Student Information Packet

Aultman Alliance Community Hospital Student Programs: Experience & Observation

Revision Date: March 2020

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HEALTH CARING EXPECTATIONS & STANDARDS

MISSION, VISION, VALUES

All AACH Colleagues are expected to adhere to the core mission, vision, and values of the Hospital and its related entities and to uphold our health caring standards, attitudes, and Planetree philosophies and practices.

MISSION. Leading our community to improved health.

VISION. Aultman Health Foundation will be the leading health system in designing products and services for the communities we serve.

- Delivering the highest quality
- Achieving service excellence
- Offering a competitive price
- Innovating toward disease prevention and wellness

VALUES:

Recognize and respect the unique talents of every Aultman team member
Exceed patient, enrollee and student expectations
Success through teamwork
Promote a highly reliable organization
Educate our community
Cost-effective management of resources
Trust, integrity and compassion in all relationships

HEALTH CARING STANDARDS

The AACH Administration insists that all Colleagues adhere to the following criterion:

1. Integrity – Colleagues must always demonstrate ethical behavior, which includes upholding high moral standards whenever and wherever they are representing AACH, developing open, honest communications, and accepting responsibility for individual actions (and when applicable, that of co- workers and/or subordinates).
2. Quality – AACH's quality standards can never be compromised. In fact, quality expectations are to be exceeded. Medical, business, professional, and support staff members alike must take pride in everything they do by maintaining the highest possible quality benchmarks.
3. Learning – The pursuit of knowledge should be active and continuous. We must constantly challenge ourselves intellectually and never stop broadening our individual and collective awareness.
4. Caring – AACH must always offer personal caring and treat patients individually and according to the dictates of their individual circumstances, instead of merely treating illnesses or symptoms.

HEATH CARING ATTITUDES

5. Greet patients (customers), visitors, and Colleagues immediately with a warm smile, calling them by name if possible. Always exude friendliness and compassion.
    1. Use kind words and gestures to help patients and all others feel special and appreciated and to help relieve anxiety.
    2. Always lend a helping hand to anyone in any type of need and if you cannot, find someone who can.
    3. Always be true to your word and go out of your way to help keep patients (customers) and visitors happy and comfortable but avoid "promising" patients anything that is unrealistic or simply not possible. Be honest but considerate.
    4. Thank our patients (customers) for choosing us to meet their health care needs.
    5. Practice good manners and use proper etiquette at all times (and in all situations) whether

dealing with people one-to-one, via telephone, or E-Mail.

6. Speak clearly and avoid using medical jargon with patients and visitors.
7. Respect the privacy of our patients. (See HIPAA manual for details on maintaining the confidentiality of patient information.)
8. Keep patients (customers) informed and comfortable while they are waiting for procedures or information.
9. When someone complains to you, take the HEAT
    a. Hear people out; sometimes all a person needs is for someone to listen to them.
    b. Empathize and do not make excuses.
    c. Apologize sincerely for the fact that they are displeased; do NOT apologize for the actions of others or assume guilt for a medical error without first consulting your supervisor.
    d. Take the next step in correcting a problem; this means following up on a matter or issue and pursuing it to some type of positive conclusion.
10. Help prevent and correct unsafe conditions by adhering to all safety practices.
11. Maintain a comfortable environment for patients.
12. Exceed any preconceived expectations and anticipate the unexpected by asking "Is there anything I or a fellow Colleague can do for you?"
13. Always provide a comforting, timely, caring departure or discharge, and always thank patients (customers) for allowing us to serve them.

WE ARE PLANETREE

Never lose sight of the fact that we are a Planetree facility. This means that, in addition to providing clinical excellence, we must always maintain an atmosphere of caring, respect, dignity, and regard for a patient/visitor's mind, body, and spirit. (Please read the following pages for a detailed explanation of our Planetree tenets.)

Our patients (customers) are our most important asset. It is our responsibility to show empathy to our patients and their families at all times.

Our patients (customers) are here not because they want to be but because it is medically necessary. Treat patients (customers) as you would want to be treated in their situation. Please note that nicknames such as "sweetie," honey," and "dear" are not acceptable and should not be used. Calling a patient by their name is respectful and helps to make a good impression; plus, offering a smile is comforting. Patients feel secure in their treatment when they are at ease with their care givers.

Never project personal issues or problems onto a patient, visitor, or fellow colleague. It is never acceptable to pass along the stress related to a busy, hectic work environment (or a private issue) to others. Whether we are at full capacity and working with a skeletal staff or if we become suddenly overrun with emergencies, NEVER forget that it is not the patient/visitor's problem. If a patient is in pain, discomfort, or distress, the last thing they need is to feel that they are not being taken care of properly and/or that they are a nuisance to the staff.

Make every attempt to make a good first impression; you will not receive another chance to do so. The way a patient (customer) feels when they leave AACH can make an impact on our business. If they feel good about the treatment they received and are pleased with their overall experience, they will tell their friends and relatives. But a displeased patient (customer) will pass his/her negative visit/experience with AACH on to not only friends, relatives, and co-workers, but also to anyone and everyone who will listen. Imagine the damaging potential in terms of the latter.

PLANETREE COMPONENTS

- Create organizational structure that promotes engagement
- Connect values, strategies and action
- Implement practices that promote partnership
- Know what matters
- Use evidence to drive improvement

Three Basic Tenets of Planetree:

- **Personalize:** Healthcare is a very personal experience. Each individual has different care needs for their current illness along with their mental and spiritual needs. Their social circumstances also affect their outcomes.
- **Humanize:** We are all human beings and deserve to be treated as such. Each human being is unique and has value. Our experiences and education also affect our perceptions of circumstances, both as a patient and as a caregiver.
- **Demystify:** We know our patients are still recovering when they are discharged. It is imperative that they have the knowledge and resources to continue their recovery and move towards wellness. Even with a patient with chronic illness, we may not be able to prevent future admissions, but give them the skills to extend the time between readmissions.

CORPORATE COMPLIANCE

Aultman Alliance Community Hospital has a formal Corporate Compliance Program as encouraged by the Federal Government, which involves all employees.

The Office of the Inspector General (OIG) of the Department of Health and Human Services (HHS) and other Federal agencies are responsible for enforcement of Federal law, especially in terms of governmental healthcare spending. As such, they emphasize the importance of voluntarily developed and implemented compliance plans. Compliance efforts within a hospital are designed to promote prevention, detection and resolution of instances of conduct not conforming to Federal, State, and private payer healthcare program requirements, as well as the hospital's ethical standards. Our Compliance Program demonstrates our organization's commitment to the compliance process.

To facilitate compliance, Aultman Alliance Community Hospital has a Corporate Compliance Program, with Brenda Greer acting as our Corporate Compliance Officer. A provided hotline service that will allow you to anonymously report any violations of our policies and procedures or voice any concerns you may have regarding potentially inappropriate activities in the workplace. All callers will remain anonymous, unless callers choose to identify themselves. To report any concerns or variances regarding a corporate compliance issue, simply call the hotline at 866-907-6901 or contact Brenda directly at 330-363-3959. The hotline is available 24 hours a day, seven days a week. Some examples of possible corporate compliance issues are: inaccurate billing practices and documentation, conflicts of interest, inappropriate business deals or fraud, waste and abuse.

HIPAA Privacy

HIPAA, which stands for Health Insurance Portability and Accountability Act, is regulated and enforced by the Federal Government. Therefore, anyone who violates HIPAA can be charged criminally and assessed a monetary

fine. As a covered entity, our hospital is obligated to abide by the regulations, and take appropriate action when patient privacy has been breached.

It is our policy at AACH that you are permitted to access health information on yourself and your children under the age of 18 for which you have custody. Any other access could be deemed a violation if you do not have an authorization signed by the patient permitting you to access their protected health information. If you receive a request for protected health information that is unusual or isn't standard practice, you should contact your immediate Supervisor, the Nursing Supervisor, or the Privacy Officer.
HIPAA privacy provisions are designed to safeguard patients' protected health information. These provisions are not meant to keep you from doing your job. An acronym that we use to determine the appropriate of disclosures is "TOP", which stands for "Treatment, Operations, and Payment". You are permitted to access information to treat a patient, to get paid for that treatment, and to do the day-to-day activities that keep our hospital operating. When you share information with other health care professionals, you should use the "minimum necessary" rule. Consequently, you should limit the information that you're using or disclosing, only giving out what is absolutely necessary to accomplish your purpose.

CONFIDENTIALITY OF PATIENT HEALTH INFORMATION

In a health care facility, **Confidentiality** is not a choice of life; it is a way of life essential to the best in patient care. Each colleague, volunteer, and student is responsible for upholding the code of ethics for this facility which includes: "**All information gathered regarding a patient, the patient's personal life, and the care rendered to the patient, must be treated confidentially."** Each colleague, volunteer, and student has both a moral and legal obligation to guard against inappropriate release of confidential information.

Patients and their families must have assurance that their medical information as well as their personal quirks will not be passed on to others unless the patient specifically requests that the information may be released. The permission to release confidential information **MUST** be in writing.

"THINK BEFORE YOU SPEAK." Colleagues, volunteers, and students must be aware of where, to whom, and what about they are speaking. Carelessness can lead to a breach of patient's privacy. There is never a right way to say a wrong thing."

Colleagues, volunteers and students must guard against inappropriate viewing of a medical record. Not all colleagues are engaging in treatment of the patient and therefore, must have a bona fide reason to view the medical record. Viewing of medical record charts must be coordinated through Medical Records Services.

"WHEN IN DOUBT, DON'T GIVE IT OUT." It is always better to not release information when there is a doubt. Colleagues, volunteers, and students are better protected by refusing to give information than they are if they breech confidentiality.

I understand the importance of and agree that in the performance of my duties as a colleague/volunteer/ student of Aultman Alliance Community Hospital, I must hold patient information in confidence. I also understand that my intentional or involuntary failure to maintain the confidentiality for this information and/or the security of the hospital's medical records may result in my immediate dismissal from employment or the expulsion from the clinical program/observation experience by Aultman Alliance Community Hospital. I further understand that breach of confidentiality may result in possible legal action as may be imposed by State and Federal legislation which action might include possible fine or imprisonment.

QUALITY & PERFORMANCE IMPROVEMENT

What is Quality? Doing the right thing right the first time. The goal of quality is to provide the very best care to our patients and their families.

Different Types of Quality:

- Performance Improvement (PI) – Improvement of a process already in place.
- Quality Control (QC) – Ongoing measurement that demonstrates proper system or equipment function. QC is always related to equipment monitoring.
- Quality Assurance (QA) monitoring of existing processes to assure they are being done correctly.

Quality is a very high priority in healthcare due to:

- Increased consumerism – patients want to know more about their diagnosis and the care that they are receiving.
- Public Reporting – We are mandated to report to the government and to the public how well we provide care based on best practice standards.
- National Standards – We need to use evidence based research and best practice standards in the care that we administer. No longer can we practice medicine "like we always did it", but rather we need to have research behind why we do what we do.
- Pay for Quality – CMS and other insurances will be judging the amount of our reimbursement by our delivery of Quality Care.

Quality of care matters to us because:

- It is a measure of ourselves to understand if we are good at something, if we are improving or if we need to focus and make changes.
- Quality matters to our consumer. Being transparent, or displaying our statistics, to the community through our website, Hospital Compare or the Joint Commission website, communicates to our customers how well we provide a service. Customers have a choice in healthcare.
- Quality of care provides a greater financial reimbursement from the government as well as from insurance companies.
- Being able to say that we are a quality facility promotes pride and respect within ourselves and our community.

Quality projects are selected and prioritized based on high risk, high volume, problem prone circumstances as well as customer service, safety issues and concerns and regulatory standards. Any one of these issues could cause us to develop a Get IT Done Team (GID) to improve our processes.

At AACH we develop Performance Improvement projects by using the PDCA Model

- Plan: Formulate a plan for improvement and define who is responsible for the various tasks, define goals and targets, establish a timeframe, define project restraints and determine how decisions will be made.
- Do: Implement the plan as it is defined.
- Check: Measure the success of the plan.
- Act: Fully implement the plan or rework the PDCA cycle as needed to make further changes. When a quality project or a performance improvement project is completed, we need to roll it out and measure it to make sure that the revisions of the process are meeting the goal of the project and that we are able to sustain the project.

Quality Reporting
The measurement statistics are defined as information. The information has to be meaningful, we have to make it transparent so that everyone could see and it has to be communicated.

The success of any organization rests on the organizations' ability to communicate information in real time so that colleagues and departments within the hospital can respond more rapidly to change. Quality reporting at AACH is done through:

- Unit Meetings
- Management Meetings
- Nursing and Medical Staff Meetings
- Quality Council
- Board of Trustees

The key to quality care for our patients is active participation by all of our colleagues to:

- "Do it Right the First Time"
- To participate in process improvement projects
- To sustain the change!

SEXUAL HARASSMENT POLICY

Sexual Harassment and Other Discriminatory Harassment. AACH is committed to a work environment in which all students, colleagues, volunteers or guests are treated with dignity and respect. AACH supports the right of all colleagues, students and volunteers to work in an environment free of sexual harassment and other discriminatory and unlawful harassment. Sexual harassment and harassment on the basis of race, color, religion, age, gender, disability or handicap, national origin, or veteran status, is strictly forbidden and will not be tolerated.

This harassment policy applies to all persons and prohibits harassment, discrimination, and retaliation whether engaged in by a , a supervisor, a manager, or someone not directly connected with AACH (e.g., vendor, consultant, patient).

Sexual Harassment. While it is not easy to define precisely what harassment is, sexual harassment involves unwelcome conduct of a sexual nature in which:

(a) Submission to such conduct is clearly stated or implied as being a term or condition of an individual's employment;

(b) Submission to, or rejection of, such conduct by an individual is used as the basis for any employment decision affecting that individual; or

(c) The existence of such conduct is sufficiently severe or pervasive to create an abusive or hostile working environment. Examples include offensive sexual flirtations; advances or propositions; continued or repeated verbal abuse of a sexual nature; graphic or degrading verbal comments about an individual or an individual's appearance; the display of sexually suggestive objects or pictures; or any other sexually offensive or abusive physical contact or gestures.

Such conduct, regardless of who commits it, is prohibited. Anyone found to have engaged in sexual harassment will be subject to disciplinary action up to and including termination.

Other Discriminatory Harassment. Other discriminatory harassment includes intimidation, ridicule, or insults that:

(d) Unreasonably interferes with an individual's work performance;

(e) Creates an abusive or hostile work environment; or

(f) Otherwise adversely affects an individual's employment opportunities.

This type of discriminatory harassment applies to such conduct, which is based on an individual's race, color, religion, age, gender, disability or handicap, national origin, veteran status, or other legally-protected characteristic. It includes actions such as repeated verbal abuse; the circulation of written material that demeans or exhibits hostility or dislike toward an individual or any of the aforementioned groups of persons; or inappropriate jokes or slurs. As with sexual harassment, such conduct likewise is prohibited and will subject the person engaging in it to disciplinary action up to and including termination.

Retaliation. All colleagues, students, etc shall be protected from retaliation for making a complaint or for assisting in an investigation concerning allegations of unlawful harassment. Retaliation includes disciplining, reassigning, lowering a performance appraisal or threatening or intimidating a person because he or she complained about harassment or participated in an investigation concerning unlawful harassment. This type of retaliation is strictly prohibited and individuals engaging in retaliatory behavior will be subject to disciplinary action.

TOBACCO FREE POLICY

All Aultman Alliance Community Hospital property (buildings, parking lots, sidewalks, vehicles, lands, and off-site locations) are tobacco-free environments in accordance with the requirements of the hospital's governing agencies and Ohio state laws. The responsibility to enforce the tobacco-free environment is shared by hospital colleagues and physicians. Failure to comply with the guidelines will result in corrective action up to and including discharge.

AACH promotes the health and safety of our patients, guests, customers, physicians, visitors, colleagues, volunteers, students, and any others as applicable, by providing a tobacco-free environment on all hospital premises; including all buildings, lands and vehicles owned and/or operated by the AACH, its affiliates, entities, and any tenants on those properties.

GUIDELINES

(1) Tobacco products, chewing, smoking, or the sale of any/all tobacco products are prohibited in hospital-owned vehicles and in or near all areas of the hospital's buildings, lands, or properties.

(2) Signs are posted at all entrances to the hospital's buildings and at all of its satellite locations, identifying the facilities as tobacco-free environments.

(3) The hospital will not hire individuals who use tobacco products. Effective as of January 1, 2007 applicants will be required to sign a tobacco free pledge.

(4) The hospital encourages all current Colleagues, physicians, and volunteers who use tobacco products to participate in hospital-sponsored programs designed to eliminate the use of tobacco products.

(5) If a Colleague, hired prior to 2007, feels he or she must smoke, they are only permitted to do so at their designated meal time, or during their designated break time.

(6) Colleagues, who wish to smoke, will be required to cross State Street, Union Avenue, Arch Avenue, or College Street to do so. Colleagues who smoke in their own vehicles must dispose of cigarette butts in their vehicle ashtrays. If a Colleague is found to have disposed of cigarette butts on hospital property, he or she will be subject to immediate discharge.

CELL PHONE POLICY

POLICY
Cell phones are not to be used in patient care areas for patient safety and privacy reasons.

Cell phones may be used by patients, visitors, students, and colleagues in non-patient care areas such as the Main Lobby, hospital Café, Roof Top Garden, and comfort areas. Cell phones may also be used by colleagues in non-patient care areas such as designated break areas and outside the building during approved break times.
PURPOSE
To restrict and control the use of cellular telephones/camera cellular telephones in our facility for our patient safety and privacy.
Patients/Visitors/Students/Colleagues

- For privacy reasons, the use of the camera function of cell phones is prohibited at all times on work premises and/or during work time.
- Cell phones are not to be used while on duty for personal usage, except during approved break times and in approved break areas.
- Texting is prohibited while driving Aultman Alliance Community Hospital vehicles or while you are driving on hospital business.

ABBREVIATED COMPUTER AND NETWORK ACCESS SECURITY POLICY AND PROCEDURE

POLICY: Aultman Alliance Community Hospital uses computer information systems to meet our clinical, financial, and informational needs. We deem the data and information processed in these systems as proprietary and confidential.

Users must understand the confidential nature of the information, understand their responsibility for keeping the information secure, and know the ramifications of any violations of security. The organization grants access to only the necessary components of the computer system required for the individual to complete his or her job.

A *security code* (i.e., password, access code) is a unique sequence of letters and/or numbers used to access the computer systems. Security codes should be at least 8 characters in length, using a combination of letters and numbers. Security codes should not be obvious words or numbers, such as birth dates, phone numbers, children's names, etc. The security code will expire every three months and you will be asked to select a new one. You can only re-use a password after twelve months have passed. The security code becomes part of the audit trail and attaches the user to every keystroke entered under the security code. *The user must not intentionally or unintentionally share their security codes with any other person.* The user has responsibility for every entry (i.e., transaction) made under the security code. *Attempting to gain unauthorized access to information contained in the computer systems by any method, including the use of another person's security code, violates the security agreement and the unauthorized person subjects themselves to disciplinary action up to and including termination and criminal prosecution.*
The *computer systems* include all electronic devices used to store, transmit, and/or manipulate data about customers, employees, users, providers, strategic plans, etc. The system includes the Hospital Information System (HIS), all software used on the network, laptop computers, archived media, and back-up media.

Computer Security Agreement:
Aultman Alliance Community Hospital uses computer information systems to meet our clinical, financial, and informational needs. We deem the data and information contained and processed in these systems as proprietary and confidential. We must restrict access to our computer systems and their data to the minimum necessary for completion of your job. The use of security codes controls access to the computer systems and also provides an audit trail of the access. <u>No other person other than the owner may use this individually unique security code.</u>

By signing off on this policy, you acknowledge that you have received and have read a copy of the Abbreviated Computer and Network Access Security Policy and Procedure. You will find the complete policy in the Administration Policy and Procedure manual and/or on the Hospital Intranet.

1. Your security code, which will allow you to access your authorized functions and may serve as an electronic signature, is **HIGHLY CONFIDENTIAL.**
2. If you divulge your security code to another individual, you have violated this agreement and become subject to disciplinary action, up to and including discharge and/or criminal prosecution.
3. To prevent unauthorized access to confidential information, you are responsible to sign-off (exit to Good-bye) the computer system when you leave the terminal or personal computer unattended.

Internet and Electronic Mail Code of Conduct

I will abide by the following rules, codes, and guidelines when accessing the Internet and electronic as seen necessary for my role as a student at Aultman Alliance Community Hospital.

I will use:

1. Licensed software installed by Information Technology (IT) department
2. The internet and/or e-mail in an effective, productive, ethical, and lawful manner and avoid:
    a. Excessive inbound messages or files
    b. Interfering with the work of others
    c. Violating another's privacy
    d. Excessive use of business chat rooms and/or list servers
    e. Advancing my own personal or individual views
    f. Using e-mail or the Internet for my own personal gain
3. My own password
4. Up to date antiviral software when downloading files

5. Electronic mail and the interned for business purposes only
6. E-mail as official company mail and not access mail intended for other recipients, unless the recipient grants access.

I understand Aultman Alliance Community Hospital specifically prohibits the following practices:

1. Transmission of messages under an assumed name
2. Non-business chat sessions
3. Downloading of pornographic and/or obscene material
4. Accessing pornographic and/or offensive material
5. Transmission of copyrighted or Intellectual property unless duly authorized
6. Transmission of chain letters
7. Sending fraudulent, harassing, and/or obscene messages or graphics
8. Solicitation of non-company business

To maintain a properly functioning and secure system, I will

1. Check e-mail daily (when applicable)
2. Delete unwanted messages immediately
3. Download needed messages to a disk (contact IT for help)
4. Never assume my mail is secure and I will take other precautions to protect sensitive material (contact IT for help)
5. Keep central system files to a minimum
6. Routinely scan my PC for viruses
7. Report any virus activity or security incidents to the IT department

immediately I understand

1. All messages created, sent, or retrieved over the Internet remain the property of AACH
2. Violation of the Code of Conduct can result in revocation of my access, disciplinary action, and/or criminal prosecution
3. My obligation to notify the IT Department immediately if I discover a violation of the Code of Conduct by employees, volunteers, or physicians
4. AACH has a right to access, monitor, and disclose all message and files on the computer network system(s) or individual PC's for violations of application laws
5. The content and maintenance of my PC and disk storage area is my responsibility (contact IT for guidance)

IMPORTANT NOTICE TO PHYSICIANS AND HEALTHCARE FACILITIES

Under the Ohio Medical Practices Act, there are a number of Ohio laws that effect medical records. These laws pertain to all privileged patient medical record information, in both paper and computerized form. Violation of these laws can result in the loss or suspension of the Physicians medical license, if it can be demonstrated that the private nature of the Physician-Patient privilege has been violated. This Physician liability can be extended to any person who gains access or is authorized to privileged information that the physician is bound to hold confidential. If a security code is issued to the physician, and then distributed to colleagues, office managers, staff etc., the **PHYSICIAN** becomes liable for any breach of the Physician-Patient Confidentiality statutes and laws. Aultman Alliance Community Hospital **DOES NOT** condone the sharing and dispensing of security codes for any purpose whatsoever. Any person requiring access to the Aultman Alliance Community Hospital computer system can obtain the appropriate access by completing an application for Computer Access and Security Codes. Applications can be obtained from the Department of Information Technology.

PATIENT RIGHTS & RESPONSIBILITIES

Policy

Aultman Alliance Community Hospital shall protect and promote each patient's rights. No person shall be denied access to treatment or accommodations that are available and medically indicated, on the basis of such considerations as race, color, creed, national origin, sex, sexual orientation, gender identity or expression, diagnosis, or the nature of the source of payment for care.

Purpose

To specify rights and responsibilities of patients treated at Aultman Alliance Community Hospital and define the processes for administration of these rights and responsibilities.

Equipment

Patient Resource Book (Unit Specific)
Patient Rights and Responsibilities Wall Posters
Patient Rights and Responsibilities Notice *(form CE-03-QP) (Please see Appendix A for all references to the Patient Rights and Responsibilities Notice form)*
Patient Acknowledgement Certificate *(NS-07-QP)*
Senior Care Unit Patient Acknowledgement Certificate *(NS-07-QP-B)*

Procedure

1. The hospital will inform each patient or when appropriate, the patient's representative of the Patient's Rights and Responsibilities in a manner that the patient and/or patient representative can understand.
    a. If translation services are needed, refer to the policy Interpreters: Foreign/Sign Language. For those unable to see to read, an offer will be made to read it to the patient.
    b. The hospital will take reasonable steps to determine the patient's wishes regarding designation of a representative. See Policy: Consent to Treat, Including Minors; Refusal of Treatment, Including Leaving Against Medical Advice (AMA)
2. Distribution to the Patient (or when appropriate his/her representative): The notice of Patient Rights and Responsibilities must be provided in advance of providing care, whenever possible. This is the responsibility of the person obtaining consent for treatment via the consent form applicable to the type of service being provided. *(Form ER-50-QP for Emergency Department; Form AM-255-QP for Outpatients; Form AM-256-QP for Inpatients/Observation)*
    a. Present information regarding Patient Rights and Responsibilities via the Patient Rights and Responsibilities Notice *(Form CE-03-QP)* or the Patient Resource Book.
    b. Have the patient (or when appropriate his/her representative), sign the Patient Rights and Responsibilities Notice or the applicable Patient Acknowledgement Certificate *(Form NS-07-QP; or Senior Care Unit Patient Acknowledgement Certificate NS-07-QP B).*
    c. Place the applicable signed form to be scanned into the Medical Record.
    d. Provide a written copy of the Rights and Responsibilities either via the Notice or the Patient Resource Book.
3. In emergency situations where the patient is unable to sign, the patient representative may sign. If no representative is present in person, the representative will be informed as part of the verbal consent to treat.
4. If the patient refuses to sign the form or is unable to sign, or the representative is unavailable to sign, document the reason and the attempts made to obtain the signature on the acknowledgement form. Include the time, date and signature.
5. Notice of Rights:
    a. We will inform each patient, or when appropriate, the patient's representative, of the patient's rights in advance of providing or discontinuing care whenever possible. We will explain the patient's rights in a language or manner that the patient or the patient's representative can understand.
    b. Each Medicare beneficiary who is an inpatient (or his/her representative) will be provided the standardized notice "An Important Message from Medicare: (the "IM"), within two days of admission.

Medicare beneficiaries who have not been admitted (e.g. observation patients or outpatients) are not required to receive the IM.

6. Patient Rights and Responsibilities are posted in clear sight for patients and visitors to view throughout the hospital including outpatient settings.
7. The notice/posting will include who to contact to resolve potential, or actual, issues arising in supporting patient rights, complaints and grievances. The notice and postings must include the phone number and address for lodging a grievance with the Ohio Department of Health. The notice and posting will also include the contact information for the CMS Quality Improvement Organization and a contact for Psychiatric issues.

References

1. CMS Conditions of Participation §482.13
2. Ohio Revised Code Section 5122.29
3. CMS State Operations Manual Appendix A
4. HFAP Manual Chapter 15
5. Aultman Alliance Community Hospital Policy
    a. Patient Directed Visitation
    b. Patient Complaint/Grievance Process
    c. Consent to Treat, Including Minors; Refusal of Treatment, Including Leaving Against Medical Advice (AMA)
    d. Case Management Policy; CMS Medicare Notifications of Hospital Discharge Appeal Rights
    e. Restraint- Seclusion, Utilization Guidelines
    f. Interpreters: Foreign/Sign Language
    g. Care of the at Risk for Suicide and Self Harm Patient

Patient Rights and Responsibilities

While you are a patient at Aultman Alliance Community Hospital, you and/or your representative have the right to exercise your rights without coercion, discrimination, or retaliation.

AS A PATIENT YOU (OR YOUR REPRESENTATIVE) HAVE THE RIGHT TO:

Have access to treatment that is medically indicated and available here, or at another facility if we do not offer the service, regardless of race, religion, sex, sexual orientation, ethnicity, age, handicap, or nature of source of payment

a. Participate in the development and implementation of your plan of care;
b. His or her representative (as allowed under state law) has the right to make informed decisions regarding his or her care. This includes being informed of your health status, being involved in care planning and treatment, and being able to request or refuse treatment. This must not be construed as a mechanism to demand provision of treatment or services deemed medically unnecessary or inappropriate;
c. Formulate advance directives and to have hospital staff and practitioners, who provide care in the hospital, comply with these directives, in accordance with 489.100 of 42 CFR 489.100, 489.102 of 42 CFR 489.102, and 489.104 of 42CFR 489.104.
d. Have a family member or representative of your choice and your own physician notified promptly of your admission to the hospital;
e. Personal privacy;
f. Receive care in a safe setting;
g. Be free from all forms of abuse or harassment;
h. Confidentiality of your clinical records;
i. Access information contained in your clinical records within a reasonable time frame. The hospital must not frustrate the legitimate efforts of individuals to gain access to their own medical records and must actively seek to meet these requests as quickly as its record keeping system permits;
j. Be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation by staff;
k. Be fully informed of and consent to or refuse to participate in any unusual, experimental, or research project without compromising your access to service;

l. Know the professional status of any person providing your care/services;
m. Know the reasons for any proposed change in the Professional Staff responsible for your care;
n. Know the reasons for your transfer within or outside the hospital;
o. Know the relationship(s) of the hospital to other persons or organizations participating in your care;
p. Access to the cost, itemized when possible, of services rendered within a reasonable period of time;
q. Be informed of the source of the hospital's reimbursement for your services, and of any limitations which may be placed upon your care;
r. Be informed of the right to have pain treated as effectively as possible;
s. Have any visitors of your choosing, including but not limited to a spouse, a domestic partner (including a same sex domestic partner), another family member, or a friend. Likewise, you may refuse to consent to any person visiting you, or may withdraw consent to a person visiting you at any time. You may designate a "Support Person" to exercise your visitation rights if you are unable to do so yourself. The hospital will not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability, nor will it permit anyone else, including your Support Person, to do so. All visitors will enjoy full and equal visitation privileges consistent with your preferences. The hospital may apply reasonable clinical restrictions and other limitations on visitation based upon, but not limited solely to any of the following:
    - A court order limiting or restricting contact;
    - A visitor's behavior presenting a direct risk or threat to you, hospital staff, or others;
    - A visitor behavior that is disruptive to the functioning of the patient care area;
    - Your risk of infection by the visitor;
    - The visitor's risk of infection by you;
    - Your need for privacy or rest;
    - The need of privacy or rest by your roommate;
    - Any special restrictions that might apply in a special care unit; and when visitation might otherwise interfere with your care or that of another patient.
t. The patient's family has the right of informed consent for donation of organs and tissues.
u. Be notified of his or her rights in a language or manner that the patient can understand:
v. Know whom to contact with a grievance and have prompt resolution of any and all grievances:

YOUR RESPONSIBILITIES AS A PATIENT ARE TO:

a. Provide complete and accurate information about your past, present, and developing health conditions;
b. Discuss pain relief with your doctors and nurses and ask for pain relief when pain begins or if your pain has not been relieved;
c. Follow the treatment plan recommended by your physician and be accountable for your actions if you refuse treatment or do not follow instructions;
d. Be considerate of the property and rights of other patients and hospital colleagues, treating them with courtesy and respect, and be responsible for your own belongings; and
e. Assure prompt fulfillment of financial obligations related to your health care.

To let us know about a concern, complaint or grievance contact:

Quality Services Department
Aultman Alliance Community Hospital
200 East State Street Alliance, Ohio 44601
330-596-7154 (7154 from a patient phone)

You may also contact one of the following to express your concern:

Ohio Department of Health
North High Street
Columbus, Ohio 43215
1-800-342-0553
Email: HCComplaints@odh.ohio.gov

Livanta LLC BFCC-QIO Program
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701-1105
1-888-524-9900TTY 1-888-985-8775

Psychiatric: Disability Rights Ohio246
200 Civic Center Drive, Suite 300
Columbus, Ohio 43215614-466-7264
1-800-282-9181 (Toll free in Ohio only)

SUMMARY OF EMERGENCY CODES

Aultman Alliance Community Hospital has adopted the Ohio Emergency Codes presented by the Ohio Hospital Association. These codes are universal throughout the state and will allow hospital employees to know what to do at a different facility if called to assist during an emergency situation. Police, Fire, EMS, Red Cross and others dedicated to public safety are also adopting these codes. All codes are activated by **dialing 5555** and telling the operator the type of code and the location.

Code Red: Fire

Fire pull stations are located near the exits and stairwells. Please locate the one closest to your unit. Know RACE and PASS acronyms (back of ID badge)

Code Gray: Tornado/Severe Weather (refer to white Emergency Management Manual)

- Phase I: Is when a "Severe Thunderstorm Warning" and/or a "Tornado Watch" alert is received by the weather watch radio. Means "Get Ready!" Pull shades, close blinds and drapes, and remove all items from window sills.
- Phase II: Means "Get Ready!" A tornado warning has been issued within a 20 mile radius of hospital.
- Phase III: Means a tornado has been spotted within a 10 mile radius of hospital. Cover patients with blankets or sheets. Staff should then lie flat or crouch down covering their heads.
- Code Gray All Clear: Means the danger has passed. Put equipment back, open shades, and proceed with normal operations.

Code Orange: Hazardous Material Spill/Release

Contain the hazardous material and refer to the yellow Healthcare Hazards manual for further instructions.

Code Blue (Location): Cardiopulmonary or Respiratory Arrest (Medical Emergency Adult)

Code Pink (Location): Medical Emergency under age 16

Code Yellow: Disaster

Code Yellow is notification that an external or internal disaster has occurred. Each department or unit has a specific plan. Refer to the white Emergency Management Manual.

Phase I: Be aware something is going on in the area and review your role in manual. Top 11 positions on HICS chart report to Incident Command (First floor staff lounge).
Phase II: 0-20 victims coming in
Phase III: 21-40 victims coming in
Phase IV: Over 40 victims coming in

If you are called in from home:

- Bring your hospital ID badge
- Attach a white flag to side mirror of vehicle
- Enter through the designated entrance

Code Violet (Location): Violent/Combative Patient

Code Silver / AS (Location): Person with Weapon /Active Shooter

Isolate patients, visitors, and staff, if possible.

Code Brown (Location): Missing Adult Patient

Dial 5555 and all units on floor where patient was last seen. Post staff at all entrances/exits to floor. Protective Services will monitor the remainder of the hospital.

Code Green: Evacuation

Partial Evacuation: A partial evacuation is called when we are going to evacuate a certain area of the hospital

for whatever reason. You would hear "Code Green 3 East" for example

Hospital Wide Evacuation: A hospital wide evacuation is called when we are going to evacuate the entire hospital. You would hear "Code Green Hospital Wide".

Infant/Child Abduction (Code Adam)

Code Adam is the alert used to indicate an infant or child abduction. If this is paged overhead, colleagues must secure all halls, stairwells, exits leading to and from the facility. Any person carrying an object large enough to conceal a newborn infant should be stopped and the package should be inspected. If the person refuses the package inspection, do not allow them to leave the building, and notify Protective Services at 7135. Law enforcement officials have found that middle-aged females are those most likely to abduct an infant. Refer to the Code Adam policy in the Administration Policy and Procedure Manual.

Bomb Threat (Code Black)

Keep the caller on the line, signal to a fellow employee to notify the operator immediately at 5555. All threats should be taken seriously. Refer to the Bomb Threat Call Information sheet located on your unit for specific questions to ask the caller. Remember to record your responses! Hold the sheet in the air to signal a colleague to call Protective Services at 7135. If a suspicious item is found, DO NOT TOUCH. Notify Protective Services immediately.

Key Points to Remember:

1. Remain Calm!
2. Keep the caller on the line as long as possible.
3. Obtain and record as much information as you can including background noises, accents, etc.
4. The two most important pieces of information to obtain are: the location of the bomb and detonation time of the bomb

PERSONAL, FIRE & ELECTRICAL SAFETY

Types of Fires

There are 4 classes of fires:

1. **Class A** - burning of ordinary combustibles like wood, paper, cloth, rubber, or certain plastics.
2. **Class B** - burning of gases and liquids.
3. **Class C** - burning of energized electrical equipment such as appliances, air conditioning and heating units, motors, and generators.
4. **Class D** - burning of certain metals (least likely to be exposed to in healthcare setting).

Types of Fire Extinguishers

Fire extinguishers are an important defense measure for putting out fires. They can save lives. Make sure you know where the fire extinguishers are located.

In healthcare facilities, fire extinguishers are designed to put out Class A, Class B, and Class C fires. ABC extinguishers can be used to fight all three types of fires and are marked with an ABC.

Be prepared before a fire…

1) Review evacuation routes
2) Keep work areas clear of clutter
3) Never block smoke doors or fire exits
4) Keep calm

If a fire starts, think and act quickly and safely: To activate the extinguisher:

R Rescue
A Activate the Alarm
C Contain
E Extinguish

P Pull the pin
A Aim the nozzle at the base of the fire
S Squeeze the handle together
S Sweep the extinguisher from side to side

Protective Services
Security officers provide a safe environment for all colleagues, patients, and visitors. Report any suspicious activities or persons to Protective Services immediately at extension 7135.

Personal Protection

- Δ Avoid walking to your vehicle alone after hours. Contact Protective Services to be escorted or walk in a group.
- Δ Do not stand in the parking lot talking.
- Δ When you park your car make sure the doors are locked and windows are up.
- Δ Be on your guard and aware of your surroundings.
- Δ Report all suspicious activity promptly. Alert Protective Services if you see a person loitering or harassing others.

Electrical Safety

- Δ To manage electrical safety:
- Δ Report all shocks immediately-even tingles.
- Δ Never work around electricity when you or your surroundings are wet.
- Δ Don't use so called "octopus" adapters. Plugging too many cords into one outlet can overload the circuit.
- Δ Examine all cords, plugs, and equipment routinely. Report any that are damaged; label, and remove them from service.
- Δ Use grounded 3 prong plugs and 3 hole outlets. Never break off or bend the third prong on a grounded plug.
- Δ All new equipment must be inspected by the Engineering Department before use.
- Δ When unplugging, pull on plug, not cord.

ISOLATION & INFECTION CONTROL

Types of Isolation Precautions Used

1. Standard Precautions: Treat everyone's blood, body fluids, excretions, secretions, non-intact skin and mucous membranes, except tears and sweat, as infectious—-at all times.
2. Transmission Based Precautions

- Δ Airborne-used for TB, Measles, Chicken Pox
- Δ Droplet-used for Bacterial Meningitis, Pertussis, Mumps
- Δ Contact-used for MRSA, VRE, C diff, Rotavirus
- Δ Environmental or Reverse–used for immunosuppressed patients

Blood Borne Pathogens
Types of blood borne pathogens include: The Hepatitis B (HBV) Virus, The Hepatitis C (HCV) Virus, and The Human Immunodeficiency (HIV) Virus.
By following Standard Precautions, we assume that everyone has potentially infectious blood and body fluids. Our Exposure Control Plan helps to educate staff to reduce the risk of transmission and is to be used when caring for all patients.

Transmission occurs when there is exposure to body fluids such as blood, semen and vaginal secretions, which may contain an infectious agent. Transmission usually occurs through:

- Δ Needle stick Injuries
- Δ Cuts, scrapes, and other breaks in the skin
- Δ Splashes into the mouth, nose, or eyes
- Δ Oral, vaginal, or anal sex

- Δ Pregnant mother to baby
- Δ Protect yourself
- Δ Wear PPE
- Δ Use safety devices
- Δ Contact Infection Control or Nursing Supervisor immediately when an exposure occurs

Infection Control
Hand hygiene is fundamental in good infection control practice. Wear gloves to prevent contamination of your hands and be sure to wash hands and change gloves between patients and/or dirty to clean activities. Soap and water or a waterless alcohol-based product may be used. Alcohol sanitizers should not be used in presence of C diff or when visibly soiled

Every colleague/student must take the time to protect himself/herself first by using appropriate Personal Protective Equipment (PPE). This may include gloves, gown, mask, goggles, head, and foot coverings.

Biohazard waste should be disposed of in red bags. Sharps should be disposed of in red bio-hazardous sharps container and all other waste, including waste from isolation rooms may go in the trash. DO NOT place red bags in a regular trash bag! Place all red bags in the dirty utility room on each unit.

For splashes to mucous membranes (eye, nose, mouth), flush the affected area with tap water for at least one minute.

Additional Ways for your Protection: Break the Chain of Infection

- Δ Follow up with annual PPD tests for Tuberculosis if you have direct patient contact.
- Δ Maintain good health and notify Infection Control if you have a communicable illness
- Δ Keep your nails trimmed and clean and do not wear artificial nails and overlays
- Δ Leave your jewelry at home
- Δ Practice good hand hygiene-wash hands with soap and water or use alcohol rub
- Δ Know where the eyewash station is located in your department

Tuberculosis Control
The incidence of TB is on the rise all over the country for various reasons. One major reason is that healthcare workers may be exposed to patients with undiagnosed infectious TB.
Two key ways to protect yourself and others from possible TB:

1. Early Identification.

- Δ Our TB Control Plan lists specific signs/symptoms to consider when trying to determine if a patient may have infectious TB. These signs/symptoms include-chronic cough, bloody sputum, fever/chills, night sweats, unintentional weight loss and/or anorexia, fatigue and/or belonging to a high risk group (medically underserved, elderly, foreign born, crowded living conditions, history of TB or positive PPD or contact with infectious TB). Often the patient's radiological films will show cavitation or fibrotic lesions. Be aware that patients admitted with Pneumonia or COPD or some other pulmonary illness may actually be suffering from TB, either alone or with another illness. Contact Infection Control for assistance.

2. Prompt Institution of Appropriate Control Measures.

- Δ Isolate using Airborne Precautions (either a negative pressure room or a Portable Isolation Chamber and use a N95 mask, that you have been fitted or a PAPR you have been trained to use). Notify the physician. ***No physician's order is required to initiate isolation because these are CDC guidelines and facility policy.***

- Δ Use Standard Precautions when caring for all patients at all times. Wear PPE appropriate for the possible may be contaminated with body fluids, wear a mask and eye protection if splattering/splashing may occur. Wash hands or use an alcohol rub before and after patient contact.
- Δ All patients should be taught respiratory etiquete to cover their mouth and nose when coughing or sneezing with a tissue and to dispose of the used tissue in a waste receptacle. Teach patients proper hand hygiene, including the use of alcohol rubs and hand washing.

HAZARDOUS MATERIALS & SDS

Hazcom

OSHA's Hazard Communication Standards, often referred to as "Right To Know", are designed to educate and protect colleagues from exposure to hazardous chemicals at work.

Although we can work safely with hazardous materials, the best approach is to keep our exposure as low as possible. To do this, use the minimum amount needed, use good ventilation, wear proper personal protective equipment (PPE), and avoid contact with skin and eyes.

Chemicals can enter the body through four common ways:

- Ingestion (eating the material)
- Absorption (through the skin)
- Inhalation (breathing)
- Injection (punctures, cuts, open wounds)

Eating or ingesting chemicals most often happens when food and hazardous chemicals are used or stored in the same area.

Absorption usually requires a long contact time and can be decreased by preventing contact with skin and using protective clothing.

Inhaling chemicals is usually the most significant route of entry. Use only the amount of chemical or product necessary for the job. Keep containers closed except when transferring or using materials and employ good ventilation to decrease your risk of inhalation exposure.

For splashes to mucous membranes (eye, nose, mouth), flush the affected area with tap water for at least one minute.

Safety Data Sheet (SDS)

The SDS provides information about a chemical's hazards, how to handle the chemical, how to protect yourself when using the chemical, first aid instructions and the chemical's routes of entry. As a healthcare worker, you may need to use SDS(s) for your own safety when working with chemicals. Remember...NEVER MIX CHEMICALS TOGETHER!
Specific questions can be answered by calling Environmental Services at extension 7067 or 2068.

Labeling

All chemicals must be labeled. Labels show:

- chemical name of the product
- hazardous warnings
- hazardous ingredients
- name and address of the chemical manufacturer

Information can be found in the "Code Orange" section of the Emergency Management Manual

Chemical Spills

Information available in the Code Orange section of the Emergency Management Manual, is located in each department to assist with the cleanup of spills. The notebook has detailed directions on the steps needed to take care of all chemical spills. If a mercury or chemical spill occurs in your area, call Environmental Services at extension 7067 or 2068. You must also complete a variance report and an Employee Injury/Illness Form if a colleague is involved. A small spill is one that is less than one gallon. A large spill is more than one gallon. In the case of a large spill, you must evacuate the area, call 5555, tell operator Green Alert/Chemical Spill. The operator notifies the spill team.

Blood Spill Safety

Blood spills must be cleaned using a solution of 1:10 bleach to water or an appropriate spill kit. Spill kits are available in Housekeeping closets. If a large spill (greater than 1 square foot) occurs, a spill report must be filled out. Reports are located in the large spill kits or call Environmental Services at 7067 or 2068.

Needle Stick Safety

Aultman Alliance Community Hospital has a needleless access system and other safety devices designed to minimize exposure to blood or other potentially infectious material. Never recap needles. Use Red Biohazard sharps container. DO NOT overfill containers.

In the event of an exposure, the following steps should be taken:

1. For needle sticks, wash the affected area vigorously with soap and water.
2. Notify your supervisor immediately to notify Infection Control.
3. During off-shift call the Nursing Supervisor.
4. Complete a Colleague Injury Report.
5. Follow up lab testing and prophylactic medications or vaccines are available to colleagues through the Infection Control Nurse.

ETHICS

Ethics

An ethical dilemma can be defined as a situation in which there is more than one possible course of action, any of these courses of action could be carried out and there is disagreement about the right course. For example, an elderly patient in a nursing home has had a stroke and is unable to eat. He is not competent to decide whether to have a feeding tube inserted and has 2 children who disagree about the right choice.

For situations like this, AACH has an Ethics Committee. The 3 main purposes of the committee are:

1. Education of the staff and community about medical ethic issues like the one in the example.
2. Assisting administration in reviewing and writing policies pertaining to ethics.
3. Performing consultation, upon request, in situations where ethical dilemmas exist.

The Ethics Committee can only respond when its members' services are requested. AACH has an "open" policy in which any individual including patient, family, colleague, and medical staff can request a consultation. Requests are made by calling the PBX operator at any time of the day or night.

You can prevent the need for an ethics consult by encouraging clear, appropriate and timely communication between physicians, nurses, and other caregivers, patients and their families. Clear communication prevents buildup of frustration and misunderstandings.

PATIENT ABUSE

Policy

No patients will be mistreated or abused in any way by a colleague of Aultman Alliance Community Hospital.

Purpose

To establish a process to follow in cases of alleged or suspected patient abuse.

Definitions

Patient Abuse is defined as an act that involved physical, psychological, sexual and/or verbal abuse, including but not limited to:

1. Intentional omission of care;
2. Willful violations of a patient's privacy or a patient's rights;
3. Intimidation, harassment, or ridicule of a patient;
4. Willful physical injury; and/or
5. Unintended injury as stated above, though colleague's course of action.

Procedure

Each colleague will be responsible to apply the minimal level of force that is reasonably necessary to control a given situation. This will apply during both emergent and routine episodes of care delivery.

Each colleague should avoid any act which could be construed as abuse and/or mistreatment of patients.

It is the responsibility of each colleague to report any actual or suspected incident of patient abuse and/or mistreatment to his/her immediate supervisor within one hour of awareness of the event, or immediately to prevent further endangerment of the patient.

The immediate supervisor will then notify the appropriate Director/Executive of the event.

Colleagues who become aware of possible abuse of a patient will complete an incident report.

An investigation of alleged instances of patient abuse and/or mistreatment will be initiated by the appropriate manager in conjunction with Colleague Relations.

The patient's perception of how she/he was treated will be taken into consideration when determining whether abuse occurred. Even without direct patient input, such as patients with limited cognitive ability, abuse can be substantiated.

Actual or possible criminal actions should be reported to Security and the appropriate law enforcement agency.

It is the responsibility of each colleague to become familiar with the contents of this policy.

IF YOU SHOULD SEE A WHITE ROSE…

A white rose magnet is placed on the door of a dying patient. It is used to gently remind staff to be respectful of the dying patient and the grieving family.

You can show respect towards the family by:

- Δ Speaking quietly in the hallway outside the patient's room
- Δ Avoid undue laughing, joke telling or loud voices outside the room
- Δ Limiting scrubbing or vacuuming floors and postponing maintenance work in areas near the room
- Δ Reminding others to be respectful in their actions
- Δ Keeping the door closed
- Δ Providing extra chairs, for the family if needed
- Δ Asking Nutritional Services to provide a beverage cart
- Δ Keeping the room tidy
- Δ Giving personal care to the patient quickly and efficiently, but gently

IMPAIRED PRACTITIONER

It is the policy of Aultman Alliance Community Hospital to be sensitive to health conditions that may affect a practitioner's ability to provide safe, competent care to patients; to structure the clinical privileges of practitioners whose abilities are affected by a health condition in the least restrictive way possible, consistent with the primary concern for quality patient care and the efficient operations of the hospital. Concerns that a practitioner is suffering from impairment will be investigated and acted upon in accordance with the *Impaired Practitioner Policy* and state and federal law, including, but not limited to, the Americans with Disabilities Act, to the extent applicable.

The American Medical Association (AMA) defines physician impairment as "any physical, mental, or behavioral disorder that interferes with ability to engage safely in professional activities." The Aultman Alliance Community Hospital *Impaired Practitioner Policy* further defines impairment as "potentially unable to exercise the clinical privileges granted with reasonable skill and safety by reason of mental illness, physical illness, including but not limited to, physical deterioration that adversely affects cognition, motor or perceptive skills, or habitual or excessive use or abuse of drugs, alcohol, or other substances that impair ability."

In general, physicians become impaired because of three major problems:

1. ***Substance abuse*** – Alcohol abuse is the most common problem. Abuse of narcotics, sedatives, and other depressants as well as stimulants, including cocaine, may also occur, (least likely to seek help for).
2. ***Psychological problems*** – Excessive stress, depression, anxiety, and divorce are the most common issues.
3. ***Physical illness*** – Physical ailments, either temporary or long-term, can lead to incapacity.

The physician who is impaired often acts in an unusual manner and exhibits behaviors that can serve as warnings, if they are recognized and understood. These indicators may include:

> Loss of enthusiasm, negative attitudes, changes in work habits, changes in prescribing habits, procedural errors, missed appointments or meetings, isolation or mistrust, changes in handwriting, wrong dates or dosage errors, antagonistic behavior, self-diagnosed health complaints, etc.

If you suspect that a physician-colleague has a problem, it is essential to realize that the problem will not go away on its own. Sometimes, a colleague, mentor, or friend's well-intended attempts to help may actually have the effect of enabling the impaired physician to persist with the very behaviors that are causing the problem. For example, trying to cover or make excuses for a colleague whom one suspects is having a problem.

Early intervention is critical. When left alone, problems caused by impairment tend to worsen – they can lead to damaged relationships, financial disaster, loss of employment, or suicide. Impaired physicians may be endangering the safety of patients and colleagues as well as themselves on a daily basis. On the other hand, the earlier an impaired person gets help, the greater the likelihood that help can be obtained confidentially, voluntarily, and without jeopardy to the physician's family, career, or permanent health.

Generally, impaired physicians do not seek help on their own. In fact, many deny that there is a problem. Because denial is so common in situations of impairment, it is even more critical that the concerned colleague take some action to see that help is made available to the physician who may need it. Failure to act often has the effect of enabling the problem to continue. Intervention by a concerned peer is the kindest and most helpful action that one can take on behalf of a colleague. It is not easy, but it is essential.

Because the problem of impairment is common among physicians, it is now increasingly acknowledged that they have a right to get help confidentially and to recover fully – including the right to retain or regain their privileges as physicians.

If any individual working at Aultman Alliance Community Hospital or one of its facilities has a reasonable suspicion that a practitioner appointed to the medical staff of Aultman Alliance Community Hospital is impaired, the following steps shall be taken:

1. A report, preferably written, shall be given to the Chief Executive Officer or his designee. The report shall include a factual description of the incident/s that led to the belief that the practitioner may be impaired. The individual making the report does not need to have proof of the impairment, but must state the facts leading to the concerns.
2. If, after discussing the incident/s with the individual who filed the report, the Chief Executive Officer or his designee believes there is sufficient information to warrant further investigation, the *Impaired Practitioner Policy* outlines the steps to be filed. A copy of this policy is available in Administration and Medical Affairs.

COMMUNITY CARE CENTER RESIDENT

RIGHTS RESIDENT'S RIGHTS – OHIO LAW

THE RIGHTS OF RESIDENTS OF A HOME SHALL INCLUDE, BUT ARE NOT LIMITED TO, THE FOLLOWING:

REGULATIONS PRESCRIBED BY THE PUBLIC HEALTH

- THE RIGHT TO A SAFE AND CLEAN LIVING ENVIRONMENT PURSUANT TO THE MEDICARE AND MEDICAID PROGRAMS AND APPLICABLE STATE LAWS AND COUNCIL
- THE RIGHT TO BE FREE FROM PHYSICAL, VERBAL, MENTAL, SEXUAL, AND EMOTIONAL ABUSE AND TO BE TREATED AT ALL TIMES WITH COURTESY, RESPECT, AND FULL RECOGNITION OF DIGNITY AND INDIVIDUALITY;
- UPON ADMISSION AND THEREAFTER, THE RIGHT TO ADEQUATE AND APPROPRIATE MEDICAL TREATMENT AND NURSING CARE AND TO OTHER ANCILLARY SERVICES THAT COMPRISE NECESSARY AND APPROPRIATE CARE CONSISTENT WITH THE PROGRAM FOR WHICH THE RESIDENT CONTRACTED. THIS CARE SHALL BE PROVIDED WITHOUT REGARD TO CONSIDERATIONS SUCH AS RACE, COLOR, RELIGION, NATIONAL ORIGIN, AGE, OR SOURCE OF PAYMENT FOR CARE.
- THE RIGHT TO HAVE ALL REASONABLE REQUESTS AND INQUIRIES RESPONDED TO PROMPTLY;
- THE RIGHT TO HAVE CLOTHES AND BED LINENS CHANGED AS THE NEED ARISES, TO ENSURE THE RESIDENT'S COMFORT OR SANITATION;
- THE RIGHT TO OBTAIN FROM THE HOME, UPON REQUEST, THE NAME AND ANY SPECIALTY OF ANY PHYSICIAN OR OTHER PERSON RESPONSIBLE FOR THE RESIDENT'S CARE OR FOR THE COORDINATION OF CARE;
- THE RIGHT TO PARTICIPATE IN DECISIONS THAT AFFECT THE RESIDENT'S LIFE, INCLUDING THE RIGHT TO COMMUNICATE WITH THE PHYSICIAN AND EMPLOYEES OF THE HOME IN PLANNING THE RESIDENT'S TREATMENT OR CARE AND TO OBTAIN FROM THE ATTENDING PHYSICIAN COMPLETE AND CURRENT INFORMATION CONCERNING MEDICAL CONDITION, PROGNOSIS, AND TREATMENT PLAN, IN TERMS THE RESIDENT CAN BE EXPECTED TO UNDERSTAND; THE RIGHT OF ACCESS TO ALL INFORMATION IN THE RESIDENT'S MEDICAL RECORD; AND THE RIGHT TO GIVE OR WITHHOLD INFORMED CONSENT FOR TREATMENT AFTER THE CONSEQUENCES OF THAT CHOICE HAVE BEEN CAREFULLY EXPLAINED. WHEN THE ATTENDING PHYSICIAN FINDS THAT IT IS NOT MEDICALLY ADVISABLE TO GIVE THE INFORMATION TO THE RESIDENT, THE INFORMATION SHALL BE MADE AVAILABLE TO THE RESIDENT'S SPONSOR ON THE RESIDENT'S BEHALF, IF THE SPONSOR HAS A LEGAL INTEREST OR IS AUTHORIZED BY THE RESIDENT TO RECEIVE THE INFORMATION. THE HOME IS NOT LIABLE FOR A VIOLATION OF THIS DIVISION IF THE VIOLATION IS FOUND TO BE THE RESULT OF AN ACT OR OMISSION ON THE PART OF A PHYSICIAN SELECTED BY THE RESIDENT WHO IS NOT OTHERWISE AFFILIATED WITH THE HOME.
- **THE RIGHT TO WITHHOLD PAYMENT FOR PHYSICIAN VISITATION IF THE PHYSICIAN DID NOT VISIT THE RESIDENT**.
- THE RIGHT TO CONFIDENTIAL TREATMENT OF PERSONAL AND MEDICAL RECORDS, AND THE RIGHT TO APPROVE OR REFUSE THE RELEASE OF THESE RECORDS TO ANY INDIVIDUAL OUTSIDE THE HOME, EXCEPT IN CASE OF TRANSFER TO ANOTHER HOME, HOSPITAL, OR HEALTH CARE SYSTEM, AS REQUIRED BY LAW OR RULE, OR AS REQUIRED BY A THIRD-PARTY PAYMENT CONTRACT;
- THE RIGHT TO PRIVACY DURING MEDICAL EXAMINATION OR TREATMENT AND IN THE CARE OF PERSONAL OR BODILY NEEDS;

- THE RIGHT TO REFUSE, WITHOUT JEOPARDIZING ACCESS TO APPROPRIATE MEDICAL CARE, TO SERVE AS A MEDICAL RESEARCH SUBJECT;
- THE RIGHT TO BE FREE FROM PHYSICAL OR CHEMICAL RESTRAINTS OR PROLONGED ISOLATION EXCEPT TO THE MINIMUM EXTENT NECESSARY TO PROTECT THE RESIDENT FROM INJURY TO SELF, OTHERS, OR TO PROPERTY AND EXCEPT AS AUTHORIZED IN WRITING BY THE ATTENDING PHYSICIAN FOR A SPECIFIED AND LIMITED PERIOD OF TIME AND DOCUMENTED IN THE RESIDENT'S MEDICAL RECORD. PRIOR TO AUTHORIZING THE USE OF A PHYSICAL OR CHEMICAL RESTRAINT ON ANY RESIDENT, THE ATTENDING PHYSICIAN SHALL MAKE A PERSONAL EXAMINATION OF THE RESIDENT AND AN INDIVIDUALIZED DETERMINATION OF THE NEED TO USE THE RESTRAINT ON THAT RESIDENT.
- PHYSICAL OR CHEMICAL RESTRAINTS OR ISOLATION MAY BE USED IN AN EMERGENCY SITUATION WITHOUT AUTHORIZATION OF THE ATTENDING PHYSICIAN ONLY TO PROTECT THE RESIDENT FROM INJURY TO SELF OR OTHERS. USE OF THE PHYSICAL OR CHEMICAL RESTRAINTS OR ISOLATION SHALL NOT BE CONTINUED FOR MORE THAN TWELVE HOURS AFTER THE ONSET OF THE EMERGENCY WITHOUT PERSONAL EXAMINATION AND AUTHORIZATION BY THE ATTENDING PHYSICIAN. THE ATTENDING PHYSICIAN OR A STAFF PHYSICIAN MAY AUTHORIZE CONTINUED USE OF PHYSICAL OR CHEMICAL RESTRAINTS FOR A PERIOD NOT TO EXCEED THIRTY DAYS, AND AT THE END OF THIS PERIOD AND ANY SUBSEQUENT PERIOD MAY EXTEND THE AUTHORIZATION FOR AN ADDITIONAL PERIOD OF NOT MORE THAN THIRTY DAYS. THE USE OF PHYSICAL OR CHEMICAL RESTRAINTS SHALL NOT BE CONTINUED WITHOUT A PERSONAL EXAMINATION OF THE RESIDENT AND THE WRITTEN AUTHORIZATION OF THE ATTENDING PHYSICIAN STATING THE REASONS FOR CONTINUING THE RESTRAINT.

- If physical or chemical restraints are used under this division, the home shall ensure that the restrained resident receives a proper diet. In no event shall physical or chemical restraints or isolation be used for punishment, incentive, or convenience.
- The right to the pharmacist of the resident choice and the right to receive pharmaceutical supplies and services at reasonable prices not exceeding applicable and normally accepted prices for comparably packaged pharmaceutical supplies and services within the community;
- The right to exercise all civil rights, unless the resident has been adjudicated incompetent pursuant to Chapter 2111 of the Revised Code and has not been restored to legal capacity, as well as the right to the cooperation of the home's administrator in making arrangements for the exercise of the right to vote;
- The right of access to opportunities that enable the resident, at the resident's own expense or at the expense of a third-party payer, to achieve the resident's fullest potential, including educational, vocational, social, recreational, and habilitation programs;
- The right to consume a reasonable amount of alcoholic beverages at the resident's own expense, unless not medically advisable as documented in the resident's medical record by the attending physician or unless contradictory to written admission policies;
- The right to use tobacco at the resident's own expense under the home's safety rules and under applicable laws and rules of the state, unless not medically advisable as documented in the resident's medical record by the attending physician or unless contradictory to written admission policies;
- The right to retire and rise in accordance with the resident's reasonable requests, if the resident does not disturb others or the posted meal schedules and upon the home's request remains in a supervised area, unless not medically advisable as documented by the attending physician.
- The right to observe religious obligations and participate in religious activities; the right to maintain individual and cultural identity; and the right to met with and participate in activities of social and community groups at the resident's or the group's initiative;
- The right upon reasonable request to private and unrestricted communications with the resident's family, social worker, and any other person, unless not medically advisable as documented in the resident's medical record by the attending physician, except that communications with public officials or with the resident's attorney or physician shall not be restricted. Private and unrestricted communications shall include, but are not limited to, the right to:
  - Receive, send, and mail sealed, unopened correspondence
  - Reasonable access to a telephone for private communications;
  - Private visits at any reasonable hour.
  - The right to assured privacy for visits by the spouse, or if both are residents of the same home, the right to share a room within the capacity of the home, unless not medically advisable as documented in the resident's medical record by the attending physician;
  - The right upon reasonable request to have room doors closed and to have them not opened without knocking, except in the case of an emergency or unless not medically advisable as documented in the resident's medical record by the attending physician;The right to retain and use personal clothing and a reasonable amount of possessions, in a reasonably secure manner, unless to do so would infringe on the rights of other residents or would not be medically advisable as documented in the resident's medical record by the attending physician;
- The right to be fully informed, prior to or at the time of admission and during the resident's stay, in writing, of the basic rate charged by the home, of services available in the home, and of any additional charges related to such services, including charges for services not covered under the Medicare of Medicaid program. The basic rate shall not be changed unless thirty days' notice is given to the resident or, if the resident is unable to understand this information, to the resident's sponsor.
- The right of the resident and person paying for the care to examine and receive a bill at least monthly for the resident's care from the home that itemizes charges not included in the basic rates;
- The right to be free from financial exploitation;
- The right to manage the resident's own personal financial affairs, or, if the resident has delegated this responsibility in writing to the home, to receive upon written request at least a quarterly accounting statement of financial transactions made on the resident's behalf. The statement shall include:
  - A complete record of all funds, personal property, or possessions of a resident from any source whatsoever, that have been deposited for safekeepingwith the home for use by the resident or the resident's sponsor;
  - A listing of all deposits and withdrawals transacted, which shall be substantiated by receipts which shall be available for inspection and copying by the resident or sponsor.

- THE RIGHT OF THE RESIDENT TO BE ALLOWED

UNRESTRICTED ACCESS TO THE RESIDENT'S PROPERTY ON DEPOSIT AT REASONABLE HOURS, UNLESS REQUESTS FOR ACCESS TO PROPERTY ON DEPOSIT ARE SO PERSISTENT, CONTINUOUS, AND UNREASONABLE THAT THEY CONSTITUTE A NUISANCE;

• THE RIGHT TO RECEIVE REASONABLE NOTICE BEFORE THE RESIDENT'S ROOM OR ROOMMATE IS CHANGED, INCLUDING AN EXPLANATION OF THE REASON FOR EITHER CHANGE.

- THE RIGHT NOT TO BE TRANSFERRED OR DISCHARGED FROM THE HOME UNLESS THE TRANSFER IS NECESSARY BECAUSE OF ONE OF THE FOLLOWING:
- THE WELFARE AND NEEDS OF THE RESIDENT CANNOT BE MET IN THE HOME.

• THE RESIDENT'S HEALTH HAS IMPROVED SUFFICIENTLY SO THAT THE RESIDENT NO LONGER NEEDS THE SERVICES PROVIDED BY THE HOME.

- THE SAFETY OF INDIVIDUALS IN THE HOME IS ENDANGERED.
- THE HEALTH OF INDIVIDUALS IN THE HOME WOULD OTHERWISE BE ENDANGERED.

• THE RESIDENT HAS FAILED, AFTER REASONABLE AND APPROPRIATE NOTICE, TO PAY OR TO HAVE THE MEDICARE OR MEDICAID PROGRAM PAY ON THE RESIDENT'S BEHALF, FOR THE CARE PROVIDED BY THE HOME. A RESIDENT SHALL NOT BE CONSIDERED TO HAVE FAILED TO HAVE THE RESIDENT'S CARE PAID FOR IF THE RESIDENT HAS APPLIED FOR MEDICAID, UNLESS BOTH OF THE FOLLOWING ARE THE CASE:

• THE RESIDENT'S APPLICATION, OR A SUBSTANTIALLY SIMILAR PREVIOUS APPLICATION, HAS BEEN DENIED BY THE COUNTY DEPARTMENT OF JOB AND FAMILY SERVICES.

• IF THE RESIDENT APPEALED THE DENIAL PURSUANT TO DIVISION (C) SECTION 5101.35 OF THE REVISED CODE, THE DIRECTOR OF JOB AND FAMILY SERVICES HAS UPHELD THE DENIAL.

- THE HOME'S LICENSE HAS BEEN REVOKED; THE HOME IS BEING CLOSED PURSUANT TO SECTION 3721.08, SECTIONS 5111.35 TO 5111.62, OR SECTION 5155.31 OF THE REVISED CODE, OR THE HOME OTHERWISE CEASES TO OPERATE.

• THE RESIDENT IS A RECIPIENT OF MEDICAID, AND THE HOME'S PARTICIPATION IN THE MEDICAID PROGRAM IS INVOLUNTARILY TERMINATED OR DENIED.

• THE RESIDENT IS A BENEFICIARY UNDER THE MEDICARE PROGRAM, AND THE HOME'S PARTICIPATION IN THE MEDICARE PROGRAM IS INVOLUNTARILY TERMINATED OR DENIED.

• THE RIGHT TO VOICE GRIEVANCES AND RECOMMEND CHANGES IN POLICIES AND SERVICES TO THE HOME'S STAFF, TO EMPLOYEES OF THE DEPARTMENT OF HEALTH, OR TO OTHER PERSONAS NOT ASSOCIATED WITH THE OPERATION OF THE HOME, OF THE RESIDENT'S CHOICE, FREE FROM RESTRAINT, INTERFERENCE, COERCION, DISCRIMINATION, OR REPRISAL. THIS RIGHT INCLUDES ACCESS TO A RESIDENTS' RIGHT ADVOCATE, AND THE RIGHT TO BE A MEMBER OF, TO BE ACTIVE IN, AND TO ASSOCIATE WITH PERSONS WHO ARE ACTIVE IN ORGANIZATIONS OF RELATIVES AND FRIENDS OF NURSING HOME RESIDENTS AND OTHER ORGANIZATIONS ENGAGED IN ASSISTING RESIDENTS.

• THE RIGHT TO HAVE ANY SIGNIFICANT CHANGES IN THE RESIDENT'S HEALTH STATUS REPORTED TO THE RESIDENT'S SPONSOR. AS SOON AS SUCH A CHANGE IS KNOWN TO THE HOME'S STAFF, THE HOME SHALL MAKE A REASONABLE EFFORT TO NOTIFY THE SPONSOR WITHIN TWELVE HOURS.

- A SPONSOR MAY ACT ON A RESIDENT'S BEHALF TO ASSURE THAT THE HOME DOES NOT DENY THE RESIDENT'S RIGHTS UNDER SECTIONS 3721.10 TO 3721.17 OF THE REVISED CODE

REGULATORY AGENCIES AND RESIDENT
ADVOCATES Stark County

Ohio Department of Health
246 North High Street
PO Box 118
Columbus, OH 43266-0118
(614) 466-3543

Ohio Department of Health
Cambridge District Office
107 North Sixth Street
Cambridge, OH 43725
(614) 432-3012

The Ohio Department of Health is responsible for licensing, certification, and applicable surveys of nursing homes and residential care facilities.

Area Agency on Aging, 10B Inc.
1550 Corporate Woods Parkway
Suite 100
Uniontown, OH 44685
(800) 421-7277

State Long Term Care Ombudsman
Ohio Department of Aging
50 West Broadway Street
Columbus, OH 43215-0501
(800) 282-1206

The office of the Long Term Care Ombudsman is responsible for providing information on how to select a long term care facility, how and where to find information about financing long term care and how to deal with concerns about the quality of care.

Ohio Legal Rights
8 East Long Street, 5th Floor
Columbus, OH 43215
(800) 282-9181

Ohio Department of Human Services
30 East Broad Street
Columbus, OH 43266-0501
(614) 466-7987

Responsible for administering the Medicaid Program. Division of Long Term Care- Responsible for monitoring the quality of care of residents in Long Term Care Facilities and reimbursing Long Term Care Facilities for delivery and administration of services.

County Department of Human Services
220 Tuscarawas East
Canton, OH 44702
(330) 452-4661

RESTRAINT/SECLUSION, UTILIZATION GUIDELINES

Policy

Aultman Alliance Community Hospital recognizes the personal dignity of all patients and their right to considerate, respectful care. All patients have the right to be free from physical or mental abuse and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraints or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others, and must be discontinued at the earliest possible time.

Orders for the use of restraints or seclusion must never be written as a standing order or as an "as needed basis" (PRN). If the attending physician did not order the restraint/seclusion the attending must be consulted/notified as soon as possible, within one hour to ensure continuity of care and patient safety, and to obtain other relevant information about the care of the patient. If the attending has delegated patient responsibility to another physician, the covering physician is considered the attending.

The use of restraints will be reflected in the individualized care plan or treatment plan for the patient. Handoff between nurses must occur at the bedside when a patient is in restraints.

Definitions

Restraint
A restraint is:

a. any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or
b. a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

Generally, if it cannot easily be removed by the patient in the same manner it was applied, and it restricts the patient's movement, it is a restraint.

Whether or not the use of a medication is voluntary, or even whether the drug is administered as a one-time dose or PRN, are not factors in determining if a drug is being used as a standard treatment. The use of PRN medications is prohibited <u>if</u> the drug is being used as a restraint. It is not the intent to interfere with the clinical treatment plans of patients. Medications that are a standard medical or psychiatric treatment for a patient's condition are not restraints. The use of medications, such as those listed below, are not considered restraint or seclusion when based on the assessed needs of patients and carefully monitored to minimize adverse effects:

1. Therapeutic doses of medication, e.g., psychotropics, to improve the level of functioning for individuals diagnosed with a mental illness,
2. Therapeutic doses of anti-anxiety medications to calm patients that experience anxiety;
3. Appropriate doses of sleeping medication prescribed to treat insomnia;
4. Appropriate doses of analgesic drugs ordered for pain management.

Criteria used to determine whether the use of a drug or medication, or combination of drugs or medications is a standard treatment or dosage for the patient's condition includes all of the following:

- The drug or medication is used within the pharmaceutical parameters approved by the Food and Drug Administration (FDA) and the manufacturer for the indications that it is manufactured and labeled to address, including listed dosage parameters;
- The use of the drug or medication follows national practice standards established or recognized by the medical community, or professional medical associations or organizations;
- The use of the drug or medication to treat a specific patient's clinical condition is based on that patient's symptoms, overall clinical situation, and on the physician's or other Licensed Practitioner's (LP) knowledge of that patient's expected and actual response to the medication.

Non-Violent/Non-Self-Destructive Behavior
Non-violent/non-self-destructive behavior requiring restraint would be behavior which interferes with medical treatment, could compromise healing, promote, infection, or could pose a patient safety risk.

Violent/Self-Destructive Behavior
Violent or self-destructive behavior requiring restraint would be behavior that jeopardizes the immediate safety of the patient, a staff member or others.

Restraint Types

1. **Soft Wrist and/or Ankle Restraint**

2. **Leather /Nylon Wrist and/or Ankle Restraint**

   Note: The use of handcuffs or other restrictive devices applied by law enforcement officials for custody, detention, and public safety reasons are not covered by this policy. However, the patients in restrictive devices are still considered to be restrained and as such the guidelines for patient assessment and care set forth, as if the person were in leather restraints, in this policy still apply. There is no need to obtain an order for handcuffs (restraint). See *Forensic Patients: Patient Under Legal and Correctional Restrictions* policy/procedure.

3. **Physical Hold-** Holding a patient in a manner that restricts a patient's movement against the patient's will is considered a restraint

4. **Physical Hold for Forced Medications** is considered a restraint, and patients have the right to refuse medications unless a court order removes that right of refusal. In an emergency situation a patient may be medicated against their will but staff is expected to use the least restrictive method of medication administration to avoid or reduce the use of force when possible. The use of force to medicate a patient, as with other restraints, must have a physician's order prior to the restraint.

5. **Chemical Restraint-** A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

6. Seclusion- Seclusion is the involuntary confinement of a person alone in a room or area from which the person is physically prevented from leaving. Seclusion is only permitted to manage violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff members, or others. If a patient is restricted to a room alone and staff are physically intervening to prevent the patient from leaving the room or giving the perception that threatens the patient with physical intervention if the patient attempts to leave the room, the room is considered locked, whether or not the door is actually locked. In this situation, the patient is being secluded. Seclusion may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member or others.

A patient physically restrained alone in an unlocked room does not constitute seclusion. Confinement on a locked unit where the patient is with others does not constitute seclusion.

7. **Time Out**- Timeout is an intervention in which the patient consents to being alone in a designated area, for an agreed upon time frame, from which the patient is not physically prevented from leaving. Timeout is not considered seclusion.

Exsamples of Restraints

1. Gerichair with the overlap table locked in the upright position or the foot of the chair propped up
2. Ankle and wrist restraints (soft or leather)

3. All side rails up (Note: A patient on a narrow cart may have both side rails up. This is not considered a restraint due to narrowness and height of cart.)
4. Seclusion

Note: If a patient or family member requests the use of a voluntary restraint (such as all four side rails be raised) it is still considered a restraint and all requirements of this policy apply. This request should prompt an assessment of the patient to determine need for intervention, use of restraint, and education for the family. It is never acceptable to use a restraint because the patient "might" fall.

Clinical justification for use of restraints regardless of patient location, when less restrictive alternative(s) appropriate to the patient's condition have failed, includes but is not limited to the following:

1. Behaviors that threaten placement and/or patency of necessary therapeutic lines/tubes, complex dressings, etc.
2. Disorientation accompanied by behavior with potential for harm to self.
3. Inability to follow directions/instructions basic to their safety and to avoid self-injury.
4. Management of violent or self-destructive behavior as a reason for restraints is primarily to protect the patient from injury to self or others possibly shown as:
    a. Emergent, dangerous behavior with suspected or obvious intent for harm to self or others, and/or injury to self or others.
    b. Verbal aggression/escalation with suspected obvious intent for harm to self or others.

Exclusions to the Definition of Restraints

- **A restraint** does NOT include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to permit the patient to participate in activities without the risk of physical harm.

- **Physical holding** is permitted for the purpose of conducting routine physical examinations or tests such as assisting a patient to "hold still" for IV starts, blood draws, etc. unless the patient refuses the examination or test.

- **Mitts** are not considered a restraint when used alone, unpinned, or not tied down and are loose enough to allow movement of the hand and fingers and are not overly bulky so as to significantly reduce the ability to use their hand.

- ***A Physical Escort*** would include a "light" grasp to escort the patient to a desired location. If the patient can easily remove or escape the grasp, this would not be considered a physical restraint. If the patient cannot easily escape or remove the grasp, this would be considered physical restraint and all requirements would apply.

Stroller safety belts, swing safety belts, highchair lap belts, raised crib rails, and crib covers are not considered restraints as long as used in age and developmentally appropriate ways. Likewise, a staff member picking up, redirecting, or holding an infant, toddler, or preschool-aged child for comfort is not a restraint.

Raising the side rails when a patient is on a cart, critically ill, recovering from anesthesia, sedated, padded raised rails as part of seizure precautions, experiencing involuntary movement, or on certain types of therapeutic beds to prevent the patient from falling out of bed, or any patient physically unable to get out of the bed whether rails are raised or not, is not considered a restraint.

Licensed Practitioner (LP)

The use of restraint or seclusion must be in accordance with the order of a physician or other Licensed Practitioner (LP) who is responsible for the care of the patient and permitted by the State and the Hospital to order. An

Advanced Practice Clinician with prescriptive authority may order the use of restraints at Aultman Alliance Community Hospital. These practitioners will have a working knowledge of the policy regarding the use of restraint and seclusion.

Staff Education Requirements

Staff who are involved in the application of restraints or seclusion or performing associated monitoring and assessment of, or providing care for, restrained or secluded patients will have training and demonstrate competence as part of orientation and periodically thereafter based on the Quality Assurance/Performance Improvement (QA/PI) result trends. A quarterly report on restraint use will be given to the Patient Care-Peer Review committee.

Education will include:

1. Alternative interventions and techniques, including nonphysical intervention skills
2. Methods to ensure the safety and well-being of the patient and others
3. Management of the patient's behavior
4. The safe application and use of restraint types available and use of seclusion
5. The appropriate monitoring and assessing of the condition of the restrained or secluded patient, including how to recognize and respond to signs of physical or psychological distress
6. Evaluation of the patient's medical and psychological conditions to choose the least restrictive intervention
7. Evaluation of the need to continue or discontinue the restraint or seclusion
8. Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require use of restraint or seclusion.
9. The use of First Aid techniques and CPR
10. In addition to the above training, staff in the Senior Care Unit, Float Pool and the Emergency Department will also receive de-escalation training.

Equipment

Physician Order Form (NS-965-P)

Leather Restraint and Seclusion Documentation Form (08-05-08C)

Procedure

1. Initial assessment of patient at admission identifies
    a. Violent/self-destructive behavior: techniques, methods, and tools to help patient control his behavior. When appropriate, patient and/or family assists in identification of these.
    b. Pre-existing medical conditions or any physical disabilities and limitations that would place the patient at greater risk during restraint/seclusion.
    c. Any history of sexual or physical abuse that would place the patient at greater psychological risk during restraint or seclusion.
    d. Age related consideration.
    e. Cultural factors and gender.

2. The nurse will evaluate the patient to determine the need for restraints including the assessment of potential medical causes leading to behavior changes such as fever, hypoxia, hypoglycemia, electrolyte imbalance, drug interactions, and drug side effects. Document all attempted alternatives or rationales for not using alternatives to restraints/seclusion to manage the observed behavior on the Initial Restraint Alternative Flow Sheet.
    a. Alternatives should be attempted (and documented) prior to the use of restraints/seclusion unless the patient cannot otherwise be protected from injury to self or others. Alternatives include, but are not limited to the following:
    b. Changing feeding/meds from enteral/IV to PO whenever possible to eliminate unnecessary tubes/lines
    c. Verbal redirection or instruction
    d. Bed alarm, personal alarm
    e. Increased supervision by staff or family
    f. Diversional activities
    g. Removal of environmental stimuli
    h. One-to-one interaction with patient

i. Pain management
j. Pharmacological review or treatment interventions as ordered by attending Licensed Practitioner
k. Toileting
l. Offering Nutrition or hydration
m. Setting limits
n. Repositioning/turning
o. Relaxation techniques
p. De-escalation

3. If restraint application is necessary, the patient's behavior, physical and mental status, and any environmental factors that may have contributed to the situation should be documented in descriptive terms. Document the patient's response to the intervention used including the rationale for continued use of the intervention.

4. The type of technique of restraint or seclusion must be the least restrictive intervention that will be effective to protect the patient, a staff member or others from harm. Least to most restrictive restraint include the use of:
    a. Four (4) side rails;
    b. Geri/restrictive chair;
    c. Soft limb (2);
    d. Soft limb (4);
    e. Physical hold;
    f. Leather/Nylon (hard limb holder) (2); and
    g. Leather/Nylon (hard limb holder) (>2).

5. The attending LP order must contain the following:
    a. The type of restraint, the reason for restraining the patient, and the time limit the restraints may be used, not to exceed 24 hours.
    b. A written order, based upon an examination of the patient by the LP, must be entered into the medical record within 24 hours of the initiation of the restraint.
    c. The attending LP must write subsequent orders every calendar day for continuation of the restraint based upon a face-to-face evaluation of the patient.
    d. PRN orders are not permitted.

6. **Orders for restraint safety non-violent/non-self-destructive behavior:**
    a. The expectation is that orders for non-violent/non-self-destructive restraints are renewed every 24 hours based on the assessment of an LP as appropriate.

    However, all restrained patients are at risk and will be treated the same way for order renewal. When an original order is renewed, another one hour face-to-face patient evaluation is NOT required. After the original 24 hours is up or the order has expired, the LP must see and assess the patient before issuing a new order.

    NOTE: For a patient being restrained by use of a gerichair with locked tray in place to be safely out of bed, it is not necessary to have a new order each time the patient sits in the gerichair.

7. **Orders for restraint for a violent/self-destructive patient (behavior restraint):**
    a. When a restraint is used to manage violent or self-destructive behavior, a physician trained in accordance with this policy must see the patient face-to-face within one (1) hour after the initiation of the intervention. This requirement also applies when a medication is used as a restraint to manage violent or self-destructive behavior.
        i. The intent of the face-to-face evaluation is to evaluate:
            a) The patient's immediate situation;

b) The patient's reaction to the intervention;
c) The patient's medical and behavioral condition;
d) The need to continue or terminate the restraint or seclusion.

b. The one-hour face-to-face evaluation includes both a physical and behavioral assessment of the patient that must be conducted by a qualified practitioner within the scope of their practice. An evaluation of the patient's medical condition would include a complete review of systems assessment, behavioral assessment, as well as review and assessment of the patient's history, drugs and medications, most recent lab results, etc. The purpose is to complete a comprehensive review of the patient's condition to determine if other factors, such as drug or medication interactions, electrolyte imbalances, hypoxia, sepsis, etc., are contributing to the patient's violent or self-destructive behavior.
c. If the face-to-face evaluation is conducted by a trained registered nurse or physician assistant, the trained registered nurse or physician assistant must consult the attending LP who is responsible for the care of the patient as soon as possible after the completion of the one-hour face-to-face evaluation.
d. The one-hour face-to-face evaluation must be conducted in person and documented in the medical record. A telephone call or evaluation by telemedicine is not permitted.
e. The one-hour face-to-face evaluation should include both a physical and behavioral assessment as appropriate.
f. Each order for restraints used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be ordered/renewed in accordance with the following limits for up to a total of 24 hours:
    i. Adults age 18 and older – four hours
    ii. Adolescents age 9-17 – two hours
    iii. Children under age 9 – one hour
g. At the end of the appropriate time frame as above, if the continued use of restraint to manage violent or self-destructive behavior is deemed necessary based on an individualized patient assessment, a new order is required.
h. When the original order is about to expire, the Registered Nurse (RN) must contact the LP, report the results of his or her most recent assessment and request that the original order be renewed.
i. Whether or not an onsite assessment is necessary prior to renewing the order is left to the discretion of the LP in conjunction with a discussion with the RN who is overseeing the care of the patient. The RN will document this conversation in the Physician Notification Intervention.
j. At a minimum, if a patient remains in restraint for the management of violent or self-destructive behavior 24 hours after the original order, the LP must see the patient and conduct a face-to face re-evaluation before writing a new order for the continued use of restraint.
k. When the LP renews an order or writes a new order authorizing the continued use of restraint, there must be documentation in the patient's medical record that describes the findings of the LP's re-evaluation supporting the continued use of restraint.

8. **Notification of the Patient's Attending Physician;**
    a. In an emergency, if the attending Licensed Practitioner (LP) is not available to issue an order, the Registered Nurse (RN) may initiate and apply the appropriate restraints based upon an appropriate assessment of the patient. The order for the restraint must then be obtained immediately, within fifteen minutes.
    b. If this face-to-face is conducted by someone other than the patient's LP, the patient's attending LP must be consulted <u>as soon as possible</u> after the one-hour face-to-face evaluation. This face-to-face evaluation must be documented along with a description of the behavior, intervention used, attempted less restrictive interventions/alternatives, the condition that warranted the use of restraint or seclusion, patient's response to the intervention(s) used, including the rationale for continued use of the intervention. The patient must be re-evaluated in person by the LP before the time limited order expires to assess need for a new order.
    c. If there is a significant negative change in patient condition, the attending LP must be notified immediately, and appropriate orders obtained.

9. **Application of Restraint:** Restraint will be applied/removed in accordance with the following:
    a. Restraint devices are to be applied/removed in accordance with manufacturer's instructions and used in a manner consistent with their intended purpose.
    b. Restraint devices are to be applied/removed in a manner that preserves the dignity, comfort, and well-being of the patient.
    c. Restraints will be secured to the bed frame if being used while the patient is in bed.
    d. Restraint devices are to be applied/removed only by staff authorized, trained and with the demonstrated competency to do so.
    e. The patient's plan of care and treatment plan must be modified to include the use of restraints by adding the Problem: Care of the Patient in Restraints.
    f. Consideration when applying restraints include the following:
        - Provide all comfort measures encouraging the participation of the patient and family.
        - Maintain good body alignment with ability to flex extremities.
        - Pad bony prominence under the restraints. Do not apply restraints over wounds or IV sites.
        - Tie slipknots that can be released quickly.
    g. Observation is on-going during the duration of the restraint. A staff member will be in attendance **at all times** with a restrained patient when off the unit for testing

10. **Assessment, Re-assessment, Observation, and Documentation of the Non-Violent/Non-Self-Destructive Behavior and Violent/Self-Destructive Behavior:**
    a. An RN must re-evaluate/re-assess for readiness to discontinue restraints.
    Note: The Clinical Technician, LPN, or RN may perform observation.
    b. Assessment, evaluation, and documentation of the **non-violent/non-self-destructive and violent/self-destructive behavior** will be completed and documented on the Restraint Flow Sheet at a minimum of every 2-2.5 hours**.** Documentation may include the following as indicated based on the condition or behavior of patient; nutrition, toileting/hydration needs, ROM/repositioning, skin integrity (redness, breakdown, swelling), and circulation (color, capillary refill, temperature, sensation, and movement).
    c. The patient's response to the intervention(s) used, including the rationale for continued use of the intervention will be documented on Restraint Flow Sheet.
    d. Education will be provided to patient/family regarding restraint usage.
    e. Documentation of a description of the observed criteria/behaviors/condition or symptoms for discontinuation of restraint will be documented on the Restraint Flow Sheet.
    Note: Based on assessment of the patient's condition, cognitive status, risks associated with the use of the chosen intervention, the RN determines a different frequency of assessment and monitoring is prudent, direction of such will be given to the staff assigned the observation.
    f. Violent/Self Destructive Restraint or Seclusion Visual Checks will be completed every 15-30 minutes. Visual checks will include signs and symptoms of distress and assessment of circulation status as related to restraint application. Visual checks will be documented on the Restraint/Seclusion Visual Safety Check.
    g. The key used to release the leather restraints will be carried by the patient's assigned nurse. Leather restraints and keys are stored in the Emergency Department and should be returned when the restraint is discontinued.
    h. For ***Physical Hold and/or Chemical Restraint the following assessments and clinical documentation components are required:***
        i. an initial assessment is required once on the Restraint Flow Sheet
        ii. a one-hour post face to face assessment on the One- Hour Face-to-Face

    This completes this cycle of restraints and orders.

11. Discontinuation of restraint:
    a. The RN will assess for readiness for restraint discontinuation and discontinue the restraint at the earliest possible time regardless of the length of time identified in the order. The change in behavior allowing the restraint to be discontinued will be documented on the Restraint Flow Sheet. This completes this cycle of restraints and orders. If the patient later exhibits behavior that can only be handled through the use of restraints, a new order must be obtained, and a new cycle will begin.
    b. The RN will discontinue the restraint and attempt alternatives when the order expires. If the restraint continues to be clinically indicated, the attending LP will be notified, and a new order will be given and a one-hour face-to-face will be indicated.
    c. A "trial" release constitutes a PRN use of a restraint or seclusion, and therefore is NOT permitted. A temporary, directly supervised release, however, that occurs for the purpose of caring for a patient's needs (toileting, feeding, ROM, etc.) is not considered a discontinuation of the restraint or seclusion intervention. The direct staff supervision and presence is serving the same purpose as the restraint or seclusion.

12. **Simultaneous use of Restraint and Seclusion** is permitted only if the patient is continuously (without interruption) monitored:
    a. Face-to-face by an assigned, trained staff member;
    b. By trained staff using video and equipment that is in close proximity to the patient, located in an area that protects patient privacy and dignity to the extent possible. Monitoring must be appropriate to protect the patient from possible abuse, assault, or self-injury.

A *Restraint Log* will be maintained. The *Restraint Log* data will be analyzed for trends and need for corrective action. The results will be reported to the Patient Care Peer Review Committee on a quarterly basis.

For SCU, a debriefing will be held within 24 hours of initiation. In other nursing units, consideration should be given to perform a debriefing with the involved staff after the use of restraint.

13. Death reporting requirements:
    Hospitals must report deaths associated with the use of seclusion or restraint to CMS as defined by:
    a. Each death that occurs while a patient is in restraint or seclusion.
    b. Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.
    c. Each death known to the hospital that occurs within one week after restraint or seclusion where it is reasonable to assume that the use of restraint or placement in seclusion contributed directly or indirectly to a patient's death. This includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or deaths related to chest compression, restriction of breathing or asphyxiation.

The Risk Manager or Designee must be notified immediately of any such deaths. The Risk Manager/Designee will notify CMS no later than the close of business the next business day following knowledge of the patient's death. The Risk Manager/Designee will document in the medical record the time and date the death was reported to CMS. See policy/procedure, *Restraint/Seclusion – CMS Mandatory Reporting Following Death*.

Reference

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Note: State law may also contain requirements related to restraint/seclusion. The pertinent Ohio law may be found in the Ohio Revised Code:
http://codes.ohio.gov/orc/3721.13 (Nursing Homes and Residential Care Facilities)
http://codes.ohio.gov/orc/5120.17 (Inmates/Department of Rehabilitation and Correction)
http://codes.ohio.gov/orc/5122.27 (Hospitalization of the Mentally Ill)

See Community Care Center's policy/procedure, *Physical/Chemical Restraint*