in collaboration with physician(s) provide a spectrum of services for adult patients.

Goals of services provided:

- To be in the home treating and educating patients, and their family members, regarding chronic disease
- Decrease ED visits and recurrent hospitalizations
- Improved communication between patient, PCP, specialists, and other patient services
- Ongoing goals of care discussions
- Advanced Care Planning
- Education on Advanced Directives and Durable Power of Attorney for Healthcare
- Disease education for patient and family members
- Coordination of complex medical care
- Hospice discussions
- End-of-Life discussions

**The Community-based palliative care team's service area consists of a 50-mile radius from Cape Girardeau and includes all of Cape Girardeau, Scott, Perry, Bollinger, and Stoddard counties and portions of Mississippi and New Madrid counties.**

**\*Provide 24/7 on-call coverage for patients and families.**

**The Community-Based Palliative Care team can be reached at 573-331-6898.**



# Palliative Care & Hospice Services Side by Side



Palliative Care	Hospice Care
<ul style="list-style-type: none"> <li>•Palliative Care can be initiated at any stage of a chronic illness</li> <li>•Palliative Care is for patients still <b>aggressively seeking treatment(s)</b></li> <li>•A Nurse Practitioner visits in your home every 4-6 weeks. Sometimes more often. They are on-call for you 24/7.</li> <li>•Insurance pays for the Nurse Practitioner to visit. There are special cases where insurance will pay for a social work visit as well</li> <li>•Palliative Care is covered under Medicare Part B</li> </ul>	<ul style="list-style-type: none"> <li>•We "wouldn't be surprised" if the patient passed in six months +/-</li> <li>•Decision made to no longer seek aggressive treatment(s). All care comes to you in your home.</li> <li>•Nurses are on-call 24/7 for you and your family's needs. A Nurse Practitioner &amp; Physician are always on-call as well and may visit you.</li> <li>•Nurses visit 2-3 times per week +/- . A Nurse Assistant may visit to assist with bathing/showering. A Social Worker &amp; Chaplain are also available to visit.</li> <li>•Hospice is covered under Medicare Part A</li> </ul>
<ul style="list-style-type: none"> <li>•Palliative Care &amp; Home Health can both treat you simultaneously</li> </ul>	<ul style="list-style-type: none"> <li>•With hospice you are not typically going out to physician visits or returning to the hospital without first speaking with hospice. The hospice nurse is on call 24/7 and can typically help manage any need that arises.</li> </ul>
<ul style="list-style-type: none"> <li>•Visits are charged the same as going to an office visit with another provider in their office; while we are coming to your home</li> </ul>	<ul style="list-style-type: none"> <li>•Visits, medications and equipment needed to assist you &amp; your family are provided <u>free of charge</u> to you (with a few exceptions). And we do not stop EVERY medication. It's not just about pain medicines anymore.</li> </ul>
<ul style="list-style-type: none"> <li>•There are no respite services available with Palliative Care</li> </ul>	<ul style="list-style-type: none"> <li>•Respite care is available to your family up to 5 days per month, free of charge to the family</li> </ul>
<ul style="list-style-type: none"> <li>•There are not bereavement services or volunteers provided</li> </ul>	<ul style="list-style-type: none"> <li>•Bereavement counseling is provided free of charge to you. Your family is able to receive bereavement services for 13 months after you pass away.</li> </ul>
<ul style="list-style-type: none"> <li>•Palliative Care requires a signed physician or APP's order to initiate services and the Palliative Care provider serves in a consult capacity. We help communicate your condition and needs to your other providers. We help co-manage your symptoms.</li> </ul>	<ul style="list-style-type: none"> <li>•Hospice requires a signed physician's order to initiate services. The Hospice provider typically serves as your Primary Care Provider, but there are times when your existing Primary Care Provider may continue to be your provider. (We just need to discuss this with Hospice and your PCP)</li> </ul>