# PROVIDER EDUCATION MATERIALS

## Table of Contents

- Antimicrobial Stewardship
- Corporate Compliance
- EMTALA & ER-On-Call Policy
- Facts You Should Know About MidMichigan Health
- Influenza Education

- Infection Prevention
  - Health Care Associated Infection (HAI)
  - Hand Hygiene
  - Foley Catheter Associated Urinary Tract Infections (CAUTI)
  - Surgical Site Infection Prevention
  - Central Line Associated Blood Stream Infection (CLABSI)
  - Immunizations

- Professionalism Policy

- Provider Education Information
  - Anticoagulation
  - Pain
  - Restraints & Seclusion
  - Role in an Emergency

- Provider Well Being

- Sedation / Analgesia

- Tobacco Smoke Free Environment

- Waived Testing
Antimicrobial Stewardship
Antimicrobial Stewardship

An Antimicrobial Stewardship Program (ASP) is defined as an ongoing and systematic effort to optimize the use of antimicrobial medicines within a health service organization. The key objectives are to reduce inappropriate antimicrobial use, improve patient care outcomes, and mitigate adverse consequences of antimicrobial use (such as antimicrobial resistance, preventable patient harm, and unnecessary costs associated with pharmaceutical expenses and drug-resistant infections).

The MidMichigan Health ASP Committee is a multidisciplinary team responsible for the development and ongoing evaluation of the ASP program. Core membership on this committee consists of infectious disease physician(s), physicians, limited independent practitioners, clinical pharmacists, infection control nurses, clinical microbiology, information technology, education, and nursing. The physician champions review the ASP activities and provide guidance on the development of any therapeutic guidelines, policies or other measures based on the best evidence of practice.

The Department of Pharmacy will:

- Provide concurrent, prospective, and retrospective review of antimicrobial use
- Review and recommend initial dosing (based on weight, renal functioning, and kinetics)
- Recommend appropriate antibiotic selection based on daily positive cultured reports
- Review dosage, route, and frequency of prescribed antimicrobials for appropriateness for the individual patient as well as the site and type of infection
- Review length of therapy of all antibiotics
- Distribute antibiogram annually to help guide physicians’ empiric therapy selections
- Work with Information Technology and physicians to help drive Physician Order Entry on recommendations based on evidence-based guidelines
- Work with physicians on the Infection Control Committee and the Pharmacy and Therapeutics Committee to establish appropriate guidelines for use of antimicrobials
- Contact physicians as necessary to communicate any of the above recommendations regarding individual patient care

Infection control nurses play an important role in the assessment and education of infection-related issues. These nurses are instrumental in enacting prevention guidelines, establishing criteria for contact precautions, and ensuring handwashing compliance. They work in conjunction with environmental services to institute appropriate environmental decontamination as well.

Clinical microbiology provides key information on local antimicrobial susceptibility and resistance patterns in the hospital by reviewing the antibiogram.
Additional activities that are applicable to antimicrobial stewardship include, but are not limited to, the surveillance for multi-drug resistant organisms, institution of isolation protocols, monitoring of antimicrobial sensitivity patterns and length of treatment, and the development of appropriate antimicrobial use criteria. The ASP Committee reports to the Pharmacy and Therapeutics Committee along with the Infection Control Committee.

The Principles of Antimicrobial Prescribing

All prescribers at MidMichigan Health are expected to prescribe antimicrobial therapy according to the following key principles:

- Therapeutic decisions regarding antimicrobial prescriptions will be based on best available evidence
- Empirical antimicrobial therapy (the infective pathogen is not known) or prophylactic therapy (given to prevent acquisition or development of infection) is prescribed according to CDC, IDSA, SHEA, and ASHP guidelines
- When the infective pathogen is known, antimicrobials are to be prescribed according to microbiology results and antimicrobial susceptibilities when available
- Prescribed antimicrobials will be of the narrowest spectrum possible for achieving the intended effect
- Dosage, route, and frequency of prescribed antimicrobials will be appropriate for the individual patient as well as the site and type of infection
- The duration of antimicrobial therapy will be defined and/or regularly reviewed (based on evidence-based guidelines and clinical improvement)
- Monotherapy is used in most indications where clinically appropriate

A list of antimicrobial formulary items is available on the MidMichigan Health intranet. Non-formulary antimicrobials are those not routinely stocked by MidMichigan Health. The use of a non-formulary product for an individual patient requires application to and approval by the Pharmacy and Therapeutics Committee; however, this process may be expedited for urgent antimicrobial therapy. Requests for non-formulary antimicrobials will usually require consultation by the infectious diseases/intensivist team prior to approval or as a condition of approval. The implementation and maintenance of antimicrobial restrictions is a core ASP strategy at MidMichigan Health as outlined in the Restricted Antimicrobial Drugs Policy. Specific monitoring activities will be undertaken according to the needs and risk assessment performed for MidMichigan Health by the Antimicrobial Stewardship Team.

Contact Information:

<table>
<thead>
<tr>
<th>Dr. David Santini</th>
<th>Dr. Atul Kapoor</th>
<th>Carol LaLonde, PharmD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Medicine</td>
<td>Hospital Medicine</td>
<td>Antimicrobial Stewardship Pharmacist</td>
</tr>
<tr>
<td><a href="mailto:david.santini@midmichigan.org">david.santini@midmichigan.org</a></td>
<td><a href="mailto:atul.kapoor@midmichigan.org">atul.kapoor@midmichigan.org</a></td>
<td><a href="mailto:carol.lalonde@midmichigan.org">carol.lalonde@midmichigan.org</a></td>
</tr>
<tr>
<td>Dr. Utibe Effiong</td>
<td>Dr. David Jordahl</td>
<td>Chelsey Bruski, PharmD</td>
</tr>
<tr>
<td>Mt. Pleasant Internal Medicine</td>
<td>Family Medicine</td>
<td>Pharmacist Supervisor</td>
</tr>
<tr>
<td>Ambulatory Antimicrobial Stewardship</td>
<td>Ambulatory Antimicrobial Stewardship</td>
<td><a href="mailto:chelsey.bruski@midmichigan.org">chelsey.bruski@midmichigan.org</a></td>
</tr>
<tr>
<td><a href="mailto:utibe.effiong@midmichigan.org">utibe.effiong@midmichigan.org</a></td>
<td><a href="mailto:david.jordahl@midmichigan.org">david.jordahl@midmichigan.org</a></td>
<td></td>
</tr>
<tr>
<td>Tiantaya Perry, PharmD</td>
<td>Tammy Costigan, PharmD</td>
<td></td>
</tr>
<tr>
<td>Antimicrobial Stewardship Pharmacist</td>
<td>Antimicrobial Stewardship Pharmacist</td>
<td><a href="mailto:tammy.costigan@midmichigan.org">tammy.costigan@midmichigan.org</a></td>
</tr>
<tr>
<td><a href="mailto:tiantaya.perry@midmichigan.org">tiantaya.perry@midmichigan.org</a></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Antibiotic-resistant bacteria cause more than 2 million illnesses and at least 23,000 deaths each year in the United States. Antibiotic resistance occurs when germs no longer respond to the drugs designed to kill them. Inappropriate prescribing of antibiotics contributes to antibiotic resistance and is a threat to patient safety.

Healthcare Providers Can:

- **Prescribe correctly**
  - Avoid treating viral syndromes with antibiotics, even when patients ask for them.
  - **Pay attention to dose and duration:** The right antibiotic needs to be prescribed at the right dose for the right duration.
  - Be aware of antibiotic-resistance patterns in your area so that you can always choose the right antibiotic.
  - Hospital and nursing home providers should reassess within 48 hours of starting the antibiotic, when the patient’s culture results come back. Adjust the prescription, if necessary. Stop the prescription, if indicated.

- **Collaborate with each other and with patients**
  - Talk to your patients about appropriate use of antibiotics.
  - Include microbiology cultures, when possible, when ordering antibiotics.
  - Work with pharmacists to ensure appropriate antibiotic use and prevent resistance and adverse events.
  - Use patient and provider resources offered by the Centers for Disease Control and Prevention (CDC) and professional organizations such as Society for Healthcare Epidemiology.

- **Stop the spread**
  - Follow hand hygiene and other infection control measures with every patient.

- **Embrace antibiotic stewardship**
  - Improve antibiotic use in all facilities—regardless of size—through stewardship interventions and programs, which will improve individual patient outcomes, reduce the overall burden of antibiotic resistance, and save healthcare dollars.
  - Recognize and participate in CDC’s Get Smart About Antibiotics Week initiatives.
Inpatient Settings

• Overuse of antibiotics creates an unnecessary risk for adverse drug events, such as Clostridium difficile infection, a sometimes deadly diarrhea.
• Antibiotic resistance adversely impacts the health of millions of hospitalized patients every year.
• Some infections in hospitals are now resistant to all available antibiotics.
• About **40% of the patients receiving antibiotics** receive unnecessary or inappropriate therapy.

Outpatient Settings

• Each year, millions of antibiotics are prescribed unnecessarily for viral infections.
• Antibiotics can cause adverse drug events and promote antibiotic resistance.
  – There are more Clostridium difficile infections in places with more antibiotic use.
  – Antibiotic use in primary care is associated with antibiotic resistance at the individual patient level.
• Antibiotics cause **1 in 5 emergency department visits** for adverse drug events and are the most common cause of emergency department visits for adverse drug events in children.

**For more information, visit CDC’s Get Smart program website:**
Get Smart Resources for Healthcare Providers
http://www.cdc.gov/getsmart/week/educational-resources/hcp.html

**Centers for Disease Control and Prevention**
For more information, please contact Centers for Disease Control and Prevention.
1600 Clifton Road N.E., Atlanta, GA 30333
Telephone: 1-800-CDC-INFO (232-4636)/TTY: 1-888-232-63548
Email: getsmart@cdc.gov Web: www.cdc.gov/getsmart
Corporate Compliance Overview & Reporting Policy
Applicability

- MidMichigan Health and all its wholly owned subsidiaries

Purpose

It is the policy of MidMichigan Health and its subsidiaries that its employees conduct themselves in an ethical manner and carry out the responsibilities of their position in full compliance with all federal, state, and local laws and regulations as well as MidMichigan internal policies and procedures. MidMichigan Health has adopted a formal Corporate Compliance Program that details the framework for legal and ethical compliance by MidMichigan Health, its subsidiaries, employees, and associated third parties¹. This policy is an overview of the program with emphasis on reporting. Please see the full Corporate Compliance Program document in the Policy Section (Appendix A) and other Compliance policies for more information.

Policy

APPENDIX A
MIDMICHIGAN HEALTH CORPORATE COMPLIANCE PROGRAM

INTRODUCTION

*Through their skill, integrity and compassion, employees have helped establish MidMichigan’s reputation of providing "a lifetime of trusted care." We strive to do the right things, in the right ways, with the right intentions.*

MidMichigan Health and its subsidiaries are committed to conducting business in an ethical manner and in full compliance with all applicable federal, state and local laws and regulations. MidMichigan Health has an ongoing commitment to ensure that its affairs are conducted in accordance with both the letter and spirit of applicable laws and regulations (including regulations such as the False Claims Act and the whistleblower provision therein). MidMichigan Health requires its employees to exercise good judgment and to conduct
**COMMITMENTS**

MidMichigan Health is an organization whose mission is to provide excellent health services to improve the quality of life for people in our communities. In order to meet its mission, MidMichigan Health and all officers, employees, and agents agree to abide by the following:

1. To the community, MidMichigan Health is committed to the promotion of good health and to using its resources to satisfy the needs of the community while operating all subsidiaries in an ethical and financially responsible manner.

2. To the organization's employees, MidMichigan Health is committed to the implementation and maintenance of employment practices and programs that comply with federal and state laws. Management will take responsibility for compliance in their areas.

3. To its patients, the organization is committed to providing quality healthcare that is responsive to patient needs and complies with the law. The hospitals are also committed to maintaining accreditation by the Joint Commission and/or other accrediting organizations.

4. To third-party payers, the organization is committed to timely and accurate billing for inpatient, outpatient, and all other services. It is also committed to legal and appropriate reporting of all reimbursable costs to government and other third-party programs.

5. To our suppliers, this organization stresses a sense of mutual responsibility that enables it to be a good customer and commits to fair and equitable bidding practices.

6. To all who do business with MidMichigan Health, the organization commits to conducting business in a manner that is consistent with its 501(c)(3) status and all other applicable laws and regulations.

**RULES OF CONDUCT**

At all times, employees are expected to exercise good judgment and common sense in their association with other people on the job, conduct themselves in an ethical manner and carry out the responsibilities of their position in full compliance with all applicable federal, state and local laws and regulations, as well as MidMichigan Health and its subsidiaries' internal policies and procedures.

Associated third parties are expected to conduct themselves in an ethical manner and in full compliance with
all applicable federal, state and local laws and regulations, as well as MidMichigan Health and its subsidiaries’ applicable internal policies and procedures.

MidMichigan Health and its subsidiaries will exercise due care in hiring and promoting individuals that will abide by all federal, state and local laws and regulations as well as internal policies and procedures. MidMichigan Health and its subsidiaries will not hire or place individuals in a position with substantial discretionary authority that it knew or should have known through the existence of due diligence, had a propensity to violate the law.

Employees found to be knowingly conducting business in a manner that is not in compliance with appropriate federal, state or local laws and regulations or MidMichigan Health or its subsidiaries’ internal policies will be subject to disciplinary action up to and including discharge.

**ADMINISTRATIVE RESPONSIBILITY**

Primary responsibility for implementing and managing the MidMichigan Health Corporate Compliance Program is that of the Corporate Compliance Officer (CCO). The CCO is also the Director of Internal Audit. The Corporate Compliance Task Force also plays an integral part in the Compliance Program. The CCO reports directly to the Senior Vice President & CFO and the Audit Committee of MidMichigan Health. The CCO may delegate compliance program responsibilities as he/she deems necessary and appropriate. MidMichigan Health corporate departments of Internal Audit and Quality/Risk Management will work in conjunction with the CCO, and appropriate administrators and managers on monitoring, conducting audits, and reviews which affect compliance within MidMichigan Health.

A Corporate Compliance Task Force has been appointed to assist the CCO, as requested, in the further development, implementation and monitoring of the Corporate Compliance Program. The Chairperson of the Corporate Compliance Task Force is the CCO. The CCO shall determine the composition of the Corporate Compliance Task Force. The members of the Task Force will have knowledge of individual subsidiary operations and/or hold positions of responsibility within departments which functions are subject to legal and regulatory compliance.

Administrators, managers and supervisors are responsible for the development of policies that address specific legal and/or regulatory requirements relevant to their department.

**RESPONSIBILITIES OF CORPORATE COMPLIANCE OFFICER**

The CCO, or his/her designee, will perform the following activities:

- Assist in the review, revision, and formulation of appropriate policies and procedures that will meet the objectives of the Corporate Compliance Program to guide MidMichigan Health employees and associated third parties in compliance activities;
- Develop the mechanisms to administer those policies and procedures and to evaluate their effectiveness;
- Identify potential compliance vulnerability;
- Monitor areas of high risk of unlawful activities;
- Ensure that employees are educated in the compliance program, specific policies and procedures, and the legal requirements relevant to their work;
- Ensure that all employee calls (to the Hotline or otherwise) regarding detected or alleged violations are investigated, including tracking and resolution of each complaint;
- Measure activities related to the Corporate Compliance Program and report data to the appropriate staff.
or governing bodies;
• Respond, in conjunction with legal counsel, to external agency requests regarding compliance issues;
• Review departmental and administrative implementation plans regarding compliance policies;
• Appoint and monitor the Corporate Compliance Task Force;
• Identify specific compliance objectives; and
• Annually review the existing Corporate Compliance Program in order to identify the need for changes.

DEPARTMENT COMPLIANCE POLICIES

The Corporate Compliance Program applies to all MidMichigan Health subsidiaries and departments. Persons in leadership positions in the subsidiary departments must endorse and encourage employee and associated third parties’ adherence to the corporate program. Every department will augment the Corporate Compliance Program, as appropriate, with policies that address specific legal and/or regulatory requirements relevant to their department.

EDUCATION AND TRAINING

The CCO shall be ultimately responsible for ensuring that the Corporate Compliance Program and appropriate MidMichigan Health policies concerning compliance are disseminated and understood. To accomplish that objective, the CCO will be responsible for presenting the Corporate Compliance Program to the appropriate administrative areas within MidMichigan Health. In addition, the CCO will work with appropriate department and administrative personnel to ensure that there are systematic and ongoing training programs that educate and maintain awareness of the Corporate Compliance Program and compliance policies among existing and newly obtained employees and associated third parties. Information on the program, including the existence of the Hotline, will be presented at the new employee orientation of MidMichigan Health.

Education materials and training on the Corporate Compliance Program will be provided to all employees annually. The training programs will be designed to review the compliance program and to delineate with specific employees any changes in current policies that effect their specific position. Some employees may be required to attend additional training sessions of particular issues that are relevant to their job responsibilities.

Administrators, managers and supervisors are responsible for training of their employees on policies and procedures that address specific legal and/or regulatory requirements relevant to their department. Failure to participate and document annual participation in this compliance education will result in, at a minimum, documentation on the employees’ performance evaluation and possible restrictions on the employees’ job duties.

All training session attendees will be provided with information on who to contact for specific questions.

MONITORING

The CCO shall establish a schedule to monitor MidMichigan Health’s performance with specific compliance issues. Reviews of various compliance issues, based on risk assessment, will be scheduled. The review will be a limited audit, generally conducted through a random sampling, of the specific compliance issue being monitored. Annually, the CCO will present a plan of compliance issues for review to the President & CEO and the Audit Committee.

The CCO, the Corporate Compliance Task Force, and other departmental and administrative leadership should identify areas which require review and monitoring. In addition, any employee can identify an issue that they believe requires review or monitoring. All suggested issues should be channeled through the CCO. The CCO has the authority to determine which issues will be reviewed and monitored, when the review will be
COMPLIANCE ISSUES REPORTING AND INVESTIGATING

In order for MidMichigan Health to achieve its expectation to conduct its business in an ethical manner and in full compliance with all federal, state and local laws and regulations, as well as internal policies and procedures, employees are encouraged to report suspected or known problems.

Examples of types of violations that should be reported include:

- Billing, payment and collection problems
- Theft, bribes and kickbacks
- Fraudulent transactions
- Conflict of interest
- Potential criminal violations
- Breaches of patient confidentiality

(This list is not all inclusive; it is only provided as a means of example.)

Employees that become aware of or suspect that a subsidiary or any of its employees are functioning in a manner that is not in compliance with federal, state, or local laws and regulations, or internal policies and procedures should first immediately report the situation by contacting their supervisor. If the employee is not comfortable reporting the concern to their supervisor, or if the concern was expressed to the supervisor and the employee does not feel comfortable with the response received, the employee should call the Compliance Hotline (989) 837-5471. This is an external number and is not part of the MidMichigan Health internal telephone system. Measures have been taken to ensure that all calls will be held in the strictest confidence (including the name of the caller). In addition to the Hotline, the CCO may be reached by calling the MidMichigan Medical Center-Midland switchboard at (989) 839-3000 and asking for the Corporate Compliance Officer. Employees may also e-mail concerns to corporate, compliance@midmichigan.org.

There shall be a zero tolerance policy against retaliation of any employee that makes such a complaint in good faith either through our internal process or as a whistleblower under the False Claims Act.

The CCO will monitor the Compliance Hotline. He/she will refer the complaint immediately to the appropriate party for investigation or may conduct the investigation. He/she will also notify the legal department that a complaint has been received. The CCO will also annually report a summary of the Hotline calls to the Audit Committee.

If the employee who has made the complaint is known, they will receive periodic updates and information concerning the investigation and any action taken.

Based on the outcome of the investigation, appropriate action will be taken to remedy any inappropriate actions. If applicable, appropriate education and training will be provided to employees, departments and...
CORRECTIVE ACTION PLAN

Whenever a compliance issue has been identified and determined to be a problem, through monitoring, reporting of possible issues, investigations, or otherwise, the department administrator/manager should develop a plan to address that issue. In developing a corrective action plan, the department should obtain advice and guidance from the CCO, and other appropriate personnel, as necessary. The CCO will consult with legal counsel and Human Resources as appropriate. The corrective action plan must be approved by the CCO prior to implementation.

Corrective action plans should be designed to ensure not only that the specific issue is addressed but also that similar problems do not occur in other areas or departments. Corrective action plans may require that compliance issues be handled in a designated way, that certain training takes place, that restrictions be imposed on particular employees, or that the matter be disclosed externally. Sanctions or discipline in accordance with MidMichigan Health policies may be necessary; see the Corrective Action - Rules of Conduct and Disciplinary policy. If it appears that certain individuals have exhibited a propensity to engage in practices that raise compliance or competence concerns, the corrective action plan should identify actions that will be taken to prevent such individuals from exercising substantial discretion in regard to that compliance area.

RESPONSE TO NOTICE OF EXTERNAL INVESTIGATIONS

Upon receipt of a notice of external investigation relating to a compliance concern, the receiving department or individual should immediately provide this information to the CCO, or in his/her absence, his/her designee. The CCO will oversee the investigation internally, including notification of appropriate individuals, development of plan of action, response, public relations, etc.

REPORT TO THE BOARD

The CCO shall report in writing annually to the MidMichigan Health Board of Directors Audit Committee on the status of compliance within MidMichigan Health. This report shall include the results of any recommendations resulting from the audit work plans conducted during the prior year, and any other information requested by the Committee or the Board.

Definitions

1 Associated third parties are defined as members of the medical staffs, volunteers, vendors and service agencies conducting business with MidMichigan Health and its subsidiaries.

Disclaimer

Employees covered under a bargaining agreement will be subject to the terms of that agreement.

Attachments: No Attachments
Applicability

MidMichigan Health, MidMichigan Home Care, MidMichigan Medical Center - Alpena, MidMichigan Medical Center - Clare/Gladwin, MidMichigan Medical Center - Gratiot/Mt. Pleasant, MidMichigan Medical Center - Midland, MidMichigan Physicians Group
Corporate Compliance - Overview and Reporting Procedure

Applicability

- MidMichigan Health and all its wholly owned subsidiaries

Purpose

It is the policy of MidMichigan Health and its subsidiaries that its employees conduct themselves in an ethical manner and carry out the responsibilities of their position in full compliance with all federal, state, and local laws and regulations as well as MidMichigan internal policies and procedures. MidMichigan Health has adopted a formal Corporate Compliance Program that details the framework for legal and ethical compliance by MidMichigan Health, its subsidiaries, employees, and associated third parties. This policy is an overview of the program with emphasis on reporting. Please see the full Corporate Compliance Program policy and other Compliance policies for more information.

Procedure

Training: MidMichigan will provide employees who occupy positions of substantial discretionary authority with training and instruction on the regulatory environment affecting their position. Employees in these positions are responsible for keeping abreast of changing regulatory environment and complying with these requirements at all times.

Reporting: Employees who become aware of or suspect that a subsidiary or any of its employees are functioning in a manner that is not in compliance with federal, state, or local laws and regulations, or internal policies and procedures, should first immediately report the situation by contacting their supervisor. If the employee is not comfortable reporting the concern to their supervisor, or if the concern was expressed to the supervisor and the employee does not feel comfortable with the response received, the employee should call the Corporate Compliance Officer or the Compliance Hotline (989) 837-5471. This is an external number and is not part of our internal telephone system. Measures have been taken to ensure that all calls will be held in the strictest confidence (including the name of the caller if so desired). Employees should be prepared to provide the following information:

- Their name and telephone number (this is optional, but strongly recommended; without this information the employee cannot receive a direct response nor can additional information be obtained if necessary).
• Subsidiary involved.
• Department involved.
• Dates and times of violations (if known).
• Name and department of individual(s) involved.

Investigation: The Corporate Compliance Officer (CCO) will monitor the Compliance Hotline. He/She will refer the complaint immediately to the appropriate party for investigation or may conduct the investigation. If the employee who has made the complaint is known, they will receive periodic updates and information concerning the investigation and any action taken.

Action: Based on the outcome of the investigation, appropriate action will be taken to remedy any inappropriate actions. Employees found to be knowingly conducting business in a manner that is not in compliance with the appropriate federal, state, or local laws and regulations of MidMichigan Health or its subsidiaries internal policies will be subject to disciplinary action up to and including discharge.

1 Associated third parties are defined as members of the medical staffs, volunteers, vendors and service agencies conducting business with MidMichigan Health and its subsidiaries.

Disclaimer

Employees covered under a bargaining agreement will be subject to the terms of that agreement.

Attachments:  No Attachments

Applicability

MidMichigan Health, MidMichigan Home Care, MidMichigan Medical Center - Alpena, MidMichigan Medical Center - Clare/Gladwin, MidMichigan Medical Center - Gratiot/Mt. Pleasant, MidMichigan Medical Center - Midland, MidMichigan Physicians Group
EMTALA Policy
(Emergency Medical Treatment & Active Labor Act)
Emergency Medical Treatment and Active Labor Act (EMTALA) Policy and Procedure

Applicability

- Medical Center-Clare
- Medical Center-Gladwin
- Medical Center-Gratiot
- Medical Center-Midland
- Medical Center - Alpena
- Medical Center-Mount Pleasant

Purpose

To assure that all MidMichigan Medical Centers, their associates and medical staff members, comply with the rules and regulations of the federal Emergency Medical Treatment and Active Labor Act (EMTALA).

Policy

The provisions of EMTALA apply not only to all MidMichigan Medical Centers, but also, through the bylaws of the Medical Staffs, to the physicians who provide on-call coverage. Failure to comply with EMTALA can result in substantial sanctions and/or fines to the Medical Centers and physicians, civil lawsuits for damages, and exclusion from Medicare, Medicaid, and other government health programs. The Medical Centers seek to assure compliance with EMTALA by explaining the obligations of the Medical Center and of on-call physicians under the law.

Any individual who comes to the Medical Centers or any of the facilities where the Medical Centers provide emergency services, who is in need of or requests emergency services, will be treated in accordance with the law. The individual is entitled to and will receive, regardless of diagnosis, race, color, nationality, handicap, or financial status, an appropriate:

- Medical screening examination by a qualified medical personnel to determine whether an emergency medical condition exists; and,
- Further medical examination and treatment to stabilize the emergency medical condition within the capability of the Medical Center or arrange for transfer to another medical facility.

There will be no delay in the provision of the medical screening examination, stabilizing treatment, or
Registered Nurse Performance of Medical Screening Examinations in the Maternity Center

1. Registered nurses with demonstrated clinical competency in obstetrics may perform medical screening examinations on persons who present to the department.

2. The specific tasks that registered nurses may perform as part of the medical screening examination include assessing fetal heart tones, the regularity and duration of uterine contractions, fetal movement, and NST.

3. "Demonstrated clinical competency" means
   a. successful completion of the department's orientation program and skills checklist at the time of the nurse's hire, minimum of one year's experience in the Maternity Center, successful completion of a basic fetal monitoring course annually, successful completion of a neonatal resuscitation course and recertification every two years;
   b. demonstrating an understanding of the physiology of electronic fetal monitoring (EFM);
   c. demonstrating competence in performing vaginal examinations.

• Registered nurses who perform medical screening examinations must consult with a physician at an appropriate time before the patient's disposition. The physician is responsible for obtaining pertinent information from the nurse, ordering appropriate diagnostic tests, analyzing the results of those tests and determining the appropriate disposition of the patient.

• When a patient requires diagnostic or treatment services that are beyond the registered nurse's scope of practice, demonstrated competency, or comfort-level, the registered nurse will request that the patient's attending physician or on-call physician come to the Medical Center to further evaluate and treat the patient. The physician is responsible to come to the Medical Center or send an appropriately credentialed practitioner with Medical Center privileges if the nurse performing the medical screening examinations determines that the physician's presence is necessary. When the attending or on-call physician refuses to come to the Medical Center when requested by the nurse, or the nurse has concerns about the physician's medical management of the patient which cannot be resolved with the physician, the nurse will contact his or her supervisor.

• A registered nurse may not discharge or transfer a patient from the Medical Center until he or she has
   a. performed a medical screening examination;
   b. consulted with a physician who has authorized the discharge of the patient; and
   c. documented the screening examination, interventions, physician orders, disposition of the patient, and if applicable, discharge instructions.

• The Medical Center's performance improvement process will include random and periodic reviews of OB
records to evaluate the appropriateness of screening examinations, interventions, and patient dispositions.

Location of Signage

Each Medical Center will post appropriate signage to notify patients of their right to a medical screening examination and stabilization treatment as specified under EMTALA. At a minimum, the signage will be posted in the following areas, but if the area is available at the particular Medical Center: Emergency Department, Urgent Care Clinic, Obstetrical Unit and Psychiatric Unit. The signage will be posted in a place likely to be noticed by all individuals entering these areas. Signage will also be place in the admitting area and waiting rooms.

Definitions

1. Qualified Medical Personnel could include a licensed physician, nurse practitioner, or physician assistant.

Procedure

I. Presenting for Care and Medical Screening Examination

A. Any individual who comes to the Medical Center Emergency Department requesting examination or treatment shall be provided with an appropriate medical screening examination. A medical screening examination is also required when the individual is in close proximity to the Medical Center and a request for care is made by the individual or on the individual's behalf and when a prudent layperson would believe the individual needs examination or treatment for an emergency medical condition. (Prudent Layperson Standard).

B. An individual will be considered to have come to the Medical Center Emergency Department if the individual is anywhere on Medical Center property (including its parking lot, driveway, or sidewalk) and is requesting emergency care. Medical Center property encompasses the entire Medical Center campus which includes the main buildings, the physical area immediately adjacent to the main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis by the Center for Medicare/Medicaid Services (CMS) regional office to be part of the Medical Center 1 campus. The Medical Center will not prohibit personnel from leaving the Medical Center to examine and/or treat the individual, however, the safety of all employees must be considered in every situation prior to doing so. The Medical Center Emergency Department will not refuse to accept a telephone or radio request for transfer or admission unless the emergency room has been placed on diversion. Refusal to do so could represent a violation of the "Duty to Accept" standard under EMTALA.

C. The medical screening examination shall include ancillary services routinely available to the Emergency Department. The medical screening examination must be similar for patients presenting with similar symptoms.

D. The EMTALA standards do not apply to the following circumstances:

   1. A patient who experiences an emergency during an inpatient admission;

   2. Once an outpatient service has begun, unless the outpatient service is part of the Medical Center's obligation under EMTALA;

   3. When an individual presents for non-emergency care, including "courtesy" patients and some
Community Mental Health patients; or

4. Individuals who do not request care/evaluation or for whom no request is made on their behalf.

E. Location in Which the Medical Screening Examination May Be Performed

1. The medical screening examination may be performed in the following areas which are considered under Federal guidelines to be part of the "Dedicated Emergency Department:
   a. The Emergency Department by the Emergency Department physician, or an appropriately privileged advanced practice provider,
   b. The Urgent Care by the appropriately privileged physician or advanced practice provider,
   c. The Obstetrical Care Unit for a pregnant women by a physician or by a certified nurse midwife with privileges to provide inpatient obstetrical care or, in certain situations as per Appendix A, by a registered nurse as defined in the attached policy statement "Registered Nurse Performance of Medical Screening Examinations in the Maternity Center", or
   d. The Psychiatric Care Unit and/or ED by the ED physician and mental health professional.

2. Individuals presenting to a dedicated Emergency Department will not be moved to a non-contiguous or off-campus facility for the medical screening examination or other emergency services.

F. In providing a medical screening examination, the Medical Center shall not discriminate against any individual because of diagnosis, financial status, race, color, national origin, or handicap.

G. The purpose of the medical screening examination is to determine if an individual is experiencing an emergency medical condition. The medical screening examination is more than providing triage; triage is a process used to determine the order in which individuals will be seen and does not determine the presence or absence of an emergency medical condition. The medical screening examination represents a spectrum ranging from a simple process involving only a brief history and physical examination to a complex process that involves performing ancillary studies and procedures. It is an on-going process, not an isolated event. If more individuals arrive seeking emergency services than the medical personnel present can immediately accommodate, those individuals will be triaged to determine the order in which they will be seen for the medical screening examination.

1. An "emergency medical condition" is a condition manifesting symptoms (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) which, in the absence of immediate medical attention, is likely to cause serious dysfunction or impairment to a bodily organ or function or serious jeopardy to the health of the individual or unborn child.

2. A pregnant woman who is having contractions is considered to be in an "emergency medical condition" if there is not enough time to safely transfer the woman prior to delivery or a transfer would pose a threat to the woman or her unborn child.

H. If the individual is determined NOT to have an emergency medical condition as a result of a properly performed medical screening examination, the individual may be admitted, transported to another facility for care, or discharged. The transport or discharge of the individual must be in accord with MidMichigan's policies and procedures regarding transfer or discharge.

I. MidMichigan Medical Centers will maintain a log listing each individual who comes to the dedicated emergency department seeking emergency medical care, including patients presenting to the Emergency Department, Urgent Care Clinic, Obstetrical Care Unit or Psychiatric Care Unit.
1. The log entry will take place at the first point of contact and may be in a "log book", on a census sheet, or on a computer, depending upon the area involved.

2. The log will contain the following information:
   ▪ The name or a description of the individual requesting emergency medical services;
   ▪ The location where the patient presented for emergency medical services or receives a medical screening examination; and
   ▪ The disposition of the individual

J. A medical record will be generated for each individual who receives a medical screening examination.

II. No Delay in Screening or Examination

A. There shall be no delay in providing a medical screening examination or follow-up treatment for an emergency medical condition in order to inquire about the patient's method of payment or insurance status.

B. For patients who are enrolled in a managed care plan, prior authorization from the plan shall NOT be required by the Medical Center before providing an appropriate medical screening examination and/or necessary stabilizing treatment. For the part of the Medical Center, neither the performance of the medical screening examination nor the provision of stabilizing treatment will be conditioned on a patient's completion of a financial responsibility form or payment of a co-payment.

C. Patients who inquire about financial responsibility for emergency care will be encouraged to delay such discussions until after the completion of the medical screening examination. These patients will also be told that the Medical Center will provide a medical screening examination and stabilizing treatment regardless of their ability to pay.

D. If a patient withdraws his or her request for examination or treatment, an appropriately trained individual from the Emergency Department staff will discuss the medical issues related to a "voluntary withdrawal". In the discussion, the Emergency Department staff member will:
   1. offer the patient further medical examination and treatment as may be required to identify and stabilize an emergency medical condition;
   2. inform the patient of the benefits of the examination and treatment, and of the risks of withdrawal prior to receiving the examination and treatment; and
   3. ask the patient to sign a "Withdrawal of Request for Emergency Care" form ER-070, which shall be completed by the Emergency Department staff member. If the patient refuses to sign the form, a description of risks discussed and of the examination and/or treatment that was refused shall be documented.

E. If the patient leaves the Medical Center without notifying Medical Center personnel, this should be documented. The documentation must reflect that the patient has been at the Medical Center and the time the patient was discovered to have left the premises. Triage notes and additional records must be retained.

III. Stabilization and Treatment Beyond the Capability of the Emergency Department

A. Except as set forth below, a patient experiencing an emergency medical condition must be stabilized prior to being discharged or transferred. A patient is considered to be stabilized when the treating physician has determined, with reasonable clinical confidence, that the patient's emergency medical
condition or status allows that the provision of additional care can appropriately be rendered on an outpatient basis and that the patient is provided with a follow-up plan. A patient is considered stable for transfer when the treating physician has determined, with reasonable clinical confidence, that the patient's condition is not likely to deteriorate during the transfer. For the purposes of transferring an individual with a **psychiatric condition**, the individual is considered to be stable when he/she is protected and prevented from injuring himself, herself or others.

**B.** An Emergency Department physician shall be responsible for the general care of all patients presenting to the Emergency Department until the patient's private physician, or an on-call physician, assumes that responsibility or the patient is discharged or transferred.

**C.** A patient may request that a particular physician be contacted to provide necessary stabilizing treatment. If the physician is on the Medical Center's Medical Staff, an attempt will be made to contact the physician.

**D.** If, a) the patient does not request a specific physician, or b) a requested physician is unavailable to come to the Medical Center, or c) the requested physician does not respond within 30 minutes, the physician listed on the on-call rotation schedule shall be contacted to provide the necessary consultation or treatment for the patient.

**E.** If a patient refuses to accept treatment that has been recommended to stabilize an emergency medical condition after being informed of the risks and benefits of the treatment and the risks of refusing such treatment, reasonable steps shall be taken to obtain the patient's signature on the "Refusal of Stabilizing Treatment" form ER-069. The patient's refusal shall also be documented in the medical record.

**F.** The attending physician shall be the private physician or the on-call specialist who is contacted to provide treatment of the emergency medical condition's primary diagnosis. If more than one physician is needed to treat the emergency medical condition, it is the responsibility of those physicians to determine who will be the attending physician.

**G.** The responsibility for the continuing care of a patient admitted through the Emergency Department is transferred from the Emergency Department physician to the admitting physician when care in the Emergency Department is completed and the patient leaves the department to be admitted to another unit in the Medical Center (as per Medical Staff Rules and Regulations).

**H.** The patient shall remain the responsibility of the on-call physician (or the physician requested by the patient) until the episode of illness or injury that prompted the patient's assignment to that physician is satisfactorily resolved and the patient has been discharged, transferred, or admitted.

**I.** The patient may be discharged after the emergency medical condition has been resolved or after a determination has been made that the patient is sufficiently stable for discharge. "Stable for discharge" means that continued care, including diagnostic work-up and/or treatment, could be safely performed on an outpatient basis, or later on an inpatient basis, provided the patient is given a plan for appropriate follow-up care with discharge instructions.

**IV. On-Call Rotation Responsibilities**

**A.** The Medical Center shall maintain an on-call rotation schedule that includes the name and contact information of each physician who is required to fulfill on-call duties. The Medical Center will work with the Medical Staff Office and the Medical Staff Departments to create and maintain the on-call rotation schedule. The on-call rotation schedule shall be accessible to the Emergency Department.

**B.** Members of the Active Staff have an obligation, but not a right, to share on-call duties. Medical Staff
members who are relieved of on-call responsibilities for any reason may be assigned other duties so that all members share as equitably as possible in Medical Staff responsibilities.

C. The on-call schedule may be general (e.g., medical or surgery) or by specialty (general surgery, orthopedic surgery, hand surgery, plastic surgery), as determined by the Medical Center and implemented by the relevant department chairpersons. The Medical Staff Executive Committee shall review the on-call schedule and make recommendations to the Chief Executive Officer when formal changes are to be made or when legal and/or operational issues arise.

D. In specialties in which there are three or more physicians, the on-call schedule must be covered 24 hours a day, 365 days a year. In specialties in which there are fewer than three physicians, each physician shall be assigned to cover at least one-third of the schedule. The department chairperson shall consider the needs of patients in developing the on-call rotation scheduling, including when certain specialties will not be covered because of a lack of physicians.

E. If a patient presents needing care when a specialty is not covered, the patient shall be transferred in accordance with this EMTALA Policy.

F. Physicians who have voluntarily restricted their practice to include less than the core privileges typically associated with their specialty may be required to participate in a general on-call schedule and to maintain sufficient competence to fulfill this responsibility. If a physician does not feel clinically competent to take general call, it shall be the physician's responsibility to arrange for appropriate coverage. If a physician responds to a call and requires additional expertise to take care of the patient, the physician should attempt to stabilize the patient and request an appropriate consult.

G. Members of the Medical Staff will not be permitted to relinquish specific clinical privileges for the purpose of avoiding on-call responsibility.

H. When an on-call physician is contacted by the Emergency Department physician and requested to respond, the physician must do so within a reasonable time period. Generally, response is expected within 30 minutes. The Emergency Department physician, in consultation with the on-call physician, shall determine whether the patient's condition requires the on-call physician to see the patient immediately. The determination of the Emergency Department physician shall be definitive in this regard and the on-call physician must come to the Emergency Department when appropriately requested.

I. Seeing the patient at the on-call physician's office or clinic is not an option until the patient is determined to be "stable" or not to have an "emergency medical condition" unless specialized equipment is available in the physician's office that is not available at the Medical Center that is necessary to diagnose and treat the patient. In order to transfer a patient as outlined above the following criteria must be met:

1. All persons with the same medical condition are moved to this location regardless of their ability to pay for treatment;

2. There is a bona fide medical reason to move the patient; and

3. Qualified medical personnel accompany the patient.

J. The on-call physician is responsible for the care of a patient through the episode that created the emergency medical condition, including office follow-up related to that episode. An on-call physician shall not, in the Medical Center or during an office follow-up visit, require insurance information or a co-payment before assuming responsibility for care of the patient.

K. If it is determined by the Emergency Department physician that an emergency medical condition
does not exist but that the patient needs follow-up treatment and does not have a pre-existing provider relationship, the on-call physician will provide such treatment through the episode that created the E.D. visit.

L. If the on-call physician disagrees about the need to come to the Emergency Department, the on-call physician must come to the Medical Center and render care regardless of the disagreement. The on-call physician may address the disagreement with the appropriate individual at the Medical Center at a later time. The medical record must not be employed to discuss, argue, or document the disputation over the need to respond. The record merely should reflect the treatment and care provided for the patient.

M. The on-call physician is not required to interrupt critical care—that is, care that requires his/her personal management—which he or she is providing to another specific patient. Immediately after the physician finishes caring for that specific patient, he or she must contact the requesting unit, respond if requested, and give an estimated time of arrival. It is not acceptable for the on-call physician to delay seeing an unstable Emergency Department patient until the end of office hours or to finish the daily surgical caseload. Nor is it acceptable to hold the unstable patient in the Emergency Department until morning. It is not acceptable to delay or decline seeing an unstable Emergency Department patient due to the fact that the on-call physician has an anticipated heavy workload the next day or that the on-call physician may be out of town following the on-call period. If, after discussion with the Emergency Department physician, it is determined that the patient has been stabilized but will require additional care that can wait until the on-call physician can arrive on site, definitive treatment can be postponed until such time. The determination of the patient's stability must be documented by the Emergency Physician in the patient medical record.

N. A refusal or failure to timely respond shall be reported immediately to the Chief of Staff, VPMA and the Chief Executive Officer, who shall review the matter and determine how to address the situation. If the refusal or failure to respond is found to be deliberate, or if it is a repeated occurrence, the matter shall be referred to the Medical Staff Executive Committee for further review and action pursuant to the Medical Staff Procedural Policy or other appropriate policy. In determining the severity of a violation, the Medical Staff Executive Committee shall consider the total circumstances, including but not limited to, whether the violation was deliberate, the seriousness of the patient's condition, and how disruptive the violation was to Medical Center operations.

O. In any situation when the on-call physician cannot or does not respond, and emergent/immediate concerns exist on the part of the Emergency Department physician contacts will be made in the order listed below. Only one attempt will be made to contact the next person in the chain of command before proceeding to the next step:

1. Chairman of the Department of the appropriate Medical Staff Department
2. Chief of Staff or delegate
3. VPMA
4. Administration/administrator on-call.

P. In any situation when the on-call physician cannot or does not respond, and urgent/non-urgent concerns, contacts will be made in the order listed below:

1. Chairman of the Department of the appropriate Medical Staff Department
2. Chief of Staff or delegate
3. VPMA
4. Administration/administrator on-call.

I. **Ambulatory Care Staff On-Call Rotation Responsibilities**

   A. The chairperson of each department, on behalf of the Medical Center, shall be responsible for developing an on-call rotation schedule for the ambulatory care staff physicians.

   B. Members of the Ambulatory Care Staff have an obligation to share phone on-call duties unless an exemption has been granted by the Medical Executive Committee.

   C. The on-call schedule may be general (e.g., medical or surgery) or by specialty (general surgery, orthopedic surgery, hand surgery, plastic surgery), as determined by the Medical Center and implemented by the relevant department chairpersons. The Medical Staff Executive Committee shall have the option to review on-call schedule and make recommendations to the Chief Executive Officer when formal changes are made or when legal and/or operational issues arise.

   D. In specialties in which there are three or more physicians, the on-call schedule must be covered 24 hours a day, 365 days a year. In specialties in which there are fewer than three physicians, each physician shall be assigned to cover at least one-third of the schedule. The department chairperson shall consider the needs of patients in developing the on-call rotation scheduling, including when certain specialties will not be covered because of a lack of physicians.

   E. If a patient presents needing care when a specialty is not covered, the patient shall be transferred in accordance with this EMTALA Policy.

   F. Ambulatory Care staff members must provide emergency call and care for unassigned patients as follows: (1) when on call, provide telephone on-call coverage for the Emergency Department for the purpose of accepting follow-up care for unassigned patients requiring admission or to assist in arranging for follow-up care for patients requiring admission or to assist in arranging for follow-up care for patients to be discharged from the Emergency Department; and (2) when on call, accept and provide follow-up outpatient care for unassigned patients who present to the Medical Center's Emergency Department.

   G. When an on-call physician is contacted by the Emergency Department physician and requested to respond, the physician must do so within a reasonable time period. Generally, response is expected within 30 minutes. The Emergency Department physician, in consultation with the on-call physician, shall determine when the on-call physician needs to see the patient in the office.

   H. The patient must be determined to be "stable" or not have an "emergency medical condition" before they can be sent to the on-call physician's office or clinic, unless specialized equipment is available in the physician's office that is not available at the Medical Center that is necessary to diagnose and treat the patient. In order to transfer a patient as outlined above the following criteria must be met:

      1. All persons with the same medical condition are moved to this location regardless of their ability to pay for treatment;

      2. There is a bona fide medical reason to move the patient; and

      3. Qualified medical personnel accompany the patient.

   I. The ambulatory care on-call physician is responsible for the follow-up of a patient that was discharged from the Emergency Department. An on-call physician shall not, during an office follow-up visit, require insurance information or a co-payment before assuming responsibility for care of the patient.

   J. If the on-call physician disagrees about the need for the patient to be seen in the office, the on-call...
physician must render care regardless of the disagreement. The on-call physician may address the disagreement with the appropriate individual at the Medical Center a later time. The medical record must not be employed to discuss, argue, or document the disputation over the need to respond. The record merely should reflect the treatment and care provided for the patient.

K. The on-call physician is not required to interrupt critical care - that is, care that requires his/her personal management - which he or she is providing to another specific patient. Immediately after the physician finishes caring for that specific patient, he or she must respond to the Emergency Department's request.

L. A refusal or failure to timely respond shall be reported immediately to the Chief of Staff, VPMA, the Chief Executive Officer, or designee who shall review the matter and determine how to address the situation. If the refusal or failure to respond is found to be deliberate, or if it is a repeated occurrence, the matter shall be referred to the Medical Staff Executive Committee for further investigation and appropriate disciplinary action. In determining the severity of a violation, the Medical Staff Executive Committee shall consider the total circumstances, including but not limited to, whether the violation was deliberate, the seriousness of the patient's condition, and how disruptive the violation was to Medical Center operations.

M. In any situation when the on-call physician cannot or does not respond, and emergent/immediate concern/s exist on the part of the Emergency Department physician contacts will be made in the order listed below. Only one attempt will be made to contact the next person in the chain of command before proceeding to the next step:

1. Chairman of the Department of the appropriate Medical Staff Department
2. Chief of Staff or delegate
3. VPMA
4. Administration/administrator on-call

N. In any situation when the on-call physician cannot or does not respond, and urgent/non-urgent concerns, contacts will be made in the Staff Department order listed below:

1. Chairman of the Department of the appropriate Medical
2. Chief of Staff or delegate
3. VPMA
4. Administration/administrator on-call

II. Patient Transfers to a Medical Facility

A. A patient in an emergency medical condition may be transferred to another medical facility before stabilization if:

1. after being informed of the risks of transfer and of the Medical Center's treatment obligations, the individual requests to be transferred - complete form ER-074.; or
2. based on the information available at the time of transfer, the physician determines that the medical benefits to be received at another medical facility outweigh the risk to the patient of being transferred (including, in the case of a woman in labor, the risks to the unborn child) and a certification to this effect is signed by the physician - complete form ER-074.

B. Appropriate steps shall be taken and treatment provided to minimize the risks associated with the transfer.
C. When a patient requests a transfer, the physician shall discuss the risks associated with the transfer and the services that will be provided if the patient is not transferred. If the patient continues to request a transfer, complete form ER-074. If the patient directs transfer against the advice of the physician, this shall be noted. If the patient refuses to sign the form, all pertinent information shall be recorded in the patient's medical record.

D. When a physician initiates the transfer, the Emergency Department or on-call physician shall complete the transfer certification form ER-074 which must include a summary of the risks and benefits of transfer. Reasonable steps shall also be taken to secure the written consent of the patient, or the legally responsible person acting on the patient's behalf, to the transfer on the form. If the patient refuses to sign the form, all pertinent information shall be recorded in the patient's medical record. In the absence of a physician at the time of transfer, a qualified medical personnel may sign the transfer form, but only following consultation with a physician and determination by the physician that the transfer is appropriate. The physician must countersign the certification within 24 hours of the patient's transfer. If a patient refuses a transfer that is recommended by a physician, steps shall be taken to obtain this refusal in writing by completing form ER-074. This shall be documented in the patient's medical record.

E. In all cases of patient transfer, consent of the receiving Medical Center must be obtained and documented in the patient's medical record before the transfer. This consent is to include that the receiving Medical Center has available space and qualified personnel to provide treatment to the patient. The patient's condition must also be documented in the medical record prior to the transfer.

Duty to Accept (on the part of the receiving Medical Center):

1. A receiving Medical Center that has specialized capabilities, (i.e., burn unit, trauma units, neonatal intensive care units or, with respect to rural areas, regional referral centers), may not refuse to accept an appropriate transfer if the receiving Medical Center has an available bed and staff to treat the individual.

2. If the MidMichigan Medical Center is seeking to transfer an individual due to a bed shortage and the individual does not require any specialized capabilities of the receiving Medical Center, the receiving Medical Center is not obligated to accept the transfer of the individual.

F. Copies of the patient's medical record, including, but not limited to, symptoms, preliminary diagnosis, treatment provided, test results, and informed written consent or transfer certification, shall be sent with the patient to the receiving Medical Center. The medical record shall also include the name and address of any on-call physician who failed or refused to appear within a reasonable period of time to provide examination or treatment to the patient.

G. The transfer of a patient shall be carried out by qualified personnel using transportation equipment appropriate for the patient's medical condition.

H. The Medical Center shall maintain the medical records of all patients transferred to or from its facility for a period of five years.

III. Accepting Patient Transfers

A. The on-call physician for the appropriate specialty is the Medical Center's authorized representative to receive requests to transfer an unstable patient with an emergency medical condition.

B. The on-call physician for the appropriate specialty, shall agree to the transfer of a patient with an emergency medical condition from a referring facility if the patient is unstable and in need of specialized capabilities offered by the MidMichigan Medical Center and the MidMichigan Medical
Center has the capacity to receive the patient. The on-call physician is expected to respond in a timely manner.

C. The on-call physician for the appropriate specialty shall discuss the case with the referring physician, encouraging the transferring facility to stabilize the patient (when medically appropriate) prior to transfer based on their available resources to minimize risk during transfer.

D. If the referring facility wants to transfer an unstable patient with an emergency medical condition because it has no beds or is overcrowded but the patient does not require any specialized capabilities, the on-call physician for the appropriate specialty may elect to accept the patient but is not obliged by the EMTALA final regulations to do so.

E. Any decision to refuse a transfer of an unstable patient with an emergency medical condition must be based solely upon a determination that the Medical Center lacks the capabilities and capacity to provide emergency services. Such a determination shall be made by the on-call physician for the appropriate specialty only after consultation with appropriate nursing supervisors.

F. Clinical services that are not typically cared for at MidMichigan Medical Center-Midland include, but are not limited to, the following: limb reattachments, burns, and open book pelvic fractures/acetabular fractures. Conditions not typically cared for at the other MidMichigan Medical Centers (those outside Midland) include, but are not limited to, the following: limb reattachments, burns, and open book pelvic fractures/acetabular fractures, as well as acute cardiac conditions requiring interventional cardiac catheterization, conditions requiring cardiothoracic surgery, or conditions requiring neurosurgery.

IV. Reporting Inappropriate Transfers from Other Facilities to a MidMichigan Medical Center

A. All MidMichigan Medical Center staff and associates who have reason to believe that the Medical Center received an inappropriate transfer in violation of the law must immediately report the incident to the Chief Executive Officer or designee and to the Risk Management Department for investigation.

B. In the event that the Medical Center receives a transfer from another facility that seems to be inappropriate in nature, the Medical Center must investigate the situation within 24-48 hours through its Risk Management office. The Risk Management office must seek input from the Emergency Department, other appropriate staff or physicians, and legal counsel, as necessary.

C. The investigation includes, but need not be limited to, the following:
   1. interviewing the reporting individual.
   2. contacting the transferring Medical Center to elicit additional information, including copies of all pertinent medical records.
   3. requesting the chair of emergency medicine to review the case for medical appropriateness.
   4. discussing the circumstances of the transfer with the individual involved and/or the family members.
   5. consulting legal counsel.

D. If, after investigation, the CEO or designee deems the transfer inappropriate, the CEO or designee will contact a member of the senior administration of the sending Medical Center. That administrator will be informed of the legal obligation to report alleged violations to the appropriate government agency, the apparent inappropriate transfer and the conclusory facts leading to the decision to report. The Medical Center must report this suspected inappropriate transfer to the government agency, which requires the report within 72 hours of the occurrence.
Disclaimer

Employees covered under a bargaining agreement will be subject to the terms of that agreement.

Attachments:  No Attachments

Applicability

MidMichigan Health, MidMichigan Home Care, MidMichigan Medical Center - Alpena, MidMichigan Medical Center - Clare/Gladwin, MidMichigan Medical Center - Gratiot/Mt. Pleasant, MidMichigan Medical Center - Midland, MidMichigan Physicians Group
Facts You Should Know
About MidMichigan Health
FACTS YOU SHOULD KNOW ABOUT MIDMICHIGAN HEALTH

Our Mission:
We provide excellent services to improve the quality of life for people in our communities.

Our Vision:
We celebrate the power of health throughout life – with you.

At MidMichigan Health, we hold these values to be fundamental:

   Excellence – We offer nothing less than the best.
   Integrity – We do the right thing, each time, every time.
   Teamwork – We provide individual commitment to a group effort.
   Accountability – We accept responsibility for all we do.

Patients’ Rights:
1. A patient will not be denied appropriate care on the basis of race, religion, color, national origin, sex, age, disability, marital status, sexual preference, or source of payment.
2. A patient, except for necessary restrictions, has the right to determine who may or may not visit. The Medical Center will not restrict, limit, or otherwise deny visitation on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation or disability.
3. A patient or resident is entitled to information about the Medical Center’s rules and regulations affecting patient care and conduct.
4. The patient has the right to have a family member or representative of personal choice and his/her own physician notified promptly of his/her admission to the Medical Center.
5. An individual who is or has been a patient is entitled to inspect, or receive for a reasonable fee, a copy of his/her medical record upon request, within a reasonable time frame. (In very rare circumstances a patient may be denied access to his/her medical records if it is determined to be medically contraindicated and documented in the medical record.)
6. A patient is entitled to confidential treatment of personal and medical records, and may refuse their release to a person outside the Medical Center except as required because of a transfer to another health care facility or as required by law or third party payment contract.
7. A patient is entitled to personal privacy, to the extent feasible, in treatment and in caring for personal needs with consideration, respect, and full recognition of his/her dignity and individuality.
8. A patient is entitled to receive adequate and appropriate care, and to receive from the appropriate individual within the Medical Center, information about his/her medical condition, proposed course of treatment, and prospects for recovery, in terms that the patient
can understand unless medically contraindicated as documented by the attending physician in the medical record.

9. A patient is entitled to refuse a recommended treatment or plan of care, to the extent provided by law, and to be informed of the medical consequences of that refusal. In case of such refusal, the patient is entitled to other appropriate care and services that the Medical Center can provide or transfer to another facility. When a refusal of treatment prevents the Medical Center or its staff from providing appropriate care according to ethical and professional standards, the relationship with the patient may be terminated upon reasonable notice.

10. A patient is entitled to exercise his/her rights as a patient and as a citizen, and to this end may present grievances or recommend changes in policies and services on behalf of himself/herself or others to the Medical Center staff, to governmental officials, or to another person of his/her choice within or outside the facility, and the patient is encouraged to do so without concern of interference, coercion, discrimination or reprisal. A Patient Complaint Process has been established and is available for the patient’s reference and use.

11. The patient is entitled to information concerning an experimental procedure proposed as a part of his/her care and shall have the right to refuse to participate in the experiment without jeopardizing his/her continuing care.

12. A patient is entitled to receive and examine an explanation of his/her bill regardless of the source of payment and to receive, upon request, information relating to financial assistance available through the Medical Center.

13. A patient is entitled to know who is responsible for and who is providing his/her direct care, is entitled to receive information concerning his/her continuing health needs and status, and alternatives for meeting those needs, so that he/she may be involved in and make informed decisions regarding care and his/her discharge planning.

14. A patient is entitled to associate and have private communications and consultations with his/her physician or any other person of his/her choice and to send and receive unopened personal mail on the same day it is received at the Medical Center unless medically contraindicated as documented by the attending physician in the medical record. A patient’s civil and religious liberties, including the right to independent personal decisions and the right encourage and assist in the fullest possible exercise of these rights. A patient may meet with, and participate in, the activities of social, religious and community groups at his/her discretion unless medically contraindicated as documented by the attending physician in the medical record.

15. A patient is entitled to receive care in a safe setting, free from mental and physical abuse, and from physical (including seclusion) and chemical restraints that are not medically necessary or to protect the patient from injury to self or others. Restraints will be used only after less restrictive measures have been found to be ineffective and not as a means of coercion, discipline, convenience or retaliation by staff.

16. A patient has the right to access protective services that may investigate evidence of neglect, abuse, or exploitation, or correct hazardous living conditions or situations in which vulnerable adults or children are unable to care for themselves.

17. A patient is entitled to the assessment and appropriate management of pain.

18. A patient is entitled to be free from performing services for the facility that are not included for therapeutic purposes in the plan of care.
19. The patient has the right to ask and be informed of the existence of business relationships among the Medical Center, educational institutions, other healthcare providers, or payers that may influence the patient’s treatment and care.

20. The patient has the right to have an advance directive (such as a health care proxy, or durable power of attorney for health care) concerning treatment or designate a surrogate decision maker, with the expectation that the Medical Center will honor the intent of that directive to the extent permitted by law and Medical Center policy. The patient has the right to timely information about Medical Center policy that may limit its ability to implement fully a legally valid advance directive.

Patients’ Responsibilities:
1. The patient is responsible for following the Medical Center’s rules and regulations affecting patient care and conduct.

2. The patient is responsible for providing, to the best of his/her ability, accurate and complete details about past illnesses and present condition. This includes telling the physician or other Medical Center personnel whether he/she has been hospitalized in the past, what for, and what medicines or medications he/she is now taking or has with them.

3. The patient is responsible for telling the physician or nurse if they do not understand his/her treatment or if he/she does not understand what he/she is expected to do.

4. The patient is responsible for following the recommendations, advice and instructions of the physician, nurses and other Medical Center personnel concerning his/her care.

5. The patient is responsible for telling the doctor or nurse if there is an unexpected change in his/her condition or if problems arise during treatment.

6. The patient is responsible for his/her refusal of treatment or the outcome if he/she does not follow instructions.

7. The patient is responsible for being considerate of the rights of other patients and Medical Center personnel and property. Visitation may be limited if a visitor’s behavior presents a direct risk, is threatening, or disruptive.

8. The patient is responsible for providing the Medical Center with accurate and timely information concerning his/her sources of payment and ability to meet financial obligations.

Ethics:
When an ethical issue arises an ethics committee will be convened by the leadership of the organization. This convened committee is responsible for ethical decisions related to patients within our organization. MidMichigan Health strives to do the right things, in the right ways, with the right intentions. Because of the importance of “doing the right things” in all aspects of our work, MidMichigan Health has a Corporate Compliance Program. Its goal is to make sure we comply with applicable laws and regulations, ethical standards, and our own policies and procedures-practicing integrity in what we do. MidMichigan Health’s Corporate Compliance Program looks at our current practices and seeks ways to reduce the potential for organizational misconduct. It is a coordinated effort throughout the organization to prevent unlawfully or undesired activity. If you have concerns about what you think might be improper or illegal actions, immediately contact your supervisor, call the Corporate Compliance Officer (989-839-3136) or call the compliance hotline (989-837-5471).
Emergency Codes (paged overhead):

- Code STAT-Immediate Action Needed
- Code Pink-Infant Abduction
- Code Green-Adult Elopement
- Code Orange-Hazardous Material
- Code Gray-Combative Person
- Code Yellow-Bomb Threat
- Code Weather-Severe Weather Imminent

- Code Red-Fire
- Code Purple-Child Abduction
- Code White-Pediatric Arrest
- Code Blue-Adult Arrest
- Code Silver-Person with Weapon/Hostage
- Code Lift-Assistance Needed for Lift
- Code Secure-Facility Lockdown

In Response to Code Red:

Remember “RACE”

R: REMOVE or RESCUE anyone in danger
P: Pull the pin on the extinguisher handle
A: Report or activate an ALARM-Dial 11911 or By Pulling ALARM STATION
C: CONTAIN-close doors, windows, etc.
E: EXTINGUISH the fire & EVACUATE

Remember “PASS”

P: Pull the pin on the extinguisher handle
A: Aim low
S: Squeeze the lever below the handle
S: Sweep from side to side

Rapid Response Team:

When a staff member identifies that a patient, visitor, or staff member requires immediate or emergent intervention, the staff member can initiate a Rapid Response Team. The team will consist of an ACLS-qualified RN and Respiratory Therapist, the unit manager, house supervisor, and laboratory personnel will be a part of the team depending on the time of day and availability. A pharmacist will also be considered a member of the team and will be available for consultation.

One or more of the following: Hospitalist, Primary Care, Emergency Department Physician or Family Practice Resident (where present) will provide the medical care for early interventions.

Infection Control Precautions/Procedures:

Standard Precautions: For the handling of all patient bodily fluids or equipment/supplies contaminated with blood or bodily fluids to prevent exposure to blood borne pathogens.

- Use of PPE-Personal Protection Equipment including gloves, mask, face shield, goggles, aprons, and gown.
- Hand-Hygiene-Wash in and Wash out of patient’s room. Use soap and water after removing gloves or when hands are visibly soiled. Alcohol gel is available when hands are not visibly soiled.
- Disposing of sharps-Use special containers to dispose of needles and other sharp items.

Transmission-Based Precautions: To prevent the spread of known infectious pathogens.

- Airborne-Spread through air, including TB and measles. Wear respirator, patient in negative pressure room.
- Droplet-Spread by droplets (from sneezing or cough) including influenza and mumps. Wear mask.
• Contact-Spread by contact with infected skin (or objects that have touched skin), including herpes and impetigo. Wear PPE.

Exposure to Bloodborne Pathogens:
• Wash area thoroughly with soap & water
• Notify staff of Exposure & Complete an Visitor Variance Report online

Hazardous Material:
An SDS provides written information about the use of hazardous chemicals that may be found in the work environment. Topics included on the SDS include information about protective equipment that must be worn, health hazards, emergency first aid and spill clean-up. If a spill occurs contact staff.

INFORMATION MANAGEMENT AND PATIENT PRIVACY
At MidMichigan Health, we are all responsible for protecting the privacy of our patients’ personal health information. At MidMichigan Health we:

• Honor the trust placed in us to maintain the privacy of Protected Health Information (PHI).
• Respect and support the privacy rights of patients and their families.
• Are accountable for understanding and following our privacy policies and procedures.
• Access and use only the patient and family information that we need to know to do our jobs.
• Share patient and family information on a need-to-know basis.
• Always provide the information needed to deliver high-quality care.

Abuse Awareness:
In compliance with Michigan law, MidMichigan Health care givers will report any adult observed, in the course of their professional capacity or within the scope of their employment, whom they suspect to be a victim of abuse or neglect. This includes:

1. Developmentally disabled adults,
2. Dependent adults,
3. Elderly vulnerable adults, and
4. Victims of domestic violence.

A Medical Social Worker in the Case Management Department will be consulted upon admission in such cases to assist with the follow up and discharge planning.

Corporate Compliance:
A corporate compliance program is simply a formal way the organization can make sure they comply with applicable laws and regulations, ethical standards, and policies and procedures specific to the organization. If there are any concerns individuals are encouraged to contact Corporate Compliance Hotline at 989-837-5471.

Patient Safety:
Any employee or provider who has concerns about safety or quality of care provided is encouraged to take them to their supervisor. You may also report these concerns to the Joint Commission. The facility will take no retaliation or disciplinary action against the employee or provider related to this reporting.

A concern may be reported:
- By phone: 800-994-6610
- By email: compliant@jointcommission.org
- Online: www.jointcommission.org
- By Fax: 630-792-5636

**Diversity:**
No individual shall be denied permission to practice at the Hospital on the basis of gender, race, creed, sexual orientation, or national origin.

**Security:**
Security/Safety is the responsibility of each individual with the Medical Centers. Be advised that all personal belongings should be secured at all times. Be aware of your surroundings at all times. Be alert.

**Sexual Harassment:**
Harassment is a form of discrimination which may be based on a prohibited basis of race, gender, color, ancestry, national origin, age, religion, disability, height, weight, marital status, veteran status, or other characteristic protected by law. It is any objectionable verbal or physical conduct, comment, or display which demeans, disparages, aggravates, intimidates, or causes humiliation to another person. Patient/residents, employees, suppliers, and contractors shall have the right to a safe and professional environment. As such, this applies to all employees, contracted staff, volunteers, vendors, trustees, physicians, patient/residents, and any other person having business with MidMichigan Health.

**Important Numbers:**
Corporate Compliance Hotline: 989-837-5471
Employee Health/Infection Control: 989-839-3286
Switchboard: 0
Security (Midland): 989-839-1911
MyHR Service Center: 855-222-3230

11/04, 11/14, 6/15
Influenza Education
Influenza Education for Providers

What is influenza?
- Influenza is also known as the flu.
- It is a contagious disease caused by the influenza virus that infects the respiratory tract.
- Unlike many other viral respiratory infections, like the common cold, the flu may cause life-threatening complications in some people including:
  - Pneumonia
  - Dehydration
  - Worsening of chronic medical conditions such as CHF, asthma, or diabetes
  - Sinus problems and ear infections
- Those most at risk for complications include people 65 years of age or older, people with chronic medical conditions, pregnant women, and young children.

Influenza statistics
- Influenza is the 8th leading cause of death in the U.S. and is responsible for more than 959,000 hospital admission and 79,400 deaths every year.
- During the 2017-2018 flu season an estimated 48.8 million people contracted the flu.

Symptoms
- The symptoms usually start suddenly and may include:
  - Fever
  - Headache
  - Tiredness
  - Cough
  - Sore throat
  - Runny or stuffy nose
  - Body aches
  - Diarrhea and vomiting (more common among children than adults)

Spreading the flu
- The flu typically spreads through respiratory droplets when someone sneezes or coughs.
- It may also be spread when an individual touches a contaminated surface and then touches his/her mouth, nose, or eyes.
- The flu can be spread for 24-48 hours before an individual has symptoms and up to 5 days after becoming ill.

Flu Season and the Vaccine
- In the U.S., the flu season is generally from October through May; however, it can occur at any time during the year. It generally peaks from late December to early March.
- An annual influenza vaccine is the best way to reduce the chances that you will get the flu and the best time to get vaccinated is in September or October.
• It takes about two weeks after receiving the flu vaccine for antibodies to develop and provide protection against infection.
• Every year MidMichigan Health offers the influenza vaccine to employees and providers free of charge; staff who do not receive the vaccine are required to wear a mask during the flu season.
• The influenza vaccine is 70-90% effective in preventing influenza among healthy individuals less than 65 years of age.

Diagnosing the Flu
• Tests are available to determine whether or not an individual has influenza; these tests need to be done within the first two or three days of illness.
• Tests to diagnose influenza can be ordered through any of the MidMichigan Health laboratories.

Treatment
• Individuals with the flu are usually treated symptomatically.
• Influenza antiviral medications can also be used to treat the flu.
  o The CDC recommends these medications be used to treat people who are very ill or who are at high risk of serious flu-related complications.

Preventing the spread of the flu
• Cover your nose and mouth when you cough or sneeze with a tissue, then throw the tissue away.
• If tissue is not available, cough or sneeze into the bend of your arm to prevent contamination of your hands.
• Wash hands often with soap and water, especially after you cough or sneeze. If soap and water are not available, use alcohol hand gel.
• Avoid close contact with others who are ill.
• When you are ill, keep your distance from others to prevent them from becoming ill and stay home from work.
• Avoid touching your eyes, nose, or mouth.

References:
www.cdc.gov/flu

Reviewed 9/2019
Infection Prevention
Practitioner Education - Infection Prevention

The prevention of HAI (health care associated infection) involves the actions of all HCW (healthcare workers)!

Standard Precautions are used to protect you, others, and the environment from blood and body fluids. We also use these precautions when patients are colonized with multi-drug resistant organisms (MDRO). Additional transmission based precautions should be instituted when the patient has “uncontained body secretions” or is infected with highly transmissible pathogens. Nursing or physicians may institute precautions.

- Please notify Infection Prevention to coordinate discontinuing precautions per the health system policy.
- Infection Prevention will coordinate reporting of communicable diseases to the local health jurisdiction.
- Respirator Fit testing for n-95 respirators is done in Employee Health (839-3286) by appointment. Fit testing should be done annually, if applicable.
- MidMichigan Health surveys for MDRO; additional precautions may be instituted in the event of an outbreak or to prevent transmission.
- Based on our risk assessment, the most common types of MDROs seen in our patient population are MRSA, VRE, C Diff, and Acinetobacter.
- Strategies for the prevention of MDROs include:
  - Consistent and appropriate hand hygiene,
  - Cleaning equipment such as stethoscopes between patients,
  - Environmental controls, i.e., pressure relationships, ventilation
  - Appropriate use of antibiotics
- Patients who have a history of colonization or who have an active infection with a MDRO will have this documented in the medical record on the “Problems & Diagnosis” list or banner bar in EPIC

Proper Hand Hygiene
- Use alcohol hand gel on visibly clean hands when entering and exiting the patient room. Hand hygiene must be performed using soap and water when hands are visibly soiled and after removing visibly soiled gloves.
- Wearing gloves does not replace hand hygiene.
- Gloves are considered soiled; avoid contamination of the environment by not wearing gloves or personal protective equipment outside the patient room.

Urinary (Foley) Catheter Associated Urinary Tract Infections (CAUTI). Use catheters only when needed; indications include:
- Assist perineal/sacral wound healing
- Bladder irrigation
- Chronic or indwelling upon admission
- Hemodynamic monitoring in a critically ill patient
- Hospice/Comfort /Palliative care
- Prolonged immobilization, trauma, surgery
- Retention or bladder outlet obstruction
- Urologic/gynecologic surgery/procedure

Remove Foley catheters as soon as possible; consider alternatives to Foley catheters.

MidMichigan Health has implemented a nurse-driven catheter removal protocol when there is no pre-existing order. Patients with an indwelling catheter will be assessed to determine if there is an appropriate indication for an indwelling catheter. If there is not an appropriate indication, the catheter will be discontinued and a “per scope (protocol) co-sign” order will be entered into the record. A culture should not be sent from a catheter that has been in place for more than 48 hours.

Surgical Site Infection Prevention:
- Aseptic technique (including hat, mask, gown, gloves) is used for all sterile procedures and surgeries at MidMichigan Health.
- Appropriate prophylactic antibiotics should be administered within 1 hour of incision (2 hours for some antibiotics) for certain surgical procedures
• Prophylactic antibiotics should be discontinued within 24 hours of surgery end time (48 hours for cardiac surgeries)
• MidMichigan Health ensures appropriate temperature, humidity levels and air flow in procedural areas
• Please report post-operative and post-procedure infections to Infection Prevention.
• Pharmacy and lab provide an antibiogram annually for each MidMichigan Health facility.

Central Line Associated Blood Stream Infection (CLABSI).
• Choosing the appropriate venous access (peripheral v. PICC, v. midline) helps prevent CLABSIs and other complications.
• Please refer to the MidMichigan Health “VENOUS ACCESS GUIDELINES” policy to help guide appropriate vascular access selection decisions. This policy includes the Michigan Appropriateness Guide for Intravenous Catheters (MAGIC) which is a strategy that has been found to decrease vascular access complications. There is also an app for MAGIC which can be downloaded to your personal devices, i.e., mobile phone.
• When ordering central venous access catheters, increased use of single lumens and avoiding the use of double and triple lumen catheters, whenever possible, has significantly decreased the rates of CLABSIs. It also decreases catheter patency issues and thrombolytic complications.
• Use proper insertion techniques to reduce the risk of infection. These include:
  o Use maximal sterile barriers during insertion (mask, cap, gown, sterile gloves, full body drape)
  o Skin antisepsis is done with > 0.5% chlorhexidene with alcohol. Scrub for 30 seconds, dry for 2 minutes.
  o Avoid femoral insertion sites; use the best site to minimize infection and complications.
  o Use sterile gauze or semi-permeable dressings
  o Document the procedure on the “Central line Insertion Procedure Note”.
  o Use catheter insertion checklist
  o Scrub ports for 15 seconds before accessing
  o Discontinue lines as soon as possible
  o Central lines considered a source of infection should not be replaced over a guide wire.

Promote Immunizations
• MidMichigan Health has implemented influenza and pneumococcal standing orders for inpatients unless otherwise contraindicated. The vaccine is given ASAP.
• MidMichigan Health has an active influenza prevention program that promotes vaccination of employees. Unvaccinated staff will wear a mask during the influenza season.
• Follow ACIP guidelines that promote pneumococcal immunization for those at risk

Clostridium Difficile
• An order set is available for C Diff with best practice recommendations for antibiotic ordering
• A nursing panel may be utilized by nursing to order C Diff testing and to implement transmission based precautions.
Professionalism Policy
Medical Staff Professionalism Policy with Procedure

Applicability

- Medical Center-Clare
- Medical Center-Gladwin
- Medical Center-Gratiot
- Medical Center-Midland
- Medical Center - Alpena
- Medical Center-Mount Pleasant

Purpose

To enhance patient care by promoting a safe, cooperative and professional healthcare environment and to prevent or eliminate to the greatest extent possible conduct which disrupts the operation of the Medical Center, affects the ability of others to do their jobs, creates a "less than safe environment" for Medical Center employees or other medical staff members, or interferes with an individual's ability to practice safely and competently.

Policy

I. POLICY

1. It is the policy of MidMichigan Health and its Medical Staff that all individuals within its facilities be treated courteously, respectfully and with dignity. To that end, the Board of Directors (the "Board") and the Medical Staff Bylaws of the Medical Center require Physicians, all members of the medical staff and other independent physicians who are granted clinical privileges to practice at the Medical Center (here and after collectively referred to as "Physicians") to conduct themselves in a professional and cooperative manner and to abide by all Medical Center policies and procedures.

2. This policy outlines collegial and educational efforts that can be used by medical staff leaders to address conduct that does not meet the standard. The goal of these efforts is to arrive at voluntary responsive actions by the individual to resolve the concerns that have been raised and thus avoid the necessity of proceeding through the disciplinary process in the Procedural Policy.

3. This policy also addresses "identity-based" harassment (defined in Section III below) of employees,
patients, other members of the medical staff, and others, which will not be tolerated.

4. If a Physician engages in inappropriate conduct as herein defined, or otherwise fails to conduct him or herself appropriately, the matter is addressed in accordance with this policy. It is the intention of the Medical Center that this policy be enforced in a firm, fair and equitable manner.

5. The Medical Executive Committee (the "MEC"), as delegated by the Board, shall have the authority to address inappropriate conduct. The Medical Center's Chief of Staff, Chief Executive Officer, and Vice President of Medical Affairs (VPMA), shall also have the authority to address inappropriate conduct as designees of the MEC. Egregious incidents, such as sexual harassment, physical or verbal assault, fraudulent acts, stealing, throwing equipment, or inappropriate physical behavior may result in precautionary suspension or immediate termination of medical staff membership and/or privileges in accordance with the Medical Staff Procedural Policy. The Board may, at its discretion, conduct an inquiry into allegations and instances of inappropriate conduct or refer disruptive behavior with clinical consequences to the MEC. Purely clinical issues are the primary responsibility of the medical staff through the MEC and its peer review process.

II. INAPPROPRIATE CONDUCT: For the purposes of this Professionalism Policy, inappropriate conduct shall be defined as conduct that:

1. Disrupts the orderly and efficient operation of the Medical Center.

2. Interferes with patient care or the Medical Center's staff, employees, or others in performing their duties.

3. Distracts from an employee's, Physician's or other health professional's ability to practice competently in the Medical Center.

III. EXAMPLES OF INAPPROPRIATE CONDUCT: To aid in both the education of medical staff members and the enforcement of this policy, examples of "inappropriate conduct" within the facilities which may undermine a culture of safety include, but are not limited to:

1. Threatening or abusive language directed at patients, nurses, hospital personnel, allied health professionals or other Physicians. (Example: Belittling, berating, and/or nonconstructive criticism that intimidates, undermines confidence, or implies incompetence).

2. Degrading or demeaning comments regarding patients, families, nurses, Physicians, hospital personnel, or the hospital.

3. Profanity or similarly offensive language while in the hospital, and/or while speaking with nurses or other hospital personnel.

4. Inappropriate physical conduct with another individual that is threatening or intimidating.

5. Derogatory comments about the quality of care being provided by the hospital, another medical staff member, or any other individual that are made outside of appropriate medical staff and/or administrative channels.

6. Inappropriate medical record entries impugning the quality of care being provided by the Medical Center, medical staff members, or any other individual.

7. Refusal to abide by medical staff requirements as delineated in the Medical Staff Bylaws, credentials policy, and rules and regulations (including but not limited to emergency call issues, response times, medical record keeping, and other patient care responsibilities), failure to participate on assigned committees, and an unwillingness to work cooperatively and harmoniously with other members of the
medical and hospital staff.

8. Inappropriate access, use, disclosure, or release of confidential patient information.

9. Audio or video recording that is not consented to by others present, including patients and other members of the care team.

10. Use of social media in a manner that involves inappropriate conduct as defined in this policy or other Medical Staff or Hospital policies.

11. Engaging in "identity-based" harassment which includes, but is not limited to, sexual harassment and racial, ethnic, religious, gender identity, or sexual orientation discrimination. Identity-based harassment is verbal or physical conduct that: (i) is unwelcome and offensive to an individual who is subject to it or who witnesses it; (ii) could be considered harassing from the objective standpoint of a "reasonable person"; and (iii) is covered by state or federal laws governing discrimination. Examples include, but are not limited to, the following:

A. **Verbal**: innuendoes, epithets, derogatory slurs, offcolor jokes, propositions, graphic commentaries, threats, and suggestive or insulting sounds;

B. **Visual/NonVerbal**: derogatory posters, cartoons, or drawings; suggestive objects or pictures; leering; and obscene gestures;

C. **Physical**: unwanted physical contact, including touching, interference with an individual's normal work movement, and assault; and

D. **Other**: making or threatening retaliation as a result of an individual's complaint regarding harassing conduct.

IV. **GUIDELINES**:

1. Issues of employee conduct will be dealt with in accordance with the hospital's Human Resources policies. Issues of conduct by members of the medical staff will be addressed in accordance with this policy.

2. Inappropriate conduct is expressly prohibited and is not to be tolerated.

3. Any instance or instances, or allegations of, inappropriate conduct, being a single occurrence or multiple acts, may be grounds for immediate inquiry by the MEC, the Chief of Staff, Chief Executive Officer, or Vice President of Medical Affairs (VPMA) as the designees of the MEC.

4. Precautionary suspension may be appropriate pending this process and may be initiated pursuant to the Medical Staff Procedural Policy.

5. Documentation of inappropriate conduct is critical since it is ordinarily not one incident that leads to disciplinary action, but rather a pattern of inappropriate conduct. Such documentation must include:

   A. The date and time of the alleged inappropriate conduct.
   
   B. A signed and dated statement which includes information as to whether the conduct affected or involved a patient in any way, and if so the name of the patient and the basis for the belief.
   
   C. The circumstances which precipitated the situation, if known.
   
   D. A signed and dated factual description of the questionable conduct limited to factual, objective language as much as possible and which incorporates the issues identified as inappropriate conduct under this policy.
   
Center operations.

F. Record of any action taken to remedy the situation including date, time, place, action, and name(s) of those intervening, and the name and title of the person making the statement.

V. **IDENTITY-BASED HARASSMENT CONCERNS:** Because of the unique legal implications surrounding identity-based harassment, a single confirmed incident requires the following actions:

1. A meeting shall be held with the physician to discuss the incident. If the physician agrees to stop the conduct thought specifically to constitute identity-based harassment, the meeting shall be followed up with a formal letter of admonition and warning to be placed in the confidential portion of the physician’s quality file. This letter shall also set forth those additional actions, if any, which result from the meeting.

2. If the physician refuses to stop the conduct immediately, this refusal shall result in the matter being referred to the MEC for review pursuant to the Medical Staff Procedural Policy.

3. Any reports of retaliation or any further reports of identity-based harassment, after the physician has agreed to stop the improper conduct, shall result in an immediate investigation by the MEC (or its designee(s)). If the investigation results in a finding that further improper conduct took place, a formal investigation in accordance with the Medical Staff Procedural Policy shall be conducted. Should this investigation result in an action that entitles the individual to request a hearing under the Medical Staff Procedural Policy, the individual shall be provided with copies of all relevant complaints so that he or she can prepare for the hearing.

This policy is the sole process for dealing with inappropriate behavior and shall be interpreted and enforced by the Board.

**Procedure**

1. Any person, including Physicians, employees, patients or visitors of the Medical Center may report potentially inappropriate conduct. The report shall be submitted to the Chief Executive Officer or the Chief of Staff.

2. Once received, the Physician shall be notified of the complaint and an inquiry will be conducted by the Chief of Staff, VPMA, or Chief Executive Officer, as designees of the MEC. Such an inquiry shall be conducted in a timely fashion, not to exceed seven days without good cause. In conducting the initial inquiry, the Chief of Staff, Chief Executive Officer, or VPMA may obtain information from relevant sources to ascertain details of the incident and to determine whether an incident of inappropriate conduct has likely occurred.

3. Within seven days of their receipt of such report, the Physician in question and his/her department chairman, if requested and accepted, shall attend a private meeting with the Chief Executive Officer, VPMA, or Chief of Staff, and the following process shall be followed:

   A. The Chief of Staff, VPMA, or the Chief Executive Officer shall provide the Physician written notice of the time, date and location of the meeting, and the notice shall include a brief written summary statement of the nature of the incident to be discussed (the time, date, location and description of the event).

   B. At the fact-finding meeting, the Physician shall be afforded the opportunity to respond to the allegations and the Chief of Staff, VPMA, or Chief Executive Officer shall be entitled to ask the Physician questions. The Physician will also be invited to submit a written summary of his/her recollection of the event in question.
C. Legal counsel for either party will not be present at this meeting since it is considered a collegial intervention.

D. The Physician shall be provided a copy of this policy, along with a verbal reminder of the Medical Center's zero tolerance for inappropriate conduct and retaliation against those who report it.

E. The meeting conducted hereunder shall not constitute a hearing as defined in the Medical Staff Bylaws, nor shall the Physician be afforded any of the procedural rights of the medical staff bylaws.

4. Once the meeting with the Physician is concluded, the Chief Executive Officer, VPMA, or the Chief of Staff shall determine what, if any, follow-up action is needed. They may continue their inquiry by referring it back to the MEC or close it, upon receipt of approval by the MEC. At a minimum, the following steps shall be taken:

A. The Chief of Staff, VPMA or Chief Executive Officer shall provide the Physician written follow-up of the discussion, summarizing the allegations and the Physician's response and restating the Medical Center's zero tolerance policy.

B. The written statement shall include the specific follow-up action determined to be appropriate, including any additional investigative steps. If the allegations are not found to be credible, a statement to that fact shall also be included. The written statement must be signed and dated by the Chief of Staff, VPMA or Chief Executive Officer, and the Physician.
   a. The Physician shall be notified that should inappropriate conduct continue or occur again, the matter will be reviewed by the MEC and that additional formal corrective action may be taken.
   b. A copy of the report and written follow-up shall be maintained in the Physician's peer review file.

5. If the Chief of Staff, VMPA or Chief Executive Officer determine, based on the above review and meeting with the Physician, that further inquiry and/or action is necessary, the matter shall be referred back to the MEC for further action. An apparent pattern of inappropriate conduct shall always warrant referral of the matter to the MEC for further investigation/inquiry.

6. If the matter is referred back to MEC and if further inquiry is determined to be warranted, the Physician shall be informed by the Chief of Staff, VPMA or Chief Executive Officer in writing of the results of such inquiry and shall be given the opportunity to make an additional response in the event new information regarding the incident is obtained. The MEC shall conduct an inquiry into the matter in accordance with the Medical Staff Procedural Policy.

7. The MEC shall, in its sole discretion, determine whether corrective action is warranted. If the MEC determines such action is indicated, the MEC shall make the appropriate recommendation, which may include a suspension or termination of medical staff privileges, and thereafter comply with the requirements imposed by the Medical Staff Procedural Policy.

8. All steps taken in the process shall be treated as a confidential peer-review matter.

9. The MEC may, in its sole discretion, refer the Physician for a psychological or medical evaluation by a provider mutually agreed upon by both the MEC and the Physician.

Disclaimer

Employees covered under a bargaining agreement will be subject to the terms of that agreement.

Attachments: No Attachments
Applicability

MidMichigan Health, MidMichigan Home Care, MidMichigan Medical Center - Alpena, MidMichigan Medical Center - Clare/Gladwin, MidMichigan Medical Center - Gratiot/Mt. Pleasant, MidMichigan Medical Center - Midland, MidMichigan Physicians Group
Provider Education Information
Providing Safe Anticoagulant Therapy at MidMichigan Health

As providers know, anticoagulant therapy is used in the treatment of a number of conditions, including atrial fibrillation, deep vein thrombosis, pulmonary embolism, and mechanical heart valve implants. As with all medications, there is the potential to cause patient harm; this risk is more likely with the use of anticoagulants due to the complexities in dosing and inconsistent patient compliance. To provide for safe and effective dosing and monitoring of patients, MidMichigan Health has developed policies, procedures, processes, and services to help ensure the safest possible care for patients receiving anticoagulant therapy. This requires a team of healthcare providers, pharmacists, laboratory staff, nursing staff, and clinical dietitians.

MidMichigan Health Strategies:

- Policies & Procedures (located on the intranet)

- Managing anticoagulants
  - Providers may choose to dose anticoagulants themselves or they can have the Pharmacy dose and manage them.
  - If providers wish to have Pharmacy dose and manage, they can do so by placing an order for a Pharmacy consult

- Anticoagulation clinics
  - Currently, we have five (5) anticoagulation clinics within our health system. They are located at our Medical Centers in Clare, Gladwin, Gratiot, Midland and Alpena.
  - To refer a patient to the anticoagulant clinic
    - Inpatients – Place order in electronic medical record; a pharmacist will see the patient prior to discharge to provide education and schedule the first clinic appointment
    - Outpatients – Place an order via the electronic medical record; the clinic will contact the patient to schedule their first appointment and education will be provided in the clinic at their initial visit and all subsequent follow-up visits.

- Importance of follow-up monitoring
  - Patients receiving heparin infusions
    - If the patient has not had a PTT within the previous 24 hours, an order for a PTT and a baseline hemogram (hemoglobin, hematocrit, and platelet count) will be placed by Pharmacy; if the patient is on warfarin at home, a PT/INR will also be ordered.
    - PTT is drawn every 6 hours; hemogram drawn every Monday/Wednesday/Friday
    - Once PTT therapeutic for two (2) consecutive results, PTT will be drawn once daily
  - Patients receiving warfarin
    - PT/INR drawn daily
    - Hemogram every Monday/Wednesday/Friday
Patients receiving LMWH or Factor Xa inhibitors

- Creatinine clearance will be obtained prior to administration

Patients receiving Direct Oral Anticoagulants (DOACs)

- DOACs include apixaban (Eliquis®), rivaroxaban (Xarelto®), edoxaban (Savaysa®) and dabigatran (Pradaxa®)
- With the rising popularity of DOACs, it is extremely important for patients to fully understand the risks of these medications
- Education will be provided to patients and their family members on DOACs to help reduce the risk of bleeding and clotting. Education will be specific to the anticoagulant prescribed.
- Creatinine clearance will be obtained prior to administration and at minimum every six months while taking a DOAC.

Patients discharged on anticoagulants will be provided education about the importance of follow-up monitoring by nursing staff and/or a pharmacist; providers are encouraged to reinforce this as well.

Patients will also receive education about the need to watch for and report signs/symptoms of unusual bleeding and when to contact physician or visit the emergency department.

• Compliance
  - Patients will be instructed about the importance of compliance with taking anticoagulant medications as well as follow-up monitoring. This education should be reinforced by the provider.

• Drug-food interactions
  - Patients discharged on warfarin will receive counseling on how diet impacts the management of warfarin. This may be provided by nursing staff, pharmacy, or the dietitian.
  - Patients are counseled to have a moderate and consistent intake of vitamin K-rich foods.

• Potential for adverse drug reactions and interactions
  - A variety of medications can interact with warfarin, in particular, either by potentiating or inhibiting its effects. Patients will be instructed not to start or discontinue any medications, supplements, etc. without first discussing it with his/her provider.

• Reversal of Anticoagulation
  - MidMichigan Health has an evidence-based anticoagulation reversal protocol in place for patients that may need to have their anticoagulation therapy reversed due to bleeding issues.

• Perioperative assessment and communication are critical when it comes to anticoagulation.
  - Before surgery and outpatient procedures, perioperative assessment is critical to assess clotting and bleeding risk.
  - Anticoagulation will be assessed by providers, nurses and pharmacists when patients will be having any procedure. Pharmacy will always be available to help make recommendations.
  - For perioperative management of anticoagulation, the following will be addressed:
- Use of bridging medication, timing for stopping an anticoagulant, and timing and dosing for restarting an anticoagulant.
- The patient’s bleeding risk and renal function, as well as the half-life of the medication.

If you have any questions or require additional information regarding anticoagulation therapy, please contact one of the MidMichigan Health pharmacists at the number listed below.

- Clare: (989) 802-5107
- Gladwin: (989) 246-9417
- Gratiot: (989) 466-7218
- Midland: (989) 839-3543
- Alpena: (989) 356-7376
- West Branch (989) 343-3536

Revised 9/2019
Pain Management for Prescribers

Statistics on Pain:
- Pain is the most common reason for patients to seek out health care.
- Over 100 million adults in the United States suffer from chronic pain (AAPM).
- Pain costs the U.S. Approximately $560-635 billion annually in health care costs as well as lost productivity.
- Research shows that 50-75% of patients dying from cancer die in moderate to severe pain.

Food for thought:
- As many as 1 in 4 patients receiving opioids for chronic pain develops opioid use disorder (JAMA, 2016).
- If pain is inadequately managed, it can result in poor functional level, diminished quality of life, and depression.
- Demerol is not favored by pain management experts. If it is used, it is recommended that it be used only for a few days because of the active metabolites which can accumulate in the body, especially in the elderly and those with renal impairment.

Pain Types:
There are two major pain pathways, these are nociceptive and neuropathic. The first major pain pathway is nociceptive pain, and it is essential to detect and minimize noxious stimuli through the process of transduction, transmission, perception, and modulation. This type can be described as the “scouts and feelers” as the function is to look for abnormal messaging to send to the brain. An easy way to differentiate this type of pain is to notice that if the pain is outside of the nerves, it is nociceptive pain. Pain due to an inflammatory response presents as hypersensitivity that reduces further risk of damage and promotes recovery. It is caused by activation of the immune system by tissue injury or infection. The second major pathway to pain known as neuropathic pain is an expression of abnormal functioning of the nervous system; it is pain as a disease. Neuropathic pain can be divided into central and peripheral pain generators. Central neuropathic pain is idiopathic in nature. This pain is derived from the limbic system and is particularly an insular cortex malfunction. There are also many other conditions that evoke dysfunctional pain such as fibromyalgia, irritable bowel syndrome or interstitial cystitis. Peripheral neuropathic pain presents in diseases such as carpal tunnel syndrome. Such pain persists well beyond resolution of the initial injury. Another example is an acute episode of shingles can cause damage to nerve endings that results in post herpetic neuralgia. The processes that drive each type of pain are quite different, treatments must be targeted at the distinct mechanisms responsible (Woolf, 2010).

Assessing Pain:
- An accurate and complete assessment screening is required for adequate pain management (R3Report)
- One common method is the “OPQRSTU” method; this assessment includes the following:
  - Location of the pain
  - Onset (When did the pain start?)
  - Palliative and provocative features (What makes it worse/better?)
  - Quality (what are the characteristics of the pain?)
  - Radiation (Does the pain move anywhere else?)
  - Severity (How bad does it hurt?)
Timing (Is the pain constant or intermittent?)
Understanding (What does the patient understand about his/her pain?)

• At MidMichigan Health the following pain scales are used as appropriate to the patient’s condition:
  o Numeric pain rating scale
    ▪ Used for patients who are cognitively intact and able to provide information
  o Wong-Baker FACES pain scale
    ▪ Often used in children
  o FLACC scale
    ▪ Used for individuals who are unable to provide information about their pain
    ▪ Pre-verbal children, patients with cognitive impairment
  o NIPS
    ▪ Used in infants

• Other ways to assess:
  o Naïve/Tolerant
    ▪ We will assess for opioid naivety/tolerance at admission
  o MOSS/POSS
    ▪ Michigan Opioid Safety Score (MOSS) and Pasero Opioid Sedation scale (POSS) will be assessed at admission and throughout stay

• Behavioral cues and vital signs may also be helpful in assessing pain
• Culture/spiritual needs/psychological beliefs
• Personal perception

Managing Pain:
• Determine if the patient has acute, chronic pain, or both; this is key to establishing an effective plan.
• Consider that patients who routinely use pain medications at home for chronic pain and those with substance abuse issues will likely require higher doses of pain medications to treat acute pain. Unless contraindicated, the patient’s usual pain medications should be ordered while they are hospitalized.
• Constant pain (including post-op pain) requires around-the-clock analgesia, not just PRN
• Pain classifications
  o Acute Pain
    ▪ A warning sign
    ▪ Time limited, diminishes as healing takes place
    ▪ Causes usually known
    ▪ May be changes in vital signs
  o Chronic Pain (Persistent)
    ▪ Pain lasting past the normal healing time
    ▪ Pain serving no protective function
    ▪ Typically persists for more than 3 months
    ▪ Vegetative, depressive signs
    ▪ Objective signs may be absent
  o Nociceptive pain
    ▪ Typically, responds well to common analgesic medications and nondrug strategies
Neuropathic pain
- Often described as tingling, or numbness
- Does not respond as predictably to conventional analgesics

Pharmacological options
- Consider that various types of pain respond better to certain types of pain medications.
  - NSAIDS tend to work best for bone pain.
  - Anticonvulsants and local anesthetics tend to work best on neuropathic types of pain.
  - Opioids tend to work best for acute moderate to severe pain.
  - Muscle relaxants trend to work well for muscular types of pain.
- A combination of these may be needed to effectively treat pain.

Consider using non-pharmacological interventions as well to treat pain
- PT can provide hot packs, TENS units, iontophoresis, and ultrasound.
- The use of a heating pad or hot pack requires a physician’s order.
- Ice packs may be helpful, if appropriate.

Consider that patients who routinely use pain medications at home for chronic pain and those with substance abuse issues will likely require higher doses of pain medications to treat acute pain while they are in the hospital.
- Unless contraindicated, the patient’s usual pain medications should be ordered while the patient is hospitalized

Consider that patients who are “drug seekers” may do so because their current treatment plan is not effective.

The consequences of persistent pain are profound. They include mood disorders (depression, hopelessness, anxiety), impaired physical and social functioning including job loss and its attendant financial problems. “Cognitive impairment alters the experience of pain, the ability to communicate that experience, and how it is treated medically.” As noted in a previous slide, health care utilization is frequent among people with pain. An estimated 42 million Americans report that pain or physical discomfort disrupts their sleep a few or more nights a week. “There is a strong relationship between pain and sleep such that insomnia increases both the likelihood and severity of clinical pain.”

Nursing staff will contact the provider if current interventions are not adequately managing the patient’s pain

Opioid Safety:
The most dangerous adverse effect of opioid analgesics is respiratory depression (R3 Report, 2017)

Pain assessment and management standards for hospitals
Effective Jan. 1, 2018, new and revised pain assessment and management standards will be applicable to all Joint Commission-accredited hospitals. These standards — in the Leadership (LD); Medical Staff (MS); Provision of Care, Treatment, and Services (PC); and Performance Improvement (PI) chapters of the hospital accreditation manual — are designed to improve the quality and safety of care provided by Joint Commission-accredited hospitals. The new and revised standards accomplish this by requiring hospitals to:
- Identify pain assessment and pain management, including safe opioid prescribing, as an organizational priority (LD.04.03.13).
• Actively involve the organized medical staff in leadership roles in organization performance improvement activities to improve quality of care, treatment, and services and patient safety (MS.05.01.01).
• Assess and manage the patient’s pain and minimize the risks associated with treatment (PC.01.02.07).
• Collect data to monitor its performance (PI.01.01.01).
• Compile and analyze data (PI.02.01.01).

**Engagement with stakeholders, customers, and experts**
Patients with the following risk factors are at increased risk for respiratory depression with the use of opioids:
- Sleep apnea
- Snoring
- BMI >40>75 years of age, concomitant sedatives received within 2 hours
- Opioid Naive
- Post-operative
- upper abdominal or thoracic surgery
- Higher doses of opioids
- Opioid tolerant
- Anesthesia time >3 hours (within 24 hours of assessment)
- Pre-existing pulmonary or cardiac disease or dysfunction or major organ failure
- Smoker

Recommendations for preventing respiratory depression/arrest include:
1. Screen patients for respiratory depression risk.
2. Use multimodal pain management techniques.
3. Equianalgesic dosing –(refer to OME chart and applications provided in this media)
4. Consider use of analgesia adjuvants such as physical therapy, ice, manipulation, or massage.
5. Consider the use of PCA with ETCO2 monitor.
6. Consider the use of non-opioid medications, i.e., acetaminophen, NSAIDs, antidepressants, anticonvulsants, muscle relaxants.
7. Consult a pharmacist or pain management expert when converting from one opioid to another or when changing the route of administration.
8. Take extra precautions with patients who are new to opioids; start at a lower dose and titrate as needed, allowing sufficient time to assess the patient’s response before increasing the dose.
9. Consider prescription for Naloxone if prescribing >50 OME/day.

**Treatment:**
• Develop treatment plan according to clinical condition, past medical history, and pain management goals (Joint Commission).
• Include patient and support persons in plan of care and expectations for pain management, including limitations, tapering plan, and appropriate disposal.
• Dispense a sensible amount of medication for pain management, specialized to individual.
• Provide the lowest effective dosage of opioids to reduce risk of opioid use disorder and overdose.
• Provide education for multi modal medications and non-pharmacological options.
• Assess improvements in pain and function regularly.
• Monitor patients for signs of opioid use disorder.
Summary:

- Pain is more than an unpleasant sensation
- Knowledge of the physiology of pain provides a framework for appropriate therapies
- Recognition of pain as a biopsychosocial experience is essential to all aspects of the care of persons with pain

Sources:
1. American Academy of Pain Management (http://www.painmed.org/)
   A complimentary publication of The Joint Commission Issue 11, August 29, 2017
3. AHRQ Pain Management Guideline (www.guideline.gov)

Reviewed 9/2019
## Oral Morphine Equivalence Chart – Drug 10

<table>
<thead>
<tr>
<th>Opioid</th>
<th>Conversion Factor</th>
<th>Drug schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Natural Opioid (Opiates)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Codeine</td>
<td>0.15</td>
<td>III</td>
</tr>
<tr>
<td>Morphine</td>
<td>1.0</td>
<td>II</td>
</tr>
<tr>
<td>Semi-Synthetic Opioid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>1.0</td>
<td>II</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>4.0</td>
<td>II</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>1.5</td>
<td>II</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>3.0</td>
<td>II</td>
</tr>
<tr>
<td>Synthetic Opioid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tramadol</td>
<td>0.1</td>
<td>IV</td>
</tr>
<tr>
<td>Tapentadol</td>
<td>0.4</td>
<td>II</td>
</tr>
<tr>
<td>Methadone</td>
<td>Variable/ high potency</td>
<td>II</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>Variable/ high potency</td>
<td>II</td>
</tr>
</tbody>
</table>

**CAUTION ADVISED:** Opioids may cause serious adverse events including sedation, respiratory depression, anaphylaxis, addiction and death. There is also a risk for diversion. Universal precautions, biopsychosocial evaluation and risk assessment are required before initiating or continuing them. Major risk factors include: 1) age > 65 years, 2) prior adverse opioid event, 3) morphine equivalence > 20 mg/day, 4) substance use disorder, 5) social alcohol use or medicinal cannabis use while taking opioids, 6) psychiatric disorder, 7) benzodiazepine/opioid prescribing, 8) high medical risk conditions such as cognitive disturbances, respiratory compromise, obesity and ornal impairment with OMR > 30, 9) opioid addiction, opioid relapse and opioid-drug interactions, and 10) red flag such as aberrant behaviors, inconsistent drug screen, violation of controlled substance agreement and dissatisfied MAPS report. Weighing the risk and benefit as well as diligent monitoring is absolutely necessary to ensure safety and quality of care.
Applications of the Oral Morphine Equivalence (OME)

Opioid selection: It is best to avoid opioids whenever possible. If an opioid is to be initiated, OME can be used to shed light on the potency selected. However, OME is not a sole indicator of risk. For example, tramadol 50 mg BID (schedule IV) and hydrocodone 5 mg BID (schedule II) have a similar OME but the risk associated with hydrocodone is much greater.

Opioid titration: It is best to use low dose opioids. If the dose is increased, slow titration is recommended while being mindful of the final dose. OME helps define the rate at which potency is increasing and the potency of the final dose.

Opioid maintenance: It is best to optimize non opioid therapies for chronic pain management. If an opioid is chronically prescribed consideration must be given to the maintenance dose. OME helps define what dose the practitioner has considered acceptable for the patient.

Opioid tapering/discontinuation: It is best to taper opioids whenever possible. Use of the OME may trigger a decision to taper. It may also be used to assist with the rate of tapering and defining the target dose if opioids are continued.

Opioid rotation: It is best to minimize exposure to different kinds of opioids except if part of a risk reduction strategy. At times a decision may be made to switch from one opioid to another. The OME can assist with calculating the doses during conversion. Due to lack of complete cross tolerance, 25 % dose reduction is advised.

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>Caution with methadone/fentanyl</td>
</tr>
<tr>
<td>Step 2</td>
<td>Caution with lung, liver and renal disease</td>
</tr>
<tr>
<td>Step 3</td>
<td>Calculate OME of current opioid(s)</td>
</tr>
<tr>
<td>Step 4</td>
<td>Calculate dose of desired opioid</td>
</tr>
<tr>
<td>Step 5</td>
<td>Reduce dose by 25 %</td>
</tr>
<tr>
<td>Step 6</td>
<td>Close follow up</td>
</tr>
</tbody>
</table>

![Graph showing number of deaths against OME (mg/m2)](JAMA.2011.305(19):1315-1321)
Provider Education on the Use of Restraints & Seclusion at MidMichigan Health

- Our philosophy regarding the use of restraints and/or seclusion is that they are used **only** when less restrictive interventions have not been effective.

- When restraints are required, the least restrictive form that protects the physical safety of the patient, staff, and others will be used.

- There are two reasons that restraint use may be necessary
  - Management of non-violent, non-self-destructive behaviors
    - Primary use in these instances is to support medical healing, i.e., prevent patient from extubating himself
    - Typically used when the patient’s safety is compromised due to impaired decision-making abilities
  - Management of violent, self-destructive behaviors
    - Utilized when there is a sudden, unanticipated burst of severely aggressive, violent, or destructive behavior that is an immediate and serious threat to the safety of the patient, staff, or others

- The use of medications to manage a patient’s behavior is considered a chemical restraint when it is used to restrict or manage a patient’s behavior and it is **not a standard treatment or dosage** for the patient’s condition. Chemical restraints must be treated the same as physical restraints used for managing violent, self-destructive behaviors.

- Seclusion is the voluntary confinement of a patient alone or in a room or area from which the patient is prevented from leaving.
  - Seclusion may only be used on the inpatient behavioral health units
  - Seclusion is used only for the management of violent or self-destructive behaviors

<table>
<thead>
<tr>
<th>Key Points for the Provider</th>
<th>Restraints used for management of non-violent, non-self-destructive behaviors</th>
<th>Restraints used for management of violent, self-destructive behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Order</td>
<td>• Must be obtained within 1 hour of initiation</td>
<td>• Must be obtained within 30 minutes of initiation and within 30 minutes of order expiration if restraints will be continued.</td>
</tr>
<tr>
<td></td>
<td>• Time-limited; each order is good for a maximum of 24 hours</td>
<td>• Time-limited</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Adult: Maximum of 4 hours</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Children 9-17 yo: Maximum of 2 hours</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Children under age 9: Maximum of 1 hour</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Order may be renewed as follows:</td>
</tr>
</tbody>
</table>

Revised 9/2019
<table>
<thead>
<tr>
<th>Assessment</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adult:</strong> Once after reassessment by RN on non-Behavioral Health Unit. On the behavioral health Unit, this cannot be done by the RN due to the Michigan Mental Health Code.</td>
<td><strong>Children 9-17 yo:</strong> Once after assessment by RN</td>
<td><strong>Children under age 9:</strong> Three times after reassessment by RN each time</td>
</tr>
<tr>
<td><strong>Must document behaviors requiring use of restraints; initially completed by RN</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Physician must conduct face-to-face assessment of patient within 1 hour of restraint initiation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Every 24 hours a physician evaluates the patient before writing a new order. On the behavioral health unit this must be done every 4 hours as orders expire after 4 hours.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Assessment</strong></td>
<td><strong>Physician must conduct face-to-face assessment of patient at least every 24 hours to determine if there is a continued need for restraint</strong></td>
<td><strong>Physician responsible for documenting that face-to-face evaluation occurred</strong></td>
</tr>
<tr>
<td><strong>Documentation</strong></td>
<td><strong>Face-to-face evaluation must include:</strong></td>
<td><strong>Face-to-face evaluation must include:</strong></td>
</tr>
<tr>
<td></td>
<td>o The patient’s immediate situation</td>
<td>o The patient’s immediate situation</td>
</tr>
<tr>
<td></td>
<td>o The patient’s reaction to the intervention</td>
<td>o The patient’s reaction to the intervention</td>
</tr>
<tr>
<td></td>
<td>o The patient’s medical and behavioral condition</td>
<td>o The patient’s medical and behavioral condition</td>
</tr>
<tr>
<td></td>
<td>o The need to continue or terminate restraints</td>
<td>o The need to continue or terminate restraints</td>
</tr>
<tr>
<td></td>
<td>To continue restraints beyond the time frames listed above, the physician must conduct a face-to-face assessment as follows:</td>
<td>To continue restraints beyond the time frames listed above, the physician must conduct a face-to-face assessment as follows:</td>
</tr>
<tr>
<td></td>
<td>o Adults: Every 8 hours</td>
<td>o Adults: Every 8 hours</td>
</tr>
<tr>
<td></td>
<td>o All children: Every 4 hours</td>
<td>o All children: Every 4 hours</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Monitoring</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Nursing staff are responsible for monitoring the patient and documenting care at least every 2 hours in the medical record</strong></td>
<td><strong>Nursing staff are responsible for monitoring and documenting care and observations every 15 minutes in the medical record</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Discontinuation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Restraints may be discontinued by the RN when:</strong></td>
<td><strong>Restraints may be discontinued by the RN when:</strong></td>
<td></td>
</tr>
<tr>
<td>o Less restrictive measures are found to be effective</td>
<td>o Less restrictive means are found to be effective</td>
<td></td>
</tr>
<tr>
<td>o There is a reduction or absence of the behaviors that warranted the use of restraints</td>
<td>o There is a reduction or absence of the behaviors that warranted the use of restraints</td>
<td></td>
</tr>
<tr>
<td>o The patient’s lines, tubes, etc have been discontinued or the patient is</td>
<td>o The patient exhibits improved orientation, improved judgment,</td>
<td></td>
</tr>
<tr>
<td>no longer pulling at them</td>
<td>decreased impulsiveness, and/or absence of aggressive behaviors</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>o Responsible family members/caregivers are willing to monitor the patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Use of restraints causes increased agitation or significant emotional distress</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Provider Well Being
Physician Well-Being Resource Listing

Michigan
Health Professional Recovery Program of Michigan
PO Box 842
Troy, MI 48099-0842 (800) 453-3784
Email: hprp@hprp.org FAX: 1-248-519-0373

Midland, Michigan
MidMichigan Physicians Group-Psychiatry
4201 Campus Ridge Dr., Suite 3950
Midland, MI 48640 (989) 839-3385

Freeland, Michigan
Caduceus Meeting for Recovering Health Care Professionals
Tuesday Nights 7:00 p.m.
Zion Lutheran Church
454 7th Street
Freeland, MI

Midland, Midland
Recovery Pathways
218 Fast Ice Drive
Midland, MI 48642 (989) 928-3566
Email: Recoverypathways@gmail.com

Traverse City, Michigan
Munson Alcohol and Drug Treatment Center
1105 Sixth Street
Traverse City, MI 49684 (231) 935-5000

Center City, Minnesota
Hazelden Betty Ford Foundation
15251 Pleasant Valley Rd
Center City, MN 55012 (800) 261-3734

Durham, North Carolina
John-Henry Pfifferling, Ph.D.
Center for Professional Well-Being
21 W. Colony Place
Durham, NC 27705 (919) 489-9167
Email: jhpiff@gmail.com
Sedation / Analgesia
Anesthesia Services Moderate and Procedural Sedation

Applicability

- MidMichigan Health and all its wholly owned subsidiaries

Purpose

The purpose of this policy is to establish the standards of care and monitoring of patients receiving procedural sedation and analgesia/anesthesia services, including but not limited to, minimal sedation (to include topical/local anesthesia), moderate sedation/analgesia at MidMichigan Health.

Deep sedation/analgesia, regional anesthesia, monitored anesthesia care (MAC), and general anesthesia at MidMichigan Health are only to be performed by those credentialed with anesthesia core privileges or those with deep sedation privileges that are included with the emergency physicians and oral maxillary facial surgeons core privileges.

The benefit to the patient receiving moderate sedation/analgesia is to 1) allow the patient to tolerate unpleasant procedures by relieving anxiety, discomfort, or pain, as well as possibly producing amnesia: 2) Expedite the implementation of procedures which are not particularly uncomfortable but which require the patient to remain immobile.

These policies and procedures apply to all locations in the MidMichigan Healthcare System where moderate and procedural sedation are administered including, but not limited to, the Operating room suite (both inpatient and outpatient), Emergency Department, Cardiovascular Department, Critical Care areas, Obstetrical Suite, Radiology department, Psychiatry department, Recovery Rooms, Clinics, Outpatient surgery areas, and Special Procedure areas, e.g., Endoscopy Suite and Pain Management Clinics, and including all departments in all campuses and off-site locations where moderate and procedural sedation services are being provided.

Policy Qualifications:

Only a provider credentialed by medical staff to perform moderate sedation is qualified to prescribe, order, and select the medication(s) used to achieve moderate sedation.
All providers of moderate sedation are required to have at least the following knowledge and competencies:

1. Proper medication dosages, administration techniques, adverse reactions, toxicity, and counter-interventions.
2. Airway management and basic life support techniques.
3. An individual with ACLS certification or equivalent Board Certification and appropriate equipment must be physically present at the bedside and immediately available during moderate sedation.
4. Ability to assess total patient care including, but not limited to, respiratory rate and ventilation, oxygen saturation, ETCO2, blood pressure, cardiac rate and rhythm, and level of consciousness.
5. Understanding of the escalation of care necessary to provide a patent airway, ventilation, and oxygenation of patients under their care including their responsibility to ensure adequate post-procedure monitoring especially when reversal agents are administered.

Administration:

Administration and/or monitoring moderate sedation may only be performed by a qualified provider/designee or registered nurse with provider supervision, who is trained in compliance with all relevant local, institutional, state and/or national standards, policies or guidelines to administer prescribed sedating and analgesic medications. The provider or RN responsible for managing the care of the patients receiving moderate sedation will complete and maintain competency in the skill yearly and be ACLS certified. Moderate Sedation requires the participation of a minimum of two qualified healthcare individuals including a provider credentialed to perform moderate sedation and a provider credentialed to supervise such sedation.

Supervision Requirements:

1. Physician order.
2. Supervising practitioner must be at the bedside for moderate sedation until in Phase 1 recovery.
3. Supervising practitioner must be readily available during Phase 1 recovery.
4. Supervising practitioner Provider may also be the proceduralist.

Process for Care

Pre-Procedure:

A. Before moderate sedation can be administered, the following criteria must be met:
   1. The patient/legal representative must receive education regarding the benefits, risk, and side effects; the likelihood of achieving the goals; the potential problems that could occur during recuperation; reasonable alternatives; and the risks, benefits and side effects of the alternatives. This education and consent must be provided by the physician, signed by the patient/legal representative, and documented within the medical record prior to the sedation.
   2. A durable and legible focused H & P is required to be on the medical record for all patients receiving sedation within 30 days and updated the day of the procedure. The H & P can be replaced by the Pre-anesthesia (or Pre-sedation) Evaluation which is a focused, targeted patient evaluation which must include components as in the Policy:
      a.
a. Vitals
   a. Allergies
   b. Current Medications History
   c. Time and nature of last oral intake
   d. Anesthesia history including Malignant Hyperthermia
   e. Abnormalities of major organ systems
   f. Focused PE including heart, lungs, and airway assessment per Mallampati Classification 1-4. (APPENDIX A)
   g. Assignment to ASA Physical Status 1-5. (APPENDIX B)

b. The plan for sedation/analgesia must be determined and ordered by a qualified anesthesia provider or the attending physician who is familiar with the relevant aspects of the patient's focused H & P and airway evaluation. This plan must be documented in the patient's medical record prior to the sedation and should document the appropriateness of the patient for sedation analgesia.

c. Immediately prior to the procedure, a pre-procedure reassessment in addition to the durable and legible focused H/P must be completed and documented. This reassessment must include initial vital signs, allergies, current medications, pertinent medical and surgical history, interval changes in patient's medical condition or labs, and a baseline physical assessment (lungs, heart, and airway).

d. Procedure/Site Verification and "Time Out": Prior to the procedure and sedation, verification of patient identity, procedure and site will be confirmed and documented in accordance with the relevant Surgical Services policy. Also, immediately prior to the start, a "time out" will occur and be documented which includes a final verification of patient ID, procedure, site, and sedation plan.

e. The patient must be NPO according to institutional and anesthesiology department policies unless otherwise directed by the physician performing the procedure for urgent/emergent cases with appropriate interventions and/or precautions for airway protection.

f. Before beginning the procedure, the assisting sedation practitioner must ensure the immediate availability of an ACLS practitioner at the bedside and verify that all participants are credentialed to perform the intended level of sedation/analgesia service and are comfortable in performing the sedation and analgesia services. If not, replacements must be recruited.

b. In patients receiving IV medications for sedation/analgesia, insert and maintain continuous IV access before, during and after the procedure and sedation until the patient is no longer at risk for cardiorespiratory depression. In patients who have received non-IV sedation/analgesia or whose IV has been dislodged or blocked, practitioners should determine the advisability of re-establishing an IV on a case-by-case basis. In all instances, an individual with the skills to establish IV access should be immediately available understanding that IV access is most often preferred and necessary.

c. Prior to the initiation of moderate sedation, ensure that all required equipment is present in the procedural room. Equipment that must be present in the room where moderate sedation is being administered includes but is not limited to:
1. Pulse oximetry
2. Non-Invasive blood pressure monitor
3. ECG monitor
4. Suction equipment with tonsil suction tip and suction catheters
5. Intubation tray
6. Oral pharyngeal and nasal airways and tongue blades
7. Syringes and needles
8. Capnography (ETCO2)
9. Temperature device
10. Glidescope if appropriate
11. Oxygen supply and delivery devices - nasal cannula, mask, etc.
12. Ambu-bag for hand-mask positive pressure ventilation

d. Prior to the initiation of sedation, ensure that all required rescue medications are present and immediately accessible. Medication that must be present in the room where moderate sedation is being administered includes but is not limited to:
   1. Naloxone (Narcan)
   2. Flumazenil (Romazicon)
   3. Atropine
e. An emergency cart with defibrillator and emergency medications must be immediately accessible at all times.

**Intra-Procedure:**

A. Once sedating medications are administered, the patient must be under continuous observation by qualified personnel dedicated to the task of monitoring the patient's airway and vital signs continually and documenting every five (5) minutes during the procedure.

B. Assessment and documentation must include:

1. The patient's vital signs, pulse oximetry, ventilatory rate, and level of consciousness are to be monitored continuously and documented prior to the start of sedation to develop a baseline and every 5 minutes thereafter during the procedure. A Sedation Scale (APPENDIX C) will be used to monitor the patient's level of consciousness before, during, and after the administration of sedation.
2. Pain level by use of a visual analogue scale will be assessed, monitored, and documented including mandatory input from the patient at least once before the procedure, every 5 minutes during the procedure and at appropriate intervals after the procedure. Documentation will also include pain intensity and quality (character, frequency, location, and duration).
3. Continuous monitoring of heart rate and rhythm by ECG allows for earlier detection of changes caused by the sedation or procedure and may help prevent major cardiovascular instability, morbidity, and mortality.
4. The monitoring of purposeful response to verbal commands is necessary during Moderate Sedation.
5. Start and end time of procedure.
6. During procedures where a verbal response is not possible (e.g., oral surgery, upper endoscopy, bronchoscopy), the ability to give a thumbs up or other indication of consciousness in response to verbal or tactile (light tap) stimulation suggests that the patient will be able to control his airway and take deep breaths as necessary. Patients whose only response is reflex withdrawal from painful stimuli are likely to be deeply sedated, approaching a state of general anesthesia and should be treated accordingly as well as stop additional sedation until a level moderate sedation is achieved before proceeding with the procedure.

7. Respiratory frequency and adequacy of ventilation must be continually monitored by auscultation, direct observation, and Capnography (ETCO2).

8. All adult patients should have supplemental oxygen titrated to maintain O2 Sat > 92% during the procedure and recovery except in certain clinical situations (right heart catheterization). Supplemental oxygenation should be less than or equal to 50% by venti-mask unless pre-procedural levels requirements are greater to allow for earlier recognition of respiratory depression and hypoxia.

9. Monitor for any signs and symptoms of respiratory compromise or cardiovascular instability. If respiratory or oxygenation issues arise, consider deep ventilation, simultaneous support of airway, increase in supplemental oxygen supply, assisted/controlled positive pressure ventilation, and pharmacological reversal of sedative/narcotics. The use of reversal drugs must be reported as an adverse drug event (ADE) to QRM and the Medical Director of Anesthesia Services within 24 hours via RL solutions.

10. Any untoward effects (i.e., vasovagal reaction, emesis, aspiration) and the interventions taken must be reported to the proceduralist and/or supervising practitioner.

11. Documentation of all administered medications, including dose, route, and time, estimated blood loss, IV fluids, etc., must be made appropriately on the Intra-procedure Record.

12. It is important to understand that the administration of reversal drugs for opioid or benzodiazepine reversal is never an emergency and should follow airway and ventilation rescue efforts in a coordinated and measured effort.

C. Special Intra-Procedure Considerations:

1. Combinations of agents may be more effective than single agents in certain circumstances. However, such combinations may increase the likelihood of adverse outcomes including depression of ventilation and hypoxemia. Narcotics for analgesia and sedatives for anxiolysis and amnesia can be combined effectively and are appropriate for specific patients and procedures recognizing that the combination of such medications constitutes the delivery of Moderate Sedation.

2. The administration of small, incremental doses of IV sedative/analgesia drugs until the desired level of sedation and/or analgesia is achieved is preferable to a single dose based upon the patient's size, weight, or age.

3. Sufficient time must elapse between doses to allow the effect of each dose to be assessed before subsequent drug administration. This is even more important for medications administered by non-IV routes (oral, rectal, IM).

Post-Procedure:

A. Maintain continuous IV access after the procedure.

B. Monitor and document the following:
1. Modified Aldrete score at the time of transfer to the post-procedure area. (Appendix D)

2. Vital signs, oxygen saturation, oxygen supplementation percentage or rate, ETCO2, pain level and level of consciousness every 15 minutes post-procedure until criteria for discontinuation is met or physician discharges the patient.

   **Note:** Continuous ECG monitoring is required if assessment reveals a history of compromising cardiovascular or respiratory disease.

3. Any untoward effects (vasovagal reactions, emesis, aspiration and other unexpected reactions) experienced by the patient and any interventions taken.

4. Use of reversal agents.

5. Modified Aldrete score at the time of discharge.

C. Notify the proceduralist or supervising practitioner directly involved in the patient's care if the patient's oxygen saturation falls and remains below 92% or signs of respiratory compromise are noted. Consider use of Rapid Response Team if additional help is needed to provide adequate airway, promote adequate oxygenation or to stabilize patient. Levels of oxygenation below 90% after sedation and post-procedure are alarming and predictive of a high potential for respiratory morbidity and mortality despite the existence of such saturation levels pre-procedurally. They should therefore be recognized and of concern requiring immediate, indicated interventions.

### Post-Procedure Discharge Criteria:

A. The patient may be discharged from the post-procedure area once the patient meets the following criteria:

   1. Aldrete Score ≥ 9.

   2. Level of consciousness - patient is easily arousable and responds to his/her environment appropriately according to pre-procedural level.

   3. Oxygen saturation at or above pre-procedural level

   4. Vital signs remain stable for three consecutive measurements

   5. Cardiovascular and airway stability is assured

   6. Pain

   7. Nausea and Vomiting

   8. Postoperative Hydration

   9. Two hours minimum monitoring if reversal agents were administered. **Note:** Current recommendations by the ASA are that patients administered reversal agents during anesthesia and sedation require at least 2 hour minimum post-procedure monitoring. If such a time interval is within the period of the procedure, a minimum of one hour of post-procedure monitoring is recommended for a total cumulative time of 3 hours.

   10. Temperature >96 degrees F.

For patients unable to participate in the post-anesthesia evaluation due to intentional prolonged sedation, underlying physiologic conditions, or other reasons, an evaluation must still be completed and documented within the 48-hour timeframe. Documentation should include reasons for the patient's nonparticipation and expectations for recovery time, if applicable.
B. If the patient does not meet the above criteria, the patient must be evaluated and discharged by a physician. This must be documented in the medical record.

**Discharge Instructions:**

A. Reinforce the education that was provided prior to the procedure with the patient/family/legal representative caregiver. Provide written instructions and an opportunity for the patient and his/her caregiver to ask questions.

B. In addition to any procedural specific discharge instructions, instruct the patient/family/legal representative/caregiver that:
   1. The patient should not drive or operate heavy or dangerous equipment for at least 24 hours following sedation.
   2. The patient should not drink alcoholic beverages, drive a motor vehicle, operate machinery or power tools, make important decisions, or sign important papers for at least 24 hours following discharge.
   3. He/she may experience light-headedness, dizziness, and sleepiness following the procedure and should not stay alone for the rest of the day.

C. Document all discharge instructions including contact and emergency numbers provided to the patient/significant other in the patient's medical record.

D. Patients are to be discharged only in the company of a responsible designated adult.

E. Document the patient's departure from the post-procedure area and who they were accompanied by in the patient's medical record.

**QRM**

A. Quality Review Management will follow existing policies and guidelines as defined by the Medical Staff at MidMichigan Medical Center.

B. Specific QRM markers as outlined below may be used for QRM review of Procedural Sedation by all departments involved in such care.
   1. Unplanned admission
   2. Cardiac Arrest
   3. Unplanned airway intervention
   4. Sustained arrhythmia
   5. Hypoxia (SaO2 < 85% for > 3 minutes)
   6. Loss of IV
   7. Failed sedation
   8. Use of reversal drugs (Narcan, Nubain, and Romazicon)
   9. Improper or absent physician supervision
   10. Uncomfortable sedation professional unable to back away from Sedation procedure - pressured into doing case
   11. Failure to return to 20% of pre-procedure vital signs
   12. Unplanned deeper level of sedation beyond target
All cases of cardiac arrest, respiratory failure requiring intubation and ventilation, and death shall be reported to the Medical Director of Procedural Sedation or his designee within 24 hours in RL solutions for review.

Appendix A:
The Mallampati Score is as follows:
Class 1: Full visibility of tonsils, uvula and soft palate
Class 2: Visibility of hard and soft palate, upper portion of tonsils and uvula
Class 3: Soft and hard palate and base of the uvula are visible
Class 4: Only hard palate visible

Appendix B:
ASA Physical Status

Appendix C:
Ramsay Sedation Scale
This scale is used to assess the conscious state of a patient achieved prior to and during a specific procedure.

<table>
<thead>
<tr>
<th>Score</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Patient is anxious or restless or both.</td>
</tr>
<tr>
<td>2</td>
<td>Patient is cooperative, oriented, and tranquil.</td>
</tr>
<tr>
<td>3</td>
<td>Patient responds to commands.</td>
</tr>
<tr>
<td>4</td>
<td>Patient exhibits brisk response to light glabellar tap or loud auditory stimulus.</td>
</tr>
<tr>
<td>5</td>
<td>Patient exhibits a sluggish response to light glabellar tap or loud auditory stimulus.</td>
</tr>
<tr>
<td>6</td>
<td>Patient exhibits no response to stimulus.</td>
</tr>
</tbody>
</table>

Instructions

A. Observe the patient and determine if awake:
   1. If the patient is anxious or restless or both, score as 1.
   2. If the patient is cooperative, oriented, and tranquil, score as 2.

B. If the patient is asleep, a test of arousability is to be made:
   1. If the patient responds to a voice command, score as 3.
   2. If not, provide a loud auditory stimulus or a light glabellar (between the eyebrows) tap. If the patient's response is:
      a. Brisk, score as a 4.
      b. Sluggish, score as a 5.
      c. Absent / no response to stimulus, score as a 6.
Appendix D:

Modified Aldrete score:

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity</td>
<td>Moves all 4 extremities voluntarily or on command</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Able to breath and cough freely</td>
<td>2</td>
</tr>
<tr>
<td>Circulation:</td>
<td>BP +/- 20 mmHg of pre-anesthesia level</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>BP +/- 20-50 mmHg of pre-anesthesia level</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>BP +/- 50 mmHg of pre-anesthesia level</td>
<td>0</td>
</tr>
<tr>
<td>Consciousness:</td>
<td>Fully awake</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Responds to calling</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Not responding</td>
<td>0</td>
</tr>
<tr>
<td>Oxygenation:</td>
<td>Maintains SpO2 &gt; 92% room air</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Requires supplemental O2 to maintain SpO2 &gt;90%</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>SpO2 &lt;90% with supplemental O2</td>
<td>0</td>
</tr>
</tbody>
</table>

**Note:** A Maximum score of 10 is possible. A score of ≥ 9 is required for discharge.

**Definitions**

**Minimal Sedation,** is a drug-induced state in which a patient responds normally to verbal commands. The patient may have impaired cognitive function and coordination but cardiopulmonary functions are unaffected. Examples of minimal sedation may include pre-procedure, preoperative medications and antianxiety medications.

**Moderate Sedation and Procedural Sedation.** (Conscious/Moderate Sedation) is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

**Deep Sedation/Analgesia.** (Monitored Anesthesia Care-MAC/Deep Sedation) A drug induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilator function may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

**Disclaimer**

Employees covered under a bargaining agreement will be subject to the terms of that agreement.

**Attachments:**

1: Procedural Sedation Guidelines

**Applicability**

MidMichigan Health, MidMichigan Home Care, MidMichigan Medical Center - Alpena, MidMichigan Medical Center - Clare/Gladwin, MidMichigan Medical Center - Gratiot/Mt. Pleasant, MidMichigan Medical Center -
Tobacco Smoke Free Environment
Tobacco - Smoke-Free Environment Policy

Applicability

- MidMichigan Health and all its wholly owned subsidiaries

Purpose

In keeping with our mission statement and to promote the health, welfare and safety of individuals on the campus of any MidMichigan Health facility, a tobacco/smoke-free environment has been adopted.

Policy

Tobacco products are defined as cigarettes, cigars, pipes, and chewing tobacco. Based on preliminary safety concerns, electronic cigarettes are also prohibited. Use of these products is not permitted on any MidMichigan Health campus including in vehicles.

Smoking cessation products including nicoderm patches, gum, lozenges and the nicotrol inhaler are allowed.

This policy complies with the Michigan Department of Community Health code, Michigan Clean Indoor Air Act of 1986 and Public Act 315 as well as the regulations and directives of The Joint Commission.

Applicability

- Employees
- Volunteers/auxiliary
- Medical staff
- Students
- Instructors
- Vendors
- Contractors/subcontractors
- Patients/residents
- Patients'/residents' families
- Visitors
- Any other person on a MidMichigan campus/property

A MidMichigan Health campus is defined as and includes:
• Hospital/facility
• Hospital/facility off-site properties, both owned and leased/occupied by MidMichigan Health staff
• Hospital/facility-owned or leased vehicles
• Hospital/facility outside grounds
• Parking lots including enclosed structures and parking ramps
• Out-lawns and sidewalks surrounding any MidMichigan Health facility
• Residential streets and private property and sidewalks adjacent to any MidMichigan Health Facility campus

Procedure

Employees

1. Human Resources will inform employment candidates of the Tobacco/Smoke-Free Environment policy during the hiring and orientation processes.

2. Employees of MidMichigan Health who are in violation of the Tobacco/Smoke Free Environment policy shall be subject to disciplinary action as outlined in the Corrective Action and Disciplinary Policy-Human Resources.

3. The expectation for a Tobacco/Smoke-Free workday includes no lingering odor of smoke on the clothing of an employee.

4. Managers/supervisors should request employees who report to work with the lingering odor of cigarette smoke to leave the building as an unexcused absence. The employee will be required to badge out prior to going home and badge in upon their return.

5. Employees of MidMichigan Health are eligible for tobacco cessation programs offered through the WellPath Wellness Program.

Patients

1. Patients will be informed during the pre-admission/admission process and any appointment confirmation letters, etc., that MidMichigan Health facilities are tobacco/smoke-free.

2. The use of cigarettes, cigars, pipes, chewing tobacco and electronic cigarettes are not permitted. This does not include physician-ordered smoking cessation products such as nicotine patches, gum, lozenges and nicotrol inhalers.

Volunteers

1. Volunteers will be informed of the tobacco/smoke-free policy during their new volunteer orientation process.

2. Volunteers in violation of this policy will be subject to their established protocols.

Visitors

1. The policy will be explained to visitors who are observed using tobacco products on any MidMichigan Health campus.

2. In the event that a visitor refuses to comply with this policy after being approached, the incident shall be reported immediately to supervision or Security at facilities where available. Employees should not put themselves at risk for any confrontation or danger.

3. In the event of a serious disregard for the policy, a visitor variance report shall then be completed.
Responsibility

It is the responsibility of all persons associated with MidMichigan Health to enforce compliance of this policy with compassion, tact, and diplomacy. They should exercise appropriate judgment so that patients, residents, co-workers, families and visitors will not be adversely affected by second-hand smoke or the lingering smell of tobacco smoke on employees' clothing.

The success of this policy will depend upon the thoughtfulness, consideration and cooperation of tobacco users and non-tobacco users. Common sense and consideration for others should prevail in situations not specifically covered in this policy.

Disclaimer

Employees covered under a bargaining agreement will be subject to the terms of that agreement.

Attachments: No Attachments

Applicability

MidMichigan Health, MidMichigan Home Care, MidMichigan Medical Center - Alpena, MidMichigan Medical Center - Clare/Gladwin, MidMichigan Medical Center - Gratiot/Mt. Pleasant, MidMichigan Medical Center - Midland, MidMichigan Physicians Group
Waived Testing
Point-of-Care Testing (POCT) is defined as tests designed to be used at or near the site where the patient is located, that do not require permanent dedicated space, and that are performed outside the physical facilities of the clinical laboratories. A few examples include capillary blood glucose, occult blood, Hemoglobin A1C, vaginal fluid pool smears for ferning and pH of body fluids.

Each provider’s office has an individual CLIA Certificate of Waiver or CLIA Certificate for Provider Performed Microscopy (PPM) procedures. Physicians performing testing in a provider’s office will adhere to the policies and procedures specific for that office.

**Waived** testing is not performed by MidMichigan Health physicians within the inpatient hospital setting.

Providers who perform **non-waived** testing will be notified of regulatory responsibilities pertaining to each testing platform by the department manager.

Questions can be directed to the Health System Point of Care Manager at 989-839-3460.