St David's | Medical Center

Austin Campus | Georgetown Campus | Heart Hospital Campus

Orientation Manual

Austin Campus
919 East 32nd Street, Austin, TX 78705
(512) 476-7111

Georgetown Campus
2000 Scenic Drive, Georgetown, TX 78626
(512) 943-3000

Heart Hospital Campus
3801 North Lamar Boulevard, Austin, TX 78756
(512) 407-7000

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Mission, Vision, Values and Goals

Our Mission

To provide exceptional care to every patient, every day with a spirit of warmth, friendliness, and personal pride.

Our Vision

To be the finest care and service organization in the world.

Our Values – I.C.A.R.E.

Integrity: Be honest and do what you say

Compassion: Be sympathetic to the needs of others

Accountability: Take ownership for how actions impact outcomes

Respect: Value the rights of others and embrace diversity

Excellence: Take personal pride in exceeding expectations

Our Goals

Exceptional Care, Customer Loyalty, Financial Strength

Patient Safety

We know patient safety is the top priority for all providers.

TOP SAFTEY OPPORTUNITIES FOR PHYSICIANS AND ALLIED HEALTH PROFESSIONALS

- Legibility
- Patient Identification – Use 2 identifiers: Name and date of birth
- Date, Time and Sign all entries in the medical record
- An H&P is completed within 24 hours of admission, but prior to any procedure. An H&P done within 30 days prior to admission may be used IF an update note is documented within 24 hours of admission and prior to any procedure
- A post op progress note is written immediately following the procedure, before the patient is transferred to the next level of care
- Re-evaluate the patient immediately prior to anesthesia/sedation
- Hand hygiene
- Appropriate use of Personal Protective Equipment (PPE)
- Security of medications
- Leading a complete TIME OUT prior to a procedure
- Complete all medical record deficiencies within 30 days of discharge
- Know your role in a disaster
- No food or drink in patient care areas
- Do Not Use Abbreviations

Unacceptable Abbreviations	Intended Meaning	Misinterpretation	Expected Action
U	Units	0	Write out the entire word "units"
IU	International Units	Misread as IV (intravenous)	Use the word "units"
ug	Micrograms	Mistaken for mg	Use mcg
PIT	Unclear, could be Pitocin or Pitressin	Pitocen mistaken for Pitressin	Write out the complete word
gr	Unclear, could be grains or grams	Grains confused for grams and vice versa	Write out the complete word
Trailing zero (i.e. 1.0 mg)	1mg	Misread as 10	Do NOT use trailing zero's after a decimal point
Lack of a leading zero (i.e. .1mg)	0.1 mg	Misread as 1 or 11mg	ALWAYS use a zero before a decimal point
Q.D. Q.O.D.	Latin Abbreviation for once daily Latin abbreviation for every other day	Mistaken for each other. The period after the Q can be mistaken for an "I" and the "O"can be mistaken for "1"	Write out "once daily" Write out "once every other day"
MS MSO_4 $MgSO_4$	Can mean morphine sulfate or magnesium sulfate	Confused with one another as meaning morphine sulfate or magnesium sulfate	Write "morphine sulfate" or "magnesium sulfate"

Any individual who provides care, treatment and services may report concerns to The Joint Commission when the hospital has not adequately prevented or corrected problems that can have or have had a serious adverse impact on patients.

The Joint Commission
Office of Quality Monitoring
One Renaissance Boulevard, Oakbrook Terrace, IL 60181
(630) 792-5636 Fax
complaint@jointcomission.org Email
or other applicable agencies

Patient Safety (Continued)

Current National Patient Safety Goals

- Improve the accuracy of patient identification.
- Improve the effectiveness of communication among caregivers.
- Improve the safety of using medications.
- Reduce the risk of health care-associated infections.
- Accurately and completely reconcile medications across the continuum of care.
- Reduce the risk of patient harm resulting from falls.
- Identify safety risks inherent in the patient population.
- Meet the expectations of Universal protocol for preventing wrong site surgery.
- Implement evidence based practices to prevent indwelling catheter-associated urinary tract infections

Anticoagulant Safety

Anticoagulation therapy poses risks to patients and often leads to adverse drug events due to complex dosing, required follow-up monitoring, and poor patient compliance. The following National Patient Safety Goal (NPSG.03.05.01): Reduce the likelihood of patient harm associated with the use of anticoagulation therapy. As a result, hospitals are implementing comprehensive anticoagulation management programs to improve the use of these medications.
Medical staff responsibilities:

- Determine the need for anticoagulation therapy
- Order anticoagulation therapy according to organizational policies and protocols
- Include the indication for use, dose prior to admission (if applicable), target laboratory values, and duration of therapy to facilitate monitoring, education, and discharge planning
- Daily medication interaction screening
- Monitor for signs and symptoms of bleeding
- Report related medication errors and adverse drug events to the pharmacy department

Patient Restraints

Application of restraints is authorized by licenses independent practitioners only. Restraint orders must be: (1) time limited; (2) include type of restraints to be used; (3) clinical justification for use.

Orders for PRN restraints will not be accepted. The use of "may use" also implies PRN and will not be accepted.

1. An order for restraint(s) must be obtained from a physician/LIP who is responsible for the care of the patient prior to the application of restraint(s). The order must specify clinical justification for the restraint(s), the date and time ordered, the duration of use, the type of restraint(s) to be used and behavior-based criteria for release.

    a) An order for restraint(s) may not be written as a standing order, protocol, or as a PRN or "as needed" order.
    b) If the patient was released from restraint(s) or seclusion, and exhibits behavior that can only be handled through the reapplication of restraint(s), a new order is required.
    c) The RN and approved staff taking a telephone or verbal order for restraint(s) must ensure that the accuracy of the order is verified through the read-back method. The order must specify:

        1. Clinical justification for restraint/seclusion
        2. Date and time ordered
        3. Restraint type or seclusion
        4. Duration of order Non-Violent-Non-Self-Destructive Restraint Orders
        5. Behavior based criteria for release

    d) The treating physician/LIP is to be notified as soon as possible if another physician/LIP (i.e.: "on call") orders the restraint(s).

2. Order for Restraint(s) for Non-Violent or Non-Self Destructive Behavior:
    a) Duration of the initial order for restraint(s) **may not exceed 24 (twenty-four) hours for the initial order.**
    b) The physician/LIP may order a shorter period of time
    c) Staff assess, monitor, and re-evaluate the patient regularly and release the patient from restraint(s) when criteria for release has/are met.
    d) To continue restraint(s) use beyond the initial order duration, the physician/LIP must see the patient, perform a clinical assessment and determine if continuation of restraint(s) is/are necessary.
    e) If reassessment indicates an ongoing need for restraint(s), **a new order must be written no less often then once per calendar day by the physician.** (i.e.:0700 today until 2359 tomorrow)

Patient Restraints (Continued)

3. Order for Restraint(s) for Violent or Self Destructive Behavior:
    a) Orders for restraint(s) or seclusion must not exceed:
        1. 4 hours for adults, age 18 years and older
        2. 2 hours for children and adolescents age 9 to 17 years
        3. 1 hour for children under 9 years of age
    b) The time frames specified are maximums.
    c) The physician/LIP may order a shorter period of time
    d) Staff assess, monitor, and re-evaluate the patient regularly and releases the patient from restraint(s) or seclusion when criteria for release has/are met.
    e) To continue restraint(s) or seclusion beyond the initial order duration, the RN determines that the patient is not ready for release and call the physician/LIP to obtain a renewal order.
    f) Renewal orders for restraint/seclusion may not exceed:
        1. 4 hours for adults, age 18 and older
        2. 2 hours for children and adolescents age 9 to 17 years
        3. 1 hour for children under 9 years of age.
    g) Orders may be renewed according to time limits above for a maximum of 24 consecutive hours. Every 24 hours a physician/LIP primarily responsible for the patient's care sees and evaluates the patient before writing a new order for restraint(s) or seclusion.

4. Monitoring /Assessment for **Violent or Self Destructive Behavior**:
    a) **A face-to-face assessment by the physician/LIP must be accomplished within one (1) hour of restraint/seclusion initiation** or administration of medication to manage violent or self destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others. At the time of the face-to-face assessment, the physician/LIP will:
        1. Work with staff and the patient to identify ways to help the patient regain control
        2. Evaluate the patient's immediate situation
        3. Evaluate the patient's reaction to the intervention
        4. Evaluate the patient's medical and behavioral condition
        5. Evaluate the need to continue or terminate the restraint(s) or seclusion
        6. Revise the plan of care, treatment, and services needed
    b) A telephone call or telemedicine methodology does **not** constitute a face-to-face assessment.
    c) If a patient who is restrained or secluded for aggressiveness or violence quickly recovers and is released before the physician/LIP arrives to perform the face-to-face assessment, the physician/LIP must see the patient face-to-face to perform the assessment within 24 hours after the initiation of restraint/seclusion.

Hospital Safety Information

Fire Response:

Rescue anyone in immediate danger from the fire
Alarm by pulling fire alarm pull stations and dialing the hospital security department phone extension to alert the hospital
Confine by closing doors to help contain smoke and the products of combustion
Extinguish, and, as needed, prepare to evacuate or relocate patients

Fire Extinguisher:

Pull
Aim
Squeeze
Sweep

Hazardous Materials

The Material Safety Data Sheets (MSDS) Communication manual is available online on the hospitals intranet. Refer to this for information specific to each unit on hazardous chemical and what to do in case of a spill or leak.

Emergency Preparedness

In the event of an internal or external disaster, the facility Incident commander may request additional practitioners to assist the facility in handling an influx of patients that might occur during a state of emergency. As a member of our Medical Staff, we want you to be aware of the process by which we would request your assistance. The Medical Staff Unit Leader will initiate a call to LIP's to determine availability for assistance. Instructions would be given as to where to enter the facility and report for assignments. A hospital ID or Travis County Medical Society Badge would be needed to gain entry into the hospital during an emergency situation. If you have any questions, or would like to view the Medical Center Emergency Operations Plan, please contact the Medical Staff Office.

In the event of an emergency, dial the hospital security department phone extension. State your name, location and type of emergency.

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CODE Information

Adam – Infant/Child Abduction	**Red –** Fire
Black – Bomb Threat	**Silver** – Firearm / Active Shooter
Exit – Suicide Elopement	**Yellow** – Person Down / RRT
Green – Evacuate Building	**White –** External / Internal Disaster
Grey – Weather Alert	**Dr. Leo** – Cardiac Arrest
Purple – Workplace Violence	**Dr. Stork –** Unattended Delivery
Orange – Hazardous Materials / Incident	

Infection Prevention

Infection Prevention

- Prevention is the best way to control the spread of infection
- HANDWASHING - the most important and easiest form of prevention
- Methods of Prevention
  - Hand hygiene – hand washing and use of alcohol hand rubs
  - Standard Precautions
  - Universal Precautions
  - Personal Protective Equipment (PPE)
  - Glucose control
  - Prophylactic Antibiotics prior to surgery
- Assume that everyone you come into contact with is capable of transmitting a blood borne infection to you!
- Wear Personal Protective Equipment

Hand Hygiene

- Hand hygiene is the single most important activity we can perform to prevent the spread of infections.
- Wash hands with soap and water for at least 10- 15 seconds before rinsing.
- Always use towel to turn off faucet to avoid recontamination.
- Disinfect hands before and after patient contact and after the removal of gloves

Isolation Precautions

- **Standard Precautions** used at all times with all patients whenever there is a risk of exposure to blood or any moist body substance.
- **Airborne Precautions** are used in addition to Standard Precautions if a patient is suspected or known to have a serious illness transmitted in whole or in part by airborne droplet nuclei. A negatively vented room must be used
- **Droplet Precautions** are used in addition to Standard Precautions if a patient is suspected or known to have a serious illness transmitted in whole or in part by large particle droplets.
- **Contact Precautions** are used in addition to Standard Precautions if a patient is suspected or known to have a serious illness transmitted in whole or in part by direct patient contact or by contact with items in the patient's environment.

St. David's Medical Center and its affiliated campuses are committed to providing a safe and healthy work environment for all its employees. In keeping with this commitment, SDMC has implemented an Exposure Control Plan (ECP) to comply with the OSHA blood borne pathogens standard. The ECP is designed to protect the employees of SDMC from health hazards associated with blood borne pathogens, and to provide appropriate treatment and counseling when exposures occur.

Infection Prevention (continued)

One of the National Patient Safety Goals is to reduce the risk of health care-associated infections by implementing evidence-based practices. Please review and follow the guidelines below in your daily practice.

Catheter –Associated bloodstream Infections

- Perform hand hygiene before catheter insertion or manipulation. Use of gloves does not obviate hand hygiene.
- Avoid using the femoral vein for central venous access in adult patients. Several nonrandomized studies show that the subclavian vein site is associated with a lower risk of bloodstream infections than is the internal jugular vein.
- Use maximal sterile barrier precautions during CVC insertion.
- A mask, cap, sterile gown, and sterile gloves are worn by all healthcare personnel involved in the catheter insertion procedure.
- The patient is to be covered with a large sterile drape during catheter insertion.
- Use a chlorhexidine based antiseptic for skin preparation in patients older than 2 months of age. The antiseptic solution must be allowed to dry before making the skin puncture.
- Assess the need for continued intravascular access on a daily basis during multidisciplinary rounds. Remove catheters not required for patient care.

Surgical Site Infections

- When hair removal is necessary, use clippers or depilatory method. Use of razors is inappropriate.
- Make sure your patient understands your post-discharge instructions.
- Control blood glucose level during the immediate postoperative period for patients undergoing cardiac surgery: controlled 6:00 am blood glucose level (lower than 200 mg/dL) on post-operative day 1 and post-operative day 2, with procedure day being post-operative day 0.
- Maintain perioperative normothermia for patients undergoing colorectal surgery.
- Follow appropriate antibiotic administration protocols.

Multi-Drug Resistant Organisms (MDRO)

- Place patients with MRSA colonization or infection on contact precautions to help reduce patient to patient spread of the organism within the hospital.
- Wear a gown and gloves on entry into the patient's room. Remove the gown and gloves before exiting the room.
- Use appropriate hand hygiene on entering and exiting the patient's room. Wearing gloves does not eliminate the need for hand hygiene.

Infection Prevention (Continued)

Clostridium difficile

- *C. difficile* is a spore-forming, gram-positive anaerobic bacillus that produces two exotoxins: toxin A and toxin B. It is a common cause of antibiotic-associated diarrhea (AAD), accounting for 15-25% of all episodes of AAD.
- Issures that result from *C. difficile* infections include: pseudomembranous colitis, toxic megacolon, perforations of the colon, sepsis, death (rarely). Clinical symptoms include: watery diarrhea, fever, loss of appetite, nausea, abdominal pain/tenderness.
- The risk for disease increases in patients with: antibiotic exposure, gastrointestinal surgery/manipulation, long length of stay in healthcare settings, a serious underlying illness, immunocompromising conditions, advanced age. The infection can usually be treated with an appropriate course (about 10 days) of antibiotics including metronidazole or oral vancomycin.
- After treatment, repeat *C. difficile* testing is not recommended if the patient's symptoms have resolved, as patients may remain colonized.

Preventions strategies:

- Use and choose antibiotics judiciously.
- Use contact precautions for patients with known or suspected *C. difficile*-associated disease.
- Perform hand hygiene using soap and water. Alcohol does not kill *C. difficile* spores

Fundamental Elements to Prevent Influenza Transmission

Influenza viruses are spread from person to person primarily through large-particle respiratory droplet transmission within a short distance (less than or equal to 1 meter) through the air. Contact with respiratory-droplet contaminated surfaces is another possible source of transmission. Airborne transmission also is thought to be possible, although data supporting airborne transmission are limited. The typical incubation period for influenza is 1—4 days (average: 2 days). Adults shed influenza virus from the day before symptoms begin through 5—10 days after illness onset. However, the amount of virus shed, and presumably infectivity, decreases rapidly by 3—5 days after onset in an experimental human infection model. Young children also might shed virus several days before illness onset, and children can be infectious for 10 or more days after onset of symptoms. Severely immunocompromised persons can shed virus for weeks or months.

Preventing transmission of influenza virus and other infectious agents within healthcare settings requires a multi-faceted approach. Spread of influenza virus can occur among patients, healthcare providers, and visitors; in addition, healthcare providers may acquire influenza from persons in their household or community. The core prevention strategies include:

- administration of influenza vaccine to Healthcare Providers and patients
- appropriate management of ill Healthcare Providers
- adherence to standard precautions for all patient-care activities, including respiratory protection during aerosol-generating procedures
- droplet isolation for suspected or confirmed flu patients
- frequent hand hygiene, including before and after all patient contact, contact with potentially infectious material, and before putting on and upon removal of personal protective equipment, including gloves
- implementation of respiratory hygiene and cough etiquette, and screening visitors for respiratory illness
- Appropriate environmental cleaning and disinfection procedures

Rapid influenza diagnostic tests (RIDTs) are immunoassays that can identify the presence of influenza A and B viral nucleoprotein antigens in respiratory specimens, and display the result in a qualitative way. RIDTs can yield results in a clinically relevant time frame, however, RIDTs have limited sensitivity to detect influenza virus infection and negative test results should be interpreted with caution given the potential for false negative results. Therefore, antiviral treatment should not be withheld from patients with suspected influenza, even if they test negative. Testing is not needed for all patients with signs and symptoms of influenza to make antiviral treatment decisions. Once influenza activity has been documented in the community or geographic area, a clinical diagnosis of influenza can be made for outpatients with signs and symptoms consistent with suspected influenza, especially during periods of peak influenza activity in the community.

EMTALA

The St. David's Medical Center and its affiliated campuses adhere to the regulations mandated by the Emergency Medical Treatment and Active Labor Act (EMTALA) 42 C.F.R. 489.20 et. seq.

Patient Access to Care:

Emergency Department EMTALA Guidelines

Purpose: To ensure compliance with State and Federal requirements regarding patient access and care.

Policy:

1) Any person presenting for evaluation and treatment on hospital property must be appropriately registered, triaged, and evaluated by appropriate healthcare personnel based solely on medical necessity.
2) All patient presentations must be appropriately registered, evaluated, logged in, and documented.
3) All patients shall have an appropriate medical screening examination with determination of the presence/absence of an emergency medical condition and undergo appropriate stabilization or transfer before ability to pay for care has been addressed.
4) When screening for medical necessity, patients may refuse evaluation based on financial concerns, but staff and physicians may not make decisions on the level and extent of evaluation based on financial considerations without the patient's knowledge and consent. Refusal by the patient shall be documented on the appropriate form, signed and witnessed.
5) When dispositioning a patient with an established emergency medical condition, that condition shall:
   a) Be stabilized for discharge from the ED
   b) Be admitted to the hospital under a physician with admitting privileges for further evaluation/stabilization, or
   c) Be transferred to an appropriate facility for definitive care after initial evaluation and stabilization.
6) When discharging a patient with either:
   a) No established emergency medical condition or
   b) An established emergency medical condition that has been stabilized in the ED…the following ongoing care will be established:
      i. Final emergency diagnosis(es),
      ii. Plan of routine outpatient care including medications, rehabilitation services, and/or social service intervention.
      iii. Referral to PMD or on-call MD when appropriate (general medical care referred to third party provider or appropriate county social services), and
      iv. Instructions for appropriate return to the ED with appropriate directions and phone numbers.

Patient Rights

Advance Directives

The Patient Self Determination Act took effect in hospitals, skilled nursing facilities, home health agencies, hospice organizations and HMOs serving Medicare and Medicaid patients in December, 1991. Specifically, advanced directives are documents that state a person's choices about medical treatment in the event they cannot make the choices for themselves. A patient may have an advanced directive that identifies a person he/she has chosen to make their healthcare decisions for them.

Patients have a right to refuse any medical or surgical treatment or procedure. It is the policy of this hospital to honor a patient's refusal to be treated or any advanced directive that meets state law requirements. A copy of an advanced directive brochure and forms can be obtained upon require from admissions or any nursing station.

Patients have a right to:

- Advance Directives
- Informed Participation in Treatment
- Privacy and Confidentiality
- Participate in Ethical Discussions Arising from Their Care
- Considerate and Respectful Care

Hospitals have obligations related to advance directives:

- To inform the patient that they have the right to formulate advance directives.
- The hospital must assist the patient by providing forms and instructions for advance directives.
- The hospital will honor the instructions in the advance directives, or the instructions of the surrogate decision maker.

HIPAA / HITECH

HIPAA/HITECH

The Health Insurance Portability and Accountability Act (HIPAA) was enacted by Congress in 1996. The HIPAA Security Rule, which became effective February 20, 2003, established national standards to protect individuals' electronic personal health information created, received, used, or maintained by a covered entity. The HIPAA Privacy Standards, which became effective April 14, 2003, established national standards to protect individual's privacy. For example, when patients register, they are given a Notice of Privacy Practices outlining our patient privacy protection policy. Physicians are covered in the facility Notice of Privacy practices since they are part of an Organized Health Care Arrangement (OHCA). Under HIPAA, the Hospital and Medical Staff are considered part of an Organized Health Care Arrangement.

The Health Information Technology for Economic and Clinical Health Act (HITECH), part of the American Recovery and Reinvestment Act (ARRA), was signed into law in February 2009. This Act made massive changes to existing 1996 HIPAA security and privacy laws. In addition to changing HIPAA regulations, HITECH rolled out sweeping new federal privacy and security laws which included adding detailed steps and process for the reporting of privacy or security breaches, financial and criminal penalties and outlining to whom and in what time frame violations are to be reported.

Complying with the HIPAA/HITECH

HIPAA security and privacy compliance require ongoing awareness, involvement, support, and commitment from all caregivers. Each section of the Security Rule includes standards and implementation specifications that are to be addressed. Below are descriptions of those sections and examples of how we can comply.

- **Security standards: General Rules** - includes the general requirements all covered entities must meet and requires maintenance of security measures to continue reasonable and appropriate protection of electronic protected health information.
- **Administrative Safeguards** - are defined as "administrative actions and policies, and procedures, to manage the selection, development, implementation, and maintenance of security measures to protect electronic protected health information and to manage the conduct of the covered entity's workforce in relation to the protection of that information."
- **Physical Safeguards** - are defined as the "physical measures, policies, and procedures to protect a covered entity's electronic information systems and related buildings and equipment, from natural and environmental hazards, and unauthorized intrusion."
- **Technical Safeguards** - are defined as the "technology and the policy and procedures for it use that protect electronic protected health information and control access to it."
- **Organizational Requirements** - includes standards for business associate contracts and other arrangements.

HIPAA / HITECH (Continued)

- **Policies and Procedures and Documentation Requirements** - requires implementation of reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of the Security Rule; maintenance (which may be electronic) documentation and/or records that includes policies, procedures, actions, activities, or assessments required by the Security Rule; and retention, availability and update requirements related to the documentation.

What Do I Need to Do and Be Aware of?

- Ask for "passcodes" when talking with family members on the phone and giving them updated information on status of patients condition
- Dispose of unused patient id labels or copies of protected health information in Shred bins- never dispose of this information in a trash can.
- Be aware of others who may hear conversations of protected health information
- Ask your patient if others in their room may stay when updating the patient of protected health information
- Never share your log in information or PINS

Management of Patient Pain

It is the policy of the St. David's Medical Center and its affiliated campuses to respect and support the patient's right to optimal pain management. A comprehensive approach has been developed to effectively manage patient's pain. **Refer to the Hospital's policy for Management of Patient Pain for complete information and pain scales.**

1. Patients should be informed of their right to pain management and their options to control pain.

2. Every patient will be assessed on admission for presence of pain and determined what their pain goal is. Components of the assessment may include, but are not limited to: Onset; Location; Character (what does the pain feel like); Intensity; Aggravating and ameliorating factors; Effect on life; Consideration of the pathological condition or procedural effects; and Patient's non-verbal indicators of pain

3. Ongoing assessments will occur throughout the hospital stay and are a routine part of the shift assessment. Physiological and behavioral signs of pain will be considered in addition to the patient's report of discomfort.

4. If pain is present, it is recommended to obtain the following:

Words to describe pain

Intensity of pain (0-10 if possible)

Location of pain

Duration of pain

Aggravating and alleviating factors

5. An appropriate pain scale will be utilized to determine the patient's perceived pain level. The following are suggestions for pain scale use:

6. The Numeric Pain Intensity Scale is used to assess reported pain intensity with adults and older children. Pain is rated on a numerical scale ranging from 0 (no pain) to 10 (worst pain possible).

Management of Patient Pain (Continued)

7. The Wong-Baker picture face scale is used for adults who are not able or desiring to use the numerical scale

8. The PAINAD (Pain Assessment in Advanced Dementia) is used for patients unresponsive, unable to use the 0-10 scale, or with mental impairment (such as those sedated and on ventilators, comatose patients, patients with dementia, and those who are developmentally disabled)

9. Appropriate pharmacological and non-pharmacological interventions will be agreed upon through collaboration with the healthcare providers, patient, and/or family.

10. The healthcare provider will consider the intensity of the pain, the patient's previous experience with pain management, co-morbidities, and recommendations established by the World Health Organization three-step analgesic ladder when selecting pain medications:

- Step 1: Mild pain (pain scale 1-3) : non-opioid medication
- Step 2: Moderate pain (pain scale 4-6): combination of non-opioid and opioid or add an oral opioid
- Step 3: Severe pain (pain scale 7-10): add an opioid with a higher dose/stronger potency.

Management of Patient Pain (Continued)

11. Dosage / Interval Adjustment:

- Always start at the lowest dose and longest interval for mild pain (pain scale 1-3)
- Increase the dosage and/or shorten the interval for moderate pain (pain scale of 4-6)
- Give the maximum dose and/or the shortest interval for severe pain (pain scale of 7-10)
- If the management of pain is not adequate, an additional dose may be given provided that the total of the initial dose and additional dose(s) does not exceed the higher dose range.

12. Patient education will be comprehensive and ongoing. Patient's instruction may include rights to pain management, reporting of pain, options for control, the importance of pain relief and recovery, effects and side effects of available medications, and the effectiveness of pain control measures. Education is documented.

13. Pain assessments will be repeated after an intervention to determine its effectiveness. Degree of relief and/or change in interventions will be documented. Reassessments should be determined at peak times of the route and specific medication. General guidelines for oral are approximately 1 hour and for IM/IV/SQ, approximately 30 minutes.

14. If patients are receiving pain management as part of end-of-life care/AND-C, assessment and monitoring may be less frequent that stated in policies in order to promote this phase of care.

15. Patients/Families will be instructed about pain medications during the discharge process. This will include information about dosing, side effects, treatment of side effects and interactions with other medications and substances.

Sexual Harassment

What is Sexual Harassment?

Sexual harassment is a form of sex discrimination prohibited by federal law under Title VII of the Civil Rights Act of 1964 and under state law by the Texas Commission on Human Rights Act. Both statutes prohibit discrimination in employment based on sex.

The EEOC has adopted a more comprehensive definition of sexual harassment. Under the EEOC's Guidelines on Discrimination Because of Sex, sexual harassment means "unwelcome conduct of a sexual nature" that affects an employee in one of three ways:

1) Submission is made either explicitly a term or condition of that person's employment;
2) Submission to or rejection of the conduct is used as the basis for employment decisions affecting that person; or
3) The person's work performance is interfered with unreasonably or the person is subjected to an intimidating, hostile, or offensive working environment.

The elements of sexual harassment are:

1) unwelcome
2) sexual conduct
3) based on sex
4) that affects a term or condition of employment

What Types of Actionable Sexual Harassment are there Under Federal or State Anti-Discrimination Statutes?

1) Quid pro quo - Literally, "this for that," occurs when an employee is required to consent to unwelcome sexual advances to remain employed or to obtain other job-related benefits, or may be denied such benefits for rejecting the sexual advances.

2) Hostile environment - Arises where an employee is subjected to a working atmosphere involving unwelcome sexual advances, innuendoes, requests for sexual favors, or other conduct of a sexual nature. Such conduct is not linked to a tangible job benefit or economic consequences, but may nonetheless constitute unlawful sexual harassment where the harassment is sufficiently severe or pervasive to alter the conditions of the victim's employment.

3) Preferential treatment: A minority of courts holds that preferential treatment based on a consensual romantic relationship is sexual harassment prohibited by Title VII; the majority of courts reject this view.

Medical Staff Health Policy – Impaired Practitioner

St. David's Medical Center and its affiliated campuses have an impaired practitioner policy in place that applies to all Medical Staff members and Allied Health Professionals. The purpose of this policy is to establish a mechanism for reporting reasonable suspicions that a physician or AHP is impaired. For purposes of this policy, impairment shall include, but not be limited to, substance abuse.

The American Medical Association defines the impaired practitioner as "one who is unable to practice medicine with reasonable skill and safety to patients because of a physical or mental illness, including deterioration through the aging process or loss of motor skill, or excessive use or abuse of drugs including alcohol."

Warning signs of impairment may include, but are not restricted to, perceived problems with judgment or speech, alcohol odor, emotional outbursts, behavior changes and mood swings, diminishment of motor skills, unexplained drowsiness or inattentiveness, progressive lack of attention to personal hygiene, or unexplained frequent illnesses.

The policy is intended to provide guidance and direction on how to proceed when confronted with a potentially impaired physician. Some of these steps include the following.

A. Self-referral to the Department Chairman, CEO, or Medical Director is encouraged.
B. Any suspicion of physician impairment, especially any impairment that would place any patient, employee, or the reputation of the Hospital at risk, must be investigated thoroughly, objectively, and in a manner to protect the reputation of the physician in as great a manner as is possible under the circumstances.
C. Any allegation of impairment that is investigated and substantiated results in immediate action to protect patients, employees and the public.
D. If any individual working in the Hospital has a reasonable suspicion that a physician appointed to the Medical Staff has a possible impairment (situation presents an immediate danger to staff, employees or patients; impairment is obvious), the following steps are taken:
    1. The person in charge of the area immediately contacts the Department Chairman, CEO, and/or Medical Director.
    2. A written report of the reasonable suspicion is made to the Medical Director and President. The report includes a description of the incident(s) that led to the belief that the physician is impaired and is factual. The individual making the report must state the facts leading to the suspicion.
    3. The name of a person who reports a reasonable suspicion will be kept confidential. The identity of the physician seeking referral or referred for assistance will be kept confidential, except as limited by law, ethical obligation or when the health and safety of a patient is threatened.

For more information regarding this policy, please contact the Medical Staff Manager at your primary place of practice.

Disruptive Physician / AHP Policy

As leaders of the delivery of healthcare, the members of the Medical Staff and Allied Health Professional Staff of St. David's Medical Center and its affiliated campuses are expected to conduct themselves in a professional and cooperative manner at all times. All individuals receiving care from the Hospital are to be treated courteously, respectfully, and with dignity. The objective of this policy is to ensure excellent patient care by promoting a safe environment of cooperative and professional behavior.

Clear and concise guidelines provided by this policy will discourage unprofessional and disruptive behavior by the members of the Medical Staff at the Hospital. Alternatively, if a member of the Medical Staff has difficulty with, or is experiencing conflict with, another member, we would encourage him or her to request the assistance of the Administrator on Call and/or a Medical Staff officer to help assist him or her if rapid resolution of the problem seems unlikely.

Disruptive behavior is conduct which adversely impacts the operation of the Hospital, affects the ability of others to get their jobs done, creates a "hostile work environment" for Hospital employees or other individuals working in the Hospital, or begins to interfere with the individual's own ability to practice competently or is inconsistent with the mission, vision, and values of the Hospital.

If there is reasonable suspicion that a medical staff / allied health member at a St. David's Medical Center facility is exhibiting practice patterns or personality traits which could potentially compromise the quality of care provided patients or is exhibiting inappropriate language or behavior in communications with patients, employees, hospital management or other medical staff / allied health members, the matter may be referred to the Department Chief, President of the Medical staff, CEO (or designee).

Any retaliation against the person reporting a concern, whether the specific identity is disclosed or not, will be grounds for immediate referral to the Medical Executive Committee for further action as required

For more information regarding this policy, please contact the Medical Staff Manager at your primary place of practice.

Focused and Ongoing Professional Practice Evaluations

St. David's Medical Center and its affiliated campuses, through Credentialed Medical Staff or Allied Health Professionals that sit on the Peer Review Committee, will conduct ongoing and focused professional practice evaluations, analyzing aggregate data and case findings to identify areas to improve professional competency, practice, and care.

The Focused Professional Practice Evaluation (FPPE) is a time-limited process through which the privilege-specific competence of a practitioner is evaluated. FPPE will be used for: (1) all new Medical Staff or Allied Health Professional appointments; and (2) if a practitioner is granted a new privilege; and (3) evaluate issues discovered during peer review. The indicators to be monitored, methodology of monitoring and time-line for monitoring are dependent upon the recommendations of the Medical Staff based upon the privileges being requested by the independent licensed practitioner, including AHP.

The Ongoing Professional Practice Evaluation (OPPE) is an ongoing program that is reported for each specialty every 8 to 10 months. Information for OPPE may be acquired through periodic chart review, direct observation, monitoring of diagnostic and treatment technique, and discussion with other individuals involved in the care of each patient including consulting physicians, assistants at surgery, nursing, and administrative personnel.

Criteria used in OPPE may include the following:

- Review of operative and other clinical procedures(s) performed and their outcomes;
- Pattern of blood and pharmaceutical usage;
- Requests for tests and procedures;
- Length of stay patterns;
- Morbidity and mortality data;
- Practitioner's use of consultants;
- Incidents or "near misses";
- Sentinel Events;
- Adherence to National Patient Safety Goals; and

St. David's Medical Center and its affiliated campuses and Medical Staff will use the results from OPPE and FPPE evaluations to identify professional practice trends that impact on quality of care and patient safety. Through this process, the Hospital plans to identify opportunities to improve the quality of care provided by individual practitioners, and provide suggested areas for hospital-wide improvement.

The OPPE and FPPE policy is available for review in the Medical Staff Office.

Mandatory Reporting

As per our Medical Staff Bylaws, section 6.5.6, you are required to report any restriction or condition imposed on or probation with respect to your medical license within thirty (30) days of the imposition of such restriction, condition, or probation. Failure to do so shall result in automatic suspension from practicing at St. David's Medical Center and your Medical Staff membership shall be automatically terminated. Please contact the Medical Staff Office at your respective campus to report any restriction, condition, or probation within the 30 day required timeframe.

Physicians Computer Systems

Physician IT Help Desk

Phone: 901-4357 (HELP) Hours: 7:00 a.m. – 6:00 p.m.

Contact the Physician Help Desk to obtain access, schedule training, and report problems.

Downtime Procedure

When electronic information systems are unavailable, downtime procedures will be implemented as per Hospital Policy. Paper forms of all orders and charting documentation are available in these instances.